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

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HAI AP News

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HAI AP Est. 1981

Health Action International (HAI) was formally founded in Geneva in 1981 and coordinated initially from Penang. In 1995 Health Action International Asia Pacific (HAI AP) was formed in the Asia Pacific Region as part of the international collaborative network to increase access to essential medicines and improve their rational use through research excellence and evidence-based advocacy. HAI AP is committed to strive for health for all now in line with the Peoples' Health Charter. *HAI AP News* is the official newsletter of Health Action International – Asia Pacific and presents the happenings in the regional campaigns for more rational and equitable health policies and carries material in support of participants' activities.

In this issue

This issue covers a wide range of topics.

HAIAP expresses solidarity with our health workers colleagues on the front lines. We cannot remain silent while the principles of neutrality and humanity, the very foundations of healthcare, are being ignored. Dr Ayesha Jihangir explains the need for peace journalism.

Thank you Uma Devi, Dr Ekbal, Tanveer Ahmed, Delen, Tariq Islam, Kris Weerasuriya, for your contributions. Congratulations Comrade Dzul on receiving the Wu Lien-Teh Award for Public Health activism.

World Health Day April 7 was celebrated in Philippines and at Gonoshasthaya Kendra and the late Dr Zafrullah Chowdhury received the Bangladesh Independence Day Award from the Government..

Dr B Ekbal has published a remarkable book *'From Plague to Covid 19: Exploring the Nexus of History, Science, Literature and Human Resilience.* A description of the book is included.

World TB Day is noted and a historic timeline of the introductions of vaccines is provided. The continuing struggle against global inequity of access to vaccines is highlighted.

AMR is documented and we share current information about Nipah virus.

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

Peace is a fundamental, essential condition for realising the right to health and protecting human rights

Health workers in war zones face immense dangers, including targeted violence, death, and detention, leading to unprecedented levels of trauma and health system collapse. Health worker deaths are extreme in high-intensity conflicts in regions like Gaza, Sudan, Lebanon and Ukraine, where professionals operate under severe shortages of resources and high mortality risks.

We in HAIAP stand in solidarity with our colleagues on the front lines. We cannot remain silent while the principles of neutrality and humanity, the very foundations of healthcare, are being ignored.

Across the world, including in Gaza, Lebanon, Sudan, Ukraine, and other war-torn regions, healthcare facilities are being deliberately targeted. Nurses, midwives, doctors, and aid workers risk their lives daily to deliver lifesaving care, yet they are being bombed, abducted, or killed simply for doing their jobs. These attacks violate international humanitarian law, including the Geneva Conventions, which clearly mandate the protection of civilians, medical staff, the wounded and sick, and humanitarian workers in times of war.

Despite international laws (such as the Geneva Conventions) that require the protection of medical personnel and ambulances, the targeting of health workers continues, creating massive gaps in care and contributing to disease outbreaks.

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Conflict deepens health crisis across the Middle East

WHO March 11, 2026

https://www.who.int/news/item/11-03-2026-conflict-deepens-health-crisis-across-middle-east--who-says#:~:text=In%20Iran%2C%20WHO%20has%20verified,16%20deaths%20and%2029%20injuries.

Beyond the immediate impact, the conflict is creating wider public health risks. Current estimates indicate more than 100,000 people in Iran have relocated to other areas of the country due to insecurity, and up to 700,000 people have been internally displaced in Lebanon, with many in crowded collective shelters under deteriorating public health conditions, with limited access to safe water, sanitation, and hygiene. These conditions increase the risk of respiratory infections, diarrhoeal diseases, and other communicable illnesses, especially for the most vulnerable populations, such as women and children.

Environmental hazards are also a rising concern. In Iran, petroleum fires and smoke from damaged infrastructure exposed nearby communities to toxic pollutants that potentially cause breathing problems, eye and skin irritation, and contaminated water and food sources.

Access to health services is becoming increasingly constrained across several countries. In Lebanon, 49 primary health care centres and five hospitals have shut following evacuation orders issued by Israel's military, reducing the availability of essential services as medical needs rise.

In the occupied Palestinian territory, increased movement restrictions and checkpoint closures are delaying ambulance and mobile clinics' access across several governorates in the West Bank. In Gaza, medical evacuations have been suspended since 28 February, while hospitals continue to operate under strain amid ongoing shortages of medicines, medical supplies, and fuel, which is being rationed to prioritise essential health services, including emergency and trauma care, maternal and neonatal services, and communicable disease management.

Temporary airspace restrictions have disrupted the movement of medical supplies from the WHO's global logistics hub in Dubai. More than 50 emergency supply requests, intended to benefit over 1.5 million people across 25 countries, are affected, resulting in significant backlogs. Current priority shipments include supplies planned for Al Arish, Egypt, to support the Gaza response, as well as Lebanon and Afghanistan. The first shipment, containing cholera response supplies for Mozambique, is expected to depart from the hub in coming weeks.

The escalation comes at a time when humanitarian needs in the Eastern Mediterranean Region were already among the highest in the world. Across the Region, 115 million people require humanitarian assistance – almost half of all people in need globally – while humanitarian health emergency appeals remain 70% underfunded.

Without protection for health care, sustained humanitarian access and stronger financial and operational support for the humanitarian health response, the strain on vulnerable populations and already fragile health systems will continue to grow.

WHO calls on all parties to protect civilians and health care, ensure unimpeded and sustained humanitarian access, and pursue de-escalation of the conflict so communities can begin to recover and move towards peace.

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Croakey Health Media is an innovative non-profit public-interest journalism organisation focused on public health, health equity, and the social determinants of health.

On April 8, the Medical Association for the Prevention of War (Australia) and *Croakey* convened a #CroakeyLIVE webinar to explore the importance of peace for health as part of its ***'Peace for Health, Health for Peace'*** theme.

These were among the key points made by speakers at the webinar:

- At a time of unrelenting violence, chaos and disinformation, the health sector has been urged to actively promote peace, confront powerful lobbies like the weapons industry, and highlight the huge toll that war and conflict are inflicting upon millions of people and the health of the planet.
- Journalists must also interrogate and transform their coverage of war and conflict to ensure they provide more in-depth coverage of its impacts upon health and healthcare, and consider whether their work is contributing to peace-making or violence.

Peace journalism

Dr. Ayesha Jehangir*, spoke to the webinar about the scale and depth of war being unevenly experienced across the globe by different people, in different places, at different times.

She is a journalism lecturer at the University of New South Wales (Australia), studying the mediation of human suffering in war and conflict zones, reparative and peace journalism, and the decolonisation of war and conflict reporting.

Ayesha Jehangir writes:

Every week before my journalism class begins, I acknowledge Country. Then I move to a slide that often carries a small gesture of solidarity with people living through war.

Sometimes it is a collage of journalists killed in Gaza – faces that once filled newsrooms but are now memorialised in press freedom reports. Sometimes it is an aerial image of Gaza or Ukrainian neighbourhoods reduced to grey rubble. Other weeks, it is simply a number: the tally of days Afghan girls have been barred from school under Taliban rule.

The intention is not to shock my students. It is to remind them that journalism does not exist in a vacuum.

While we sit in a lecture theatre discussing ethics, news values and audience engagement, journalists and civilians elsewhere are living the realities these concepts are meant to capture. Will a journalist assist them in an emergency? Is their personal suffering worthy of attention? Will their testimony compel people to watch?

At first, these slides often sparked thoughtful conversations. Students asked about the safety of journalists in war zones. They debated the responsibility of news organisations to document atrocities. Sometimes the room fell quiet in a way that signalled they were genuinely thinking.

But over time, something else became visible.

The discussions grew shorter. The silence felt different. Instead of reflective stillness, I sometimes saw blank faces. Their expressions did not suggest indifference or disinterest, but emotional fatigue.

My students are not apathetic. Many care deeply about global injustice. They speak passionately about human rights, climate change and inequality. They are thoughtful, politically aware, and often more globally informed than students were even a decade ago.

Curious, I asked what was happening. To my surprise, several students said they worried that growing up in a media environment saturated with images of suffering was making them feel 'immune to watching violence'.

But is it only the constant witnessing of suffering that is making them seem distant?

Violence is the message

In 1964, Canadian philosopher Marshall McLuhan famously argued that 'the medium is the message'. He explained that the technology or platform through which information is delivered, such as television, newspapers, social media, and smartphones, changes how people perceive and experience that information.

In other words, every medium alters human perception and behaviours. McLuhan explained that a photo of war casualties in a newspaper can feel serious and reflective, while on television, it may feel immediate and dramatic. Now, on social media, it may appear between memes and ads, making it easier to scroll past.

Sixty years after McLuhan’s declaration, something else may be happening.

Photographs of lifeless or wounded children pulled from rubble now appear on our screens so constantly that it’s becoming hard to tell whether the scenes are from Lebanon, Gaza, or Iran and how they were captured, and harder, later to remember where you saw them.

They disappear faster than they appeared, and another image of destruction replaces them. The breaking news cycle is cruel by design to capture your momentary attention.

The news of the deadly US missile strike on a girls school in Iran’s Minab city, where more than 165 people, mostly schoolgirls, were killed, was soon replaced by commentary on whether it was an Iranian Shahed or a US Tomahawk missile that hit, and then whether the target was the Islamic Revolutionary Guard Corps (IRGC) naval base adjacent to the school.

US lobbyist Matt Schlapp even went so far as to defend the missile attack, saying in a news interview that *'Iranian schoolgirls are better dead than alive in a burqa.'*

Meanwhile, the US officials have been repeatedly, almost mechanically, repeating 'short-term pain for long-term gain' in their media appearances to justify the unjustifiable war on Iran to the American public.

In such an environment, the problem is no longer only the medium. Violence itself risks becoming the message.

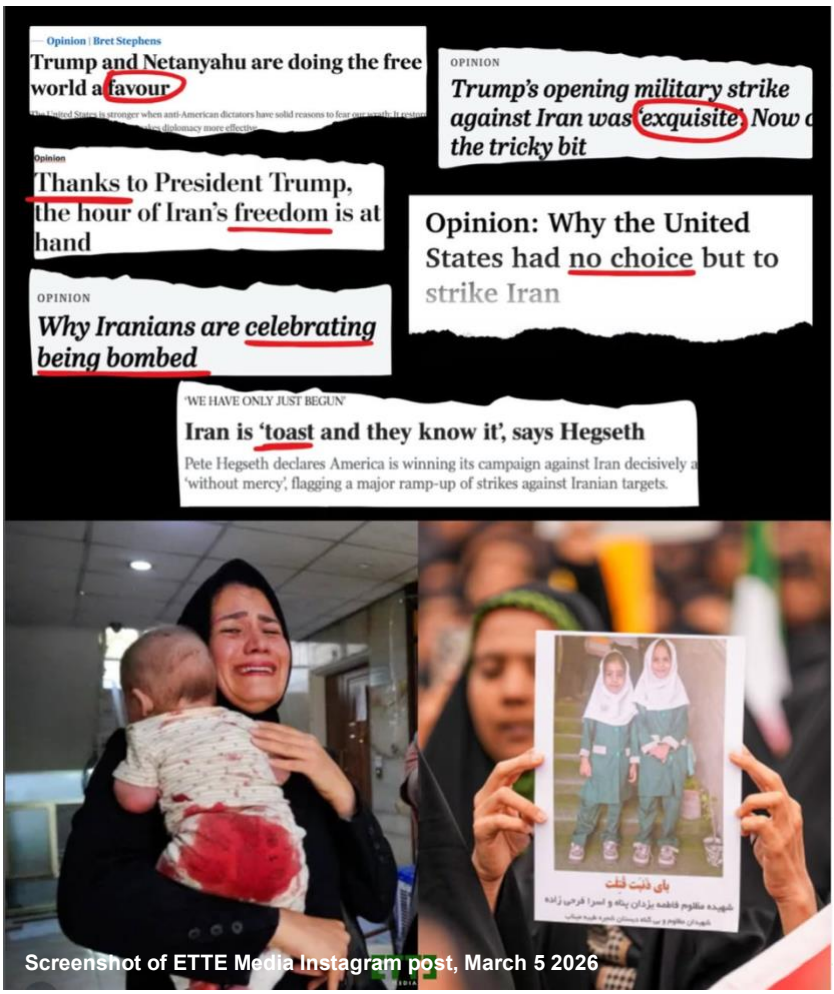
And this message appears on our screens with unsettling regularity, amplified by pop culture until war and violent drama become inseparable, as in the Whitehouse's bizarre video promos for its Iran campaign, posted on its official YouTube channel.

The devastating images and the messages our screens carry are no longer exceptional interruptions to everyday life; they signal that violence is normal and inevitable.

The fault is in the broader structures of governance and social power that normalise violence.

A recent Australian study notes that societies, especially children and young people, are not simply witnesses to violence. Rather, they are shaped by environments in which 'sanctioned violence' – violence that is socially, politically, or institutionally legitimised – becomes normalised.

This situation poses a terrifying question: Are news media gradually conditioning us to absorb violence and suffering into the background of everyday life? Or as my student asked, 'are we becoming immune to watching violence?'



Screenshot of ETTE Media Instagram post, March 5 2026

How media normalise violence

It has long been argued that repeated media exposure to distant suffering can produce a paradox: audiences feel morally compelled to care while simultaneously becoming overwhelmed by the scale and repetition of what they see.

There is a phrase for the burnout we are feeling: compassion fatigue.

It is described as the gradual emotional numbing that can occur when audiences are repeatedly exposed to images of conflict, crisis and human suffering.

We are already seeing signs of this feeling in public conversations about war coverage. We see the way people talk about reports on Afghanistan or Ukraine as too hard to watch. Online debates increasingly question whether images of injured children should be shown at all. Some viewers turn away entirely. Others accuse news organisations of exploiting suffering for clicks.

The news media do not just normalise violence and suffering by showing it frequently, but by legitimising it.

Euphemisms such as 'precision strikes' or 'collateral damage', reported as spoken rather than analysed, soften the human consequences of war, making suffering inevitable or mandatory for 'long-term gain'.

Neutral, passive language performs a similar role. This BBC headline, for instance, reads: 'Iran school and nearby military base struck multiple times, satellite image reveals'.

In my regular War and Peace Journalism class, I would give my students this headline and ask them to fix it.

The use of the passive voice hides responsibility, focusing on technology rather than people and equalizing civilian and military targets. I'd prefer: 'Satellite images reveal repeated deadly US strikes on Iranian girls' school near military base'.

In Australia, ETTE Media'[1]s 'read the news right' media literacy segment, where journalists/co-founders Jan Fran and Antoinette Lattouf regularly analyse news headlines, reveals how particular language choices can obscure accountability or subtly legitimise violence.

Language matters because it exposes the realities that political rhetoric often obscures.

[1] https://www.ettemedia.com/

When violence is repeatedly framed as justified or unavoidable, audiences are not only witnessing suffering, but they are also learning to accept it.

Perhaps my students are not becoming immune to images of violence after all, but to the language that steadily frames that violence as normal, inevitable, or justified.

The danger, therefore, is not witnessing war and suffering, but making evil – as Hannah Arendt notes – banal. This danger lies in the circulation of images of suffering without reflection. Because without reflection, we risk normalising the very violence we seek to expose.

What can be done?

If constant exposure to violence risks dulling our collective response, then the challenge is not to look away, but to look differently.

News organisations can begin by reporting war in ways that put human consequences in the foreground rather than sanitised military and political language.

They could provide the context that explains why violence occurs, why certain images are published and why others are not to help audiences understand the ethical considerations involved. They could also amplify the voices of civilians and journalists directly affected by conflict, to better convey the embodied experience from the frontline.

Journalism schools also have a role to play by preparing future reporters to recognise how language, framing, and sourcing can legitimise certain forms of violence.

This is where the idea of *reparative journalism* becomes important. These are reporting practices that aim not only to expose harm but to interrupt socio-political and media narratives that produce harm, such as making violence appear routine or inevitable. By minimising the language of war, foregrounding dignity, and restoring the human context behind statistics of death and destruction, journalism can help counter the normalisation of suffering.

A recent study shows that repeated exposure to violent news can take a profound toll on journalists themselves. This makes strengthening trauma-informed approaches to war reporting essential. This involves reporters foregrounding dignity rather than spectacle, challenging euphemistic language such as 'hostilities' or 'humanitarian intervention,' and ensuring stronger newsroom support for journalists routinely exposed to traumatic material.

At the same time, audiences need spaces to process what they see, through public conversation, media literacy, and education that helps people engage with difficult news without becoming overwhelmed.

Violence in the news should never become routine background noise. Keeping it visible, contextualised and human is essential if journalism is to retain its democratic purpose: bearing witness without normalising harm.

*Dr Ayesha Jehangir grew up in a very conservative, remote village in Western Pakistan. This area exists where the Durand Line separates Pakistan from Afghanistan, and so while Ayesha's family were culturally Afghan, they ended up on the 'wrong' side of the border during partition.

Her family eventually left their village, moving to the city of Lahore, where Ayesha went to university to study journalism.

As a journalist, she went into Afghanistan for the first time in her 20s, to cover the changes in the country after the Taliban had been overthrown.

This was an exciting time in Afghanistan, as the Taliban had been overthrown, and women were thriving in politics. But it was still quite dangerous, especially for a 'foreign', female journalist.

After Ayesha escaped an attempted kidnapping, she went to Australia to become an academic;.

Further information

Ayesha's PhD thesis *Afghan Refugees, Pakistani Media and The State: The Missing Peace* has been published as a book by Routledge.

From Page 6 continued

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On the following page a letter to *the Lancet* is reproduced. You will notice *the Lancet* editorial comment that:

'The Lancet Group takes a neutral position with respect to territorial claims in the published text'

This comment has accompanied each article that has been published in support of the rights of the Palestinian people.

Health, human rights, and the Palestine exception

In December, 2025, Harvard T H Chan School of Public Health announced that Mary T Bassett would be stepping down as Director of the François-Xavier Bagnoud (FXB) Center for Health and Human Rights. Framed as an institutional reorientation on children's health,[1] the announcement omitted that Bassett had been abruptly asked to resign[2] following more than a year of political pressure over the Center's work on Palestinian health and human rights.

Under Bassett's leadership, the FXB Center partnered with Palestinian institutions to document the health consequences of occupation and military violence, in line with reporting by international humanitarian organisations including Israeli human rights groups.[3] More than 90% of Gaza's hospitals have been damaged or destroyed, health workers have been systematically targeted, and the civilian population has been deliberately deprived of food, water, electricity, and medical care.[4] These are not incidental effects of war but a manufactured public health catastrophe.

Documenting such devastation lies at the core of health and human rights, a field that combines epidemiological analysis, health-systems assessment, and legal accountability under international humanitarian law to expose forms of violence that states and institutions seek to obscure. Bassett's removal therefore signals not merely a personnel change but an erosion of institutional ethics and academic freedom; Harvard has made clear that universal principles are tolerated only when they do not threaten power.

At stake is the credibility of global health and human rights themselves. Both fields claim universality—that preventable suffering demands documentation, that all lives are equally grievable, and that health cannot be separated from the political conditions that shape violence and deprivation. Yet critics have shown how these fields have developed within a geopolitical order marked by selective application and double standards, operating from their origins to shore up colonial and neocolonial inequalities.[5]

Elite universities help sustain these contradictions. They proclaim universal truth, free inquiry, and independence from partisan loyalties, yet their horizons are bounded by donor interests, state power, and reputational risk.[6,7] Appeals to institutional neutrality function less as principled commitments than as strategies for avoiding confrontation with entrenched power.

In this context, institutions increasingly invoke a familiar distinction between rigorous scholarship and advocacy. Work on Palestinian health has been recast as advocacy—not because of methodological failure, but because its findings implicate powerful actors. But public health has never been politically neutral. Its tools are designed precisely to identify preventable harm and clarify responsibility. Branding such work as advocacy allows institutions to dismiss uncomfortable findings instead of confronting the political consequences of the knowledge they claim to seek.

Calls for balance, viewpoint diversity, or counterpoints are similarly misplaced. There is no serious scholarly dispute over the protected status of hospitals and medical personnel or the health effects of siege, blockade, and occupation. Treating the documentation of these realities as merely one perspective among others collapses the distinction between empirical inquiry and partisan apologetics.

The Palestine exception refers to the selective suppression of discourse that supports Palestinian rights or critically examines Israeli policies—particularly scholarship and speech that document Palestinian experiences of injustice, occupation, or inequality—despite broader ostensible institutional commitments to free expression.[8] Although the Palestine exception has long been evident at elite North American universities, such as Harvard, and at prominent medical and public health journals,[8–10] it clearly also extends far beyond them. Across the USA and increasingly in Europe as well, clinicians, scholars, and researchers have faced reprimand or dismissal for documenting Gaza's devastation.[11] When the legitimacy of human rights work depends on political convenience, universality collapses into an empty slogan, used not to challenge oppressive power but to obscure and entrench it.

A public health field that cannot describe the destruction of Gaza's health system forfeits its ethical authority everywhere, a human rights discourse that excludes Palestinians cannot credibly claim universality, or any legitimate basis at all, and a university that disciplines scholars for applying established methods to politically inconvenient realities does not merely betray its ideals; it actively reshapes itself in the service of repression.

ER declares receipt of honoraria for lectures from the Association of State and Territorial Health Officials. JMA-R declares no competing interests.

Editorial note: The Lancet Group takes a neutral position with respect to territorial claims in published text.

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World Health Day April 7 2026

WHO

World Health Day is celebrated annually on **April 7** to mark the anniversary of the founding of the World Health Organisation in 1948. Established by the First World Health Assembly, the day has been observed since 1950 to highlight a specific, priority health area of global concern and promote international cooperation.

World Health Day 2026, observed on 7 April, calls on people everywhere to stand with science. Under the theme 'Together for health. Stand with science', this year's observance launches a year-long campaign celebrating the power of scientific collaboration to protect the health of people, animals, plants, and the planet. The campaign spotlights both scientific achievements and the multilateral cooperation needed to turn evidence into action – through a strong focus on the One Health approach.

Anchoring the 2026 campaign are two major global moments: the International One Health Summit (7 April), hosted by the Government of France under the French G7 Presidency, and the inaugural Global Forum of WHO Collaborating Centres (7–9 April), gathering nearly 800 scientific institutions from over 80 countries. Together, these events form the largest scientific network ever convened around a United Nations agency, underscoring how science-driven partnerships can build a healthier, safer future for all.

The campaign invites people everywhere to participate – by celebrating scientific achievements, engaging with evidence, sharing personal stories of how science improves lives, and joining the global conversation through #StandWithScience and #WorldHealthDay.

Campaign goals

The campaign calls on governments, scientists, health workers, partners, and the public to stand with science by engaging with evidence, facts, and science-based guidance to protect health; rebuild trust in science and public health; and support science-led solutions for a healthier future.

World Health Day Philippines

Edelina de la Paz

The Health Alliance for Democracy, the People's Health Movement – Philippines and the International League of People's Struggles - Commission

Currently, there is a deepening global and Philippine health crisis. According to the World Health Organization, 4.6 billion people lack access to essential health services, 2.1 billion people face financial hardship just to get care and 1.6 billion people are pushed deeper into poverty due to health costs. In the Philippines, deaths are still due to preventable and curable diseases, only five out of 10 Filipinos are attended to by health professionals and out-of-pocket expenses account for 44.4% of the total health expenditure.

Instead of prioritising people's health, science is weaponised for biological warfare, trauma medicine for soldiers and surveillance health systems are used as counter insurgency measures while public health systems collapse. Bombs are funded, healthcare is denied.

The US attack in Palestine and Iran has destroyed civilian infrastructure, including hospitals and ambulances. Patients are left to die not because treatment does not exist, but because war has made it inaccessible. Health workers are put at risk.

There are clear violations of International Humanitarian Law. The recent arrest of Dr. Ana Marie Rilloraza, health worker Marc Mendiola and their companions on March 11, 2026 was on trumped-up charges of illegal possession of firearms and explosives to criminalise and demonise them. Dr. Rilloraza is a community medicine physician, health environmentalist and rights activist for indigenous peoples . Mendiola, a psychologist, provides psychological first-aid in communities. Their arrest is a grave injustice and a chilling example of how the state targets health workers who stand with the people. For their commitment to delivering essential services in underserved communities, they are red-tagged, arrested and vilified. These arrests are part of a broader pattern of attacks against those who challenge a broken and exploitative system.

Under the Ferdinand Marcos Jr. regime, neoliberal policies have deepened privatisation, underfunded public hospitals, and worsened the conditions of health workers. Bureaucrat capitalism and corruption continue to plunder public resources, while fascist repression silences dissent.

Our demands are clear:

• Develop science for people's health, nor for imperialist greed and war

• End US-Israel war on Iran

• Ensure a free, comprehensive, progressive, national and public health care system

• End neoliberal policies that commodify health

• End state repression and attacks on those serving the people Immediately

Health is a right. The struggle for health is inseparable from the fight against imperialism, bureaucrat capitalism, and fascism.

World Health Day at GK

Dr Tariq Islam

Gonoshasthaya Kendra (GK), Bangladesh, celebrated World Health Day on 7th April, with a seminar on ONE HEALTH and AMR.

It was announced that the Bangladesh government has decided to give an Independence Day Award to GK and posthumously to Dr Zafrulllah Chowdhury who died on April 11, 2023. The Prime Minister will present the award in a national ceremony.

Gonoshasthaya Kendra Special Tribute: Dr Zafrullah Chowdhury 1941-2023

Thank you Dr Tariq Islam, Gonoshasthaya Kendra

This video is in Bangla language but the pictures can be easily understood

https://youtu.be/gUpS9GFaZYk?si=MTQZcrAptJp4d3qz

On April 11 a memorial tribute was paid to Dr Zafrullah Chowdhury in the PHA Hall at GK on the third anniversary of his death. HAIAP joined in the tribute to Zafrullah.

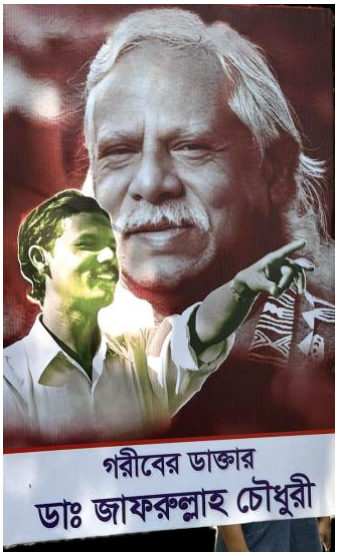
Zafrullah Chowdhury was one of the founders of Health Action International. He was born in December 27, 1941 in Raozan, Chittagong. He passed away at 11 pm on April 11, 2023. We will remember forever his uncompromising role in the battle for health and justice for all.

In 1971, during the Bangladesh Liberation War, Dr Zafrullah and colleagues set up the 480-bed Bangladesh Hospital for freedom fighters and refugees; run by a team of Bangladeshi doctors, medical students and volunteers. Women were trained within days to help provide care for patients.

Gonoshasthaya Kendra (GK) was set up in Bangladesh in 1972 when Dr Zafrullah Chowdhury took on the challenge of developing an effective rural health care delivery system based on his experience of running a field hospital with young women and men with no previous medical training. GK began providing all basic healthcare to the community as paramedics from the community – trained at GK and supported by a strong referral system. The experience of GK became the basis of one of the main working papers on which the Alma Ata Declaration of the World Health Organisation was framed. One of the first initiatives of GK was the local manufacture of affordable high quality essential medicines. Over the years GK expanded geographically as well as beyond health care to include appropriate technology and skills building especially for women's empowerment while continuing to respond to current challenges such as

natural and man-made disasters, epidemics and working conditions - especially for women.

Zafrullah believed that women should not be the recipients of training in only stereotypical women's pursuits - craft work, basket making etc. Women's development options should include professional training to provide the services that a population cannot live without: electricians, plumbers, drivers, builders, carpenters, boiler makers, printers and more. GK has succeeded in breaking social barriers and creating a training environment conducive to women's confidence building and skills development, as well as self-determination for the whole community.



Zafrullah Chowdhury, doctor of the poor and helpless - posters prepared by the staff of GK to pay their respects.

This GK environment has allowed both capacity building and job creation for those rendered poor, especially women; as well as better health care for those who have not in the past had the access to the means to health care. Nationally, this work has influenced the government to include community health workers in its health and family planning program and also influenced the government to increase opportunities for women in other sectors.

The mainstay of GK's health care delivery system rests on the team of community health workers called 'paramedics', most of whom are young rural women. Through them, health services have reached rural homes and the poor in particular have been able to gain access to education, medical services, health education and essential medicines.

Zafrullah Chowdhury was instrumental is setting up the Bangladesh National Drug Policy. The Bangladesh National Drug Policy formulated in 1982 ensured access to essential medicines for all Bangladeshis. Before that most drugs – many unnecessary or even dangerous - were manufactured and distributed by multi-national companies, priced out of reach for most of the people - while the most essential 150 remained in short supply.

The GK centre also runs a university, hospital, agriculture cooperatives, printing press, community schools, a generic drug manufacturing plant and a vocational training centre. All basic services, for example plumbing, electrical services, vehicle maintenance, carpentry are provided by women who are trained on site. GK's philosophy of people's health care has two main pillars: economic and health security. Primary Health Care with a holistic approach to health is a basis for human rights.

Every student enrolling at GK plants a tree that they care for until their graduation.

Shireen Huq, the late Dr Zafrullah's wife, is currently the Chairman of GK.

https://www.youtube.com/watch?v=FzLuI54RYDE

Interview with Dr Zafrullah, 2013, on the occasion of his Right Livelihood Award.

WORLD TB DAY March 26
WHO recommends new diagnostic tools to help end TB

https://www.who.int/news/item/24-03-2026-who-recommends-new-diagnostic-tools-to-help-end-tb

24 March 2026

News release

On World TB Day, the World Health Organization (WHO) urges countries to accelerate action to end tuberculosis (TB) and expand access to lifesaving services by using new innovations such as diagnostic tests that can be used near the point-of-care and tongue swabs that can help detect the disease faster reaching more people.

The new guidelines on tests for TB that can be used near the point-of-care, issued by WHO, mark another step towards faster detection and treatment of one of the world's deadliest infectious diseases. These portable, simple-to-use tests bring TB diagnosis closer to where people routinely seek care. Available at less than half the cost of many existing molecular diagnostics, they can help countries expand access to testing. The tests can operate on battery power and deliver results in less than one hour, allowing patients to start treatment sooner.

'These new tools could be truly transformative for tuberculosis, by bringing fast, accurate diagnosis closer to people, saving lives, curbing transmission and reducing costs,' said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. 'WHO calls on all countries to scale up access to these and other tools so every person with TB can be reached and treated promptly.'

Beyond TB, these devices have the potential to test for other diseases like HIV, Mpox, and HPV, making diagnostics more patient-centred, equitable, and aligned with one-stop-shop style services for emerging and circulating diseases.

New sample collection methods to expand TB testing

The guidelines also recommend easy-to-collect tongue swab samples, as well as a cost-saving sputum pooling strategy to increase testing efficiency for TB and rifampicin-resistant TB. Tongue swabs allow adults and adolescents who cannot produce sputum to receive TB testing for the first time, enabling disease detection among people who are at an increased risk of dying from TB. Sputum pooling, where samples from several individuals are combined and tested together, can significantly reduce commodity costs and machine time, leading to faster results for people and TB programmes – an approach specifically recommended when resources are exceptionally constrained.

Global progress at risk without faster diagnosis

TB remains one of the world's deadliest infectious killers. Each day, over 3300 people die from TB and more than 29 000 people fall ill with this preventable and curable disease. Global efforts to combat TB have saved an estimated 83 million lives since 2000, however cuts in global health funding are threatening to reverse these gains. Uptake of rapid diagnostic tools has been a challenge in many countries due, in part, to high costs and reliance on sample transport to support testing at centralised laboratories.

Scaling up proven solutions, including point-of-care urine tests for people living with HIV, and near-point-of-care, low- or moderate-complexity tests for people with and without HIV, can collectively be used to close diagnostic gaps across all levels of the health system. Such efforts can help advance toward global targets for universal access to TB and drug resistance testing, reduce delays in treatment initiation and curb transmission.

World TB Day 2026: Countries and communities leading the way

On World TB Day 2026, under the theme 'Yes! We can end TB: Led by countries, powered by people', WHO is calling for urgent action to:

- accelerate the roll out of diagnostic technologies that can be used near the point-of-care and other innovations as part of a comprehensive testing network;
- strengthen people-centred TB care with meaningful community leadership and continuous engagement;
- build resilient health systems to safeguard health security;
- tackle the social and economic drivers of TB through multisectoral action;
- protect essential TB services amid global crises and funding constraints.

Further innovation and research

While new diagnostic tools represent a critical step forward, ending TB will require sustained investment in research and innovation. Global funding for TB research remains far below the estimated annual need of around US$ 5 billion, leaving major gaps in the development of new diagnostics, medicines and vaccines needed to end the epidemic.

WHO is working with partners to accelerate progress through initiatives such as the TB Vaccine Accelerator Council, launched to fast-track the development and equitable access to new TB vaccines by aligning governments, researchers, funders and industry around shared priorities and coordinated investment.

As countries mark World TB Day 2026, WHO urges governments and partners to prioritise TB as a central pillar of health security and universal health coverage.

Tuberculosis Cases and Deaths Averted by PEPFAR

Letter to the Editor NEJM March 24, 2026

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https://www.nejm.org/doi/pdf/10.1056/NEJMc2506284

(In September 2025 US President Trump terminated the funding for the PEPFAR program resulting in immediate, widespread interruptions to HIV treatment and prevention services worldwide.)

To the Editor: Since 2003, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has made transformative investments to address the global human immunodeficiency virus (HIV) epidemic. [1] PEPFAR has expanded access to HIV testing, delivered lifesaving antiretroviral therapy, and strengthened local health systems in more than 50 countries. These investments have tangibly improved survival and quality of life for persons with HIV and have generated substantial cost-effective, long-term societal benefits.[1,2]

Tuberculosis remains the leading cause of death among persons with HIV worldwide.[3] Since its inception, PEPFAR has indirectly contributed to reductions in the incidence of tuberculosis by improving population health and access to health care in settings with generalized HIV epidemics.

In 2018, PEPFAR intensified a scale-up of direct, tuberculosis-specific prevention efforts, including implementing universal symptom screening, expanding access to tuberculosis-specific diagnostic testing, and offering preventive treatment to all eligible persons with HIV.[4] Although the effect of PEPFAR on the HIV epidemic is well described, the relative contribution of this program toward the elimination of tuberculosis worldwide is unclear.

In this study, we expanded on a previous statistical framework to estimate the numbers of tuberculosis cases and related deaths averted that could be attributed to PEPFAR.[5]

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From 2003 through 2024, indirect and direct interventions from PEPFAR averted an estimated 11.0 million cases of tuberculosis.

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Although study results are subject to several important data and methodologic limitations, they suggest that the long-term investments made by PEPFAR to address the HIV epidemic have accelerated progress toward the elimination of tuberculosis worldwide. These findings underscore the importance of sustained, integrated global health investments to ensure durable progress in tuberculosis control around the world.

Ethiopian poster illustrating the activities of the Smallpox Eradication Programme Gift of Donald A. Henderson, M.D. M.P.H.1970

World Immunisation Week April 24–30

World Immunisation Week 2026 from **24–30 April 2026**, aimed to highlight the need to promote vaccine use to protect people of all ages. Under the theme '[For every generation, vaccines work]' the campaign reinforces the value of vaccines in saving lives.

While the WHO promotes the week in April, some sources also identify **November 10** as a specific 'World Immunisation Day' for raising awareness.

https://tinyurl.com/5bee5kcc

History of vaccination - timeline

https://www.who.int/news-room/spotlight/history-of-vaccination

1400s to 1700s

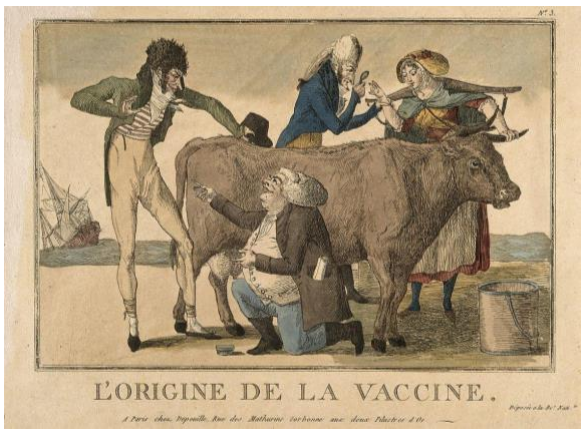
From at least the 15th century, people in different parts of the world have attempted to prevent illness by intentionally exposing healthy people to smallpox– a practice known as variolation (after a name for smallpox, 'la variole'). Some sources suggest these practices were taking place as early as 200 BCE.

In 1721 (75 years before Jenner) Lady Mary Wortley Montagu brought smallpox inoculation to Europe, by asking that her two daughters be inoculated against smallpox as she had observed practice in Turkey.[2]

In 1774, Benjamin Jesty made a breakthrough. Testing his hypothesis that infection with cowpox – a bovine virus which can spread to humans – could protect a person from smallpox.

In May 1796, English physician Edward Jenner expanded on this discovery and inoculated 8-year-old James Phipps with matter collected from a cowpox sore on the hand of a milkmaid. Despite suffering a local reaction and feeling unwell for several days, Phipps made a full recovery.

Two months later, in July 1796, Jenner inoculated Phipps with matter from a human smallpox sore in order to test



Phipps' resistance. Phipps remains in perfect health, and became the first human to be vaccinated against smallpox. The term 'vaccine' is later coined, taken from the Latin word for cow, *vacca*.

Read more about the history of Smallpox vaccination.[3]

The 1800s

In 1872, despite enduring a stroke and the death of two of his daughters to typhoid, Louis Pasteur created the first laboratory-produced vaccine: the vaccine for fowl cholera in chickens.

In 1885, Louis Pasteur successfully prevented rabies[4] through post-exposure vaccination.

In 1894, Dr Anna Wessels Williams isolated a strain of the diphtheria[5] bacteria that is crucial in the development of an antitoxin for the disease.

The 1900s

From 1918 to 1919, the 'Spanish' Flu pandemic killed an estimated 20–50 million people worldwide, including one in 67 United States soldiers, making an influenza vaccine[6] a US military priority. Early experiments with influenza vaccines were carried out: the US Army Medical School tested two million doses in 1918, but results were inconclusive.

In 1937 Max Theiler, Hugh Smith and Eugen Haagen developed the 17D vaccine against yellow fever.[7] The vaccine was approved in 1938 and over a million people received it that year. Theiler went on to be awarded the Nobel Prize.

In 1939, bacteriologists Pearl Kendrick and Grace Eldering demonstrated the efficacy of the pertussis (whooping cough)[8] vaccine.

By 1945, the first influenza vaccine[9] was approved for military use, followed in 1946 by an approval for civilian use. The research was led by doctors Thomas Francis Jr and Jonas Salk, who both went on to be closely associated with the polio vaccine.

From 1952–1955, the first effective polio vaccine was developed by Jonas Salk and trials began. Salk tested the vaccine on himself and his family the following year, and mass trials involving over 1.3 million children took place in 1954.

By 1960, a second type of polio vaccine, developed by Albert Sabin, was approved for use. Czechoslovakia became the first country in the world to eliminate polio.

Read more about the history of Polio vaccination.[10]

In 1967, the World Health Organisation announced the *Intensified Smallpox Eradication Programme,* which aimed to eradicate smallpox in more than 30 countries through surveillance and vaccination.[11]

In 1969, four years after Dr Baruch Blumberg discovered the hepatitis B virus, he worked with microbiologist Irving

[2] https://www.theguardian.com/society/2021/mar/28/how-mary-wortley-montagus-bold-experiment-led-to-smallpox-vaccine-75-years-before-jenner

[3] https://artsandculture.google.com/story/qAURxyAnf5tcXg

[4] https://www.who.int/news-room/fact-sheets/detail/rabies

[5] https://www.who.int/news-room/questions-and-answers/item/diphtheria#:~:text=What%20is%20diphtheria%3F,a%20sore%20throat%20and%20fever.

[6] https://artsandculture.google.com/story/wwVRjxWcNcJiqw

[7] https://www.who.int/news-room/fact-sheets/detail/yellow-fever

[8] https://www.who.int/health-topics/pertussis#tab=tab_1

[9] https://www.who.int/teams/global-influenza-programme/vaccines

[10] https://artsandculture.google.com/story/6QWhgYkCnslptw

[11] https://www.who.int/news/item/17-05-2010-statue-commemorates-smallpox-eradication

Millman to develop the first hepatitis B vaccine,[12] using a heat-treated form of the virus.

In 1971 the measles vaccine (1963) was combined with vaccines against mumps (1967) and rubella (1969) into a single vaccination (MMR) by Dr Maurice Hilleman.

Read more about the history of measles vaccination.[13]

In 1974 the Expanded Programme on Immunisation (EPI, now the *Essential Programme on Immunisation)* was established by WHO to develop immunisation programmes throughout the world. The first diseases targeted by the EPI were diphtheria, measles, polio, tetanus, tuberculosis and whooping cough.

In 1978 a polysaccharide vaccine that protects against 14 different strains of pneumococcal pneumonia [14] was licensed, and in 1983 it was expanded to protect against 23 strains.

In 1980 the World Health Assembly, acting on recommendation from the WHO Global Commission for the Certification of Smallpox Eradication, declares smallpox eradicated:[15]

> *The world and all its people have won freedom from smallpox, which was the most devastating disease sweeping in epidemic form through many countries since earliest times, leaving death, blindness and disfigurement in its wake.*

From 1970s to 1980s in the USA, whooping cough cases hit an all-time low in 1976. But the success of the pertussis vaccine is hampered by a decline in uptake: with so few whooping cough cases, fears about rare but serious side effects of the whole-cell vaccine start to outweigh fears of the disease itself.

In 1985 the first vaccine against diseases caused by Haemophilus influenzae type b (Hib)[16] was licensed, after David H Smith founded a company to produce it. Smith and Porter W Anderson Jr had been working together on a vaccination since 1968.

In 1988 following the eradication of smallpox, WHO set its sights on poliomyelitis, launching a ***Global Polio Eradication Initiative.*** In the late 1980s, polio was endemic in 125 countries, and the initiative aimed to achieve its eradication by the year 2000.

By 1994, polio was eradicated from the Americas, followed by Europe in 2002, and by 2003 the disease was endemic in just 6 countries. The effort continues.

In 1995 Anne Szarewski led a team to outline the role of human papillomavirus (HPV) [17] in cervical cancer detection and screening, and researchers began work on an HPV vaccine.

In 1999 the first vaccine against rotavirus,[18] the most common cause of severe diarrhoeal disease in young children, was withdrawn only a year after it was approved, due to concerns about the risk of intestinal problems. A lower-risk version of the vaccine was introduced in 2006. It took until 2019 for it to be in use in over 100 countries.

From 2000

In 2006 the first vaccine for Human Papillomavirus (HPV) was approved. HPV vaccination goes on to become a key part of the effort to eliminate cervical cancer.[19]

In 2016 the success of the Meningitis Vaccine Project[20] highlighted the key role public–private partnerships can play in helping to develop vaccines.

The World Health Assembly welcomed the *R&D Blueprint*, a global strategy and preparedness plan that allows the rapid activation of research and development activities during epidemics. Its aim is to fast-track the availability of effective tests, vaccines and medicines that can be used to save lives and avert large-scale crises.

Following years of accelerated vaccinations, the Americas region was declared free of endemic measles. Outbreaks in several countries, caused by gaps in vaccination coverage, see the disease begin to re-emerge in 2018. WHO and PAHO have increased surveillance and launched vaccination campaigns.

In 2019, the malaria vaccine[21] pilot implementation was launched in Ghana, Malawi and Kenya. The RTS/S vaccine is the first vaccine that can significantly reduce the deadliest and most prevalent strain of malaria in young children, the group at highest risk of dying from the disease.

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[12] https://pmc.ncbi.nlm.nih.gov/articles/PMC9320049/

[13] https://artsandculture.google.com/story/hwVRpd7MxQrtmA

[14] https://www.who.int/teams/health-product-policy-and-standards/standards-and-specifications/norms-and-standards/vaccine-standardization/pneumococcal-disease

[15] https://www.who.int/news/item/17-05-2010-statue-commemorates-smallpox-eradication

[16] https://www.who.int/teams/health-product-policy-and-standards/standards-and-specifications/norms-and-standards/vaccine-standardization/hib

[17] https://www.who.int/teams/health-product-policy-and-standards/standards-and-specifications/norms-and-standards/vaccine-standardization/human-papillomavirus

[18] https://www.who.int/teams/health-product-policy-and-standards/standards-and-specifications/norms-and-standards/vaccines-quality/rotavirus

[19] https://www.aacr.org/blog/2021/09/28/the-past-present-and-future-of-hpv-can-vaccination-help-eliminate-cervical-cancer/

[20] https://www.path.org/our-impact/articles/about-meningitis-vaccine-project/

[21] https://www.who.int/initiatives/malaria-vaccine-implementation-programme

WHO prequalified an Ebola vaccine[22] for use in countries at high risk, as part of a broader set of tools in response to the disease and in 2021 a global vaccine stockpile was established to ensure outbreak response.

A third-generation smallpox vaccine was approved for prevention of monkeypox, [23] thus becoming the first monkeypox (Mpox) vaccine.

On 30 January, 2020 the WHO Director General declared the outbreak of novel coronavirus 2019 (SARS-CoV-2) to be a Public Health Emergency of International Concern. On 11 March, WHO confirmed that COVID-19 was a pandemic. Effective COVID-19 vaccines were developed, produced and distributed with unprecedented speed, some using new mRNA technology. In December 2020, just 1 year after the first case of COVID-19 was detected, the first COVID-19 vaccine doses were administered.

In 2021 the COVID-19 vaccine roll-out continued, with doses delivered and administered across continents. But efforts to curb the pandemic have been threatened by inequities in vaccination coverage: as of July 2021, almost 85% of vaccines had been administered in high- and upper-middle-income countries, and over 75% administered in only 10 countries alone.

WHO called on Member States to prioritise vaccination of health workers and at-risk groups in lower-income countries, in order to stop severe disease and death, keep health workers safe and reopen societies and economies.

For over two centuries, people have been vaccinated against deadly diseases, ever since the world's first vaccine was devised against smallpox. History has taught us that a full and effective global response to vaccine-preventable diseases takes time, financial support and collaboration – and requires continued vigilance.

In many parts of the world, 1 in 5 children still goes unvaccinated. The coming decades will need global cooperation, funding, commitment and vision to ensure that no child or adult suffers or dies from a vaccine-preventable disease.

The drivers of global inequity in access to COVID-19 vaccines

from an article written in 2023 by Deborah Gleeson, Brigitte Tenni, Belinda Townsend *

Aust N Z J Public Health. 2023 Feb 27;46(4):423–425.
https://pmc.ncbi.nlm.nih.gov/articles/PMC9348465/
See also
https://www.bu.edu/gdp/2026/01/23/what-the-eus-new-compulsory-licensing-policy-signals-for-global-health-governance-and-flexibilities-for-middle-income-countries/

The issues associated with inequity have not been addressed

Drivers of inequitable access include vaccine nationalism, failure to share the exclusive rights to the means of production, and the reluctance of governments to intervene and correct for market failure.

The preconditions for these inequities were set early in the pandemic, as rich countries quickly monopolised the global supply of vaccines even before they were manufactured. By November 2020, countries accounting for only 14% of the global population had pre-purchased 51% of the first 7.5 billion vaccine doses. Despite its slow domestic rollout, Australia joined other countries in entering pre-purchase agreements for excessive quantities of vaccines, and by August 2021 had secured agreements for 280 million doses – enough to vaccinate its population more than five times over.

There is no sign that vaccine nationalism is abating as high-income countries (HICs) achieve high vaccination rates. The WHO's call for a moratorium on booster shots until 2022, to allow redistribution of doses to LICs, was ignored by many HICs, including Australia. By the end of 2021, more boosters had been administered in HICs than the total doses given in LICs.

Wealthy governments pledged to donate over a billion vaccine doses, falling well short of the 7 billion doses needed by LICs and lower-middle-income countries to achieve global vaccination by the end of 2022. Delivery of these promised doses has been slow and often ill-timed, with many arriving within three months of expiry. Although useful in the short term, donations can entrench a charity model that perpetuates inequities and fails to address their root causes.

Monopolies on the means of production have limited the global supply, with a handful of companies holding exclusive rights to manufacture COVID-19 vaccines and largely refusing to share. No COVID-19 vaccine manufacturer has yet agreed to contribute its intellectual property (IP), know-how and technology to the WHO COVID-19 Technology Access Pool set up almost two

[22] https://www.who.int/news/item/12-11-2019-who-prequalifies-ebola-vaccine-paving-the-way-for-its-use-in-high-risk-countries

[23] https://www.who.int/news-room/fact-sheets/detail/mpox

years ago,(2021) or the WHO-backed mRNA technology-transfer hub established in South Africa.

Most COVID-19 vaccine manufacturers (with the notable exception of AstraZeneca) have even avoided sharing their IP and technology by entering into voluntary licensing arrangements with companies in low- and middle-income countries (LMICs).

Negotiations for a temporary waiver of monopoly rights governed by the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) for COVID-19 health products and technologies, first proposed by India and South Africa in October 2020, remain deadlocked. Co-sponsored by 63 of the World Trade Organisation's (WTO) 164 members and supported by more than 100, the so-called TRIPS Waiver proposal would suspend patents and other monopoly rights and allow companies around the world to freely produce COVID-19 health products, including vaccines, and use technologies (such as mRNA platforms) without fear of litigation over infringing IP rights.

Unlike existing flexibilities available under TRIPS, the TRIPS waiver would apply not only to patents but also to trade secrets protection, which covers the detailed information and technology required for vaccine manufacturing. The TRIPS Waiver continues to face opposition from the EU, Switzerland and the UK.[17] While Australia announced its support for the TRIPS Waiver in September 2021,[18] it has not become a formal co-sponsor.

In March 2022, four WTO members drafted a compromise 'solution' to try to break the impasse.[19] However, the compromise was limited to vaccines (excluding treatments and tests), excluded many developing countries and was criticised for being too procedurally onerous.[20] At the time of writing, Australia's position on the compromise is not clear.

Governments of countries where COVID-19 manufacturers are headquartered have also so far failed to force the industry to share the 'recipes' and technology for making vaccines, despite the huge investment of public funding in their development. Médecins Sans Frontières reported in November 2020 that "the six front running vaccine candidates have had a total of over US$12 billion of taxpayer and public money poured into them".[21] Each received between $455 million and $2.1 billion in funding, largely from the US Government and the Coalition for Epidemic Preparedness Innovations.[22] Australia has invested $350 million in public money into vaccine research and development (R&D).[10] Yet vaccine manufacturers are set to profit handsomely: Pfizer, for example, was expecting revenues of US$32 billion from its COVID-19 vaccines in 2022.23

* The writers are PHM members and have been associated with HAIAP for many years.

Is the Pathogen Access and Benefit-Sharing (PABS) system a blueprint for piracy?

TWN

A recent webinar co-hosted by TWN, PSI, PHM and G2H2 unpacked the latest proposed text of the Bureau of Intergovernmental Working Group negotiating the PABS System and examined whether the PABS System will deliver on the promise of equity or entrench a new global model of extraction.

With negotiations on the Pandemic Agreement entering what may be the final phase, the future of the Pathogen Access and Benefit-Sharing (PABS) System hangs in the balance. A newly released Bureau's draft text has sparked concern for largely accommodating the demands of the European Union and other G6 countries while sidelining proposals from developing nations aimed at ensuring transparency, accountability, legal certainty and concrete benefit-sharing on an 'equal footing'.

Critics warn that the current approach risks turning what was meant to be a mechanism for equity into a framework for institutionalising biopiracy—where pathogen samples and genetic sequence data are shared from the Global South, through a system that is not fully accountable and where the resulting vaccines, diagnostics, and technologies are captured and controlled through intellectual property monopolies.

The WHO Pandemic Agreement (often called the Pandemic Treaty or Accord) is a legally binding international instrument adopted by the World Health Assembly in May 2025 to strengthen global cooperation in preventing, preparing for, and responding to future pandemics. It is a direct response to the massive inequalities, critical gaps, and fragmented response experienced during the COVID-19 pandemic.

Why does it matter?

It matters for everyone because it aims to make the world safer, ensuring that the next pandemic—which is widely considered a matter of *when* not *if* — does not result in the same catastrophic loss of life and economic disruption as COVID-19.

Key Components of the Pandemic Agreement

Equitable Access (Core Pillar): Ensures that vaccines, tests, and treatments are distributed based on public health needs rather than wealth. The agreement includes a commitment to a 'Pathogen Access and Benefit-Sharing' (PABS) system, where manufacturers contribute a portion of pandemic-related products (targeting 20% in some provisions) for global distribution.

'One Health' Approach: Strengthens surveillance to detect outbreaks early at the human-animal-environment interface.

Stronger Global Coordination: Establishes a Global Supply Chain and Logistics Network and a 'Coordinating Financial Mechanism' for sustainable, faster responses.

Local Production and Tech Transfer: Boosts the ability of developing nations to produce their own vaccines and medical products.

Why It Matters to Everyone

The agreement aims to fix the vulnerabilities exposed by COVID-19, which saw over 28 million excess deaths and massive economic contractions.

Faster, More Effective Response: By mandating early warning systems and coordinated action, the treaty helps stop pandemics earlier, limiting their spread and impact on daily life.

It seeks to stop wealthy nations from hoarding vaccines, which previously prolonged the pandemic by allowing new variants to emerge in unprotected populations.

Health System Resilience: It invests in strengthening national health systems, ensuring they can cope with future emergencies without suspending regular care.

Reduced Economic Impact: A better-coordinated response helps minimise lockdowns, border closures, and the severe economic shutdowns that follow.

Equity and Solidarity: It ensures that developing countries are not left waiting at the back of the vaccine queue.

Important Considerations and Status

(As of 2026)

National Sovereignty: The agreement does not give the WHO authority to direct national policies, impose lockdowns, or mandate vaccinations. It explicitly reaffirms the sovereignty of states in health matters.

Status of the Agreement: While adopted in May 2025, negotiations on a key annex (the PABS system) were extended to be finalised at the World Health Assembly in May 2026.

Ratification: The treaty will officially enter into force 30 days after 60 countries have ratified it.

Challenges: The US withdrew from final negotiations in 2025, casting doubt on the participation of the largest global health donor, although many other nations continue to support it.

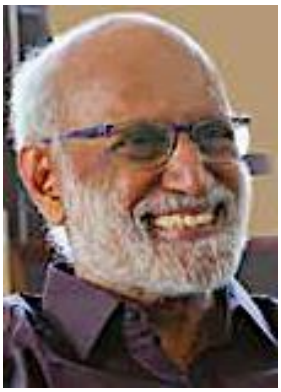
The agreement is designed to ensure that in the future, **'no one is safe until everyone is safe'.**

MSF Poster

Feature: Plague to COVID-19

Exploring the Nexus of History, Science, Literature and Human Resilience

B Ekbal -



Dr B Ekbal has produced an enormous and fascinating, creatively illustrated book entitled ***Plague to COVID-19 Exploring the Nexus of History, Science, Literature and Human Resilience.***

It is a wonderful achievement. Congratulations Ekbal!

Ekbal has very generously shared with us an electronic version. Thank you!

https://www.haiasiapacific.org/wp-content/uploads/2026/04/Ekbal-Pandemics-Plague-To-COVID.pdf

Dr Ekbal's Preface to the book follows:

Preface

The COVID-19 pandemic, like a global storm, confined us all to our homes. As a senior citizen with underlying health conditions, I found myself particularly vulnerable, compelled to adhere to rigorous safety protocols, including self-isolation. Social interactions were severely curtailed, and digital platforms became the sole means of connection.

While the isolation was challenging, it unexpectedly afforded me like many others ample time for reading and writing. As the COVID-19 pandemic unfolded, I delved into the history of past pandemics. I soon realised that my medical training, while equipping me with the fundamental medical knowledge of diseases like the plague, smallpox, and cholera, had overlooked their broader societal and historical implications.

Unfortunately, most medical textbooks focus primarily on the clinical aspects, neglecting the comprehensive and pervasive impact of pandemics on various societal facets. This realisation spurred me to explore the deeper dimensions of these historical events.

Intrigued by this realisation, I embarked on a deeper exploration of pandemics, delving into scholarly articles, books, and even artistic expressions. I was astounded by the profound impact these events had on human history, shaping civilisations, economies, and societies. I understood that literary works such as Albert Camus's *The Plague* and Thakazhi Sivasankara Pillai's *Scavengers Son* provided poignant insights into the human experience during these tumultuous times by re-reading these books with this perspective.

Driven by this newfound understanding, I decided to write a book that would explore pandemics not only from a medical perspective but also through historical and literary lenses. I aimed to delve into the societal and cultural impacts of these global crises. Furthermore, the encouragement of my dear friend and former state president of the Kerala Sastra Sahithya Parishad, Dr. Kavumbayi Balakrishnan, who urged me to write a substantial book for the organisation, further fuelled my motivation.

The Malayalam book Mahamarikal: *Plague Muthal Covid Vare; Charithram, Sahithyam, Athijeevanam* (2022) was initially published by the Kerala Sastra Sahithya Parishad. While the positive response from readers was encouraging, it also highlighted certain areas for improvement. This feedback, coupled with the demand for an English version, inspired me to undertake the publication of the English version of the book with suitable modifications. This English Edition builds upon the original Malayalam book, incorporating updates, addressing omissions, and expanding the focus to global and Indian perspectives. While I have retained the unique Kerala experience of COVID-19 management, the primary emphasis is on the broader global and Indian contexts of pandemics.

I have written this book with the invaluable help and guidance of many friends. I am particularly grateful to Dr. Suresh Kumar, Director of the Institute of Palliative Medicine, Kozhikode, who generously shared numerous books from his collection.

Dr. Sreekumar E, Director of the Institute of Advanced Virology, Dr. Arun T. R., Scientist B, National Institute for One Health, Nagpur, Dr. R Chandni, Professor of Emergency Medicine at Kozhikode Medical College, Dr. Rakhal Gaitonde, Professor at the Achutha Menon Centre for Health Science Studies, Dr. R Arvind, Professor of Infectious Medicine at the Medical College Thiruvananthapuram, Dr. Sarada Devi K L, Professor of

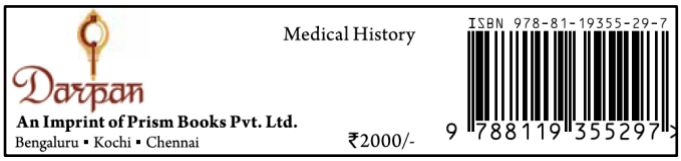
Microbiology at SUT Academy of Medical Sciences, Dr. P P Ajay Kumar, Emeritus Professor, Institute of the English University of Kerala, and many other friends have contributed significantly to this work. I am deeply indebted to the late Dr. M. S. Valiathan, former Director of Sree Chitra Tirunal Institute for Medical Sciences and Technology, for his insightful suggestions that helped to enhance the English version of the book.

The most significant contribution to this book came from Dr. Jameela Begum A, former Professor and Head of the Institute of English and Director of the UGC Area Study Centre for Canadian Studies at the University of Kerala. She meticulously edited the language of the book, ensuring its clarity and precision.

I am grateful to Rizwan C, Editor of *Luca Online Portal* (Kerala Sastra Sahithya Parishad), for his invaluable assistance in selecting the appropriate photographs and paintings for the various chapters. My friend Godfrey Das and his son Anand Godfrey deserve special thanks for their exceptional work in designing the book's layout.

This book explores a limited number of pandemics, hoping to encourage research and publications that delve into the medical, socio-economic, and political dimensions on others. I dedicate *The Pandemics: Plague to COVID-19* to all who are concerned about the profound effects of pandemics on humanity.

Contents:



Li Wenliang: A Martyr of COVID-19

Li Wenliang is given a chapter in the book. Dr Li's story is not widely known so the chapter is shared here:

Li Wenliang (12 October 1985– 6 February 2020) was not just a doctor; he became a symbol of courage and truth-telling during the early days of the COVID-19 pandemic. Tragically, he later succumbed to the disease himself. Li Wenliang's story has become a beacon of inspiration for health workers worldwide who risked their health and lives to combat the pandemic.

An ophthalmologist at Wuhan Central Hospital, Li noticed that a few patients were being treated for a respiratory infection like that of the SARS outbreak in China from 2002-2004, but with unique characteristics. On December 30, 2019, Li warned some of his colleagues through the Chinese messaging application WeChat about the potential for a serious epidemic.

Dr. Ai Fen, the director of Wuhan Hospital's emergency department, had first noticed SARS-like symptoms in a patient who was unresponsive to standard therapy. This patient, who worked at the Huanan Seafood Wholesale Market, showed concerning signs. Ai Fen shared the patient's laboratory reports with her colleagues, and Li

Wenliang, upon observing seven patients with similar symptoms, alerted his peers.

Despite his warnings, authorities attempted to silence Li.

However, his early alerts and subsequent ordeal highlighted the importance of transparency and swift action in managing infectious diseases. Li Wenliang's legacy endures as a symbol of courage and dedication in the global fight against COVID-19.

Wuhan health officials ignored Li's warning. On January 3, 2020, the Wuhan Public Security Bureau summoned him for spreading rumours through WeChat, issued a warning, and demanded that he retract his message and admit to spreading false information.

However, Li's concerns soon proved to be correct as the spread of COVID-19 was officially confirmed. Returning to work, Li contracted COVID-19 from an infected patient being treated for glaucoma. He later died at the age of thirty-three on February 7, 2020, thirty-eight days after being questioned by authorities.

By that time, the virus had spread to many countries. The news of Li's death was received with shock and profound sadness by health workers not only in China but worldwide. Hundreds of thousands of messages were circulated on social networks expressing solidarity with Li and sharing in the grief of his family. At the time of Li's death, he had a son, and his wife, Fu Xuejie, was pregnant.

Fu gave birth to their second son on June 12, 2020.

Public reaction to Li's death was intense, with around 200,000 people responding to the hashtag '#WeWantFreedomOfSpeech' on the Chinese chat group Weibo. Disturbed authorities removed the hashtag.

Recognising public sentiment, the Wuhan Health Department was compelled to conduct an official investigation into Li's involvement. Following the investigation, authorities exonerated Li. The Chinese Communist Party officially apologised to Li, revoked the warning issued to him, and honoured him with the highest martyr accolade given to those who die while serving the country.

The WHO praised Li's intervention on social media.

In a similar case, when SARS broke out in China and spread to Vietnam and other neighbouring countries, Italian microbiologist Dr. Carlo Urbani (1956-2003) informed the WHO and the Vietnam Health Department that a patient in a French hospital in Hanoi was infected with a new infectious disease. Unfortunately, Urbani, the first to warn about SARS, also contracted the disease. He died on March 29, 2003, at the age of forty-six, after falling ill while traveling from Hanoi to Bangkok and being admitted to a hospital in Bangkok. Like Li Wenliang, Urbani died of the disease he warned against. However, Urbani did not face the harshness of Chinese authorities. The Vietnamese government and the WHO took his warnings seriously and implemented precautionary measures.

Dr. Li Wenliang's story transcends borders. He serves as a powerful reminder of the importance of speaking truth to power, especially in the face of public health threats. His courage and dedication in the early days of the COVID-19 pandemic continue to inspire healthcare workers around the world.

Prof. Dzulkifli Abdul Razak receives the 5th Dr Wu Lien-Teh Award for leadership in Public Health

Dr Wu Lien-Teh, was a Penang-born physician who revolutionised public health and played a pivotal role in controlling the deadly pneumonic plague in China in 1910. His invention of the first modern face mask laid the foundation for the masks we use today.

He also campaigned against the opium trade, which had caused irreparable harm to health in China and Southeast Asia.

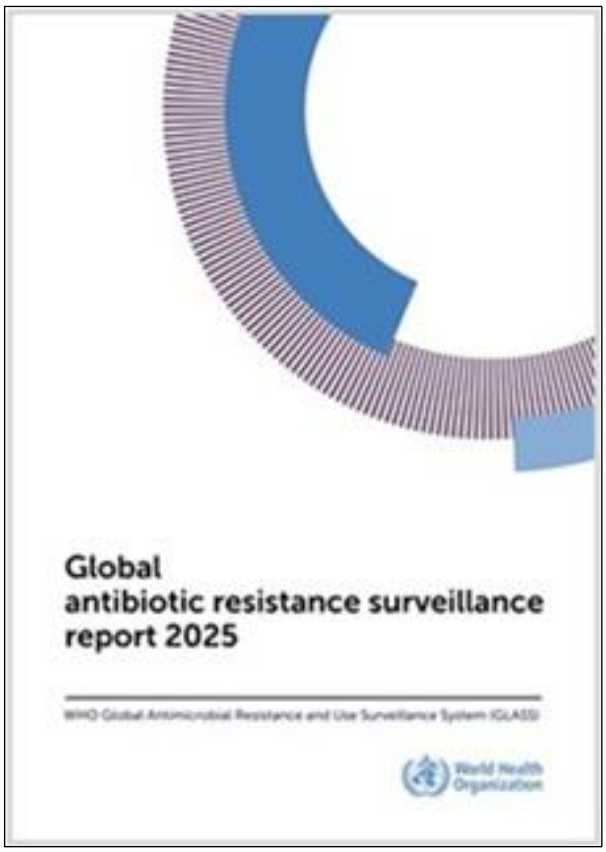
Beyond his battle against the pneumonic plague in Manchuria, Wu was also in the forefront of efforts to create a modern public health service in China. His efforts helped China regain control of quarantine centres in all major ports that had come under the supervision of foreign powers. Wu was also called to deal with the cholera epidemic in China's north-east region in 1920–21. Active in international conferences and research, Wu was the first Chinese to have his work published in the prestigious medical journal, *Lancet.*

For his contributions, Wu was conferred honorary doctorates by Peking University, Hong Kong University and Tokyo University. In 1935, he was nominated for the Nobel prize for his fight against the 1910 Manchurian plague and for identifying the role of tarbagan marmots in the transmission of the disease. The epidemic, one of the deadliest of its kind, killed an estimated 60,000 people in

the affected regions of Manchuria during the seven months that it lasted.

For a full account of the life of Dr Wu see Singapore Med J. 2014 Feb;55(2):99–102.
https://pmc.ncbi.nlm.nih.gov/articles/PMC4291938/

Antimicrobial Resistance AMR



This WHO report presents a global analysis of antibiotic resistance prevalence and trends, drawing on more than 23 million bacteriologically confirmed cases of bloodstream infections, urinary tract infections, gastrointestinal infections, and urogenital gonorrhoea. Data were reported by 104 countries in 2023 and 110 countries between 2016 and 2023.

The report:

- provides adjusted global and regional estimates of AMR in 2023 for 93 infection type–pathogen–antibiotic combinations;
- presents adjusted national AMR estimates for 2023 for key pathogen–antibiotic combinations; and
- tracks global and regional resistance trends for 16 combinations between 2018 and 2023.

It also reviews progress in building global and national AMR surveillance systems since 2016 and introduces a scoring framework to assess the completeness of national data. Based on these findings, the report proposes priorities for action to strengthen surveillance systems and support country-level responses aligned with global targets.

A companion summary provides a concise overview of the key findings and recommended actions.

Emerging and Dangerous Antibiotic-Resistant Organisms:

Carbapenem-Resistant Gram-negatives:

Acinetobacter baumannii and *Pseudomonas aeruginosa* are considered highest priority due to resistance to last-resort treatments.

Superbugs *E. coli* and *Klebsiella*: Over 40% of *E. coli* and 55% of *K. pneumoniae* show resistance to standard third-generation cephalosporins.

Neonatal Sepsis Bacteria: An alarming rise in resistance is causing infections in newborns, particularly in Southeast Asia.

Drug-Resistant Gonorrhoeae: *Neisseria gonorrhoeae* is showing increasing resistance to cephalosporins and fluoroquinolones.

Ancient Resistance: Bacteria found in 5,000-year-old ice are resistant to over ten modern antibiotics.

Key Findings and Trends:

Rising Mortality: By 2050, antibiotic resistance could cause 10 million deaths annually, according to reports in 2026.

Environmental Spread: Superbug-creating genes have been identified in major water sources like the UK's Lough Neagh.

New Discoveries: Scientists are discovering new antibiotics, such as pre-methylenomycin C lactone (against MRSA/VRE) and a new bacterium found in soil called *pennybasilus* which produces the substance flioidin.

Antibiotic Pipeline Issues: Too few new antibacterials are in development, with many companies prioritising more profitable drugs.

Australian CDC Report:

AURA REPORT

https://www.amr.gov.au/resources/sixth-australian-report-antimicrobial-use-and-resistance-human-health-aura-report-0
Publication date:16 February 2026
Sixth Australian report on antimicrobial use and resistance in human health
[This report of Australian might reflect what is happening more generally. BS]

Summary

The Antimicrobial Use and Resistance in Australia (AURA) surveillance program collects and analyses data

on antimicrobial use and AMR across Australian public and private hospitals, and the community, which includes frontline health services (e.g. general practice and community health services) and aged care.

AU data are used by antimicrobial stewardship (AMS) programs, which include organised efforts in health service organisations and the community to make sure that antimicrobials are used appropriately.

AMR data are used to monitor resistance patterns in Australia, inform treatment guidelines and measure the success of efforts to reduce resistance.

This Sixth Australian report on antimicrobial use and resistance in human health is a compilation of data gathered by the AURA systems between 2022 and 2024.

This report serves to emphasise that mitigating AMR requires a collective effort. Healthcare professionals and the public play a crucial role in ensuring the responsible use of antimicrobials. Continuous action is necessary to safeguard the future health and wellbeing of Australians.

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Australian Report - Key findings: antimicrobial use and appropriateness

• A combined analysis of usage and appropriateness data shows that participating hospitals are complying with guidelines on restricting the use of last-resort type of antimicrobials with a usage rate of 6.7 defined daily dose (DDD)/1,000 occupied bed days (OBD) and a rate 88.1% of appropriate prescribing.

• There is opportunity to improve antimicrobial prescribing in hospitals, especially for those antimicrobials used as first or second option treatment. Antibiotics in these groups are prescribed correctly about 72% and 73% of the time, respectively.

• Prescriber practices varied for antimicrobial classes: narrow-spectrum penicillins had lower usage (25.5 and 69.7 DDD/1,000 OBD) and higher appropriateness (83.5% and 84.2%), while broad-spectrum penicillins showed higher use (57.0 and 136.5 DDD/1,000 OBD) and lower appropriateness (78.8% and 67.2%).

• In the case of cephalosporins, use of narrow-spectrum antimicrobials was higher (119.6 DDD/1,000 OBD) than broad-spectrum antimicrobials (58.6 DDD/1,000 OBD); however, appropriateness rates were similar for both classes (64.3% and 69.7%).

• Although the overall appropriateness of antimicrobial prescribing for surgical procedures increased from 55.3% in 2022 to 57.3% in 2023, the rates remain low.

• Of all antimicrobials given during surgeries, 61.5% were deemed appropriate; by contrast, only 45.0% of those prescribed postoperatively met appropriateness criteria.

• Inappropriate prescribing exceeding 80% was identified for 2 of the most frequently used antimicrobials for post-procedural prophylactic antibiotics, cefalexin and amoxicillin–clavulanic acid.

• Antifungal prescriptions were classified as appropriate in 77.1% of audits, with prophylactic prescriptions showing the highest appropriateness rate at 85.1%.These data are available following the establishment of the Antifungal National Prescribing Survey in 2023.

• Fluconazole was the most prescribed antifungal in acute hospital settings in 2022 (49.9%) and 2023 (50.5%).

The four most frequently dispensed antimicrobials in the community in 2024 were: amoxicillin (22.0%), cefalexin (21.7%), amoxicillin–clavulanic acid (14.6%) and doxycycline (11.5%), accounting for 69.8% of all prescriptions.

Residential settings

Older Australians living in aged care homes received more than double the number of prescriptions of antibiotics under the PBS (3.1 average annual prescriptions) compared to their peers living at home (1.48 average annual prescriptions) in 2024.

While 11.9% of residents of aged care homes participating in the Aged Care Antimicrobial Prescribing Survey were prescribed an antimicrobial, only 3.6% showed signs or symptoms of a suspected infection.

In aged care homes, 34.7% of antimicrobials prescribed to residents were used for prolonged periods (over 6 months), suggesting a lack of regular medication review and reassessment

Key findings: antimicrobial resistance

Reports of critical antimicrobial resistances increased by 25.2% between 2023 (n=2,706) and 2024 (n=3,389).

Carbapenemase-producing Enterobacterales was the most frequently reported critical antimicrobial resistance (45.1%) in 2024.

Reports of Enterococcus resistance to linezolid increased from 17 in 2022 to 51 in 2023, and to 118 in 2024.

Between 2022 and 2024, *Shigella* species with resistance to third-generation cephalosporin antibiotics rose from 13% to 40%, and resistance to fluoroquinolone antibiotics rose from 20% to 46%.

From 2023 to 2024, there was a slight increase in the number of reports of carbapenemase-producing *Pseudomonas aeruginosa* and carbapenemase-producing *Acinetobacter baumannii* complex.

In 2024, high-level resistance to azithromycin was identified in 46 isolates of *Neisseria gonorrhoeae*, the highest number ever reported by the Australian Gonococcal Surveillance Program. This number rose from 27 isolates in 2023.

The proportion of methicillin-resistant *Staphylococcus aureus* remained stable at 17.1% in 2024 and 17.2% in 2023; however, rates varied greatly across Australia and increased with remoteness from major cities.

In 2023, 15.9% of Enterobacterales infections in children with bloodstream infections were resistant to third-generation cephalosporin antibiotics, the highest proportion ever recorded by the Australian Group on Antimicrobial Resistance in 11 years of surveillance.

Multidrug-resistant bacteria were present in 12.2% (n=222) of bloodstream infections in children.

Insights and implications

Within hospital settings and the wider community, prescribing practices vary; some areas demonstrate robust adherence to clinical guidelines, while others indicate a need for considerable improvement. A focus on appropriateness, not just volume, of prescribing is key to driving improvements needed.

The continued emergence and spread of AMR threats within Australia place pressure on the health system and highlight the need for continued surveillance.

The key findings in this report highlight the need for strengthening AMS practices, improved prescribing practices, enhanced infection prevention measures, and increased public awareness of AMR. Addressing these challenges requires a coordinated effort across healthcare settings, government agencies and the public.

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Allen Cheng comments on the AURA Report

Almost half of antibiotic prescribing for surgery is inappropriate, new report shows

Published: February 20, 2026
https://tinyurl.com/27mdu44h

Allen Cheng, Professor of Infectious Diseases, Monash University and Kelly Cairns, PhD Candidate studying antimicrobial resistance, Department of Infectious Diseases, The Alfred Hospital and School of Translational Medicine, Monash University

Inappropriate antibiotic prescribing around the time of surgery and long-term prescribing in aged care are among a mixed bag of findings of a recent report into antibiotic use and resistance in Australia.

Why is antibiotic use and resistance important?

Factors driving antibiotic use tend to be different in hospitals and in the community.

In hospitals, there are more patients with infections, and these are also places where patients come to with resistant infections. Here, a common dilemma is making sure sick patients receive antibiotics quickly, balanced with not overusing them unnecessarily.

In the community, GPs often have to use careful clinical judgement to determine whether antibiotics are required, or if the patient will recover without them.

Why are antibiotics used in surgery?

Antibiotics are mostly used around the time of surgery as one way to prevent, rather than treat, an infection.

They are generally needed only for procedures where there is a higher risk of infection and for a short period (mostly a single dose before surgery or for up to 24 hours afterwards).

This report shows that just under half (42.7%) of antibiotic use for surgical procedures was not appropriate. The main areas that we need to work on are:

- only using antibiotics for surgery where there is a high risk of infection
- the time we administer the antibiotic dose, ideally within an hour before the skin is cut
- the choice of antibiotic – sufficient to cover the organisms that could cause infection, but not unnecessarily broad that it may cause side effects or antibiotic resistance.

Inappropriate antibiotic use in surgery may have several consequences

Giving the antibiotic at the wrong time (too early, or too late) reduces its effectiveness. Giving it for surgery where there is a low risk of infection, or for too long unnecessarily exposes patients to the risk of antibiotic side effects such as diarrhoea, as well as increasing the risk of antibiotic resistance.

How about aged-care facilities?

The report shows residents of aged-care homes receive high amounts of antibiotics.

Aged-care residents are at a higher risk of developing infections and it can sometimes be harder to spot the signs and symptoms of an infection.

So using antibiotics to prevent infection can sometimes be appropriate but should be a last resort. This is because infections that 'break through' to cause infection despite preventative antibiotics are more likely to be resistant.

What else did the report find?

The report also included critical antimicrobial resistances. Particular microorganisms are a serious threat to some of our last-line antibiotics. These are very difficult to treat and require specialised antibiotics and medical care.

The report also highlights that many of these organisms are acquired overseas, reinforcing the regional and global context of antibiotic resistance.

What can we do to reduce antibiotic resistance?

We've previously written about actions we can take to reduce antibiotic use. This latest report reinforces that we

should raise awareness that many infections will get better by themselves, and don't necessarily need antibiotics. For aged-care residents, regularly review medications, including antibiotics, and check if they are still needed

- use the antibiotics we have more appropriately and for as short a time as possible, supported by appropriate oversight in hospitals, and at state and national levels
- continue to monitor for infections due to resistant bacteria to inform control policies reduce cross-transmission of resistant organisms in hospitals and in the community
- prevent infections by other means, such as clean water, sanitation, hygiene and vaccines
- continue to develop new antibiotics and alternatives to antibiotics, and ensure the right incentives are in place to encourage a continuous pipeline of new antibiotics.

The wider context

This report is only one part of the picture of how and where antibiotics are used in Australia. We have previously estimated that around 60% of antibiotics in Australia are used in animals.

This issue was highlighted by recent use of the antibiotic florfenicol in Tasmanian salmon farms. This product is closely related to chloramphenicol, an antibiotic used in humans. This disclosure reinforces the need to take a co-ordinated strategy across different sectors, an approach that has worked before in Australia.

There would also be benefits from responding to antibiotic resistance in a way similar to how we respond to other public health threats. So bringing the national response into the Australian Centre for Disease Control, which was launched officially at the start of 2026, should strengthen our efforts.

Allen Cheng receives funding from the National Health and Medical Research Council, the Australian Centre for Disease Control and the Department of Health, Disability and Aged Care. He is a Director of Therapeutic Guidelines, which publishes national treatment guidelines.

Kelly Cairns is the Vice President of the Australian Society for Antimicrobials, a professional society to support education, research and collaboration in antimicrobial use

Read more: *The rise and fall of antibiotics. What would a post-antibiotic world look like?*

https://theconversation.com/the-rise-and-fall-of-antibiotics-what-would-a-post-antibiotic-world-look-like-213450

Why Antibiotic Innovation is slowing down

Uma Raja Devi

Antibiotics have saved millions of lives, but fewer new ones are being developed today. The article Historicising the 'Empty Pipeline': How Antibiotic Innovation Became a Market Failure (1980–2024) explains that the slowdown is largely due to economic and structural problems in the pharmaceutical industry.

From the early 1900s to the 1970s, antibiotic discovery was very active because governments, universities, and pharmaceutical companies worked closely together. However, starting in the 1980s, many companies stopped focusing on antibiotics and shifted to more profitable drugs such as cancer or chronic disease treatments. Antibiotics usually bring in less profit because they are taken for short periods and are often replaced by cheaper generic drugs.

In the 1990s, experts began describing the situation as an 'empty antibiotic pipeline', meaning that very few new antibiotics were being developed. Governments and organisations introduced financial incentives and public–private partnerships to encourage research, but these efforts have not fully solved the problem. Many small biotech companies now lead antibiotic development, yet they often struggle financially or even go bankrupt.

The article argues that the real issue is that antibiotics are essential public health tools but are treated as normal commercial products in the pharmaceutical market, making long-term innovation difficult.

Read the full article: Historicising the 'Empty Pipeline': How Antibiotic Innovation Became a Market Failure (1980–2024) | Public Humanities | Cambridge Core - https://bit.ly/47UeieX

Abstract

Historicising the 'Empty Pipeline': How Antibiotic Innovation Became a Market Failure (1980–2024)

Part of *Antimicrobial Resistance: Just Transitions for Shared Futures*. Published online by Cambridge University Press: 21 November 2025[24]

Nadya Wells, Mirza Yanira Alas Portillo, Erin Lindsey Paterson, Frédéric Vagneron and Claas Kirchhelle

Antibiotic innovation has slowed. Despite substantial public investment, research and development (R&D) remains insufficient to address rising antimicrobial resistance (AMR). In this historical review, we draw on quantitative and qualitative historiographic methodologies, as well as on testimony from key stakeholders, to reconstruct antibiotic innovation challenges and public interventions since 1980.

[24] https://www.cambridge.org/core/journals/public-humanities/issues/antimicrobial-resistance-just-transitions-for-shared-futures

Emerging in the 1990s and gaining traction around 2010, the 'empty antibiotic pipeline' metaphor, as well as its market failure diagnosis, has played a key role in structuring the global R&D response. This reframing described AMR as an incentives-based innovation challenge, which suited industrial and high-income country interests. However, the introduction of so-called push and pull incentives has so far failed to halt the exit of large developers, sustain diversified R&D ecosystems, or address global access challenges. This article explores challenges and conflicts involved in the implementation of the incentives-based innovation approach alongside the ever-greater subsidies required to stabilise small and medium-sized enterprises (SMEs) and attract larger pharmaceutical companies and investment from financial markets. Several SME bankruptcies since 2019 and the mothballing of novel compounds suggest that this is an unsustainable innovation model. This article also explores whether public interventions have been insufficient or whether there is a deeper problem with the central metaphor structuring global action.

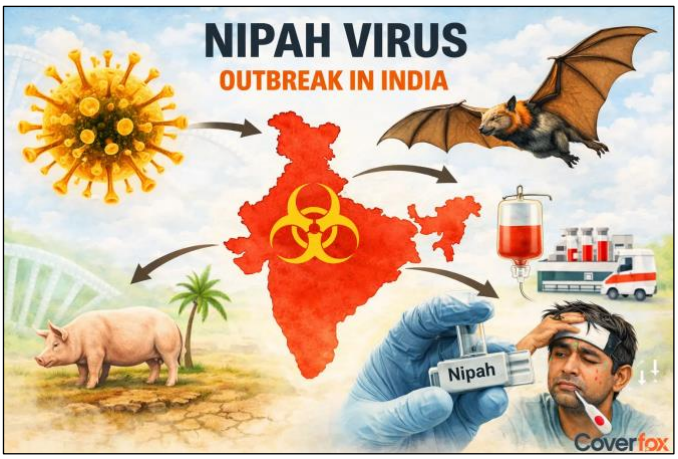
Nipah virus in India January 2026

What is Nipah virus? And what makes it so deadly?

Published: January 30, 2026

Also from Allen Cheng: https://tinyurl.com/cnztvs8r

(Nipah virus was covered in some detail in *HAIAP News* August 2024 and in *HAIAP at 40* on page 253.)
https://www.haiasiapacific.org/wp-content/uploads/2024/08/HAIAPNewsAugust2024.pdf)



https://www.coverfox.com/news/nipah-virus-outbreak-in-india-2026/

An outbreak of the deadly Nipah virus in India put many countries in Asia on high alert, given the fatality rate in humans can be between 40% and 75%. Several countries, including Thailand, Malaysia and Singapore, introduced new screening and testing measures, after at least two people died of Nipah virus in the Indian state of West Bengal in January 2026.

But what is Nipah virus, and how concerned should we be?

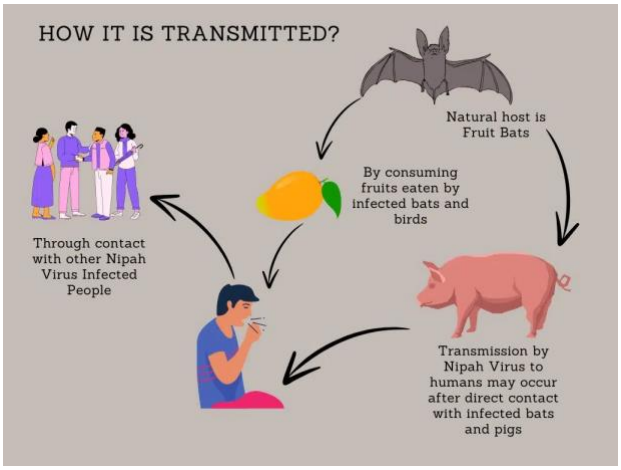
Here's what you need to know.

What is Nipah virus?

Like Hendra virus, Nipah is in a category of viruses called henipaviruses. It is zoonotic, meaning it can spread from animals to humans. As I explained in a previous Conversation article,[25] outbreaks happen in Asia from time to time. The first outbreak was reported in 1998 in Malaysia.

There are three major ways it's transmitted.

The first is via exposure to bats, and in particular via contact with the saliva, urine or faeces of an infected bat. Infections can also occur from contact with other infected animals, such as pigs in the original outbreak in Malaysia.



The second way it can be transferred is by contaminated foods, particularly date palm products. This method means consuming date palm juice or sap that is contaminated with the bodily fluids of infected bats.

The third is human-to-human transmission. Nipah transmission between humans has been reported via close contact such as caring for a sick person. This transmission can mean, for instance, being infected with bodily secretions contaminated with the virus in households or hospitals. It is thought to be less common than the other transmission pathways.

What are the symptoms?

Nipah virus infections happen quickly. The time from infection to symptoms appearing is generally from four days to three weeks.

It's a terrible disease. Around half the people who get severe Nipah virus infection die with it.

[25] https://theconversation.com/5-virus-families-that-could-cause-the-next-pandemic-according-to-the-experts-189622

The symptoms can vary in severity. It can cause pneumonia, just as COVID could.

But the illness we worry most about has neurological symptoms; Nipah can cause encephalitis, which is inflammation of the brain. These effects on the brain are why the fatality rate is so high.

Symptoms might include:

- fever
- seizures
- difficulty breathing
- falling unconscious
- severe headaches
- being unable to move a limb
- jerky movements
- personality changes, such as suddenly behaving oddly, or psychosis.

Unusually, some patients who survive the acute phase of a Nipah infection can suffer from relapsed encephalitis many years later, even more than a decade later.

Is there any treatment or vaccine?

Not yet, but in Australia development of a treatment called m102.4 is underway.

It is still quite a way off being actually available to help people infected with Nipah virus, but there's hope.

There is currently no vaccine for Nipah virus. In theory, m102.4 could be a preventative but it's too early to say; at this point it is being trialled as a treatment.

How worried should I be?

This Nipah outbreak in India is worrying because there's currently no prevention and no treatment available, and it's a severe disease. While it is an important disease, it isn't likely to be a public health issue on the same scale as COVID because it doesn't transmit efficiently from person to person, and the main way it is transmitted is from food and infected animals.

For people living outside of areas where cases are currently being reported, the risk is low. Even in the affected areas, the number of cases is small at this stage, but public health authorities are taking appropriate control measures.

If you become unwell after travelling to areas where cases have been reported, you should let your doctor know where and when you travelled.

If someone gets a fever after travelling to affected areas, we would probably be much more worried it was caused by other infections such as malaria or typhoid than Nipah, at this stage.

Overall, though, everything needs to be put in context. We hear about new viruses and incidents all the time. Nipah is important for affected countries, but in other countries it is something we closely monitor and be alert for.

https://theconversation.com/5-virus-families-that-could-cause-the-next-pandemic-according-to-the-experts-189622

Training Midwives in Sri Lanka

Kris Weerasuriya

https://srilanka.unfpa.org/en/news/empoweringlivestogether-how-unfpa-empowering-midwives-sri-lanka-safeguard-mothers-and-newborns

Although the above article is a promotion for UNFPA it is both true and relevant. What is important is the midwives are Public Health Midwives and so not focussed on Pregnancy and Delivery but the whole area - childhood vaccinations, well baby clinics etc.

Sri Lanka has the lowest Maternal Mortality in the region; the main cause of death is not post-partum haemorrhage but respiratory infections in pregnancy.

A major outcome is the vast majority of the deliveries (over 90%, possibly more) are in the hospitals so high level care is available. The midwives arrange for mothers to be to go for the clinics and for the delivery. That also helps to lead into breast feeding (very high percentage until 6 months) and immunisation. Nestle and infant nutrition supplements are kept at bay also.

Polluters have to pay – Farmers' voice on Climate Justice from Pakistan

Climate Crisis and Pakistan's Vulnerability

Tanveer Ahmed HANDS

https://hands.org.pk/

Natural calamities have existed since the dawn of the Earth, but human-driven development has transformed many of them into large-scale disasters. Industrialisation, urbanisation, deforestation, and the extensive use of fossil fuels are among the key drivers of today's climate crisis.

Although Pakistan contributes less than 1% to global carbon emissions, it remains among the most severely affected countries.

Historically, the major emitters have been industrialised nations such as the United States, European countries, and Great Britain. Unfortunately, weak governance and inadequate infrastructure in Pakistan often turn natural events into humanitarian catastrophes.

https://www.facebook.com/HANDSWelfareFoundation/posts/the-farmers-assembly-on-climate-justicepolluters-should-pay-demand-by-the-flood-/1365123642329093/

At HANDS, we are striving to set a global precedent by holding major carbon-emitting corporations accountable. In collaboration with our German partners, Medico International and ECCHR, we have initiated legal action against two German companies. Baseline research has already been conducted, identifying small farmers from Larkana and Jacobabad who suffered severe losses during the 2022 floods.

The research establishes that these floods were a direct consequence of climate change. Consequently, we argue that these corporations must compensate the affected farmers. Together with our partners, HANDS will soon file a lawsuit in a German court, a case that we hope will set a precedent for corporate accountability worldwide, ensuring that those responsible either reduce their carbon emissions or compensate the vulnerable communities they harm.

Pakistan continues to endure the devastating impacts of climate change. The country had yet to recover from the catastrophic floods of 2022, when once again this year, torrential rains unleashed another wave of destruction.

Pakistan ranks among the most climate-vulnerable regions in the world, as evidenced by rapidly melting glaciers, frequent landslides, cloudbursts, floods, and episodes of extreme rainfall.

Fertile agricultural lands have been destroyed, leading to acute food shortages; the livestock sector has faced irreparable losses; and the country's health, education, and transport systems have suffered extensive damage. Millions of people have been displaced, both temporarily and permanently.

It is an undeniable global truth that the reckless exploitation of fossil fuels and other destructive energy sources has pushed the planet to the brink of ecological collapse. The capitalist model of industrial development has poisoned our environment and endangered life on Earth. Our generation may be the last with a genuine opportunity to avert total ecological disaster.

The Farmers Assembly on Climate Justice, brought together farmers, policymakers, labour representatives, legal experts, civil society organizations, political party representatives, and UN agencies at Arts Council of Pakistan, Karachi, to underscore the urgent need for climate accountability and justice for vulnerable communities in Pakistan. The event drew over 300 participants from diverse sectors.

The event concluded with a Farmers Rally from Arts Council Karachi to the Press Club, where hundreds of participants marched to highlight their demands. The Assembly demanded, with a strong unified message, that climate justice is a fundamental human rights issue and that the voices of affected farmers must remain central to global climate decision-making.

The Assembly called upon the international community to:

- Recognize climate-induced loss and damage as a matter of justice,
- Ensure accountability of historically high-emitting corporations,
- Strengthen global climate litigation mechanisms,
- Support climate-resilient livelihoods and policies.

Participants stressed the need for a global penalty mechanism under the United Nations framework, holding major corporations accountable under the principle of 'Polluters must pay', ensuring compensation for developing countries and affected populations.

The Speakers of this session were the Secretary of Youth Affairs, Mr. Munwar Ali Mahesar, climate-affected farmers, Mr. Hamza Khan Kalhoro, Dr. Shaikh Tanveer

Ahmed, Chairman of HANDS Welfare Foundation, Nasir Mansoor, National Trade Union Federation (NTUF), Ms. Karin Zennig from medico international, Germany, Mr. Abdul Khaliq Leghari-Farmer from Dadu and Maqbool Ahmed Rahu, Chief Executive of HANDS Welfare Foundation.

A unified global movement is essential, one that transcends borders to confront humanity's greatest existential threat. The Climate Justice Movement embodies this awakening, but it must remain clear-eyed about the root cause: the fossil fuel industry and the states that protect and profit from it.

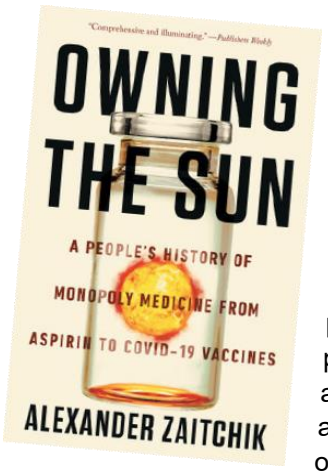
(*Make Polluters Pay* pact is a global alliance demanding fossil fuel companies pay for climate-related damages. https://www.greenpeace.org.au/our-work/climate-justice/make-polluters-pay/)

Owning the Sun

Book review by Prof Rob Moulds, re-printed from the ISIUM Newsletter March 2026

***Owning the Sun:* A people's history of monopoly medicine from aspirin to COVID-19 vaccines**

Alexander Zaitchik



This book is for those who are interested in the whole history and complexities of the cost of medicines – although the book is written largely from a US perspective. The main thread right through the book is the evolution of the protection of intellectual property in the same way as all other personal property, and particularly the awarding of patent protection to innovative discoveries. In doing so, it also shows how the pharmaceutical industry was (and still is) at the forefront of the promotion of these concepts in the US. Importantly, the author is a freelance journalist and does not have a healthcare background. So, he approaches the topic without an obvious 'agenda' – either pro- or anti- the pharmaceutical companies.

The book starts with describing how, at least in Western nations, monopolies were first introduced centuries ago as royal charters granted by monarchs to important nobles. These charters bestowed monopoly rights over an essential good or service to ensure the support of their holder when needed by the monarch – usually financial support for waging wars.

It then moves on to what I found the most interesting parts of the book, which describe the attitudes of the medical profession and academia in the late 19th and early 20th centuries to the whole concept of 'ownership' of new knowledge. Perhaps surprisingly, organised medicine and academia strongly took the moral and ethical stance that new knowledge seldom arose from individual flashes of genius that warranted monopoly rights on its discoverer. Rather, it was usually building on past contributions that had been made freely available, and the public good was better served by maintaining the principle that all new knowledge should be freely available.

Examples given include the battles over the availability of aspirin before WW1, when Bayer tried to prevent its manufacture and sales in the US, and the refusal of Jonas Salk to patent his polio vaccine to ensure it could be made widely available as soon as possible.

The book then takes us through the gradual change of thinking to support the ideas that had always been championed by the pharmaceutical industry - that innovation requires expensive investment that will not occur unless there is the promise of monopoly rights on new products that ensue. This later led to the battles over the generic manufacture of AIDS drugs under the TRIPS agreement.

And the book finishes by describing how monopoly behaviour is now maintained more by trade secrets than by patents, and how this led to initial problems with the availability of COVID vaccines.

Although the book was published in late 2022, so predates Mr Trump's tariffs, I commend it as an excellent overview of how society (or at least the US) has wrestled with the complex forces driving the costs and availability of new drugs.