Health Action International Asia Pacific (HAIAP)
(in collaboration with USM TWN DMDC IIUM)

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HAI AP News

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HAI AP Est. 1981

Health Action International (HAI) was formally founded in Geneva in 1981 and coordinated initially from Penang. In 1995 Health Action International Asia Pacific (HAI AP) was formed in the Asia Pacific Region as part of the international collaborative network 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 in line with the Peoples' Health Charter. *HAI AP News* is the official newsletter of Health Action International – Asia Pacific and presents the happenings in the regional campaigns for more rational and equitable health policies and carries material in support of participants' activities.

In this issue

August is a significant month. This month we have remembered Hiroshima on August 6 and re-iterated the need to take a stand against nuclear war. We have recognised the need for self determination as a pre-requisite for indigenous health on August 9, UN's International Day of the World's Indigenous Peoples. Other significant August anniversaries include The Berlin Wall, built August 13, 1961; and importantly Independence Day August 14 in Pakistan 1947 and Independence Day in India August 15: 1947.

In this issue we have contributions from many members of our HAIAP family. Thank you all!

Dr Chan Chee Khoon marks the 78th anniversary of the bombing of Hiroshima with a passionate plea for an ASEAN peoples' no nukes network.

Claudio Schuftan is calling for genuine public health systems and re-thinking of UN organisations while South Centre colleagues explain the status of attempts to achieve a pandemic treaty.

Mira Shiva shares the results of a nutritional support trial for TB patients in India and Delen de la Paz shares the story of the plight of the people of Negros in the Philippines and the campaign that has been launched for justice and human rights for those people.

Barbara Mintzes raises awareness of the role of Pharma companies in their so-called patient education activities and Mohamad Haniki Nik Mohamed, Professor of Pharmacy, Kulliyah Pharmacy, International Islamic University, Malaysia explains the current situation in Malaysia concerning the delisting of nicotine 'vapes' from the Poisons List thus unleashing a potential epidemic of nicotine poisoning and mental illness particularly among school children.

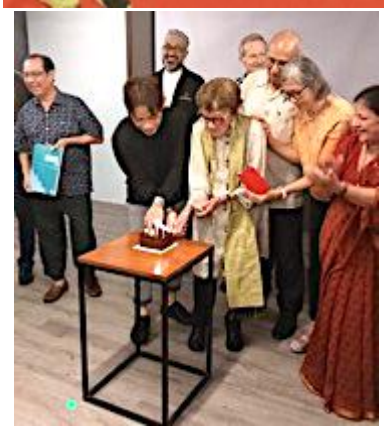
Niyada Angsulee Kiatying keeps us informed about the wide range of AMR related activities in Thailand and Thai colleagues provide an update on health for the elderly programs in Thailand.

HAIAP Forum 'Health Action for All - the way forward' May 27-29 in Penang

In collaboration with friends from the Universiti Sains Malaysia, Third World Network (TWN) and the International Islamic University Malaysia (IIUM) we presented an exciting program. The records of the event will be wonderful to share and to inspire newcomers.

Long time HAIAP partners have continued to expand their activities and they shared their challenges and achievements. Dr Tanveer Ahmed from HANDs Pakistan and Dr B Ekbal from Kerala could not be present but our USM colleague Yap Beow Kat was able to pre-record their presentations and to weave them seamlessly into the program. Similarly, Olle Hansson Award recipient Michael Tan could not be present in person but he was also with us electronically.

The complete proceedings will be an electronic document that we can share widely.



On the third day (May 29) we discussed the future of HAIAP and planned our 'way forward' together with colleagues from USM, TWN and IIUM. As May 29 was HAIAP's 42nd birthday we celebrated with a cake.

We are extremely grateful to our Penang colleagues for their enormous role in putting the event together and making it run like clock-work.

The Report of the Penang Forum will be available on the website.

Meetings of key colleagues will be held in the next weeks to discuss maintenance of key HAIAP management issues and the way forward....

Time for an Asean Peoples' No Nukes Network?

Chan Chee Khoon
Co-founder, Citizens' Health Initiative
Shah Alam, Malaysia

August 6, 2023 marked the 78th anniversary of the first use of an atom bomb against a populated city, Hiroshima.

An estimated 90,000 to 140,000 people died immediately as a result of the blast, heat, or acute effects of radiation.

Three days later, a second atom bomb was dropped on Nagasaki, killing 60,000 to 80,000 people.

The acclaimed filmmaker Christopher Nolan's biopic *Oppenheimer* was released two weeks ago to a global audience on July 21, 2023.

As of today, Universal's local distributor in Japan (Toho) has still not announced a theatre release date for *Oppenheimer*, which presumably will await a suitable interval after the anniversaries of the Hiroshima and Nagasaki bombings. The sensitivities of mass screenings in Japan, along with reminders of the end-of-war context of the bombings[1] are evident from this chronology:

May 7, 1945: Nazi Germany unconditionally surrenders to the Allies; confirmation of earlier intelligence that the Nazis were nowhere close to making an atom bomb, despite the efforts of a team led by Werner Heisenberg.

July 16, 1945: successful 'Trinity' test of a plutonium fission bomb using an implosion mechanism at Alamogordo, New Mexico.

July 17 - August 2, 1945: Potsdam conference where Stalin repeats his Yalta promise (Feb 1945) to FDR and Churchill to launch an attack against Japan once the Nazis were defeated in Europe.

Aug 6, 1945: untested uranium fission bomb dropped on Hiroshima.

Aug 7, 1945: USSR declares war on Japan, invades Manchuria, defeats Japan's Kwantung Army, *en route* to planned invasion of Hokkaido.

Aug 9, 1945: plutonium fission bomb dropped on Nagasaki.

The geostrategic objectives of the US in 'demonstrating' its weapon of mass destruction to its emerging Soviet rival, extensively documented by the American historian Gar Alperovitz, also emerged in a contemporaneous film documentary on Ted Hall (2023),[2] the youngest scientist on Oppenheimer's Manhattan Project team, who along with Klaus Fuchs and other project scientists, leaked crucial bomb design details to the Soviets in the 1940s. The intention, the film informs us, was to prevent a US monopoly over WMDs and its anticipated resort to nuclear blackmail in the post-WW2 era.

In the ensuing decades, this Balance of Terror was almost upset on too many occasions, most dramatically during the

[1] https://www.youtube.com/watch?v=bfWmqBDGvr4

[2] https://www.youtube.com/watch?v=hukxJ2slKkM&t=5s

Cuban missile crisis in 1962 when we were, without exaggeration, literally seconds from nuclear Armageddon.[3]

In the 1980s, millions were on the streets in Berlin, London, New York protesting against the madness of short and intermediate range ballistic missiles on hair-trigger alert, in NATO bases (Pershing 2 missiles) and in their Warsaw Pact counterparts (SS20 missiles).

In Southeast Asia, many still harboured comforting illusions that it was all happening 'over there'.

Carl Sagan and his atmospheric scientist colleagues duly dispelled our sense of remove. An enveloping persisting blanket of carbon soot lofted into the stratosphere from burning cities would precipitate a protracted nuclear winter globally, leading to agricultural collapse and worldwide famine.

On July 18, 2023, *USS Kentucky* made a port call at Busan in a show of force *vis-à-vis* North Korea, the first time in 42 years a US ballistic missile submarine visited South Korea.

Just as US residents within 50 km of an ICBM base might feel nervous as high priority targets in a nuclear exchange, an Ohio-class ballistic missile submarine docking at Busan (or Singapore's Changi Naval Base, or a Filipino naval base) is in effect a mobile launch platform for 200+ independently targetable nuclear warheads (475-kiloton hydrogen bombs).

Penny Wong, Australia's Minister for Foreign Affairs struggled vainly[4] to square her country's obligations under the South Pacific Nuclear Free Zone (Treaty of Rarotonga, 1985), with her US treaty ally's dictum of *neither confirm nor deny* (nuclear) armaments of visiting warships and warplanes.

It's time for an **Asean Peoples' No Nukes Network** to hold governments to account for painting bull's eyes on the backs of their citizens.

The world's health and medical community is being urged to take a stand against nuclear weapons, with 11 of the world's leading health and medical journals publishing an editorial about the increasing threat of nuclear war.

https://insightplus.mja.com.au/2023/29/the-medical-journal-of-australia-joins-with-other-journals-to-call-for-elimination-of-nuclear-weapons/

The Medical Journal of Australia MJA) has joined other health and medical journals to call for urgent steps to curb the threat of nuclear war and for the elimination of nuclear weapons.

The editorial, co-authored by the *MJA*'s Editor-in-Chief Professor Virginia Barbour, was published in the *MJA* August 6.

'As editor-in-chief of Australia's premier medical journal, I believe it is right that the *MJA* takes a stand on this issue,' Professor Barbour said. 'We are living in a time of intense fighting in Ukraine and increased tensions on the Korean peninsula.

'These concerning developments have prompted leaders across the health and medical community to highlight that any use of nuclear weapons would be catastrophic for humanity.'

The *MJA* was pleased to join with other prominent journals to advocate for this issue, Professor Barbour said. 'It is important to see a call for coordinated for action from a variety of international journals such as *The Lancet*, the *BMJ*, the *New England Journal of Medicine* and the *JAMA*,' she said.

Indigenous health: self-determination is key

https://www.thelancet.com/action/showPdf?pii=S0140-6736%2823%2901238-2

August 9 marked the UN's International Day of the World's Indigenous Peoples, a day to raise awareness and highlight the rights of the 476 million Indigenous people across 90 countries. The anniversary comes in what could be a landmark year for Indigenous people and their health.

In May, 2023, the World Health Assembly passed an unprecedented resolution aimed at strengthening the health of Indigenous people. As well as tasking WHO with developing a global plan of action by 2026, the resolution contains several ambitious obligations for member states to improve Indigenous health, including the development of national plans to improve access to health care for Indigenous peoples; the integration, where possible, of traditional and complementary medicine in health systems, particularly in primary care and mental health; and the training and recruiting of Indigenous people as health workers. It hopes to reduce some of the stark inequalities faced by many Indigenous peoples as a result of colonisation, displacement, and repression.

Discussion of Indigenous health is often focused on disadvantage. But it is more than simply some global health problem to be solved. As WHO's constitution recognises, health is not merely the absence of disease or infirmity; it is a state of complete physical, mental, and social wellbeing. For Indigenous communities and their health to flourish, they must be in control of their own destinies.

[3] https://www.researchgate.net/publication/357864783_Time_to_get_serious_about_an_Asean_NWFZ

[4] https://twitter.com/KellieTranter/status/1625690336709480448

Oh! Health, health ...blessing of the rich, desired wealth of the poor ...who can buy you at such high prices?

Claudio Schuftan

https://claudioschuftan.com/683-oh-health-health-blessing-of-the-rich-desired-wealth-of-the-poor-who-can-buy-you-at-such-high-prices-ben-jonson-volpone/

If we lived in a democracy, we would have a fully public healthcare system, because the majority wants it**.** The fact that we do not have such a system proves that we do not live in a democracy**.**

Businesses and governments view public-sector spending as a drain on the economy**.** While public facilities can deliver social services more effectively, this costs money! The same services delivered for profit in the private sector make money --and that is seen as a benefit for the economy. The way things are, every medical service that can be removed from a public hospital has been or will be removed soon.

[David Hunter in the *NEJM* described the fate of the British NHS which for decades was the flagship of equitable health care.[5] [6]

'Crisis,' 'collapse,' 'catastrophe' — these are common descriptors from recent headlines about the National Health Service (NHS) in the United Kingdom.

The NHS has undergone many rounds of structural reforms without reaching a sustainable equilibrium. The Conservative government is accused of deliberately underfunding the NHS in order to force patients into private health care and usher in a two-tier system.

The state of the NHS makes for much misery among patients and frustration among already exhausted health professionals. And the rest of the world should care as well: 75 years ago, the United Kingdom became the first large country to make health services 'free at the point of care' and paid for by collective taxation, and the NHS has become the model for many other systems that seek to remove the profit motive from health care provision in the name of equity and cost control.]

The only services left in the public sector will be those too unprofitable to privatise. Hospitals themselves are being privatised through Public Private Partnerships (PPPs). PPP hospitals are built with public funds and managed by a private corporation. When nurses there demand staff-to-patient ratios, and when anyone demands higher wages, it is seen as if they are challenging the primacy of profit, the foundation of capitalism.

To maximise profits, private clinics will do simple surgeries such as cataracts, and hip and knee replacements, leaving more difficult, complex surgeries in the public system. When clinic surgeries become complicated, patients will be off-loaded to the public system, along with the cost of treating their complications (assuming patients survive the transfer). The push for maximum profit also inevitably leads to fraudulent billing.

Who can we count-on to protect our health services, then? Corporations in the field are surely not required to protect the public interest. Politicians will not protect the public when doing so means angering the business class and losing corporate donations. The only people we can really count on are those who use the services and those who work in public health services, because their job conditions directly affect the quality of services.

Who would you rather manage a hospital? Executives and bureaucrats obsessed with the bottom line? Or medical and support staff who actually do the work? We need to stop wasting time on what does not work, and face the problem squarely. (S. Rosenthal)

It is not enough to win elections and come into government to sever these ties (we have already tried this and not always with success). First, we must ask ourselves: do we come to government to manage what we have, or to build and manage something new? As a result, we end up promoting targeted, non-universal, disease-centred social policies.

There is a perennial problem with targets, and that is that we think they are always still reachable -- until they are not…

We must, therefore, rethink and reformulate health systems and this requires deconstructing and dismantling this categorical framework that expresses coloniality and dependence on the North.

In the territories where lifestyles and health are socially constructed, we do not need vertical and centralised programs, but need communities and health workers to trigger and bring about processes and links based on comprehensive primary health care and *buen vivir*. We must put at the centre of social policies actions that address the social determination of health. (O. Feo)

Health does not begin in clinics or hospitals any more than justice begins in law courts or peace starts on the battlefield. Rather, health starts with the conditions in which we are born and raised, and in schools, streets, workplaces, homes, markets, water sources, kitchens, and in the very air we breathe. (Tedros A. Ghebreyesus)

Worrying

- Diseases are not a calamity, but an extremely profitable business for investors who profit from these things. The pretext used is of biblical simplicity: public facilities are insufficient and inefficient, so this creates space for private activity. ...Aha! but public facilities are more and more insufficient, because neoliberal governments

[5] n engl j med 389;2 nejm.org July 13, 2023

[6] https://www.nejm.org/doi/full/10.1056/NEJMp2301257

reduce investments and staffing, close public hospital and clinics, on-and-on... (Louis Casado)

- We do not have medical schools merely to explain diseases; we have medical schools to cure diseases. We do not have schools of public health merely to explain epidemics; we have schools of public health to prevent and control epidemics. These disciplines should be moral (and political) disciplines, in the sense that they should aim to improve the world, not merely to explain or predict it. Getting there is within reach in a very practical and affordable sense. But.. (Jeffrey Sachs)
- Ensuring patient rights is an extension of applying human rights principles to health care. In the context of neoliberalism, they are predominantly embedded within the logic of quality of care, economic, and consumerist perspectives. Relatively powerful actors such as care-providers and health facility administrators use a long list of strategies such as emphasising alternative discourses and controlling resources to suppress the promotion of patient rights among care-seeking individuals. Health facility administrators and care-providers wield power to oppress care-seeking individuals. (Meena Puttaraj et al)

Not less worrying

WHO at 75 is a technocratic institution dependent on the politics of its member states, with too little socio-political autonomy to advance truly global public goods for health. Health systems and social determinants look rather downgraded and it is universal health care (UHC, and not PHC and a NIEO) that gets mainstreamed. (Remco van der Pas) [NIEO: New International Economic Order].

It is important to note that WHO, however ideal we might envision it as an institution for realising the right to health, is not a panacea and, in times of crisis, institutions like it will and do fail. No institutional model is perfect, but WHO can be significantly improved. To do so will require considerable political and financial support from member states; require the Organisation to audit and radically revise its mandate, scope, financing and relationship-towards with member states. The starting point for WHO reform must be to assess what states want and seek from it democratically; and to work to make that vision a reality for the Organisation, rather than continue with the mismatch between expectations, achievements and failures that only creates broader challenges later in the perceived success of a flawed WHO. (Clare Wenham, Sara Davies)

- Put more teeth into peace-establishing and peace-keeping missions by clarifying their mandate, terms of engagement, specific objectives, resources and exit strategy -- not missing the opportunity to put HR and humanitarian principles centre-stage.
- Appoint a high-level HR expert to the staff of the UNSC to warn members of HR issues being overlooked in its resolutions.

Specialized Agencies, Funds and Programs under the aegis of the General Assembly

The first three agencies created in 1945 were the World Bank, the IMF and the Food and Agriculture Organization (FAO). In the intervening 75 years, scores more have cropped up. Rarely are any agencies ever phased out.

Problems:

Overlapping mandates: Some agencies are sectoral (WHO, FAO, UNIDO, UNEP, UNAIDS) while others target a specific group of beneficiaries (UNICEF, UN WOMEN, UNHCR). A dozen agencies deal with health; three handle displaced persons.

Corruption: Highly publicised allegations of organisational waste and fraud, eg Food-for-Oil, UNOPS, are difficult to identify, investigate and prosecute.

Abuse and impunity: Abuse by individuals (sexual exploitation; racial, ethnic, or gender discrimination; bullying or harassment) is rarely uncovered and even more rarely punished. There are simply colossal obstacles to bringing about cultural change within UN institutions.

Biased recruiting: UN recruitment and staffing still favour candidates from industrialised nations. Donor nations have unfair advantages at all levels.

Donor driven programs: Unequal power of donor nations to define and set details of projects (where agencies will work, what sectors are a priority) and set administrative guidelines (who is hired, where equipment is purchased).

Private sector chokehold: Increasing commandeering of development efforts by private sector entities. Examples: public-private partnerships and multistakeholder platforms, not only like GAVI[7] --the Vaccine Alliance (that ostensibly works to extend immunisation to poorer developing countries) but also the Scaling Up Nutrition (SUN) Initiative, COVAX and quite a few others.

Human rights too often relegated to lip service: Every UN agency is bound by the UN Charter to put HR upfront, but too often HR are added-on as a window dressing.

Suggestions:

Re-vision and re-mission, as well as rationalisation of the coverage and efficiency of the several specialised UN

[7] See notes at end of piece.

agencies, emphasising sectoral distribution in a logical manner.

- Standardise administrative and contractual arrangements across all agencies, organisations and funds, so that all are governed by the same rules.
- Consolidate and put teeth into the various legal and ethical and HR watchdog initiatives (UN Ethics Office, OIOS, UNHCHR…) to ensure institutional culture change.
- Promote multi-lateral over bi-lateral funding of agencies. Divert private sector funding/donations to a central UN Fund that will allocate the same to programs.
- End the prerogative of certain donor nations to name UN agencies' directors, eg World Bank to the USA; IMF to the EU; UNICEF to the USA.
- Provide equivalent training opportunities for potential staff from LDCs. Open JPO opportunities to citizens of the Global South keeping them funded by the Global North.(see Note at end)
- Demand that these agencies, funds and programs design and implement actions in the field around HR imperatives. Monitoring and evaluation of the same must include measuring HR impacts.

Other Miscellaneous Suggestions (in no particular order.)

- Revisit the financing of the UN System, to make the annual member states' assessments fairer, proportional and more appropriate, ensuring that the economies of the Global North pay a much greater share.
- Move the General Assembly and the Security Council out of New York City. Subsidise the relocation of headquarters with more funds for programs and agencies, to capitals in the Global South.
- Revisit the UN policy of civil-military collaboration in humanitarian contexts, taking into consideration the real impact and consequences of using military assets of donor nations that have their own geo-political strategic interests.
- Stop viewing the private sector as the panacea to all the problems of the UN!.

Note: GAVI has been criticised for giving private donors more unilateral power to decide on global health goals, prioritising new, expensive vaccines while putting less money and effort into expanding coverage of old, cheap ones, harming local healthcare systems, spending too much on subsidies to large, profitable pharmaceutical companies without reducing the prices of some vaccines, and its conflicts of interest in having vaccine manufacturers on its governance board.' (Source: GAVI - Wikipedia).

Junior Program Officer. JPO is an introductory entry level for UN officers. Typically, JPO posts are established by a UN agency (WHO, WFP, UNICEF, UNHCR...) at the request of a donor nation which, in return for funding the post, gets to place one of its up-and-coming young stars in that agency. The JPOs overwhelmingly come from the wealthy donor nations. That is why there is an abundance of sharp young professionals from the North always ready to apply for a UN post.

Health Promotion and a Health Behavioural Model for the Elderly in Thailand:

A Systematic Review

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https://www.haiasiapacific.org/wp-content/uploads/2023/08/ThailandElderly.HealthPromotion-EditedbyHBDS.pdf

Abstract

The aim of this research was to evaluate the health promotion models used and health behaviours of the elderly in Thailand by adopting a systematic search for relevant articles from appropriate databases published between 2017 and 2021. The PICO framework search terms were used and represent Problem/Population, Intervention, Comparison, and Outcome. The systematic review process adopted was according to the Joanna Briggs Institute guidelines, and Heller's research article quality assessment form was adopted. The data collected indicated that effective health promotion for the elderly involved participation of the community in caring. Involvement included group discussions between seniors, caregivers, community leaders, and community representatives. Well-designed health promotion programs resulted in the elderly having high levels of self-care including knowledge, attitude, and behaviours. In addition, adoption of an adequate health promotion model for the elderly involved families. Most health promotion models incorporated health education and group discussions about health literacy, and they emphasised five health behaviours that improved the health of the elderly; these included proper eating, exercising, emotions, stopping smoking, and stopping drinking. The adoption of an elderly health promotion model that encouraged self-practice improved the health behaviours of the elderly.

Nutritional support for adult patients with microbiologically confirmed pulmonary tuberculosis: outcomes in a programmatic cohort nested within the RATIONS trial in Jharkhand, India

Contributed by Mira Shiva

Anurag Bhargava, Madhavi Bhargava, Ajay Meher, G Sai Teja, Banurekha Velayutham, Basilea Watson, Andrea Benedetti, Ganesh Barik, Vivek Pratap Singh, Dhananjay Singh, Adarsh Kibballi Madhukeshwar, Ranjit Prasad, Rajeev Ranjan Pathak, Vineet Chadha, Rajendra Joshi

Read the whole article:
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(23)00324-8/fulltext

Summary

Background Undernutrition is a common comorbidity of tuberculosis in countries with a high tuberculosis burden, such as India. RATIONS is a field-based, cluster-randomised controlled trial evaluating the effect of providing nutritional support to household contacts of adult patients with microbiologically confirmed pulmonary tuberculosis in Jharkhand, India, on tuberculosis incidence. The patient cohort in both groups of the trial was provided with nutritional support. In this study, we assessed the effects of nutritional support on tuberculosis mortality, treatment success, and other outcomes in the RATIONS patient cohort.

Methods We enrolled patients (aged 18 years or older) with microbiologically confirmed pulmonary tuberculosis across 28 tuberculosis units. Patients received nutritional support in the form of food rations (1200 kcal and 52 g of protein per day) and micronutrient pills. Nutritional support was for 6 months for drug-susceptible tuberculosis and 12 months for multidrug-resistant tuberculosis; patients with drug-susceptible tuberculosis could receive an extension of up to 6 months if their BMI was less than 18·5 kg/m. at the end of treatment. We recorded BMI, diabetes status, and modified Eastern Cooperative Oncology Group (ECOG) performance status at baseline. Clinical outcomes (treatment success, tuberculosis mortality, loss to follow-up, and change in performance status) and weight gain were recorded at 6 months. We assessed the predictors of tuberculosis mortality with Poisson and Cox regression using adjusted incidence rate ratios (IRRs) and adjusted hazard ratios (HRs). The RATIONS trial is registered with the Clinical Trials Registry of India (CTRI/2019/08/020490).

Interpretation In this study, nutritional support was provided to a cohort with a high prevalence of severe undernutrition. Weight gain, particularly in the first 2 months, was associated with a substantially decreased hazard of tuberculosis mortality. Nutritional support needs to be an integral component of patient-centred care to improve treatment outcomes in such settings.

Funding India Tuberculosis Research Consortium, Indian Council of Medical Research.

Added value of this study

To our knowledge, this is the largest single programmatic cohort of predominantly HIV-negative patients with drug-susceptible tuberculosis who underwent comprehensive evaluation of clinical, nutritional, and performance status at enrolment and in whom the effect of a food rations-based nutritional intervention on clinical and nutritional outcomes was documented. The study shows high levels of severe and extremely severe undernutrition in patients at diagnosis, which is a contributor to tuberculosis mortality that is currently unaddressed in most national tuberculosis programs. Most deaths occurred in the first 2 months, 80% occurred at home, and performance status, nutritional status, haemoglobin, and diabetes were identified to be predictors of death. The effect of nutritional support on tuberculosis mortality in this cohort can be inferred from the survival, with nutritional support, of more than 85% of patients with potentially fatal undernutrition (BMI <13 kg/m. in men and <11 kg/m. in women), and the 61% reduced hazard of death in those with desirable (5%) weight gain in 2 months. The case fatality ratio was considerably lower than in another National Tuberculosis Elimination Program cohort with a similar patient population that had no nutritional support. The nutritional intervention was well accepted and was associated with high rates of adherence to treatment and low rates of treatment failure. However, nutritional recovery was incomplete at 6 months in patients with severe undernutrition at enrolment.

Implications of all the available evidence

Nutritional assessment, counselling, and support need to be implemented in settings with a high burden of tuberculosis and undernutrition, such as India, to improve tuberculosis treatment outcomes. Food-based nutritional support during treatment is associated with weight gain, improved performance status, and a decreased hazard of tuberculosis mortality. However, nutritional recovery in patients with severe undernutrition might require graded support for a longer period.

Feature: Justice for Negros: A Campaign Against Hunger and Disease

From Edelina de la Paz, PHM Philippines

The campaign will be coordinated at the national level by a task force composed of different health organizations including PHM Philippines, HEAD, HAHR, CHD, CPRH, COMPASS, SOS and PMSA. It will involve health workers and their unions in hospitals and health facilities especially those who are from Negros.

https://tinyurl.com/45wk26ke

Concept and Campaign Paper

May 18, 2023 (revised version)

Background: Hunger and Militarization in Negros

The image of Joel Abong continually haunts the Filipino people. In 1985, Joel Abong, seven-year old son of a sugar cane worker in Negros died due to severe malnutrition and disease because of poverty. Joel was a symbol of the 'Batang Negros,' 'child victims of a disaster spawned by greed, corruption, tyranny, and a long entrenched system of injustice'.[8]

Joel was among the severely malnourished children of Negros who were victims of famine that hit the island of Negros in 1980s. The famine was caused by the Marcos administration's efforts to control sugar production through the NASUTRA (National Sugar Trade Authority) monopoly held by Marcos crony Roberto Benedicto and by a sudden crash in international sugar prices, that created a 'social volcano'.[9]

In the same year, farmer-protesters who gathered in Escalante to demand agrarian reform and land distribution for sugar cane workers were gunned down by paramilitary forces. Twenty protesters were killed and 24 others were wounded. The incident became known as the Escalante massacre.

Negros is the country's sugar bowl. Negros Occidental is the 6th wealthiest province in terms of gross income in the country. But behind the sugar wealth of a handful of landlords are millions of landless sugar farmers, migratory farm workers or *sacadas,* and mill workers who toil amid back-breaking and hazardous work and continue to receive the lowest wage rates and no benefits. The situation has prompted intense struggles by the organised peasantry against sugar *hacienderos* who are also the political elite backed up by military forces.

The situation in Negros, even after the end of Martial Law, remained largely the same. Based on accounts of Escalante Massacre survivor Toto Patigas, 'tracts of land, beaches and sugar farms are still with the same old families, the poor still bear the brunt of gentrified modernisation, and paramilitary groups still roam the area, many deployed for surveillance and peacekeeping'. Patigas was killed in 2019, the 48th Negros human rights advocate murdered since 2016.[10]

In 2018, Negros Oriental registered a growth rate of 40% for stunting among children aged five and under, higher than the nationwide rate of 33.4%, according to data from the Food Nutrition Research Institute (FNRI).[11] In 2020, while the prevalence of various forms of malnutrition in Western Visayas Region was much lower than those in 2019, stunting remains a concern. The cities with the highest prevalence rate of stunting were San Carlos City – 14.15%, Himamaylan City – 11. 4%t, Escalante City – 8.97 percent, Bacolod City – 7.72%, and Sagay City – 6.74%, all in Negros Occidental.[12]

In the same year, Negros Occidental had the highest number of deaths by malnutrition in the Western Visayas region, accounting for 91 out of total 475 cases across the region.[13] Negros island has a poverty incidence of 45%, twice the 21.6%national average.

Malnutrition and hunger in Negros, as in other parts of the country, is connected to lack of food security, decreasing food production and land problems. Comprehensive Agrarian Reform Program (CARP) failed to break the land monopoly in Negros. According to *Unyon ng Mga Manggagawa sa Agrikultura* (UMA), in Negros Island, 70% of the land that was supposed to be distributed to sugar workers was locked in '*aryendo*', a system wherein agrarian reform beneficiaries lease their land back to landlords.[14] In 2019, Negros Occidental has the biggest

[8] https://www.rappler.com/nation/visayas/joel-abong-starvation-rage-negros-occidental-martial-law/

[9] https://en.wikipedia.org/wiki/Negrosfamine

[10] https://hrvvmemcom.gov.ph/the-story-of-negros-and-the-escalante-massacre-of-1985-2/

[11] https://www.philstar.com/the-freeman/region/2018/07/26/1837128/negros-oriental-tops-provinces-kids-stunting-growth-rate

[12] https://www.panaynews.net/wv-kids-nutrition-status-improving-but/

[13] https://www.statista.com/statistics/1121720/malnutrition-cases-western-visayas-by-province-philippines/

[14] Hamletting, which involves the isolation of civilians in a small settlement, was used by the late dictator Ferdinand E. Marcos to combat communist guerrillas in the southern Philippines.

balance of CARP- identified lands still to be distributed – 95,000 hectares, according to DAR Western Visayas.[15] Farmers dissatisfied with the failed land reform program have no other choice but to stage organised protests and actions which are met with violence by landlords and State forces, similar to the 1980s situation.

Based on reports of local chapters of Karapatan and Bayan in Negros 'there is continued hamletting[16] of far-off peasant communities, where the Armed Forces of the Philippines and other state mercenaries fabricate 'encounters' with alleged rebels to justify the displacement of civilians.' The groups cited the case in Himamaylan City, where 'more than 15,000 civilians were forced to evacuate and leave their homes while the Armed Forces of the Philippines continued indiscriminately firing at their homes, shelling mortar canons and howitzers, and stealing the masses' livestock.'

Farmers are not the only victims of human rights violations. In the face of hunger and disease, even doctors and health workers are red-tagged and killed. Dr. Avelex Amor, a people's doctor, chief of the Canlaon District Hospital in Negros Oriental was murdered in Guihulngan City on November 20, 2018. Human rights educator and health worker Zara Alvarez was gunned down on August 17, 2020 in Bacolod City, after being red-tagged by government forces. Similarly, Dr. Mary Rose Sancelan was killed by two gunmen on December 20, 2020, a year after she was also red-tagged by a vigilante group. The lone public doctor in the municipality, Dr. Sancelan was the municipal health officer of Guihulngan City in Negros Oriental province and a front-liner in the city's COVID-19 pandemic response. Dr Sancelan shouldered three times the average service burden.

Decades of landlessness and poverty, human rights violations, state repression and violence breed further hunger and deaths. There are many more like Joel Abong in Negros, as hunger, poverty and militarisation continue to plague the island.

We cannot allow such needless deaths and injustice to continue. Militarisation and state violence should stop. Food, livelihood and health services should be prioritised. It is imperative for service-oriented individuals and groups, health, justice and peace advocates to stand with Negros against hunger, disease and militarisation.

Campaign Objectives:

- Raise the awareness of the health sector and the broad public of the worsening peace and human rights situation in Negros and its negative impact on health, human rights, and people's livelihood;
- Reach out to and mobilise health workers, health professionals, health students, and health advocates locally and abroad;
- Support and popularise the call to prioritise food, livelihood, and health services and stop militarisation in Negros;
- Raise and provide timely support (food, psychosocial intervention, technico-material) for the malnourished children and their impoverished families, the displaced communities and victims of human rights violations;
- Expand the support network among individuals, institutions, church groups and other service-oriented, justice and peace-loving individuals and groups locally and abroad; and
- Project the Negros people's health and human rights issues, calls and demands internationally.

A program timeline of action has been prepared.

[15] https://www.panaynews.net/martial-law-in-carp-covered-negros-lands/

Assessing the State of Play in the WHO Pandemic Instrument Negotiations

By Viviana Muñoz Tellez
South Centre Policy Brief 121. 18 July, 2023
https://www.southcentre.int/policy-brief-121-18-july-2023/

Abstract:

This Policy Brief discusses the state of play of the negotiations of the pandemic instrument at the World Health Organisation. The Intergovernmental Negotiating Body (INB) is increasing its meetings as the target deadline for completion in the first half of 2024 draws closer. To advance, the political will needs to be scaled up in the next months. The expectations should not be lowered to the lowest common denominator. Real progress needs to be made in priority areas of concern for developing countries to keep momentum.

Members of the WHO have set the ambitious target to negotiate and conclude a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response (hereafter 'the pandemic instrument'), by 2024. It has been agreed that the instrument should be legally binding, while elements of the text may vary between legally binding and non-legally binding. The instrument will be adopted under Article 19 or 21 of the WHO Constitution. In parallel to this process, conducted by the Intergovernmental Negotiating Body (INB) established in December 2021, negotiations are on-going to make targeted amendments to the International Health Regulations (IHR) as last revised in 2005.

Medicines Law & Policy

Seven recommendations for the Intergovernmental Negotiating Body (INB) to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response

To achieve its aims, the INB should ensure the instrument it is negotiating can:

1

Finance biomedical research & development (R&D):
Sustainable financing for innovation, both pre-pandemic and crisis-related, is critical. Governments have a key role to play in subsidising, rewarding and/or derisking R&D investments. R&D funders (public and private) must coordinate and collaborate.

2

Create conditions for government-funded R&D:
A pandemic treaty should establish binding conditions on government-funded R&D, such as a requirement to share any resulting intellectual property, technology and know-how, and to disclose clinical trial data.

3

Mandate technology transfer:
Technology sharing should be a norm in pandemic preparedness and response. A pandemic treaty should require technology transfer for government funded research, and incentivise/ subsidise/ provide mandates it for privately funded research. Financing should also be provided for technology transfer.

4

Require intellectual property (IP) and knowledge sharing:
Voluntary IP sharing mechanisms are insufficient in pandemics; a treaty should require that a declaration of a public health emergency of international concern (PHEIC) trigger compulsory sharing of IP and knowledge.

5

Streamline regulatory standards and procedures:
A treaty should address regulatory barriers that can delay access to pandemic countermeasures, such as excessively restrictive approval pathways for novel technology or inconsistent application of emergency use provisions.

6

Greater transparency:
International coordination is stifled by a lack of information sharing at all levels of medical countermeasure, development, financing, procurement and use. A treaty should address the need for transparency on a range of issues.

7

Inclusive governance:
A treaty should provide financial support to allow low-resourced states to participate in negotiations, and ensure equitable global cooperation to meet the six prior recommendations at three levels: binding in cases of strong consensus, opt-in for harder-to-agree provisions, and normatively for more novel provisions.

This infographic was developed from a longer research paper, the full text of which is available here: https://gh.bmj.com/content/7/7/e009709?rss=1
More Medicines Law & Policy resources are available at: https://www.medicineslawandpolicy.org

Are pharma-funded 'awareness' campaigns a blind spot in prescription advertising rules?

Sydney researcher and HAIAP colleague Professor Barbara Mintzes says it's a grey area.

Rachel Carter for *AusDoc* with Professor Barbara Mintzes

https://www.ausdoc.com.au/news/are-pharma-funded-awareness-campaigns-a-drug-advertising-blind-spot/

10 August 2023

For almost a decade, US men were faced with TV, online ads and billboards about the risks of low testosterone or 'low T', as it was branded.

Eventually, in 2014, the Food and Drug Administration (FDA) issued a safety warning about the potential link between testosterone treatment and cardiac events.

This warning noted that testosterone was only approved for specific medical disorders and that treatment benefits and safety had not been tested 'for the treatment of low testosterone levels due to ageing', including for symptoms seeming to be related to low testosterone.

The FDA also insisted that the companies 'clarify the approved uses' of testosterone and the 'low T' advertising ended basically overnight.

However, campaigns of this nature — pharmaceutical companies paying to 'raise awareness' of conditions — continue to live in a grey area even in strictly regulated prescription markets like Australia.

AusDoc: What are we talking about with 'disease awareness campaigns'?

Professor Barbara Mintzes: Disease awareness campaigns within pharmaceutical marketing are campaigns carried out by pharmaceutical companies that do not actually name the product being promoted; instead, they focus on the condition it treats.

These campaigns tend to be carried out by companies that have a product that is the market leader within a specific treatment area. Or sometimes, it is when a product is the first out to treat a condition, and the company is then raising awareness of the condition as part of a strategy to promote sales.

AusDoc: Do these campaigns make a difference in terms of patients turning up to GP practices and asking about the conditions?

Professor Mintzes: There was an analysis in the US looking at the effects of the different levels of advertising of testosterone products, which did find a major effect from the disease awareness advertising on men starting on testosterone — even in men starting on testosterone when they had not had their testosterone levels tested beforehand. The effect was presumably in terms of requests but certainly in terms of prescribing rates, including prescribing that was clearly inappropriate given the man had not even had his testosterone tested before. There was also an early US study that looked at a disease awareness campaign for migraine drugs, which used internal company data and did find an effect.

I think you can certainly look at areas where there has been a lot of continual disease awareness advertising as an indication that the company's internal market research is likely showing it is effective; otherwise, they would not continue to put their money into that type of advertising.

AusDoc: What are the rules regarding disease awareness advertising in Australia?

Professor Mintzes: In general, this advertising is not being dealt with very well by regulators — either in Australia or internationally — in terms of trying to ensure it is not promoting off-label use or that it is consistent with what the product has actually been shown to do in clinical trials and the approved product information.

In Australia, *Medicines Australia* — which is the trade association of the research-based prescription pharmaceutical industry — is the responsible body.

So, this is really a case of the Australian Government delegating to the industry to self-regulate, and that also happens in many other countries.

The Medicines Australia process is complaints driven, so if there is prescription drug advertising or advertising that is in some way seen by the person who views it as related to prescription drug advertising, they can lodge a complaint with Medicines Australia. It has a committee that will then review the complaint.

Medicines Australia has a code, but that is only enforceable for its own members.

The TGA can also step in directly.

AusDoc: Do you think it's inherently a problem if disease awareness campaigns are funded by drug companies?

Professor Mintzes: There is a problematic side. This is to do with both the framing of conditions in relation to drug treatment and because the types of campaigns that might hit the public are not necessarily the most important ones from a public health perspective.

Pharma-funded disease awareness campaigns are quite different from public health campaigns, which might be linked to a specific problem that is not being adequately addressed, for example.

There is a conflict of interest for pharmaceutical marketers to be carrying out these disease awareness campaigns — in terms of potential best framing of a condition and the various options available to seek help

and treat it versus the companies' need to increase sales of their products.

There is also a difficulty in terms of regulation in that, if the product is not being named, then often the regulator does not end up stepping in even when the way in which the disease or risks are being presented is misleading and inaccurate.

AusDoc: What changes would you like to see?

Professor Mintzes: There needs to be more consideration of whether the company that is carrying out the awareness campaign has a product to sell for that condition or a product that is about to come on the market for that condition.

I feel a bit uncomfortable about calling Medicines Australia the regulator in the sense that Australia, like every other industrialised country, does have national pharmaceutical legislation that includes the promotion and advertising of medicines. There is an underlying issue of the extent to which that task should be delegated to the pharmaceutical industry or whether it would be much more consistent with regulatory aims to support qualities of medicines within Australia's national medicines policy to keep that regulation in-house.

Medicines Australia Response

The CEO of Medicines Australia, Liz de Somer, said: 'Pharmaceutical companies are valuable partners in disease education and awareness, and play an important role in raising public awareness about diseases and management options.

'The community should have access to information about medical conditions and options that may be offered by their doctors, which helps to raise the overall understanding of health issues in our communities.

'We are fortunate that, in Australia, resources developed by pharmaceutical companies are led by science and provide healthcare professionals and the broader community with access to important information about medical conditions that may not otherwise be available.

'Medicines Australia has a key role in the regulation ecosystem and our remit is to support the application of the Therapeutic Goods Act as relative to the pharmaceutical industry. The [Medicines Australia Code of Conduct] distinguishes between disease education and advertising.

'Unlike in other countries, disease education in Australia stops short of promoting medicine brands, and this distinction is important.

'The Code outlines principles that guide pharmaceutical companies in how to deliver ethical disease awareness activities that serve community needs, whilst observing clear legislative boundaries.

'Our Code of Conduct is commended internationally for its effectiveness in supporting the industry to self-regulate. The Code is supported by a robust and accessible complaints process that is adjudicated by legal experts with input from healthcare professionals, patient representatives and the TGA. This process is independent of Medicines Australia.'

Legal *lacunae* in regulations of electronic cigarettes in Malaysia

Mohamad Haniki Nik Mohamed, Professor of Pharmacy, Kulliyah Pharmacy, International Islamic University, Malaysia

(See also HAIAP News April 2023, page 15, Dzulkifli Abdul Razak)

People's fears and concerns can no longer be hidden when there are more cases involving the use of electronic cigarettes or vapes shared on mainstream and social media.

Parents have done their best to ensure that their children do not smoke vape or cigarettes. However, this matter is not within parents' control per se when there is no clear policy that protects their children from advertising and promotion of these poisons.

[In May 2023 Australia passed a Law making the sale of nicotine 'vape' products completely illegal except by prescription from especially authorised medical practitioners. There is still a battle against the illegal availability of the products from 'black markets' in Australia. At about the same time Malaysia did exactly the opposite: vaporised, liquid and gel nicotine products became freely available to all. Needless to say our colleagues in Malaysia are doing everything possible to reverse the situation.]

STOP PRESS: August 14 Court allows lawsuit against Malaysia's health minister on vape liquid to proceed:
https://www.malaymail.com/news/malaysia/2023/08/14/court-allows-lawsuit-against-malaysias-health-minister-on-vape-liquid-to-proceed/85250
and https://tinyurl.com/3nd598jf

In Malaysia, Nicotine is controlled under the Poisons Act 1952, which stipulates that all nicotine-containing preparations are under Group C, unless exempted. Group C poison[17] may be dispensed without a prescription but only by licensed health professionals, including pharmacists. All tobacco products[18] are fully exempt from being classified under Group C poisons while the available nicotine replacement therapy products (gums and patches) were recently moved from Group C to over-the-counter (OTC) in October 2022. The existing Control of Tobacco Product Regulations 2004 and the Food Act 1954, while addressing tobacco control, do not extend to nicotine-containing products devoid of tobacco leaves, including electronic cigarettes (e-cigs).

The introduction of e-cigs ('vapes') in Malaysia as early as 2014 has added complexity to the public health framework. Such products were regulated under the Poisons Act 1952 until the Malaysian Minister of Health went against the unanimous decision of the Poisons Board and declared the full removal of nicotine in liquids and gels of e-cigs from the Poisons Act on 30 March 2023, making them available as

[17] Products containing Group C poisons include medicine for diarrhoea, antihistamines and non-steroidal anti-inflammatory drugs and they are available only as dispensed medicine at pharmacies. The pharmacists are required to personally supply medicines of this category and not through the pharmacy assistants.

[18] The law prohibits the sale of tobacco products via vending machines, the internet, small packets of cigarettes, and single cigarettes. There are no restrictions on the sale of tobacco products based on location. The sale of tobacco products is prohibited to persons under the age of 18.

freely as junk food. That action was immediately followed by the gazettement of taxation on e-cigs at a rate of MYR0.40 per ml, by the Malaysian Minister of Finance (who is also the Prime Minister) on 1st April 2023.

The exemption of nicotine in the liquids and gels of e-cigs created a legal *lacunae* since the regulations on e-cigs were drafted in the new standalone Control of Tobacco Product and Smoking Bill. This Bill was referred to the Parliamentary Special Select Committee after the first reading but missed the third or final reading due to the dissolution of the Parliament on 10th October 2022. With the new coalition government in power since November 2022, it was envisaged that the new Health Minister would urgently table the Bill and reconsider the delisting that occurred on March 30. Despite requests from the public and tobacco control advocates for the tabling of the Bill, it was only tabled on 12th June 2023. The Hon. Health Minister referred the Control of Smoking Products for Public Health Bill 2023 to another Parliamentary Special Select Committee without having it debated by members of the Parliament. The next Parliament session is expected only in October 2023. In short, nicotine containing e-cigs are currently being sold without any restrictions in Malaysia. This situation exposes Malaysians especially children and teenagers to the aggressive advertising, promotion, sponsorship and sales of e-cigs by the vape industry.

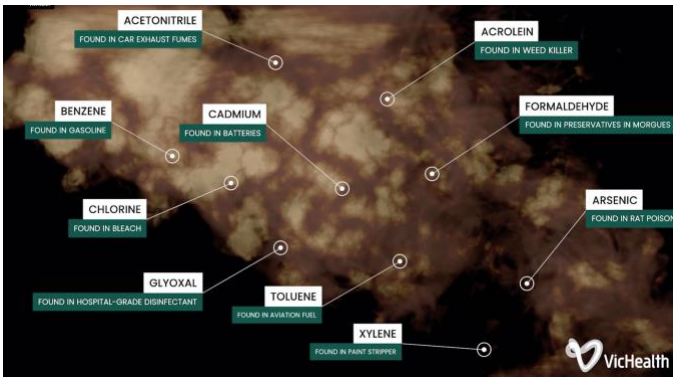
The vaping and tobacco industry is using every trick in the book to hook a new generation on these highly addictive products, such as:
Product design: Producing e-cigarettes with sweet flavours, such as cola ice and candy floss, and creating devices that are brightly coloured and with discrete packaging, designed in ways that appeal to young people. |
Marketing: Using social media extensively to market and sell vaping products to young people, with vape challenges promoted across TikTok and YouTube. This content is often sponsored by tobacco and e-cigarette companies and endorsed by influencers with large social media followings.
Labelling: Mislabeling nicotine e-cigarettes as 'non-nicotine' so they are easily available at convenience stores and online without a doctor's prescription.

The American Academy of Paediatrics produced a policy statement since 2015 showing evidence regarding the effects of nicotine on the developing brain. Nicotine is highly addictive and is the primary psychoactive component causing addiction in tobacco products.

Nicotine has neurotoxic effects on the developing brain. In early adolescence, development of executive function and neurocognitive processes in the brain has not fully matured.

Adolescents are more likely to engage in experimentation with substances such as cigarettes, and they are also physiologically more vulnerable to addiction. Particularly in adolescence, nicotine also has an effect on the brain as a 'gateway' drug for cocaine and other illicit drugs.

Vapes contain more than nicotine.



The Adolescent Health Survey 2022 found a significant jump in prevalence of vaping among Malaysian students between 13 to 17 years old. Out of 33,523 students, 14.9% were identified as vapers or using e-cigs, with 23.3% of boys and 6.2% of girls. This is a significant increase given that the prevalence of vaping among the same age group was reported as 9.8% in 2017. There have also been cases of accidental nicotine poisoning reported among children and even deaths suspected to Electronic Cigarette or Vaping Product Use-Associated Lung Injury (EVALI).

> *'The impact of vaping on my son and his friend's mental health has been very obvious and quite extreme. His symptoms included agitation, anxiety, vomiting and a loss of appetite'.* Mother of 14 year old boy

Clearly, an unambiguous policy is needed urgently as an effort to protect all Malaysians especially children and adolescents from becoming lifelong nicotine addicts. It is feared that if immediate action is not taken, the future issue of vape/e-cigs use will be the same as the issue of conventional cigarette use. Therefore, implementation of the Control of Smoking Products for Public Health Bill 2023 is the beginning of continuous efforts to protect all Malaysians from an ongoing fall into the trap of nicotine addiction and harm from non tobacco products.

The Consumers' Association of Penang (CAP)[19] calls upon the government to impose a blanket ban on e-cigarettes and vaping devices (EVC).
' We have a ticking time-bomb in our midst. There are an estimated 1 million vapers in Malaysia and about 10% of whom are minors.'
'Malaysia may be on the edge of a possible public health crisis if there are cases of unreported vaping-related lung diseases. Tracing the source of the cause would then be a horrendous nightmare. Unlike in the US, here in Malaysia, the health authorities have not set up a system to check if there are similar undetected vaping-related cases in the country. This is where the danger lurks. The government must short-circuit the problem before it gets out of hand,' said the President of the CAP, Mr Mohideen Abdul Kader.

[19] https://consumer.org.my/ban-e-cigarettes-and-vaping-devices/

Sudan's armed conflict and risk of escalating antimicrobial resistance

Abdul Rahman A Saied
For full article with references see
https://www.thelancet.com/action/showPdf?pii=S0140-6736%2823%2901421-6

In July, 2017, cooperation between WHO and the Sudanese Ministries of Agriculture and Forestry, Health, Animal Resources, and Fisheries yielded a National Action Plan (NAP) for antimicrobial resistance in Sudan—making it one of the first nations in Africa to draft an NAP addressing this matter.[1] Afterwards, in collaboration with the Food and Agriculture Organisation, the World Organisation for Animal Health, and the UN Environment Program, the Sudanese NAP on antimicrobial resistance was launched in July, 2018.[2] Many reports revealed an increase in antimicrobial resistance during the COVID-19 pandemic era, especially in Sudan.

Before conflict flared up again in April, 2023, Sudan had seen an increase in antimicrobial resistance as a result of numerous factors, including a rise in the distribution of antibiotics without a prescription.[3] [A significant number of newly multidrug-resistant isolates were found from 2019-2021.] [4-6]

Antibiotic-resistant bacterial infections are a serious and intricate worldwide health problem. Over the past two decades, antimicrobial resistance has been strongly associated with conflict wounds.[7] Most often, it is considered that antimicrobial resistance develops due to the selection pressure that antimicrobial treatment exerts, especially when treatment is insufficient (eg, due to low dosage, substandard antimicrobial drugs, or a shortened duration of therapy).

On April 15, 2023, fighting between the Sudanese Armed Forces and the Rapid Support Forces erupted in Khartoum and other parts of Sudan. Current estimates indicate that over 1,100 people have died, 11,000 have been injured, and the death toll is expected to rise. The Sudanese health-care system is inadequate, making it difficult to prevent antimicrobial resistance from emerging and spreading — due to disrupted immunisation, substandard access to clean water and sanitation, and inefficient infection prevention and control strategies.[1]

Arguably, the health of citizens both inside and outside Sudan will be greatly affected by antibiotic resistance and war-related infections, which will result in a large reservoir of potentially contagious multidrug-resistant Gram-negative infections, especially in light of Sudan's already fragile health-care system. In the Middle East, post-traumatic osteomyelitis is a frequent condition in war-wounded civilians, which frequently involves *Enterobacteriaceae* resisting first-line antibiotics.[8]

In conclusion, it is crucial to maintain infection control across the military health-care system. It is necessary to use novel tactics to stop the spread of diseases in combat field hospitals. Sudan needs to implement effective legislation to prohibit dispensing antibiotics without prescription and an antimicrobial stewardship program throughout the country. Khartoum hospitals' intensive care units must maintain regional antibiotic resistance surveillance and strengthen infection control procedures to stop further spread. When the conflict settles, improving awareness, hygiene, and the optimisation of antimicrobial medicines should be top priority in tandem with enhancing supervisory systems in Sudan.

Antimicrobial Resistance Policy Advocacy in Thailand: Role of the Drug System Monitoring and Development Centre in a Case Study of Civil Society [20]

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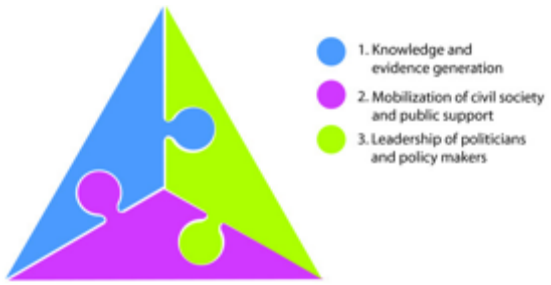
[Thai Health Promotion Journal Vol.1 No.2 April - June 2022. The full article is written in Thai language and currently being translated. For more information please contact Niyada Kiatying-Angsulee.]

Abstract

Thailand's national strategic plan on antimicrobial resistance 2017-2021 was the first AMR policy of the country. It has one health approach with the concept of 'the triangle that moves the mountain' through the balance of knowledge generation and management,



social movement and political will. The studies on antimicrobial resistance policy focus on policy contents rather than actors' roles and policy process.

Acknowledgement of civil society roles in policy advocacy may facilitate engagement of civil society in policy process both financially and technically. This article aims to elaborate roles of civil society by using the case study

[20] Thailand is in the process of drafting the second National Action Plan to start this year (2023) and it will last for five years and will target the issue of increasing knowledge and awareness in the whole population in the country.

of the Drug System Monitoring and Development Centre (DMDC.) involved in the process of policy formation and implementation.

The study included three parts: collation and explanation of activities performed by DMDC and civil society network, analysis of strengths and weaknesses, and proposal for improvement.

We found that civil society played significant roles in antimicrobial resistance policy processes. These include networking, testing of antibiotic residue in meat, campaigning, training, and public communication. Strengths consist of commitment, flexibility, and community focus. Weaknesses involved lack of financial support, non-continuity, lack of enough technical knowledge in some groups, as well as insufficient access to data and information.

Thai Health has a significant role in encouraging engagement and empowerment of civil society. Government should consider continuous support for civil society roles in policy process in terms of financial and technical support.

Overview

The situation of antimicrobial resistance and policy came from many sectors.

The Mountain-shifting Triangle Concept reflects the roles of both the public sector civil society in Thailand and international agencies[2,3].

In the Triangle-Moving Mountain Theory in driving policy in the country, including changing what is difficult to happen, it is necessary to strike a balance between three parts: building related knowledge, social movement, and state power.

All three parts are connected [4] which the fund Office Support for Health Promotion (Thai Health) has given importance to with the role of civil society. To work on the movement by supporting the civil society network, the concept of Social Determinants of Health is added. This concept reinforces the role of the creation of people's strength which is accepted as part of civil society playing a role in shaping national health policy.

There was a process for formulating six policies: education and pushing for agenda formation; participation in the development of policy drafts; policy driving network; mobilisation in co-creation; consensus and monitoring and auditing of operations; policy compliance.

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