Webinar Report

***Community Engagement within Research Uptake:***

***Antimicrobial Resistance (AMR)***

*June 2022*

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## **Introduction**

On 12th May and 19th May 2022, the [Applying Research to Policy and Practice for Health (ARCH)](https://arch.tghn.org/) programme and the [Community Engagement Hub, Mesh](https://mesh.tghn.org/) at [The Global Health Network](https://tghn.org/) conducted the [**Antimicrobial resistance (AMR)**](https://arch.tghn.org/topics/community-engagement-support-research-uptake/antimicrobial-resistance/) virtual webinar, which was the third part of the “**Community Engagement within Research Uptake**” webinar series. Currently, there is a wide separation between teams that undertake health research, those making decisions on health priorities and policies, and those who are delivering healthcare and pushing social change, particularly in resource-limited settings. Nevertheless, if research is to deliver its maximum impact and positively change health outcomes, findings from health research should be translated into recommendations that are relevant to communities and can be implemented within policy and practice.

The session brought together experts in the field:

***Part one***:

* Professor Paul Cooke, Centenary Chair in World Cinemas, University of Leeds, Co-lead of CE4AMR **(chair)**
* Dr Rebecca King, an Associate Professor in International Health, University of Leeds, UK, and Co-lead of CE4AMR **(speaker)**
* Dr Rumana Huque, the Executive Director, ARK Foundation, Bangladesh **(speaker)**
* Abriti Arjyal, a Research Manager: Qualitative and Multidisciplinary Science, HERD International, Nepal **(speaker)**

***Part two:***

* Dr Alun Davies, a Social Scientist, Community and Public Engagement with Health Research, Health Systems Collaborative, University of Oxford, UK **(chair)**
* Tassawan Poomchaichote, a project coordinator at Mahidol Oxford Tropical Medicine Research Unit (MORU), Thailand **(speaker)**
* Ravikanya Prapharsavat, a social scientist at MORU, Thailand **(speaker)**
* Mackwellings Phiri, a social scientist based at Malawi-Liverpool-Wellcome Trust **(speaker)**

## **Content Summary**

## **Part one: Finding the Right Language to Discuss AMR with Communities and Policy Makers**

## **The CE4AMR handbook of Community Engagement for Antimicrobial Resistance**

***Dr Rebecca King*** *is an Associate Professor in International Health, University of Leeds*

AMR challenges across the globe have highlighted the importance of raising awareness for people to act. However, this suggests a top-down and unidirectional health education approach that does not suffice behaviour change. Community engagement is a participatory process through which equitable partnerships are developed with community stakeholders who are enabled to identify, develop, and implement community-led sustainable interventions to issues that are of concern to them. The CE4AMR community engagement handbook has been developed through a collaboration between 11 partners working in 6 areas to address AMR issues. The handbook was developed through internal workshops between the partners together with workshops held with key stakeholders in countries such as Bangladesh, India, Ghana, and Vietnam.

The handbook has 6 themes including:

* who is the community that we engage with?
* which community engagement strategies have already been utilised to understand context of AMR in LMICs?
* what are the One Health drivers in addressing AMR?
* What are the best ways to make community engagement scalable and sustainable?
* defining success, to measure effectiveness and learn from failures
* engaging with national and international stakeholders beyond the community

Stakeholders are defined as anyone with an interest in or association with the project (local, national, and global actors) following the One Health triad of human, animal, and environmental health.

**Discussing AMR with Communities and Policy Makers; the Bangladesh Experience**

***Proffessor Rumana Huque*** *is the executive director of the ARK foundation*

Background

Despite the growing awareness and concern about AMR globally, there is limited understanding and experience about AMR in communities and engaging policy makers. Various stakeholders work with limited coordination in addition to limited knowledge, priorities, and motivation to support activities. Additionally, stakeholders have limited understanding of the One Health approach. Therefore, identifying key issues and messages for the development of AMR advocacy strategy tools and other communication materials is significant.

Evidence-based advocacy strategy comprises of 5 key stages:

* identifying key stakeholders
* accessing their knowledge, priorities, and innovations
* identifying stakeholders’ resources available
* identifying factors that could influence sustainability
* identifying key issues and messages

Challenges to Behaviour Change

First, sharing information and increasing knowledge is not enough to prompt change. It is well known that culture and social networks also influence the way people think and behave, therefore limiting change. Furthermore, top-down, and generic approaches have been proven to be ineffective since context may or may not work for different parties. Additionally, interventions aiming at behavioural change require very big coverage and are resource intensive.

The Community Dialogue Study

The University of Leeds in collaboration with the ARK Foundation and the Malaria Consortium carried out a community engagement study in Bangladesh. Its aims were to engage the community through community dialogues and create awareness of appropriate antibiotic use. Local volunteers were used as facilitators after being trained on AMR. Following this, they passed their knowledge to the wider community through the community dialogue approach which assisted in identifying local AMR issues in a participatory manner.

Key features of community dialogues

* More than health education: dialogues place emphasis on collective exploration of health issues rather than unidirectional sharing of information.
* Context and culture matter: community dialogues encourage identification of locally appropriate behaviours other than a top-down, one size fits all approach.
* Coverage isn’t everything: foster collective decision making which shape the social norms affecting the entire community.
* Limited resources are required: dialogues build on non-specialist volunteers and community ownership rather than resource-intensive external interventions.

Key lessons of community dialogues

* Local perceptions matter: it is important to understand what “community” means in the local context.
* Embeddedness increases sustainability: linking community dialogues to existing health system elements increases the sustainability of the platform beyond a specific project.
* Volunteering is key: this increases community ownership (however it is important to note that the workload needs to be kept to a minimum).
* Engaging with gatekeepers: buy-in of local leadership is important for identifying facilitators, trainings, and activities.

Lessons from the community dialogue study

* AMR is a complex concept
* Appropriate training of facilitators is important
* Facilitators must not monopolise discussions
* Facilitators must create space to understand the AMR knowledge and behaviours of the wider community
* There is need to expand to animal and environmental health

Key Decision-makers and Influencers for AMR Advocacy

There are several stakeholders that may influence policy on AMR issues. These include the government (ministries of health, fisheries, agriculture and environment), development partners (the WHO, FAO, CDC, USAID), the private sector (animal feed producers, health care providers, pharmaceutical industries), and other professional bodies. Knowledge about AMR is limited in many areas. This is because AMR is described as an “invisible disease” unlike other health problems. As such, there is varying understanding and awareness of AMR by stakeholders in health and livestock sectors. Additionally, there is limited awareness and depth of the long-term effects of AMR among various stakeholders.

Key points

* There is need for continuous engagement with policy makers to make them aware and understand AMR issues (sharing research findings and policy implications).
* There is need for dialogue, and for pharmaceutical industries, animal feed producers/sellers and animal breeders to improve awareness of the effects of AMR.
* There is need to establish relations with the media by providing them with technical materials and reports that they can use in their stories.
* There is need to create a pathway for all stakeholders to communicate.
* There is need to incorporate environmental stakeholders in AMR programmes.

**Engaging policy and community actors; an example of tackling AMR in Nepal.**

***Abriti Arjyal*** *is a Research Manager: Qualitative and Multidisciplinary Science, HERD International*

Federalised Context and Antimicrobial Resistance

Nepal has a new structure of government falling under three tiers: federal, seven provinces, and 753 local governments. However, health is shared responsibility among the three. Despite AMR calling for a multisectoral approach (human, animal, and environmental), policy actions, and engagement, it lacks political space. Although a national action plan for AMR was developed in 2016, its finalisation has been delayed. The one health approach is in its early stages and calls for a strategic leadership.

The Co-creation Approach

The approach involved engaging policy stakeholders from the outset of the project through a series of discussions, meetings, and workshops. During this process, stakeholders defined the problems, discussed, and contextualised the process, implemented and assessed the interventions, and disseminated information.

Sensitisation meetings with stakeholders were done at 3 levels:

* federal level coordination was done with the National Technical Working Group for AMR
* municipal level coordination, where elected representatives such as the mayor were involved
* ward level coordination was done to identify gatekeepers.

All this aimed at finding the right tools and strategies to implement the project’s intervention. Regular discussions were held to ensure that stakeholders were familiar with AMR and the community engagement approach used in the study. Community members explored and identified issues leading to AMR within their communities and identified local solutions to the AMR issues using audio visual materials, documentaries, project reflection blogs, and social media, and a methods manual. An international AMR event was also conducted, focusing on national and global discussions around AMR issues and challenges and the way forward.

Impact of the stakeholder meetings

* Understanding local issues to AMR
* Realisation of the need to prioritise addressing AMR issues
* Greater impact among stakeholders through community engagement
* Understanding that addressing AMR needs a multisectoral approach
* Commitment to address the issues e.g., monitoring and updating of policy on over-the-counter antimicrobials in the communities

Key take aways

* Engagement is a continuous process
* There is need to build from a local context
* There is need to use language that can be easily understood by policy and community actors
* The real change agents are directly engaged
* There is need to create platforms for dialogue and sharing of knowledge
* Co-creation of policy and community actors require adapting to the local context

**Summary of Q&A**

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| **Has anyone studied alternative terms of the word “resistant”?** “We had to use multiple sentences or explanations to describe what resistance or antimicrobial mean. In Nepal, the same definition approach is used. For example, people were unable to differentiate antimicrobials and medicines”. |
| **What strategies were used to identify stakeholders that were genuinely willing to take part in the project? Why would policy stakeholders want to engage with the community stakeholders?** “Stakeholders were identified by levels the central and local level, district, and sub district level. At central level, we found entry points through line ministries who were working on antibiotic resistance or antibacterial resistance. These included the ministry of health, agriculture, and environment. At the local level, we dealt with the ministry of local government for example, the ministry of health and community clinics and other health centres, non-governmental organisations, and AMR professional bodies. The national technical group on AMR was our entry point. It was not easy engaging policy stakeholders because this is a new method of engaging them. We responded to their queries and in the end, they were able to understand why it was important for them”.  |
| **Community dialogues are more effective in rural settings than urban settings. What were your experiences and are there any effective approaches to these two settings?** “In Bangladesh, for example in the ministry of health, there is a structure on health service delivery which is used as an entry point in community engagement. People in rural areas were less mobile and this made it easy to contact them on a regular basis. This was opposite in the urban areas and so the approaches were different. we need to adapt and use dialogue approaches that are contextualised to the community”**How to you manage scepticism when dealing with AMR e.g., negotiating beliefs of AMR by WHO to traditional beliefs?** “We keep on explaining why it is important and bringing all stakeholders together. Evidence is also a good way to help explain the situation. For the facilitators, it is important to develop their capacity to engage with the community. Political involvement at different stages is also very critical” |

## **Part two**

### **Embedding Public and Community Voices in Shaping Thailand’s National Strategic Plan on Antimicrobial Resistance**

***Tassawan Poomchaichote*** *is**a Project Coordinator, and* ***Ravikanya Praphasavat*** *is a Social Scientist at Mahidol Oxford Tropical Medicine Research Unit (MORU)*

Background of antibiotic use in Thailand

Antibiotics in Thailand are cheap and readily available for both human and animals. People in Thailand can buy antibiotics to treat minor illnesses such as sore throats and headaches from local drug stores. In 2018, human consumption of antibiotics was at approximately over 2500 tonnes, and that of animals reached 3800 tonnes. To address this problem, Thailand developed a national security/action plan that established strategies aimed at raising awareness on AMR and the appropriate use of antimicrobials. The campaign focused on awareness through education and engagement of stakeholders and policymakers. To achieve this, the project used the Wellcome Responsive Dialogue toolkit to develop and share ideas and solutions into policy and strategies.

Objectives of the project

* Co-create an engagement strategy with AMR stakeholders and communities
* Co-create context specific solutions relevant to the local communities to reduce the burden of AMR
* Inform and provide recommendations to support the next Thailand NSP-AMR for the period 2023-2027

Project activities

The project used three phases to implement its activities.

1. Planning dialogues with AMR stakeholders: 20 to 30 participants were expected, and these included authors of the Thailand NSP-AMR, doctors, policy makers, journalists, FDA, government agencies. The discussions revolved around rethinking, reframing, and refocusing AMR issues in Thailand.
2. Community dialogue: Three online sessions of the national adult (for example students, farmers, members of the household) dialogues, another 3 online sessions of the national youth dialogues comprising participants aged 18 to 24 were held
3. Regional dialogues: On-going and in-person regional dialogues have been running in the 4 regions of the country. The discussions in this phase center on local AMR issues such as the locally available informal suppliers of antibiotics, enforcement, demographics and socio-economic status of communities.

Dialogue setting

Dialogues followed the Wellcome responsive dialogue toolkit design using three stages.

1. *Identifying problems*. Participants shared their experiences and observations towards pharmaceutical consumptions within their families and communities using the “fishbowl activity”.
2. *Ideate local solution*. Participants discussed problems with rational drug use and the primary health care system in Thailand and how to embed AMR literacy in the existing primary health care system.
3. *Co-create and promise a solution*. Participants were asked to develop a one-year action plan to tackle the AMR issue in their area. They reflected on the successful communications and how that can be linked to the primary health care system and their quality of life.

**Gaps and Recommendations following dialogues on AMR communication**

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| **Gaps** | **Recommendations** |
| Misunderstanding: anti-inflammatory vs antimicrobial e.g., people in Thailand use antibiotics to treat minor illnesses  | Healthcare providers, teachers, experts should make it clear that antibiotics are not inflammatory medicines |
| Low awareness on AMR | Increase media channels to reach a wider audience  |
| Lack of research on effective communication and target communication  | Research and evaluation on target audience and communication  |
| The media is not attractive and does not aim at the right and/or no target audience | More interesting and catchy media content for non-specialist audiences to easily remember |
| Context does not have optimal outcomes for all target groups | The definition of AMR should be clear and concise |

**Gaps and Recommendations following dialogues on AMR public engagement**

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| **Gaps** | **Recommendations** |
| Many people at the grassroot level do not know about AMR | Establish the definition of AMR |
| Limited reach (how to reach the wider community) | Media and platform should fit the target audience e.g., online platform for youths |
| Limited impact (e.g., limited level of behavior changes or raise in awareness): fixed/hard-to-change beliefs, behaviors, and misconceptions | Audience should take ownership in the solutions they make (feel empowered to act)  |
| Lack of faces/ examples (patient group/leaders) for people to identify with | Example cases of AMR, survivors and information should be given back to the community so that they can relate AMR problems with themselves, emotionally. |

**Challenges in conducting the dialogues**

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| **Virtual** | **In-person** |
| Limited digital literacy | COVID-19 restrictions |
| Not much opportunity for networking  | Participants from different backgrounds which is hard to communicate in the same level of understanding |
| The co-creation solutions are not concrete (have not been put into actions) | Power dynamics (participants are hesitant to speak out) |
| Power dynamics (participants are hesitant to speak out) |  |

**Summary**

Following these dialogues, 12 sessions with approximately 200 participants have been conducted. Attendees were able to give insights to the problems and this facilitated further identification of the gaps and recommendations that could be included in the national action plan. Furthermore, empowering community members and work in the communities can be an effective and efficient tool in moving the project further. The dialogues also give special attention to the people in the implementation level. To effectively communicate with the implementation level actors, the projects use the 4 M’s (methods, managing, materials, and money). A report of the preliminary findings has been submitted to the authors of the Thailand National Action Plan and community members have been able to create AMR programs in informal and orderly schools as well as facilitating discussions on AMR in village health volunteers.

### **Responsive Dialogues: Piloting Strategies to Deliver Policies and Actions on Antimicrobial Resistance in Malawi**

***Mackwellings Phiri*** *is a social scientist at the Malawi Liverpool Wellcome Trust (MLW)*

Overview of AMR in Malawi

Malawi is a low-income state that faces major challenges in its health system. Antibiotics are said to be one of the most commonly used medicines. Researchers at MLW conducted a research at Queen Elizabeth Central Hospital (QUECH) in Blantyre which revealed that there is a rapid increase of blood stream infections that are resistant to 1st and 2nd line antibiotics. The MLW responsive dialogues project aims at building and extending existing partnerships between the microbial resistance unit at the Ministry of Health and collaborative work with MLW expertise in social research on AMR and public engagement. Responsive dialogues enable a change in attitudes and behaviors, and policies, and practice on antimicrobials. The dialogues enable stakeholders to examine and use evidence-based data and messages provided by researchers and experts to come up with solutions.

Aims of the project

* To engage with the public, communities, and stakeholders in discussing complex issues
* To empower the public to collaborate on developing solutions and policy needs to address AMR
* To facilitate inclusive policy making that considers public perceptions and local realities

Implementation and evaluation

Before implementing the dialogues, a stakeholder workshop was conducted with stakeholder groups such as policy makers. Key goals of the project applied groups to work with, and keyways of communicating AMR were discussed. The project was implemented in 3 stages over a 2-year plan (October 2020 to present). Evaluation of the project’s impact was done through a qualitative inquiry where a subset of the participants was interviewed. Additionally, the process was evaluated through field notes and reflective meetings following each responsive dialogue. More interviews were also scheduled six months after.

Project phases

**Phase 1**: scoping and design stakeholder mapping and development of messaging (scientists, policy makers and NGOs)

**Phase 2**: implementing dialogues between key groups, stakeholders, and experts

**Phase 3**: synthesizing evidence, establishing impact and dissemination

A visual artist was used to develop images that communicated key messages. A linguist was also used to translate messages into the local language (Chichewa) to easily communicate with the masses.

Three participant groups: animal and poultry farmers (including veterinary professionals and animal health experts), community prescribers and dispensers (participants from drug stores, government health facilities, private clinics, local medical professionals, human health experts) and community members (chief councilors, villagers etc.) were involved in the project.

Key learning outcomes

* Response dialogues are an effective tool for sharing complex concepts and stimulating discussions between participants and experts.
* Competing priorities (profit-making versus safety) in a precarious economy can affect the adoption of AMR interventions.
* Communicating with AMR requires consideration of local language barriers.
* Managing complex power dynamics between participants and experts fosters participation and enriches engagement.
* Historical engagement of communities in research can limit communities' ability to contribute and take ownership of co-produced interventions.

# **Summary of Q&A**

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| **To Mackwellings and Tassawan: Did you have to adapt to the approach in your context in Malawi and Thailand? Did you have to amend the dialogue approach to implement it?***“The Wellcome toolkit frame was used as the methodology, and we stuck to it. However, we used a different language to match our culture and language. The AMR language used by laymen and that of medical professionals is different and therefore by adapting them, we get everyone on the same page”.**“In Malawi, changes were made. For example, to approach calls for 9 sessions with the participants and it was reduced to 5 to make it feasible (we didn’t want to disengage people from their daily routines for too long). We also changed period when to engage specific stakeholders e.g., chiefs. This was in relation to the power dynamics. The community members would separately, without interference of policy makers, discuss the issues and possible solutions. Subsequently, local policy makers in the villages e.g., chiefs were brought in to provide additional input on the effectiveness and feasibility of the solutions”.* |
| **To Tassawan and Mackwellings: How long were the activities in Thailand and Malawi, respectively?***“In Thailand, the activities were done in three months. The project commenced in 2021 and is still ongoing”.**“In Malawi, each event lasted for a day from 8 to 4 pm. 4 sessions were included in the day”.*  |
| **To Tassawan and Mackwellings: Could you comment more on ways that some relevant stakeholders, such as the local Regulatory Authorities, may join efforts and are readily contributing to the current efforts to help disseminate information and increase awareness.** *“In Malawi, one of the regulatory authorities was the drug regulatory authorities who were introduced after the participants had already discussed the solutions. For example, one of the proposed solutions was strengthening drug control mechanisms and the several steps to be taken. The authorities were able to listen to the participants solutions and share some the mechanisms that are currently in use to control drug use in the country”.* *“As the project aimed to provide solutions at the national level, we engaged ministers, the FDA and other main key stakeholders. On the regional level, we invited members from the village and district levels e.g., administration, schools, education, and farmers practicing animal husbandry. We tried to engage people who were already working in target areas”.* |
| **To Tassawan and Mackwellings: Were new terminologies formed following the lack of local terms that mean antibiotics?***“In Thailand, people use the terms antibiotic and anti-inflammatory interchangeably. We haven’t yet defined the right terminology.”* *“In Malawi, we used phrases rather than a single word to describe antibiotics or AMR. Working with a linguist assisted in communicating. We are still working on finding the right terminologies.”*  |
| **To Tassawan and Mackwellings: How do you initiate a culture change for people to learn about AMR and change?** *“Creating an environment where people have discussions amongst themselves would encourage a culture change. For example, trainings need to start with the participants deliberating on the subject area and then the training institutions must (learn what the communities are doing) form training materials following the discussions by participants. It should not take a top-down approach.”**“We should give power back to the community. We should have information on AMR and its cases, then maybe the community can relate to the AMR problems and make changes”*  |

# **Call to action and next steps**

We look forward to seeing you in the future event under the “[Community Engagement within research Uptake” Webinar Series](https://arch.tghn.org/workshops-webinars/community-engagement-support-research-uptake/maternal-and-child-health/) in 2022 (Sexual and Gender Rights in July). You are encouraged to register for the free for the ARCH and Mesh knowledge hubs and at [arch.tghn.org](https://arch.tghn.org/) and [mesh.tghn.org](https://mesh.tghn.org/) respectively. The webinar recordings and speakers’ slides are shared here: [AMR Webinar](https://arch.tghn.org/topics/community-engagement-support-research-uptake/antimicrobial-resistance/).

# **Demographics**

### **Geographical coverage**

A total of **806** people from **92 countries** registered for this two-part series, and **354 participants** from **55 countries** attended the webinar which corresponds to an **attendance rate of 44%.**



**Figure 1. Heat map showing the geographical distribution of webinar registrants. The scale bar shows how the colour corresponds to the number of registrants from each country.**

### **Participants’ work**

In the registry, participants were asked to fill in their occupations. Most of the participants were health researchers, physicians, nurses, lab technicians, students, community engagement officers, and public health practitioners.

**Feedback**

Out of the 354 individuals that attended the webinar, 41 completed the feedback form.

Participants registered and attended for many reasons as seen below:



We then asked participants their agreement with the following statements:



We asked participants what they had learnt and how they would act differently after attending this webinar. The answers were positive. Many expressed that they had gained more knowledge on the relevance of community engagement in response to AMR, and that during a community dialogue, everyone's voice matters. Several participants stated that their key takeaway from the webinar was that community engagement processes had to be contextualized and inclusive of local individuals to promote ownership. It was also interesting and surprising to learn that the workshop also gave an opportunity for participants to understand the burden on AMR in communities as well as its associated challenges. Most participants agreed that they would do something differently as a result of attending this webinar.

Participants gave us suggestions on what we could change for future workshops:

Participants suggested that with online events such as this, to have maximum benefit for participants, it would be ideal if presentations were shared to attendees prior to the event and the Q&A discussion would make the conversations richer. Participants further suggested that speakers could have a pre-recorded discussion so that their presentation wouldn’t be hindered by poor internet connection. Lastly, one participant felt that the presentations seemed to be focused on research purposes and information gathering other than suggestive of solid actions.

We also asked participants on what we could continue doing:

Participants appreciated and encouraged the consistency in our work to holding such online events with such topics of health concern. Participants also appreciated the webinar structure of inviting multi-country experts and not just people based in the “West”.

We finally asked participants, if the following development opportunities were available, which ones they would be interested on:

