Ethical reflections from a partnership to mitigate antimicrobial resistance in Vietnam: Do collaborative and participatory methods address issues of equity and power in research partnerships?

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Brief description of context

Collaborative and participatory research models involving knowledge co-production by researchers and non-academic stakeholders have been touted as "the future" of health research and practice (1). Beyond tokenistic engagement, such approaches seek to recognise local authorities, practitioners and communities as research partners rather than informants. To generate contextualised knowledge and interventions with more sustainable impact, they further argue for the redistribution of power over research decisions and resources to these stakeholders.

Antimicrobial resistance (AMR) has been recognised as a site for social inequalities, which requires confronting power structures and promoting the flourishing of traditionally marginalised communities (2). Yet this continues to be framed as an expert issue requiring technical fixes rather than social transformation. In Vietnam, AMR mitigation efforts have been mainly biomedical and top-down. For example, the National Action Plan on AMR up until 2023 focused on antimicrobial stewardship in the human health sector and mainly involved healthcare professionals and academic actors in awareness raising, surveillance, and research (3). Local authorities and communities have not been actively involved in planning or executing the agenda, despite the presence of extensive state-sanctioned networks for community mobilisation.

This paper draws on reflections from a study which aims to explore the potential of mobilising community knowledge and resources in AMR mitigation via a participatory learning and action intervention. It is conducted in Nam Dinh Province, Vietnam, by the Wellcome Trust-funded Oxford University Clinical Research Unit (OUCRU) in partnership with Nam Dinh Department of Health and Sub-Department of Animal Health. Past activities include participatory exercises with provincial government stakeholders in One Health sectors to identify mechanisms driving local inappropriate antibiotic use, and partner consultation and collaboration at different stages such as baseline survey, intervention design, community entry, and implementation. The current ongoing intervention brings together groups of primary healthcare doctors, women, and farmers across six rural communes. These groups are regularly convened by community facilitators recruited from the local primary healthcare system to discuss infectious health issues, local care practices and AMR, identify the root causes of and solutions for inappropriate antibiotic use in each community, and mobilise community resources to implement selected solutions.

Our research partnership, therefore, involves a range of stakeholders with different levels of participation. Yet it is arguable to what extent these stakeholders have been recognised as a partner, and to what extent power has been and can be redistributed. These questions emerged as important ethical tensions during the study, inviting critical reflections on whether our methods were sufficient for promoting partnership equity.

Ethical tensions

Whose agenda matters?

Through stakeholder consultations and participatory activities, the study team has ensured that our local partners, the provincial Department of Health, Sub-Department of Animal Health and

subordinate agencies under their line management, are able to contribute and provide feedback throughout the research process. However, their participation is limited to after, rather than before, our research objectives and approaches were defined. In the first place, outlining the parameters of the research, including its objectives, intended methods, and timeline, was necessary for funding acquisition. The agenda at this stage was guided by the interests of the funding scheme, OUCRU, and the principal investigator, without input from the provincial partners or the communities concerned. The decision to focus on AMR was based on its recognition as one of the most urgent global health threats and a major existing research programme of OUCRU. Only after relevant resources and approvals were granted did we approach these partners and commence relationship building.

The necessity for addressing AMR in Vietnam is not a point of contention: it is backed by a clear global and local evidence base and recognised by our partners in human health and animal health governance. However, efforts to prioritise this issue are complicated by competing political and institutional interests. For example, primary healthcare providers face increasing pressure to compete with private healthcare providers and have expressed their preference for technology transfer and financing to improve their facilities and diagnostic capacities. For public health and animal health stakeholders, epidemic management is perceived as more urgent and highly prioritised by the government; therefore given that their allocated budgets and other resources are limited, “affording” to address AMR would be a major challenge. Whereas in the environment sector, the provincial stakeholders that we consulted were unaware of their role in mitigating AMR and uncertain how to contribute, believing this to be an issue under medical authorities’ purview. These concerns were not reflected in the pre-defined research agenda, which prevents the non-academic partners from committing adequate resources and personnel to the partnership.

Research partnerships inevitably involve negotiating interests which can emerge and change over time. Yet the pragmatic constraints of research often necessitate compromises, resulting in “hidden politics” that limit non-academic partners’ capacity to participate and define the research agenda (4). Some of these constraints reflect the current neoliberal structure of academia: the push to increase research productivity and meet funding deadlines often leaves little time for partner engagement and negotiations prior to research commencement (5). Streamlined administrative procedures such as financial paperwork and ethical approval forms may further resist the flexibility to include non-academic stakeholders as equal partners (5).

Distributive justice along existing power structures

Engaged and participatory research is not necessarily equipped to address local power dynamics. So far in this section, the terms “partner” and “stakeholder” have referred to government agencies and expert actors, reflecting the conventional framing of key players in our partnership in grant proposals and research protocols. This highlights the fact that community facilitators and members of participatory groups, despite their central role and contribution to the research, are often not formally represented as research partners.

Indeed, local stakeholders are not a homogeneous category but one with embedded hierarchies and differential power positions. Seeking to engage the grassroots community as an international research NGO, local authority approval is first required before any community-level activities could be conducted. Collaborators with higher authority generally have more influence on the implementation of the study than grassroots collaborators. For instance, while we initially wanted to conduct community entry meetings where interested members of the public could volunteer as community facilitators, government partners preferred that community health workers be assigned the task of faciliators. These appointed facilitators shoulder the burden of engaging multiple community groups and delivering the intervention, which is particularly challenging as participatory methods are an awkward fit for their hierarchical, assignment-based work culture. Yet despite having reservations about the approach and lacking confidence, their options were limited by the research design.

The distribution of benefits from the research was governed in compliance with local government policy and structures. For instance, research expenses except payments for full-time research staff

must be disbursed by government partners, including compensation and allowances for the appointed facilitators. The bureaucratic checks and payment processes often have a knock-on effect for the appointed facilitators who, despite their fieldwork burden, may have to wait for months to be compensated, which has undermined their motivation and trust in the study. In addition, such protracted processes potentially leave an opening for corruption practices and attempts to redistribute payments beyond the study team's control.

Similarly, it remains to be observed if and how the intervention will burden or benefit the participatory learning and action groups where local community mobilisation is a top-down model and community members perceive health as an expert-controlled domain.

Conclusion and recommendations

Addressing AMR as a multisectoral issue with local complexities and embedded inequalities requires partnerships beyond academia. Collaborative and participatory methods can indeed increase non-academic actors' participation in knowledge production, generating insights that better reflect the local context. However, for these insights to be meaningful and actionable for local stakeholders, there should be critical awareness of and concrete action to address the structures that sustain power imbalances and injustices in the partnership. Otherwise, there would be a risk of co-opting collaborative and participatory methods as the new technical intervention for AMR instead of introducing real change. Questions such as who should be considered a partner, who should set the agenda, and how to ensure fair allocation of burdens and benefits are critical and need to be carefully reviewed within each context.

As a recommendation, global health funding and research reforms are needed to encourage inclusion of partners with different perspectives and positionalities in shaping research agendas and funding priorities. Such reforms should actively attend to unconscious biases within funding and research structures (6). While funding schemes are available that support non-academic co-applicants, eligibility criteria may still favour academic applicants representing global North research interests, with little consideration for including local communities and historically marginalised groups (e.g. Indigenous peoples). It will also be necessary, at the research development and grant application stage, to factor in appropriate amounts of time and administrative support for relationship building, negotiation of interests, and/or co-design with non-academic partners (5). This should be a consideration for both researchers and research funders.

Reflexive ethics and evaluation practices are further recommended to promote partnership equity. While this paper has discussed the influence of local power dynamics and cultures on partnership politics, it seeks not to blame but to acknowledge that these complex structures are inherent in the partnership and involve an ongoing process of understanding. Beyond procedural ethics, research partners should exercise constant reflexivity throughout their project and be responsive to emerging ethical tensions. This can also be supported by iterative research evaluation approaches such as developmental evaluation, which employs feedback loops to stimulate joint reflection and decision-making between partners (7).

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