

## 11.8 Antimicrobial resistance

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### In focus

[A77/5](#): WHO strategic and operational priorities to address drug-resistant bacterial infections in the human health sector, 2025–2035.

The Executive Board at its 154th session in January 2024 noted an earlier version of this report ([EB154/13](#)) and considered the text of a draft decision introduced by Member States ([EB154/CONF.7](#)). The Board anticipated further informal consultations among Member States on the draft resolution during the intersessional period.

The present report (A77/5) incorporates feedback on the draft strategic and operational priorities from Member States and partners during the session and through the online consultation. A revised version of the draft resolution proposed in [EB154/CONF.7](#) is also anticipated.

In 2024 a high level meeting of the UN on the theme of AMR is scheduled. This current report ([A77/5](#)) is a part of the build up towards the UN Meeting on antimicrobial resistance scheduled for later this year.

### Background

See also [PHM Comment on EB154/13](#) (Jan 2024).

See record of debate at EB154 [M12, page 24](#) and [M13, page 9](#)

### PHM Comment

[A77/5](#), posted for this item is a revision of [EB154/13](#) considered by the EB in January. The revision is based on the intersessional discussions.

### **WHO strategic and operational priorities to address drug-resistant bacterial infections in the human health sector, 2025-2035**

1. The first five paragraphs of A77/5 (DG report dated 11th April, 2024) set out the magnitude of the problem and the pervasive harm it does across the health system and other sectors and the

excessive mortality and morbidity that it leads to. The Report then notes, in paragraphs 6 to 10, the earlier efforts by WHO with regard to AMR and the creation of a quadripartite alliance to address it as part of a comprehensive One Health approach. The Quadripartite organizations consist of WHO, the Food and Agriculture Organization (FAO), the United Nations Environment Programme (UNEP) and the World Organisation for Animal Health (WOAH). All have endorsed the global action plan drawn up in 2015 (in [WHA68.7](#)), and agreed on multisectoral actions for its implementation. The other three have adopted sector-specific strategies against AMR, and this is the WHO's step to do the same in the human-health sector. As of now 170 countries have made national plans, though only 27% report progress on effective implementation of these (para 7) and only 11% have provided a budget for this.

2. The strategic vision (para 11) and the four strategic priorities (paragraph 12) are most welcome. To quote "The strategic vision underlying the development of the priorities is the control and reversal of the urgent public health and socioeconomic crisis due to drug-resistant infections in humans, as a crucial contribution to the global effort to build a healthier world for all". PHM hopes and calls for an interpretation of a healthier world for all to include all the elements of nature in the Buen Vivir sense and not be limited to narrow reductionist anthropocentric interpretation of the same.

3. The recommendations proposed are cast as "four urgent strategic priorities for a comprehensive public health response to antimicrobial resistance in the human health sector." The first is the prevention of all infections that give rise to the use of antibiotics, noting that viral and other infections also contribute to inappropriate antibiotic use. The second strategic priority is universal access to quality diagnosis and appropriate treatment of infections. The third priority is termed strategic information, science and innovation and includes surveillance of both antimicrobial resistance and antimicrobial consumption/use as well as the development of new vaccines, diagnostics and antimicrobial agents; and measures to make these accessible and affordable; and the fourth is called governance and financing.

4. This report is surprisingly silent on the role of antibiotic use in the animal husbandry/agricultural/veterinary sectors, though it is well known that much of the antibiotic resistance that arises is from the commercial pressures on this sector that leads to high levels of inappropriate antibiotic use. Perhaps this is because this issue is addressed in the sector-wide strategies of the other Quadripartite partners, especially the Food and Agriculture Organization of the United Nations, and the World Organisation for Animal Health. Links to these reports have been provided. However a brief discussion of each of these showing the points of convergence is required.

4A. The WOAH document '[Enhanced surveillance system to support responsible antimicrobial use](#)', which presents the Key findings of the 8th Annual Report on Antimicrobial Agents Intended for Use in Animals, points out that, worryingly, *progress toward optimal antimicrobial use shows signs of slowing down in the animal health sector*. The [four pillars adopted by WOAH](#) in its [strategy to support responsible antimicrobial use](#) fail to address the social and economic factors that are likely to contribute to producers, especially in poorer countries, to using antimicrobials

unwisely, if they can afford to at all. The strategy acknowledges the importance of education about AMR, but it is tilted towards individual producer responsibility in curbing excessive use rather than economic pressures on producers. The ongoing intensification of animal production systems and promotion of antimicrobial medicines by pharmaceutical companies are not mentioned in the strategy. And one plank of the strategy, well-trained veterinarians and veterinary paraprofessionals to guide national and regional efforts, does not acknowledge the impact of neoliberal doctrines in starving public workforce training, and public sector services generally.

5. Paragraph 20 which elaborates the first strategy of prevention of infection is a very brief statement of intent that flags some proximal determinants of infection. This is inadequate to guide action or measure progress. The structural determinants of the high rates of infection in the poor and marginalized as well as the proximate determinants of water, sanitation, adequate housing and clothing, decent working and living conditions require to be addressed by introducing and enforcing public health standards. Many countries do have such public health laws, with local government institutions as their duty bearers but local governments are generally not provided with the capacities and financial powers needed to play this role.

7. The second strategy (para 21), “Universal access to affordable, quality diagnosis and appropriate treatment of infections”, is most welcome. It integrates concerns of ensuring access to essential antibiotics with restraints on inappropriate use. We also welcome the statement that “this priority requires integration of specific interventions – notably for diagnostic and antibiotic stewardship based on WHO’s AWaRe (access, watch, reserve) classification and the WHO AWaRe antibiotic book. It includes ensuring gender-equitable access and addressing the specific needs of vulnerable groups including migrants and refugees.” AWaRe is most welcome. However we point out this paradox: on one hand major population sub-groups are experiencing serious problems of access to essential antibiotics (and other medicines) while at the same time the entire population is experiencing high degrees of wasteful, irrational, unscientific and even hazardous use of antibiotics. The roots of this paradox are in the nature of capitalist production, and whereas state action can mitigate and adapt to this problem, it cannot do away with it altogether.

9. Notwithstanding measures for mitigating inappropriate antibiotic use, the silence on some of the drivers of inappropriate use is a major weakness of this strategy. Much of inappropriate use of antibiotics is because of commercial pressures and the nexus it has with professional behaviors. These pressures lead to shaping public demand in favour of inappropriate use and leads to a legitimizing vicious cycle. This report addresses this entire problem as an issue of consumer behavior and somewhat implicitly of providers, but completely leaves out the political economy considerations which include the commercial and unethical marketing of pharmaceuticals. This problem is not limited to antibiotics, but in treatment of infections, inappropriate individual provider-patient transactions have an adverse effect on the entire population. There is no mention in the report of the need for controls over marketing of antibiotics, through regulatory restraint over unethical marketing and prescription practices. There is no mention of the need for better access to good quality prescription information for

doctors from institutions which are free of conflict of interests. There is no mention of the complicity of professional associations in such unethical marketing both for reasons of professional power and for financial gain. There is no mention of the use of generics as different from brand names. There is no mention of the difficulty of restraining use of third and fourth generation antibiotics in a setting of almost no regulation of the private sector in healthcare.

10. When it comes to stewardship, there is a need for more practical and affordable solutions to making appropriate prescription choices rather than calling for a massive expansion in microbiological and genomic diagnostics where every individual infection episode requires heavy expenditure on diagnostics. The central challenge to stewardship as of now in most LMICs is in ensuring the minimal essential access to microbiology capacity (viz laboratory, microbiologists, standard treatment guidelines) and appropriate public health informatics and disease surveillance. This problem of access to bacteriological capacity gets mentioned only as one of the indicators. This report does not even acknowledge the problems of developing these capacities. There is no mention of how we would achieve this strategy in the private sector, without strengthening the regulation of private clinical establishments.

11. The third strategy proposed in this report has now been termed strategic information, science and innovation. The emphasis of this strategy is on surveillance both of resistance and of antibiotic consumption and of resistance prevalence surveys. There is a line in para 22 that states: "Comprehensive measures to promote increased research and development for vaccines, diagnostics and antibiotics (and alternatives) targeted to greatest public health needs" but beyond that no mention is made of this in the tables or indicators. Even with regard to surveillance, a stand-alone surveillance for AMR will not work. AMR surveillance would be adequate only if it is part of strengthening health systems to deliver comprehensive health services, with better diagnostic capacity, and with better hospital information systems and with an integrated disease surveillance system. There is also no mention of how these systems will extend into a private sector. A call for better regulation of the private sector is essential to achieve an impact at a population level.

12. The current innovation and knowledge regime is bad for all essential medicines of public health importance, but when it comes to antibiotics it is terrible. By definition third and fourth generation antibiotics have to have very restricted use, which means a very limited market size and very high price mark-ups. It is not possible to create an intellectual property regime and a financing model just for newer antibiotics. Public financing of antibiotic research would help, but without control over patents and distribution we will see the same outcome as we saw with Covid vaccines, a huge profit to big pharma with high inequities in access, despite the public finance. The minimum measures for an effective innovation regime are a) delink the price of innovation and development from the price of marketing the drug, the latter reflecting only manufacturing costs and b) where public financing is involved, public acquisition of IPRs and mandatory licensing of multiple generic manufacturers to undertake production including where possible public sector manufacture. There is awareness of some of these problems, but the proposal to address them as stated in para 36 is disingenuous. WHO's role is portrayed and monitoring and promoting write choices in what industry and other partners would take up in

research and development and some additional managerial measures that would have little impact without addressing the central questions.

13. In summary though there are many welcome measures in these strategies every single strategy is too incomplete to succeed. I

**Draft resolution: Accelerating national and global responses and preparing for the UN High Level Meeting on AMR.**

The draft resolution included in [EB154/CONF.7](#) makes frequent reference to the strategic and operational priorities for accelerating national and global responses. Since those priorities were still undergoing discussion the Board did not formally recommend the draft to the Assembly. However, the broad direction and framework of the draft resolution is clear and assuming the priorities included in A77/5 are now agreed, the resolution as amended will be presented to the Assembly. Even more important this resolution will also guide the discussions in the Special Session on AMR of the UN General Assembly later this year.

The PHM welcomes the three main strategies that constitute the Action Plan against the growing problems of AMR. These are – 1. prevention of infections; 2. universal access to affordable, quality diagnosis and appropriate treatment; and 3. strategic information, science and innovation. These three independent elements of a comprehensive public health approach for sustained impact in slowing the emergence and spread of drug-resistant bacterial infections and preserving effective antibiotics. The PHM also welcomes the call to strengthen governance and financing and to support country level plans as the operational elements to achieve progress towards these goals

While these are all essential, there are a number of other concerns that we call for inclusion in this resolution and in the in the political declaration of the scheduled United Nations High Level Meeting on Antimicrobial resistance:

1. A call to countries to enact and implement public health legislations that can enforce the rights of the residents on the state to ensure that access to safe water, sanitation, and hygiene measures is delivered as an entitlement through public services. This would need to go along with local-self-governments being provided with the financial powers, the transfers of technology and other capacities required to play their role. Also a call for countries to enact public health standards for quality assurance in all health care facilities. Taken together these are specific measures that would move us forward towards infection prevention and control and at least in part redress the inequities in current causes and consequences of high levels of infection in the poorer and more vulnerable sections.
2. Acknowledge the role that poorly regulated private markets in medical commodities and in healthcare provision has made to the spread of antibiotic resistance and call for strong regime of antibiotic marketing regulation, accompanied by provision of

good quality information and proactive promotion of better antibiotic choices. This would have to be part of a better regulatory regime for private sector care in LMICs. Especially in primary health care, but in all levels of health care, one principle of organizing health services must be that clinical decision making is not subject to market pressures. This can be best assured by public provisioning of services and in designing contracts with private providers, which adhere to this principle.

3. Ensuring public provision of microbiological guidance including affordable rate-controlled or free testing services to all patients irrespective of choice of provider. It should also call for local availability and use of information from ongoing microbial surveillance to guide appropriate local guidance on antibiotic use.
4. Banning the use of antibiotics for preventive purposes and growth promotion in rearing animals for food, better microbial surveillance and feedbacks to farmers and veterinarians to guide antibiotic choice, and restriction of some antibiotics for use in some sectors.
5. Call for the UN high-level meeting and political declaration to become a convergent call of the quadripartite alliance and not only of the human health sector.
6. Expedite the development of better antibiotics with putting in place a more effective innovation regime for antibiotics which should a) delink the price of innovation and development from the price of marketing the drug- the latter reflecting only manufacturing costs and b) where public financing is involved, mandate a public acquisition of IPRs and mandatory licensing of multiple generic manufacturers to undertake production including where possible public sector manufacture.

**These demands are in addition to the many welcome measures that the resolution has itself proposed.**

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Notes of discussion