



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



Third World Network



DMDC



Garden of Knowledge and Virtue

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HAI AP News

Penang, Malaysia

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HAI AP Est. 1981

Health Action International (HAI) was formally founded in Geneva in 1981 and coordinated 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.

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This issue covers a wide range of topics.

Thank you Uma Devi for the comprehensive report of the Penang WAAW 2025 event: One Health, One Future: Students' Voices Against AMR.

At least three significant 'Days' fall in December: AIDS Day, Disabled Persons Day, Human Rights Day.

Dzul Razak looks at Human Rights in the current global setting and Niyada Angsulee and Rainny Sittiphon and colleagues prepared special contributions about the issues associated with the control of unsafe medicines along Thai borders.

Dr Ekbal explains how Kerala responds as foreign corporates attempt to swallow the Kerala health sector.

Thank you Syed Rizwanuddin and Barbara Mintzes and colleagues for sharing important publications.

TWN's Third World Resurgence considers the future of WHO - philanthropy cannot save WHO - and we look at the future of the US Centers for Disease Control that is facing huge assaults from the current US government.

Beverley Snell discusses expiry dates on medicines.

Hard copies of HAIAP at 40 are available free but postage needs to be covered. Contact linda@twnetwork.org

It can be downloaded free of charge at:

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



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## World AIDS Day December 1

The theme of this year's World AIDS Day is **Overcoming disruption, transforming the AIDS response**.

Winnie Byanyima, Executive Director of UNAIDS and 2022 Olle Hansson Awardee writes:

'AIDS is not over—and this year's disruption to the global response has exposed the fragility of the progress we have fought so hard to achieve. Yet 2025 has also been a year of transformation, laying the foundations for a more sustainable, inclusive and nationally owned HIV response.

The impact of a sudden acceleration of cuts to international HIV financing, coupled with a retrenchment in human rights, has been devastating. 'The number of people using PrEP—HIV prevention medicines—has fallen by 64% in Burundi, 38% in Uganda and 21% in Viet Nam. Over 60% of all women-led HIV organisations have lost funding or been forced to suspend work, leaving entire communities without access to vital services. A failure to reach the 2030 global HIV targets of the next Global AIDS Strategy could result in an additional 3.3 million new HIV infections between 2025 and 2030.

'And yet we are seeing important signs of resilience. Communities are rallying to support each other and the AIDS response. Although the most impacted countries are also some of the most indebted, limiting their ability to invest in HIV, governments have taken swift action to increase domestic funding where they can. As a result, some countries have maintained or even increased the number of people receiving HIV treatment.

### **Overcoming Disruption: Transforming the AIDS response**

'Regional initiatives such as the Accra Reset and the African Union Roadmap to 2030 and Beyond are carving out a new path towards health sovereignty.

'New agreements with generic pharmaceutical manufacturers will soon enable many developing countries to access long-acting injectable PrEP for just US\$ 40 per person per year. In a tough financial landscape, some donor governments are maintaining or increasing their commitment. The replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria has so far secured pledges of more than US\$ 11.34 billion.

'World AIDS Day is a moment to renew our commitment to the AIDS response. In the hardest of circumstances, this is what I have seen this year—countries and communities coming together to overcome disruption and transform the response. It is within our grasp—we must seize it.'

'The commemoration of World AIDS Day, on 1 December 2025, provides an important opportunity to highlight the impact that the funding cuts from international donors have had on the response to AIDS as well as to showcase

the resilience of countries and communities stepping up to protect the gains made and drive the HIV response forward.

'In 2025, a historic funding crisis is threatening to unravel decades of progress. HIV prevention services are severely disrupted. Community-led services, vital to reaching marginalised populations, are being deprioritised while the rise in punitive laws criminalising same-sex relationships, gender identity, and drug use is amplifying the crisis, making HIV services inaccessible.

'Countries must make radical shifts to HIV programming and funding. The global HIV response cannot rely on domestic resources alone. The international community must come together to bridge the financing gap, support countries to close the remaining gaps in HIV prevention and treatment services, remove legal and social barriers, and empower communities to lead the way forward.

'Political leadership is paramount to advancing policies that address structural inequalities and protect vulnerable populations. Transformative solutions are needed to improve access to HIV services, eliminate stigma and discrimination once and for all, and ensure the protection of rights for women, girls, and LGBTQ+ people, who continue to face disproportionate barriers in accessing healthcare.'

'In a time of crisis, the world must choose transformation over retreat,' said Ms Byanyima. 'Together, we can still end AIDS as a public health threat by 2030—if we act with urgency, unity, and unwavering commitment.'

Join us in calling for sustained political leadership, international cooperation, and human-rights-centred approaches to end AIDS by 2030.

<https://www.unaids.org/sites/default/files/2025-11/2025-WAD-reporten.pdf>

<https://www.unaids.org/sites/default/files/2025-11/2025-WAD-reporten.pdf>

<https://www.youtube.com/watch?v=TJ0jQDe-DO>

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## **Fiji faces major HIV outbreak**

[www.thelancet.com](https://www.thelancet.com) Vol 406 December 6, 2025

With cases rising by 3091% since 2010, Fiji is introducing same-day testing and treatment, peer education and support, and harm reduction.

Jacqui Thornton, *Lancet* Journalist reports:

In 2010, the island nation of Fiji, with a population of fewer than 1 million, had a miniscule number of people living with HIV—fewer than 200, according to UNAIDS estimates. The epidemic in the Pacific was largely centred on Papua New Guinea, which accounted for almost all the region's HIV infections. By 2024, the estimated number of people with HIV in Fiji had leapt to 5900. The Ministry of Health and Medical Services (MHMS) recorded 1583 new cases in that year—triple that of 2023. According to UNAIDS estimates, new HIV infections in Fiji increased by 3091% from 2010.

In January, 2025, Health Minister Ratu Atonio Lalabalavu declared an HIV outbreak, which shows no signs of slowing. There were 1226 new cases in the first 6 months of 2025, and in October, Assistant Health Minister Penioni Ravunawa warned that Fiji may record more than 3000 new HIV cases by the end of the year, describing the situation as a 'national crisis'.

...

The reason for the increase can, in part, be explained by COVID-19. The pandemic meant the illegal drugs supply route was blocked, so crystal meth was being marketed locally. With minimal access to sterile needles, unsafe practices such as needle sharing were common.

'Injecting drug use was the accelerant of an HIV epidemic that was obviously larger than people had recognised', Eamon Murphy, Regional UNIADS Director said. 'The two collided.' Preliminary programmatic data from the MHMS seen by *The Lancet* indicate that in 2024, of those in medical care, injecting drugs accounted for 48.0% of cases, sexual transmission 47.3%, and mother to child 4.6%. Of the newly infected individuals, 62.5% were aged 10–29 years. Unconfirmed data suggest that all of those in this age group being treated were likely to have contracted HIV due to injecting drug use.

Mark Shaheel Lal, who founded the awareness-raising platform *Living Positive Fiji* (Suva, Fiji), told *The Lancet* that the current crisis is not just about data but about people's lives. 'It's the young man who hides his pills because he's afraid his family will find out', he said. 'It's the mother who skips treatment because the nurse might gossip. It's the teenager who never got proper sex education.'

Lal, who is one of a handful of people in the country who have disclosed their diagnosis publicly, said: 'In smaller towns, everyone knows everyone. Going to the clinic for HIV testing or treatment can feel impossible because word spreads quickly, and fear of exposure keeps people away. Many clinics are open plan and lack privacy; if you enter to pick up medications, everyone can see you, and there are no discreet ways to carry or store medication bottles.'

## Response

The Fijian Government has responded with a focused plan and strong political leadership. Previously, the annual HIV budget was FJD 200 000 (£67 000). This year, it has committed domestic funding of FJD 10 million (£3 million), which has enabled the establishment of a new dedicated Sexual Reproductive Health and HIV Unit within the MHMS, led by Jason Mitchell, a Fiji-born doctor and HIV program specialist, who began his role as Chair of the National HIV Outbreak and Cluster Response Taskforce in February. The governments of Australia (FJD 5.7 million [£2 million]) and New Zealand (FJD 5.2

million [£1.7 million]) have also made significant financial contributions and given technical assistance.

...

Renata Ram, the UNAIDS Country Director for Fiji and the Pacific, and a native Fijian, said that the current situation is confronting, but also an opportunity. 'My hope is that this new phase of the response and the renewed donor support won't just help us manage the epidemic but will also build lasting local capacity. Fiji and the Pacific need home-grown expertise, not just imported solutions. If we can use this moment to strengthen systems, reduce stigma, and create a generation of Pacific HIV professionals, then something good will come out of this very difficult chapter.'

Read the full article including details of Fiji's response here:

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(25\)02430-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)02430-4/fulltext)

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## International Day of Persons with Disabilities December 3

<https://www.un.org/en/observances/day-of-persons-with-disabilities>

An estimated 1.3 billion people experience significant disability. This represents 16% of the world's population, or 1 in 6 of us.

Some persons with disabilities die up to 20 years earlier than those without disabilities.

Persons with disabilities have twice the risk of developing conditions such as depression, asthma, diabetes, stroke, obesity or poor oral health.

### Theme 2025: Fostering disability inclusive societies for advancing social progress

Across all regions, persons with disabilities and their households face challenges and barriers in the attainment of social development objectives:

The three core themes of social development, ie poverty eradication, promotion of full and productive employment and decent work for all, and social integration, are interrelated - mutually reinforcing and require an enabling environment so as to be achieved simultaneously. The inclusion of persons with disabilities as both agents and beneficiaries of social development is indispensable. Disability inclusion in all aspects of social, economic, cultural and political life is therefore an imperative.

The theme of the International Day of Persons with Disabilities 2025, '*Fostering disability inclusive societies for advancing social progress*', builds on the reaffirmed commitment of world leaders gathered at the Second World Summit for Social Development to build a more just, inclusive, equitable and sustainable world and their understanding that advancing progress on social development depends on, and indeed necessitates, the inclusion of all segments of society.

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## Human Rights Day December 10

<https://www.un.org/en/observances/human-rights-day>

### Dzul kifli Abdul Razak

December 10 is Human Rights Day. It commemorates the UN General Assembly's adoption of the Universal Declaration of Human Rights (UDHR) in 1948, a foundation document expanding on the UN Charter's commitment to human dignity by setting out fundamental rights for all people - becoming a global standard and inspiring further international human rights laws.

The United Nations Charter on 28 June 1945 articulated the mission of maintaining international peace and security to develop friendly relations among states, to promote international cooperation, and to serve as a centre for harmonising the actions of states in achieving those goals. After 80 years, this year seems to be among the most challenging given the status of the world today.

The recent extreme weather around Asia-Pacific, especially South-East Asia, emphasises a new dimension of human rights in the context of the three missions stated. While before, international peace and security were more focused on socio-military aspects, currently the climate crisis takes the issues far beyond, in that it matters not which military or ideological leanings one belong to.

Like the COVID-19 pandemic, the climate crisis is people-blind throughout the region. In fact, it puts an extra burden on the military outfit when the army personnel are called to assist victims who are affected by the climate tragedies. Perhaps enjoining a collaboration effort to minimise the impact of climate change to fellow humans, regardless who or where there are is an appropriate response.

Incidentally, a new report by the CIVICUS Monitor makes a response more challenging. The report entitled, 'People Power Under Attack 2025' examines civic space conditions in 198 countries and territories, assessing citizens' ability to exercise freedoms of assembly, association and expression.

Overall, across Asia-Pacific, the situation is not much better according to CIVICUS researchers who found that more than 85 per cent of the population live in countries where civic space is either 'Repressed' or 'Closed'. In Afghanistan, China, Hong Kong, Laos, Vietnam, Myanmar and North Korea civic space is rated 'Closed'. While nine countries are 'Repressed' and six 'Obstructed'. South Korea and Timor-Leste are 'Narrowed', with Japan and Taiwan the only 'Open' countries in the region. In the Pacific region, more countries (seven) are rated 'Open' and five 'Narrowed'. Papua New Guinea and Nauru are 'Obstructed' with none categorised as 'Repressed' or 'Closed'.

If human rights are already trampled on in 'fine' weather conditions, what chance do we have in extreme conditions? For example, allegedly, Malaysia's civic space is categorised as 'obstructed', with authorities continuing to target online critics, activists and protesters, according to the report.

In January this year, organisers of the anti-corruption rally Himpunan Rakyat Benci Rasuah (People's Gathering Against Corruption) reportedly 'faced restrictions ahead of the event.' Later, in June, student activists from a local university were arrested under the draconian Sedition Act for a demonstration urging the Prime Minister to act against corrupt politicians said to be involved. Whereas, in the larger academic circles, an Australian journalist who formerly worked in a Malaysian university was arrested by Thai police on criminal defamation charges, reportedly at Malaysia's request, after publishing articles critical of the Malaysian authority implicated in the issue. This begged the question: How can someone be charged for writing about political issues in Malaysia, in Thailand?

Apparently this incident is the first of its kind involving a neighbouring country. Known as SLAPPS - Strategic Lawsuits Against Public Participation are deemed as a tactic used to weaponise the courts against those who stand up or speak out for the public interest, according to the Australian-based Human Rights Law Centre. It says these lawsuits are not about justice — they are designed to intimidate, silence dissent, and suppress public debate. Tactics can include threats, assault, harassment, detention, unlawful deportation, abuse of Interpol notes, coercion of family members, digital surveillance; even assassinations.

The most alarming trend across the region in 2025 was the mass detention of protesters and activists. Demonstrations demanding democratic reforms, anti-corruption measures, climate justice and solidarity with Palestine prompted arrests in at least 18 countries, including Indonesia, the Philippines, Australia, India, Malaysia, Pakistan and Timor-Leste.

'Governments are criminalising dissent on a massive scale. Peaceful protest is being painted as a crime, and those who dare to speak out and mobilise are paying with their freedom,' said Josef Benedict, CIVICUS Monitor's Asia-Pacific researcher.

It is interesting to note that on this occasion transnational repression as an arsenal to reach across borders is becoming more real. 'Transnational repression is a set of physical and digital tactics used by governments to reach across borders in order to silence dissent,' said Yana Gorokhovskaia, research director of Freedom House, an NGO that promotes democracy and human rights globally. She is quoted as saying anyone who has a national or ethnic connection to a foreign government and voices dissent is potentially at risk. In an interconnected digital

world this risk cannot be underestimated in the struggle for human rights of the most vulnerable people members of ethnic or religious minorities (like the Uyghurs).

In this regard, the on-going genocide in the Gaza massacre deserves our special attention after almost 80 years of Israel's occupation of Palestine and on the 80th anniversary of the Human Rights Day!

*It always seems impossible until it is done*  
Nelson Mandela (1918-2013).

**The 2025 Human Rights Day Theme is: Human Rights, Our Everyday Essentials**

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## The Peoples Health Movement and Gaza

**On Human Rights Day (December 10) in 2025, the People's Health Movement (PHM) highlighted the catastrophic health and humanitarian crisis in Gaza and advocated for an immediate end to the war and blockade, emphasising the right to health as a core human right.**

The PHM's activities and statements surrounding Human Rights Day 2025 included:

**Global Webinar:** The PHM hosted a global webinar on Friday, December 6, 2025, to celebrate 25 years of the movement; and to amplify current struggles (with Gaza being central), and to map future actions.

**Ongoing Advocacy and Campaigns:** Throughout late 2024 and 2025, the PHM has actively campaigned against the 'genocidal war' in Gaza, calling for international action.

**Gaza Health Declaration:** PHM is a key member of a coalition that launched the *Gaza Health Solidarity Declaration*, demanding an end to the war and a reorientation of health engagement to centre Palestinian sovereignty and justice.

**Aid and Sanctions:** The Peoples Health Movement calls for global actions, including Boycott, Divestment, and Sanctions (BDS) against the Israeli occupation, and organising medical aid flotillas to break the blockade and support the health system.

**Accountability:** The PHM demands accountability for the targeting of hospitals, medical personnel (over 1,000 health workers killed), and patients, which they describe as a deliberate destruction of Gaza's healthcare system.

**Focus on Long-term Needs:** The PHM emphasises that the resulting injuries, disabilities, psychological trauma, and malnutrition in Gaza will require lifelong care, underscoring the necessity to rebuild the healthcare infrastructure for the long term, not just immediate acute needs.

Their message for Human Rights Day 2025 reiterates a standing call for an immediate and permanent ceasefire, respect for international humanitarian law, unimpeded

humanitarian access, and the reconstruction of health systems and civilian infrastructure to allow for the rehabilitation of the population. The PHM website provides ongoing updates and opportunities to get involved in their campaigns and find resources on the crisis in Palestine: <https://phmovement.org>.

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## When Foreign Corporates Swallow the Kerala Health Sector

Dr B Ekbal



Kerala's proud healthcare system now stands at a crossroads, facing a challenge of historic proportions. In recent years, foreign investment in private hospitals has surged dramatically. Global corporate giants such as KKR (Kohlberg Kravis Roberts), Blackstone, and TPG Growth are steadily buying controlling

stakes in super-specialty hospitals, especially in Kochi, Kozhikode, and Thiruvananthapuram. In effect, the steering wheel of Kerala's healthcare is slipping out of our hands. Interestingly, healthcare has become the only sought-after destination for foreign capital in Kerala.

### Why Kerala?

*The Heavy Disease Burden:* Lifestyle illnesses, infectious diseases, mental health conditions, and rising road traffic injuries have made Kerala a fertile ground for healthcare business. With an ageing population adding to this burden, foreign investors see this situation not as a public health crisis, but a lucrative market.

*Health-seeking behaviour:* Kerala also has a significant segment of people with strong health-seeking behaviour, going for medical care even for minor illnesses.

*Affluent Consumers:* The proportion of the population with disposable income and the ability to pay is high in Kerala. And the affluent people are increasing. The uptake of private health insurance is high among the affluent and the high- and middle-income groups. This combination has painted Kerala as an attractive 'medical marketplace' for global corporations.

### The Vicious Cycle: A Looming Crisis

Kerala already spends more out of pocket on healthcare than any other Indian state. With corporate control tightening, these costs will escalate further, pushing families, especially the middle class, into catastrophic health expenditure and impoverishment. Over-prescription, unnecessary diagnostic tests, and profit-driven procedures—often outside accepted clinical norms—could become rampant, fuelling hospital-based diseases (iatrogenic diseases) and further straining the state's celebrated healthcare model.

Equally concerning is the erosion of professional autonomy. Many of these hospitals were once run by doctors; today, that control is being replaced by boardroom strategies. The fallout: junior doctors, nurses, and health workers face increasing exploitation, job insecurity, and loss of dignity in their profession.

### *The Path Forward: A Call to Action*

Kerala must act decisively to reclaim its healthcare future. This requires:

**Preventive Health as a People's Movement:** To reduce the morbidity burden should be our immediate task. Just as the Total Literacy Mission mobilised society, preventive health and education must become a grassroots campaign with mass participation. This should be an ongoing process.

**Robust Regulation:** Expanding the Clinical Establishments Act to ensure treatment and diagnostic standards, protocols and regulated and transparent fee structures.

**Strengthening Public Hospitals:** With 30–35% of people already relying on government hospitals, investments in infrastructure, medical human resources, staffing, and facilities must raise this share to at least 50%, creating a strong, reliable public alternative.

This is not just about healthcare, it is about sovereignty, justice, and the values we attach to human well-being. Kerala's healthcare must not be surrendered to profit-driven corporations. Instead, it must be fortified as public good, a people's right, and a model of equity.

Dr B Ekbal, Public Health Activist and former Professor of Neurosurgery.

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## Vaccine Safety

### WHO expert group's new analysis reaffirms there is no link between vaccines and autism

<https://www.who.int/news/item/11-12-2025-who-expert-group-s-new-analysis-reaffirms-there-is-no-link-between-vaccines-and-autism>

**Statement** 11 December 2025

New analysis from a WHO global expert committee on vaccine safety has found that, based on available evidence, no causal link exists between vaccines and autism spectrum disorders (ASD). The conclusion reaffirms WHO's position that childhood vaccines do not cause autism.

The Global Advisory Committee on Vaccine Safety (GACVS), established in 1999, brings together international experts to provide independent and authoritative scientific advice to WHO on global vaccine safety related priorities.

The latest analysis, discussed by the Committee on 27 November 2025, focused first on the relationship between thiomersal-containing vaccines and ASD, and the association between vaccines in general and ASD. Evidence based on 31 primary research studies, published between January 2010 and August 2025, including data from multiple countries, strongly supports the positive safety profile of vaccines used during childhood and pregnancy, and confirms the absence of a causal link with ASD.

The Committee also assessed the review of potential health risks associated with vaccines with aluminium adjuvants, drawing on studies conducted from 1999 through March 2023. In addition, it reviewed a recent large cohort study analysing nationwide registry data of children born in Denmark between 1997 and 2018. In summary, the available high-quality evidence shows no association between the trace amounts of aluminium used in some vaccines and ASD, supporting the ongoing use of vaccines with aluminium adjuvants.

Following its review, GACVS reaffirms its previous conclusions from 2002, 2004 and 2012: vaccines, including those with thiomersal and/or aluminium, do not cause autism.

WHO advises all national authorities to rely on the latest science and ensure vaccine policies are grounded in the strongest available evidence. Global childhood immunisation efforts represent one of the greatest achievements in improving lives, livelihoods and the prosperity of societies. During the past 50 years, childhood immunization has saved at least 154 million lives.

### **Summing up: Is there a link between vaccines and autism?**

No. Extensive research has shown that vaccines do not cause autism. Many large, high-quality studies conducted in different countries and involving large populations have all reached the same conclusion.

Research using a variety of different methods and conducted over many years has demonstrated that the measles, mumps and rubella vaccine does not cause autism. The study that was interpreted as indicating any such link was later proven to be wrong and fraudulent. The journal that published it withdrew the study, and the doctor who authored it lost his medical license.

Evidence also shows that other childhood vaccines do not increase the risk of autism. Extensive research into the preservative thiomersal and the additive aluminium that are contained in some vaccines strongly concluded that these constituents in childhood vaccines do not increase the risk of autism.

## Related

see <https://www.who.int/news/item/11-12-2025-who-expert-group-s-new-analysis-reaffirms-there-is-no-link-between-vaccines-and-autism>

[The Global Advisory Committee on Vaccine Safety](#)

[Questions and answers on vaccine safety](#)

[Questions and answers on autism](#)

[Vaccination information hub](#)

[Regulation and Prequalification, Pharmacovigilance](#)

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## US Centers for Disease Control - a New Low

from *The Conversation* December 12 2025

**Hassan Vally** Associate Professor, Epidemiology, Deakin University

<https://tinyurl.com/mpr73dmu>

**The CDC once stood as a global benchmark of scientific integrity. Sadly, it now risks becoming a megaphone for misinformation and a tool for those whose goal is to undermine science.**

The United States Centers for Disease Control and Prevention (CDC) has revised its long-standing guidance about vaccines and autism.

The guidance once stated clearly and correctly that the evidence shows no link between vaccines and the development of autism.

Now it claims 'studies supporting a link [between vaccines and autism] have been ignored by health authorities'. It also says:

*The claim 'vaccines do not cause autism' is not an evidence-based claim because studies have not ruled out the possibility that infant vaccines cause autism.*

Donald Trump's Health Secretary Robert F. Kennedy Jr directed the CDC to make these changes, despite promising at his confirmation not to alter the CDC's vaccine advice.

**With this change in wording on the website the CDC has been dragged to a new low.**

Let's look at the updated CDC statement about vaccines and autism, and how this is at odds with how science works.

### Science can't prove universal negatives

Saying 'studies have not ruled out the possibility that infant vaccines cause autism' is in direct conflict with how science works.

Using science, we can demonstrate that two things are linked by showing consistent, reproducible associations that stand up across multiple study designs. We can also test a hypothesis repeatedly and from many angles.

Therefore, for example, when high-quality studies using different methods, populations and measurements, all fail to find a link between vaccines and autism, the rational conclusion is there is no causal connection.

If we were to accept the notion that we cannot prove the universal **absence** of a link, someone could always claim they aren't convinced by the current evidence because maybe the next study will find something. Using this same logic, it's impossible to rule out the Earth is flat or that fairies exist.

Speculation about a link between the measles, mumps and rubella (MMR) vaccine and autism began with a fraudulent and now-retracted 1998 *Lancet* paper by the discredited doctor Andrew Wakefield.

Even if you accepted everything in Wakefield's paper as true (it wasn't) and assumed he was an honest researcher (he wasn't), you would still be left with nothing more than a case series of 12 children. This study design is incapable of establishing a causal link between the MMR vaccine and autism.

Subsequent investigations also uncovered a long list of damning findings about Wakefield, including:

### 1) He hid major financial conflicts of interest

Wakefield was paid large sums by lawyers preparing a lawsuit against MMR manufacturers, money he failed to disclose. He was contracted to find evidence supporting a link between MMR and autism.

At the same time, he had filed patents for a single-dose measles vaccine and a diagnostic test that stood to profit if public fear about MMR increased.

### 2) He committed serious ethical violations

Wakefield falsely claimed the study had ethics approval. It did not. Children with developmental conditions were subjected to invasive procedures, including colonoscopies and lumbar punctures, without valid clinical justification or proper oversight.

### 3) He misrepresented how the children were recruited

The paper claimed the children were consecutively referred, implying an unbiased clinical sample. In reality, several were recruited through anti-vaccine groups or families involved in the lawsuit funding Wakefield, meaning the sample was deliberately cherry-picked to support his predetermined hypothesis.

### 4) He altered and falsified data

Comparisons between medical records and the published paper revealed extensive falsification:

- symptoms that began before vaccination were rewritten as occurring after MMR
- gastrointestinal findings were exaggerated or invented
- diagnoses were manipulated to fit his fabricated 'autistic enterocolitis' syndrome
- normal clinical results were presented as abnormal.

The tragedy in all this is that a fraudulent study that never should have seen the light of day continues, even now, to erode confidence in life-saving vaccines. This has led to

reduced vaccination rates, the resurgence of preventable childhood illnesses, and unnecessary deaths.

It has also inflicted immeasurable harm on autistic people and their families by fuelling stigma and misinformation.

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## Talking about expiry dates

Beverley Snell

Discussions about expiry dates on medicines often focus on the perceived waste of medicines that are discarded after their expiry date. In addition pharmaceutical companies are accused of using expiry dates to ensure turnover of stock to increase profits.

Good stock management practices avoid the accumulation of stock beyond the expiry date; while occasionally it will be necessary to deal with such stock.

There are many more issues that need to be considered. The 'use before' or 'expiry' date is the date beyond which the manufacturer will not guarantee quality. Inappropriate storage conditions can lead to deterioration long before the 'use by' date. For example:

- Medicines that are badly stored may deteriorate long before the date on the container.
- Vaccines left at the wrong temperature can be destroyed in a couple of hours or less.
- Stored at an inappropriate temperature, tablets can discolour, change, become stuck together, break up etc. You can often tell by looking at them whether they are good or not.
- Liquid mixtures can become thick, dried up, or may develop crystals or lumps that shouldn't be there, or may be impossible to shake up. The doses at the bottom of the bottle could be much stronger than those taken at the beginning and could be an overdose.

Vigilance is crucial no matter what the expiry date.

### Other scenarios

In 1984 a batch of cotrimoxazole tablets newly received in Somalia from a reputable Swiss company prompted questions. The staff had become suspicious when the tablets developed grey spots and smelt bad when the new sealed tin had been opened. The batch had a long expiry date but was sent to Geneva for testing. It was found that the preservative had not been put in the mixture.

Around the same time, a new batch of 400,000 Unit penicillin would not dissolve in 2 mls of water for injection. That meant it was necessary to dissolve it in a much bigger volume that was too big for children. That batch was returned to the manufacturer and replaced with a new good batch.

**So the most important thing is not the expiry date, it is your judgment.**

If you have any concern about quality of medicines, discuss it with your colleagues immediately.

## Fear of expiry dates - another perception

In some settings there has been an irrational fear of expired medicines. This example is illustrated by instances in the Somali setting in the 1980s.

Experienced health workers noted that community members had informed them that when something went wrong with a patient, particularly in hospitals, and maybe the patient died, or didn't get better, the staff often told the patient's family that it was because the medicine used was expired. The health workers thought perhaps hospital staff found it easier to give that explanation than to try to find out what really happened. It was easier than trying to explain complications of the illness, or that patients were so sick that they were unlikely to recover, and so on.

The idea of expiry being a dangerous problem seems to have been introduced a long time before.

### What was behind the perception?

We never discovered the source of the perception. Perhaps there are people who cannot read and write in any language who have learnt to read an expiry date. They look only for this expiry date on the medicine because maybe they have been taught that this expiry date is a very important thing about medicine.

### Scenario examples:

A woman stopped me in the street. She had a packet of nystatin vaginal pessaries she had bought from a shop. She asked me to check the expiry date for her. That was all that interested her. I tried to determine whether she understood that these were vaginal pessaries and not tablets for swallowing. I am not sure she did – even after I tried to explain in her own language. That was not really a problem for her – so long as they weren't expired.

A nurse died in the hospital when he gave himself an IV infusion of Dextran 70 plasma expander. He thought it was glucose infusion and glucose infusions were very popular in the community. There was a rumour that he died because the infusion was expired. We knew that he died of anaphylactic shock because he used plasma expander when his plasma was normal. He did not know the difference between Dextran 70 and 5% glucose.

We know that the expiry date is not the most harmful thing about medicine but it seemed to be the thing that greatly interested many people.

(Sometimes medicine hardly deteriorates at all. It is just as effective many years after the date stamped on it, provided it has been stored properly.)

## Donations of Expired Medicines

It is NOT all right for countries to send medicine with an expired date or very short date to developing countries. We know that many organisations did, and still do, dump ('donate') things they want to get rid of in developing countries. They might even get a tax refund for doing that.

There are International Donation Guidelines that stipulate that there must be at least one year before expiry from the time a donation arrives at the destination.<sup>1</sup> The guidelines cover all issues about sources, appropriateness and quality of products.

Some inappropriate donated products have been dangerous and their sale prohibited in the countries where they are made. Many others have been useless, or quite inappropriate for the setting where they are being sent - as well as being close to expiry.

**Import according to a national standard drug list that has been generated by setting specific treatment guidelines and keeping good records is the key to maintaining a supply of good medicines.**

The principles articulated in the guidelines are that donors should be only supplying (donating) approved quality medicines that are on the national standard drug list, or specified list, and only when the recipients have asked for them. If those principles are respected we would not have problems.

It should be noted however, that a financial contribution is usually much more appropriate than medicines sent from other countries. Medicines and supplies can then be responsibly sourced as needed locally or nearer the destination at a fraction of the cost and disruption of unpredictable donated medicines from other countries.

Expiry dates are not the only things to consider.

### Community education

**It is important to explain the role of expiry dates to patients and community members.**

Medicines should only be used for the right purposes. Nearly all medicines are poisons if taken in excess. Or some can be dangerous taken with other particular products. Medicines should only be used when absolutely necessary.

**Real dangers of medicines are:**

Medicine used for the wrong problem.

The wrong dose of medicine. The wrong dose can be very dangerous, an overdose or - too frequent dose can kill.

Labels on medicine containers must include the full generic name and route to be taken of the medicine and its strength and dosage.

Medicine given by the wrong method can kill. For some example injections given I.V. can be dangerous. I.M. is not so dangerous. Medicines to put on your skin must not be swallowed.

It is necessary to be careful about giving different medicines together. They can mix and add the effects together and cause harmful or even dangerous effects.

It is necessary to know about the possible side effects and take care, and warn others to take care.

Unlabelled medicines are dangerous. Medicines in a container with no label should never be used. You never know what might be inside. Medicine with no label should be discarded appropriately.

Inappropriate storage containers must not be used. Liquids like paraffin or solvents must not be stored in medicine bottles. The contents could be drunk by accident. Conversely medicines should never be stored in containers that have held petroleum or other similar liquids.

Avoid giving I.V. infusions. There can be dangers associated with less experienced people giving injections — abscesses at the site, reactions from injections given too fast. Injections of air bubbles - the fastest way to kill a person.

Tablets and capsules are MUCH safer than injections and almost always just as effective.

**All the above points about medicines are much more important for community people to know than an expired date.**

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## Evaluation of medicines with an expired date

**There are quite easy ways to judge whether medicine is usable or not - regardless of the expiry date.**

### ANTIBIOTICS

Antibiotics do deteriorate as they become older particularly in hot climates. But normally this begins only gradually. They don't suddenly become useless. After the date of expiry it is **possible** that an antibiotic can lose its strength. ... It is only guaranteed until that date. For example 3 months after the expiry date appropriately stored penicillin tablets labelled that they contain 500 mg have been analysed and shown to contain 495 mg. These tablets can be used at times when new medicine is not available and when a dose of anything up to 400 mg is sufficient anyway.

Streptomycin was an important focus when it was a key part of TB treatment.

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<sup>1</sup> for example see <https://pmc.ncbi.nlm.nih.gov/articles/PMC10474724/>

When streptomycin was the key to TB treatment in Somalia in the early 1980s, some TB patients tried to refuse their streptomycin injections when the expiry date on the vials had been reached – as if the medication had become poisonous at midnight on that date.

The daily dose (minimum) of streptomycin in the treatment of TB - EVERY DAY FOR THE INTENSIVE PHASE - for a thin man is 0.75 g. But because Streptomycin comes in 1 g vials, a 1 g dose had been given except for very weak old patients.

The most important thing about T.B. treatment was that it was given every day without missing.

So it is much more dangerous to miss a day because you are frightened of an expiry date than to inject a vial which might only contain 0.95g instead of 1 g. when only 0.75g is needed anyway.

While a clinic is waiting for new streptomycin to arrive, available stock that has been cared for appropriately should be used until new stock arrives, rather than miss treatments. In the case of streptomycin, if it appeared clear in the solution in the vial, it was fine. It was not to be used if it looked yellow.

### Use of expired antibiotics

It is not a good idea to use antibiotics more than 3 months after the expiry date because it will be unsure how much they contain, unless they have been officially evaluated. Sometimes antibiotics have been sent to laboratories for checking when they are near their expiry date and have been found to be still full strength after 2 years. At times they have been tested and given a further one year guarantee beyond the original date.

But some antibiotic preparations do deteriorate very quickly. Antibiotic eye drops and eye ointments are examples. Antibiotic eye drops should not be used more than one month after they are opened. Eye ointments last longer but they do deteriorate after opening and should be discarded appropriately at the end of a treatment – not saved until next time. With eye products it is also

important to use fresh products because they can become contaminated and spread infection in the eyes.

Tetracycline is a particular antibiotic that does cause problems after expiry. It can become toxic for the liver so tetracycline must not be used after the expiry date.

### Other medicines

ASPIRIN TABLETS often have no expiry date on the package. But they do deteriorate. It is possible to tell by looking at them and smelling them. After a while aspirin can develop shiny little spikes and smell very sharp. This means it is turning into something else - salicylic acid. Salicylic acid is very irritating and harmful to the stomach, so even if there is no expiry date on aspirin tablets but they look and smell bad - don't take them.



### EYE DROPS AND INJECTIONS

If these products are clear when they are new, they should remain clear and their colour should not change. If particles are floating, or if they have changed colour, don't use them. The chemicals may have begun to change even if the expiry date has not passed.

**It is better to use your own judgment rather than only look at an expiry date.**

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## Feature 1: One Health, One Future: Students' Voices Against AMR

Organised by Third World Network (TWN) & School of Pharmaceutical Sciences, Universiti Sains Malaysia (USM)

Uma Devi, TWN HAIAP

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### One Health, One Future: Students' Voices Against AMR

11 November 2025

**Venue:** Dewan Kuliah X, School of Pharmaceutical Sciences, USM



#### Introduction

On 11 November 2025, in conjunction with World Antimicrobial Resistance Awareness Week (WAAW) 2025, Third World Network (TWN) and the School of Pharmaceutical Sciences at USM organised a One Health workshop to raise awareness about antimicrobial resistance (AMR) and to mobilise youth as agents of change.

The event featured students, speakers, guests, facilitators, and kindergarten children, underlining its multi-sectoral and intergenerational design.

The program addressed AMR through:

**Human health**, via clinical stewardship discussions and infectious disease expertise.

**Animal health**, with veterinary experts talking about antimicrobial use in livestock and the food chain.

**Environmental / water health**, through presentations on how contamination drives resistance.

**Stewardship and youth advocacy**, led by UGAS and student pledges.

**Early childhood education**, via a 'Teddy Bear Pharmacy' to teach medicine safety, hygiene, and AMR concepts to young children.

**Interactive exhibitions**, enabling attendees to engage with AMR science through hands-on learning (pathogen observation, quizzes, games).

This holistic structure reinforced that AMR is a shared, systemic challenge, demanding collaboration across

disciplines and generations. The workshop aimed to empower students and children not only to understand AMR but to become advocates and stewards who can influence behaviour in their communities and future professions.

#### The key objectives of the program were:

- To empower students as frontline AMR advocates by developing their knowledge, responsibility, and leadership.
- To promote the One Health concept, showing how human, animal, and environmental health are interconnected in AMR.
- To raise awareness of rational antimicrobial use in human healthcare, veterinary care, and agriculture.
- To encourage student-led advocacy, using creative means such as pledges, quizzes, videos, social media, and games.
- To build lasting peer engagement, fostering continuous AMR outreach and education on campus and in communities.

#### Highlights

Dr. Lim Mah Hui, Chairman of TWN, opened the event by describing AMR as a 'slow-moving pandemic' and urging students to actively protect the effectiveness of antimicrobials.

Assoc. Prof. Dr. Nurzalina Binti Abdul Karim Khan, Dean at USM's School of Pharmaceutical Sciences, emphasised the role of student ambassadors in driving AMR awareness.

**Keynote Address: 'Antibiotic Resistance is Everyone's Problem'** — Dato' Dr. Chow Ting Soo (Head, Infectious Disease Service, Ministry of Health)

Dr Chow stressed that AMR affects hospitals, communities, farms, and the environment. Everyone has a role in combatting AMR.

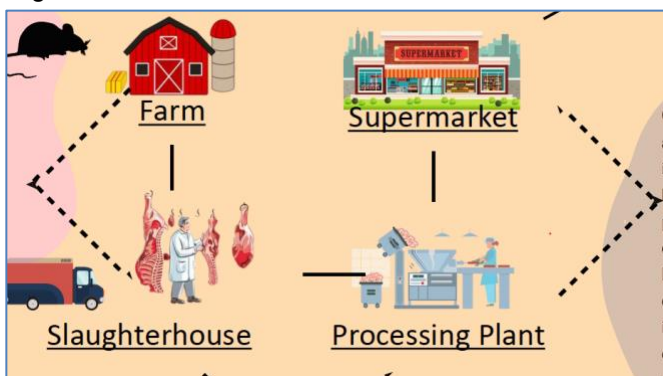
She shared data suggesting that about half of antibiotic prescriptions are inappropriate, that many patients do not complete their antibiotic regimens, and that a large portion of the global population lacks reliable access to essential antibiotics.

She also described how clinician behaviours contribute to overprescribing: some doctors feel pressured to prescribe to validate a visit; others worry about damaging relationships with patients; and some believe certain patients cannot be satisfied without antibiotics.

She concluded by underlining how weak infection prevention and control (IPC) systems accelerate the spread of resistant organisms.

**Prescribing Wisely: AMR and Human Health** — Dr. Ang Peng Peng, Head, Infection and Prevention Unit, Hospital Seberang Jaya focused on rational prescribing, antimicrobial stewardship, and patient-centred care. Dr. Ang suggested shifting the mindset from ‘prescribing wisely’ to ‘practising wisely’ every day, emphasising consistent, thoughtful decision-making.

**Farm to Fork: AMR in Animals and the Food Chain** — Dr Nur Indah Ahmad, Head, Department of Veterinary Pathology and Microbiology, Universiti Putra Malaysia, explored how antibiotic use in livestock drives AMR, and proposed improved monitoring, farming practices, and regulation to reduce risk.



**Water Knows: Environmental Transmission and Water Sanitation** — Dr. Noor Haza Fazlin binti Hashim, Research Officer and Technical Manager, NAHRIM presented research showing antibiotic-resistant bacteria in river water.



She illustrated the issue in an accessible way, joking that one could ‘jump into our rivers ... for the antibiotics,’ highlighting how pervasive environmental contamination can be.

**Towards Prudent Use of Antimicrobials in Animals: DVS Roles and Initiatives** - Dr. Adam Abdullah Kwan, Department of Veterinary Services (DVS) described important 2025 regulatory developments: veterinary antibiotics across the value chain (import, licensing, use) are now more tightly regulated by both the Ministry of Health (via NPRA & Pharmacy Services Bureau) and DVS’s Animal Feed Section (including aquaculture). He also referred to the Poisons (Amendment) Bill 2025, which increases enforcement powers and expands the

definition of ‘premises’ under the Poisons Act. Further, he proposed restrictions on antibiotic raw materials in animal feed starting January 2026, along with a phased reduction in antibiotic use in feed through to 2030, guided by WHO and World Organisation for Animal Health (WOAH) priority lists.

**Youth-led advocacy, safe disposal of unused antibiotics, and ways to engage communities in AMR stewardship** - Mr. Calvin Shee Min Ying, President, United for Global Antimicrobial Stewardship (UGAS) spoke passionately about the role of youth in new leadership.

Together, these sessions reinforced the One Health nature of AMR — showing that regulation, clinical practice, environmental protection, and youth engagement are all essential.

## Side Events

### Teddy Bear Pharmacy: Early health literacy



78 kindergarten children joined this engaging, hands-on activity. Led by educators from USM’s School of Pharmaceutical Sciences and the National Poison Centre, children learned: when antibiotics are and aren’t needed, how to store medicines safely, the concept of ‘germs learning to fight back,’ and the importance of handwashing.

The session used role-play, storytelling, soft-toy ‘patients,’ and games like Germie and Toxland, making the learning process fun yet meaningful.

### Interactive Exhibitions

Exhibits encouraged active learning and reinforced the One Health approach by connecting science with everyday action.

**TWN booth:** Posters, quizzes, and interactive games highlighting global and local AMR issues.

**Biological Sciences booth:** Microscopes for viewing live microbes, helping attendees understand microbial behaviour and resistance in real time.

**UGAS booth:** Demonstrations on safe disposal of antibiotics, hand hygiene, and responsible use.

Exhibits encouraged active learning and reinforced the One Health approach by connecting science with everyday action.

**TWN booth:** Posters, quizzes, and interactive games highlighting global and local AMR issues.

### Participants

Students: 170 (USM & AIMST)  
 Speakers, guests and facilitators: 40  
 Kindergarten Children: 78

### Outcomes and the Way Forward

#### Outcomes:

- Enhanced participants' understanding of AMR across health, animal, and environmental sectors.
- Empowered youth to commit to AMR stewardship, as reflected in pledges and discussions.
- Introduced early AMR literacy among young children through age appropriate education.
- Reinforced practical action through hands-on exhibits and interactive learning.

#### Way Forward:

- Expand the network of student AMR ambassadors across more universities and institutions.
- Scale AMR education into primary schools and kindergartens to build lifelong health literacy.
- Strengthen cross-sector partnerships (healthcare, veterinary, environment) to sustain One Health initiatives.
- Continue youth-led advocacy and peer engagement via social media, campus programs, and community outreach.

### Conclusion: Advocacy and Awareness in AMR Prevention

Antimicrobial resistance is not only a technical biomedical problem — it is a social and behavioural challenge. Sustained awareness, community education, and advocacy are essential to drive behaviour changes that

reduce misuse of antimicrobials. The One Health, One Future programme, by engaging students, children, and youth advocates, translated complex policy discussions into practical understanding and action. This approach aligns with global AMR strategies, such as those promoted by the WHO, which stress the importance of behaviour change and community-level engagement in addressing AMR.

**Play the AMR SLEUTH**

**Case File 1: The Hospital Puzzle**  
 A city hospital reports a sudden increase in infections that no longer respond to the usual antibiotics. The same resistant bacteria are appearing in multiples wards. **Clues:**

- 1. Some patients were given antibiotics "just in case" before lab results came in.
- Medical staff are short-handed, and hand hygiene audits have decreased.
- Cleaning supplies ran low for several days.
- A few patients were transferred from other hospitals.

**?: What factors likely caused the AMR outbreak?**

**Case File 2: The Farm Connection**  
 A rural community is facing an outbreak of resistant E. coli infections. Surprisingly, none of the patients had been in hospitals recently — but all live near several poultry and pig farms. **Clues:**

- Farmers routinely add antibiotics to animal feed to promote growth.
- Animal manure is spread directly on nearby vegetable fields.
- Runoff water from the farms flows into the village stream.
- The resistant E. coli strain found in people matches the one in farm animals.

**?: How did resistant bacteria spread from the farm to people?**

**Case File 3: The Traveler's Mystery**  
 A patient returns from overseas with an infection that resists nearly all antibiotics available locally. Soon, similar cases appear in the same city. **Clues:**

- The patient had surgery abroad.
- No travel screening or infection control measures were done on return.
- The bacteria carry a "super-resistance" gene common in that region.
- Several contacts of the patient also become infected.

**?: What allowed this resistant strain to spread across borders?**

**Case File 4: The Household Hazard**  
 A family reports recurring skin infections that no longer respond to their usual antibiotic cream. Investigators notice similar issues among neighbours. **Clues:**

- Family members frequently use leftover antibiotics for minor cuts.
- Cleaning and personal care products advertise "antibacterial" properties.
- Pets are also given human antibiotics when sick.
- No one completes full antibiotic courses.

**?: What household habits contributed to the resistant infections?**

**Case File 5: The River Riddle**  
 A city's main river tests positive for multiple resistant bacteria species. No hospital wastewater is directly connected — yet resistance keeps spreading. **Clues:**

- Pharmaceutical factory upstream discharges untreated waste.
- Local farms use river water for irrigation.
- Fish and shellfish caught in the river test positive for resistant genes.
- People bathing in the river develop skin infections.

**?: How did resistance spread through the environment?**

**Case File 6: The Kitchen Cluster**  
 A restaurant faces an outbreak of foodborne infections that don't respond to usual antibiotics. Several diners fall ill after eating undercooked chicken. **Clues:**

- Raw chicken is prepared on the same counter as vegetables.
- Meat suppliers report using antibiotics in poultry feed.
- Kitchen staff don't always wash hands between tasks.
- The same resistant Salmonella strain is found in food and patients.

**?: Where did the resistance come from, and how did it reach customers?**

By building capacity, raising awareness, and empowering participants, the event helped nurture a generation of informed, responsible stakeholders committed to preserving antimicrobial effectiveness—showing that advocacy and education are as vital as science in the fight against AMR.



## Assessing the Impact of Antimicrobial Resistance Awareness Interventions Among Schoolchildren in Bangladesh

<https://www.mdpi.com/2079-6382/14/10/979>

S. M. Sabrina Yesmin<sup>1,\*</sup>, A. T. M. Golam Kibria Khan<sup>1</sup> Umme Habiba<sup>2</sup>, S. M. Shanzida Yeasmin<sup>3</sup> and Mohammad Delwer Hossain Hawlader<sup>4,5†</sup>

### Abstract

**Background:** Antimicrobial resistance (AMR) is a critical global health issue. Like other low- and middle-income countries, the misuse of antimicrobial medicine, including widespread self-medication, exacerbates AMR in Bangladesh. Making future generations aware of AMR through educational interventions is an effective tool in combating AMR. This research focuses on understanding the effects of AMR awareness interventions on the knowledge, attitudes, and behaviours of the school children in the selected district of Bangladesh. **Methods:** In this study, 241 students of the 12- to 16-year-old age group participated in a two-day program. The programs include four hours of activities, including participation in reading comics and colouring books, presentations, quizzes, and watching an animation about AMR on the first day, followed by an art competition on the second day. To assess changes in knowledge earlier and after the intervention, pre- and post-tests were conducted. **Results:** This pilot study demonstrates that using age-appropriate interactive educational tools can significantly improve students' knowledge about AMR, showing a mean difference of 1.28 ( $p < 0.001$ ). The regulatory step of the Directorate General of Drug Administration, incorporating red identification marks on antibiotic packaging, makes it easier and shows that 93.36% of students could identify antibiotics, which helps them to be aware of these types of medicines. Interventions were equally effective for boys and girls and science and commerce students, and these helped participants recognise the inappropriate practices of antibiotic use in their daily lives. **Conclusions:** The

interventions in this study identified the importance of incorporating AMR issues into the educational curriculum to address AMR for future generations.

### Conclusions

This study has shown that children are a very effective target population for creating awareness about antimicrobial resistance. If children can be taught about the dangers of antimicrobial resistance from childhood with awareness when they grow up. This will make future generations become more aware of risks associated with self-medication or taking antibiotics without a doctor's advice. Currently, where it is difficult to make people aware of different concepts and to implement awareness programs, which requires a lot of manpower, money, and the involvement of print and electronic media, it is possible to easily create awareness among the entire nation by including the issue of antimicrobial resistance in children's textbooks. Although this will take some time, it is expected to be very effective.

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### Supplementary Materials

The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/antibiotics14100979/s1>.  
 File S1: Survey questionnaires; File S2: Comic book 'Tinu Minu and Super Bug'; File S3: Coloring book 'Invention of Penicillin'; Video S1: Animation of the comic book 'Tinu Minu and Super Bug', [https://drive.google.com/file/d/10Ymj0pazJRbhQzARnisq3sPh\\_eDMTRabh/view](https://drive.google.com/file/d/10Ymj0pazJRbhQzARnisq3sPh_eDMTRabh/view), accessed on 30 July 2025.

## Feature 2: Problems of Medicines and Health Products along Thailand's Borders

Supanai Prasertsuk<sup>1</sup>, Inkaew Singkaew<sup>2</sup>, Pailin Saramon<sup>3</sup>, Pongsak Nata<sup>4</sup>, Sopit Sittiphans,

Niyada Kiatying-Angsulee<sup>6</sup>

### Abstract

IJPS, 2025; 21(2) \*

The distribution and usage of high-risk corticosteroids along Thailand's border areas reveal vulnerabilities in regulatory systems under the complex borderland contexts, affecting public health nationwide. This study aims to understand these phenomena to highlight structural realities and propose appropriate community-level and policy-level solutions.

**Methods:** This qualitative study collected data through literature reviews, field notes, in-depth interviews, and participant observation. The research spanned Thailand's border provinces with Laos, Cambodia, Myanmar, and Malaysia, involving health officials, public health personnel, migrant workers, local vendors, and patients. Data underwent triangulation and thematic analysis, with insights validated through expert consultations between October 2024 and April 2025.



**Results:** Thailand's border regions face significant challenges related to the smuggling of unregulated and substandard pharmaceuticals, notably health products containing banned substances such as dexamethasone. These findings underscore inadequacies in regulatory mechanisms, evident in all Thai border areas despite existing checkpoints. Border areas serve as hubs for medication access among local populations and migrant workers who lack formal health coverage due to systemic inequalities in neighbouring countries. This situation has led to reliance on purchasing medicines from local vendors and markets, with many utilising informal 'YA-CHUD' (a combination of different drugs in the form of a capsule or tablet and packed in small plastic bags) or counterfeit drugs with unknown efficacy.



Overuse of certain drugs, such as Lincomycin injections at clinics, has also been observed.

**Conclusion:** The Landscape of border medicine situation along Thailand's borders highlights critical gaps in regulatory frameworks, particularly for high-risk drugs. Addressing the identified issues requires an understanding of the informal and pragmatic governance evident in these areas, where illegal but socially accepted practices persist alongside the transboundary movement of people, goods, and cultural practices. Recommendations include improving regulatory processes, leveraging surveillance technologies, fostering international collaboration, and empowering border-area volunteers to enhance public health and state security sustainably.

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## Addressing Thailand's cross border challenges associated with the movement of unsafe medicinal products.

Beverley Snell, Niyada Kiatying Angsulee, Supanai Prasertsuk, Sopit Sittiphang, Panupmg Putyurak

Awareness of the distribution and use of high-risk and poor quality medicinal products including corticosteroids along the Thai borders arose as far back as 2013.

Thailand shares borders with four countries: Myanmar, Laos, Cambodia, and Malaysia. Neighbouring countries such as China, Vietnam, and Singapore also have close borders. The ASEAN community inevitably lead to greater movement of people and cultural exchange. Therefore, it became necessary to study the movement of medicines in these areas, as well as the impact of movement on lifestyles, culture, healthcare, and pharmaceutical systems.

At the border, there are various systems or measures for managing incoming and outgoing goods. They include permanent, formal checkpoints, temporary border crossings, and natural or cultural checkpoints. There are many agencies in authority, including the Customs Department, Immigration Checkpoints, Food and Drug Administration, the military, border patrol police, and local agencies under the Ministry of Interior.

Currently, the Thai Food and Drug Administration (FDA) has a total of 44 food and drug checkpoints nationwide. 15 are located in Bangkok and its surrounding areas, 8 in the North, 6 in the Northeast, 2 in the East, and 13 in the South. Some are under the direct supervision of the FDA, while others have functions delegated to the Provincial Public Health Offices. The FDA frequently complains of insufficient personnel. Surveys reveal that some FDA checkpoint officers oversee two checkpoints, making comprehensive oversight impossible, especially when strict consumer protection measures are in place. Numerous goods, including food, consumer products, forest products, smuggled goods, steroids, and narcotics, are swept across the border.

The Thai Pharmaceutical Association (TPA) supports local pharmacists, known as border pharmacists, to monitor the drug system at border areas. It is essential that a network of healthcare professionals, especially pharmacists, form groups to exchange information and experiences, conduct surveillance in their areas, and engage in community work. Problems at border checkpoints are very difficult to solve and require specialised expertise. Border agencies need to work in an integrated manner, overseeing both incoming and outgoing trade while balancing economic considerations and consumer protection.

Thailand's border areas serve as hubs for medication access among local populations and migrant workers who

lack formal health coverage due to systemic inequalities in neighbouring countries. In addition products can 'travel' to become available to the wider populations.

Lack of appropriate access to safe essential medicines and health services has led to reliance on purchasing medicines from local vendors and markets, with many utilising informal 'YA-CHUD' (a combination of different drugs in the form of a capsule or tablet and packed in small plastic bags) as well as the questionable available



products and counterfeit drugs with doubtful efficacy.

Overuse of certain controlled medicines, such as Lincomycin injections at clinics, has also been observed (Prasertsuk. S, et al 2025 in Thai).

The sorts of products under investigation include food supplements, 'medicines' themselves, medicinal and herbal supplements adulterated with poisonous substances or spiked with dangerous or controlled substances or contaminated with dangerous ingredients such as heavy metals. Products can contain approved medicines but in excess of the recommended doses or in harmful combinations. Cosmetics can be contaminated with mercury or other dangerous ingredients. Products might contain excipients that are not permitted in Thailand or the content of food colourings are not compliant with Thai law. Coffee has been found to contain sildenafil or other phosphodiesterase type 5 (PDE5) inhibitors.

The work of the investigators has revealed many issues requiring attention. Besides the widespread sale of drug kits in convenience stores, pharmacies, and clinics along the border, there is the export of over 100 million steroid pills annually to neighbouring countries, coupled with significant smuggling of steroids from China, along with herbal and traditional medicines. It is believed that a large amount of steroids were secretly mixed in.

Labels are usually incomplete, whatever the language they are written in.

As part of investigations, literature reviews have been undertaken, field notes gathered, in-depth interviews conducted; and participants have recorded their observations.

Activities have been conducted in grocery shops, teashops, clinics, pharmacies, customs warehouses, in

Thailand's border provinces with Laos, Cambodia, Myanmar, and Malaysia.

Investigations are carried out by pharmacists, health officials, public health personnel, migrant workers, local vendors, and patients.

Between October 2024 and April 2025 information gathered was examined and data underwent triangulation and thematic analysis, with insights validated through expert consultations. Information was analysed so the phenomena and structural realities could be understood. Understanding could lead to the development of appropriate community-level and policy-level responses and solutions.

Addressing the identified issues requires an understanding of the informal and pragmatic governance evident in these areas, where illegal but socially accepted practices persist alongside the transboundary movement of people, goods, and cultural exchanges.

The findings underscore inadequacies in regulatory mechanisms, evident in all Thai border areas despite existing checkpoints.

Recommendations include improving regulatory processes, leveraging surveillance technologies, fostering international collaboration, and empowering border-area volunteers to enhance public health and state security sustainably.

To promote understanding of the issues and to develop a strategy to deal with the problems that would be identified a Goodwill Committee meeting was organised in Krabi, in the southern province not far from the Malaysian border, between July 21 and 23, 2025.

At the conclusion of the meeting plans were made for the development of an App that would guide activities and responses; and for ongoing collaboration between the involved authorities.

Collaboration with Malaysia through the National Malaysian Poisons Centre and USM is being explored.

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**Examples of incidents involving the smuggling of drugs and pharmaceutical chemicals, including steroids, in the north-eastern region.** (Source: Border Crossing and Situation on Problems of Medicine and Health Products along Thailand's Borders – the Case of Corticosteroids Prasertsuk S. *et al.*)

On November 15, 2016, Nong Khai Customs, in cooperation with Nong Khai Food and Drug Administration, Officers, inspected a public bus at the Thai-Lao Friendship Bridge at the international inbound bus inspection point. They found a plastic bag with cartoon designs inside the bus, with no one claiming ownership. Upon opening the bag, they discovered white plastic bottles labelled Dexamethasone and Piroxicam, totalling 170,000 tablets. These were confiscated. In Loei Province, steroids with Chinese labels were found smuggled across the border from Laos. A Hmong vendor was selling them at the border market in Chiang Khan District. The Loei Provincial Public Health Office investigated and prosecuted the case. They found steroids with Chinese labels, drug combinations, and other unregistered medications. The Hmong vendor stated that she brought the drugs from Laos to sell to both Thai and Lao citizens.

In Mukdahan province, at the Thai-Savannakhet border crossing, Mukdahan Customs and Food and Drug Administration (FDA) officers discovered the smuggling of unregistered drugs, including steroids with Chinese labels, along with a quantity of drug sets from a Vietnamese female vendor. She confessed to selling the drugs primarily to sick Vietnamese citizens and not to Thais. However, information indicates that similar drugs are also being sold in pharmacies in Mukdahan city.

In **northern Thailand, specifically** in Wiang Kaen and Chiang Khong districts of Chiang Rai province, steroids are widely available at border markets. Initial investigations reveal that they are sold to Thai citizens, both retail and wholesale, as well as to Hmong and Lao people who cross the border to buy and sell goods at the markets. In Chiang Rai province, Chiang Saen and Chiang Khong have large border checkpoints with a high volume of goods from China.

Customs officials and pharmacists from Somdej Phra Yuparat Chiang Khong Hospital (and Food and Drug Administration officials) conducted a search and discovered a Vietnamese female vendor smuggling pain relievers, steroids, and NSAIDs from Vietnam and China into Thailand. These drugs were not registered or authorised in Thailand, and the intended target was Chiang Mai city.

On the Lao PDR side, in Bokeo Province, Lao officials had discovered a quantity of sibutramine that was about to be smuggled across the border into Thailand (but it was unsuccessful and was discovered by Lao authorities beforehand – Lao PDR's drug laws include regulations controlling drug exports).

**Eastern Region** The primary care pharmacist network reported data from home visits in Mueang District, Trat Province, revealing patients using steroid medications with Chinese labels, a practice similar to that found in many other areas of the country. Information indicates that many drugs are targeted for urban areas such as Chiang Mai and Chiang Rai, and in some areas, unregistered steroids are found for sale, even in villages in central Trat province. Furthermore, border areas aren't solely plagued by steroid smuggling; unregistered steroids (the same type widely prevalent in Thailand) are also being smuggled across the border into neighbouring countries.

## Pharmacy Implementation

1. Inspect health products and advertisements
2. Collect samples of suspected health products to the official laboratory for analysis
3. Check suspected substances in health products with test kits
4. Public relations (PR) and consumer warning
5. Consumer Education



## inspections for grocery stores and tea shops by public health officers and volunteers



## Inspection of health products in grocery stores

- Pharmacist, Sungaikolok FDA check point, Narathiwat Provincial Public Health Office
- Pharmacists and Public Health Officers in Health consumer protection Department, Narathiwat Provincial Public Health Office.



## Kolok Customs House seizure of smuggled products that are harmful to health



## Unregistered laxative drug resale as dietary supplement



## Public Relations & Consumer Education



## Some examples of products found in Thai border provinces

**Weight gain vitamins:** detected dexamethazone and cyproheptadine

**Kokando Detox Supplement:** detected bisacodyl

**Cosmetics - Collagen plus Vitamin E Day and Night Cream:** detected mercury

**Natural herbs and coffee:** detected sildenafil, tadalafil, vardenafil

**Chinese herbs:** detected dexamethazone

**Food colouring:** non compliance with Thai standards

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## Philanthro-capitalism will not save the World Health Organisation

Vivek ND.

TWN *Third World Resurgence* Issue 364 2025, Page 4.

WHO's growing dependence on funding from wealthy private entities is skewing global health priorities and undermining democratic accountability.

In the past two decades, global health governance has undergone a quiet revolution, shaped less by sovereign states and more by the growing influence of private capital. The World Health Organisation (WHO), once envisioned as the democratic engine of international public health, has increasingly come to rely on large-scale philanthropic foundations. This shift towards what is now commonly termed 'philanthrocapitalism' – where billionaire-funded entities use business strategies and methods to tackle social and environmental challenges – has profound implications. It is not just a matter of money, but of power, accountability and legitimacy.

Amid what many now describe as a global health financing emergency, WHO's growing dependence on a handful of wealthy private actors has exposed deep cracks in the system of multilateralism upon which it was founded. Thus, philanthrocapitalism is undermining democratic global health governance by concentrating power in the hands of the wealthy and eroding public accountability.

### Philanthrocapitalism and WHO's financial shift

When WHO was established in 1948, its financing rested primarily on assessed contributions – mandatory payments from member states calculated by metrics such as gross domestic product (GDP) and population. These payments formed the backbone of its budget and enabled the organisation to pursue independent, needs-based global health priorities. But by the 1990s, austerity-driven reforms and dwindling political interest in global public goods led to a freeze – and in some cases, a rollback – of these core state contributions.

Into this vacuum stepped philanthropic foundations, corporate-linked charities and other non-state actors, who began offering voluntary contributions. Today, these voluntary funds make up over 80% of WHO's budget. The vast majority are earmarked – meaning that donors, not WHO, decide how and where the money is spent.

This is where the logic of philanthrocapitalism takes hold. According to WHO's Program Budget Portal for 2024–2025, the Gates Foundation is currently the largest donor, providing over \$763 million or 13.16% of voluntary contributions to WHO. The second largest contributor is another private actor, the GAVI Alliance which contributed \$645 million or 11.61%. Notably, over 90% of the Gates

Foundation's donations were earmarked for specific diseases or technical programs, rather than WHO's core functions. In May 2025, the Novo Nordisk Foundation pledged \$57.76 million to WHO. Through its holding company Novo Holdings, the Denmark-based Novo Nordisk Foundation owns Novo Nordisk, which made \$42 billion in sales in 2024 from drugs like Ozempic and Wegovy, using the profits to fund scientific, social and humanitarian grants.

To regulate these interactions, WHO adopted the Framework of Engagement with Non-State Actors (FENSA) in 2016. It was designed to establish guardrails for interactions with philanthropic and corporate entities. But FENSA has proven largely toothless. The framework has been inadequate for managing the vast power asymmetries between sovereign governments and mega-donors like Gates or the Rockefeller Foundation. In effect, it treats all 'non-state actors' equally, even though only a handful control the majority of voluntary financing.

### Funding gaps and the distortion of global health priorities

This structural imbalance now sits at the heart of WHO's growing crisis. WHO revealed it is falling nearly \$1.9 billion short of the planned \$4.2 billion budget for 2026–27, with an additional \$600 million deficit projected through the end of 2025. These resources are needed to support essential global health functions such as disease surveillance, regulatory coordination and health system strengthening. At the same time, its earmarked programs – targeting diseases like polio, malaria and COVID-19 – are flush with resources. The result is a misaligned institution, overfunded for technical verticals and underfunded for horizontal public health priorities. This distortion is not an accident – it is a direct outcome of the political economy of philanthrocapitalism.

Philanthropic foundations, under the guise of neutrality and technical problem-solving, increasingly undermine democracy by using their wealth to shape development agendas, weaken public institutions, depoliticise structural issues like poverty and bypass democratic accountability – all while benefiting from tax privileges and promoting a corporate-driven vision of global change.

Philanthropic foundations tend to favour technical, vertical programs with measurable results – such as eradicating polio or developing a vaccine for a specific disease – over systemic, long-term investments like public health workforce training or community-based care. The Gates Foundation's focus on malaria, polio and tuberculosis exemplifies this phenomenon. GAVI's funding model follows suit, focusing heavily on vaccine procurement and delivery while underemphasising the broader ecosystem of primary healthcare infrastructure.

## The political risks of philanthrocapitalist dependency

Moreover, the ideologies embedded within philanthrocapitalist giving emphasise efficiency metrics and public-private partnerships – concepts borrowed from business strategy rather than social justice. Thus, philanthrocapitalism is entrenching a neoliberal development agenda by enabling elites to dominate and direct global policy priorities. GAVI, largely created and funded by Gates, has promoted a model of vaccine distribution that relies on corporate manufacturers and intellectual property protections. During the COVID-19 pandemic, GAVI co-led COVAX, a global vaccine-sharing initiative intended to ensure equitable distribution. Yet COVAX was criticised for failing to deliver on its promises, as high-income countries hoarded early vaccine stocks and patent waivers were fiercely resisted.

Beyond the structural distortions, there are real political risks. The rise of philanthrocapitalism and impact investing reflects a broader shift in development financing, where public aid is increasingly privatised and aligned with financial sector interests, allowing elites to reshape global development agendas under the guise of innovation and efficiency.

As more governments retreat from public financing, WHO becomes even more dependent on philanthropic largesse. This situation can become a vicious cycle. Governments, seeing WHO's needs met through private donors, feel less obliged to contribute themselves. But when philanthropic funding priorities shift – as they inevitably do – WHO is left vulnerable. Its ability to respond to emerging crises, strengthen health systems or tackle neglected areas like mental health and climate-related diseases is hobbled.

### Conclusion

None of this is to say that philanthropic contributions are inherently harmful. The generosity of donors like Gates, Wellcome and Bloomberg has undeniably saved lives and accelerated innovation. But the political consequences of allowing billionaire-backed foundations to shape the priorities of a multilateral public institution must be confronted honestly. These actors operate with minimal transparency, are not subject to democratic oversight and often mirror corporate values that are ill-suited to addressing the structural inequalities at the heart of global health.

Ultimately, WHO's crisis is not merely financial – it is a crisis of governance, of legitimacy and of global solidarity. Philanthrocapitalism may provide resources, but it cannot replace the foundational idea that global health is a public good, to be protected and promoted through democratic multilateralism. The more WHO becomes a vehicle for donor-defined agendas, the more it drifts from the universal mission upon which it was founded.

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## Should drug companies be allowed to run 'awareness' ads for conditions their drugs treat? Five experts were asked.

from *The Conversation* October 24, 2025

<https://tinyurl.com/4u55j9ab>

Unlike in the United States and New Zealand, it is illegal in Australia to advertise prescription medicines directly to the public. The main idea is to avoid demand for a drug that may not be appropriate, but which doctors may feel under pressure to prescribe.

Drug companies can get around this restriction by running 'awareness' ads that indirectly promote their products.

For instance, we're currently seeing ads raising awareness about weight loss that don't mention the names of specific Ozempic-style drugs. Instead, these ads recommend you speak to your doctor about your weight. The doctor will have been visited by the company representative promoting prescription of the drug.

The main argument for such awareness ads is they encourage people to seek help from their doctor, rather than suffer from symptoms they might have been embarrassed about, or have not been able to address themselves.

Novo Nordisk and Eli Lilly – who make weight-loss drugs – told the ABC recently that their campaigns were trying to raise awareness of obesity as a chronic disease.

The main counterargument is that awareness ads act as drug promotion in disguise.

So, should pharmaceutical companies be allowed to run awareness ads for diseases or conditions their drugs treat?

**We asked five experts. Four out of five said no. Here are their detailed answers.**

### Barbara Mintzes

Professor in Pharmaceutical Policy, School of Pharmacy and Charles Perkins Centre, University of Sydney

No.

These obesity ads are clear examples of why drug companies should not be allowed to run disease-awareness ads. Even if they don't name the drug, this is still product promotion, pure and simple. Disease-awareness ads stimulate sales. In one long-term analysis from the United States they had stronger effects than ads with product names.

Unlike public health messages, these latest obesity ads say diet and exercise are ineffective. Dieting isn't perfect: people often gain weight afterwards. Then again, people

gain weight after stopping obesity drugs. The drugs aren't perfect either, but that message is nowhere to be seen.

Disease-awareness advertising also distorts how the 'disease' or health condition is presented – by framing the condition in terms of the product it aims to sell.

For obesity drugs, this means calling obesity a chronic disease. This shifts attention away from social causes and solutions, such as curbing advertising of unhealthy foods.

Public health messages need to be truly independent of commercial interests.

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**David Menkes**

Associate Professor in Psychological Medicine, University of Auckland, Waipapa Taumata Rau New Zealand

No.

In essence, this boils down to a marketing strategy to promote sales of usually new, expensive drugs.

Why is this a problem? Most wealthy countries, including Australia, prohibit marketing prescription medicines directly to consumers due to concerns about costly and unnecessary treatment, drug-related harms, and distortion of the doctor-patient relationship.

'Awareness' advertising skirts this restriction by omitting mention of specific products. These ads shouldn't be allowed because, as wolves in sheep's clothing, they pose essentially the same risks as 'full' direct-to-consumer advertising, where drug names are mentioned.

Controversially, New Zealand and the US continue to allow marketing of named prescription drugs directly to consumers. NZ practitioner and consumer groups have tried to ban the practice, but have encountered fierce pushback from the pharmaceutical industry. This is unsurprising given its effectiveness in prompting patients to seek prescriptions.

Disease awareness, like pharmaceutical information, should be regarded as a public good, free from the bias of corporate marketing.

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**Fiona Willer**

Lecturer, Dietitian and Bioethicist, Queensland University of Technology

No.

The reason flaws exist to ban companies marketing prescription medicines directly to consumers is to uphold the public's trust.

When you go to the doctor you want to be sure you're receiving evidence-based, unbiased advice. Australians already receive trustworthy health and wellbeing advice from their GP and allied health professionals, including accredited practising dietitians.

Allowing drug companies to rebrand the term 'obesity' and overtly medicalise body size, exploit societal fears, dismiss size inclusivity and market their 'solutions' via 'awareness' ads undermines the integrity of these relationships.

We need public health information – on a whole range of conditions and diseases – to be run by public health authorities, and void of any real or perceived conflicts of interest.

We don't need drug companies inserting their agendas into the very private conversations we have with our health-care providers.

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**Ray Moynihan**

Senior Research Manager, University of Sydney and Honorary Assistant Professor, Bond University

No.

Drug companies have a duty to their shareholders to maximise markets for their medicines. Company-sponsored 'disease awareness' campaigns are designed to expand sales of the newest, most profitable products, by turning people into patients.

For decades, these marketing campaigns have been transforming the common experiences of human life into signs and symptoms of diseases and conditions. Shyness becomes social anxiety disorder, sexual difficulties become dysfunctions, and higher weight is framed as a disease called obesity.

The obvious problem is overdiagnosis, when too many people end up with diagnoses and treatments that can cause them more harm than good.

Unnecessary care is now recognised as a major threat to both human health and the sustainability of health systems, taking precious resources from those who need them most.

Industry's promotion, including their 'disease awareness' campaigns, is an important driver.

Banning drug company-funded 'disease awareness' campaigns would be an extremely healthy step forward.

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**Jennifer Power**

Principal Research Fellow, Australian Research Centre in Sex, Health and Society, La Trobe University

Yes.

But only when awareness raising is clearly in the public interest and supports a broad approach to health promotion.

For health issues that carry a high level of stigma, such as HIV, shame and embarrassment can be major barriers to people engaging with prevention, testing or treatment. When done well, awareness campaigns can help overcome this.

For example, in Australia, multiple social media campaigns have helped promote and normalise uptake of pre-exposure prophylaxis (PrEP) medication as a valid option to prevent HIV.

These campaigns, which were not run by pharmaceutical companies, were sex-positive and avoided negative or fear-based messaging which heightens stigma.

Pharmaceutical companies have the resources to run large campaigns that raise awareness of new treatments and prevention options for HIV and other stigmatised conditions.

This could be effective if regulations are in place to ensure these campaigns align with health-promotion priorities and community interests, rather than being solely designed to increase sales.

#### **Disclosurers:**

Barbara Mintzes receives research funding from the National Health and Medical Research Council (NHMRC). She is also an expert witness for the Therapeutic Goods Administration. She is General Secretary of the International Society of Drug Bulletins (ISDB), Associate Editor of the UK Drug & Therapeutics Bulletin, and a member of Health Action International (HAI-Europe) and HAI Asia Pacific

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## **Australia must resist US blackmail on wholesale medicine prices**

<https://mailchi.mp/aftinet/wins-on-labor-trade-policy-and-webinar-video-on-corporations-suing-governments-5861893?e=5751601d91>

Following reports that the British government has agreed to a 25% rise in the wholesale price of medicines to remove a threat of a hundred per cent tariffs on British medicine exports to the US, the Australian government has said it is conducting similar negotiations with the US.

“The Australian government should keep its promise that the Pharmaceutical Benefits Scheme (PBS) will continue to provide access to medicines at affordable prices and will continue to regulate the wholesale price of medicines,” said Dr Patricia Ranald, AFTINET convener.

Dr Ranald explained that the PBS is economically sustainable because the Australian government negotiates with pharmaceutical companies to set the wholesale price of medicines based on both medical effectiveness and value for money in return for listing

them on the PBS, which provides a guaranteed market. The government then subsidises the price at the chemist at \$7.70 for pensioners and \$31.60, for others, which is due to be reduced to \$25 on January 1, 2026. The annual cost of the PBS is \$22.586 billion.

“The Australian government should not agree to a 25% rise in the wholesale price of medicines as the British government appears to have done. This is simply enriching pharmaceutical companies who are already amongst the most profitable in the world, and will put unacceptable pressures on Australia's health budget,” said Dr Ranald.

“The claim that US consumers are subsidising lower prices in other countries is simply a lie. The truth is that the US is the only advanced industrialised country that does not have a system to regulate the wholesale price of medicines. US Pharmaceutical companies charge high wholesale prices, which are then passed on to consumers, and many people without private health insurance cannot afford medicines. The US government and pharmaceutical companies are using tariff threats to force other governments to raise wholesale prices to the US level,” said Dr Ranald.

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## **Special Issues in Pharmacovigilance in Resource-Limited Countries**

Edited by Syed Rizwanuddin Ahmed

<https://link.springer.com/book/10.1007/978-981-96-6154-1>

### **About this book**

Examining the state of pharmacovigilance systems in resource-limited countries, this book addresses the critical role that pharmacovigilance systems play, as drugs and vaccines become increasingly accessible in these settings. Issues unique to these countries are explored, including medical product safety and quality problems, the nature of support needed to build pharmacovigilance system capacity to effective level, global and regional strategies and efforts to develop institutional and professional capacity; the challenges being faced and how these are being tackled. This book is a must-read resource for anyone involved in the provision of safe, and quality medical products; and its rational use in resource-limited settings, including staff of pharmacovigilance centres, regulatory authorities, academia, contract research organizations, the pharmaceutical industry, donor agencies and technical assistance providers.

*The editor has built an exceptional and well-balanced pharmacovigilance compendium. The individual chapters by experts provide a valuable resource of national and regional pharmacovigilance experiences. A very good read not only for pharmacovigilance professionals in RLCs, but also for donors and other international organisations.*

Hubert G Leufkens, PhD, FISPE, Professor of Pharmaceutical Policy and Regulatory Science, Utrecht Institute for Pharmaceutical Sciences (UIPS), Former Head of the Dutch regulatory agency (MEB), The Netherlands.