



## Summary of AMR Proposal Development Workshop

9<sup>th</sup> April 2026, The Fairway Hotel, Kampala



## Participants

<b>Name</b>	<b>Institution</b>
Mr Stephen Kasaija	Ministry of Gender, Labor and Social Development
Dr Alex Ndyabakira	KCCA-DHO Kampala Central
Dr Dennis Buluma	KCCA- Supervisor of Medical Services Rubaga Division
Dr Christine Najjuka	Makerere University
Dr Etheldreda Nakimuli-Mpungu	MRC-LSHTM
Dr Femke Bannink Mbazzi	MRC-LSHTM
Ms Amy Potter	British High Commission
Dr Darius Owachi	Kiruddu Hospital
Dr Caroline Nakate	St Francis Hospital Nsambya
Dr Kapisi James	IDRC
Ms Maxenica Nabiryo	CWPAMS
Dr Shevin Jacob	IDI/LSTM
Prof Richard Walwema	IDI
Dr Nanyunja Grace	Makerere University, Mak TB project
Ms Monica Nakibuuka	Caregiver
Mr Batwawula Mawazi	Patient
Mr David Tumwesigye	Save the Children
Dr Rogers Kisame	Baylor Uganda
Dr Charlene Rodrigues- Online	LSHTM
Dr Heidi Hopkins- Online	The Fleming Fund
Ms Christine Nabirye	LSHTM / IDRC
Ms Audrey Namajja	Independent
Dr Susan Nayiga	LSHTM / IDRC
Prof Clare Chandler	LSHTM

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## Purpose

The workshop brought together 25 researchers, clinicians, policymakers, social protection experts, disability advocates and a patient and carers with lived experience of AMR to discuss the impacts of AMR and develop interventions to reduce these impacts. The workshop served as an early co-development platform for a potential collaborative research proposal aligned with an [NIHR call on AMR](#). The workshop was hosted by IDRC and LSHTM and led by Dr Susan Nayiga and Prof Clare Chandler.

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## Programme

Time	Topic	Presenter/Person chairing
09:00 am	Arrival	
09:30am	Welcome formalities	Professor Moses Kanya (IDRC) (10 min)
09:40am	Introductions <ul style="list-style-type: none"><li>• Prompt: top single intervention to reduce AMR burden in Uganda</li></ul>	All (20 min)
10:00am	Meeting overview and objectives <ul style="list-style-type: none"><li>• Bring together representatives from relevant ministries, district/municipal authorities, and partner organisations</li><li>• Present data on the nature of the AMR burden in Uganda, and the drivers of this burden.</li><li>• Discuss feasible interventions and implementation pathways that are likely to reduce the burden of AMR through combined health and social protection approaches.</li><li>• Identify which interventions can most realistically be sustained by government and district/municipal bodies beyond the lifetime of the project.</li><li>• Co-develop an evaluation plan that can demonstrate impact on AMR outcomes, co-benefits and unintended consequences.</li></ul>	Professor Clare Chandler (LSHTM) (10 min)
10:10am	Presentation 1. Status of AMR knowledge in Uganda: priority infections/ pathogens / antimicrobials for intervention	Professor Richard Walwema (IDI) (10 min)
10:20am	Presentation 2. Nature of the AMR burden in Uganda: clinical, economic and social impacts	Dr Susan Nayiga (IDRC / LSHTM) (20 min)
10:40am	Fireside chat. Patient and carer experiences with drug resistant infections	Ms Monica Nakibuuka (Caregiver) Mr Batwawula Mawazi (patient)

11.00am	Break	20 min
11:20am	<p>Presentation 3. Rapid talks: interventions that could impact AMR outcomes</p> <ul style="list-style-type: none"> <li>• Improving antibiotic supplies at the point of DRI diagnosis</li> <li>• Improving patient ability to pay for supplies and support</li> <li>• Establishing care pathways for patients with DRI</li> <li>• Improving information on post-infection care on discharge</li> <li>• Linking patients to social protection services</li> <li>• Home visits post-discharge</li> <li>• Care navigators</li> <li>• Peer to peer support</li> <li>• Community action groups</li> </ul>	<p>Multiple introducers (30 min) including:</p> <p>Dr Femke Bannink Mbazzi (MRC Uganda)</p> <p>Mr David Lambert Tumwesigye (Save the Children)</p> <p>Ms Maxencia Nabiryo (Commonwealth Pharmacists Association)</p> <p>Ms Grace Nanyunja (Makerere TB project)</p>
11:50am	<p>Discussion: Comments and feedback on presentations</p> <ul style="list-style-type: none"> <li>• Prompt: what interventions can feasibly be expected to impact AMR burden in Uganda? <ul style="list-style-type: none"> <li>○ Create long list of potential interventions needing to be tested</li> </ul> </li> </ul>	All (20 minutes)
12:10pm	<p>Breakout session:</p> <ul style="list-style-type: none"> <li>• Assessment of potential interventions for criteria: <ul style="list-style-type: none"> <li>○ Potential size of impact</li> <li>○ Feasibility</li> <li>○ Ability to evaluate in a study</li> <li>○ Sustainability</li> <li>○ Potential for co-benefits</li> <li>○ Potential unintended consequences</li> </ul> </li> </ul>	All in two groups with rapporteur (30min)
12:40pm	Discussion: Feedback to all from the breakout groups	(15 min)
12:55pm	Concluding remarks and next steps	Prof. Clare Chandler (10min)
13:00pm	Lunch	
14:00 – 17:00	Writing workshop	For those interested to stay



Master Slide Deck  
Workshop

Slide deck:

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## Key observations

- Laboratory data on AMR in Uganda shows a **rise in AMR over the past decade** across multiple pathogens.
- AMR policy and research rightly emphasise **prevention, surveillance, diagnostics, and stewardship**, but it was observed that what happens **after a patient is diagnosed** with a drug-resistant infection has largely been overlooked.
- Drug-resistant infections are often treated as **short-term clinical events**, yet recent data from Uganda suggests that for many patients the impacts of their illnesses are longer term, including leading to disability, recurrent illness, loss of income, and long-term caregiving needs.
- Participants valued hearing the **experiences shared by the patient and caregivers** who joined the workshop, which informed the focus of intervention discussions.  
Specific notes from the patient and caregivers about what would make a difference:
  - Turnover time for lab results - can it take less than 5 days for a result? By then, lots of drugs have been tried, and even medicines that don't work have to be paid for. Eg 130,000/= per day.
  - Socially, unable to go anywhere with the caring responsibilities, so having someone who would be able to care for her son's complex needs would make a difference.
  - Ways to reduce the length of hospital stays, to be able to care from home.
  - Need support for the leg, eg a prosthetic leg.
  - Need support in starting a business, help for children to go to school, but getting back to work is the most important priority, to be able to get back to supporting others who had been depending on him.
- AMR and its management was discussed by participants as a **systems and structural issue**, shaped by granular challenges within health facilities as well as in community settings, amplified by poverty, gender, disability, and labour precarity.
- Participants were invited to consider some of the **social, economic, and health burdens** that AMR creates and exacerbates and to identify **interventions that could reduce this burden** and generate policy-relevant evidence.
- It was noted that While prevention and stewardship have better evidence bases, there is a clear **evidence gap** around interventions that address the **post-diagnosis burden** of AMR.
- Participants heard evidence from a variety of programmes that have been implemented in Uganda to improve maternal sepsis deaths and length of stay in hospitals, disability inclusion in schools and access to health services, cash transfers and intersectoral collaboration with Community Development Officers for TB patients and the Expanded Social Protection programme.
- Researchers were also encouraged to embed an inclusive lens into the design and implementation research, echoing the mantra, '**nothing about us without us**'

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## Potential interventions and criteria for selecting for research

Participants were asked to consider interventions to address the burden of AMR, with a focus on post-diagnosis recovery, care, and reintegration:

Potential interventions to consider for research project	Criteria to consider for potential interventions to research
<ul style="list-style-type: none"><li>• Improving antibiotic supplies at the point of DRI diagnosis</li><li>• Improving patient ability to pay for supplies and support</li><li>• Establishing care pathways for patients with DRI</li><li>• Improving information on post-infection care on discharge</li><li>• Linking patients to social protection services</li><li>• Home visits post-discharge</li><li>• Care navigators</li><li>• Peer to peer support</li><li>• Community action groups</li></ul>	<ul style="list-style-type: none"><li>• Potential size of impact</li><li>• Feasibility</li><li>• Ability to evaluate in a study</li><li>• Sustainability</li><li>• Potential for co-benefits</li><li>• Potential unintended consequences</li></ul>

Drawing on evidence and experience from health, disability, and social protection sectors, participants worked in two groups to consider the above (and additional) interventions and criteria, and **developed the following suggestions:**

- **Reviewing the continuum of care** for patients with suspected / confirmed drug-resistant infections, from the diagnosis through to discharge and through to recovery and reintegration support in the community. This could incorporate the following points of intervention:
- **Improving diagnostic pathways** – from test requests to information going to the clinician to be optimally informative for decision making
- Plug into upcoming digital system for **tracking patient records** across services to improve knowledge of patient histories – previous tests, treatment
- Improved **supplies** of needed antibiotics as well as for laboratories
- Improved protocols for patient diagnosis and treatment (like for TB and HIV) such that the **system is built, known and becomes habitual** and supported through in-service training and internal hospital projects that build accountability on AMR (including strengthened trust in labs, supplies for rapid turn-around of tests, affordability of testing for patients esp blood culture, communication of results, understanding of results for prescribing, counselling patients, reducing duration of hospital stays)

- Improved **patient information at discharge** (explain diagnosis, explain drugs (and not to be used routinely), hygiene (including around wound care), what to expect in recovery process, follow-up plan to check on recovery, signposting to support and services)
- Stronger **continuity of care** between hospitals and communities, potentially through social workers
- Linking patients to **existing social protection and disability support systems**
- **Community health insurance**, in lieu of national insurance scheme
- **Income or cost-offset support** to support recover (and also prevent harmful coping strategies e.g. working while infectious)

Potential initiatives to link to:

- Digital patient records system
- NMS have been trying to boost the Drug and Therapeutics Committees
- Social Support Services Framework
- VHTs/Community committees attached to Health Facilities

In addition to the above suggestions, participants noted that it is important to be identifying provisional solutions, rather than waiting for ideal solutions, and that once a system has changed and new ways of working established, the effort to sustain is less than the initial effort to change. Choice of intervention should consider co-benefits/ amplifier effects.

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