

# 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

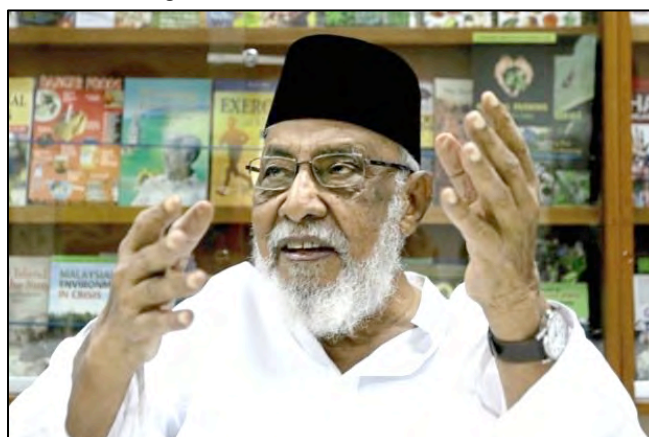
Tribute: SM Mohamed Idris	1
WHO 21 <sup>st</sup> Model List of Essential Medicines	4
Improving affordability of new cancer medicines	5
<b>Australia:</b> NMP review	6
Antibiotics in agriculture	7
<b>India:</b> Colistin in animal feed ban	8
E-cigarette ban	8
Trade agreements and health	9/10
Award to Margaret Ewen	11
Historic Books	11
<b>Feature 1:</b> Towards UHC Aadram Mission Kerala	12
<b>Feature 2:</b> Healthy Ageing – Kerala & Sri Lanka	15

In this issue we share tributes to SM Mohamed Idris who died in May at the age of 93.

We acknowledge and comment on the WHO 21<sup>st</sup> Model list of Essential Medicines and the 7<sup>th</sup> Children's List while Ellen 'tHoen *et al* provide a very important article on improving access to affordable cancer medicines. Also included are discussions of India's banning of e-cigarettes and of colistin in the animal sector; and the impact of trade agreements on health. Strengthened Universal Health Care in Kerala and innovative programs for senior community members in both Kerala and Sri Lanka are featured.

## Vale SM Mohamed Idris 1926-2019

S.M. Mohamed Idris, Consumers Association of Penang's President for 50 years, died on Friday May 17, 2019, at the age of 93.



He was born in a village in southern India on December 6, 1926, and received his early education at a Madarasa and Tamil school in India before accompanying his father to Penang at a young age.

Prominent Malaysian journalist Datuk Seri Wong Chun Wai described Mohamed Idris as 'the man who stood up for us'. He said 'I have known the country's greatest consumer advocate for more than 30 years' ... 'His quest was simple – transform mindsets, especially

those who chased material things'. Idris Mohamed said 'I have never celebrated my birthday but if you ask what my birthday wish will be, it is for everyone to change the way they think. .. I hope everyone can transform their mindsets. Don't be enslaved by materialism' .....

#### **Dato Dzulkifli Abdul Razak**

There is an old African proverb that says when a wise person dies, a whole library is burnt down. There can never be a better illustration of this than the recent demise of the legendary consumer-environment-people's (the list goes on) advocate, the late SM Mohamed Idris (1926-2019), fondly known as 'Uncle'.

A rare gem with a very human and humane heart. He could relate to all, but only if the other party is equally concerned and sincerely so. 'Uncle' would not have it any other way as clear as it is in the following quote:

*'I do not seek any acknowledgement or praise for the work. It is a cause for bringing about change and improvement in society which should not be limited by one's own desire for fame or self-glorification.'*

I knew 'Uncle' since I was a student in Penang. Who would not? - when his name was synonymous with CAP - the Consumers Association of Penang, otherwise known as the defender of the people's rights. It is a household name where the *rakyat* [people / populace] went to in any confrontation with the powerful. That is how extensive the influence of CAP was under the stewardship of Idris, who subsequently inspired the establishment of Sahabat Alam Malaysia (SAM), and the Third World Network (TWN). The three completed the circle making the combination a global nexus of repute.

As a student, to see such development emerging opened up lessons that were almost absent in the lecture halls - especially for those doing sciences. It was devoid of the human essence making the subject boring (and we wonder why it is not attracting others to the discipline except in utilitarian ways).

As for the social sciences and humanities, they did not go far enough to articulate the local and traditional wisdom that Idris always came back to. In other words, our minds are still 'colonised', setting their own limits disguised as 'world class' education defined by someone else, somewhere for some other purpose.

Idris had long been critical of this situation and mooted decolonisation discourses which of late have caught on in other parts of the world, including the 'Rhodes Must Fall' campaign in a UK university. In this sense, Idris was not only a bold leader (who called a spade, a spade), but was consistent in what he wanted in bringing about 'real' changes without flip-flopping or apologising for it.

This approach is what made working with him a privilege (though demanding) because we knew what it was all about and what to focus on. As such the teamwork and synergy was phenomenal ensuring why NGOs like CAP under 'presidents' like Idris are mission-oriented, resourceful and prudent. The rattan chair that was allocated to him is still there. It is due to his disciplined-way in preserving the precious little resources available for better use. Thus change is not the only constant as we are often told. Preservation too. His approach contrasted with how other organisations are 'managed' - more on form instead of substance, which Idris abhorred.

So 50 years went by. Idris, in the same vintage as the Prime Minister, ably demonstrated how 'simplicity' can lead the way to a better, more equitable and just world. If it sounds like 'sustainable development', do not be surprised. It may well be a Malaysian idea that can be traced to the CAP-SAM-TWN nexus. And finally, nestling as a brainchild of the visionary Idris.

News that Idris and a few friends were instrumental in breaking the palm oil cartel of the 60s has just surfaced. There are many more. But humble as he was, stories that tend to put him as the 'star' performer were never encouraged. Now that he is gone, his legacy must be given a meaningful place. Not only for Penang to immortalise the name of SM Idris in the pages of its history, more importantly to tell the story as it is. It would not be too presumptuous to name a 'citadel' after him, where his dreams can continue to inspire coming generations (as I was as a student), more so to nurture courageous and humane Malaysians who will not hesitate to come forward to further advance the cause of a truly just world.

Rest in peace, Uncle Idris. You more than deserve it. It is now our turn to make things happen as you have envisioned them. You will be sorely missed no doubt.

#### **Dato Anwar Fazal**

On Friday evening we lost one of the greatest public interest leaders in Malaysia and the Third World.

I worked very closely with him over 55 years setting up the Consumers Association of Penang (CAP) and Consumers International.

We formed CAP in 1969. He became the president and I became the secretary. However, even before CAP, he was already amazing as a municipal councillor in the 1950s and 1960s. He was also the chairman of the former Penang Library, and he made it open on Sundays and until 10 pm on weekdays. In the days when the Internet did not exist, that was really vital for Penangites, and our library was packed after working hours.

He started the Penang Festival and lots of Penangites set up stalls and booths. It was the earliest tourism event I could remember. He also led a tree-planting campaign and thanks to him, George Town has so many large roadside trees today.

He was the Chairman of Sahabat Alam Malaysia (SAM) that was awarded the Right Livelihood Award (RLA) in 1988 for their exemplary struggle to save the tropical forests of Sarawak. The Sarawak office of SAM - the Friends of the Earth organisation in Malaysia - has been involved since 1986 with the native people of Sarawak in a desperate struggle against logging in the province. The logging is systematically destroying the culture and livelihood of the area's native inhabitants, including the Kelabit, Kayan, and Penan people. I am currently the Vice President of Sahabat Alam Malaysia. We will continue his passion.

More recently, Uncle Idris was vocal in his protests against recent developments pursued by the state government of Penang, Malaysia including the Penang Transport Master Plan and Penang South Reclamation project. This is what Khoo Salma a leading writer and heritage activist wrote about Idris on May 18:

*'We have lost the greatest champion and protector of green Penang. He defended our rights as consumers, and spearheaded the discourse about healthy and planet-conscious living in this part of the world. He was gentle with his friends and fierce with shameless polluters and destroyers of the environment.'*

One of Mohamed Idris' idiosyncrasies was that he never caught onto the mobile phone culture. He was a person-to-person guy. He delighted in face-to-face conversations and full-fledged correspondences.

He was 93 but was to Chair a Press Conference on Monday against what has been described as a monster transport infrastructure project involving massive reclamation, tunnels and super highways across the beautiful island of Penang ... the battle for a better and just world will continue ever more vigorously.

#### **Dr Zafrullah Chowdhury:**

Idris: a living saint, a great environmentalist, and a courageous fighter who cannot be replaced easily.

The first time I met Idris was through Anwar Fazal. Over our many meetings since then he became a father, brother and a friend. My main attraction for visiting Penang was the long hours of discussion we would have on a whole range of topics. His knowledge of so many subjects, education, environment and religion impressed me. He was a devout Muslim and an enlightened religious leader. I stayed with him during Ramadan one year. Although I fasted I did not say any prayers. He was disappointed but did not insist. He

simply said I could be a great Muslim if only I would perform my prayers.

Every time he would hear of my problems in Bangladesh, he would call me and express his fury at the powers that be and those harassing me. At the same time he would reassure me that I was in his prayers. I wanted very much to see him again, and am deeply sorry that I could not. May he rest in peace.

#### **Dr Mira Shiva**

My association with Uncle has been since mid 80s when I was invited to Penang by then Director of International Organisation of Consumers Union, Dr Anwar Fazal for a Pharmaceuticals meeting held at the University. Dr Bala was also there.

I visited CAP, met Uncle Idris and saw the work CAP was doing on drugs. CAP incidentally is a Founder member of HAI.

Uncle had visited Dehradun and Bija Vidyapeeth Earth University where traditional seeds are being conserved and he had planted a tree which has become very big.

He was concerned about growth of agrochemicals, GM crops, erosion of diversity, commercialization and corporatization of food and health. We were together in Johannesburg for the World Summit on Sustainable Development 2002.

I visited him each time I ever came to Penang, and I deeply valued his hospitality in his home, where nice vegetarian food was cooked and there was also so much food for thought. He was extremely motivating, inspiring, challenging, questioning, wanting to know your views, opinion and stand on many critical issues. He was conceptual and analytical, as well as extremely practical. He was deeply religious and had close friends from diverse faiths.

He organised extremely important conferences, meetings and dialogues. One such initiative was with *Multiversity and Citizen International* to which I had been invited. The theme was *Addressing Hegemony in Different Sectors*. I was dealing with Pharmaceuticals and Public Health. Our HAIAP and ARDA Founders Dato Anwar Fazal and Dato Dzulkifli Abdul Razak were involved in organizing it along with Uncle Idris.

I came to Penang to wish Uncle well on his 90th Birthday and to be with him and his wonderful daughters Fathima and Khatija. Uncle's mind was sharp as a razor and his memory a hundred times better than mine and that of others much younger.

Being with Uncle we grew, we learnt; and we felt understood, accepted and appreciated. His affection and his warmth as well his admonishments were all so important. He had scolded me many times for not writing and documenting my insights and experiences.

I was to meet him in June this year. Uncle passed away at the age of 93. May his soul rest in peace.

#### **Martin Khor**

SM Mohamed Idris was the most special man on Earth to me, my spiritual and intellectual father. Malaysia lost a great man.

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## **WHO 21<sup>st</sup> (2019) model list of essential medicines**

<https://apps.who.int/iris/handle/10665/325771>

The 21<sup>st</sup> Model List and the new (7<sup>th</sup>) Children's List were released in June. It is clear that the process of generating the lists is based on consideration of the best treatment for the target conditions. It is important that national lists are developed according to the same procedure, ie setting specific treatment guidelines should come first, and then the essential drug list automatically becomes the list of drugs recommended in the guidelines.

### **Zinc with ORS for childhood diarrhea**

Both the new 21<sup>st</sup> (2019) WHO Essential Medicines List and the new Children's List include Zinc with ORS for childhood diarrhea.

21<sup>st</sup> list: <https://apps.who.int/iris/handle/10665/325771>

EML for Children:

<https://apps.who.int/iris/handle/10665/325772>

According to the British Medical Journal <sup>1</sup>

*Acute diarrhoea is the second biggest cause of death in children worldwide, causing 1.2 million deaths each year. Rotavirus vaccines, clean water, sanitation, and other preventive measures are important in reducing this burden. However, vaccines are only partially effective and will not prevent many deaths, and other preventive interventions are relatively costly or difficult to scale up quickly. Treatment with ORS and zinc could rapidly and cost efficiently avert most of the deaths not prevented by vaccines.*

The WHO includes co-packaged ORS and Zinc but that form is not widely available. Zinc tablets are being divided and used in many places. Dispersible zinc tablets are becoming more easily available and their use leads to better accuracy of dosing.

**Cancer treatments:** While several new cancer treatments have been marketed in recent years, only a few deliver sufficient therapeutic benefits to be considered essential. The 12 medicines WHO added to the new Medicines List for five cancer therapies are regarded as the best in terms of survival rates to treat

melanoma, lung, prostate, multiple myeloma and leukemia cancers.

For example, two recently developed immunotherapies (nivolumab and pembrolizumab) have delivered up to 50% survival rates for advanced melanoma, a cancer that until recently was incurable.

**Antibiotics:** The Essential Medicines Committee strengthened advice on antibiotic use by updating the AWARE categories, which indicate which antibiotics to use for the most common and serious infections to achieve better treatment outcomes and reduce the risk of antimicrobial resistance. The committee recommended that three new antibiotics for the treatment of multi-drug resistant infections be added as essential.

### **Other updates to the medicines list include:**

- New oral anticoagulants to prevent stroke as an alternative to warfarin for atrial fibrillation and treatment of deep vein thrombosis. These are particularly advantageous for low-income countries as, unlike warfarin, they do not require regular monitoring;
- Biologics and their respective biosimilars for chronic inflammatory conditions such as rheumatoid arthritis and inflammatory bowel diseases;
- Heat-stable carbetocin for the prevention of postpartum haemorrhage. This new formulation has similar effects to oxytocin, the current standard therapy, but offers advantages for tropical countries as it does not require refrigeration.

Not all submissions to the EML Committee are included in the list. For example, medicines for multiple sclerosis submitted for inclusion were not listed and some relevant therapeutic options currently marketed in many countries were not included in the submissions; it will welcome a revised application with all relevant available options. The EML Committee also did not recommend including methylphenidate, a medicine for attention deficit hyperactivity disorder (ADHD), as the committee found uncertainties in the estimates of benefit.

### **The List of Essential (in vitro) Diagnostics**

The first List of Essential Diagnostics was published in 2018, concentrating on a limited number of priority diseases - HIV, malaria, tuberculosis, and hepatitis. This year's list has expanded to include more non-communicable and communicable diseases.

**Cancer tests:** Given how critical it is to secure an early cancer diagnosis (70% of cancer deaths occur in low- and middle-income countries largely because most patients are diagnosed too late), WHO added 12 tests to the Diagnostics List to detect a wide range of solid tumours such as colorectal, liver, cervical, prostate, breast and germ cell cancers, as well as leukaemia and

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<sup>1</sup> <https://www.bmj.com/content/344/bmj.e940>

<sup>2</sup> <https://consultations.health.gov.au/ohpd-health-protection-policy->



lymphomas. To support appropriate cancer diagnosis, a new section covering anatomical pathology testing was added to be made available in specialised laboratories.

**Infectious diseases tests:** The list focuses on additional infectious diseases prevalent in low- and middle-income countries such as cholera, and neglected diseases like leishmaniasis, schistosomiasis, dengue, and Zika.

In addition, a new section for influenza testing was added for community health settings where no laboratories are available.

**General tests:** The list was also expanded to include additional general tests which address a range of different diseases and conditions, such as iron tests (for anaemia), and tests to diagnose thyroid malfunction and sickle cell (an inherited form of anaemia very widely present in Sub-Saharan Africa).

Another notable update is a new section specific to tests intended for screening of blood donations. This is part of a WHO-wide strategy to make blood transfusions safer.

**The List of Essential Diagnostics** was introduced in 2018 to guide the supply of tests and improve treatment outcomes,' said Maria Ângela Simão, WHO Assistant Director-General for Medicines and Health Products. 'As countries move towards universal health coverage and medicines become more available, it will be crucial to have the right diagnostic tools to ensure appropriate treatment.'

[https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(19\)30459-0/fulltext](https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(19)30459-0/fulltext)

## Improving affordability of new Essential Cancer Medicines

Ellen 'tHoen, Salomi Meyer, Patrick Durisch, Wilbert Bannenberg, Katrina Perehudoff, Tim Reed, Melissa J Barber  
Published: July 11, 2019

Effective cancer care requires investment in health infrastructure, a trained health workforce, and quality-assured, affordable medicines within a sustainable supply chain. To this end, in a major move to increase access to cancer medicines in low-income and middle-income countries (LMICs), WHO has added ten new cancer therapies to its 21st Model List of Essential Medicines.<sup>1</sup> When WHO labels medicines as essential, it means that they have proven their utility and should be available and affordable to all. Therefore, these medicines should be included in national essential medicines lists, which would enable governments to use scarce resources to select medicines more effectively.

Including cancer medicines in the WHO Essential Medicines List is the crucial first step. Effective national policies incorporating legal and regulatory frameworks

that promote access are needed to make cancer diagnosis and treatment widely available.<sup>2</sup> Cancer medicines often come at a high price, creating challenges even for high income countries (HICs), while their availability in LMICs is limited or non-existent. The new WHO Essential Medicines List should prompt governments and other stakeholders to take action to decrease the price of medicines in order to make them accessible.

The situation of lenalidomide in South Africa is a case in point. Lenalidomide is an essential medicine for the treatment of multiple myeloma. Until 2016, South African patients had access to generic lenalidomide manufactured in India under a section 21 legal authorisation that allows the sale and use of unregistered products. The generic lenalidomide was priced at US\$2289 per patient per year. This authorisation was withdrawn when Celgene registered its patented product in the country and priced it at \$51,000 per patient per year.

The medicine is now no longer available in the public sector, which cares for 84% of the population. Patients in the private sector are also struggling to pay the 20% co-payment. In India, however, where the patent application for lenalidomide was rejected, the generic versions are available for \$2000 per patient per year.<sup>3</sup> Another example is afatinib, which is a first-line tyrosine kinase inhibitor used to treat lung cancer, the leading cause of death from cancer in men in LMICs and the second leading cause after breast cancer in women.<sup>4</sup> Afatinib, now listed in the Essential Medicines List as equivalent to erlotinib, is not widely available in LMICs, and when this medicine is available, its price is a major challenge to access. For example, in Pakistan, where afatinib costs over \$1000 per month of treatment,<sup>5</sup> many patients cannot afford it.

Studies on the cost of production of cancer medicines show that substantial reduction in price is possible. Using a validated algorithm<sup>6</sup> for estimating the cost of production, accounting for tax and a 10% profit margin, it is estimated that lenalidomide could cost \$2.55 per month, afatinib could cost \$8.85 per month, and abiraterone \$60.97 per month.

The drive to lower the price for medicines is always met by concern about the loss of revenue to finance the research and development sector. Yet the global sales figures for medicines that have been on the market in HICs further provide evidence that this concern is unwarranted. For instance, cumulative sales incomes of cancer medicines in 2017 for trastuzumab and rituximab were \$88.18 billion and \$93.74 billion, respectively. WHO studied sales revenue from 99 cancer medicines approved by the FDA from 1989 to 2017, illustrating that the average financial return on investment was \$1450

for every \$1 of spending. A third of the cancer medicines studied had already reached blockbuster status with over \$1 billion annual sales income.<sup>7</sup> Most of these sales take place in HICs. Therefore, making these new medicines affordable in LMICs is not likely to impair future research and development.

Countries could take some of the following measures to improve access to cancer medicines, including new paediatric cancer drugs: pooling their procurement at the regional or subregional level to create economies of scale and increase their negotiating power, encouraging sustainable supply of low-cost generics<sup>8</sup> and the uptake of biosimilars, and using flexibility in trade-related aspects of intellectual property rights (TRIPS) agreements to lift a patent monopoly when needed to access generics. Pharmaceutical companies should also engage in public health oriented voluntary licensing of products through the Medicines Patent Pool. There is ample evidence that the abovementioned options work in other fields, notably in the area of HIV and hepatitis C virus.<sup>9,10</sup>

Countries will continue to need the support of WHO in expanding cancer care and treatment. WHO's pivotal report on cancer medicines pricing necessitates that the organisation steps up its attention on cancer care and translates these efforts into forceful strategies.

We declare no competing interests.

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## Australia: *National Medicine Policy Review*

Medical Journal of Australia *Perspective*

[https://www.mja.com.au/system/files/issues/211\\_06/mja250268.pdf](https://www.mja.com.au/system/files/issues/211_06/mja250268.pdf)

The world and Australia today are nothing like they were back in 1999 when the first Australian NMP was published. Even if the four pillars in the original policy stand the test of time, the issues around them have evolved. The NMP should be comprehensively reviewed with a brief to involve all stakeholders in the medicines system in a broad consultation process, including dialogue, forums and conferences. Consultation should involve groups such as government, consumers, health care professionals and industry.

The review should consider the strategic background and issues that influence Australia's medicines policy environment today and into the future to improve the health outcomes of Australians. How will disruptive innovation, digital and information technologies, precision medicine, the interaction of medicines with devices and diagnostics, changing consumer preferences in areas such as complementary medicines, an ageing population, climate change, immigration, the geopolitical and economic environment, and the emerging economies in the world affect Australia's medicines policy environment going forward? The review should include an evaluation of the impact of the existing NMP and its four pillars on health policy and health outcomes for the broader community. There are many issues that should be considered as part of the review. A thematic review of national medicines policies from various countries include areas not addressed in Australia's current NMP:

- pharmaceutical waste disposal and environmental protection;
- management and disposal of unsafe and unwanted medicines;
- antimicrobial resistance and antibiotics;
- information technology, data analysis, web-based systems;
- electronic media;
- patient responsibility and health literacy;
- health workforce planning and development;
- intellectual property; and
- globalisation, international cooperation and global health issues.

Finally, there is a need for an awareness campaign for policy makers, politicians, the private sector, stakeholders and the community on what the NMP is and what it does.

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### **Australia: Time to Focus on Antibiotics in Agriculture**

Tony Marshall, MJA Insight Issue 30 / 5 August 2019  
<https://tinyurl.com/y337yb5r>

In 2017, the Chief Medical Officer wrote to general practitioners in the top 30% of prescribers to seek their assistance in reducing unnecessary antibiotic prescribing. The result was 12% reduction in antibiotic prescriptions filled or approximately 126,000 fewer scripts over an initial 6-month period.

While this is undoubtedly some achievement, it is likely to have a negligible effect on overall level of antibiotic use. The reason why is that doctors are not the only culprits when it comes to overusing antibiotics – farming is the big elephant in the room.

According to the US Food and Drug Administration, around 80% of all antibiotics are sold or distributed for use in food-producing animals. And in Denmark, pigs account for over three-quarters of antimicrobial agents consumed.

The issue seems no better in low income countries. In June 2019, Professor ABM Faroque of Dhaka University in Bangladesh called a press conference to reveal that several antibiotics, including levofloxacin, ciprofloxacin and azithromycin, were found in seven of the country's popular pasteurised milk brands.

The antibiotics used on animals are not used solely for treatment or even prevention of infection. The prime reason for their use is to increase animal productivity – that is, to fatten the animals up in order to enhance meat production. Apparently, this is achieved by antibiotics changing the animals' gut flora, so that they

digest and excrete, not in the usual way, but in a way that retains most of what they eat.

Simply put, antibiotics are used by clever capitalists to produce meat cheaply. We can reasonably assume that none of them have much regard for the long term effects of this abuse of science on the health of the entire population of earth.

An additional indirect and longer term effect of this practice is on global warming.

Approximately 20% of global warming is due to methane gas, with about 40% of that amount produced by farmed animals for meat production.

While the argument here is not to deny the virtues of evidence-based medicine that doctors should abide by, it is to highlight the government's failure to date to put enough focus on the major root cause of the antimicrobial-resistance crisis.

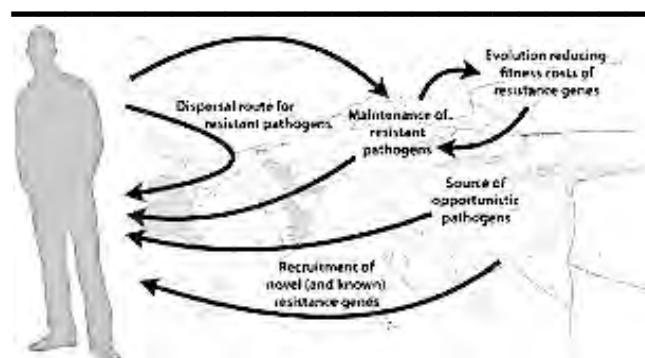
### **However, there is a ray of hope in Australia**

The federal Department of Health's latest consultation paper on the issue – Australia's antimicrobial resistance strategy: 2020 and beyond<sup>2</sup> – has been drawn up in conjunction with the federal Department of Agriculture.

The consultation calls for 'implementing effective antimicrobial stewardship across human health and animal care settings to ensure the appropriate and judicious prescribing, dispensing and administering of antibiotics'.

The 20-year vision will see the development of specific action plans for different sectors and will include not only health care and pharmaceutical professionals, but veterinarian food animal producers and food manufacturers, agriculture and consumers.

As doctors we need to do everything we can to prevent the disastrous doomsday scenario where no antibiotics are effective. That means doing our part but also encouraging others to do theirs.




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<sup>2</sup> [https://consultations.health.gov.au/ohpd-health-protection-policy-branch/consultation-on-next-amr-strategy/user\\_uploads/amr-report-accessible-version.pdf](https://consultations.health.gov.au/ohpd-health-protection-policy-branch/consultation-on-next-amr-strategy/user_uploads/amr-report-accessible-version.pdf)

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## India

### ***Colistin 'banned' in animal food industry in India***

It was reported in *The Hindu*, July 20, 2019<sup>3</sup> that the Indian Ministry of Health and Family Welfare has issued an order prohibiting the manufacture, sale and distribution of colistin and its formulations for food-producing animals, poultry, aqua farming and animal feed supplements.

Colistin is a valuable, last-resort antibiotic that saves lives in critical care units. In recent years, medical professionals have been alarmed by the number of patients who have exhibited resistance to the drug. Therefore, any move to ensure that arbitrary use of colistin in the food industry, particularly as growth supplements used in animals, poultry, aqua farms, would be likely to reduce the antimicrobial resistance within the country.

The order directed manufacturers of colistin and its formulations for human use to affix a label on the container reading thus: 'Not to be used in food producing animals, poultry, aqua farming and animal feed supplements: on the package, insert and promotional literature'.

Late last year, researchers from Apollo Cancer Hospital, Chennai, and Christian Medical College, Vellore, claimed, in a paper in the *Journal of Global Antimicrobial Resistance*, that samples of raw food lifted from across Chennai had tested positive for colistin-resistant bacteria.

V. Ramasubramanian, infectious diseases expert, and medical director, Capstone clinic said. 'Excessive use of any drug leads to resistance. If you can cut the use of colistin as a growth factor in animals and limit it to therapeutic usage only, the chances of developing resistance to it goes down,' while pointing out it might be a challenge to implement the order.

Awareness programmes need to be conducted for farmers, who are mostly unaware of the dangers of colistin in animal food. It is suggested that since the bulk of colistin (nearly 95%) is imported from China, it would be easy to stop importing it within a short time.

*We in HAIAP also wonder how the ban will be enforced and the import from China stopped.*

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<sup>3</sup><https://www.thehindu.com/news/natin-animal-food-industry/article28621663.ece>

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## Indian government proposal to ban e-cigarettes

### ***Smoking e-cigarettes is more injurious to health***

Amit Yadav in *The Hindu*, July 23, 2019

Amit Yadav is a postdoctoral scholar at the Centre for Tobacco Control Research and Education, University of California, San Francisco

<https://tinyurl.com/y2bf42n>

The Narendra Modi government's proposal to ban e-cigarettes and other electronic nicotine delivery systems (ENDS) needs to be welcomed as such a move will ensure that Indians, especially, children, are kept away from these pernicious products. Such a ban has also been recommended by the Indian Council of Medical Research (ICMR), which called for a "complete prohibition on ENDS and e-cigarettes in India in the greater interest of protecting public health, in accordance with the precautionary principle preventing public harm from a noxious agent."



The Health Ministry last year issued an advisory asking the States to ensure that products like e-cigarettes and e-nicotine-flavoured hookahs are not manufactured, distributed, advertised or sold. Following this, 15 States, including Karnataka, Kerala, Tamil Nadu, Jammu and Kashmir and Mizoram, banned them. Several of the bans were under the Drugs and Cosmetics Act or the Poisons Act, under which nicotine was included as a 'poison'. Further, the Central Board of Indirect Taxes and Customs (Anti-Smuggling Unit) and the Drug Controller General of India directed all their officials to ensure compliance with the advisory.

### **Popularity among youth**

Introduced about 10 years ago in India, e-cigarettes rapidly gained popularity, especially among the youth. A misconception among students, parents and teachers that these cigarettes are free of nicotine also contributed to their appeal. The reality is that the tobacco industry, hit by the success of efforts to reduce tobacco use, had developed such products to hold on to



customers who would have otherwise quit. Research suggests that many youngsters, who would otherwise have never started using nicotine, took up conventional smoking after being introduced to e-cigarettes.

While the tobacco companies promote e-cigarettes as a 'less risky' smoking option, some industry documents show that their real goal is to introduce ENDS products as an alternative to quitting. One company started selling its e-cigarette brand in 2014, promising that it will give the consumers the 'pleasure of smoking any time anywhere' (suggesting that they could use the product even at public places, where smoking is banned).

Further, even though warnings on many ENDS products clearly indicate that they are not a 'smoking cessation product', e-cigarettes are often promoted that way. Dozens of studies show that smokers who use e-cigarettes are less, not more, likely to quit smoking. In fact, most of them become 'dual users', continuing to smoke cigarettes while also taking to e-cigarettes. This makes them vulnerable to added health risks.



The tobacco industry plans to expand by attracting more youngsters and reducing quitting by adults. After all, the industry's end goal is profit and not improvement in health indicators. The fact that the industry continues to produce and sell conventional cigarettes, its flagship product that brings it the greatest amount of profit, despite marketing e-cigarettes as an alternative is evidence enough of its sinister design.

### Myths and reality

A recent white paper by the ICMR and several other research studies have contradicted several claims of the industry. First, the industry says that ENDS products provide a safer alternative to conventional cigarettes. However, the reality is that ENDS users are almost at the same risk of contracting lung diseases and cancer as conventional cigarette users. In fact, 'dual users' are at greater risk of heart attacks.

Further, the industry claims that the sale of ENDS products does not violate any regulations despite the fact that the companies are in clear violation of WHO's Framework Convention on Tobacco Control, which prohibits the sale of any product that appeals to minors. The marketing of ENDS products, targeted at youth, also affects minors and schoolchildren. The industry's assertion that e-cigarettes are safe is contradicted by the many fires and explosions caused by devices, resulting in injuries, loss of lives and property. Further, their accidental ingestion by children has also caused some deaths.

All these points make it clear that the Central government has shown great foresight in bringing out the ban proposal, a move that is likely to avoid causing another epidemic of nicotine addiction in the country. The ban needs to apply to all forms of ENDS products, including all 'heat-not-burn' devices that profess to be an alternative to the existing tobacco products.

## Trade agreements lead to obesity, diabetes and heart disease

You wouldn't think that free-trade deals could lead to a diabetes and obesity epidemic, but they have. The global south has free trade to thank for its obesity and diabetes epidemic. Junk food companies seeking growth markets flood poor countries with cheap, unhealthy food. The consequences are devastating.<sup>4</sup>

There is plenty of research evidence of the impact of trade and investment agreements on NCDs such as heart disease, and on major risk factors such as obesity and tobacco use.<sup>5</sup>

One study for example, revealed that consumption of sugar-sweetened beverages in Vietnam spiked dramatically after that country opened itself to trade and foreign investment. Soft drink companies based in the United States increased their market presence even as the World Health Organization identified the rise in consumption of high-sugar content drinks as a major cause of rising youth obesity.

Another study found that consumption of unhealthy foods and sugary drinks increases after implementation of trade agreements, often those with the U.S. There



<sup>4</sup> <https://www.theguardian.com/commentisfree/2015/apr/06/global-south-has-free-trade-to-thank-obesity-diabetes-epidemic>

<sup>5</sup> <https://theconversation.com/the-hidden-connection-between-obesity-heart-disease-and-trade-85883>

was also a correlation between such trade agreements and higher rates of heart disease and obesity.

### **Pacific islanders pay a heavy price for abandoning traditional diet**

Replacing traditional foods with imported, processed food has contributed to the high prevalence of obesity and related health problems in the Pacific islands.



Scattered across the Pacific Ocean are thousands of islands which make up three regions known as Melanesia, Micronesia and Polynesia. Beyond the image of white sandy beaches and carefree lifestyles, the Pacific islands are facing serious health problems, the prime culprit being imported foods.<sup>6</sup>

Colonized by Australian, American, New Zealand, British or French nations after the World War II, the diets and social lives of the people living on the islands were drastically changed. The former colonial powers remain responsible for keeping the supermarket shelves full of processed, fatty and sugary foods,

Traditional foods of the islands such as fresh fish, meat and local fruits and vegetables have been replaced by rice, sugar, flour, canned meats, canned fruits and vegetables, soft drinks and beer.

## **Can Trade Policy Really Impact Public Health?**

### ***An Obesity Case Study from Mexico***

July 24 2019

By Ioulia Fenton

Institute for Agriculture and Trade Policy (IATP) researchers specifically looked at the increases of

imports of certain U.S. originated foods and agricultural products into Mexico that followed the implementation of the North American Free Trade Agreement (NAFTA). NAFTA is a tri-lateral trade liberalization agreement between Mexico, Canada, and the United States that came into effect in 1994.

The researchers tracked increases of U.S. exports of such categories as soft drinks, snack foods, processed meats, and dairy products. They also measured cross-border flows of raw agricultural inputs, such as corn and soybeans, which are used in food processing. They linked the resulting increased consumption of unhealthy foods among the Mexican population to a 12 per cent increase in obesity between 2000 and 2006—a rise that coincides with NAFTA implementation over the same period. The study concluded that United States exports obesity to Mexico arguing that, ‘facilitated by NAFTA, these exports are one important way in which U.S. agriculture and trade policy influences Mexico’s food system.’

Sodas and other sugary beverages are a big part of the problem. Researchers from Yale University’s Rudd Centre for Food Policy and Obesity, for example, analysed 88 previous studies on the links between them and health and nutritional outcomes. They concluded that high soft drink consumption has proven biomedical links with obesity, type 2 diabetes, hypertension, high blood pressure, dental caries, and reduced calcium intake, among others. These findings are worrying for a country like Mexico, which, facilitated by trade liberalization, is now the largest consumer of Coca-Cola products in the world. The company sold 172 litres of beverage per capita in 2011, up from a pre-NAFTA level of 69 litres in 1991.

<sup>6</sup> <https://www.who.int/bulletin/volumes/88/7/10-010710/en/>



Professor Barry Popkin at the University of Carolina Population Centre also believes that governments can and should use trade to improve the health of their citizens.

'The Mexican government is panicking about the economic repercussions of the obesity crisis and is devising a number of non-trade initiatives to help combat it,' he noted. A food packaging labeling system that alerts shoppers to healthy and unhealthy foods is one such proposed example. However, according to Popkin, who has worked with the Mexican authorities for a number of years, the proposal is facing an uphill battle. It has seen a major split within the food industry. 'It has won the backing of such international players as Kraft, Unilever, and Danone, but faces fierce opposition from Coca-Cola, Pepsi-Co, General Mills, and Kellogg's,' he said.

See the whole article here

<https://www.theguardian.com/global-development/gallery/2018/jan/01/free-trade-deal-health-crisis-mexico-obesity-malnutrition-in-pictures>

## Award to Marg Ewen - HAI Europe

Helen Clark - JoPPP Award Winner

Started in 2018, the annual Helen Clark Journal of Pharmaceutical Policy and Practice (JoPPP) Award recognises the talents of exceptional researchers, who are making a significant contribution to the field of pharmaceutical policy and practice. The Award is named after Honourable Helen Elizabeth Clark, former Prime Minister of New Zealand.

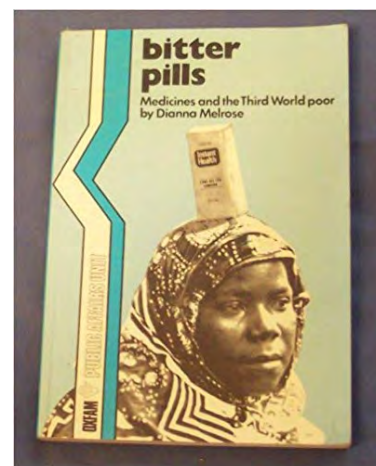
Professor Zaheer-Ud-Din Babar, Chair of the Judging Panel and Editor-in-Chief of the journal said: 'This year Award Winners, Marg Ewen and Sabine Volger, both have made a significant contribution towards our understanding of pharmaceutical pricing and policy research.'

Dr Margaret Ewen is Senior Projects Manager, Medicines Prices at Health Action International in Amsterdam. In addition to being a pharmacist, Margaret is an internationally-recognised expert in medicine pricing issues. She co-led the WHO/HAI Project on Medicine Prices and Availability which included developing a methodology to measure medicine prices, availability, affordability and price components. Since its publication, she has lead or provided expertise to over 100 of these surveys around the world.

Marg Ewen currently co-leads the Addressing the Challenge and Constraints of Insulin Sources and Supply (ACCISS) Study. She came to HAI from New Zealand in 2000 where she had been a senior advisor at the Medicines Regulatory Authority (Medsafe).

## 'Historic' Books for Advocacy and Action

Many of you will remember the world changing books written and published – particularly in the 1970s and 80s - ... books that informed, exposed and explained activities of 'actors' with vested interests in developments in the essential medicines movement; while providing guidance for those of us working for equity of access to health and essential medicines.

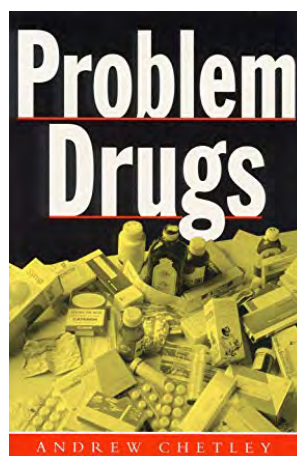


These are books that should not be forgotten. Many of them are no longer generally available but many will be on your shelves. Some of the 'old' titles can be found as

second hand copies from international commercial on-line distributors.

In 2014, Douglas Ball, one of the E-drug moderators, compiled a list of these significant books.

The list ended up with around 250 titles – starting in 1908. Douglas prepared the list as an Excel document as the convenient way to store the information.



You can download the document from here

<http://www.haiasiapacific.org/wp-content/uploads/2019/07/List-of-books-Essential-Meds-Advocacy-Action-to-2014-by-date.xlsx>

The document opens in chronological order. However by clicking on the column headings and selecting **Sort** under the **Data** pull-down menu you can choose any other point of reference.

There is more information available under the headings along the bottom row of the document: Categories of books, films, other references, useful links, rejects from the list, key words and an export table.

More publications can be added as they are found. Please do let use know about anything you think should be included.

**We look forward to receiving your suggestions for additions**

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## Feature 1: Towards Universal Health Care (UHC): Second Kerala Development Model - AARDRAM MISSION Transformation

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Dr Ekbal Bappukunju

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Kerala's health sector has been celebrated as 'good health at low cost'. In many respects Kerala's health indices are comparable with those of developed economies. The State has the lowest infant and maternal mortality, highest life expectancy and literacy and the best sex ratio in the country. A well coordinated effort to address various social determinants of health along with an effective publicly funded health care delivery system has contributed to this achievement.

However since the early 80s, due to the epidemiological and demographic transition of the past three decades, the state has been facing the double burden of diseases - non-communicable and communicable diseases. The incidence of lifestyle diseases or non-communicable (NCD) like diabetes, hypertension, coronary artery diseases, cardiovascular diseases and cancer have increased. The society is also facing resurgence of communicable diseases like malaria and new epidemics like dengue, leptospirosis and H1N1. The incidence of mental illnesses including suicides and death and disability due to accidents and trauma is also on the rise. The health of marginalized groups like tribals, fisher-folk and migrant labourers is an added challenge to the state.

The inability of the public health system to manage the huge patient load due to its poor infrastructure and human resources, inefficient primary care services, lack of proper referral linkages and excessive privatization had ranked the state to the highest for out-of pocket expenditure (OOPE) in health.

The challenges in the health sector of the state call for a total revamp of the health care delivery system with a sharp focus on a strong primary and preventive care while strengthening the secondary and tertiary care.

The **Aardram Mission** (Aardram means compassion) is an initiative taken up by the Government of Kerala in a mission mode under the 'Nava Kerala' initiative in 2016.<sup>7</sup> The Mission aims at transforming the public health sector towards a people friendly model with the

target of achieving Sustainable Development Goals (SDG).<sup>8</sup>

The Government of Kerala with the help of various expert groups on health has charted the core areas in health that the state need to focus upon. The targets and specific goals to be achieved by 2020 and 2030 are in sync with SDGs and strategies to be adopted to achieve these goals is also formulated. To achieve SDG 2020 and 2030, the state has to improve the quality of health care delivery at the primary, secondary and tertiary levels by increasing resources both human and financial and also addressing the inequality in health care provision.

To transform the public health sector so as to be accessible for all citizens especially the poor, **Aardram Mission** focuses on four key areas.

*Medical Colleges, General Hospitals, District Hospitals, Community Health Centres and Primary Health Centres will benefit from this process.* The aim is to change the hospital administration and processes so that hospitals are more patient friendly - for example: Improved infrastructure with adequate seating facility, drinking water and toilet facilities; introduction of conveniences such as advance booking of doctor's appointments, token system; digitization in registration, consultation, pharmacy, laboratory and other investigation areas; location maps and signing. When the 'E-health' system is fully functional, it will enable a Web based appointment system, patient reception and registration, an electronic display board for each consultant, and an improved system for referrals and follow up.

The **Mission** also envisages improving patient management by following clinical guidelines prepared by expert groups and also monitoring the quality of services provided. To maintain the quality, adequate human resources and logistics are to be provided. The Local Self Government (LSG) plays an important role in provision of both in public health institutions transferred to them.

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<sup>7</sup> **Nava Kerala Mission** is an initiative of the Pinarayi Vijayan-led Government of Kerala launched in November 2016. The initiative seeks to address problems faced in four key social sectors, namely, health, education, agriculture and housing, with the help and involvement of local self-governments.

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<sup>8</sup> The 2030 agenda for Sustainable Development Goals adopted by 54 nations in United Nation's Sustainable Development Summit in September 2015 includes a set of 17 SDGs with 169 targets to end poverty and provide good health and well being to all by 2030.



### **Provision of all basic specialty services in all Taluk level hospitals / General and District hospitals and introduction of Super Specialty services in major General and District hospitals:**

Taluk level and District level hospitals are presently delivering secondary care services. The majority of Taluk and District level hospitals started before independence or within the first decade of independence. Except for a few General hospitals all of the above category hospitals have been transferred to LSGs with introduction of the 73<sup>rd</sup> amendment. With good leadership of LSG with community participation and governmental support a few of these institutions have developed par excellence. However, due to various reasons not all these hospitals could provide services as expected and moreover there is a huge variation in human resources and services provided. This situation is more evident in backward districts of the state.

To address the issues, the **Aardram Mission** aims at standardisation of different categories of hospitals in infrastructure, human resource and service provision.

In Taluk hospitals, modernised patient-friendly out patient (OP) services with all basic specialty services and standardised investigation facilities, dialysis services and regular supply of drugs as per guidelines will be available.

Major super-specialties like Cardiology, Nephrology and Neurology services will be available in major General and District level hospitals.

All Government Medical Colleges in the state will benefit from the **Aardram Mission** through OP service transformation, digitization and conversion to centres of excellence.

**Marginalised groups:** Basic health care services will be available for all marginalized groups in the state: tribal communities and fisher folk continue to be marginalized groups. Recently this group has expanded to include migrant labourers especially in urban slums as well as transgenders.

Even though the health indicators of the state compare better to the rest of India, the health indicators of these groups are far below the state average. Each group has varied and unique health issues need to be addressed as part of their mainstreaming.

**Aardram Mission** gives special focus on strengthening health care delivery services in tribal, coastal and urban areas.

### **Re-engineering Primary Health Centres (PHC) into Family Health Centres (FHC):**

Though the existing Primary Health Centres were constituted to provide comprehensive primary care, the

majority ended up focusing mainly on curative aspects of health care.

### **What is a Family Health Centre?**

The idea of bringing in a new health culture with a comprehensive approach provides a vision of considering the family as a unit for health service delivery. The plan resulted in the formation of Family Health Centres.

Therefore the Family Health Centre is the most revolutionary part of the **Aardram Mission** which is intended to provide comprehensive people friendly services to all families thereby ensuring universality of primary care. It follows certain basic principles like universality and non-discriminative, equitable, family based, comprehensive care, ie preventive, promotive, curative, rehabilitative and palliative care. The framework includes financial protection, quality rational care, continuity of care, community participation, protection of patients rights, transparency and accountability and responsiveness.

The strategic agenda for the conversion to FHCs includes strengthening the primary health care framework, improving quality of services, addressing social determinants of health and community participation.

Activities are being implemented all over the state according to the **Aardram Mission** strategies. In selected Primary Health Centres there is standardized infrastructural modification to develop capacity for functioning as FHCs and Subcentres - appointment of additional doctors, nurses, lab technicians and pharmacists together with procurement of equipment and recruitment of community volunteers (Arogyasena). Standard clinical guidelines and treatment protocols have been developed to strengthen curative services through evidence based management of common clinical conditions in FHC. Capacity building of Medical Officers, Staff nurses, Paramedical and field staff are going on. **Aardram Mission** also ensures strengthening of field activities with provision for rehabilitative services, improving quality of existing palliative care and integrating volunteer groups to improve community participation.

In addition to the existing clinical services in FHCs, innovative clinical services are added, eg 'SWAAS'<sup>9</sup> program to manage patients with Chronic Obstructive Pulmonary Diseases (COPD) and Bronchial Asthma and "AASWAS" programme to deal patients with mental illness especially depression. Counselling services will be ensured by the nurses in FHCs to support nutrition and diet management in lifestyle diseases, physical

<sup>9</sup> "SHWAAS" is a Sanskrit word meaning 'breathe.'

activity, tobacco cessation, etc. Another initiative under **Aardram** is **outreach institutional services** catering for the health needs of inmates in orphanages, old age homes and hostels; and provision of basic health care in workplaces, offices and schools.

The Health Care Services Delivery Plan in FHCs is based on an individual and family health plan which grows out to a ward and panchayath health care plan. The individual Health Care Plans are developed based on age, gender and disease. Each Health Care Plan ensures all domains of primary care.

In FHCs OP services will be available from 9.00 AM to 6.00 PM.

#### **Role of Local Self Government (LSG) in FHCs:**

The LSGs play a crucial role in the day to day functioning and ensuring quality primary care to each and every citizen in the area. Identifying the health problem in the community, addressing social determinations of health, developing punchayath specific SDG targets, preparing and implementing panchayath projects based on the SDG target and health issues and mobilization of resources are the most important functions of the LSG. Moreover the LSG has the responsibility to develop trained community health volunteer teams (Arogyasena) and to empower each and every individual for a healthy living.

For the success of any program in the health sector convergence (coming together) is essential.

Convergence of various departments and other missions in Nava Kerala at the State and District and LSGs levels plays a vital role in moving the mission forward.

**Aardram Mission** work is complementary to the other three missions under Nava Kerala initiative <sup>10</sup> – Livelihood inclusion and Financial Empowerment (LIFE), Comprehensive Public Education and Rejuvenation, (universal education) and Haritha Keralam Mission (water and food safety, sanitation and safe disposal of waste and sustainable development of water resources).

#### **Funds for Aardram Mission:**

Financial support for the mission is through different sources. Existing governmental support through plan schemes, various developmental funds like NABARD Scheme, MPs and MLAs LAC – ADC funds, LSG projects, National Health Mission funds are streamlined in such a way that the institution master plan is fulfilled in a time bound manner without duplication or wastage of resources. Moreover funds are allotted under Kerala Infrastructural Investment Fund Board (KIIFB). Human resources in supported by the state government by creating additional posts in various categories.

Thus with a strong political will, good planning and coordinated effort the **Aardram Mission** hope to create history and show the world a 'Second Kerala Model Development.



With a NQAS score of 99% Kayyur Primary Health Centre in Kasaragod district has been selected as the best PHC in the country by National Health Mission. A total of seven PHCs in the Kerala state secured the National Quality Assurance Standards (NQAS) certification. The NQAS certification is awarded by the National Health Mission, under the Ministry of Health and Family Welfare.



<sup>10</sup> The initiative seeks to address problems faced in four key social sectors, namely, health, education, agriculture and housing, with the help and involvement of local self-governments.

## Feature 2: Healthy Ageing, Clubs and PHC: Indian State of Kerala and the Nuwara Eliya District in Sri Lanka

The process of rapid population ageing poses tremendous challenges to the provision of health care and social services and demands on such services could intensify as the number and proportions of older persons in populations continue to increase. The global disease profile over all is shifting from infectious to non-communicable and chronic diseases such as heart disease, stroke and cancer, many of which can be prevented or delayed through strategies which include health promotion and disease prevention.

In 1991 The *United Nations Principles for Older Persons*<sup>11</sup> reaffirmed the principles of independence, participation, care, self-fulfillment, and dignity, with older people having access to health care and benefit from family and community care and protection, in accordance with each society's system of cultural values.

In 2002, at an international conference convened by WHO in Perth, Australia, a framework was developed for older persons' universal access to community-based

primary health care; and to establish community health programs for older persons.

<https://www.who.int/ageing/projects/perth/en/>

Guidelines for Integrated care for older people were developed in 2017.

<https://www.who.int/ageing/publications/guidelines-icope/en/><sup>12</sup>

### Primary Health Care approach

[https://www.who.int/ageing/primary\\_health\\_care/en/](https://www.who.int/ageing/primary_health_care/en/)

WHO recognizes the critical role that PHC centres play in maintaining health of all people including older people worldwide and the need for PHC centres to be adapted and accessible to older populations: PHC is the principle vehicle for the delivery of health care services at the most local level of a country's health system.

**Developing countries will become old before  
they become rich**

**while industrialized countries became rich  
before they were growing old**

All countries need to be prepared to address the consequences of demographic trends. Dealing with the

### Primary Health Care (PHC) centres and PHC staff should be “age-friendly”, with particular attention to these areas:

#### Information, education and training

- ▶ Provide basic training in age, gender and culturally sensitive practices addressing knowledge, attitudes and skills for all PHC staff
- ▶ Provide basic training in core competencies of elder care for all clinical PHC staff
- ▶ Provide age, gender and culturally appropriate information on health promotion, disease management, and medications for older persons as well as their informal carers
- ▶ Review regularly the use of all medications and other therapies, including traditional medicine and practices.

#### PHC management systems

- ▶ Adapt administrative procedures to the special needs of older persons
- ▶ Facilitate access to services for low-income patients
- ▶ Support a continuum of care across the community level and between the primary, secondary and tertiary care levels
- ▶ Support continuity of care through good record-keeping across all care levels
- ▶ Ensure participation of older people in decisions on the organisation of PHC
- ▶ Provide age-appropriate information on the operation of PHC centres (such as opening hours and fee schedules).

#### Physical environment of the PHC centre

- ▶ Apply the common principles of Universal Design to the PHC centre whenever practical and affordable
- ▶ Make safe and affordable transport to the PHC centre available
- ▶ Post simple and easily readable signage to facilitate orientation of older persons
- ▶ Identify key health care staff with name boards and name badges
- ▶ Equip PHC centres with good lighting, non-slip surfaces, stable furniture and clear walkways
- ▶ Ensure that PHC facilities, including waiting areas, are clean and comfortable.

**Ensure responsiveness and sensitivity to the community by adapting these General Principles to the PHC centre.**

<sup>11</sup>  
<https://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx>

<https://apps.who.int/iris/bitstream/handle/10665/43030/9241592184.pdf;jsessionid=F335F0642BF65E1377DBC118BFCFA70A?sequence=1>  
<sup>12</sup>



increasing burden of chronic diseases requires health promotion and disease prevention intervention at community level as well as disease management strategies within the health care system.

WHO in collaboration with partners and Ministries of Health from developed and developing countries, has produced an age-friendly PHC toolkit aimed at sensitizing and educating PHC providers about the needs of older clients.

The toolkit addresses key concerns such as comprehensive and integrated care; continuum of care; physical and social environment; and PHC workers' core competencies.

WHO's 'age-friendly' primary health care project aims to sensitize and educate PHC providers about the specific needs of their older clients. Principles include:

- improving the attitudes, education and training of health care providers so that they can assess and treat conditions that afflict older persons and empower them to remain healthy
- adapting PHC management systems to the needs of older persons
- making physical access easier for older persons who may have mobility, vision or hearing impairments.

While age-friendly primary health care addresses the specific health needs of older persons, it also benefits people of all ages.

The issues covered in the brochure on the previous page are all very important but what do they mean in practice? For example:

**Medicines:** A continuous supply of particular medicines like heart or diabetes medicines is necessary to maintain continuity of treatment, so it is important to make sure that those necessary medicines are always available for regular older patients. Supporting a reliable supply of the right medicines are accurate comprehensive records of patient's conditions, treatment and stock of medicines leading to accurate quantification of stock needs and good stock management.

At the same time older people might be taking medicines that are needed only for a limited time. Those medicines should be stopped when the treatment is complete. Studies have shown that often there has been no 'stop date' on prescriptions for older people.<sup>13</sup> It is always important to check medicines that are still being taken and make sure that those that should have been stopped – have been stopped – before adding more medicines.

<sup>13</sup> <https://www.racgp.org.au/afp/2015/april/antibiotic-use-in-residential-%E2%80%A8aged-care-facilities/>

**Communication:** Quite often prescribers don't communicate as much with older patients as they do with others. Sometimes doctors provide less information and fewer instructions to older people than they do for other family members. Prescribers might talk to carers and other staff about the older patient as if the patient is not present. That issue is not addressed in the above leaflet. It is crucial that older people are included in the decision-making that affects them wherever possible.

Examination of some 'real-life' implementation of principles will provide some insight into what can make up 'Age-friendly' care.

### **Kerala: Geriatric Club attached to Primary Health Care Centre, Amrita, Kerala.<sup>14</sup>**

In the *Journal of Family Medicines Primary Care* Premnazer et al (2018) describe a Geriatric Club attached to a primary Care Hospital in Kerala. Kerala has good indicators of health and social development with life expectancy at birth of 75 years and female literacy at almost 93%. However, the authors demonstrate that aging leads to further challenges that need to be addressed. Challenges include physiological, social and mental changes with increasing depressive orders and perceived decrease in quality of life. The authors quote studies that show that absence of social engagement in older people is associated with adverse health outcomes including cognitive decline or mortality.

Amrita Urban Health Centre is a primary healthcare centre attached to the Community Medicine Department of Amrita School of Medicine, Kochi, India. The centre provides free primary healthcare to people accessing this centre; and clinical services include patient consultations, essential medicines including those for primary care management of non-communicable diseases, and basic laboratory services including blood routine, urine routine, and blood sugars using glucometer. About 30% of the OPD attendance has been by people above 60 years.

Organisation of a geriatric clinic on a particular day each week led to the opportunity for the older patients to sit together and chat over a cup of tea. It became clear that more than a cup of tea was needed and the idea of a 'club' was generated by the participants and the staff. It began meeting on Thursdays after the clinic consultations in the morning. Starting with musical participation around traditional and religious songs, the

<sup>14</sup> Lakshmi Premnazer,<sup>1</sup> Arun S. Nair,<sup>1</sup> Sujith Suji,<sup>1</sup> Amrita M. Das,<sup>2</sup> S. Divyamol,<sup>3</sup> and P. S. Rakesh<sup>1</sup>. Geriatric club attached to a primary care hospital as an effort to physically, socially, and mentally engage elderly: A case study from Kerala, India *J Family Med Prim Care*. 2018 Nov-Dec; 7(6): 1476–1481



program grew to include games, films, picnics, and festival celebrations.

*'they started celebrating their birthdays, wedding days, events happening in their families like birthdays, exam success, and marriages of their grandchildren.'*

Later, participants formed a 'Kaikottikali' team – a traditional folk-dance form – and trained each other for giving performances. Activities around this interest grew to include the presentation of performances and support for other groups and charities with the 'active' members being supported with organisation by the more passive members. Yoga training is also provided.

The Amrita club has grown to include family members and other peers; and clubs have been initiated in areas beyond Amrita.

The authors concluded that

*'Geriatric social clubs attached to primary health care hospitals with suitable contextual adaptations can engage elderly patients physically, mentally and socially such activities can have positive impact on depression and cognitive improvement'*

The following quotes from some members support the authors' conclusions:

*'I have been attending the club since the last 3 years. Attending the club is a tension relieving activity for me. I also familiarised with new medical knowledge and cleared all doubts relevant for my diabetes. My mind is more peaceful after joining the club. I wish to continue coming to club till the time I am able to.'* [71 year old woman retired high school teacher]

*'I like singing the Kolkali part most in the club. I wait for every Thursday so that I can come to the club. I felt happiness in life after joining the club'* - [94 year old woman who has attended the club since its inception]

*'To be honest our children were not taking care of us properly. We have a feeling that we have someone to take care of us now. Me and my wife are coming regularly now for this club. It is our club.'* [78 year old male retired clerk]

*I have been benefitted from the physical activity and dance happening there to keep my blood cholesterol levels under check'* [73 year old male member]

*'Thursdays are the best days in my life now. It gives us nothing other than hope. I am happy I have many to share my sorrows. But nowadays I am not getting time to share sorrows. Everybody including me is busy singing dancing and cooking'* [74 year old woman]

## Challenges and Lessons presented by the authors

**Challenges:** Throughout the formation and evolution of geriatric club at our health centre, we have not encountered any major challenges other than isolated conflicts among the members on certain decisions, for example, to have yoga next week or film show. But to a great extent, involvement of our doctors whom they respect and our social workers whom they love has solved those issues easily. We have seen such conflicts in a newly started geriatric club in the community, which has reached almost to a dead stage, before our active involvement in revamping it. Keeping the external stimulation at optimal minimal level and making the club self-reliant need to be planned and implemented carefully. Another challenge foreseen is limiting the attendance of the club for want of space and logistics. Even though two of the members who were on mobility support instruments used to attend this club, many elderly members in the community may find it difficult to participate in such ventures regularly.

**Lessons Learnt:** The club was initially perceived as an ongoing self-sustainable organization which will help senior citizens to socialize with their peers. Despite rapid growth, we are still at a formative stage and will refrain from making far-reaching suggestions or predictions. We would recommend that geriatric social clubs to be attached to primary healthcare hospitals. The value of this club lies not only in helping those old people to overcome psychological difficulties but also restoring them to their self-confidence and self-respect and ability to make fundamental social contacts. It may give them an interest, a meaning, and a purpose – a sense of still belonging to the community for remaining years of their life.

Elderly people are facing many physical, mental, emotional, and social issues. It remains so mainly in the absence of social cohesion. The bends and curves of elderly care entangle into chaos in the absence of hands to untwine them. Physically, mentally and socially engaging elderly patients attending primary healthcare setting through development of a geriatric club is a reality feasible under routine primary healthcare conditions. This model is easily replicable with suitable local adaptations to all primary healthcare facilities which has committed staff who love grey hairs.

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## **Sri Lanka: Nuwara Eliya Case study:**

### **Addressing social participation of elders in tea estate communities in Sri Lanka**

Holmes and Joseph; Globalization and Health 2011, 7:43 <sup>15</sup>

Sri Lanka is a lower middle income country with one of the fastest growing populations of older people in the world due to early gains in life expectancy and reduction in fertility rates.

A project that aims to improve the health and well-being of elders in the tea estate sector has provided useful lessons about how to increase social participation. The project is a collaboration between the PALM Foundation <sup>16</sup>, a local community development non-government organisation in Nuwara Eliya, and an international health research institute in Australia. The project, which began in 2004, covers a population of about 50,000 predominantly Tamil tea estate workers and adjacent Sinhala villagers with 4,000 elders - of age over 60 years - and their family members, in the district of Nuwara Eliya.

**Background:** In the 19th century the British brought workers from India to work in the tea estates of [then] Ceylon; they have remained a socio-economically disadvantaged group. The retired tea estate workers had little or no income, poor and crowded living conditions, and limited access to services. Many were reported to be less socially engaged than before their retirement.

Using a participatory approach a strategy was developed that included establishment of Elders' Clubs. PALM community mobilisers first made a register of older people in their estate communities and consulted them about forming Elders' Clubs. At the first meetings the elders mapped households where elders lived, including those bedridden or disabled. The Elders' Clubs chose two leaders, a woman and a man, and a name for their Club. They arrange monthly meetings and a variety of activities. There are now more than 60 Clubs with a total of several thousand members. Participatory project evaluations, with focus group discussions with elders and interviews with officials, community mobilisers and the project team, have found that the strategy has been successful at promoting social participation and has had wider benefits than anticipated.

**Greater social contact:** Activities such as playing music, dance competitions, sports, oral history and excursions to religious sites have provided greater

social contact between elders. This engagement has led to increased self-esteem, more friendships, and better relationships within families.

*'Now we live in unity. Earlier when we go on the road we don't recognise other elders, but now we are like brothers and sisters'* [Male elder].

Opportunities to practice religious rituals together are often especially important to older people. Ritual provides meaning, a sense of familiarity, belonging and continuity, opportunity to meet regularly with others, and motivation. Elders now organize their own activities:

*'A cultural competition was organized - many took part for the first time. Some of the women were saying that they danced forgetting themselves. It was one of the happiest days of their lives.'* [Field staff member]

**Greater social support:** Club members visit sick or bereaved peers, often giving pooled donations, and have organised their own saving and small loan schemes.

*'When I was sick last month, five members of our club visited me at home. I felt very happy and safe during that time. And also they offered a pooja at our kovil (temple) on behalf of me. I think that's why I recovered soon'*. [Male elder]

**Improved access to services:** Through Elders' Club meetings illiterate members were assisted to obtain identity cards which enable them to access welfare entitlements. Club meetings also facilitated the organization of eye and oral health screening (with help from *Help-Age Sri Lanka*) with referral for cataract surgery or dental treatment. The screening data has enabled advocacy with government services, for example, to treat the backlog of cataract blindness. Treating preventable blindness has great impact on quality of life of both elders and their family members:

*'In Mahauva in a family one person was paid to look after the elder who had cataract. Now after surgery there is no need for a person to look after him.'* [Community mobiliser]

*'We have come from darkness to light'* [Male elder]

*'When I was blind I felt like my hands and legs are not functional, now (after surgery) I can walk well and go anywhere, that is why I could come for this discussion too'* [Female elder]

**Greater community participation:** Leadership skills training and inter-generational activities with young people have resulted in greater community participation and respect for elders.

*'Many opportunities have reached the elders who are involved in PALM project; it has changed them psychologically; they have come out from their houses'* [Grama Niladari - Local administrative officer]

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<sup>15</sup> <http://www.globalizationandhealth.com/content/7/1/43>

<sup>16</sup> <https://palmfoundation.lk/>

*'Our way of dressing, behaviour etc, have totally changed from how it was in at the beginning, we feel like studying at schools. We are not elders, we feel like students'* [Male elder]

*'We are amazed at ourselves. We feel like youth'* [Male elder]

More youth and children are helping elders, for example, in repairing latrines, helping in watering vegetable gardens, accompanying elders to the hospital for cataract surgery, and helping with preparing and serving tea at elders' meetings.

*'They tell stories, they sing lullabies, they take us to temple festivals, they advise us not be involved in bad habits - if only they live better they will look after us'* [Young person]

**Opportunities for health promotion:** Club meetings provide opportunities for interactive health promotion sessions and have allowed the identification and training of peer educators who provide information and support about chronic conditions such as diabetes and hypertension to all age groups; those who have had cataract surgery have encouraged others who were previously reluctant to attend for surgery. Knowledge and care seeking behavior has improved:

*'The older people said that their knowledge and understanding of diseases has improved. They tend to seek medical advice more than before. Their beliefs have changed and they have realized the importance of managing some of the non communicable diseases.'* [PALM team member]

**Increased leadership:** The Clubs have grown in strength and independence and the elders soon took over managing their own clubs.

*'I am very proud of being of a leader, I have been able to get walking sticks to four people, six people have undergone surgery and they are seeing well. 16 persons have received spectacles, one person got a wheel chair. All of us have gone on trips, I am the one who organized all these and this gives me satisfaction.'* [Club Leader]

However, taking on leadership is not without its challenges and conflicts, particularly in relation to saving and small loan schemes. The leaders have their own monthly regional meeting to support and learn from each other. Clubs are vulnerable to illness, death and migration of leaders and members. Some members have domestic commitments or jobs that limit their involvement. Club leaders helped to develop their own evaluation criteria to identify weak clubs, which are invited to visit and learn from stronger clubs, with good results. The clubs have made their own savings and opened bank accounts, allowing them to apply successfully for government registration, which then

entitles them to certain benefits. The registration of the clubs has increased their status and their meetings and events are now often attended by the *Grama Niladari* (local administrative officer), and estate management. There has been steady progress towards sustainability, with many stories demonstrating increasing strength and independence.

*'The elders of Mayfield estate decided that they would publicize their active Elders' Club. They organized a sports event and decided to present gifts to poor elders. But funds were a problem. They approached business people and others and collected around Rs 10,000 (~US\$100) in cash and kind. Representatives of the central provincial council, other government officers, officers of the estate management, school heads etc. were invited. They did it in a big way.'*

*'It was amazing that the Elders' Club<sup>17</sup> themselves, with the CBO, organized this kind of a program. Most of all the people from outside came to know of this Elders' Club.'* [PALM project coordinator]

**Greater visibility and a collective voice:** Elders now have greater visibility, for example, estate management and the estate community based organizations are recognising and responding to their needs:

*'In Dayagama West 5th a water project was implemented and usually people get one tap for five houses. To get an individual connection it will cost Rs.2,500.00. There were two elders who could not pay for this. The CBO considered their situation, gave them connection to their house, and it bore the cost.'* [Field team member]

*'Thirteen elders had to climb a difficult and slippery path to get to toilets. With the involvement of the CBO a flight of stairs was constructed with railings to hold and now the elders safely go to the toilet.'* [Field team member]

Through their clubs the elders now have a collective voice to influence politicians, government services and estate management. Some Clubs have made their own official letterheads to write about their needs.

*'Medawatha elders have written a letter to the local council member requesting a common gathering hall for them, and Maha-Ouvah elders have written a letter to a Provincial Council member who was selected in the last elections, informing their activities and requests.'* [Field team member]

The success of these efforts to encourage greater social participation by elders was assisted by the familiarity of PALM Foundation workers with their own communities' social and political dynamics.

<sup>17</sup> Holmes and Joseph. Globalization and Health 2011, 7:43  
<http://www.globalizationandhealth.com/content/7/1/43> Page 5 of 8