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

The 5th Peoples Health Assembly - PHA5 - was held in the city of Mar del Plata, Argentina, for 5 days from April 5. HAIAP was evident through Niyada Kiatying Angsulee, Delen de la Paz, Claudio Schuftan and Chan Chee Khoon.

April includes **World Health Day - April** 7. This year the theme was 'My Health, My Right'.

March included World TB day - March 24 - with the theme **Yes! We can end TB!'** – that conveys a message of hope that getting back-on-track to turn the tide against the TB epidemic is possible. The focus turns commitments into tangible actions.

This edition of HAIAP News covers a wide range of issues. India has taken on the challenge of TB elimination by 2025 and Kerala is well on the way to achieving that goal. The ISIUM Newsletter highlighted rational medicines use workshops including one conducted by Nepali colleagues. We have shared the report here.

Andy Gray from South Africa draws attention to the WHO Model Essential Medicines List and calls for discussion about whether the List should pay more attention to the needs of low and middle income countries.

The New England Journal of Medicines acknowledges and confronts its racist and discriminatory history.

We share the story of provision of essential affordable eye care and blindness prevention in LICs.

Professor Dinesh Abrol asks 'Do Free Trade Agreements benefit India' and the campaign for freedom from tobacco and nicotine products continues. We look at the situation in Malaysia, with a response from CAP, New Zealand and Australia.

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 at PHA5

5th People's Health Assembly, Mar del Plata Argentina 2024

In an era where health disparities loom larger than ever, the People's Health Movement (PHM) proudly held the 5th People's Health Assembly, in the city of Mar del Plata, Argentina, from April 7th to 11th, 2024. This event marked a pivotal moment, the result of six years of cross-border collaboration, uniting hundreds of hours of dedication. ‘Health for All’ as a Pledge for ‘Buen Vivir’.

Over 600 activists from across the globe gathered in Mar del Plata, Argentina, marking the launch of the 5th People's Health Assembly (PHA 5). Coinciding with World Health Day on April 7, the Assembly promised an engaging five-day journey through the challenges and opportunities in the global health arena.

PHA5 paper: Confronting Capitalism and Imperialism in the Struggle for Health

https://phmovement.org/discussion-paper-for-pha5

The purpose of this Paper was to present some key ideas regarding the role of capitalism and imperialism in producing the global health crisis. The Paper is conceived as a ‘discussion resource’ intended to inform the discussions at PHA5, including around the proposed Call to Action (CTA).

It was hoped that PHA5 participants would find this paper useful during discussions in plenaries, sub plenaries and workshops as well as during informal discussions.

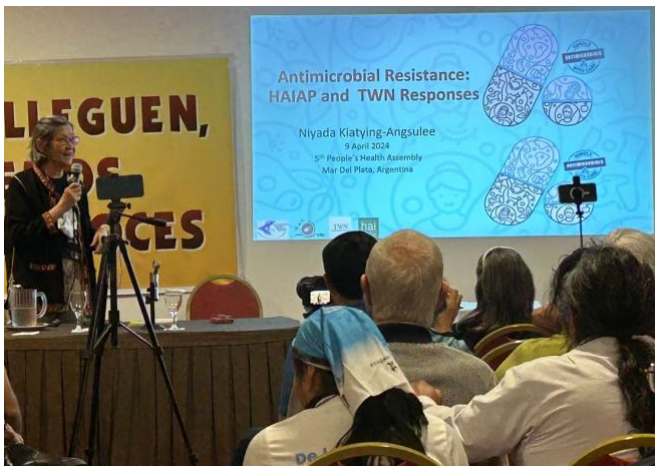
In 6 chapters the paper reviews:

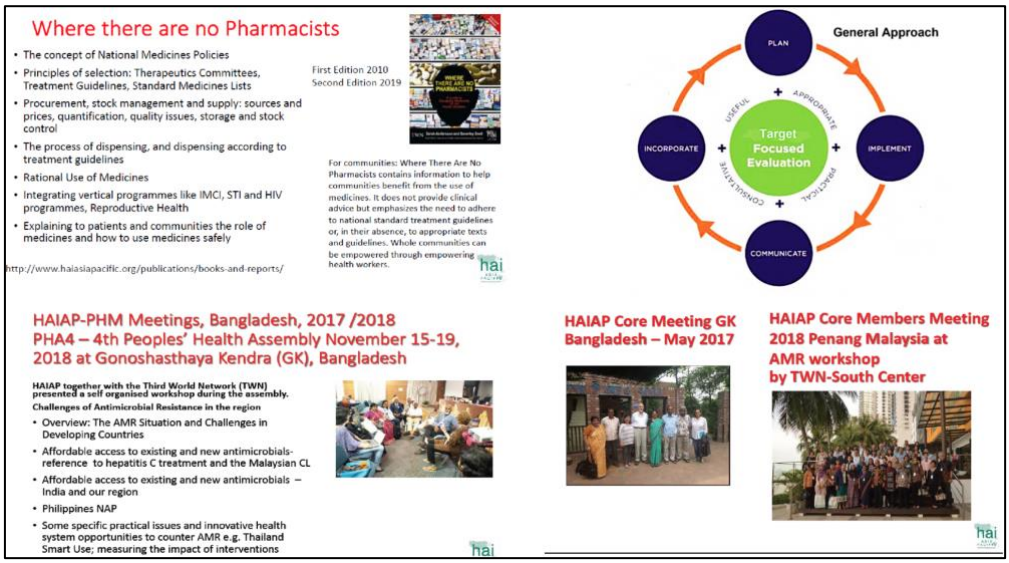
- the broken promises of Health for All;
- the barriers arising, from capitalism and imperialism, to achieving Health for All;
- the commitments PHM has made in previous People’s Health Assemblies to confronting capitalism and imperialism, as barriers to HFA;
- key elements of the contemporary world order, what has to change;
- possible futures, from the current disastrous trajectory to more hopeful scenarios and possibilities, and forms of action;
- how PHM might best prepare for the next period of struggle.

HAIAP

Niyada Kiatying Angsulee, Claudio Schuftan and Delen de la Paz attended, with Rajnia Devito from Colombia representing TWN.

Rajnia and Niyada were involved in several activites that highlighted the challenges of AMR, the struggle for a Pandemic Agreement and other HAIAP and TWN acitivities..





World Health Day April 7: my health, my right

World Health Day is a global health awareness day celebrated every year on 7 April, under the sponsorship of the World Health Organisation, as well as other related organisations.

- Around the world, the right to health of millions is increasingly coming under threat.
- Diseases and disasters loom large as causes of death and disability.
- Conflicts are devastating lives, causing death, pain, hunger and psychological distress.
- The burning of fossil fuels is simultaneously driving the climate crisis and taking away our right to breathe clean air, with indoor and outdoor air pollution claiming a life every 5 seconds.

https://www.who.int/campaigns/world-health-day/2024

The WHO Council on the Economics of Health for All has found that at least 140 countries recognise health as a human right in their constitution. Yet countries are not passing and putting into practice laws to ensure their populations are entitled to access health services. This underpins the fact that at least 4.5 billion people — more than half of the world's population — were not fully covered by essential health services in 2021.

To address these types of challenges, the theme for World Health Day 2024 is 'My health, my right'.

The theme was chosen to champion the right of everyone, everywhere to have access to quality health services, education, and information, as well as safe drinking water, clean air, good nutrition, quality housing, decent working and environmental conditions, and freedom from discrimination.

Overview

Human rights are enshrined in human rights instruments. All WHO Member States have ratified at least one international human rights treaty that includes the right to the highest attainable standard of health. After ratifying a treaty, a country has a legal obligation to protect and fulfil the rights recognised in the treaty. To deliver on binding human rights commitments countries need to adopt a human rights-based approach to health.

Health and human rights

The right to the highest attainable standard of physical and mental health is enshrined in several international legal instruments including the International Covenant on Economic, Social and Cultural Rights. It includes freedoms and entitlements. Freedoms include the right to control one's health and body (for example, sexual and reproductive rights) and to be free from interference (for example, free from torture and non-consensual medical treatment and experimentation, particularly relevant for persons with disabilities). Entitlements include the right to access quality health services without any discrimination.

Fundamental human rights principles

A human rights-based approach (HRBA) requires mainstreaming fundamental human rights principles and standards across health services and health system policies, including public health emergency preparation and responses. They include:

Non-discrimination and equality: This requires prioritising the needs of those furthest behind to achieve equity. Equity is used as a framework in public health to identify and address unfair and remediable health disparities among different sub-populations. HRBA provides legal standards and obligations to put legal protections for equality and non-discrimination into action.

Participation: Participation requires empowering health service users, communities and civil society to engage in planning, decision-making and implementation processes for health across the programme cycle and at all levels of the system. To be meaningful, participation must include explicit strategies to address power imbalances, value experiential evidence, and manage conflicts of interest so that the needs and expectations of people are met. Participatory planning techniques can be used to engage beneficiary populations in designing health services or public spending prioritisation.

Accountability: Countries must establish accessible and effective accountability mechanisms. These may include administrative and judicial remedies and oversight by other institutions, such as national human rights institutions and health and social care regulators. The United Nations human rights mechanisms, including the Committee on Economic Social and Cultural Rights, play a crucial accountability role by regularly reviewing countries' compliance with their health-related human rights obligations.

Progressive realisation and international cooperation

Some human rights obligations are of immediate effect, such as the guarantee of non-discrimination. Other components of the right to health, like access to cutting edge health technology, are subject to the principle of progressive realisation. Countries are legally obliged to use the maximum available resources to develop and implement rights-based legislation, policies and programmes. Countries in a position to assist have an obligation to cooperate with those with fewer resources.

Core components of the right to health

The right to health includes 4 essential, interrelated elements: availability, accessibility, acceptability and quality.

Availability refers to the need for a sufficient quantity of functioning health facilities, goods and services for all. Availability can be measured through the analysis of disaggregated data to different stratifiers including by age, sex, location and socio-economic status and qualitative surveys to understand coverage gaps.

Accessibility requires that health facilities, goods, and services must be accessible to everyone. Accessibility has four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility. This is particularly important for persons with disabilities who often encounter significant barriers to health related to the inaccessibility of services, facilities and health information.

Assessing accessibility requires analysis of physical, geographical, financial and other barriers to health systems and services, and how they may affect people who are marginalised. It requires the establishment or application of clear norms and standards in both law and policy to address these barriers.

Acceptability relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centred and cater to the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.

Quality extends to the underlying determinants of health, for example safe and potable water and sanitation as well as requiring that health facilities, goods, and services are scientifically and medically approved.

Human rights treaties which include the right to health

International Covenant on Economic, Social and Cultural Rights (Article 12)

Elimination of All Forms of Racial Discrimination (Article 5(e) iv)

International Convention on the Elimination of All Forms of Discrimination Against Women (Articles 11(1) (f), 12 and 14(2)(b))

Convention on the Rights of the Child (Article 24)

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Articles 28, 43 (e) and 45 (c)

Convention on the Rights of Persons with Disabilities (Article 25)

Human Rights Day (December 10) 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 World Health Day 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/

The Universal Declaration of Human Rights (UDHR)

Claudio Schuftan

In 1948, the newly formed United Nations Organisation's General Assembly adopted the Universal Declaration of Human Rights (UDHR), a document that represented the necessity of human rights for all peoples. Consequently, international law, national constitutions, and other conventions support and expand on the UDHR to promote and protect the rights of people(s).

Speaking about the UDHR, it is pertinent to talk about the 'natural rights' theory. The same is very helpful in our understanding of the origin of the concept of the current-day HR. Natural rights are a very old philosophical concept. Related to natural law, natural rights refer to rights that are universal and inalienable. They are not related to any government or culture. By being human, a person is entitled to their natural rights –that is where the concept of universal HR comes from.

As an aside, note: International lawyers do agree that there cannot be a 'legal black hole' when it comes to the over-arching principles of HR law. Up until December 9, 1948, international law did not contain a specific and

explicit ban on genocide, for example, so crucial after the holocaust, Rwanda and now the Middle East: **Collective punishment of any kind is contrary to every system of law.**

The right to one's homeland is a human right, because a) self-determination cannot be exercised if one is driven from one's homeland, and b) the right to one's homeland is a precondition to the exercise of most civil, political, economic, social and cultural rights.

World TB Day March 24

The theme of World TB Day 2024 - **'Yes! We can end TB!'** – conveys a message of hope that getting back-on-track to turn the tide against the TB epidemic is possible through high level leadership, increased investments and faster uptake of new WHO recommendations. Following the commitments made by Heads of State at the UN High Level meeting in 2023 to accelerate progress to end TB, this year's focus shifted to turning these commitments into tangible actions.

To help countries scale-up access to TB preventive treatment, WHO released an investment case on scaling up the roll out of TB preventive treatment.[1] A modelling study developed with Governments of four countries - Brazil, Georgia, Kenya and South Africa - highlights the impact to be achieved from expanding TB screening and preventive treatment.

The analysis shows that modest investments could lead to significant health and economic benefits in all four countries, with a return on investment up to US$ 39 gained for every dollar invested. The investment case has been released to support countries in advocating for and allocating increased resources to scale-up TB screening and preventive treatment towards reaching new targets committed by Heads of State at the 2023 UN High-Level Meeting on TB.

'The investment case outlines the health and economic rationale for investing in evidence-based, WHO-recommended interventions on TB screening and prevention that can contribute to advancing universal health coverage,' said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. 'Today, we have the knowledge, tools and political commitment that can end this millennia-old disease that remains one of the world's top infectious killers'.

According to the investment report, implementing TB screening plus preventive treatment can substantially reduce TB incidence and mortality. It argues that these crucial public health investments are essential for addressing the needs of vulnerable populations and achieving the End TB targets.

In 2022, WHO reported a significant worldwide recovery in the scale-up of access to TB diagnosis and treatment services.

However, the scale-up of access to TB preventive treatment has been slow. Preventing TB infection and stopping progression from infection to disease are critical for reducing TB incidence to the levels envisaged by the WHO's *End TB Strategy*.[2] To do this, it is vital to offer TB preventive treatment to those with HIV, household contacts of TB patients, and other high-risk groups.

Multidrug-resistant TB (MDR-TB) remains a public health crisis. While an estimated 410,000 people developed multidrug-resistant or rifampicin-resistant TB (MDR/RR-TB) in 2022, only about 2 in 5 people accessed treatment. Progress in the development of new TB diagnostics, drugs and vaccines remains constrained by the overall level of investment in these areas. It is clear much more efforts are needed to combat TB, which remains one of the world's leading infectious killers.

'The next five years will be critical for ensuring that the political momentum we have now is translated into concrete actions towards reaching global TB targets,' said Dr Tereza Kasaeva, Director of WHO's Global Tuberculosis Programme. 'WHO will continue to provide global leadership for the TB response, working with all stakeholders until we reach and save every person, family and community impacted by this deadly disease'.

The global targets approved at the 2023 UN High-Level Meeting on TB include: reaching 90% of people in need with TB prevention and care services; using a WHO-recommended rapid test as the first method of diagnosing TB; providing a health and social benefit package to all people with TB; ensuring the availability of at least one new TB vaccine that is safe and effective; and closing funding gaps for TB implementation and research by 2027.

The Global Strategy serves as a blueprint for countries to reduce TB incidence by 80%, TB deaths by 90%, and to eliminate catastrophic costs for TB-affected households by 2030. The Strategy is not a 'one size fits all' approach and its success depends on adaptation for diverse country settings.[3]

TB in India

Recently, the Ministry of Health and Family Welfare released the India TB Report 2024, which highlights that the mortality rate due to Tuberculosis (TB) had declined

[1] https://www.who.int/publications/i/item/9789240091252

[2] https://www.who.int/teams/global-tuberculosis-programme/the-end-tb-strategy

[3] https://www.who.int/teams/global-tuberculosis-programme/the-end-tb-strategy

from 28 per 100,000 population in 2015 to 23 per 100,000 population in 2022.

Key Highlights of the Indian Report[4]

Trends in TB Cases and Deaths:

The majority of the TB cases are still reported by the government health centres, while there has been an increase in notifications by the private sector.

Nearly 33% or 840,000 of the 2,550,000 cases reported in 2023 came from the private sector. To compare, only 190,000 cases were reported by the private sector in 2015, the year considered to be the baseline by the programme that is geared towards the elimination of the disease.

The estimated incidence of TB in 2023 increased slightly to 2,780,000 from the previous year's estimate of 2,740,000.

The mortality due to the infection remained the same at 320,000.

India's **TB mortality dropped** from 494,000 in 2021 to 331,000 in 2022.

India reached its 2023 target of initiating treatment in 95% of patients diagnosed with the infection.

TB CASES IN INDIA OVER THE YEARS

	India TB Report 2020	2023	2024
Estimated TB cases	26.9 lakh	27.4 lakh	27.8 lakh
Number of cases reported	24.04 lakh	24.2 lakh	25.5 lakh
Reporting from private sector	6.8 lakh	7.3 lakh	8.4 lakh
% cases from private sector	28.20%	30%	32.90%
Estimated mortality	4.36 lakh	3.2 lakh	3.2 lakh

Challenges in Meeting Targets:

Despite setting ambitious goals to eliminate tuberculosis by 2025, India has faced challenges in meeting these targets. The number of cases and deaths recorded in 2023 fell short of the targets set by the country.

There **are various risk factors** that contribute to the incidence and treatment outcomes of tuberculosis. They include undernourishment, HIV, diabetes, alcohol use, and smoking.

TB in Kerala State

Kerala received the Union Government's award for best TB eradication program.

The award is in recognition in February of the state's efforts to coordinate the National TB Eradication program in the private sector, Health Minister Veena George said in a statement on February 23. Kerala received the award from the Union Ministry of Health and Family Welfare for best TB prevention activities. The award was received for the best coordination of National Tuberculosis Prevention Activities (NTEP) including the private sector. The health department had formed a special action plan to find patients reaching the private sector. According to the information, the award is for registering the highest number of tuberculosis patients from the private sector through the *Nikshay* portal[5].

The state government has been taking strong steps with the aim of making Kerala tuberculosis free by 2025 by ensuring partnership with the private sector. Tuberculosis free panchayat activities are being implemented with the cooperation of local self-government institutions for the goal of TB-free Kerala. The number of registrations rose from 4,615 in 2019 to 6.542 in 2023.

The Kerala government conducts TB-free panchayat programs with the support of local self-governments. The state has a 330 System for TB Elimination in Private Sector (STEP) centres. [6] This mechanism connects people coming for TB treatment at private hospitals with the public health system. The state project offers detection, treatment and high-quality medicines.

Nutrition food kits are given to TB patients utilising Corporate Social Responsibility (CSR) funds. Cochin Shipyard and KIMS Hospitals are providing funds in Ernakulam, Wayanad and Thiruvananthapuram districts. Efforts are being taken to distribute kits in other districts with the support of State Bank of India and some private organisations.

[4] https://www.drishtiias.com/daily-updates/daily-news-analysis/india-tb-report-2024#:~:text=Recently%2C%20the%20Ministry%20of%20Health,per%20lakh%20population%20in%202022.

[5] National TB Elimination Program quick access portal.

[6] A Solution for ensuring standards of TB care for patients reaching private hospitals in India

BMJ discusses the WHO Model List of Essential Medicines

the bmj | BMJ 2024;385:e077776

Veronika J Wirtz, Andrew L Gray, Sangeeta Sharma, Jing Sun, Hans V Hogerzeil

Refocusing the World Health Organisation's Model List of Essential Medicines on the needs of low and middle income countries

In the wake of escalating medicine prices worldwide, Veronika Wirtz and colleagues argue for refocusing the WHO Model List of Essential Medicines on the needs of low and middle income countries, while retaining its global relevance as a model process

Andy Gray from South Africa said in a recent E-Drug message:

> *'The key message in this BMJ analysis piece is that the 'model process' represented by the WHO Model List of Essential Medicines remains globally relevant and applicable, but that the 'model product' needs to be clearly and explicitly focused on the needs of LMICs. High-income countries can continue to apply the model, but may differ in their ability to include higher-priced medicines and those that require access to more sophisticated diagnostic and therapeutic capacity. We hope this article will stimulate debate on the issue.'*

The World Health Organization's Model List of Essential Medicines promotes equitable access to medicines for the priority health needs of the population but

- An increasing number of applications for very expensive and highly specialised medicines is challenging its global reputation
- WHO should reconfirm the original goals of the modellist as a globally relevant model process with, as a practical example, a model list specifically geared to the needs of low and middle income countries
- WHO should enhance the functionality of the publicly accessible searchable electronic database of all decision data, including rejections, to aid national formulary committees and maintain the model list's future relevance.

You might not agree with
the recommended Next Steps
Your feed back would be wonderful

From the *BMJ* Article, the next steps:

Since 2002, WHO has accepted the principle that the high price of a medicine alone does not preclude its listing.[18] Examples include the selection of antiretroviral medicines in 2002 and direct acting antivirals for hepatitis C in 2015.

The advocacy that followed the listing of these antiretroviral medicines enabled intensive international efforts to lower the prices of the medicines through a series of mechanisms such as voluntary licensing, generic production, and global financing. Evidence suggests that a more coordinated international governance mechanism facilitating access via the Medicine Patent Pool,[19] fair pricing,[20] and global financing could further accelerate access once medicines are listed.

The existing structure—comprising a 'core list' for essential medicines and a 'complementary list' for priority disease treatments requiring specialised facilities—remains effective for guiding healthcare in low and middle income countries, considering their diverse healthcare capacities. But we suggest not adding a third category for advanced medicines for rare diseases or personalised medicine. Instead, national formulary committees in low and middle income countries can consult health technology assessment institutions in high income countries for guidance on these medicines.

There is a pressing need for WHO to perform more systematic reviews of therapeutic groups of medicines, potentially leading to the removal of certain medicines. These reviews should focus on relevance to low and middle income countries, and be primarily conducted by experts from these regions to ensure contextual appropriateness. This approach contrasts with the current reliance on individual applications or reviews by organisations in high income countries. Additional resources might be required for such initiatives, with priority areas including mental health and non-communicable diseases, which substantially affect low and middle income countries.

To enhance the consistent application and transparency of selection criteria, we recommend that WHO implements a formal evidence-to-decision framework.[21] This framework would standardise the presentation of evidence and key discussion points, aiding in the structured consideration of secondary criteria used by the WHO model list expert committee. These criteria include population size, diagnostic and treatment technical requirements, regulatory status in low and middle income countries, availability of global quality standards, potential for generic and biosimilar competition, alignment with WHO clinical guidelines, and support from UN organisations and civil society.

To ensure quality data submission and standardisation of evidence appraisal, WHO needs to refine its guidelines for submitting price and cost effectiveness data pertinent to low and middle income countries and clarify its methodology for reviewing these data.

Finally, to enhance the global relevance of the WHO Model List of Essential Medicines, it is crucial to improve the dissemination of information about the process. Enhancing the functionality of the publicly accessible, searchable electronic database to include all past and current listed medicines, including those rejected or deleted, would greatly benefit countries and health systems. This enhancement should also provide better access to all underlying evidence and a summary of the

committee's deliberations, which are currently mainly available through manual searches of biennial technical reports. An upgraded database would be a valuable resource for national formulary committees and would reinforce the WHO model list's role and practical importance in the coming decades.

The whole article can be found here

https://www.haiasiapacific.org/wp-content/uploads/2024/04/Wirtz-BMJ-2024.pdf

Nepal: workshops to promote rational medicine practices

... with support from ISIUM

Report prepared by Kadir Alam1, Subish Palaian2, Renly Lim3

ISIUM Newsletter March 24 2024

Introduction

Inappropriate use of medicines is a major problem worldwide. The World Health Organisation (WHO) estimates that more than half of all medicines are prescribed, dispensed, or sold inappropriately and that half of all patients fail to take them correctly. The overuse, underuse, or misuse of medicines results in waste of scarce resources and widespread health hazards. Hence, improving medicine use is an urgent need. The International Society to Improve the Use of Medicines (ISIUM) is one of the few organisations working to raise awareness and promote the best use of medicines throughout the world – the aim being not only to improve health and better manage disease in human beings but also to address situations that affect health and the use of medicines in the wider environment.

Overview

Nepal, a South Asian country, shares common drug usage challenges with other low-income nations. The challenges include inappropriate self-medication, polypharmacy, misuse of antimicrobials (both under- and over-dosage), and non-adherence to dosing regimens. To address these issues, pharmacy school members organised a workshop and seminar in Nepal targeted at pharmacy students and retail pharmacists. ISIUM provided a resource person, Renly Lim, to assist. Other distinguished ISIUM members helping to organise the educational outreach included Kadir Alam, Subish Palaian, Renly Lim and Professor Dr. Mohamed Izham B. Ibrahim, a Professor of Social and Administrative Pharmacy at the College of Pharmacy and Head of Research and Graduate Studies-Pharmacy Medical and Health Sciences Office at Qatar University, Doha, Qatar.[7]

Workshop on patient-centred clinical pharmacy services

This workshop, organised by the Faculty of Medical and Allied Sciences at Purbanchal University, took place on July 25, 2023, in Gothgaun, Morang. Purbanchal University – a public university established by the Government of Nepal in 1993 with more than 122 affiliate colleges – conducts academic programs on seven campuses. The central focus of the workshop, tailored for graduating bachelor and master's students of pharmacy entering professional practice, included topics such as patient-centred clinical pharmacy, telepharmacy services in the post-COVID era, antimicrobial stewardship programs, disaster medicine, inter- professional education, and the role of artificial intelligence in clinical pharmacy. Representing ISIUM, Renly Lim presented virtually on post-COVID era telepharmacy services.

Pharmacy students entering professional practice attending workshop in Gothgaun, Morang, in July 2023.

National seminar on patient care service to community pharmacy

This seminar was organised by Sunsari Technical College, Dharan, Nepal and held at the Hotel Ratna Inn in Dharan on July 26, 2023. The seminar was tailored to meet the educational needs of outgoing Diploma in Pharmacy students and practising assistant pharmacists. Topics covered included current community pharmacy practice in Nepal, barriers to pharmaceutical care, extended community pharmacy services, policy intervention to improve community pharmacy services, patient counselling, and the future of community pharmacy, with comparison of low-, middle-income and developed countries. Renly Lim presented virtually on policy interventions to improve community pharmacy services.

1. Kadir Alam is Associate Professor in the Department of Clinical Pharmacology and Therapeutics at B.P. Koirala Institute of Health Sciences, Dharan, Nepal.
2. Subish Palaian is Associate Professor in the Department of Clinical Sciences at the College of Pharmacy and Health Sciences, Ajman, United Arab Emirates.
3. Renly Lim is a Senior Research Fellow (NHMRC Early Career Fellow) from the Quality Use of Medicine and Pharmacy Research Centre at UniSA Clinical & Health Sciences, University of South Australia.

Kadir and Subish are both HAIAP colleagues. It is great to hear from them

[7] We remember Professor Izham as a HAIAP partner when he led the USM Poisons Centre in Penang.

Equal rights to affordable accessible eye care and blindness cure

An Intra Ocular Lens implant can cost from $1200-$2500 each

But a lens can be available for $25

- Almost 40 per cent of the world's blindness is caused by cataract - and most cataract blindness is treatable
- Most people with severe vision loss from cataract live in low income countries. It is particularly devastating because work, education and family life are affected, making it hard to escape the cycle of poverty.
- A cataract operation is a fairly simple, 20-minute operation to replace the clouded lens with an artificial intra ocular lens, but unfortunately, this operation is something millions of people around the world are still unable to access.

Thirty years ago - in 1994 - an Intra Ocular Lens factory was opened in Asmara in Eritrea that could produce the lenses at $10 each. A second factory was commissioned in Nepal in 1995. Now more than 80 countries are accessing affordable IOLs from these two factories.

There are enough good quality affordable IOLs produced to export to other countries and the total cost including labour, quality control and distribution is still less than $25.

What is a cataract

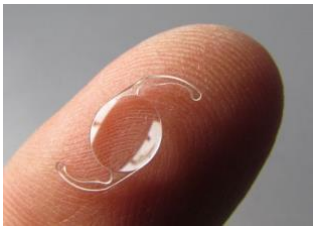
When someone suffers from cataract, they experience a clouding in the normally clear lens of their eye, and it can affect one or both eyes and the clouding can increase until the person is blind. It usually occurs in older people but an occur in children too.

While cataract is commonly associated with ageing, not everyone who suffers from it is old. Some children are born with cataract (congenital cataracts) and, in these cases, early detection and treatment is critical to prevent permanent damage.

As well as being hereditary, other causes of cataract can include eye trauma, sunlight exposure, diabetes, genetic disorders or dehydration in children from severe diarrhoeal infection and fevers, and even some medications.

The impact of a cataract is an inexcusable injustice because it is a disease for which a safe, effective and relatively inexpensive treatment can and must be made available in less developed parts of the world.

What is an artificial Intraocular lens (IOL)



The intraocular lens is a tiny piece of plastic with two handles called haptics. It used to be one of the biggest costs involved in sight-restoring cataract surgery and Fred Hollows once called them the most expensive pieces of plastic in the world.

Fred Hollows always stood for equality. In fact, he once said: 'inequity diminishes us all.'

Fred believed the only way to eliminate avoidable blindness was to break down every barrier in his way. One of these barriers was making sure developing countries had access to new technologies. Access was the first step, followed by reducing the cost of getting these tools to the people who needed them most, and providing skilled local staff .

Who was Fred Hollows?

Fred Hollows was an Australian who was born in New Zealand on 9 April 1929**.** He became a well-known ophthalmologist who believed in equal eye care for all.

He was also a humanist and a global citizen, who was revered around the world for his contributions to eye health.

He believed that everyone, no matter whether they were rich or poor, had the right to affordable eye care. He said the work won't stop until the injustice of avoidable blindness is completely eradicated.

It was his dream that low cost IOLs would be available to the world and a Foundation was set up to support all the components of the dream, Part of The Foundation's early work was to set up IOL factories in Eritrea and Nepal as a step to lower the cost of cataract surgery in developing countries. Since they've opened, the factories have produced over 4 million lenses.

Fred's medical career began in New Zealand, and his pursuit of knowledge on eye health took him to the UK. At that time, there was no post-graduate training available in New Zealand so Fred decided to go to the UK to complete a Diploma of Ophthalmology. After earning enough money he travelled to England to study at the University College London Institute of Ophthalmology (Moorfields Eye Hospital).

Fred was interested in practicing medicine in Africa as he had read that there was a need for properly run clinics, free from political or church influence.

Fred had also found out from an acquaintance that in order to be of any use in Africa, it was important to know cataract surgery because of the sheer volume of blindness caused by this eye condition.

The completion of his ophthalmology fellowship brought him to Australia, where he settled and went on to achieve extraordinary feats for local Aboriginal communities, as well as for people in need of quality eye care all over the world.

Australia from 1965

He was made the chairman of ophthalmology at the Prince of Wales Hospital in Randwick, Sydney.

Fred encountered two senior Aboriginal men from Wattie Creek that he treated with diseases that were rare in an industrialised country like Australia. Surprised by the ailments troubling both men, he visited their camp in the Northern Territory to examine the eyes of people in that Indigenous community.

He saw poor eye health in almost everyone he encountered, be it small children or the elderly. Both men and women were suffering from painful trachoma that could lead to blindness.

It was this experience together with his other work in Aboriginal communities that saw Fred's humanitarian streak leap to the fore, fuelling the next chapter of his work, which was work in Aboriginal and Torres Strait Islander communities.

Eritrea

Fred first visited Eritrea - in the Horn of Africa - in 1986 when the country was embroiled in its long struggle for independence.

While he observed many people suffering from blindness, he also saw great hope. He was inspired by the capacity and energy of Eritrean people and the work carried on underground during the war.

Fred decided he was going to open a factory to produce and bring down the cost of intraocular lenses. Opening a factory would empower the Eritrean people to take charge and create valuable export income for the country. Part of the plan was to also impart skills and knowledge to local doctors, so they could continue the work and help their people.

While Fred set in motion the local training, he sadly never got to see the factory. He died of cancer in February 1993.

Starting a factory for making IOLs was not as simple as he had imagined. It required very special manufacturing conditions and skills that could produce high quality products according to very strict specifications. The manufacturing process and the products had to match up in every way with the manufacturing processes and expensive products of the multinational companies that would have loved to destroy the competition. Fortunately there were highly qualified engineers and technical people who were willing to give their time and knowledge. Finally the factory and the products passed all tests and there was a skilled local work force running everything.

Skills and knowledge were imparted to local doctors and the Eritrean eye health program became a model example.

Nepal

Fred Hollows and Dr Sanduk Ruit met in Nepal in the mid '80s while consulting for the World Health Organisation. They soon realised they shared a common dream: to end avoidable blindness in developing countries through introducing modern technology and skills.

Fred and Dr Ruit set about planning to build an IOL factory to mass-produce lenses needed in Nepal. Fred became Dr Ruit's mentor, and after studying with Fred in Sydney, Dr Ruit went on to help establish the Intraocular Lens Laboratory in Nepal with the help of the Fred Hollows Foundation.

In 1994, the same year the factory opened, Dr Ruit became the medical director of the Tilganga Institute of Ophthalmology in Nepal – a key partner of The Foundation. It is now a world-class facility and is still led by master surgeon Dr Ruit, who has restored sight to over 120,000 people.

Dr Ruit at an Outreach Microsurgical Eye Clinic in Dolakha in 2018 Photo: Michael Amendolia

Since 1994, Tilganga has trained 19,381 eye care personnel from 43 countries, of which 493 are doctors. In 2016 alone, 1,625 individuals trained at Tilganga at all levels, ranging from equipment maintenance to sub-specialty fellowships and everything in between.

National eye surgeons and other staff are trained and equipped to carry out eye programs including surgery that will make a huge contribution to good eye health and to prevention of avoidable blindness. BUT while there is an ample supply of IOLs, there are still not enough doctors to perform cataract surgery in all countries. So more training is needed so that there well be more doctors to help people with cataract.

Dr Ouk Soleaphy, 26, the first woman to complete the Ophthalmology Residency Training Program established by The Foundation and Cambodia's

Now the two factories - in Asmara, Eritrea and Tilganga, Nepal - are making enough top quality affordable intra ocular lenses for low income countries across the globe.

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Do Free Trade Agreements Benefit India?

Professor Dinesh Abrol is currently working at the Institute of Studies in Industrial Development (ISID) affiliated to the Indian Council of Social Science.

On April 2, he spoke to the Hindu about India's Free Trade Agreements. He asked whether India's Free Trade Agreements benefit India or only the rich countries also involved on the agreements.

https://www.thehindu.com/business/Economy/tepas-ip-encroachment-a-new-barrier-to-indigenous-innovation/article68068278.ece

https://www.thehindu.com/podcast/do-indias-free-trade-agreements-with-european-nations-benefit-the-country-in-focus-podcast/article68019831.ece

The Hindu: April 2, 2024 *TEPA's IP encroachment: A new barrier to indigenous innovation* and April 16, 2024 *Do India's Free Trade Agreements Benefit the country?*

Listen to his podcast here THGU8577408618 1.mp3

The Comprehensive Economic Partnership Agreement with Japan enabled Japan to double its exports to more than $16 billion in 2023 from $8 billion in 2011. On the other hand, India's exports to Japan remained static at $5.46 billion in 2023, a tad up from $5.09 billion in 2011. This mirrors other trade pacts like the one signed with the IO-member Southeast Asian block, ASEAN, in 2010. In 2022-23, India exported goods worth about $44 billion to the region, while its imports were valued at $87 billion. The trade deficit in 2022-23 was $43 billion, compared with $7.5 billion in 2010.

Why then is India entering into more such agreements? How different is the EFTA from those signed with other nations and blocs? And are such deals a substitute for larger WTO-led trade frameworks, where India tends to have a larger say because of the backing of other developing nations?

Professor Dinesh Abrol explained:

The new approach to intellectual property and investment through FTAs accepts an IP maximalist agenda of the United States Trade Representative; it threatens to upset the fine balance between public and private interests and pushes India away from essential innovations.

In any case Free Trade Agreements can over-ride legislation, for example legislation that enshrines access to affordable medicines, thus having negative impact on access to medicines and medical technologies.

Lessons ignored

Recently, India and South Africa had sought TRIPS (The Agreement on Trade-Related Aspects of Intellectual Property Rights) waiver related to COVID-19 innovations. The TRIPS waiver was sought to meet requirements of indigenous technological innovation and independent

scientific research to produce affordable COVID vaccines. While this garnered support for India from the developing world, even when the EU and U.S. stood against the grant of TRIPS waiver at the WTO, the Modi government granted major IP concessions to the European Free Trade Association (EFTA).

The amount spent on importing technology in every area is rising in India. The ratio of expenditure on domestic innovation *vis-a-vis* technology import has seen a drastic decline. Available statistics, show the ratio declined to 2.18% in 2018 from 13.63% in 2000. The rise in foreign exchange outflows are due to foreign companies like Syngenta and Bayer with headquarters in EFTA or Europe. These companies have increased their control over markets through intellectual property.

It is the parent firms having headquarters in Europe and the U.S. that control the rights and royalty payments gained from patentable inventions developed with Indian inventors in the fields covering chemicals and computer related inventions. Indian society is paying twice, first to educate and train the STEM[8] talent and then to pay for imports, royalties, and fees to companies employing Indian talent.

Newsclick interviewed Professor Dinesh Abrol, as a member of the National Working Group on Patent Laws and WTO, to get to know the nuances of India's National Intellectual Property Rights Policy and its implications.

For the recording and a transcript see
https://www.newsclick.in/national-ipr-policy-what-does-it-hold-country

The *New England Journal of Medicine* is reckoning with its history

https://www.nejm.org/doi/full/10.1056/NEJMp2307309

Recognising Historical Injustices:

> *'The Journal and other medical institutions have historically advocated and justified the mistreatment of groups on the basis of their race, ethnicity, religion, gender, and physical or mental conditions. To grapple with this history, we have commissioned an independent group of historians to examine various aspects of these biases and injustices. The series is meant to start a conversation, to help us learn from our mistakes and equip us to prevent new ones from occurring.' NEJM*

https://www.nejm.org/recognizing-historical-injustices

HERE ARE SOME EXERPTS FROM THE SERIES:

Slavery and the *Journal*

David S. Jones, M.D., Ph.D., Scott H. Podolsky, M.D., Meghan Bannon Kerr, M.L.I.S., and Evelynn Hammonds, Ph.D.

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.[1]

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.[2] 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.

[8] science, technology, engineering and mathematics

Nazism and the *Journal*

J.M. Abi-Rached and A.M. Brandt

Between 1935 and 1944, the *Journal* remained all but silent regarding the heinous motives of Nazi science and medicine. What is the nature and significance of silence in the face of such oppression?

Any consideration of the legacy of historical injustices in the *Journal* must address the rise of National Socialism in Germany, the antisemitism of Adolf Hitler's Third Reich, and the Holocaust. Hitler was first specifically mentioned in the *Journal* in 1935, in an article by Michael M. Davis, a noted American health expert and reformer, and his collaborator Gertrud Kroeger, a leading German nurse.[1] Yet between this article and 1944, when Nazi war crimes were first explicitly acknowledged in an editorial,[2] the *Journal* remained all but silent regarding the explicit motives of Nazi science and medicine and the threat to the 'ideals' of civilisation, as Albert Einstein put it in an open letter to the Prussian Academy of Sciences.[3]

Antisemitism was a critical element of Nazi racial science. The Nazis developed an elaborate ideology based on deeply racist assumptions about non-'Aryan' people, whom they considered to be 'defective' and 'undesirable.'[4] What does this lack of critical attention reveal about the *Journal* and its engagement with issues of racism and medical science? What is the nature and significance of silence, as we attempt to understand the role that oppression played in the medicine and science of the time?

One explanation could be that the rise of Nazism as a state-sanctioned persecutory regime did not receive editorial attention in the 1930s since it was deemed irrelevant to the *Journal*'s focus on evolving medical knowledge and therapeutic innovation, as well as to medical practice and policy. Articles on Germany or Nazis in the 1930s and 1940s are overwhelmingly about the compulsory and oversubscribed sickness insurance system,[5] 'socialised medicine,' and 'quackery,'[6] not the persecution and mass extermination of Jews. In fact, when it did address Nazi 'medical' practices, the *Journal* enthusiastically praised German forced sterilisation[7-9] and the restrictive alcohol policies of the Hitler Youth.[10]

Ridding the race of his defective blood

P.A. Lombardo

From the early 20th century until well after World War II, the *Journal* amplified attention to eugenics and provided important support among medical professionals for the U.S. eugenics movement.

In 1923, Boston City Hospital chose Dr. William Mayo, already famous for the work of his Minnesota clinic, to speak at the inauguration of a new laboratory. Mayo's thoughts on hospital administration, published in the *Boston Medical and Surgical Journal* (which would be renamed the *New England Journal of Medicine* in 1928), highlighted the common anxieties of his profession and went far beyond the anodyne comments that were usual on such occasions.[1] Mayo amplified the phobias and fed the moral panic stemming from the eugenic thought of that time, saying that municipal hospitals were swamped by the poor, as cities were besieged by criminals and the country threatened with demise by waves of defective immigrants. While Congress debated increased restriction on immigration, Mayo traced poverty to 'constitutional inferiority and mental instability,' declaring both 'to a large extent hereditary.'

Mayo said one goal of public hospitals should be to 'reduce the number of people whom it must care for at the expense of the taxpayer.' A robust sterilisation program and limits on immigration of the 'defective' would serve that goal. His search for 'the final solution of the immigration problem' rested on the assertion that poverty and disease were proof that 'the alien is a public health problem, just as he is a social problem,' and he saw 'alien lawbreakers' as the cause of rising crime. Mayo was suspicious of 'peoples from southern Europe,' but saved his most pointed bigotry for the Chinese: 'The exclusion of the yellow race from the United States is not a matter of prejudice, but of self-preservation.'[1] Mayo also supported eugenic sterilisation and was proudly identified as 'an apostle of the school of eugenics.'[2] Mayo's sentiments were not unique: his was just one of the prominent voices in U.S. medicine that normalised advocacy for eugenics in the pages of the *Journal*.

The *Journal*'s Historical 'Indian Problem'

D.S. Jones, M. Abdalla, and J.P. GoneN Engl J Med 2024; 390:1-7

Racism against Indigenous people infected *Journal* articles about civilisation, Indigenous medicines, disease susceptibility, and possible Indigenous extinction, but the erasures are equally striking.

By the time the *Journal* was launched in 1812, Boston had witnessed two centuries of destructive confrontations between Europeans and Indigenous Americans. Although some Indigenous communities persisted in New England, most conspicuously in whaling, few Indigenous people would have been visible on Boston's streets. But away from the Atlantic coast, North America remained an Indigenous continent.[1,2] Over the ensuing years, the *Journal* published thousands of articles that mentioned Indigenous people, but far fewer that focused on them.

The *Journal*, like American society more broadly, had an 'Indian problem.' Racism against Indigenous

Americans and settler-colonial strategies shaped centuries of dispossession, war, subjugation, and impoverishment; these attitudes persist today.[3] The *Journal*'s authors theorised about the merits of savagery and civilisation, decried Indigenous medicines, speculated about susceptibility to epidemics, or prophesised Indigenous extinction. The disdain was often gratuitous. An 1895 article about syphilis slandered Indigenous women who had been sent to assimilationist industrial schools: 'A prevalent opinion, especially among philanthropists, is that the Indian s— is a model of chastity. God spare the model! Even some of the girls who have been to the schools on the Atlantic coast are common property for white men. What their habits with the bucks are is not known, but many white devils contract venereal diseases from the 'blankets.''[4] A 1913 essay by Ernest Codman about appendicitis included a striking caption: 'There is no good Indian but a dead Indian and there is no safe appendix but a completely obliterated one.'[5] This adage, a relic of frontier wars, endured for decades.[6] Equally striking are the erasures: decades could pass without the *Journal* seriously engaging with problems of Indigenous health.

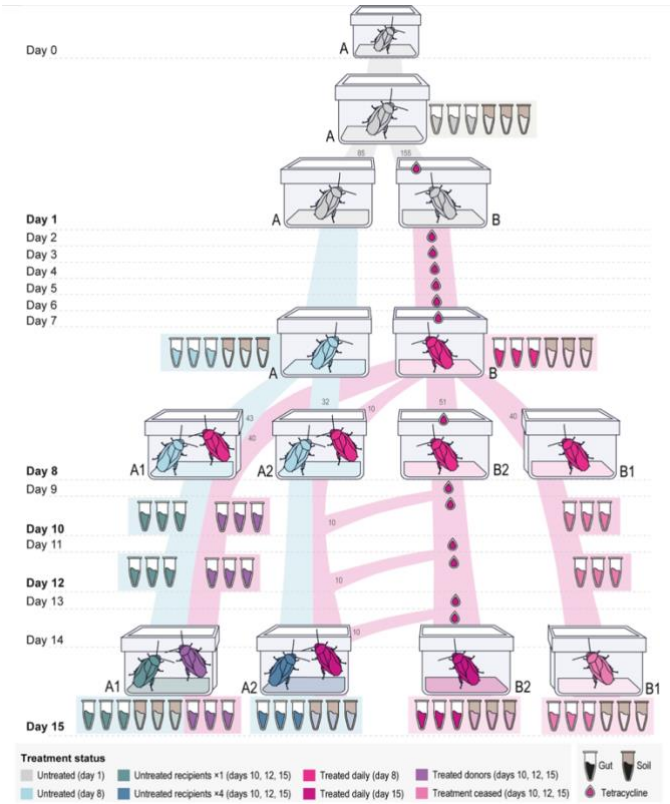
Cockroaches and AMR

(with thanks to ReAct April 2024)

Research suggests that cockroaches, along with potentially other social species, may be facilitating the spread of AMR through microbiomes, contributing to the transmission of resistance genes among local bacterial populations.

A study conducted by the Technical University of Denmark utilised *Pycnoscelus surinamensis* cockroaches, known for their dense and sociable living arrangements, as an in vivo model to investigate AMR dynamics. By introducing tetracycline, an antibiotic, into the diet of these cockroaches, researchers observed an increase in tetracycline resistance genes within the gut microbiomes of treated populations. Subsequent interactions between treated and untreated cockroaches led to elevated levels of tetracycline resistance in the untreated population, as well as in the soil microbiomes of their enclosures, with resistance levels influenced by the frequency and extent of interaction.

These findings elucidate how interaction among microbiomes facilitates AMR gene transmission to previously unchallenged hosts, thus supporting theoretical AMR transmission models in densely populated urban environments.



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Feature : Controlling tobacco and nicotine products: Malaysia, New Zealand, Australia

Dzulkifli Abdul Razak and other acknowledged sources

April Fools Day | 1 April 2024

One Year After Malaysians Were 'Fooled' with the Delisting of Liquid Nicotine

Dzulkifli Abdul Razak

https://codeblue.galencentre.org/2024/04/01/one-year-after-malaysians-were-fooled-with-the-delisting-of-liquid-nicotine-prof-dzulkifli-abdul-razak/

One year after then-Health Minister Dr Zaliha Mustafa delisted liquid nicotine, Prof Dzulkifli Abdul Razak says the tragic situation has yet to be curbed, instead of introducing the Control of Smoking Products for Public Health Act that omits the GEG.[9]

A vape company from China advertises their disposable vapes styled after the company's mascot. Picture taken by *CodeBlue* at the vape convention in Kuala Lumpur on May 13, 2023.

Today is April Fool's Day, taken advantage of by many to carry out pranks on others. In other words, making a fool of someone. Fair enough, it's somewhat fun!

Last year, however, April Fool's Day took a different twist. The 'prank' is no longer fun nor funny. It became deadly thanks to a last-minute decision to delist nicotine in the liquid and gel form for use in electronic cigarettes (vapes).

That it was executed at a ministerial level against the advice of the Poisons Board stance, made members of the Board no less like fools – each being a full-blooded professional totally committed to protecting the public health of the rakyat. What is more, they were supported by the majority of their medical and health fraternities countrywide.

Clearly April 1, 2023 was a notably tragic day for all intents and purposes. Especially for those under the age of 18 years who are now 'a new breed' of (ab)users of the addictive substance that was beyond their reach until the 2023 April Fool's Day.

A total of 365 days have passed since. Three professional bodies filed a suit against the minister involved, something that has never been done in manipulating the Poisons List drawn up decades ago.

It was not until eight months later, in November 2023, that a related bill – the Control of Smoking Products for Public Health Bill – was presented in Parliament.

Hopes were raised that the availability of nicotine for vaping could be once again placed under tight control, given the chaotic madness induced by the previous decision to delist nicotine unilaterally.

Unfortunately, it was the converse. The Bill was presented, but did not include policies, such as the ban on smoking for those born after 2007 and regulations for e-cigarette or vape devices – meaning the chaos continues to ensue for at least a year today.

The ban on smoking for those born after 2007 would have led to a whole new generation of non-smokers.

The 'bigger surprise', however, burst open during the recent Parliamentary session, when the Deputy Health Minister reportedly spoke of an engagement between the tobacco and vape industry with Members of Parliament.

'If we look at our experience when we tabled the GEG, there was a clash of views due to the [tobacco and vape] industry pressure, with representatives from the industry entering parliament and they met MPs [to lobby them], which influenced the decision [to drop the GEG],' the deputy health minister was quoted as saying.

To this, a former health minister, as the architect of the GEG, commended the honesty in admitting that Big Tobacco had influenced lawmakers, which is not new, not only for Malaysia but the world over.

Malaysia, being a signatory to the WHO's Framework Convention of Tobacco Control (FCTC), is meant to prohibit Big Tobacco from influencing policy decisions.

Health Minister Dzulkifly Ahmad has told Parliament that he aims to produce regulations under the Control of Smoking Products for Public Health Act 2024 (Act 852) by June. Although the Ministry of Health has reportedly proposed regulations like plain packaging and retail display bans for both conventional cigarettes and vapes, as well as a ban on vape liquid bottles, flavour controls or bans, and a standardised shape for vape products, it

[9] The Generational End Game element that sought to ban those born in 2007 and onwards from smoking or purchasing smoking products has been done away with.

remains to be seen if Big Tobacco or Vape may end up killing these proposals.

Meanwhile, the influential Consumers' Association of Penang (CAP) expressed shock and disappointment over the delay thus far that has allowed vape-vested interest groups to continue exploiting the health vulnerabilities of our youth.

It is time to urgently restore the situation to what it used to be – by relisting the nicotine back into the Poisons List. In other words, stop wasting the lives of innocents immediately.

Enough of the insensitive inhuman policy that literally causes harm and injuries intentionally to the rakyat! They deserve better.

Prof Dzulkifli Abdul Razak is a neuropharmacologist and recipient of Malaysia's Tobacco Control Icon Award 2023.

From the Consumer Association of Penang

'Consumers Association of Penang (CAP) urges the government to set up a Royal Commission of Inquiry (RCI) concerning the recent revelation that tobacco and vape industry players had lobbied Members of Parliament (MP) in the Parliament House, defiling its sanctity as a place where laws are to be enacted in the national interest.

'The tobacco and vape industry had clearly violated the World Health Organisation (WHO) Framework Convention for Tobacco Control (FCTC).

> Article 5.3 states explicitly:
>
> *'In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.'*

'We want to know why Malaysian policymakers allow the industry to influence the outcome of the proposed Generational End Game (GEG) Bill.

'Malaysia ratified the WHO FCTC in 2005, close to two decades ago, and yet this can happen in the very sanctum where laws are passed.

'It is an absolute shame and a subversion of the legislative process.

'This should not be in any way tolerated.

'We are grateful that the Deputy Health Minister, Datuk Lukanisman Awang Sauni admitted that the tobacco and vape industry players had met with Members of Parliament (MPs) in the parliament itself to lobby for the exclusion of GEG.

'He has finally confirmed this incident that has been in the grapevine since October 2023.

'These lobbyists are like drug merchants (by the way, nicotine is also highly addictive) lobbying MPs to legalise something that will eventually destroy the youth and the nation.

'Unfortunately, there are some policy makers who are complicit in this grand scheme of things, excluding the GEG to serve the agenda of the lobbyists who want to continue addicting Malaysians for many generations to come so that they can profit from it.

'In view of the current developments, we reiterate our call for the government to set up a Royal Commission of Inquiry (RCI) on this matter of national importance.

'We want to know the extent of 'infiltration' and 'influence' of the lobbyists on our MPs.

'We also want to know who are behind the sabotage of GEG.

'Unless this corruption of the Parliamentary process is prevented, it will open the door for external forces, including foreign governments, to influence the government to serve their agenda.

'Further, we call on the Parliament to amend the Control of Smoking Product for Public Health 2023 Act to reinstate the GEG components without any delay.

'We must protect the integrity of our Parliament so that narrow vested interests are not able to influence parliamentarians, with their money, to legislate laws that serve them and not the people, as happens in the United States with its gun, defence industry and Big Oil lobbies.'

20 March 2024

Mohideen Abdul Kader
President
Consumers Association of Penang (CAP)

Up in Smoke: What Happened to New Zealand's Tobacco Ban Plan?

by Eric Trump, MS March 6, 2024

(Trump is a writer and a Professor of Medical Humanities.)
https://www.medpagetoday.com/opinion/second-opinions/109039

Despite its diminutive size and geographic isolation, New Zealand has an international reputation for pragmatic and sensible political action. Just six days after an Australian terrorist shot 51 people to death at two mosques in 2019, the government banned all possession of assault rifles and semi-automatic weapons. During the COVID-19 pandemic, Prime Minister Jacinda Ardern's 'team of five million' fought the virus with vaccinations, managed quarantines, and 'kindness' The teamwork paid off. In 2020, the Bloomberg COVID Resilience Ranking designated New Zealand out of 53 countries as the 'best place to be in the coronavirus era.'

This forward-looking country just took a giant step backward

As part of the newly elected coalition government's rush to tick 49 'actions' off its 100-day list by March 8, it has repealed the Smokefree Environments and Regulated Products Amendment Act of 2022. This act, passed by the previous Labour government, would have banned selling tobacco products to those born on or after January 1, 2009, reduced the nicotine in tobacco products to non-addictive levels, and slashed the number of outlets allowed to sell tobacco by 90%, from 6,000 to 600. Overall tobacco use was predicted to drop from the current 8% to lower than 5% by 2025, and the act was expected to create a tobacco-free generation.

Clinical trials and modelling studies showed Smokefree policies would have reduced mortality rates by 22% for women and 9% for men in a new tab or window, saving up to 5,000 lives annually. Also, it would have saved New Zealand $1.3 billion in healthcare expenditures over the next 20 years, and New Zealanders would have enjoyed a cumulative gain of $29 billion in disposable (and taxable) income by 2050. This world-leading legislation would have shown that fighting the tobacco industry is possible, encouraging other countries to do the same and perhaps eventually saving some of the more than 8 million people who die annually from tobacco-related causes.

Why would New Zealand's new coalition government, an alliance of the conservative National Party along with the libertarian ACT and populist New Zealand First parties, repeal data-driven and life- and money-saving legislation? Without a shred of evidence, Prime Minister Christopher Luxon and his coalition partners have repeatedly claimed restricting tobacco and reducing nicotine levels is experimental (as though that were a bad thing), leading to black markets and a proliferation of crime. ACT's health spokesperson Todd Stephenson, for example, said that the 'radical prohibitionism' of creating a smoke-free generation would 'push smokers into the arms of gang members.'

This rhetoric uncannily echoes the tobacco lobby. Public health experts at the University of Otago recently released a damning report showing that the coalition government's arguments in favour of a repeal closely mirror the tobacco industry's own narratives on this subject.

So suspicious are the similarities between the flimsy remarks of coalition partners and tobacco companies' talking points that the report's authors are calling on all members of parliament to declare any past associations with tobacco companies.

The government's fear-mongering is disingenuous because the Smokefree Act is not a full prohibition. Tobacco products would still have been available, just a lot harder to obtain. Moreover, levels of nicotine would have been reduced by 95%, making cigarettes less addictive and appealing, so more people would have likely quit or not started, presumably driving demand down, not up. Given these outcomes, where exactly would the crazed Kiwis clamouring for black-market tobacco come from?

In a twist to its tobacco-friendly logic, the coalition also promises, before March 8 of cold medicines containing pseudoephedrine, a main ingredient in methamphetamine. These medicines were designated 'high risk of harm' under the country's Misuse of Drugs Amendment Act and made prescription-only in 2011 precisely *because* pharmacists were confronting robberies. If we speculate about black markets, shouldn't a new supply of over-the-counter pseudoephedrine for New Zealand's meth trade be reason for concern?

In an interview with the news service *Newshub*, National Party Finance Minister Nicola Willis appeared to inadvertently reveal that the real reason for disallowing the Smokefree Act is not crime, but money. Grinding out smoking would 'significantly reduce revenue to the Crown,' and therefore reduce income to fund its promised tax cuts. In other words, facing a fiscal gap, the new government appears to *want* citizens to smoke cigarettes at upwards of $25 a pack, of which it receives approximately a 70% cut.

This callous repeal is reminiscent of Jonathan Swift's 'Modest Proposal.' Instead of urging New Zealanders to boil their infants for food, as Swift urges his Irish readers, the National Party and its partners embrace smoking in an apparent attempt to head off an embarrassing budget shortfall.

The Māori Party co-leader Debbie Ngarewa-Packer calls the legislative reversal a 'deliberate...systemic genocide' of the indigenous Māori people, who have among the highest smoking rates in the country. She's right. Māori children will continue to find cigarettes and begin a lifetime of smoking.

Despite protests at parliament, petitions with tens of thousands of signatures, and an open letter signed by more than 100 health organisations wlth Coalition Aotearoa -- a group of medical professionals promoting public health equity -- the repeal has gone through.

When Professor Chris Bullen, PhD, MPH, an expert on smoking-related issues at the University of Auckland, learned about the legislation's repeal, he 'felt like buying a one-way ticket out of New Zealand.' What a change this is from 2020, when Kiwis flocked home, proud of their country's public health response to COVID.

I sympathise with Professor Bullen. When I moved here in 2020, one of the trade-offs for geographic isolation was sensible, pragmatic public health policy that nudges people in a healthy direction. New Zealand seemed to me a kind of utopia: perhaps a 'no place' that's sometimes left

off world maps, but also a ‘good place,’ where healthcare is a priority right, not a privilege. Still, I haven't lost hope. I am counting on that ‘team of 5 million’ to join me in fighting this cynical embrace of tobacco however we can in order to save the lives of future New Zealanders.

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Australia: GPs play 'vital role' in helping quit nicotine

https://insightplus.mja.com.au/2024/9/gps-play-vital-role-in-helping-australians-quit-nicotine/

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New provisional guidance from the Royal Australian College of General Practitioners (RACGP) on the use of e-cigarettes to help Australians quit smoking provides a balanced approach for GPs, according to tobacco control experts.

E-cigarettes have been widely promoted as a smoking cessation aid to help people who have struggled and failed to quit smoking with first line treatment of pharmacotherapies and counselling. The putative benefits of e-cigarettes are in fact modest and interpretation of the evidence is far from unanimous. Against this, the uptake of vaping by young people who have never smoked has reached concerning levels in many countries, including the United States, the United Kingdom, New Zealand and Australia.

E-cigarettes are not safe, there is no doubt about this. In December 2023, the World Health Organisation (WHO) recognised the harms at a population level from widespread use far exceed the potential benefit.

These harms include nicotine addiction, poisoning, seizures, acute cardiovascular and respiratory effects and burns. The long term health effects of regular use on the body are not yet known. People who have never smoked are around three times as likely to take up smoking if they use e-cigarettes compared to if they do not. Tellingly, to date, no tobacco or e-cigarette company has submitted a product to the Therapeutic Goods Administration (TGA) for consideration as a therapeutic device, yet tobacco companies have heavily invested in marketing and product design development that maximises appeal to a younger demographic.

The vaping reforms

In late 2023, Australia’s Health Minister the Hon Mark Butler MP announced a series of policy reforms aimed at reducing e-cigarette use by young people who do not smoke. These include, from 1 January 2024, a ban on the importation of single use disposable vapes which have flooded Australia. From March, further measures will come into place including:

- stopping the personal importation of vapes;
- a ban on the importation of all non-therapeutic vapes;
- a requirement for therapeutic vape importers and manufacturers to notify the TGA of their product’s compliance with the relevant product standards; and
- requiring importers to obtain a licence and permit from the Office of Drug Control before the products are imported.

These measures will further strengthen and streamline the prescription access model for e-cigarettes. New product standards expected to come into effect later in the year will limit nicotine strength to 20 mg/mL (2%), in line with European Union, UK and Canadian regulations; regulate allowable flavours to tobacco, menthol and mint; and require pharmaceutical-like packaging. Prescribing will also be easier, with any approved medical or nurse practitioner able to do so.

The Government is expected to shortly introduce legislation to prevent domestic manufacture, advertisement, supply and commercial possession of non-therapeutic and disposable single-use vapes. Once adopted, this legislation will put a firm date on the end of vape shops in our communities. In a nutshell, the reforms seek to curb illegal activity while, importantly, facilitating a treatment pathway for people addicted to nicotine.

The industry response

The reforms proposed by Minister Butler have passed the ‘scream test’ with flying colours – if tobacco industry front groups are ‘screaming’ about the negative impact of reforms on their business via their usual tactics, then the policy is likely to be successful in preventing uptake. Despite the fact that general practitioners (GPs) have welcomed the announcement, some retail industry bodies claim the changes will overwhelm the medical system, as people who use e-cigarettes will flood GP offices seeking a prescription, and that the reforms will stoke illicit trade. Those who risk losing profit have combined these two claims – along with a good dose of 'astroturfing' [10]– with the result that one of the strongest narratives against the reforms is a fear that people who use e-cigarettes will not be able to obtain prescriptions from ‘doctors who are apathetic or unwilling to provide assistance‘ and, therefore, will be forced to turn to the illicit market to obtain their e-cigarettes.

The claims incorrectly assume that every person who currently uses e-cigarettes will continue to vape. It also assumes that every person will suddenly demand a prescription from a GP. These ideas fail to recognise what we know well: in the same way most people who smoke

[10] The practice of publishing opinions or comments on the internet. media, etc that appear to come from members of the public but actually come from a particular company or political group as a way to make it seem that a particular product or idea has a lot of public support.

want to quit, we know that among young Australian adults, over 40% want to quit vaping and quit attempts are increasing. Additionally, most young people who use e-cigarettes are not vaping daily and report most frequently vaping in social situations. Just as we know that the most common smoking cessation method is to quit unassisted, also known as 'cold turkey', so too we will expect to see most quit vaping attempts to be unassisted.

As to the illicit market claims, the industry argument is that retailers should now be legally allowed to sell nicotine e-cigarettes. The e-cigarette industry and irresponsible retailers quite simply cannot be trusted. Not only have some retailers fuelled the current illicit market by knowingly and illegally selling e-cigarettes to children, but they have also driven a narrative that misleadingly positions the reforms as a ban.

Implications for clinicians

The Australian Government's reforms are supported by most national health, scientific and consumer bodies because they comprehensively address the availability and attractiveness of vaping to young Australians. For those people who do seek cessation support, medical and nurse practitioners have a vital role to play in ensuring they are managing nicotine addiction with a view to cessation.

When a patient is given medical advice to quit, along with combination pharmacotherapy and behavioural support, this increases nicotine cessation rates. The recent provisional guidance from the Royal Australian College of General Practitioners (RACGP) on the use of e-cigarettes for cessation has upgraded the evidence for e-cigarettes in cessation from low to moderate certainty. However, since e-cigarettes remain an unapproved therapeutic medicine with unclear long term health impacts, the decision to use e-cigarettes to manage nicotine addiction must therefore be made based on an individual's personal circumstances and medical history. These combined factors make the prescription access framework the most appropriate for managing e-cigarette access.

One of the major parts of the reform package recognises the need to streamline the e-cigarette prescribing process. The previous requirement for prescribers to apply for and become an authorised prescriber was time-consuming and complex. Recognising the need to remove this obstacle, the authorised prescriber scheme is no longer a requirement, and the prescription of e-cigarettes can be managed through Special Access Scheme C. Under this scheme a medical or nurse practitioner can use the online notification system to immediately access the unapproved product without waiting for special approval.

Until the evidence matures, we believe the RACGP guidance document provides a balanced and appropriate approach to assisting practitioners to prescribe e-cigarettes. We welcome these reforms, which are consistent with the advice of the WHO as they aim to restrict e-cigarette use to the only population that might benefit; that is, people who are struggling to quit smoking (or vaping) by usual means. Health care professionals need to be aware of the industry-driven narratives that seek to undermine the effectiveness of the reforms. Medical and nurse practitioners have a vital role to play in supporting nicotine cessation and the RACGP Provisional Guidance provides them with support to help patients with proven effective methods to quit.

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WHO: Draft negotiating text of pandemic instrument devoid of deliverables on equity

Geneva, 18 April (K M Gopakumar TWN) – The draft negotiating text of the pandemic instrument is devoid of any concrete deliverables on equity and does not create any legal obligations to facilitate predictable and sustainable access to finance, pandemic-related products and technology.

The resumed 9th session of the INB will take place from 29 April to 10 May at the WHO Headquarters in Geneva in a hybrid mode. The INB is scheduled to negotiate the draft text over that week. From 7 to 10 May the INB is expected to negotiate and finalise the WHA resolution on the pandemic instrument.

The new draft text is a streamlined text prepared by the Bureau based on the textual proposals made by Member States during the 9th session of INB, which took place on 18-28 March.

The draft text has removed several provisions contained in the earlier draft negotiating text for INB 9 along with many suggestions made by various developing countries during the March session.

The absence of deliverables on equity makes the draft text tilted to protect the interest of developed countries by creating obligations to change the *status quo* on surveillance and data sharing and at the same time maintaining the *status quo* on access to pandemic-related products and technology as well as finance.

In the absence of predictable and sustainable assistance the draft text effectively proposes developing countries to undertake obligations on public health surveillance, one health and health system strengthening, which are beyond their means to implement.

Read the whole piece from Gopakumar:
https://www.twn.my/title2/health.info/2024/hi240404.htm