PMAC | PRINCE MAHIDOL AWARD CONFERENCE 2017

REPORT

ON THE 2017 CONFERENCE ON

ADDRESSING THE HEALTH OF VULNERABLE POPULATIONS FOR AN INCLUSIVE SOCIETY

29 JAN - 3 FEB 2017 | 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


VULNERABLE POPULATIONS
FOR AN INCLUSIVE SOCIETY
PRINCE MAHIDOL
AWARD CONFERENCE
2017
PMAC 2017

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Prince Mahidol Award

The Prince Mahidol Award was established in 1992 to commemorate the 100th birthday anniversary of Prince Mahidol of Songkla, who is recognized by the Thais as 'The Father of Modern Medicine and Public Health of Thailand'.

His Royal Highness Prince Mahidol of Songkla was born on January 1, 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine

at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of activities in accordance with his conviction that human resource development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand. One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928, Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang Mai and performed operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health of Thailand".

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on January 1, 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty King Bhumibol Adulyadej to bestow an international award - the Prince Mahidol Award, upon individuals or institutions that have made outstanding and exemplary contributions to the advancement of medical, and public health and human services in the world.

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend selection of laureates whose nominations should be submitted to the Secretary-General of the Foundation before May 31st of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in any one year. The prizes will be given to outstanding performance and/or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of health for the sake of the well-being of the people. These two categories were established in commemoration of His Royal Highness Prince Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

"True success is not in the learning,
but in its application to the benefit of mankind."

True Success is not in the Learning, but in its Application to the Benefit of Mankind

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

In the past 24 years, 70 individuals, groups of individuals, and institutions had received the Prince Mahidol Award. Among them, 4 subsequently received the Nobel Prize. More importantly, 2 of the most the recent Nobel Prize (2015) laureates in physiology or medicine were conferred the Prince Mahidol Award prior to their continual prestigious recognition:

Professor Harald Zur Hausen
Prince Mahidol Award in the field of Medicine in 2005

Nobel Prize in Physiology or Medicine 2008

Professor Dr. Satoshi Omura
Prince Mahidol Award in the field of Medicine in 1997

Nobel Prize in Physiology or Medicine 2015

Professor Barry J. Marshall
Prince Mahidol Award in the field of Public Health in 2001

Nobel Prize in Physiology or Medicine 2005

Professor Tu YouYou
A member of The China Cooperative Research Group on Qinghaosu and its Derivatives as Antimalarials

Prince Mahidol Award in the field of Medicine in 2005

Nobel Prize in Physiology or Medicine 2015

Dr. Margaret F.C. Chan, M.D.
Prince Mahidol Award in the field of Public Health in 1998

Director General of the World Health Organizatiion

Dr. Jim Yong Kim, M.D., Ph.D.
Prince Mahidol Award in the field of Public Health in 2013

President of the World Bank Group

For more information see:
www.princemahidolaward.org

The Prince Mahidol Award Foundation
of which H.R.H. Princess Maha Chakri Sirindhorn
is the President, decided to confer
the Prince Mahidol Award 2016

in the Field of Medicine to
Sir Gregory Paul Winter, Master of Trinity College,
University of Cambridge, United Kingdom.

In the Field of Public Health,
the Prince Mahidol Award 2016 was conferred
to Vladimir Hachinski,
Distinguished University Professor,
University of Western Ontario, Canada.

Prince Mahidol Award Laureate 2016
In the Field of Medicine

Sir Gregory Paul Winter

Master of Trinity College
University of Cambridge
United Kingdom

Sir Gregory Paul Winter is one of the world's leading scientists and a pioneer in the field of antibody engineering and modification technology. In the mid 1980's he invented techniques to humanize antibodies for therapeutic uses, which later led to the creation of cutting-edge therapeutic drugs used widely in medicine.

Previously, attempts to use antibodies to treat human disease had been limited by the way they had been made from animals, as the antibodies were recognized by the human immune system as foreign and rejected. Sir Gregory developed techniques to isolate the antibody genes from the animal cells and alter the antibodies so that they were now compatible with human immune system when injected into the human body. These newly developed antibodies were called "Humanized Therapeutic Antibodies". The advances in the use of humanized antibodies as therapeutic drugs have provided new ways to prevent and treat several diseases, including immune disorders, degenerative diseases, and different types of cancer.

There are now more than 50 new antibody-based drugs in clinical use. For example, trastuzumab has been used to treat breast cancer, and adalimumab to treat inflammatory diseases such as rheumatoid arthritis, Crohn's disease, and plaque psoriasis. The latter is reported to be the top selling drug in the world. At the current rate, 3-5 new therapeutic antibodies are being approved each year. The application of therapeutic antibodies ranges from treatment of illnesses in small group of people such as paroxysmal nocturnal hemoglobinuria to illnesses of million patients such as cancers, multiple scleroses, asthma, and rheumatoid arthritis.

Sir Gregory Paul Winter graduated from Trinity College, University of Cambridge in 1973 and obtained his PhD in 1976. He was Joint Head of Division of Protein and Nucleic Acids Chemistry of the Medical Research Council Laboratory of Molecular Biology (LMB) and Deputy Director of the MRC Center for Protein Engineering. He is one of the most successful academic entrepreneurs by establishing biotech companies; Cambridge Antibody Technology, Domantis and Bicycle Therapeutics, which is worth over £930 million. His current position is the Master of Trinity College, University of Cambridge.

Prince Mahidol Award Laureate 2016 in the Field of Public Health

Professor Vladimir Hachinski

Distinguished University Professor
University of Western Ontario
Canada

Vladimir Hachinski, CM, MD, FRCPC, DSc, FRSC, Doctor honoris causaX4 is Distinguished University Professor of Neurology and past Richard and Beryl Ivey Chair of the Department of Clinical Neurological Sciences, University of Western Ontario, London, Canada. He graduated with an MD from the University of Toronto and trained in internal medicine and neurology in Montreal and Toronto and in research in London, U.K. and Copenhagen.

His contributions include pioneering with Dr. John W. Norris of the world's first successful acute stroke unit, now the standard of care. He coined the term brain attack to stress the urgency of stroke and discovered the key role of the brain insula in cardiac complications including sudden death. He has been an advocate, contributor and thought leader in the vascular (treatable) component of dementia, crystallizing the concepts and coining the terms multi-infarct dementia, leukoaraiosis, vascular cognitive impairment, brain at risk stage, and devising the Hachinski Ischemic Score that identifies the treatable component. (over 2500 citations) He was the principal neurological investigator of the Canadian American Ticlopidine Study (PI M. Gent), the EC/IC Bypass Study and the North American Symptomatic Carotid Endarterectomy Trial (PI HJM Barnett). With Shawn Whitehead and David Cechetto he discovered a link between Alzheimer disease and stroke, paving the way for novel therapeutic approaches. Recently he and colleague showed for the first time decreased dementia incidence at a whole population level, concomitant with a successful stroke strategy.

He led the adoption of a Proclamation addressing stroke and potentially preventable dementia on behalf of the World Stroke Organization endorsed by Alzheimer's Disease International, World Federation of Neurology, World Hypertension League, American Heart/Stroke Association, American Academy of Neurology, World Heart Federation, European Academy of Neurology, Heart and Stroke Foundation of Canada, Alzheimer's Association, Alzheimer Society of Canada and 12 other organizations aimed at uniting the stroke and dementia communities in a common effort to prevent stroke and potentially preventable dementias.

He authored, co-authored or co-edited 17 books, and over 700 scientific and scholarly publications resulting in over 32,000 citations and a Hirsh index of 84. His publications were cited over 2000 times in 2015. He has mentored over 100 physicians and scientists, some now leaders in their own right. He was the Editor-in-Chief of the journal STROKE, the leading publication of this field from 2000-

2010. He introduced 9 international editions and a unique mentorship program for authors of developing countries.

He won the first Trillium Clinical Scientist Award of the Ontario Ministry of Health to honor medical scientists working in Ontario, "in recognition of outstanding research accomplishments and contributions to Ontario health care." He received a Doctor honoris causa from the University of Salamanca, Spain, the Mihara Award of the International Stroke Society and the Willis Lecture Award, the American Stroke Association's highest honor. He is a Fellow of the Canadian Academy of Health Sciences.

In 2008 he was named to the Order of Canada, the country's highest award. In 2010 he received the Ontario Premier's Discovery Award in the Life Sciences and Medicine for "ground breaking research on the relationship between stroke and Alzheimer disease", and the World Stroke Organization Leadership in Stroke Medicine Award: "Stroke: Committing to a World Agenda".

He won the 2011 International BIAL Merit Award in Medical Sciences for a monograph on "The Long Fuse: Silent Strokes and Insidious Alzheimer Disease" and in 2012 got a Doctor honoris causa from the Russian Academy of Medical Sciences. In 2013, he received the Order of Ontario and a Queen Elizabeth II Diamond Jubilee Medal. He was the 2013 Paddison Lecturer and was awarded the Chancellor's Award Lecture in Neuroscience and Neurology for his "contributions to neurological sciences and for outstanding academic leadership" at the University of Louisiana. He is past and first Canadian President of the World Federation of Neurology and the Founding Chair, World Brain Alliance.

In 2014, Dr. Hachinski was the Allan & Maria Myers International Visiting Fellow at the Florey Neurosciences Institute, Melbourne, Australia, he received the Karolinska Stroke Research Award, he became the Brain Visiting Scholar at Oxford, Cambridge and London Universities and a Fellow of the Royal Society of Canada. In 2015 he was awarded the Career Scientist Award from the Lawson Research Institute, Ontario and in 2016 the McLaughlin Medal of the Royal Society of Canada, recognizing "research of sustained excellence in medical science".

Message from the Chairs

of the International Organizing Committee

When the 2030 Agenda for Sustainable Development was agreed in 2015, a bold vision was set for a world where all humans are able to fulfil their potential in dignity and equality and in a healthy environment. World leaders pledged to leave no one behind and to strive for societies that are just, equitable and inclusive. This ambition is not only noble and urgently needed, but also daunting. Success will require concerted and deliberate efforts across a diverse set of actors – government institutions, civil society, the private sector, development partners, and communities –and across different sectors to reach the most marginalized and change the conditions which create, reinforce and perpetuate vulnerability.

The public health and medical communities have a great responsibility and opportunity to advance health for all, starting with the most vulnerable. The sad truth is that a child born today into a poor household in a low income country can expect to live a much shorter life, with more illness and suffering and less access to quality care, than one born to a wealthy family in a high income country. If she is a girl child, in addition to her own poorer health prospects she may be pulled out of school and later drop out of paid employment to care for a sick family member. And if she is a refugee or from an indigenous community, born with a disability or with HIV, she will have many more obstacles to overcome -- obstacles that the health sector alone will not be able to remove. A whole-of-society approach is essential.

As stressed in the Rio Political Declaration on the Social Determinants of Health (2011), inequities are unfair and largely avoidable. They are not simply the unfortunate consequence of development or genetic bad luck; health inequities are in large part the result of bad policies, laws and practices. They are the result of deliberate decisions. The result is the inequitable distribution of choice. Understanding this is empowering. It gives us hope that current trends can change and health inequities can narrow. But reaching those most excluded will require new ways of working. At a minimum, emphasis will need to be given to changing discriminatory laws and strengthening of community systems; empowering politically marginalized groups, including women, children and adolescents, older people, people living with HIV, persons with disabilities, migrants, internally displaced populations and refugees, ethnic and religious minorities, lesbian, gay, bisexual, transgender and intersex people, and indigenous people. Full engagement means joint decision making; real progress towards universal health coverage.

This year, the Prince Mahidol Award Conference brings together international partners, the World Health Organization, the World Bank, the United Nations Development Programme, the United Nations Population Fund, the Joint United Nations Programme on HIV/AIDS, the International Organization for Migration, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Agency for International Development, the National Institutes of Health, the Japan International Cooperation Agency, The Rockefeller Foundation, the China Medical Board, the Chatham House, and the Bill & Melinda Gates Foundation, to explore the theme "Addressing the health of vulnerable populations for an inclusive society". We have embraced this theme because the cost of inaction is just too high: discrimination, stigma, and marginalization do not only harm the health and well-being of individuals and families, but can cripple economies, societies and reverse development gains.

As Chairs of the International Organizing Committee, we are delighted to welcome you to Bangkok, Thailand, to join more than 800 fellow health leaders, practitioners, and reformers from around the world. Throughout the discussions we are determined to hear a diversity of voices. It is our collective obligation to engage and confront the discriminations that undermine progress towards health and development. We encourage your active participation in the plenary and parallel sessions to share experiences, challenges and ideas, and develop practical ways for supporting the mission to build a more inclusive and equitable world.

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

Mr. Magdy MARTÍNEZ-SOLIMÁN
Co-Chair
United Nation Development
Programme

Dr. Babatunde OSOTIMEHIN
Co-Chair
United Nations
Population Fund

Dr. Michel SIDIBÉ
Co-Chair
Joint United Nations
Programme on HIV/AIDS

Ambassador William Lacy SWING
Co-Chair
International Organization
of Migration

Dr. Mark DYBUL
Co-Chair
The Global Fund to Fight AIDS,
Tuberculosis and Malaria

Dr. Jennifer ADAMS
Co-Chair
U.S. Agency for
International Development

Dr. Roger GLASS
Co-Chair
National Institutes
of Health

Dr. Takao TODA
Co-Chair
Japan International
Cooperation Agency

Mr. Michael MYERS
Co-Chair
The Rockefeller Foundation

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

Dr. David HEYMANN
Co-Chair
Chatham House

Dr. Trevor MUNDEL
Co-Chair
Bill & Melinda Gates
Foundation

Prince Mahidol Award Conference 2017 International Organizing Committee and Scientific Committee Members

A full list of the PMAC 2017 Organizing Committee members is given in ANNEX I, and Scientific Committee Members in ANNEX II

Conference Co-hosts and Supporting Organizations

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
United Nations Development Programme
United Nations Population Fund
Joint United Nations Programme on HIV/AIDS
International Organization for Migration
The Global Fund to Fight AIDS, Tuberculosis and Malaria
U.S. Agency for International Development
National Institutes of Health
Japan International Cooperation Agency
The Rockefeller Foundation
China Medical Board
Chatham House
Bill & Melinda Gates Foundation
Asian Development Bank
British Medical Journal
People's Health Movement

Programs

PMAC 2017

ADDRESSING THE HEALTH OF VULNERABLE POPULATIONS FOR AN INCLUSIVE SOCIETY

Pre - Conference

Sunday 29 – Tuesday 31 January 2017

There were 30 side meetings and workshops held during the conference (ANNEX III), and 6 optional field visit sites (ANNEX IV).

Main Conference

Wednesday 1 - Friday 3 February 2017

At the Conference, there were

- 3 Keynote addresses
- 4 plenary sessions
- 19 parallel sessions
- 4 Launches: books, programs
- 62 poster presentations
- Art contest
- Conference synthesis

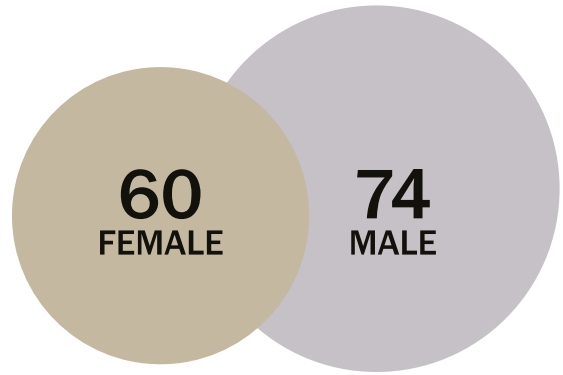
Total registered participants

There were a total of 888 participants (female 46%, male 50%, not spell out 4%) from 72 countries.

Profile of moderators, speakers and panelists

Of the total 134 office bearers such as moderators, speakers and panelists; 45% were female. Female proportion has increased from the last PMAC 2016 (37% female).

23 Plenary & Parallel sessions	
Chair/Moderators	21
Speakers	35
Panelists	78
Total	134



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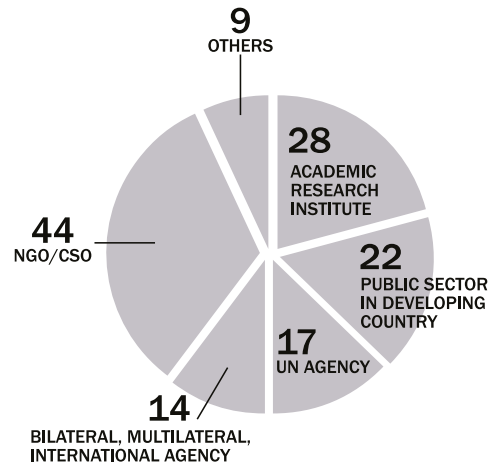


ORGANIZATION

WHO REGIONS

A full list of the PMAC 2017 Conference Speakers, Panelists, Chairs, Moderators and Rapporteurs is given in ANNEX V.

In addition, during the Conference, a total of 62 posters were displayed in front of the Conference room (ANNEX VI). The PMAC 2017 World Art Contest under the topic “Everyone Matters” had been conducted and the rewards were given to the winners (ANNEX VII).

PMAC 2017

ADDRESSING THE HEALTH OF VULNERABLE POPULATIONS FOR AN INCLUSIVE SOCIETY

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 2017 was co-hosted by the Prince Mahidol Award Foundation, the World Health Organization, the World Bank, the United Nations Development Programme, the United Nations Population Fund, the Joint United Nations Programme on HIV/AIDS, the International Organization for Migration, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the U.S. Agency for International Development, the National Institutes of Health, the Japan International Cooperation Agency, the China Medical Board, the Rockefeller Foundation, the Chatham House, and the Bill & Melinda Gates Foundation with the support from other key related partners. The Conference was held in Bangkok, Thailand, from 29 January - 3 February 2017.

Why Social Inclusion Matters?

The year 2015 marked the endpoint for achievement of the Millennium Development Goals (MDGs). In assessing the MDG response and outlining a plan for the next era of development, the United Nations Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda called for designing development goals that focus on reaching excluded groups. The vision of "Leave no one behind" focuses on eradicating extreme poverty by 2030 and putting justice and equity at the heart of development goals. Though the MDGs have made a big progress in solving pressing problems, in some cases they have resulted in a widening of inequalities between groups. National level success achieved from the MDGs did not translate to the same success across different groups of people. Reduction in child mortality in Burkina Faso and Cameroon, for example, are different between the richest and poorest group, whereby the child death rate in the richest 20% reduced much faster than the death rate in the poorest 20%. Moreover, social exclusion has economic consequences in terms of loss of productivities and economic growth, and deprives human capital from the excluded. "Leave no one behind" is, thus, the right direction toward a sustainable development in bringing people left behind to the heart of attention. The SDGs have set an ambitious goal to have a society "that is just, equitable and inclusive, and committed to work together to promote sustained and inclusive economic growth, social development and environmental protection and thereby to benefit all, in particular the children of the world, youth and future generations of the world without distinction of any kind such as age, sex, disability, culture, race, ethnicity, origin, migratory status, religion, economic or other status." Unlike the MDGs where targets were more relevant to a developing country context, SDGs are relevant to all countries, developed and developing countries alike.

For PMAC 2017, the theme was in line with the SDGs on social inclusion and focused on the health of vulnerable populations. Thus, the theme was "Addressing the Health of Vulnerable Populations for an Inclusive Society".

How to Measure Social Inclusion?

Converting principle into practice requires a clear understanding of the issues and having measurable targets and indicators. Social exclusion is viewed with different perspectives which will lead to different policy implications. Silver (1994) using solidarity paradigm defined social exclusion as “a disruption of the social ties between society and the individual due to the failure of institutions to integrate individuals into the society.” Amartya Sen (2000) has proposed to consider social exclusion not just related to poverty but to capability deprivation. Sen has distinguished between constitutive relevance of social exclusion and instrumental importance, where the former means that being excluded is the deprivation in itself while the latter refers to relational deprivations that in themselves are not bad but can lead to other deprivations.

The World Bank in their report looked at social inclusion as “The process of improving the terms for individuals and groups to take part in society.” Though different in perspective, there is consensus that social exclusion is multidimensional, dynamic and relational.

How to measure social inclusion is challenging. There are some efforts to measure social inclusion such as using well-being, better life indicators or Multidimensional Poverty Measure (MPM). A study by Ward et al. in 2013 analyzed four key inter-linking factors of SDH on social cohesion, social inclusion, social empowerment and socio-economic security in order to improve health of the most vulnerable groups of society. They developed a 50-question survey, divided into four categories according to the four factors above. The survey was conducted in 2009-2010 in six research participating countries, namely Australia, Hong Kong, Japan, South Korea, Taiwan, and Thailand.

Policy and Strategies to Tackle Social Inclusion

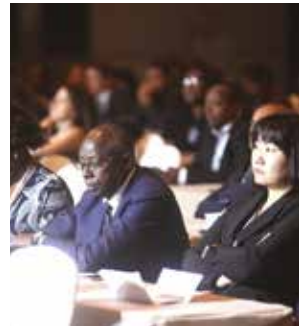
To develop an inclusive society needs interventions that are inter-sectoral and contextually relevant. The vulnerable population approach focuses on decreasing health inequalities between socially defined groups may be a better approach compared to population at risk or population approaches. Alleviation of fundamental causes that create vulnerabilities especially in social determinants of health is the key of this vulnerable population approach. The policies and actions included approaches to poverty reduction/eradication, the provision of new services, initiatives to improve access to existing services and/or to improving the co-ordination of policies and new strategies for policies and actions had been mentioned in the final report in 2008 of the Social Exclusion Knowledge Network (SEKN). Improving health equity is at the core of Health 2020 proposed by the EU which emphasized that the strategies for health equity and sustainable development should come together.

The Territorial Dimension of Poverty and Social Exclusion in Europe (TiPSE) project is the first comprehensive and systematic attempt to map regional patterns of poverty and social exclusion across Europe to inform the decisions of policymakers at EU and national levels. The World Bank proposed to enhance social inclusion by improving ability, opportunity and dignity, while at the same time, paying attention to attitude and perception.

Objectives of the Conference

- To understand the situation, causes and consequences of social exclusion on health of vulnerable populations in different contexts
- To discuss indicators and how to measure and monitor progress on social inclusion that have yielded better health in the most vulnerable populations
- To share experiences in implementation of policy/programs to enhance social inclusion of vulnerable populations in different settings and groups
- To advance policy opportunities to make UHC inclusive and accessible for the marginalized through multisectoral engagement, policy coherence and engagement of the marginalized
- To draw recommendations to move toward social inclusion to achieve UHC and SDGs



Sub-theme 1

Vulnerable Populations: Who, Where and Why?

Development must be more equitable if it is to be sustainable. Deepening, divisive and destabilizing inequalities within and among countries are threatening social progress and economic and political stability, affecting all pillars of development including health, human rights, peace and security. The United Nations Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda called for designing development goals that focus on reaching excluded groups. The vision of "Leave no one behind" focuses on eradicating extreme poverty by 2030 and putting justice and equity at the heart of the new Sustainable Development Goals (SDGs). Learning from the experience of the MDGs, the new 2030 Sustainable Development Agenda is a universal, transformative and people-centered plan of action, strongly grounded in international human rights law and aims to collectively work towards achieving sustainable development through cooperation and integrating social, economic and environmental dimensions of development.

The imperative to promote more equitable development permeates all 17 SDGs of the new Agenda, including through promoting universal, equitable and inclusive access to health, education, food, water, sanitation, justice, opportunities and outcomes across many of the targets. This is further underscored by a cross-cutting commitment to the disaggregation of data, which will help to ensure that no one is being left behind. The new Agenda gives special attention to the poorest, most vulnerable and marginalized, including women and girls, all children,

youth, persons with disabilities, people living with HIV/AIDS, older persons, sexual and gender minorities, indigenous
peoples, refugees and internally displaced people and migrants.

Vulnerability, broadly defined, can vary significantly within a community and is subject to change over time. Vulnerability is closely associated with poverty, isolation, insecurity or conflict as well as more structural features of society such as gender norms and roles or education and the surrounding legal and policy environment. Factors of vulnerability – sex, age, race, gender, ethnicity, sexual orientation and gender identity (SOGI), displacement, disability, health status - are also, more often than not, intersecting and overlapping, rather than occurring in isolation from each other. Clear correlations can be seen where different factors of vulnerability or characteristics intersect, leading to increased vulnerability and poor health outcomes.

With more than one billion migrants across the globe, in a world that is increasingly interconnected – yet still characterized by profound disparities – the link between migration, human mobility and health is an evolving domain of critical importance, bridging aspects of public health and health security, human rights and equity, and human and societal development [1].

The conditions in which migrants travel, live and work often carry exceptional risks to their physical and mental well-being, including for those families left-behind. For example, irregular migrants and their families often lack access to health care because of their legal status. In addition, even if migrants have access to health services, they tend to avoid them due to fear of deportation, xenophobic and discriminatory attitudes, and

other linguistic, cultural, and economic barriers. From a global health security perspective, the lack of targeted outreach health services and surveillance along mobility pathways undermines the effectiveness of disease control measures. Additionally, more than 50 conflicts around the globe, persisting human right abuses, and environmental changes have produced more than 60 million displaced people world-wide, and this against a general backdrop of mounting xenophobia and anti-migrant sentiments that exacerbate the vulnerability of people seeking protection abroad. This is all the more evident when one considers that lasting conflicts have largely diminished the resilience and the capacity to dispense care of health systems in many parts of the world.

The field of migration and health has also become increasingly important from a sustainable development perspective. Remittances from low-skilled labor migrants from many low-income countries contribute significantly to the economic growth of their country of origin. It is now widely acknowledged that migration carries development potential, owing to migrants' intellectual, cultural, social and financial capital and their active participation in societies of origin and destination. Nevertheless, discussions of the health and well-being of migrants have not yet gained much momentum in relevant global debates, such as the 2006 and 2013 United Nations High-level Dialogue on International Migration and Development and the Global Forum on Migration and Development. Nor has the concept gained much traction in the discussion and definition of the Sustainable Development Goals.

There are gross inequalities in health between and among countries and vulnerable populations are affected the most. Life expectancy at birth, as an example, ranges from 34 years in Sierra Leone to 81.9 years in Japan [2]. Within countries there are also large inequalities – a 20-year gap in life expectancy between the most and least advantaged populations in the USA [3]. Furthermore, socially-marginalized populations are disproportionately subjected to health vulnerability and inequity. For example, men who have sex with men, female sex workers, and transgender women are 19, 14, and 49 times more likely to contract HIV, respectively, when compared with adults of reproductive age [4, 5] Persons with disabilities are often excluded from disaster

responses and face higher fatality and other health risks in emergencies [6].Cross-border labor migrants, particularly those under-documented, do not seek healthcare until they reach a critical condition and they often fall outside universal health coverage discussions [7, 8]. Women living with HIV face rights violations in healthcare settings, including treatment refusal, confidentiality breach, and forced sterilization and abortion [9] People living with neglected tropical diseases are disabled, impoverished, and rendered hopeless with insufficient R&D and policy attention for affordable treatment and care [10].

While trends from MDG progress reports have shown that some populations are systematically faring worse than others, the purpose of 'leaving no one behind' is to recognize that vulnerability occurs in all contexts, and demands that we look beyond the labels to understand what is driving vulnerability, where, and how to mitigate it to promote and protect the right to health.

Though challenges exist and there is much work to be done, there are exciting developments afoot in a variety of disciplines to better monitor social inclusion, exclusion, health inequalities, discrimination and the costs to economies and societies of exclusion, as well as the cost effectiveness of addressing marginalization and promoting a more universal and equitable agenda. The new SDG Agenda provides a new research imperative to ensure that we have robust information systems that collect and disaggregate data, contain adequate safeguards and draw from multi-disciplinary methods to monitor those being left behind. The nature of those on the margins of development is that they are hard to find in routine monitoring processes. The new SDG paradigm requires that this should no longer be the case.

Sub-theme 2

Interventions to Reach the Vulnerable

Social inclusion is high up in the global policy agenda and is a major focus of the SDGs. Complex demographic, social and economic transitions over the past decades, combined with expansion in education and connectedness, has catapulted the need for social inclusion in developing and developed countries alike. In the realm of health, increased societal expectations, recognition of health as a human right, and the understanding that health matters for social and economic wellbeing have put UHC at the core of policy discussions worldwide.

While there has been significant improvement in global health coverage in recent decades, some groups continue to be systematically left out of quality health services. These groups are often, but not always, the poorest members of their societies. They may have poor access because of their location or social and economic status, but also because of social processes and legal, cultural and political constraints that systematically leave them behind. Social exclusion may be enshrined in law or policy; it can also be practiced by service providers, wittingly or unwittingly, despite being proscribed by law or policy.

Individuals and groups are often excluded or included based on their national and social origin and identities. Quite often, multiple identities overlap to accentuate the impact of exclusion. This can lead to lower social standing, accompanied by lower development outcomes, including poor access to quality healthcare. Examples of socially excluded groups are myriad and include undocumented migrants, guest

workers with limited rights, incarcerated populations, the homeless or highly mobile, those diagnosed with mental illness or addictions, those with mental or physical disabilities or living with HIV, those excluded due to gender or gender identity, ethnic, tribal or caste reasons, and those excluded for lifestyle or behavioural reasons, including LGBTI (lesbian, gay, bisexual, transgender and intersex), sex workers, people who use drugs and young or unmarried people seeking sexual and reproductive health care services.

Social inclusion is the process of improving the ability, opportunity, acceptance and dignity of people, disadvantaged on the basis of their identity or origins, to take part in society (World Bank, 2013). Ensuring health coverage to those groups most at risk of being left behind requires that laws and policies promote and protect their right to access health care and address the social determinants of health. Successfully implemented policies such as these can enhance the ability of and opportunities for those most marginalized to fully participate in social and political processes and ensure their right to non-discrimination.

Ability is both innate and acquired; it is acquired ability that policy can strengthen by ensuring, for instance, pre-natal attention to the mother and then on to the individual at every stage of the life cycle. In addition, social inclusion/exclusion is very dependent on social and political ability to engage and share legal and policy decisions that affect their access to services. Ability and opportunity are related, but they are not the same. Access to health care is both a demand side and supply side construct. It may be possible to have perfect supply of opportunity in an ideal world, but some groups may be physically, socially or culturally prevented from accessing them.

For instance, women in some communities may need permission to go to the health center, even if they come from well-off families. In other cases, people stigmatized on the basis of their sexual identity may be physically or psychologically prevented from accessing certain services, and women from criminalized populations such as women who use drugs often face even greater stigma than their male counterparts. Finally, the notion of dignity and rights, including the legal right to care, is intrinsic to the design and implementation of policies and programs. Historically excluded groups are also often those that experience stigma and discrimination, humiliation and indignity at the hands of service providers. Thus, they may be unable or unwilling to access to available health care.

It is important to understand the processes of discrimination and exclusion and to guard against them through a range of interventions that target both users and providers. Yet, no single set of policies or programs can be classified as “social inclusion” policy or program. Interventions need to be context specific, depending on the rights that need to be deepened. They must tackle both demand and supply side obstacles, by promoting and protecting the right to health- including but not limited to promoting health-seeking behaviors and facilitating increased access to services as well as ensuring high quality services are delivered without stigma or discrimination and in a safe and secure environment, including legal protections. Understanding the underlying drivers of exclusion is central to developing effective policies to make universal healthcare accessible for all.

Sub-theme 2 applies the following principles that could guide the development of interventions for socially excluded groups:

- Human rights are universal and are applicable for all people without discrimination.
- All people especially those at risk of exclusion must live in a fair and just society where they are respected and protected, so they can achieve their full potential.
- Socially excluded groups are entitled the equitable distribution of health and social resources.
- There can be no UHC without social inclusion. Those who belong to historically excluded groups must be integrated into UHC – as the first mile not the last mile - like all others without discrimination.
- Addressing stigma and discrimination throughout the health, social and community response systems needs to be a priority if we are to achieve UHC.
- The voice of the socially excluded must be reflected in health systems

Interventions to promote social inclusion through UHC are classified into two groups of demand and supply sides (see table of a taxonomy below)

A Taxonomy of Interventions to Promote Social Inclusion

Demand Side Interventions	Supply Side Interventions
Promoting legal literacy, laws, policies and reforms that address the determinants of social inclusion, remove obstacles to social inclusion and promote measures to strengthen social inclusion	Multisectoral interventions, including interventions to address social determinants of health as well as increasing access to justice, to develop UHC and supporting interventions to provide comprehensive, integrated services to the socially excluded
Societal and community interventions to reduce stigma and discrimination against socially excluded communities	Expanding physical access to services needed by the socially excluded, including situating services near socially excluded communities and in accessible manner, at times convenient to socially excluded communities. Also recognizing the different needs of excluded women, men, trans people and young people across all categories. Holding health care providers accountable for treating excluded groups with dignity and respect
Financial incentives to promote the inclusion of socially excluded groups, including incentives to access UHC services	Conducting regular analyses to understand the needs of the socially excluded
The removal of financial obstacles to accessing UHC and associated services, by ensuring the services are free and equitable	Based on an understanding of the needs of socially excluded communities, developing an expanded range of services and instruments. The interventions should explicitly promote rights-based programming and interventions, including programs and approaches to address gender-based barriers to services.
Social interventions to increase demand for UHC and related services, by promoting health seeking behaviours and by making the services culturally, socially, legally and psychologically accessible, ensuring the socially excluded do not face stigma and discrimination or experience abuses and violations.	Expanding the provision of socially, culturally and psychologically acceptable service providers and services, which includes recruiting appropriate providers, training providers to be more receptive to the needs and rights of the socially excluded, structuring services appropriately, and sensitivity training and orientation

Demand Side Interventions	Supply Side Interventions
Active promotion of inclusive services through community systems, groups representing socially excluded groups and mass, targeted and social media	Strengthening community delivery systems to provide a vehicle to reach and engage the socially excluded
Interventions to strengthen voice, agency and self-empowerment among the socially included and to enable them to participate in the governance of policies and services and monitor how policies are implemented, and services – provided.	Representation of groups who are at risk of being left out, in decision making at the local and through to the national levels.

Sub-theme 2 has an objective to advance understanding and resolve to implement policies and interventions to make UHC inclusive and accessible for excluded populations. This would be achieved through sharing experiences in implementation of policies and programs to enhance inclusion in different settings and groups, including measuring impact of those on better health in excluded populations.

The focus was on concrete, practical examples of measures to achieve social inclusion – on the how not the what. Wherever possible, real-life experiences and case studies were used.

Sub-theme 3

Political Economy of Vulnerability and UHC

Sub-theme 3 focused on the importance of political economy of vulnerability and UHC. It had three specific following objectives as follows:

- To understand and appreciate the human rights and equity principles underpinning universal health coverage and recognize where these rights are not be respected.
- To share lessons on how to extend effective coverage to vulnerable populations, for example people living in fragile states, refugees, internally displaced people, the poor, economic migrants, ethnic minority groups and disadvantaged demographic groups (women, children, LGBT people, disabled people, the chronically sick and the elderly)
- To discuss the political benefits of implementing truly inclusive and equitable UHC reforms that not only “leave no one behind” but also prioritize the needs of vulnerable populations.

Opening Session
by Her Royal Highness Princess
Maha Chakri Sirindhorn

Chairman, Board of Trustees and President
Prince Mahidol Award Foundation

PRINCE MAHIDOL AWARD CONFERENCE 2017

It is a great honor for me to be here at the opening of the eleventh annual Prince Mahidol Award Conference 2017 on the theme “Addressing the Health of Vulnerable Populations for an Inclusive Society”.

I am pleased that the theme of the 2017 conference will support the implementation of the new global Sustainable Development Goals, with the vision of “Leave no one behind”. It is a real challenge for all our countries to develop policies into concrete actions to build inclusive societies and to reduce discrimination and disadvantage of vulnerable populations. I believe the conference will provide sharing of experiences and best practices as well as guidance and recommendations that can be adopted to address various challenges in different countries, ultimately yielding better health in vulnerable populations. I am convinced that our intensified efforts and commitments will lead to a socially inclusive world in which the needs of vulnerable populations are met.

I would like to sincerely thank our co-hosts and international partners – the World Health Organization, the World Bank, the United Nations Development Programme, the United Nations Population Fund, the Joint United Nations Programme on HIV/AIDS, the International Organization for Migration, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Agency for International Development, the National Institutes of Health, the Japan International Cooperation Agency, The Rockefeller Foundation, the China Medical Board, the Chatham House, the Bill & Melinda Gates Foundation, the Asian Development Bank, the British Medical Journal, and the People’s Health Movement – for their great contributions for the conference.

I wish for the success of the conference and for the achievement of our goal to move toward social inclusion to achieve Universal Health Coverage and the new Sustainable Development Goals.

I now declare the Prince Mahidol Award Conference 2017 open.

KEYNOTE
ADDRESSES

Sir Gregory Paul Winter

Prince Mahidol Award Laureate 2016
in the Field of Medicine

Master of Trinity College
University of Cambridge
United Kingdom

The Development of Humanized Therapeutic Antibody Technology

More than thirty years ago I started working on technologies for making antibody pharmaceuticals. The field has now come of age, antibody pharmaceuticals are transforming the practice of medicine and have escaped from academia to take the pharmaceutical industry by storm. Thirty years ago there was a single monoclonal antibody approved as a pharmaceutical drug; now there are more than thirty-five approvals with many others in late stage clinical trials. Antibodies have become some of the best-selling medicines: in 2015 the pharmaceutical charts of world drug sales were topped by the antibody adalimumab (marketed as Humira). This antibody alone had sales of more than $15 billion per annum, and together with similar antibodies has transformed the treatment of rheumatoid arthritis.

Although the use of monoclonal antibodies as pharmaceutical drugs is recent, antibodies date back to Man's origins, and are found in all mammals and birds. Antibodies are produced naturally by the immune system in response to foreign proteins (or antigens) and help protect against infectious agents such as bacteria and viruses. Antibodies can stay in the blood for months; they are big enough to escape filtration through the kidneys, and have recycling mechanisms to escape digestion by the cells lining the blood vessels. In many senses, antibodies are nature's own pharmaceuticals.

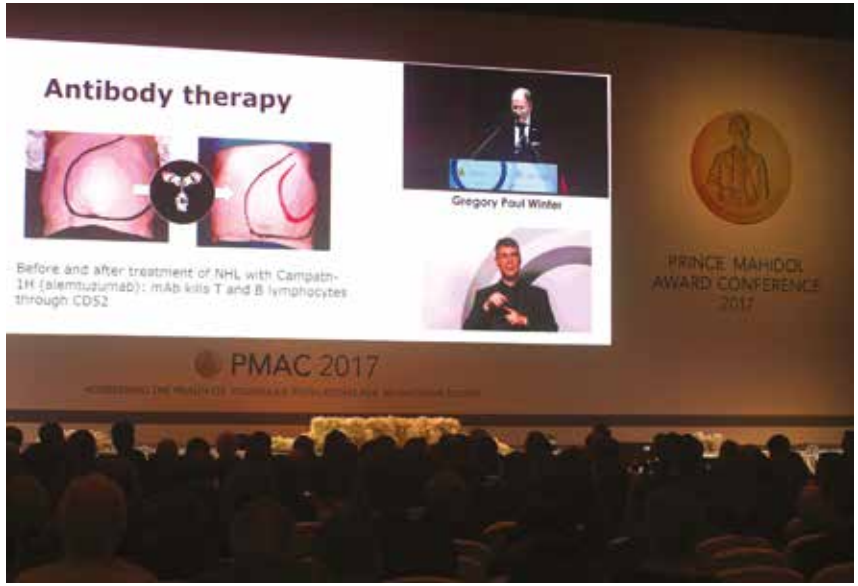
However, compared to traditional chemical pharmaceutical drugs, antibodies are huge protein molecules; the antibody immunoglobulin G molecule has a molecular mass of 150,000 Da compared to 500 Da for a typical chemical drug (300 times bigger). Generally, antibodies have a Y-shape, with two arms and stem, represented here by a trace of the protein backbone.

Like the Swiss Army knife, the antibody is a multi-functional tool. The tips of the antibody arms bind to the virus or bacterium; this alone may be sufficient to prevent it adhering to or infecting a cell. The antibody stem can also act as a flag to the immune system, and trigger the release from immune cells of a stream of reactive and damaging chemicals such as peroxides or superoxide, or of proteins that punch holes in bacterial membranes. Alternatively, the stem can help phagocytes attach to, engulf and digest the pathogen.

Although in nature, antibodies have evolved to attack infectious agents and toxins, we have learned in the last thirty years to direct them against non-infectious diseases such as cancer and immune disorders. This includes cancers of the breast, bowel, head and neck, bone and blood; immune disorders ranging from transplantation rejection, rheumatoid arthritis, osteoporosis, Crohn's disease, psoriasis, ankylosing spondylitis, asthma, multiple sclerosis and acute macular degeneration. Antibodies have transformed the treatment of these diseases.

Antibodies can be extremely potent. The slide shows the action of a modern pharmaceutical antibody, alemtuzumab (marketed as Lemtrada), directed against human T and B cells. This was the first antibody pharmaceutical we made, and was the first ever used in patients. This patient had non-Hodgkins lymphoma with an accumulation of white cells in the spleen. Over the 30 days of treatment a great mass of tumour (several kg) was destroyed, leading to clinical remission. Other pharmaceutical antibodies have been used to kill cells in similar manner, such as trastuzumab (marketed as Herceptin) for treatment of breast cancer and cetuximab (marketed as Erbitux) for treatment of bowel cancer.

It is not always necessary for the antibody to kill cells in order to have a therapeutic action. For example, the antibody adalimumab mentioned earlier as the world's top selling drug, works by blocking the action of TNF, a mediator of inflammation. The antibody bevacizumab (marketed as Avastin) works by blocking the action of a growth factor that stimulates



the formation of new blood vessels around a tumour, and in this way starves a tumour of the nutrients it needs to survive.

The application of antibodies to treat non-infectious human diseases is very recent and required the development of novel technologies. It was a particular challenge to make human antibodies against the human disease proteins. Although the immune system readily makes antibodies against foreign proteins, such as those involved in cancer, it is blocked from making antibodies against self-proteins.

During the last thirty years we developed several possible solutions to this conundrum. The approach I first adopted was to make “humanized antibodies”. Mice are first immunized with human proteins involved in diseases such as cancer or inflammatory disorders, to raise mouse antibodies against these proteins. The mouse antibodies are then transformed into their human counterparts by the alchemy of genetic engineering. In essence, and as shown in the slide, we take the tips of the antibody arms from the mouse antibody, knit these into a human antibody, and use this “humanized” antibody as a lead for the development of antibody drugs.

The good news is that this and other technologies have been used to generate a wealth of new human antibody drugs, and new applications are discovered every year. Recently there have been spectacular results with antibodies such as the humanized antibody pembrolizumab (marketed as Keytruda) that help T-cells recognize and kill melanomas

and other tumours; there are already hundreds of clinical trials of these so-called “immune checkpoint inhibitors” in progress.

Finally, I was asked to direct some remarks to healthcare provision. Unfortunately, antibody drugs are incredibly expensive, typically in the region of $30,000 - $100,000 per year for treatment of cancer but up to USD $400,000 per year for treatment of the rare disease paroxysmal nocturnal hemoglobinuria (PNH). Clearly the prices of the drugs will have to come down.

The biggest driver of high prices is the need to recoup the costs and risks of drug development and marketing. These costs are huge; the development of a pharmaceutical can typically run into billions of dollars before it receives marketing approval. The costs are accelerating; including the costs of failures, and using inflation-adjusted dollars, in 1979 it took the pharmaceutical industry $100 M to develop a new drug. By 2015 this figure had risen to $3.8 bn. Not only is the scale of these costs driving up the prices of the drugs but choking off the development of new drugs.

This is a challenge that needs to be tackled and we may need to change the entire model for drug development and marketing. I wish good fortune to those tackling these problems and although I doubt we will ever reach equality of healthcare provision, but we could do better.

“This is a challenge that needs to be tackled and we may need to change the entire model for drug development and marketing.”

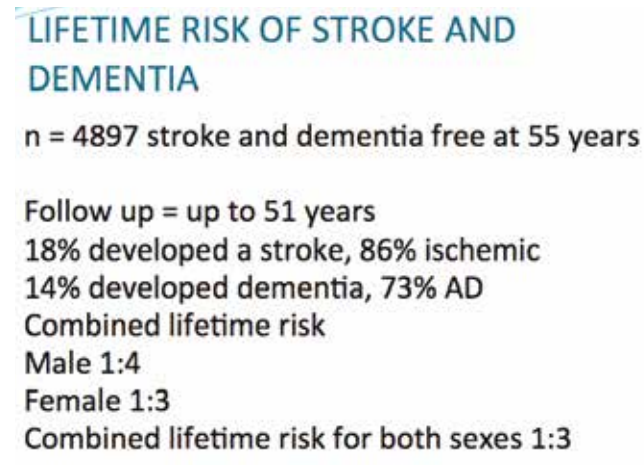
Vladimir Hachinski

Prince Mahidol Award Laureate 2016
in the Field of Public Health

Distinguished University Professor
University of Western Ontario
Canada

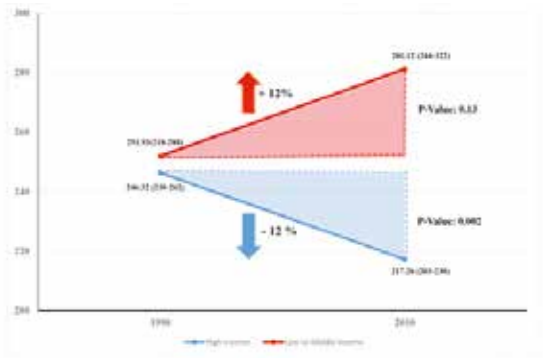
Preventing Stroke and Dementia Together

Stroke and dementia together represent the greatest threat to our brains, personally and globally. One in three of us will have a stroke, dementia or both unless we improve prevention.



Globally, stroke represents the second leading cause of death. Together stroke and dementia account for 2/3 of DALYS (disability adjusted life years) related to the brain.

Globally, stroke and dementia incidences and prevalences are rising. However, there is also good news. Although the stroke incidence in low income and middle income countries has increased by 12% from 1990 to 2016, it has decreased by 12% in high income countries suggesting that we can do something about it.



Age-standardised incidence of stroke in low to middle income VS high income countries:

From 1990 to 2010, the age-standardised incidence of stroke significantly decreased by 12% (95% CI -17) in high-income countries, and increased by 12% (-3 to 27) in low-income and middle-income countries, albeit non significantly

Moreover, 90% of strokes are potentially preventable, including 1/3 of the attributable risk being due to air pollution. This has become an increasing problem and it is not limited to places where pollution is a major problem. Given the within and between continent air currents, what happens in Beijing, matters in Bangkok.

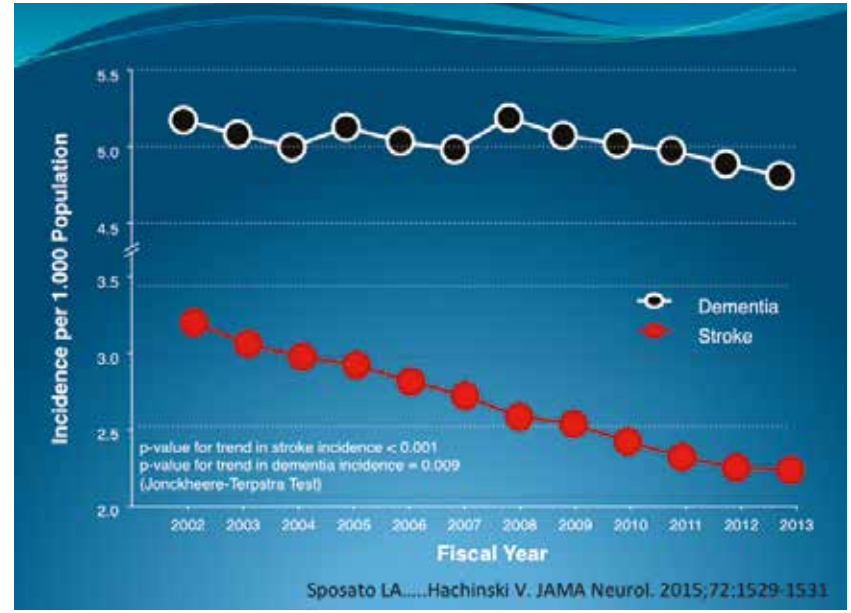
There is also some good news regarding dementia. Stroke and dementia share the same risk factors and stroke doubles the chances of developing dementia.

EFFECT OF STROKE ON INCIDENT

Systematic Review

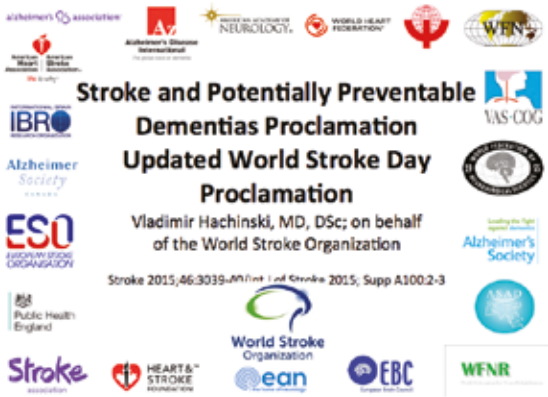
"A doubling of the risk of incident dementia in those with stroke compared with those without" (5 studies)

Savva et al Stroke 2010; 41:e41-e46

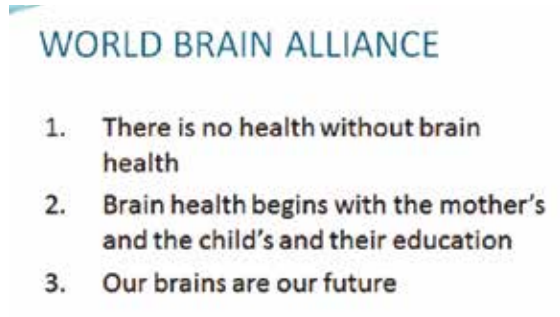


In the Province of Ontario (pop. 14 million) a stroke strategy was implemented in the year 2000 consisting of opening more stroke units and stroke prevention clinics and undertaking prevention campaigns, resulting in better outcomes both for stroke and for threatened stroke patients. So we looked at the incidence of stroke and dementia together. Stroke incidence has been decreasing steadily for the past 12 years for the past 6 years, also the incidence of dementia.

Based on this and other evidence, all the major organizations dealing with the brain, stroke and dementia have endorsed a Proclamation calling for the joint prevention of stroke and dementia.



Most of the organizations are part of the World Brain Alliance, of all major international brain organizations, that we founded in 2011 on the following premises:



"I appreciate the great opportunity of addressing you, because together we can work for better brains for a better world."

Amartya Sen

Nobel Memorial Prize
in Economic Sciences 1998
“for his contributions to welfare economics”

Professor
Harvard University
USA

Your Royal Highness, Excellencies, and Other Friends, I feel deeply honoured to be speaking here this morning.

Thailand has an extraordinary record in pioneering universal health care – without waiting for a distant future when the country would be much richer and economically opulent. There is a global lesson here for all countries with moderate economic means. Thailand is also a country in which new thinking on bettering human lives has been going on for many decades. In fact, the late King Bhumibol Adulyadej’s innovative idea of a “sufficiency economy” was a radical contribution in that direction. Providing health care for all through a sequence of public initiatives (to which the powerful – and rightly admired - 30 Baht program belongs) has followed a reasoned approach from which the rest of the world has much to learn.

In line with Thailand's intellectual leadership in the field of health policy, the initiative of Prince Mahidol Award Conferences has been working towards solving global health problems, including those of equity and justice. So it is a great privilege for me to be here this morning at this PMAC meeting.

I am also very happy to be present here when two great medical scientists are being honoured by Prince Mahidol's distinguished awards. Greg Winter is a close friend of mine from my own college, Trinity in Cambridge, of which he is Master, and I know how brilliant - and fruitful for humanity - his biochemical research has been. Also, I have heard a lot about Vladimir Hachinski's splendid neurological work, and I can take some pride in that too, since I am an alumnus of Western University (even though, I must concede, only through an honorary degree from there). Progress in health care, including in taking better care of vulnerable populations through building an inclusive society (the theme of this year's conference), is greatly dependent on outstanding medical research, and the two laureates have made exceptional contributions not only to science but, through their work, also to healthcare and social equity.

There is nothing more important to human beings than our health. This is reflected in the fact that people across the world even greet each other through a "salute" – the word "salute" originally stood only for being in good health. By saluting each other, we literally wish each other health – not more wealth, nor more opulence, not even more happiness, but better health. The association of health with the goodness of people is so firm in our mind that the word salute has come to acquire an additional meaning altogether, which has overshadowed its original use. Indeed, salutation now stands simply for greeting and wishing each other well. When Alfred Tennyson wrote in his poem addressed to the great Latin poethis favourite (Virgil came – hence addressed as Mantovano). Of course Tennyson was not wishing good health to Virgil, who had been dead for nearly two thousand years when Tennyson was writing. Because of the importance of health to human life and success, salutation has acquired a much larger meaning.

The centrality of health in human accomplishment makes it easy to see why the health of vulnerable people must be a major – indeed essential – priority of social justice. Every person deserves a salute, and to neglect the health of some, while others are being well cared, is a sure way of perpetuating injustice in the world. I am delighted that in this conference this critically important theme has been taken up, and I am also very happy that among the invitees here are some of the greatest experts in the world on health and health care in the broadest sense, like Gro Brundtland and Keizo Takemi - people I have also had the good fortune of having as close friends.

In the context of Thailand, the subject of taking care of the healthcare of vulnerable people may be seen at this time as being of two broad types. There is, first of all, what Thailand has largely achieved already (ahead of most countries in the world in a similar situation). The triumphs include, of course, universal health coverage (or at least something very close to it), but also paying special attention to healthcare in rural areas,



and making the state directly responsible for healthcare expenditure (rather than following the cumbersome and costly procedure of going via private insurance – as in the United States). But the achievements include furthermore – and this is really important for catering to vulnerable people - establishing systems of public discussion on health and healthcare, thereby making the public better informed, and also allowing neglected patients to use accessible channels for complaints to the authorities as a way of seeking remedy.

For the world, there are a lot to learn from Thailand in these respects (as I have discussed elsewhere). For example, my own country India can benefit greatly from studying and learning from the Thai experience – from the importance of universal coverage to the constructive use of public discussion on health care (both of which are badly neglected in India at this time).

A second category of issues relates to what further can be done in Thailand itself to provide better service to the vulnerable people who happen to be neglected. There is, of course, always the possibility of expanding the resources to be dedicated to health and healthcare. To cater adequately to more and more vulnerable people do not come cheap, since all the categories of specially vulnerable people tend to have challenging problems of one kind or another, like having difficult diseases to remedy, through more medical research – a subject on which today's Laureates can teach us a great deal. There are also people with serious disabilities which can be hard to rectify, and others subject to particular genetic risks from which some people suffer. There are also locational problems in that it may be expensive to guarantee easy access to good healthcare for people living in very remote areas. These are some examples of difficulties, but they all need attention – and urgently too.

There is also the big issue that healthcare may have to include not merely the provision of clinical diagnosis, medicine and surgery, but also what has come to be called – following Michael Marmot – the "social determinants of health." There is a well-established general connection between economic and social inequality, on the one hand, and public health, on the other, which has been studied by researchers such as Michael Marmot – and others like Kate Pickett and Richard Wilkinson. If living in a sharply unequal society, with systematic and significant disparities in economic and social fortunes, itself generates frustration or deprivational behavior (for example in the form of smoking or excessive

drinking), or a sense of serious discontent that affects human health, then the issue of inequality has to be seen as a pervasive challenge that demands a much broader social change – going well beyond providing diagnosis, medicine, clinical advice and surgery. I cannot go further into this subject on this occasion, given the limits of the time I have, but I must note firmly here that that hundreds of millions of people in the world, including in Thailand, suffer from vulnerabilities that stem from relational deprivation (in particular being at the bottom of social and economic inequality), rather than from just medical deprivations.

Since my time is about to be up, let me end with a brief categorization of some of the sources of vulnerability. There are, first of all, biological vulnerabilities arising from having diseases with unknown or imperfect cure. I would add to that the increasingly important vulnerability arising from overuse of antibiotics which can generate new ailments that are resistant to what used to be effective treatment earlier on.

There are, second, economic vulnerability arising from poverty, making some people more prone to health problems connected with undernourishment and inferior food habits which often go with seeking cheaper – and faster – food.

Third, there are infrastructural sources of vulnerability arising from deficiencies in sanitary and other facilities, which can have disastrous effects on the health of many people. Indeed, this type of correlate deprivation can be seen as another kind of unfavourable social determinants of health.

Fourth, there are special difficulties arising from inadequate knowledge of what good health demands, which links the success of health care very closely with education. We must add to this the inability to make use of that knowledge even when it exists, of which smoking or excessive drinking may be seen as good examples.

Finally, there are relational vulnerabilities that apply to people at the bottom of a highly stratified society, whether the stratifications relate to social barriers such as in a historically established caste system, or more modern divisions related to class and occupational disadvantages that transcend social history.

These are difficult problems, but I end with the comfortable recognition that Thailand has already achieved so much – particularly through universal healthcare and through integrating health in public reasoning – that it can now take on more difficult problems that remain. That is a happy thought, and I close my brief talk with congratulating – indeed saluting - Thailand for what it has already done, and wishing it well for solving the further problems that it must now address. Accomplishment in healthcare is never the end of the story – the successful end of one story is always the beginning of another. There is something of the Scheherazade of the Arabian Nights in humanity's battle for better health.

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CONFERENCE

SESSIONS

OPENING SESSION & KEYNOTE ADDRESSES

PLENARY 0

SOCIAL INCLUSION:
WHAT DOES IT MEAN FOR HEALTH POLICY AND PRACTICE?

PLENARY 1
VULNERABLE POPULATIONS: WHO, WHERE AND WHY?

PS1.1
The Truth is Hard to See:
The Political Economy of Visibility

PS1.2
Discrimination in Health Care – Determinants and Consequences

PS1.3
Health Consequences of Social Exclusion

PS1.4
Information for More Focused Acton and Monitoring Progress to Ensure that No One is Left Behind

PS1.5
Addressing Vulnerability from Discrimination, Displacement, War and Emergencies

PLENARY 2
THE POLITICAL ECONOMY OF SOCIAL INCLUSION

PS2.1
Political Strategies to Tackle Social Exclusion and Improve Health

PS2.2
Can the Right to Health be Used to Overcome Exclusion from Health Services

PS2.3
Women and Children First?

PS2.4
Integrating Migration and Community Health within UHC

PS2.5
Access to Medicines: How to Fix the Broken System

PS2.6
From Exclusion to Leadership: Learning from the AIDS Response

PS2.7
Can International and National Human Rights Instruments Support Social Inclusion? : Lessons Learned from UNCRPD

PLENARY 3
INTERVENTIONS TO PROMOTE SOCIAL INCLUSION

PS3.1
Mobilizing for Social Inclusion: Persons with Vulnerability as Agents of Change

PS3.2
Maximizing Universal Coverage: Interventions to Ensure Universal Inclusion

PS3.3
Enabling the Critical Role of Communities in Building Socially Inclusive and Responsive Health Systems

PS3.4
The Role of Demand Side Interventions to Promote Social Inclusion

PS3.5
Integrated, Interdisciplinary Interventions

PS3.6
Overcoming Stigma and Discrimination as Barriers to Social Inclusion

PS3.7
Massive Population Flows: the Plight and Solutions for Refugees and Migrants

SYNTHESIS SUMMARY, CONCLUSION & RECOMMENDATIONS

CONFERENCE

SYNTHESIS

I.

THE PROBLEM STREAM

1.

Who are the Vulnerable Population and Socially Excluded?

The conference has identified a number of types of individuals and groups who are vulnerable and socially excluded.

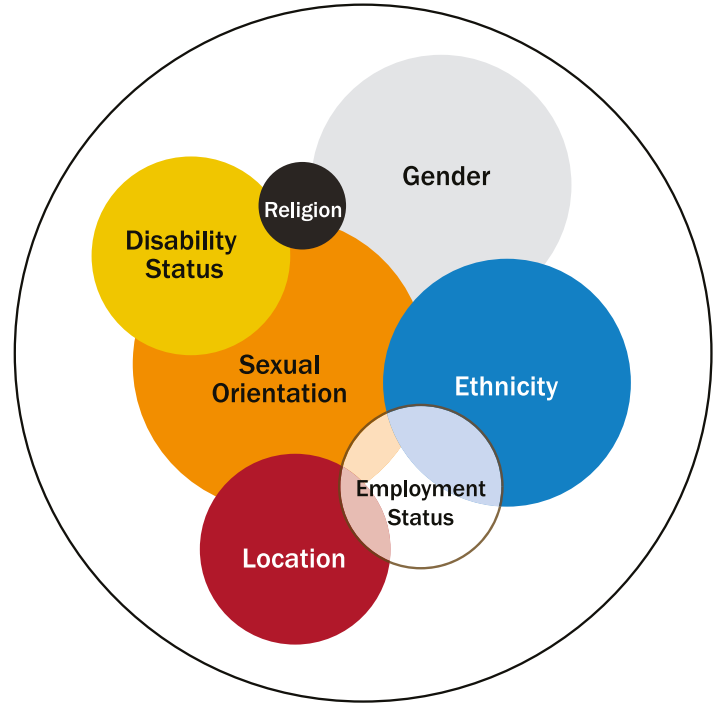
Individuals and groups of people are excluded due to various vulnerability attributes: gender, race, caste, indigenous origin, ethnicity, religion, disease, disability, migration and displacement status. They include:

The poor and those with very limited financial means

- People with disabilities
- People living with HIV/AIDS
- People from among sexual minorities
- People who live in remote areas and are isolated
- Members of minority groups, religions and certain castes
- The elderly and in some cases, widows

The co-existence of multiple attributes creates extreme vulnerability amongst such individuals, as seen in this figure. For example, a disabled young girl belonging to a disadvantaged caste living in a tribal area of India is categorized as the most vulnerable of the vulnerable people. We often refer to this as “intersectionality”.

The consequences of social exclusion are enormous. The vulnerable are often invisible in the society in which they live, and their social exclusion is associated with low social standing, poverty, low human capital endowments, restricted access to employment and services, and lack of voice.



2.
The Pain and Suffering of Refugees

In 2015, the International Organization for Migration (IOM) estimated that 65 million people were forcibly displaced due to conflicts; 21 million were refugees, 34 million were internal displaced persons and 10 million were stateless people whose existence was not acknowledged by any nation state. Natural disasters resulted in an additional 19 million being displaced. The numbers are undoubtedly higher today, with religious and political conflicts being the major drivers of refugee flight.

Evidence clearly shows the grave health consequences of refugee status: physical assault, mental breakdown, and depression. In some settings refugees are sexually abused and their human rights violated, as in many of the detention centers for asylum seekers. Despite the contributions by the United Nations High Commissioner for Refugees (UNHCR), Médecins Sans Frontières (MSF) and other humanitarian actors, the increasing numbers of refugees and displaced persons due to armed conflicts far exceed their resources, limiting their ability to provide effective support to all.

Humanitarian action aims to preserve life and relieve suffering, protect human dignity and restore people's ability to make their own decisions. Humanitarian action is not development or peace building, state-building, or long term support to human rights.

As stated by James Orbinski, MSF International President, at the Acceptance Speech for the Nobel Peace Prize in 1999:

Humanitarianism is not a tool to end war or to create peace. It is a citizens' response to political failure. It is an immediate, short-term act that cannot erase the long-term necessity of political responsibility.

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3.
The Plight of Migrants



The IOM estimates that there are around 1 billion migrants worldwide, of whom three quarters are internal migrants and a quarter international migrants. Economic disparity across rich and poor countries, and demographic imbalances between the global north with a low fertility rate and labour shortage and the global south with labour surplus, are the main drivers of migration.

The stereotyping and public discourse which discriminate against a large number of migrants is the main driver of xenophobia and violence against this group. Evidence shows, however, that the migrant friendly policy towards Syrian refugees in Turkey contributes to improved economic wellbeing of both the migrants and the host country.

Poor migrant workers face high costs when sending money home to their families. The fees on average amount to 7.5% of total remittances. In 2015, the worldwide remittance flows from the United States to other countries was 134 billion US$. It is estimated that cutting transfer charges by at least 5 percentage points can save up to $16 billion a year, improving the economic livelihood of these migrants and their families. The SDG target 10.c aims to reduce to less than 3% the transaction costs of migrant remittances and eliminate remittance corridors with costs higher than 5%. The profits benefit private enterprises such as Western Union, and Money Gram.

4.

Persons with Disability

Disability is not caused only by physical, mental and other impairments, but family and social attitudes and stigma are additional burdens. The UN Convention on the Rights of Persons with Disability (UNCRPD) has shifted the paradigm from medico-charity to a social model of disability.

National laws are required to be in line with the principles of the UNCRPD. Country experiences demonstrate a need for harmonization with other conventions such as the Convention on Child Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and other international human rights instruments to address the challenges of multiple vulnerabilities. Despite the two Conventions ratified by State Parties, the UNCRPD and the CEDAW, governments lack capacity to implement the national laws, leaving huge room for major improvement not only in low and middle income countries, but also in high income countries. Support to ensure full social participation by persons with disability are grossly lacking, for example there are linguistic barriers affecting the deaf, and physical environment challenges for the blind. Eugenic sterilization of people who are either mentally ill or mentally defective, without their consent, is not uncommonly practiced in countries which have ratified UNCRPD and CEDAW.




A survey in 2010 by the Disabled People's International (DPI) Women's Network Japan, has uncovered the trauma in the lives of women with disability. One physically disabled women in her thirties reported as follows:

"I was sexually molested by my mom's boyfriend. While he was assisting me during my bath time, he touched my breasts and other parts of my body. It was horrible. told my mom but she did not believe me. That was even worse."

Another said:

"I somehow managed to get a job, but my boss asked me to go out for a drink. I got drunk and fell asleep. He then took me to a hotel and raped me. Afterwards, he repeatedly forced me to have sex with him."

5.
Ethnic Minorities

Ethnic minorities worldwide are violated of their human rights, their rights to their lands, their culture, and their religious and ritual practices. They are often not recognized by their states, as they were not recognized by their former colonial masters.

The Stolen Generations history exemplifies the abuse of ethnic minorities. They are the generations of Aboriginal children taken away from their families by governments, churches and welfare bodies to be brought up in institutions or fostered out to white families. This was official government policy in Australia until 1969, but the practice had begun in the earliest days of European settlement, when children were used as guides, servants and farm labourers. Almost every Aboriginal family has been affected in some way by the policy of child removal. Taking children from their families was one of the most devastating practices since white settlers arrived, and has continuing, profound repercussions for all Aboriginal people today. In 1995, the Commonwealth Attorney General established a National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families. The Inquiry report, "Bringing them home", was tabled in the Commonwealth Parliament on 26 May 1997, the day before the opening of the National Reconciliation Convention. Bringing them home made 54 recommendations.

Former High Court Judge, Sir Ronald Wilson, chaired the HREOC Inquiry. After Bringing them home was released, he told an audience in Canberra that:

Children were removed because the Aboriginal race was seen as an embarrassment to white Australia. The aim was to strip the children of their Aboriginality, and accustom them to live in a white Australia. The tragedy was compounded when the children, as they grew up, encountered the racism which shaped the policy, and found themselves rejected by the very society for which they were being prepared.

The Inquiry found that between one in three and one in ten Indigenous children were removed from their families under past government policies, but could not be more precise due to the poor state of records.

Across Asia and Latin America “tribal peoples” and “indigenous peoples” have lower social status, limited voice and poor health outcomes. They live in remote forested areas, with limited control over their lives and lands. While poverty has reduced and human development outcomes have improved across the board, improvements among indigenous peoples have not been as dramatic as those among the general population. This has often led to increased inequality between indigenous and non-indigenous populations.

Bringing Them Home

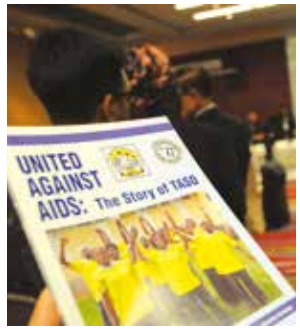
6.

Stigma and Violence Stemming from Sexual Orientation and HIV/AIDS

Those who are Lesbian, Gay, Bisexual and Transgender (LGBT), and those affected by HIV/AIDS and TB, are the classic presentation of multiple vulnerabilities. Social attitudes and criminalization in certain states exacerbate the exclusion of LGBT, and those affected by HIV/AIDS and TB. In particular, they result in violence, and physical and mental assaults of LGBT people.

HIV-related stigma is pervasive in the lives of those living with the disease. Stigma marks people as different and as disgraced. It denies individuals their dignity, respect and right to fully participate in their community. Stigma manifests in discriminatory and sometimes violent treatment of people living with HIV, their families and others affected by HIV. Stigma and social exclusion takes place in families, communities, employment opportunities, and education and healthcare settings. The negative attitudes towards persons with HIV/AIDS result in extreme statements that majority groups find no hesitation in voicing, such as:

The negative consequences for the individual are clear, but such responses to internalized stigma also undermine familial and community networks and represent a great waste of states' social capital. Efforts to increase public awareness and encourage the proper understanding of HIV/AIDS, through campaigns by UNAIDS, Civil Society Organisations and other partners, have contributed greatly to minimizing the stigmatization of HIV/AIDS, though uneven progress is apparent.



"People with HIV should be jailed and people with HIV are immoral..."

II.

THE SOLUTION STREAM: A LONG MARCH TOWARDS SOCIAL INCLUSION

Social Inclusion is defined in two ways. The first is a broad sweep definition, which frames social inclusion as the process of improving the terms for individuals and groups to take part in society. The second is a sharper definition takes into account how the terms of social inclusion can be improved and for whom. It articulates social inclusion as:

> …the process of improving the ability, opportunity, and dignity of people disadvantaged on the basis of their identity to take part in society…

The Conference has discussed and proposed various solutions which are specific for different actors, in support of social inclusion.

1

The Role of State Actors

First and foremost, is political commitment. States must do a number of things. First, they must recognise the issues and strengthen their capacities to identify the socially excluded in their countries, capacities to devise effective inter-sectoral policies and actions to progressively realize social inclusion, and capacities to monitor progress and reformulate effective actions. These state responses must be framed within human right principles. Second, they must increase opportunities for inclusion in markets, services, and spaces, for the socially excluded. Third, they should strengthen and sustain institutional capacities to implement the various Conventions and other international human right instruments, in order to progress towards social inclusion. Fourth, they should strengthen policy and practice to reduce all types of stigma and discrimination in all settings, - labour and employment, education, and health-care settings. Fifth, they must improve legal and policy responses, and crack down on all types of violence related to stigma and discrimination. Sixth, they need to recognize the intersections of multiple vulnerability attributes and devise effective intersectoral actions for social inclusion.

2

The Role of Health Sector

The health sector has a very important role to play to ensure the health of the vulnerable population is protected. To name some key actions:

- Demand side financing, such as the use of conditional cash transfers for health services for certain vulnerable groups, has been a positive experience in several countries though there are challenges on monitoring and ensuring sustainability. However, demand has to go hand in hand with a well-regulated supply of services.
- Progress can be made in ensuing the provision of dignified and respectful services.
- Anti-stigma interventions should be embedded in cohesive national HIV policy and program responses.
- The use of a community score card, local assemblies, and creation of effective dialogues between community and health care providers can encourage “collaborative governance for health” and enhances the accountability of providers and the state to citizens.
- Health professional education should be transformed in both institutional and instructional dimensions towards a “socially accountable health workforce”, by providing greater opportunities for students from socially excluded groups to train as health professionals and be located in their home communities. This can ensure more dignified and respectful services to their local populations.

3

The Role of Scientific Communities

Scientific communities have important roles to play.

For example, they should:

- Develop greater understanding of stigma and discrimination based on social identity.
- Understand the social dimension of and solutions to “stereotyping” which generates stigma and social exclusion.
- Devise innovations for effective reduction of stigma and discrimination.

4

The Role of Non-State Actors

Experiences of non-state actors demonstrate the contributions they can make:

- The Culture Centre of the Deaf in Mongolia has good experiences in advocating for awareness of UNCRPD, it has also contributed to the CRPD shadow report.
- The Disabled People's International (DPI) Women's Network in Japan has addressed the multiple discriminations toward women with disabilities, disability reform, and linkages between CRPD and the CEDAW.
- The creation of the Tunaweza Children's Centre in Uganda, which empowers children with special needs to reach their full potential, was triggered by the "nodding syndrome", diagnosed since 1970s, which is endemic in certain countries in Africa affected by the Black Flies and onchocerchiasis.

More broadly, Civil Society Organisations have a critical role to play in holding State Actors accountable, as in their parallel report of the UNCRPD.

III.

CONCLUSION

Finally, the conference concludes that the ethical principle of leaving no one behind by addressing social inclusion requires a top down approach from responsive and accountable governments, and a bottom up approach through an active citizenship.

This requires triple government efforts to (a) strengthen health delivery systems and ensure services are equitably distributed, (b) progressively extend financial risk protection and (c) address the health needs of the vulnerable population who are not heard or counted, and who are excluded from economic prosperity. All these require responsive and accountable governments and the widespread engagement of active citizens who hold politicians and governments accountable. Social inclusion is often not about doing more, but rather about doing things differently to achieve a life with dignity for all.

IV.

ADDITIONAL CONTRIBUTIONS OF PMAC 2017 IN DRIVING VULNERABILITY AGENDA

THE BULLETIN OF THE WORLD HEALTH ORGANIZATION

The PMAC Secretariat had worked closely with the Editors of the Bulletin of the World Health Organization; and had jointly agreed that PMAC2017 is an opportune time to mobilize the scientific community to publish evidence on health of and solutions for the vulnerable population. It called for papers [11], and finally published a special theme vulnerable populations in Volume 95, Number 2, February 2017, pp 85-164 [12]. An editorial by Sakolsatayadorn et al [13] concludes that

> *The inclusion of an SDG target for reaching universal health coverage, including financial risk protection, affirms the power of health to build fair, stable, and cohesive societies while also contributing to poverty alleviation. The target provides a unifying platform for moving towards all other health targets through the delivery of integrated, people-centred services that span the life course, bring prevention to the fore and protect against financial hardship. Universal health coverage is the ultimate expression of fairness and one of the most powerful social equalizers among all policy options.*

BANGKOK STATEMENT

ON ADDRESSING THE HEALTH OF VULNERABLE POPULATIONS FOR AN INCLUSIVE SOCIETY

We, Ministers of Health, [other ministries as may be applicable], representatives of government institutions, civil society organizations, communities, the private sector and development partners, participants of the Prince Mahidol Award Conference 2017, gathered in Bangkok on 1-3 February 2017 to learn and share experiences;

1. Reaffirming the right to health enshrined in the Universal Declaration of Human Rights, the World Health Organization Constitution, and the 1978 Declaration of Alma-Ata;
2. Welcoming the vision of the 2030 Agenda for Sustainable Development for a society that is just, equitable and inclusive, and its pledge to leave no one behind without distinction of any kind such as age, sex, disability, culture, race, ethnicity, origin, migratory status, religion, economic or any other status;
3. Noting global evidence on the negative health consequences of discrimination, stigma, and marginalization on individuals and families, and the high cost to economies, societies and broader development efforts, of social and political exclusion;
4. Recognizing that implementation of essential public health functions and moving towards universal health coverage require strengthening of governance and public health capacities and an explicit focus on identifying and meeting the needs of vulnerable populations, including ensuring access to health information, care and technologies;

5. Aware of the critical role of communities in building social inclusion and advancing health and health equity, and acknowledging that reaching those most excluded requires strengthening of community systems, enhancing of community-health systems, and empowering politically marginalized groups, including women, children and adolescents, people living with HIV, persons with disabilities, migrants, internally displaced populations and refugees, LGBTI, and indigenous people, in decision-making;
6. Welcoming the report of the United Nations Secretary-General's High-Level Panel on Access to Medicines (2016) and in particular, its call for greater investments in biomedical research and development for diseases of the poor and its recommendations to increase transparency and cooperation across the public and private sectors to ensure affordable and sustainable access to life-saving technologies;
7. Recalling the Rio Political Declaration on the Social Determinant of Health (2011) which reaffirmed that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable;
8. Agree to work together and across sectors and levels to advance the health of vulnerable and marginalized populations, promote social inclusion, and tackle the root causes of health inequities and the economic, social, and environmental determinants of health, in particular;

National governments, in partnership with CSOs and communities, and with support from development partners as appropriate to:

- Develop and/or strengthen capacities to measure health inequities and monitor progress on social inclusion of vulnerable populations at the national and sub-national level;
- Increase the allocation of domestic financial resources to strengthen national health systems and promote the adaptation and reform of laws, policies, and practices that ensure the rights and dignity of people and address the determinants and consequences of social exclusion, removing barriers to social integration and well-being, and accelerating progress towards universal health coverage;
- Ensure that communities, civil society, historically excluded groups, and the general public can engage in and inform the design, delivery and accountability of initiatives and effectively claim their rights;

Development partners, including international organizations, bilateral, regional and multilateral banks, Foundations and others

- Support efforts to build the institutional, administrative, and scientific capacity of governments and civil society for integrated, multisectoral and participatory approaches to health and health equity, access to justice, and universal health coverage;
- Facilitate south-south and triangular exchange of knowledge and experiences across countries and regions, especially with regards to achieving the targets of Sustainable Development Goals 3, and realizing the co-benefits for health and other sectors through action across other Goals;

All stakeholders including industry, academia, professional organizations and others

- Invest in building and strengthening the evidence-base and understanding of the particular needs and barriers of vulnerable populations to health in order to develop appropriate solutions, including through incentives and innovations to ensure that socially excluded groups can better access health and other services;
- Identify social, economic, environmental and global security co-benefits of greater health equity, and encourage action on the structural determinants of health and health inequities to realize them;
- Encourage actions outside the health sector to ensure better policy coherence and service quality, including on reducing corruption, reducing predatory industry marketing practices, and any other discriminatory practices, which can have a particularly negative impact on the health of vulnerable populations;


Welcome Spe
PMAC
2017


PMAC
2017

Prince Mahidol Award Conference 2017 International Organizing Committee

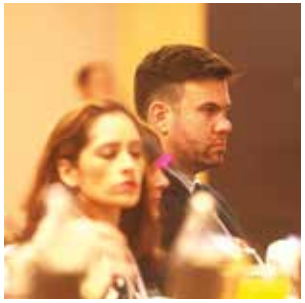
NAME – SURNAME	POSITION	ORGANIZATION	ROLE
Dr. Vicharn Panich	Chair, International Award Committee	Prince Mahidol Award Foundation, Thailand	Chair
Dr. Marie-Paule Kieny	Assistant Director-General for Health Systems and Innovation	World Health Organization, Switzerland	Co-Chair
Dr. Timothy Evans	Senior Director for Health, Nutrition and Population (HNP)	The World Bank, USA	Co-Chair
Mr. Magdy Martínez-Solimán	Assistant Secretary General, Assistant Administrator, and Director, Bureau for Policy and Programme Support	United Nation Development Programme, USA	Co-Chair
Dr. Babatunde Osotimehin	Executive Director	United Nations Population Fund, USA	Co-Chair
Dr. Michel Sidibé	Executive Director	Joint United Nations Programme on HIV/ AIDS, Switzerland	Co-Chair
Ambassador William Lacy Swing	Director General	International Organization of Migration, Switzerland	Co-Chair
Dr. Mark Dybul	Executive Director	The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland	Co-Chair
Dr. Jennifer Adams	Assistant Administrator, Bureau for Global Health	United States Agency for International Development, USA	Co-Chair
Dr. Roger Glass	Director, Fogarty International Center Associate Director for International Research	National Institutes of Health, USA	Co-Chair
Dr. Takao Toda	Vice President for Human Security and Global Health	Japan International Cooperation Agency, Japan	Co-Chair
Dr. Lincoln C. Chen	President	China Medical Board, USA	Co-Chair

NAME – SURNAME	POSITION	ORGANIZATION	ROLE
Mr. Michael Myers	Managing Director	The Rockefeller Foundation, USA	Co-Chair
Dr. David Heymann	Head of the Centre on Global Health Security	Chatham House, United Kingdom	Co-Chair
Dr. Trevor Mundel	President of the Global Health Division	Bill & Melinda Gates Foundation, USA	Co-Chair
Dr. Poonam Khetrapal Singh	Regional Director of WHO South-East Asia Region	Regional Office for South-East Asia, WHO, India	Member
Dr. Soonman Kwon	Technical Advisor (Health)	Asian Development Bank, Philippines	Member
Dr. Kamran Abbasi	International and Digital Editor	British Medical Journal, United Kingdom	Member
Ms. Bridget Lloyd	Global Coordinator	People's Health Movement, South Africa	Member
Mrs. Busaya Mathelin	Permanent Secretary	Ministry of Foreign Affairs, Thailand	Member
Dr. Sopon Mekthon	Permanent Secretary	Ministry of Public Health, Thailand	Member
Dr. Supat Vanichakarn	Secretary General	Prince Mahidol Award Foundation, Thailand	Member
Secretary General	Secretary General	National Health Security Office, Thailand	Member
Dr. Peerapol Sutiwisesak	Director	Health Systems Research Institute, Thailand	Member
Dr. Udom Kachintorn	President	Mahidol University, Thailand	Member
Dr. Prasit Watanapa	Dean, Faculty of Medicine Siriraj Hospital	Mahidol University, Thailand	Member
Dr. Piyamitr Sritara	Dean, Faculty of Medicine Ramathibodi Hospital	Mahidol University, Thailand	Member
Dr. Suwit Wibulpolprasert	Vice Chair	International Health Policy Program Foundation, Thailand	Member
Dr. Viroj Tangcharoensathien	Senior Advisor	International Health Policy Program, Thailand	Member
Dr. Phusit Prakongsai	Director, International Health Bureau	Ministry of Public Health, Thailand	Member


















NAME – SURNAME	POSITION	ORGANIZATION	ROLE
Mr. James Pfitzer	Technical Officer (Legal), Health Systems and Innovation, Office of the Assistant Director-General	World Health Organization, Switzerland	Member & Joint Secretary
Dr. Toomas Palu	Sector Manager for Health, Nutrition and Population, East Asia and Pacific Region	The World Bank, Thailand	Member & Joint Secretary
Dr. Douglas Webb	Cluster Leader, Mainstreaming, Gender and MDGs, HIV, Health and Development Group	United Nation Development Programme, USA	Member & Joint Secretary
Mr. Anderson E. Stanciole	Technical Adviser, Health Economist, Asia and the Pacific Regional Office	United Nations Population Fund, Thailand	Member & Joint Secretary
Ms. Tatiana Shoumilina	Country Director	Joint United Nations Programme on HIV/ AIDS, Thailand	Member & Joint Secretary
Dr. Davide Mosca	Director of the Migration Health Division	International Organization for Migration, Switzerland	Member & Joint Secretary
Dr. Osamu Kunii	Head, Strategy, Investment and Impact Division (SIID)	The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland	Member & Joint Secretary
Dr. Aye Aye Thwin	Special Advisor, Office of the Assistant Administrator, Bureau for Global Health	United States Agency for International Development, USA	Member & Joint Secretary
Mr. Ikuo Takizawa	Deputy Director General	Japan International Cooperation Agency, Japan	Member & Joint Secretary
Dr. Piya Hanvoravongchai	Southeast Asian Regional Coordinator	China Medical Board, Thailand	Member & Joint Secretary
Ms. Natalie Phaholyothin	Associate Director	The Rockefeller Foundation, Thailand	Member & Joint Secretary
Dr. David Harper	Deputy Head of the Centre on Global Health Security	Chatham House, United Kingdom	Member & Joint Secretary
Dr. Damian Walker	Deputy Director, Data & Analytics, Global Development	Bill & Melinda Gates Foundation, USA	Member & Joint Secretary
Dr. Pongpisut Jongudomsuk	Senior Expert	National Health Security Office, Thailand	Member & Joint Secretary
Dr. Churnrurtai Kanchanachitra	Professor	Institute for Population and Social Research, Mahidol University, Thailand	Member & Joint Secretary

Prince Mahidol Award Conference 2017 Scientific Committee Members

NAME – SURNAME	POSITION/ ORGANIZATION	ROLE
Prof. Panich, Vicharn	Chair, International Award Committee and Scientific Advisory Committee, Prince Mahidol Award Foundation, Thailand	Chair
Dr. Duong, Quyen	Program Executive, Resources for Health Equity, Vietnam	Member
Prof. Harper, David	Deputy Head of the Centre on Global Health Security, Chatham House, United Kingdom	Member
Dr. Kanchanachitra, Churnrurtai	Director, Mahidol University Global Health, Thailand	Member
Dr. Kayasith, Prakasit	Director, Thai Health Promotion Foundation, Thailand	Member
Dr. Mosca, Davide	Director of the Migration Health Division, International Organization for Migration, Switzerland	Member
Mr. Nakamura, Shintaro	Senior Advisor (Social Security), Japan International Cooperation Agency, Japan	Member
Dr. Patcharanarumol, Walaiporn	Senior Researcher, International Health Policy Program, Thailand	Member
Mr. Pfitzer, James	Technical Officer, Health Systems and Innovation, Office of the Assistant Director-General, World Health Organization, Switzerland	Member
Dr. Prakongsai, Phusit	Director, International Health Bureau, Ministry of Public Health, Thailand	Member
Prof. Sanders, David	Founding Director of the School of Public Health, University of the Western Cape and People's Health Movement, South Africa	Member
Ms. Shoumilina, Tatiana	Country Director, the Joint United Nations Programme on HIV/AIDS, Thailand	Member
Prof. Sritara, Piyamitr	Dean, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand	Member

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Dr. Talungchit , Pattarawalai	Director of Siriraj Health Policy Unit, Faculty of Medicine, Siriraj Hospital, Thailand	Member
Dr. Thaiprayoon, Suriwan	Bureau of International Health, Ministry of Public Health, Thailand	Member
Dr. Thwin, Aye Aye	Senior Advisor for Health Systems and Financing, US Agency for International Development, USA	Member
Dr. Tobe, Makoto	Senior Advisor (Health Financing), Japan International Cooperation Agency, Japan	Member
Dr. Vathesatogkit, Prin	Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand	Member
Dr. Webb, Douglas	Team Leader, Health and Innovative Financing, HIV, Health & Development Group, Bureau for Policy & Programme Support, UNDP, USA	Member
Dr. Wilson, David	Global AIDS Program Director, The World Bank, USA	Member

List of Side Meetings and Workshops

TITLE	ORGANIZATION
One Health University Networks: From Concept to Impact	U.S. Agency for International Development (USAID), South East Asia One Health University Network Foundation (SEAOHUN)
Informal Workers and Universal Health Coverage: challenges and opportunities	Rockefeller Foundation (Asia Regional Office), Women in Informal Employment: Globalizing and Organizing (WIEGO)
Informal Workers and Universal Health Coverage: challenges and opportunities	Rockefeller Foundation (Asia Regional Office), Women in Informal Employment: Globalizing and Organizing (WIEGO)
Stronger health financing to meet the needs of the most vulnerable	The Global Fund to fight AIDS, Tuberculosis and Malaria, APCASO
Health Workforce Demography: A framework to ensure the health of vulnerable populations, attain universal health coverage, and support the SDGs	World Health Organization (WHO)
An informal Dialogue on Reinforcing Health and Security among Migrant and Mobile Populations in the Greater Mekong Sub-region	International Organization for Migration (IOM)
The last mile of UHC in Thailand, “Do we reach the vulnerable?”	Health Systems Research Institute (HSRI), Thailand
WHO Workshop on Health Inequality Monitoring	World Health Organization (WHO)
Capacity Building for Patient Engagement in an Aging Society	Mahidol University, World Health Organization (WHO)
NCDs and Sustainable Development - The Way Forward	World Health Organization (WHO)
21st century SMART Hospitals for Universal Health Coverage and Inclusive Growth	Asian Development Bank (ADB)
PMAC 2017 World Art Contest Award Ceremony	Prince Mahidol Award Conference (PMAC)
Prince Mahidol Award Youth Program Conference 2017	Prince Mahidol Award Youth Program
Role of governance in ensuring inclusive health	U.S. agency for international development (USAID)
Connecting the Dots: Delivering the health technologies to meet SDG3	United Nations Development Programme (UNDP)

TITLE	ORGANIZATION
Grand Challenges, Untapped Opportunities: An Evidence Based Approach to Addressing Antimicrobial Resistance in Asia's Animal Production Industry	U.S. Agency for International Development(USAID), Food and Agriculture Organization of the United Nations (FAO), World Health Organization (WHO), World Organisation for Animal Health (OIE), Elanco Animal Health
Integrating externally-financed health programs while building sustainable and inclusive health financing systems to move toward universal health coverage (UHC)	The World Bank
Advancement and Challenge in UHC	National Health Security Office (NHSO)
Developing work plan of Asia-Pacific HRH network forwards Global Strategies on HRH 2030 milestones	Asia-Pacific Action Alliance on Human Resources for Health (AAAH)
PMAC Assessment	Prince Mahidol Award Conference (PMAC)
Experiences with extending healthcare to the elderly in the Asia Pacific. Lessons from Thailand and Sri Lanka	Asia Pacific Observatory on Health Systems and Policies (APO)
Use of digital technology to improve health service delivery for vulnerable populations	ThoughtWorks

TITLE	ORGANIZATION
Social Inclusion for Health for All: The imperative of Civil Society Engagement	People's Health Movement (PHM)
People's Health Movement Steering Council: Growing a health movement –inclusion matters!	People's Health Movement (PHM)
WHO Framework on integrated people-centred health services: reaching out to vulnerable populations	World Health Organization (WHO)
Should off-label medicines be included in Universal Health Coverage (UHC) schemes?	Health Intervention and Technology Assessment Program (HITAP)
Vulnerable Populations: At High Risk for Disrespect and Abuse in Health Services	U.S. agency for international development (USAID)
Moving towards universal health coverage in Asia and Pacific: improving the future for women and children	UNICEF Thailand and Regional Office for East Asia and Pacific
Extending coverage and sustaining health outcomes for marginalized groups	U.S. agency for international development (USAID)
Creating sustainable programs to address the needs of children with disabilities and their families.	Tunaweza Children's Center

Field Trip Program

Achieving universal health coverage (UHC) with the National Health Security Act in 2002 has enabled all Thai citizens to access to necessary health services as needed. However, accessing to necessary health service has been a key challenge to achieve the goal especially in people living in remote areas or having other socio-economic and/or health conditions that prevent them from reaching their needs.

After fifteen years of UHC implementation, efforts to improve accessibility to necessary health services, quality of health care, and financial protection for families have been introduced and implemented by related stakeholders, not only government agencies but also the non-government sector, civil societies and consumers. Evidences of these efforts include financial and non-financial interventions to promote the health status of vulnerable populations such as women and children, disabled people, the elderly, chronic disease patients, people living in rural areas, and other risk groups.

High impact interventions include benefit package for HIV/AIDS and risk groups, rehabilitation services and instruments for disabled people, vaccinations and other prevention and promotion services for high risk groups, and other health services for specific groups such as palliative care, long-term care, and alternative and Thai traditional medicines. Other related interventions to enable accessibility to UHC include setting up a collaboration process and system with the Ministry of Interior to expedite the birth registration process so children will be eligible to UHC, setting up a community health fund in the local community to promote civil society participation in health care, setting up an integrated claim and reimbursement system among the three main schemes to reduce redundant processes.

The Prince Mahidol Award Conference 2017 (PMAC 2017) was organized under the theme “Addressing the Health of Vulnerable Populations for an Inclusive Society.” The PMAC 2017 field trip was arranged to share experience in implementing health care initiatives to reduce barriers and enhance social inclusion of vulnerable populations in different settings and groups in UHC implementation. The six site visits were:




Site 1
Social and Health Support to Female Prisoners: Insights from a Thailand Sample

Location: Prison of Ratchaburi




Site 2
Access to Health Care and Social Services for Older People in the Community

Location: Khao Phra Ngam Municipality, Lopburi Province




Site 3
Collaboration to Develop Social Welfare and Health Care for Vulnerable Children

Location: Phayathai Babies' Home




Site 4
Holistic and Humanized Care for HIV/AIDS

Location: Bamrasnaradura Infectious Diseases Institute




Site 5
Empowerment and Promote Quality of Life for People with Disabilities

Location: The Redemptorist Foundation, Chonburi Province




Site 6
Moving Beyond Health Services for Vulnerable People at Siriraj Hospital

Location: Siriraj Hospital, Mahidol University

List of Speakers, Panelists, Chairs, Moderators, and Rapporteurs

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
OPENING SESSION		
Vladimir Hachinski		Brianna Harrison
Amartya Sen		Bowwarn Juengwattanasirikul
Gregory Paul Winter		Jurairat Phromjai
		Waraporn Suwanwela
PLENARY 0: SOCIAL INCLUSION: WHAT DOES IT MEAN FOR HEALTH POLICY AND PRACTICE?		
Abheena Aher	Maitreyi Bordia Das	Suhong Deesamer
Sara Bennett		Hongye Luo
Gro Harlem Brundtland		Somil Nagpal
Timothy Evans		Candyce Silva
Takao Toda		Saowaluk Srikajornlarp
PARALLEL SESSION 1.1 : THE TRUTH IS HARD TO SEE: THE POLITICAL ECONOMY OF VISIBILITY		
Shahira Ahmed	Jesse Bump	Ma. Elena G. Filio-Borromeo
Victoria Y. Fan		Nguyen Hoang My Thuyen
Joseph Harris		Suladda Pongutta
Akudo Ikpeazu		Polathep Vichitkunakorn

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 1.2 : DISCRIMINATION IN HEALTH CARE – DETERMINANTS AND CONSEQUENCES		
Brianna Harrison	James Campbell	Orana Chandrasiri
Sigrun Mogedal		Banthida Komphasouk
Sarojini Nadimpally		Pattarawalai Talungchit
Dainius Puras		
Evelyn Rodriguez		
Suparoek Srikham		
PARALLEL SESSION 1.3 : HEALTH CONSEQUENCES OF SOCIAL EXCLUSION		
Fran Baum	Daniel Miller	Marie T. Benner
Mary Jo Larson		Aree Jampaklay
Bente Mikkelsen		Piyawan Kanan
Kelly Saldana		Prasinee Mahattanatawee
Pamela Titi		
PARALLEL SESSION 1.4 : INFORMATION FOR MORE FOCUSED ACTION AND MONITORING PROGRESS TO ENSURE THAT NO ONE IS LEFT BEHIND		
Téa E. Collins	Alex Ross	Saowaros Kongcheep
Herve Isambert		Hui Sin Teo
Edmund Settle		Thitiporn Sukaew
Abhay Shukla		
Miriam Were		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 1.5 : ADDRESSING VULNERABILITY FROM DISCRIMINATION, DISPLACEMENT, WAR AND EMERGENCIES		
Tamara MacKean	David Sanders	Shneha Acharya
Amit Sengupta		Siriwan Limsakul
Cem Terzi		Khunjira Udomaksorn
Aed Yaghi		
Anele Yawa		
PLENARY SESSION 2 : THE POLITICAL ECONOMY OF SOCIAL INCLUSION		
Argee Macliing Malayao	David Harper	Ei Ei Aung
Keizo Takemi		Nissara Spence
Anele Yawa		Sangay Wangmo
Ernesto Zedillo		
PARALLEL SESSION 2.1 : POLITICAL STRATEGIES TO TACKLE SOCIAL EXCLUSION AND IMPROVE HEALTH		
Gro Harlem Brundtland	Robert Yates	Jittinee Khienvichit
Mirai Chatterjee		Mariko Shimomaki
Tedros Adhanom Ghebreyesus		Orarat Wangpradit
Risa Hontiveros		
Shri Satyedar Jain		
Naoko Yamamoto		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 2.2 : CAN THE RIGHT TO HEALTH BE USED TO OVERCOME EXCLUSION FROM HEALTH SERVICES		
Clare Danby	Peter Hill	Rodley Desmond Daniel Carza
Khairunissa Dhala	Gorik Ooms	Hitomi Kimura
Walter Flores		Kazuki Miyazaki
Rachel Hammonds		Noppakun Thammatacharee
Ines Keygnaert		
Everaldo Lamprea Montealegre		
Moses Mulumba		
PARALLEL SESSION 2.3 : WOMEN AND CHILDREN FIRST?		
SAS Kargbo	Emanuele Capobianco	Nobuaki Inoue
Unni Karunakara		Candyce Silva
Nazib Khan		Vasinee Singsa
Anne Mills		
Sulakshana Nandi		
Simon Wright		
Jenny Yates		
PARALLEL SESSION 2.4 : INTEGRATING MIGRATION AND COMMUNITY HEALTH WITHIN UHC		
Eduardo Banzon	Hernan Montenegro von Muhlenbrock	Tamsin Fernandez-Cox
Joel Buenaventura		Karin Fukatani
Chee-Khoon Chan		Sirinard Nipaporn
Davide Mosca		
Brahm Press		
Aphichat Rodsom		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 2.5 : ACCESS TO MEDICINES: HOW TO FIX THE BROKEN SYSTEM		
Tenu Avafia	Amit Sengupta	Chieko Matsubara
Kajal Bhardwaj		Woranan Witthayapipopsakul
K.M. Gopakumar		Inthira Yamabhai
Marc Lallement		
Amulya Nidhi		
Lotti Rutter		
PARALLEL SESSION 2.6 : FROM EXCLUSION TO LEADERSHIP: LEARNING FROM THE AIDS RESPONSE		
David Barr	Alisa Tang	Ma. Elena G. Filio-Borromeo
Heart Dino		Surangrat Jiranantanagorn
Mark Dybul		Aaron Schubert
Noerine Kaleeba		Athip Tanaree
Svitlana Moroz		
David Parirenyatwa		
Nittaya Phanuphak		
PARALLEL SESSION 2.7 : CAN INTERNATIONAL AND NATIONAL HUMAN RIGHTS INSTRUMENTS SUPPORT SOCIAL INCLUSION? : LESSONS LEARNED FROM UNCRPD		
Jocelyn Rosemarie Cris Cevallos Garcia	Soya Mori	Raoul Bermejo
Kumiko Fujiwara		Donruedee Srisuppaphon
Anita Ghai		Saya Uchiyama
Dulamsuren Jigjid		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PLENARY SESSION 3 : INTERVENTIONS TO PROMOTE SOCIAL INCLUSION		
Jennifer Adams	Ulrich Zachau	Somil Nagpal
Mark Dybul		Noppawan Piaseu
Corazon Juliano-Soliman		Shaheda Viriyathorn
Phouthone Moungpak		
William Lacy Swing		
PARALLEL SESSION 3.1 : MOBILIZING FOR SOCIAL INCLUSION: PERSONS WITH VULNERABILITY AS AGENTS OF CHANGE		
Rahima Abdul Ajij Miah	Ikuo Takizawa	Orana Chandrasiri
Rod Koohaa		Suphanna Krongthaeo
Monisha MafruhaMony		Aries Valeriano
Krissana Puttawong		
Peter Tan		
PARALLEL SESSION 3.2 : MAXIMIZING UNIVERSAL COVERAGE: INTERVENTIONS TO ENSURE UNIVERSAL INCLUSION		
Sara Bennett	Somil Nagpal	Kan Kledmanee
Eiji Hinoshita		Wachara Riewpaiboon
Barry Kistnasamy		Hui Sin Teo
Francie Lund		
Toomas Palu		
Sujatha Rao		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 3.3 : ENABLING THE CRITICAL ROLE OF COMMUNITIES IN BUILDING SOCIALLY INCLUSIVE AND RESPONSIVE HEALTH SYSTEMS		
George Ayala	Noerine Kaleeba	Lokachet Tanasugarn
Taye Tolera Balcha		Prin Vathesatogkit
Joseph Boye Cooper		Nimali Widanapathirana
Risa Hontiveros		
Kate Thomson		
PARALLEL SESSION 3.4 : THE ROLE OF DEMAND SIDE INTERVENTIONS TO PROMOTE SOCIAL INCLUSION		
Khairul Islam	Maitreyi Bordia Das	Eri Fujita
Pallavi Jain Govil		Banthida Komphasouk
David Wilson		Charay Vichathai
Vivi Yuliaswati		
PARALLEL SESSION 3.5 : INTEGRATED, INTERDISCIPLINARY INTERVENTIONS		
Jeffry Acaba	Mandeep Dhaliwal	Prasinee Mahattanatawee
Olga Atroshchanka		Merla Rose D. Reyes
Justice Dingake		Melanie Santillan
Kelvin Khow		Kanokwaroon Watananirun
PARALLEL SESSION 3.6 : OVERCOMING STIGMA AND DISCRIMINATION AS BARRIERS TO SOCIAL INCLUSION		
Guemou Achille	Quarraisha Abdool Karim	Trassanee Chatmethakul
Christine Amisi	Jennifer Adams	Brianna Harrison
Anchalee Avihingsanon		Sirinart Tongsiri
Michael Cassell		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 3.7 : MASSIVE POPULATION FLOWS: THE PLIGHT AND SOLUTIONS FOR REFUGEES AND MIGRANTS		
Alistair Boulton	Davide Mosca	Ines Keygnaert
Maria Guevara		Rapeepong Suphanchaimat
Helena Legido-Quigley		
Natapanu Nopakun		
Paul Spiegel		
Teresa Zakaria		

LEAD RAPPORTEUR TEAM

Monthian Buntan

Maitreyi Bordia Das

Jeff John

Anne Mills

Viroj Tangcharoensathien

RAPPORTEUR COORDINATOR

Warisa Panichkriangkrai

Walaiporn Patcharanarumol

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P08	Case of implementation of a project to reduce social exclusion in the populations affected by insecurity due to armed groups	Gaspard Mahangaiko Muyumba
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P11	Empowering Women with Disabilities as Leaders	Susan Dunn
P12	Inclusion of Persons with Disabilities in the Cambodian Health Sector	Vanny Peng
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P16	Design of a National Health Insurance Program benefit package to improve access to rehabilitative services among children with developmental disabilities in the Philippines	Ramona Luisa Santos

ID	POSTER TITLE	AUTHOR
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P18	A Case of Scaling-up Community Support Group to Improve Utilization of Maternal Health Care Services by Vulnerable Women in Rural Bangladesh	Yukie Yoshimura
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P21	Strengthening Child Protection System for protection of vulnerable children through community awareness raising	Myat Aung
P22	Engaging vulnerable social groups for improving uptake of polio vaccination in Mau district of Uttar Pradesh, India	Parul Ratna
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P24	Exploring young women's lived experience of mental well-being and the role of the existing health system in coping with mental distress	Ruchi Bhargava
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P26	Challenging experience to effectively protect the vulnerable population in Lao PDR	Sekeun Daniel Yu
P27	Experience of an Integrated MNCH Project Facilitating the Collaboration between National Health System and Ethnic Health System in Shan State of Myanmar	Wai Yee Khine
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P29	Are elderly women living in the dark? Factors determining visual impairment and eye care seeking among elderly women in the Indian Sundarbans	Debjani Barman
P30	Lay health supporters aided by a mobile phone messaging system to improve care of villagers with schizophrenia in Liuyang, China: a randomized control trial	Dong (Roman) Xu
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P34	Evaluating and improving health equity among patients with chronic diseases: case of an innovative integrated care delivery model in China	Wenxi Tang
P35	Assessing the disparity in spatial access to hospital care in ethnic minority regions in Sichuan Province, China	Xiuli WANG
P36	Context based learning (CBL) in Thailand for district health system integration and better people-centeredness	Yongyuth Pongsupap
P37	Interventions for containing HIV AIDS epidemic in India: success through interventions for migrants at Destination	Madan Gopal Kavuru
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P39	Family based services for HIV: the role of programs for children in improving efficiency of HIV interventions	Chris Desmond
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P44	Quality improvement at the frontier of healthcare delivery through participatory tool development, novel documentation and provider feedback - Experiences of the Guidelines Adherence in Slums Project	Pratap Kumar
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ID	POSTER TITLE	AUTHOR
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P55	How the social ties of Informal Health Providers address the health needs of vulnerable islanders? - A Social Network Analysis from Indian Sundarbans	Rittika Brahmachari
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P60	Maya Apa, the Digital Sister for the Urban Youth: Accessing SRHR Information Through ICT in Bangladesh	Shahana Siddiqui
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P63	Child, Early and Forced Marriage Project: A Community-Based Approach for Knowledge Building and Intervention.	Dee La
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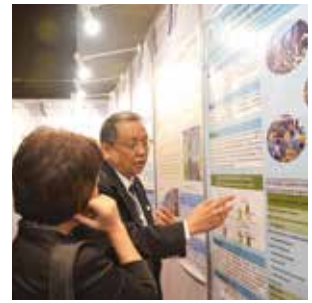

PMAC 2017
World Art Contest

Since 2013 a unique activity called the “Art Contest” was introduced to the Prince Mahidol Award Conference (PMAC) which not only crossed over two different sides of knowledge, art and science, but also brought the public audience, the community, closer to the PMAC concept.

The Art Contest project was initiated as an instrument to communicate the idea of the conference theme to the public audience. The contest was open to everyone, with the aim of raising the awareness of the young generation in how their health is connected to their little families and through the entire World. Vice versa, the various new perspectives of a successful world where all people live better, happy, healthy and equitably from the young generation have been presented to our prestigious participants.

This year, the Prince Mahidol Award Conference invited students and all people to take part in the PMAC 2017 World Art Contest under the topic “Everyone Matters” through Drawings & Paintings and Photos. The project received positive response nationally and internationally from young people, parents and schools. 493 entries from 17 counties were sent in and 136 young artists won prizes totaling 470,000 Baht.

The winners were invited to receive the award during PMAC 2017 on 28 January 2017, 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 Northern provinces, schools from the Southern border provinces, schools from disadvantaged North-Eastern provinces. All the winning artworks were displayed during the conference. The display art pieces amazed most PMAC participants by their high quality artistic skill and creativity.

We recognized the difficulties of many schools which support our program as well. Consequently, we introduced the “art contribution”. The purpose was to provide financial contribution from our prestigious PMAC participants to schools which supported the art program for their students. Last year the “art contribution” of winning art pieces from PMAC 2016 had raised 46,861 Baht and 9 schools were invited to received 5,000 Baht each from the PMAC 2016 Art Contribution. This year, the PMAC 2017 art contribution raised 120,940 Baht.

Drawings & Paintings Category

Group: Under 9 years old

World First Prize

Pornpisut Chottechakit

World Second Prize

Pornpawit Choosuwan, Wacharakorn Kawinram, Thanadon Changkaset, Nunthida Somnuek

World Third Prize

Napatrapee Tangkratok

World Honorary Mention

Jadsada Suwannason, Kanokwan Suwannason, Wiraya Seatang, Dechodit Atichayo, Thanawat Joemwatthana, Eakkachai Beanglae, Nuan Khameai, Wimwipa Yawirai, Karuntarat Phonsri, Autsadawut Yaigam, Warunya Sukchu, Nantiwat Thong-Hgoa

World Young Artist Recognition

Suvachara Mitprayoon, Manha Hossain, Boonika Thamkittichoke, Chanyamon Meesamran, Sippaphas Wongchaipeng, Nutthawan Kotchasorn, Nattha Kaeokamkong, Thitirat Laosakun, Suriya Prathumwan, Rungthiwa Duangchampa, Chonthicha Pidtathasa, Rachawin Promchampa, Thawankorn Prayunhan, Pimyada Rabaipetch, Ketsuda Kiengsri, Khomkaeo Yuakklang, Thanaporn Sriin, Pachariya Kutnok, Suphavit Pasanpot, Suphasuta Pasanpot, Thanakit Karaon, Zannatul Maowa, Chonpansa Ngeumnanjai

Group: 9-13 years old

World First Prize

Varin Surakringsak Intira

World Second Prize

Sirirach Rattamanee

World Third Prize

Thatchaphon Kaeokamkong, Thanakorn Santhaweesuk, Prachya Sanaunram

World Honorary Mention

Chongwut Thaimai, Sirawich Yanatam, Pronkanokwan Khamnoi, Siwat Lerdchaisuwan, Chakkit Panprasong, Supidsara Pasanpot, Kamonnet Khamklong, Kaeoladda Khamsaman, Kanokrat Ruangrat, Abdulrahman Salamah, Sami Ali Alheddi,

World Young Artist Recognition

Kantaphit Somnueknaitham, Pandaree Somnueknaitham, Plaipha Butta, Juthamanee Khamdam, Nuttasith Sirisupavich, Nattanan Jitaree, Janyamon Tuiwong, Papitchaya Sangnak, RukPhet Mamuy, RukPhoy Mamuy, Phetcharat Mariphan, Supapit Poonsawat, Kotchanan Puttirak, Pitchayanin Poonnapol, Chanunchida Wongsirasawat, Punyapa Chaiyarat, Watchareewan Sanguansin, Dylan Johner, Phankorn Phannil, Anan Samaair, Phuphiphat Sillasheevanon, Pongsakron Kumsanit, Chotika Wongkiatkajorn, Ming Muang Maneekorn

Group: 14-17 years old

World First Prize

Boonyakorn Udompol, Wigavee Rattamanee

World Second Prize

Anant Wongsin Chanthakan Chantaragomol Irin Leaung-on Siriroj Kotwongsa Miss Maneerat Rattanasupha

World Honorary Mention

Kamonwan Saikasun, Paveena Srathongrad, Paveenuch Srathongrad, Pannapach Keereedej

World Young Artist Recognition

Tiwtus Kanama, Suktawee Korlai, Bantita Rodkred, Nannanin Rueangyoungmee, Surasee Tammasawut, Phimphichaya Hongsahin, Sasitorn Chotvutakorn, Pithchakon Salangsing, Toungthip Mala, Natthawut Phimthi, Kanlayanee Preecha, Sirirat Kongsing, Thepanan Sonseeda, Thinnakon Thinkrathok, Natthawut Ainkrag, Samat Suwanpak, Arnika Tahsin Borsha, Oyudari Otgonjargal, Katunyu Wattanapraditchai

Group: 18-25 years old

World First Prize

Pongsatorn Tipasatien

World Second Prize

Khachen Playbun

World Third Prize

Jamille Bianca Aguilar

World Honorary Mention

Yuka Sato

World Young Artist Recognition

Sitthichai Chankun

Group: 25 years old & above

World First Prize

Narunart Joemwatthana Sataporn Somasri

World Second Prize

Annop Rattamanee

World Third Prize

Phuttiphong Phongsard, Sarintip Ploypradab, Sitthichai Chanklai

World Honorary Mention

Wattana Plainphum, Ascharaporn Yarangsee, Natthaporn Rungloetsittikun, Nikorn Sathuchat

Photos Category

World First Prize

Ratanan Rattana

World Second Prize

Eakkachai Tolertmongkol

World Third Prize

Thanongsuk Harakunno

World Honorary Mention

Surat Kulapatana, Ruslee Yaena, Krittaya Samarngkit

World Young Artist Recognition

Jai Soni, Arthit Thammakirati

REFERENCES

1. International Organization for Migration (IOM), World Health Organization (WHO) and United Nations High Commissioner for Human Rights (UNHCHR), 2013 International Migration, Health and Human Rights. IOM, WHO and UNHCHR, Geneva.
2. WHO. The World Health Report 2004: changing history. Geneva: World Health Organization, 2004.
3. Murray CJL, Michaud CM, McKenna MT, Marks JS. US patterns of mortality by county and race: 1965–94. Cambridge: Harvard Center for Population and Development Studies, 1998.
4. UNAIDS. The GAP Report (2014)
5. UNDP Key population. http://www.undp.org/content/undp/en/home/ourwork/democratic-governance-and-peacebuilding/hiv-and-health/key-populations.html
6. WHO. Guidance Note on Disability and Emergency Risk Management for Health, 2013
7. GUINTO, Ramon Lorenzo Luis R. et al. Universal health coverage in 'One ASEAN': are migrants included? Global Health Action, v. 8, Jan. 2015.
8. Hacker K et al. Barriers to health care for undocumented immigrants: a literature review. Risk Management and Healthcare Policy. Volume 2015:8 Pages 175—183
9. Asia Catalyst. First Do No Harm: Discrimination in Health Care Settings against People Living with HIV in Cambodia, China, Myanmar, and Viet Nam (2016).
10. Loset J-R, Chang S. Drugs for neglected disease initiative model of drug development for neglected diseases: current status and future challenges. Future Medical Chemistry September 2011 (3-11), 1361-1371 (2011).
11. Tangcharoensathien V., Kanchanachitra C., Thomas R., Pfitzer JH., and Whitney P. Addressing the health of vulnerable populations: a call for papers. Bulletin of the World Health Organization 2016;94:235.
12. Bulletin of World Health Organization. Volume 95, Number 2, February 2017, 85-164 Special theme: vulnerable populations. Available from http://www.who.int/bulletin/volumes/95/2/en/ [access 7 April 2017]
13. Sakolsatayadorn P, Chan M, Breaking down the barriers to universal health coverage [] Bull World Health Organ 2017;95:86 | doi: http://dx.doi.org/10.2471/BLT.17.190991

PMAC 2017

ADDRESSING THE HEALTH OF
VULNERABLE POPULATIONS
FOR AN INCLUSIVE SOCIETY

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