
MEETING REPORT

WHO Civil Society Task Force on Antimicrobial Resistance

Steering Committee Meeting

Brussels, Belgium | **30–31 March 2026**

WHO Representation Office to the European Union

Background and Context

About the WHO Civil Society Task Force on Antimicrobial Resistance

AMR is among the top global health threats of our time. However, civil society has historically been under-resourced and inconsistently engaged in the global AMR response. The 2015 Global Action Plan on AMR (GAP-AMR) acknowledged the role of civil society in raising awareness, improving hygiene practices, and enhancing access to and stewardship of antimicrobials. The 2024 United Nations General Assembly Political Declaration on AMR further called for the meaningful involvement of civil society in global, national, and local AMR governance, to ensure optimal access to health products for managing infections and to support a globally coordinated AMR response.

Against this backdrop, WHO announced the establishment of the Civil Society Task Force on Antimicrobial Resistance (CSTAMR) in October 2025, the first such mechanism of its kind within WHO. Following an open, competitive call for expressions of interest that attracted over 200 applications, 81 civil society organizations from across all WHO regions were selected to form the Task Force.

The CSTAMR is a WHO informal network, administered and housed within WHO in accordance with the Framework of Engagement with Non-State Actors (FENSA), and WHO's General Programme of Work (GPW14). Its overarching goal is to support and strengthen WHO's engagement with nongovernmental organizations and civil society groups globally, and to foster collaborations, build capacity, and amplify the voices of communities affected by AMR. The CSTAMR operates through three governance bodies:

- The WHO Secretariat: Hosted by WHO's AMR Department, the Secretariat oversees day-to-day management, coordination, membership, and budget.
- The Steering Committee: Comprising 12 members appointed by WHO from among the 81 Task Force participants, the Steering Committee provides strategic direction, oversees working group activities, and supports the Secretariat in organizing the annual plenary meeting.

- Working Groups: Thematic working groups, established by joint decision of the Secretariat and Steering Committee, bring together interested Task Force members to work collectively on specific activities aligned with the Task Force's mission.

The Steering Committee is co-chaired by Katherine Urbacz and Tracie Muraya. The WHO Secretariat function is performed by Philip Mathew, with oversight from Benedikt Huttner (Unit Head, AMR) and the AMR Department under the direction of Yvan Hutin, Director for AMR at WHO Headquarters.

First in-person meeting of the steering committee in Brussels

The first in-person Steering Committee meeting was held in Brussels, Belgium on 30–31 March 2026, hosted at the WHO Representation Office to the European Union. The meeting brought together 9 Steering Committee members in person, with 3 additional members participating online.

The meeting followed the inaugural virtual plenary held in November 2025 and aimed to transition the Task Force from reflection and orientation to concrete planning and action. The two-day agenda was structured to address working group progress, strategic direction, financing, stakeholder engagement, and key performance indicators (KPIs).

The meeting was opened by Yvan Hutin, Director of the AMR Department at WHO Headquarters, who provided strategic framing and context. Dr. Hutin noted that the meeting was taking place at a consequential moment for both WHO and the global AMR agenda, with a shifting geopolitical environment, tightening funding landscape, and persistent AMR challenges. He emphasized the importance of civil society as a key building block of health system resilience, able to hold governments accountable, reach communities directly, and sustain public attention in ways that intergovernmental bodies cannot.

Dr. Hutin articulated three priorities for the Task Force: (1) serving as a coordinating force that harmonizes civil society messaging for global AMR processes including the World Health Assembly and the upcoming ministerial meeting in Nigeria; (2) activating civil society's watchdog function to track progress against the quantified targets of the 2024 UN Political Declaration on AMR; and (3) supporting resource mobilization, including ring-fenced funding for civil society-led AMR engagement and

advocating for a well-resourced global health architecture.

The strategic framing was complemented by agenda-setting remarks from the Co-Chairs, Katherine Urbaez and Tracie Muraya, who outlined the working principles for the two days: purpose-driven participation, constructive and evidence-based dialogue, and a commitment to documentation and concrete outputs.

Day 1 – Progress and Priority Setting

2.1 Session 1: Task Force Progress and Priorities

Facilitated by Tracie Muraya, this session reviewed the key takeaways from the November 2025 inaugural plenary and assessed progress made since. Several cross-cutting priorities had been identified at that plenary:

- Complementarity, not competition, among civil society mechanisms, to ensure distinct yet complementary roles.
- Articulating a clear value proposition for civil society in the AMR landscape, underpinned by a Theory of Change.
- Moving from fragmentation to coordinated advocacy through mapping, investment in coordination platforms, and South–South exchanges.
- Reframing AMR as a development and justice issue, going beyond a biomedical or 'silent killer' narrative.
- Securing meaningful, resourced civil society engagement, which can enable transitioning from tokenistic consultation to core design and implementation roles.
- Centering youth, community, and fraternal groups as active shapers rather than passive recipients of the AMR agenda.
- Evidence, transparency, and accountability through civil society-led AMR scorecards and data transparency initiatives.

The plenary had also identified regional priorities, with access gaps and inadequate surveillance flagged in Africa; heavy antimicrobial use in food production in the Americas; over-the-counter sales and conflict-affected settings in the Eastern Mediterranean; complex messaging and fragmented CSO landscape in Europe; access paradox and AMR literacy gaps in South-East Asia;

and variable AMR burden and weak youth engagement in the Western Pacific.

Flowing from these priorities, three working groups had been established:

- Working Group 1: Global Civil Society Campaign on Access to Penicillins
- Working Group 2: Community-Led Monitoring and Accountability for AMR
- Working Group 3: Coordinated Civil Society Engagement and Resourcing

The session originally planned to include a SWOT analysis. Following discussion, participants agreed that this would be more appropriate during the working group discussions, and proposed to complement it by a more forward-looking SOAR framework (Strengths, Opportunities, Aspirations, Results).

2.2 Session 2: Progress of Working Groups and Strategic Direction

Facilitated by Katherine Urbaez, this session provided an overview of the three working groups, followed by breakout group discussions on strategic direction.

Working Group 1: Global Civil Society Campaign on Access to Penicillins

Presented during the plenary by Anthony So, Working Group lead. The campaign focuses on persistent global shortages of life-saving penicillins, with the 2028 centenary of Alexander Fleming's discovery of penicillin providing a compelling campaign anchor. Key dimensions discussed included:

- Supply security: There is currently only one WHO-prequalified manufacturer of benzathine penicillin G (BPG), with a limited number of API producers (predominantly in Asia). Supply disruptions have significantly affected treatment of syphilis and secondary prophylaxis for rheumatic heart disease (30+ million people globally). A factory fire in China affecting a key penicillin API producer was cited as an example of supply chain fragility.
- Formulation and access: The aqueous formulation (though safer for administration) is significantly more expensive than the lyophilized preparation, with reconstitution challenges still prevalent in low-resource settings. The 10-year, monthly intramuscular administration regimen for RHD secondary

prophylaxis presents logistical and patient burden challenges.

- Potential campaign angles identified: (a) access and affordability: addressing barriers including over-diagnosis of penicillin allergy; (b) manufacturing resilience: considering regional diversification of API and finished product manufacturing; (c) formulation innovation: exploring depot formulations to reduce injection frequency and remove cold-chain dependency.
- Debates on scope: The group discussed whether to focus exclusively on BPG or broaden to all penicillins or beta-lactams. The group also discussed the potential inclusion of early cephalosporins, particularly cefazolin, which are recommended by WHO for surgical antibiotic prophylaxis but are frequently unavailable in many settings. Participants noted that these shortages appear to stem from challenges similar to those affecting penicillins, including limited numbers of manufacturers and insufficient regional production capacity. In the absence of these first-line agents, third-generation cephalosporins are often used instead, increasing selection pressure for AMR. Given the magnitude of peri-surgical antibiotic use globally, the group agreed that it would be worthwhile to undertake further analysis to determine whether first-generation cephalosporins face comparable manufacturing and supply-chain vulnerabilities, before deciding whether to formally extend the scope of the campaign. The WHO secretariat cautioned against broadening, noting that long-acting penicillins have the clearest unmet need and no good alternatives, while including amoxicillin and cefazolin may dilute the campaign focus.
- Decisions pending: Finalization of BPG vs. all penicillin scope; priority geographies for phase one engagement; the nature of coalition building; and definition of year-one versus 2028 milestones.

Working Group 2: Community-Led Monitoring and Accountability for AMR

Presented during the plenary by Geminn Apostol, Working Group lead. The CLM working group had held its initial virtual convening on 26 March 2026, bringing together 15–19 civil society organizations from Africa, Asia, South America, and beyond, spanning community health, consumer protection, media, clinical medicine, veterinary science, and One Health advocacy.

Key outcomes from the initial convening and breakout discussions:

- Shared definition of CLM: A systematic, recurring, action-oriented process in which trained community members gather data to drive service, policy, or system improvements. A critical principle established: communities are the monitors, not the monitored, and they own data, define indicators, and drive advocacy.
- Insights from a survey conducted within the working group members: Familiarity with CLM ranged widely; CLM was seen as a paradigm shift from a medicalized to community-led AMR response; HIV and TB CLM precedents were consistently cited; and participants agreed not to reinvent the wheel. One particularly notable finding was the call for practical, offline-friendly tools: 'fancy apps won't work; a good toolkit is one that a community health worker in a rural area can pick up and use without a training course.'
- Design principles: The toolkit must serve a triple function- awareness building, monitoring, and advocacy translation. AMR literacy must be built before any data collection is expected. Community-level AMR surveillance is largely absent from national systems and this gap must be addressed. The toolkit must be an end-to-end accountability system; if it stops at data collection, it will not be used.
- Audience: Community health workers are the strategic primary implementers. People with lived AMR experience (patients, survivors, caregivers) must be centred in the design process, with explicit mention of possible collaboration with the WHO Task Force of AMR Survivors.
- Implementation risks: The toolkit would fail if it assumed internet access, uses technical language, is released only as a PDF, ignores competing health priorities, or is overly prescriptive. Testing with communities is essential before finalizing any materials.
- One Health framing: Non-negotiable; to include human, animal, and environmental health data. Concerns were raised about the term 'pharmacists' being exclusionary in contexts where pharmacy outlets are staffed by non-pharmacist personnel; the group agreed to use 'professional health workers' instead.
- Proposed development arc: Nine months (April–December 2026), across five phases: synthesis and scoping; indicator development; drafting; pilot testing (subject to resources); and revision and launch.

- Resource gaps: The group was candid about needing technical coordinators, financial resources for community testing, translation support, and accessibility review, and reliance on volunteers alone is insufficient.

Working Group 3: Coordinated Civil Society Engagement and Resourcing

Presented during the plenary by Milka Sokolovic, Working Group lead. The working group met on 20 March 2026 with 14 organizations present from diverse regions and sectors. Three main priorities emerged during the initial convening and breakout group discussions:

- Mapping and knowledge sharing: A shared mapping of who is doing what across civil society actors working on AMR, including documenting existing policy initiatives and opportunities for collaboration, was identified as a critical first step. This would address fragmentation and duplication and serve as the foundation for all subsequent coordination activities.
- Resourcing and donor engagement: Across all regions, funding access is becoming increasingly difficult, particularly for organizations in low- and middle-income countries. The group agreed that one of the Task Force's primary value-adds should be to help identify funding opportunities and improve coordination around donor engagement.
- Value proposition: A concise paper or statement was proposed, articulating what civil society contributes to the AMR response, why it matters, and what support is needed. This was described as the platform on which all other work would be painted.
- Participation in major upcoming events: The working group explored a side event or touchpoint at the World Health Assembly in Geneva and a push for more participation from members during the upcoming 5th Ministerial Meeting in Abuja.

Broader discussion following all three presentations focused on the financing landscape. Participants noted that civil society organizations across income levels are facing unprecedented funding pressures, and several organizations have lost senior staff, seen operating grants withdrawn by major donors, and witnessed the retreat of philanthropies from AMR. The pharmaceutical industry as a funding source was debated, with many Task Force members unable to accept industry funding due to organizational conflict-of-

interest policies. The need for a clear funding policy for the Task Force was identified as urgent.

Another cross-cutting theme from all three breakout groups was the tension between ambitious scope and limited voluntary capacity. The importance of being realistic, focusing on highest-leverage actions within a nine-month horizon, was emphasized by multiple participants, who cautioned against over-promising given resource constraints.

Day 2 – Implementation and Impact

Session 4: Financing and Resource Mobilisation

This session was shifted to Day 2 and was facilitated by Andrew Bowskill and Victoria Rutter. The objective was to understand the possibilities in the current challenging landscape and to identify possible funders to prioritize.

Key points of discussion:

- Preferred financial architecture: The preferred model of resource mobilization for civil society-led AMR response is for any funds raised by the task force to flow directly to constituent organizations, not through WHO. At the same time, the task force should be advocating for a well-resourced WHO that can support the initiatives of the task force.
- Funding models for task force's work: Two scenarios were outlined: (a) top-level coordination funding for the Task Force as a whole, and (b) activity-specific funding for Working Groups 1 and 2. Both require a robust value proposition document and, in the case of working groups, concept notes with budgets. The importance of not 'selling' funders on unrealistically large asks was noted.
- Philanthropic sector: Wellcome Trust and the Fleming Initiative were discussed as potential partners. Concerns were raised about conflict-of-interest restrictions for some Task Force members in accepting funding linked to pharmaceutical or diagnostic industry foundations. The group noted a critical mismatch between stated philanthropic commitments to health equity and actual funding flows to civil society.
- Expanding the funder landscape: Some members proposed looking beyond traditional

health funders towards socially responsible investment firms, pension funds, and foundations from emerging economies (e.g., Tata Trusts). It was noted that the WHO–UNDP–UNEP wastewater treatment guidelines process had demonstrated the importance of engaging the environmental sector. Linking AMR to WASH, vaccination, and other adjacent sectors' funding streams was also proposed, with AI tools suggested as useful for rapid landscape scanning.

- Coordination with WHO investment rounds: Milka Sokolovic raised the idea of involving civil society in WHO's investment round preparations, where organisations could advocate at the Member State level for stable WHO funding, a form of mutual reinforcement between WHO and civil society. This has been already proposed through the WHO Civil Society Commission steering committee.
- Brokering function: Geminn Louis Apostol raised the equity dimension of funding access, noting that most Task Force members are relatively privileged CSOs who can navigate WHO processes and global health financing, while frontline civil society groups (e.g., women's aquaculture cooperatives in the Philippines working on climate-AMR intersections) cannot. He proposed exploring a brokering function within the Task Force, where members with funding access can support and co-apply with resource-limited frontline organizations.

Session 5: Stakeholder Engagement Strategy

The session was facilitated by Hamisi Msagama and Marina Paullelli and was aimed at identifying key stakeholder groups and developing an engagement strategy.

Three agreed action points emerged from the discussion:

- Gather and organize existing information on Task Force members, drawing on the applications database and the downloadable organizational profiles already available on the Task Force website. Using AI tools to extract key insights from application data was proposed to avoid duplication of effort.
- Develop a targeted, time-efficient shortlist of external stakeholders, organized according to the three action pillars (Action, Accountability, Advocacy). The list should distinguish between global-level stakeholders relevant to all

members, and regional/national stakeholders that individual Task Force members are best placed to identify.

- Establish a programme of quarterly webinars or virtual seminars (rather than a newsletter, which was deemed resource-intensive and likely to have low engagement rates) to keep the broader Task Force membership engaged, featuring external speakers on priority themes (e.g., socially responsible investment and AMR, WASH funders, community health models). LinkedIn was identified as the preferred communications channel, with the possibility of a LinkedIn Group for the 81 Task Force member organizations.

Additional discussions during the session:

- The risk of framing AMR narrowly within the biomedical or 'health security' frame was raised. While useful for donor engagement, it risks diluting the One Health and development dimensions. The Task Force's diversity was identified as a strength, enabling entry into multiple funding and policy streams.
- Some members highlighted the importance of integrating communication scientists, behavioural scientists, and social scientists into the AMR policy process, citing the [European Code Against Cancer \(ECAC 5\)](#) as a model where a dedicated communications and dissemination working group was embedded within the scientific process.
- The need for shared communications guidelines, covering how Task Force members represent the WHO connection, mention their own organizations, and use the Task Force brand, was flagged as an urgent need.
- Substack and Linktree were proposed as alternatives to the WHO website for sharing content, given the approval process constraints for WHO web publishing.

Session 6: Key Performance Indicators (KPIs)

The session was facilitated by Sangeeta Sharma, with a brief introductory presentation by Philip Mathew. The session aimed to define KPIs for the Task Force and civil society's broader role in the global AMR response.

Philip Mathew framed the purpose of KPIs in this context: to demonstrate accountability, translate civil society action into benefits visible to Member States and donors, maintain evidence-based management, and align with WHO's internal

reporting requirements (GPW 14). He noted that the working groups had already begun developing internal timelines and deliverables that could serve as a starting point.

The discussion identified three levels of KPIs:

- Working Group KPIs: Specific, measurable indicators tied to each working group's deliverables, timelines, and RACI matrices. Working groups should develop their own KPIs through their respective consultation processes.
- Task Force KPIs: Broader indicators for the Task Force as a whole, covering dimensions such as: policy influence (e.g., Task Force recommendations cited in official documents or reports); engagement (e.g., number of organizations actively engaged, working group participation rates); civil society positioning (e.g., number of NAPs listing civil society as co-implementers; dedicated civil society budget lines within national AMR budgets); and legitimacy (e.g., civil society represented in AMR working groups at country level).
- Broader Civil Society / AMR System KPIs: High-level aspirational indicators for the sector,

linked to the 2024 UN Political Declaration targets on AMR.

Key principles agreed for the KPI framework:

- Keep it simple and limited in number-quality over quantity. The group cautioned against replicating donor-driven 'body count' metrics that count attendance rather than change.
- Include both quantitative and qualitative indicators. The latter are harder to measure but often more meaningful for advocacy impact.
- Build in a results chain logic: work backwards from desired outcomes and impacts to identify appropriate process and output indicators.
- Adopt a six-monthly review cycle at the working group level, with annual reporting at the Task Force level. Quarterly check-ins within working groups were also recommended.
- Maintain a shared online dashboard (simple shared spreadsheet) for real-time tracking, populated by thematic leads.

It was agreed to prepare a first draft of high-level KPIs by the third week of April 2026, to be circulated to all working groups and the broader steering committee for input and finalization.

Key Takeaways from the Steering Committee Meeting

Value proposition	Across all sessions, the absence of a concise, compelling articulation of what civil society uniquely contributes to the AMR response was identified as the single most urgent gap. This value proposition document will underpin donor outreach, statements at political forums, and the Task Force's legitimacy as a coordinating body.
Financing landscape	The funding crisis facing civil society organizations working on AMR is acute. Several Steering Committee members have lost senior staff, seen operating grants withdrawn, and are functioning largely on volunteer capacity. Traditional philanthropic sources are either retreating from the space or attached to conflict-of-interest constraints that many Task Force members cannot navigate. The meeting agreed that new, unconventional funders, including socially responsible investors, pension funds, foundations from emerging economies, and sector-adjacent funders, must be systematically explored.
Penicillin campaign	The global campaign on penicillins is valuable not merely as an access initiative but as a vehicle for demonstrating the broader AMR supply chain crisis and the consequences of under-investment in essential antibiotic manufacturing. The 2028 Fleming centenary provides a rare, time-bound hook that can anchor media, policy, and fundraising narratives. The group must still resolve questions of scope and priority geographies, but the strategic rationale for the campaign (penicillin as a low-AMR-risk, high-visibility drug reaching every tier of health systems) is well-founded.

Community-led monitoring	Grounding AMR accountability in communities, rather than governments or technical bodies only, was broadly seen as one of the Task Force's most distinctive and high-impact contributions. The principle that communities are the monitors, not the monitored, and the insistence on a toolkit that is practical, offline-functional, and culturally adaptable rather than a top-down technical instrument, represents a meaningful break from prevailing AMR governance models. The HIV and TB CLM precedents provide proof of concept and an infrastructure not to be reinvented but built upon.
Political moments	The World Health Assembly, the Abuja Ministerial Meeting on AMR in Nigeria, and the Independent Panel for Evidence and Action on AMR (IPEA) represent near-term windows for civil society to engage, be visible, and shape outcomes. These moments require preparation now: a constituency statement for the WHA, a formal presence in Abuja, and clear, differentiated messaging for each audience (Member States, donors, WHO itself). The Task Force must be proactive rather than reactive in these spaces.
Realism and ambition	A recurring theme across both days was the tension between the scale of ambition the Task Force members bring to this work and the very real constraints of operating on a largely voluntary basis, with no dedicated civil society AMR funding in sight. Multiple participants called for deliberate prioritization with fewer commitments, followed through with rigour. The Task Force's credibility will be built not by the breadth of its agenda but by the depth and reliability of what it delivers.

Conclusion

The first in-person Steering Committee meeting was a significant milestone for the WHO Civil Society Task Force on AMR. The two days confirmed that the Task Force's three working groups are not only conceptually sound but already building the foundations for tangible deliverables within the 2026 horizon.

The meeting also laid bare the structural challenges the Task Force must navigate: a contracting funding landscape, the absence of ring-fenced civil society AMR resources, a shrinking civic space in many regions, and the ever-present risk of over-commitment by well-meaning organizations operating on voluntary capacity. These are not new challenges, but they are pressing ones, and the Task Force is now better positioned to address them collectively than individually.

Three strategic priorities emerge from the meeting, in addition to the three already established work

streams. First, the Task Force must produce a compelling, evidence-based value proposition that articulates the unique contribution of organized civil society to the AMR response, not as a courtesy statement but as a functional tool for donor engagement, political advocacy, and internal alignment. Second, it must establish a disciplined yet flexible KPI framework that holds the working groups accountable without bureaucratizing their work or replicating the output-counting metrics that have long frustrated civil society actors in global health. Third, it must capitalize on the political windows of 2026, including the WHA, the Abuja Ministerial Meeting, and the IPEA process, with well-prepared, coordinated interventions that make the Task Force visible and its voice consequential.

The closing observation from the Co-Chairs reiterated that the Task Force must be kind to itself in the face of limited resources and competing priorities, while remaining ambitious about the change it intends to drive. The energy and intellectual depth on display over these two days in Brussels suggest that this balance is achievable.

Annex: Meeting Agenda

Day 1 – Progress and Priority Setting

Time	Session
8:30 – 9:00	Arrival of participants
9:00 – 9:30	Opening Session Introductory welcome: Yvan Hutin, Director (AMR), WHO Strategic framing and expected outputs: Benedikt Huttner and Philip Mathew Agenda and working principles: Katherine Urbaez and Tracie Muraya
9:30 – 10:30	Session 1: Task Force Progress & Priorities Facilitation: Tracie Muraya Objective: Establish a shared evidence foundation
10:30 – 10:50	Coffee break
10:50 – 12:00	Session 2: Progress of working groups and strategic direction Facilitation: Katherine Urbaez Presentations: Anthony So, Geminn Apostol, Milka Sokolovic
12:00 – 12:30	Session 3: Breakout groups – strategic direction for each working group in 2026 Facilitation: Working Group chairs
12:30 – 14:00	Lunch + Group photo
14:00 – 15:40	Session 3 continued: Breakout groups and plenary presentations Facilitation: Katherine Urbaez
15:40 – 16:00	Coffee break
16:00 – 16:45	Session 4: Financing and resource mobilization Facilitation: Andrew Bowskill and Victoria Rutter
16:45 – 17:15	Presentation on the European Observatory on Health Systems and Policies

Day 2 – Implementation & Impact

Time	Session
9:00 – 9:20	Recap of Day 1 and reflections Facilitation: Tracie Muraya
9:20 – 10:15	Session 5: Stakeholder engagement strategy Facilitation: Hamisi Msagama and Marina Pallelli
10:15 – 10:40	Coffee break
10:40 – 11:30	Session 6: KPIs for the task force and broader civil society action on AMR Facilitation: Md Ahmar Khan and Sangeeta Sharma
11:30 – 12:00	Summary, next steps & closing Facilitation: Katherine Urbaez and Tracie Muraya Closing remarks: Benedikt Huttner, Unit Head (HQ/AMR/RSA)
12:00 – 13:30	Lunch



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