ADVOCACY BRIEF

The value proposition of civil society in the global antimicrobial resistance response: a ten-year vision (2026–2036)

WHO Civil Society Task Force on Antimicrobial Resistance





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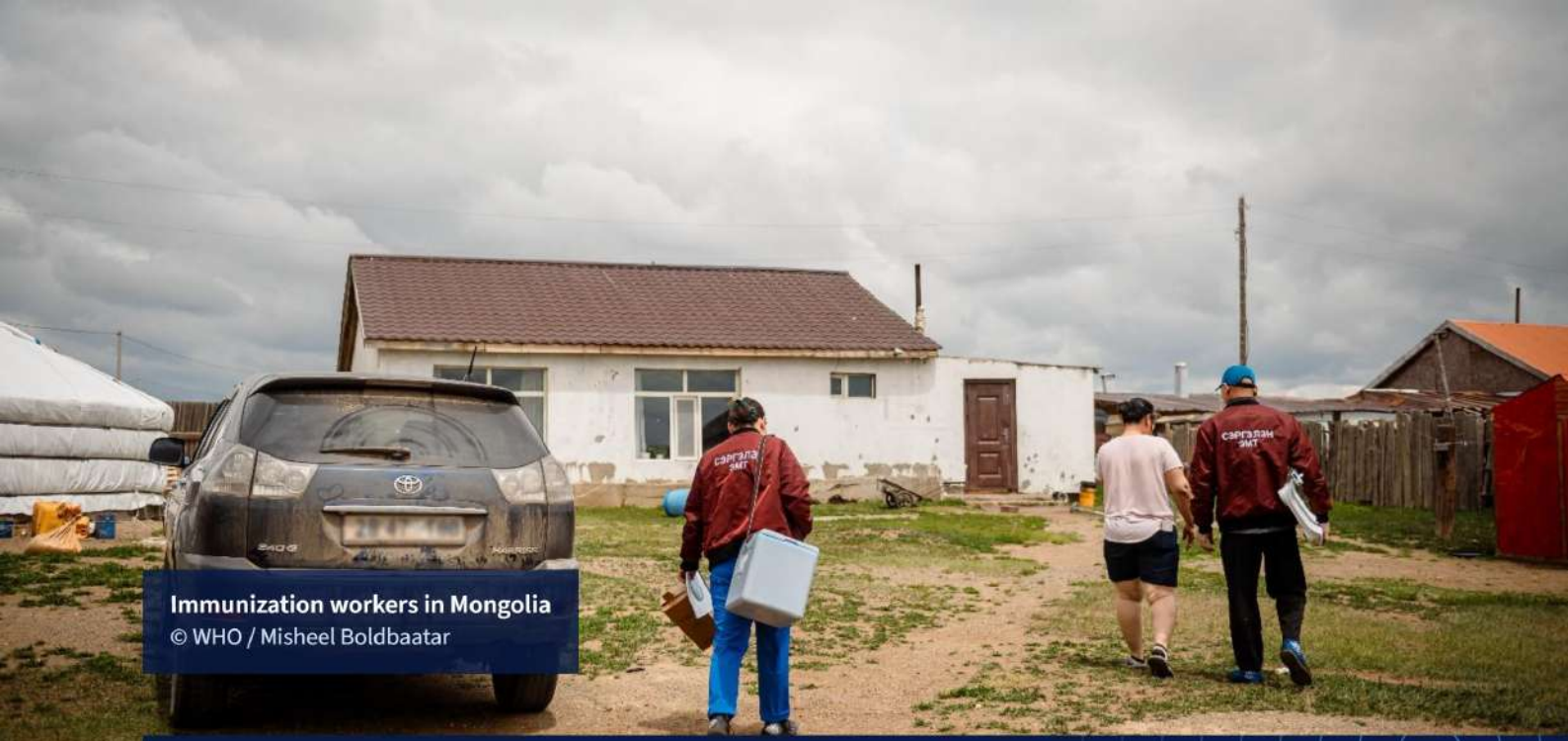
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List of Abbreviations

Abbreviation	Full form
AMR	Antimicrobial resistance
AMU	Antimicrobial use
COVID-19	Coronavirus disease 2019
CSO(s)	Civil society organization(s)
GAP-AMR	Global Action Plan on Antimicrobial Resistance
GLASS	WHO Global Antimicrobial Resistance and Use Surveillance System
GLG	Global Leaders Group (on AMR)
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IACG	(UN) Interagency Coordination Group on Antimicrobial Resistance
IPC	Infection prevention and control
IPEA	Independent Panel for Evidence for Action (against AMR)
LMIC(s)	Low- and middle-income country/countries
NAP(s)	National action plan(s)
NGO(s)	Non-governmental organization(s)
TAC	Treatment Action Campaign
UN	United Nations
UNGA	United Nations General Assembly
USD	United States dollar
WASH	Water, sanitation and hygiene
WHO	World Health Organization

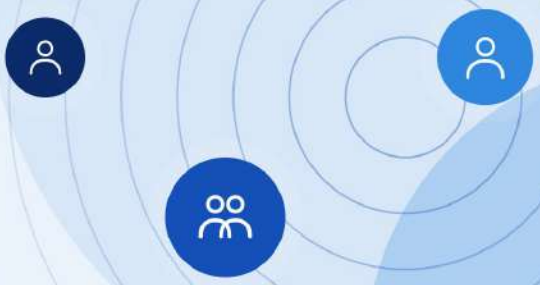


Immunization workers in Mongolia
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Executive Summary

Antimicrobial resistance (AMR) is among the most consequential global health threats of our time. In 2021, drug-resistant bacterial infections were linked to 4.71 million deaths globally, and was the directly attributable reason for 1.14 million deaths. The 2024 United Nations General Assembly (UNGA) Political Declaration on AMR and subsequent commitments have created a historic window for accelerated action, but translating political commitments into measurable change requires more than intergovernmental coordination alone.

Civil society is not peripheral to this effort. It is a strategic, indispensable actor in the global AMR response. This briefing document articulates the core value proposition of civil society in the AMR response. Civil society organizations (CSOs) bring unique and complementary capabilities across the full spectrum of the AMR response: mobilizing communities, generating accountability, bridging equity gaps, co-designing policy, and sustaining political momentum when formal institutions face resource and governance constraints.



Evidence from HIV, COVID-19, and early AMR initiatives demonstrates that civil society-led approaches deliver results that governments and technical bodies cannot achieve alone, particularly in reaching underserved populations, ensuring buy-in, driving policy and behavioural change, mobilizing collective action and accountability, and ensuring community-level implementation of national action plans (NAPs).

This document calls on member states, and donors to: recognize civil society as a co-designer and co-implementer in AMR governance; support civil society as a key collaborator in ensuring social and public participation in AMR programmes; enable civil society to build implementation capacities; provide ring-fenced, sustainable financing for civil society AMR engagement; and embed civil society accountability functions into national and global AMR monitoring frameworks.

1 Introduction



AMR represents a systemic threat to modern medicine, food security, and sustainable development. In 2019, WHO identified AMR as one of the top ten global public health threats. (1) In 2021, 4.71 million deaths were associated with drug-resistant infections and 1.14 million were directly attributable to AMR. (2) Projections warn of up to US$ 412 billion in annual treatment costs by 2050, with disproportionate impacts on low- and middle-income countries (LMICs).

The global response, anchored in the 2015 Global Action Plan on AMR (GAP-AMR) and reinforced by the 2024 UNGA Political Declaration, (3) has established critical foundations: 178 countries have developed AMR national action plans; over 100 countries report data to the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS); and global governance structures including the Quadripartite Joint Secretariat have been established. (4) The updated GAP-AMR 2026–2036, adopted at the Seventy-ninth World Health Assembly, further consolidates these commitments within a whole-of-society, One Health framework.

Yet, as the Steering Committee of the WHO Civil Society Task Force on AMR observed at its March 2026 meeting in Brussels, persistent gaps between commitments and implementation remain. (5) Implementation failures are not primarily technical in nature; they reflect governance, equity, community trust, behavioural change and accountability deficits – all areas where civil society holds a distinctive comparative advantage.

The recognition of multisectoral and whole-of-society engagement has grown steadily. The Interagency Coordination Group on Antimicrobial Resistance (IACG), in its landmark 2019 report, called for systematic and meaningful engagement of civil society as a key partner in the One Health response to AMR, with roles in advocacy, accountability, planning, monitoring, and promoting appropriate and responsible antimicrobial use.(6) It also emphasizes strengthening partnerships across related sectors and providing political, financial, and technical support to enable civil society organizations to engage effectively while maintaining their independence. The 2024 UNGA Political Declaration and the updated GAP-AMR also explicitly mentions civil society engagement as a priority. Against this backdrop, civil society's role must be understood not as supplementary, but as architecturally central to achieving the targets mentioned in the 2024 UNGA Political Declaration.

2 Defining civil society in the AMR context

Civil society, in the AMR context, encompasses a broad and diverse ecosystem of non-state, non-market actors operating in public interest independently of governments and are mostly free from concerns which are primarily of a private, commercial or profit-making nature. (7) This includes non-governmental organizations (NGOs), community-based organizations, patient and survivor groups, professional associations (medical, veterinary, pharmacist), academic and research networks, consumer advocacy groups, faith-based organizations, youth networks, and trade unions.

A review of 129 AMR national action plans found that references to CSOs appeared in 52 (40%) of NAPs, while NGOs were mentioned in 61 (51%), though the extent and specificity of engagement varied widely. (8) This variability reflects a systemic under-integration of civil society, not a lack of relevant capacity.

Civil society is capable of both challenging and collaborating with formal institutions. This dual positioning, as both watchdog and implementation partner, is the foundation of its value proposition.

Within global health governance, civil society occupies a distinctive space: simultaneously independent of government, proximate to communities, and capable of both challenging and collaborating with formal institutions. This dual positioning, as both watchdog and implementation partner, is the foundation of its value proposition.



3 Core value proposition of civil society in AMR





3.1 Advocacy and Agenda-Setting

Civil society organizations are uniquely positioned to elevate AMR on political agendas, shape normative discourse, and sustain public and political pressure between high-level meetings. Advocacy was the most frequently identified area of CSO involvement in AMR national action plans globally, appearing in 42 (33%) of NAPs reviewed, with 37 (88%) of these in LMICs. (8)

The Task Force's framing of AMR as a development, equity, and justice issue, rather than a purely biomedical or health security concern, exemplifies civil society's agenda-setting power. (9) Historical precedents illustrate the impact: South Africa's Treatment Action Campaign (TAC) successfully mobilized public demand for equitable access to antiretroviral therapy, challenging pharmaceutical monopolies. (10)

Unlike governments, which are constrained by diplomatic and electoral considerations, civil society can articulate inconvenient truths, call out implementation gaps, and demand accountability from both national governments, regional groupings and international bodies, making it an irreplaceable voice in global AMR governance.

3.2
Community Engagement and Trust-Building

AMR is experienced daily in communities through treatment failures, antibiotic stockouts, suboptimal quality of care for infections etc., yet communities are almost entirely absent from the national systems designed to monitor and respond to it. (9) Civil society bridges this gap.

CSOs serve as trusted intermediaries between governments, health systems, and communities, particularly in settings where public trust in formal institutions is limited. They possess existing relationships with vulnerable and marginalized populations, the communities most exposed to the consequences of AMR and least served by formal health system responses.

3.3
Acceptability and Effectiveness of Interventions

Consistent with the principles of the Lusaka Agenda, civil society helps bridge the gap between policy and practice by ensuring that interventions are grounded in local realities, responsive to community needs, and shaped by those most affected. (11) The Lusaka Agenda is a collective commitment by global health partners to make health financing and programmes more country-led, coordinated, equitable, and sustainable in support of universal health coverage. This is particularly important in AMR, where sustainable progress depends on behavioural change across patients, health care professionals, farmers, and communities. By helping to co-design solutions, build trust, and foster local ownership, civil society can increase the relevance, acceptability, and effectiveness of AMR interventions, translating political commitments into meaningful and lasting action.

3.4
Accountability and Transparency

Civil society's watchdog function is among its most distinctive contributions. Where formal accountability mechanisms are delayed, politicized, or absent, civil society organizations can independently monitor commitments, assess implementation, and generate public pressure for corrective action.

For example, the WHO Civil Society Task Force on AMR has identified three priority accountability functions for itself: serving as a coordinating force that harmonizes civil society messaging for global AMR processes; activating civil society's watchdog function to track progress against the quantified targets of the 2024 UNGA Political Declaration; and advocating for a well resourced global health architecture. (5) The proposed civil society AMR scorecard and community monitoring toolkit are concrete instruments designed by the Task Force, to operationalize this accountability function at multiple levels.

3.5
Service Delivery and Implementation Support

In many health contexts, civil society organizations are not merely advocates but primary service delivery actors, particularly in LMICs and settings where government capacity is limited. CSOs provide essential health services, including immunization, maternal and child health care, HIV/AIDS treatment, and access to essential medicines, often reaching populations that formal systems cannot. (8)

In the AMR context, CSOs contribute to service delivery through community education and behavioural change communication; supporting appropriate antibiotic use in both formal and informal health settings; facilitating adherence to treatment protocols; and linking communities to formal health services. A CSO sensitization workshop in India, for instance, identified specific roles including disseminating standard treatment guidelines to private practitioners, training of prescribers and advocating for the removal of non-recommended antibiotic combinations. (12)

3.6
Knowledge Generation and Translation

Civil society contributes to evidence generation, ensures transparency and accountability from data collection exercises, and helps in the translation of complex technical findings into accessible, actionable information for diverse audiences, including policymakers, communities, media, and health workers alike.

Patient and survivor narratives represent a distinctive form of evidence that technical surveillance data cannot replicate. AMR often remains invisible within patient experiences because it accompanies other conditions, underscoring the need for better health literacy and the use of patient-reported experience data to elevate AMR within advocacy spaces.

3.7
Equity and Inclusion

AMR disproportionately burdens populations in LMICs, fragile and conflict-affected settings, and communities with limited access to clean water, sanitation, and quality health care. The AMR burden in countries is not proportional to the access and use of antimicrobials, and in fact lack of access to essential antibiotics and diagnostics impacts patient outcomes and AMR. For example, the burden of AMR in sub-Saharan Africa is higher than in Europe, even though the level of antibiotic use is generally lower. Without explicit equity and justice lenses, AMR responses risk reinforcing existing inequalities. Civil society is among the most reliable actors in introducing and maintaining equity considerations across AMR governance, policy, and implementation.

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The Task Force's core principles explicitly incorporate a strong equity and justice lens. (5) The regional priorities identified at the inaugural plenary, including access gaps and inadequate surveillance in Africa, over-the-counter sales in conflict-affected settings in the Eastern Mediterranean, and the access paradox in South-East Asia, demonstrate civil society's capacity to surface context-specific equity dimensions that global governance processes risk obscuring.

Civil society also plays an essential role in centering historically underrepresented voices, such as patient groups, AMR survivors, women, youth, and frontline community health workers, in AMR policy processes. The Task Force explicitly prioritizes centering youth, community, and fraternal groups as active shapers rather than passive recipients of the AMR agenda.

4 Civil society contributions across the updated GAP-AMR objectives


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The updated GAP-AMR is structured around six strategic objectives, which will define the global AMR response till 2036. Together, they translate the approach into practical priorities, enabling countries and stakeholders to accelerate implementation of national action plans and address the complex drivers of antimicrobial resistance. Civil society can offer clear value in all the six strategic objectives.


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STRATEGIC OBJECTIVE 1:

Strengthen awareness and promote appropriate social and behavioural change to reduce AMR risks across all sectors

Civil society plays a critical role in driving inclusive, culturally relevant awareness and behavioural change on AMR by serving as a trusted bridge between communities and policymakers. It can co-design and deliver community-led campaigns, counter misinformation, promote peer-to-peer learning, and ensure that messaging reaches vulnerable and marginalized populations. By providing real-time feedback from communities, civil society also helps refine and strengthen behavioural interventions for sustained impact.

STRATEGIC OBJECTIVE 2:

Strengthen surveillance systems and laboratory networks to inform effective, evidence-driven AMR policies and actions across all sectors

Civil society contributes to strengthening AMR and antimicrobial use (AMU) surveillance by supporting data collection, particularly in informal or underserved settings, and by advocating for transparency and accountability in data use. It can help translate technical surveillance data into accessible information, facilitate collaborations with academic partners, and ensure that evidence reflects real-world practices and informs equitable policy decisions.

STRATEGIC OBJECTIVE 3:

Intensify infection prevention across all sectors to reduce the burden of infectious diseases and the need for antimicrobials

Civil society organizations are essential for implementing infection prevention measures at the community level, particularly in areas with limited health system reach. They support water, sanitation and hygiene (WASH) interventions, promote vaccination uptake, strengthen awareness of hygiene and infection prevention and control (IPC) practices, and operate in humanitarian and fragile settings. Through advocacy, they also highlight the need for equitable access to basic infrastructure such as water, sanitation, and waste management systems and biosecurity measures in farms.

STRATEGIC OBJECTIVE 4:

Ensure equitable access, appropriate use and safe disposal of antimicrobials, diagnostics and other health products across sectors

Civil society helps advance equitable access to quality antimicrobials, diagnostics, and vaccines while promoting their appropriate use. It empowers patients and communities to understand and adhere to treatments, supports antimicrobial stewardship campaigns, and raises awareness about safe disposal practices. Additionally, civil society can highlight issues such as substandard or falsified medicines and strengthen accountability for equitable and responsible access.

STRATEGIC OBJECTIVE 5:

Accelerate AMR research and innovation across all sectors

Civil society contributes to AMR research and innovation by ensuring that studies reflect community needs and lived experiences, particularly through participation in implementation and operational research. It facilitates co-creation of locally relevant solutions, supports the uptake of new tools and practices, and plays a key role in translating and disseminating research findings to broader audiences, thereby bridging the gap between evidence and practice.

STRATEGIC OBJECTIVE 6:

Strengthen multisectoral governance, sustainable financing and accountability for a coordinated AMR response across all sectors and at all levels

Civil society is central to inclusive and accountable AMR governance by participating in national coordination mechanisms, advocating for transparent financing, and monitoring implementation of national action plans. Civil society can also find strategic intersection and synergy across contexts, disciplines, and sectors to make AMR relevant and actionable to new or untapped allies. It amplifies community voices in decision-making processes, proposes needed or novel policy solutions, fosters multi-stakeholder dialogue, and serves as an independent accountability actor to ensure sustained political commitment and alignment with equity principles.

5 Challenges and Gaps



Despite the evident value civil society brings to the AMR response, substantial structural, financial, and political barriers impede effective engagement.

In many regions, political and regulatory environments are constraining the ability of civil society organizations to operate, receive foreign funding, or engage critically with governments.

Severe and worsening funding constraints:

The funding crisis facing civil society organizations working on AMR is acute. Several Task Force member organizations have lost senior staff, seen operating grants withdrawn by major donors, and are functioning largely on volunteer capacity. (5) Only around 20% of countries reported dedicated domestic funding for their multisectoral AMR national action plans in 2024. (13) The lack of resources is most acute in LMICs. However, the assumption that civil society groups from high-income countries somehow have adequate resources to participate in policy convenings and can resource their own activities on AMR also seldom holds true.

Fragmentation and coordination deficits:

Many organizations work towards similar goals without sufficient visibility of each other's efforts, creating duplication and a weaker collective voice. (9) The absence of a shared mapping of who is doing what across civil society actors in AMR contributes to this fragmentation. The lack of resources also limits the opportunity to encourage dialogue and collective action that might bridge the work of civil society actors.

Tokenistic engagement models:

Civil society is too often engaged as a consultant or implementer of pre-designed interventions, rather than as a strategic partner in co-designing policy and programmes. A review of 129 NAPs found that only 9% proposed participation of CSOs on committees or working groups. (8)

Shrinking civic space:

In many regions, political and regulatory environments are constraining the ability of civil society organizations to operate, receive foreign funding, or engage critically with governments. The Task Force members identified shrinking civic space as an existential risk for the AMR civil society response. (5) In many instances, policymaking processes by governments and intergovernmental agencies are not sufficiently open to acknowledge and give voice to civil society concerns.

Narrow framing of AMR:

The tendency to frame AMR purely within a biomedical or health security narrative risks excluding the development, equity, food systems, and environmental dimensions that are central to sustainable AMR reduction, and where civil society across sectors has the most to contribute.

6 Strategic Opportunities and Recommendations



The convergence of the 2024 UNGA Political Declaration commitments and the updated GAP-AMR creates a rare and time-limited opportunity to fundamentally reposition civil society within the global AMR architecture.

For Member States

Recognize civil society as a co-designer and co-implementer in AMR governance. Explicitly incorporate civil society as a strategic partner, not merely a stakeholder, in AMR National Action Plan design, implementation, monitoring, and evaluation, with formal representation in national coordination mechanisms.

- **Establish civil society accountability mandates within NAP monitoring frameworks.** Create dedicated indicators to track civil society engagement and co-implementation in AMR NAPs.
- **Integrate community-led monitoring into systems for surveillance and monitoring at the national level.** Recognize civil society-generated community data as a legitimate, complementary input to formal surveillance, and provide technical and financial support for community-led monitoring tools.
- **Invest in capacity-building for civil society organizations on AMR, surveillance literacy, and stewardship.** Create the right incentives and ecosystem for partnerships between civil society, academia, and government to enhance impact and knowledge exchange.
- **Protect civic space and enabling environments for civil society engagement in AMR.** Advocate for and protect the conditions that enable independent civil society action, including freedom of association, access to information, and non-discriminatory funding flows.

For Donors and Development Partners

- **Provide ring-fenced, flexible, and sustained financing for civil society-led AMR engagement.** Create dedicated funding streams for CSOs working on AMR (separate from government-tied implementation grants) that enable independent advocacy, coalition-building, and community-level action.
- **Support civil society to expand the funder landscape beyond traditional health donors.** Explore socially responsible investment firms, pension funds, foundations from emerging economies, and sector-adjacent funders (WASH, food systems, climate) as potential supporters of civil society AMR work.
- **Support South–South resource brokering and enable civil society groups with funding access to support and co-apply with resource-limited frontline organizations, particularly in LMICs, to address the structural equity deficit in civil society AMR funding.**

7 Conclusion

Addressing AMR requires more than technical solutions: it requires inclusive governance, accountability, and people-centred implementation. Civil society is not peripheral to this effort but central to translating commitments into lasting impact.

Civil society brings what neither governments nor technical bodies can replicate: proximity to communities, independence from political cycles, capacity to hold institutions accountable, and the ability to translate global commitments into lived experience. These are not supplementary capabilities; they are foundational to a functioning, equitable, and sustainable global AMR response.

The WHO Civil Society Task Force on AMR and the civil society cluster of the AMR Multi-Stakeholder Partnership Platform are promising initiatives. But mechanisms without resources, and commitments without accountability, will not move the needle. The civil society representation, or the lack of it, on instruments like the Global Leaders Group (GLG) on AMR or the upcoming Independent Panel for Evidence for Action (IPEA) against AMR are also concerns, from a civil society perspective.

The targets mentioned in the 2024 UNGA Political Declaration and robust implementation of the updated GAP-AMR require an unprecedented mobilization of civil society alongside governments, international organizations, and donors. The case is not merely moral; it is strategic. Civil society engagement is among the most cost-effective investments in the AMR response and among the most underfunded. WHO, member states, and donors must treat civil society not as a constituency to be managed, but as a partner to be resourced, respected, and genuinely included in the decisions that determine whether the medicines we depend on today will still work tomorrow.

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