

The Challenges of Japanese Community Medicine from the Global Health Perspective^{*1}

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Global Health Committee of the Japan Medical Association¹

Introduction

In 2008, when the Toyako G8 Summit took place, the Japan Medical Association (JMA) initiated the Global Health Committee. Since then, activities continued with 2 years as one term. For 2014 and 2015, the 4th Global Health Committee took place.

During the 3rd term, Dr. Yoshitake Yokokura, the JMA President, focused on the topic of “International contribution through the activity of World Medical Association (WMA) and community medicine in Japan.” As a result, JMA played a major role in WMA activities, such as the revision of Declaration of Helsinki. In addition, JMA Junior Doctors Network (JMA-JDN) was established during this time.

On the other hand, a concern was raised whether this involvement of the international activities could contribute to improve community medicine in Japan. For example, how the finding from the Declaration of Helsinki would link with the improvement of community medicine, and how the current contents discussed at the World Health Organization (WHO) would improve the Japanese community medicine. Based on these discussions, the 4th term investigation topic was set as “the challenges of Japanese community medicine from the global health perspective.”

In Japan, discussion about global health problems is not new. For example, the Ebola virus disease in 2015 was a hot topic in Japan. While there was much support for West Africa, Japan took various measures to minimize possible public health risks. In 2016, the Zika virus was the most talked about matter. However, it is

important to note that it is not all infectious diseases that are imported from the developing countries. The United Nations Millennium Development Goals was ended in 2015, and the new initiatives have already been started towards the Sustainable Development Goals in 2016. In the new era of sustainable development, when Japan faces and may continue to face financial difficulties, Japan might utilize better and sustainable health measures used by the countries with limited resources. In order for this to occur, it is important to re-evaluate the value of “local” while paying attention to “global” and make use of lessons learned from “local” successful actions.

For the medical community in Japan, “local” is almost equivalent to the communities in the villages, towns and cities. In Japan where aging and population reduction are taking place, JMA has been aiming at strengthening health care with “adherence to universal coverage by the public health insurance” and “contribution to public health safety policy” as key concepts.

In the recent years, consumption taxes have increased from 5% to 8%. The increased amount of the taxes is supposed to be used for the resources of social security in Japan, and the Medical Care Act and Long-term Care Insurance Act have been revised. In each medical district of each prefecture, it was mandated to create a community health care initiative, and it was required that it should ensure “a system that provides efficient and effective healthcare for the local residents.” The creation of the “Community-based Comprehensive Care system” has been advocated for this reason as well. Now is the time for transforming the healthcare system in Japan. Not a hospital care first. “One

^{*1} This article is based on a report compiled by the JMA's Global Health Committee in March 2016.

¹ The members of the JMA Global Health Committee are listed at the end of the article.

should be able to live where they are used to living for their whole life,” by selecting a “Kakaritsuke physician.*2” There should be a “system that provides efficient and effective healthcare for the local residents”: and it is desired and created in the community.

Then, what does it mean by the “system that provides efficient and effective healthcare for the local residents”? For medical beneficiaries (patients), it might mean for a clinic that is available late night, holidays, and open 24 hours. However, if these were the terms, the doctors will be obliged to overwork. A rotation system may improve the situation slightly. Although the burden on them varies depending on the number of patients during the month, it will become physically impossible when medical doctors get older to work with this system. At this point, teaming up with a doctor from a hospital for assistance is not an option. When a public installation is carried out as the responsibility of a social security, should doctor behave as a public service provider or as a private citizen? When such a system urges doctors to play a role as public service providers, appropriate public support is necessary and citizens should raise awareness about it.

How should the “Community-based Comprehensive Care system” be created? In order to do this, the health care and long-term care needs of each individual must be collected at a community level. There must be a person responsible for a program; he or she tracks for what reason, at what time support is needed, and determines who needs which support by whom. When the Community-based Comprehensive Care system is created, a chief executive to run the whole operation needs to be assigned, something that is not considered at the current status. It is difficult for community medicine to function as an organisation unless we think about the whole community as one facility for all the medical and nursing care.

Although the roles of the ‘local’ have been emphasized in Japan, its roles tend to be overlooked in global health. Under the name of global health, developed countries with much wealth and power have focused on building a

scale-up of the invested programs and evidence building which they can compare globally. They are spreading the belief in “numbers.” They made people believe that numbers are important. To complement the weakness of this current trend, the concept of “Slow Research” was born derived from the Slow Food movement. This is a concept proposed by a medical anthropologist in the US. In this concept, “local” is not just a place, but taken as a means. It is advocating that we should not solely learn from “global,” but also from ‘local actions’ as a means of health care activity, thereby transferring various pieces of knowledge and wisdom obtained from ‘a local action’ to ‘other local actions.’

The expression “viewed from global health” found in the current report topic is possible to interpret as “viewed from health care activities in various local communities in developing countries.”

This document first reports what Japanese community medicine can learn from various health care measures taken in developing countries. These are Ebola virus disease measures, maternal child health handbook, Indonesia local initiatives, environment-improving health activities in developing countries, and the positive deviance approach which pays more attention to successful solutions than problem identification. Next, it reports the activities of the WMA, CMAAO, Takemi Program, and JMA-JDN activities.

Lastly, the future global health activities by the JMA are recommended.

From Global Communities to Japanese Communities

Lessons learned from the outbreak of Ebola Virus Disease

The beginning

A 2-year-old boy who lived in Gueckedou in Guinea died on December 6th, 2013. His mother, older sister, and grandmother followed him. However, no one suspected that their deaths were caused by the Ebola virus.

As of March of 2014, Ebola virus infection has been found among local residents as well as

*2 A kakaritsuke physician is a physician who people can consult on any issues, is well versed in the up-to-date medical information, can refer a patient to a specialist or specialized medical institution when needed, and is a trustworthy and familiar figure with comprehensive capabilities entrusted with community medicine, health, and welfare.

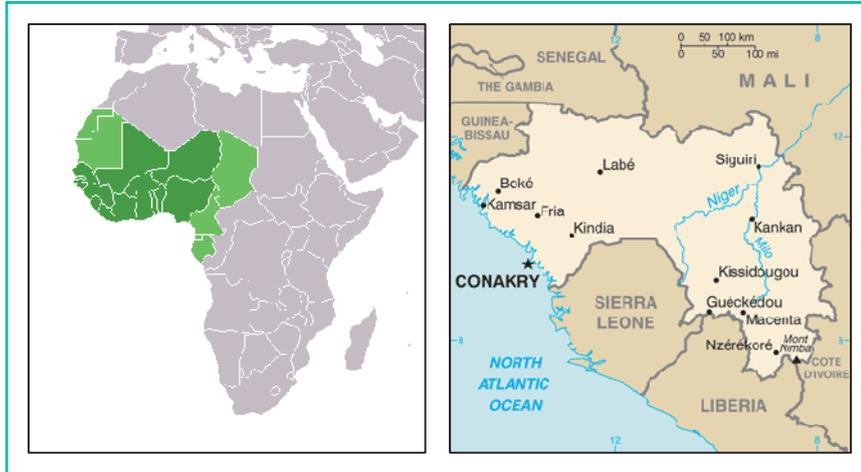


Fig. 1 West Africa (World atlas modified by Yamamoto)

medical service providers, and a few dozens of people died of Ebola virus disease (EVD). Although EVD was uncommon in West Africa, people still believed that the outbreak would be contained soon. However... it spread.

Timeline of the outbreak

2014

Jun 17th

Seven people living in the capital of Liberia died of EVD.

Jun 23rd

Doctors Without Borders (Médecins Sans Frontières; MSF) announced that the situation was out of control.

Jul 27th

Liberia closed its border in order to prevent the virus from spreading.

Jul 31st

Sierra Leone declared a state of emergency.

Aug 6th

Liberia declared a state of emergency.

Aug 8th

The WHO declared a Public Health Emergency of International Concern.

Aug 13th

Guinea declared a state of emergency.

Aug 15th

MSF announced that EVD was spreading faster beyond their control.

Aug 29th

The first EVD patient in Senegal was confirmed positive.

Sep 18th

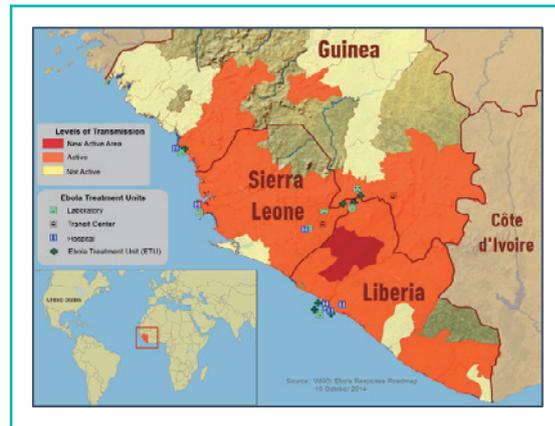


Fig. 2 Ebola response roadmap (WHO, 2014)

The UN Security Council held an emergency meeting and adopted a resolution on public health.

Why did the Ebola virus spread?

There were several reasons. First, Gueckedou, the place where outbreak occurred first, is located in the southern part of Guinea, near border with Liberia and Sierra Leone. Second, the population in that area expanded from 79,140 in 1996 to 221,715 in 2008 because of civil war in Liberia and Sierra Leone, resulting in an influx of refugees. Rapid urbanization, civil war, and other factors caused shortage in local health resources and precipitated people’s distrust for health systems.

There were also other reasons unique to the

areas affected. In these areas, there was a kind of tradition that people expressed their condolences by caressing the dead, which paved the way to an Ebola outbreak. In addition, delay in the early response made the situation worse.

The difficulties of risk assessment

At an early stage of an outbreak, risk assessment is not an easy task. Risk assessment is measured by the equation below:

$$\text{Risk} = \text{Severity of symptom} \times \text{Probability of infection}$$

However, it is often impossible to have a precise count of infected people at the early stage of an outbreak. Local population dynamics change as infection spreads, pathogens may undergo mutation, and epidemiological tools are continuously changing. Therefore, the risk assessment methodology is not yet fully established. Furthermore, an overall picture of an outbreak changes over time. In spite of these facts, we need to respond to outbreaks at a very early stage. Repeated evaluations and feedback are essential for a well-timed necessary response.

What is the Ebola virus?

The natural host of the Ebola virus is the fruit bat. The virus transmits from bats or other primates to humans. This virus was first found in Sudan (present: South Sudan) in June of 1976. A watchman suddenly developed a high fever of 39 degrees Celsius with headache and abdominal pain and received treatment. He later died of severe bleeding from the nose and intestine. Next to him, 2 others developed symptoms. Infection spread through blood or medical equipment. The number of people who were infected and died were 284 and 151, respectively. Later on, in West Africa, more than 10 Ebola outbreaks occurred. However, the outbreak in 2014 was different in the magnitude from previous outbreaks. Although it is a Public Health Emergency of International Concern, Japan's contribution was limited. A bitter regret!

The way forward

Upon this situation, the Government of Japan made an important decision on the development of human resources related to international infectious disease emergency. The Early Response and Emergency Relief Team was to be established in the Japan Medical Team for Disaster Relief. It is composed of 500 rosters.

Lessons learned from Ebola Virus Disease Preparedness: Part 2

Ebola virus disease

Ebola, previously known as Ebola hemorrhagic fever, is an acute viral hemorrhagic disease caused by infection with *Ebolavirus* and characterized by its high fatality rate. There is no standard treatment for this disease, and supportive care is considered as the best intervention. The disease is now referred to as EVD because patients do not necessarily exhibit hemorrhage as a symptom.

The past outbreaks of EVD

EVD was initially identified in 1976 in two simultaneous outbreaks, one in Nzara and the other in Yambuku in Sudan. Yambuku is a village near the Ebola River, from which the disease takes its name. EVD outbreaks have occurred intermittently in tropical regions of sub-Saharan Africa. The WHO reports that between 1976 and 2013 there were 24 outbreaks involving 1,716 cases in total. Most outbreaks were of brief duration, and were contained before spreading beyond limited regions. However, the outbreak in 2014-2015 was quite different from those in the past; it spread to the United States and Europe. The death toll was 28,639 as of February 2016, making it the largest outbreak in the history of EVD.

The EVD of 2014-2015 expanded from a small village in Guinea to Liberia, Sierra Leone, Nigeria, Senegal, and Mali. Foreign health care workers who were involved in the EVD response were also infected. Moreover, new cases occurred through secondary infection in the United States, Spain, and the United Kingdom. On August 8, 2014, as EVD continued to spread, the WHO declared the outbreak a public health emergency. In May 2015, the WHO finally declared that the outbreak was over.

Favipiravir (AVIGAN®), a new antiviral medication

Favipiravir, or AVIGAN®, is a new antiviral medication developed by Fuji Film Company and Toyama Chemical that is effective against viral infectious diseases such as avian influenza and EVD. It is a pyrazinecarboxamide derivative and works by interrupting the transcription of many RNA viruses. In animal experiments, favipiravir was shown to be effective against influenza viruses, West Nile virus, yellow fever virus, and foot-and-mouth disease virus, as well

as other flaviviruses including arena viruses, bunya viruses, and alpha viruses. Favipiravir does not inhibit the RNA activity involved in DNA synthesis in mammalian cells, and is therefore not toxic to the host. In addition, favipiravir has shown effectiveness against the Ebola virus in several laboratory studies. Favipiravir might be useful in treating EVD even in pandemics, although no solid clinical trial has been performed yet.

On March 26, 2014, the Japanese Ministry of Health, Labor and Welfare (MHLW) conditionally approved favipiravir by considering the potential emergence of anti-viral medication-resistant influenza. The conditions however, were very strict. First, there needed to be more evidence of clinical effectiveness in humans. Second, because of the teratogenicity and embryotoxicity demonstrated in animal testing, favipiravir was to be produced and administered to patients only after a decision by the MHLW to use favipiravir during an outbreak of anti-viral medication-resistant influenza. This meant that, without the government's permission, favipiravir could not be manufactured or stocked in Japan. Such strict requirements posed a great challenge for Fuji Film Company and Toyama Chemical. Several international agencies have shown strong interest in the possibility of developing favipiravir, but both companies hoped to contribute to the patient welfare in Japan.

Involvement of the JMA

Being placed in a difficult position, Fuji Film Company and Toyama Chemical consulted the JMA. The JMA confirmed the effectiveness of favipiravir and that this medication could be one of the final solutions for an outbreak of anti-viral medication-resistant influenza or EVD. Also, favipiravir had the potential to save patients' lives around the world and contribute to global health.

Doctors have medical discretion in clinical decision-making. After considering several factors including scientific evidence, the advantages and disadvantages of possible treatments, and the patient relationship, doctors select the best treatment option for each patient. The strict restrictions on favipiravir production can compromise doctors' medical discretion. The JMA hoped to overcome this difficulty.

Favipiravir and EVD

EVD is listed in the Act on Prevention of

Infectious Diseases and Medical Care for Patients with Infections in Japan, which came into effect in 1999, and is categorized as a Category 1 infectious disease (Category 1 Disease) along with other viral hemorrhagic fevers, plague, and smallpox. Therefore, EVD patients should be treated at one of the designated and specified infectious disease hospitals (Specified Hospitals) and Class 1 Infectious Disease Hospitals (Class 1 Hospitals). However, high-risk patients with fever and a travel history to/from West Africa might go to ordinary clinics or community hospitals for initial consultation. The JMA recognized this potential and collaborated with the public health department.

Additionally, because of possible teratogenicity and embryotoxicity, special attention should be paid when treating women, especially pregnant women. It is not socially or ethically easy to administer a medication with a known side effect to a patient, even when the patient's condition is critical. On the other hand, the loss of both a pregnant woman and her fetus because of a delay in treatment should be prevented. In medical education and in practice, how to prioritize the life of a mother and that of a fetus is an ethical issue for doctors in the clinical setting. There is no one definitive answer, but saving mothers is often considered as the first priority.

In October 2015, the WMA adopted the Resolution on Ebola Viral Disease, which supports the use of medication not authorized by governments when the Paragraph 37 of the WMA Declaration of Helsinki is followed. Paragraph 37 states:

Unproven Interventions in Clinical Practice
37. In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available. <WMA Declaration of Helsinki (revised in 2013), Paragraph 37>

As of October 21, 2014, no drug is proven effective against EVD. Since this represents an international crisis, using a new medication such as favipiravir against EVD would be acceptable if Paragraph 37 of the Declaration of Helsinki (rev. 2013) is respected along with other WMA resolutions that include EVD.

Use of favipiravir by France

With the support of the Japanese government, Fuji Film Company and Toyama Chemical provided favipiravir to France, which was treating EVD patients in Guinea. The clinical study, named the JIKI study (JIKI means “hope” in the local language), was led by Dr. Denis Malvy of l’Institut national de la santé et de la recherche médicale (Inserm). Usually, a clinical trial is conducted as a double-blind randomized study to reduce bias; however, it was considered unethical to use a placebo in such a critical situation. Dr. Malvy also decided against a randomized controlled trial and instead designed a study where all participants would receive the same high-dose favipiravir treatment. In low-income countries like Guinea and Liberia, it is not easy for patients in remote areas to visit clinics in towns, both geographically and financially. Dr. Malvy and his colleagues pursued a difficult treatment plan in a high-risk environment and later published a paper to demonstrate the effectiveness of favipiravir against EVD. The study results indicated that patients with lower virus loads and no multiple organ dysfunction had a lower mortality rate, and that treatment delays led to poor outcomes.

Lessons from the 2014-2015 EVD outbreak

In the EVD outbreak of 2014-2015, Japan contributed to a global health emergency by using favipiravir. A drug invented by Japanese pharmaceutical companies saved lives in distant parts of the world. This was a breakthrough for Japan. The next step would be healthcare workers from Japan working locally to treat patients. Research and development efforts should also continue. Another EVD outbreak can occur in the future, and there are other infectious diseases globally with no solid treatment options. The lessons learned from the 2014-2015 EVD outbreak will give us great leverage in future disease control.

Lessons learned without borders: Reverse-imported Maternal and Child Health (MCH) Handbook after its evolution in developing countries

The origin of the Maternal and Child Health (MCH) Handbook is Japan

The MCH Handbook is a home-based record book that contains essential information kept by the family, to promote and maintain the health of mothers and children. In 1948, the first version of the MCH Handbook was distributed by the Ministry of Health and Welfare, Japan. The MCH Handbook consists of records of pregnancy, delivery, and child development and health information on mothers and child-rearing. Now, obstetricians, pediatricians, public health nurses, and midwives write down medical records in the MCH Handbooks. Parents bring in their MCH Handbooks to clinics when their children get sick. The coverage is almost 100% in Japan.

Japan’s infant mortality rate (IMR) has shown a drastic decrease from 76 per 1,000 live births in 1947 to 2.1 in 2014. This is one of the lowest IMRs in the world. The life expectancy at birth as of 2014 was 86.8 years for women and 80.5 for men.

A joint Japanese and American research team investigated the reasons why the IMR in Japan was so low. The team concluded that there were five possible explanations for Japan’s low IMR, one of which was the use of the MCH Handbook. Japan’s experience is different from that of many countries. However, it is certain that the MCH Handbook program is just as important in ensuring the quality of life of mothers and children.

MCH Handbook around the world

Now, an MCH Handbook program is being introduced in more than 30 countries including African countries. An MCH Handbook program based on the needs of mothers and children is the most effective when many health professionals and health care workers are actively involved in one’s care and when a sufficient health care delivery system exists. The contents of the handbook should be appropriate for the community. When there are many non-literate parents, many pictures and figures should be added. The basic concept of the MCH Handbook is very similar in many countries. However, the content, colors, pictures, and illustrations in the various handbooks are quite diverse, because each country

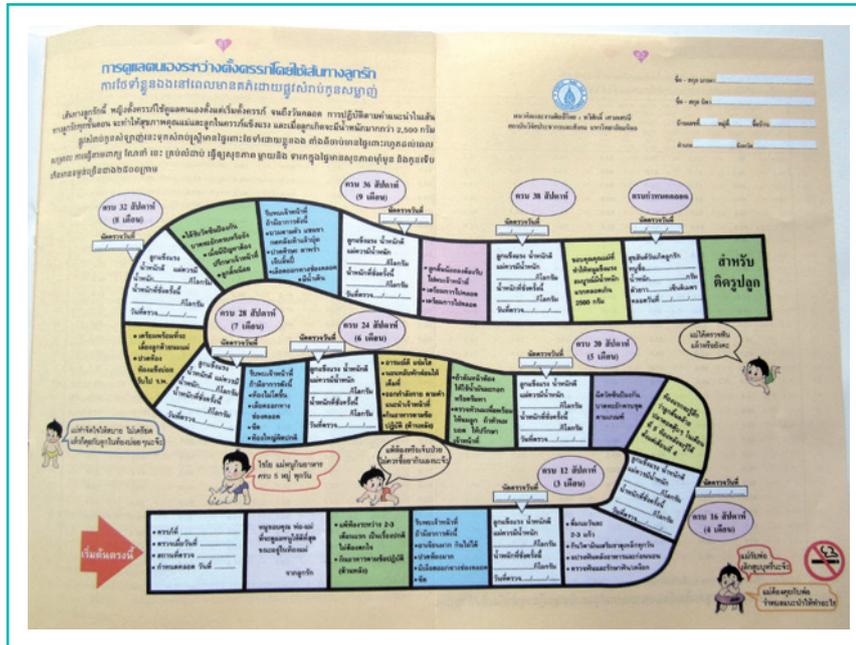


Fig. 3 The MCH Handbook in Thailand is very attractive with many illustrations.

has its own unique cultures and customs.

The 9th International Conference on MCH Handbook was held by the Ministry of Public Health of the Republic of Cameroon and the International Committee on the MCH Handbook on September of 2015 in Yaoundé, Cameroon. Over 250 participants from 20 countries gathered under the theme “Effective Use of the MCH Handbook: A Tool to Continue Progress for MDGs 4 and 5 beyond 2015.” The official opening of the conference was attended by 8 ministers, including the Cameroonian Minister of Public Health and the Minister of Women’s Affairs.

The conference was conducted in English and French, official languages of Cameroon, securing equal participation of both English- and French-speaking countries. Many health professionals in African countries stated that the MCH Handbook is a miracle tool to ensure the continuum of care for maternal, newborn, and child health.

What Japan can learn from the experience of developing countries

In developing countries, many health records and educational materials have been published, such as pregnancy examination records, child

growth charts, immunization cards, and many beautiful posters and pamphlets for the health education of mothers and children. When their MCH Handbooks were first developed, these existing materials and records were utilized in their MCH Handbooks. The keyword is “user-friendly” for the MCH Handbooks with many descriptive pictures and illustrations and fewer explanatory sentences. The idea of a user-friendly MCH Handbook should also be imported to Japan, because young mothers in Japan prefer pictures and illustrations over written documents.

The 10th International Conference on the MCH Handbook will be held in Tokyo from November 23 to 25, 2016. The theme for the conference is “Leave No One Behind.” It will enhance the use of the MCH Handbook in the delivery of MCH services to disadvantaged groups, including the poor, the disabled, migrants, refugees, and other minority groups.

I hope the conference will give an opportunity to share the lessons learned regarding the MCH Handbook beyond the borders between Japan and many other countries.

Local initiatives based on trust

There is little to learn from less disaster-prepared countries.

Being one of the most disaster-prepared countries in the world, there is little for Japan to learn from less prepared countries. Why? The greatest reason is that many of those less-prepared countries were colonies until 60 or 70 years ago, and their suzerain states were never serious about taking measures against natural disaster to protect colonial residents. For example, the director of the Association of Medical Doctors of ASIA (AMDA) Indonesia Branch sarcastically describes his nation as being a department store of disasters; He is the first Muslim person who became a physician after Indonesia became independent because the Netherlands had never allowed a non-Christian to become a physician.

Lessons from local initiatives

The AMDA Indonesia Branch director is a descendant of the sultan of the South Sulawesi Island. A sultan is a Muslim political leader. As mentioned earlier, there is little that Japan can learn from a country that is less prepared against disaster; however, Dr. Shigeru Suganami, President of AMDA, personally learned a great deal from him. Above all of these lessons, “local initiative” comes at the top of the list—meaning that we should respect the initiatives of those who are familiar with local situations. Local initiatives are based on trust from local people. A local initiative cannot exist without people’s trust. In an extreme expression, “If you are mistakenly sent to hell, I will go to hell with you; if you are to go to heaven, I will go to heaven, too.”

On December 26, 2004, a mega-earthquake hit the coast of the Sumatra Island followed by a giant tsunami. This disaster resulted in an enormous number of disaster victims with nearly 230 thousand deaths. The Indonesian government issued an order prohibiting medical teams from abroad from entering the regions where the Aceh independence movement was active.

Then, as unbelievable as it may be, the director of the AMDA Indonesia Branch said, “The sultan of the South Sulawesi Island married the sultan of the Aceh about 100 years ago, and the people in the Aceh independence movement will welcome us as their family.” Surprisingly, he was right, and AMDA medical teams were welcomed. The areas of the Aceh independence movement had also suffered extensive damage. Naturally,

our medical teams started making a round of visits. We asked local people what they wanted to help with their reconstruction. They requested a meeting place. Their mosque, which served as their spiritual anchor, had collapsed due to the disaster. The building was reconstructed as an AMDA community center.

Similar experiences in Japan

On March 11, 2011, the Great East Japan Earthquake occurred. Dr. Suganami went through a similar experience. Professor Taro Yamamoto of the Nagasaki University Institute of Tropical Medicine and Dr. Suganami entered Kamaishi City and Otsuchi Town, which were damaged by the disaster. Neither of them had ever been to these areas. A female physician who was originally from Kamaishi City and a nurse from Otsuchi Town were with them, serving as both local navigators and assistants as we all stayed in a shelter and provided medical care. Without their support, medical teams from both AMDA and Nagasaki University would have been unable to work so promptly. Their motivation for joining the AMDA medical teams was pure and simple; they were hoping to go back home and learn about the whereabouts of their families by joining the AMDA’s medical relief activities.

Disaster management proposal for the Nankai Trough earthquake and tsunami

In order to prepare against the Nankai Trough earthquake and tsunami that are bound to occur in the near future, AMDA is in the process of establishing a disaster management platform based on the agreement with the Governors of Kochi and Tokushima. More than 40 physicians originally from Tokushima Prefecture are registered in Kawasaki Medical School, Okayama. The key players of the AMDA Nankai Trough Disaster Management Platform in Tokushima Prefecture will be the Kawasaki Medical School graduates. We asked Mr. Seiji Kawasaki, Chief Director of Kawasaki Medical School, to send physicians who are from Tokushima Prefecture. Because Kawasaki Medical School also has many physicians who are from Kochi Prefecture, Chief Director Kawasaki decided to involve Kochi Prefecture as well, and a 4-party agreement, among Kawasaki Medical School, AMDA, Kochi Prefecture, and Tokushima Prefecture, was swiftly realized.

The following is a proposal. Medical schools and institutions across Japan have many medical

staff who have some kinds of bonds with the regions that will be affected by the Nankai Trough earthquake and tsunami. Why not establish a dispatch program with a priority to send these people to their hometowns? The dispatched medical staff will have the joy of being able to contribute to the local people of their hometown and their families. The local people will have a pleasure of being cared for by familiar physicians and nurses in their time of despair. Local medical institutions and governments will take comfort in having support available from outside the affected areas. Without joy, nothing can be done appropriately.

So who will bear the cost of dispatching medical staff? Of course, the national government. One month will suffice as a period of compensation. Without compensation, those who manage medical institutions with strong Hippocratic spirit will have to suffer. The most important thing is having local exchanges among governments, medical associations, and medical institutions before a Nankai Trough disaster strikes. This is especially true for local governments because *regulations at normal times become the greatest obstacle in times of emergency*. This is the secret of secrets of local initiatives in Japan because Japan is a leading constitutional state in the world and because Japan is a bureaucratic nation with the least level of corruption in the world. The cornerstone of the AMDA Nankai Trough Disaster Management Platform lies in the extensive collaboration of local governments across 4 prefectures.

The essential element of local initiatives in Japan will be the local medical associations. Dr. Suganami has served as the president of the Otsu Medical Association of Okayama Prefecture for 2 years (plus 4 years as the vice-president), so he understands it very well. It is hoped that this concept of local initiatives that was learned in disaster medicine relief in Asia will be useful in the upcoming Nankai Trough earthquake and tsunami.

Lessons from the world: To overcome new public health crises

Current health issues in Japan

Japan is sometimes referred to as having a good example of universal health coverage among developing countries as it was the country that achieved universal health insurance coverage in

the early post-war period when Japan was not rich enough to achieve it. However, the current Japanese healthcare system also has many issues to overcome. Specifically, a rapid increase in aged and impoverished populations challenges the sustainability of the Japanese health and welfare systems. An increase in nuclear families and live-alone households has weakened the informal local safety net stemming from community solidarity. Consequently, new social issues such as “the unattended death” or “lonely death” and the expansion of health disparities have emerged.

These social trends may explain the unsatisfactory achievement of the Health Japan 21 (*Kenko Nippon 21*), the government-initiated nationwide health promotion movement since 2001. Less than 20% of all goals have been achieved, because the individuals who have strong chronic social stresses are less likely to start and continue healthy activities with their own reflective intents. Upon reflecting on the poor achievement of the movement, the new stage of the movement, called the Health Japan 21 the Second Term, set “the reduction of health disparity” as one of its primary and ultimate targets in addition to the expansion of healthy life longevity. To achieve these targets, its primary strategy focuses not only on individuals but also on the social environment.

The population strategy targeting social environment is strongly recommended by the 2008 Final Report of the WHO’s Commission on Social Determinants of Health headed by Sir Michael Marmot, the current president of the WMA. However, effective experiences and know-how are not sufficient in Japan, and no remarkable achievements have been observed so far.

Successful cases from developing countries

There are many impoverished people in low- and middle-income countries, and it is unrealistic to expect that many of those people will give priority to having better health over more attractive choices. This means that what Japan needs—good examples of health promotion and life-benefiting activities—in fact exists in those countries. Although health problems may be different among countries, there should be great opportunities for lessons for Japan from developing countries.

Here are some examples. Financial management is difficult for many socially vulnerable

people. Simply providing cash may not be effective as some may use the cash for gambling, drinking, and so on. There is a good solution for this in Mexico: conditional cash transfer. Under the system, cash is provided for impoverished people under a series of conditions. Those conditions include making their children attend school, buying necessary nutritious foods. Conditional cash transfer could be applied for Japan.

Microcredit is another good strategy of social welfare. This Nobel-awarded, group-based non-collateral small-amount loan system has had tremendous success all over the world and could be applied in Japan, too. Microcredit is especially important as it could lead to the strengthening of community solidarity and social capital, which is a key target of Health Japan 21 the Second Term.

The positive deviance approach is another applicable scheme, which has attracted many global health communities as a promising approach to health promotion in the context of limited resources. In this approach, people find the successful cases despite the difficult contexts, analyze them, and apply them for all remaining people. Good examples include a nutritional program in famine incidences and malaria prevention. In Japan, a positive deviance approach could be used for the cases that suffer from serious resource shortages, e.g., long-term care prevention in some depopulated areas and sanitation management in disaster evacuation sites.

The Hope Soap Project in South Africa is a new and unique health promotion idea. An NGO has long committed to preventing gastrointestinal infections among children in this region; however, some children have less access to health education opportunities. For such children, the NGO started to provide soaps with small toys inside. To get those toys out, children start washing their hands heavily using the toy-in soaps, resulting in the 70% reduction in gastrointestinal infections. Because of the toys, children can unconsciously change their health behavior and get clean hands, not because they care for their own health but simply because they want to have a toy. This concept of behavioral modification by “being healthy unconsciously” could be a great lesson for Japan, where the number of people who ignore their own health is increasing.

Lessons from developing countries: application

The important thing we should capture from these excellent examples is that these activities could only be achieved with close collaborations of multiple sectors and players, including education, employment, and financing. This cross-disciplinary collaboration evokes Japan’s current concept of “Community-based Comprehensive Care” in which close collaborations between governmental and private service agencies are required. Physicians, long-term-care service providers, community-building consultants, and many other organizations should participate in a new healthcare scheme. All of the examples mentioned above are great examples of such cross-disciplinary collaborations. Many healthcare activities in Japan are often vertically segmented with little cross-disciplinary interaction. We should learn more from these examples of other countries worldwide.

Some proposals for the Japan Medical Association

These important lessons from all over the world present some suggestions for the future activities of the JMA. First, the JMA should increase the opportunities for its members and clinicians to learn more about global health and local public health activities. This should work to increase collaboration between JMA members, clinicians, and community public health practitioners more effectively. The opportunities to mutually learn regional/local good practices among communities will be also effective. Those activities should also have an international environment. For example, it would benefit both Japan and other countries to mutually learn about good regional/local examples from each other under collaboration with the WMA. The attitude of “mutual leaning” is essential in conquering Japan’s current health crises and contributing to the world.

Positive deviance approach

Within many of the communities and organizations, there are individuals and groups who take different but positive actions. These individuals face the same problems as the rest of the people, but solve the problems in better ways. These individuals are called “Positive Deviant,” and the action is called “Positive Deviance.” Here, such actions and people will be collectively referred to as PosDev.

In the 1990s, there was an attempt to increase

the PosDev during the undernutrition crisis in Vietnam. ‘Save the Children USA’ and Vietnam National Institute of Nutrition were the first to conduct such a measure. First, the nutritional surveys were conducted in four villages. Of three hundred 3-year-old children and below, 64% were suffering from undernutrition, mainly in low body weight. Usually, experts of nutrition and health look at these numbers. Then, they would first investigate the 64% of the children in detail to figure out the root cause and come up with solutions. However, since time and budget were limited, instead of directly tackling with the solution, the practitioners in charge of the matter decided to focus on the remaining 36% of children that were not suffering from undernutrition. Setting aside the children of the village leaders and influential members, they examined the reason of their PosDev who were in a good nutrition condition, despite them being poor like the rest of the population.

As a result, three features in PosDev were identified. First, the parents of the PosDev brought back small crabs and shrimps from the field for their children to eat. All of them were free. Second, each time the children would touch something dirty, the parent would wash the children’s hands regardless of how many times it takes. The third feature was that these children would eat four to five meals a day, with the help of other family members while the parents were out to work, whereas, children in a typical family would only have two meals a day.

The next step was to make these PosDev actions a routine so a two-week workshop was conducted. The targets were now the mothers of the children who fell in the 64% (ones who have undernutrition children). The families were instructed to practice the three aforementioned PosDev features, and the weights of the children were measured at the end of the two weeks. They were asked to continue to take these actions even after returning home. As a result, two years later, 85% of the children suffering from undernutrition improved their health. This PosDev approach was then implemented on 250 villages, and the health of 50,000 children were improved after seven years.

This approach was later spread to 55 countries across the world. It has also been used for nosocomial infection control of MRSA infection in the United States, infant mortality improve-

ment in Pakistan, obesity measures in various countries, and nutritional measures for pregnant women.

PosDev approach is effective as a means particularly to overcome behavioral changes, especially nutritional problems and health problems. It is the most effective in bringing changes to chronic issues and habits. In addition, this approach focuses on the assets (advantages) than the needs (disadvantages, shortcomings). Experts tend to focus on the weakness of the target area and have strong wills to solve the problem. However, by focusing on the assets, it is possible for the demand side and the supply side to be active in healthcare services in a sustainable manner.

In Japan, similar actions are already on-going without using the name of PosDev. For example, when investigating suicide, experts tend to look at the areas in which suicide is prevalent and examine the reasons for these behaviors. However, Ms. Mayumi Oka from Wakayama Prefectural Medical University has investigated the lowest suicide rate region, Kaifu-cho, Tokushima Prefecture, over 4 years. She examined the reasons why this area pertained low suicide rates. Although it is difficult to say how to define features for the PosDev, she came to figure out a number of characteristics from interviews with local residents.

1. In Kaifu-cho, there is little red feather fundraising. The elderly participant rate is low for senior clubs. They value the participation of different types of people.
2. They emphasize “problem solving skills,” when nominating town leaders. They do not require educational background, but it is a people-oriented principle.
3. There are not many people who think that people like themselves cannot influence the government decisions. They do not belittle themselves.
4. When feeling ill or worried, people take action towards early consultation, thinking that someone would help them. There are many people who answered that they do not feel embarrassment when they ask for help or advice when they are worried. In Kaifu-cho, such a way of thinking is referred to as “submit disease to city.”
5. Not many residents answered that they have everyday cooperative relationships with their

neighbors. However, many replied that they do have casual run-ins with their neighbors or greet their neighbors regularly. They value on relatively loose bond among themselves.

These features are not ones that can be apparent after a two-week research, such as the PosDev study in Vietnam. Investigating local advantages, that is, suicide from a less prevalent area, rather than comparing with a prevalent area, is very similar to the PosDev approach. This approach has a lot of potential to be applicable effectively in local societies in the Japanese aging and population-declining society.

Activity Reports of the WMA and CMAAO

The activities of the WMA and the Confederation of Medical Associations in Asia and Oceania (CMAAO) during the 4th period of the Global Health Committee revolved around international contribution in healthcare through introducing various healthcare challenges that the JMA has been working for. The list below is a summary.

1. Improved the WMA's presence by the success of the WMA Tokyo Council Sessions
2. Made suggestions for the Trans-Atlantic Trade and Investment Partnership (TTIP) negotiations, referencing to our request to uphold Japan's universal health insurance system in the TPP framework and our accomplishment from the negotiations with the government
3. Successful zoonosis management under "One Health" by the World Veterinary Association (WVA) and WMA
4. Collaborated with the WHO Western Pacific Regional Office (WPRO) in CMAAO activities
5. Responded to the request for aid from the Myanmar government
6. Dispatched a medical assistance team for the colored powder accident in Taiwan
7. Disaster relief (e.g., mega-earthquake in Nepal)

As illustrated in this list, introducing our experiences in Japan to overseas areas and responding to requests for aid from other nations were steadily carried out. The following describes the details of some representative activities.

WMA activities

In April of 2014, the WMA Tokyo Council Session was held with about 250 people from 40

countries; the Prime Minister Abe; the then Minister Tamura of Health, Labour and Welfare; and the Vice Governor Ando of Tokyo Metropolitan Government were present as the guests of honor at the opening. The Japan Medical Association Junior Doctors Network (JMA-JDN) also held their JDN meeting concurrently. The 3-day meeting was successfully completed, and Dr. Kloiber, the WMA's Secretary General, expressed high appreciation. The WMA's presence was greatly improved through the collaboration and strong influence of the national government, public administration, municipal governments, and JMA; we could say that the meeting was held in the ideal manner for the WMA.

In October of the same year, the WMA Durban General Assembly was held in the Republic of South Africa. This meeting was held in Africa while the Ebola virus fever was still on the rampage after it had spread from West African countries such as Guinea, Liberia, and Sierra Leone. There was a sense of urgency in the meetings as the Doctors Without Borders (Médicins San Frontières) had just released a report concerning their medical activities in the infected regions. The General Assembly adopted the WMA Resolution on Ebola Viral Disease, which recommends prompt provision of personal protective equipment and sufficient training to reduce the risk of cross-infection, as well as the WMA Resolution on Unproven Therapy and the Ebola Virus, which urges physicians to conform to the Declaration of Helsinki Article 37 when treating the Ebola virus disease.

In November of 2014, a commemorative ceremony was held in Helsinki, Finland, to mark the 50th anniversary of the WMA Declaration of Helsinki. The WMA Declaration of Helsinki is the most important guidelines that stipulate the ethical principles in medical research involving humans as study subjects, including those studies that use test agents and data that are identifiable as the human-origin. Since its adoption in June of 1964 at the WMA Helsinki General Assembly, it has undergone several amendments as medicine advances and healthcare changes. The latest version was adopted in October of 2013 at the Fortaleza General Assembly in Brazil. Also, in November, the WMA held the H20 International Health Summit in Melbourne, Australia, as the G20

Summit was concurrently held.

In April of 2015, the WMA Oslo Council Session was held in Norway. In deliberation, the WMA Proposed Statement on Trade Agreements and Public Health, which urges countries to secure stable healthcare provisions under the TPP and TTIP, was adopted as the Council Resolution.

In May of the same year, the Global Conference on One Health Concept co-hosted by the WVA and WMA was held in Madrid, Spain. In October of 2012, the WVA and WMA had signed a memorandum of understanding with the aim of mutual cooperation of veterinarians and physicians under the concept of One Health in order to promote the concept. In response, the JMA and Japan Veterinary Medical Association signed an agreement concerning the promotion of academic collaboration in November of 2013, and medical and veterinary associations in 31 municipalities subsequently have signed similar agreements.

In October of 2015, the WMA Moscow General Assembly was held in Russia, and Sir Michael Marmot (UK) was inaugurated as a new WMA president. The General Assembly adopted 3 emergency resolutions including the health problem of the Syrian refugees. Dr. Yoshitake Yokokura, the JMA President, explained the JMA's efforts to the Japanese government regarding its TPP negotiations and stated that the JMA was successful in having the government include a statement that assures the universal health insurance in the Overview of TPP Agreement released by the Cabinet Secretariat. He urged the WMA to make necessary recommendations to protect people's health and closely observe to avoid letting the Investor-State Dispute Settlement procedures and ratchet clauses damage the healthcare systems of different nations. In the public debate session, Dr. Yokokura also invited the audience to aid the revitalization project for the Tree of Hippocrates, which is dying on the Kos Island in Greece. He also talked to the Kazakhstan Medical Association about cooperation on radiation medicine.

CMAAO activities

In September of 2014, the CMAAO Manila General Assembly was held in the Philippines. During the stay, the JMA visited Dr. Takeshi

Kasai, WPRO Director of Program Management, and they exchanged opinions and discussed regional information on infectious diseases, Ebola hemorrhagic fever, and dengue fever. Dr. Jose Asa Sabili, a former president of the Philippines Medical Association, was inaugurated as the new president. The council decided to establish a fund for disaster relief for the member national medical associations. The symposium was held with a theme of "Health Database in an Information Society." The Indian Medical Association reported serious problems of multi-drug resistant bacteria and a re-emerging outbreak of tuberculosis in developing countries, and a WHO staff member from the WPRO Stop Tuberculosis Unit and Leprosy Elimination Team was invited to describe the current status of the diseases and management options. At the end of the general assembly, the CMAAO Resolution on Ethical Frameworks for Health Databases and Human Genetic Databases was adopted.

In September of 2015, the CMAAO Myanmar General Assembly was held in Yangon. The symposium was also held at the same venue with the theme "Ensuring Food Safety: An Important Challenge Today." Professor Rai Mra, the president of the Myanmar Medical Association, was inaugurated as a new CMAAO president. In the discussion of the proposed resolution on food safety, Dr. Yokokura stated that securing safe water should take priority over food safety; the council unanimously agreed to incorporate this statement in the preamble, and the CMAAO Resolution on Ensuring Food Safety was adopted. In addition, the JMA came forward to host the 32nd CMAAO General Assembly in 2017 and was approved by the council.

Request for aid from the Myanmar government

Dr. Thein Thein Htay, the Myanmar Deputy Minister of Health, asked Dr. Yokokura for the JMA's assistance in the future of Myanmar healthcare, and a meeting was held during the CMAAO sessions. Deputy Minister requested assistance in 2 areas: one concerning making efforts and preparing for disaster medicine and the other concerning the introduction of a universal health insurance system.

Myanmar has been attempting to promote disaster medicine preparedness as the collabo-

rated efforts of the Ministry of Health (MOH), other ministries and agencies, and municipal governments, making efforts in human resource development. At present, however, there is a limit as to how far the MOH can manage all those efforts. The MOH intends to improve their disaster management capacity not only at the national government level but also at various local levels, and they hoped that Japan could assist them in developing their capacity building and training programs.

As for the introduction of universal health insurance, Myanmar has been trying to improve the accessibility to healthcare and quality of health of the public as a part of the reform agenda aiming to raise the overall level of social and economic growth. The then Myanmar President Thein Sein was promoting the reconstruction of healthcare sectors so that all citizens would have access to healthcare toward establishing a public health insurance system. The government developed various activities to achieve universal health insurance by expanding the existing healthcare programs. However, international procurement has not been possible due to the frameworks of supply chains for medical supplies and devices and management. Myanmar also needs a capacity building of healthcare staff to cope with international procurement.

The JMA expressed an intention to assist the introduction of universal health insurance and capacity building of healthcare staff in Myanmar from now on as a part of the JMA's international contribution in healthcare.

As for preparing disaster medicine programs, the Disaster Medical Assistance Team (DMAT) program, whose team members are physicians of large hospitals designated as the acute-phase disaster management institutions by the government to manage an acute phase of a disaster, and the Japan Medical Association Team (JMAT) program, which handles the post-acute phase, were introduced. The JMA suggested that the Myanmar MOH may be able to consult with the Japan Ministry of Health, Labour and Welfare (MHLW), which manages the DMAT program, for assistance in capacity building and other specific issues.

This meeting gave us hope that the JMA and the Myanmar Medical Association as well as the Japan MHLW and the Myanmar MOH will

develop good relationships in both governmental and non-governmental sectors as we all work to realize the 2 healthcare targets of Myanmar.

The signing of the Agreements Between the JMA and the National Medical Associations Concerning Mutual Consent on Dispatching Physicians and Assistance Systems for Medical Relief Assistance in Disaster Situations

There was a colored-power explosion accident in a theme park in Taiwan on June 27, 2015, resulting in many young patients who were severely burned. Japanese burn experts were asked to assist in their care using donated artificial skins and medical supplies in July. Upon receiving requests for assistance from the Taiwan Medical Association and other parties, the JMA dispatched 6 burn experts recommended by the Japanese Society of Intensive Care Medicine, Japan Association for Acute Medicine, and Japanese Society for Burn Injuries as the JMA's "Joint Burn Care Assistance Team of Physicians by Three Medical Societies."

This accident led to further promoting civilian-based international cooperation in disaster medicine and relief efforts, and the JMA signed the Agreements Between the JMA and the National Medical Associations Concerning Mutual Consent on Dispatching Physicians and Assistance Systems for Medical Relief Assistance in Disaster Situations, with the Taiwan Medical Association and Taiwan Root Medical Peace Corps (a non-government organization in Taiwan for international disaster medicine assistance), respectively.

Takemi Program in International Health at the Harvard T.H. Chan School of Public Health

The JMA delegates visited Boston, USA, in June of 2015. During the visit, they were introduced to Associate Professor Jesse Boardman Bump (the 2010-2011 Takemi Fellow, USA) who was appointed as a new secretary-general of the Takemi Program in lieu of Professor Michael R. Reich, a directing professor of the program for many years, who would be on sabbatical for a year starting September of 2015. They also met Dean Julio Frenk and exchanged opinions on the evaluation and future framework of the Takemi Program and the successor of Professor

Reich. Dr. Yokokura expressed his wish to Dean Frenk that the person who replaced Professor Reich be expected to have an understanding of Japan and continue to work with the JMA in supporting the program. Dean Frenk expressed his strong intent to maintain the program with the support of the JMA for years to come, acknowledging that the Takemi Program has been active for over 30 years now, has produced fellows from over 50 nations, is unique in that the fellows study international and public health, and is highly appreciated within the Harvard programs.

A commendation ceremony was also held at the Consulate-General of Japan in Boston to honor Professor Reich for being awarded the Order of the Rising Sun, Gold Rays with Neck Ribbon in the Year 2015 Foreign Recipients of the Spring Imperial Decorations for his over 30 years of service as a directing professor of the Takemi Program and great contribution to the development of public and international health in Japan. A commemorative event was also held in Japan in July of 2015 at the JMA Building.

Japan Medical Association Junior Doctors Network (JMA-JDN) Activities

The JMA-JDN was established in October of 2012 to create a platform for promoting the activities of Japanese junior doctors both in Japan and abroad. The four missions of the JMA-JDN are to promote international activities, to foster cooperative learning among doctors regardless of their areas of specialization, to engage in active studies and make proposals concerning junior doctors, and to make contributions that reach regions and communities. The following is a report on the international and domestic activities for the current term.

International activities

With the support of the JMA, junior doctors now have the opportunity to participate in international conferences. Specifically, the JMA-JDN contributed to organizing the WMA-JDN meeting on April 27, 2014, which was held concurrently with the WMA Council Session in Tokyo. Seven members of the JMA-JDN participated and helped organize the meeting. At the meeting, the participants primarily exchanged ideas concerning the development of support systems

for pregnant and expecting doctors and the labor environment for junior doctors in each country. The JMA-JDN also had Dr. Masami Ishii, the Executive Board Member of the JMA, conduct a lecture concerning disaster medicine in Japan. His discussion of disaster management systems in Japan, which were developed from the foundation of the country's wealth of experience, gave great knowledge to the participants. On April 25, prior to the WMA-JDN meeting, the JMA-JDN guided participants on hospital visits. The JMA-JDN visited the Disease Control and Prevention Center at Japan's National Center for Global Health Medicine and exchanged ideas with participants concerning reporting systems for emerging/re-emerging communicable diseases as well as the systems of vaccination and measures against communicable diseases that are in place in various countries. Additionally, the JMA-JDN endeavored to introduce participants to Japanese culture such as sightseeing in Asakusa and Tokyo Tower and deepened international friendships through karaoke and visiting *izakaya* (Japanese-style tavern).

Two members of the JMA-JDN attended the WMA General Assembly in Durban, South Africa, held in October of 2014. At the time, the Ebola virus was ravaging various West African countries, and the general assembly provoked the JMA-JDN members to think of what junior doctors could do to assist with relief efforts. One JMA-JDN member attended the WMA General Assembly in Oslo, Norway, held in April of 2015. At the general assembly, the JMA-JDN reported their seminar plans, Japan-Korea exchange projects, participation in the Subcommittee Meetings for Junior Residents of the JMA Employed Physicians Committee, and the reality of the working environment for interns and young physicians in Japan, and won the 2nd place among the various countries in the presentation rankings. Three members attended the WMA General Assembly in Moscow in October of 2015. The WMA-JDN adopted the WMA Statement on Physicians Well-Being that was submitted during the WMA plenary session. Ever since its founding in 2010, the WMA-JDN had received many reports from various countries around the world concerning harsh labor conditions faced by junior doctors. The submission of this declaration resulted in a momentous event that, for the first time, reflected the consensus of the WMA-JDN

and marked the active resolution of a long debate. At the same general assembly meeting, the JMA-JDN once again received the prize for best presentation, and the group's foreign and domestic activities garnered global recognition. Additionally, the JMA-JDN Deputy Chair Chiaki Mishima came forward as a candidate for the Membership Director position of the WMA-JDN and was elected.

One member attended the CMAAO General Assembly in Manila, the Philippines, in September of 2014, and one member attended the CMAAO General Assembly in Yangon, Myanmar, in September of 2015. Since the WMA-JDN has few participants from the Asia-Pacific region, the JMA-JDN sent one member to visit South Korea in November of 2014 to start the Japan-Korea JDN Meeting with the goal of advancing medical knowledge exchange between closely neighboring countries in the region. In July of 2015, a member of the South Korean JDN visited Japan and exchanged ideas on mobile healthcare. Again, in January of 2016, 4 members of the South Korean JDN visited Japan and exchanged ideas on topics such as work-life balance, the system of medical specialty board, mobile healthcare, and maldistribution of doctors. In the Asia and Oceania region more junior doctors should be encouraged to participate in the October 2016 WMA General Assembly in Taiwan. The JMA-JDN will be collaborating with the WMA-JDN in an attempt to develop the Global Educational Exchange in the Medicine and Health Professions, a global program of exchange study for junior doctors.

Domestic activities

The JMA-JDN has also enriched its domestic activities in exchanging ideas and the understanding of junior doctors regarding the Japanese health care system and medical service. For example, JMA-JDN seminars were held to provide opportunities for co-operative learning regardless of areas of expertise, providing junior doctors with a broader perspective, and spurring growth. The JMA-JDN also held several workshops, such as the community medicine plan workshops in November of 2014 and June of 2015, a workshop on international health and universal health coverage, and the Japan Vision Health Care 2035 workshop held in February of 2016, which encouraged junior doctors to consider health care 20

years from now. In addition, the JMA-JDN works to co-sponsor seminars with regional junior doctors' groups to promote community activities by junior doctors. The JMA-JDN also took part in a residency meeting sponsored by the Tokushima Medical Association in April of 2015; the 11th Annual Gender Equality Forum held in Tokushima Prefecture in July of 2015; a mental health seminar sponsored by Education X Café, a young doctors group for mental health promotion among physicians and residents, in Osaka in October of 2015; and, finally, a conference for dialogue between medical students and residents sponsored by the Hokkaido Medical Association in February of 2016.

At the Subcommittee Meetings for Junior Residents, for both the 2014 and 2015 fiscal years, two members of the JMA-JDN served as the subcommittee members, and one member served as an observer. Those members endeavored to grasp the problems among residency training and the needs from junior doctors and were encouraged to give their candid opinions on various topics.

Even though the JMA-JDN's activities are supported by the JMA, unfortunately only a few junior doctors are members of the JMA. The JMA-JDN is actively recruiting additional junior doctors to join the JMA.

Future prospects

The JMA-JDN has actively participated in the WMA-JDN and CMAAO meetings with the support from the JMA, and the years of effort has won the trust of other countries. The JMA-JDN hopes to contribute to the operation of the WMA-JDN by continuing to produce its board members, and will share new developments surrounding junior doctors with other Japanese members as they learn from abroad and likewise strive to share any new developments surrounding junior doctors in Japan with the rest of the world. The JMA-JDN also wishes to lead the networking of junior doctors by closely cooperating with neighboring countries in the Asia-Pacific region.

As activities within Japan are necessary for international activities, the JMA-JDN will continue to provide domestic workshops and seminars. Of course, such activities will not end with merely having events; it is necessary to proceed in a manner that presents actual results, such as

putting together academic theses and proposals made from the consensus of junior doctors. As of February 28, 2016, the JMA-JDN has a network of 103 junior doctors. The JMA-JDN is now planning events that will utilize information technology and grass roots movements to create an environment where more junior doctors know and participate in JMA-JDN activities. Building more solid bridges is essential between the JMA and junior doctors.

The JMA-JDN is approaching its 4-year anniversary. To sustain the organization, it is necessary to construct a stable system that enables the seamless transfer of information to the next generation of JMA-JDN members. The JMA-JDN will start preparing for its next system and forming deep partnerships with the medical students who will lead the next generation.

Lastly, the JMA-JDN is grateful for the continued support and instruction from the JMA, which enables us to be a place for junior doctors to grow for many years to come.

Summary

The 4th term investigation topic was set as “the challenges of Japanese community medicine from the global health perspective.” In other words, it means how much the Japanese medical community can benefit from health activities, which are, first, conducted on a global scale, and second, conducted in various local communities around the world. However, there is a strong nuance in global health that it covers public health in developing countries, and the various local communities (in the second point above) mean those of the developing countries. In this 4th term, the focus was emphasized on this area.

Concerning the world-wide activity, there are many lessons that can be learned from the WMA actions. We learn much also from WHO activities. These are learning activities that have been continued by the Global Health committee since the first term.

On the other hand, what about the secondly focused point? Initially, there were voices from the members of the committee that little lesson can be learned from community medicine of the developing countries. However, as explained above, from examples such as measures against infectious diseases, maternal and child health measures, disaster preparedness, and regional

health measures, much lesson has been learned from all this.

As previously stated, even during the times of financial difficulties, Japan was successful to establish cost-effective and efficient healthcare systems for the “community.” Japan’s financial situation gets much better now but still we can learn something meaningful from the developing countries. In these countries, human resources such as doctors and nurses in public health are also lacking. Money is lacking. Materials are lacking. However, as in Japan, every life should be saved. In the health care activities conducted in all-lacking communities, we can gain native knowledge and wisdom. It is not about the resources, but about the wisdom.

Doctors working in the community should have such wisdom and understanding. Knowledge and wisdom will be communicated to a different area once it is first born. For instance, why not put aside the differences between the work of a hospital-based medical doctor and a community-based medical practitioner. If the hospital-based clinical department and community-based practitioners come together, the community medicine design will be feasible. Secondly, with the spirit of professional autonomy, we will be able to reach out to a wider field. Finally, in the “Community-based Comprehensive Care system,” just as “one should be able to live where they are used to living for their whole life,” people such as doctors should have a sense of duty and act in a way in which the people are expecting. To be able to influence the system and people, we should behave appropriately with insight and foresight on top of understanding the full situation.

The knowledge and wisdom borne in one community should be wisely used in the other communities. Through various network opportunities, a unique community medical care activity can be spread across the world. Thereby, such community action network can bring about outcomes that are comparable to those obtained from the use of Big Data.

Slow pace is fine, as long as it is a steady progress. And, if it is firmly acknowledged in a community, we call it a success.

As Mahatma Gandhi says, “*Good travels at a snail’s pace. Those who want to do good are not selfish, they are not in a hurry, they know that to impregnate people with good requires a long time.*”

Global Health Committee of the Japan Medical Association (Apr. 2014-Mar. 2016)

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