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

https://www.haiasiapacific.org
Haiasiapacific@gmail.com

HAIAP News Bulletin, 1 February 2024

1. News from HAIAP

2. Information sharing

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1. News from HAIAP

1.1 HAIAP activities

Our colleagues in Malaysia and Thailand will meet in Penang, February 15 to discuss possible HAIAP projects and to plan ongoing production of the HAIAP New and Bullletins as well as the website

1.1.2 Niyada Kiatying Angsulee has expanded the Thai Border Medicines work (See HAIAP News December 2023

- https://www.haiasiapacific.org/wp-content/uploads/2023/12/HAIAPNewsDec2023.pdf)

to include work from the Laos side of the border as well.

1.2 Dr Mira Shiva shares

Feeling absolutely overwhelmed...

A documentary film that draws upon our work on men and masculinities in Jharkhand India, has been nominated for the Oscars!

It is the story of a young girl who was raped and the journey of her empowerment after that. There was pressure to get her married to the rapist. Instead the father with the support of a men's group and a local NGO - all were trained through our approach. They ensured the prosecution of the rapist and supported the father to continue the girls education including putting her through college.

Its based on the approach that we at Centre for Health & Social Justice have honed over the years.

The film - ***To Kill a Tiger***

Director - Nisha Pahuja

The trailer https://youtu.be/mC6-igJWWM?si=cEtZIIWlQ6dAL8q1

You ***might*** be able to see this https://www.tvo.org/video/documentaries/to-kill-a-tiger

It can't be seen in all countries.

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2. Information sharing

2.1 Too much side effect information 'reduces medication uptake'

by Jessica M Barker, Kate Faasse 22 January 2024

https://insightplus.mja.com.au/2024/2/too-much-side-effect-information-reduces-medication-uptake/

Evidence suggests that long lists of side effects on patient information lists do not improve informed consent but instead decrease consumer willingness to take medication.

Informed consent is central to Western medicine, and sharing medication side-effect information with patients is viewed as core to patient autonomy and shared decision making (here). Information about medication side effects can also help prepare patients to manage side effects.

However, these warnings about medication side effects can worsen medication outcomes via the nocebo effect. The nocebo effect is considered the opposite to the placebo effect, where patients experience unpleasant effects through negative expectations (here). Side-effect information can also contribute to non-adherence (here and here), which is one of the biggest barriers to medication effectiveness worldwide (here).

Although PILs often go unread for common medications (here), readership is as high as 91% (here) for new and prescription medications (here), so this information can have a significant impact on consumer beliefs about the medication they are taking. Historically, providing consumers with more information is considered beneficial, although research suggests that this is not the case, with one overseas study showing (here) as many as 62% of patients discontinued their medication after reading patient information leaflets.

So, side-effect information is important, but it is a delicate balance between giving patients information for informed consent while not worsening outcomes.

What we studied

A study by my research team (here) investigated how consumers respond to being informed about different numbers of side effects. Participants were recruited to take part in a study about a fictitious medication, being either informed about a small number of side effects (one or four); a large number of side effects (26); or had side effect information completely omitted. We then asked participants about their memory of side effect information and their willingness to be involved in future studies in which they may take the (fictitious) medication in question.

Our results suggest that there may well be a sweet spot of side effect information in which we can optimise both informed consent and consumer willingness to take medication. The results suggest that medication consumers are wary of side effects even when they are not given any information, but that longer lists (that include side effects lacking evidence of their relation to the specific medication) mean that patients may not remember those of significance (that are evidence-based) as these cannot be distinguished from non-specific symptoms. Therefore, providing medication consumers with a list of evidence-based side effects, resulting in a much briefer list of side effects than is currently provided (here), may be optimal for both their awareness of evidence-based side effects (therefore informed consent) as well as their willingness to take medication.

Conclusion

Overall, the evidence suggests that long lists of side effects do not improve informed consent but instead decrease consumer willingness to take medication. Therefore, side-effect information offered in PILs should be changed to reflect this. Instead of recommending patients seek as much side-effect information as possible (here), we suggest informed consent should be contextualised (here) so that patients are informed about only side effects that are evidence-based and relevant to them specifically, to make side-effect information more useful.

Our research found that particular caution should be taken with disclosing non-specific symptoms that are most easily recalled by medication consumers, such as drowsiness and nausea. Written information requirements in PILs could also be modified such that only side effects shown to be caused by the medication are included, beyond that experienced by a placebo control group.

After all, patients deserve evidence-based side-effect information that allows an accurate risk perception of side effects. Contextualised informed consent may provide a goldilocks zone between informed consent and negative medication expectations.

Jessica Barker is a third year PhD candidate at the University of Sydney, a Certified ESDM Therapist and a Psychologist.

Kate Faase is an Associate Professor at the University of New South Wales Sydney where her main research focus is the nocebo effect.

2.2 PHM excluded from Prince Mahidol Award Conference (PMAC)

Where is the Peoples Health Movement (PHM) at the prince Mahidol Award Conference (PMAC) 2024 ?

PMAC has, for many years, created the platform for critical perspectives and voices from the Global South, including PHM, and that this has been unique and highly valued by many people working in global health.

Since the first PMAC the People's Health Movement (PHM) has brought a cutting-edge civil society voice to PMAC. We have been active on its International Organising Committee

(IOC), and as such assisted in developing the concept notes and conference sessions; been co-Chair of that group and have been invited to the PMAC every year since 2007. We were initially on the IOC for PMAC 2024, and given the topic contributed significantly to both the concept note and many sessions.

So why isn't PHM here in 2024?

PMAC told us that we were no longer welcome at the IOC or at the conference..

The reason: We objected to the involvement of fossil fuel corporations at PMAC 2023 and through an article in the BMJ (The dangers of 'health washing ' the fossil fuel industry https://www.bmj.com/content/381/bmj.p843)

We find this decision perplexing, sad and deeply worrying. Critical perspectives on the state of global health are needed more than ever, and the exclusion of the BMJ and PHM is indicative of inappropriate and unhealthy censorship.

How PMAC 2024 misses out

PHM is a large global network of health activists, professionals, academics and organisations with a presence in more than eighty countries, most of which are low and middle income countries.

Discussions at PMAC 2024 will be noticeably less inclusive and less rich without PHM's voice.

|People's Health Movement (phmovement.org)

2.3 Oxfam research - access to affordable health care

Across low- and middle-income countries, many private for-profit hospitals are systematically exploiting and abusing patients and denying them healthcare, causing hardship, suffering and impoverishment. A number of these hospitals are funded by European governments and the World Bank Group.

In these hospitals, patients are imprisoned for not paying their bills. The right to emergency care is denied. Treatment is impossibly expensive. Patients entitled to free care are instead pushed into poverty, having to pay high fees to access health services. During the COVID-19 pandemic, some of these hospitals behaved appallingly, profiteering from people's pain and fear in the face of this new disease.

Oxfam's research for this paper maps the money trail between the development finance institutions (DFIs) of the UK, France, Germany, the EU and the World Bank Group to for-profit private healthcare providers in the Global South. Via primary research and detailed country case studies, as well as broader desk-based reviews and investigative searches of nearly 400 investments, Oxfam assesses whether DFI promises to advance universal health coverage (UHC) are being delivered and whether obligations to protect rights are being upheld. The research finds clearly that they are not.

Instead, taxpayers' money is being used to back expensive, for-profit private hospitals that block, bankrupt or even detain patients who cannot pay – and all this with funds mandated to fight poverty and achieve development goals.

2.4 The next generation of tobacco control measures

MJA Insight 29 January 2024 by Coral Gartner

https://insightplus.mja.com.au/2024/3/the-next-generation-of-tobacco-control-measures/

The World Health Organization Framework Convention on Tobacco Control Tenth Conference of the Parties will discuss next generation tobacco control policies, as the incoming New Zealand Government receives strong international condemnation for repealing recent tobacco control measures.

In November, the Tenth session of the Conference of the Parties (COP10) of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) was to occur in Panama. Significantly, COP10 marks two decades since the adoption of the WHO FCTC. Disappointingly, COP10 was delayed to February 2024 due to security concerns around (unrelated) large-scale protests in Panama City. At the time that COP10 was due to meet, global tobacco control experienced additional setbacks in Aotearoa New Zealand and Malaysia, which are likely to be heavily discussed at COP10 in February.

If the Aotearoa New Zealand and Malaysian governments had stayed the course on implementing their planned measures, they could have expected to be lauded as tobacco control world leaders at COP10, rather than the strong criticism they are receiving. Nevertheless, several lessons from the recent events in Aotearoa New Zealand, Malaysia and the UK are likely to inform constructive dialogue on two priority topics scheduled for discussion at COP10: tobacco product regulation (eg, denicotinisation of tobacco products) and forward-looking measures beyond minimum requirements (eg, retailer reduction and smoke-free generation laws), which are supported by FCTC articles 9 and 2.1 respectively.

What happened to New Zealand's smoke-free laws?

On 24 November 2023, Aotearoa New Zealand's National Party announced it would repeal the country's world-leading smoke-free law as part of a deal with two minor parties (ACT and New Zealand First) to enable it to form a coalition government following the October election. The law, passed by the former Labour-led government, would denicotinise smoked tobacco products (reducing their addictiveness), reduce the number of tobacco retailers by 90% (reducing tobacco availability and triggers to purchase), and end tobacco sales to anyone born after 2008 (creating a smoke-free generation). These measures are considered key to achieving the country's goal of less than 5% smoking prevalence by 2025 for both Māori and non-Māori citizens alike. The laws commenced in 2023, but the measures would not take effect until mid-2024.

The smoke-free goal and the laws to achieve it were the culmination of public health efforts initiated by Māori leaders in 2005, who called for returning Aotearoa New Zealand to its original *tupeka kore* (tobacco-free) status, which would eliminate inequities in tobacco-related diseases experienced by the Māori population due to the introduction of tobacco smoking through colonisation. Modelling indicates the smoke-free laws would achieve enormous health and economic benefits for citizens in Aotearoa New Zealand and would be particularly pro-equity for Māori. By 2040, over 8000 premature deaths would be averted. Those who quit smoking because of the laws would cumulatively gain 56 590 health-adjusted life-years and US$23.2 billion from greater income due to less tobacco-related disease and savings from not buying tobacco.

It is imperative that governments prioritise health and wellbeing over commercial profits by progressing bold measures to rapidly and permanently end the commercial tobacco epidemic. With Aotearoa New Zealand's new government appearing set to abandon the country's world-leading smoke-free laws, the upcoming COP10 discussions provide an opportunity for other countries, such as the UK, Canada or Australia to step up and demonstrate global leadership on these next generation tobacco control policies.

2.5 The UN's top court didn't call for a ceasefire in Gaza – how does NZ respond now?

http://tinyurl.com/bden23uh

Published: January 30, 2024 11.45am AEDT The Conversation

Author: Alexander Gillespie Professor of Law, University of Waikato

The provisional measures issued by International Court of Justice (ICJ) in South Africa's case against Israel under the Genocide Convention was, on balance, a victory for Israel.

While South Africa's application was not thrown out, and the ICJ accepted it could rule on what is happening in Gaza, there was no provisional order for an immediate ceasefire. This leaves New Zealand's options less clear than in the case of Russia and Ukraine. In that instance, the ICJ urged that 'the Russian Federation shall immediately suspend the military operations that it commenced' when it invaded.

Russia simply ignored the court, of course. But New Zealand will now have to take stock of what the ICJ has ordered in the case of Gaza. It goes beyond the Genocide Convention. While the court found some of the assertions by South Africa were 'plausible', at this point it did not find that genocide was occurring. However, the ICJ was clearly disturbed by some of the rhetoric that has emerged from Israel during the conflict, which is also a humanitarian disaster.

It has ordered that Israel must carefully abide by the Genocide Convention, control its military, and 'prevent and punish the direct and public incitement to commit genocide in relation to members of the Palestinian group in the Gaza Strip'. Significantly, Israel must report back to the court on what measures it has taken in a month's time. So, even though the full case will now proceed in a process that could take years, the ICJ is watching matters closely. If Israel is not respecting the court's provisional measures, the matter may quickly escalate.

Push for humanitarian aid

New Zealand will need to watch these next steps closely. The previous government focused on the 'good faith' application of the Genocide Convention rules when it joined the proceedings in the Russia-Ukraine case. As New Zealand highlighted then, the Genocide Convention was originally adopted with a dual purpose: to safeguard the very existence of human communities, and to confirm and endorse the most elementary principles of morality.

There is scope to expand New Zealand's thinking on this further if it joins the next stage of the ICJ process over Gaza. New Zealand would need to focus not only on explicit acts of genocide, but also on the preconditions and context surrounding this most horrendous of all crimes, and the importance of a precautionary approach. New Zealand also needs to focus on the ICJ's ruling that 'the State of Israel shall take immediate and effective measures to enable the provision of urgently needed basic services and humanitarian assistance to address the adverse conditions of life faced by Palestinians in the Gaza Strip'.

This outcome is a direct reflection of recent demands by the UN Security Council: the parties to the conflict must allow safe and unhindered delivery of humanitarian assistance, at scale, directly to the civilian population of Gaza. The importance of supporting such humanitarian assistance has been a standard New Zealand demand since this latest conflict began. How the government reconciles support for this principle at the same time as pausing funding for the UN Relief and Works Agency for Palestine Refugees (UNRWA) presents an awkward conundrum, however.

Uphold international law

The ICJ went one step further than ruling on the Genocide Convention by emphasising that 'all parties to the conflict in the Gaza Strip are bound by international humanitarian law'.

This emphasis includes the court's 'grave concern about the fate of the hostages abducted during the attack in Israel on 7 October 2023 and held since then by Hamas and other armed groups', and its call for their 'immediate and unconditional release'.

This area is where New Zealand can provide the most support. One of the shortcomings of South Africa's case was that it focused on the most significant issue of all – genocide – but risked eclipsing dozens or hundreds of other possible violations of international humanitarian law. Taking hostages, murder, sexual violence, restricting humanitarian assistance, attacking hospitals, schools and places of worship, and collective punishment of civilians are all crimes. As such they are regulated by the 1949 Geneva Convention on the Protection of Civilians in Times of War.

Furthermore, the ICJ has already ruled that Israel is bound by these treaty obligations within its occupied territories on the West Bank. The next step at the ICJ should be to focus on the applicability and accountability required by all sides in the conflict under the Geneva Conventions.

Just as individuals should be held accountable for war crimes and crimes against humanity at the International Criminal Court, states should be held accountable under international humanitarian law at the ICJ, as much as they are for allegations of genocide. If New Zealand wants to help bring justice to this terrible conflict, these are the main areas where it should now plan to contribute.

It is also worth watching Electronic Intifada podcast with Susan Akram discussing the ICJ decisions
https://www.youtube.com/watch?v=8e5SmSy99Iw&ab_channel=TheElectronicIntifada

2.6 Global inequities in access to COVID-19 health products and technologies: A political economy analysis

Deborah Gleeson a,*, Belinda Townsend b, Brigitte F. Tenni a,c, Tarryn Phillips d a School of Psychology and Public Health, La Trobe University, VIC, 3086, Australia b Menzies Centre for Health Governance, School of Regulation and Global Governance, Australian National University, 8 Fellows Road Acton, Canberra, ACT, 2000, Australia c Nossal Institute for Global Health, University of Melbourne, 5th Floor, 333 Exhibition Street, Melbourne, Victoria, 3189, Australia d Department of Social Inquiry, La Trobe University, VIC, 3086, Australia

https://pubmed.ncbi.nlm.nih.gov/37379732/

This paper presents a political economy analysis of global inequities in access to COVID-19 vaccines, treatments, and diagnostic tests. We adapt a conceptual model used for analysing the political economy of global extraction and health to examine the politico-economic factors affecting access to COVID-19 health products and technologies in four interconnected layers: the social, political, and historical context; politics, institutions, and policies; pathways to ill-health; and health consequences. Our analysis finds that battles over access to COVID-19 products occur in a profoundly unequal playing field, and that efforts to improve access that do not shift the fundamental power imbalances are bound to fail. Inequitable access has both direct effects on health (preventable illness and death) and indirect effects through exacerbation of poverty and inequality. We highlight how the case of COVID-19 products reflects broader patterns of structural violence, in which the political economy is structured to improve and lengthen the lives of those in the Global North while neglecting and shortening the lives of those in the Global South. We conclude that achieving equitable access to pandemic response products requires shifting longstanding power imbalances and the institutions and processes that entrench and enable them.

2.7 Vaccine hoarding had led EU countries to destroy over €4 billion in COVID vaccines

https://aftinet.org.au/cms/aftinet.org.au/cms/latest-news/EU-dumps-4b-in-vaccines

8 January, 2024:

Politico reports that EU countries have discarded at least 215 million COVID vaccine doses, an average of 0.7 doses per person, costing the EU over €4 billion and demonstrating the extent to which EU countries unnecessarily hoarded vaccines during the pandemic.

In early 2021, during the height of the pandemic, the EU Commission negotiated a massive COVID contract with Pfizer, securing 3.5 doses per person for people in EU countries. The World Health Organisation (WHO) Director-General Tedros Adhanom Ghebreyesus, however, cautioned of countries hoarding vaccines, which he said would be 'paid with lives and livelihoods in the world's poorest countries ' as at the time the African Union still only had COVID vaccines for 0.2 doses per person.

However, the EU still 'ring-fenced ' additional doses for booster vaccines, rather than working within multilateral vaccine sharing systems. In doing so it was tied into excessive and expensive COVID contracts. In 2022, after demand for vaccines dropped, EU countries began to complain they were oversupplied and would have to buy, and then destroy, millions of vaccines. Poland and Hungary refused to accept any additional vaccine doses in 2022 and Pfizer has sued both countries for non-payment.

The Peoples Vaccine Alliance said that the EU has 'not learnt from its COVID mistakes ' and said that the EU is attempting to roll back crucial provisions in a draft Pandemic Agreement aimed at improving global pandemic response.

However, public health advocates continue to press for strong provisions in the WHO Pandemic Agreement now being negotiated which would prevent vaccine hoarding and dumping, and ensure greater equity in a future global health emergency.

See more on AFTINET's medicines access campaign here.