PRINCE MAHIDOL AWARD CONFERENCE

REPORT

ON THE 2015 CONFERENCE ON

GLOBAL HEALTH POST 2015

ACCELERATING EQUITY

PRINCE MAHIDOL AWARD CONFERENCE 2015

26-31 JANUARY 2015 I BANGKOK, THAILAND

True Success is not in the learning
but in its application to the benefit of mankind

His Royal Highness Prince Mahidol of Songkla


From
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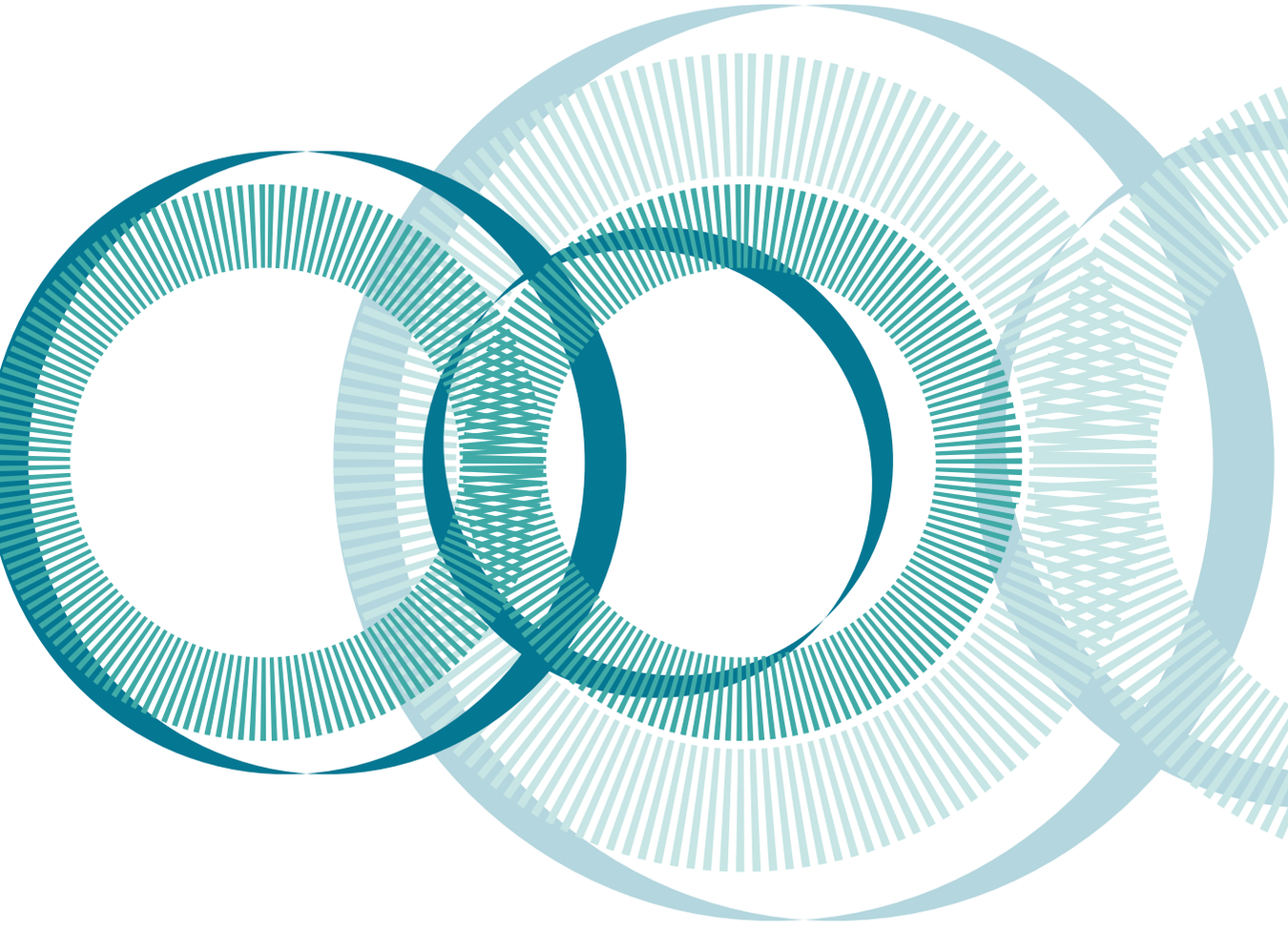
to
Huumanistic Medicin



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BACKGROUND OF

THE PRINCE MAHIDOL AWARD

The Prince Mahidol Award was established in 1992 in commemoration of the centenary of the birth of His Royal Highness Prince Mahidol of Songkla on January 1, 1892. The Award is managed by the Prince Mahidol Award Foundation under the Royal Patronage with Her Royal Highness Princess Maha Chakri Sirindhorn as president. The Foundation annually confers two Prince Mahidol Awards upon individual(s) or institution(s), which have demonstrated outstanding and exemplary contributions to the advancement of the world's medical and public health services. Each Award consists of a medal, a certificate and a sum of US $100,000.

His Majesty the King of Thailand graciously designated Her Royal Highness Princess Maha Chakri Sirindhorn to preside over the Presentation Ceremony of the Prince Mahidol Award 2014 at the Chakri Throne Hall on January 28, 2015.

There were a total of 59 nominations from 25 countries. The Scientific Advisory Committee carefully screened all candidates from the year 2014, 2013, and 2012 and then submitted a short list of the candidates to the International Award Committee who scrutinized and made a recommendation to the Board of Trustees. H.R.H. Princess Maha Chakri Sirindhorn presided over the meeting of the Board of Trustees on 17th October 2014 in which the final decision on the Prince Mahidol Award 2014 was made.

In the past 23 years, 68 individuals, groups of individuals, and institutions had received the Prince Mahidol Award. Among them, two subsequently received the Nobel Prize in Physiology or Medicine, namely Professor Dr. Barry James Marshall and Professor Dr. Harald zur Hausen. Two Thai had received the Prince Mahidol Award in 1996, they were Professor Prasong Tuchinda and Professor Suchitra Nimmannitya and two more in 2009: Dr. Wiwat Rojanapithayakorn and Mr. Mechai Viravaidya.

The Prince Mahidol Award Foundation of which H.R.H. Princess Maha Chakri Sirindhorn is the President, decided to confer this year's Prince Mahidol Award in the field of medicine to Professor Akira Endo. In the field of public health, the Prince Mahidol Award was conferred to Professor Donald A. Henderson.

For more information:
www.princemahidolaward.org

Prince Mahidol Award Laureate 2014

In the Field of Medicine

Dr. Akira Endo

President,
Biopharm Research Laboratories, Inc.

Distinguished Professor Emeritus,
Tokyo University of Agriculture and Technology, Japan

Dr. Akira Endo discovered the first anticholesterol statin called compactin (previously known as ML-236B), which he isolated from the fungus *Penicillium citrinum* in 1976.

Dr. Endo studied over 6,000 types of fungi before he found one that reduced the amount of cholesterol in the blood, which he named ML-236B. It was able to block the enzyme HMG-CoA reductase, the critical rate-limiting step in the cholesterol synthesis pathway.

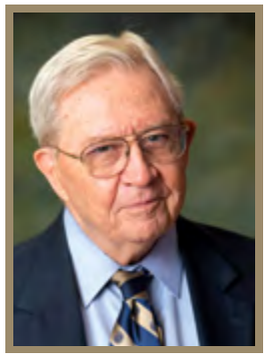
Cardiovascular diseases have been a major health burden in most nations around the world for many decades. Moreover, coronary heart disease (CHD) is also known to be responsible for a number of fatalities globally. These CHD fatalities are shown to be closely associated with hypercholesterolemia. Although cholesterol is important to the functioning human cells, its excessive level can lead to a formation of cholesterol plaque inside of arterial walls. The rupture of this plaque can result in the formation of blood clot inside arteries, thus reducing or blocking the blood flow, leading to a condition known as heart attack.

Dr. Endo's pioneering work in discovery of Statin has been recognized as a major milestone to the prevention and treatment of coronary heart disease as well as other major vascular diseases. The discovery of Statin by Dr. Endo has shifted the paradigm in coronary heart disease from an unpreventable to a preventable one. His discovery also led to an effective treatment of hypercholesterolemia and a significant reduction of coronary heart disease and stroke, thus saving millions of lives worldwide.

Dr. Akira Endo obtained a PhD in Biochemistry at Tohoku University in 1966. During 1957-1978, he worked as a biochemist at Sankyo Co. He had been appointed as a full Professor at the Tokyo University of Agriculture and Technology from 1986 to 1997. After retirement, he obtained the post of Directorship of Biopharm Research Laboratories Inc. He also serves as a Professor on Special Mission at Tohoku University and Waseda University, and a Visiting Professor at Kanazawa University and Hitosubashi University.

Prince Mahidol Award Laureate 2014

In the Field of Public Health



Dr. Donald A. Henderson

Distinguished Scholar, Center for Health Security,
University of Pittsburgh Medical Center

Dean Emeritus, Bloomberg School of Public Health,
Johns Hopkins University, USA

Dr. Donald A. Henderson led the World Health Organization's Global Smallpox Eradication Campaign. Smallpox is considered the first and only deadly disease that has been completely eradicated from the world.

Although the prevention of smallpox by inoculation of smallpox scabs was practiced as early as 1000 BC, smallpox continued to be an important public health problem throughout the world in the 20th century especially

developing countries. Although a vaccine for smallpox was discovered as early as 1796, there was still no way to prevent the spread of this disease. Smallpox caused an estimated 300–500 million deaths during the 20th century.

From 1966 to 1977, Dr. Henderson led the WHO Smallpox Eradication Unit. The unit coordinated a global effort of mass vaccination campaign and intensive case surveillance that led to eradication of smallpox. The smallpox eradication campaign came to a successful conclusion in 1977 when the last case was reported in Somalia. On 8 May 1980, the WHO declared that the global goal of smallpox eradication had been achieved. Smallpox eradication has not only saved billions of lives but also has set an example on how to tackle more effectively other health problems.

Dr. Donald A. Henderson received his A.B. in 1950 from Oberlin College and his M.D. in 1954 from the University of Rochester School of Medicine. He served both an internship (1954-1955) and a residency (1957-1959) in medicine at the Mary Imogene Bassett Hospital. Between his internship and residency he worked in the epidemiology intelligence service of the Communicable Disease Center (CDC). In 1960, Dr. Henderson received an M.P.H. from the Johns Hopkins University School of Hygiene and Public Health.

MESSAGE FROM CHAIRS

OF THE INTERNATIONAL ORGANIZING COMMITTEE

In the year 2000, leaders of the world community set forth a shared vision for development based on the fundamental values of freedom, equality, solidarity, tolerance, respect for nature and shared responsibility, in the form of the Millennium Declaration adopted by the UN General Assembly. The Millennium Development Goals (MDGs) which followed have since provided milestones for global and national development efforts, with the overall target date of 2015. The MDG framework helped to galvanize development efforts and set global and national priorities. While important progress has been made much more work remains to be done in the future.

We know that the circumstances in which we now discuss the post-2015 development framework are very different from those in the late 1990s when the MDGs were being framed. We are no longer thinking in terms of what one set of countries commits to doing with financial or technical support from others. Rather, we are looking for ways of structuring new global goals so that they reflect global challenges of concern to us all.

The vision for global development contained in the Millennium Declaration was intended to unify pursuance of economic, social and environmental objectives along with ensuring peace, security and respect for democratic values. Priority was given to protecting the destitute and vulnerable with recognition that reduction of inequalities in all societies is essential to inclusive, sustainable development. The adoption of explicitly inclusive approaches to ensure equity at all levels is merited not only on ethical grounds, but also from the perspectives of development and peace and security. This vision is as relevant today as in 2000, notwithstanding the major changes that have occurred since then.

The world is now faced with the task of building a new vision. In moving forward, it will be essential for the post-2015 development framework to seek to achieve inclusive, people-centered, sustainable development as well as a resilient society with an approach that is based on social justice, equity, structural transformation, economic diversification and growth.

Health is important as an end in itself and is an essential component of the post-2015 development framework. Health enables people to reach their full potential. Health is also at the center of sustainable development as health is a beneficiary of development, a contributor to development, and a key indicator of what people-centered, rights-based, inclusive, and equitable development seeks to achieve. Healthy children learn better and become healthy adults. Healthy adults work more effectively, earning higher and more regular wages. Benefits of investing in health are immediate and obvious, both for specific interventions and for strengthening health systems more broadly. Ensuring people's right to

health, including through universal health coverage with quality healthcare, is vital for inclusive social development and has been identified as a critical element for the post-2015 world.

In recognizing the world's unique opportunity today to ensure that all of our voices are reflected in the post-2015 development framework to build a better and more prosperous tomorrow, the Prince Mahidol Award Conference has joined forces with international partners to host the Prince Mahidol Award Conference 2015 with the theme "Global Health Post 2015 -Accelerating Equity."

Within the post-2015 development framework, health is an integral part of human wellbeing, which also includes material, psychological, social, education, work, environment, political, and security dimensions. These dimensions of wellbeing are interrelated and interdependent. The new development framework should clearly articulate and support the synergies between health and the other goals; the goals should be framed in a way that their attainment requires policy coherence and shared solutions across multiple sectors-a whole-of-government approach, with equity for all at the core.

As Chairs of the International Organizing Committee, we are delighted to contribute to this ongoing global discussion and to welcome you to Bangkok, Thailand to join more than 600 fellow leaders and educators from around the world. We strongly encourage your active participation and ideas to contribute to developing a better world for future generations. This is an awesome responsibility which rests upon all of us. We must aspire to eradicate poverty, protect the environment and promote economic opportunity for all. Failure is not an option so we must work together to create a just world where all people live with dignity and fulfill their potential. What a truly exciting opportunity we have!

Dr. Vicharn PANICH
Chair
Prince Mahidol
Award Conference

Dr. Marie-Paule KIENY
Co-Chair
World Health Organization

Dr. Timothy EVANS
Co-Chair
The World Bank

Dr. Luiz LOURES
Co-Chair
Joint United Nations
Programme on HIV/AIDS

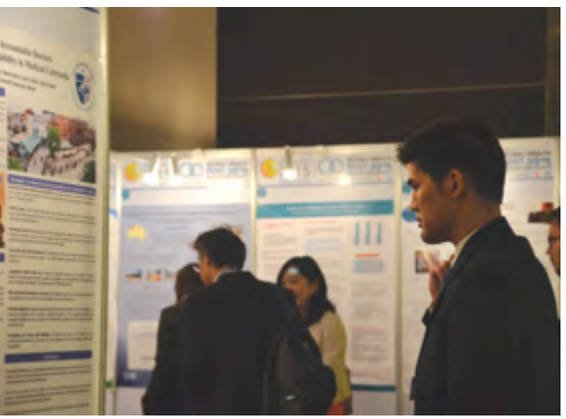
Dr. Ariel PABLOS-MENDEZ
Co-Chair
U.S. Agency for
International Development

Mr. Kiyoshi KODERA
Co-Chair
Japan international
Cooperation Agency

Mr. Michael MYERS
Co-Chair
The Rockefeller
Foundation

Dr. Lincoin C.CHEN
Co-Chair
China Medical Board

Prof. David HEYMANN
Co-Chair
Chatham House




PHOTO

SUMMARY
IN BRIEF

Monday, 26-Tuesday, 27 January 2015

There were 28 side meetings and workshops convened by partners.

The list of side meetings is shown in ANNEX IV.

Wednesday, 28 January 2015

There were 6 optional field visit sites, where 178 PMAC participants attended.

Thursday, 29-Saturday, 31 January 2015

3 Keynote Addresses
5 Plenary Sessions
20 Parallel Sessions

PARTICIPANTS

There were 619 participants from 53 countries.

Argentina, Australia, Bangladesh, Belgium, Bhutan, Brazil, Burkina Faso, Burundi, Cambodia, Canada, China, Congo, Costa Rica, Croatia, Denmark, Egypt, Fiji, France, Germany, Ghana, Haiti, Hong Kong, India, Indonesia, Italy, Japan, Kenya, Korea, Lao, Lebanon, Malawi, Malaysia, Maldives, Mexico, Myanmar, Nepal, New Zealand, Nigeria, Norway, Oman, Philippines, Rwanda, Singapore, South Africa, Sri Lanka, Sweden, Switzerland, Tanzania, Thailand, Uganda, United Kingdom, United States, Viet Nam


2015
GLOBAL HEALTH
POST 2015
ACCELERATING EQUITY
Open Working Group Proposal SDG 3:
Ensure healthy lives and promote well-being for all at all ages
• Outcome focus, broad definition of health, includes social determinants
• Redundancy, nebulous, difficult to hold governments to account
• "Health is everyone's business" – no specific role or focus for the health sector
Mr. Robert Yates

CONFERENCE PROGRAM IN BRIEF

BACKGROUND

The Prince Mahidol Award Conference (PMAC) is an annual international conference focusing on policy-related health issues of global significance. The conference is hosted by the Prince Mahidol Award Foundation, the Thai Ministry of Public Health, Mahidol University and other global partners. It is an international policy forum that Global Health Institutes, both public and private, can co-own and use for advocacy and for seeking international perspectives on important global health issues.

The Conference in 2015 will be co-hosted by the Prince Mahidol Award Conference, the World Health Organization, the World Bank, Joint United Nations Programme on HIV/AIDS, U.S. Agency for International Development, Japan International Cooperation Agency, the Rockefeller Foundation, China Medical Board, and Chatham House with the support from other key related partners. The Conference will be held in Bangkok, Thailand, from 26 -31 January 2015.

The year 2015 marks a significant year; it is the year set for the achievement of the Millennium Development Goals. The timing is appropriate to review the situation and determine forthcoming challenges. Several forums have been organized to brainstorm on a set of new targets for the post 2015 development agenda, which will be adopted at the Development Summit in September 2015.

There are serious concerns on which global health issues should be included in the post 2015 development indicators and targets. Some prefer targets on the progress with health systems, including Universal Health Coverage, human resources for health and access to essential medicines. Others prefer specific targets on unfinished agenda around maternal and child health and infectious diseases such as HIV, TB and malaria (MDGs 4, 5 and 6), and also non communicable diseases (NCDs). Finally, a few additional global health indicators and targets may be put to the post 2015 development goals.

There is a need to agree on a set of priority global health issues to be collectively tackled by the global community. This will enable commitments to addressing these priorities irrespective of their inclusion into the post 2015 development goals

Furthermore, there is a consensus from every major forum that inequity in health outcomes between the rich and the poor is unjust and unfair and should be reduced. Changes are needed in health financing systems that put the economic burden inequitably on poor households with income losses and unreasonable health care payments associated with ill-health. The movement to address health inequities has started more than a

decade since 1998 with the World Health Assembly resolution to reduce socioeconomic inequalities in health. The WHO Commission on Social Determinants of Health was established in 2005 and issued a report on "Closing the gap in a generation: health equity through action on the social determinants of health" in 2008 which called attention to the collective action needed globally.

The World Conference on Social Determinants of Health in Rio de Janeiro, Brazil in October 2011 stressed the importance and urgency of taking action on social determinants of health to reduce health inequities between and within countries. Likewise, the Report of the Global Thematic Consultation on Health in April 2013 proposed guiding principles for new development agenda to include human rights, equity, gender equality, accountability and sustainability.

The landscape of health governance has changed substantially in the past two decades. With many other global health initiatives established, the players now involve not only public entities but also non-state actors including private sectors and civil societies. Non-health sectors are also contributing much more. The World Trade Organization is one of the most important international institutions in public health policies especially related to trade policies that impact on health products and pharmaceuticals. There is serious concern that the trade and economic policy based on neoliberal approaches including global economic liberalization, privatization, market competition, and the pursuit of efficiency, may worsen health inequity. Likewise, economic and geopolitical transitions have influenced

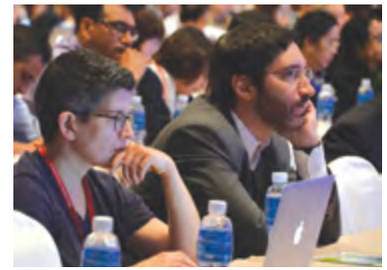
how local and national leaders promote and invest in health systems, legislation and service delivery.

International finance institutions have also put priority on global health issues. The World Bank's first report on Investment in Health in 1993 and the more recent one in 2013 on "Global health 2035: a world converging within a generation" highlighted priority health issues and the gains from investing in health.

PMAC 2015 will focus on accelerating health equity by discussing important health issues; governance and health financing systems that will reduce gaps in social stratification, differential exposure, differential vulnerability, and differential consequences of ill health and improving the quality of health care services. The theme of 'inequity' cuts across all issues and will be the focus throughout all the consultations. Concerted efforts from multi-stakeholders are crucial for successful implementation of the policies. The conference will also discuss measurement and information systems that need to be strengthened for monitoring health inequities over time.

OBJECTIVES

- To discuss and provide recommendations on priority global health issues in the next two decades, including priority global health indicators and targets that should be included in the post 2015 development goals;
- To discuss and provide recommendations on global health governance structures and global health financing strategies;
- To discuss, share experiences, and provide recommendations to develop measurements and information systems to assess inequities in health in relation to priority health issues, governance and financing.

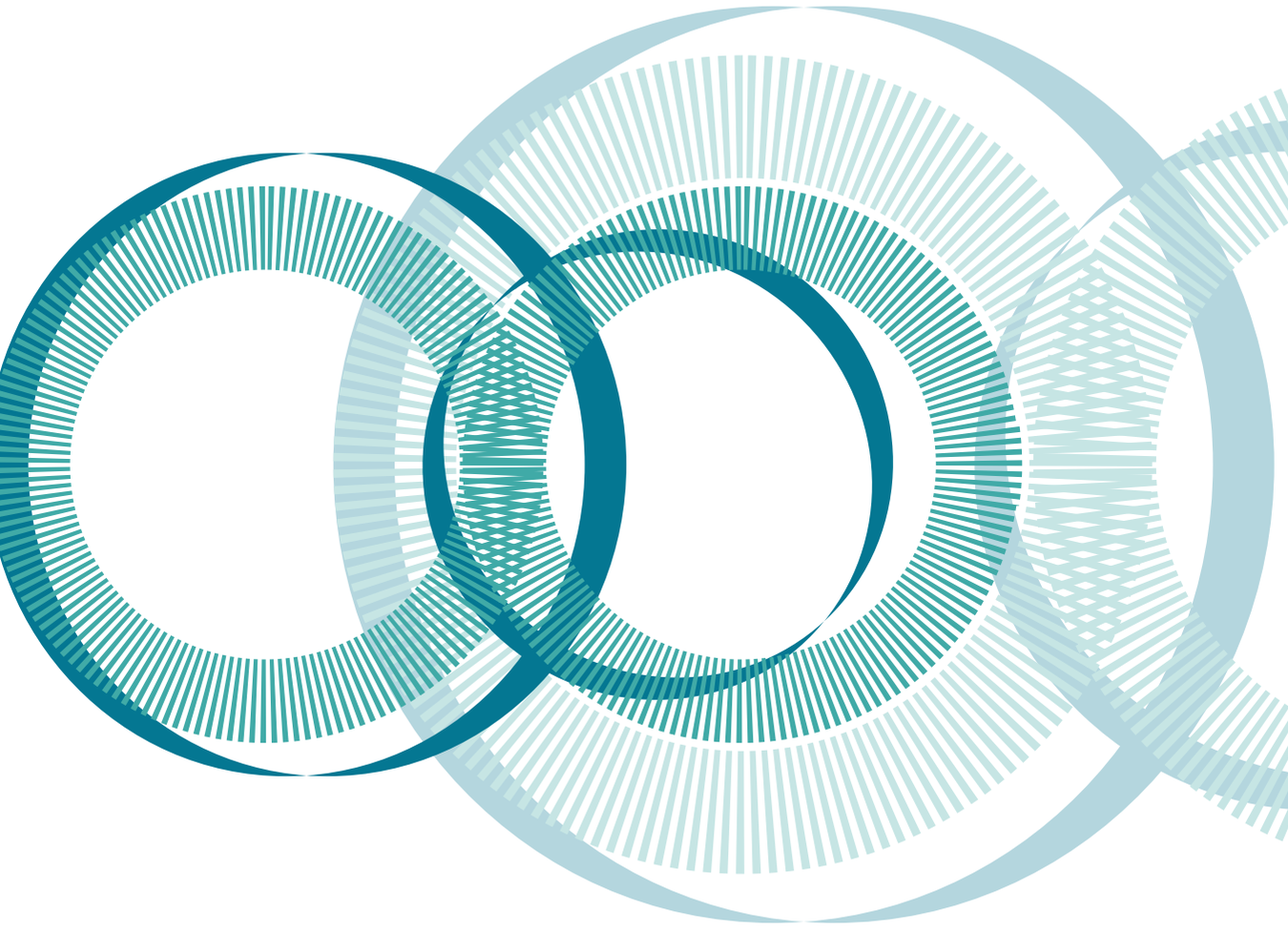


CONFERENCE PARTNERS

The Conference in 2015 was co-hosted by

The Royal Thai Government
Prince Mahidol Award Foundation under the Royal Patronage
Ministry of Public Health, Thailand
Mahidol University, Thailand
World Health Organization
The World Bank
The Joint United Nations Programme on HIV/AIDS
U.S. Agency for International Development
Japan International Cooperation Agency
The Rockefeller Foundation
China Medical Board
Chatham House

with the support from other key related partners.



SUB-THEMES
AND ISSUES

Issues to be discussed will be under three main sub-themes below:

(1) Priority global health issues and health related Post-2015 development goals/ targets/indicators;

(2) Moving towards new global health governance; and

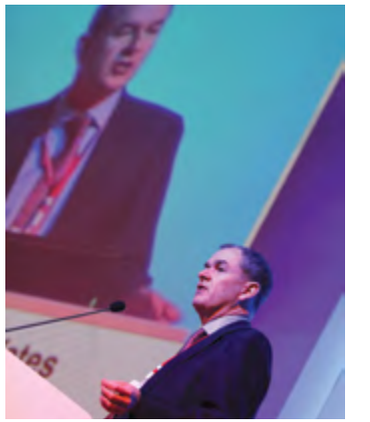
(3) Global Health Systems and Financing Priorities for the Post-2015 Agenda.

SUB-THEME 1

PRIORITY GLOBAL HEALTH ISSUES AND HEALTH RELATED POST-2015 DEVELOPMENT GOALS/ TARGETS/INDICATORS

Global Health deals with issues affecting health that cannot be resolved by one country or agency working alone. It demands the creative engagement and commitment of many different bodies including governments, international agencies, civil society and the private sector. Global public health is impacted upon by a variety of strategies and policies, at the local, the national and the international levels, and is concerned with the biological, economic, environmental and social determinants of health that affect us all as global citizens, whether in high-, middle-or low income countries.

The full enjoyment of the right to health is critical for the enjoyment of other human rights. Good health is thus an end in itself and it plays an integral role in human capabilities and well-being. Health is central to sustainable development and to economic development and health is both a beneficiary of and a contributor to development. Health is also a key indicator of what people-centred, rights-based, inclusive, and equitable development seeks to achieve.



Today, health is on the radar of Heads of State because it has become integral to at least three global agendas:

Security-driven by the fear of global pandemics or the intentional spread of pathogens and an increase in humanitarian conflicts, natural disasters, and emergencies;

Economic-concerned not only with the economic effect of poor health on development or for example of infectious disease outbreaks on the global market place but also the gain from the growing global market in health goods and services;

Social justice-reinforcing health as a social value, human right and essential component of human security, supporting the United Nations Millennium Development Goals and the Post-2015 development agenda, advocating for access to medicines and primary health care at an affordable cost, and calling for high income countries to invest in a broad range of global health initiatives.

Thus, it is no longer Ministries of Health alone who design policies for health, but increasingly, Ministries of Foreign Affairs, of Finance, Home Affairs and Defence are taking an active role. In order to increase strategy and policy coherence, it is important to understand the range of interests that governments have in global health: this will help to identify the policy space for public health.

This sub-theme will consider how health is prioritized or de-prioritized and address the underlying challenges for policy coherence at the various levels of governance (local, national and global) as well as to identify the policy space to address key equity issues.

SUB-THEME 2

MOVING TOWARDS
NEW GLOBAL HEALTH GOVERNANCE

There are several reasons why the issue of global health governance needs to be reviewed.

The health sector has no longer the sole control "over health" as health is influenced by a multitude of factors. The social determinants of health are the conditions in which people are born, grow, live, work, age and die. Such conditions have a much bigger impact on population health than the health sector itself. In the last 20 years, economic transformation in the global economy has vastly increased the resources available for investment in health but has also resulted in massively increased social and economic inequalities, including in health status. There is an urgent need to understand how public health can be better protected and promoted in the realm of global governance.

Actions taken by governments and actors outside the health sector - in relation for instance to trade, economics, migration, conflict and the environment - increasingly have an impact on people's health in ways that are not properly identified or monitored. There are political determinants of health where global accountability is deficient.

The private sector plays an increasing role in governing health. The intensified inter-relations, connections and mutual dependencies between States, societies and corporate businesses can be described as the commercial determinants of health. The way in which global food, soda and tobacco do their business, and how they interact with each other and with national, regional and international organizations needs to be much better understood by public health actors.

Health has become one of the most important of the world's industries.The last decade alone has seen a doubling of global health spending from 3 to 6.5 trillion USD.

Health has increased in importance on the national and global policy agendas. More and more national elections are won or lost on population health matters. Increasingly, public health issues and policy are discussed by heads of state. Finally, there are an increasing number of actors - new global health institutions, increasing interest by non-state actors active in global health.

In broad terms, global health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population.[1] The organization and function can be formal or informal to prescribe and proscribe behaviour. The governance mechanism can be situated at the local/subnational, national, international and global levels. Health governance can also be public, private or a combination of both.

Core functions of the global health system include the production of global public goods, management of externalities across countries, mobilization of global solidarity, and stewardship[2]. This means architecture is also needed to support technical work, monitoring, multilateral negotiations, etc.

Global health governance is often used to refer to the governance of the global health system and focuses on the actors and institutions with the primary purpose of health. Global governance for health refers to all other governance areas that can affect health and implicitly, it makes the normative claim that health equity should be an objective for all sectors.

[1] The Lancet, Volume 382, Issue 9897, Page 1018, 21 September 2013

[2] New England Journal of Medicine, March 7, 2013, Governance Challenges in Global Health, http://www.nejm.org/doi/full/10.1056/NEJMra1109339

This sub-theme will consider that there currently exists no global mechanism that follows all parallel and ongoing discussions related to global public health, particularly given the broad spectrum of fora addressing issues that impact public health including the World Trade Organization, ILO, WIPO, NGOs, civil society and others. The broad spectrum of subject-matter with direct impact on public health (trade, climate change, development, governance, water sanitation, etc.) further heightens inherent complexities and challenges.

Today there is increasing recognition that the existing rules, institutional mechanisms and forms of organization need to evolve to better respond to the emerging challenges of globalization and ensure that globalization benefits those currently left behind in the development process.

This sub-theme will address both the issues of "global health governance" as well "global governance for health":

On global health governance, discussions will be held around the following issues:

- The role of state actors - UNAIDS, WHO, UNICEF, GAVI, World Bank, G8, G20, regional health collaborations and others;
- The role of the non-state actors - private sector, social enterprise and civil society organizations, especially in terms of health in critical under privileged groups;
- Appropriate and effective monitoring and evaluation mechanisms as well as global health information systems to ensure transparency, accountability and fit for purpose.

On global governance for health, discussions will be held around:

- Social, political and commercial determinants of health and "health in all policies;"
- Appropriate coordination mechanisms to ensure that health is being considered in broader policy development (joined-up government at all levels);
- Appropriate instruments to assess the potential health and social impact of policies during the policy development process.

SUB-THEME 3

GLOBAL HEALTH SYSTEMS AND FINANCING PRIORITIES FOR THE POST-2015 AGENDA

This sub-theme focuses on how management and financing of health systems can improve quality, equity and raise health outcomes. The discussions will foster wider agreement of collective actions for providing financial protection, ensuring programs are responsive to people's expectations and services address the needs of poor and vulnerable populations. A number of tenets will guide the discussions:

The dynamic nature of health priorities require flexible and adaptable financing, management and delivery systems;

- Achieving quality and financial sufficiency are not the end but the means to achieve better health;
- External financing should not crowd out but promote domestic resource mobilization;
- As countries go through economic transition, stewardship of the health sector should prevent disproportionate increases in out-of-pocket expenditures and further disparity in access;
- Health financing strategies should work with the contribution from non-health sectors, such as education, defense, labor and social security sectors, and the influence of trade and foreign policies;
- Universal Health Coverage requires political commitment and calls for expanding services to the underserved, with financial protection and resilient health systems that meet quality standards.

At PMAC 2015, the international community will take pulse on the status of health financing globally and discuss trends and new ideas in resource mobilization. The growing trend of disparities among countries and strong upward pressures increasing costs and financing requirements will bereviewed with an analysis of the drivers. Weighing costs escalation against the returns on investing in health, the meeting will provide a venue to develop a good value proposition on increased financing on health for wider acceptance at global and country levels. This is critical for the debate on universal health coverage and has implications on both international financing and domestic resource mobilization. The discussions will highlight advocacy for poor countries to spend more, and for rich countries to get more value for the money spent. And overall, to re-affirm the notion of good health for low cost and review lessons learned amongst all countries.

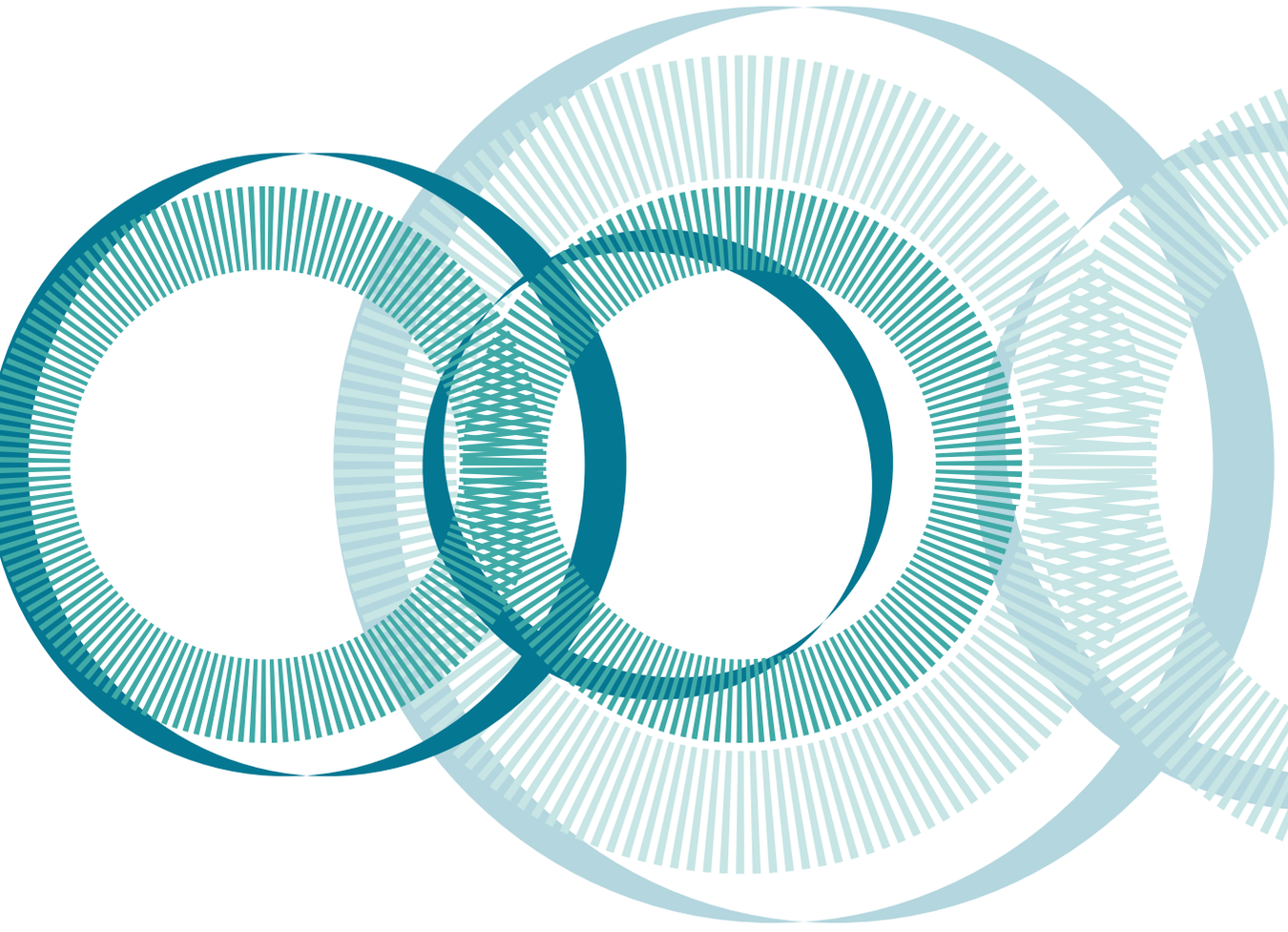


The key pathways to achieving equity and improved health outcomes are adequacy/ sufficiency, allocative and technical efficiency (including sub-sectoral priorities and incentives) and the level of financial protection provided. The sessions will review financial investments and with emphasis on the need to demonstrate measurable results. The discussions will take stock of accountability by the international development community as well as Ministers of Finance asked to increase outlays and Ministers of Health who have to decide among competing priorities.

Worldwide, countries are weighing the unfinished agenda in health, emerging priorities such as non-communicable diseases, pandemic threats and global climate change. Common threats to health security call for shared solutions including cross-border and regional collaboration, and the need for strategies to finance regional public health goods. In addition, the sub-theme will provide opportunities for an exchange with emerging donor countries, and learn about their shared interests, strategic priorities and explore partnerships with long-standing donors. Special sessions may be arranged with BRICS countries, and other transitional economies that are moving into upper middle income status, their experiences with moving towards donorstatus, reaching self-reliance, including the assurance to procure and supply sufficient drugs, vaccines and other health commodities.


Collectively, the sessions under this sub-theme will address the following issues:

- What is the current situation with health financing globally? What progress has been made with mobilizing domestic resources and establishing sustainable sources of financing?
- What are the lessons learned from vertical global financing mechanisms, sectoral programs and what is needed to address neglected health threats and broader health goals?
- What are the emerging challenges for the next two decades that will define plans for reaching universal health coverage and what adaptations are needed within service delivery and financing systems to address them?
- What systems changes are needed to enable providers and managers to manage for results, including practical, manageable and measurable improvements in quality?
- What are the lessons learned with innovative strategies such as using incentives to promote quality of care? How can results-based financing systems extend coverage and improve quality? How can demand-side subsidies reduce out of pocket expenditures?
- How can clients and civil society effectively participate in decisions on service delivery, quality and financing of health care?



KEYNOTE SESSIONS

Summary of the Opening Session
& Keynote Addresses

Dr. Donald A. Henderson

Distinguished Scholar, Center for Health Security,
University of Pittsburgh Medical Center

Dean Emeritus, Bloomberg School of Public Health,
Johns Hopkins University, USA

Prince Mahidol Award Laureate 2014, Distinguished Scholar, Center for Health Security, University of Pittsburgh Medical Center, Dean Emeritus, Bloomberg School of Public Health, Johns Hopkins University, USA

It is a signal honor to receive the esteemed Prince Mahidol Award for Public Health. And for this, I am especially grateful to the Foundation. It recognizes an unparalleled achievement in medical progress-the eradication of a disease which had plagued mankind since the earliest days of written history-a disease which was universal and could and did spread everywhere and in every season-a disease which killed 25% or more of its victims and left the others permanently scarred and sometimes blind. As recently as 1967 when the global program began, more than 10 million cases and 2 million deaths occurred in 43 countries. The last case was detected and contained just 10 years and 9 months after the campaign began. On May 8, 1980, the World Health Assembly announced that eradication had been achieved and advised that vaccination should be stopped everywhere.

The fact that there has been no case of smallpox for more than 37 years is still difficult for many to grasp. And that is understandable. It is the only disease that mankind has been successful in eradicating!

The achievement is worthy of celebration of itself; more important was the demonstration of the potential for achievement when countries join together in a common effort. The smallpox campaign was unique in that, for the first time, it required the development of national vaccination and surveillance activities that extended throughout all populations however remote and hostile-of cooperation between countries and peoples that seldom communicated.

Photo Credit: In Ethiopia, there were limited roads which were sometimes impassable. But the bridge shown here was crossed four times in 1974, Ethiopia, 1974. World Health Organization.
http://www.who.int/features/2010/smallpox/work_conditions/en/index1.html

For eradication, there were a number of daunting obstacles. Smallpox vaccine had been available and in use for more than a century. However, when the program began, the vaccine was hopelessly deficient in quantity, in quality, and in heat stability. Research was needed to improve production and testing methods. Countries and laboratories had to be persuaded of the need for international standards and of the importance of independent quality controls. New vaccination instruments and techniques for vaccination had to be tested and introduced throughout the world.

Epidemiological field studies demonstrated that smallpox spread less readily and rapidly than many believed. It was discovered that a single successful vaccination protected for 10 years or more. New containment methods called "ring vaccination" were perfected which could contain widespread outbreaks when even a comparatively small proportion of the population had been vaccinated.

Cumbersome, ineffectual management structures, both internationally and nationally, had to be finessed - delicately or forcefully as the needs dictated - while sustaining needed political acceptance.

Throughout the duration of the program, communication was a challenge. Activities in some 40 countries were needed; our headquarters staff consisted of only 10 persons; international staff never numbered more than 150 world-wide. Communication was especially difficult and effectively limited to personal contact and ordinary mail. Telex and telephones were out of the question. And yet, as many as 150,000 health workers were active in the field during special programs.

The ultimate keys to success depended on the active involvement of national and local government authorities, laboratory scientists, epidemiologists, and the public - in planning, in educating, in participating, in problem solving. Surveillance reports documenting progress, innovations, and problems were prepared and distributed every 2 to 3 weeks; field staff contributed special reports as did laboratories.

Photo Credit: The logo certifying the eradication of smallpox in Somalia, and consequently, in the world, 1979. World Health Organization.
http://www.who.int/features/2010/smallpox/last_cases/en/index6.html

Overall success in smallpox eradication cannot be attributed to the dynamic insight or leadership of a few motivated individuals, or breakthrough discoveries in the vaccine field or in laboratories, or of special donations or contributions by agencies or national authorities. It was all of these and more. Thus, the recognition of the achievement of smallpox eradication highlights what can be achieved where there is interest, flexible innovation, research, and imagination.

I was first introduced to smallpox and the devastation caused by that disease nearly 50 years ago. That year, there were more than 10 million cases. Throughout the developing world, smallpox vaccine was virtually the only vaccine of any type that was available and little was provided outside of populated urban areas. More than 90% of the vaccine failed to meet a minimum standard and most of it was not heat stable. No country had a vaccine program of any sort intended to reach all of its citizens.

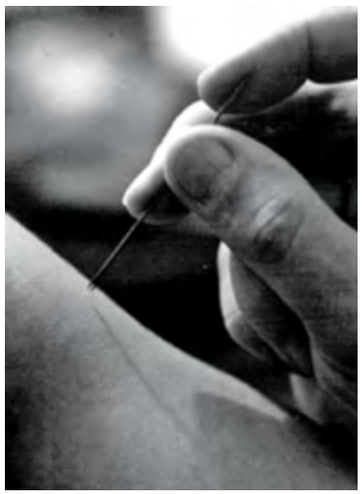


Photo Credit: The bifurcated needle proved to be a simple and efficient vaccination device, 1970s. World Health Organization.
http://www.who.int/features/2010/smallpox/vaccination/en/index6.html

Photo Credit: Ali Maow Maalin, the last case of smallpox in Somalia, 1978. World Health Organization.
http://www.who.int/features/2010/smallpox/last_cases/en/index1.html

Smallpox eradication catalyzed the early stages of a transformation. From the smallpox base many initiatives were to emerge: the expanded global programs for immunization; control campaigns for such as poliomyelitis, measles, hepatitis; vitamin A distribution; bed net distribution programs; and others. For each of these, the goal emphasized the need for inclusion of citizens throughout the country.

At this conference whose theme is Accelerating Equity, it is especially appropriate to recognize the primary role of smallpox vaccination as the earliest of initiatives in developing countries endeavoring to reach all citizens and to provide needed equity.

Dr. Tim Evans

Senior Director,
Health Nutrition and Population,
World Bank Group, USA

SOLIDARITY AND SECURITY IN GLOBAL HEATH:

WHAT CAN WE LEARN FROM THE EBOLA CRISIS?

It's been nearly *14 months* since the Ebola virus first emerged in rural southwestern Guinea with the "index case"- a 2-year-old who died on December 6, 2013. *14 months.* What could have been an isolated and swiftly contained outbreak instead spiraled and spread out of control across Guinea and to neighboring countries to become the world's worst Ebola epidemic ever.

We know all too well the human and economic toll this deadly epidemic has had, and continues to have, in Guinea, Liberia, and Sierra Leone. And until we get to zero Ebola cases, the rest of Africa - indeed the rest of the world - continues to be at risk of contagion - both health and economic-wise.

Last week, the World Bank Group released a new report showing that even as Ebola transmission rates in the three most-affected countries show significant signs of slowing, the epidemic continues to cripple the economies of these countries - with a projected $1.6 billion in lost GDP for 2015. Of course, Ebola isn't our first wake-up call that pandemics are costly. From 1997-2009, six major utbreaks of animal-borne diseases that can be transmitted to humans, such as SARs, avian and swine flu, resulted in billions of dollars in economic losses. And following the 2009 H1N1 epidemic, a *Review Committee on the Functioning of the International Health Regulations in relation to H1N1,* aka "the Fineberg Report" identified serious shortfalls in the global pandemic response capacity noting:

"The world is ill-prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public-health emergency."

Moreover, the succinct recommendations of the Fineberg Report proposed, for example, a global pandemic workforce and a pandemic fund, but failed to move beyond the paper on which they were issued. But it is possible, indeed imperative, that we do better in managing global pandemic risk.

Larry Brilliant - a key leader in the eradication of small pox along with DA Henderson - commented recently that "outbreaks are inevitable, epidemics are optional." The good news is that this Ebola epidemic is now being contained. We are seeing light at the end of the tunnel- although it's still too early to declare victory. We know this deadly disease has a history of resurgence, and we must remain vigilant.

But while the terrifying reality of the Ebola crisis is close at hand, let's look now at what we can learn. ***I would like to offer 10 lessons from the Ebola crisis - on which we must act NOW so we are prepared and can respond smartly and swiftly to the next pandemic.***

LESSON 1
Public Health and Health Care Services Go Hand-in-Hand.

In 1875, Theodor Billroth, a Professor of Surgery, noted, "The fanatical champions of public healthare fighting for a goal that is too high for my myopic vision. I can admire the struggle, but I cannotbecome interested in it."

Professor Billroth may have thought differently if he had been working in the Kipe hospital in Guineain April 2014 when a patient with stomach pain and fever presented in the emergency room. Thepatient was admitted with a suspected bleeding ulcer, scoped by the gastroenterology service,admitted to an intensive care unit in shock and died. Nine of the hospital's 71 nurses and doctorssubsequently developed Ebola infection and 6 succumbed to the disease!

Were Professor Billroth working in any of the Ebola-affected countries and presented with a motherwith obstructed labor who also had a fever, he too might become a "public health fanatical" indemanding a rapid diagnostic to rule out Ebola infection prior to proceeding to a Caesarian section.

Indeed the sinister nature of Ebola, whereby it infects the compassionate hands of health careproviders that tend to sick patients, illustrates the inseparability of public health and clinical services.Moving forward, we must build a seamless intersection in the planning and delivery of public healthand clinical services that strengthens primary health care systems- the best defense against Ebolaand other epidemic infectious diseases.

LESSON 2

Informed Citizens and Empowered Communities are the Most Effective Front Line of Preparedness and Response.

The fatal attacks on Ebola workers in rural Guinea underscore the harsh reality that efforts to protectthe public's health are not necessarily welcomed by the community. Instructions from public health authorities for "safe burials" to prevent further transmission of Ebola,which required abandoning traditional rituals of dealing with the deceased, were met with greatsuspicion and even outrage by aggrieved family members. Attaining good levels of adherencerequired active engagement with communities such that they could better understand and acceptthese practices. Community insights among Muslim populations, led to abandoning "black" bodybags for "white" ones in order to match the white sheets in which the deceased are traditionallydraped.

Much of the success of the efforts to prevent spread of Ebola in Senegal, Mali and Nigeria was linkedto the mobilization of religious and community leaders. Dr. Awa Coll-Seck, the Minister of Health inSenegal --- and also the Senegalese "Man of the Year" for 2014 --- emphasizes the critical rolewomen community leaders played across all of the villages of Senegal in spreading awareness of Ebola.

In Monrovia-it was volunteers from the community who assisted families to care for Ebola victims,and meet their daily food and water needs as they stayed at home for the 21-day quarantine period. These same volunteers were instrumental in helping to integrate Ebola survivors back into thecommunity. These innovations in community engagement/ empowerment should contribute to a rich legacy of know-how in the control of Ebola and other Epidemic Infectious Diseases.

LESSON 3

Secure "staff, stuff and systems" to deliver services.

My dear colleague, Paul Farmer is "famous"… and well-known for repeatedly calling attention to the "staff, stuff and systems," the basic resources required to protect populations and to provide services of quality to those with the greatest needs.

Shortfalls in these basics, as we have seen in the Ebola-affected countries, prevent the provision of life-saving services and contribute to the spread of the disease. It is not only availability of the staff, stuff and systems. but the way in which these ingredients come together in a timely way…or not… that also explains performance. For example, while the standard diagnostic test for Ebola only takes 3-4 hours to yield a result, in many places patients were waiting 3-4 days before finding out whether they had infection. Similarly, even when staff are successfully recruited and trained to work in Ebola Treatment Units, running out of protective equipment such as gloves or goggles can bring a halt to care. In overcoming such bottlenecks, the resources and know-how of the private sector should be tapped more systematically. This could include rapid setting up of communications networks in areas that are off the grid, such as with Vodaphone's Instant Network, or drawing on the supply chain expertise of companies like FedEx or DHL, which can guarantee regular and timely delivery of key commodities. Excellent managerial and logistic competencies-often the human resource that is he most scarce-are critical to making sure the staff, stuff and systems from various sources can come together to deliver quality services in a timely way.

LESSON 4

"Command and control pluralism"
- 21st Century leadership for epidemic infectious disease.

The powerful concept of "One Health"-the theme of PMAC in 2013-recognizes that health interdependence is a growing reality of the 21st century, not only between animal and human health, but also across sectors like agriculture and education; across public, private, civil society institutions; and across geographies-local through global. The paradox, however, is that operationalizing the "One Health" concept is dependent on coordinating One Hundred partners! In each of the affected countries, the various national coordinating mechanisms have attracted a large number and wide array of institutional actors and constituencies that must be, or want to be, involved in the Ebola response, thereby creating a major leadership and coordination challenge. National leaders from Liberia, Sierra Leone and Guinea have identified an important agenda of issues where international partners could improve their support in terms of speed and common sense (e.g. limiting the use of UN equipment to UN staff!) Encouragingly, over the months of the Ebola crisis, we have witnessed growing strength in the national coordinating mechanisms, with some veterans of emergencies claiming they have never witnessed such a high level of discipline and alignment amongst so many. This leadership ability of bringing discipline and efficiency to a wide array of partners is what I call "command and control pluralism," and should be harnessed to deal with other complex health emergencies.

LESSON 5

There is a need to make more room for analysis and accountability in the midst of a crisis response.

While the basic descriptive epidemiology of the Ebola crisis has emerged… albeit slowly…there has been a virtual absence of more analytic assessments of the crisis. This epidemic has clustered in poor urban areas-does this reflect a change in Ebola virus disease transmission dynamics? How many transmission chains are there? Is there evidence of herd immunity? Why do case fatality rates differ widely across treatment facilities? As my colleague Ariel Pablos-Mendez, the Assistant Administrator of USAID, recommended recently, we need more "analytic epi on the go."

At the same time, we can use new information technologies to bring greater accountability to the response. In providing "hazard pay" to health workers, for example, the World Bank Group has advocated a shift from cash payments and paper records to e-payments made directly to bank accounts of health workers. This has shaved large numbers of "ghost workers" off the payroll and improved overall accountability.

LESSON 6

We need to establish and/or strengthen regional disease surveillance networks.

The current crisis is defined by the fact that it took root in three countries that share borders, and that it poses a persistent threat to the health security of the entire West African region. This reflects not only inadequate national capacities to manage epidemic infectious diseases; it also reveals a deficit in regional collaborative arrangements. There is growing recognition of the value of regional networks-in East Africa, Southern Africa, Southeastern Europe, and in the Mekong Basin-in fostering cooperation among neighboring countries to control cross-border disease outbreaks at their source and improve health outcomes. Regional organization of laboratories, surveillance, and training capacity is more cost-effective than each country trying to manage its own. It also encourages more truthful reporting and sharing of sensitive information, and helps to reinforce common standards. Encouragingly, many partners, including the World Bank Group, are supporting the development of this type of regional disease surveillance capability in West Africa

LESSON 7

We need a global health workforce ready to respond.

For Ebola, fear of infection, uncertain working conditions and the lack of treatment and medical evacuation options have limited the in-flows of foreign health workers at rates needed to scale up the response quickly. Securing a stronger supply of workers required to respond to a wide range of epidemic infectious diseases-what Michele Barry and Larry Gostin refer to as a "global health reserve force"- is a good idea that needs to be operationalized. We can build on the Global Outbreak and Alert Response Network model and extend it to assure the full range of skills required. Managing it requires a professional, end-to-end deployment capability, from recruitment and proper training (that is refreshed regularly and properly accredited); to housing, pay, insurance, and health care in case workers get sick; to repatriation support. To be successful and sustainable, the workforce must draw from as many national contexts as possible to ensure sufficient multicultural and multilingual depth.

LESSON 8

We need to sustain "fast-tracking" in the development and distribution of new vaccines, drugs and diagnostics.

The efforts to fast-track clinical trials/testing of candidate vaccines have led to important breakthroughs in collaborative arrangements between institutions, as well as trial designs for evaluating the safety, efficacy and effectiveness of new vaccines. Unfortunately, with the rapid decline in the number of cases of Ebola, the window for testing the promising candidate vaccines is closing quickly. It is critical to sustain interest and investment in Ebola vaccine development so that further testing can be done wherever and whenever conditions are appropriate. A point-of-care diagnostic that can determine Ebola infection status within minutes is also an important research and development priority, given its importance in the triaging of patients that present with fever to health facilities. Preparing manufacturing capacity and distribution logistics, including stockpiles, will ensure that an adequate volume of products is produced and accessible when needed.

LESSON 9

We need new financing tools to ensure that money can flow quickly in the event of a pandemic. World Bank Group President Jim Yong Kim has laid out a vision for creation of a Pandemic Emergency Facility.

The idea for the Pandemic Emergency Facility (PEF) is being developed in consultation with a number of multilateral, bilateral, private sector and civil society partners. Most recently, this was the topic of several discussions last week in Davos. There is growing interest in this idea across stakeholders. The basic idea for the facility is create a pool of resources that will encourage development of preparedness plans and ensure that money can flow quickly to enable a robust pandemic response. The facility would build on existing financing mechanisms (such as the Crisis Response Window of IDA -- the World Bank Group's fund for the poorest countries) and create new ones, such as a pandemic insurance market and a contingency fund. Funds would be released based on a pre-agreed trigger, which would signal a reliable assessment of pandemic threat. We envision a pre-negotiated, global coordination platform that identifies distinct, but integrated, roles for public institutions, including international organizations, national governments, bilateral and multilateral donors. Funds raised could enable support for a range of actors in the pandemic response. The facility could also provide a platform to direct private sector and philanthropic initiatives toward the areas of greatest need.

LESSON 10

Underinvestment in public health kills people and derails economies!

As Larry Summers and Gavin Yamey wrote in the *Financial Times* in November 2014, "We play with fire if we skimp on public health." Investments in public health are a notorious blind spot in health systems financing: Interventions are often invisible to consumers of health care and, as such, fall to the bottom of the priority list. Following the Avian Flu Pandemic in 2007, Integrated National Action Plans for public health preparedness and response were drawn up across Africa. The cost of these plans across Guinea, Sierra Leone and Liberia amounted to $26 million dollars in 2007 and failed to find any investors. In hindsight, this was a miniscule amount compared to the multi-billion dollar price tag of the Ebola crisis!

In closing, your Royal Highness, and colleagues, the World Bank Group is so concerned about the Ebola crisis, not only because of its devastating impact on health, but because it is quickly eroding hard-won gains in development. The World Bank Group recognizes that investing in health is one of our best investments for economic growth and shared prosperity.

Looking forward, we are excited by the prospect that the post-2015 global health agenda can accelerate equity in health and development. The Ebola crisis reminds us of a shared threat and shared responsibility that unites us in this most important mission. As Winston Churchill said, "Never let a good crisis go to waste."

Ms. Taniya Akter

Adolescent member,
BRAC, Bangladesh

Thank you very much for the kind introduction and for having me here. It is a great honor to be speaking on behalf of my adolescent peers on this wonderful occasion.

I come from a small village in the North of Bangladesh. I am the eldest of 3 daughters and a son. I must say I am among the lucky girls in Bangladesh. Because at 17, I am still attending school instead of being married. Right now in Bangladesh 1 in 2 girls are married by the age of 16. Many of my friends are already married and have dropped out of school. Some of them are pregnant. My parents wanted me to marry too. My father is a small business man and my mother is a housewife. Running a family of six has been difficult for them. So, when I was in Grade 9, they wanted to marry me off. I was a burden. I knew the bad result of getting married early. I have been attending the BRAC adolescent club in my village since I was in Grade six. You may know about BRAC, it is a largest NGO of the world and one of the main objective of BRAC is empowering women. From my club I received Life skill based education. Therefore I knew my life would end if I got married. My health would suffer, my education would stop, and my choices will be taken away. I did not want this to be my fate. I wanted to study more. So I was adamant. I explained to my parents the bad effects of child marriage. I reached out to other family members and explained them. I cried non-stop for three days and refused to eat. Finally, they gave in and my marriage was stopped.

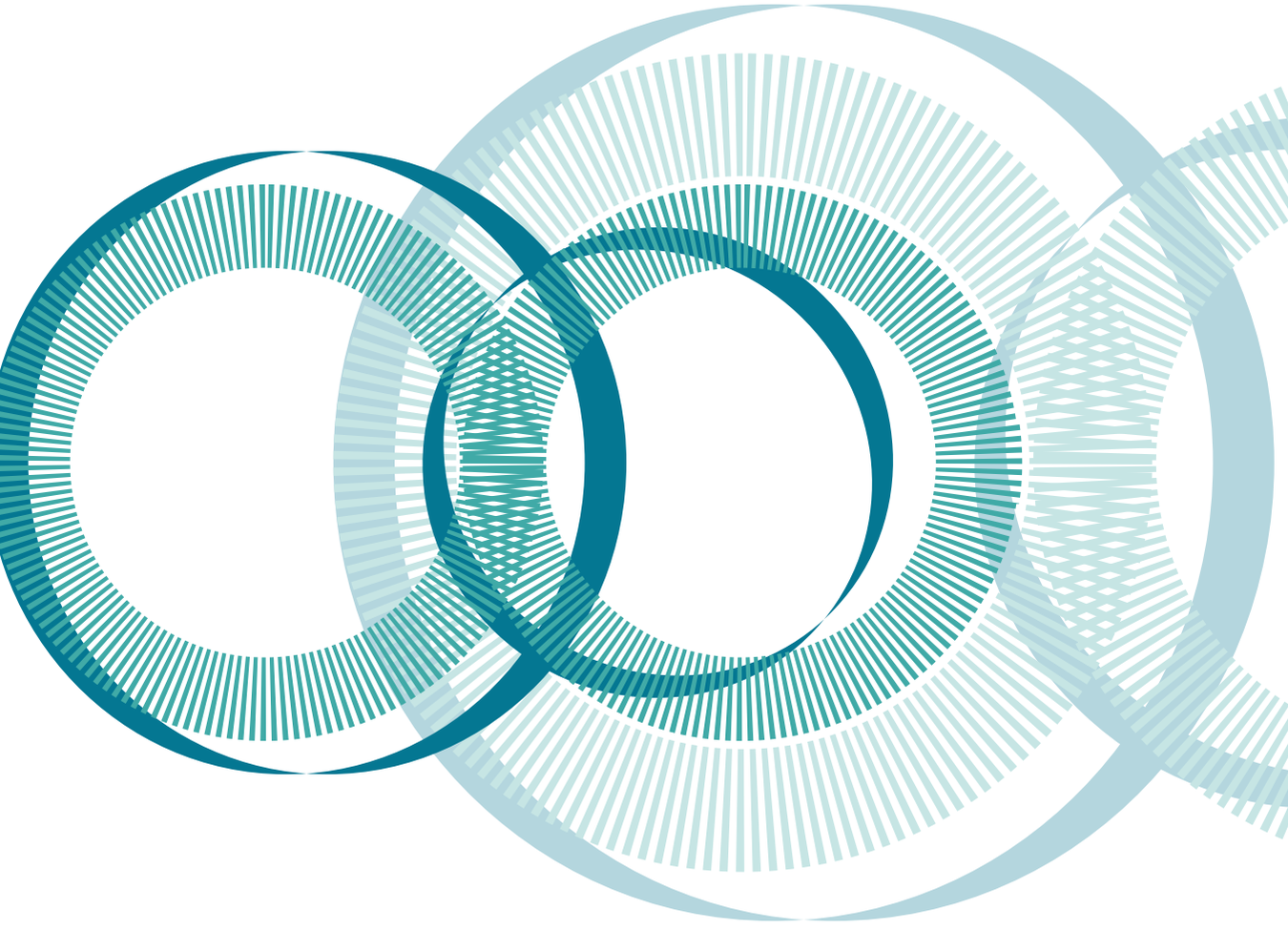
I realized I was a financial burden on my parents and one reason why they wanted me to marry. I realized that it is very important for girls to have access to a livelihood and to earn an income. So in order to continue my education and support my expenses I did various jobs and started earning income. Today I feel very happy that I am studying in higher secondary school through my own income and finance the education expenses of my siblings too.

I had a lot of other support that helped me be a confident person and believe in myself. I feel proud to be the peer leader of my adolescent club today. I received training on leadership and awareness about issues that we need to know at our age. I share what I learnt with my girl friends in the club. I feel happy that we have a space in our community where we can just be ourselves. Boys can go wherever they want, talk to their friends whenever they want, but we girls could not. So when BRAC opened the club for girls, it really gave us a space where we can sing, dance and learn about important issues such as sexual and reproductive health and rights, child marriage etc.

We may be aware about issues but translating awareness into action remains a challenge. For example, we know child marriage is harmful but the rule of law is not strong enough in Bangladesh to prevent 63% of girls in Bangladesh from becoming child brides. Sexual abuse and harassment is punishable by law and yet we suffer in public spaces and at home. We may learn how sanitary napkins can help us maintain hygiene, or about contraception that can help prevent unwanted pregnancy but we do not have access to such products. I worry about financing college education after I finish Higher Secondary. I worry about finding a job because as a girl, my options are very limited.

But I know it does not have to be this way. The world can be a better place for girls. And so I look to you for helping us in creating such a world. I would like to live in a world where we girls and women have our human rights and the power to make choices. A world where all girls have access to education and the right skill sets so we do not have to be financial burdens on our family. I want us to have control over our sexual and reproductive lives and have full access to health services. Equality is important but equity is essential. We girls are so far behind our male peers, that providing us with the same opportunities as boys is just not enough.

The world needs to heavily invest in girls and only then we will be able to stand equal to the boys. No parents should be forcing their daughter into a child marriage because she is a financial burden. No girl should have their sexual and reproductive health rights taken away from them. If we have a world where girls have their rights and are able to make their own decisions, then I assure you that this world will be different a better place. Thank you for listening!



CONFERENCE
SESSIONS

As expected, much of the PMAC discussion centered on the upcoming SDG 2030. There was a general consensus that better health is a "precondition for, an outcome of, and an indicator of all three dimensions of sustainable development" (Rio+20). There were clear views that, compared with the MDG, the proposed 17 goals and 169 targets of SDG were too many, although they were comprehensive, with clear interlinks between health and sustainable development. It may create reporting burden to countries having less capacities to do so. There is now an obvious need for thorough consultations, and engagements by countries, civil society organizations, and international development partners. For many, the SDG targets seem ambitious, and they question whether they are realistic and really achievable in light of many failures to achieve the MDG's. The proposed SDG's promise huge challenges, not least the loads on country reporting, and building sufficient capacity to monitor equity. The main bottleneck to achieving SDG will likely be the untouched political determinants of inequity, and supranational influences, in particular trade interests. SDGs should focus on universal health coverage (UHC) as one of the main goals, not sub-goal, as universalism has been proven to contribute to equity, as shown in the case of Thailand (see Fig. 1, 2 and 3).

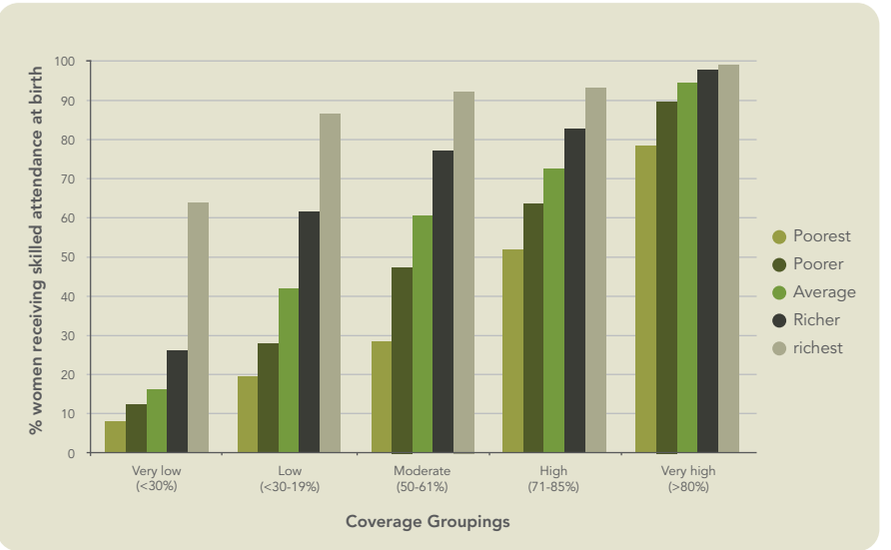


Figure 1 Skilled birth attendance among five wealth quintiles, and groups of coverage from very low (<30%) to very high (>80% of total births)

In Figure 1, data from 35 countries conducting Demographic and Health Surveys (Channon et al 2005) showed that the higher the coverage of skilled birth attendance, the smaller the gaps of coverage inequity between the poorest and richest wealth quintiles. For example, among countries with very low coverage below 30% of total births, rich-poor gaps were large, at around 60 percentage points. However for the very high SBA coverage countries (>80%), the rich-poor gap was small, less than 20 percentage points.

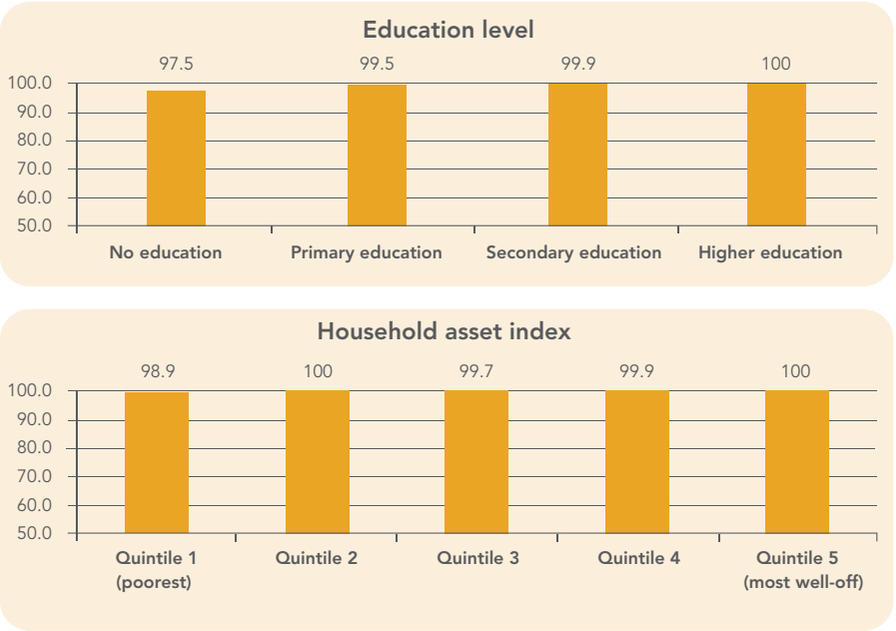


Figure 2 Universal skilled birth attendance, Thailand
Source, Reproductive Health Matters 2011; 19(37) : 86-97

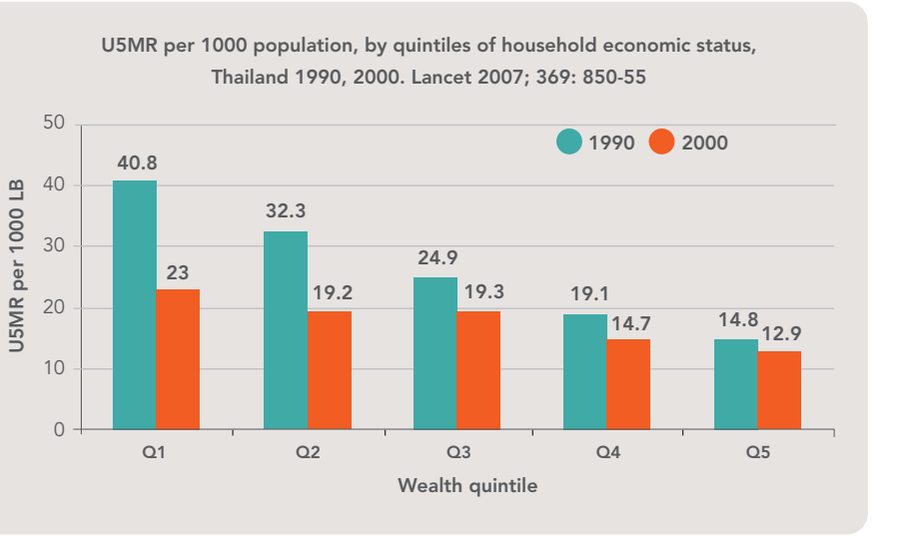


Figure 3. Child mortality gap between two national Census, 1990 and 2000, Thailand
Source: *Lancet* 2007; 369: 850–55

In Figure 2, Thailand had reach almost 100% of skilled birth attendance for the whole population. There are neither education gaps in the upper panel nor rich-poor gaps in the lower panel.

Thailand had reached universal coverage of Maternal and Child Health (MCH) services well before the UHC in 2001, with a very high level of MCH service coverage. This resulted in rapid reduction in the rich-poor gaps of child mortality between the two censuses in 1990 and 2000. The gap of 26 per 1,000 live births in 1990 had reduced to 10.1 per 1000 live births in 2000, an extraordinary achievement in ten years.

A study using Demographic and Health Surveys [Amouzou et al. BMC Public Health 2014, 14:216, http://www.biomedcentral.com/1471-2458/14/216] conducted between 1995 and 2010 in 67 developing countries, using a population attributable risk approach, computed the proportion of global child mortality gap and the absolute number of child deaths that would be reduced if the child mortality rate, and in each of these 67 countries it was lowered to the level of the top 10% economic group in each country. This study found that in 2007, approximately 6.6 million child deaths were observed in the 67 countries in the analysis. This could be reduced to only 600,000 deaths if these countries had the same child mortality rate as developed countries.

If the child mortality rate was lowered to the rate among the top 10% economic group in each of these 67 countries, child deaths would be reduced to 3.7 million (compared to the observed 6.6 million deaths. This corresponds to a 48% reduction in the global mortality gap with 2.9 million child deaths averted. Using cutoff points of the top 5% and top 20% economic groups showed reduction of 37% and 56% respectively in the global mortality gap. With these cutoff points, respectively 2.3 and 3.4 million child deaths would be averted. This study concluded that child mortality disparities within developing countries account for roughly half of the global gap between developed and developing countries. Hence within-country inequities deserve as much consideration as do inequalities between the world's developing and developed regions.

This compelling evidence contributes to a conclusion that to improve health and equitable distribution of health status across socio-economic classes, universal access to health services is the only instrument which can accelerate health equity. Health equity is the centrality of PMAC 2015 theme and the post-2015 Sustainable Development Goals.

DIVERSE COUNTRY EXPERIENCES: PLATFORMS FOR LEARNING AND SHARING

The Japanese UHC experience was discussed, with its successes in improved access through UHC. Empirical evidence showed that UHC contributed to improved income re-distribution, as measured by the Gini index, together with inclusive economic growth and social stability. However the challenges to sustain UHC in view of the ageing population and low economic growth are now clearly obvious.

UHC has been a good learning platform for the global community, with a diversity of country experiences providing platforms for learning and sharing. Rwanda and Ethiopia in particular have shown significant health improvements through improved access by minimizing the geographical and financial barriers, and progressing towards UHC. Rwanda has managed to achieve more than 90% population coverage by the Mutuelle de Santé; for which all levels of political commitment matter. Currently, in additional to all high income countries having achieved UHC, about 30 middle-income countries are implementing programs to advance the transition to UHC, and many other low- and middle-income countries are considering starting similar programs.

The path to UHC, however, has highlighted the need for clear government leadership, increased domestic resources, and alignment of donor support. Many countries have failed to meet their MDG targets, and their challengers remain including failing health delivery systems and lack of financial risk protection. The recent Ebola outbreak has clearly demonstrated the failing of health system capacities and lack of resilience in affected Western African countries.

TRANSITION FROM DONOR DEPENDENCE

Countries moving from low income (LIC) to lower middle income (LMIC) and upper middle income (UMIC) status face a significant transition from donor dependence, particularly the transition for GAVI and GFATM, the two major global health initiative, funded projects, and large bilateral programs such as PEPFAR. Transitioning requires strong political commitment and the need to create fiscal space for health, and programmatic and financial sustainability transition planning.

Access to disease prevention commodities in post 2015 will likely to be dominated by GAVI and GF efforts in shaping the market so that commodities are affordable by countries transitioned from their funding support. The current target is to bring down vaccine prices to below 19USD per fully immunized child (DTP, Hb, Hib, Pneumo, Rota) by 2017, and it is planned that middle income countries will purchase vaccines at 20% above low income countries through affordable tier pricing. The remaining challenges are those of oligopoly and monopoly markets especially for antiretroviral therapies and vaccines, and the public disclosure of pricing by these monopoly industries. Suggested solutions have been for middle income countries to access pooled procurement for best possible prices, given assured quality, and to encourage market transparency, publishing of vaccine prices, market share and procurement knowledge.

GOVERNANCE AND ACCOUNTABILITY

As Ilona Kickbusch stated, "We are challenged to develop a public health approach that responds to the globalised world. The present global health crisis is not primarily one of disease, but of governance...". Accountability is not only required for the health sector, but there is a strong call for the same accountability across other sectors (trade, transport, urban planning, and education) that impact the health of populations. Embedding a culture of accountability into governance, using the Human Rights framework would seem to be an effective way to move the SDG forward. This will require better data and information and improved use for performance assessment to hold healthcare providers accountable and responsive.

CHANGING POWER RELATIONS: BETWEEN ELITES AND LOCAL HEALTH WORKERS

There is an overwhelming need to strengthen the local health workforce in terms of numbers and competencies to face the challenge of overcoming inequality. In many cases this is an issue of deployment in the right places, and retention of that workforce. Evidence shows better retention when recruiting students from local communities, ethnic minorities for health workforce training and home town placement. A good example was the upgrading training of medical assistants in Vietnam. Accountability can be achieved through quite simple approaches, such as in all rural clinics in Rwanda where the names and mobile phone numbers of all health workers are posted to achieve accountability, and in West Africa, where to ensure transparency, ghost doctors were removed from payrolls after implementing electronic transfer of salaries in the healthcare workforce.

POLITICAL ORIGINS OF HEALTH INEQUITY

Unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone - they require global political solutions. The norms, policies, and practices that arise from transnational interactions should be understood as political determinants of health that cause and maintain these health inequities. The power asymmetry and global social norms limit the range of choices and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas (Ottersen et al, Lancet 2014; 383: 630-67).

There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health. State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health. Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet.

A CALL FOR ACTION

BY PMAC 2015

Five strategic areas were proposed in the call for actions.
These were discussed and endorsed by the conference participants.

I. Universal Health Coverage

- **Amend the current Sustainable Development Goal 3:**
  Replace original text: *Ensure healthy lives and promote well-being for all at all ages* by *Progressively achieve universal health coverage and ensure healthy lives for all*

- **Government commitment on progressive universalism**
  Expand supply side capacities to provide quality services, ensure financial risk protection through a mix of financing sources and strategic purchasing to achieve pro-poor benefit incidence, reduce OOP, contain cost and improve efficiency

- **Health workforce:**
  Rapid scaling up training of adequate number of competent, committed health workforce; also helps create economic opportunities for local communities and employment

  Retain them in places where needed with adequate resources

  Governments should abide by the Global Code of Practice on International Recruitment of Health Personnel, to mitigate negative impacts of economic migration

II. Accountability

- Strengthen accountability framework, enforcement mechanisms and reporting in order to hold governments, private sectors, transnational corporations, and supra-national agencies accountable to sustain or accelerate MDGs and implement the upcoming SDGs.
- Ensure effective local citizen/community engagement in health delivery systems, through local accountability mechanisms, e.g. public disclosure reporting;
- Strengthen information systems and institutional capacities for monitoring UHC achievement (effective coverage, financial risk protection) stratified by wealth index, vulnerability (mentally ill, migrants, people with disability, ethnic minorities, LGBT, etc)
    - Service Availability and Readiness Assessment (SARA) or Service Delivery Indicators are useful tools to assess effective coverage, hence enhancing accountability.

III. Increase Fiscal Space for health through

- Domestic action e.g. tax reform, earmarked tax for health, drive down cost of health products and commodities through pooled purchasing, mobilize innovative financing sources e.g. sin tax, reduce fuel subsidies
- International solidarity actions e.g. financial transaction tax, 21% of ODA for health (20% of 0.7% of GDP)

IV. Health Systems

Strengthen health systems preparedness to combat outbreaks and prevent epidemics by strengthening IHR core capacities.

"Underinvestment in public health kills people and derails economies!" [Tim Evans]

V. Global Health Governance

In the context of increased numbers of global health actors, WHO has repositioned itself but has yet to achieve its unique role in global health and do first things first: namely at global level, pandemic preparedness and responses, normative functions, and convening for public health actions; and at country level, targeting support where needs are greatest, taking into account the budget constraint and the volume of earmarked voluntary contributions.

Figure 4
Conceptual framework: contributing factors to accelerating health equity in the context of Post 2015 SDG.

In Figure 4, six contributing factors to achieve health equity are, progressive universalism, which requires increased fiscal space, functioning, responsive and resilient primary health care accessible by the majority of people, and introduction of financial risk protection, especially starting with the poor and vulnerable populations. In so doing, there needs an effective accountability framework and empowering of local communities, including accountability in other sectors which have impact on health of people, and finally, address the major bottleneck of political origins of health inequity at national and transnational levels.







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CLOSING CEREMONY

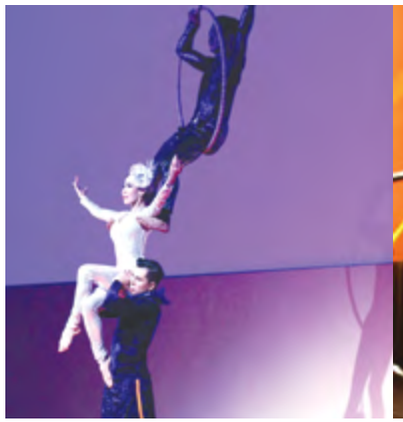
At the closing, Pattanan Arunvichitsakul, a young blind girl came on stage and sang a song, Imagine, and at the end of her song, she read Braille as follows:

"I am glad that I am given the chance to be here today. People have different talents and capabilities but they might not have the opportunity to show them. I want to thank you for the opportunity you give me today. I believe that the world will be a better place if equal opportunity is given"


2015
GLOBAL HEALTH
POST 2015
ACCELERATING EQUITY


Join our hands


See you next year
PMAC 2016
Points Setting for Universal Health Converage



ANNEX I

International Organizing Committee Members

No.	Name - Surname	Position	Organization	Role
1	Dr. Vicharn Panich	Chair, International Award Committee and Scientific Advisory Committee	Prince Mahidol Award Foundation / Mahidol University, Thailand	Chair
2	Dr. Marie-Paule Kieny	Assistant Director-General for Health Systems and Innovation	World Health Organization, Switzerland	Co-Chair
3	Dr. Timothy Evans	Director for Health, Nutrition and Population (HNP)	The World Bank, USA	Co-Chair
4	Dr. Michel Sidibé	Executive Director	Joint United Nations Programme on HIV/AIDS, Switzerland	Co-Chair
5	Mr. Kiyoshi Kodera	Vice President	Japan International Cooperation Agency, Japan	Co-Chair
6	Dr. Ariel Pablos-Mendez	Assistant Administrator, Bureau for Global Health	United States Agency for International Development, USA	Co-Chair
7	Dr. Lincoln C. Chen	President	China Medical Board, USA	Co-Chair
8	Dr. David Heymann	Head of the Centre on Global Health Security	Chatham House, United Kingdom	Co-Chair
9	Mr. Michael Myers	Managing Director	The Rockefeller Foundation, USA	Co-Chair
10	Dr. Clifton Cortez	Cluster Lead for Democratic Governance, HIV, Health and Development Practice	United Nations Development Programme, USA	Member
11	Dr. Mark Dybul	Executive Director	The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland	Member
12	Dr. Seth Berkeley	Chief Executive Officer	GAVI Alliance, Switzerland	Member
13	Dr. Patricia Moser	Lead Health Specialist	Asian Development Bank, Philippines	Member
14	Dr. Julia Watson	Senior Economic Advisor, Health Service Team, Human Development Department	UK Department for International Development	Member
15	Representative		Foreign Policy and Global Health	Member
16	Dr. Todd Summers	Senior Adviser for the Global Health Policy Center	Center for Strategic and International Studies, USA	Member
17	Dr. Kenji Shibuya	Professor and Chair, Department of Global Health Policy, Graduate School of Medicine	University of Tokyo, Japan	Member
18	Dr. Kamran Abbasi	International and Digital Editor	British Medical Journal, United Kingdom	Member
19	Dr. Thomas Quinn	Director, Johns Hopkins Center for Global Health	Consortium of Universities for Global Health	Member
20	Ms. Bridget Lloyd	Global Coordinator	People's Health Movement, South Africa	Member
21	Mr. Narong Sahametapat	Permanent Secretary	Ministry of Public Health, Thailand	Member
22	Mr. Sihasak Phuangketkeow	Permanent Secretary	Ministry of Foreign Affairs, Thailand	Member
23	Dr. Supat Vanichakarn	Secretary General	Prince Mahidol Award Foundation, Thailand	Member
24	Dr. Winai Sawasdivorn	Secretary General	National Health Security Office, Thailand	Member

No.	Name - Surname	Position	Organization	Role
25	President, Mahidol University, Thailand	President	Mahidol University, Thailand	Member
26	Dr. Udom Kachintorn	Dean, Faculty of Medicine Siriraj Hospital	Mahidol University, Thailand	Member
27	Dr. Winit Puapraditt	Dean, Faculty of Medicine Ramathibodi Hospital	Mahidol University, Thailand	Member
28	Dr. Suwit Wibulpolprasert	Vice Chair	International Health Policy Program Foundation, Thailand	Member
29	Dr. Viroj Tangcharoensathien	Senior Advisor	International Health Policy Program, Thailand	Member
30	Dr. Pongpisut Jongudomsuk	Senior Expert	National Health Security Office, Thailand	Member
31	Director, International Health Bureau	Director, International Health Bureau	Ministry of Public Health, Thailand	Member
32	Mr. James Pfitzer	Technical Officer (Legal), Health Systems and Innovation, Office of the Assistant Director-General	World Health Organization, Switzerland	Member & Joint Secretary
33	Dr. Toomas Palu	Sector Manager for Health, Nutrition and Population East Asia and Pacific Region	The World Bank, Thailand	Member & Joint Secretary
34	Mr. Steve Kraus	Director, UNAIDS Regional Support Team for the Asia and Pacific	Joint United Nations Programme on HIV/AIDS, Thailand	Member & Joint Secretary
35	Dr. Aye Aye Thwin	Senior Health Technical Advisor to the office of Health System, Global Health Bureau	United States Agency for International Development, USA	Member & Joint Secretary
36	Mr. Naoyuki Kobayashi	Deputy Director General	Japan International Cooperation Agency, Japan	Member & Joint Secretary
37	Dr. David Harper	Senior Consulting Fellow	Chatham House, United Kingdom	Member & Joint Secretary
38	Dr. Stefan Nachuk	Associate Director	The Rockefeller Foundation, Thailand	Member & Joint Secretary
39	Dr. Guo Yan	Professor, School of Public Health, Peking University Health Science Centre	China Medical Board	Member & Joint Secretary
40	Dr. Wanicha Chuenkongkaew	Vice President for Education	Mahidol University, Thailand	Member & Joint Secretary
41	Dr. Jiraporn Laothamatas	Deputy Dean for Cooperate Communication, Faculty of Medicine Ramathibodi Hospital	Mahidol University, Thailand	Member & Joint Secretary
42	Dr. Churnrurtai Kanchanachitra	Director	Mahidol University Global Health, Thailand	Member & Joint Secretary













ANNEX II

List of Scientific Committee Members

No.	Name	Position / Organization	Role
1.	Dr. Wiwat Rojanapithayakorn	Director, Center for Health Policy and management, Faculty of Medicine Ramathibodi Hospital, Mahidol University	Chair
2	Dr. Claude Bodart	Principal Health Specialist, Urban and Social Sectors Division Asian Development Bank - Mongolia Office	Member
3.	Dr. David Harper	Chatham House, UK	Member
4.	Mr. Steve Kraus	Director, UNAIDS Regional Support Team for Asia and the Pacific	Member
5.	Mr. Stefan Nachuk	Associate Director, The Rockefeller Foundation, Bangkok Office	Member
6.	Dr. Walaiporn Patcharanarumol	Senior Researcher, International Health Policy Program, Thailand	Member
7.	Asst. Prof. Denla Pandejpong	Chief, Siriraj Health Policy Unit, Faculty of Medicine Siriraj Hospital	Member
8.	Mr. James Pfitzer	Technical Officer, Health Systems and Innovation, Office of the Assistant Director-General, World Health Organization	Member
9.	Dr. Kenji Shibuya	Professor and Chair, Department of Global Health Policy Graduate School of Medicine, The University of Tokyo	Member
10.	Dr. Tomohiko Sugishita	Senior Advisor on Health, Human Development Department Japan International Cooperation Agency	Member
11.	Dr. Thaksaphon Thamarangsi	Senior Researcher, International Health Policy Program, Thailand	Member
12.	Dr. Aye Aye Thwin	Director, Office of Public Health, U.S. Agency for International Development, Regional Development Mission Asia	Member
13.	Mr. Kazuyuki Uji	Policy Specialist, HIV, Health and Inclusive Development, UNDP Asia Pacific Regional Centre	Member
14.	Prof. Guo Yan	Professor, School of Public Health, Peking University Health Science Centre, China	Member

ANNEX III

Conference Speakers/Panelists, Chairs/Moderators and Rapporteurs

Speaker/Panelist	Chair/Moderator	Rapporteur
Opening Session		
Taniya Akter Timothy Evans Donald Ainslie Henderson		Watinee Kunpeuk Pitchaya Nualdaisri Miho Sodeno
Overarching Plenary : Global Health Post 2015 - Accelerating Equity		
Paul Farmer Sigrun Mogedal Michael Myers Michel Sidibé	Lincoln Chen	Chalermpol Chamchan Yumiko Miyashita Andreas Seiter
Plenary 1.1 : Priority Global Health Issues and Health Related Post-2015 Development Goals/Targets/Indicators		
Keizo Takemi Robert Yates	Alex Ross	Akiko Maeda Pattarawalai Talungchit Suteenoot Tangsathitkulchai
Parallel session 1.1 : Security Interests in Global and Public Health		
Dennis Carroll Didier Houssin Nigel Lightfoot Virginia Murray Jean Jacques Muyembe	David Harper	Claude Meyer Songyot Pilasant Candyce Silva
Parallel session 1.2 : A Fine Balance: Seeking a "Win-Win Solutions" for Achieving Health Equity and Promoting Economic Opportunities		
Edson Araujo James Buchan Marla Salmon	Akiko Maeda	Damien de Walque Jintana Jankhotkaew Vuong Lan Mai Tanita Thaweethamcharoen
Parallel session 1.3 : Foreign Policy Interests in Global Health		
Mmathari Matsau Sigrun Mogedal Hiroyuki Yamaya	Sek Wannamethee	Michael Adelhardt Hoang Thi My Hanh Sripen Tantivess Chanwit Tribuddharat
Parallel session 1.4 : Philanthropic Interests in Global and Public Health		
Lara Brearley Jesse Bump Piya Hanvoravongchai Dan Kress Michael Myers Toomas Palu	Stefan Nachuk	Bart Jacobs Natakorn Satienchayakorn Nattha Tritasavit
Parallel session 1.5 : Maximizing Synergies between Health and Inclusive Development		
Chris Beyrer Khama Rogo Chong Chan Yau	Mandeep Dhaliwal	Sarah Greenbaum Patou Musumari Sarah Greenbaum
Parallel session 1.6 : Health-related Post-2015 Development Goals and Targets		
Andrew Channon Gloria Joyce Quansah Asare James Pfitzer Kenji Shibuya Laura Sochas Isimeli Tukana	Naoyuki Kobayashi	Kohki Fujita Arimi Mitsunaga Payao Phonsuk Inthira Yamabhai
Parallel session 1.7 : Ensuring Equitable and Sustainable Access to Health Commodities and Services in MICs in the Post-2015 Development Agenda		
Manica Balasegaram Mark Dybul Adetokunbo Lucas Doreen Mulenga Robert Newman Saul Walker	John Mac Arthur	Kimberly Junmookda Hongye Luo Kitiporn Tupsart

Speaker/Panelist	Chair/Moderator	Rapporteur
Plenary session 1.2 : Presentation of Priority Issues from PS1.1-PS1.6		
Mandeep Dhaliwal David Harper Naoyuki Kobayashi Akiko Maeda Stefan Nachuk Sek Wannamethee	Alex Ross	Anna Charnyshova Prasinee Mahattanatawee Tingting Qiao
Plenary session 2 : Moving towards New Global Health Governance		
Carmen Barroso Ole Petter Ottersen Alex Ross David Sanders	Jan Beagle	Bart Jacobs Patou Musumari Warisa Panichkriangkrai
Parallel session 2.1 : Global Health Governance: Who and How?		
Manica Balasegaram Andrew Cassels David Legge Anne Mills Ariel Pablos-Mendez Srinath Reddy	Charles Clift	Dorjsuren Bayarsaikhan Sarocha Chootipongchaivat Somil Nagpal Payao Phonsuk
Parallel session 2.2 : Role of Non-State Actors in Global Health Governance		
Jan Beagle Denis Broun Goran Tomson	Roberta Clarke	Jintana Jankhotkaew Sripen Tantivess Jean-Marc Thome
Parallel session 2.3 : Governance by Market Forces - How to Get the Best While Avoiding the Worst		
Olivier Basenya Richard Bergstrom Clinton De Souza Thulani Mbatha Patricia Moser Nathan Sigworth	Andreas Seiter	Raoul Bermejo Jean-Olivier Schmidt Schmidt Nattha Tritasavit

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 2.4 : Global Governance for Health in the Post-2015 Era		
Virasakdi Chongsuvivatwong Sigrun Mogedal Cecilia Oh Amit Sengupta	Ole Petter Ottersen	Puwat Charukamnoetkanok Sarah Greenbaum Pattarawalai Talungchit
Parallel session 2.5 : Accountability for Health in the Post-2015 Development Agenda		
Najeeb Al SHORBAJI Carmen Barroso Tarek Meguid Gorik Ooms Hani Serag	Daniel Miller	Martina Pellny Candyce Silva Jun Zhao
Parallel session 2.6 : Global Health Treaties - Do We Need More?		
Thiruk Balasubramanian Carlos Correa Steven Hoffman	James Love	Suchunya Aungkulanon Kai Straehler-Pohl Weranuch Wongwatanakul
Parallel session 2.7 : Governance by Partnership - an Answer for Post 2015?		
Pasakorn Akarasewi Mushtaque Chowdhury Amphon Jindawattana Robert Newman	Thein Thein Htay	Watinee Kunpeuk Claude Meyer Hoang Thi My Hanh Tipicha Posayanonda
Plenary session 3 : Global Health Financing - What Lies Ahead?		
Timothy Evans Dean Jamison Kiyoshi Kurokawa Mai Oanh Tran	Ariel Pablos-Mendez	Michael Adelhardt Iyarit Thaipisutikul Aye Aye Thwin
Parallel session 3.1 : Fiscal Space for Health: Mobilizing and Efficiently using Domestic Funds		
Lara Brearley Caryn Bredenkamp Jane Doherty Mawuli Gaddah Jeremias Paul Jr. Samrit Srithamrongsawat	Kara Hanson	Manasigan Kanchanachitra Filip Meheus Pitchaya Nualdaisri

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 3.2 : Results-Based Financing in the Health Sector and Equity in Access to Quality Care		
Hossain Ishrath Adib Olivier Basenya	Damien De Walque	Yumiko Miyashita Yoko Shimpuku Inthira Yamabhai
Parallel session 3.3 : Health Systems Responsiveness: Health Service Delivery Ensures the Dignity, Confidentiality, Autonomy and Promptness in Empowering the Poor and Marginalized		
Alex Ergo Jetsada Mingsamorn Hitoshi Murakami Miriam Were	Tomohiko Sugishita	Kanako Fukushima Prasinee Mahattanatawee Kanitsorn Sumriddetchkajorn
Parallel session 3.4 : New Trends and Innovative Strategies for Global Health Financing		
Fran Baum Timothy Evans Lisa Forman Osamu Kunii Rachael Le Mesurier Gorik Ooms Trygve Ottersen Walaiporn Patcharanarumol	Anne Mills	Anna Charnyshova Phiradol Koopthavonrerk Min Li
Parallel session : 3.5 Universal Health Coverage: Political Commitment and Financing for Complex Public Health Needs in the Next Two Decades		
Takashi Fukuda Naoki Ikegami John Masasabi Inke Mathauer Bounfeng Phoummalaysith Francisco Soria	Naoyuki Kobayashi	Chieko Matsubara Prapaporn Noparatayaporn Kazuyuki Uji

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session : 3.6 The Role of Emerging Economies and Private Sector in Global Health Financing		
Peilong Liu Mmathari Matsau Srinath Reddy	Aye Aye Thwin	Alia Cynthia Luz Miho Sodeno Rapeepong Supanchaimart

Lead Rapporteur Team
Jeff Johns
Anne Mills
Toomas Palu
Viroj Tangcharoensathien

Rapporteur Coordinator
Walaiporn Patcharanarumol

ANNEX IV

List of Side Meetings and Workshops

NO	MEETING TITLE	ORGANIZATION
SE001	Achieving Universal Health Coverage with Information and Communications Technology (UHCICT): Post-2015	Asia eHealth Information Network (AeHIN)
SE002	Priority-Setting for Universal Health Coverage: the role of the international Decision Support Initiative	Health Intervention and Technology Assessment Program (HITAP)
SE003	Learning from practice: HTA capacity development across Asia	Health Intervention and Technology Assessment Program (HITAP)
SE004	ASEAN Integration and its Health Impacts	HealthSpace.Asia (HSA), The Rockefeller Foundation, Thailand Research Center for Health Services System (TRC–HSS), Global Health Action Journal
SE005	The Prince Mahidol Award Youth Program Conference 2015	Prince Mahidol Award Foundation (PMAF), Prince Mahidol Award Youth Program (PMA YP)
SE006	The Prince Mahidol Award Youth Program Conference 2015	Prince Mahidol Award Foundation (PMAF) Prince Mahidol Award Youth Program (PMA YP)
SE007	Health Information Equity at the Heart of Universal Health Coverage	World Health Organization (WHO)
SE008	Health Governance: Lessons Learned from Thailand	National Health Commission Office, National Health Security Office, Thai Health Promotion Foundation, World Health Organization, United Nations Development Programme and The Rockefeller Foundation
SE009	Introducing the Global Master's in Health & Sustainable Development	Faculty of Health Sciences at the American University of Beirut and EARTH University
SE010	Universal Health Coverage: Ensuring quality care for all!	The World Health Organization (WHO) Department of Service Delivery & Safety, USAID/URC and the Healthcare Accreditation Institute (HAI) Thailand
SE011	Emerging Infectious Diseases: Sharing lessons learned in Asia and pointing the way forward for health and development beyond 2015	The United States Agency for International Development (USAID), International Development Research Centre (IDRC)
SE012	Youth leadership for global health equity in the Pos-2015 framework	IFMSA - International Federation of Medical Students'Associations
SE013	Asia Alliance on Global Health (AAGH)	Mahidol University Global Health (MUGH)
SE014	Finance, Audit and Risk Management Subcommittee Meeting	Asia Pacific Observatory on Health Systems and Policies
SE015	People's Health Movement: coordinating commission and strategising meeting-building a strong health movement	People's Health Movement
SE016	Global Health Watch 4: The evidence for addressing the Global Health Crisis	People's Health Movement
SE017	Asia-Pacific Action Alliance on Human Resources for Health Steering Meeting (AAAH)	Asia-Pacific Action Alliance on Human Resources for Health (AAAH)
SE018	Announcement of Universal Health Coverage Interactive Platform	World Health Organization (WHO)
SE019	Universal Health Coverage: Sharing lessons and developing country strategies	The World Bank

NO	MEETING TITLE	ORGANIZATION
SE020	Promoting More Sustainable and Equitable UHC: Proposals to the G8 2016 in Japan	University of Tokyo, Japan Center for International Exchange (JCIE)
SE022	Strategic Technical Advisory Committee Standing Members Meeting	Asia Pacific Observatory on Health Systems and Policies
SE023	The Prince Mahidol Award Youth Program, Working Committee Meeting	Prince Mahidol Award Youth Program (PMA YP)
SE025	PMAC World Art & Photo Contest Award Ceremony	Prince Mahidol Award Conference
SE026	The World Bank Meeting	The World Bank
SE027	Asian Country Consultation on Equitable Access to Health in Low and Middle-income countries (LMICs)	The Global Fund
SE028	Migrant Health in the Mekong Region - Cambodia, Lao PDR, Myanmar, Thailand and Viet Nam	International Health Policy Program Foundation (IHPP), The United States Agency for International Development (USAID)
SE030	Remaining Challenge of Thai UHC in post 2015	Capacity Building for Universal Health Coverage (CapUHC)
SE031	HSRI Strategy Sub-Committee	Health Systems Research Institute

ANNEX V

List of Posters

P 1 Has Ghana's free maternal care policy promoted continuum of care for maternal and child health after almost half a decade of its implementation? Evidence from the three Health and Demographic Surveillance Sites in Ghana

Sheila ADDEI, Dodowa Health Research Centre, Ghana;
Doris SARPONG, Dodowa Health Research Centre, Ghana;
Francis YEJI, Navrongo Health Research Centre, Ghana;
Charlotte TAWIAH, Kintampo Health Research Centre, Ghana;
Clement NARH, Dodowa Health Research Centre, Ghana;
Abraham ODURO, Navrongo Health Research Centre, Ghana;
Seth OWUSU-AGYEI, Kintampo Health Research Centre, Ghana;
Kimiyo KIKUCHI, The University of Tokyo, Japan;
Masamine JIMBA, The University of Tokyo, Japan;
GYAPONG Margaret, Dodowa Health Research Centre, Ghana;
The Ghana EMBRACE Implementation Research Team

P 2 Complex adaptive systems and global development : an analysis of approaches towards the post 2015 Development goals

Amin MANSSOURI, Thammasat University, Thailand;
Hannah GREIJDANUS, Thammasat University, Thailand;
Andrea KÖNIG, Thammasat University, Thailand;

P 3 Rhetoric to reality: lessons learned from implementing a social accountability mandate into two medical schools and creating next steps to Universal Health

Sarah STRASSER, Health Science North, Canada;
Flinders University, Australia and Northern
Ontario School of Medicine, Canada;
THEnet community: www.thenetcommunity.org/cop.

P 4 Meeting Demand for Family Planning: Monitoring Progress and Equity

Yoonjoung CHOI, US Agency for International Development, United States;
Madeleine SHORT FABIC, US Agency for International Development, United States

P 5 Monitoring of Regional Disparities of Achievement and Sustainability of Millennium Development Goals 4 and 5 in Selected Districts of Sri Lanka

Dilantha DHARMAGUNAWARDENE, Ministry of Health, Sri Lanka;
Kapila JAYARATHNE, Family Health Bureau, Sri Lanka;
Sarath SAMARAGE, World Health Organization, Sri Lanka;
Jayani HERATH, Department of Geography, University of Sri Jayewardenepura, Sri Lanka;
Dilip HENSMEN, World Health Organization, Sri Lanka;
Prabath MALAWIGE, Sri Lanka Ports Authority, Sri Lanka

P 6 Maternal Mortality Ratio: Implication for the post-MDG on Health

Worawan CHANDOEVWIT, Thailand Development Research Institute,
Khon Kaen University, Thailand;
Rungphet PHATCHANA,Thailand Development Research Institute, Thailand;
Saray RUANGDEJ, National Health Security Office, Thailand

P 7 Policies to solve health inequities: a Center for Research Exellence which applies complex system science

Fran BAUM, Flinders University, Australia; Sharon FRIEL, RegNet, Australian National University, Australia

P 8 The mediating role of self-efficacy in the relationship between Big five personality and depressive symptoms among Chinese unemployed population: a cross-sectional study

Yang WANG, School of Public Health, China Medical University, China

P 9 Innovaton in Maternal and Child Health Care - Closing The Equity Gap with Conditional Cash Transfers - A Case Study From Nigeria

Chibugo OKOLI, National Primary Health Care Development Agency, Nigeria

P 10 Expanding Health Equity through the Mobilization of Non-Physician Clinicians: Examples from Five Continents

Nadia COBB, Office for the Promotion of Global Healthcare Equity, University of Utah, United States;
Rebecca BAILEY, IntraHealth International/Capacity*Plus*, United States;
Ebin V. ABRAHAM, Indian Association of Physician Assistants, India;
David LUSALE, Africa Network of Associate Clinicians, Zambia;
Sandi LEAR, Australian Society of Physician Assistants, Australia;
Shane Ryan APPERLY, UK Association of Physician Assistants, United Kingdom

P 11 Health Care Utilization of Older People in China

Tuohong ZHANG, Department of Global Health, Peking University, China

P 12 Using community participation to strengthen primary health care

Carole REEVE, Centre for Remote Health,
Flinders University, Australia

P 13 Final evaluation of Health Japan 21 and the revision for the succeeding 10 years

Tetsuji YOKOYAMA, National Institute of Public Health, Japan;
Hiroko MIURA, National Institute of Public Health, Japan;
Midori ISHIKAWA, National Institute of Public Health, Japan

P 14 Spatial and Socio-Demographic Determinants of Contraceptive Use in the Upper East region of Ghana

Fabian ACHANA, Navrongo Health Research Centre, Ghana;
Ayaga BAWAH, Columbia University, United States;
Elizabeth JACKSON, Columbia University, United States;
Paul WELAGA, Navrongo Health Research Centre, Ghana;
Timothy AWINE, Navrongo Health Research Centre, Ghana;
Eric ASUO-MANTE, Columbia University, United States;
Abraham ODURO, Navrongo Health Research Centre, Ghana;
John Koku AWOONOR-WILLIAMS, Ghana Health Service, Ghana;
James F. PHILLIPS, Columbia University, United States

P 15 Health status and healthcare for older people: How are these impacted by retirement policies?

Trang NGUYEN, School of Global Studies, Thammasat University, Thailand

P 16 China's provincial diplomacy to Africa: applications to health cooperation

Gordon SHEN, School of Public Health, Yale University, United States;
Victoria FAN, Office of Public Health Studies, University of Hawaii at Manoa, United States

P 17 Rethink of TRIPS-PLUS and Its Impact on Public Health

Jing CHEN, Department of Pharmacy, Administration and Clinical Pharmacy, School of Pharmaceutical, Sciences, Peking University, China;
Luwen SHI, Department of Pharmacy, Administration and Clinical Pharmacy, School of Pharmaceutical, Sciences, Peking University, China

P 18 Return to Nursing - Preparing Internationally Educated Nurses (IENs) for Practice

Edward CRUZ, Centennial College, Canada;
Rhea Faye FELICILDA, Department of Nursing, Missouri State University, United States;
Patricia MAZZOTTA, Centennial College, Canada;
Alexander CLARK, Faculty of Nursing, University of Alberta, Canada

P 19 Universal Health Coverage in "One ASEAN": Are migrants included?

Ramon Lorenzo Luis R. GUINTO, Universal Health Care Study Group, University of the Philippines Manila, Manila, Philippines;
Ufara Zuwasti CURRAN, Nuffield Department of Population Health, University of Oxford, Oxford, United Kingdom;
Rapeepong SUPHANCHAIMAT, International Health Policy Programme, Ministry of Public Health, Nonthaburi, Thailand and Department of Global Health & Development, London School of Hygiene and Tropical Medicine, London, United Kingdom;
Nicola S. POCOCK, Department of Global Health and Development, London School of Hygiene and Tropical Medicine, London, United Kingdom

P 20 Improving local health systems for universal health care & transformative learning - a working model

Raymundo S BAQUIRAN, Ateneo School of Medicine and Public Health, Philippines;
Celina Pia Patricia OLIVEROS, Ateneo School of Medicine and Public Health, Philippines;
Limuel ABROGENA, Ateneo School of Medicine and Public Health, Philippines;
Elmira DIZON, Payatas B Health Center, Quezon City Health Department, Philippines;
Melchor GABAGAT, Lupang Pangako Health Center, Quezon City Health Department, Philippines

P 21 Reducing inequity by reaching marginalized groups to improve immunization coverage - Lessons from India Polio Eradication Program for Health System Strengthening and Universal Coverage.

Jitendra AWALE, CORE Group Polio Project, India;
Roma SOLOMON, CORE Group Polio Project ,India;
Manojkumar CHOUDHARY, CORE Group Polio Project ,India;
Rina DEY, CORE Group Polio Project, India

P 22 Producing Socially Accountable Doctors: Embedding Social accountability in Medical Curricula

Shrijana SHRESTHA, Patan Academy of Health Sciences, Nepal;
Rajesh GONGAL, Patan Academy of Health Sciences, Nepal;
Jay Narayan SHAH, Patan Academy of Health Sciences, Nepal;
Kedar BARAL, Patan Academy of Health Sciences, Nepal;
Arjun KARKI, Patan Academy of Health Sciences, Nepal

P 23 Civil society engagement for health for all (CSE4HFA): An action-research project by the people's health movement (PHM)

Chiara BODINI, Centre for International Health, University of Bologna, Italy;
Amit SENGUPTA, People's Health Movement associate coordinator, India;
David SANDERS, School of Public Health, University of the Western Cape, South Africa

P 24 Social Determinants of Migration of Health Workers from the Philippines

Erlinda CASTRO-PALAGANAS, University of the Philippines Baguio, Philippines;
Caricativo RUEL, College of Social Sciences, University of the Philippines, Philippines;
Sanchez MARIAN, Luke Foundation, Philippines

P 25 A new paradigm in patient safety in Africa: A case study of the rights based approach to health in communities in Africa (Uganda) by the People's Health Movement Uganda Circle in Partnership with Human Rights Research Documentation Centre (HURIC)

Denis BUKENYA, People's Health Movement, Uganda

P 26 Assessment of Health and Nutrition Accountability and Governance Issues in Rural India (Post 2015 Health Agenda)

Vishal DOGRA, Save the Children, India;
Isha DWIVEDI, Post Graduate Institute of Medical Education and Research, Chandigarh, India

P 27 Developing a Human Resources for Health (HRH): Effort Index to Measure Country - Level Status in HRH

Randi BURLEW, IntraHealth International/Capacity*Plus*, United States;
Alfredo FORT, IntraHealth International/Capacity*Plus*, United States;
Rachel DEUSSOM, IntraHealth International/Capacity*Plus*, United States

P 28 Building the capacity of African Institutions to respond to emerging Infectious diseases through curriculum review and development: The Rwanda Example

Hellen AMUGUNI, Tufts University, United States;
Melissa MAZAN, Tufts Cummings School of Veterinary Medicine, United States;
Robert KIBUUKA, University of Rwanda, School of Veterinary Medicine, Nyagatare Campus, Rwanda

P 29 Building Human Resources for Health Governance and Leadership Capacity at the Country Level: Approaches, Results, and Recommendations

Lisa HOWARD-GRABMAN, Training Resources Group/Capacity*Plus*, United States;
Jim MCCAFFERY, Training Resources Group/Capacity*Plus*, United States

P 30 The People that Deliver Initiative: Addressing the Health Supply Chain Capacity Development Gap

Andrew BROWN, People that Deliver, Denmark

P 31 Financing Models for Universal Health Coverage [UHC]: Fostering Equity and Integrated Care Delivery

Marilyn A DELUCA, Global Health-Health Systems-Philanthropy and New York University, United States

P 32 What level of domestic government health spending should we aspire towards for Universal Coverage?

Filip MEHEUS, Health Economics Unit, University of Cape Town, South Africa;
Diane MCINTYRE, Health Economics Unit, University of Cape Town, South Africa

P 33 Social Determinants of Health and Factors Influencing Health Care Utilization in Nayao Rural Community, Thailand

Thanawat RUENGCHAISIWAWAITH, Phramongkutklao College of Medicine, Thailand;
Narisara TUNTIYATORN, Phramongkutklao College of Medicine, Thailand;
Supavit KOONTAVEESAP, Pramongkutklao College of Medicine, Thailand;
Monchai DUANGPHAPHAT, Phramongkutklao College of Medicine, Thailand;
Natthanose PANAROJWONGSE, Phramongkutklao College of Medicine, Thailand;
Nathathai PRATUMCHAT, Phramongkutklao College of Medicine, Thailand;
Charin CHEUNGSIRAKULVIT, Phramongkutklao College of Medicine, Thailand;
Thitirat RAKWIT, Phramongkutklao College of Medicine, Thailand;
Chayanon JAIUA, Phramongkutklao College of Medicine, Thailand;
Tanongson TIENTHAVORN, Department of Military and Community Medicine, Phramongkutklao College of Medicine, Thailand

P 34 Universal Health Care (UHC): Neoliberal response to the global health crisis?

Amit SENGUPTA, People's Health Movement, India;
Susana BARRIA, People's Health Movement, India;
Erika Arteaga CRUZ, People's Health Movement, Ecuador

P 35 Investing in Health Workforce Education and Training for Expanded Access to Essential Health Services for Underserved Populations

Rebecca BAILEY, IntraHealth International/Capacity*Plus*, United States;
Kate TULENKO, IntraHealth International/Capacity*Plus*, United States

P 36 Practical Use of Big Data for Universal Health Coverage in Healthy Aging and Aged Society

Toshiro KUMAKAWA, Health and Welfare Services Department, National Institute of Public Health, Japan

P 37 Fact finding study on the efforts for universal health coverage at a rural area in Vietnam

Chieko MATSUBARA, National Center for Global Health and Medicine, Japan;
Masahiko DOI, National Center for Global Health and Medicine, Japan;
NGUYEN Anh Tai, Center for Community Development Aid, Viet Nam;
Tomomi MIZUNO, National Center for Global Health and Medicine, Japan;
Kimiko INAOKA, National Center for Global Health and Medicine, Japan;
Yumiko TANAKA, National Center for Global Health and Medicine, Japan;
Yasuko SATO, National Center for Global Health and Medicine, Japan;
Hitoshi MURAKAMI, National Center for Global Health and Medicine, Japan

P 38 China's role as a global health donor in Africa: what can we learn from studying under reported resource flows?

Karen GREPIN, New York University, United States;
Victoria FAN, Office of Public Health Studies, University of Hawaii at Manoa, United States
Gordon SHEN, Yale University, United States;
Lucy CHEN, Peking University Institute for Global Health, China

P 39 "Post-2015 Framework for Healthy Youth and Adolescents"

Josko MISE, International Federation of Medical Students' Associations (IFMSA), Croatia;
Michael KALMUS-ELIASZ, Barking, Havering and Redbridge NHS trust, United Kingdom;
Agostinho SOUSA, International Federation of Medical Students' Associations (IFMSA), Portugal;
Roopa DHATT, International Federation of Medical Students' Associations (IFMSA), United States

P 40 Policymaking in times of transition: examining the position of Arab civil society actors in the changing policy landscape

Nasser YASSIN, American University of Beirut, Lebanon;
Maria EL-SOLH, American University of Beirut, Lebanon

P 41 The problem of the action of actors in international relations in global health governance: the case of neglected diseases

Hermy MPUTU, UNICEF, The Democratic Republic of the Congo diseases

P 42 Resource Mapping For Health in Malawi Using Forward-Looking budget information to enable evidence-based planning for health systems strengthening Pa

Sangwani PHIRI, Health Promotion and Communications, Ministry of Health, Malawi;
Rabson KACHALA, SWAP, Ministry of Health, Malawi

P 43 Altruism, Compassion, and Empathy: Spirituality among Health Care Providers

Chris BEYRER, Johns Hopkins Bloomberg School of Public Health, United States;
Adeeba KAMARULZAMAN, Faculty of Medicine, University of Malaya, Malaysia;
Joe MAIER, Mercy Center, Thailand; Shreelata Rao SESHADRI, Azeem Premji University, India;
Sharon SALZBERG, Insight Meditation Centre, Barre, Massachusetts, United States;
Timothy HOLTZ, Emory University, United States;
Canon Gideon BYAMUGISHA, Friends of the Canon Gideon Foundation, Uganda;
Sonal SINGH, Johns Hopkins University, United States

ANNEX VI

PMAC 2015
World Art & Photo Contest

This year, the Prince Mahidol Award Conference invited students and all people to take part in the PMAC 2015 World Art and Photo Contest in the submissions of Two Dimensional Art and Photo under the topic 'Global Health'. The Art Contest project was launched as an instrument to communicate the idea of the PMAC 2015 theme "Global Health Post 2015: Accelerating Equity" to the public audience. Moreover, it not only brought the public audience closer to the PMAC concept, but also motivated all people to present new perspectives of a successful world where all people live better, happy, healthy and equitably.

This project has again received the positive response nationally and internationally from young students, parents and schools. Out of 8 nationalities from 3 continents that participated, 351 entries were sent in. Two International and 29 Thai young artists won the prizes. All the winners were invited to receive their awards at the PMAC 2015 World Art & Photo Contest Award Ceremony on 31 January 2015, at the Centara Grand at CentralWorld. The award ceremony event was a fulfilling and enjoyable experience for the winners and participants, as most of the winners came from very difficult and remote areas of Thailand for example, schools located in the mountainous areas in the Northern provinces, and schools from three Southern border provinces, schools from rural North-Eastern provinces.

All winning art pieces were exhibited at PMAC 2015. All display art pieces amazed most PMAC participants by their high quality artistic skill and creativity in illustrating the Global Health theme. The auction of winning art pieces raised more than 860 USD. This financial contribution from our prestigious PMAC participants will be donated to schools which supported the art program for their students in Thailand.

TWO DIMENSIONAL MEDIA CATEGORY

Group: Under 9 years old

World First Prize	Thanawat	Joemwatthana
World Second Prize	Paintfa	Chanchutiwanit
World Third Prize	Prachya Achita Kittiphum	Sunuanram Kawokamkong Hongsa
Honorary Mention	Alfal Keeratisak Phapangkorn	Ngan-khang Choonookaw Chokguer
Honorary Mention	Penny	Chottachakit
Honorary Mention	Thanakorn Athibodi Apiwat	Santaweesuk Rachata Rasri

Group: 9-13 years old

World First Prize	Wigavee	Rattamanee
World Second Prize	Katunyu	Wattanapraditchai
World Third Prize	Passawat	Liabsawat
Honorary Mention	Maria Angelica	Tejada
Honorary Mention	Nutnicha	Kanjanapituk
Honorary Mention	Buachompoo	Saiboonruan
	Patcharaporn	Pila

Group: 14-17 years old

World First Prize	Kanyapak	Laohasrisakul
World Second Prize	Porndanai	Wattanapraditchai
World Third Prize	Suparat Jidapa	Boonyapreedee Tharak
Honorary Mention	Karnvavee	Jitvilai
Honorary Mention	Thayamon	Silamom
Honorary Mention	Tiwtus	Kanama

Group: 18-25 years old

World First Prize	Jaran	Boonpraderm
World Second Prize	Terdtanwa	Kamana
World Third Prize	Teeratat	Namkaew
Honorary Mention	Thaniwan	Kumpeng
Honorary Mention	Pasutee	Weerachai
Honorary Mention	Kittachaphol	Watcharachaisakul

PHOTO CATEGORY

World First Prize	Banhan	Prangted
World Second Prize	Samut	Sarawichairut
World Third Prize	Keereekhan	Chaiyaporn
World Third Prize	Jamikorn	Srikam
Honorary Mention	Ahama	Sareema
Honorary Mention	Phasut	Waraphisit
Honorary Mention	Chusak	Uthaipanumas

WORLD POPULAR VOTE

World Popular Vote	Wigavee	Rattamanee
World Popular Vote	Kanyapak	Laohasrisakul

ANNEX VII

Field Trip Program




Site No. 1.
Thailand Post 2015: An Emerging Demand for Long-Term Care (LTC)
Location: Lum Sonthi Hospital, Lopburi Province

Site No. 2.
Provincial Health Assembly: Moving Towards Governance by Network
Location: Lopburi Province

Site No. 3.
Health Statute : Governance by Network in Community Level
Location: Nongyow Sub-district, Panusalakarm, Chachoengsao Province

Site No. 4.
High Tech High Cost Services: How to Manage to Get Equitable Access
Location: Nonthaburi Province

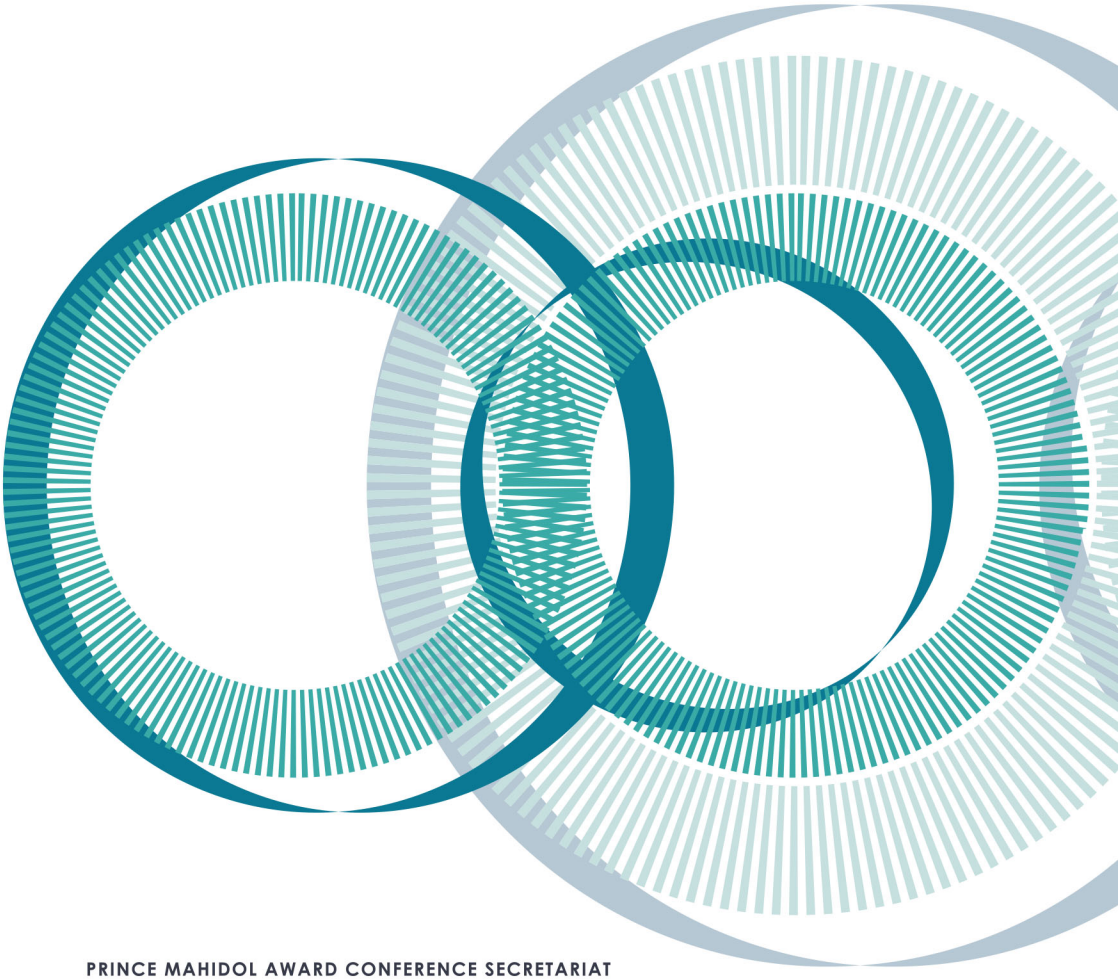
Site No. 5.
Emerging Health Problems from Regionalization (Immigrant Workers)
Location: Samut Sakhon Province

Site No. 6.
Thai Health Promotion Foundation: Innovative Financing for Health Promotion through Inclusive Governance
Location: Thai Health Promotion Foundation, Bangkok


PRINCE M MAHIDOL
AWARD CONFERENCE 2015
GLOBAL HEALTH
POST 2015
ACCELERATING EQUITY
26-31 JANUARY 2015 BANGKOK, THAILAND
World Health Organization
THE WORLD BANK
UNAIDS
USAID
JICA
THE ROCKEFELLER FOUNDATION
CMB
CHATHAM HOUSE

PRINCE MAHIDOL
AWARD CONFERENCE
2015

GLOBAL HEALTH
POST 2015
ACCELERATING EQUITY



PRINCE MAHIDOL AWARD CONFERENCE SECRETARIAT
Institute for Population and Social Research
Mahidol University, Salaya, Phutthamonthon
Nakhon Pathom 73170, Thailand
Tel: (66) 2441-0202 ext. 627 or 628 Fax: (66) 2441-9333
E-mail: pmaconference@mahidol.ac.th

www.pmaconference.mahidol.ac.th