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

December 2023

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

December includes many special 'days'.

December 1 International AIDS Day;

December 2 International Day for the Abolition of Slavery;
December 2-3 Bhopal Memorial day;

December 3 International Day of Persons with Disabilities;
December 9 International Day of Commemoration and Dignity of the Victims of the Crime of Genocide and of the Prevention of this Crime;

December 10, International Human Rights day;

December 12 International Universal Health Coverage Day.

December 18 International Migrants Day

In this issue we share HAIAP's plans for ongoing activities. We remember Amit Sengupta who we lost at the end of November in 2018. We remember his warm comradeship along with his enormous courage and skills. He remains an inspiration. We also remember David Sanders who we lost in 2019. He wrote *The Struggle for Health* in 1985 and a second edition was finished and published this year.

World AMR Awareness Week was celebrated November 18 - 24 and Dr B Ekbal keeps us informed about the implementation of the AMR Strategic Plan in Kerala while Niyada Angsulee has shared information about the wide range of AMR related activities in Thailand as well as the challenging work on Thailand's borders with neighbouring countries.

The battle to control the sale of nicotine vapes in Malaysia continues while New Zealand fears their huge achievements in the control of tobacco products could be reversed following the election of a new government.

We look back at 'Spanish' flu while plans are underway to achieve the Sustainable Development Goals in health and education.

HAIAP at 40 can be downloaded free at
https://www.twn.my/title2/books/pdf/HAIAP%20at%2040.pdf
Hard copies are available free but postage needs to be covered.
Contact linda@twnetwork.org

HAIAP Activities

A small group met by Zoom on November 29 to discuss future activities.

Following the Forum in Penang in May 2023 several pathways had been flagged for further exploration such as the development of curriculum in the universities according to the visions of Dzulkifli Abdul Razak - to bridge the gap between academic life and real life. An outline has already been developed at IIUM and USM has engaged (see page 8). This outline will be discussed further.

Plans are in place to make the website (https://www.haiasiapacific.org) easier and more attractive to use and to publicise its value. The website is a repository for HAIAP publications and records of all HAIAP activities as well as being a complete resource centre covering topics relevant to equity of access to essential medicines, health care and human rights. We encourage everyone to make use of this website and to share it with others.

The Catalyst video competition will run again with themes **Health Equity: Bridging the Gaps** and **Building a Healthy Community.**

Participants can showcase initiatives that promote health and well-being at the community level. They could include community gardens, fitness programs, or initiatives that improve access to healthcare.

The competition will be announced to students now so they can fulfill the award requirements and plan their entries. Last years entries showed enormous skill and ingenuity. [1]

The Olle Hansson Award will be a bi-annual Award with nominations for the 2025 Award offered at the end of 2024.

Days to Remember in December

December 1. World AIDS Day aims for inclusion, respect, and equity and is held on 1 December each year to help raise awareness about HIV and AIDS. To mark the pivotal impact communities have had in shaping the HIV response, as well as global health at large, the theme of World AIDS Day 2023 was **'Let communities lead'**.

World AIDS Day is an opportunity to reflect on the progress made to date, raise awareness about the challenges that remain to achieve the goals of ending AIDS by 2030 and mobilise all stakeholders to jointly increase efforts to ensure the success of the HIV response and support for people living with HIV and AIDS.

December 2: International Day for the Abolition of Slavery.

For over 400 years, more than 15 million men, women and children were the victims of the tragic transatlantic slave trade, one of the darkest chapters in human history.

Slavery aided the colonial masters in their bid to colonise African and other countries and in subsequent resource exploitation, which they institutionalised under their imperial governance.

According to modern research, roughly 12.5 million slaves were transported through the Middle Passage to the Americas. An estimated 15% of them died during voyage, with mortality rates extremely high in Africa itself during the process of capturing and transporting slaves to the coast.

Treatment of the enslaved people was horrific with captured men and women being considered less than human; to enslavers, they were 'cargo', or 'goods', and treated as such.[2]

The International Day for the Abolition of Slavery, December 2, marks the date of the adoption, by the General Assembly, of the United Nations Convention for the Suppression of all Traffic in Persons and of the Exploitation of the Prostitution of Others (Resolution 317(IV) of 2 December 1949).

The New England Journal of Medicine (December 7 2023) recognised the day:

> The *New England Journal of Medicine and Surgery and the Collateral Branches of Science* published its first issue in January 1812. Even though slavery had been abolished in Massachusetts in 1783, its legacies there lingered for decades. Slavery remained legal in the United States until 1863 and shaped every aspect of American life, medicine included. The word 'slavery' first appeared in the Journal in 1813, in a tribute to Benjamin Rush that highlighted his writings opposing slavery. But the Journal's relationships with slavery and racism were complicated. Its founders' families had profited from slavery. Its authors wrote casually about slavery. And it provided a prominent forum where physicians perpetuated race hierarchies before and after the Civil War.
>
> It is essential that this complicity be recognised. The Journal's engagement with slavery illustrates how medical theories, practices, and institutions influenced, and were influenced by, social and political injustices. The effort to reckon with this history must be sincere, deliberate, and persistent.

Read the complete very interesting article here:

https://www.nejm.org/doi/full/10.1056/NEJMp2307309?query=TOC&cid=NEJM%20eToc,%20December%207,%202023%20DM2307322_NEJM_Non_Subscriber&bid=1967427327

[1] https://www.haiasiapacific.org/events/haiap-forum-penang-may-27-28-2023-health-for-all-the-way-ahead/

[2] https://en.wikipedia.org/wiki/MiddlePassage#:~:text=The%20total%20number%20of%20deaths,up%20to%20four%20million%20deaths.

The focus of this day is on eradicating all contemporary forms of slavery, such as trafficking in persons, sexual exploitation, the worst forms of child labour, forced marriage, and the forced recruitment of children for use in armed conflict.

December 2-3 Remembering Bhopal 1984

On December 3, 1984, thousands of people died after a cloud of methyl isocyanate gas escaped from a pesticide plant operated by a Union Carbide subsidiary in Bhopal, India. December 2-3, 2023 marks the 39th anniversary of the Bhopal tragedy where 15000 people lost their lives and at least 500,000 people were maimed or seriously affected by the gas leak from the Union Carbide Pesticide plant in Bhopal, Madhya Pradesh. Almost four decades on, survivors of the tragedy continue to suffer its ill-effects and are fighting a protracted legal battle for adequate compensation. We pay tribute to the victims' organisations who have continued to struggle.

The *Remember Bhopal Museum* was set up in Bhopal by some of these groups, documenting the tragedy in the voices of the victims, the doctors and the community. Surviving families donated articles for the museum: some belongings of the loved ones, a small baby dress, little shoes, a bridal dress of another loved one who did not survive. Newspaper cuttings of that time, photos of the scene and numerous reports have been collected. The creation of the museum is a labour of love - so that people don't forget the biggest industrial disaster in history: the gas leak, denial of antidote, toxic effluents in soil and water, compensation concerns, second generation tragedy of continued birth defects.

Hazardous pesticides continue to be manufactured and used in food crops. The health hazards continue to be denied. It is not just pesticides, but also herbicides (Monsanto 's glyphosate) and fungicides.

December 03 - International Day of Persons with Disabilities / World Disabled Day

When launching the United Nations Disability Inclusion Strategy in June 2019, the Secretary-General stated that the United Nations should lead by example and raise the Organisation's standards and performance on disability inclusion—across all pillars of work, from headquarters to the field.

The theme for 2023 is 'United in action to rescue and achieve the Sustainable Development Goals (SDGs) for, with and by persons with disabilities.'

The annual theme provides an overarching focus on how society can strive for inclusivity through the removal of physical, technological and attitudinal barriers for people with disability. It has been occurring since 1992 when the General Assembly announced 3 December as the International Day of Disabled Persons.

Our 40th Anniversary Book HAIAP at 40 includes a description of HANDS community based initiatives for inclusion of people with disabilities, Page 73.

https://www.twn.my/title2/books/pdf/HAIAP%20at%2040.pdf

December 9 International Day of Commemoration and Dignity of the Victims of the Crime of Genocide and of the Prevention of this Crime

In September 2015, the United Nations General Assembly established 9 December as the International Day of Commemoration and Dignity of the Victims of the Crime of Genocide and of the Prevention of this Crime. The 9th of December is the anniversary of the adoption of the 1948 Convention on the Prevention and Punishment of the Crime of Genocide (the 'Genocide Convention'.

The purpose of the day is to raise awareness of the Genocide Convention and its role in combating and preventing the crime of genocide, as defined in the Convention, and to commemorate and honour its victims.

In adopting the resolution, without a vote, the 193-member Assembly reiterated the responsibility of each individual State to protect its populations from genocide, which entails the prevention of such a crime, including incitement to it.

'The prevention of genocide is a specific obligation under international law. Governments must act on this imperative by investing in prevention and taking preventive action. On this new international observance, let us recognise the need to work together more concertedly to protect individuals from gross human rights violations and uphold our common humanity.'

December 10 International Human Rights Day

International Human Rights Day is celebrated annually on December 10. This date holds immense significance as it marks the day when the U.N. General Assembly adopted the Universal Declaration of Human Rights in December 1948.

For 75 years, the core ambition of the Declaration has been to infuse societies with equality, fundamental freedoms and justice. The Declaration enshrines the rights of all human beings and is a global blueprint for international, national, and local laws and policies and a core of the 2030 Agenda for Sustainable Development.

The theme for 2023 is: **'Consolidating and Sustaining Human Rights Culture into the Future'**

This **75th anniversary of the Universal Declaration of Human Rights**, coincides with the 30th anniversary of

establishing the Office of the High Commissioner for Human Rights.

Human Rights Day creates a focus that seeks to increase knowledge on the universality of human rights; inspire people to create a movement of shared humanity while empowering them to fight for their rights and take action.

This year's celebration is marred by a tumultuous human rights challenge in Palestine (not the only one though). Deprivation of the right to self-determination, extrajudicial killings, restrictions on freedom of movement and assembly and illegal settlements are some of glaring manifestations of human rights violations of the Palestinian people.

See also https://www.amnesty.org.au/10-december-world-human-rights-day-75-years-of-human-rights-75-years-of-nakba/

Israel has been accused of inciting or carrying out genocide against the Palestinians. Israeli Prime Minister Benjamin Netanyahu has asked his top adviser, Ron Dermer, the minister of strategic affairs, to design plans to 'thin' the Palestinian population in the Gaza Strip 'to a minimum,' according to a report[3] in an Israeli newspaper.

UN HR Covenants are clear: the beyond-any-doubt-oppressed also have HR obligations; these were transgressed October 7. The October 7 Hamas attack on Israeli citizens and the taking of hostages were atrocities whose details and perpetration are still being clarified. An essential aspect of our reflection on these tragic events is an informed understanding of the history and contextual circumstances that contributed to the horrific tragedies.

It is time for our leaders - as our governments - to comply with international humanitarian law and not to support active war crimes. The must call for a cease fire now and must treat the Palestine people in their Palestinian homeland and in other countries as worthy of life and self determination.

See also *HAIAP News December 2021*, page 8, Human rights - Food for Thought by Claudio Schuftan

https://www.haiasiapacific.org/wp-content/uploads/2021/12/HAIAPNewsDecember2021Red.pdf

December 12 - International Universal Health Coverage Day

On 12 December 2012, the United Nations General Assembly endorsed a resolution urging countries to accelerate progress toward universal health coverage (UHC) – the idea that everyone, everywhere should have access to quality, affordable health care.

International Universal Health Coverage Day aims to raise awareness of the need for strong and resilient health systems and universal health coverage with multi-stakeholder partners. Each year on 12 December, we call on leaders to make bigger and smarter investments in health, and encourage diverse groups to make commitments to help move the world closer to UHC by 2030.

The COVID-19 pandemic has again shown us that UHC and health security are intertwined goals to protect everyone, everywhere, that we achieve through the same health system – in crisis and calm. For health systems to work, they must work for everyone – no matter who they are, where they live, or how much money they have. Equitable health coverage puts women, children, adolescents, and the most vulnerable first because they face the most significant barriers to essential care.

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Universal Health Coverage Beyond Rhetoric: Executive Summary

Amit Sengupta [4]

> 'There is a rich man's tuberculosis and a poor man's tuberculosis. The rich man recovers and the poor man dies. This succinctly expresses the close embrace between economics and pathology.' Norman Bethune, circa 1930

Read the whole paper:

rhttps://www.municipalservicesproject.org/images/07_OccasionalPapers/PDF/OP20_Universal_Health_Coverage_Beyond_Rhetoric_Nov2013_0.pdf

This paper raises critical questions around the wide and growing enthusiasm for Universal Health Coverage (UHC), which is increasingly seen as a silver-bullet solution to healthcare needs in low and middle-income countries. Although confusion still exists as to what UHC actually means, international development agencies typically define it as a health financing system based on pooling of funds to provide health coverage for a country's entire population, often in the form of a 'basic package' of services made available through health insurance and provided by a growing private sector. Global health agencies such as the World Health Organisation, and international financial institutions such as the World Bank, are promoting this approach in response to the rise in catastrophic out-of-pocket expenditure for health services, and in the face of crumbling public health systems in the global South (both of which were precipitated by the fiscal austerity imposed by these same international financial institutions in the 1980s and early 1990s). In this new model, UHC prescribes a clear split between health financing and health provision, allowing for the entry of private insurance companies, private health providers and private health management organisations. The logic is that healthcare challenges require an immediate

[3] https://theintercept.com/2023/12/03/netanyahu-thin-gaza-population/

[4] This was a research project that explored alternatives to the privatisation and commercialisation of service provision.

remedy, and since the public system is too weak to respond, it is strategic to turn to the private sector. In short, the UHC model is built on, and lends itself to, standard neoliberal policies, steering policymakers away from universal health options based on public systems.

Building and improving the public healthcare system is not part of this mainstream narrative, with the state generally confined to the role of system manager. Although these programs are now zealously promoted by global health agencies, the evidence to support their implementation remains extremely thin. Reliable data upon which to evaluate their performance are hard to come by (Giedion et al 2013) and methodologies designed to collect good evidence are singularly lacking, illustrated in this paper by the highly contested data of some early health reforms based on universal insurance in the South, eg Chile, Colombia and Mexico, which have nonetheless been used to legitimise the current UHC agenda. The paper argues that secure finances for health care are a necessary but insufficient condition for systems that are equitable and provide good quality care. We analyse the reasons why finances need to be channelled through well-designed public systems if they are to be spent efficiently. We further argue that, in glossing over the importance of public provisioning of services, many proponents of UHC are actually interested in the creation of health markets that can be exploited by capital. To contextualise the UHC debate, we look at Europe's experiences in constructing similar models, whereby health becomes a marketable commodity. We also present the cases of Brazil, India and Thailand to illustrate how this trend has become global, reinforced by the implementation of new UHC initiatives. Our analysis shows that despite policies in favour of universal public health care, the neoliberal ethos has become dominant in these countries' health systems. Thus, even in the case of widely acclaimed reforms, equity and efficiency tend to be compromised because ideological pressures prevent the adoption of an entirely public system of care provision. The challenges of high quality and equitable health care are most acute in low and middle-income countries because of faster growing populations, higher prevalence of infectious diseases, and growing burdens of non-communicable illnesses. Re-imagining public health care – rather than the private sell-out of health systems via UHC – is argued to be the only way forward in building truly universal health outcomes.

[Gonoshasthaya Kendra and Jamkhed CRHP are both comprehensive community programs that provide genuine universal health **care**. They are described in our anniversary book *HAIAP at 40.* Both the Jamkhed program and the GK program see two main pillars of peoples' health care - economic and health security. See *HAIAP at 40* from pages 54, 55. 76, 83, 94. Download the book here:

https://www.twn.my/title2/books/pdf/HAIAP%20at%2040.pdf]

December 18: International Migrants Day

Public Services International (PSI) and the European Public Service Union (EPSU) mark International Migrants Day by strongly reaffirming the right to healthcare for all migrants regardless of legal status.

in February of this year, Member States, international organisations, civil society and various actors came together in Marrakech for the Third Global Consultation on the Health of Refugees and Migrants (where participants reaffirmed the right to health of every human being, without distinction of any kind, and outlined commitments for migrant and refugee health in the Rabat Declaration (https://cdn.who.int/media/docs/default-source/documents/health-topics/refugee-and-migrant-health/rabat-declaration_final.pdf?sfvrsn=b62e87cf_9) .

Remembering Amit Sengupta

It is five years since we lost Amit Sengupta on November 28, 2018. Amit was a dear friend and comrade who is greatly missed. He remains an inspiration to us all. He was a magician who helped make PHA4 happen in Bangladesh the previous week – in spite of overwhelming challenges. Along with many others he must have been exhausted. After that, he was celebrating his wedding anniversary with his family in Goa.

What distinguished Amit from other doctors and activists, said friend and Delhi Science Forum member Prabir Purkayastha, was how he combined the politics of medicine with the knowledge of medicine. 'Amit wanted real change in society and worked towards that. It wasn't wooly-eyed idealism,' he said.

A range of Amit's publications can be seen here:
https://www.haiasiapacific.org/publications/amit-sengupta/

See also
https://www.haiasiapacific.org/wp-content/uploads/2018/12/HAIAPNewsDec2018.pdf

For the Municipal Services Project he also wrote 'Universal Health Care in India':
https://www.haiasiapacific.org/wp-content/uploads/2019/02/Universal-Health-Care-in-India-A-Sengupata-May-2013.pdf

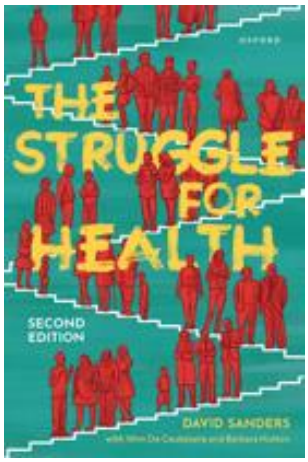
David Sanders:

A luta continua: the struggle for health continues

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)02644-2/fulltext

In 1985, David Sanders published the first edition of The Struggle for Health, completing it in his native Harare, Zimbabwe, which had gained its independence 5 years earlier. The second edition of this book, finalised by Wim De Ceukelaire and Barbara Hutton, was published posthumously this year after Sanders' untimely death in 2019.

T*he Struggle for Health: Medicine and the Politics of Underdevelopment* 2nd Edition 2023 is reviewed in *the Lancet.*



This second edition marks progress over the past four decades, such as the substantial decline in mortality among children younger than 5 years. Yet one-fifth of the world's children remain affected by stunting, rising to about one in three children in sub-Saharan Africa and south Asia, and malnutrition contributes to nearly half of all deaths in children younger than 5 years.

The new edition offers extensive data on health trends to tackle issues that were nascent, evolving, or even non-existent in the mid-1980s—the climate crisis, the rise in non-communicable diseases, the HIV and AIDS epidemic, and, more recently, the COVID-19 pandemic.

But what made the first, slimmer edition so iconic, and makes the second edition equally important, is the framework Sanders deployed to analyse reasons for—and actions to address—health inequities. A focus on 'medicine and the politics of underdevelopment' is the central import of this book.

Publication: Third World Resurgence #357 2023/4. Justice is non-negotiable

https://www.twn.my/title2/resurgence/2023/pdf/357.pdf

Included in this issue:

Gaza: Savagery versus solidarity

Justice is non-negotiable Why Israel cannot destroy Palestinian resistance By *Ramzy Baroud*

As Israel's brutal assault on Gaza rolls on unrelentingly, it is time, asserts *Ramzy Baroud*, to return the discussion to where it should have always been – the priorities of the oppressed, not the oppressor.

'We will not be silent' By *Nada Tarbush*

Responding to Israel's statement at a United Nations meeting in Geneva on 17 November, Palestinian delegate *Nada Tarbush* underlined her people's 'will to be free' in the face of the Israeli attack on Gaza. A transcript of her address follows.

With Hamas gone, Gaza still wouldn't be free By *Jonathan Cook*

Hamas is a symptom of the decades of trauma Palestinians in Gaza have been through, not the cause of that trauma, which is rooted instead in Israel's settler-colonial designs.

The long siege of Gaza By *Timothy Erik Ström*

Israel's pummelling of Gaza constitutes the extreme escalation of a suffocating, years-long regime of hunger and deprivation imposed on the territory.

'I live in Gaza. Israel's horrific bombing campaign is like nothing I've ever seen before' By *Raji Sourani*

In a harrowing dispatch from Gaza, Palestinian human rights activist and Gaza City resident *Raji Sourani* gives an account of daily life amid Israeli airstrikes that are killing entire families. Despite it all, Palestinians in Gaza are clinging to hope.

A paradigm shift in the hundred years' war on Palestine? By *Rashid Khalidi*

Since 7 October, there have been five elements that indicate we may be seeing a paradigm shift in the hundred years' war waged against the Palestinian people, contends *Rashid Khalidi* in the following piece, which is based on a talk delivered on 16 November at Columbia University in the US.

International reaction to Gaza siege exposes growing global rift By *Jorge Heine*

Diverging from the West, developing countries' positions on the Gaza conflict reflect a Global South that is coming into its own.

Amidst tears and grief, Afghan women call out to the world

The author is an Afghanistan-based female journalist trained with Finnish support before the Taliban takeover. Her identity is withheld for security reasons.

ECOLOGY 'Blood carbon': Why Indigenous peoples are paying the price for false solutions to the climate crisis By *Martin Léna*

Conservation schemes that purport to absorb carbon from the atmosphere not only do little to remedy climate change but also undermine the land rights and livelihoods of Indigenous communities.

The Green Revolution is a warning, not a blueprint for feeding a hungry planet By *Glenn Davis Stone* The Green Revolution of the 1960s and ’70s holds lessons for food production today – but not the ones that are commonly heard.

HEALTH & SAFETY: How a Big Pharma company stalled a potentially life-saving vaccine in pursuit of bigger profits By *Anna Maria Barry-Jester*

Development of a potential breakthrough vaccine against tuberculosis, the world’s deadliest infectious disease, has been held up as the company controlling the rights seeks more lucrative business – highlighting the skewed priorities of a corporate-centred pharmaceutical pipeline system.

World Antimicrobial Awareness Week 2023 becomes World AMR Awareness Week

World Antimicrobial Awareness Week has been renamed World AMR Awareness Week (WAAW) after global consultation meetings with participants from various sectors and regions. The decision to rebrand the global campaign stems from the need for a more appropriate term encompassing the concept of resistance, which is the main challenge that needs to be addressed.

While the acronym 'WAAW' remains unchanged, its expansion now stands for 'World AMR Awareness Week'. This global campaign aims to raise awareness and encourage action among One Health stakeholders to tackle the emergence and spread of drug-resistant pathogens.

Various events and activities are held worldwide in November to celebrate World AMR Awareness Week.

The theme for WAAW 2023 remained "Preventing antimicrobial resistance together", as in 2022. AMR is a threat to humans, animals, plants and the environment. It affects us all.

That is why this year's theme called for cross sectoral collaboration to preserve the efficacy of antimicrobials.

To effectively reduce AMR, all sectors must use antimicrobials prudently and appropriately, and take preventive measures to decrease the incidence of infections. The following actions can help reduce the need for antimicrobials and minimise the emergence of AMR:

- strengthen infection prevention and control in health facilities, farms and food industry premises;

- ensure access to clean water, sanitation and hygiene, and vaccines;

- minimise pollution and ensure proper waste and sanitation management;

- provide access to quality assured healthcare for all; and

- access to advice from experts during animal, food and agricultural production.

Preventing AMR requires collective action from all sectors of society. The misuse and overuse of antimicrobials primarily drive AMR, which happens in multiple sectors. We need a whole-of-society and multi-sectoral approach to tackle this global issue effectively.

Our Kerala and Thailand comrades share their strategies for the best use of antimicrobials across all sectors and for controlling AMR .

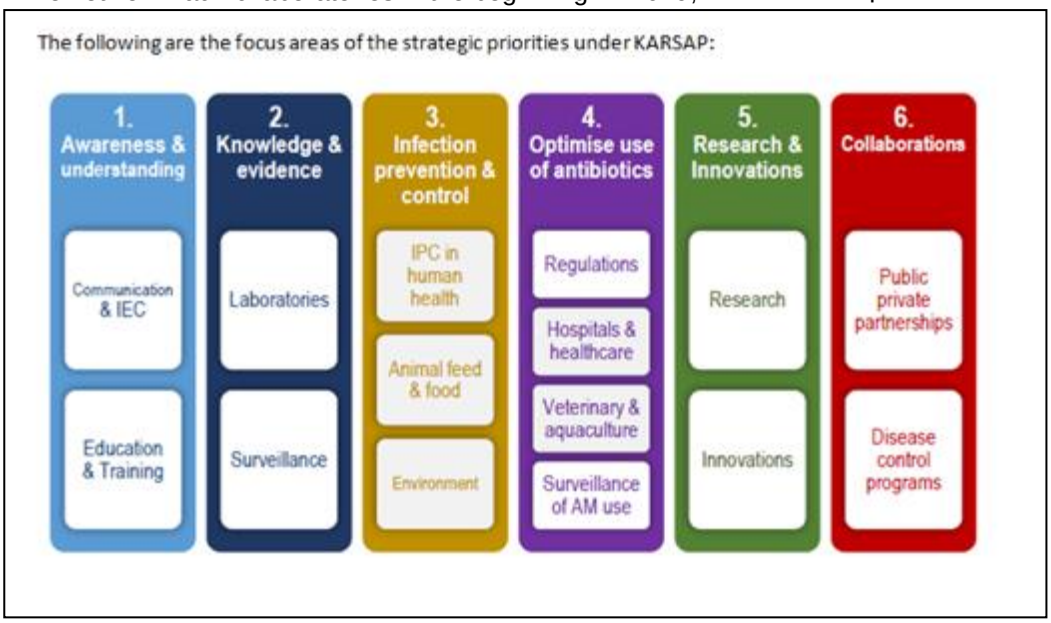
See also Kerala wants to be savvy with medicine: https://thesouthfirst.com/kerala/kerala-wants-to-be-medicine-savvy-has-plan-to-combat-pandemic-in-slow-motion/

Feature 1: Kerala Antimicrobial Resistance Strategic Action Plan (KARSAP)

Dr. B. Ekbal Chairperson,
Covid Expert Committee, Government of Kerala

The Global Action Plan on AMR [GAP-AMR] was released in 2015. The Indian National Action plan on AMR [NAP-AMR] was released in 2017. In 2018 the Kerala Antimicrobial Resistance Strategic Action Plan (KARSAP) was the first Sub-national AMR Action plan conceptualised in India. The Kerala Antimicrobial Resistance Surveillance Network (KARS-NeT) was established in 2018 to foster standardisation and estimate the extent, burden and monitoring of AMR in Kerala. KARS-NeT data is routinely analysed and reported to the State and national government on a regular basis to contribute towards the estimation of extent, burden and monitoring of AMR in Kerala and to detect emerging resistance and its spread in Kerala.

The network had 10 laboratories in the beginning. In 2019, with the technical support from World Health Organisation (WHO), the network was expanded from 21 labs in 9 districts to 31 labs across 11 districts in a phased manner with laboratories from both public and private sectors.



KARSAP identified AMR surveillance as a strategic priority in line with National and Global AMR action plans. The WHO Country Office for India collaborated with KARS-NeT with the co-operation of the State Government and NCDC. KARS-Net currently includes surveillance of AMR in 7 key priority pathogens responsible for the highest antibiotic resistance rates among bacteria that commonly cause human infections.

These include *Staphylococcus aureus*, *Enterococcus* species, *Escherichia coli*, *Klebsiella* species, *Pseudomonas* species, *Acinetobacter* species, *Salmonella enterica* serotype Typhi and Paratyphi. The WHONET software is used for the collection and analysis of Antimicrobial Susceptibility data. KARS-Net plans to generate the State AMR Surveillance report annually and the 2021 data is submitted in WHO's Global Antimicrobial Resistance Surveillance System (GLASS).

KARSAP has Six strategic priorities.

In Nov 2021, a Consultancy workshop and review meeting of strategic Priority 2 AMR surveillance was conducted at TVM which was jointly organised by WHO and the Government of Kerala.

Six activities under KARSAP to strengthen IPC (Infection Prevention and control)

1. All hospitals in the State were directed to form functional HICC [Hospital Infection control committees].

2. In 2017 nurses were given a seven-day training in IPC at Thiruvananthapuram. These certified nurses in IPC were deployed as link nurses and Infection control nurses in medical colleges. And six months later when Nipah struck in the northern district - Calicut - these were the same nurses who were in the fore front of all Nipah control activities there.

3. All IPC trained nurses were used to train other healthcare workers in their respective institutions and because of this all the 14 Government Medical colleges in the state have a robust link nurse led IPC programme.

4. In 2019, advanced IPC training program was given to all the initially trained nurses and based on the exit exam, 25 of them were certified as master trainers in IPC.

5. Small group learning sessions [SGL's] on IPC - basically a decentralised learning platform based on 'each one teach one concept' were piloted in the Government Medical College (GMC) Thiruvananthapuram and were a huge success.

6. IPC forms a major part of quality improvement initiatives in all hospitals. Hospital Quality improvement initiatives [HQII] are a priority of the Kerala Government

and phase 1 has been successfully implemented in GMC Thiruvananthapuram in 2022. HQII has been extended to other major Government Medical colleges also. Quality improvement circles have been formed as part of this.

In 2016, the recipient of the first liver transplant done in GMC Thiruvananthapuram died following infection. Due to the HQII by the Government, in 2022 four liver transplants were done successfully in the Government sector. GMC Kottayam routinely perform Heart transplants also. All these were made possible due to the meticulous attention paid to IPC activities.

Under KARSAP, the Government also has envisaged a 5-year target of getting all the hospitals in the state accredited. As of now there are 148 Govt Hospitals in the State which has NQAS [National Quality Assurance standards] accreditation.

The focus on IPC helped the State in tackling COVID 19 also. The success of *'Break the Chain'* and *'Back to Basics'* campaigns for COVID 19 prevention are testimony of that.

Also, Kerala was the first state to make universal mask use mandatory months prior to same recommendation from WHO.

Impact of KARSAP on COVID 19

Since all the health care workers [HCWs] in the state had already been trained in IPC practices like donning, doffing, droplet, and airborne precautions etc as part of KARSAP, the mortality among HCWs in Kerala is 0.06 which is one of the lowest in the world.

Adherence to mask etiquette, cough etiquette, social distancing. hand hygiene, etc. were high in Kerala resulting in plateauing of both first and second COVID 19 waves. These practices ensured that the number of COVID 19 cases in the state even during the peak of the second wave never exceeded the capacity of health care infrastructure.

Spreading out of cases over a prolonged period was in contrast to rapid peak and descent of the epidemic curve witnessed in other states, and ensured that Kerala was never short of oxygen or COVID specific medications.

Adherence to particularly good IPC practices in ICUs and glycaemic optimisation ensured that incidence of COVID 19 associated mucormycosis in Kerala was exceptionally low compared to other states.

Feature 2: Controlling AMR in Thailand - a One Health approach

Niyada Kiatying Angsulee

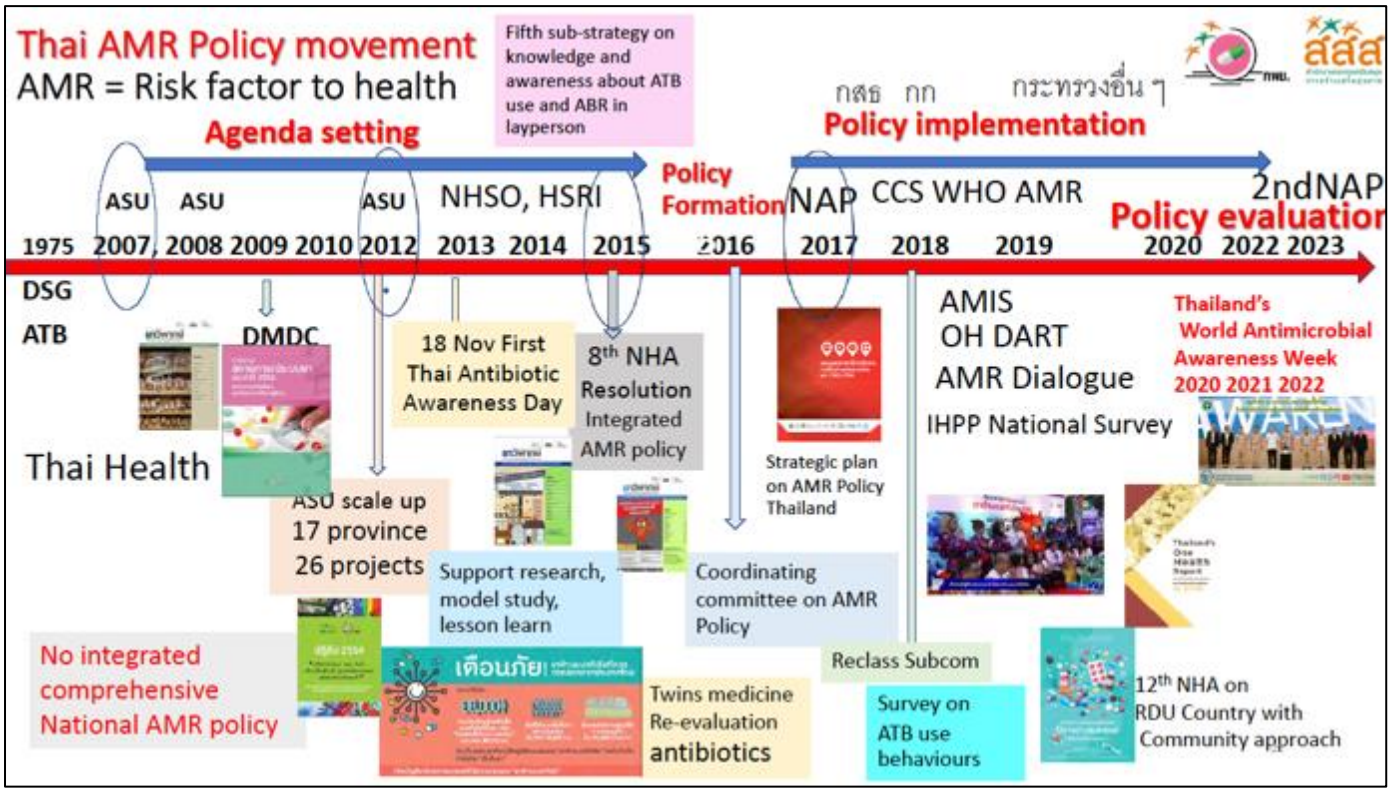
Thailand Drug System Monitoring and Development Centre (DMDC)

We work well together so the underlying concept of the process of the government using a One Health approach is a triangle that moves the mountain.[5] The weak side of the triangle is the political commitment.

Side one is the technical and academic commitment and the second side is the public and lay person's commitment. There should be a good policy to guide the day to day implementation of a good system supported by government with mobilistion of resources needed for the intervention making the third side.

Underlying concepts:

- One Health approach
- The triangle that moves the mountain
  - Internal allocation of resources
  - Networking between Government, CSO, Academia
  - Consultation collectively
  - Creation of evidence and data
  - Monitoring and evaluation system



DMDC Objecives

1. Resources for drug system monitoring
2. Public communication to signal drug problems
3. Community empowerment for using mechanism on drug system monitoring
4. Policy advocacy on drug systems: RDU, AMR, Border medicines, ethics and governance, etc.

DMC Strategies

1. Community approach as bottom-up strategy
2. Regional Network (academic nodes)
3. Civil Society and academic voices
4. Target on change agents
5. Human resources development (collective leader training)
6. Focus on regulatory policy for consumer protection and for drug selection at upstream level.

Academic Nodes as regional monitoring mechanisms with DMDC

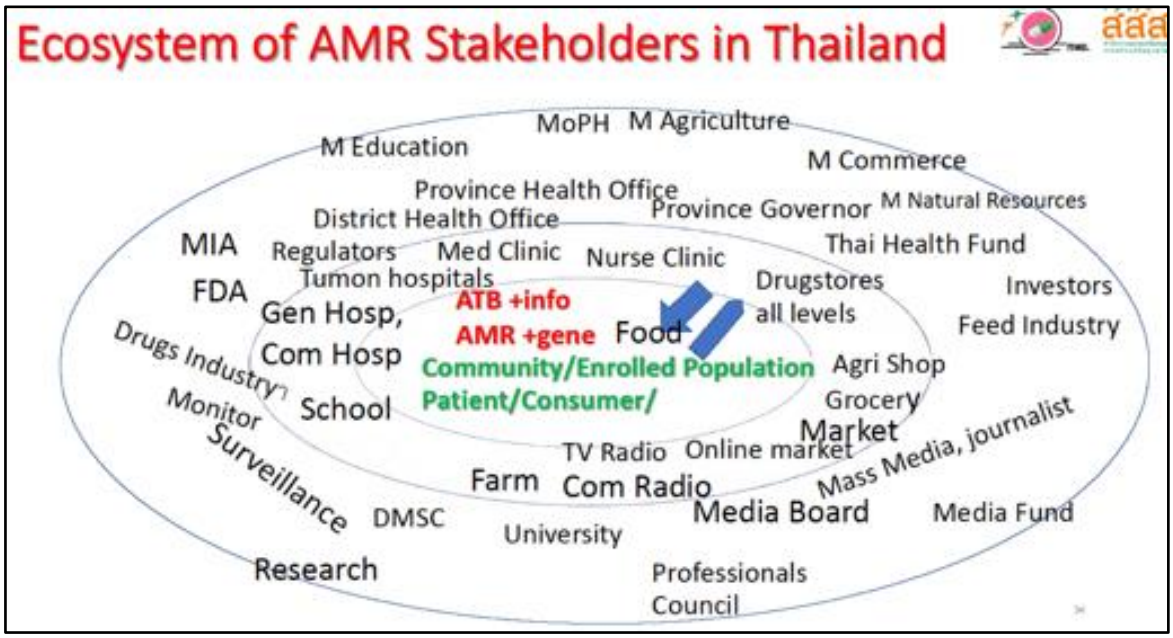
North: Pharmacy School CMU - 8 provinces, 3 projects (Border medicine, ATB in agriculture, Community RDU)

[5] https://en.nationalhealth.or.th/wp-content/uploads/2017/11/The-Triangle-That-Moves-The-Mountain.pdf

South: Pharmacy School PSU - 9 provinces, 4 projects (Border medicine, RDU, media for literacy, drug situation)

North-Eastern: Pharmacy School MMU - 17 provinces, 4 projects (Border medicine, ATS in livestock, RDU literacy, cannabis.

For the number five strategy instead of AMR awareness, now we tend to focus on AMR literacy which is a little bit higher and more important and we see that as more important than just only awareness and knowledge.



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The green text at the middle of the graphic refers to one single province and then we expand to the second phase in the next ring. Finally in the outer ring the national health and security office will oversee all health security for Thai citiens apart from the government staff and the private staff. They accept that policy.

Some international published papers say it is all government of Thailand work. No. In Thailand the Community is at the middle. We start at the bottom and then we work up. The second circle is probably across all the communities. Outside is the Minister of Public Health, with the Minister of Education in the central area.

So if we know all the stakeholders, how they support us, or how they are against us, we know how we are supposed work together. So then we support everyone, and we can work together with collaboration. in addition, we can work together with HAIAP, Third World Network, South Centre, Oxfam, ReAct. All the very important global momentum can help by collaboration, communication and sharing experience, for empowering people and engagement, improving knowledge, attitude, awareness. The literacy of stakeholders is very important.

We have the National AMR Forum every 2 years. The report of academic work is presented at the forum together with the work of the CSOs. There are two days of very good discussion and very good research has been presented. Results are documented and some more agenda items identified for the next meeting. Ambitious high goals are targeted and we try to achieve those.

The Thai Smart Use (ASU) program works on Antimicrobial Stewardship (AMS) as a model for rational use. We have three phases of a bottom up approach including guidelines for rational prescribing. It is a multi level interwoven structure with a central collar to secure sustainability and provide policy support.

We try to institutionalise organisation and leadership in the hospitals and support the initiatives they create. There are many areas where leadership is needed to deal with AMR issues. Staff involvement in the hospital at the very beginning is needed to work together in partnership with reference groups and community. Community participation is very important in the antibiotic smart use of medicines.

We propose three key conditions where antibiotics should not be used: cough and colds of upper respiratory tract infections, common acute diarrhea, and clean wounds. Research has shown that success with this concept of three conditions can expand to almost all hospitals and it is included in the policy now.

ASU has unfolded in the three phases. It began as a partnership with pharmacists and doctors from Srinakharinwirot University and Chulalongkorn University. They piloted educational and training reforms to improve rational prescribing in 10 hospitals and 87 primary health centres in the Saraburi province. During this first phase, the provincial health office monitored four areas: antibiotic prescription rates; provider attitudes of effectiveness and knowledge of antibiotics; non-prescription rates in cases of non-bacterial infections; and patient health and satisfaction. Applying these same indicators, the second

phase scaled up the intervention to 44 hospitals and 621 primary health centres in three provinces and two hospital networks. The National Health Security Office (NHSO) piloted a pay-for-performance system to realign financial incentives to prescribers and providers. Under the guidance of the Thai FDA, local health authorities managed this initiative with additional assistance from the NHSO and the Health Systems Research Institute. The third phase has strengthened and expanded the network to 22 public hospital systems in 15 provinces, with the focus on longer-term sustainability.

Without hierarchical leadership, Antibiotics Smart Use built decentralised networks that engaged local partners to adapt these guidelines in their own healthcare settings and communities. These local partners were made up of networks of multidisciplinary groups across the healthcare, government and academic sectors. They included hospital directors, provincial health administrators, university researchers, medical and pharmacy students as well as local physicians, nurses and pharmacists. For more about the Smart Use program see:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8381094/pdf/BLT.20.280644.pdf

Health and medicine - related challenges at Thailand's International Borders

From Niyada Kiatying Angsulee, Manager of the Drug System Monitoring and Development Centre

Thailand has borders with Myanmar, Lao PDR, Cambodia and Malaysia as well as being very close to the border with China. The land border is approximately 5,700 kilometres covering 31 provinces. Thailand's Food and Drug checkpoints have the legal duty to control the importation of health products into the Kingdom of Thailand.

The situation associated with Thai border medicine problems is new to us and complicated owing to social and cultural differences between the communities concerned as well as economic and geographical diversities.

There are some health problems in communities along the borders associated with population mobility, such as people travelling from the border to an urban centre where jobs and income are better. As a result, definition, regulation and enforcement of control as well as reasons and objectives of medicine use by people differ according to the community context.

The following examples illustrate the enormous challenge for the DMDC and their colleagues trying to map the situations and then implement programs to educate the communities, the health workers and border control workers and to try to control the traffic of hazardous medicines while caring for the affected communities.

Steroids in containers with Chinese labels crossed the border and were found in a collection of medicines by military doctors when the Thai Public Health Ministry was strictly controlling a general influx of steroidal medicines in the country. This medicine was being smuggled across the border throughout Thailand: in Chiang Rai, Nong Khai, Muk Da Han and Ubol Ratchathani. It was also found in the centre of Chiang Mai, Prachuab Khirikhan, Khon Kaen and steroids were illegally combined with other drugs and herbal health products and used in the south of Thailand in areas such as Songkhla and Yala.

From this study, it is found that the problems of improperly used steroids is not only clustered in Thailand but there are similar characteristics in neighbouring countries. The cross border movement of steroid medicines has been creating a burden on the underlying health system for a long time. Values about medicines and their meanings differ and law enforcement and medical knowledge vary throughout the path of the drug flow causing inefficiency of surveillance mechanisms and regulatory systems as well as dangers to communities.

Northern Region

In the area of Wiang Kaen District and Chiang Khong District, Chiang Rai Province, steroids are distributed widely in border markets for Thai people, both retail and wholesale, and sold to Hmong and Laotians crossing the border to buy and sell at their flea markets.

While the monitoring network was in Chiang Khong to collect data, non registered NSAID analgesics from Vietnam and China were found in Thailand - to be sold in Muang District, Chiang Mai.

There was information from the Food and Drug Checkpoint officials at the Lao PDR point in Bo Kaeo District that officials of the Lao authorities have detected a number of sibutramine being brought across into Thailand. (The study is not yet completed, due to investigations by Laos authorities first, according to the drug laws of the Lao PDR regarding the control of drug exports).

North Eastern Region

Nong Khai Customs, in cooperation with the Food and Drug Checkpoint officers, searched Nong Khai public transportation at the Thai-Laos Friendship Bridge, in the area of the international arrivals bus terminal.

A bag was found inside a bus, which contained a white plastic bottle containing 70,000 tablets named 'Dexamethasone' and 'Piroxicam', without any owner's or manufacturer's identification.

In the area of Loei Province (NE Thailand), cross border steroids with Chinese labels were discovered to be from Laos. Hmong merchants sell them across the border market in Chiang Khan District, together with *YA-CHUD* (cocktails of usually unidentified drugs in one pack) and other drugs not registered in Thailand. They gave information that they bought drugs in Lao PDR to sell to both Thai and Laotian people because of good sales.

Southern region

In Narathiwat Province, in collaboration with Kelantan's Food and Drugs Checkpoint, Malaysia has reported the continuous detection of steroids in many supplements and traditional medicines, weight gain vitamins and herbal medicines, such as: Motalin, Jamu Ajaib products, Maajun Ayam selasih, gout painkillers, Steroid-contaminated herbal medicine, KOKANDO Detox supplement.

A Thailand-Malaysia Border Health Goodwill Committee for study Situation and Health Product Vigilance along the Thailand- Malaysia Border (Narathiwat-Kelantan) Pharmacy Implementation has been established to:

- Inspect health products and advertisements
- Collect samples of health products for analysis
- Undertake Public relations (PR) and consumer warnings
- Implement consumer education.

Western Region

Drugs and health products were found at the border of Sangkhlaburi District, Kanchanaburi Province. Modern drugs classified by law as dangerous and specially controlled drugs were being sold. Many were available in grocery stores. Also, illegal drugs from Myanmar were being used among migrant workers. Although hospitals are the area's most common places for people to buy drugs, some still buy them from grocery stores, flea markets, and medical clinics. Products are also procured via the Internet, and some sold in those places. Products such as antibiotics, dangerous drugs, and specially controlled drugs are among them.

Community Education

Community education is conducted in all regions at two levels: Pharmacists work in collaboration with the DMDC program at district and provincial levels. 'Non-health' officials educate community people abut the legal and regulatory aspects of cross border medicine traffic and the risks associated with the use of many of the medicines.

Lay persons are involved with the health team in promoting health and safe use of medicines. They are also involved in developing ways to monitor what is going on.

Problems in neighbouring countries

Thai authorities are collaborating with authorities in the neighbouring countries and problems have been identified with products as follows.

Malaysia: dexamethasone, NSAIDs, many diabetes drugs and adulterated traditional medicines

Brunei Darussalam: dexamethasone and silbutramine and many other modern drugs in multiple products.

Lao PDR: Illegal steroids imported from Thailand.

Australian PM apologises for thalidomide

in parliament on 29 November 2023 - 60th anniversary of Australia's withdrawal of thalidomide.

See also

https://theconversation.com/thalidomide-survivors-are-receiving-an-apology-for-the-pharmaceutical-disaster-that-changed-pregnancy-medicine-218691

and

https://www.abc.net.au/news/2023-11-25/canberra-prime-minister-saying-sorry-to-thalidomide-survivors/103110008

Mr Speaker,

Sixty-two years ago, today, the 29th of November, 1961 was the day thalidomide was withdrawn from sale in Australia. Every day between then and now, Australians affected by thalidomide have been owed an apology.

Today, at long last, Australia will say sorry.

I want to acknowledge and welcome all the thalidomide survivors and their families here with us in the Parliament. I extend that same respect to all those watching from afar, here with us in spirit.

You have been survivors from the day you were born. More than that, you have been advocates, organisers, champions and warriors. Time and time again you have summoned remarkable resolve, you have shown an extraordinary strength of character.

Yet for so long, parliaments and governments have not proved equal to this, or worthy of it. Too often, we have let you down. Today, your presence lifts all of us up.

And together, today, we mark an absence too. At the conclusion of these proceedings, we will join in a minute's silence to remember and honour all those this tragedy took from us far too soon. Because this apology will forever belong to those Australians, as well.

Mr Speaker, Thalidomide was recommended to pregnant women to help with anxiety, insomnia and morning sickness. All over the country, expectant mothers were assured by doctors and chemists and advertisements that this drug was perfectly safe, for them and for their baby.

There was no system for properly evaluating the safety of medicines. And the terrible cruelty of thalidomide was that far from being safe. Just one dose was enough to cause devastating harm. Just one dose was enough to inflict a lifetime of damage on an unborn child, or indeed cause premature death, either in utero or in the early years.

A survivor named Patricia put it like this:

> *'Thalidomide is like tossing a stone into the water: it causes a ripple effect. The drug didn't just destroy me; it rippled onto my parents, my siblings, my family, my ambitions, my relationships, my jobs, my earnings, my health—my everything.'*

Those ripples ran through lives around our nation. Bullying and teasing at school. Trauma and sadness at home. Exclusion and rejection when looking for work. A constant battle against declining health and increasing need. Hidden struggles and invisible pain. The thousand different ways that ordinary tasks can be ordeals.

And mothers and fathers and families haunted by a lifetime of undeserved regret. A regret that could never be reasoned away, because it was fuelled by that all-powerful all-consuming instinct every parent knows that inescapable sense of responsibility for your child's health and happiness.

So let it be said today, and recorded for all time: these parents, these mothers, did nothing wrong. These parents did not fail their children. The system failed them both. Which is why, as so many survivors have requested: the Apology we offer today embraces and includes their parents and their families as well.

Mr Speaker, Today, on behalf of the people of Australia, our Government and this Parliament offers a full, unreserved and overdue apology to all thalidomide survivors, their families, loved ones and carers. This apology takes in one of the darkest chapters in Australia's medical history. When expectant mothers, through no fault of their own, were exposed to a drug with devastating effects that were realised far too late.

To the survivors: we apologise for the pain thalidomide has inflicted on each and every one of you, each and every day. We are sorry. We are more sorry than we can say. We are sorry for the harm and the hurt and the hardship you have endured. We are sorry for all the cruelty you have had to bear. We are sorry for all the opportunities you have been denied. We are sorry for the battle you have had to fight – over decades - for fair support and due recognition. And we are sorry that there are so many who deserved this apology, who have not lived to see this day.

We offer our respect to their memories, and we extend our deepest sympathies to their families and friends. To the mothers and fathers, today we apologise because you were failed too.

We are sorry you have endured decades of knowing your children's lives are harder than they should have been. We are sorry you have suffered your own hurt, even

though what happened is not your fault and it never was. We say sorry, not imagining that these words can resolve the anguish or remove the pain.

We understand an apology does not balance years of inaction and inadequate support. We know the toll of thalidomide is still felt today, we know it will still be felt tomorrow. We promise your legacy – and your example - will never be forgotten.

A National Apology was the first recommendation of the 2019 Senate Inquiry, chaired by former Senator Rachel Siewert. I thank her and the other committee members from across Parliament for their important work. I recognise the initiative taken by former Prime Minister Morrison and the support his government provided.

But without question, the heroes of those proceedings are the survivors and their families who shared their stories with such searing honesty. The people who put, on the parliamentary record, a hard truth too long denied. Their courage demands that at the heart of this national apology must be an acceptance of Australia's moral responsibility.

So, today, as we express our sorrow and regret, we also acknowledge the inescapable historical facts. The fact that even after the grave dangers of this drug were known, importing thalidomide was not prohibited. Selling it was not banned. Products and samples in surgeries and shops were not comprehensively recalled or entirely destroyed.

Saying sorry does not excuse this, or erase it.

There are no words that can undo what has been suffered. There is no sum of money that can square the ledger. But our Australian commitment to a fair go for all, demands that we try. That's why the former Government established the Australian Thalidomide Survivors Support Program. A lifetime support package which includes a one-off lump sum payment in recognition of pain and suffering, as well as ongoing annual payments. To date, 148 survivors have received this support.

Today, I can confirm our Government is re-opening this program to ensure that anyone who may have missed the previous opportunity to apply does not miss out on the support they need and deserve. Further to this, for all survivors who currently receive the annual, tax-exempt payment - and any new applicants who qualify for it.

I want to make it clear that from now on, rather than these payments being locked at a particular level, we will act to ensure that support increases through indexation.

One of the Australians who spoke to the inquiry was a woman named Mary. In November 2018, she said:

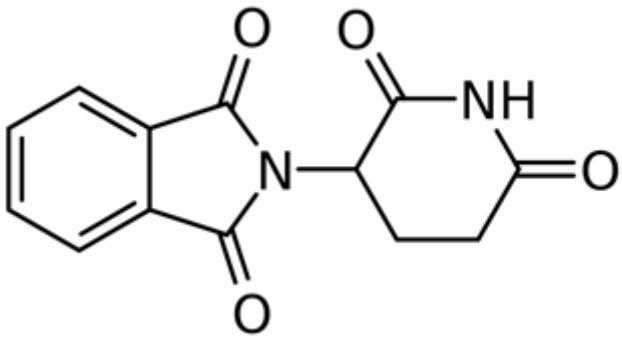
'I wasn't really meant to live outside of infancy, and there have been many days throughout my life when I wish I hadn't.'

Imagine that. And imagine what it takes to share those words with people you've never met. Mary was one of many survivors who requested a meaningful and public apology from Government.

Tomorrow, in Kings Park on the northern shore of Lake Burley Griffin the Minister for Health and Aged Care will formally dedicate the ***National Site of Recognition for Thalidomide Survivors and their Families***. It will offer a space for reflection and contemplation. Along with a gateway of glass bricks, chosen by the artist to represent the ripple effect across lives. And an information display that will tell the story to every visitor.

I conclude today by saying to the survivors, their families and loved ones, here with us and all of you watching or listening around the nation and even overseas. The people of Australia are offering this apology to you. And make no mistake, we are offering this apology because of you. You deserved this apology. And you made it happen. Because you fought for what was right. Because you spoke the hard truth, until it was heard. Because you knew you deserved better. And because you continued to demand better - from your government, your Parliament and your country. For six decades you have had to carry this cause.

Now the challenge is on all of us here, to do better for you. Together. I know we can, I know we must, I know we will. I commend the National Apology to all Australians impacted by the Thalidomide Tragedy, to the House.



Malaysian and New Zealand colleagues battle to control availability of life threatening 'vapes'

Please see the whole story in December 1 Bulletin

https://www.haiasiapacific.org/wp-content/uploads/2023/11/HAIAP-News-Bulletin-1-December-2023-1.pdf

See full presentations https://www.haiasiapacific.org/wp-content/uploads/2023/11/Perspektif-Perundangan-PerlembagaanReduced.pdf

https://www.haiasiapacific.org/wp-content/uploads/2023/11/BULLEN-SFG-NZ-Nov-2023Reduced.pdf

'Vapes' are battery-operated electronic devices that are used to heat a liquid commonly containing nicotine, flavouring and a range of toxic products to produce a vapour, which is then inhaled – mimicking the act of smoking. The strength of nicotine varies greatly.

On November 27, Dr Haniki Mohamed and IIUM colleagues conducted a Zoom meeting to share the status of the situation regarding control of availability of nicotine vapes in Malaysia together with the tobacco control experience in New Zealand.

When 'vapes' were introduced, the Malaysian government removed them from control under the Poisons Act (that controlled other tobacco products) making them as freely available as junk food to people of all ages. As in many other countries they have become very popular, especially among school age children, and have caused near deaths in several cases. [6] See also HAIAP Bulletin 1 July 2023 [7]

Associate Prof. Madya Dr Khairil Azmin Mokhtar, IIUM, explained the whole Malaysian scenario since the emergence of e-cigarettes and vapes; and the impact of the increasing use - particularly among young people.

What is meant by Generational End Game?

The End Game is a target set by global experts to achieve a smoking prevalence of less than 5% and a set of implementations to prohibit certain activities related to smoking for the generation born on 1st January 2007 onwards.

Malaysian health professionals are doing everything possible to convince the government that the products should be banned in order to protect the population - particularly young people. However cabinet discussion of the issue has been postponed again and again - now until August next year - and vapes remain freely available to all.

The 'end game' (GEG) policy is designed to protect future generations from harm caused by use of vaporised nicotine products but it has been alleged - by politicians, tobacco companies and others - that the GEG is 'discriminatory', therefore unconstitutional and must be discarded - because it identifies a particular group.

Professor Chris Bullen - the New Zealand setting

In New Zealand there has been major progress towards a nicotine free country but Professor Chris Bullen from Auckland University in New Zealand and others fear their achievements could go 'go up in smoke' since the election of a new government.

Professor Bullen explained the history of their movement and the major contribution of the Maori First Nations people to the positive outcomes of their campaigns for a smoke-free generation.

Medical Groups Demand Relisting of Liquid Nicotine as a poison

By Boo Su-Lyn | 7 November 2023

https://codeblue.galencentre.org/2023/11/07/medical-groups-demand-relisting-of-liquid-nicotine-after-cabinet-moots-geg-decoupling/

The Malaysian Pharmacists Society, Malaysian Council for Tobacco Control, Galen Centre, and the Commonwealth Medical Association demand the relisting

[6] https://nceph.anu.edu.au/files/E-cigarettes%20health%20outcomes%20review%20summary%20brief%202022.pdf

[7] https://www.haiasiapacific.org/wp-content/uploads/2023/07/HAIAP-News-Bulletin-1-July-2023.pdf

of liquid nicotine into the Poisons List, after a Cabinet decision to decouple GEG from the tobacco bill.

The Malaysian Pharmacists Society (MPS) condemned the Cabinet's decision to drop provisions related to the generational tobacco and vape prohibition from the bill, saying it reflected the lack of political will for a proposed standalone tobacco control Act.

MPS president Amrahi Buang told *CodeBlue:*

'The government has not been serious about getting this bill, right from the beginning since last year. There is no commitment to get this done even though the health aspects overcome the financial aspects.'

MPS told the government to immediately restore liquid and gel nicotine used in e-cigarettes and vaporisers into the Poisons List, since the highly addictive substance was exempted from control under the Poisons Act 1952 by Health Minister Dr Zaliha Mustafa last March 31.

'The logical step is to control it since it is a *lacuna* now,' Amrahi said, referring to the gap in the law that permits the legal sale of nicotine vape products to children and teens aged below 18 after the declassification of liquid nicotine.

Prof Dzulkifli Abdul Razak, a neuropharmacologist who is also International Islamic University Malaysia (IIUM) Rector, similarly slammed the Cabinet's move to decouple the GEG from the Control of Smoking Products for Public Health Bill.

'More uncertainties and more toxic exposure to those below 18 years. It is unacceptable under any circumstances, especially after so many unreliable promises,' Dzulkifli told *CodeBlue.*

'The right thing to do is to go back to the status quo prior to April 1, that is to relist [liquid] nicotine immediately, ensuring that health wellbeing remains uncompromised!'

Community Education Malaysian Control of Tobacco Council (MCTC) chairman Dr M. Murallitharan told *CodeBlue* that 'We find it really odd that the AG – keeping in mind that these are institutions and not merely individuals – can, as a whole, suddenly now decide that this bill is unconstitutional,'

'Someone in the AGC has to take the blame for this blunder – if this is indeed a blunder – or is this now a case where there has been some subversion? These are questions that the AGC has to be transparent in answering now when they throw such a huge spanner into the works.'

'This is a huge win for the industry that continues to reap all the benefits from the lack of legislation and controls'.

He described the generational ban as a 'strategic' process to reduce the prevalence of smokers and e-cigarette users.

Like MCTC, the Commonwealth Medical Association (CMA) opposed the Cabinet's decision.

'We are talking about our children and grandchildren's health. There must be a political will by the Reformist government to do the right thing.'

'There is no regulation now on nicotine. Evali,[8] a lung injury due to electronic cigarettes and vape, will cause lots of suffering for patients. It requires long-term hospitalisation and imposes a very high cost for the government.

'We already have deaths from Evali. We have to stop this now, immediately. Since there is no regulation, minors in schools are also vaping. The vape juice content is unknown to most smokers.'

The Galen Centre for Health and Social Policy also urged the government to immediately place liquid and gel nicotine used for the production of e-cigarettes and vape back into the Poisons List, amid the continued absence of legislation.

Regional Centres of Expertise (RCE) Conference

Highlighting the whole community approach for Education for Sustainable Development (ESD)

November 2023

https://www.rcenetwork.org/portal/13th-global-rce-conference-highlights-whole-community-approach-esd

The 13th Global Regional Centres of Expertise (RCE) Conference was held from 31 October to 2 November 2023 in Kuala Lumpur, Malaysia, co-hosted by RCE Greater Gombak and RCE Greater Kuala Lumpur, under the theme 'Whole Community Approach for Education for Sustainable Development (ESD)'.

Discussions focused on transformative learning, partnership and global movement, capacity building and empowering youth for the whole community approach.

Prof. Emeritus Tan Sri Dzulkifli Abdul Razak, Rector of IIUM and co-chair of RCE Greater Gombak, outlined seven practical steps for the whole community approach in embedding the SDGs. He noted these were the steps taken at IIUM to embed SDGs, and that the whole process was an 'experiment' that others could perhaps learn from. The seven steps were:

(1) breaking silos – encouraging working together transcending disciplines to achieve IIUM's mission of bringing about betterment for human life and civilisation;

[8] https://www.health.harvard.edu/blog/evali-new-information-on-vaping-induced-lung-injury-2020040319359

(2) creating a common platform through the SDGs flagships at IIUM;

(3) engaging the community – from the hand to the head to the heart in transforming the community;

(4) introducing experiential learning – beyond the classroom and theories / Usrah in Action;

(5) developing education programs which promote flexibility, empowerment, innovation and accountability;

(6) humanising education through the IIUM roadmap to instill sympathy, empathy and compassion – bringing back the heart to education; and

(7) creating a new learning ecosystem with emphasis on community engagement. He stressed that co-learning, collaborating, co-creating and co-existing underlie the concept of Communiversity where the community and

university come together to initiate transformation.

The third day of the conference was held at UCSI University. The day began with a visit to Garden Spring, a gardening community in Cheras, Kuala Lumpur. Prof. Emeritus Tan Sri Dr. Zakri Abdul Hamid (Founding Director and Distinguished Professor, International Institute of Science Diplomacy and Sustainability, UCSI) delivered the second keynote speech in which he reminisced on the establishment of RCEs.

The origins of RCEs can be traced back to the UN World Summit on Sustainable Development in Johannesburg, South Africa in 2002 in which the Ubuntu Declaration was signed. The declaration suggested greater global emphasis on education is essential to reaching SDGs and creating a major global alliance to promote science and technology courses and teaching throughout educational systems.

The core elements of RCE are governance, collaboration, research and development, and transformative education. ESD in RCE aims at re-orientating education towards SD, by integrating SD and ESD into the current curriculum and tailoring it to address issues and local contexts of the community in which they operate.

Spanish flu: People dropped whisky into their noses to treat it

Here's what else they took that would raise eyebrows today

https://theconversation.com/people-dropped-whisky-into-their-noses- to-treat-spanish-flu-heres-what-else-they-took-that-would-raise-eyebrows-today-167525

Author Philippa Martyr Lecturer, Pharmacology, Women's Health, School of Biomedical Sciences, The University of Western Australia

[Many of the deaths from the 'Spanish Flu were from bacterial co-infections before the development of antibiotics]

While researching COVID-19 in a fast-paced world with new data becoming available all the time, we track which interventions work well and which ones don't. But in 1918, during the 'Spanish flu' pandemic, the world was a different place. No one was entirely sure what caused influenza. By the time health authorities began to find out, it was too late.

Our knowledge about viruses was limited in 1918, but we knew about bacteria. People who died of flu had bacterial infection in their lungs. However, this threw researchers off track because these were secondary infections without available antibiotic treatment, not caused directly by the flu.

With this lack of knowledge, it was still an anything-goes medical research world. There were unregulated vaccine trials and lots of hype for the latest 'cure', even in respectable medical journals.

Here's what we know about the Spanish flu 'cures' of the day, whisky included.

Doctors, pharmacists and nurses had cures

Sydney's chief quarantine officer, Dr Reid, treated patients in March 1919 with 15-grain (1 gram) doses of calcium lactate every four hours, and a 'vaccine' containing influenza and pneumococcus bacteria. In 203 cases, he had no deaths.

Calcium lactate is used today to treat low levels of calcium in the blood. But Dr Reid's doses were well above the current recommended daily level.

Nan Taylor, a New Zealand nurse, advocated whisky — lots of it, including gargling and drops up the nose. She also recommended quinine and castor oil.

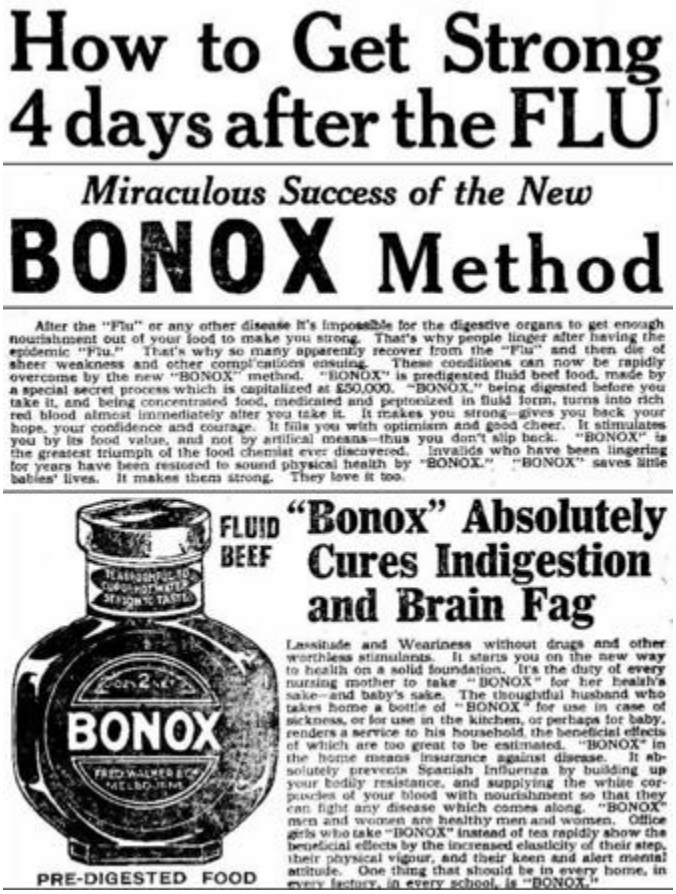
Nurse Kate Guazzini cared for Spanish flu patients in South Africa in late 1918, and caught the flu there before moving to Sydney. She said:

> *I was kept alive on brandy and milk for six weeks […] That, with quinine and hot lemon drinks, were found to be the only effective remedies.*

Food manufacturers linked themselves to flu cures. In 1919 a brand new beef extract, *Bonox*, had just hit the

Australian market, and the flu epidemic was a great marketing opportunity. *Bonox* was advertised as a sure way to recover your health and strength after the flu.

This *Bonox* advertisement promised a robust recovery.[9]



How to Get Strong 4 days after the FLU

Miraculous Success of the New

BONOX Method

After the "Flu" or any other disease it's impossible for the digestive organs to get enough nourishment out of your food to make you strong. That's why people linger after having the epidemic "Flu." That's why so many apparently recover from the "Flu" and then die of sheer weakness and other complications ensuing. These conditions can now be rapidly overcome by the new "BONOX" method. "BONOX" is predigested fluid beef food, made by a special secret process which is capitalized at £50,000. "BONOX," being digested before you take it, and being concentrated food, medicated and peptonized in fluid form, turns into rich red blood almost immediately after you take it. It makes you strong—gives you back your hope, your confidence and courage. It fills you with optimism and good cheer. It stimulates you by its food value, and not by artifical means—thus you don't slip back. "BONOX" is the greatest triumph of the food chemist ever discovered. Invalids who have been lingering for years have been restored to sound physical health by "BONOX." "BONOX" saves little babies' lives. It makes them strong. They love it too.

"Bonox" Absolutely Cures Indigestion and Brain Fag

Lassitude and Weariness without drugs and other worthless stimulants. It starts you on the new way to health on a solid foundation. It's the duty of every nursing mother to take "BONOX" for her health's sake—and baby's sake. The thoughtful husband who takes home a bottle of "BONOX" for use in case of sickness, or for use in the kitchen, or perhaps for baby, renders a service to his household the beneficial effects of which are too great to be estimated. "BONOX" in the home means insurance against disease. It absolutely prevents Spanish Influenza by building up your bodily resistance, and supplying the white corpuscles of your blood with nourishment so that they can fight any disease which comes along. "BONOX" men and women are healthy men and women. Office girls who take "BONOX" instead of tea rapidly show the beneficial effects by the increased elasticity of their step, their physical vigour, and their keen and alert mental attitude. One thing that should be in every home, in every factory, in every school, is "BONOX."

News of 'cures' spread far and wide

In much of Australia just after WWI there were often no doctors close by. So many people were used to dosing themselves with homemade potions and remedies. They shared their prescriptions in the pages of local newspapers.

Between 1918 and 1920, Australian newspapers were flooded with Spanish flu cures of all kinds.

Aspirin was very popular as a Spanish flu treatment worldwide. But people sometimes took it at dangerously high doses, which may have boosted the number of deaths attributed to the flu. In the absence of many other treatments, government authorities promoted aspirin, along with quinine and phenacetin.

The pain killer phenacetin is now banned because it's linked to kidney and urinary tract cancers.

Like aspirin, its overuse might have boosted the Spanish flu death rate.

THERE'S NO NEED to CATCH the 'FLU this WINTER

They do not affect the heart

Aspro WILL STOP IT

The 'Flu is about again. That isn't any reason why you should catch it, though, because a way has been discovered to stop it. The way is "Aspro" Tablets—the remedy that was proclaimed a necessary commodity by the Commonwealth Government during the Spanish influenza epidemic. As soon as you feel a bit dopey—or if your temperature rises—or a headache

They're using it in America

Australians were also eagerly reading about international experiments, and wanting to try cures locally. In June 1919, the Richmond River Herald reported:

> *On Friday we published the following New York cable: — 'Dr. Charles Duncan, at the Convention of the American Medical Association, said the cure for influenza was one drachm of infected mucus pasteurised and with filtered water injected subcutaneously … Yesterday (says Tuesday's Tweed 'Daily') a youth was seen inquiring for a chemist, having in his hand the above clipping and sixpence, his object being to secure that amount's worth of the 'cure.' Several others, it is understood, have also been inquiring into the same matter, with a view to 'having it made up' locally.*

Some of these cures lingered. Once the Spanish flu pandemic was over, many of the cures remained. Most of them, like aspirin, incorporated the threat of influenza into regular advertising. Some 'cures', like quinine, have made a reappearance during the COVID-19 pandemic.

And one of the most commonly recommended cures — whisky taken at frequent intervals — hasn't lost its popularity.

Disclosure statement: Philippa Martyr does not work for, consult, own shares in or receive funding from any company or organisation that would benefit from this article, and has disclosed no relevant affiliations beyond their academic appointment.

['Spanish' flu caused by an H1N1 virus did not originate in Spain. It most likely reached Spain from France, perhaps as the result of the heavy rail traffic of Spanish and Portuguese migrant workers to and from France. The earliest documented case was March 1918 in the state of Kansas in the United States, with further cases recorded in France, Germany and the United Kingdom in April.]

[9] Trove Digitised Newspapers, Herald (Melbourne), April 26, 1919, p9, National Library of Australia

Concerns about 'unfair' WHO Pandemic Agreement negotiations

AFTINET:
https://mail.google.com/mail/u/0/#inbox/WhctKKZPGSwMnfTNBhdsFvVlGBqDcHJLhvstmhWGBFkzghJbhWWVgSnVpqBWZgdBlRfNKJv

WHO negotiations resumed in early December to discuss the Pandemic Agreement. There have been reports that the US and EU have exerted pressure to influence negotiations to remove a lead Africa Group negotiator known for strongly supporting equity provisions. These claims have led to questions on whether equity provisions are unfairly under threat from powerful wealthier nations.

The WHO Pandemic Agreement intends to strengthen pandemic prevention, preparedness and response. Lower-income countries have been advocating for more equitable access to medicines as pharmaceutical company monopolies on vaccines during the COVID pandemic meant that most vaccines were sold at high prices to high-income countries, excluding lower-income countries.

Leaked negotiation documents show that the US has been continually attempting to weaken the provisions of the text and make action to prepare for the next pandemic almost entirely voluntary.

One of the most contested provisions is the inclusion of time-bound waivers for WTO intellectual property rules in the Pandemic Agreement, which would allow for production of more medicines at more affordable prices but has been met with strong opposition from wealthier countries.

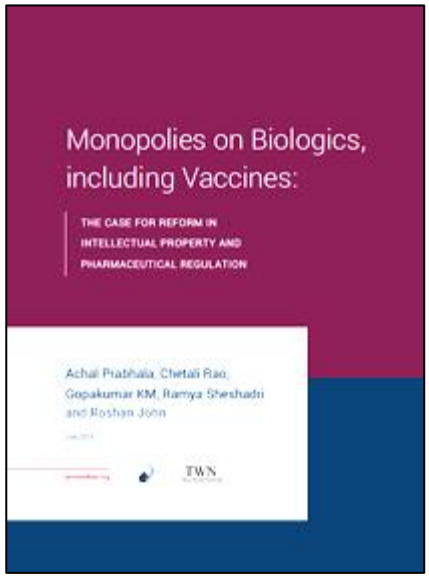
High-income countries have been pushing for heightened surveillance and information sharing obligations. Lower-income countries are concerned that they will share information, which will help develop crucial medicines, but will not get access to the medicines in return. They have viewed providing information access as one of their few areas of bargaining power for equitable resource sharing. However, surveillance mechanisms have been included in the draft negotiating text, despite many other equity provisions being unaddressed.

The Third World Network commented the negotiation process 'pressurise[d] developing countries to agree on the surveillance agenda without addressing the concerns on equity.' It said that the process of negotiation, in which groups split into sub-group discussions, was unfair and forced developing countries to dilute their proposals before negotiations had even begun.

From TWN - Report: Monopolies on Biologics including Vaccines

https://www.twn.my/title2/books/pdf/Monopolies%20on%20Biologics,%20including%20Vaccines.pdf

This report, a collaborative effort from the AccessIBSA project and the Third World Network examines monopolies on biologics, including vaccines, in India, and makes the case for reform of' Indian laws and policies governing the management of intellectual property and pharmaceutical' regulation. It dives deep dive into India's experience with biologics (a category that includes vaccines) over the last decade.



The first chapter of this report examines intellectual property monopolies, primarily through patents, on biologics. The next chapter of this examines monopolies created by pharmaceutical regulation, primarily through trade secrets. Biologics are popularly referred to as macromolecules, which are large complex molecules originating from bacteria, yeast, insects, plants, and engineered mammalian cells, and is a category that includes both biotherapeutics and vaccines. We began work before the Covid pandemic was declared a global health emergency in 2020, and its publication now coincides with a universal awareness of the importance of affordable and accessible biologics, especially vaccines. We are now fully aware of both the importance of non-vaccine biologics (such as monoclonal antibodies, popularly referred to as mAbs) for the treatment of Covid, as well as vaccines for the prevention and mitigation of Covid.

Intellectual property creates significant monopoly barriers to accessing biologics, including vaccines.'''We need to develop the tools to overcome intellectual property monopolies on biologics – and we need an expansion of the terms of compulsory licensing, in order to bring them in line with the terms of government use, so that the compulsory licensing process can cover products without a set of comprehensively identifiable patents, as well as technological platforms.