ReAct AFRICA

ReAct AFRICA ANNUAL AMR CONFERENCE 2026

CONFERENCE REPORT

AFRICA LEADING THE WAY TO INSTITUTIONALIZING PRAGMATIC PEOPLE-CENTRED AMR SOLUTIONS FROM GRASSROOTS TO REGIONAL LEVEL

Lusaka, Zambia 21st-22nd July



FOREWORD



Over the past decade, the ReAct Africa Annual Antimicrobial Regional Conference has grown into an established regional platform bringing together governments, policymakers, researchers, health professionals, civil society, communities and partners working to translate antimicrobial resistance (AMR) commitments into action.

Annual Antimicrobial Regional Conference 2026 (The ReAct Africa Annual AMR Conference (RAAC 2026) held in Lusaka, Zambia, on 21–22 July 2026, brought together 176 participants from 35 countries at an important moment for Africa's AMR response. National Action Plans are now widespread across the region, but the central challenge is increasingly one of implementation: ensuring that commitments translate into sustained, financed and accountable action within countries, institutions and communities.

Across the two days, the conference highlighted both progress and persistent gaps. Countries are strengthening surveillance, antimicrobial stewardship, infection prevention and control, One Health coordination and community engagement. African institutions are also demonstrating practical, locally led solutions that can be adapted and scaled up. Yet implementation remains uneven, financing is inadequate, laboratory and diagnostic capacity is constrained in many settings, One Health approach remains fragemented, and too many successful interventions remain projects rather than being embedded within routine systems.

The changing global financing environment makes this challenge even more urgent. A contraction in external development assistance reinforces one of the strongest messages from RAAC2026: sustainable AMR action will require stronger domestic ownership, clearer institutional responsibility, adoption of a truly One Health approach, better prioritisation and financing arrangements that extend beyond individual funding cycles. International partnerships remain essential, but they should reinforce African leadership and strengthen national systems.

The discussions converged around a central question: how can effective AMR action become institutionalised, financed, measurable and accountable? Progress will depend on embedding AMR within existing systems and budgets including innovative country mobilization efforts; strengthening prevention, diagnostics, surveillance, stewardship and access together; and making One Health operational across human health, animal health, agriculture, food systems and the environment. Full adoption of the UNGA 2024 commitments would be a good starting point.

RAAC 2026 also reaffirmed that AMR must remain people-centred. Communities, health workers, farmers, youth, faith leaders, civil society and people affected by drug-resistant infections all have a role in shaping solutions that are relevant, equitable and sustainable. The central message is clear: Africa is not short of ideas, evidence or working solutions. The task now is to prioritise what works, institutionalise it, finance it sustainably and take successful African-led approaches to scale. As we move towards the 2029 review of the UN commitments on AMR, progress should increasingly be judged by tangible changes in implementation.

I commend this report to governments, national AMR coordinating mechanisms, regional institutions, partners and the wider AMR community as a practical agenda for the work ahead. Some of the interventions and priorities discussed could help inform the the upcoming 5th Global High-Level Ministerial Conference on Antimicrobial Resistance in Abuja..

Prof. Mirfin Mpundu
Executive Director, ReAct Africa

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Acronyms and Abbreviations

AMR	Antimicrobial Resistance
AMU	Antimicrobial Use
AMS	Antimicribial Stewardship
AST	Antimicrobial Susceptibility Testing
AWaRe	Acess, Watch, and Reserve
DAH	Development Assistance for Health
DHIS2	District Health Information Software 2
DRC	Democratic Republic of the Congo
elDSR	Electronic Integrated Disease Surveillance and Response
ESBL	Extended-Spectrum Beta-Lactamase
FAO	Food and Agriculture Organization
GLASS	Global Antimicrobial Resistance and Use Surveillance System
IPC	Infection Prevention and Control
InFARM	International FAO AMR/AMU data platfrom
LIMS	Laboratory Information Management System
MAAP	Mapping AMR and Antimicrobial Use Partnership
MSF	Mèdecins Sans Frontières
NAP	National Action Plan (on AMR)
ODA	Official Development Assistance
PHC	Primary Health Care
R&D	Research and Development
RENOFARM	FAO Reduce the Need for Antimicrobials on Farms Initiative
SIDA	Swedish International Development Cooperation Agency
TrACSS	Tripartite AMR country Self-Assessment Survey
UHC	Universal Health Coverage
UNGA	United Nations General Assembly
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WOAH	World Organisation for Animal Health
ZNPHI	Zambia National Public Health Institute


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Conference at a Glance

Lusaka, Zambia · 21–22 July 2026

176	35	2	12
Participants	Countries	Days	Main Sessions

Stakeholder representation

Governments and National Institutions	**Regional & global organisations**	**Academia & researchers**	**Animal & human health actors**
Agriculture, plant, food safety and environment actors	**Civil society & communities**	**Youth & faith actors**	**Development partners**

Across twelve main sessions, RAAC 2026 moved from the continental AMR implementation picture and country experience on Day 1 to technical delivery, innovation and people-centred action on Day 2. Day 1 included opening and partner perspectives, continental progress and global commitments, country-status discussions across One Health sectors, governance and accountability, sustainable financing and One Health implementation. Day 2 featured six parallel technical discussions on access to antimicrobials and diagnostics, primary health structures, lessons from COVID-19 in addressing emerging threats, AMR surveillance, IPC/WASH and biosecurity, and antimicrobial stewardship, followed by sessions on technology and AI in AMR interventions, people-centred approaches and the final high-level action dialogue. Across the programme, five formal panels addressed continental progress, challenges and possible solutions, supporting countries towards global goals, governance, financing and the transition from conference evidence to action.

ReAct AFRICA ANNUAL AMR CONFERENCE 2026













Executive Summary



The ReAct Africa Annual Antimicrobial Conference 2026 (RAAC 2026) was held in Lusaka, Zambia, on 21–22 July 2026 under the theme “Africa Leading the Way to Institutionalizing Pragmatic People-Centred AMR Solutions from Grassroots to Regional Level.” It brought together 176 participants from 35 countries to connect implementation experience from communities, health facilities and One Health sectors with the policy, financing and accountability mechanisms required to sustain and scale effective action.

RAAC 2026 met at a transition point between the UNGA 2024 Political Declaration on AMR and the next UN High-Level Meeting on AMR in 2029. Political commitment has strengthened, National Action Plans (NAPs), and countries are building surveillance, stewardship, community-engagement and One Health programmes. Yet implementation remains uneven and frequently dependent on projects, individual champions and external financing. The central question was therefore no longer what should be done, but how effective interventions become part of routine systems, receive sustainable budget allocations and be embedded within institutional accountability mechanisms.

The implementation gap in one line. Among reporting Member States in the WHO African Region:

100%
Have a National Action Plan

→

~32
Have a costed investment case

→

~9%
Report sustained implementation

Five findings emerged consistently across the conference.

Firstly, governance emerged as one of the strongest determinants of whether plans translate into implementation; countries need assigned responsibilities, resourced secretariats, political engagement and monitoring that leads to decisions, not just reports.

Secondly, financing emerged as one of the most significant risks to sustained progress, most AMR NAPs remain unfinanced, worsened by a contraction in external assistance; the priority is to prioritise, cost and legislate NAPs, engage ministries of finance, and use existing resources more efficiently.

Thirdly, infection prevention and control (IPC) and water, sanitation and hygiene (WASH) programmes continue to lag behind global targets. Strengthening prevention must go hand in hand with improving access to diagnostics, antimicrobial stewardship and appropriate treatment; continental laboratory mapping across 14 countries with 50,000 laboratories found only 1.3% performed routine bacteriology and an estimated 261 million people lacked access to bacteriology testing.

Fourthly, translating One Health commitments into coordinated action across human health, animal health, agriculture, food systems and the environment remains a key challenge, particularly in the environmental sector, where AMR implementation continues to lag behind other sectors.

Fifthly, people-centred action — through communities, faith networks, youth and vulnerable populations remain uncapitalized — a key determinant of whether programmes work or not.

A growing body of African implementation experience. Several African countries and programmes are reporting progress in key areas of AMR implementation.
Examples include Zambia’s Broiler Farmer Field Schools, which reported a 59.7% reduction in antimicrobial use without loss of productivity; at Kabinda General Hospital in the DRC, rational prescribing increased from 20% to 83% alongside improvements in IPC; Aweil Hospital in South Sudan reduced blood-culture contamination from 20–50% to below 5%; and ReAct’s innovative stewardship initiative, the Antimicrobial Stewardship Program through Innovation, Research and Education (ASPIRE) programme in Kenya and Zambia combined digital innovation and AI-enabled clinical support with facility-based antimicrobial stewardship, recording an improvement across the project facilities’ AMS functionality by 26–44 percentage points at midline evaluation. Together, these experiences highlight the potential of African-led interventions and reinforce the importance of evaluating, financing, institutionalising and adapting promising approaches for sustainable implementation and scale-up.

A six-point agenda. The conference distilled its way forward into six priorities:

- **Prioritise** a realistic set of high-impact interventions within national AMR plans.
- **Institutionalise** responsibilities within routine systems and formal institutional mandates.
- **Finance** implementation through domestic budgets, investment cases and existing financing mechanisms.
- **Implement** integrated interventions across prevention, diagnostics, surveillance, stewardship and access.
- **Include** communities, frontline workers and vulnerable groups in decision-making and implementation.
- **Measure and scale** proven approaches using evidence, accountability mechanisms and regional peer learning.

Together, these priorities provide a practical pathway for moving from commitments and isolated interventions towards sustained implementation. One Health cuts across this pathway, requiring human health, animal health, agriculture, food and environmental sectors to jointly plan, implement, monitor and report.

The closing panel recorded a number of concrete follow-up actions, including drafting and disseminating a conference message ahead of the Abuja Conference in December 2026, strengthening legislative pathways for NAPs, engaging with FAO's RENOFARM network, and supporting shared AMR financing mechanisms.

RAAC 2026 leaves a clear message: Africa's AMR response does not primarily need another layer of commitments. It needs delivery — country-owned priorities, functioning institutions, sustainable financing, implementation close to communities, and accountability for measurable results.







1. Background and Rationale

Antimicrobial resistance (AMR) remains a major and growing threat to health, health systems, food security and sustainable development across Africa. While political attention to AMR has increased substantially over the past decade, the central challenge has shifted from developing strategies and securing commitments to ensuring that agreed actions are implemented, sustained and translated into measurable improvements at country, facility and community levels.

The 2024 United Nations General Assembly (UNGA) High-Level Meeting on AMR strengthened the global accountability agenda by establishing measurable commitments for implementation. For African countries, this created renewed urgency to assess progress, identify persistent gaps and strengthen the systems required to deliver. Countries have made important advances in developing NAPs, strengthening multisectoral governance, expanding surveillance and advancing stewardship, infection prevention and control, and public awareness. However, implementation remains uneven, with persistent challenges related to sustainable financing, laboratory and diagnostic capacity, data use, access to quality-assured antimicrobials, workforce capacity and coordination across One Health sectors.

These challenges are becoming more pressing in a changing global health financing environment. Reduced external funding that supported most activities and competing national priorities reinforce the need for greater country ownership and more sustainable approaches. Effective interventions cannot remain dependent on short-term projects or parallel structures; they need to become part of routine government planning, financing, service delivery, workforce development, surveillance and accountability across the human, animal, agriculture, food and environmental sectors.

Against this background, ReAct Africa convened its Annual Antimicrobial Resistance Conference 2026 (RAAC 2026) in Lusaka, Zambia, on 21–22 July 2026 under the theme “Africa Leading the Way to Institutionalizing Pragmatic People-Centred AMR Solutions from Grassroots to Regional Level.” The theme reflected a shift from isolated interventions and pilots towards solutions embedded within systems and sustained over time. Pragmatic solutions were understood as approaches that respond to the realities of African health systems and communities; a people-centred approach placed patients, health workers, farmers and communities at the centre of AMR action; and the focus from grassroots to regional level recognised that locally generated experience should inform national policy and regional learning. At its core, the conference was built around a clear proposition: Africa is not short of ideas, evidence or practical solutions to AMR — the priority now is to create the conditions that allow effective, people-centred interventions to become routine, sustainably financed and governed by accountable systems.

2. Conference Objectives

RAAC 2026 was designed to move the regional AMR dialogue beyond identifying priorities towards understanding how effective interventions can be institutionalised, sustained and scaled. Bringing together 176 participants from 35 countries, it connected implementation experience from communities and health facilities with national and regional policies, financing, accountability and regional collaboration. The conference sought to:

- **Advance institutionalisation** of effective AMR interventions within health systems, community platforms and One Health structures, so successful approaches become part of routine systems rather than dependent on individual projects.
- **Showcase pragmatic, Africa-led models** that have demonstrated feasibility in real-world settings and can inform adaptation and scale-up across countries.
- **Connect grassroots implementation with national and regional decision-making,** ensuring lessons from facilities, communities and frontline actors inform policy, financing and accountability.
- **Strengthen One Health collaboration** across human health, animal health, agriculture, food systems, the environment and communities, with greater emphasis on joint implementation and shared accountability.
- **Mobilise political commitment, financing and partnerships** to move priority interventions from plans and pilots into sustained implementation.
- **Promote innovation, equity, local leadership and people-centred approaches** as essential elements of an effective and sustainable AMR response.

Together, these objectives were framed around a practical question: **what must countries and regional actors do differently to make effective AMR action routine, equitable, sustainably financed and scalable?**

3. Conference Format, Participation and Report Methodology

The RAAC 2026, brought together 176 participants representing 35 countries. Participants included representatives from governments and national public health institutions, regional and international organisations, healthcare and veterinary professionals, researchers and academic institutions, civil society and community organisations, youth and faith-based groups, media and development partners working across human health, animal health, agriculture, food systems and the environment.

The conference was intentionally designed to connect three levels of AMR action: grassroots and frontline implementation; national policy and health-system delivery. Plenary sessions established the strategic context, while country-status discussions, technical sessions and moderated panels enabled participants to examine implementation experience and identify transferable lessons.

3.1 How the conference unfolded

The two-day programme moved from the continental implementation picture and country experience on Day 1 - setting the scene of global funding towards global health and the African score card against the UNGA HLM targets, country reports - to technical delivery, innovation and people-centred action on Day 2.

Day 1 · 21 July

- Opening and partner perspectives
- Setting the scene: AMR in Africa 2026: Progress, Gaps, and Urgent Priorities.
- Supporting countries towards achievement of global AMR goals
- Country-status reports across human, animal and the environmental sectors
- Governance and accountability
- Sustainable financing

Day 2 · 22 July

- Leveraging innovative interventions to advance the AMR agenda
- Six parallel technical discussions:
  - Access to antimicrobials and diagnostics
  - Primary health structures
  - Lessons from COVID-19 and emerging threats
  - AMR surveillance
  - IPC/WASH and biosecurity
  - Antimicrobial stewardship
- Technology, AI and innovation
- People-centred approaches: community, youth, faith and equity
- Final high-level panel and closing

On Day 2, much of the programme ran with simultaneous parallel discussions rather than single plenary sessions. One group of discussions examined equitable access and frontline systems — antimicrobials and diagnostic access and pooled procurement, human and animal primary health structures, and lessons from COVID-19 and emerging threats. A second group examined how to reduce the emergence, transmission and impact of resistant pathogens — AMR surveillance, IPC/WASH and biosecurity, and antimicrobial stewardship. These were followed by sessions on technology and AI-led AMR solutions, people-centred implementation and the final high-level action dialogue.

HOW PARALLEL DISCUSSIONS ARE REFLECTED IN THIS REPORT

RAAC 2026 used parallel tracks to allow for deeper technical discussion. Rather than reproduce each track as separate proceedings, their findings were integrated into the thematic chapters that follow. Distinct parallel discussions are identified within those chapters to preserve their contribution to the conference.

Parallel Discussion	Focus
Access to antimicrobials & diagnostics	Pooled procurement, market fragmentation, forecasting, registration, affordability and diagnostic access
Primary health structures	Human and animal PHC, vaccination, veterinary services, community engagement, stewardship and referral
Lessons from COVID-19 & emerging threats	Preparedness, IPC, health-worker safety, surveillance and laboratory systems, and institutionalising pandemic investments
AMR surveillance	National laboratory networks, animal-health pathogen prioritisation, diagnostics, stewardship and One Health surveillance
IPC/WASH & biosecurity	Infection prevention across healthcare and animal-health systems
AMS: from guidelines to practice	Facility implementation, behavioural barriers, multidisciplinary teams, diagnostics, audit and feedback





3.2 Report methodology

This report synthesises evidence, implementation experience and key messages from the conference programme, rapporteur reports, presentation materials and session documentation. Reports covering the same session were consolidated to capture complementary information without duplication. Because sessions took different formats, not every reporting element applied to every session; the report reflects the substance of each discussion rather than imposing a uniform template. Findings are organised thematically so that evidence from different sessions can be brought together around common implementation challenges. Quantitative data are included selectively where they demonstrate the scale of a problem, measure progress or clarify an implementation gap. Where a figure relates to a defined geography, reporting group or study population, this is stated in the text to avoid over-generalisation.

3.3 Pre-Conference Events

Two events were convened in Lusaka on 20 July 2026, ahead of the main programme, and fed directly into the conference's themes of research-to-policy translation and people-centred participation.

Partners Forum on AMR Research and Policy Translation (20 July)

The ZNPHI–ReAct Africa Partners Forum and Knowledge Exchange on AMR Research, Policy Translation and Implementation in Zambia brought together 30 participants (22 in person and eight virtually) from research institutions, government, regulatory agencies, academia and implementing organisations, alongside ICARS experts. It examined how Zambia's growing body of AMR research and implementation experience — including work on antimicrobial stewardship, neonatal infection management, the National Multipathogen Diagnostic Programme, the ASPIRE initiative and Farmer Field Schools — can be translated more consistently into policy and routine practice.

Discussion emphasised moving from evidence generation to evidence uptake; extending stewardship to diagnostic, antifungal and antiparasitic stewardship; strengthening laboratory use for clinical decisions, hospital antibiograms and routine data review through ZNPHI Technical Working Groups; and a more proactive regulatory role for ZEMA and ZAMRA across environmental monitoring, medicines quality assurance, post-market surveillance and traceability. A key follow-up was agreement to co-develop a policy brief consolidating the forum's lessons, timed to inform Zambia's forthcoming AMR Research Agenda.

- Move from evidence generation to evidence uptake — judge AMR research by its contribution to policy, programmes and implementation.
- Strengthen the research–policy interface through sustained engagement among researchers, policymakers, regulators and implementers.
- Invest in diagnostics and data-to-action, embed environmental and agricultural dimensions in One Health surveillance, and strengthen domestic financing.
- Convert dialogue into a concrete output — the proposed policy brief.





Youth Side Event: Strengthening Youth Engagement in One Health AMR Governance

The pre-conference youth side event, "Strengthening Youth Engagement in One Health AMR Governance in Africa," brought together 50 participants (10 joining virtually) from youth-led organisations, young AMR champions, student and university associations, technical partners and early-career professionals, with contributions from institutions including WHO Egypt, Amref Health Africa, the Zambia AMRCC, the Fisheries Commission of Ghana and tertiary institutions. It examined how young people already contribute to AMR action and the barriers to meaningful participation in governance.

Participants noted that young people are active implementers — in awareness, One Health Clubs, operational research, surveillance and advocacy — but remain under-represented in National Action Plan development, Technical Working Groups and National One Health Platforms. The event called for a shift from engagement centred on awareness towards meaningful representation, supported by leadership and mentorship, universities as platforms for future AMR leaders, recognition of youth-generated evidence, and broader One Health participation beyond medicine and veterinary sciences. Proposed follow-up included a regional survey and collaborative research to strengthen the evidence base for youth-inclusive AMR governance.

- Move from youth engagement to youth representation in national and regional AMR and One Health governance.
- Invest in leadership, mentorship and policy competencies alongside technical AMR knowledge.
- Use universities as platforms, recognise youth-generated evidence, and broaden participation across One Health disciplines.
- Strengthen networks, Communities of Practice and domestic investment to institutionalise youth participation.



4. Opening Remarks and Partner Perspectives

The main program's opening session established the central proposition of the conference: Africa has accumulated substantial knowledge, institutional experience and practical approaches to AMR, but the next phase must focus on institutionalising, financing and scaling what works. The scale of participation itself reflected the growth of the regional AMR community, from a small group a decade earlier to 176 participants from 35 countries.

Professor Mirfin Mpundu, Co-founder and Executive Director of ReAct Africa, positioned the conference as a bridge between grassroots implementation and regional policy, investment and accountability, emphasising that the experience of facilities, communities and frontline actors should not remain isolated from policy processes.



"Grassroots are a key stakeholder in shaping our response and translating local context into regional action."

Prof. Mirfin Mpundu
ReAct Africa

Dr Sam Barrell, Chief Executive Officer of LifeArc, reinforced the need to translate strategies into interventions that improve practice — highlighting antimicrobial stewardship and the ASPIRE programme — and argued that progress must be visible in clinical practice and patient outcomes, not only in policies.



"I have had two relatives suffer severe consequences from drug-resistant infections — the threat is immediate, so we need to talk less and act fast."

Dr. Sam Barrel | LifeArc

Dr Kadia Petricca of the Global Strategy Lab / AMR Policy Accelerator stressed policy capability and institutionalisation: successful interventions remain fragile unless embedded within national policies, governance and institutions. **Carol Ruffell, Executive Director of GARDP Africa,** emphasised the relationship between innovation and access — new antibiotics are necessary but insufficient if effective products do not reach patients. **Dr Samson Kefas, representing the Quadripartite Joint Secretariat,** situated the meeting within the wider One Health and global AMR agenda.

The official opening by **Professor Roma Chilengi, Director General of ZNPHI and Chair of Zambia's AMR Coordinating Committee,** illustrated institutionalisation at country level, citing progress in national coordination, surveillance and microbiology capacity, susceptibility testing, treatment guidelines, stewardship guidance, IPC and awareness.W

Dr Merawi Aragaw (Africa CDC) reaffirmed Africa CDC's commitment to supporting Member States in meeting the AMR targets of the 2024 UNGA Political Declaration, stressing that effective responses must move beyond commitments to implementation, with stronger ownership at community, institutional and national levels. Highlighting persistent gaps in laboratory capacity, infection prevention and control, and stewardship, he called for greater leadership from health professionals and institutions alongside sustained political support and investment.

These perspectives converged around four priorities — **implementation** (policies must result in action at facility and community level); **institutionalisation** (successful approaches should become part of routine systems and budgets); **access and equity** (innovation has limited value unless interventions and effective commodities reach those who need them); and **partnership and accountability** (progress requires coordinated action with measurable responsibility for delivery).



"The era of commitments alone is over, and the era of accelerated implementation, enhanced partnership, accountability and measurable impact has just begun."

Dr. Samson Kefas
Quadripartite Joint Secretariat



5. Setting the Scene: AMR Progress, Gaps and Priorities in Africa

The setting-the-scene session moved from vision to evidence, asking whether Africa is progressing quickly enough from political commitment to measurable implementation ahead of the 2029 UN High-Level Meeting review and the 2030 targets. The 2024 UNGA Political Declaration established a more measurable framework: by 2030, a 10% reduction in deaths associated with bacterial AMR (against an estimated 4.95 million AMR-associated deaths in 2019), at least 60% of countries with funded NAPs, at least 70% of human antibiotic use from the with basic WASH and waste-management services in all health facilities. The years 2026–2029 were therefore framed as a decisive implementation and accountability period.

The central gap: plans exist, but sustained delivery remains limited

The strongest quantitative signal came from countries' own self-assessments in addressing AMR. Among reporting Member States in the WHO African Region: 100% reported having a NAP; only about 9% reported sustained implementation; around two-thirds remained at the stage where a plan existed but was not yet demonstrably implemented at scale; only about 32% reported a costed investment case; about 51% reported integrated AMR surveillance; and only about 36% reported multisectoral coordination at demonstrated or sustained levels.

Indicator (reporting WHO African Region Member States)	Reported status
Have a National Action Plan	100%
Sustained NAP implementation	~9%
Costed investment case	~32%
Integrated AMR surveillance	~51%
Demonstrated/sustained multisectoral coordination	~36%

The discussion consequently shifted from “Does the country have an AMR plan?” towards three more demanding questions: **What will the country fund? What will it measure? What will it institutionalise?**

A high burden measured through an incomplete surveillance window

A second concern was the disparity between Africa’s AMR burden and its capacity to measure it. Data presented during the session indicated that only 27 of the 47 Member States in the WHO African Region contributed data to GLASS 2025 (reporting 2023 data), and that the region accounted for only about 2.2% of the bloodstream and gastrointestinal-infection isolates in the comparative dataset, despite a disproportionately high burden. Laboratory capacity is a core constraint: continental laboratory mapping across 14 African countries and more than 50,000 laboratories found that only about 1.3% performed routine bacteriology, fewer than one-quarter of bacteriology laboratories used automated identification or susceptibility testing, and an estimated 261 million people lacked access to bacteriology testing.

1.3% of mapped labs perform routine bacteriology (14-country MAAP mapping)	**261m** people without access to bacteriology testing	**27/47** WHO AFRO Member States reported to GLASS 2025

From plans to financed implementation

Financing emerged as one of the most important structural constraints. Against the backdrop of a significant contraction and restructuring in global health financing, the conference highlighted the growing need for domestic resource mobilisation and sustainable financing mechanisms for AMR. With only about 32% of reporting Member States holding a costed AMR investment case, many countries have identified priorities but still lack a sufficiently costed proposition with which to engage ministries of finance, development banks and developmental partners. The conference therefore emphasised moving beyond general calls for “more AMR funding” towards prioritising interventions, estimating costs, identifying domestic budget opportunities and demonstrating value — and positioning AMR within wider agendas including universal health coverage, health security, primary health care and food security.

Governance, evidence-to-action and prevention gaps

The data indicated that the existence of multisectoral structures does not by itself produce sustained joint implementation; discussions therefore focused on the next layer of governance — clear responsibilities, functioning secretariats, joint priorities, financing and measurable accountability, with political engagement (as in Zambia’s work with parliamentarians) broadening responsibility beyond technical agencies. A further weakness identified was that data and research do not consistently lead to policy or practice change: strengthening the pathway from data to evidence, to implementation and to measurement of impact emerged as a regional priority. Closer to the point of care, only about 15% of reporting Member States were at demonstrated or sustained levels for IPC implementation, and about 13% were at demonstrated or sustained levels for optimising antimicrobial use in hospitals, reinforcing the need to move stewardship, IPC and WASH from national guidance into routine facility practice.

THE IMPLEMENTATION CHALLENGE IN ONE VIEW

100% have a plan → ~32% have a costed investment case → ~9% report sustained implementation (among reporting WHO African Region Member States). Africa must now move from demonstrating that plans and commitments exist to demonstrating financed implementation, functioning institutions, expanded coverage and measurable outcomes.

PANEL DIALOGUE

From political commitments to country delivery
Africa CDC · AMR Policy Accelerator · ZNPHI · ReAct Africa

The setting-the-scene panel focused on how global and continental commitments become country-owned implementation. Panellists argued that AMR action should be embedded within existing government systems, budgets and accountability structures rather than run as standalone programmes; that in-country leadership must own and translate commitments to local realities, since no two countries are the same; and that civil society belongs inside coordinating committees as a route from community realities to national decisions.

5.1 From Global Commitments to Country Support

A dedicated multi-agency panel — drawing together FAO, WHO AFRO, WOAH and the environmental sector — examined how global and regional partners should support countries to achieve their commitments, assessing progress against global goals and the persistent bottlenecks that slow NAP implementation. It confirmed the broad regional picture already set out in Section 5 — near-universal NAPs, but many countries still lacking dedicated NAP financing, functioning IPC programmes and robust laboratory quality-management systems. The distinctive contribution of the panel was less its technical content than its framing of the partner role.

FAO	**WHO**	**WOAH**	**Environmental institutions**
Farmer-level implementation; InFARM, ATLASS and RENOFARM; practical agri-food tools	NAP implementation, surveillance, stewardship, IPC and access	Animal-health systems and standards	Integrating the environmental dimension into One Health

The common message was that technical assistance should strengthen country-owned systems, align with national priorities, and help convert global commitments into implementable, financed action — mainstreaming AMR into universal health coverage, primary health care, health security and climate platforms rather than sustaining it as a vertical, donor-dependent programme.

5.2 Country Implementation Snapshots

The Day 1 country-status exercise ran as three simultaneous One Health streams — human health; animal health, aquaculture and agriculture; and the environment. The human-health stream is summarised below; the animal and environmental streams are carried in Sections 6.6 and 6.7.

Country	Selected quantitative evidence	Institutionalisation & remaining gaps
Zambia	16 AMR surveillance sites (human and animal); sample processing nearly doubled 2020–2025; ~78% of consumption in the WHO Access category (above the 70% target); third-generation cephalosporins restricted to higher levels of care	Institutionalised through government planning cycles (facility annual plans; AMR posts in the ZNPHI structure) with quarterly coordination; gaps in microbiology diagnostic coverage and sustainable domestic financing
Egypt	~100 AMR Model Hospitals across all 27 governorates (since 2023); >1,800 health workers trained; 5 hospitals internationally accredited (3 as centres of excellence); a 2024 point-prevalence survey across 220 hospitals and >10,000 patients; ~80 GLASS sentinel sites; June 2024 decree phasing out over-the-counter Reserve antibiotics	Strong national IPC platform, One Health Supreme Committee and KPIs enabling scale-up; gaps in stewardship, awareness and workforce financing; next NAP to be prioritised, costed and budgeted
Nigeria	16 sentinel laboratories analysed >4,000 isolates in 2024 (>50% of priority isolates multidrug-resistant); AWaRe in the essential medicines list; >4,000 health workers trained; point-prevalence surveys in 16 tertiary hospitals; the Turn Nigeria Orange IPC initiative (since 2019)	NAP 2.0 aligned to the 2024 UN declaration with governance as a strategic pillar and AMR/IPC embedded in health-security performance frameworks; gaps in subnational implementation, surveillance representativeness, diagnostic quality and financing

The three countries illustrate the conference's central pattern in the human-health sector: governance and surveillance foundations are advancing and beginning to inform treatment and formulary decisions, but representative coverage, diagnostic quality, sustainable financing and subnational and community-level implementation remain the shared frontier.

6. Thematic Conference Findings

The discussions consistently returned to one issue: Africa has developed policies, institutions, technical expertise and promising interventions, but these are not yet translating consistently into sustained implementation at scale. Across sectors, participants focused less on identifying new priorities and more on the conditions required to make existing priorities operational, financed, measurable and sustainable.

6.1 Governance and Accountability

During the governance session, country experiences from Kenya, Malawi, Tanzania, Ghana and Zambia demonstrated different routes to institutionalisation, and a review of One Health governance tools set out the gap between structures and delivery. Governance emerged as one of the strongest determinants of whether NAPs move beyond policy documents into sustained implementation. Establishing a multisectoral committee or approving a NAP is only the beginning; effective governance requires clear mandates, institutional responsibility, leadership, financing, inclusive participation and mechanisms through which evidence leads to decisions. Of 33 One Health governance tools examined, only eight explicitly addressed AMR, and many were stronger at assessing structures than at supporting implementation and accountability — the implication being that countries often need existing structures to function better rather than new ones.

Country	Approach highlighted	Implementation lesson
Kenya	Mandated One Health structures, dedicated secretariats, costed plans and integrated monitoring	Clear mandates and monitoring turn coordination into delivery
Malawi	Responsibilities assigned to state and non-state actors within the NAP	Naming who is accountable strengthens implementation
Tanzania	Redistribution of AMR functions to institutions with existing mandates and resources after funding cuts	Institutionalisation can mean embedding roles in existing organisations, not parallel structures
Ghana & Zambia	Parliamentary engagement on AMR	Political engagement raises AMR above the technical level and opens a path to public financing

Governance was also linked to transparency: reporting to systems such as GLASS and TrACSS was valued, but participants stressed that accountability cannot end with the submission of reports — monitoring should lead to time-bound decisions, corrective action and resource reallocation.



"Policy without resources is poetry."

Dr. Kadia Petricca
Global Strategy Lab / AMR Policy Accelerator

Political leadership was repeatedly identified as the mechanism that raises AMR above the technical level. A presentation from the Zambia National Assembly described Zambia's establishment of a Parliamentary Caucus on AMR — a voluntary, cross-party grouping of at least 15 members of parliament with formal recognition — as a more effective platform than individual committees for coordinating a One Health response, given that AMR cuts across the human, animal, agriculture and environmental sectors. Such a caucus would raise awareness among parliamentarians, champion One Health legislation, strengthen oversight of NAP implementation and advocate for sustainable domestic financing, and the proposal was extended as a model for other African legislatures. As the presenter put it, without knowledge of AMR, members of parliament will not see the need to fund it.

PANEL DIALOGUE

Governance panel: Key Message
ECSA-HC · Tanzania · Ghana · AMR Policy Accelerator

The governance panel's distinctive message was that governance requires more than committees. What converts a plan into delivery is political leadership, assigned responsibilities, dedicated and resourced secretariats, domestic financing, monitoring that changes decisions, and meaningful participation — including the ability to redistribute responsibilities to institutions that hold operational resources when external funding contracts.

KEY CONFERENCE TAKEAWAY

Accountability must connect responsibility, resources, results and corrective action — not end at reporting.

6.4 Antimicrobial Stewardship and Access

The stewardship and access session treated the two as mutually dependent rather than competing objectives. Restricting use without ensuring access can harm patients; expanding access without stewardship can accelerate resistance. Facility experiences from South Africa, South Sudan, Kenya and Zambia showed that stewardship becomes effective when it moves from guidelines into daily practice — through multidisciplinary teams, decision support, prospective audit and feedback, and local champions — while access discussions from a 25-country survey exposed persistent market failures. The two agendas are best read side by side.

Stewardship

- Multidisciplinary AMS teams and local champions
- Guidelines and point-of-care decision support
- Prospective audit and feedback (supportive, not punitive)
- Diagnostics linked to prescribing decisions
- Digital tools integrated into clinical workflows

Access

- Demand forecasting and national registration
- Coordinated / pooled procurement and initiatives such as SECURE
- Updated Essential Medicines Lists and guidelines
- Diagnostics to generate appropriate demand
- Equitable, last-mile distribution

In Aweil, South Sudan, MSF integrated a microbiology mini-laboratory with antimicrobial stewardship, infection prevention and control (IPC), and staff training, resulting in a reduction in blood-culture contamination rates from an initial range of 20–50% to below 5%. The ASPIRE programme in Kenya and Zambia demonstrated how AI-enabled clinical decision support can be integrated into facility-based antimicrobial stewardship. Across four hospitals, it combined prospective audit and feedback, multidisciplinary engagement and digital tools to support appropriate prescribing, and showed that supportive, non-punitive feedback is central to changing clinician behaviour. A total of 527 healthcare workers used the clinician AI chatbot — 269 doctors, 174 pharmacists, 71 nurses and 13 laboratory personnel — generating 3,143 clinical queries, while 1,388 patients were enrolled for prospective prescribing review..

On access, a survey across 25 countries showed sharp differences by product:

~20% reported access problems with amoxicillin (Access)	**~2 in 3** reported difficulty accessing meropenem and vancomycin (Watch)	**44%** reported barriers to nitrofurantoin availability (Access)

Newer Reserve antibiotics such as ceftazidime-avibactam and cefiderocol were reported as poorly available, with high prices and lack of national registration among the main barriers. Coordinated and pooled procurement can make smaller markets more attractive to suppliers, but procurement alone cannot solve access: successful approaches require aligned product priorities, reliable forecasts, financing, regulatory cooperation, transparent governance and equitable distribution — and any increase in availability must be accompanied by stewardship and diagnostic capacity.

The stewardship track was explicitly about moving from guidelines to practice, and much of its value lay in explaining why guidelines alone do not change prescribing. Recurring behavioural and system barriers included prescriber hierarchy and team dynamics, communication gaps, sharp differences between public and private sectors (from medicine stock-outs to overuse where medicines are readily available), and the need to start with small, feasible interventions — a digital pocket guide, a single ward-round tool — and to extend stewardship quality improvement beyond tertiary hospitals into primary care.

Leadership	Team culture	Diagnostics	Practical guidelines
Supportive feedback	Local champions	Feasible workflows	Extend to primary care

KEY CONFERENCE TAKEAWAY

Access and stewardship are mutually reinforcing, not competing priorities.

6.5 IPC, WASH, Prevention and Primary Health Systems

6.5.1 IPC, WASH and infection prevention

Prevention was consistently identified as one of the most cost-effective ways to reduce antimicrobial use and resistance, yet it remains insufficiently institutionalised: only about 15% of reporting Member States were at advanced levels of IPC implementation, against the 2030 commitment for 90% of countries to meet WHO minimum requirements. The conference positioned IPC, WASH, vaccination and biosecurity not as supporting activities but as central AMR interventions, because preventing infections directly reduces demand for treatment. A dedicated parallel track on Day 2 focused on experiences from Kenya and Uganda — examined how these practices become institutionalised across human and animal health rather than remaining emergency responses.

Both country experiences showed that infection prevention works when it is embedded in governance and routine systems rather than run as a campaign. Functional facility-level IPC, antimicrobial stewardship and medicines-and-therapeutics committees provide multidisciplinary oversight; standardised assessment tools — WASH FIT and IPC self-assessments, adapted from referral hospitals to lower-level facilities through supportive supervision — feed indicators into routine platforms such as DHIS2; and multimodal hand-hygiene programmes combine training, monitoring, feedback, leadership support and reliable supplies. Uganda's surgical-site-infection surveillance, linked to antimicrobial-use and laboratory data, illustrated how connecting IPC to surveillance improves patient safety and informs national guidance.

The clearest message concerned behaviour change: leadership, local champions, mentorship, audit and feedback, and peer-to-peer learning drive lasting change far more than one-off training. One example described a successful root-cause analysis and mentorship intervention that curtailed the recurrence of an outbreak caused by a lapse in routinely changing medical tubing. The lesson was shared across referral hospitals for proactive adoption. Hand-hygiene compliance was best measured through discreet, unannounced observational audits against the WHO Five Moments — and participants stressed that every cadre, including support staff and patients themselves, have a role in infection prevention.

In animal health, biosecurity, vaccination, surveillance and farmer engagement tailored to different production systems effectively prevent infection and reduce antimicrobial use., However, high upfront biosecurity costs and limited veterinary access constrain adoption.

Across both sectors, the recurring theme was a shift from reactive outbreak response to proactive prevention through routine surveillance and early-warning systems. Good practices included Kenya's local production of alcohol-based hand rubs (improving supply resilience), county laboratory hubs supporting 23 AMR sentinel sites, and Uganda's use of routine AMR data to trigger outbreak investigations. Persistent constraints — inadequate WASH and IPC infrastructure and financing, commodity and laboratory-supply stock-outs, workforce shortages and turnover, weak antimicrobial-use data systems, and uneven multisectoral coordination — reinforced the central recommendation: fund IPC, WASH, AMS and biosecurity as core, budgeted components of health and agricultural systems, not emergency activities.

> "Prevention is more effective and less costly than responding to outbreaks."
>
> Ritah Namusoosa, Uganda





KEY CONFERENCE TAKEAWAY

Infection prevention reduces AMR only when it is financed and routine — embedded in governance, data systems and everyday behaviour, not mounted after outbreaks.

6.5.2 Primary health systems: bringing AMR closer to communities and farms

The primary-care discussion covered both human and animal primary health structures, emphasising that AMR must increasingly be addressed where most antibiotic use occurs, even though many stewardship, surveillance and diagnostic initiatives remain concentrated in tertiary facilities. It described the primary animal-health network closest to farmers — veterinary camps and posts, extension and community animal-health workers, agrovet outlets, district veterinary offices, cold-chain points and subnational laboratories — and argued that weak primary structures create risk through service failure, not farmer behaviour alone. It proposed a minimum AMR-sensitive package that applies across human and animal primary care:

Prevention . Clinical care . Medicine governance . Community engagement . Surveillance . Supervision

In human primary care, this means prevention and vaccination, appropriate diagnosis and referral, responsible prescribing, community education and basic surveillance; in animal primary care, it includes vaccination, veterinary access, farmer advice, responsible antimicrobial access, biosecurity and surveillance. A rural survey covering the catchment areas of 14 health centres in southern Chad found that 94.3% of respondents were unaware of AMR, with only 5.7% reporting prior awareness. Self-medication and informal medicine markets were also common. A subsequent community-based programme was implemented through community health personnel and household visits, aiming to increase AMR awareness from approximately 6% to 20%. The programme reported reaching 104,897 people, comprising 44,297 men and 60,600 women. This experience highlights the potential of integrating AMR communication into existing community health structures to strengthen community awareness and engagement.

Community & PHC → Prevention & vaccination → Early diagnosis → Referral & appropriate treatment → Fewer infections and less unnecessary antimicrobial use

6.5.3 Institutionalising lessons from COVID-19 and emerging-threat preparedness

A dedicated Day 2 discussion used the COVID-19 experience to strengthen the AMR response, with the explicit aim of institutionalising pandemic-era infrastructure and systems rather than allowing them to lapse between emergencies. A WHO EMRO perspective stressed that the next health emergency is inevitable — recent outbreaks including Mpox and Ebola underline the point — and that systems must be ready for rapid detection and response, health workers protected through IPC and appropriate PPE, and systemic by-products addressed, including the antimicrobial overuse and healthcare-waste burdens that the pandemic amplified.

A national intra-action review (Zambia) distilled four transferable lessons: risk communication and community engagement build the trust needed for compliance; enhanced surveillance, contact tracing and laboratory capacity enable early detection; strengthened IPC, PPE use and structured case management protect health workers and improve outcomes; and investment in logistics, supply chains and continuity of essential services creates resilience under pressure. A country example (Senegal) illustrated institutionalisation in practice — an integrated One Health approach, 45 sentinel surveillance networks strengthening detection in rural areas, and a move toward local vaccine sovereignty through domestic manufacturing.

> “The next health emergency is not a question of if, but when.”
>
> Dr Imani Heweidy, WHO EMRO

The consolidated message was that COVID-19 exposed both strengths and weaknesses in African health systems and that the task now is to build resilient, adaptive and sustainable systems that withstand shocks while protecting populations and health workers. The clearest recommendation was not to train only in response to outbreaks but to institutionalise these interventions within routine systems and training institutions, and to link AMR to broader health-security capacity rather than treating it in isolation.

6.6 Animal Health, Agriculture and Food Systems

The animal-health and agri-food discussions demo
nstrated both substantial innovation and persistent gaps, with country experiences from Zambia, Kenya, Namibia and Ethiopia showing that progress is strongest where AMR is integrated into existing veterinary, extension and surveillance systems. FAO framed the scale of the challenge with projections that antimicrobial use in animal production could rise by around 30% to approximately 143,000 tonnes by 2040 without action, and presented practical tools — the ATLASS assessment (strengthening surveillance in 26 countries), the InFARM data platform, and the RENOFARM initiative with its "5G" framework (good health services, good production practices, good alternatives to antimicrobials, good connections and good incentives), applied across more than 150 farms in 30 countries. Zambia was recognised as the first country to develop a national RENOFARM roadmap, supported by a blended financing model (government, private sector and FAO).

Country	Approach highlighted	Implementation signal	Strategic lesson
Zambia	Broiler Farmer Field Schools (CAAZAP)	59.7% reduction in AMU without loss of productivity	Farmer-centred prevention and stewardship can reduce use while protecting livelihoods
Kenya	Govern–Prevent–Detect–Steward; farm/lab surveillance	Integration with ANIMUSE and InFARM	Link prevention, surveillance and stewardship
Namibia	AMU surveillance and regulation	WOAH reporting since 2015; growth-promoter restriction	Regulation and consumption intelligence shape practice
Ethiopia	Agricultural extension and workforce model (4th NAP 2026–2030)	12 ISAVET cohorts (380+ experts) and 150+ meat inspectors trained; 19 veterinary labs (5 sentinel); mobilisation across all 14 subnational states	Existing extension systems provide a route to institutionalisation

Common gaps remained across the sector: over-the-counter access to veterinary antimicrobials; peripheral laboratories lacking equipment, financing and connectivity; underdeveloped animal-sector stewardship and treatment guidelines; cross-border movement of animals creating surveillance and biosecurity challenges; and limited sustainable financing. The conference concluded that an effective agricultural response should place disease prevention first — combining vaccination, biosecurity, good husbandry, farmer education, veterinary access, surveillance and appropriate regulation.



"Our goal is not simply to reduce antimicrobial use. Our goal is to build healthier animals that need fewer antimicrobials."

Dr Cameline Mwai,
Ministry of Agriculture and Livestock Development, Kenya



6.7 Environmental AMR

Environmental AMR remains one of the least mature components of national responses. Country discussions drawing on Mali, Mozambique and Burkina Faso showed a common pattern: environmental AMR is increasingly recognised within policy, but financing, surveillance and implementation remain limited. Burkina Faso illustrated early, concrete steps — incorporating the environmental sector into its revised 2024 NAP, creating a One Health data-sharing platform, and establishing two food-safety and two environmental sentinel surveillance sites — while noting continuing constraints in financing, reagent supply and regulation. An important technical message was that the existence of wastewater-treatment facilities does not mean AMR risks are being managed — conventional systems may meet water-quality standards while having limited capacity to detect or remove antimicrobial residues, resistant bacteria or resistance genes. Unsafe disposal of unused medicines was a further concern, with Mali's medicine take-back initiatives cited as a practical community intervention. The conference set out four immediate priorities:

Surveillance Develop laboratory capacity and standardised methods for detecting antimicrobial residues and resistant organisms; agree indicators.	**Wastewater** Integrate environmental surveillance and wastewater management into funded NAPs; recognise that treatment plants are not automatically AMR infrastructure.
Pharmaceutical waste Strengthen waste management, medicine-return systems and regulatory enforcement; address informal and black-market sales.	**Regional coordination** Build regional surveillance and learning mechanisms so countries can compare methods and share emerging evidence.

Environmental AMR should move from being treated as the "third" One Health sector to being included in joint planning, financing, monitoring and accountability alongside human and animal health.



"Without sustainable financing, National Action Plans risk remaining strategic documents rather than operational programmes."

Dr Sidy Ba, Mali



6.8 People-Centred Approaches, Youth, Faith and Equity

The people-centred discussions challenged the tendency to frame AMR primarily around pathogens, consumption and resistance profiles. WHO's people-centred framework presented 13 core interventions across prevention, access, diagnosis and treatment, supported by data for action and enabling governance, financing and behaviour change, and emphasised that people encounter AMR through a journey — whether infection is prevented, quality care is accessible, a diagnosis can be made, effective treatment is available and recovery is possible without catastrophic cost. Four groups of actors featured strongly.

People & communities Prevention · access · diagnosis · treatment, understood through lived experience rather than technical messaging alone.	Youth Leadership · One Health Clubs · digital engagement · policy participation — as partners in governance, not audiences for awareness events.
Faith networks Trusted community platforms for hygiene, vaccination, responsible medicine use and safe disposal, via ReAct Africa's Christian and Muslim AMR guides.	Equity & vulnerable populations Gender · geography · affordability · high-risk groups; data disaggregated by sex, age and location so inequities are visible.

The presentations illustrated the scale of the opportunity for people-centred action. WHO highlighted that 80–90% of antibiotics are used at primary-care and community levels and that women make up around 70% of the health workforce, reinforcing the need to bring both stewardship and equity closer to frontline care. The faith-engagement presentation cited that more than 80% of Africans subscribe to a faith and that faith-based organisations provide an estimated 40–60% of health services in many settings, giving faith networks considerable reach for behaviour change and community mobilisation. The youth-engagement presentation noted that around 60% of Africa's population is young and reported youth engagement across 33 African countries through One Health Clubs, leadership programmes, educational tools and digital campaigns. The equity dimension was also grounded in facility-level experience. At Kabinda General Hospital in the DRC, an MSF programme combining microbiology, stewardship and IPC demonstrated measurable improvement among high-risk patient populations, including people living with advanced HIV.

20% → 83% Rational antibiotic prescribing (Kabinda, DRC, 2020→2025)	**63% → 89%** IPC assessment score (Kabinda, DRC, 2019→2025)

The conference also gave weight to lived experience and communication as people-centred practice. A patient account described the personal and financial burden of a multidrug-resistant infection — following surgery, an infection susceptible to only two antibiotics that had to be sourced externally, compounded by delayed diagnosis, high costs and limited awareness. The message was that surveillance statistics and human stories are both needed: strategic communication, contextualised to local audiences and sustained through trusted and digital channels, should be treated as a core pillar of AMR programmes alongside surveillance, stewardship and IPC.

KEY CONFERENCE TAKEAWAY

Community participation and equity are determinants of whether programmes work, not communication add-ons.

6.9 Innovation, Workforce, Digital Health, AI and R&D

Innovation was discussed as an important accelerator, but the conference consistently resisted framing technology as a substitute for functioning health systems. The relevant question was not whether a technology is novel, but whether it solves an implementation problem, works within local infrastructure, is supported by evidence and can be sustained. Innovation at RAAC 2026 also extended well beyond technology, taking five forms:

Lived experience & communication	Workforce learning & mentorship	Parliamentary & policy innovation	Digital stewardship	R&D & product innovation

Two of these are carried elsewhere in this report — lived experience and strategic communication in Section 6.8, and parliamentary and policy innovation (the proposed AMR Parliamentary Caucus) in Section 6.1. The remaining forms are set out below.

6.9.1 Workforce learning and mentorship

A health-workforce innovation addressed the reality of overstretched, under-resourced services by moving knowledge rather than people. The Project ECHO / TEACH AMS model uses a virtual hub-and-spoke structure connecting multidisciplinary experts with frontline providers through case-based learning, guided by an "All Teach, All Learn" principle and a low-dose, high-frequency cadence that fits around clinical duties.

At the time of RAAC 2026, the ECHO model was presented as active in 35 African countries, working with 21 governments and Africa CDC across more than 70 disease areas. Within AMR, eight stewardship programmes had been supported — seven in Africa and one in Latin America — using a standardised 34-module curriculum available in English, French, Spanish and Portuguese. The free iECHO platform supports participation, scheduling, attendance reporting and access to learning materials. The model demonstrates how technology can extend specialist expertise and continuous mentorship to frontline health workers without requiring travel.

6.9.2 Digital stewardship

Digital stewardship was illustrated by the ASPIRE programme, which integrates guideline-informed decision support, clinician and patient AI-chatbots, structured data capture, dashboards and prospective audit and feedback into facility stewardship across four hospitals in Kenya and Zambia. Its contribution was less the technology than its integration with multidisciplinary teams and workflows: reducing documentation burden, delivering trusted guidance at the point of care, and turning stewardship into a continuous learning cycle in which artificial intelligence supports — but does not replace — clinical judgement.

Building on this foundation, Ambient AI-assisted clinical documentation and OCR/Vision AI-enabled capture of existing patient records were presented as proposed next-phase enhancements to the ASPIRE digital stewardship ecosystem. Ambient AI would convert clinical conversations into structured draft notes, while OCR/Vision AI would extract relevant information from patient files, prescriptions, laboratory reports and microbiology results. Both approaches retain human oversight: clinicians or AMS teams review and validate the generated information before it enters stewardship workflows. The aim is to reduce documentation and data-entry burden while improving the completeness and timeliness of information available for audit, feedback and clinical decision-making.

6.9.3 AI, diagnostics and early-warning technologies

The dedicated technology session examined AI and early-warning tools for diagnostics and surveillance — including imaging, cough analysis, digital stethoscopes, clinical decision support and surveillance dashboards — and set out six technologies reshaping AMR early warning at different levels of maturity: genomic surveillance, wastewater and environmental surveillance, AI and machine learning, mobile and digital field tools, clinical decision support, and dashboards and mapping. Reported performance was promising — presented as emerging external evidence rather than RAAC 2026 outcomes — including roughly 91% accuracy in outbreak prediction, about 90% accuracy in resistance-gene detection, and an approximately 30% reduction in inappropriate ICU prescribing where AI-supported decision support was trialled. The central caution was that models trained largely on European and North American data underperform on African pathogen diversity, making African-data-trained models an urgent priority. With only about 1.3% of mapped laboratories performing routine bacteriology, the immediate need in many settings remains basic diagnostic capacity: technology can compress the sample-to-action gap, but cannot replace specimen collection, culture, susceptibility testing, biosafety, quality assurance and trained personnel.

6.9.4 R&D and African innovation ecosystems

The R&D discussion argued that Africa must lead its own AMR research agenda, both for sustainability and because locally generated evidence is more likely to translate into local implementation. It positioned R&D as a health-security and economic driver, called for connecting fragmented initiatives into a coherent ecosystem — spanning point-of-care diagnostics, new therapeutics, IPC, workforce capability and affordable, lower-cost manufacturing — and emphasised talent retention and capacity-building so that expertise and infrastructure remain in the region.

Examples presented illustrated different parts of this ecosystem: research networks investing in both scientists and technologists; a drug-discovery accelerator spanning eight African countries; South African research infrastructure demonstrating the value of sustained investment in clinical development capability; international platforms linking science, diagnostics and surveillance; and efforts to lower the cost of advanced biologic manufacturing. Together, these examples reinforced that African R&D capacity requires not only individual projects, but connected infrastructure, talent, financing, manufacturing capability and pathways from discovery to implementation.

CONFERENCE PRINCIPLE

Technology should strengthen rather than bypass diagnostic fundamentals. Institutions, people, data quality, financing and governance determine whether innovation produces sustainable impact.

7. African Solutions and Innovation Spotlights

One of the strongest messages of RAAC 2026 was that Africa is not starting from zero. Across the two days, countries and institutions presented interventions already addressing different parts of the AMR challenge, with evidence of feasibility or measurable results. Six are profiled below, each with the implementation lesson it offers for adaptation elsewhere.



"Africa is not only the centre of the AMR challenge, it really can and should be the centre of the solution for Africa and beyond."

Dr Ghada Zoubiane, LifeArc

Zambia — Broiler Farmer Field Schools (CAAZAP)

Challenge: High, often unregulated antimicrobial use in smallholder poultry, with residues in feed and limited farmer knowledge of stewardship and biosecurity.

Intervention: Community-anchored Farmer Field Schools (2022–2026) training farmers in husbandry, biosecurity and prudent antimicrobial use, with standard poultry treatment guidance.

How it works: Participatory, farmer-centred learning delivered through local schools, paired with residue surveillance and improved veterinary prescribing.

Evidence: Seven Farmer Field Schools were established and 159 poultry farmers graduated from the programme; antimicrobial use fell by 59.7% without compromising poultry productivity.

Lesson / adaptation: Uses trusted extension-style structures; a replicable model for reducing agricultural antimicrobial use while protecting livelihoods.

ASPIRE — AI-enabled Digital antimicrobial stewardship, Kenya and Zambia

Challenge: Paper-based records, fragmented clinical information, limited point-of-care access to guidelines and delayed stewardship reviews.

Intervention: A digital stewardship platform — clinician and patient chatbots, a stewardship application and dashboards — integrated with multidisciplinary AMS teams.

How it works: Guideline-based, AI-supported decision support complements clinical judgement; prospective audit and feedback and patient education are built into workflows.

Evidence: Across four hospitals: 527 healthcare workers engaged the clinician AI chatbot; 3,143 clinical queries generated; 1,388 patients enrolled for stewardship review.

Lesson / adaptation: Digital innovation adds most value when embedded within multidisciplinary teams, trusted clinical guidance and existing workflows.

Aweil microbiology mini-lab — MSF, South Sudan

Challenge: Delivering stewardship in a fragile, resource-constrained setting with no functional microbiology.

Intervention: A functional microbiology mini-laboratory (established 2022) combined with stewardship, IPC, training and structured ward-round tools.

How it works: Start small on achievable priorities; iterative training, review and constructive feedback.

Evidence: Blood-culture contamination reduced from 20–50% to below 5%.

Lesson / adaptation: Meaningful stewardship gains are possible in humanitarian settings; the model warrants Ministry-of-Health engagement for sustainability.

Kabinda General Hospital — MSF, DR Congo

Challenge: High-risk patients (including people living with advanced HIV) in a constrained health system with weak diagnostics.

Intervention: An integrated package combining microbiology, antimicrobial stewardship and IPC.

How it works: Laboratory strengthening feeds prescribing decisions; stewardship and IPC reinforced by workforce development.

Evidence: Rational prescribing rose from 20% (2020) to 83% (2025); IPC assessment scores rose from 63% (2019) to 89% (2025).

Lesson / adaptation: Measurable improvement is achievable even in highly constrained settings when diagnostics, stewardship and IPC are combined.

Sierra Leone — repurposing epidemic-response infrastructure

Challenge: Building AMR surveillance where dedicated systems and financing are limited.

Intervention: Reuse of an electronic Integrated Disease Surveillance and Response (eIDSR) network and post-Ebola genomic capacity for AMR.

How it works: AMR is layered onto existing outbreak-response systems rather than built as a parallel platform.

Evidence: eIDSR operates across more than 1,300 facilities with more than 90% timely priority-disease reporting; genomic infrastructure is reusable for AMR.

Lesson / adaptation: A low-incremental-cost approach for countries with existing outbreak-response systems.

Ethiopia — AMR in agricultural extension and workforce systems

Challenge: Reaching farmers at scale and sustaining animal-sector stewardship beyond projects.

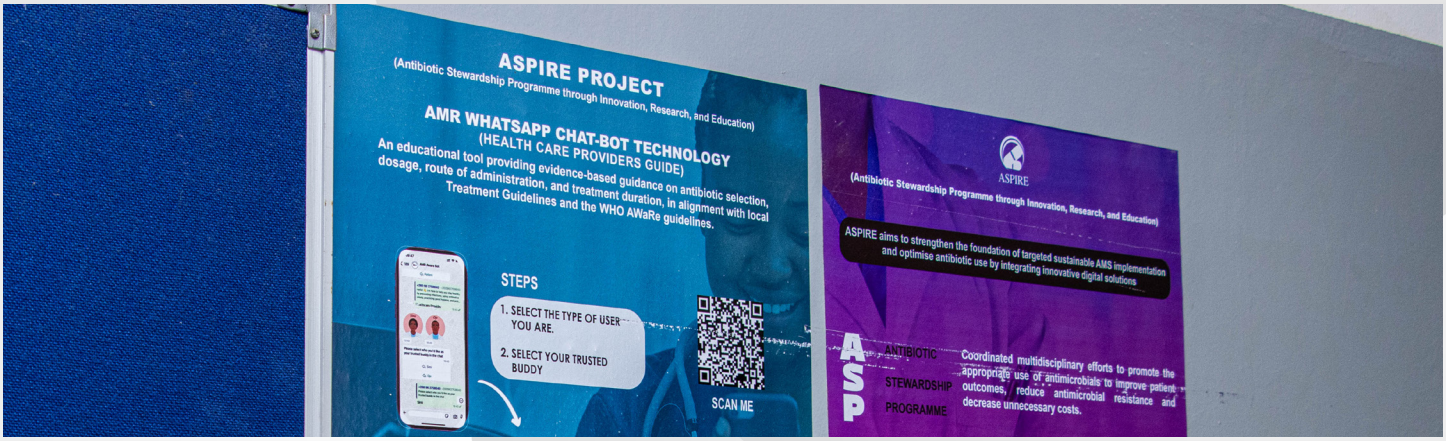
Intervention: Integration of AMR into Ministry of Agriculture planning and the national animal-health extension programme, with structured training.

How it works: Existing, trusted extension networks carry stewardship and biosecurity messages; specialised training cascades to frontline workers.

Evidence: More than 380 frontline professionals across 12 ISAVET cohorts and 150+ meat inspectors trained; a network of 19 veterinary laboratories, including five sentinel sites, supports surveillance.

Lesson / adaptation: Embedding AMR in pre-existing extension systems supports institutionalisation and farmer ownership.

Across these examples, the intervention itself differed, but the conditions for progress were remarkably consistent: locally identified problems, integration with existing systems, strong frontline ownership, investment in people and institutional capacity, and feedback mechanisms that make results visible. The lesson for scale is therefore not to replicate individual models unchanged, but to preserve these implementation principles while adapting interventions to local systems, resources and priorities.



8. Final High-Level Panel: From Conference Evidence to Action

Formal panel discussions were held across RAAC 2026 on continental AMR progress, supporting countries towards achievement of global goals, governance and accountability, sustainable financing, and the final high-level action dialogue. The final session was a distinct high-level panel chaired by Professor Mirfin Mpundu. It brought together senior perspectives from policy, financing, One Health, research and implementation and was explicitly action-oriented. Rather than revisiting the technical evidence presented over the two days, the panel asked what must now change in procurement, financing, One Health implementation, innovation and policy if promising approaches are to move from pilot or project status into sustained implementation and scale.

On procurement and regulation, participants highlighted stronger regulatory frameworks (including opportunities linked to the African Medicines Agency), traceability and track-and-trace systems, quality-assured generic and biosimilar competition, integration of AMR and WHO AWaRe considerations into tendering, health technology assessment, better forecasting and stronger last-mile distribution.

On financing, the panel reflected on the scale of the shock — described in the discussion as an approximately 27% decline in official development assistance and around US$10 billion in global health financing over the past year — and called for stronger domestic resource mobilisation alongside new regional and blended financing including stronger legislative and parliamentary pathways for national action plans to unlock domestic government funding. The panel further emphasised that financing cases must speak to competing government priorities: data and surveillance evidence should be combined with economic evaluation and compelling human stories, with ministries of finance and treasury engaged from the outset rather than only after successful pilots have been completed.



"It's how much local responsibility you take that makes the difference."

Emmanuel Kabali,
FAO Rome



On One Health, innovation and prevention, the panel reinforced that operational One Health requires shared responsibilities, indicators and accountability across sectors; that promising pilots do not scale without early policymaker involvement, local leadership and financing planned beyond the initial project (an "invest-to-save" proposition); that sustainable innovation should be locally identified, embedded within communities and institutions, and supported by the wider ecosystem required for delivery; and that WASH, IPC and vaccination are foundational investments that high-quality antibiotics cannot replace.



Africa must move from commitments to consistent delivery and accountability.
Financing must become more domestically anchored and supported by stronger investment cases.
One Health implementation needs shared responsibilities and operational integration across sectors.
Procurement, regulation and supply chains are central to equitable antimicrobial and diagnostic access.
African-led innovations should now be evaluated, institutionalised and scaled rather than remaining isolated pilots.

9. Cross-Cutting Messages from RAAC 2026

Although RAAC 2026 addressed many technical areas, five messages recurred across almost every session. Together they are the intellectual synthesis of the conference.

INSTITUTIONALISE Projects → systems	**FINANCE** Plans → funded priorities	**CONNECT** Prevention → diagnosis and surveillance→ access → stewardship	**OPERATIONALISE ONE HEALTH** Coordination → joint implementation	**USE EVIDENCE & SCALE** Data → decisions → African-led scale-up

9.1 Institutionalisation and country ownership

The strongest cross-cutting message was the transition from projects to systems. Institutionalisation means an intervention continues when a grant ends, a project team leaves or a champion changes role — requiring political commitment, prioritised plans, clear mandates, domestic financing, workforce capacity, routine monitoring and accountability. Declining external financing made country ownership an immediate operational priority: ownership does not mean governments finance everything alone, but that countries define priorities, coordinate external support around them, integrate AMR into national systems and retain responsibility for results.

9.2 Financing and accountability

Sustainable financing depends on prioritised, costed NAPs integrated into budgets and, where appropriate, legislation; on engaging ministries of finance with a clear investment case; and on using existing resources efficiently. Accountability, in turn, depends on clear responsibilities, transparent reporting and monitoring that leads to time-bound decisions rather than ending at the submission of a report.

9.3 The prevention–diagnosis–access–stewardship continuum

Prevention reduces infection and antimicrobial demand; diagnostics improve treatment decisions; access ensures that people and animals with genuine need receive effective treatment; and stewardship protects those medicines from inappropriate use. The conference framed the response as one connected pathway rather than as separate programmes.

9.4 Operational One Health and equity

Participation across sectors is not operational One Health. The next stage requires joint priorities, integrated surveillance, assigned responsibilities, shared financing and indicators through which sectors can be held collectively accountable — with the environment in particular moving from recognition to funded implementation, and equity treated as a determinant of whether interventions reach the people who need them.

9.5 Data, innovation and African-led scale-up

Across multiple discussions, a recurring problem emerged: evidence is often collected without being systematically used. The value of data lies in what changes because of it. Technology can shorten the distance between information and action but cannot compensate for weak governance, poor laboratory quality, workforce shortages or unsustainable financing — and because numerous African institutions are already solving practical problems, regional collaboration should focus on identifying transferable African models, evaluating them and supporting adaptation.

10. Conference Outputs, Synthesised Priorities and Follow-Up Actions

RAAC 2026 did not seek to produce another broad statement of intent. Its contribution was to clarify how global and continental commitments can be translated into implementation and to identify practical priorities for institutionalisation. The items below represent immediate conference outputs, synthesised priorities and recorded follow-up actions — not downstream outcomes such as subsequent policy changes or budget allocations, which cannot yet be assessed.

10.1 The six-point RAAC 2026 implementation agenda

The conference evidence is synthesised in this report into six connected priorities for moving AMR from commitments and pilots into sustained implementation:

- Prioritise — focus NAPs on feasible, high-impact interventions.
- Institutionalise — embed AMR responsibilities within routine institutional mandates, plans and systems.
- Finance — connect priorities to budgets, costed investment cases and sustainable financing.
- Implement — strengthen prevention, diagnostics, surveillance, stewardship and equitable access as one package, with One Health across sectors.
- Include — give communities, frontline workers, farmers, youth and vulnerable populations meaningful roles.
- Measure and scale — use evidence to improve delivery and expand African-led models that demonstrate value.

10.2 Recorded follow-up actions

RAAC 2026 recorded a number of specific follow-up actions with identified stakeholders and, where available, indicative timelines. These are presented separately from the broader recommendations in Section 11 and reflect concrete next steps emerging from individual sessions and the final high-level panel.

Recorded follow-up action	Stakeholders identified	Timing / status
Draft and disseminate a conference message for the Abuja conference	ReAct Africa and conference organisers	Before the Abuja Conference, December 2026
Engage with FAO's RENOFARM network	Countries and institutions working on AMR in food and agriculture	Ongoing / immediate
Support replenishment of the multi-partner trust fund towards its declared US$100 million target	Member States and partners	Ongoing
Integrate WHO's 13 Core AMR Interventions and selected 21 PHC entry points into NAPs	Ministries of Health and WHO Country Offices	2026–2027
Strengthen legislative and parliamentary pathways for NAPs and domestic financing	National governments and parliamentarians	Country-led follow-up
Disseminate and adapt Faith Leader AMR Guides for communities	ReAct Africa, Africa CDC and Faith Leaders Network	Ongoing
Scale MSF Academy AMS/IPC training to additional facilities	MSF Academy	September 2026; 76 facilities*
Establish Youth Hubs of Excellence and One Health Clubs	Youth AMR Champions and universities	Ongoing
Expand use of InFARM for AMR/AMU reporting	FAO and national Ministries of Agriculture & Health	Ongoing; target 80% of countries by 2028*
Strengthen laboratory quality systems and integrate environmental surveillance	WHO AFRO, national reference laboratories and environmental agencies	Mid-term review 2027

*Session-recorded milestone/target; not a RAAC 2026-wide target.

11.Recommendations and Action Framework

Drawing on recommendations generated across plenary, technical and country sessions, this report synthesises the conference evidence into the action framework below. The recommendations do not imply formal commitments by every participating organisation or country. They are organised within the conference's six-point framework — Prioritise, Institutionalise, Finance, Implement, Include, and Measure & Scale — with One Health treated as cross-cutting within Institutionalise and Implement rather than as a separate priority.

11.1 Prioritise: translate NAPs into feasible implementation priorities

Countries should move from comprehensive NAPs containing many ambitions towards a smaller number of clearly prioritised, high-impact and feasible interventions that can realistically be financed, implemented and monitored — informed by local AMR and antimicrobial-use data, disease burden, health-system capacity, equity and economic evidence, and reflecting the needs of all One Health sectors. Priority actions: review NAPs and identify a manageable set of interventions capable of measurable impact; connect priorities to national planning and budget cycles; define indicators and baselines for each priority; and ensure priorities address both access to effective antimicrobials and protection of their effectiveness.

11.2 Institutionalise: move AMR from projects into routine systems

Institutionalisation requires AMR responsibilities to survive the end of a project, grant or individual champion — formally incorporated into the mandates, workplans, staffing and accountability systems of existing institutions. Recommended actions: define AMR responsibilities across relevant ministries and agencies; establish or strengthen functioning national and subnational One Health coordination with resourced secretariats; integrate AMR into annual institutional plans and performance frameworks; strengthen parliamentary and high-level engagement; establish shared cross-sector indicators; ensure reviews trigger time-bound corrective action; and decentralise implementation so district, facility and community actors have defined responsibilities and resources.

11.3 Finance: connect priorities with sustainable resources

Countries should progressively reduce dependence on fragmented project financing and integrate prioritised interventions within national development plans, sector budgets and existing health-financing mechanisms. Recommended actions: develop credible, prioritised, costed investment cases; engage ministries of finance, planning and treasury alongside technical ministries; demonstrate the health, economic and development return of investing in AMR; integrate AMR into existing PHC, UHC, health-security and surveillance investments; explore responsible blended and public–private approaches; improve efficiency through strategic and, where appropriate, regional pooled procurement; and explicitly finance recurrent costs — workforce, reagents, maintenance, surveillance, specimen transport and data systems.

11.5 Include: make people and communities implementation partners

People-centred implementation should become a routine component of NAP design, implementation and monitoring: involve communities and people affected by drug-resistant infections in design and accountability; incorporate youth meaningfully into governance; use trusted faith and community networks for stewardship, vaccination, hygiene and responsible-use communication; extend interventions into primary and community health care; address gender, geographic and socioeconomic inequities; disaggregate data by sex, age and geography where feasible; and address both inappropriate use and inadequate access. Participation should be measured by influence over decisions, not attendance at awareness activities.

11.6 Measure and Scale: move African solutions from pilots to systems

The next step is not to replicate every intervention unchanged, but to determine what works, why, in which contexts, at what cost and under what institutional conditions. Governments, implementers, researchers and partners should build evaluation into implementation from the outset; define baselines and outcome indicators before scale-up; generate evidence on effectiveness, feasibility, equity and cost; engage policymakers early; adapt rather than mechanically reproduce; establish peer-learning mechanisms between African institutions; and shift financing from repeated small pilots towards progressive institutionalisation of models that demonstrate value.

11.7 Action Framework

The framework below consolidates the recommendations into an implementation guide, nested within the six priorities. It should not be read as assigning new formal commitments to organisations that did not explicitly make them during RAAC 2026.

Priority / lever	Recommended action	Accountability signal
Prioritise	Translate NAPs into a limited set of feasible, high-impact interventions based on local evidence	Prioritised implementation plan with measurable indicators
Institutionalise	Embed AMR responsibilities in mandates, annual plans, staffing and routine systems	Named institutional responsibility and routine reporting
Finance	Cost priorities and integrate them into domestic budgets and existing financing	Budget line, financing source or approved investment case
	Prevent: Scale IPC, WASH, vaccination and biosecurity.	Coverage and quality indicators in routine monitoring
	Diagnose & surveil: Strengthen functional bacteriology, referral systems, quality systems and data-to-action.	Increased diagnostic access and routine use of AMR data.
	Steward & ensure access: Integrate stewardship into clinical workflows while improving equitable access.	Guideline adherence, access and appropriate-use measures.
	Operationalise One Health: Establish shared priorities and surveillance across human health, animal health, agriculture, food systems and the environment.	Joint plans, indicators, datasets and review mechanisms.
Include	Give communities, youth, faith actors, farmers and frontline workers meaningful roles	Representation linked to design, implementation or accountability
Measure & scale	Evaluate African-led models and progressively institutionalise those that demonstrate value	Evidence of adaptation, financing and transition to routine systems

12. Way Forward and Follow-Up

RAAC 2026 should be viewed as part of a continuing implementation process rather than an endpoint. The conference closed with the challenge of ensuring that, by the time stakeholders reconvene, measurable interventions have moved from commitment and pilot to routine practice.

12.1 Communicate the RAAC 2026 message

Consolidate the evidence, recommendations, African solutions and recorded follow-up actions into a clear regional message. A specific action recorded during the final panel was to draft and disseminate a conference message to inform the Abuja Conference in December 2026; this report should provide its evidence base, focusing on moving from NAPs to prioritised implementation, domestic financing, institutional accountability, the prevention-to-access continuum, operational One Health, people-centred action and scaling African solutions.

12.2 Translate learning into country action

Country delegations and national AMR structures should examine where existing NAPs remain dependent on external projects or lack clear delivery mechanisms, concentrating on four questions: what are the highest-priority interventions; where should responsibility sit (embedded within an institution with an existing mandate); how will it be financed (identifying domestic and complementary routes and recurrent costs); and how will progress be demonstrated (baselines and routine monitoring from the outset).

12.3 Sustain political and regional engagement

Political engagement should continue beyond the conference, particularly around NAP financing and accountability, including routing NAPs through appropriate legislative processes and engaging finance, treasury, agriculture, environment and planning as well as health. The diversity of country experiences also creates an opportunity for structured South–South learning — on stewardship, extension approaches, procurement, laboratory networks, environmental surveillance, digital surveillance and financing — including through FAO's RENOFARM network and continental One Health platforms. Wherever possible, AMR should be integrated into existing systems (PHC and UHC, national laboratory networks, IDSR, digital health, agricultural extension, health-financing mechanisms and WASH/IPC programmes) rather than new parallel structures.

12.4 Track movement from pilots to routine implementation

To help track whether RAAC 2026 contributes to implementation rather than only generating proceedings, ReAct Africa could consider a lightweight follow-up mechanism organised around the six conference priorities — for learning and accountability rather than ranking countries. This is offered as a proposal, not a commitment recorded at the conference.

RAAC 2026 priority	Core follow-up question
Prioritise	Have countries identified a feasible set of priority interventions?
Institutionalise	Have responsibilities been embedded within routine institutional mandates and plans?
Finance	Are priority interventions linked to domestic or sustainable financing?
Implement	Are prevention, diagnostics, surveillance, stewardship and access being delivered?
Include	Are communities, frontline workers and vulnerable groups meaningfully participating?
Measure & scale	Is implementation generating evidence, and are effective models being adapted or scaled?

> "The conference confirmed that the challenge is no longer only knowing what to do, the next phase of Africa's AMR response must focus on delivery, institutionalisation and accountability"
>
> Closing synthesis, RAAC 2026

13. Conclusion

RAAC 2026 demonstrated that Africa's AMR response has entered a different stage. The central challenge is no longer establishing the importance of AMR or developing national plans. Across the region, countries increasingly possess policies, technical guidance, institutions, trained professionals and locally developed interventions. The more difficult task is ensuring that these assets translate into consistent, financed and accountable implementation.

One principle stood out: institutionalisation is what converts an intervention from a temporary activity into a sustained public-health function. It requires political ownership, prioritised plans, clear institutional mandates, domestic financing, capable workforces and routine monitoring linked to decision-making. No single intervention will suffice — prevention, diagnostics and surveillance, stewardship and equitable access, and operational One Health must advance together, with communities, young people, faith actors, farmers, frontline professionals and people affected by drug-resistant infections given meaningful roles. Innovation will remain essential, but as an enabler rather than a substitute for functioning institutions, reliable data, trained people and sustainable financing.

RAAC 2026 therefore closed with a clear challenge for governments, institutions and partners: the next phase of Africa's AMR response must be measured not by how many new commitments are made, but by how many effective interventions become financed, institutionalised and sustained. The measure of progress will be whether successful approaches move from grassroots solutions to national systems, from national systems to regional learning, and from commitments and pilots to implementation at scale with measurable and lasting impact.



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