HGPI

Health and Global Policy Institute

Immunization and Vaccination Policy Promotion Project

Recommendations for Reinforcing Stakeholder Cooperation to Advance Immunization and Vaccination Policy

Health and Global Policy Institute (HGPI)

Table of contents

Introduction

About Health and Global Policy Institute (HGPI)

Health and Global Policy Institute (HGPI) is a Tokyo-based independent and non-profit health policy think tank, established in 2004. Since our establishment, HGPI has been working to help citizens shape health policy by generating policy options and bringing together stakeholders as a non-partisan think-tank. Our mission is to enhance the civic mind along with individuals' well-being and to foster sustainable, healthy communities by shaping ideas and values, reaching out to global needs, and catalyzing society for impact. We commit to activities that bring together relevant players from various fields to deliver innovative and practical solutions and to help interested citizens understand available options and their benefits from broader, global, long-term perspectives.

The significance of immunization and vaccination policy and the purpose of these recommendations

Examining current circumstances surrounding immunization and vaccination policy in Japan, we see that the efforts of related parties have resulted in high vaccination coverage, particularly for vaccines administered to children. However, for certain vaccines like the rubella vaccine, pneumococcal vaccines for adults, and the shingles vaccine, vaccination rates have not reached target levels for many years. From a public health perspective, it is clear there are a number of major challenges that remain to be addressed.

In the past few years, the Coronavirus Disease 2019 (COVID-19) outbreak grew to pandemic proportions and has become a major challenge that must be addressed through global action. Although people in Japan have had few opportunities to hear the word "vaccine" in recent years, as demonstrated by the fact that a large proportion of the population rapidly vaccinated for COVID-19, we are now seeing an unprecedented transformation in the environment surrounding immunization and vaccination policy.

To advance immunization and vaccination policy, it goes without saying that cooperation from various relevant parties will be essential, and the emergency presented by the COVID-19 pandemic has reaffirmed the importance of broad cooperation that includes not only the national and local governments and healthcare professionals, but also researchers, employers, schools, the mass media, NPOs, and citizens. In this context, it is that much more important that we broadly consider, during non-emergency periods, specifics regarding how diverse stakeholders can cooperate effectively and how to advance immunization and vaccination policy through mutual cooperation. Although the decision was made at the end of 2021 to extend the fifth round of routine rubella vaccinations for three years, half a year later, we see that these efforts have faced limitations due to the impact of the COVID-19 pandemic. Given that this extended period will last until the end of March 2025, measures unlike any taken before will be necessary to make society a place where women can conceive and give birth with peace of mind.

On June 15, 2021, HGPI presented, "A Life Course Approach to Immunization and Vaccination Policy – Five Perspectives and Recommended Actions," which was based on discussions held during our Immunization and Vaccination Policy Promotion Project in FY2020. Its fourth perspective reads, "Steps should be taken to create a system that enables multi-stakeholders to hold continuous discussions on vaccine policy." These recommendations have been compiled by HGPI after repeated discussions with various experts based on this perspective.

Various measures that must now be taken to control future infectious disease outbreaks were outlined by Prime Minister Kishida based on advice from the “Expert Meeting on Novel Coronavirus Disease Control” or in past discussions and verification studies. These include providing a legal basis for the national and local governments to secure medical resources, establishing the “Infectious Disease Crisis Management Agency” (tentative name) in the Cabinet Office to serve as a central command tower, and creating a “Department for Infectious Disease Countermeasures” (tentative name) by uniting relevant sections at the MHLW. A more effective, efficient system of operations must be built on the foundation of immunization and vaccination policy.

It is our strong hope that these recommendations are utilized in future immunization and vaccination policy to further deepen cooperative ties among stakeholders.

Executive Summary

Examining the current situation surrounding immunization and vaccination policy in Japan, we see there is sufficient public understanding toward the need for vaccines and the benefits of vaccines, and that vaccinations needed to ensure good public health are being conducted with relatively high rates, including those for children. However, there are still certain vaccines for which vaccination rates have not reached target levels for many years. Notable examples of insufficient coverage include the rubella vaccine among middle-aged men and the adult pneumococcal vaccine among older adults.

Two necessary actions for effectively increasing vaccination rates among members of the public who require vaccinations will be to (1) build awareness toward vaccinations through proactive steps to provide information using various methods and (2) actively provide accurate information to enhance acceptance while preventing vaccine hesitancy caused by hearsay or discourse that has no scientific basis.

The emergency response to the ongoing COVID-19 pandemic has reaffirmed the importance of broad cooperation that includes not only the national and local governments and healthcare professionals, but also researchers, employers, schools, the mass media, NPOs, and citizens, with each party acting in their own capacity. It also goes without saying that it will be important to continuously build cooperation among many stakeholders during non-emergency periods, as well.

Recognizing these circumstances, HGPI offers the following three recommendations for advancing immunization and vaccination policy more effectively through broad stakeholder cooperation during non-emergency periods.

1 The Government (or other parties such as NPOs) should gather, maintain, and regularly publicize data on the results of vaccination programs in each municipality in a format that allows for comparisons.

2 The Ministry of Health, Labor and Welfare (MHLW) should collaborate with the Ministry of Education, Culture, Sports, Science and Technology (MEXT), local governments, and similar bodies to establish an environment in which educational institutions and workplaces can actively conduct awareness-raising and similar activities for immunization and vaccination policy.

3 Academic societies, the administration, and the mass media should cooperate to disseminate, in an active and continuous manner, information for decreasing misunderstandings and concerns, such as by providing definitions and usage outlines for terms like “adverse event,” “adverse reaction,” “recommended vaccination,” and “obligation to endeavor (to be vaccinated).”

It is our strong hope that these recommendations are utilized in future immunization and vaccination policy to further deepen the cooperative ties among stakeholders.

Policy Recommendations

1. Accomplishments, challenges, and issues for immunization and vaccination policy

1-1. Accomplishments

- Looking at the current situation surrounding immunization and vaccination policy in Japan, it is safe to say there is sufficient public understanding toward the need for vaccines and the benefits of vaccines, and, overall, **the vaccinations needed for good public health are being administered at relatively high rates**.
- For example, efforts to continuously provide information to parents and guardians have been significant, and have resulted in generally high vaccination rates among children for both routine and voluntary vaccinations.[1]
- Looking at the situation surrounding influenza vaccinations (which are voluntary, but are classified as routine vaccinations for older adults), people make the decision whether to vaccinate independently, based on prevalence and degree of risk they may face if infected.
- During the domestic deployment of the COVID-19 vaccines for adults, some citizens expressed concern or dissatisfaction toward the slow vaccine rollout. The logistics of administering COVID-19 vaccines to many people over a short time period were also a source of confusion. However, Japan did not see a surge of vaccine hesitancy driven by ideology or anti-vaccine movements based on unscientific beliefs, as could be observed in certain developed countries. These elements helped Japan achieve a relatively high vaccination rate for the third dose of COVID-19 vaccines.

1-2. Challenges and issues

Key vaccines with low vaccination rates

- **Taking a look at individual vaccines, however, there are still some with major challenges that must be addressed before coverage can be improved.**
- For example, there are vaccines (such as adult pneumococcal vaccine and shingles vaccine) for which coverage remains low among adults (especially older adults) because target populations possess an insufficient understanding of the risks associated with infection, the significance of vaccinating, and the effects of vaccination. In addition, there are major challenges when approaching members of generations who missed vaccinations due to temporary changes in

[1] Vaccinations fall into two categories: routine or voluntary. By law, routine vaccinations are administered by basic local governments, with certain vaccines requiring the vaccinated person to cover payment. Voluntary vaccinations (including mumps vaccine and influenza vaccine) are administered to the people who want them and are paid for at the vaccinated person's own expense. Routine vaccinations include (A) those administered to build herd immunity (called "Category A" diseases; includes BCG, 4-in-1 vaccine (DPT-IPV), combined measles-rubella (MR) vaccine, varicella vaccine, etc.) and (B) those intended to protect individuals (called "Category B" diseases; includes influenza vaccine, adult pneumococcal vaccine for elderly people, etc.).

vaccine policy to provide catch-up vaccinations[2] (such as for rubella vaccine, HPV vaccine for cervical cancer prevention, etc.; see Table 1).

- COVID-19 vaccine uptake among children ages 5 to 11 has been sluggish, with vaccination rates reaching only around 17%. This is extremely low when compared to rates for people ages 12 and over. Some are also concerned about the possibility of a jump in cases of severe illness and deaths among children due to the spread of COVID-19 in the future.

Table 1: Key vaccines with low vaccination rates

Vaccine name	Category	Vaccination rate (FY2019)	Main target population
1. Adult pneumococcal vaccine	Routine	13.7%	Elderly people
2. Shingles vaccine	Voluntary	Low	Elderly people
3. Rubella vaccine	Routine	38% (Among group on right)	Middle-aged men (esp. age 40s to 50s)
4. HPV vaccine	Routine	A few percent	Young women (esp. age 20s)

Factors influencing vaccine hesitancy from the perspectives of target group members

- Examining factors that lead to low vaccination coverage for key vaccines from the perspectives of target group members, typical contributors to vaccine hesitancy are related to "awareness," "acceptance," and "access" as summarized below (see Table 2 on the next page).[3]
  1. Awareness: Inadequate knowledge means people do not perceive themselves as affected parties
  2. Acceptance: Vaccine-associated risks are perceived as greater than they actually are
  3. Access (Opportunities): Opportunities to get vaccinated easily are too few

- Furthermore, some experts have pointed out that the deployment of COVID-19 vaccines has been influenced by trends in vaccine hesitancy. For example, for members of the general public, there have been changes in complacency caused by thinking such as, "Children are less likely to be infected," or "Children only experience mild symptoms." The spread of previous information also had an impact on confidence by leading people to believe things like, "Infected children will only experience mild symptoms," "The vaccines are growing less effective," or "Be wary about vaccinating children ages 5 to 11." There have also been

[2] Catch-up vaccinations: When vaccines should be administered temporarily beyond age ranges specified for existing routine vaccination programs. For example, about one decade ago, unsubstantiated claims of adverse reactions to the HPV vaccine resulted in a major decrease in coverage and caused the active recommendation of the HPV vaccine to be suspended from June 2013. Active recommendation was resumed in April 2022. Catch-up vaccinations are now being administered to those who missed out on being vaccinated for HPV over approximately the past decade, mainly for women in their 20s.

[3] According to earlier research, the determinants of vaccine coverage and root causes for hesitancy can be analyzed using five factors: 1. Access, 2. Affordability (in terms of time or cost), 3. Awareness (volume of knowledge), 4. Acceptance, and 5. Activation (or opportunities) ("The 5As: A practical taxonomy for the determinants of vaccine uptake" (Thomson et al, 2016).

convenience hurdles for healthcare professionals, who must grapple with conditions like having to vaccinate patients in groups of ten.

Table 2: Factors for vaccine hesitancy from target groups' perspectives

Main target group	Key vaccine with low coverage	Main challenges
Elderly people	Adult pneumococcal vaccine	**[Awareness]** Adults have far fewer opportunities to learn about vaccinations and **awareness that people require certain vaccinations even after reaching adulthood is lacking**. Steps to actively recommend vaccinations in workplaces and other settings where information can be provided to adults are not being taken. **[Access (Opportunities)] Workplace and mass vaccinations are not being conducted** (like during the COVID-19 vaccine rollout), so people lack ready opportunities to get vaccinated.
	Shingles vaccine	
Middle-aged men (esp. ages 40s to 50s)	Rubella vaccine	**[Awareness]** Due to the **misconception** that only pregnant women are at high risk of contracting rubella, **people do not view it as something that concerns them**. **[Awareness]** Middle-aged men are unaware that they are eligible for routine vaccinations. **[Access]** People in this age group are often busy with work and other commitments that make it difficult for them to get vaccinated.
Young women (esp. age 20s)	HPV Vaccine	**[Acceptance]** The influence of certain unproven claims caused **the misconception that HPV vaccines are extremely risky to spread.**

- Two important actions that are likely to be necessary to effectively increase vaccination coverage among members of groups like those described above are (1) **improve awareness toward vaccinations** through proactive steps to provide information using various methods and (2) actively provide accurate information to **increase acceptance** and to prevent vaccine hesitancy caused by exposure to unscientific hearsay or discourse.

Challenges for approaching vaccination target groups, by stakeholder

- Examining methods for approaching target groups for vaccination by each of the various stakeholders,[4] **there are several issues related to stakeholders' roles and to mutual cooperation among stakeholders** (Tables 3-1 and 3-2).

[4] Although the people who are members of vaccination target groups are of course important stakeholders, for the sake of convenience, here we have divided stakeholders along the lines of those who approach target groups and those who are approached.

Table 3-1: Key issues related to stakeholder roles and cooperative ties (Overview)

1. Basic local governments (Government) → [Awareness] ・Because the subsidy system and other national Government-operated systems do not currently serve to incentivize or encourage better assessments, **there is variation among basic local governments in interest and concrete initiatives for improving vaccination coverage.**
2.Schools 3. Workplaces (Administration) → [Awareness] ・The lack of cooperation and support from municipal governments and ministries means **steps to actively provide information and recommendations for vaccination to children, students, employees, and other groups are not being taken.**
4. Academic societies, the administration, and mass media → [Acceptance] ・**Efforts to clear misunderstandings and alleviate concerns regarding vaccinations by disseminating information to the public are insufficient.**

Table 3-2: Main challenges related to stakeholders' roles and cooperative ties

Stakeholder and responding body	Main challenges
1. Basic local governments (Government)	[Insufficient financial incentive] As a result of legal revisions, financial resources earmarked for vaccination programs are no longer available, and subsidies from the national Government are now provided in lump sums that are detached from vaccination coverage and number of vaccines administered to community members.[5] This results in the utility of financial resources to vary among municipalities, meaning **the financial incentive to increase vaccination coverage is weak.**
	[Lack of data development] The Government does not disclose data which can be used to compare the results of vaccination programs,[6] so **there is insufficient encouragement to improve vaccination program assessments.**
	[Motivation disparities] As a result of the above, many leaders and staff members at local governments tend to **have negative attitudes, citing insufficient human resources, financial resources, or know-how**, and **there are disparities in interest and concrete initiatives to expand preventive healthcare among citizens**.[7]

[5] Under decentralization laws (namely, the "Omnibus Decentralization Law" promulgated in 1999), in general, the national Government can only provide technical support for vaccination policies.

[6] During the COVID-19 vaccine rollout, vaccination rates were announced by municipality in near real time. This encouraged competition among municipalities.

[7] While many local governments have made focused, repeated, and independent efforts to increase coverage and are generating steady results, novel incentives for local governments that are different from lump-sum subsidies are necessary.

2. Schools[8] (Administration)	[Collaboration with ministries and agencies] Efforts to gain sufficient understanding toward immunization and vaccination policies from MEXT have been unsuccessful, so **it is difficult to conduct awareness-raising activities in schools.** [9] For example, health education is generally assigned low priority and vaccine education for students is superficial. Furthermore, MEXT does not provide assistance for conducting HPV seminars for school health staff.
3. Workplaces (Administration)	[Collaboration with local governments and ministries] Given the lack of cooperation from local governments and ministries, **it is difficult to conduct awareness-raising activities on immunization and vaccination policies** at individual workplaces in a manner they do not become mandatory.[10]
4. Academic societies, administration, and mass media	[Provision of information on vaccination safety and related topics] Regarding topics like "adverse events," "adverse reactions," "recommended vaccinations," and "obligations to endeavor," **information has not been sufficiently disseminated so that misunderstandings are cleared and concerns are alleviated**.

- **To improve awareness and acceptance among aforementioned target groups and to effectively increase vaccination coverage**, **gaining cooperation from various stakeholders will be essential**. These stakeholders include basic local governments, prefectural governments, the national Government, healthcare professionals, researchers, employers, schools, the mass media, NPOs, and citizens.

[8] If young children and students, who are at impressionable ages, can be made to understand the importance of immunization as a matter that affects them on a personal level, it is highly likely to have positive effects on their parents and guardians, as well.

[9] The amount of information on vaccines in textbooks is gradually increasing. For example, they are starting to include firsthand accounts of the difficulties faced by people who did not receive the rubella vaccine, such as from people whose children were born with disabilities after infection.

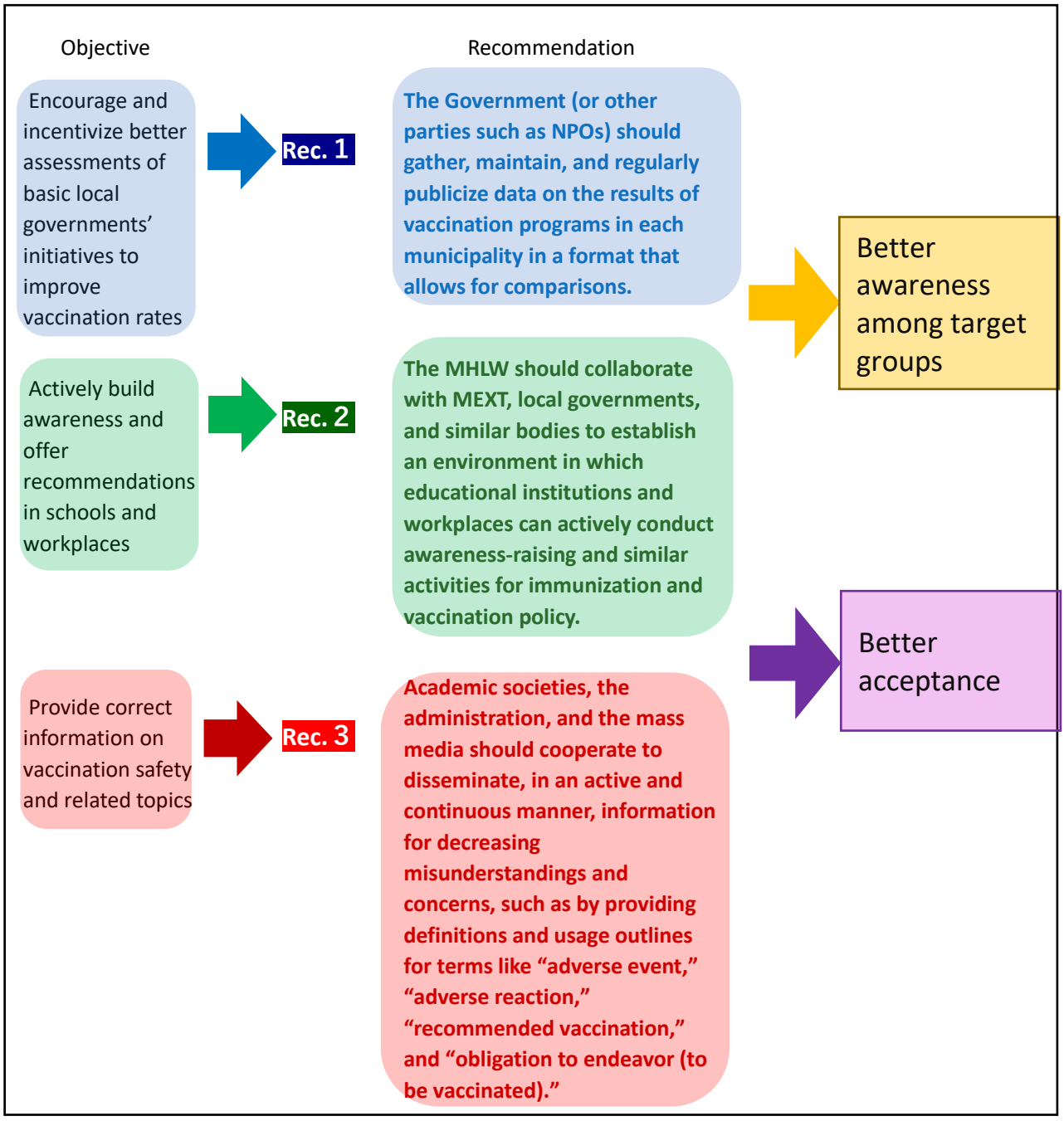
[10] Under the guidance of the national Government, COVID-19 vaccinations were advanced in a different manner than normal vaccination programs, such as by including efforts from local governments to promote group vaccinations at workplaces.

2. Recommendations

2-1. Overview

- Based on our recognition of the issues described in the previous section, we offer the following three recommendations (Table 4).

Table 4: Three recommendations on reinforcing stakeholder roles of and cooperation



2-1. Commentary

- Based on our recognition of these issues, we offer the following three recommendations.

Recommendation 1

The Government (or other parties such as NPOs[11]) should gather, maintain, and regularly publicize data on the results of vaccination programs in each municipality in a format that allows for comparisons.

- On an institutional level, the central Government can no longer link subsidies to vaccination coverage and number of vaccines administered to community members, but it is desirable that alternative incentives are established that lead to the active promotion of vaccination policies.
- During the COVID-19 vaccine rollout, vaccination coverage by municipality was publicized in near real time. This encouraged better assessments of initiatives among municipalities. Similar practices are likely to be effective for vaccination policies during non-emergency periods.
- Specifically, a standardized format could be created, publicized, and used to conduct nationwide comparisons of each basic local or prefectural government for (1) budget allocation for promoting vaccinations; (2) specific measures for increasing vaccination coverage; and (3) results.[12] In addition to making it easy for citizens, researchers, and other parties to compare performances among local governments, such a format could also be used to create "report cards" for heads of basic local governments to use during elections and similar occasions.

Recommendation 2

The MHLW should collaborate with MEXT, local governments, and similar bodies to establish an environment in which educational institutions and workplaces can actively conduct awareness-raising and similar activities for immunization and vaccination policy.

- Immunization and vaccination policies cannot advance only through efforts from the MHLW or local governments. Additional actions like conducting awareness-raising in schools and workplaces can make it possible to approach a larger segment of the public.
- Although an emergency measure, group vaccinations were conducted in schools and workplaces during the COVID-19 vaccine rollout to a certain degree of success. Implementing similar measures in immunization and vaccination policies for non-

[11] If data is made available to be independently compiled and publicized by healthcare-related think tanks like HGPI or other NPOs, civil society organizations, or research institutes, it is likely to generate similar results even if not performed by the central Government. However, progress in digitalizing data collection practices will be necessary for this to occur.

[12] For example, items like vaccination coverage by vaccine type (for basic local governments, prefectural averages, national average, and averages of municipalities with populations of similar sizes) could serve as quantitative benchmarks.

emergency periods is likely to be effective. For those measures to be effective, however, related parties must make sufficient efforts to build mutual understanding while working to reduce the physical and mental burdens of implementing said measures in schools and workplaces.

Recommendation 3

Academic societies, the administration, and the mass media should cooperate to disseminate, in an active and continuous manner, information for decreasing misunderstandings and concerns, such as by providing definitions and usage outlines for terms like "adverse event," "adverse reaction," "recommended vaccination," and "obligation to endeavor (to be vaccinated)."

- Responses to the COVID-19 pandemic have made immunizations and vaccines a familiar topic to the public, and great advances have been made in enhancing public understanding of the fact that fevers and other adverse reactions occur at a certain rate when administering vaccines. However, as seen during the uproar that occurred over the HPV vaccine in the past, there is always the lingering possibility that the public will develop a sudden tendency toward vaccine hesitancy due to the spread of unscientific accounts and opinions meant to cause concern.
- In light of these circumstances, it will be necessary for academic societies, the administration, and the mass media to continue efforts to actively disseminate accurate vaccine safety information. Understanding the differences in meaning between terms like "adverse events"[13] and "adverse reactions" or "recommended vaccination" and "obligation to endeavor (to be vaccinated)" can be especially difficult for the general public. Carefully explaining the correct definitions and usage of these terms to the public will be important for alleviating concerns and clearing misunderstandings regarding vaccinations.

[13] "Adverse event" includes any adverse health event that occurs after a vaccination. As long as the event occurred after a vaccination and falls into a before-and-after sequence of events, that event is reported as an "adverse event" (or a "suspected adverse reaction") regardless of whether there is a cause-and-effect relationship. This means "adverse events" can encompass a broad range of events which are not caused by vaccines (or which have no causal relationship to vaccines). To give an extreme example, even an automobile accident that occurs after a vaccination is treated as an "adverse event" if reported. (Adapted from "How should we comprehend vaccine information? The difference between an 'Adverse Event' and an 'Adverse Reaction,'" MHLW.)

Acknowledgements

While formulating these recommendations, we received input from many people representing industry, Government, academia, and civil society since the beginning of FY2021. In particular, we would like to express our deepest gratitude to all members of Working Group 4 for their expert advice on multi-stakeholder engagement, as well as for their support for the objectives of these recommendations.

Please note that these recommendations were compiled by the author, HGPI, in its capacity as an independent think-tank based on discussions and opinion exchanges with experts and other parties as well as trends and developments in relevant policies. They should not be taken to represent the opinions of any advisory board member or related party, or of any organization to which they belong.

2021 Advisory Board Working Group 4 (Titles omitted; in Japanese alphabetical order by last name)

Members:

- **Kyoko Ama** (Representative, Children and Healthcare Project)
- **Nobuhiko Okabe** (Director, Kawasaki Institute for Health and Safety Research Institute)
- **Kayo Kani** (Co-representative, The Hand in Hand Committee for the Elimination of Rubella)
- **Akihiko Saitoh** (Professor, Department of Pediatrics, School of Medicine, Niigata University; Vice Dean, School of Medicine, Niigata University)
- **Yasuhiro Suzuki** (Vice President, International University of Health and Welfare; Former Chief Medical and Global Health Officer, Ministry of Health, Labour and Welfare)
- **Asako Nakai** (Secretariat, KNOW VPD! Protect Our Children)
- **Yoko Fujimoto** (Member of the Board and Operating Officer, Vaccines Lead, Pfizer Japan Inc)
- **Hiroyuki Moriuchi** (Professor, Graduate School of Biomedical Sciences, Nagasaki University; Professor, School of Tropical Medicine and Global Health, Nagasaki University)

Special Advisor:

- **Keizo Takemi** (Member, House of Councilors; Chairperson, Association for the Promotion of Improved Public Health through Vaccinations, Parliamentary Group for Vaccines and Prevention)
- **Noriko Furuya** (Member, House of Representatives; Acting Chairperson, Association for the Promotion of Improved Public Health through Vaccinations, Parliamentary Group for Vaccines and Prevention)

HGPI Guidelines on Grants and Contributions

As an independent, non-profit, non-partisan, private think tank, Health and Global Policy Institute (HGPI) complies with the following guidelines relating to the receipt of grants and contributions.

Approval of Mission

The mission of HGPI is to improve the civic mind and individuals' well-being, and to foster a sustainable healthy community by shaping ideas and values, reaching out to global needs, and catalyzing society for impact. The activities of the Institute are supported by organizations and individuals who are in agreement with this mission.

Political Neutrality

HGPI is a private, non-profit corporation independent of the government. Moreover, we receive no support from any political party or other organization whose primary purpose is political activity of any nature.

Independence of Project Planning and Implementation

HGPI makes independent decisions on the course and content of its projects after gathering the opinions of a broad diversity of interested parties. The opinions of benefactors are solicited, but the Institute exercises independent judgment in determining whether any such opinions are reflected in its activities.

Diverse Sources of Funding

In order to secure its independence and neutrality, HGPI will seek to procure the funding necessary for its operation from a broad diversity of foundations, corporations, individuals, and other such sources. Moreover, as a general rule, funding for specific divisions and activities of the Institute will also be sought from multiple sources.

Exclusion of Promotional Activity

HGPI will not partake in any activity of which the primary objective is to promote or raise the image or awareness of the products, services or other such like of its benefactors.

Supporting organizations are asked to submit written agreement with HGPI's compliance with the above guidelines.

This proposal was compiled by Health and Global Policy Institute (HGPI) in its capacity based on a discussion conducted under the Chatham House rule at Working Group Meetings and interviews held in 2021 along with external discussions on the related topics.

Project sponsors (in alphabetical order)

AstraZeneca K.K.
Janssen Pharmaceutical K.K.
Meiji Seika Pharma Co., Ltd.
Pfizer Japan Inc.
Sanofi K.K.
Takeda Pharmaceutical Company Limited.

For inquiries, please contact:
Health and Global Policy Institute Vaccinations Project Team (in no particular order)
Joji Sugawara (Manager, HGPI)
Takahiro Sakauchi (Associate, HGPI)
Yui Kohno (Associate, HGPI)

特定非営利活動法人 日本医療政策機構
〒100-0004
東京都千代田区大手町 1-9-2
大手町フィナンシャルシティ グランキューブ 3 階
グローバルビジネスハブ東京
TEL: 03-4243-7156 FAX: 03-4243-7378
Info: info@hgpi.org
Website: https://www.hgpi.org/

Health and Global Policy Institute (HGPI)
Grand Cube 3F, Otemachi Financial City,
Global Business Hub Tokyo
1-9-2, Otemachi, Chiyoda-ku, Tokyo
100-0004 JAPAN
TEL: +81-3-4243-7156 FAX: +81-3-4243-7378
Info: info@hgpi.org
Website: https://www.hgpi.org/en/