

MRC/CSO Social and Public Health Sciences Unit Consultation Response

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| **Title of consultation** |
| Antimicrobial resistance national action plan: call for evidence |
| **Name of the consulting body** |
| Department of Health and Social Care, UK Government |
| **Link to consultation** |
| [https://www.gov.uk/government/consultations/antimicrobial-resistance-national-action-plan-call-](https://www.gov.uk/government/consultations/antimicrobial-resistance-national-action-plan-call-for-evidence/antimicrobial-resistance-national-action-plan-call-for-evidence) [for-evidence/antimicrobial-resistance-national-action-plan-call-for-evidence](https://www.gov.uk/government/consultations/antimicrobial-resistance-national-action-plan-call-for-evidence/antimicrobial-resistance-national-action-plan-call-for-evidence) |
| **Our consultation response** |
| **Q1.** From your experience, how has the scale of the threat of AMR changed since the national action plan was published in 2019?   1. **the threat of AMR has increased since 2019** 2. the threat of AMR has stayed the same since 2019 3. the threat of AMR has reduced since 2019 4. don’t know   **Q2.** In your opinion, what are the top 3 drivers of AMR? Please give 3 short answers.   * + Overreliance on antibiotic treatment rather than infection prevention (e.g., through vaccination). This is a particular issue in intensive farming systems.   + Syndromic diagnosis (informed by clinical rather than diagnostic assessment) and over- prescription of antibiotics by general practitioners without microbiological confirmation of infection cause and appropriate treatment choice.   + Insufficient engagement of the general public in AMR-related issues and ineffective and confusing communication, e.g., regarding when antibiotic treatment is necessary versus when it is not (e.g., upper respiratory tract infections)   **Q3.** Which of these areas would you most like to see prioritised over the next 5 years? Rate order or priority.   1. reducing the need for, and unintentional exposure to, antimicrobials -1 2. optimising the use of antimicrobials - 3 3. investing in innovation, supply and access - 2 |

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| **Q4.** Are there any actions you think are required to tackle AMR that do not fall within one of these categories?   1. **yes (please specify)** 2. no 3. don’t know   Yes – health communication campaigns co-designed with ultimate beneficiaries (antibiotic users/providers/decision makers).  **Q5.** Within the UK, what are the key successes we should look to maintain or build on in responding to AMR? Please include up to 3 examples in no more than 250 words.  Global advocacy work: Championing an integrated global response to AMR that is rooted in principles of mutual solidarity and equity. Responses to global health issues (COVID-19; HIV/AIDS, Ebola, Zika, H1N1) have all revealed the challenges of global equity in preparation and response to global health events and AMR faces similar issues (<https://doi.org/10.1186/s13756-022-01071-5>).  UK should only consider their response to AMR and advocacy work at a global scale a success if i) it politicise AMR and the structural barriers facing the global majority in responding to it ii) supports broader movements for universal free health care and health system strengthening both vital in the fight against AMR at a global level iii) operates on a global stage in ways which actively listens and responds to the voices from LMICs and iv) works to dismantle the global barriers to good health that privilege the lives of the wealthy and abandons the global majority (Ibid.).  Continue to support initiatives aimed at researching and addressing AMR on a global scale (e.g. through initiatives such as the Global Challenges Research Fund.  **Q6.** Within the UK, what are the areas that require more focus or development to address AMR? Please include up to 3 examples using no more than 250 words in total.  Diagnostic development particularly focusing on rapid diagnostic tools that would enable health providers to make informed treatment decisions at point-of-care. This applies to both the human and veterinary sectors, particularly the latter where diagnostic confirmation of infection is not performed routinely.  **Q7.** Within your sector, do you think the UK has sufficient capacity and capability to tackle AMR?   1. Yes 2. **Yes, in some areas (please specify) – diagnostic capabilities** 3. no 4. don’t know |

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| **Q8.** What additional capacity and capability is needed in your sector to effectively tackle AMR? Please give up to 3 examples using no more than 250 words in total.  Initiatives to enable tailored training on AMR in higher education, particularly at postgraduate level (e.g. MSc and PhD programmes). Inter-disciplinary training bringing together all disciplines that would enable an integrated response to the AMR challenge is particularly lacking. Such programmes should also facilitate, for example through dedicated studentship opportunities, attendance by international students from parts of the world where AMR poses the greatest risks.  **Q9.** What, if anything, do you think we can learn from other countries’ responses to AMR? Please be specific about which countries you are referring to in your answer. Please give up to 3 examples using a maximum of 250 words in total.  Data driven, co-produced, AMR campaigns in Tanzania: Recognising the complexity of AMR, the multidisciplinary URKI GCRF funded project Supporting the NAP for AMR in Tanzania co- designed, delivered and evaluated data-driven health intervention campaigns in Tanzania which aligned with the Tanzanian NAP. These campaigns took place i) within health systems (in neonatal wards) and ii) in communities (sensitising citizens on AMR just prior to hospital visits through multimedia public-transport information campaign (<https://www.youtube.com/watch?v=-5q5404mt2w>).  Both campaigns followed the same SNAP-AMR logic model and principles: i) use evidence- based research to identify the problem ii) co-produce the campaign with relevant stakeholders to ensure appropriateness and risk-assess against unintended consequence and iii) evaluate the campaign. Within neonatal wards i) interviews with doctors coupled with clinical swabbing worked to identify high rates of ESBL producing organism, and limited association between IPC and AMR ii) work with health care providers explored messaging, design, required equipment’s and iii) sampling of babies and environments coupled with interviews with health care providers demonstrated improved knowledge, reported behaviour change and a reduction in bacterial carriage within the ward, as well as lessons to improve in future campaigns. Within communities i) interviews with doctors which identified a want to increase AMR awareness but limited time to discuss with patients ii) work with doctor, NGO Roll Back AMR; singer-songwriter and vehicle drivers iii) passenger exit surveys demonstrated increase awareness and understanding of AMR amongst those who travelled on campaign vehicles.  **Q10.** In your opinion, which of these tools should be prioritised for adapting to use in tackling AMR? Rate in order of priority.   1. Diagnostics - 1 2. Surveillance - 3 3. Therapeutics - 4 4. Vaccines -2 |

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| **Q11.** In your opinion, are there any other tools that should be adapted from use during the COVID-19 pandemic for tackling AMR?   1. **Yes (please specify)** 2. No 3. Don’t know   Yes – citizen science approaches to enable contact-tracing and tracking of disease.  **Q12.** Do you believe the changes in ways of working within your organisation due to the COVID-19 pandemic have affected efforts to respond to AMR, such as delivery of the current national action plan (NAP)?   1. **Yes** 2. No 3. Don’t know   **Q13.** In what way have they affected the response to AMR or delivery of the NAP? Please give up to 3 examples using no more than 250 words in total.  Mitigation strategies enforced to reduce COVID-19 transmission risks (e.g., hand hygiene, assessments of ventilation, stringent cleaning mechanisms etc.) are very relevant also to AMR. But it is disappointing to see how little has been retained in current working practices.  **Q14.** Are there other ways in which the COVID-19 pandemic has altered the AMR risk landscape? Please give up to 3 examples in no more than 250 words in total.  Before the pandemic, AMR was among the top priorities both in terms of research and policy. COVID-19 re-inscribed inequitable global health governance, the response demonstrated the failings of a nation-by-nation approach to global health problems (<https://doi.org/10.1186/s13756-022-01071-5>). This approach saw countries attempt to deal with a global issues in both an inequitable and inefficient manner e.g. promoting vaccine nationalism and sending (almost out of date) vaccines to LMIC countries was an unethical and inefficient global response. The unprecedented nature of COVID-19 provided an opportunity to move global health out of its current failed model of ‘charity’, couched in blame and suspicion and self-preservation, into a model which demonstrates a genuine equitable approach rooted in solidarity. This failure in imagination in how to mutually respond to COVID-19 was a missed opportunity and one which represents a risk to how AMR is responded to at a global scale. If AMR is not tackled through a truly equitable global approach, AMR will reinscribe and reinforce global health inequalities to the detriment of us all, especially those already carrying the heaviest health burdens.  To address this genuine risk, the UK should show global leadership by reflecting on its own failures in contributing to a global response to COVID-19, and learn lessons so as to not replicate this response in relation to AMR. Voices from LMIC countries have to be genuinely |

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| listened to, new approaches taken forward that are underpinned in collective solidarity and rights for all rather than myopic nationalism.  **Q15.** Are there other global events, such as supply chain disruption or the conflict in Ukraine, that have changed the UK’s ability to respond to AMR?   1. **Yes** 2. No 3. don’t know   Yes in that these events exacerbate health inequalities.  **Q16.** In your opinion, what are the best measures of success in tackling AMR? Please give up to 3 suggestions.   * + reduce the number of resistant infections   + reduce antimicrobial use in humans and animals   **Q17.** Do you believe that there is sufficient public and professional awareness of AMR?   1. Yes 2. **No** 3. don’t know   If no, what should be done to increase awareness of AMR? Please tell us in a maximum of 250 words.  There is a need to improve communication strategies, e.g. through multi-pronged co-created campaigns targeting various audiences and segments of the population through different channels to convey the urgency of the AMR crisis and to empower the direct beneficiaries to feel part of the problem and of the solution. These campaigns need to tackle the communication complexities that are pervasive in global and national AMR narrative. These have given rise to unhelpful dichotomies that place antimicrobial providers and users in opposition and compromise trust in public health information. Blaming messages, for having inaccurate knowledge or using antimicrobials inappropriately for instance, permeate global and national communication strategies. Similarly, if not properly contextualised, means of information provision can promote social, cultural and linguistic inequalities by creating further isolation of already marginalised groups, whose involvement is obstructed by a lack of access to or literacy of technologies (e.g. in the context of public health social media campaigns).  There is a need to develop “user-focused” and “provider-focused” AMR communication  strategies that take these complexities into account and address communication gaps that currently hinder multi-level dialogues. |

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| **Q19.** Are you content for the DHSC AMR policy team to contact you to take part in further stakeholder engagement as we develop the 2024 to 2029 national action plan?   1. **Yes** 2. No |
| **When was the response submitted?** |
| 20th January 2023 |
| **Find out more about our research in this area** |
| [https://www.gla.ac.uk/schools/healthwellbeing/research/determinantsofhealthandhealthinequalit](https://www.gla.ac.uk/schools/healthwellbeing/research/determinantsofhealthandhealthinequalities/antimicrobialresistance/) [ies/antimicrobialresistance/](https://www.gla.ac.uk/schools/healthwellbeing/research/determinantsofhealthandhealthinequalities/antimicrobialresistance/) |
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