December 2018

HAI AP News

Penang, Malaysia
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HAI AP Est. 1981

Health Action International (HAI) was formally founded in Geneva in 1981 and coordinated from Penang by Action for Rational Use of Drugs in Asia (ARDA). In 1995 Health Action International Asia Pacific (HAI AP) was formed as a collaborative network in the Asia Pacific Region to increase access to essential medicines and improve their rational use through research excellence and evidence-based advocacy. HAI AP is committed to strive for health for all now. *HAI AP News* is the organ of Health Action International – Asia Pacific and presents the happenings in the regional campaigns for more rational and fairer health policies and carries material in support of participants' activities

In this issue

HAIAP Tribute to Amit Sengupta

Prepared by Beverley Snell and Mira Shiva on behalf of HAIAP members

Sadly we make this tribute to Amit Sengupta who we lost in an accident, when his tremendous contribution in addressing social and economic injustices is needed more than ever. Amit, because of his engagement with drugs issues was part of Health Action International Asia Pacific and known to many even before the birth of PHM.

Amit studied medicine at Maulana Azad Medical College (MAMC) in Delhi, and graduated in the early 1980s. MAMC is affiliated to the University of Delhi and

run by the Delhi government. It is named after the Indian freedom fighter and first education minister of independent India –Maulana Abul Kalam Azad.

After graduating, Amit was attached to one of the four teaching hospitals linked to MAMC. However, according to colleagues he didn't fit in. Idealism came before himself. Within a week of starting a clinic near Sainik Farms, he is remembered as asking how could he charge the poor for treatment.

He joined the Communist Party of India (CPI [M]) in 1979 as a student activist and played a key role in formulating the Party's policies on the popular science campaign and on public health. That was just after the Alma Ata conference on Primary Health Care. Later, he was the convenor of the All India Popular Science Committee of the Party. Following graduation, Amit was working in the Delhi Science Forum and was busy in the science popularisation movement. He was actively engaged with All India Peoples Science Network of which he later became national General Secretary. He came to the health movement little later.

A national platform for science organisations in India had started in the late 1960s and that network interested Amit from his student days. The network had expanded by the 1980s and the Bhopal Gas Tragedy of 1984 created a situation for groups to work together against the abuse of science and technology.

After graduation Amit had a low key private practice but basically gave up what could have been a lucrative career to work for people's health.

Amit and the movement for peoples' access to health care and essential medicines

HAIAP member Manuj Weerasinghe remembers hearing the name Amit Sengupta almost 26 years ago – around 1992 – and then finally meeting him almost a decade after.

A few Sri Lankan medical students had just formed *Students Involved in Rational Health Action* (SIRHA) in the Colombo Medical faculty and were looking for opportunities to expand their work. Manuj tells us that he and a few others had the opportunity to meet Dr Mira Shiva and Dr Zafrullah Chowdhury during a brief encounter at the Pharmacology Department meeting room. Mira and Zafrullah had visited the Faculty of Medicine in the University of Colombo at the invitation of Dr Balasubramaniam and they insisted that they should visit the Department of Pharmacology from where Prof. Senaka Bibile[1] started his struggle against Big Pharma in the late 1950s and where Professor Bibile's picture hung. Amit's name came in during this discussion as a possible contact point.

The association with Dr. Balasubramaniam at the International organisation of Consumer Unions made it possible to establish regular contact with Amit and for him to learn about the work done in India and elsewhere.

[1]**Senaka Bibile** (1920-1977) was a Sri Lankan pharmacologist. He was the founder of Sri Lanka's drug policy, which was used as a model for development of policies based on rational pharmaceutical use in other countries as well by the World Health Organization, the United Nations Conference on Trade and Development(UNCTAD) and the Non-Aligned Movement. Due to the far reaching effects of his proposals and policies, he has been called the 'greatest medical benefactor of humanity that Sri Lanka has hitherto produced'.

Amit's links with other organisations: During the 1980s he remained in touch with Dr Balasubramaniam and Dr Mira Shiva who were active in the All India Drug Action Network (AIDAN) and Action for the Rational Use of Drugs in Asia (ARDA).

The Drug Action Forum (Karnataka) (DAFK), the All india Drug Action Network (AIDAN) and National Campaign Committee for Drug Policy (NCCDP) filed a Public Interest Litigation in the Supreme Court of India in 1993 praying for a Ban on irrational and hazardous drugs. LOCOST, Community Development Medicinal Unit (CDMU and Saheli (Women's Group) all collaborated. Amit represented NCCDP, Dr Gopal Dabade, DAFK, Mira Shiva, AIDAN, and Dr Chinu Srinivasan LOCOST. Hearings went on for over eight years. The issue of banning hazardous and irrational drugs remains an ongoing issue.

Amit also researched and wrote about the impacts of privatisation on healthcare and the performance of global health institutions.

Amit Sengupta, Dr Bala and National Drug Policies

Dr Kumariah Balasubramaniam highlighted and promoted the significance of National Drug Policy as a framework for access to appropriate health care and essential medicines for all. Dr Bala was a Professor in the Clinical Pharmacology Department of the Medical Faculty in Sri Lanka succeeding Professor Senaka Bibile in Sri Lanka. In Sri Lanka Dr Bala had initiated Government procurement of medicines by launching an International Tenders policy action which resulted in lowering of drug prices but it was resisted by Pharmaceutical multi-national corporations. The efforts of Dr Bala and colleagues led to a global crusade to establish NDPs as a framework to guide access to safe, appropriate, affordable and accessible medicines for all who need them. Dr Bala continued these efforts when he joined UNCTAD, International Organization of Consumer Union - later called Consumers International - ARDA, HAIAP and the Peoples Health Movement.

In 1995, Dr Bala provided a history of India's movement towards NDP as a background to the meeting that was to be held in Siliguri, West Bengal. Dr Bala told how the Indian representative to the Alma Ata conference, in supporting the concept of PHC told the participants, among other things, the following:

> *'The new direction which we [India] have given to our health programs seeks to take basic health care to the doorstep of the people in the villages!'*

The promise was that the Indian Government would give a new direction to the health care services by formulating and implementing a national health policy based on PHC and its eight components including access to essential medicines as outlined in Alma Ata in

1978 and the Director General of WHO had the answer to how that could be done:

> *'National drug policies and essential drug programs are now and in the foreseeable future, the best means we have available of pursuing and eventually attaining the dual objectives of rational management of drug resources and better health for all.'*

Dr Bala continued

> *'Historically India, with its ancient civilization, has been a pioneer in contributing original concepts, thoughts and ideas that have enriched mankind. This has been true of drug policy making too.'*

Before WHO published its first selection of essential drugs, introducing the concept of an integrated rational drug policy based on the concepts of essential drugs and their rational use, the Government of India in 1974 had set up an expert committee, popularly known as the Hathi Committee[2], to develop a rational drug policy based on a limited number of essential drugs; and a report was published in 1978.

The Government of India announced a National Drug Policy in March 1978 and a National Health Policy in 1983 but the Hathi Committee's major recommendations were either rejected or diluted and the policy replaced in December 1986 by a new drug policy. It was called 'Measures for Rationalization, Quality Control and Growth of Drugs and Pharmaceutical Industry in India', and was developed by the Department of Chemicals and Petrochemicals, Ministry of Industry. The major objective was industrial expansion. It was described by the Rational Drugs Advocacy and Public Health promoting organizations of India as an 'anti-people' and 'pro-industry' policy.

The Government of India came up with yet another drug policy in September 1994 called 'Modification in Drug Policy' that would not meet the needs of the country and the people. Dr Bala believed that the way that the pharmaceutical industry in India was allowed to develop and grow resulted in structural injustice leading to a pharmaceutical situation that was both tragic and scandalous. Victims of disease became victims of neglect by government; and victims of exploitation by those hungry for profits.

So more than ever, India was needing a new paradigm for the way the health needs of the people would be viewed. The NCCDP had the Federation of Medical and Sales Representatives' Associations of India FMRAI as member. As FMRAI was a Trade Union they did not want to become part of AIDAN which had consumer health, and women's groups even though all worked together.

Silguri, West Bengal 1995

I (Beverley Snell) first met Amit in Siliguri in 1995 at the International Seminar on the Rational Use of Drugs, organised by the Community Development Medicinal Unit of Bengal, the Rational Drug Use Campaign Committee, West Bengal, and the International Organisation of Consumers Union Malaysia (coordinated by Dr K Balasubramaniam).

The list of participants for that meeting shows Amit as representing the National Campaign Committee for Drug Policy (NCCDP). The theme of the meeting was *Right to Essential Drugs at Affordable Prices for Better Health – a Consensus Approach.* Amit was one of the technical advisors for the event along with Dr Mira Shiva AIDAN and Amitava Guha FMRAI. The opening session began with a presentation from Amit on the *Present Drug Policy in the Background of New Economic Policy*, followed by Dr Bala and Dr Ekbal on the *Effect of the New World Economic Order Globalisation, Patents, WTO etc – on Pharmaceuticals* and then Dr Mira Shiva and Dr QasemChowdhury on *Rational Drug Policy in the Context of Rational Health Care Policies*; setting the scene not only for that that meeting but for the focus and activities for the following almost 25 years of CIROAP until 2002 and then HAIAP.

Amit Sengupta and HAIAP Regional Consultations

Amit became associated with the network that became HAIAP before he became involved in the movement that became the Peoples Health Movement, launched in 2000. He had connected with Dr Balasubramanian through the Rational Drugs in Asia group listing his affiliation as the NCCDP throughout the years he was associated with HAIAP.

In 2004, HAIAP came together at Universiti Sains Malaysia (USM) in Penang around the themes Health *Care Financing and Traditional Medicine*. Amit spoke about the Rise of the Corporate sector and the expansion of Medical Tourism at the expense of nation's public sector. [3]

In 2005 HAIAP met again at USM in Penang around the theme *Making the Best of Resources - Towards Equity in Health*. Amit's presentation on Pricing and manufacture of generic drugs in India – post 2005 scenario - succinctly covered the history of the movement and the national and international policies

[2] HAIAP member Dr B Ekbal has produced an analysis of the Hathi Committee activities and developments. Contact ekbalb@gmail.com

[3] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmiitSengupta2004MedicalTourism.pdf

affecting the production and prices of drugs; as well as predictions for the future. [4]

In 2006, at the Gonoshasthaya Kendra HAIAP Regional Consultation, Amit covered Intellectual Property Rights Protection in Least Developed Countries and Options Available[5]; and Patents: Obstacles or Facilitators of Access to Knowledge.[6]I

HAIAP regional Consultation 2007 at the Cinnamon Grand Hotel in Colombo focused on General Agreement on Trade in Services (GATS) and Public Health. Amit considered GATS and Public Health in the Indian context – the Government versus the people - concluding that clearly India's position on GATS is driven by corporate needs and not by health needs - dangers in India's commitments are not just limited to India – there is potential for the same impact in other developing countries.[7]

In Bangkok 2008, the impact of Free Trade Agreements (FTAs) on access to medicines was examined. Amit examined the impact in a wide range of countries and concluded

'Overall, bilateral agreements have been a disaster for the developing countries and for the global trading system. These FTAs are creating a world in which there are two groups – the first consists of 'my friends who can get in free' and the other of countries that have to pay tariffs. Secondly bargaining between the United States and developing countries is not bargaining – it has been a take it or leave it situation. There are thousands of people dying in developing countries because of trade agreements with the USA. They don't want to talk about it that way – but that is what is happening.

'It's not about trading goods - it's about losing sovereignty. And it's about helping American drug companies. It's about America pushing for a particular agenda. It has not benefited any country.

'They are not free trade agreements. They are not about free trade, but they are advantaged trade agreements. And they managed to advantage the United States at the cost of the developing countries. [8]

In Negombo, Sri Lanka in 2009, the HAIAP regional Consultation focussed on health systems and access to medicines and health care. In the context of India, Amit saw the strong growth of the for-profit sector and its relation to the decline of the public sector – the introduction of market principles in the public sector, ie user fees, contracting out, and insurance schemes with private sector participation. He provided a comprehensive history of the development in the Indian context.[9]

In regard to access to medicines in India he summarised:

- Estimated by different sources -- 50% to 80% sre not able to access all the medicines they need
- The World Medicine Report (2004) of WHO shows India has largest number of people (649 million) without access to essential medicines
- Given India is the 4th largest producer of drugs in the world and exports medicines to over 200 countries, local production/availability not major constraints.
- Studies indicate that poorer populations spend a larger proportion of health care expenditure on medicines.
- World Bank Study: out-of-pocket medical costs alone may push 2.2% of the population below the poverty line in one year

Factors that determine access to medicines include:

- rational selection and use
- affordable prices
- sustainable financing
- responsive health system.

At the final HAIAP regional Consultation before the retirement of Dr Bala, in Sri Lanka in 2010, and again looking at Financing for Health Care in India across the private and public sectors, Amit saw that prominent features of the Health Sector in India remained as growth of the for-profit sector related to the decline of the public sector. Introduction of market principles in the public sector meant user fees, contracting out and insurance schemes with private sector participation. Between 1980 and 2004, public facilities doubled whereas the private sector grew eight fold!

He emphasised that the present situation, where in excess of 80% of drugs consumed are paid for through out of pocket contribution by the consumer, is

[4] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmiSengupta2005Pricing_MfrGenericDrugs2005IndiaScenario.pdf

[5] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmitSengupt2006IntellectualPropertyOptions.pdf

[6] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmitSengupta2006PatentsObstaclesorFacilitators.pdf

[7] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmitSengupta2007GATTS_India_GovtvPeople.pdf

[8] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmitSengupta2008NDPFTA.pdf

[9] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmitSengupta2009HealthSystems.pdf

unacceptable. It is necessary to ensure availability of a majority of drugs through the Public Sector.There are no alternatives to instituting price controls -market mechanisms do not help to stabilise drug prices. What is needed:

- Revival of Public Sector Units as a priority
- Pooled Purchasing to minimise costs in the Public Sector
- Weeding out Irrational drugs as a priority.[10]

Amit Sengupta, the PHM, the Global Health Watch and HAIAP members

The historical Peoples Health Assembly (PHA1) was held in GK Savar in 2000 when, as per WHO Health for All by 2000 AD was supposed to have been made a reality. The Founders and organizers of the PHA felt there was a need to carry on the effort of Health for All Now. They included CI (Consumers international), GK (Gonoshasthya Kendra), International Peoples Health Council (IPHC), Third World Network (TWN), Dag Hammarskjold Foundation, Global Network of Women's Reproductive Rights, etc. The Global Coordinatorship and PHM Global Secretariat moved from Dr Qasem of GK to Dr Ravi Narayan, Sochara, Bangalore India, then later to Hani Serag in Cairo and Brigitte Lloyd South Africa. The Global Secretariat responsibilities and Coordinatorship were later shared between South Africa and Delhi India with Amit undertaking the responsibility of the Delhi Secretariat.

With the creation of the People's Health Movement globally and the Jan Swasthya Abhiyan in India, Amit Sengupta became deeply involved with understanding and addressing problems in healthcare due to globalisation. He coordinated the editorial group of the Global Health Watch, a people-centred initiative that highlighted social justice; an alternative to WHO's World Health Report brought out by PHM, Medact and Zed Books. Five Editions of GHW have been brought out with active engagement and coordination by Amit - reflecting his Coordination and editing skills.His work with the Global Health Watch linked him importantly with HAIAP members in their own countries.

For example, Dr Mohammad Ali Barzgar recalls the opportunity to know and work with Amit for the first time in 2003 when they were together as members of WHO Watch at the World Health Assembly; and later in Iran with the Commission on Social Determinants of Health (SDOH) preparing an analysis of the role of NGOs in attainment of SDOH.

[10] http://www.haiasiapacific.org/wp-content/uploads/2018/12/AmitSengupta2010FinancingHalthCareIndia.pdf

PHA4 and HAIAP

In November 2018 almost 1400 members of the Peoples' Health Movement came together in Bangladesh. They were to gather at Gonoshasthaya Kendra (GK) – the birth place of the movement. In collaboration with the Third World Network (TWN) a small group of HAIAP members delivered a self-organised workshop on the Challenges of Antimicrobial Resistance the in the region, see page 13.

HAIAP members also took the opportunity to meet, see page 16.

Unfortunately, unforeseen circumstances forced the relocation of the whole event at the last minute shooting up the cost in terms of finance, physical labour and mental stress.

The Bangladesh government was about to face an election and was sensitive to the presence of so many unknown foreigners. They refused to allow GK to host PHA 4 on its Campus when all arrangements had been made for the event. Amit Sengupta along with the organising team deserves the credit for leading the magic that made it possible for the whole event to be relocated and re-accommodated and the program adjusted and reprinted within 24 hours. He remained

calm, efficient and smiling throughout, taking on the pressure as he amongst the PHM Chair and coordinators was the only Bengali speaking person; and besides being Co-Coordinator PHM, he was also responsible for PHM India (JSA) with over 200 participants to PHA 4. He was just relieved and amazed that no-one had complained.

That is the Amit we will love, cherish and remember and who will never cease to inspire us.

Our heartfelt sympathy is with his wife Tripta and his son Arijit.

40 Years of Alma-Ata — Translating 'Health for All' into the Present and Future

Written in May 2018 by Amit Sengupta

The Alma-Ata Declaration of 1978 emerged as a major milestone in the field of global public health. Referring to the social, political and structural determinants of health, emphasizing the importance of accountability to the people, and proposing comprehensive Primary Health Care (PHC) as key to the attainment of the goal of Health for All, the Declaration still reads as a visionary and revolutionary text.

2018 is the year of commemorating and celebrating 40 years of the Alma-Ata declaration. The official 'AA40' celebration took place on 25-26 October 2018 in Kazakhstan.

https://www.who.int/primary-health/conference-phc

A full-day workshop critically revisited the Alma-Ata Declaration and the core principles expressed in it (in particular: addressing determinants of health; global solidarity for health equity; accountability to the people and communities, access to comprehensive health care services for all through a system structured around the principles of Comprehensive Primary Health Care) for its potential to be used as inspiration and guidance in our quest for Health for All.

The workshop was organized by a Task Group 'with representatives of Brot für die Welt, Difäm, medico international, MMI Network, People's Health Movement, World Council of Churches and World Federation of Mental Health and supported by the G2H2 Secretariat.

Read the declaration of the workshop here.[11]

He was instrumental in providing us the opportunity to learn from others. His words made us think. His actions encouraged us to walk through barriers.
Manuj Weerasinghe

Amit was above all a great humanist - weaving humour, sagacity, lived wisdom, intellectual brilliance and a love of life to his unusually intense activist life - a very admirable mix of competencies and a inspiring friend. Thank you Amit for all that you were and meant to all of us in the health movement!
Ravi Narayan

What distinguished Amit from other doctors and activists was how he combined the politics of medicine with the knowledge of medicine. Amit wanted a real change in society and worked towards that. It was not woolly-eyed idealism…… **friend and Delhi Science Forum member Prabir Purkayastha**

[11] http://www.haiasiapacific.org/wp-content/uploads/2018/12/2018KazakhstanPHCHubstatement.pdf

Memories of Amit Sengupta

AIDAN shares its deep condolences and grief at the sudden, shocking, untimely passing away of Dr Amit Sengupta, a leading activist in the Indian and Global People's Health Movement. Starting from the editing of the book in 1986, 'Drug Industry and the Indian People,' Amit was deeply involved in the advocacy for pro-people rational drug policy. Since then he had consistently worked on different aspects of pharma policy – especially on Access to Essential Medicines, national self-reliance, Intellectual Property Rights and the full use of the TRIPS flexibilities.

His important contribution to the National Working Group on Patent Laws to ensure inclusion of TRIPs flexibilities in the Indian Patents Act was widely appreciated. Amit wrote and shared the concerns for Policymakers as well as lay persons with equal ease. After the formation of the Jan Swasthya Abhiyan, as colleagues in the JSA we in AIDAN were happy to see Amit grow into the leadership role in the JSA due to his all round qualities like his unflinching commitment to the cause of People's Health, his sharp intellect and analytic mind, capacity to articulate in a simple understandable convincing manner, and involvement at grassroot levels. The sudden passing away of this fellow activist-intellectual and friend has created a big, big unbridgeable void in the movement for pro-people rational drug policy and in People's Health Movement in general. As AIDAN we join fellow activists in JSA in paying our homage to Amit.

Mira Shiva, Chinu Srinivasan and other friends at All India Drug Action Network (AIDAN)

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One of my mentors in Global Public Health and founding member of Global People's Health Movement (PHM) Dr Amit Sengupta is no more. Dr Amit Sengupta, a beloved colleague, friend, mentor and activist.
Considering my association with Health Action International since 1989 (30 years) and then with PHM from its inception, my relations with him has the same history of bonding. Whenever I met him in PHM or HAIAP meetings he starts speaking Hindi which happens to be my mother language also. So, I really enjoy listening to my native language and accent, in addition to what else I gain from comrades and colleagues.

Amit brought his enormous political, organizational and leadership capacity to PHM. The untimely demise of this special comrade and friend is an irreparable loss to all of us personally, Amit's family and for the broader health movement globally and in Pakistan.We offer our condolences and solidarity to Amit's wife Tripta and son Arijit. PHM Pakistan will continue to carry forward Amit's vision of strengthening the public health movement towards health for all.
Thank you Amit.**Shaikh Tanveer Ahmed (Chief Executive – HANDS Pakistan)**

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I'm devastated by the demise of my close friend and comrade Dr Amit. For the last four decades we were working arm in arm for the realisation of a people oriented health system for the country. We worked together with our friends for the founding of PHM (JSA) India and PHM Global in 2000. I share the grief with Amit's family and bid tearful adieu to my dear friend.

…… **B EkbalJSA (PHM) India**

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I was in disbelief when I saw the email - Amit is no more!!! It was difficult to accept the reality. Less than a week before we were all together.

It was almost 26 years ago, (1992) that I first heard the name of Amit Sengupta. I personally met him almost a decade after. Dr Mira Shiva and Dr Zafrullah Chowdhury visited Faculty of Medicine University Colombo. They were attending a meeting in Colombo and have insisted that they should visit the Department of Pharmacology from where Prof. Senaka Bilible started his struggle against Big Pharma in late 1950s. Dr. Krisantha Weerasuriya invited them to the department and arranged a brief meeting.

A few of us as medical students had just formed 'Students Involved in Rational Health Action (SIRHA)' in the Colombo Medical faculty and were looking for all the opportunities to expand our work. With the late Sanjeewa Ranwalle, Sajeewa Ranaweera, and a few others I had the opportunity of meeting Mira and Zafrullah during that brief encounter at the Pharmacology Department meeting room where Professor Bibile's photograph was kept.

As I can remember, Amit's name came up during this discussion as a possible contact point for us. In that era internet was not heard of and regular post was the only method of communication for us, so it took a couple of years for us to establish a regular contact with Amit and others beyond the Indian Ocean. Our association with Rational Drugs in Asia

(RDA) and with Dr. Balasubramamiam at International Organisation of Consumer Unions (IOCU) made it possible to establish regular contact with Amit and his work in India and elsewhere.

Amit was a true global leader who led the struggle for *Right to Health* from the forefront. He was an inspiring model for us trying to orient ourselves for a long struggle. Our main focus in SIRHA was on access to medicine. That is what we got together and fought for a considerable time. Reading and listening to Amit gave us a broader scope to act. Fight for the Right to Health - it will deliver a sustainable platform to ensure access to medicines.

He was instrumental in providing us the opportunity to learn from others. His words made us think. His actions encouraged us to walk through barriers.

The establishment of HAIAP was definitely the turning point for us in Sri Lanka to initiate regular contact with Amit. It was further galvanized by the Peoples Health Assembly 1 in Dhaka. Amit introduced us to many forums and activists across the globe who were working for the health rights movement.

Amit had major presence in Sri Lanka on three occasions within the last decade as I can recollect. The three day HAIAP meeting, IUPH in Colombo and the workshop on Building Movements for Health we had in 2016. Amit enquired from me whether PHM SL could facilitate organising the workshop in Colombo. I had no hesitation in giving my reply to him stating we are more than happy to do it. Dr Vinya Ariyarathe and Sirimal were equally interested in doing it in Colombo.

It was pleasure to work with Amit on organizing this workshop and Sarvodaya took the main load in handing the logistics. I feel it was the last occasion Amit came to Sri Lanka - two years ago.

Above all those, I had the opportunity to work very closely with Amit during last two years. He invited me to contribute to the BMJ Asia Series publication in 2017. It was a learning excercise for me - working with Amit and other colleagues on this paper titled 'The rise of private medicine in South Asia'[12]. I also had the unique opportunity to participate as a panellist with Amit and others stationed in the Habitat Centre New Delhi through a web cast from Colombo during the official launching of the publication. Continuing the same work, Amit initiated another paper on 'Tackling the primary care access challenge in South Asia'[13] for the BMJ which addressed a key issue in the Right to Health campaign. It was unfortunate that Amit could not witness the release of this publication just two days after his untimely death. The journal placed a tribute to Amit, Simply - '*Sadly, Amit Sengupta died just before publication of this article*'.
Comrade Amit, you will be with us for ever ..... **Manuj C Weerasinghe, Sri Lanka**

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A great loss....in order that he continues with us .. we should begin a portal which can be called PEOPLES HEALTH HEROES ...where there is an inspirational story of people with us who passed away ...photo, sketch, key quotes, writings ..there could be special example projects that can be replicated ...even videos ..

It's destined not as an obituary or a Roll of Honour but a case study of inspiration...a resource ...we had Shila now Amit and many more ..

Let them be with us always in this digital age ..... **Anwar Fazal**

……

It is with much sadness and feeling of great loss that we share the tragic and sad news of the untimely passing away of our dear colleague, friend, mentor, comrade in the struggle for health, Dr Amit Sengupta. Amit has been an inspiration to us all in the PHM and he was the magician of the PHA4 who really worked hard to make PHA4 happen. His passing is a big LOSS for the people and for the PHM.

We deeply mourn his untimely passing and express our condolences to his family who must also be very distraught about what happened.So long Amit. You will always be our inspiration as we carry on with the struggle for health. We love you and will forever cherish and propagate what you have taught us. We will surely miss you.

May you rest in peace. **Delen de la Paz**

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I had the opportunity to know and meet Amit first time in 2003 when both of us were a member of WHO Watch at the World Health Assembly. I , Amit , Hani Serag and Erick stayed about one week during the Assembly in Dr Woodward's

[12] http://www.haiasiapacific.org/wp-content/uploads/2018/12/bmj.RiseofPrivateMedicines-AmitSengupta.pdf

[13] http://www.haiasiapacific.org/wp-content/uploads/2018/12/BMJ-AmitSenguptaetaltackling-the-PC-access-challenge-in-SA.pdf

apartment in Geneva, while Dr Woodward was in duty mission out of Switzerland. All the three of my roommates were much younger than me. I found all of them brilliant, enthusiastic, friendly and cooperative.

Amit had a lot of sympathy and commitment for the poor people of the world and those whose voice was not heard. Also he was willing that PHM should do and would do a lot for the health and well being of the poor people of the world specially in developing countries. He was innovative, committed, honest, frank and very hopeful that a better world is possible. We had very wonderful time that week with some side events regarding Primary Health Care (PHC) and Health For All (HFA) strategy. Amit was a true believer and defender of the HFA strategy through PHC.

The second time we were together was in Porto Alec Brazil. He was super active, restless and showing a great capacity of leadership in organizing the meeting. He believed the march for a better world was possible and he delivered a good number of lectures.

When the Sustainable Development in Health Commissioners visited Iran in 2006 Amit was there. A good analysis of the role of Iran NGO's in attainment of SDOH was prepared with his assistance. The last time we met was in Quenca Equador at PHA2 in 2005. Amit was working like a locomotive - full of energy, enthusiasiasm and high aspiration with many initiatives and brilliant ideas. His death was a big lost for PHM, Global Health, poor people of the world and Health For All Strategy. We will miss great people like Dr. Mahler, Dr. Bala, and Amit in the field of public Health and will remember them always. ……. With deep Sorrow, **Mohammad Ali Barzegar.**

……

The devastating news has shattered people like me and other young activists and advocates for people's health. His exemplary life, talent and spirit will create an extraordinary void in our world.
How can we (even collectively) fill that void?
This is an extraordinary loss …. **Nafis Faizi** (Welcomed as a new member to HAIAP at PHA4)

……

Absolutely shocking news about the demise of Amit Sengupta. May he rest in peace, My condolences to his family and dear ones … **Tariq Bhutta**

……

What a shocking news, I could not believe. My heartfelt condolences to family and friends. It is an irreparable loss. May his soul Rest In Peace. ….**Pranaya Mishra**

……

It is very shocking to know of Amit Sengupta's sudden and untimely demise. I do not know him much but met on few occasions in his office while I was with WHO Country Office for India as National Technical Officer on Essential Medicines. I met him to know his views on access to medicines and how the prices impact. This was a very thorough and in depth discussion. His concern for reaching the unreached is exemplary. May his soul rest in peace. We have lost a comrade……. **Guru Mohanta**

……

To say something about Amit is difficult since I have been working with him so intensely that I can not think of continuing work in his absence.
Amit worked intensely in the area of health and medicines in multiple issues. He presented in the HAI-AP meetingson healthcare financing, GATS, Free trade agreements, access to medicines – everything.. At the same time WHO had South Asian country's meetings on the same issues. I remember one of the recommendations of their meetings was to use a *Tobin Tax*[14]which could generate enough funds for universal health care in India. Amit said let us take it up for a wide campaign establishing that free health care is possible. This became his next agenda for movement.
His work on patents/IPR issues was widely used by the political circle which finally shaped amendment in the Indian Patents Act in maximum use of TRIPS flexibility which is considered as most suitable Act in post WTO Agreement. He also helped preparing documents in legal battles like clinical trials, patent applications, and others. The movement finds itself helpless in multiple areas of the health movement and Amit was there to help …. **Amitava Guha**

……

[14]defined as a tax on all spot conversions of one currency into another. Tobin's tax was originally intended to penalize short-term financial round-trip excursions into another currency.

The sudden and unexpected demise of Dr Amit Sengupta is a huge loss to public health activities globally and for one have lost a great friend. We worked together on several issues and Dr Amit had always stood with us during tough times. His work and contribution will continue to inspire activists all over the world .... **Gopal Dabade**

……

How cruel can life be? Only a week ago, we were sitting together after the 4th People's Health Assembly in Bangladesh with the Steering Council and were planning the future work of the PHM. Now we will never here his voice, his wit, his humour, his anger about the unjustice and the status quo of this world again. His voice was clearly heard in the global arena of health politics, when he warned WHO of the increasing influence by the big philanthro-capitalist foundations and criticized the damaging results for health of Free Trade Agreements and the power and actions of Trans international profited from his knowledge, his public presence and narrative skills many times at events in Germany or at the Geneva Global Health Hub in Switzerland, we discussed with him in Frankfurt funding strategies for the PHM in a world where critical voices of the civil society are increasingly under pressure and donors are looking towards 'quick impacts' rather than sustained structures in advocacy and campaigning. We discussed and celebrated with him at the meetings of the People's Health Movement. His death is a great loss for the progressive health movement in India and globally. We grieve with his family, friends and comrades for a powerful voice for the Health Rights for All people.

Andreas Wulfmedico international - friend of HAIAP

……

Amit was based in the 'Newsclick' office and we share a tribute from Praneta Jha who had worked with him on many issues[15]**'An Ever-Accessible, Go-To Person for Those Writing on Health Sector'** -

I feel too sad for words tonight. I feel like I have lost a beloved friend in Dr Amit Sengupta, and I have (even though I would mostly only talk to him seeking understanding and analysis and resources while researching for my stories on the health sector); he was calm and gentle and patient and kind and funny and would lay your anxiety to rest. On most days, he would sit in office till late, often the last person on the first floor, his always reassuring presence still completely occupied with work on his desktop; barring the brief smoke breaks on the balcony.

I feel I have lost a mentor, my comrade, a vast and reassuring sea of commitment and knowledge (distilled and always accessible, at one place) accumulated through a lifetime of work in shaping the people's science movements in the country and in building the People's Health Movement (PHM) worldwide that is fighting for people's right to universal healthcare (not universal health coverage, mind you) in the face of the strongest attack yet of neoliberal capitalism and the International Financial Institutions dictating health policy in the Global South and killing people while destroying lives of the living who are poorer and the poorest and now even the middle classes (and packing off future generations to doom) to clear the path for unthinkable profits into an ever-shrinking size of private hands.

In these times of all the talk about 'universal health coverage' and health insurance and Modicare/Ayushman Bharat or whatever it is named next, his short Occasional Paper written for the Municipal Services Project in 2013, wherein he examines the UHC model and its impact in different parts of the world and the politics and unified economic logic behind it is a must read.[16]

Among his numerous other roles (oh, and he was trained as a medical doctor), he was the editor of *Global Health Watch*, the definitive source and repositories of healthcare developments and health movements' documentation around the world from a perspective other than that of big pharma and big capital. He recently oversaw the successful conduct of the People's Health Assembly - 4 that took place in Savar, Bangladesh from November 16-19, where people fighting in struggles for universal access to healthcare from across the world came together. Amit Sengupta was among the prominent leaders of the Delhi Science Forum, the All India People's Science Network, and founder of the PHM (and Convenor of the Jan Swasthya Abhiyan in India).

I remember he also bailed me out on the phone once (more than once, but this time it was the landline) even as he was busy at home in the evening and I was running foul of my deadline for a story on a topic I was still learning about but was feeling more confused after talking to some experts. Just knowing that he was around used to be deeply reassuring.

A reporter's personal tribute to Dr Amit Sengupta, a crusader for people's right to universal healthcare .. **Praneta Jha**

[15] https://www.newsclick.in/ever-accessible-go-person-those-writing-health-sector

[16] http://www.haiasiapacific.org/wp-content/uploads/2018/12/Universal_Health_Coverage_Beyond_Rhetoric_Nov2013AmitSengupta-5.pdf

Free Trade Agreements and the current RCEP(Regional Comprehensive Economic Partnership)

In 2007, Amit Sengupta explained to the HAIAP Forum in Colombo that Free Trade Agreements are a Paradox.

Article 24 (8b) of GAT states:

> 'A free-trade area shall be understood to mean a group of two or more customs territories in which the duties and **other restrictive regulations of commerce**(…) are eliminated on **substantially all the trade** between the constituent territories in products originating in such territories'

BUT the supposed cornerstone of the WTO is the Most-Favoured-Nation (MFN) treatment among the member-countries -- meaning that countries cannot discriminate between their trading partners

FTAs sit on top of the multilateral system, creating 'more favoured' trading partners

Free Trade – From Theory to Practice

- Assumes that those who have a 'comparative advantage' will always maintain this advantage.
- Assumes that nations that are disadvantaged due to historical reasons will continue to remain disadvantaged.
- Maintains the present balance between developed and developing nations.

India and the RCEP

The Regional Comprehensive Economic Partnership (RCEP) is a so-called mega-regional economic agreement being negotiated since 2012 between the 10 ASEAN (Association of South-East Asian Nations) governments and their six FTA partners: Australia, China, India, Japan, New Zealand and South Korea.

The stated goal of the negotiations is to *'boost economic growth and equitable economic development, advance economic cooperation and broaden and deepen integration in the region through the RCEP,'* according to the ASEAN website. From what is known of the agreement's contents, the proposed RCEP would cover almost every aspect of economy such as goods, services, investment, economic and technical cooperation, intellectual property rights (IPR), rules of origin, competition and dispute settlement

A 2015 leaked text on intellectual property rights proposed by Japan's negotiators confirmed concerns that the deal could go beyond the rules agreed to at the World Trade Organisation, known as the Trade Related Aspects of IPRs (TRIPS) agreement.

There is concern that India's trade deficit with China will increase manifold and will threaten India's growth potential and that the survival of Indian small and medium sized enterprises will be in question.

In addition, Australia's competitiveness in export of wheat, dairy and meat products, and New Zealand's competitiveness in dairy export, could make Indian agriculture and dairy sectors very vulnerable.

Implications for access to affordable medicines are alarming. Japan and South Korea are promoting demands by big pharma for longer patent terms and for monopoly rights over clinical trial data. These provisions could undermine access to price-lowering generic medicines, and thus, life-saving treatment for millions of people in the developing world

Indian activists say India cannot afford to compromise the access to medicines by agreeing to any TRIPS plus provision in the IPR chapter either and must build alliances with specific ASEAN countries like Indonesia and the Philippines, and get them to support its position.'

It was hoped the Singapore round of RCEP talks in November would lead to consensus but the talks had actually failed to reach consensus on issues of e-commerce and investment. They will have to keep going on to yet another round.[17]

At the 2009 HAIAP regional consultation on Free trade Agreements, Amit Sengupta gave an overview of FTAs in a range of countries since the introduction of these sorts of ventures. He summed up

> *'They are not free trade agreements. They are not about free trade, they are advantaged trade agreements. And they manage to advantage the United States at the cost of the developing countries.*
>
> *'It's not about trading goods; it's about losing sovereignty. And it's about helping American drug companies. It's about America pushing for a particular agenda. It has not benefited any other country.'*

Amit concluded in 2008

'Overall bilateral agreements have been a disaster, for the developing countries and for the global trading system. These FTAs are creating a world in which there are two groups – the first consists of 'my friends who can get in free' and the other consists of countries that have to pay tariffs. So it is a disaster.

'Secondly bargaining between the United states and developing countries is not bargaining. It is a 'take it or leave it' situation. There are thousands of people dying in developing countries because of the trade agreements with the USA. They don't want to talk about it that way but that is what happens.'

[17] https://www.bilaterals.org/rcep

A Statement of opposition to the Regional Comprehensive Economic Partnership was released at the 4th global people's health assembly, Savar Bangladesh, 15-19 November

We, the undersigned civil society groups and individuals, who are committed to Health For All Now and the principles set out in the Alma-Ata Declaration of 1978, condemn the secretly negotiated Regional Comprehensive Economic Partnership (RCEP) which will erode people's sovereignty and undermine health equity. We call on our governments to reject a RCEP agreement that serves *Ruthless Companies Entrenching Power* and to embrace an alternative RCEP, recognising that *Real Cooperation Empowers People.*

We reject the neoliberal free trade and investment model of RCEP because it will

- Further accelerate the race to the bottom
- deny the people our right to determine the policies that govern our lives and our health
- guarantee that commercial interests have primacy over human rights especially the right to health
- exclude peoples' participation in decisions and shield governments and corporations from accountability
- intensify climate change, the biggest threat to people and planet in the 21 century
- have a destructive impact on women's lives and livelihoods and other vulnerable groups
- worsen job insecurity and workers' rights, especially for exploited and migrant workers
- perpetuate the centuries-long genocide of indigenous peoples
- deny people's sovereignty over food, traditional medicines, and bio-diversity
- further entrench the power of pharmaceutical companies to extract super-profits for medicines and deprive millions of people from affordable treatment
- further promote the privatisation of public health services and profiteering by transnational corporations (TNCs)
- strengthen corporate lobbying and influence over health policy decisions
- embolden alcohol, tobacco, sugar, and processed food industries that are drivers of non-communicable diseases
- endanger national sovereignty by enabling foreign investors to hold our governments to ransom through investor-state dispute settlement (ISDS)
- further erode public revenue through tariff cuts and corporate tax avoidance
- transfer control over health data to untrustworthy private firms to use and abuse
- erect another barrier to a world of health for all, social justice and survival of the planet.

Recognising that *Real Cooperation Empowers People*, we demand an alternative RCEP consistent with the principles of Alma-Ata and which commits to

- the positive pursuit of internationally recognised human rights and health obligations
- universal quality public health services and a valued public health workforce
- actively empower women as the catalysts for personal and community self-determination in health and life
- achieve targets that will genuinely reverse the onset of catastrophic climate change
- guarantee access to affordable medicines through publicly provided health programmes
- food sovereignty, strong food safety standards, and health-based product labelling
- ban toxic agro-chemicals and make agricultural work safe
- impose enforceable obligations on corporations, especially foreign investors, including a strong UN Binding Instrument on Human Rights Responsibilities of TNCs
- guarantee the rights of people to control their health data
- negotiate and implement this alternative through open, participatory and accountable ways, and
- conduct participatory human rights and health impact assessments prior to, during and after agreements to ensure the alternative RCEP deliver on these goals.

Biological Drugs – Challenges to Access

Author Dr Amit Sengupta

Published by TWN just before Dr Amit Sengupta died, it is available as a small booklet from TWN publishing www.twn.my

Synopsis: In this paper Dr Amit Sengupta examines the landscape of biological medicines, and locates this analysis in the characteristics of biological drugs which set them apart from small molecule drugs (SMDs). These characteristics of biological drugs have an impact on the way these drugs are manufactured; on the development of follow-on versions of innovator biological drugs; on the way biological drugs – both innovators and follow-ons – are regulated; on the way these drugs are protected by different kinds of intellectual property rights (IPRs) and data protection mechanisms; and on the opportunities and challenges

in the introduction of biological drugs, including biosimilars, in a range of countries.

1. The Growing Therapeutic and Commercial Importance of Biologics
2. How Biological Drugs Differ from Small Molecule Drugs
3. Recombinant Technologies in the Manufacture of Biological Drugs
4. Renewed Interest in Biological Medicines
5. Why Are Biologics and Biosimilars So Expensive?
6. Biosimilars vs Generics of SMDs: Different Treatment by Regulators
7. Technological Barriers to Manufacture of Biosimilars
8. Barriers Related to Intellectual Property Rights and Data Exclusivity
9. The Evolving Regulatory Landscape for Approval of Biosimilars
10. How Necessary Are Present Requirements to Establish Similarity?
11. Uptake of Biosimilars in Clinical Practice: Interchangeability and INN

The paper concludes with the following conclusions and recommendations:

- The potential role of biological drugs in promoting real therapeutic advances needs a deeper analysis. However, current evidence suggests that they will play an increasingly major role in the future in advancing therapeutic outcomes for several autoimmune and de-generative diseases and in cancer treatment.
- Biological drugs are extremely expensive. Their high prices are a reflection of protected monopolies in the biotech sector. Further, unlike in the case of SMDs, the anticipated drop in prices after introduction of biosimilars is conventionally pegged at only around 30%. There are no clear technical reasons why price drops cannot be much sharper.
- Regulatory barriers (ie, onerous requirements for regulatory approval) are key factors preventing introduction of cheaper follow-on products of equivalent safety and efficacy. The current regulatory regimes and the underlying WHO guidelines are not in sync with advances in the science of biological products. Insistence, by regulatory agencies and in the WHO guidelines, on head-to-head comparisons, including comparative pharmacokinetic studies, between innovator products and follow-ons is no longer justifiable. Moreover, it is possible to obviate the need for expensive and difficult-to-design clinical trials given better techniques for characterization of follow-ons, which could be combined with animal studies. Regulatory regimes and guidelines, including the WHO guidelines, need to be revised taking the above into account.
- Given monopolies enjoyed by innovator biologics and their very high market prices, there appears to be little incentive available to reduce the cost of manufacture of biological products through introduction of more efficient technologies. On the other hand, the manufacturers of follow-on products appear better placed to introduce more efficient and cheaper technologies.
- Intellectual property protection, just as in the case of SMDs, promotes monopolies and prevents the early introduction of follow-on biologics. Process patents and trade secrets are major barriers to the introduction of biosimilars. In addition, the biotech industry is more aggressive in demanding data exclusivity rules. All these act as layers of barriers to the early introduction of cheaper biosimilars.
- The proposed introduction of 'Biological Qualifiers' to be tagged on to INNs for biosimilars is unjustified and WHO should not pursue this proposal.
- It is necessary to harmonize rules and allow for interchangeability between innovator products and biosimilars which have received regulatory approval. This would make uptake of biosimilars in clinical practice easier.

World Congress of Bioethics was held in Bengaluru from 3rd to 7th of December. Amit Sengupta was to contribute to the Opening Plenary and his presentation was submitted.

His slot was made available to Dr Mohan Rao and Dr Ravi Narayan to pay tribute to Amit, his life and contributions. A tribute prepared for the occasion is available.[18]

HAIAP at PHA4

Report of the Self Organised Workshop

Title: Challenges of Antimicrobial Resistance in our regions

Organised and presented by Third World Network (TWN) and Health Action International – Asia Pacific (HAIAP)
November 17, 15.00 – 17.00

Aim of the workshop: Within the two hour period allowed, the workshop aimed to increase knowledge of AMR and to develop strategies for implementing, measuring and sustaining the objectives that have been articulated in National AMR Plans to promote rational use of antimicrobial medicines and control AMR.

[18] http://www.haiasiapacific.org/wp-content/uploads/2018/12/CELEBRATING-THE-LIFE-AND-CONTRIBUTION-OF-THE-LATE-DR-AMIT-SENGUPTA.pdf

National AMR Plans can be found here under WHO Regions.[19]

Dedication: The workshop was dedicated to Dr Balasubramanian and Shila Rani Ranjith Kaur. Dr Bala guided Health Action International Asia Pacific (HAIAP) from 1988-2010, supporting and lighting the way. His spirit continues to guide and support us. We also pay tribute to Shila, a wonderful friend and a colleague, as well as the passionate and indefatigable coordinator of HAIAP between 2011 and 2017. We remembered the passing of Bala and Shila with great sadness but also with enormous love, appreciation and thanks.

Following the dedication, participants were provided with a background and overview of issues.

Background

Antimicrobial Resistance (AMR) according to the WHO's definition is a microorganism's resistance to antimicrobial medicines that once were able to treat an infection by that microorganism. Overuse and misuse of antibiotics is increasing the number of organisms that are now resistant to antibiotics world wide. In 2014 WHO called on all member countries to formulate national plans to combat AMR and now almost all member countries have identified their challenges and have their National AMR plans. Now the real work begins.

Presentations

1. **Uma Raju** presented **an overview of the AMR Situation and Challenges in Developing Countries** with emphasis on countries in our regions and the extent to which AMR is a 'ONE HEALTH' issue. She stressed the importance of not only making National AMR Plans according to the WHO template for a One Health approach, but of implementing the plans comprehensively and evaluating activities and sustaining the programs.
2. **Chee Yoke Ling** described the **challenges associated with affordable access to existing and new antimicrobials** and the use of compulsory licensing if needed.
3. Focusing on **the Indian setting Dr Mira Shira** described the enormous challenges associated with providing access to appropriate, affordable, essential antimicrobial medicines as well as controlling the use of those medicines across all sectors. India has a well thought out comprehensive National AMR Plan but in the absence of political will and effective enforced regulation, changes will not be happening. Dangerous fixed dose combinations of medicines including irrational antimicrobial medicines remain available even though their distribution is not only against national regulations but in addition banned in 2016 - then later almost entirely 'unbanned' due to pressure from pharmaceutical manufacturers. Their status remains uncertain.
4. **Dr Delen de la Paz** used **the Philippines National AMR Plan** to illustrate the situation in the Philippines. Recognising no comprehensive national health plan there is a need to improve surveillance, secure the drug supply chain, develop positive changes in knowledge and practices of prescribers, dispensers and patients; while strengthening sanitation, infection control and prevention; and research and development. Strengthening workforce capacity, controlling quality of pharmaceuticals, sustaining access to good quality pharmaceuticals and developing and enforcing use of appropriate treatment guidelines are all crucial in a frameworks of effective legislation and regulation. The success and sustainability of all actions and commitments by all stakeholders in overcoming AMR necessitates good and effective communication in all levels from planning, implementation, monitoring and evaluation.
5. Recognising that most countries in our regions have National AMR Plans in place, **Beverley Snell** suggested that now it is **time to measure the impact of the implementation of those AMR plans** and consider sustainability – if they have been implemented. Using examples from Thailand and from Australia she described ongoing programs that included situation analyses, cycles of planning targeted interventions, implementation, evaluation, incorporation of findings, re-implementation, measurement of impacts of implementation, recognition of barriers, feedback to participants, further implementation of targeted interventions, evaluations in a continuing cyclical pattern to ultimately achieve and maintain goals.

Group discussions

Two groups of around 20 each formed and their discussions were facilitated by Dr Nafis Faizi and Dr Syed Danish.

Having demonstrated specific practical issues that have been barriers or enablers to implementation of National Plans to combat antimicrobial resistance; and the need for a sustained cycle of implementation of plans followed by evaluation, measurement of impact, identification of targets for ongoing attention, organisers asked participants in both groups to address the same issues. In each group there were participants from India, Bangladesh, Nepal and Sri Lanka. Participants were able to present setting-specific issues while at the same time demonstrating significant common challenges.

Group 1 findings: Led by Dr Syed Mohammad Danish

- Irrational prescription of antibiotics by the healthcare providers (Doctors/Dentists/quacks/other traditional

[19] http://www.who.int/antimicrobial-resistance/national-action-plans/library/en/

healers) either due to incentives given by pharma companies or due to lack of knowledge for rational prescription. Rampant use of antibiotics in treating viral infections, such as influenza, the common cold, runny nose or a sore throat.

- Non-Compliance by the patients in completing the antibiotic regime due to financial reasons or lack of knowledge; example: tuberculosis regimen.
- Lack of strict regulations to check over-the-counter selling of antibiotics in pharmacies and also existence of non-certified pharmacies.
- Lack of regulations to minimise use of antibiotics in poultry and farming, current antibiotic metaphylaxis as a hurdle in 'one health' approach.
- Use of substandard and counterfeit drugs which are leading to AMR. It was also discussed that we need to be cautious while using terms like 'counterfeit' as the big pharma are using these words to malign the generics in transit. The recent WHO 'Impact' article was also discussed.
- Antibiotic stock outs in primary health care centres also lead to AMR. Example: stock out of paediatric antibiotics in PHCs in India, where adult antibiotic tablets were broken in 3 pieces and given to children. Such practices can never insure the correct dose and hence lead to resistance.
- Faecal wastes and unsafe water harbour antimicrobial-resistant bacteria and their antimicrobial resistance genes. Ensuring universal access to sanitation, hygiene and safe water in households, health facilities and schools can play an important role in prevention of resistance. Studies have shown that universal access to WASH could reduce AMR by 60%.

Group 2 Findings: pLed by Dr Nafis Faizi:

- Irrational use and prescription in Nepal and other countries depends both on the demand and supply side. On the supply side, the health professionals prescribe antibiotics irrationally and pharmacists freely provide over-the-counter antibiotics. On the demand side, many patients act like consumers and demand to be treated with antibiotics. Therefore, there it is important to focus on knowledge, attitude and behaviour of prescribers, dispensers and patients.
- Unethical marketing through Medical Representatives and other 'freebies' are a source of misinformation to the prescribers, especially doctors. Therefore, there is a need to manage the conflicts of interest from the pharmaceutical industry promotional activities and to ensure rational antimicrobial prescribing training in the medical curriculum.
- We must understand that antimicrobials have become a sort of automatic response to a number of illnesses; many of them having no role in treatment. So, the actions should be understood in terms of reflex response to prescribe or take antibiotics. It is important to remember that finger pointing towards the Doctors or Pharmacists or the Communities would not be the right starting point against irrational Antibiotic Use.
- Online marketing and over the counter sales are common and must be curbed.
- We (as CSOs and individuals) should make it a point to monitor the implementation of National Action Plans in our respective countries.
- Tightened regulations, a legally binding drug policy under the hands of the government with adequate response to socio-economic conditions that lead to infections are important.
- Under the one health agenda, we should stop using antimicrobials in agriculture and animal rearing and make necessary regulatory changes to cover these issues.
- Timely updated Standard Treatment Guidelines are required to discourage the irrational prescription of antibiotics.
- We (JSA, NAPM, FMRAI etc) plan to conduct a One Day Consultation Program on Antibiotic Resistance for further discussion and planning on how to work in this agenda and how to involve communities in this battle against AMR.

Dr Nafis summed up:

In the absence of a proper regulatory environment, AMR Plans are toothless.

The legal system must be supported by:

- Optimal awareness among professionals in all the 'One Health' communities as well as in community people.
- Meticulous infection prevention and control (IPC) to avoid fostering the development of nosocomial MDR organisms.
- Availability of regularly updated protocols and treatment guidelines and optimal understanding among prescribers of the use of protocols and standard treatment guidelines.
- Immaculate records including prescribing and medicines use, laboratory and microbiology findings, other relevant stock use, that allow monitoring and surveillance and information that guides ongoing AMR Plan implementation as well as maintenance of appropriate stock levels of the right essential medicines.

Antimicrobial Stewardship teams should develop Terms of Reference to cover their particular 'constituencies' and these teams should be adequately supported financially, politically and with appropriate human resources.

HAIAP and TWN websites will be kept up to date, with user friendly and topical material.

Conclusions

Within a very limited time we were able to define and share key issues associated with Antimicrobial Resistance and many of the challenges and barriers

associated with controlling AMR and working towards sustained quality use of antimicrobial medicines across all sectors.

The two groups were able to see where the challenges lay and were able to suggest feasible strategies to overcome challenges and work towards optimal understanding and use of antimicrobial medicines in all sectors.

Political commitment has been demonstrated by the formation of National AMR plans and operational plans of activities. But Plans must be implemented, evaluated and sustained.

Most of the framework for controlling AMR depends on the legal system: regulation of marketing, regulation of persons and their practices including prescribing, of availability of products in human, animal and environmental sectors, of premises where products are available or distributed and on penalties for non-compliance with legal issues.

HAIAP - Looking forward from PHA4

Marking the 40th anniversary of Primary Health Care declaration of Alma Ata the 4th People's Health Assembly (PHA4) was held near Savar in Bangladesh 15-19 November 2018 - 18 years after the first People's Health Assembly was held at Gonoshasthaya Kendra.

A core group of HAIAP members was among participants and fortunate to have the opportunity to come together as a group during the event to consider the future.

A vote of sincere thanks was expressed to TWN for their ongoing support and assistance to HAIAP since the passing of our coordinator, Shila, in 2017. Shila had been based at TWN since the transfer of HAIAP from Colombo to Penang in 2010.

The group unanimously agreed that HAIAP should continue as a living organisation even without funding, and members wished also to continue as a tribute to Dr Balasubramaniam and the other founders: Dr Zafrullah Chowdhury, Dr Mira Shiva and Dato Anwar Fazal. Dr Zafrullah emphasisied that HAIAP had been ***the*** organisation that has pushed Access to Essential Drugs as a priority issue.

Beverley Snell was asked to continue in the role as virtual coordinator - with TWN as a continuing base - sharing information through the website and HAIAP News and facilitating communication between members in collaboration with Uma Raju from TWN - with a view to secession to Uma. Uma had worked closely with Shila while HAIAP was based at TWN in Penang.

The demand for ***Where There are No Pharmacists*** continues and copies are almost finished. Suggestions for updates in a revised edition include expanded attention to antimicrobial resistance and rational use of antimicrobial medicines.

Infection control needs more emphasis and it was unanimously agreed that more attention be given to facilitating the most beneficial use of medicines by older adults.

As there are currently no funds for re-printing, the publication can be made available electronically. That proposal has been accepted by the relevant people at TWN who share ownership with HAIAP. However, we still believe that the printed copy is easiest for field workers to use. The update will be undertaken by the authors and further printing will also be explored.

We anticipate continued sharing and supporting members in important setting-specific activities. Activities might include advocacy concerning renunciation of trade agreements, for access to new Hepatitis C, cancer medicines and other essential new expensive medicines – as well as rational use of medicines and related issues such as the banning of FDCs in India.

We look forward to sharing a fruitful new year.

Latest News from HAI Europehttp://www.haiweb.org

(18 December 2018) A Year at the Heart of Regulatory Decision Making

(13 December 2018) TRIPS Flexibilities and Access to Medicines: A European Approach

(7 December 2018) HAI and Snakebite Programme Partner, James Ashe Antivenom Trust, Applaud Government Action on Antivenom at Bio-Ken Snakebite Symposium

(6 December 2018) Dutch Government Not Living up to Promises to Make New Medicines Affordable

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