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## 1 **Abstract**

2 Despite political commitment to address antimicrobial resistance (AMR), countries are facing  
3 challenges to implementing policies to reduce inappropriate use of antibiotics. Critical factors to the  
4 success of policy implementation in low and middle income countries, such as capacity for  
5 enforcement, contestation by influential stakeholders and financial interests have been insufficiently  
6 considered.

7 Using Pakistan as a case study representing a populous country with extremely high antibiotic usage,  
8 we identified 195 actors who affect policies on antibiotic use in humans and animals through a  
9 snowballing process, and interviewed 48 of these who were nominated as most influential. We used  
10 a novel card game based methodology to investigate policy actors' support for implementation of  
11 different regulatory approaches addressing actions of frontline healthcare providers and antibiotic  
12 producers across the One Health spectrum.

13 We found that there was only widespread support for implementing hard regulations (prohibiting  
14 certain actions) against antibiotic suppliers with little power – such as unqualified/informal healthcare  
15 providers and animal feed producers – but not to target more powerful groups such as doctors,  
16 farmers, and pharmaceutical companies. Policy actors had limited knowledge to develop  
17 implementation plans to address inappropriate use of antibiotics in animals, even though this was  
18 recognised as a critical driver of AMR.

19 Our results indicate that local political and economic dynamics may be more salient to policy actors  
20 influencing implementation of AMR national action plans than solutions presented in global guidelines  
21 that rely on implementation of hard regulations. This highlights a disconnect between AMR action  
22 plans and the local contexts where implementation takes place. Thus if the global strategies to tackle  
23 AMR are to become implementable policies in LMIC, they will need greater appreciation of the power  
24 dynamics and systemic constraints that relate to many of the strategies proposed.

## 25 **Background**

26 Despite high-level political commitment to tackle antimicrobial resistance (AMR), moving from  
27 rhetoric to action is proving to be far from straightforward [1,2]. In 2015, all 194 World Health  
28 Organization (WHO) member states endorsed the Global Action Plan on AMR, and committed to  
29 developing multisectoral national action plans (NAP) – considering human, animal and environmental  
30 drivers of AMR - within two years. The reason for this heightened attention to AMR is the huge  
31 predicted impact on morbidity and mortality in humans and animals, on food production, on economic  
32 growth and on global trade and travel [1]. However, only 79 countries had an action plan by 2017,  
33 with progress notably slower in low- and middle-income countries (LMIC) [3].

34 AMR is an archetypal ‘wicked problem’ [4] that presents major challenges for policy implementation  
35 as this requires engagement of many different actors, often with conflicting interests and the power  
36 to influence policymakers [5,6]. In particular, tackling one of the major drivers of AMR – inappropriate  
37 use of antibiotics – requires actions that affect multiple sectors, including human and veterinary  
38 medicine, agriculture, and trade [7,8]; this is why a One Health approach has been proposed.  
39 Inappropriate use encompasses clinically unwarranted or inappropriate dispensing for illnesses in  
40 humans and animals or without a confirmed diagnosis, as well as overuse in farming for growth  
41 promotion and prophylaxis of infectious diseases in animal populations through medicated feed and  
42 water. This contrasts with appropriate use of antibiotics, which is defined as access to quality-assured  
43 drugs, at an effective dose and treatment duration [9], supported by evidence collected through  
44 clinical and laboratory investigation.

45 There is insufficient evidence about how effective different types of regulatory approaches will be in  
46 moving statements about tackling inappropriate use of antibiotics from paper to practice in LMIC.  
47 Hard regulatory approaches, which appear frequently in Global Action Plan on AMR, typically consist  
48 of binding laws or guidelines with associated penalties for failure to comply, and therefore rely on  
49 monitoring and enforcement. An example is prescription only access to antibiotics in the UK through

50 licenced pharmacists, implementation of which is supported by clear antimicrobial stewardship  
51 guidelines for secondary care (Start Smart then Focus) and primary care (TARGET antimicrobial toolkit)  
52 [5]. Soft regulatory approaches, in contrast, rely on voluntary compliance often supported by training  
53 [10]. Researchers have highlighted that approaches relying primarily on implementation (including  
54 setting, monitoring and enforcement) of hard regulations in LMIC typically fail owing to interrelated  
55 constraints: insufficient resourcing of regulatory bodies, contestation of regulatory policies by private  
56 stakeholders, low technical capacity or power of regulatory bodies, and insufficient political support  
57 owing to vested interests [5,6]. These issues are particularly salient in relation to addressing  
58 inappropriate use of antibiotics, because suppliers of antibiotics may have a stake in preventing  
59 implementation of regulations that they believe would reduce use to the detriment of their financial  
60 interests. For example, doctors may receive incentives from pharmaceutical companies to over-  
61 prescribe specific antibiotics and may oppose antimicrobial stewardship initiatives to check this  
62 behaviour [11]. The political influence of different antibiotic suppliers can be critical in determining  
63 which groups domestic policymakers choose to target with interventions and whether hard or soft  
64 interventions are implemented. For example, interventions that prohibit dispensing of antibiotics by  
65 a small number of drug sellers may receive a different level of opposition to hard interventions that  
66 constrain incentives given to doctors by pharmaceutical representatives.

67 Our study systematically identifies policy actors that influence implementation of action plans on  
68 inappropriate use of antibiotics in humans and animals in one high AMR burden LMIC – Pakistan – and  
69 investigates the extent to which the most influential policy actors would support implementation of  
70 different regulatory approaches. We also examine the use of an innovative methodological approach  
71 using a card-sorting exercise to generate richer data from interviews with policy actors.

## 72 ***Characterising suppliers of antibiotics in LMIC***

73 We defined suppliers as organisations or individuals who play a role in the supply of antibiotics to  
74 human or animal populations. In most LMIC with fragmented health systems, there is a large and

75 diverse set of ‘proximate’ suppliers of antibiotics, who are directly involved in providing antibiotics to  
76 patients or farmers [12]. In contrast, ‘distal’ suppliers are organisations that typically provide  
77 antibiotics to proximate suppliers but do not have direct contact with patients or farmers. Table 1  
78 shows the key characteristics of the different suppliers across the One Health spectrum. A critical step  
79 in developing an AMR NAP is to identify which of these suppliers to focus on as target groups of  
80 interventions to reduce inappropriate use of antibiotics.

### 81 ***Interventions to address inappropriate use of antibiotics***

82 Potential interventions that could be implemented to reduce inappropriate use of antibiotics by  
83 different suppliers were classified into three broad categories (Table 2, [13-15]): encourage (the  
84 softest option, usually positive incentives to encourage adherence to regulations or guidelines without  
85 any penalties); prohibit (the hardest regulatory approach, which typically includes a complete ban on  
86 certain practices with penalties for failure to comply); and constrain (less severe than a complete ban  
87 as it involves restriction of access). Policymakers developing and implementing AMR action plans have  
88 two linked decisions to make: which suppliers of antibiotics should be targeted as a priority in their  
89 context, and what type of intervention(s) should be used.

## 90 **Methods**

### 91 ***Study setting***

92 Pakistan, the sixth most populous country in the world, is facing challenges with high levels of drug  
93 resistance. This was demonstrated by a recent outbreak of multidrug-resistant *Salmonella* Typhi,  
94 which affected more than 300 patients in two cities within 6 months [16] and has continued to spread.  
95 Pakistan was one of the earliest LMIC to initiate development of a national AMR action plan, being  
96 recognised at the World Health Assembly in 2017 for proactively engaging in the Joint External  
97 Evaluation (JEE) to assess preparedness to combat health emergencies including AMR [17,18].  
98 Although the country performed well on some elements of the JEE, in the self-assessment Pakistan

99 had the lowest possible score on capacity and policies to combat AMR [19]. This partly reflected weak  
100 regulations to monitor and control the use of antibiotics in human and animal sectors as noted in the  
101 JEE[19]. For example, even though Drug Regulatory Authority of Pakistan (DRAP) was established  
102 under the DRAP Act of 2012 to provide for effective coordination and enforcement of The Drugs Act  
103 1976, the Pakistan AMR National Action Plan indicates that infectious disease expertise in DRAP and  
104 implementation of the aforementioned regulations is lacking [18]. Similarly, surveys indicate that  
105 human antibiotic consumption is extremely high in Pakistan, and data on use are limited [18,20].  
106 Challenges to implementing large-scale interventions to reduce excessive antibiotic use in Pakistan  
107 include the presence of very large, well-organised dairy and poultry industries [21], and a health  
108 system that is dominated by for-profit providers; as a result of the lack of provision in the public sector  
109 approximately 80% of the population visit private clinics, with out-of-pocket expenditure estimated at  
110 56% [22,23]. These actors providing antibiotics to human and animal populations may perceive that  
111 their profits are linked to continued overuse of antibiotics and oppose the introduction of specific  
112 interventions.

### 113 ***Data collection***

114 We first conducted a snowballing exercise to identify the range of actors that could influence  
115 operationalisation of government strategies to reduce inappropriate use of antibiotics in both humans  
116 or animals (thus applying a One Health lens). We started with a list of 12 'seed' informants covering a  
117 range of core sectors related to AMR, including infectious disease physicians, clinical microbiologists,  
118 veterinarians, government policymakers working in human and animal health, civil society  
119 organisations, media representatives and the pharmaceutical industry. This group included members  
120 of the committee tasked with developing Pakistan's national AMR action plan. We asked informants  
121 to identify people or organisations that are shaping the approach taken by the government to reduce  
122 inappropriate use of antibiotics in human and animal populations in Pakistan. We contacted all

123 nominees by email or telephone and continued the snowballing process until no new actors were  
124 identified.

125 During the second stage of the study, we contacted actors identified as influential (mentioned at least  
126 twice during snowballing) and interviewed those who agreed to participate in the research. This is the  
127 stage at which we applied our methodological innovation, which allowed us to collect rich qualitative  
128 and quantitative data simultaneously. During the interview we asked actors their views on what types  
129 of interventions – encourage, constrain, prohibit – they would support to address the actions of  
130 specific antibiotic suppliers, explicitly focusing on antibiotic use in human health and animals. If the  
131 interviewee agreed, we used a ‘thinking aloud’ approach in which they were asked to place cards  
132 representing the suppliers listed in Table 1 on pieces of paper printed with Encourage, Constrain or  
133 Prohibit to indicate what type of intervention they would propose to reduce inappropriate use of  
134 antibiotics by that supplier, while talking through their thought process [24,25] (Figure 1). Details of  
135 where each interviewee placed each card were noted and entered into an Excel spreadsheet. The  
136 methodology was piloted in Pakistan by the research team before two researchers conducted the  
137 interviews. Since we were seeking to solicit interviewees’ thoughts about preferred policy options and  
138 contextual factors influencing these thoughts, possible unspoken prior to the interview, we designed  
139 the card-sorting task to help interviewees forget they were being recorded. We anticipated that they  
140 would possibly more open about their views on recommended interventions owing to the  
141 incorporation of this methodological innovation into our interviews.

142 Interviews lasted 45 to 60 minutes and were run jointly, with the aid of a semi-structured interview  
143 topic guide, by two or three researchers (all female) with post-graduate level training in qualitative  
144 research. The researchers had no prior relationships with the interviewees and had not conducted  
145 research on this topic previously.

146 All except one interview were conducted face to face. All interviewees gave permission to record the  
147 interviews. Participants were able to choose the location of the interview, which usually took place at

148 their workplace. Brief notes were taken by the researchers during the interview and these were  
149 written up immediately after each interview.

### 150 ***Data management and analysis***

151 The interviews were transcribed and translated into English (when required) before thematic analysis  
152 was conducted. All authors, including a veterinarian to ensure a One Health approach during the  
153 analysis, collectively identified and validated emerging themes across a sample of transcripts before a  
154 line-by-line analysis was conducted by two researchers on all 48 interview transcripts, using NVivo 12  
155 qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018). Data from the card  
156 sorting exercise were used to construct bar charts to quantitatively compare responses of actors to  
157 potential interventions addressing different target groups.

158 We sought feedback on our preliminary results from interviewees and government policymakers from  
159 human and animal health during two consultation workshops that took place at the National Institute  
160 of Health in Islamabad and Aga Khan University in Karachi (November 2018).

161 The study was approved by the Research Ethics Committees of the Pakistan and UK-based primary  
162 investigators' institutions.

163

## 164 **Results**

### 165 ***Who has influence over policy interventions to reduce antibiotic misuse?***

166 195 policy actors were nominated in total during the snowballing process. The majority of these  
167 worked in the field of human health (n=149), and about one quarter in animal health (n=46). The  
168 pattern of nomination indicated that human health and animal health/livestock actors were typically  
169 not well connected to each other.

170 Of the 195 actors, we identified 48 as 'most influential' based on the frequency of nomination being  
171 greater than or equal to two (Table 3), and summarise below findings about their reactions to the



172 proposed implementation of different approaches to address inappropriate use of antibiotics by each  
173 group of suppliers.

174 ***Healthcare providers supplying antibiotics to humans***

175 (i) Unqualified healthcare providers

176 The majority of interviewees who engaged in the card sorting exercise favoured strong measures  
177 (prohibit or constrain) to deal with unqualified providers in the human health sector, specifically drug  
178 sellers and ‘unqualified doctors’ (quacks; Figure 2). Those who did not favour complete banning of  
179 unqualified providers suggested that these suppliers might be allowed to sell a very limited set of  
180 medications such as painkillers but not ‘critical drugs’ such as antibiotics.

181 When arguing for constrain-type interventions some interviewees expressed reluctance to support  
182 the hardest regulatory measures owing to concerns about lack of universal health access to qualified  
183 providers. Two medically trained interviewees emphasised that quacks and drug sellers provide a  
184 useful service in remote rural areas where there is no other access to the health system.

185 *‘for quackery you not only need to provide more access for the general population to good quality*  
186 *services in the public sector, but you also need to educate the masses ...’ [A47, International*  
187 *agency].*

188 (ii) Qualified doctors

189 In contrast, when asked about measures to address inappropriate prescribing of antibiotics by  
190 qualified doctors, interviewees favoured softer measures (encourage) such as update training or  
191 awareness raising and systems to track prescribing practices to increase transparency. There was a  
192 commonly held view that doctors were ‘doing their best’, sometimes with limited diagnostic (and  
193 other) resources. A range of interviewees highlighted that the lack of resources to guide diagnosis and  
194 decision-making was compounded by inadequacies in medical education; two senior medical  
195 professionals asserted that doctors in Pakistan often practise medicine in a way that reflects gaps and

196 a need to strengthen training: ‘you know, unfortunately, I even call the doctors quacks [...] because  
197 the way they prescribe is like quacks’ [A18, Human health government official].

198 However, not all interviewees favoured a soft approach to doctors. Several focused on the ‘unethical’  
199 relationship between pharmaceutical companies and medical professionals. They argued that stricter  
200 regulation was required to constrain the incentives provided by these companies that encourage  
201 doctors to prescribe antibiotics.

202 Interviewees from the public human health sector and the domestic pharmaceutical industry were  
203 more reluctant to support constraints on doctor-pharmaceutical company relations than other actors  
204 such as those representing international agencies and non-profit organisations, perhaps reflecting  
205 their own interests. The Pakistan Medical Association and the Pakistan Medical and Dental Council  
206 were identified by interviewees as having the potential to play a stronger role in improving antibiotic  
207 use by doctors.

208 (iii) Pharmacies and drug shops

209 It was widely felt that private pharmacies, with a qualified pharmacist needed to be encouraged, to  
210 support qualified pharmacists in taking over jobs from untrained drug sellers, and that strict  
211 enforcement measures were required to prevent antibiotic dispensing without an appropriate  
212 prescription. Over-the-counter sale of antibiotics was mentioned frequently as a key issue to be  
213 addressed through ‘constrain’ interventions. It was suggested that pharmacists could monitor what  
214 doctors were prescribing and discuss any discrepancies with them.

215 ***Providers supplying antibiotics to livestock***

216 When discussing suppliers in the animal health or livestock sectors, a large proportion of interviewees  
217 declined to comment due to a perceived lack of expertise.

218 (i) Veterinarians

219 Among those who did express a view, veterinarians were commonly perceived to be responsible users  
220 of antibiotics and thus as needing to be supported with ‘encourage’ measures that would allow them  
221 to play a larger role in controlling use of antibiotics in animals (Figure 3). The current limited role of  
222 veterinarians in Pakistan was explained by interviewees to be related to farmers’ tendency to avoid  
223 the expense of paying for a veterinary consultation and instead going directly to pharmacies to buy  
224 antibiotics without a prescription.

225 (ii) Farmers

226 Opinions on measures to tackle self-prescription of antibiotics by farmers were divided, mainly  
227 between ‘encourage’ and ‘constrain’ approaches. Approximately half of those who responded opted  
228 for encourage measures based on educating farmers to be able to diagnose and treat their animals  
229 (without veterinary input) more effectively. This group of interviewees asserted that harder measures  
230 to prohibit self-prescribing by farmers would not be feasible given how common it is, and instead  
231 better use of antibiotics by farmers should be facilitated:

232 *‘There are huge numbers of farmers and breeders [...] they get all these antibiotics [...] so just*  
233 *prohibit or constrain would not be that much important here [...] they should be encouraged*  
234 *and educated not to use antibiotics, just to give them when needed’ [A11, Animal health*  
235 *government official].*

236 Others felt that stronger regulations were needed to prevent overuse of antibiotics, particularly in the  
237 poultry sector, where farmers were believed to administer large quantities of antibiotics to bird  
238 populations via medicated feed]. Several interviewees indicated that the poultry industry is hard to

239 regulate due to its economic power, professional organisation, and the fact that some large poultry  
240 farms are owned by politicians [A11 and A12, Animal health government official; A52, Human health  
241 government official].

242 (iii) Animal feed producers

243 There was greater support for stronger measures to address use of antibiotics by animal feed  
244 producers than farmers, with some interviewees expressing concern about the lack of implementation  
245 of regulations by the government:

246 *'In the animal feed mills the government should check the ingredients... they [animal feed*  
247 *producers] are using different drugs and also they are using chemicals in the feed' [A40, Domestic*  
248 *non-profit organisation].*

249 (iv) Animal drug shops and pharmacies

250 Interviewees commonly stated that shops selling animal drugs need to be regulated and monitored,  
251 and that over-the-counter sales without a prescription should be prohibited. Informal drug sellers,  
252 without a qualified pharmacist, were recognised as a major issue in the animal as well as the human  
253 health sector and most interviewees who responded stated that they should be prohibited from  
254 selling antibiotics:

255 *'[informal drug sellers] need strict legislation about prohibition because these things should*  
256 *not exist in the first place... this is a big problem in both humans and animals' [A11, Animal*  
257 *health government official].*

258 The support for stringent measures to reduce inappropriate access to antibiotics for animals through  
259 pharmacies and drug sellers contrasted with commonly expressed reluctance to limit access to  
260 antibiotics for farmers. Larger farmers purchase antibiotics directly from pharmaceutical companies  
261 or drug ingredient wholesalers, and therefore prohibition of over-the-counter animal antibiotic sale  
262 by pharmacies would largely impact small-sized farmers.

263 ***Distal suppliers of antibiotics***

264 (i) Supplier of raw materials for pharmaceutical products

265 There was a general consensus that companies involved in the supply of raw materials for  
266 manufacture or packaging of antibiotics in Pakistan should be constrained (to meet minimum quality  
267 standards) or prohibited (if supplying substandard raw materials) (Figure 4). Our interviews indicated  
268 that it is common practice for pharmaceutical companies to import raw materials and package drugs  
269 for sale in Pakistan. An international agency representative explained that import of raw materials  
270 typically involves a bidding process that selects companies that can supply raw materials at the lowest  
271 price, irrespective of quality. The same interviewee suggested that the government should enforce a  
272 minimum quality standard on suppliers of raw materials that are imported into Pakistan. In general,  
273 quality control was considered an issue both in the animal and human health sectors:

274 *'We must do something to them, to stop, to prohibit... to stop them preparing compromised*  
275 *drug[s], which are not quality controlled so I think legislation should be very strict about the drug*  
276 *ingredient'* [A22, Senior doctor]

277 (ii) Pharmaceutical companies

278 The pharmaceutical industry was mentioned frequently as a key actor both in driving inappropriate  
279 use of antibiotics, particularly through using bribes to doctors as a standard practice, and having the  
280 opportunity to affect positive change. Most interviewees chose encourage, constrain or a mixture of  
281 the two to address the role of the pharmaceutical industry and were reluctant to opt for harder  
282 measures:

283 *'In general encouraging them [pharmaceutical companies] I think, or saying what are best*  
284 *practices, rather than saying 'you get kickbacks because you do such and such'* [A16, Senior  
285 doctor].

286 Interviewees indicated that the limited resources available to the DRAP when compared to those  
287 available to the pharmaceutical industry mean implementation of more stringent measures are  
288 unlikely to be effective. Specifically, it was highlighted that resources available to pharmaceutical  
289 companies could be used to influence doctors' prescribing behaviour through sponsorship of  
290 continuing medical education and financial incentives offered in return for prescription of their  
291 proprietary medicines, as well as to bribe officers responsible for enforcing rules. In this context, DRAP  
292 was considered necessary to implement measures to address both quality issues and inappropriate  
293 marketing practices by pharmaceutical companies, but was commonly described as ineffectual,  
294 understaffed, and open to influence in its current form:

295 *'DRAP [...] are lacking in human resources. One person, one drug inspector in the whole district,*  
296 *maybe looking after two to three districts. How can he manage?'* [A35, Human health  
297 government official].

298 Some actors were bolder in suggesting that marketing practices of sales representatives giving  
299 financial incentives to doctors, pharmacies or drug sellers to overuse specific antibiotics should be  
300 prohibited.

301 Differences between the domestic and international pharmaceutical industries were also noted in the  
302 qualitative analysis. Many interviewees perceived international companies to be better regulated than  
303 domestic companies and more likely to be following international guidelines on marketing practices  
304 and internal drug quality controls (e.g. bar coding) to enable better detection of counterfeit drugs. In  
305 contrast, there was a common feeling that domestic companies were often not following ethical  
306 marketing practices, largely because they do not have to abide by the standards that international  
307 companies have signed up to in recent years.

**308 Discussion**

309 This study used a novel approach to systematically investigate support (or lack thereof) for different  
310 interventions to reduce inappropriate use of antibiotics among actors who can influence  
311 implementation of policies in Pakistan, applying a One Health lens by including eligible human and  
312 animal health actors in our study. Our findings are novel, timely, and policy-relevant as the majority  
313 of countries report that they are still to develop a strategy to operationalise their AMR NAPs [3], and  
314 there is limited attention given to supporting countries in navigating major political and economic  
315 barriers to implementing actions that potentially reduce the use of antibiotics [5,8,9]. Existing  
316 literature documents a gap in evidence about the types of interventions that might be locally  
317 appropriate in LMIC [26] and about strategies to tackle 'local barriers' [11]; our findings address this  
318 gap in evidence for Pakistan, and have implications for other LMIC developing AMR action plans.

319 Although enactment and enforcement of regulations has been advocated as an important approach  
320 to tackle inappropriate use of antibiotics, many interviewees suggested that doctors and the  
321 pharmaceutical and livestock industries may be too powerful for government agencies to enforce  
322 rules on; the latter were presented as under-resourced, poorly organised, and lacking in authority to  
323 implement the existing regulations, which is similar to the status of regulatory bodies in many LMIC  
324 [22]. Instead, interviewees expressed support for awareness-raising interventions to address  
325 inappropriate prescribing by doctors and farmers, which was acknowledged as a serious issue.  
326 Although resource constraints of regulatory agencies were certainly salient in the Pakistani context,  
327 some interviewees working outside government agencies highlighted that vested interests connecting  
328 politicians and health policymakers with the pharmaceutical and livestock industries may also explain  
329 the reluctance to support harder regulatory approaches. The tendency to take a softer approach based  
330 around awareness raising for doctors, as demonstrated by the placement of cards in the card-sorting  
331 exercise and/or comments in interviews, may also reflect the composition of interviewees who were  
332 mostly medically trained. However, evidence of a substantial and sustained impact on antibiotic

333 prescribing by doctors in LMIC owing to soft interventions that encourage responsible use is currently  
334 lacking [26]. It is important to consider that there is a lack of evidence of a substantial and sustained  
335 impact of awareness campaigns on sustained impact on prescribing practices in LMIC, even though  
336 this is often a politically palatable intervention [26]. In contexts such as Pakistan where doctors rely  
337 on continuing medical education sponsored by pharmaceutical companies, awareness campaigns  
338 alone are unlikely to be effective [27,28].

339 Our study identified a number of interventions for which there was widespread support from  
340 interviewees across different stakeholder groups, and these could be prioritised as strategies to  
341 address AMR in Pakistan. Among these were prohibition of untrained doctors and unlicensed drug  
342 sellers from providing healthcare services. However, several interviewees highlighted that a major  
343 impediment to implementing a complete ban on unqualified healthcare providers is the lack of public  
344 health services, particularly in rural areas of the country, and therefore preferred to constrain the  
345 types of services provided or to provide basic training to unqualified providers. Our thinking aloud  
346 interviews revealed that this was a major concern for some civil society organisation representatives.  
347 Geographical differences in the distribution of qualified or licenced providers is a well-documented  
348 issue in Pakistan [22,23] and other countries in the region, rendering groups of the population  
349 dependent on unqualified healthcare providers who tend to inappropriately use antibiotics [29,30].  
350 Our findings from Pakistan indicate that although there is impetus to prevent untrained providers  
351 from operating, a sizeable group of actors may not support a full ban owing to concerns about the  
352 government's ability to provide health services [31].

353 Pharmacists and veterinarians were identified two groups that could be empowered to play a bigger  
354 role in ensuring appropriate access, with many interviewees expressing concern that these are often  
355 bypassed by patients and farmers in favour of unqualified drug sellers and self-medication, resulting  
356 in this cadre of health professionals being devalued in Pakistan.



357 A striking finding from the card-sorting exercise was that many that many policy actors, owing to their  
358 human healthcare background, did not feel knowledgeable enough to discuss interventions targeting  
359 suppliers of antibiotics to animals and that actors with animal health expertise were lacking in  
360 regulatory agencies such as DRAP; this may hinder implementation of effective strategies to address  
361 inappropriate use of antibiotic use in animals, despite commitments to applying a One Health  
362 approach by international agencies [3]. Other studies have also reported a (perceived) imbalance in  
363 power and representation between human and animal health stakeholders [32].

364 We developed and applied a novel method, which benefitted from an initial network analysis that  
365 enabled us to systematically identify actors that were perceived to be most influential, combined with  
366 an innovative card sorting exercise that aimed to facilitate open discussion by policy elites during  
367 interviews [33]. There were two main advantages of our novel methodology. First, the card-sorting  
368 exercise enabled the interviewer and interviewee to follow a more systematic approach to discussing  
369 each supplier of antibiotics one by one. Even if some interviewees were unable to comment on the  
370 role of a particular supplier, the card-sorting exercise allowed this finding to be captured explicitly.  
371 This helped to reveal that many of the influential policy actors did not feel knowledgeable to comment  
372 on interventions addressing antibiotic use in the livestock sector. Second, the card sorting exercise  
373 allowed us to gain information based on where interviewees placed cards (along the spectrum of hard  
374 to soft interventions) even if they did not fully verbalise their rationale.

375 Reflecting on the value of the card sorting exercise in generating richer qualitative data, we felt that  
376 it did help to initiate dialogue, but it was time-consuming, so some of the interviewees were not able  
377 to complete the exercise. Although the majority of interviewees spoke openly about their support or  
378 opposition for different types of interventions some respondents involved in the implementation of  
379 regulations stated that they were reticent to speak freely while being recorded. In terms of limitations,  
380 this study was conducted in one country, Pakistan, and findings may not be representative of other  
381 LMIC. However, we have successfully adapted and applied the novel methodology in Cambodia and

382 Indonesia. In the Cambodian study we reduced the number of cards used, in order to shorten the time  
383 taken, and had cards representing different types of healthcare providers (formal and informal) to  
384 understand policy actors' support for interventions to reduce inappropriate use of antibiotics  
385 targeting each type of healthcare provider [34]. In terms of future work, evidence from this study  
386 about political support for specific interventions targeting individual antibiotic supplier groups could  
387 be coupled with quantitative epidemiological studies of the likely impact on overall inappropriate  
388 antibiotic misuse from these interventions to design evidence-based and politically acceptable policies  
389 to operationalise the national AMR action plan. We found that our methodological innovation could  
390 easily be adapted to study policy actors' views on interventions to address inappropriate use of  
391 antibiotics, and we would encourage application of the novel method to study other wicked problems  
392 such as tobacco control or regulation of medical education in LMIC contexts.

### 393 **Conclusion**

394 Our study provides new insights about challenges to implementing hard regulatory approaches to  
395 address inappropriate use of antibiotics in LMIC with weak governance structures, and additionally  
396 developed a new methodology that can be applied to support policy research in other countries. In  
397 Pakistan we found that measures to prohibit untrained drug sellers and untrained doctors were clearly  
398 more palatable to influential policy actors than implementation of strong regulations targeting groups  
399 perceived to be powerful such as (qualified) doctors, pharmaceutical companies and the livestock  
400 industry. Hard regulatory approaches – such as prescription-only access to antibiotics or banning of  
401 growth promoters in livestock – were considered 'technical' solutions which do not take account of  
402 the political opposition these may face.

403 These findings have implications for other countries developing AMR NAP as they highlight the need  
404 for a clear understanding of socio-economic context, policy processes and underlying interests and  
405 power [33]. We conclude that in each country prioritising development of a NAP, an analysis of the  
406 key stakeholders and their interests is a prerequisite step for global health actors wishing to support

407 national efforts to tackle AMR. Such an analysis will enable development of more effective strategies  
 408 that that will incorporate a greater appreciation of the power dynamics and systemic constraints that  
 409 relate to many of the strategies proposed. Ultimately, if ambitious global strategies to tackle AMR,  
 410 such as the Global Action Plan on AMR, are to become implementable in LMIC, they will need to strike  
 411 a balance between technically ideal solutions and options that are feasible to implement.

412 **List of abbreviations:** AMR: Antimicrobial resistance; DRAP: Drug Regulatory Authority of Pakistan;  
 413 JEE: Joint External Evaluation; LMIC: Low and middle income countries; NAP: National Acton Plan;  
 414 WHO: World Health Organization.

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