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QUESTIONS AND ANSWERS FROM PSBI COP WEBINAR

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RESPONSES BY DR. EREMIN, SERGEY ROMUALDOVICH AND DR. SHAMIM QAZI

ANTIMICROBIAL RESISTANCE AND ACCESS TO ANTIBIOTICS

QUESTION: HOW DO WE GET THE DATA THAT INFORMS THE POLICIES AND PRACTICES? HOW DO WE COLLECT THAT INFORMATION?

Dr. Eremin: In the case where referral is not feasible or possible, it's difficult to hope that in the near future we can establish systematic surveillance of Antimicrobial Resistance (AMR) or consumption use, or both. That's why we're working hard now on developing the tools, including protocols for surveys and point prevalence studies that could be applied in a way that representative data could be obtained. This is a less expensive and feasible approach. We still need to train people who will apply the protocols, but at least having this relevant data would help to inform and adjust the practices, ensure that people trust the recommendations, or will have to change the approach if the data shows otherwise.

QUESTION: WHICH CATEGORY DOES CO-TRIMOXAZOLE FALL INTO, IN TERMS OF POTENTIAL FOR RESISTANCE?

Dr. Eremin: Co-trimoxazole remains in the access group. But being there shows the need for data to inform the application of this recommendation. Because in many settings the resistance rates for this drug are too high to consider as a first line choice, or even any choice, and that's why the [WHO's Essential Medicines List] (EML) is not for guiding the treatment on the patient side. The EML is intended to help countries organize procurement of antimicrobial drugs, organize the national EML data, to provide guidance in terms of the initial choice. But we need more data, including resistance data, to guide practices at the local level and community level.

QUESTION: DO WE HAVE EVIDENCE OF WHERE THE NEONATAL SEPSIS IS ACQUIRED WHEN DELIVERY TOOK PLACE IN A FACILITY?

Dr. Qazi: It depends on the time of the infection. The early onset of infection within the first 72 hours of birth is most likely to occur either due to unhygienic birth practice, prematurity or a maternal infection. An infection occurring later is more likely to be caused from something in the environment or

unhygienic practices when the newborn goes home. Having said that one can never be really sure when the sepsis was acquired.

QUESTION: IN MANY COUNTRIES THERE SEEMS TO BE A SYSTEMATIC USE OF ANTIBIOTICS, PARTICULARLY AFTER BIRTH FOR MOTHERS AND OFTEN FOR BABIES. HOW DO WE DEAL WITH THAT? WE HAVE THE WHO STANDARD PROTOCOLS, AND ENCOURAGE THE NONSYSTEMATIC USE OF ANTIBIOTICS AFTER DELIVERY, BUT THAT DOESN'T SEEM TO BE TAKING US FAR. ANY GUIDANCE THAT YOU CAN GIVE US ON THAT WILL BE APPRECIATED.

Dr. Qazi: This is a very difficult question. Behavior change is one of the most difficult interventions, as all of us know. Even if people know and have been trained to do something, their own perception and feeling may affect the practice despite the information they have been given. An example is tobacco use. Everybody knows that tobacco is bad for health, but smokers still smoke, they don't stop. There is a similar kind of issue we face with many of the health workers, particularly untrained health workers, who use antibiotics for everything because it is available and they think it is going to help the patient. Often many of the infections that are treated with antibiotics actually don't need them. So, there are no real easy answers. What we can do is share the information and build the capacity of the health workers, also in the private sector. This is really challenging because in the private sector the profit also comes in, as far as the management is concerned, and to stopping people from looking from that angle is very difficult.

QUESTION: INFORMATION AND CAPACITY BUILDING ON ITS OWN IS NOT ENOUGH AND HASN'T TAKEN US FAR. ARE THERE ADDITIONAL STRATEGIES THAT WE NEED TO CONSIDER IN ORDER TO ADDRESS FUTURE RESISTANCE?

Dr. Qazi: There's a perception that if we give antibiotics it will prevent infections from happening. It might be true in some cases, but it's not always true. Because something is easily available, so many people are doing this, and many a time they don't use the appropriate antibiotic. They may be using a totally ineffective antibiotic for that purpose. So the only thing that we can do is to inform them and let them know that this is what they are doing and this is the use, or misuse, of the drug. But to physically stop them from using it, it is difficult. It's a behavior change, and obviously a hygiene and infection control environment, which many places do not have.

Dr. Eremin: I'm kind of biased or limited in my knowledge of all the available tools and resources that are available or put into practice because I work specifically in field of surveillance, and our task is to make sure that the use of antimicrobials is informed by local data on resistance and appropriateness of use. This is essential for what we call antimicrobial stewardship. Developing the specific tools to address the community needs. I should confess that we are in the very beginning of the process. I'm aware of some products that are in the pipeline, but I cannot offer you any magic bullets right now. This is quite the challenge. This is both because of the lack of data and because of the concentration of efforts previously on the health care facilities, mostly in the high-risk units of health care facilities and high-risk groups of patients. This is a challenge and we're at the very beginning.

QUESTION: HOW WE CAN DEVELOP A SIMPLE COMMUNICATION PACKAGE FOR MEDICAL OFFICERS AS WELL AS FOR THE COMMUNITY ON AMR RESISTANCE AND APPROPRIATE USE OF ANTIBIOTICS?

Dr. Qazi: What we have noticed in many places is that people who use antibiotics don't know which antibiotics are to be used against which bacteria, they just have heard that they can use the antibiotic for this thing, and that's what they do. Antimicrobial resistance data is hardly available to them to make a decision whether to use that specific drug or not. We have faced this in many places, even in hospitals with very experienced professors have no idea of the AMR data in their community. Except for a very small proportion of bacteria which are usually resistant gram-negative bacteria, in routine, aetiology is difficult to establish in most laboratories. We are actually handicapped by many of these issues. I think that communication packages about the epidemiology and AMR for providing information at the country level or regional level would be useful for health workers. Through use of social media, simple messaging could be beneficial for the parents, as well. Many educated parents don't want their children to be given antibiotics unnecessarily, but at the same time in low resource settings a lot of families are not educated and whatever the health worker tells them, they follow the advice.

QUESTION: USE OF ANTIBIOTICS IN LOW INCOME SLUM SETTING MAKES IT HARD FOR BOTH SURVEILLANCE AND MANAGE PRACTICES THAT SEEMS TO ACCELERATE RESISTANCE. WHAT ADVOCACY STRATEGIES CAN WE BUILD TO ENSURE SUCH PRACTICES CAN BE LOWERED?

Interventions should combine different strategies to influence behaviour of both patients and providers (prescribers, dealers, sellers etc.). The ABX use practices are influenced by many factors, including health system quality; education, knowledge, attitudes, and beliefs of both professionals and public; profit and competition; cultures of care and many others. Messaging and educational interventions (and quite a number of generic messages and tools is already available from different sources incl. WHO) need to be adapted, based on good understanding of lay knowledge and demand.