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Third World Network



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Garden of Knowledge and Virtue

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HAI AP Est. 1981

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

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This issue covers a wide range of topics.

International Rational Use of Medicines Day fell in July reminding us that rational use of medicines still matters!

We remember Hiroshima and the atomic bomb that was dropped on August 6 1945 and we honour the new gallery set up to teach future generations about peace, humanitarian values, and intercultural understanding.

International public health and affordable access to essential health services are under serious attacks. Uma Devi has provided wonderful analyses of the situations we are facing. She has also provided a comprehensive view of the scope of interventions needed to address AMR that are far beyond hospitals and communities.

The feature shows how many epidemics have been prevented - largely by communities and their health workers.

There is news from Sri Lanka and from Bangladesh. Thank you Dr Tariqul Islam.

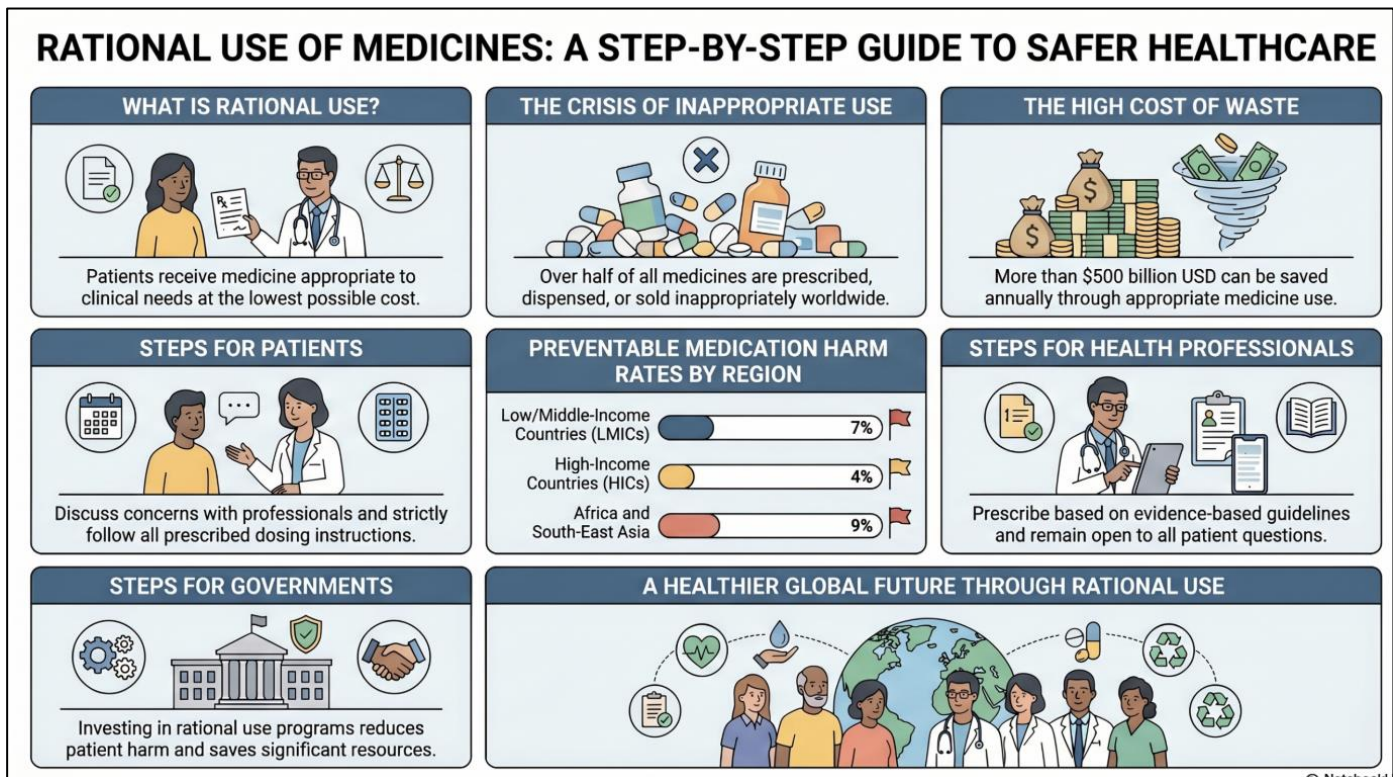
Two important new books are featured: ***How to sell a genocide*** by Adam Johnson and ***Fighting corruption, seeking integrity*** by Anwar Fazal.

Hard copies of **HAIAP at 40** are available free but postage needs to be covered. Contact linda@twnnetwork.org. It can be downloaded free of charge at:

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



International Rational Use of Medicines Day



Why rational use of medicines still matters

Editorial

For HAIAP, rational use is not simply about individual prescribing decisions. It is about whether health systems enable people to receive the right medicine, at the right dose, for the right length of time, at a cost that they and their communities can afford.

WHO defines rational use as patients receiving medicines appropriate to their clinical needs, in doses appropriate to their individual requirements, for an adequate period and at the lowest cost to them and their community.

WHO continues to identify rational use as an essential part of improving health outcomes, reducing waste and progressing towards universal health coverage.

1. Rational use is fundamental to universal health coverage

WHO defines rational use as patients receiving medicines appropriate to their clinical needs, in doses appropriate to their individual requirements, for an adequate period and at the lowest cost to them and their community.

Good medicine use is therefore not a minor technical issue. It is part of achieving equitable and effective health care.

2. Medicines consume a large share of health spending

Medicines account for around 20–60% of health spending in developing countries. In some developing countries, up to 90% of people purchase medicines through out-of-pocket payments.

For many families, medicines are among the largest health-related household expenditures after food. Ensuring that this expenditure provides good value is therefore essential.

3. Better use of medicines could save hundreds of billions of dollars

An Institute of Medical Science (IMS) analysis published in 2012 estimated that approximately US\$500 billion in avoidable healthcare costs could have been addressed in 2011 through more responsible use of medicines.

The figure is historical and should not be presented as a current estimate of today's health expenditure. Its continuing importance is the message: poor use of medicines represents a major source of avoidable waste and harm.

The analysis identified problems including non-adherence, delayed use of medicines, medication errors, inappropriate antibiotic use, sub-optimal generic use, mismanaged polypharmacy and medicine shortages.

4. Medication-related harm is common

WHO's evidence indicates that at least 1 in 20 patients globally – around 5% – experience preventable medication-related harm. The estimate is approximately 7% in low- and middle-income countries and 4% in high-income countries.

The highest reported regional prevalence was around 9% in both Africa and South-East Asia.

5. Much of this harm can be serious

Almost one quarter of preventable medication-related harm is severe or potentially life-threatening.

WHO's Medication Without Harm initiative aims to reduce severe avoidable medication-related harm by 50%.

6. The problems are familiar

Irrational or sub-optimal use includes:

- inappropriate use of antimicrobials;
- sub-optimal use of generic medicines;
- inappropriate polypharmacy;
- delayed or inadequate use of medicines for chronic conditions;
- medication errors; and
- patients not taking medicines as intended.

WHO continues to identify polypharmacy, inappropriate antimicrobial use, non-adherence and failure to follow treatment guidelines among the major problems of irrational medicine use.

7. Older people are particularly vulnerable

Older people are more likely to experience medication-related harm while also being among those most likely to receive multiple medicines.

WHO's evidence highlights geriatric care as a particularly important area for medication-safety action.

8. Some medicines are repeatedly implicated

WHO's evidence identifies medicines affecting the cardiovascular and central nervous systems, as well as antibiotics, antipsychotics, gastrointestinal medicines and NSAIDs, among important contributors to medication-related harm.

Rational use is therefore about much more than reducing unnecessary prescribing. It is about ensuring that medicines actually improve health – safely, effectively, equitably and affordably.

Remember Hiroshima and Nagasaki August 6 and 9, 1945

Professor Emeritus Tan Sri Dr. Dzulkifli Abdul Razak carries forward the legacy of his late father, Abdul Razak Abdul Hamid (known as Razak Sensei) — the sole Malaysian survivor of the 1945 Hiroshima atomic bombing.

For the full story commemorating the 80th Anniversary of Razak Sensei's survival of the Hiroshima bombing see <https://www.haiasiapacific.org/wp-content/uploads/2025/08/HAIAP-News-August-2025.pdf>



In August 2025, Dzulkifli Abdul Razak (Dzul) told *Free Malaysia Today* of his late father's experience as a student at Hiroshima University when the atom bomb was dropped on August 6, 1945.



<https://www.freemalaysiatoday.com/category/leisure/2025/08/06/thatswhy-he-lived-a-malaysian-survivors-memories-of-hiroshima>

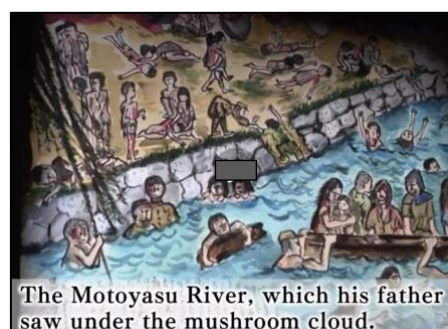
Please look at

<https://drive.google.com/file/d/1kYMHnWKEAZJyYTZAnrP0iK2KWrfdpBv4/view>

and

<https://www.youtube.com/watch?v=5KQy5VcHooQ>

While Dzulkifli retraced his father's steps in Hiroshima during past milestone visits, ongoing 2026 events and media continue to



feature his prominent peace advocacy, lectures, and reflections connecting his father's survival to global nuclear disarmament.

Razak Sensei Gallery

The Razak Sensei Gallery opened on August 6, 2026, at the National Education Museum within Universiti Pendidikan Sultan Idris (UPSI) in Tanjung Malim, Perak—not Penang. It honours Datuk Abdul Razak Abdul Hamid, the sole Malaysian survivor of the 1945 Hiroshima atomic bomb, promoting peace and education. [1, 2]

Razak Sensei Gallery At UPSI: Symbol Of Peace, Strengthening Malaysia-Japan Ties

© 06/08/2026 08:25 PM



The Gallery was established to mark 81 years since the Hiroshima tragedy. The exhibition features historical materials, photographs, and personal collections to teach future generations about peace, humanitarian values, and intercultural understanding.

According to the *Press Reader* of Malaysia¹ The establishment of the Razak Sensei Gallery at Universiti Pendidikan Sultan Idris (Upsi) serves to preserve the legacy of the late Datuk Abdul Razak Abdul Hamid, a national educator who was known as Razak Sensei.

It also serves as a symbol of peace and strengthens educational and cultural ties between Malaysia and Japan.

Japanese Ambassador to Malaysia Shikata Noriyuki said the choice of August 6 as the opening date also holds deep significance, as it coincides with the 81st anniversary of the atomic bombing of Hiroshima, an event that claimed thousands of lives and profoundly changed Abdul Razak's life.

'His miraculous survival from the Hiroshima tragedy, and his courage in turning that painful experience into a lifelong commitment to peace and education, serve as examples worth emulating. His life story reminds us that education goes far beyond merely imparting knowledge. Education is a force that shapes character, fosters mutual respect and helps build peaceful societies....'

¹ https://www.pressreader.com/malaysia/the-sun-malaysia/20260808/281595247346175?srsltid=AfmBOophUbFnKOWLib1gVDbge5N9B_RNGjTNIV8PQQsGL7wSPxqhFdn

PUBLIC HEALTH UNDER PRESSURE

The US CDC on the brink²

Uma Devi

In April 2026, *The Lancet* published a disturbing editorial, **'The US CDC on the brink**. It is worth reading not simply as a story about what is happening to a US government agency, but because the consequences could reach much further.

The US Centers for Disease Control and Prevention (CDC) has long been one of the world's leading public-health institutions. Its work extends well beyond the United States. It has contributed to disease surveillance, outbreak investigation, laboratory science, vaccination programs, epidemiological research and training, and has worked with health agencies around the world.

The Lancet describes an organisation being severely disrupted following changes introduced by the Trump administration and the US Department of Health and Human Services. At the time the editorial was published, 80% of the CDC's highest-level positions were vacant, directors of 20 of its 25 centres had left, and around 2,000 staff – almost one in five employees – had been fired. A further 300 were reported to be on administrative leave. The agency was also without a permanent director.

In the original *Lancet* editorial the numbers quoted are extraordinary numbers. But the loss of people is only part of the story. What happens when public-health expertise disappears?

Public-health institutions accumulate knowledge over many years. Epidemiologists know where unusual disease patterns are likely to appear. Laboratory scientists know how to investigate them. Program managers know who to call when an outbreak occurs. Researchers and health officials build relationships with counterparts in other countries.

Much of this activity does not appear on an organisational chart. It is institutional memory. When experienced people leave in large numbers, it is not simply a matter of filling vacant positions with new staff. The expertise, relationships and experience that have been lost may take years to rebuild. That result is particularly concerning for an organisation whose job is to identify health threats early - the world's early-warning system.

Disease surveillance is one of the less visible but most important functions of public health. Someone has to notice that the number of children presenting with a particular illness is unusual. Someone has to recognise that a disease is appearing in a new area. Laboratories have to identify unfamiliar pathogens. Epidemiologists have to determine whether apparently separate cases are

² <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2826%2900799-3>

connected. The earlier that happens, the greater the chance of containing an outbreak.

The Lancet reports that CDC services for disease detection have already been reduced and that 38 CDC datasets, mostly relating to vaccination, had been halted.

This outcome should concern everyone. A disease does not become an international threat only when it crosses a border. By then, it may already have been spreading for weeks or months. COVID-19 made that painfully clear. But the same principle applies to measles, influenza, dengue, mpox and other infectious diseases.

Public health cannot respond effectively to a threat that it cannot see.

Why should Asia and the Pacific care?

For countries in Asia and the Pacific regions, it is not a distant American problem. Many countries in our region have strong public health programs, but surveillance and laboratory capacity can be uneven. International cooperation and access to scientific expertise are therefore important parts of the safety net.

The CDC has historically worked with WHO, ministries of health, universities, laboratories and public-health agencies in many countries. *The Lancet* raises concerns about the loss of these international partnerships as well as the loss of capacity within the agency itself.

If one important part of the international public-health network becomes weaker, other parts have to carry more of the burden.

That does not mean that the world is helpless, nor that other agencies cannot take on some of the work. But rebuilding expertise and cooperation takes time. And outbreaks do not wait for institutions to reorganise themselves.

The importance of trust: There is another issue that deserves attention: trust. Public-health authorities have to be trusted if people are to accept vaccination, follow advice during an outbreak or believe warnings about a new health threat.

That trust is already fragile in many countries. Vaccine misinformation has become a serious problem, and the politicisation of health information can make matters worse.

A scientific agency does not have to be infallible. But people need confidence that its advice is based on evidence and that its scientists are able to speak honestly about what is known, what is uncertain and what needs to be done.

If that confidence is lost, rebuilding it can be much harder than rebuilding an organisational structure. It is not only about infectious disease. The CDC's role is also much broader than outbreak control.

Its work includes chronic diseases, tobacco control, environmental and occupational health, injury prevention, maternal and child health, vaccination and many other areas of public health.

Weakening the institution therefore has implications beyond the next epidemic.

It also raises a more fundamental question about what governments expect public health institutions to do. Are they primarily agencies that respond to crises, or are they part of the infrastructure that allows societies to prevent crises in the first place? The answer matters. A global public good. There is a reason why countries invest in surveillance and public-health research even when there is no immediate emergency.

The benefits do not stop at national borders. When a country detects a new disease and shares that information, other countries benefit. When a laboratory develops expertise in identifying a pathogen, that expertise can be shared. When epidemiologists are trained and connected internationally, the entire public health system becomes stronger. In that sense, public health capacity is a kind of global public good.

The weakening of a major institution such as the CDC therefore matters beyond the United States. It adds pressure to the international system at a time when that system is already dealing with multiple health threats and, in many places, declining confidence in public institutions.

Preparedness cannot be built overnight.

The most important message from *The Lancet* editorial may be the simplest one: public health capacity takes years to build and can be lost surprisingly quickly. The next pandemic will not give governments time to recruit thousands of epidemiologists, rebuild laboratory networks or recreate international partnerships.

Those things have to exist before they are needed.

The same applies to reliable disease surveillance, vaccination programs and the institutions that provide independent scientific advice.

Conclusion

The Lancet editorial's concern is ultimately larger than the disruption of one US government agency. The CDC has been an important part of the infrastructure through which the United States detects disease, produces public health evidence, trains specialists and contributes to international health security.

The editorial warns that weakening this capacity risks destroying expertise and institutional knowledge that took decades to build. Once experienced scientists, epidemiologists and public health leaders have left, programs have been dismantled and international relationships disrupted, restoring them will not be straightforward.

The consequences may not be immediately visible. The real test will come when the next infectious disease emerges, when an unusual cluster needs to be investigated, when a vaccine program needs reliable scientific guidance, or when countries need to work together to contain a threat. *The Lancet* therefore presents the crisis at the CDC as a warning about the importance of strong, independent and scientifically grounded public health institutions.

Public health depends on preparedness before a crisis occurs. Once that capacity has been lost, it may be too late to rebuild it when it is needed most. The question is not whether the CDC can survive this period of disruption, but whether the damage to its scientific capacity and institutional memory can be repaired before the next major public-health emergency tests it.

Read the original

'The US CDC on the brink'

The Lancet, Volume 407, Issue 10539, page 1573, 25 April 2026. DOI: 10.1016/S0140-6736(26)00799-3.

<https://www.thelancet.com/action/showPdf?pii=S0140-6736%2826%2900799-3>

AUSTRALIA

US Drug Companies attack Australia for providing affordable drugs on PBS

Australia's Pharmaceutical Benefits Scheme has once again become a focus of debate over medicine prices and the power of pharmaceutical companies.

Prepared by Uma Devi and Beverley Snell

AstraZeneca withdraws critical breast cancer drug

<https://www.abc.net.au/news/2026-06-04/astrazeneca-pulls-critical-breast-cancer-drug-from-shelves/106757490>

<https://www.abc.net.au/news/2026-06-04/breast-cancer-endometriosis-drug-zoladex-discontinued/106726158>

National health reporter **Stephanie Dalzell** and Specialist Reporting Team's **Mary Lloyd**

AstraZeneca said the Australian price for the product, sold as Zoladex, (goserelin) was too low, "making it unsustainable to supply the medicine on the PBS".

Pharmaceutical commentator Paul Cross said the nature of pricing negotiations meant it was likely more financially advantageous for AstraZeneca to supply Zoladex in Australia for free than create a low pricing precedent for other countries.

When drugs are placed on the PBS, patients can receive their medications at a small portion of the cost: currently \$25, or \$7.70 for concession card holders.

US pharmaceutical companies have long been lobbying against the scheme, arguing its pricing processes undervalue innovation and threaten billions of dollars in lost sales.

As revealed by the Australian Broadcasting Corporation (ABC) last month, AstraZeneca, the maker of life-saving breast cancer and endometriosis medication goserelin 3.6mg implant, said it would pull the drug from both the Pharmaceutical Benefits Scheme (PBS) and the private market in Australia in November.

AstraZeneca said the Australian price for the product, sold as Zoladex, was too low, 'making it unsustainable to supply the medicine on the Pharmaceutical BS'.

The move triggered criticism from advocates, patients and the broader public and a Change.org petition calling for urgent action gathered more than 42,000 signatures in a matter of weeks.

AstraZeneca had initially promised to set up a six-month access program to provide the medication for free to those without alternative treatments.

However, AstraZeneca has since announced it would supply the medication indefinitely to those whose doctors determine there are no other suitable treatments available. [Only doctors approved by AZ. Ed]

'This plan includes patients who are currently prescribed and patients who may need to be prescribed the implant as a treatment option after 1 November 2026. an AstraZeneca spokesperson said.

Pharmaceutical commentator Paul Cross said the nature of pricing negotiations meant it was likely more financially advantageous for AstraZeneca to supply Zoladex in Australia for free than create a low pricing precedent for other countries.

He said international reference pricing — where governments can use lower prices in other countries as a negotiating benchmark — was probably a factor behind the company's decision to remove Zoladex from the PBS.

'It's quite possible that because it's been provided for free it's not included in the benchmark and that's one of the workarounds,' he said.

Mr Cross, who worked as an advisor on the PBS for the Howard government and used to be a pharmaceutical executive, said Australia could become increasingly vulnerable to decisions made to keep prices high overseas. That could include drugs being withdrawn from sale in Australia.

'International reference pricing has been a feature of the global pharmaceutical industry for many, many years,' he said.

'Because you've got two behemoths now in the US and China being far more assertive on pricing, I think it's fair for Australian patients who are already accessing medicines to contemplate whether they could be the next group to be affected.'

The medication, delivered monthly as a pellet injected under the skin, stops a patient's ovaries from producing

oestrogen, a hormone which promotes the growth of many forms of breast cancer and can fuel endometriosis.

Victorian public servant Katie Elson has had breast cancer twice and said because her type of cancer was hormonally fuelled, stopping Zoladex could cause it to grow out of control and claim her life.

Ms Elson said despite AstraZeneca's latest decision, she remained fearful about accessing the drug.

'It does feel like they could still pull the carpet from under us at any time,' she said, 'how can you trust a drug company that says one thing and then switches overnight?'

Men with aggressive prostate cancer who were being treated with a ground breaking drug have been told the therapy is no longer available at public hospitals.

One patient who has been taking Zoladex for about six years said she thought it was strange that a company would decide to withdraw a drug for 'commercial reasons' then announce they would provide it for free. 'I'm not a commercial decision,' she said. 'I'm a person. I have a family, I have friends, I have people that love me.'

Further pressure

The Australian government has recently been in several protracted, high-profile stand-offs with major pharmaceutical companies over the way the PBS works.

In April, Eli Lilly [withdrew diabetes drug Mounjaro from the PBS](#) listing process, arguing the price Australia was willing to pay was too low.

In July [a pricing dispute with two major drug manufacturers](#) who make multiple sclerosis medications sparked fears people with MS would have to pay tens of thousands of dollars to access life-changing treatments. The government later [confirmed the drugs would remain on the PBS](#).³

These challenges matter beyond Australia.

The PBS is one of the better-known examples of a public system using purchasing power and price negotiation to improve affordability.

Pressure on countries to pay higher prices for medicines threatens not only national health budgets but the principle that medicines should be priced according to what health systems and patients can reasonably afford.

Further pressure from the United States

The issue has taken on an international dimension.

On 2 April 2026, the United States announced a **100% tariff on specified patented pharmaceutical products and associated ingredients**, with different arrangements for certain countries, companies and

products. Generic pharmaceuticals and their associated ingredients were excluded from the tariffs at that time.

The policy is part of a broader US effort to encourage domestic pharmaceutical production and push other countries towards higher medicine prices through Most-Favoured-Nation pricing arrangements.

For countries that rely on public purchasing systems, the implications are significant.

The question for public health is simple:

Will countries be able to continue using their collective purchasing power to obtain medicines at affordable prices?

When drugs are placed on the PBS, patients can receive their medications at a small portion of the cost: currently \$25, or \$7.70 for concession card holders.

US pharmaceutical companies have long been lobbying against the scheme, arguing its pricing processes undervalue innovation and threaten billions of dollars in lost sales.

Remembering South Africa - the need for fluconazole in 2000

A memorable experience associated with this same sort of drug company behaviour was the episode in South Africa with Pfizer. Pfizer had influenced South Africa to legislate that only original brand name drugs could be imported.

Fluconazole was needed for HIV-related opportunistic fungus infections in patients in South Africa in year 2000. Fluconazole was patented by Pfizer under the trade name Diflucan in 1981.

Zackie Achmat (Treatment Action Campaign) challenged Pfizer in 2000 by importing affordable generic fluconazole into South Africa to protest the company's high patent pricing. At the time, brand-name manufacturer Pfizer sold the drug in South Africa for roughly R80 per capsule privately and R28 publicly. Achmat purchased the generic Thai version for about R1.78 per tablet. [1] On his return to South Africa Zackie Ahmat was arrested at the airport and imprisoned. There was an international outcry.

Eventually Pfizer offered South Africa donated fluconazole on their terms with their chosen doctors only. That would not interfere with their overall selling price. As shown in the discussion above - donations are not an answer.

³ <https://www.abc.net.au/news/2026-07-08/ms-drugs-could-be-pulled-from-pbs-pricing-stoush/106890154>

BANGLADESH

Measles resurgence signals an immunisation emergency

<https://www.thelancet.com/action/showPdf?pii=S2772-3682%2826%2900072-7>

<https://www.thelancet.com/action/showPdf?pii=S0140-6736%2826%2900687-2>

Bangladesh has experienced a major resurgence of measles in 2026.

WHO reported widespread transmission across 58 of the country's 64 districts, with 19,161 suspected cases and 2,973 laboratory-confirmed cases reported between 15 March and 14 April, alongside 166 suspected measles-related deaths. Children under five accounted for 79% of reported cases.

The response has included a nationwide measles-rubella vaccination campaign supported by the Government of Bangladesh, WHO, UNICEF and Gavi. The campaign particularly targets children who have missed routine immunisation.

The scale of the outbreak has placed considerable pressure on hospitals.

A correspondence published in The Lancet, 'Unusual measles mortality in Bangladesh signals an immunisation emergency,' reported that the Infectious Diseases Hospital in Mohakhali, Dhaka, admitted 560 suspected measles cases during the first three months of 2026, compared with 69 suspected cases during the whole of the previous year.

The outbreak is a reminder that vaccination programmes cannot be taken for granted.

Even where national coverage has improved substantially, pockets of missed children, disruption of routine services, inequalities in access and immunity gaps can create the conditions for a preventable disease to return.

The lesson is particularly important for countries that have made substantial progress in immunisation: maintaining coverage is just as important as achieving it in the first place.

Original article

Jamil, S., Asif, U., & Mohammadnezhad, M. (2026). Unusual measles mortality in Bangladesh signals an immunisation emergency. *The Lancet*, 407(10539). Published 20 April 2026. DOI: 10.1016/S0140-6736(26)00687-2.

No measles in Gonoshasthaya Kendra (GK) villages

Tariqul Islam

GK has had an actively surveillance system to collect health related information since 1972, implementing a PHC program among the population of 1(+) million in the 23 different geographical sites in Bangladesh. Health related information - including measles cases - is collected and compiled routinely. GK is also participating

in the measles vaccination program with the Government of Bangladesh.



Currently, nationwide, measles death cases are reported every day in the mass media as explained in the *Lancet* article.



However, **there have been no deaths due to measles in the GK program area in 2026.**

SRI LANKA

Healthier school canteens

In December 2020 Manuj Weerasinghe et al published:

Healthy food in school canteens, policy directions and deviations: A cross sectional study from Sri Lanka

[The Journal of Community Health Management](https://www.researchgate.net/publication/405210794_Healthy_food_in_school_canteens_policy_direction) 5(1):26-31

https://www.researchgate.net/publication/405210794_Healthy_food_in_school_canteens_policy_direction

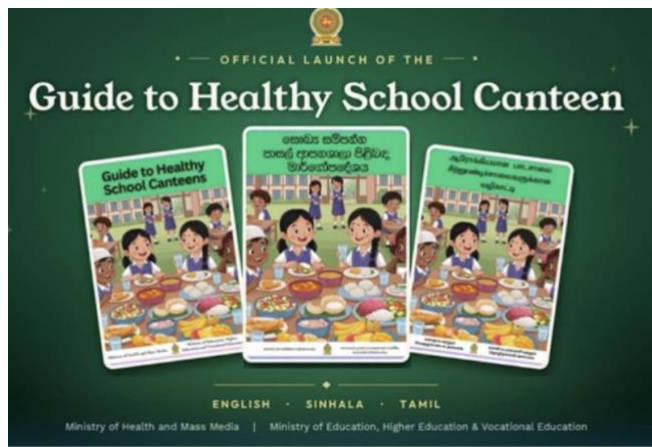
file:///Users/bev/Desktop/Healthy_food_in_school_canteens_policy_directions_.pdf

Now Sri Lanka has introduced new Healthy School Canteen Guidelines, aimed at creating school canteens that provide safe, affordable and nutritious food while restricting the sale and promotion of unhealthy products. The '**Guidelines on Healthy School Canteens**' were unveiled during National Nutrition Month - June 2026, aiming to ensure affordable, safe, and nutritious meals for students while instilling healthy eating habits.

The measures restrict foods considered unhealthy because of high levels of fat, salt or sugar, as well as energy-dense foods with limited nutritional value and a range of ultra-processed products.

The policy is aimed at improving children's nutrition and addressing concerns about overweight, obesity and non-communicable diseases.

School food policies are an important example of the difference between an approach focused only on individual responsibility and one that changes the environment in which choices are made.



Children cannot be expected to make healthy choices if the environment around them is designed to promote unhealthy ones. The school canteen is therefore more than a place where children buy food. It is part of the environment in which eating habits are formed.

A policy that changes what is available, affordable and promoted to children can make the healthier choice easier – without placing the entire responsibility on children themselves.

Health Minister Nalinda Jayatissa stressed urgent action against rising nutrition challenges, as surveys show worrying levels of stunting, wasting, underweight, and obesity among children, alongside high rates of anaemia in pregnant mothers and unhealthy food consumption among adolescents. Officials said the guidelines must extend beyond schools to institutions and public events to drive long-term change.



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UNITED KINGDOM:

https://en.wikipedia.org/wiki/Tobacco_and_Vapes_Act_2026

Tobacco control

Creating a smokefree generation

There is an important development in the United Kingdom.

The Tobacco and Vapes Act became law on 29 April 2026, creating a smokefree generation by making it illegal to sell tobacco products to anyone born on or after 1 January 2009. The age at which tobacco can legally be purchased will therefore rise progressively over time.



The policy represents a shift from trying only to persuade individuals not to smoke towards changing the commercial environment that continually recruits new users. An earlier policy paper by Jon Berrick⁴ provides a useful discussion of the Tobacco-Free Generation concept.

For countries in Asia and the Pacific, where tobacco and nicotine industries continue to develop new products and marketing strategies, this is an issue worth watching closely. Can governments prevent the next generation from becoming customers of an industry whose products are known to cause serious disease and premature death?

As reported in the HAIAP News April 2024, the Control of Smoking Products for Public Health Bill was presented in the Malaysian Parliament in November 2023. The Bill presented did not include some policies originally included - such as the ban on smoking for those born after 2007. The ban on smoking for those born after 2007 would have led to a whole new generation of non-smokers in Malaysia.

<https://www.haiasiapacific.org/wp-content/uploads/2024/04/HAIAPNewsApril2024.pdf>.

⁴ <https://pubmed.ncbi.nlm.nih.gov/39754741/>

Feature: The Impact of epidemics and epidemics that did not happen

Prepared by the editors

Sydney's 1789 smallpox epidemic came from the First Fleet and killed up to 220,000 Indigenous Australians: new research

Published: July 10, 2026

<https://theconversation.com/sydneys-1789-smallpox-epidemic-came-from-the-first-fleet-and-killed-up-to-220-000-indigenous-australians-new-research-284098>

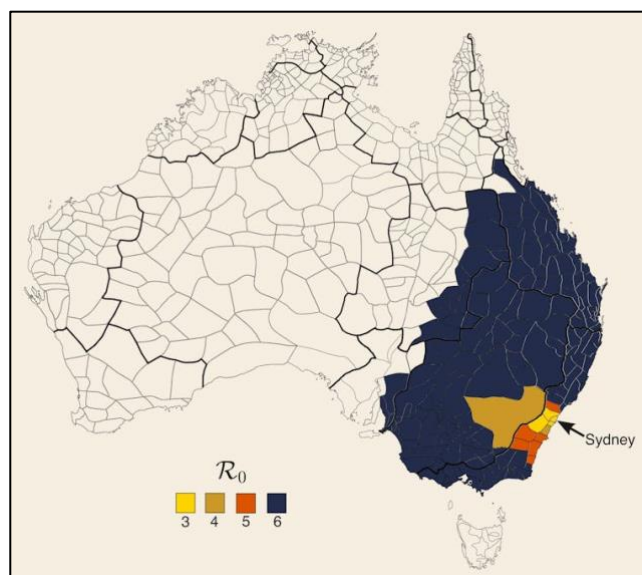
The Conversation warns readers that the content of this study is confronting and may be distressing.

In April 1789, the first smallpox epidemic among Aboriginal people in the Sydney region began, just 16 months after Europeans arrived on the First Fleet.

Little is known of the true scale of the epidemic, and historians have sometimes argued it was not caused by the newcomers.

In new research published in *Nature Human Behaviour*, they used modelling of smallpox transmission and the connections between Indigenous societies to understand how it could have spread.⁵

The results strongly suggest the disease did come from the British outpost. What's more, it might have spread thousands of kilometres north and west, lasting decades and killing as many as 220,000 Aboriginal people.



Infectious disease: a destructive force throughout history

Infectious disease has long been one of history's most destructive forces. The COVID pandemic, which killed an estimated 15 million people in 2020–2021, is only the most recent entry in a list including the Black Death, which killed up to half of Europe's population in the 14th century, and the 'Spanish' influenza of 1918 that was responsible for some 17 million deaths.⁶

One of the earliest recorded – and most feared – diseases was the now-eradicated smallpox, caused by the variola virus.

Evidence of smallpox has been identified in Egyptian mummies dating to as early as 1500 BCE. In 18th century Europe, an average 400,000 people died every year from smallpox. An estimated 300 million people died of the disease during the 20th century, about double the total deaths from wars fought during the same period.

For Indigenous peoples around the world, smallpox was one of the most devastating diseases introduced by Europeans. The disease was a major driver of the catastrophe that killed countless Native Americans from Canada to Tierra del Fuego after the arrival of Spanish and Portuguese in the 16th century.

Smallpox caused fever, severe illness, and high death rates, especially in Indigenous populations with no previous exposure. Survivors were left with severe scarring.

Mathematical modelling by Dr M. Cody Nitschke and colleagues at Flinders University published in *Nature Human Behaviour* demonstrates that the 1789 Australian smallpox epidemic originated from the British colonial outpost in Sydney rather than northern trade routes.^{7,8}

What caused the 1789 smallpox epidemic?

A persistent narrative in Australia's colonial history is that the disease did not come from the First Fleet. Instead, the argument goes, it was introduced earlier by Makassan traders in the far north of the country. Supporters of this idea proposed that it just happened to make its way to Sydney by the time the British established a colony there.

⁵ <https://www.nature.com/articles/s41562-026-02504-6>

⁶ More recent analysis indicated that bacterial co-infections in the pre-antibiotic era were responsible for many deaths associated with 'Spanish' flu.

⁷ **Potential spread of smallpox from the 1789 epidemic in Sydney under various assumptions of R_0 (average number of secondary cases infected by each primary case).** M.C. Nitschke, Flinders University, [CC BY-NC-ND](#)

⁸ <https://news.flinders.edu.au/blog/2026/07/28/modelling-reveals-sydneys-1789-smallpox-outbreak-killed-up-to-220000-indigenous-australians/>

That interpretation gained some traction because no sailors in the First Fleet were known to have smallpox when they arrived. There were also some anecdotal reports of smallpox survivors in the far north shortly after the 1789 outbreak.

Modelling the spread of the disease

Flinders University research looked at how the disease could realistically have spread across Australia. The model combined what we know about smallpox transmission with how Indigenous people were connected through regular exchange, trade, and long-distance movement.

Before colonial invasion, the movement of Aboriginal people followed known paths – for water, ceremony, food, trade, and family. The disease could only travel where people could realistically walk, rest, and recover.

The reconstruction shows there was no plausible pathway for the disease to travel from northern Australia to Sydney in time to cause the 1789 outbreak. The evidence strongly supports a Sydney origin linked to the British colony.

The spread of the disease followed coastlines and major rivers. But it did not reach all of Australia.

Exactly how the outbreak started is still unclear. The colonists had brought 'variola matter' with them – biological samples infected with the virus responsible for smallpox – to be used if needed for inoculation. It is possible this material could have been accidentally or intentionally released.

Another myth the model deflated is the notion that the disease did not extend much beyond the Sydney region. In fact, the disease could have persisted in the Indigenous population for up to 21 years. It might also have spread as far north as Townsville and as far west as Adelaide.

Even more striking was the estimated death toll. Using recent reconstructions of the Indigenous Australian population at the time of European invasion, the model suggests the epidemic could have killed as many as 220,000 Aboriginal people.

An impact that lasted generations

This new evidence outlines the catastrophic impact of smallpox on Indigenous communities, including enduring effects passed down through generations.

Families, knowledge systems, and ways of caring for Country were badly damaged, and the effects are still felt today. Elders, children, and pregnant women were especially vulnerable, meaning knowledge, language, and culture suffered deep harm alongside population decline.

Epidemics that did not happen

Uma Devi

The role of communities and community health workers

We often measure an outbreak by the number of cases and deaths that occurred.

But there is another story worth telling: the outbreaks that were detected early, contained quickly or prevented from becoming disasters.

Preparedness rarely makes dramatic headlines.

A health worker noticing an unusual cluster, a community volunteer reporting a sick child, a farmer alerting veterinary authorities, a laboratory confirming a result quickly, or emergency funds being released at the right moment can prevent a much larger crisis.

The lessons are remarkably consistent.

Local communities are part of the early-warning system.

Communities are often the first to notice that something is changing: an unusual illness, unexplained deaths, animals becoming sick, mosquitoes appearing in unusual numbers, or a pattern of symptoms that does not fit the normal seasonal picture.

Community engagement also matters because people are much more likely to report illness and follow public-health advice when they trust the people delivering it.



A recent example comes from **Cox's Bazar⁹ Bangladesh**, where community health volunteers played an important role in outbreak surveillance among the Rohingya refugee population.¹⁰

Rapid collection and sharing of information can make the difference between early treatment and a disease progressing unnoticed.

Human involvement remains essential

Technology, laboratories and surveillance systems are valuable, but they do not replace people.

Health workers, community volunteers, farmers, veterinarians, teachers and local leaders all contribute to the detection and containment of outbreaks.

Cambodia provides another useful 'One Health' example. After lumpy skin disease was detected in an endangered wild banteng, veterinary authorities and conservation organisations worked together to vaccinate domestic cattle around protected areas.

More than 20,000 cattle and buffalo were vaccinated, and subsequent monitoring found no further signs of the disease in banteng or gaur.

This kind of prevention rarely appears in global headlines: livestock vaccination, community cooperation, surveillance and coordination preventing a problem at the wildlife–livestock interface from becoming worse.

Emergency money matters

Preparedness also requires money that can be released quickly.

WHO's Contingency Fund for Emergencies supports rapid outbreak response, including surveillance, laboratory work, emergency supplies, rapid response teams, risk communication and community engagement.

A recent allocation for cholera response in Nigeria, for example, supported precisely these activities.

Leadership and collaboration matter

Successful outbreak response rarely belongs to one institution.

It depends on cooperation between ministries, laboratories, hospitals, communities, local government, international agencies and – increasingly – animal and environmental health services.

The lesson is straightforward

Preparedness changes the trajectory of an outbreak. The most successful outbreak is sometimes the one that never becomes a crisis.

These stories demonstrate that we can prevent epidemics - saving lives and protecting livelihoods

<https://etdh.resolvetosavelives.org/2024/conclusion/>

The threat of a new or known infectious disease outbreak is constant. These stories show how responsive health systems, in partnership with communities, acting quickly with available funding, and paying attention to signals, can fundamentally alter the trajectory of an outbreak.

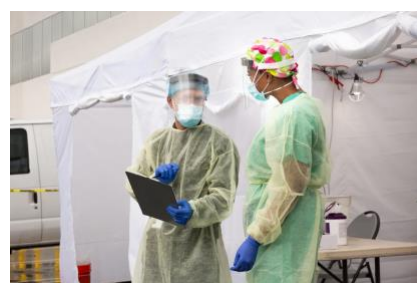
There are important lessons for health systems aiming to emulate these successes:

Be responsive to communities



Health systems can only be responsive to communities if they have long-lasting relationships, fit-for-purpose technology systems that allow them to receive early signals, and funding to get response activities off the ground. Even \$5,000 of early, flexible funding skillfully allocated in the very first signals of an outbreak can stop an epidemic in its tracks. PHC facilities are often the first point of contact with the health system: they must be fully supported to fulfill this essential role. We learned about the benefits of responsive communities in these case studies:

- Lassa fever in Ghana: early access to emergency funds enabled a rapid response effort
- Avian influenza in Finland: a surveillance system allowed a concerned farmer to sound the alarm
- Neethling disease in Cambodia: partnering with rangers and vets protected endangered wildlife.



⁹ <https://www.care.org.au/stories/women-and-girls-safe-space-in-coxs-bazar/>

¹⁰ <https://etdh.resolvetosavelives.org/2024/conclusion/>

Make timeliness a priority

7-1-7 is a global timeliness target promoting early and effective action to contain infectious disease outbreaks. The 7-1-7 target includes clear performance standards for three timeliness metrics—7 days to detect a suspected disease outbreak, 1 day to notify relevant public health authorities and 7 days to complete early response actions—that enable health systems to stop outbreaks as quickly as possible and minimizing their impact on livelihoods and lives. We saw how timeliness saves lives and economies in these case studies:

- Avian influenza in Finland: authorities responded the day they received a sample from a farmer
- Dengue fever in Somalia: the response team arrived in the village just two days after the report
- Cholera in Bangladesh: a team was deployed to investigate every reported case within 24 hours.

Protect health care workers



Strong infection prevention and control (IPC) programs are a cornerstone of health care delivery and essential for keeping health care workers, patients, and communities safe. **Every country needs its own dedicated domestic IPC budget** to make sure its health care workers can work with the dignity they deserve in safe facilities, minimising their exposure to avoidable infections and providing them the equipment and skills needed to stay safe while protecting the rest of us. These case studies highlighted the importance of protecting health care workers so they can protect communities:

- Lassa fever in Ghana: quarantining and treating an infected health worker led to a full recovery
- Avian influenza in Finland: health workers treating suspected cases were protected with PPE
- Leptospirosis in Vanuatu: workers visiting affected communities were trained how to stay safe.

Pay attention to climate signals

There are many indicators suggesting an increased risk of an outbreak well before a first case has even been found. Such early-warning approaches include paying attention to predictable seasonal shifts (like rainy season) and more sporadic triggers (like cyclones), upstream signals that could be the key to stopping an outbreak before it can start. It is critical for health systems to be responsive to such signals if they wish to overcome the heightened threats posed by climate change. We saw the role of climate in these case studies:

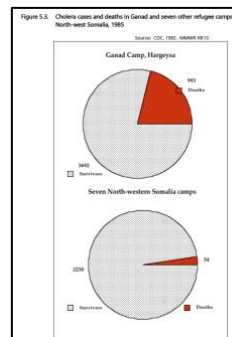
- Dengue fever in Somalia: stronger rains driven by El Niño suggest more mosquito breeding sites
- Cholera in Bangladesh: unusual heavy rains led to predictable flooding and contaminated water
- Leptospirosis in Vanuatu: tracking impending cyclones allowed officials to prepare a response.



Responsive health systems are the bedrock of epidemic prevention.

By making strides to prioritise and act on important lessons, decisionmakers can work towards health systems that are more responsive and better prepared to deal with outbreaks quickly and decisively. Health systems must remain adaptive to the shifting circumstances of the world around us, so they can respond to the changing needs of their communities, and ultimately do their part to save lives and protect livelihoods.

In Northern Somalia in 1984 a PHC program was in place throughout the region with trained Community Health Workers (CHWs) serving their communities.



With a new influx of refugees from Ethiopia during 1984 a cholera epidemic developed. In the one new camp with no CHWs almost one quarter of those infected with the disease died. In the seven refugee camps in the region where CHWs were trained to care for the communities there were almost no deaths from cholera.¹¹

¹¹ CDC Morbidity and Mortality Weekly Report Vol 41 RR 13

Antimicrobial resistance

Uma Devi

Antimicrobial resistance (AMR) is increasingly understood as a problem that extends far beyond the inappropriate use of antibiotics in hospitals and communities.

Resistance can emerge and spread through interconnected systems involving healthcare, agriculture, pharmaceutical manufacturing, wastewater, pollution and the wider environment.

In this issue, we look at four developments that illustrate this broader picture.

First, WHO has highlighted the neglected problem of **fungal diseases and antifungal resistance**, reminding us that the AMR agenda must encompass more than bacteria and antibiotics.

Second, **emerging research is examining the relationship between microplastic pollution and antibiotic resistance**, including the role of microplastics in supporting bacterial biofilms and the exchange of resistance genes.

Third, research from South Africa examines how **antimicrobial-resistance genes associated with extracellular DNA can persist through wastewater systems and enter receiving rivers**.

Finally, new research on pharmaceutical manufacturing examines how **antibiotic production and environmental pollution raise difficult questions about regulation, scientific uncertainty and environmental justice**.

Together, these stories point to a larger challenge for AMR policy:

Resistance is not only a problem of prescribing and patient behaviour. It is also a problem of production, pollution, infrastructure and environmental governance.

AMR also includes resistance to antifungal, antiviral and antiparasitic medicines.

Antifungal resistance deserves particular attention because the number of effective antifungal medicines is already limited, while fungal diseases remain under-recognised and under-resourced.

In June, the World Health Organization (WHO) released its Blueprint for strengthening responses to fungal disease and antifungal resistance, providing countries with practical guidance for strengthening prevention, diagnosis, treatment, surveillance, stewardship and research.

WHO estimates that fungal diseases affect more than 300 million people each year and are associated with

substantial illness, deaths and economic losses. The growing threat of antifungal resistance is further eroding an already limited number of effective antifungal medicines.

The problem is particularly serious for people whose immune systems are weakened, including people living with HIV, people with cancer and transplant recipients.

WHO notes that fungal diseases and antifungal resistance remain under-recognised in national health plans and are largely absent from many AMR, universal health coverage and One Health strategies.

The new blueprint is intended to help close these gaps.

The guidance is organised around four interconnected areas:

- public health and health-system interventions;
- therapies, technologies and innovation;
- laboratory systems, surveillance and outbreak preparedness; and
- social, environmental and One Health drivers.

The guidance identifies gaps in diagnostics, access to treatment, surveillance, stewardship, workforce capacity and research, particularly in low- and middle-income countries. It is important for the Asia-Pacific region, where access to antifungal medicines and diagnostic capacity can be limited.

Without reliable diagnosis, appropriate treatment and surveillance, resistance can remain invisible until infections become difficult or impossible to treat.

The WHO blueprint therefore makes an important point for the wider AMR agenda:

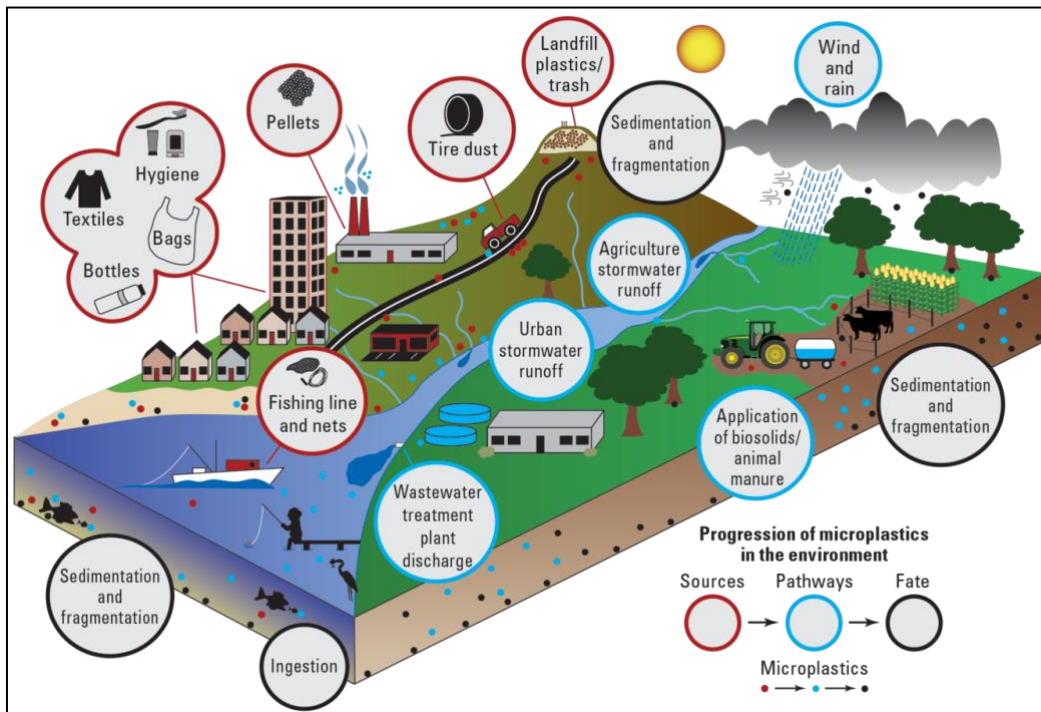
We cannot protect the effectiveness of antimicrobials if we focus only on antibiotics. Fungal disease and antifungal resistance need to be incorporated into national AMR strategies, health-system planning and One Health approaches.

Original source

World Health Organization (2026). *Blueprint for strengthening responses to fungal disease and antifungal resistance: Implementation guidance*. Geneva: WHO.

Microplastics and antibiotic resistance - An emerging environmental connection

Plastic pollution and antimicrobial resistance are normally treated as separate environmental and public-health problems. However, emerging research suggests that the two may be connected.



inadequate waste management, limited wastewater treatment and high burdens of infectious disease can occur together.

The policy implication is not simply that plastic should be regarded as another AMR threat. Rather, plastic pollution, waste water management and antimicrobial stewardship need to be considered together where they intersect.

From Mongabay

Asher, C. (2026, July 8). *Microplastic pollution can fuel rise in antibiotic resistance, studies find.*

A July 2026 report by Claire Asher for Mongabay¹² examines growing evidence that microplastics can provide favourable surfaces for bacterial biofilms and may contribute to the development and spread of antibiotic resistance.

Bacteria that colonise surfaces can form biofilms – communities of microorganisms embedded in a protective matrix.

These communities can be more difficult to eliminate with antibiotics and can provide opportunities for bacteria to exchange genetic material.

Research discussed by Mongabay has found that bacteria exposed to microplastics can develop increased resistance to several antibiotics. Other studies have found that microplastics can harbour antibiotic-resistant bacteria and resistance genes.

Microplastics may also facilitate horizontal gene transfer, allowing resistance genes to move between bacteria.

The concern becomes particularly relevant in wastewater systems, where bacteria, antibiotic residues, microplastics and other pollutants can occur together. The evidence is still developing.

It would be premature to conclude that microplastics directly cause resistant infections in humans. But the findings reinforce a broader understanding of AMR: resistance is shaped by environmental conditions as well as by what happens in healthcare settings.

This knowledge is particularly relevant for low- and middle-income countries, where plastic pollution,

AMR in water

Resistance genes can persist through wastewater treatment. This environmental dimension of AMR is also illustrated by new research from South Africa.

A study published in *Cell Reports* examined wastewater and river systems in South Africa and found high-risk antimicrobial-resistance genes associated with extracellular DNA in wastewater effluent and downstream rivers.

The findings suggest that extracellular DNA can represent an environmental reservoir of resistance genes that is not fully addressed by conventional wastewater treatment.

The study, by John Paul Makumbi, Samuel K. Leareng, Oliver K. Bezuidt, Luis Pedro Coelho and Thulani P. Makhalanyane, is titled *Persistence of high-risk antimicrobial resistance genes in extracellular DNA along an urban wastewater-river continuum*. It was published in March 2026.¹³

The finding is significant because wastewater treatment is normally assessed partly by how effectively it removes or reduces living bacteria. But bacteria that die during treatment can release DNA into the water.

That extracellular DNA can contain antimicrobial-resistance genes. Those genes may then be taken up by other microorganisms in the environment.

In other words, resistance may persist even after the original resistant bacteria have been removed or killed.

¹² <https://news.mongabay.com/by/claire-asher/page/2/>

¹³ <https://pubmed.ncbi.nlm.nih.gov/41916285/>

The researchers found evidence of high-risk resistance genes in extracellular DNA along the wastewater–river continuum. Some were associated with resistance to antibiotics regarded as treatments of last resort.

The study raises an important question for environmental AMR policy:

Is reducing the number of living bacteria enough?

If resistance genes themselves remain in treated effluent, wastewater surveillance and treatment may need to look beyond conventional measures of bacterial contamination.

The researchers point to technologies such as UV treatment, ozonation, ultrafiltration and other approaches capable of degrading or removing extracellular DNA.

But these technologies can be expensive and are not widely available.

For many countries in Asia and the Pacific, the more immediate priority remains basic infrastructure: reliable sanitation, effective wastewater treatment, environmental monitoring and protection of water supplies.

AMR therefore becomes inseparable from water policy and public infrastructure.

Original research

Makumbi, J. P., Leareng, S. K., Bezuidt, O. K., Coelho, L. P., & Makhalanyane, T. P. (2026). *Persistence of high-risk antimicrobial resistance genes in extracellular DNA along an urban wastewater-river continuum*. Cell Reports. DOI: 10.1016/j.celrep.2026.117128.

Wasting antibiotics

Pharmaceutical manufacturing and environmental AMR

AMR does not begin when a patient takes an antibiotic. It can begin much earlier – including during the manufacture of the medicine.

A new paper in *Social Science & Medicine* examines the environmental consequences of antibiotic manufacturing and the difficulties governments face in regulating pharmaceutical pollution.

The paper, by Helen S. Lambert, Amishi Panwar, Neelam Taneja and Elizabeth M. H. Wellington, is titled *Wasting antibiotics: Antimicrobial resistance, environmental pollution and unsettled science in the governance of pharmaceutical manufacturing*.

It was published in Volume 400 of *Social Science & Medicine* in July 2026, article 119292.

The paper examines how scientific evidence is used to determine what constitutes an acceptable level of environmental antibiotic pollution. It is difficult.

Antibiotic residues released through manufacturing waste can enter water and the environment, potentially creating selective pressure that favours resistant microorganisms.

Determining how much antibiotic pollution is too much is not straightforward

One approach is to establish environmental thresholds such as predicted no-effect concentrations (PNECs), below which antibiotic concentrations are considered unlikely to cause harm.

The authors question whether threshold-based approaches are adequate for governing AMR, arguing that they are poorly suited to the complexity and uncertainty of AMR. They also highlight the role of institutional structures and environmental justice in determining how pharmaceutical pollution is governed.

The issue is not simply whether a particular country can impose a numerical limit.

It raises a larger question about who carries the costs of producing essential medicines.

Antibiotics are essential public-health goods. Their manufacture is necessary to treat infections around the world.

Yet if environmental pollution from production is not adequately controlled, some of the costs may be transferred to communities, water systems and ecosystems – potentially undermining the effectiveness of the medicines being produced.

This is an important extension of antimicrobial stewardship.

Stewardship cannot stop at the point of prescribing

A genuinely comprehensive AMR strategy needs to consider the entire life cycle of antimicrobials – including how they are manufactured, what happens to manufacturing waste, and who is responsible for preventing environmental contamination.

Original research

Lambert, H. S., Panwar, A., Taneja, N., & Wellington, E. M. H. (2026). *Wasting antibiotics: Antimicrobial resistance, environmental pollution and unsettled science in the governance of pharmaceutical manufacturing*. Social Science & Medicine, 400, 119292. DOI: 10.1016/j.socscimed.2026.119292.

What these four stories tell us about AMR:

Taken together, these four articles illustrate why AMR needs to be approached as a systems problem.

The WHO fungal-resistance blueprint expands the discussion beyond antibiotics.

The microplastics research shows how pollution may create conditions that favour resistance.

The South African wastewater study demonstrates that resistance genes associated with extracellular DNA can persist through wastewater systems and enter receiving rivers.

And the pharmaceutical-manufacturing research asks whether the way we produce antibiotics can itself contribute to environmental AMR.

These are different problems, but they are connected.

AMR runs through the entire life cycle of antimicrobials – from production and use to disposal and release into the environment.

For medicines and public-health policy, this means that antimicrobial stewardship cannot be limited to prescribing behaviour.

It needs to be connected with access to diagnostics and treatment, pharmaceutical regulation, environmental protection, water and sanitation, surveillance and meaningful public participation in health-policy decisions.

For HAIAP, the broader lesson is clear: protecting the effectiveness of antimicrobials requires action across the health system, not simply at the point where a medicine is prescribed.

‘Responsive Dialogues’, an engagement framework for antimicrobial resistance: a cross-country qualitative evaluation in Thailand and Malawi 2026

GLOBAL HEALTH ACTION 2026, VOL. 19, 2676473 <https://doi.org/10.1080/16549716.2026.2676473>

<https://www.tandfonline.com/doi/epdf/10.1080/16549716.2026.2676473?needAccess=true>

ABSTRACT Antimicrobial resistance (AMR) is a global health crisis requiring multisectoral responses that extend beyond biomedical interventions. Participatory approaches can ensure that policies and practices reflect community realities, yet evidence from low- and middle-income countries (LMICs) remains limited. To examine how the Responsive Dialogues (RD) framework was implemented in Malawi and Thailand, and to identify lessons on adapting participatory methods for AMR engagement, managing power dynamics, overcoming structural barriers, and supporting policy uptake. This cross-country evaluation applied the RD toolkit developed by the Wellcome Trust, which included three phases: groundwork, community conversations, and post-conversation sharing. Both countries followed this framework but adapted it to their social and political contexts. Data included field observations, facilitator reflections, participant feedback, and analysis of policy outcomes. Four themes emerged across both sites. First, adaptation was engagement process which shaped by

trust, flexibility, and cultural sensitivity. Second, entrenched hierarchies influenced participation; strategies such as stakeholder briefings, ground rules, and rotating leadership roles helped mitigate imbalances, while in Malawi, village leaders’ authority supported antibiotic regulation. Third, although Malawi’s RD recommendations informed its revised National Action Plan on AMR, Thailand’s community generated ideas were less visible in the national strategy, underscoring persistent gaps between local insights and high-level policy. Finally, reflective practice strengthened iterative learning and inclusivity. Overall, RD offers a promising model for facilitating participation in AMR mitigation plan. However, the differences in policy uptake in both countries highlight the limits of participatory approaches when not aligned with policy scale and resourcing.

- **Main findings:** Responsive Dialogues enabled inclusive dialogue across community and policy stakeholders in Malawi and Thailand, demonstrating how relational adaptation, power-aware facilitation, and reflective learning are essential for effective participatory AMR engagement

- **Added knowledge:** This study offers new empirical evidence from LMIC settings on how participatory methods can surface community-generated solutions, navigate hierarchical constraints, and support pathways for policy influence in AMR policies.

- **Global health impact for policy and action:** Strengthening institutional support and resourcing for participatory engagement can help embed community insights into AMR policy design and implementation, promoting more equitable, sustainable, and context-responsive strategies worldwide.

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<https://doi.org/10.1080/16549716.2026.2676473> © 2026 Mahidol Oxford Tropical Medicine Research Unit.

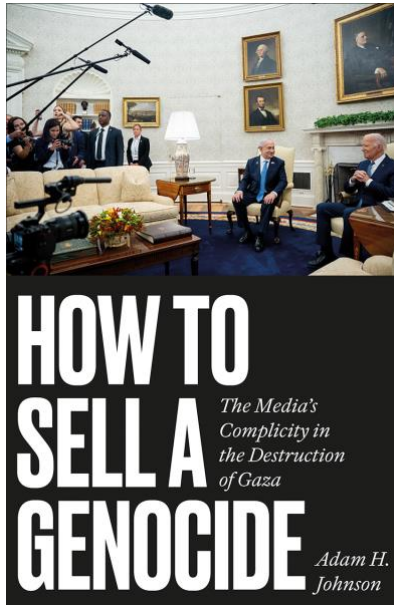
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BOOKS

How to Sell a Genocide

The Media's Complicity in the Destruction of Gaza

Author: Adam H. Johnson – Pluto Press, 2026



How to Sell a Genocide: The Media's Complicity in the Destruction of Gaza is a 2026 media analysis book written by **Adam H. Johnson**, co-host of the podcast *Citations Needed*. The book presents a data-driven indictment of United States corporate media—specifically highlighting networks and publications like the *New York Times*, CNN, and MSNBC—arguing

that their coverage sanitised war crimes and manufactured consent for the destruction of Gaza.

In HAIAP News April 2026 we looked at **Peace Journalism** as covered in a webinar by the Medical Association for the Prevention of War (Australia) and Croakey exploring the importance of peace for health as part of its '**Peace for Health, Health for Peace**' theme.

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.

Dr Jehangir 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. She explains her intention is not to shock her students. It is to remind them that journalism does not exist in a vacuum.¹⁴

This fact is highlighted in **How to sell a genocide** and the response to it publication in 2026.

HOW TO SELL A GENOCIDE

Key Themes and Content

Johnson utilises original data-driven analysis collected over a 12-month period to dissect the mechanics of modern media propaganda. The book highlights several core strategies used by major outlets:

Selective empathy: Disproportionate focus and humanisation of certain victims over others.

Language manipulation: Forensic shifts in adjectives and descriptions depending on the parties involved.

Strategic omissions: Failing to report on the structural role and central involvement of the United States government.

Dehumanisation: Utilizing anti-Palestinian frameworks and state-sanctioned falsehoods to rationalize mass casualties.

Targeting dissent: Dishonest framing of campus protests and the demonisation of humanitarian aid workers.

All author royalties from the book are donated to the Middle East Children's Alliance (MECA)

Recent News and Controversies

In August 2026, the book became the centre of a free-speech debate in Australia. The Waverley Council Library in Bondi Junction, Sydney, removed the book from its 'new release' shelves for official review.

The Complaint: The removal followed complaints from community members, including a survivor of the December 2025 Bondi Beach attack, who stated that the prominent display of the book was distressing.

The Response: Media advocacy groups, the Australia Palestine Advocacy Network, and the author criticised the removal, arguing public libraries have a duty to protect freedom of thought and provide access to challenging materials. Conversely, groups like the Executive Council of Australian Jewry supported the council's decision. Other Sydney library networks (such as Parramatta and the City of Sydney) continue to keep the book available.

Calling the actions in Gaza a genocide reflects a mainstream human rights consensus. Public interest dictates that media analysis should be widely accessible, even if the reality is upsetting.

The author condemned the book removal, rejecting suggestions that describing Israel's actions in Gaza as genocide represented a 'fringe' position

Nasser Mashni¹⁵ President of the Australia Palestine Advocacy Network, condemned the decision to withdraw the book from the library and warned against restricting access to books dealing with the war in Gaza.

It was a 'library's duty to provide its community access to a broad range of published works, including those that may challenge or discomfort,' Mashni told The Guardian.

'Hundreds of thousands of Palestinians have been killed, maimed and displaced,' he said, adding that the use of the word 'genocide' was intended to describe what Palestinians were experiencing rather than cause offense. 'History has

¹⁴ <https://www.haiasiapacific.org/wp-content/uploads/2026/04/HAIAPNews-April2026-1.pdf>

¹⁵ <https://www.arabnews.com/node/2655122/amp>

taught us too well what happens when books start getting banned,' he said.

Waverley Council said that the book had been 'removed from library shelves for review' and that it would consider introducing greater oversight of book selection.

Rejecting suggestions that describing Israel's actions in Gaza as genocide represented a 'fringe' position Mashni said 'That it makes some people upset is unfortunate but reality is often upsetting.'

'But 'genocide' is not my word, or my finding. The fact of genocide in Gaza is the overwhelming consensus of the human rights world and it is a wholly mainstream opinion among those tasked with studying and determining such matters.'

Israel has repeatedly rejected accusations that its actions in Gaza constitute genocide.

The library's decision also drew criticism from the Jewish Council of Australia, whose executive member Bart Shteinman described it as 'deeply alarming.' 'Public libraries belong to all of us and should host a range of views and topics,' he said.

The New South Wales government amended the state's Library Act earlier this year to strengthen protections for public libraries against campaigns seeking to remove books. Shteinman said that if Waverley Council decided to remove Johnson's book permanently officials would need to explain how such a decision complied with the amended legislation.

Pluto Press, which published the book, also criticised the removal. David Shulman, a senior commissioning editor, said public understanding of events in Gaza and how they had been covered by the media was a matter of significant public interest, arguing that the book should be made widely available through public libraries.



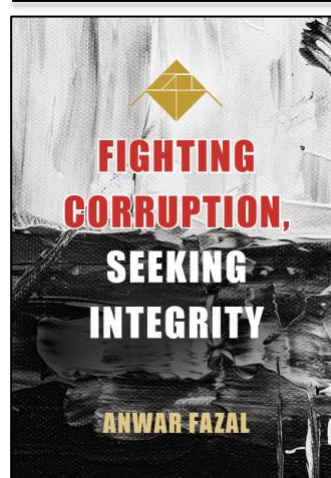
*Dr Ayesha Jehangir grew up in a very conservative, remote village in Western Pakistan.

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.

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.



With equal breath and unwavering vigour, we must never forget the lessons of Eleven Sins against Humanity, which also stresses the spiritual fundamentals and culture of integrity to its cores.

1. Politics without Principles
2. Wealth without Work
3. Enjoyment without Conscience
4. Knowledge without Character

5. Business without Morality

6. Science without Humanity

7. Religion without Compassion

8. Rights without Responsibilities

9. Power without Accountability

10. Development without Sustainability

11. Laws without Justice

'The Eleven Sins' are based on an original statement, called the 'Seven Social Sins' attributed to Mahatma Gandhi. It was adapted and expanded by Anwar Fazal.

The four added statements are 'Rights without Responsibilities', 'Power without Accountability', 'Development without Sustainability' and 'Laws without Justice'.

There is adaptation in the statement 'Religion without Compassion', which was originally 'Religion without Sacrifice'.

