PRINCE MAHIDOL AWARD CONFERENCE

REPORT: PRINCE MAHIDOL AWARD CONFERENCE (PMAC) SIDE MEETING, 30 JANUARY, 2018

THE HEALTH INTERVENTION AND TECHNOLOGY ASSESSMENT PROGRAM
MINISTRY OF PUBLIC HEALTH, THAILAND

Acronyms and Abbreviations

AAR	After Action Review
ANC	Ante-natal care
CHE	Catastrophic Health Expenditure
HEF	Hospital Equity Fund
HITAP	The Health Intervention and Technology Assessment Program
HSS	Health Systems Strengthening Support
iDSI	International Decision Support Initiative
M&E	Monitoring and Evaluation
MCH	Maternal and Child Healthcare
MCHVS	Maternal and Child Healthcare Voucher Scheme
MoHS	Ministry of Health and Sports, Myanmar
NIMU	National Health Plan Implementation Monitoring Unit
OOPE	Out of Pocket Expenditure
PMAC	Prince Mahidol Award Conference
PNC	Post-natal care
SDGs	Sustainable Development Goals
SEAR	Southeast Asia Region
SHI	Social Health Insurance
THE	Total Health Expenditure
WHO	World Health Organization

Table of Contents

Executive Summary 3
Section Summaries 4
Lessons Learned 10
Annexes 13
Annex 1: Agenda 13
Annex 2: List of participants 14
Annex 3: Materials 16
Invitation graphic 16
News event 16

Executive Summary

Financial protection from has been one of the central tenets of the movement to achieve universal health coverage and has been enshrined as one of the Sustainable Development Goals for 2030. Out-of-pocket expenditure (OOPE) on health is high in many of the countries in the Southeast Asia region and over the last two decades, several countries have experimented with health financing schemes to reduce the barriers in accessing affordable healthcare.

To understand and share lessons from some of the countries in the Southeast Asia region, the World Health Organization (WHO) and the Health Intervention and Technology Assessment Program (HITAP), Ministry of Public Health, Thailand, organized a side meeting at the Prince Mahidol Award Conference (2018) on the theme "Out-of-pocket expenditure and the Quest for Universal Health Coverage: Lessons learned from implementing innovative health financing schemes in the South-East Asia Region" on 30 January, 2018. The session showcased studies and observations from four countries in the region, namely, Myanmar, India, Vietnam and Thailand.

OOPE remains relatively high in the Southeast Asia region and continues to warrant attention of policy makers. In Myanmar, a study on the impact of two health financing schemes highlighted the importance of targeting beneficiaries to reduce catastrophic health expenditure including setting the appropriate criteria for identifying those in need. Experiences in India show that healthcare costs have risen substantially over the past two decades with households spending more on medicines. Studies indicate that public investments in healthcare yield results in terms of improving utilization of healthcare services. In Vietnam, OOPE continues to be high and while coverage of the population has increased, there are systemic issues such as non-coverage of preventive services and lack of a strict referral system. Thailand, which implemented a Universal Coverage Scheme (UCS) has witnessed a decline in the proportion of OOPE although the absolute amount spent by households on healthcare has remained stable.

From the four countries, it is evident that catastrophic health expenditure (CHE), a common indicator for assessing the effect of OOPE, depends on a variety of factors and does not respond to policy changes; it can occur even when there is a strong primary healthcare system, underlining the need to account for indirect costs in the system; and finally, to appreciate that the indicator of OOPE has many dimensions and that to understand the impact of schemes on financial protection, researchers need to look at variables beyond the indicator.

Introduction

Out-of-pocket expenditure (OOPE) on healthcare can push households into poverty and in the Southeast Asia Region (SEAR), more than 65 million people have been impoverished on its account. Reducing OOPE of households has therefore been at the forefront of discussions related to achieving Universal Health Coverage (UHC), one of the Sustainable Development Goals (SDGs) for 2030. Several governments in the region have implemented health policies to alleviate the financial burden of healthcare on households.

With a view to understand and share the lessons learned from designing and implementing health financing schemes, the World Health Organization (WHO) and the Health Intervention and Technology Assessment Program (HITAP), Ministry of Public Health, Thailand, organized a side meeting during the Prince Mahidol Award Conference (PMAC) 2018. The objective of the meeting was threefold: to present findings of studies conducted on the impact of health financing schemes on OOPE, to learn about the issues related to the design and implementation of the schemes, to discuss the lessons learned from the experience of four countries in reducing OOPE through the schemes and potential solutions for the way forward. The session showcased experiences of four countries in the Southeast Asia region namely, Myanmar, India, Thailand and Vietnam, that have rolled out health financing schemes with a focus on financial protection.

This report summarises the proceedings of the side meeting which took place on 30 Janurary, 2018 during the Prince Mahidol Award Conference (PMAC) 2018 (see Annex 1 and 2 for agenda and list of participants). The meeting was supported by the International Decision Support Initiative (iDSI), a network of priority setting institutions that HITAP is a part of and through which it supports the development of evidence-informed decision making in countries; the meeting was also supported by the WHO Myanmar Office and PMAC.

Section Summaries

The side meeting opened with an overview of the topic and was followed by presentations by speakers from four countries viz Myanmar, India, Vietnam and Thailand on the impact of health financing schemes as well as trends on OOPE. The discussions were moderated after each presentation and after all presenters and discussants had spoken. The summary of the session is provided below:

Overview of trends in OOPE and in the context of achieving UHC

The opening remarks were given by Dr. Alaka Singh, Deputy WHO Representative, Myanmar who contextualized the discussion on OOPE and UHC in her talk titled "*Out-of-pocket expenditure and the quest Universal Health Coverage: Lessons learned from implementing innovative health financing schemes in the South-East Asia Region"*. Noting that the SDG goal calls for UHC including financing protection, she emphasized that health financing is crucial in unlocking the puzzle of presented by the UHC cube i.e. Who is covered, which services are covered and what people pay out-of-pocket. The trend in this regard has been to pool resources for spreading financial risks. The share of OOPE has declined only marginally among low income and low and middle-income countries (LMICs). While there has been much progress globally in reducing OOPE, the WHO

SEAR continues to register high rates of OOPE compared to other WHO regions. A WHO study showed that at about 70% of total health expenditure (THE), OOPE in SEAR was also responsible for a third of the annual increase in poverty. With regards to equity, Dr. Singh drew out one of the key choices to be made while implementing UHC: whether to provide a limited package to the entire population or to target a group for providing an expanded set of services. With a targeted approach, the issue of the "missing middle" becomes relevant as this group is neither able to access quality private healthcare nor is it eligible for schemes targeting the poor, making it vulnerable. Sri Lanka offers an example where OOPE is progressive in the sense that 80% OOPE comes from the upper quintiles. Delineating the path to UHC, countries may move from a system dominated by OOPE to an intermediate stage of a fragmented system of finance, leading to a UHC system which may be tax-based, social insurance based or a mix of tax and social insurance.

Results of study conducted to assess impact of two health financing schemes under the Gavi Health Systems Strengthening Support (HSS) in Myanmar.

Dr. Thiri Win from the Ministry of Health and Sports (MoHS), Government of Myanmar, shared findings from the Gavi HSS study that was conducted at the close of the grant. Myanmar is an LMIC with low public expenditure on healthcare, which has been increasing in recent years. As part of the Gavi Health Systems Strengthening Support (HSS), two health financing schemes were introduced in 2012, the Hospital Equity Fund (HEF) and the Maternal and Child Healthcare Scheme (MCHVS). The two schemes applied different models: the HEF covered inpatient care for deliveries with complications and emergencies at the district level hospitals or Township Hospitals in about 120 Townships whereas the MCHVS covered antenatal (ANC), delivery and post-natal care (PNC) for mothers and immunization of children in two townships. Both schemes targeted the poor. The study applied multiple methods and, in this presentation, results from the monitoring and evaluation (M&E) data and the household survey data were presented.

The study raised issues on targeting of beneficiaries, impact on financial protection, measured by catastrophic health expenditure (CHE), and utilization rates, differences in design and sustainability. The scheme showed that in terms of targeting, the MCHVS was relatively more pro-poor and that the criteria initially used for identifying beneficiaries under the HEF underestimated the poor. In terms of averting CHE, households reporting use of MCHVS were less likely to experience CHE compared to households who did not report using the scheme. The benefits package under HEF were more likely to cause households to incur CHE which suggested coverage of these services as appropriate. Notwithstanding the increase in utilization of services, households evinced a preference for home-based services. Many of the differences in the scheme were related to the differences in the design of the schemes which offers insights on how efforts in the future may be undertaken. Finally, it was noted that these schemes were one step towards UHC in Myanmar.

The next presentation was delivered by Dr. Shankar Prinja, Additional Professor of Health Economics at the School of Public Health, Post-Graduate Institute of Medical Education and Research (PGIMER), India. He spoke on the topic of *"Providing Financial Protection to the Poor: The Case of Publicly Financed Health Insurance Schemes in India"* and started by providing an

overview of the health financing landscape in India which relies on the private sector, with households accounting for 67% of THE.

Review of structure of costs and OOPE of households in India.

Health sector costs have ballooned over the past 20 years, particularly in the private sector. This may be attributed to demographic, epidemiological and social transitions, as well as the financing structure including privatization and the advent of new drugs and technologies. India, he noted, is a paradox as the country struggles to provide affordable healthcare to its populace on the one hand but has a thriving generic drugs industry which has reduced costs for a number of countries. Indeed, the "70:70 paradox" is that 70% of health expenditure is out-of-pocket of which 70% is spent on medicines. In terms of the costs by diseases, cancer dominates other diseases including as the major source of CHE and impoverishment compared to communicable diseases. Interestingly, it costs more upon death during hospitalization than when a patient recovers after being hospitalized. In fact, CHE has increased significantly over the years and studies estimate that the number of people impoverished due to health care ranges from 32 million in 2005 to 47 million in 2011.

Government focus and expenditure on the health sector has increased in the past decade, with aspirations most recently expressed in the National Health Policy 2017. Dr. Prinja then went on to show the policy options for financing which may see public funds directed towards supply side financing or demand side financing, the latter involving the private sector for purchasing care. While public health financing has not been found to have an effect in reducing CHE, utilization has been found to be more equitable. Even though there is a positive effect of public health financing, it is a fraction of what is spent by the private sector. In conclusion, it was recommended that the public sector be strengthened and the governance and regulatory system for both, the public and private sectors be improved.

Structure of health financing and trends in out-of-pocket expenditure in Vietnam

Mrs. Vuong Lan Mai from the Vietnam Social Security (VSS) gave a presentation titled *"A review of out-of-pocket health expenditure and policy response in Vietnam"*. Vietnam is a country with a population of about 93 million and an LMIC. The healthcare system is dominated by the public sector which has four tiers of delivery at the national, provincial, district and commune level. In terms of health financing, it is a mixed system, with tax-based sources, the Social Health Insurance (SHI) scheme, external assistance as well as other sources. OOPE accounts for a major proportion of financing at about 50%, reducing from about 65% in 2000. Medicines and medical supplies account for the most spending by households. The government had introduced a health insurance law as early as 1992 and in 2013, announced a Master Plan for Universal Coverage which aimed to increase enrolment in the SHI program and lowering the proportion of OOPE. Population groups were incrementally included in the fold of the program to cover those in the informal sector. The government has also made investments in strengthening the primary health care system by upgrading the infrastructure and investing in human resources.

Although strides have been in made, OOPE has remained high. This may be because the SHI, which provides a generous benefits package, is limited to curative care and does not include

preventive care. The SHI is riddled with some problems such as the perception of low quality under the program coupled with adverse selection of those who opt into the program. There are three possible reason for the persistence of high OOPE: higher utilization of health services, limited screening interventions which shifts the burden to treatment, hospital autonomy policies which have encouraged profit-seeking and irrational use of health services and rising healthcare costs. One suggestion put forward were to strengthen the primary health care system including the referral system. Another area that could be addressed is strategic purchasing which includes developing a benefits packages at each level of delivery based on cost-effectiveness evidence and designing appropriate payment mechanisms such as pay for performance.

OOPE in Thailand

The next presentation was made on *"Out-of-pocket expenditure on health in Thailand"* by Ms. Saudamini Dabak, Technical Advisor at HITAP. The presentation was based on a study conducted under the Thailand Research Fund (TRF) which involved analysis of the Socio-economic Survey (SES) from 1990 through 2015. Thailand is an upper middle-income country in Southeast Asia with a population of about 70 million. Government expenditure on health has increased is about 80% of THE and OOPE has decreased since the mid-nineties. Thailand introduced the Universal Coverage Scheme (UCS) in 2002 which covers three quarters of the population and is financed by general taxation. The UCS has been widely studied and found to have reduced inequities in access to health and decreased incidence of CHE. However, many supply side and institutional factors such as decentralization have contributed to its success, with political buy-in for the universal health coverage and use of evidence for policy making.

The analysis of the SES data over the last twenty-year period suggests that while the proportion of OOPE has declined, the absolute amount spent by households on healthcare has remained stable. Most of this household expenditure on health occurs in private health facilities. The lower income deciles have experienced a decline in spending on outpatient and inpatient services, particularly in the public sector. The top ten percent of households spends more than ten times as much as the lowest decile on healthcare. Households with the elderly and disabled spend more on healthcare although the gap between households with and without each of these groups has reduced over the years indicating support for these groups. Among other factors, the level of education of the household head was found to be associated with lower healthcare expenditure across income groups. In terms of composition of expenditure, households spend a large proportion on medicines and in recent years, there has been a sharp increase in the consumption of vitamins, particularly among households in the top deciles.

The main themes for designing and implementing health financing schemes are outlined in Table 1 below:

Table 1: Themes for designing and implementing health insurance schemes

Type	Main points
Target population	• Universality versus targeting • The "missing middle" • Coverage of people in the informal sector • Identifying the vulnerable such as disabled and elderly
Structure of health financing	• Source of finance and sustainability • Demand-side versus supply-side financing • Political buy-in • Regulation and governance of public and private system
Household expenditure items	• Dominance of medicines and, in countries such as Thailand, rise in expenditure on vitamins and supplements • Capturing indirect costs
Strengthening the health system	• Primary care and the referral system is important but not adequate

Synthesis of presentations and discussion

The participants engaged in a lively discussion throughout the session and was moderated by Dr. Raymond Hutubessy from the WHO and Dr. Yot Teerawattananon from HITAP. The UHC questions on "who, what, how and impact" were critical to the discussion. On Myanmar, one person noted the importance of affordability for UHC and how one needs to look at the system holistically. He also asked about whether indirect costs of accessing care were also incorporated, to which the presenter responded in positive. Some questions were raised on the sustainability of the schemes given the end of external support. The issue of targeting versus universality was also discussed. For India, clarification was sought on the studies conducted on CHE, whether they also take indirect costs into account and if retrospective, they are missing baseline information. Another question was asked regarding the feasibility of the governance and regulatory system in India. Regarding benefits coverage, a question was asked on where the marginal spend would go and what comprehensive health coverage would look like. Social transition was identified as an important area for policy intervention such as taxation. One of the participants called for the retention of demand side financing. Resource pooling at the central treasury or facility level was also discussed.

For Vietnam, a question was asked about whether there was any effort to make the health insurance scheme compulsory to which answered that by law, the scheme is compulsory however, there are no tools to monitor or enforce this policy for the general population. Another question was asked about how visit possible to cover the large informal sector under the health insurance scheme. The scheme is focused on covering the poor and ethnic groups however, 15% of the population in the

informal sector remains excluded from the scheme. There is variation in the coverage between groups leading to high OOPE and the issue of accessibility, particularly for those residing in mountainous areas was also raised as a barrier. On Thailand, a person from Indonesia asked about the whether supplements, consumption of which is growing in many countries including Indonesia, should be included in insurance schemes. It was clarified that the results presented for Thailand reflected voluntary purchases by households and that this is a major issue in countries such as the United States where there is limited regulation in the area. In Thailand, supplements are regarded as food and therefore are not subjected to the same standards as medicines; this requires more stringent regulation in the future. Another person asked about the Thai model of UHC is sustainable given the high level of government support and its applicability to countries in Africa. Further, it was noted that the OOPE is stable in Thailand because government expenditure has increased and the rich are opting out to consume healthcare.

The presentations were followed by discussants sharing their remarks. Dr. Thant Sin Htoo, Director of the National Health Plan Implementation Monitoring Unit (NIMU), Government of Myanmar, noted that one of the common findings across the four countries has been that OOPE has not reduced due to various factors. In Myanmar, the Gavi HSS schemes were a one-time intervention calling to question sustainability of interventions. The MoHS will have to negotiate with the government for funding and explore the feasibility of demand versus supply side financing for healthcare. Prof. Supasit Pannarunothai said that in Myanmar, there appears to be a need for a more active role by the government as many countries still depend on external support. Political support for the UCS has also been crucial in the case of Thailand. The presentations raise the question on whether investments in primary care, which has shown positive results in improving health care, can help reduce OOPE as one cannot prevent hospitalization.

The session was summarized by Dr. Yot Teerawattananon, and the points are presented in Figure 1:

Figure 1: Takeaways from session

- CHE can occur for those using primary care and there is a need to take indirect costs and accessibility issues into account
- CHE depends on a number of factors and increasing coverage will not automatically have an effect on this indicator on financial protection
- OOPE is not a simple indicator and one needs to unpack the various aspects to uncover the impact of the health financing interventions

Lessons Learned

The HITAP team conducted an After-Action Review (AAR) meeting on Tuesday, 13 February, 2018. The agenda for the meeting was to provide an overview and summary of outcomes of the workshop, discussion on what went well and why as well as areas of improvement. The discussion covered the following: logistics, content, delivery and communications materials. Below is a summary of the same:

Table 2: Lessons Learned

Areas	Lessons

Logistics	• General
	  ○ Preparatory meetings were useful – initial meeting with communications team and subsequently, with all, to discuss roles and responsibilities.
	  ○ Having some people stay close to the venue helpful.
	  ○ Multi-team effort involving communications, administration and HIU. Worked as a team and solved problems.
	  ○ Suggestion that the event manager from communications team should work closely with the person who is responsible for any side event from the planning process to wrap up part, esp., during registration both of them should monitor the number of people who have registered in order to decide when to close it and to what extent it should expand the registration period.
	• Promotion of event:
	  ○ Requesting biographies of speakers, including the photo – for promotional or introductions during event (can use the HTAsiLink format)
	  ○ Promotion of event using attractive invitation form (see Annex 3)
	• Registration of participants:
	  ○ Google form for event promotion was useful and design was attractive.
	  ○ Registration sheet, derived from Google form, was useful and we were also able to count all participants.
	  ○ Invitation list broader than PMAC was useful.
	  ○ Registration sheet: bigger font (16-20 point). Alphabetical order of names would be better.
	  ○ Registration confirmation: change the wording on the google form or have a confirmation email (send the email – as a reminder, the day before with information on event).
	  ○ Plan to monitor the registered participants, closing registration upon completion of quota.
	  ○ External participants: 76 registered, 55 attended.
	• Venue:
	  ○ See the venue and request changes to theatre style

	○ Equipment – laptop, clicker was readily available. ○ Standing advertisements with findings, logos, etc. can attract more people. ○ Classroom versus theatre style: if workshop type, have classroom. For this type of event -either, preferably, theatre. ○ Share roles, floor plans, other materials in both soft copy and hard copy with organisers and speakers.
Content	• Enlisting speakers: ○ Invitation to speakers. ○ Coordinate with speakers about the expected content of the presentation in advance. ○ Worth specifying what costs are being covered for speakers being funded eg visa. ○ Maintain flexibility with speakers/have a plan B. • Topic: ○ Presentations from four countries in the region. Presenters spoke on specific research as well as overall trends related to OOPE in their countries. We also had two discussants to provided and overview, ○ Interesting topics/title. Use relevant terms (eg UHC). ○ Even though topic not related to theme of conference, attracted participants. ○ Lot of interest in the topic even during the registration. ○ Unique country experience ○ Interact with people involved interested in topics, enriching discussions. More time for discussion. Also had more people in the room
Delivery	• Format of session: ○ Having four speakers, mini discussions and then a longer discussion at the end. ○ Variety in the topics kept participants engaged. ○ Advertisement before the break, arrange session so that there are interesting sessions in both parts. ○ Could share communications materials, including policy briefs. • Timing: ○ Morning session during PMAC is good for getting participants. • Management of session: ○ Microphones were limited as there were too many side events running at the same time. can carry some of our own (best option). Need to talk with organisers or ask beforehand. Ask for more microphones in advance.

	○ Have two people manage the microphone: one at the front and one at the back. ○ Pros and cons of room size: expect a larger room. But small room allows greater engagement. ○ During discussion time, keep chairs near podium for speakers. ○ Keep speaker name tags (for table). ○ Wifi available at PMAC but prepare for alternative as signal may not be strong enough. ○ Add time keeping as a role.
Communications materials	• Prepared policy brief for Myanmar in time for the event • Were able to promote GEAR using policy brief. However, too many things to do and limited time so could not get registrations. • Prepared a news event/Facebook with photos.

Annexes

Annex 1: Agenda

Prince Mahidol Award Conference (PMAC) 2018 Side Meeting

Out-of-pocket expenditure and the Quest for Universal Health Coverage: Lessons learned from implementing innovative health financing schemes in the South-East Asia Region

Date: Tuesday, 30 January, 2018
Time: 9:00-12:30 hrs
Venue: Lotus 11, 22nd Floor, Centara Grand & Bangkok Convention Centre at CentralWorld

Agenda:

Master of Ceremonies (MC): Ms. Waranya Rattanavipapong, HITAP
Moderated by: Dr. Raymond Hutubessy, WHO and Dr. Yot Teerawattananon, HITAP

Time	Session	Speaker
9:00 – 9:15	Opening remarks	Dr. Alaka Singh, WHO Myanmar
9:15 – 9:40	Impact assessment of the Gavi Health Systems Strengthening Support (HSS) in Myanmar	Dr. Thiri Win, Ministry of Health and Sports (MoHS), Myanmar
9:40 – 10:05	Providing Financial Protection to the Poor: The Case of the Publicly Financed Health Insurance Schemes in India	Dr. Shankar Prinja, Post Graduate Institute of Medical Education and Research (PGIMER), India
10:05 – 10:20	Break	
10:20 – 10:45	Out-of-pocket expenditure on health in Thailand	Ms. Saudamini Dabak, HITAP, Thailand
10:45 - 11:10	An overview of out-of-pocket health expenditure and policy response in Vietnam	Mrs. Vuong Lan Mai, Vietnam Social Security (VSS), Vietnam
11:10 - 12:15	Discussion	Discussants: Dr. Thant Sin Htoo, Ministry of Health and Sports (MoHS), Myanmar and Prof. Supasit Pannarunothai, Centre for Health Equity Monitoring Foundation, Thailand
12:15 – 12:25	Summary	Moderators
12:25 – 12:30	Vote of thanks	Ms. Waranya Rattanavipapong
End		

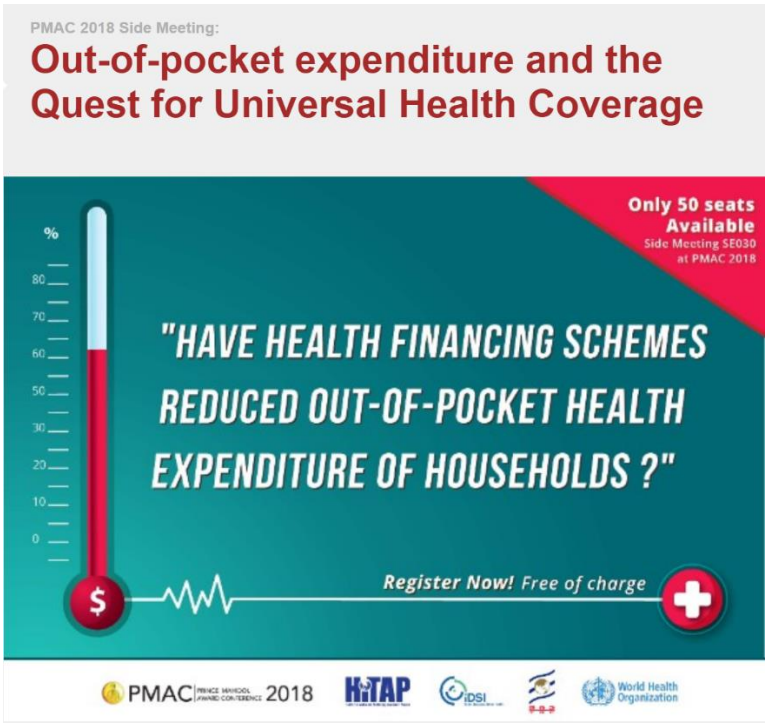
Annex 2: List of participants

Sr. No.	Name	Organization	Country
1	Aiban Pillay	National Department of Health	
2	Apiruck Watthanasurorot	Johnson and Johnson, Thailand	Thailand
3	Asst. Prof. Dr. Araya Prasertchai	Sukhothai Thammathirat Open University	Thailand
4	Chieko Matsubara	National Center for Global Health and Medicine	Japan
5	Devon Ray Pacial	Republic of the Philippines â€" Department of Health	Philippines
6	Dr Dayo Adeyanju	Guaranteed Health Care Foundation	Nigeria
7	Dr khin Thida Moe	Miinistry of Health and Sports	Myanmar
8	Dr. Ahmed Mushtaque Raza Chowdhury	BRAC	Bangladesh
9	Dr. Kanchan Mukherjee	TISS	India
10	Dr. Kittima Sriwatanakul	Pfizer Thailand Foundation	Thailand
11	Dr. Phyllida Travis	WHO	India
12	Dr. Soulivanh Pholsena	MoH Laos	Lao PDR
13	Eddie Mukooyo	Ministry of Health	Uganda
14	Ei Ei Aung	IHPP	Thailand
15	Elvi Siahaan	ACT-AP/MAP-Int	
16	Fatim. Lakha	LSHTM	Thailand
17	Jane Robertson	WHO Regional Office for Europe	Denmark
18	Jiraphan Jaratpathararoj	National Health Security Office	Thailand
19	Jittinee Khienvichit	USAID/ Regional Development Mission for Asia	Thailand
20	Joe Harris	Boston University	USA
21	Johan Dahlstrand	SIGHT	
22	John McDermott	The Economist	
23	Kasinee Wongsang	Alliance for Safe Medicines Asia	Thailand
24	Khuat Thisaiohn	SCDI	
25	Kotoji Iwamoto	WHO	Japan
26	Kyi Kyi Thar	MOHS	Myanmar
27	Manoj Kumar Biswas	MoHFW	
28	Mattias Gbanya	Ministry of Health Liberia	Liberia
29	Mina Ohata	GHIT Fund	Japan
30	Mrs. Yupadee Sirinsak	NHSO Board member	
31	Ms. Benjaporn Niyomnaitham	Ministry of Foreign Affairs, Thailand	Thailand
32	Ms. Khin San Lin	MoHS Myanmar	Myanmar
33	Ms. Thiri	MoHS Myanmar	Myanmar
34	Nandan Raltanasam		
35	Nitichen Tangathporn	Sukhothai Thammathirat Open University	Thailand

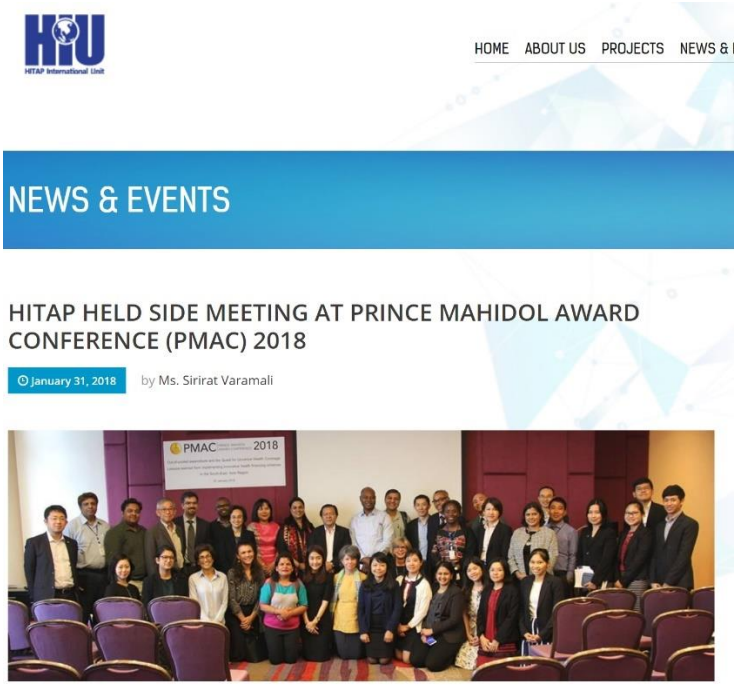
Sr. No.	Name	Organization	Country
36	Orapan Srisiikwatana	NHCO	
37	Pan Myat Mon	Australian Volunteers Program	
38	Peerapat Kosulsaksakul	PSU	
39	Peter Coyte	University of Toronto	Canada
40	Pitthaporn Chotikanokrat	Novo Nordisk Pharma (Thailand)	Thailand
41	Pornpit Silkavuti	MoPH	
42	Ri Harayam	MCGM	Japan
43	Roypim Techo	USAID	Thailand
44	Samita Wisetsutthichai	Novo Nordisk Pharma (Thailand)	Thailand
45	Sita Shahi	ICWAP	Thailand
46	Sohir Hassan Abdelkader	FAO	Egypt
47	Surasak Thanaisawanyangkoon	Bureau of AIDS TB and STIs	Thailabd
48	Taketo Tanaka	National Center for Global Health and Medicine	Japan
49	Thadchawadee Wejrungsikul	MSD (Thailand), Ltd.	Thailand
50	Thanarath	Imsuwansri	Thailand
51	THARANI LOGANATHAN	University of Malaya	Malaysia
52	Uzoma Nnankwo	Federal Ministry of Health Nigeria	Nigeria
53	Van Tran	Social Science Research Council	USA
54	Wannaporn Wattanakasemsat	Pfizer (Thailand) Ltd.	Thailand
55	ผศ.ดร.ครุณวรรณ สมใจ	มหาวิทยาลัยหัวเฉียวเฉลิมพระเกียรติ	ไทย
56	Apinya Mattadet	HITAP	Thailand
57	Benjarin Santatiwongchai	HITAP	Thailand
58	Dr. Roongnapa Khampang	HITAP	Thailand
59	Jatuporn Uansri	HITAP	Thailand
60	Juliet Eames	HITAP	Thailand
61	Manushi Sharma	HITAP	Thailand
62	Md. Rajibul Islam	HITAP	Thailand
63	On-iriya Fugthaworn	HITAP	Thailand
64	Rukmanee Butchon	HITAP	Thailand
65	Sarayuth Kuntha	HITAP	Thailand
66	Sirirat Varamali	HITAP	Thailand
67	Suppawat Permpolsuk	HITAP	Thailand
68	Suradech Doungthipsirikul	HITAP	Thailand
69	Tanagrit Latthibuddhakarl	HITAP	Thailand
70	Wittawat Chatchawanpreecha	HITAP	Thailand

Annex 3: Materials

Invitation graphic



News event



Link: http://www.globalhitap.net/newsandevents/hitap-held-side-meeting-at-prince-mahidol-award-conference-pmac-2018/