August 2018

HAI AP News

Penang, Malaysia
Web: http://www.haiasiapacific.org
Chair: Dr Niyada Kiatying Angsulee <niyada.k.ang[AT]gmail.com>
Ed: Beverleyfsnell(AT)gmail.com

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

August Message

This issue of HAIAP News recognises the anniversaries of Alma Ata – PHC – 40 years, WHO and UK NHS – 70 years and the 1918 Flu epidemic - 100 years.

We also share some of the many achievements of one of our member organisations - HANDS - Health and Nutrition Development Society in Pakistan. Over a period of 37 years HANDS programs expanded from Health, Nutrition and Education sectors to include Disaster Preparedness and Response, Water and Sanitation, Micro Credit, Gender and Development, and secondary care facilities, empowering people with disabilities, training for income generation, and more, in a population of more than 22 million.

Almost all countries in our regions now have their National Antimicrobial Resistance Plans and news of the challenges of AMR is being circulated. We share some of the current news of resistance.

Preparations are already progressing for Antibiotic Awareness Week 2018 from November 12-18. The focus is on the correct use of antibiotics and we look forward to getting reports of members' activities during the 'week' so they can be shared in the December HAIAP News.

Another very important event to look forward to is PHA4. The Fourth People's Health Assembly is taking place between 15 and 19 November 2018 in Dhaka, Bangladesh hosted by Gonoshasthaya Kendra. PHA4 will provide a unique space for strengthening solidarity, sharing experiences, mutual learning and joint strategising for future actions.

The details can be seen here

https://archive.phmovement.org/en/node/10805

We look forward to some very active and fulfilling months.

2018 – A year of anniversaries

Alma Ata – PHC – 40 years

WHO and UK NHS – 70 years

1918 Flu epidemic - 100 years

Alma Ata – PHC – 40 years

http://www.internationalhealthpolicies.org/40-years-alma-ata-middle-age-or-a-mid-life-crisis/

In the International Health Policies Journal the piece was headed:

40 years Alma Ata: middle age or a mid-life crisis?

The author Kristof Decoster, a man in his 40s, reflected that 'the original Alma Ata vision has not really materialized. Not by 2000, and not by 2018 either. With a bit of imagination, it feels a bit like how quite a few men, when they get 40, begin to reflect on their journeys and lives so far and realize that many of their dreams have not been realized (or worse)'.

Doom and gloom descriptions follow and the author notes

> *'Alma Ata 2.0 should try to spell out what the world needs to do to avoid such a doom scenario. In a world of disorder and chaos, PHC and the like will almost certainly remain pipe dreams. I hate to say so, but economists (preferably of the Kate Raworth kind) should probably be on the front rows in Almaty.*
>
> *'There's not much wrong with the vision and core principles of Alma Ata, and no doubt if 'Health for All' and PHC are to be reached by 2030, we can build on many insights and lessons from the past. Still, in the current draft, I miss a bit of unpredictability, nonlinearity, anticipation of chaos/doom, tipping points, … In short, a bit of complexity (theory).*'

In the run up to the 2018 WHA **Sameera Hussein** CIHR Health System Impact Fellow provided a **Short reflection on the workshop (Geneva, 18 May)** ***'40 years of Alma Ata: Translating 'health for all' into the present and the future'***

http://www.internationalhealthpolicies.org/author/sameera-hussain/

In the run-up to the 71st World Health Assembly (WHA), the Geneva Global Health Hub (G2H2) organized an excellent workshop on '40 years of the Alma-Ata: Translating Health for All into the Present and Future', bringing together academics and civil society organizations from around the world. We can only hope that the ideas discussed in the workshop (and summarized here) will materialise in the near future, as well as inspire many participants at the WHA in the years to come.

The opening plenary began with a reading by panel members of the Alma Ata Declaration (1978), and was powerful and inspiring. Unfortunately, it also felt more than a bit sad - almost two decades beyond the 2000 deadline for realizing 'Health for All'. Eighteen years into the 2000s, inequities in health have risen, despite the better health outcomes many analyses report. The planet is not in very good shape either.

Calling for a revival of the vision of the Alma Ata declaration (some call it 'Alma Ata 2.0'), participants focused on several key areas in follow-up sessions:

- Going beyond the health sector: addressing root causes and determinants of health inequity
- Cooperation and solidarity beyond charity: health and social justice as a human rights and a global public health obligation
- Primary health care compared with Universal Health Coverage
- Communities: from objects to full participation and ownership.

An important reminder for those of us working in the civil society space was the issue of its decline in many parts of the world.

All in all, workshop participants reckoned realising the vision of Alma Ata and Health for All is 'more urgent than ever'. That's probably an understatement.

An interesting take home message from the day's proceedings was a comment/query from the People's Health Movement (PHM - interesting, at least for me - 'Is UHC as it is conceived really PHC?', noting that UHC, referring to Universal Health Coverage rather than Universal Health Care, reflects an economic and market-driven language that is counter to the move toward finally realizing the (comprehensive) Primary Health Care vision of the Alma Ata Declaration of 1978.

The conspiracy theorists among us don't think that's a coincidence.

The PHM commented on the Draft Declaration for the Second International Conference on Primary Health Care

https://phmovement.org/peoples-health-movement-comments-on-the-draft-declaration-for-the-second-international-conference-on-primary-health-care-towards-universal-health-coverage-and-the-sustainable-development-goa/

> *While recognising the importance of having a declaration arising from the Astana conference, which reaffirms the importance of Primary Health Care (PHC), we would like to state upfront, that for PHM, the Alma Ata declaration has defined PHC and continued to guide and inform PHM's work (and indeed that of many member states) on PHC. The definition and principles enshrined in the Alma Ata are ones we have not achieved and that we should still be*

striving to achieve. This declaration should upfront state this, and reaffirm the Alma Ata declaration

PHM concluded

Throughout the document, we note that primary health care is being translated as 'public health and primary care'. While we welcome the focus on public health (preventive and promotive actions), we are concerned that aspects of comprehensive PHC, eg rehabilitative and palliative components are absent.

We are concerned that there is insufficient reference to the responsibilities and role of governments and the declaration as currently worded risks placing most responsibility on the shoulders of individual citizens.

We would also like to reaffirm the Alma Ata declaration statement that better health for all the people of the world can be attained through a fuller and better use of the world's resources, and the recognition that a considerable part continues to be spent on armaments and military conflicts - and that as stated in the Alma Ata Declaration: 'A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.'

We would like to emphasise a point made in our response to the first draft 'The whole document fails to provide a critique of the corporate private sector and the evidence that a high level of private sector involvement is inimical to PHC and the achievement of UHC in particular. UHC should be defined as universalist, based on social solidarity and built mainly on a unified public funded system, with most service provision through public institutions. The problems of privatisation of health systems need to be highlighted – and the benefits of publicly funded and publicly provided and comprehensive services, free at the point of use stressed.'

Early in the year *The Lancet* welcomed two anniversaries - Declaration of PHC- 40 years - and the birth of the NHS in UK – 70 years

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30003-5/fulltext

'In the UK, the **National Health Service (NHS)** is 70 years old in July, and the global health community will mark the 40th anniversary of the **Alma-Ata Declaration on Primary Health Care** at a conference on Oct 25–26 in Almaty, Kazakhstan. Common to both anniversaries will be recognition of universal health coverage (UHC) as a goal, and the place of primary health care in achieving that goal.

The Lancet was quite optimistic about PHC.

'The 1978 Declaration of Alma-Ata was the first international declaration to advocate for primary health care as the main strategy to achieve WHO's stated goal of health for all. Since then, strong primary care systems, based in local communities, are recognised to be essential to achieving UHC. The core values and principles of the 1978 Alma-Ata Declaration still stand, while the Declaration 2.0 to be discussed in October is expected to renew the emphasis on primary care as the main driver of people-centred health systems leading to UHC. Zsuzsanna Jakab, WHO Regional Director for Europe, told *The Lancet* 'Making health care truly universal requires a shift from health systems designed around diseases and health institutions towards health systems designed around and for people'. Yelzhan Birtanov, Minister of Health of Kazakhstan, recognised the 'need to focus on non-communicable diseases, which are responsible for 70% of deaths globally, and the role that the citizens should be playing in health prevention and protection by actively participating in the maintenance of their health status.'

The Lancet observed that the UK **National Health Service (NHS)** was founded in 1948 to provide a comprehensive health service based on clinical need, not on the ability to pay, and available to all. The NHS is admired by many for its ambitious goals and achievements but in its 70th year, the NHS now faces a

genuine crisis. As recognised by a House of Lords Select Committee report in April, 2017, the biggest internal threat to the sustainability of the NHS is the lack of a long-term strategy to secure an appropriately skilled, well trained, and committed workforce. Last month, the first step to remedy this gap was taken with the publication of a draft strategy for the health and care workforce for England. Published by Health Education England, the draft is open for consultation until March 23, and the final strategy will be published in July, 2018.

Specific measures recommended by the draft strategy include targeted retention schemes; improvements to medical training and career support, especially where there are the biggest shortfalls in doctors such as in primary care (general practice) and psychiatry; a technology review; and making the NHS a more inclusive, family-friendly employer.

A key priority is recruitment and retention of primary care staff, particularly general practitioners.

***The Lancet* continues:**

With 2018 set to be a crucial year for the NHS and more generally for primary care globally, now is the time for bold thinking and action on reforms to ensure a sustainable future. Almaty Declaration 2.0 could shape the future of primary health care. A partnership between the London School of Economics and *The Lancet* will result in a Commission on the future of the NHS, which aims to report in 2019. The health workforce is an often underestimated critical component to all health strategies and is where substantial investment should be made.

WHO 70 years

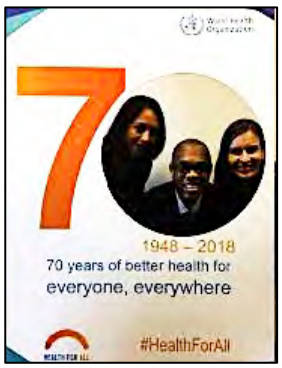
WHO succeeded the League of Nations' Health Organization, and Its establishment was approved by the UN Conference in San Francisco, USA in 1945. The WHO Constitution was drafted by a committee, chaired by Dr Brock Chisholm, who became WHO's first Director-General in 1948. The Constitution was approved by Member States during the International Health Conference in New York, USA.

The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948.

The following statement was released by WHO April 5 2018:

http://www.who.int/mediacentre/news/releases/2018/who-at-70/en/

WHO at 70 - working for better health for everyone, everywhere



Over the past 7 decades, WHO has spearheaded efforts to rid the world of killer diseases like smallpox and to fight against deadly habits like tobacco use. This year, World Health Day was dedicated to one of WHO's founding principles: '*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'*

'Good health is the most precious thing anyone can have,' says Dr Tedros Adhanom Ghebreyesus, WHO Director-General. 'When people are healthy, they can learn, work, and support themselves and their families. When they are sick, nothing else matters. Families and communities fall behind. That's why WHO is so committed to ensuring good health for all.'

The tagline for this year's World Health Day was 'Universal Health Coverage: everyone, everywhere'. WHO offices worldwide organised events to mark the day, with Dr Tedros joining celebrations in Sri Lanka.

The press release was issued under the following headings

- **70 years of progress**
- **Producing international reference materials**
- **Making a difference on the ground**
- **Responding to new challenges**
- **Using data to target our efforts**
- **Remaining on constant alert**

The Peoples Health Movement (PHM) commented on WHO at the time of the election of the new WHO Director General the former Minister of Health of Ethiopia, Tedros Adhanom Ghebreyesus in May 2017

The PHM preliminary reaction in May 2017

http://www.haiasiapacific.org/?page_id=1578

The WHO faces possibly its biggest crisis since it was set up in 1948. Its finances are in shambles and it faces a USD 500 million deficit this year – potentially meaning many work programs will not go forward and staff might be laid off. For years now the WHO has been dependant on donor funds (mainly from rich countries and Foundations like the BMGF) rather than through secured funding from countries. As a result, currently, 80% of WHO's funding is tied to programs that donors cherry pick.

Work programs that are vital to WHO's mandate as a norm setting organisation remain under funded as they clash with the interests of big donors – especially rich countries of the North. Consequently WHO's role as a leader in global health has been supplanted by other intergovernmental bodies such as the World Bank, and increasingly by big foundations like the BMGatesF. The organisation's effectiveness has come under question, especially after its lack lustre role in containing the Ebola epidemic of 2014 in West Africa.

These are the challenges that Tedros is facing. While it appears that the low income countries have voted against the domination of big powers, often through back room manoeuvres, it is yet to be seen if this unity will be maintained when the WHO debates different

issues where the rich and poor countries are often arrayed against each other.

100 years – after the 1918 flu epidemic.

One hundred years of progress, but where now?

Wendy Barclay and Peter Openshaw

https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(18)30272-8/fulltext

In the Lancet Respiratory Medicines Wendy Barclay and Peter Openshaw reported:

Controversy still surrounds the nature of the direct ancestors of the 1918 virus, with some people believing it to be derived directly from an avian precursor. It is pertinent that host responses in non-human primates infected with the reconstituted 1918 virus share some similarities with responses in animals infected with the zoonotic avian influenza virus H5N1.

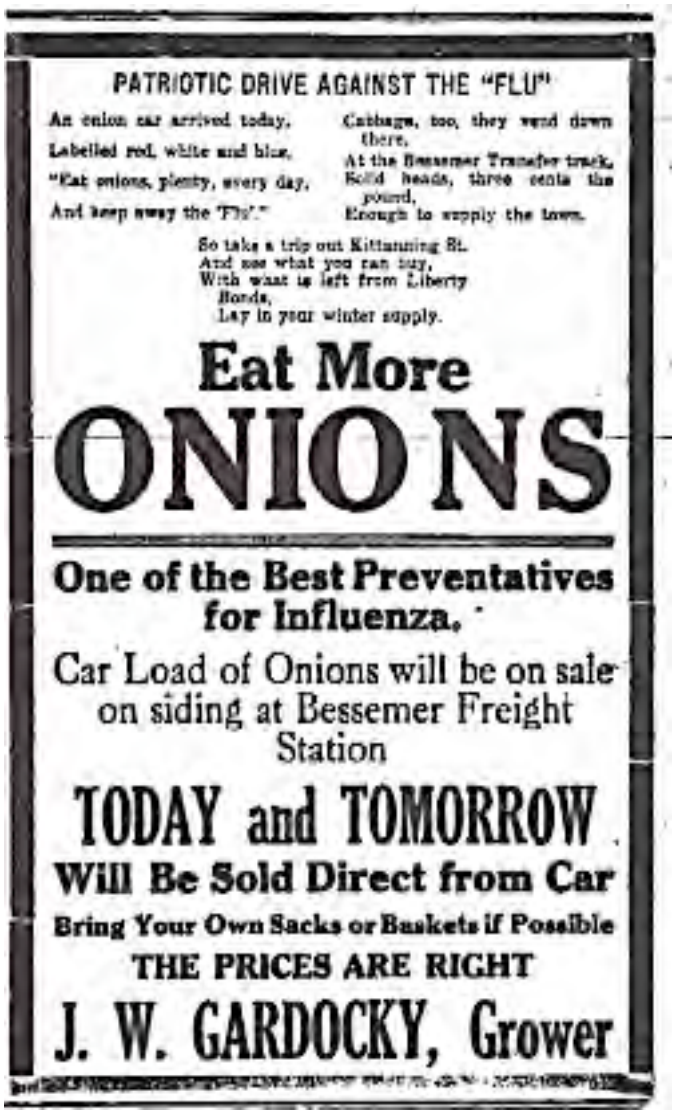
In the years that followed 1918, the pandemic virus transformed into seasonal influenza and accumulated mutations that calmed its behaviour.

Although the 1918 influenza virus is especially virulent in cells and experimental animal models, a strong body of evidence implicates other pathogens in the extreme loss of life of the pandemic: most of the human victims were co-infected with bacteria such as *Streptococcus pneumoniae, Strep.pyogenes* or *Staphylococcus aureus*.

In 1918 an exceptional number of influenza-related deaths occurred in relatively young healthy adults between 15–30 years of age.

Just as in 2009, and in the H1N1 mini-pandemic of 1977, people older than a certain age who had been infected in early life with a virus of similar antigenicity were likely to have either maintained sufficiently high levels of antibody or retained immunological memory that was quickly activated to protect them from infection or disease.

In the 2013–14 influenza season, people in their 50s were particularly vulnerable to an antigenically drifted version of the H1N1 pandemic virus. Why were children aged 5–15 less likely than 25-year-olds to succumb to infection in 1918?



Barclay and Openshaw: Understanding the exceptional impact of the 1918 influenza pandemic, including the immunological explanations for the atypical age-related sensitivity to virus infection, might have important implications for dealing with future influenza pandemics: at a time when the world is calling for new approaches to influenza vaccination, we are embarking on novel vaccination strategies that induce quite different arms of the immune response to those engaged by traditional vaccines or natural immune responses. It is important that we consider the possible immunological ramifications of these innovations on the outcome of infection by contemporary and future influenza viruses.

‘Spanish’ influenza - *the mother of all pandemics*

Mark Honigsbaum

In *Lancet Perspective - the Art of Medicines*
www.thelancet.com Vol 391 June 23, 2018

In this article Honigsbaum looks more from a social and historical perspective. Excerpts are presented here:

He notes that in 11 months between the spring of 1918 and the winter of 1919, influenza killed at least 50 million people worldwide. That is 40 million more than perished on the killing fields of Flanders and northern France and 10 million more than AIDS has killed in nearly 40 years. The result is that a disease event that medical historians once described as ‘forgotten’ is now anything but. On the contrary, the 1918 pandemic has become a subject of respectable academic study and something of a global publishing phenomenon.

‘It has been the dream of scientists working on influenza for over a half century to somehow obtain specimens of the virus of Spanish influenza, but only something as unlikely as a time capsule could provide them’, ventured Crosby in 1976.

In 1997, however, scientists based at the US Armed Forces Institute for Pathology obtained just such specimens, not from a time capsule but from an overweight Inuit woman, known as ‘Lucy’, who had been buried in a mass influenza grave overlooking the Seward Peninsula in Alaska. The permafrost had preserved just enough of Lucy’s lung tissue to enable the molecular pathologists Jeffrey Taubenberger, Anne Reid, and their colleagues to retrieve fragments of influenza virus from her cells.

Although most people in 1918 suffered nothing more serious than a mild illness, in about 2·5% of cases the virus penetrated deep into the respiratory tract causing extensive inflammation and cyanosis, a ghastly mauvey-blue discoloration of the lips, ears, and cheeks as victims’ lungs filled with choking fluids. This could explain why, in association with secondary pneumonia-causing bacteria, the death toll was so high. However, it does not explain why two-thirds of the victims were adults aged between 20 and 40 years, which is the reverse of most influenza seasons where mortality falls most heavily on people aged 60 years and older or children aged 5 years or younger.

The source of the virus:

Theories around the source of the virus are examined - from US military camps to Europe or the other way round - from a pre-pandemic wave in Copenhagen, Denmark, in the early summer; or from a vast military hospital at Etaples in northern France near migratory bird routes.

Seven of the eight genes of the 1918 virus closely resembled influenza genes found in birds in North America. That would seem to support the claim by John Barry, the author of The Great Influenza, that the pandemic strain originated in a remote farming community in southwest Kansas from where it spread to Camp Funston, Fort Riley, and other large US Army training camps along the eastern seaboard of the USA, before being introduced to northern France via American transatlantic troop carriers.

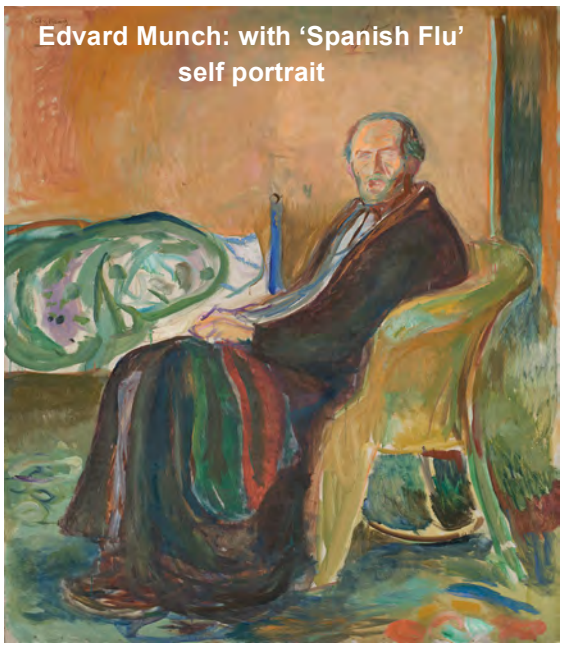
The whole article is worth reading. It can be read here:

http://www.haiasiapacific.org/wp-content/uploads/2018/08/LancetRevisit1918Flu.pdf

See Lancet Exhibition
http://www.haiasiapacific.org/wp-content/uploads/2018/08/LancetOutbreakEpidemicsExhibition.pdf

Understanding, preventing, and stopping epidemics
www.thelancet.com Vol 391 June 23, 2018

Also CDC https://wwwnc.cdc.gov/eid/article/12/1/05-0979_article



Edvard Munch: with ‘Spanish Flu’ self portrait

The 1918 flu epidemic – Correcting the Myths: *The Conversation* *'Flu series 2018*

https://theconversation.com/the-greatest-pandemic-in-history-was-100-years-ago-but-many-of-us-still-get-the-basic-facts-wrong-89841

1. The pandemic originated in Spain

No one believes the so-called 'Spanish flu' originated in Spain. The pandemic likely acquired this nickname because of World War I, which was in full swing at the time. The major countries involved in the war were keen to avoid encouraging their enemies, so reports of the extent of the flu were suppressed in Germany, Austria, France, the United Kingdom and the U.S. By contrast, neutral Spain had no need to keep the flu under wraps. That created the false impression that Spain was bearing the brunt of the disease.

In fact, the geographic origin of the flu is debated to this day, though hypotheses have suggested East Asia, Europe and even Kansas (see previous page).

2. The pandemic was the work of a 'super-virus'

The 1918 flu spread rapidly, killing 25 million people in just the first six months. This led some to fear the end of mankind, and has long fuelled the supposition that the strain of influenza was particularly lethal.

However, more recent study suggests that the virus itself, though more lethal than other strains, was not fundamentally different from those that caused epidemics in other years.

Much of the high death rate can be attributed to crowding in military camps and urban environments, as well as poor nutrition and sanitation, which suffered during wartime. It's now thought that many of the deaths were due to the development of bacterial pneumonias in lungs weakened by influenza.

3. The first wave of the pandemic was most lethal

Actually, the initial wave of deaths from the pandemic in the first half of 1918 was relatively low.

It was in the second wave, from October through December of that year, that the highest death rates were observed. A third wave in spring of 1919 was more lethal than the first but less so than the second.


PUBLIC MEETINGS ARE FORBIDDEN

Sweeping Order Issued by Health Board to Prevent Influenza Epidemic.

WARNING AGAINST VISITING

Scientists now believe that the marked increase in deaths in the second wave was caused by conditions that favoured the spread of a deadlier strain. People with mild cases stayed home, but those with severe cases were often crowded together in hospitals and camps, increasing transmission of a more lethal form of the virus.

4. The virus killed most people who were infected with it

In fact, the vast majority of the people who contracted the 1918 flu survived. National death rates among the infected generally did not exceed 20 percent.

However, death rates varied among different groups. In the U.S., deaths were particularly high among Native American populations, perhaps due to lower rates of exposure to past strains of influenza. In some cases, entire Native communities were wiped out.

Of course, even a 20 per cent death rate vastly exceeds a typical flu, which kills less than one per cent of those infected.

5. Therapies of the day had little impact on the disease

No specific anti-viral therapies were available during the 1918 flu. That's still largely true today, where most medical care for the flu aims to support patients, rather than cure them.

One hypothesis suggests that many flu deaths could actually be attributed to aspirin poisoning. Medical authorities at the time recommended large doses of aspirin of up to 30 grams per day. Today, about four grams would be considered the maximum safe daily dose. Large doses of aspirin can lead to many of the pandemic's symptoms, including bleeding. However, death rates seem to have been equally high in some places in the world where aspirin was not so readily available, so the debate continues.

6. The pandemic dominated the day's news

Public health officials, law enforcement officers and politicians had reasons to underplay the severity of the 1918 flu, which resulted in less coverage in the press. In addition to the fear that full disclosure might embolden enemies during wartime, they wanted to preserve public order and avoid panic.

But officials did respond. At the height of the pandemic, quarantines were instituted in many cities. Some were forced to restrict essential services, including police and fire.

7. The pandemic changed the course of World War I

It's unlikely that the flu changed the outcome of World War I, because combatants on both sides of the battlefield were relatively equally affected.

However, there is little doubt that the war profoundly influenced the course of the pandemic. Concentrating millions of troops created ideal circumstances for the development of more aggressive strains of the virus and its spread around the globe.

8. Widespread immunization ended the pandemic

Immunization against the flu as we know it today was not practiced in 1918, and thus played no role in ending the pandemic.

Exposure to prior strains of the flu may have offered some protection. For example, soldiers who had served in the military for years suffered lower rates of death than new recruits.

In addition, the rapidly mutating virus likely evolved over time into less lethal strains. This is predicted by models of natural selection. Because highly lethal strains kill their host rapidly, they cannot spread as easily as less lethal strains.

9. The genes of the virus have never been sequenced

In 2005, researchers announced that they had successfully determined the gene sequence of the 1918 influenza virus. The virus was recovered from the body of a flu victim buried in the permafrost of Alaska, as well as from samples of American soldiers who fell ill at the time.

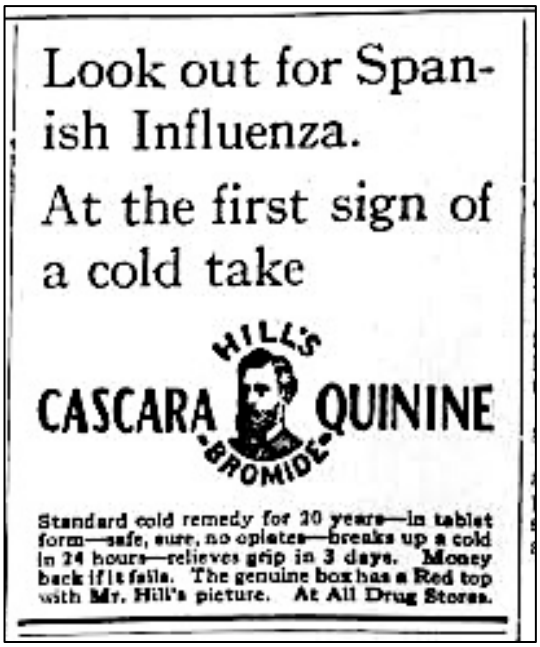
Two years later, monkeys infected with the virus were found to exhibit the symptoms observed during the pandemic. Studies suggest that the monkeys died when their immune systems overreacted to the virus, a so-called 'cytokine storm.' Scientists now believe that a similar immune system overreaction contributed to high death rates among otherwise healthy young adults in 1918.

10. The 1918 pandemic offers few lessons for 2018

Severe influenza epidemics tend to occur every few decades. Experts believe that the next one is a question not of 'if' but 'when.'

While few living people can recall the great flu pandemic of 1918, we can continue to learn its lessons, which range from the common sense value of hand-washing and immunizations to the potential of anti-viral drugs. Today we know more about how to isolate and handle large numbers of ill and dying patients, and we can prescribe antibiotics, not available in 1918, to combat secondary bacterial infections. Perhaps the best hope lies in improving nutrition, sanitation and standards of living, which render patients better able to resist the infection.

For the foreseeable future, flu epidemics will remain an annual feature of the rhythm of human life. As a society, we can only hope that we have learned the great pandemic's lessons sufficiently well to quell another such worldwide catastrophe.



Feature: The ongoing work of HANDS in Pakistan

Prepared with the assistance of Dr Sheikh Tanveer Ahmed

Compiled from information provided by the Health and Nutrition Development Society (HANDS), Pakistan, with the assistance of Dr Tanveer Ahmed.

It is impossible to do justice to the achievements of Pakistan community based organisation HANDS. However we highlight some significant areas of work that have proved challenging in many settings.

HANDS was founded by Prof. A. G. Billoo (Sitara-e-Imtiaz) in 1979 and has evolved using an integrated development model as one of the largest Non Profit Organizations in Pakistan. After 37 years HANDS has expanded to serve more than 22.2 million people in more than 17,000 villages and settlements in 48 districts of Pakistan. HANDS strength is 12 volunteer Board Members, > 5,000 full time staff and thousands of community based volunteers and more than 6,100 partner organizations. See http://hands.org.pk/live

The 2016/17 Profile provides updates of all the areas covered by this astounding program.
http://www.hands.org.pk/UNDP2/Profile%202016-17.pdf

In the introduction to the 2016/7 Profile, chairman Prof. A. G. Billoo explains '

'HANDS has evolved in 37 years as one of the largest Non-Profit Organization of the country with integrated development model and disaster management expertise. HANDS has a network of 33 district branches across the country (till June 2016) and has access to more than 22.2 million population in more than 17,000 villages/ settlement of 48 districts of Pakistan. These branches are supported by 6,100 medium and small size organizations' network in Pakistan.

This publication is an attempt to share the experiences of last 37 years and Best Practice models of each program. We at HANDS have successfully applied these models in our intervention for our communities. These models are offered here to all the developing organizations to take advantage from our experiences and replicate these models in their respective intervention areas. We are providing this opportunity for others to learn from our lessons and success stories in the process of implementation and not to go through the same learning cycle through which we have gone in all these years'.

The organization gradually gained momentum through its wide ranging activities/interventions.

Programs expanded from Health and Education sector to Water and Sanitation, Micro Credit, Gender and Development, and secondary care facilities. The services of the organization scaled up to upper Sindh and lower Punjab after agreeing to do a project of capacity building on Family planning. By 2006 HANDS reached a total 15 projects with annual budget of Rs. 40 million.

Then 10 more District Disaster Risk Reduction Centers were included and one Provincial Disaster Risk Management Centre; and in 2012 HANDS reached a network of 31 offices across the country with access to more than 16 million people in 20,274 villages in 34 districts. Under the HANDS leadership community skills and capacity to deal with natural disasters including floods and earthquakes have developed along with capacity for community resilience and early response. http://hands.org.pk/live/?p=6069

A degree awarding Institute of Development Studies (at Gadap Karachi Pakistan) has been established to complement services for poor communities.

Universal access to health care: Marginalized Area Reproductive Health Viable Initiative (MARVI)

As described in the HAIAP News December 2012 http://hands.org.pk/live/?p=5865, HANDS recognised that there were women who remained marginalised and cut off from the PHC services and in addition there were areas with no Lady Health Workers (LHWs) – the community health workers who provided the crucial links between the Primary Health Care program and the community. There was a need for another level of health worker to ensure links with marginilsed women and to support their access to the PHC program. The concept of MARVI workers was born.

The MARVI workers are now integrated or partnered with *Model Integrated Society for Action and Learning Initiative* (MISALI) workers so there are 3,604 Misali/Marvi Workers in 4 provinces and 20 districts of Pakistan, accessing a population of approximately 4 million poeple.

For behavior change different strategies are being used including Information Communication Technology (ICT) based mobile applications with recorded health education messages.

The health services are integrated with social mobilization, income generation opportunities, gender empowerment and other program components.

Ongoing challenges

HANDS understands the grave issue of climate change and global warming and encourages climate smart programming throughout its interventions. The HANDS Institute of Community Development (ICD) has been designed to keep its carbon footprint to the lowest: from the innovative design of buildings to make best use of natural air and light, to the 48 KW solar system which has been designed to cater for the power needs of the campus.

Furthermore, a wetland has been constructed to support the drainage for this institute and to grow plants and trees as well.

The staff can enjoy a healthy working environment by participating in outdoor sports which include cricket, football, volleyball and basketball.

There is a kilometer long jogging track and bicycles are available for men and women to ride within the premises. Staff feels that this is an ideal working environment that helps make them more productive than ever.

The ICD will be able to train up to 500 managers in a year. Course include:

- Organizational Management
- Community Health Services
- Community Education Services
- Livelihood Enhancement
- Resilience in Community Infrastructure
- Logistics and Procurement
- Monitoring and Evaluation

Horticulture, community and home gardening and chicken keeping

Community skills have been developed to provide access to a reliable supply of good food and possibility for income generation from the sale of produce.

Empowerment and inclusion of people with disabilities

Identification of people with disability and their support has been included in health interventions of the organization. The Marvi worker model intervention includes this component and is integral part of identification and health interventions.

The Rehabilitation Mobile Unit:

HANDS has been working in partnership with other NGO/Orthopedics health staff in identifying limbless persons, mobilizing them and fitting them with artificial limbs in various districts of Pakistan through the Mobile Prosthetic Rehabilitation Unit. So far, around 14,000 patients have been assisted in these camps; 1140

patients have been screened and approximately 450 patients are provided with artificial limbs and orthotic support. Referral for orthopedic surgical corrections has been provided for 350 patients and 500 were referred for Physiotherapeutic Rehabilitation.

Independence and self esteem are fostered along with skills to support economic independence.

Independent Living Centre

The Independent Living Centre (ILC) is an advanced facility and unique resource for disabled people. It is a consumer based and consumer controlled centre rather than a social service.

Services and training offered for people with disabilities

- Peer Counseling
- Advocacy and Awareness
- Personal Attendant services
- Assistive devices
- Capacity Building (Art of daily living)
- Employment opportunities

Education and Literacy

HANDS Education and Literacy Program has been working for 18 years to improve the literacy status of poor, marginalized children and adults through formal and non-formal education both in private and public sectors. So far the program has managed more than 60 projects throughout the history of HANDS. The Government of Sindh outsourced schools located in four Districts to HANDS (As EMO) under a Public Private Partnership, PPP-Education (Node):

Objectives of Program:

- To improve retention and reduce dropout rate
- To increase enrollment and attendance
- To improve confidence and creativity and learning skills of Children
- To improve social and emotional behavior of children
- To improve nutrition and health status
- To improve parent-child relationship

Public Private Partnerships (PPPs)

HANDS has demonstrated successful implementation of PPPs.

With the intention of improving the overall health care delivery, with primary focus on improving the health care delivery at the health facility level in the province, the Health Department Government of Sindh invited expressions of Interest from the private NGO sector to outsource management of Primary Health Care facilities in Malir district (Bin Qasim and Gadap Town).

The Primary Health Care services include Dispensaries, MCH centers, Basic Health Unit (BHU), and Rural Health Centers (RHC)

The HANDS Health facilities entered into an Agreement with Government of Sindh to deliver quality healthcare services to the population in an equitably accessible manner.

Health Facilities (HF) Assessment Findings during December 2016 when HANDS took over management of 34 health facilities of District Malir in December 2016:

- Half of the Health Facilities did not have any functional toilets.
- Ultrasound and x-ray machines were not available in any HF.
- Attendance of staff was 36.6% for 430 filled positions.
- Functional generator was available in only one HF.
- Legal electricity connection was available in 8 HFs.
- Pipe water supply was available in 6 HFs.
- Gas connection was available in 2 HFs.

Solid Waste Management

Waste management is a logical part of the water and sanitation program. Waste management or waste disposal are all the activities and actions required to manage waste from its inception to its final disposal: collection, transport, treatment and disposal of wastes together with monitoring and regulation. Management also encompasses the legal and regulatory framework that relates to waste management encompassing guidance on recycling.

Objectives:

- Minimise the quantity of waste produced by efficient management of procurement and use of materials.
- Reduce the quantity of toxic and hazardous chemicals and materials acquired, used, or disposed of by the agency and maintaining waste recycling programs
- Provide efficient and economical way of reuse of collections through recycling.
- Recover and reuse the materials from waste.

Monitoring, evaluation and research (MER)

The MER program is responsible for the monitoring of all projects and programs; and interventions/activities as well as for conducting internal and external research.

It is MER's responsibility to establish and maintain Management Information Systems (MIS) throughout the organization from community to district office and head office level. It is within MER scope of work to conduct baseline, mid term, post intervention, periodical evaluation and issue based research.

The process is a continuous cycle of monitoring, evaluation and identification of issues to be addressed followed by interventions and then evaluation of the impact of the interventions and so on continuously. This model is applied appropriately in each area of the program.

News in brief

News from India

Dr Mira Shiva

Access to oxytocin

In India, oxytocin sales have been banned from all retail chemist shops and manufacture is banned by all private manufacturers - with only Karnataka Antibiotic Pharmaceutical Limited (KAPL) unit based in Karnataka authorised to supply the whole country through Government procurement and through Public and Private registered hospitals. The ban was initially meant to be imposed from 1st July 2018 but has been moved to 1st Sept 2018. KAPL which has never manufactured oxytocin before, started manufacture from 2nd July 2018.

Now the Health Ministry has given another notice that oxytocin will be made available from the Governments Jan Aushadhi Stores; and AMRIT stores that are in Medical Colleges. However, all have to procure only from KAPL because of alleged misuse of oxytocin in milk animals.

There have been articles in papers that cows were more important than mothers and suddenly August 23, in an affidavit submitted to the court to justify action, it is being alleged that oxytocin is being used to accelerate puberty in young girls for prostitution and trafficking. Blogs, vague websites and articles written by lay persons are being quoted. **Female sex hormones** are **definitely used for maturing the young girls,** and also post menopause – not oxytocin.

It seems a calculated effort to give oxytocin a bad name. Many health people have started believing that oxytocin is a banned drug. We have to constantly remind that it is an essential life saving drug, included in WHO EML. Oxytocin is in the Indian National List of Essential Medicines 2015 as well as in WHO EML. Its use is crucial for:

- **Induction of Labour**
- **Prevention of Post Partum Haemorrhage** - recommended for use in all deliveries - after delivery of the baby as part of active management of third stage of labour .
- **Treatment of PPH**

Health personnel involved with safe delivery, Maternal health issues and Rational Use of Drugs are extremely concerned as access to oxytocin, which is an essential and life saving drug, cannot be jeopardized. Bleeding is the commonest cause of maternal mortality. Most vulnerable are women residing in peripheral areas with poor back up health services. Large numbers of pregnant women are anaemic and blood loss with PPH would be fatal. Oxytocin controls blood loss.

A public Interest Litigation is being filed by the all India Drug Action Network to ensure access to oxytocin as an Essential and Life Saving drug. If we can counter to show that it is oestrogen, a female sex hormone used for illicit purposes and it is not oxytocin, it will be a big help .

Irrational Fixed Dose Combinations in India

In March 2015, 344 irrational fixed dose combination drugs were banned by the government of India. By the end of that year they had been 'unbanned' due to pressure from vested interests. Early this year India's chief drug advisory body formed an expert committee under Chairpersonship of Dr Nilima Kshirsagar to review the status of the 344 fixed dose combination (FDC) drugs banned in 2015. DTAB Subcommittee invited industry to give proof of Safety Efficacy of these irrational FDCs. AIDAN was invited to make its oral and written submission concerning the safety and efficacy of these irrational FDCs, especially FDCs of antibiotics.

The Health Ministry response is now awaited.

Universal health coverage and chronic kidney disease in India

Bull World Health Organ 2018;96:442

Beverley M Essue, Vivekanand J, Oommen John, John Knight and Stephen Jan

The impact of kidney diseases has been quantified in India, in a cohort of 119 working-age dialysis patients, most of whom lacked health insurance. In this cohort, 35/119 (29%) patients died and 16/119 (13%) discontinued dialysis within 12 months. Despite receiving highly subsidized treatment, dialysis patients receiving care in these two sites in northern India still faced high medical out-of-pocket costs: 87.1% of patients in public hospitals were spending over 100% of their monthly income on dialysis compared to 78.9% of patients in private care. This expenditure excluded non-medical costs, which can also be substantial. As part of its agenda to achieve universal health coverage (UHC) by 2022, the Indian government has committed to establishing at least one eight-station dialysis unit in each of its 688 districts, and is offering free haemodialysis to people living below the poverty threshold.

http://www.twn.my/title2/health.info/2018/hi180505.htm

Other News in Brief

Early assessment of China's 2015 tobacco tax increase

Mark Goodchild and Rong Zheng

Bull World Health Organ 2018; 96:506–512
http://www.haiasiapacific.org/wp-content/uploads/2018/08/BullWHOTobaccoTaxChina-3.pdf

Introduction

In China, tobacco use is contributing to the increase in noncommunicable diseases. More than one million Chinese adults die annually from tobacco use and this number is estimated to increase in coming years. In 2012, the United Nations (UN) addressed heightened concerns about the impact of noncommunicable diseases in a High-Level Meeting of the UN General Assembly. Indeed, diseases caused by smoking account for around 3% of health expenditures in China, while out-of-pocket medical expenditures, due to smoking, impoverish more than 10 million Chinese households each year.

China was an early adopter of the Framework Convention on Tobacco Control (FCTC) having ratified the Treaty in 2005. Since ratification, tobacco control efforts in China have accelerated with interventions including tighter controls on tobacco marketing, improved health warnings and bans on smoking in public places in several cities. Tobacco taxation is a cornerstone of global tobacco control efforts, with Article 6 of the FCTC recognizing tax as an important and effective means of reducing the demand for tobacco.

Taxation is recognized to be the single most effective tobacco control measure available and the guidelines for Article 6 implementation emphasise that any comprehensive tobacco control strategy should include taxation. In 2015, China introduced its fourth major national tobacco tax reform since 1994. Many other large developing countries like Brazil, the Philippines, South Africa and Ukraine have raised tobacco taxes to help meet tobacco control objectives. The French government has increased cigarette taxes substantially from the mid-1990s, with cigarette prices tripling in real terms by 2005. Among French males, rates of adult lung cancer deaths fell by 50% over the same period. The study assesses the immediate impact of the 2015 Chinese tobacco tax increase on cigarette prices, sales volumes and tax revenues across the different price categories of China's cigarette market. It also explores the potential impact on smoking prevalence and considers the way forward for tax policy design in China.

Tax reform and cigarette pricing

Changing from previous practice, the State Tobacco Monopoly Administration raised its cigarette prices at the same time.

Between 2014 and 2016, the retail price of cigarettes increased on average by 11%, with the cheapest category of cigarette brands increasing by 20%. The average proportion of tax in the price of cigarettes rose from 51.7% to 55.7%. Annual cigarette sales decreased by 7.8%, from 127 to 117 billion packs. The increase in cigarette prices could be associated with a 0.2% to 0.6% decrease in the proportion of adults smoking, representing between 2.2 and 6.5 million fewer smokers. Tax revenues from cigarettes increased by 14%, from 740 to 842 billion Chinese Yuan between 2014 and 2016, reflecting an extra 101 billion Chinese Yuan in tax revenues for the government.

The 2015 tax increase shows that tobacco taxation can provide measurable benefits to both public health and finance in China. The experience also highlights the potential for tobacco taxation to contribute to China's broader development targets, including the sustainable development goals and Healthy China 2030. Looking forward, this link to development can be facilitated through multi-sectoral research and dialogue to develop consistent cross-sectoral objectives for tobacco tax policy design and implementation.

China: following the 'Health Silk Road'

Jane McCredie
MJA Insight 26 February 2018
https://www.doctorportal.com.au/mjainsight/2018/7/china-following-the-health-silk-road/

A communiqué issued by participants in a 2017 Beijing summit on the Health Silk Road – also known as the Belt and Road, including the World Health Organization (WHO) and the OECD among others stated: '… improving the people's health quality is our common goal; creating a community with a shared health future for mankind is our common aspiration'.

What do all the fine words mean in practice? The communiqué's goals are somewhat short on detail. While it may well deliver health benefits, it is fundamentally about economic and strategic objectives.

Some outcomes of the Belt and Road initiative may actually be antithetical to public health. An article in *Tobacco Asia* in 2017, for example, detailed the expected benefits for China's tobacco industry.

'The countries and regions on the Belt and Road[1] account for 63% of the global population, which means a vast market to be tapped by China's tobacco industry, helping to solve the problem of possible surplus of tobacco production,' the article said.

[1] The Belt and Road Initiative or the Silk Road Economic Belt is part of a Chinese Government development strategy which focuses on connectivity and cooperation between China, the land-based Silk Road Economic Belt and the ocean-going Maritime

'Around the world, there are still cigarette markets to the tune of 22 million cases (110 billion cigarettes) yet to be developed.'

In the language of tobacco marketing, I'm assuming 'cigarette markets yet to be developed' means non-smokers.

More broadly, experts interviewed by the *BMJ* this month saw both potential gains and harms from the Health Silk Road.

On the downside, experts raised concerns about the potential export of hazardous industries or the increased spread of infectious diseases along busier transport routes.

On the plus side, though, improved health and sanitation infrastructure could bring benefits to billions of people across Asia and Africa.

Global expansion of China's huge pharmaceutical manufacturing capacity could also reduce drug prices, said Dr Joan Kaufman of Harvard Medical School. Provided there was adequate quality control, this could make crucial medications more accessible across low income countries.

Still, it's worth remembering that powerful nations are fundamentally motivated more by their own interests than the desire to do good.

For China, including health initiatives in its program of expansion has clear public relations benefits, a strategy Dr Kaufman suggests the Chinese have learned from US foreign policy.

'You get a lot of mileage out of foreign aid for health,' she told the *BMJ*.

Australia's tobacco plain packaging not WTO-illegal

says WTO Published in SUNS #8714 4 July 2018

TWN Info Service on Trade. FTA, Health and UN Sustainable Development 9 July 2018
www.twn.my

Geneva, 3 Jul (Kanaga Raja) - A dispute panel at the World Trade Organisation has ruled that the complainants had not demonstrated that Australia's tobacco plain packaging (TPP) regulations were inconsistent with Australia's WTO obligations.

In a landmark ruling of over 880 pages (not including addendum and appendices) on 28 June, the panel rejected the complaints raised by Honduras, the Dominican Republic, Cuba and Indonesia that Australia's measures violated the Agreement on Technical Barriers to Trade (TBT) or trademark rights under the TRIPS Agreement.

Vitamins and CHOICE

https://www.choice.com.au/health-and-body/medicines.../vitamins-and-supplements

In response to public pressure the Australian Parliamentary Opposition has promised to change the way vitamins and supplements are regulated if they get voted in at the next election.

Previously Labor had backed the Government's new legislation, allowing therapeutic goods companies to make claims with no scientific evidence. Now, the Opposition has promised to introduce a disclaimer on vitamins and supplements so that consumers are warned about claims that have no scientific basis.

This would be a great step in the right direction for consumers, and is all thanks to pressure from CHOICE supporters. Thousands emailed, called and posted on social media to put this issue on the national agenda.

Now it's our job to keep the Opposition accountable to this promise and encourage the Government to reconsider its position and put consumers first.

Prescrire: Statins in primary cardiovascular prevention: Little benefit, documented harms

Prescrire Int 2018; 27 (195): 183-190. (Pdf, subscribers only)

Given its weak efficacy and sometimes serious adverse effects, the harm-benefit balance of statin therapy in primary cardiovascular prevention is uncertain and close to neutral. Much else can be done to reduce cardiovascular risk via smoking cessation, physical activity and healthier eating habits.

Abstract

The risk of having a cardiovascular event increases with age, blood pressure and serum cholesterol levels. There is an increased risk in men and in case of smoking, diabetes, a family history of premature cardiovascular events, and physical inactivity.

Smoking cessation, regular physical activity, weight loss for obese patients, a Mediterranean diet, and some antihypertensive or antidiabetic treatments reduce the risk of cardiovascular events.

In patients with no history of cardiovascular disease, there is no proof that statin therapy reduces the risk of cardiovascular events in patients younger than 40 years or older than 75 years.

In some patients aged 40 to 70 years, daily statin therapy for about 5 years reduces the risk of fatal and non-fatal cardiovascular events. Assuming that the percentage reduction in cardiovascular risk obtained through statin therapy remains constant across all levels of baseline cardiovascular risk, which remains unproven, daily use of statin therapy for 5 years by 1000 persons with no clinically evident cardiovascular

disease would prevent about: 2 to 10 deaths for those whose 5-year risk of cardiovascular death was 2%; 5 to 25 deaths for those whose 5-year risk of cardiovascular death was 5%; and 10 to 50 deaths for those whose 5-year risk of cardiovascular death was 10%.

But the risk of adverse effects would be the same in all of these individuals.

Whatever their baseline cardiovascular risk, most patients will gain nothing in terms of cardiovascular events, some will avoid a cardiovascular event without gaining any additional days of life, and a few will gain a few extra days of life. A tiny minority may gain a few months or years of life. The data available are insufficient to identify who would derive the most benefit from statin therapy.

No trials have evaluated the potential benefits of taking statins for 10 years or more.

Daily statin therapy can provoke potentially debilitating muscle pain, the incidence of which is difficult to quantify. It causes about 4 new cases of diabetes per 1000 patients taking a statin for 4 years, and probably more among those who already have other risk factors for developing type 2 diabetes.

It causes about 1 additional haemorrhagic stroke per 1000 to 2000 patients receiving statin therapy for 5 years.

The harms of taking a statin every day for more than 10 years are unknown. In the long term, the risks of diabetes and of haemorrhagic stroke have not been quantified.

Given these uncertainties and the cost of this preventive therapy, it is usually preferable not to use statins for primary prevention.

When statin prevention is nevertheless chosen after discussing these issues with the patient, it is reasonable to choose pravastatin at a daily dose of 40 mg. It is the statin with the most favourable harm-benefit it balance in secondary cardiovascular prevention. It provokes fewer drug interactions than other statins.

WHO: Proposed work program on 'fair price' undermines affordability of essential medicines

http://www.twn.my/title2/health.info/2018/hi180505.htm

Geneva, 21 May 2018

The document was prepared by the Secretariat of the WHO for the consideration of the 71st World Health Assembly.

Paragraph 56 of the document states: 'There is a need to establish a fair-pricing model that ensures sustainability for health systems and access for patients as well as sufficient profit for industry to sustain the production of quality products'.

The document defines 'fair price' as 'one that is affordable for health systems and patients and that at the same time provides sufficient market incentive for industry to invest in innovation and the production of medicines. In this context, fairness implies positive incentives/benefits for all stakeholders, including purchasers and those involved in the research and development and manufacture of medicines'.

As per the definition, fair price is different from affordable price and it is a price reached taking into consideration the market incentive for industry to invest in innovation and the production of medicines. Thus the definition in effect means that prices of the medicines should not be as low as are currently available due to generic competition; instead it should compensate those involved in the research and development and manufacture of medicines.

There is ample evidence that generic competition brings down the prices of medicines drastically. For instance, though the price of Gilead Sciences' sofosbuvir for 12 weeks of hepatitis C treatment is USD 84000 in the United States, the company offered the medicine to a few developing countries for USD 900, almost 90% less than the US market price. However, generic competition could bring down the price to below USD 100.

The fair price initiative thus undermines generic competition that can be increased though the use of flexibilities in the Trade-related Aspects of Intellectual Property Rights Agreement (TRIPS) such as compulsory license and government use license.

The 'fair price' initiative could legitimise high prices. Most importantly, it raises the question of fairness for whom?

To date there is no transparency with regard to the actual cost of research and development (R&D). The cost of R&D is not open for public scrutiny and verification. The opaqueness around R&D cost has been long used to justify high, even exorbitant, prices for patented medicines. The fair price to provide incentives for innovation would then legitimise the high prices for medicines and compromise access to medicines in many WHO Member States. Read more http://www.twn.my/title2/health.info/2018/hi180505.htm

---

The Lancet Hepatitis C day

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31654-4/fulltext?dgcid=raven_jbs_etoc_email

July 28 was World Hepatitis Day, which this year was commemorated by a series of events in Ulaanbaatar, Mongolia, where great progress has been made in scaling up hepatitis testing and treatment - offering a model for other countries to follow. Globally, the aim of the day is to support hepatitis prevention, testing, treatment, and care services, showcase best practices,

and develop partnerships and funding. In 2015, 71 million people were estimated by WHO to have chronic hepatitis C infection.

As part of the events for World Hepatitis Day, on July 26, WHO released new care and treatment guidelines, updating their 2016 recommendations.[2] The new guidelines strongly recommend offering treatment to all people aged 12 years and older (except pregnant women) who have chronic hepatitis C infection, irrespective of disease stage. Treatment regimens that can cure all six major subtypes of hepatitis C infection are recommended, including the use of direct-acting antivirals, which have become available since 2016. These new 'treat all' guidelines simplify treatment, and enable task shifting so that non-specialised health-care workers can deliver care.

New too is the guidance on treating adolescents and children older than 12 years. Two specific direct-acting antiviral regimens are recommended for those aged between 12 and 17 years, with pangenotypic direct-acting antivirals recommended for those aged 18 years and older. In children younger than 12 years with chronic hepatitis C infection, treatment is not recommended, although the guidelines recognise that the evidence here is poor. Trials are ongoing in this age group.

The continued price reduction of direct-acting antivirals means that rolling out treatment for all can be cost effective, while also reducing deaths, preventing liver cancer development, and reducing new infection rates. It is fair to say that the development and success of direct-acting antivirals is transforming hepatitis C treatment.

Australian NPS[3] Be Medicinewise Week

20-26 August 2018: Our families matter, so it's important to make safe and wise decisions about medicines and health.

This year focus is on *medicinewise* families. Medicines are part of most people's lives, so it's critical to have access to all the information needed about the medicines we, and our family members, are taking.

Important information that *medicinewise* families need to know includes:

- Taking medicines during pregnancy
- Taking medicines while breastfeeding
- How to give medicine to a child in your care
- How to remember what medicines you're taking
- How much medicine to take and when to take it
- How to store medicines correctly.

[2] http://www.who.int/hepatitis/publications/hepatitis-c-guidelines-2018/en/

[3] National Prescribing Service

https://mailchi.mp/nps/be-medicinewise-week-1617709?e=bb98f88e55

PHU Course Announcement: The Struggle for Health - Savar, Bangladesh 5-13 November 2018

Applications are now open for '**THE STRUGGLE FOR HEALTH**', an IPHU short course for young health activists from 5 to 13 November in Savar (just outside Dhaka), Bangladesh. **Application deadline September 14.** This course is held in the lead up to the 4th People's Health Assembly (more here) which will also be held at Gonoshasthaya Kendra (GK) from 15-19 November.

It will commence as a single course, then split into two parallel streams, dealing with **medicines policy**, and **gender and health**, and then come together again for the final day. It is expected that IPHU participants will also participate in PHA4.

THE STRUGGLE FOR HEALTH is presented by the International People's Health University (IPHU) of the People's Health Movement (PHM) - jointly with PHM-Bangladesh, Gonoshasthaya Kendra, Third World Network and SAMA Resource Group for Women and Health with Naripokkho.

https://iphu.org/en/announcement/iphu-savar2018.

AMR – Resistance Roundup

FAO chief - Stop using antibiotics as animal growth promoters

TWN Info Service on Health Issues 31 May 2018

www.twn.my

The Director General of FAO has called for the immediate halt in the use of antibiotics as growth promoters in animals.

On 30 May 2018, Graziano da Silva said antimicrobials are still being used as growth promoters, especially in livestock and acquaculture. Such practices 'should be phased out immediately.'

He added that FAO advocates that 'antibiotics and other antimicrobials should be only used to cure diseases and alleviate unnecessary suffering. Only under strict circumstances they should be used to prevent an imminent threat of infection.'

He also pointed to the use of antimicrobials as biocides on crops, a situation which is leading to some crop funguses becoming more resistant to treatment and which, he said, also needs to stop.

Strengthening surveillance and monitoring systems

A Food and Agricultural Organisation (FAO) AMR Action Plan seeks to improve awareness on AMR and related threats; develop capacity for surveillance and monitoring; strengthen governance; and, promote good practices and the prudent use of antimicrobials.

As part of efforts to implement the action plan, FAO is supporting countries and rural communities.

'This is particularly important where legislation, regulatory surveillance and monitoring systems are weak or inadequate,' Graziano da Silva said.

New drug-resistant superbug behind deadly typhoid outbreak in Pakistan

TWN Info Service on Health Issues (June 18/01)

www.twn.my

In February, scientists reported a major outbreak of typhoid fever in Sindh, Pakistan caused by an extensively drug-resistant superbug strain.

Research by Britain's Wellcome Sanger Institute found that the typhoid strain had mutated and acquired an extra piece of DNA (from another microbe, likely *E.coli*) that rendered it resistant to multiple antibiotics.

The typhoid outbreak began in the city of Hyderabad, Pakistan in November 2016 and has since spread and local health authorities detected more than 800 cases of drug-resistant typhoid in Hyderabad alone in a ten-month period between 2016 and 2017.

The typhoid strain causing the outbreak is now resistant to five antibiotics, more than seen in any outbreak before. This is the world's first outbreak of 'extensively drug resistant' (or XDR) typhoid.

This new superbug typhoid strain is resistant to three first-line antibiotics, ie chloramphenicol, ampicillin and trimethoprim-sulfamethoxazole, as well as fluoroquinolones and third generation cephalosporins.

The results of this study were published in Jan/Feb 2018 in the scientific journal *mBio*. For details of the study click the link given here:

http://mbio.asm.org/content/9/1/e00105-18.full.pdf

NRDC report: antibiotic overuse in pig production contributing to spread of antibiotic resistance

TWN Info Service on Health Issues 27 June 2018
Third World Network
www.twn.my

A recent report from the US Natural Resources Defence Council (NRDC) estimates that more than 27 percent of all medically important antibiotics sold in the US are for pig production, while a roughly equivalent amount (27.6%) is sold for use in human medicine. According to the NRDC report, the widespread antibiotic overuse in the pork industry and livestock production is a key contributor to the spread of antibiotic resistance in both animals and humans. The key findings in the report reveal:

- The US pork industry accounts for 37 percent of all US livestock sales of medically important antibiotics;
- The pork industry feeds medically important antibiotics to entire herds of animals even when no pigs are sick;
- Overuse of antibiotics occurs with the growing consolidation of the US pork industry dominated by larger, specialised farms and by fewer businesses, which dictate production practices;
- US pork producers use twice as much antibiotic per kilogram of animal as do UK producers, and seven times the levels used in Denmark or the Netherlands;
- Robust information on the use of antibiotics in livestock production, including in pigs, remains scarce in the US.
- 'The irresponsible use of antibiotics on pig farms has created ripe conditions for drug resistant bacteria to multiply and spread from farms to people', states the report.
- Giving an example, the report cites the rise of a livestock-associated strain of methicillin-resistant

Staphylococcus aureus (MRSA) in pig farm workers and their families in several countries.

In the absence of federal action, the report hopes that consumer demand for antibiotic free pork will make an impact on the pork industry as it has on the poultry industry in the US. This 13-page NRDC report entitled Better Bacon: Why it's high time the US pork industry stopped pigging out on antibiotics can be downloaded from the link given here:

https://www.twn.my/title2/health.info/2018/hi180610.htm

Study shows how antibiotic use affects resistance in urinary E.coli

TWN Info Service on Health Issues 13 July 2018
Third World Network
www.twn.my

A retrospective multi-centre study showed a dose-response relationship between antimicrobial use and resistance in uropathogens in older adults. The purpose of the research was to study the influence of different variables of antimicrobial prescribing on the occurrence of resistance in *E.coli* isolated from urine samples in Belgian adults over the age of 65. The study contained information on resistance status for 7,397 *E.coli* isolates obtained from 5,650 patients. The results showed that resistance in *E.coli* was higher when more antibiotics (more than nine prescriptions) had been prescribed before isolation of the sample, especially in women. This study was reported in Antimicrobial Resistance and Infection Control which is available at the following link:

https://aricjournal.biomedcentral.com/articles/10.1186/s13756-018-0368-3

Risk of methicillin resistant S. aureus and C. difficile in patients with a documented penicillin allergy

http://www.bmj.com
BMJ 2018;361: (27 June 2018)

Kimberly G Blumenthal, Na Lu biostatistician, Yuqing Zhang Professor of Medicine., Yu Li Research Assistant, Rochelle P Walensky, Professor of Medicine,, Hyon K Choi, Professor of Medicine

Abstract

Objective — To evaluate the relation between penicillin allergy and development of meticillin resistant *Staphylococcus aureus* (MRSA) and *C difficile.*

Design — Population based matched cohort study. **Setting** — UK general practice (1995-2015).

Participants — 301,399 adults without previous MRSA or *C difficile* enrolled in the Health Improvement Network database: 64,141 had a penicillin allergy and there were 237,258 matched comparators.

Main outcome measures — The primary outcome was risk of incident MRSA and *C difficile*. Secondary outcomes were use of β lactam antibiotics and β lactam alternative antibiotics.

Results — Among 64,141 adults with penicillin allergy and 237,258 matched comparators, 1365 developed MRSA (442 participants with penicillin allergy, 923 comparators) 1,688 developed *C difficile* (442 participants with penicillin allergy and 1246 comparators) during a mean 6.0 years of follow-up.

The adjusted incidence rate ratios for antibiotic use among patients with penicillin allergy were 4.15 for macrolides, 3.89 for clindamycin, and 2.10 for fluoroquinolones. Increased use of β lactam alternative antibiotics accounted for 55% of the increased risk of MRSA and 35% of the increased risk of *C difficile.*

Conclusions — Documented penicillin allergy was associated with an increased risk of MRSA and *C difficile* that was mediated by the increased use of β lactam alternative antibiotics. Systematically addressing penicillin allergies may be an important public health strategy to reduce the incidence of MRSA and *C difficile* among patients with a penicillin allergy label.

Infants in India die from sepsis caused by antimicrobial-resistant infections

2 August 2018 Third World Network
www.twn.my

The second story of a six-part series by two Canadian journalists tells the personal stories of survivors of antibiotic resistance and exploring how the unfettered use of antibiotics pushes humanity closer to a post-antibiotic era in which common infections may be impossible to treat.

A 2013 study[4] estimated 60,000 infants in India die from sepsis caused by antimicrobial-resistant infections every year. The expert who authored this study now believes the figure has doubled to 120,000.

Doctors increasingly treating babies with colistin (a drug of last resort) see even those just born carry a frightening resistance to the drug. They worry about what to do when the last line of defence fails.

Multi-drug resistant infections have risen drastically and prescribing colistin has become commonplace. Doctors must use it because it's the only way to save dying babies. In India, 26 million babies are born every year, of which some 650,000 die in infancy and about 25 percent of the deaths are caused by infection, notes Dr. Neelam Kler from Sir Ganga Ram Hospital.

[4] https://globalnews.ca/news/4297687/drug-resistance-takes-devastating-toll-on-families-in-india/

There are many reasons for the growth of antimicrobial resistance but Dr Kler is particularly concerned about three issues in India: pharmacies sell antibiotics without prescription; crowded hospitals lack strong infection control; and few diagnostics available to confirm bacterial infections before antibiotics are started.

Global review finds antibiotics frequently supplied without prescription

6 August 2018 Third World Network *www.twn.my*

- reported in

CIDRAP's Stewardship/Resistance Scan for Jul 06, 2018

About three in four antibiotics requests and three in five consultations in community pharmacies around the world result in the sale of antibiotics without a prescription, according to a systematic review and meta-analysis published in the *Journal of Infection* recently.

In a review of 38 studies published from 2000 through 2017 on the frequency of non-prescription sale and supply of antibiotics in community pharmacies in 24 countries, an international team of researchers found that the overall pooled proportion of non-prescription supply of antibiotics following a patient request was 78 percent and the non-prescription supply of antibiotics based on community pharmacy staff recommendation was 58 percent.

Antibiotics were most commonly supplied to patients with symptoms of urinary tract infections (68%), upper respiratory tract infections (67%), and gastroenteritis (63%). Penicillins, fluoroquinolones, and macrolides, respectively, were the most commonly supplied antibiotics for these conditions.

Although all included countries, except one, classified antibiotics as prescription-only medicines, the pooled estimate of non-prescription supply of antibiotics was 62 percent, with non-prescription antibiotics being sold most frequently in community pharmacies in Indonesia (91%), Syria (87%), Saudi Arabia (85%) and Ethiopia (85%). Regionally, the supply of non-prescription antibiotics was highest in Latin America (78%).

'Despite the limitation of our review, the findings suggest that antibiotics are frequently supplied without prescription in many countries even where this supply remains illegal,' the authors conclude. 'This overuse of antibiotics could facilitate the development and spread of antibiotic resistance.'

World Antibiotic Awareness Week
November 12-18, 2018
Start Planning now

Tools and Resources

Tackling Antimicrobial Resistance Together Working paper 1.0: Multisectoral coordination –

This framework is to be used as a reference guide, applied according to local priorities and needs, and targeted at academic institutions, educators, accreditation bodies, regulatory agencies and other users. The ultimate aim is to ensure that all health workers are equipped with the requisite competencies at pre-service education and in-service training levels to address AMR in policy and practice settings.

It can be accessed at this link:

http://www.who.int/hrh/resources/WHO-HIS-HWF-AMR-2018.1/en/

WHO Competency Framework for Health Workers' Education and Training on AMR

was conceived to offer practical tips and suggestions on how to establish and sustain the multisectoral coordination needed to develop and implement National Action Plans on AMR (NAPs). It is intended for anyone with responsibility for addressing AMR at country level. Drawing on both the published literature and the operational experience of four 'focal countries' (Ethiopia, Kenya, Philippines and Thailand), it summarizes lessons learned and the latest thinking on multisectoral working to achieve effective AMR action. The experience in focal countries points to a number of tools and tactics that can be used to help establish and enhance sustainable multisectoral collaboration for AMR action. These can be grouped into four categories: political commitment, resources, governance mechanisms, and practical management. It can be accessed on

http://www.who.int/antimicrobial-resistance/publications/Tackling-AMR-multisectoral-coordination-june2018.pdf?ua=1

HAI Europe
Overtoom 60 (2)
1054 HK Amsterdam
The Netherlands
info(AT)haiweb.org http://www.haiweb.org

HAI Asia Pacific
Penang Malaysia http://www.haiasiapacific.org

HAI Africa
P.O. Box 66054 - 00800 Nairobi Kenya
Email: inf[AT]haiafrica.org Web: www.haiafrica.org

HAI Latin America (AISLAC) Email: ais[AT]aislac.org Web: www.aislac.org
AccionInternacional Para la Salud Apdo
41 – 128 Urb Javier Prado