RADAAR

AMR Policy & Advocacy: Some Reflections

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Battle Mantra of the Warrior Turtle
The Known, the Unknown, and the possibly Unknowable

- Sources and pathways of transmission, and their relative contribution to AMR, are yet to be quantified -- needs reliable, timely, and quality data

- Burden of morbidity and mortality attributable to resistant infections is yet to be accurately estimated and will vary by setting and country contexts.

‘Access versus Excess’: Dilemmas Confronting LMICs

- Rising incomes and mobility
- High burden of infectious diseases
- Limited or delayed access to antibiotics
- Growth in consumer demand for livestock products
- Substandard and falsified drugs

... are together driving the emergence and spread of AMR.
Use of Data for Policymaking

Number of countries who responded to the question:
"Is the country using relevant AMC/U and/or AMR data to amend national strategy and/or inform decision-making, at least annually?"

Total number of countries who reported to WHO-TrACCS (2019-2020):
- Global: 136
- Fleming Fund countries: 19

(Source: Adapted from WHO TrACCS survey database 2019-2020 for NAPs: www.amrcountryprogress.org)
Characterizing the AMR policy and planning ‘problem’

**CHARACTERISTICS OF ‘WICKED PROBLEMS’**

1. Difficult to clearly define the problem.
2. Have many interdependencies and are often multi-causal.
3. Attempts to address them often lead to unforeseen consequences.
4. They are often not stable.
5. Usually do not have a clear solution.
6. They are socially complex.
7. Do not sit within the responsibility of any one organization.
8. Involves changing behavior.
9. Often characterized by chronic policy failure.

**‘Super-wicked Problems’**

1. Time is running out.
2. There is no central authority, or only a weak central authority, to manage the problem.
3. The same actors causing the problem are attempting to solve it.
4. The future is discounted radically so that contemporary solutions become less valuable.

“Usually, wicked problems require more than a whole-of-government approach: solutions require involving many social stakeholders, particularly citizens.”
Unpacking the AMR problem: The Cynevin Framework for Leaders & Decision-Making

“Known Knowns”
- Clear cause-effect relation
- Right answer exists
- Domain of ‘Best Practice’
- Fact-based management

“Known Unknowns”
- Cause-effect relation discoverable
- Multiple right answers possible
- Domain of ‘Experts’
- Fact-based management

“Unknown Unknowns”
- Emergent instructive patterns
- No right answers possible. Competing ideas
- Domain of ‘Emergence’
- Pattern-based management

“Unknowables”
- No clear cause-effect relationship
- No point looking for right answers
- Domain of ‘Rapid Response’
- Pattern-based management

Asks of AMR ‘Strategic’ or ‘Technical’ Policymakers

1. “Where are we today?”
2. “Where do we need to go?”
3. “How do we get there?”
4. “What works?”
5. “What’s it going to cost?”

REQUIRED
- Reliable and up-to-date evidence
- In an easy-to-understand format
- That lends itself to weighing options

But It’s Complicated
Emergence and spread of AMR is driven by human action/behaviors.

And there are closes linkages to issues of:
- Livelihoods
- Public trust in the (health) authorities

RADAAR’s Objectives

Identify barriers/enablers to data sharing and analysis
Establish mechanisms to facilitate policy dialogue
Create a demand for policy-relevant data
Unpacking ‘Trust’

Trust-Confidence-Cooperation Model (Simplified Version)

Narrative Information

Values Similarity

Past Performance

Personal Experience

Reports from Others

Social Trust (Trust in Motives)*

Confidence (Trust in Competence)*

Cooperative Intention

Cooperative Behaviours

PERCEIVED

MOTIVES

COMPETENCE

FAIRNESS

Building trust is a slow, complex, and long-term task.

Mechanically applying some operational guidelines or SOPs does not build trust.

Trust grows with the experience of trustworthiness.

Only one golden rule:

Talk Less, Listen More

* Refers in this instance to public trust in the motives and competence of the (health) authorities.

Trust-Confidence-Cooperation Model of Risk Communication

Source: Adapted from the simplified version of Siegrist et al.’s (2003, 2005) model as depicted in Twyman et al. (2008, p 112)
• Actions to address drug-resistant infections on the ground are simply not happening at the scale and urgency required.

• Groundswell of public and societal support needed to push and hold political leaders accountable.

• Current AMR communication and advocacy approaches need to be dramatically re-framed and scaled-up.
# Framing of the AMR Problem and Response

## Differential Framing and Discourse of the AMR Problem

<table>
<thead>
<tr>
<th>Policy Frame</th>
<th>Policy Focus and Intervention Characteristics</th>
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</thead>
<tbody>
<tr>
<td>1. A healthcare issue</td>
<td>Focus on the healthcare sector; promotion of early diagnosis and treatment through rational/prudent use of antimicrobials and antimicrobial stewardship.</td>
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<tr>
<td>2. A development issue</td>
<td>The high burden of infectious diseases and lack of awareness in LMICs drives overuse and misuse of antimicrobials. Universal and equitable access to quality antimicrobials seen as a right to health. Achievement of SDGs imperiled.</td>
</tr>
<tr>
<td>3. An innovation issue</td>
<td>Lack of new compounds and diagnostics. Market failure and lack of incentives for R&amp;D in the pharmaceutical sector. Incentivization of R&amp;D through new mechanisms</td>
</tr>
<tr>
<td>4. A security issue</td>
<td>AMR viewed as a threat to individual and national (health) security as a result of globalization and imperiling the global North. Focused on systematic surveillance, capacity building, and containment of AMR ‘at source’ (i.e. largely the global South)</td>
</tr>
<tr>
<td>5. A One Health issue</td>
<td>Developed in the context and as a response to rising incidences of zoonoses and the large-scale overuse/misuse of antibiotics in food animal production, requiring multi-sectoral engagement. Globally endorsed overarching approach for containing AMR. Despite operationalization challenges, improved coordination and collaboration between human, animal, and environmental sectors is the policy response emphasis.</td>
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A conceptual re-framing of the AMR problem and response

**A Proposition**

**ESTABLISH:**

1. Attaining and Sustaining ‘National Antimicrobial Security’ as the overarching Strategic Goal of National Action Plans (NAPs)

**RECONFIGURE:**

2. NAPs as a Progressive Pathway to achieving ‘National Antibiotic Security’, with a robust ‘Theory of Change’ and time-bound numerical targets.

**Acknowledging and Foregrounding**

the ‘Access versus Excess” dilemma facing policymakers in LMICs
A conceptual re-framing: *Attaining and Sustaining ‘National Antimicrobial Security’*

**Working Definition**

Every country retains the continued ability to treat infectious diseases of the highest burden with effective and safe antimicrobials in an affordable and equitable manner by preventing the emergence and spread of AMR, and thereby reducing the impact of infectious disease on the human, animal, environmental, and economic health of the country.

- **Starting when?**
  - By when?
  - Till when?

- Which diseases or pathogens have become, or are becoming, resistant to the antimicrobials currently available and being used in the country?

- Which infectious diseases have the highest burden and economic impact on the country?

- Access to which important antimicrobials is being denied due to costs or availability?

- Which antimicrobials have become, or are in imminent danger, of becoming ineffective in the country due to resistance or sub-standard quality?

- What impacts can and need to be reduced, by how much, and by when?

- What are the antimicrobial consumption and usage levels and patterns (including professional and social behaviors and practices) that are driving the emergence and spread of AMR?

- Do the benefits outweigh the costs?
  - Which sector needs the highest investments?
  - Investments in which sector will bring the maximum and quickest benefits? Are the required investments affordable?

**ASSURING ACCESS without EXCESS**
Linking the ‘Technical’ with the ‘Social’

Contribution and ratio of social science versus science in The Web of Science

Emergence and spread of AMR is driven by human action/behaviors. AMR prevention and control will require strong linkages between epi-surveillance and socio-behavioral data:

- Intricate and complex link with livelihoods
- Prescribing habits, consumer/patient demands, farming practices
- The ‘Political Economy’ of AMR

**Emerging Imperative (?)**
Consider: A sentinel AMR Socio-Behavioural Surveillance System
## Policy, Advocacy, Communication, and Social Mobilization (ACSM) Coalitions

<table>
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<tr>
<th>DISEASE/ISSUE</th>
<th>COALITION</th>
<th>Lead Agencies</th>
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<tbody>
<tr>
<td>Polio Eradication</td>
<td>Global Polio Eradication Initiative</td>
<td>WHO, UNICEF, CDC, Rotary International + thousands of in-country Partners</td>
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<tr>
<td>HIV/AIDS</td>
<td>World AIDS Campaign</td>
<td>UNAIDS + thousands of CSOs/NGOs</td>
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<tr>
<td>Tuberculosis</td>
<td>Stop TB Partnership</td>
<td>Stop TB Partnership Sectt + thousands of CSOs/NGOs</td>
</tr>
<tr>
<td>Avian Influenza</td>
<td>One Health Partnership (emerged)</td>
<td>FAO-WHO-OIE + UNICEF + hundreds of CSOs/NGOs</td>
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<tr>
<td>Covid19/Ebola</td>
<td>RCCE Collective Service</td>
<td>WHO, UNICEF, IFRC, GOARN + dozens of in-country Partners</td>
</tr>
<tr>
<td>AMR</td>
<td>???</td>
<td>(ReACT? Tripartite? Others?)</td>
</tr>
</tbody>
</table>
So, when it comes to ‘data’, remember...

“Not everything that can be counted counts, and not everything that counts can be counted.”

(Attributed to multiple sources)

It just needs to be policy-relevant.
Thank you

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