ISSUE
07/2026
January-June 2026

SEMI-ANNUAL BULLETIN

NARS-Net Sites

Lady Hardinge Medical College (LHMC), Delhi
Vardhman Mahavir Medical College (VMMC), Delhi
Mysore Medical College & Research Institute, Mysuru,
Government Medical College & Hospital (GMCH), Chandigarh
B.J. Medical College (BJMC), Ahmedabad, Gujarat
B.J. Medical College (BJMC), Pune, Maharashtra
SMS Medical College, Jaipur, Rajasthan
GSVM Medical College, Kanpur, Uttar Pradesh
Gauhati Medical College & Hospital (GMC), Assam
KAPV Government Medical College, Trichy, Tamil Nadu
NEIGRIHMS, Shillong, Meghalaya
GMC Thiruvananthapuram, Kerala
M.G.M Medical College & Hospital, Indore,
IGMC, Shimla, Himachal Pradesh
Govt. Medical College, Aurangabad, Maharashtra
Osmania Medical College (OMC), Hyderabad, Telangana
Govt. Medical College, Jammu
Agartala Government Medical College (AGMC)
SCB Medical College & Hospital, Cuttack, Odisha
Guntur Medical College (GMC), Guntur, Andhra Pradesh
Pt. Jawaharlal Nehru Memorial Medical College, Raipur
RIMS Ranchi, Jharkhand
Pt. B D Sharma, PGIMS, Rohtak, Haryana
Indira Gandhi Institute of Medical Sciences (IGIMS), Patna
Govt. Medical College, Haldwani, Uttarakhand
Gandhi Medical College, Bhopal, Madhya Pradesh
LLRM Govt. Medical College, Meerut, Uttar Pradesh
GMERS Medical College, Valsad, Gujarat
School of Tropical Medicines (STM), Kolkata, West Bengal
Coimbatore Medical College & Hospital, Tamil Nadu
Sardar Patel Medical College (SPMC), Bikaner, Rajasthan
Maulana Azad Medical College (MAMC), Delhi
Indira Gandhi Medical College & RI, Puducherry
NAMO MERI, Silvassa, Dadra and Nagar Haveli
Goa Medical College, Bambolim, Goa
STNM Hospital, Gangtok, Sikkim
Zoram Medical College, Aizawl, Mizoram
GMC Patiala, Punjab
Andaman & Nicobar Institute of Medical Sciences, Port Blair
TRIHMS, Naharlugan, Arunachal Pradesh
Jawahar Lal Nehru Institute of Medical Sciences, Manipur
Moti Lal Nehru Medical College, Allahabad, Uttar Pradesh
RNT Medical College, Udaipur, Rajasthan
Andhra Medical College, Vishakhapatnam, Andhra Pradesh
Vijayanagar Institute of Medical Sciences, Ballari, Karnataka
Pt. Raghunath Murmu MCH, Baripada, Odisha
Burdwan Medical College & Hospital, Burdwan, West Bengal
Govt. Medical College, Karan Nagar, Srinagar, J&K
GGMC & Sir JJ Group of Hospitals, Mumbai, Maharashtra
Govt. Medical College, Thrissur, Kerala
Bangalore Medical College and Research Institute, Karnataka
Kakatiya Medical College, Warangal, Telangana
Madras Medical College, Chennai, Tamil Nadu
S.V. Medical College Tirupati, Andhra Pradesh
Gajra Raja Medical College Gwalior, Madhya Pradesh
Jorhat Medical College and Hospital, Jorhat, Assam
University College of Medical Sciences & GTB Hospital, Delhi
Pandit Dindayal Upadhyay Medical College, Rajkot Gujarat
Netaji Subash Chandra Bose Medical College, Jabalpur, MP
Government Medical College, Kota, Rajastan
Government Medical College, Kozhikode, Kerala
NMISR, Kohima, Nagaland

National Antimicrobial Resistance Surveillance Data

Antimicrobial resistance (AMR) has become one of the most significant global public health challenges of the 21st century. The increasing prevalence of resistant pathogens threatens to reverse decades of medical progress, rendering common infections more difficult to treat. Addressing AMR requires urgent and coordinated global efforts encompassing strengthened surveillance, responsible antimicrobial stewardship, continued innovation, and increased public and professional awareness.

The Government of India has duly recognized the challenge posed by AMR and has undertaken initiatives to address this important public health issue. The **"National Programme on Antimicrobial Resistance Containment"**, coordinated by the National Centre for Disease Control (NCDC), New Delhi, represents a strategic response to the growing challenge of AMR.

As part of this initiative, NCDC has established the **National AMR Surveillance Network (NARS-Net)** to systematically monitor resistance patterns among a wide range of pathogens, enabling the early detection of emerging threats and supporting timely interventions to prevent their spread. By linking surveillance insights with clinical practice, the programme strengthens India's ability to manage resistant infections and maintain the effectiveness of currently available antimicrobials.

The NARS-Net sentinel sites adhere to the Standard Operating Procedures (SOPs) while submitting the data to NCDC monthly. To ensure data quality, sites also follow internal quality control (IQC) measures and participate in National External Quality Assessment Scheme (EQAS) programs.

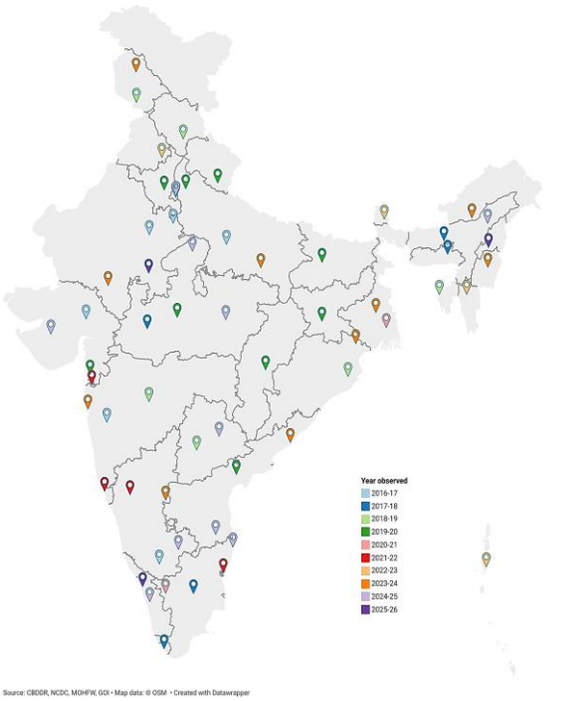


Fig. 1- Geographic location of 62 NARS-Net Laboratories submitting AMR data for

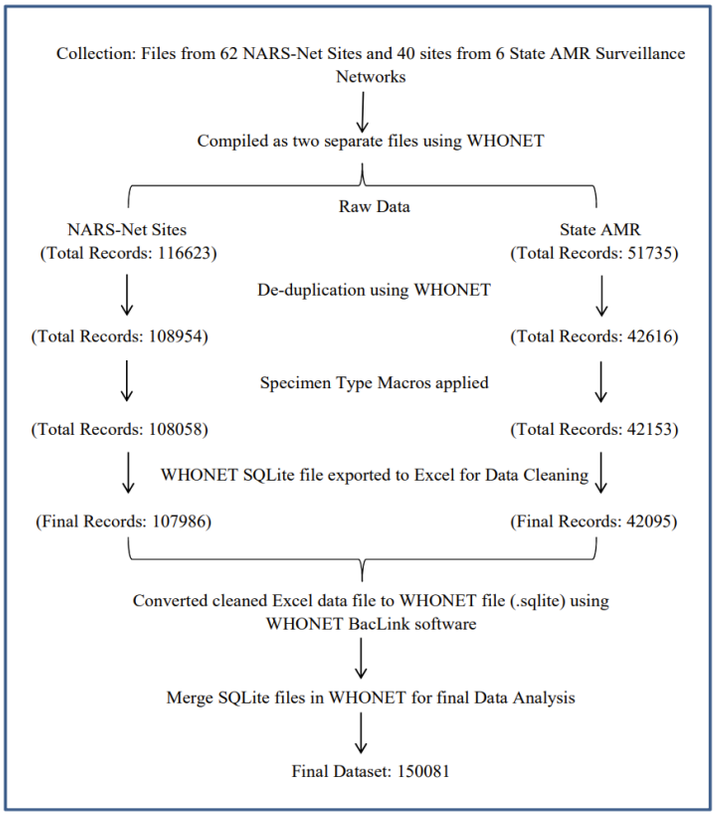


Fig. 2- Flowchart to obtain a clean WHONET Datafile

This is the seventh semi-annual bulletin representing AMR data for the period between January-June 2026 from 102 laboratories. Of the 102, 62 NARS-Net sites are medical college laboratories in 27 states and 6 UTs (Fig. 1) and 40 medical college laboratories are under 6 State AMR Surveillance networks viz. DENSAR (Delhi Network for Surveillance of AMR), KARSNET (Kerala AMR Surveillance Network), MAHASAR (Maharashtra State Surveillance for AMR), GUJSAR (Gujarat State Surveillance for AMR) and RAJSAR (Rajasthan State Surveillance for AMR) and KASAR (Karnataka State AMR Surveillance). Data from state surveillance networks includes data only from NABL accredited labs to ensure their participation in EQAS.

AMR Surveillance Findings

In this six-monthly bulletin, AMR data comprising 1,50,081 isolates corresponding to 1,50,071 unique patients were collated and analysed. The revised WHONET data files received on monthly basis from 102 sites were combined in 2 separate sqlite files, one for NARS-Net sites and the other for State AMR network sites which were further subjected to deduplication.

The specimen type WHONET macros were applied to filter data for the priority pathogens and priority specimen types as per the programme data management SOP. Thereafter, the deduplicated WHONET data files were exported to excel by WHONET software for final data cleaning. The cleaned data files in excel format were backlinked to obtain WHONET (.sqlite) file for initiating the data analysis. Subsequently the 2 (.sqlite) files obtained were merged for initiating data analysis (Fig. 2). Among unique patients, 51.7% of 1,38,788 included in the gender analysis were male and 48.2% female (Fig. 4). In the age analysis (N=1,39,687), the 45-64 year group was the largest (28.5%) and the 1-4 year group the smallest (3.7%) (Fig. 5).

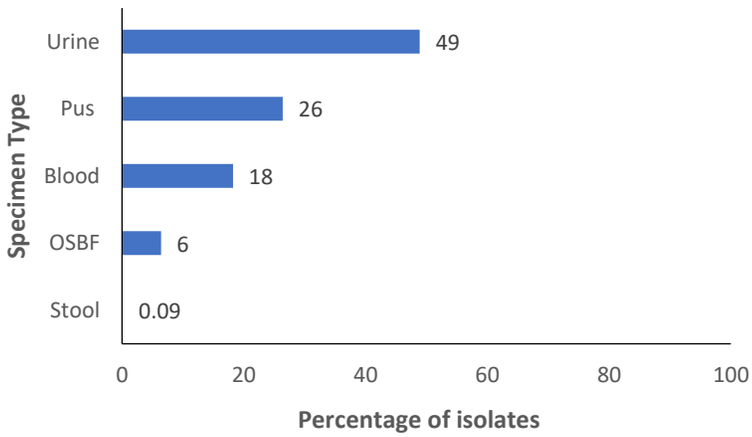
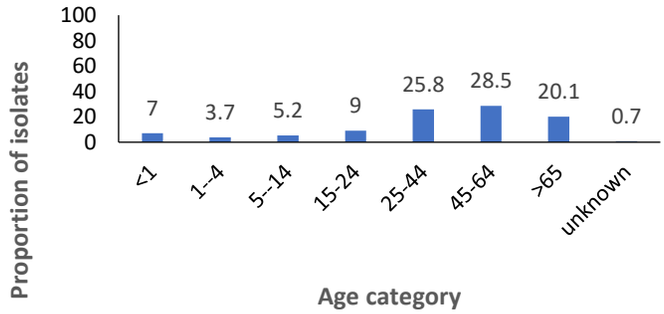


Fig. 3- Percentage Distribution of priority pathogen isolates based on specimen type (JAN - JUNE 2026)



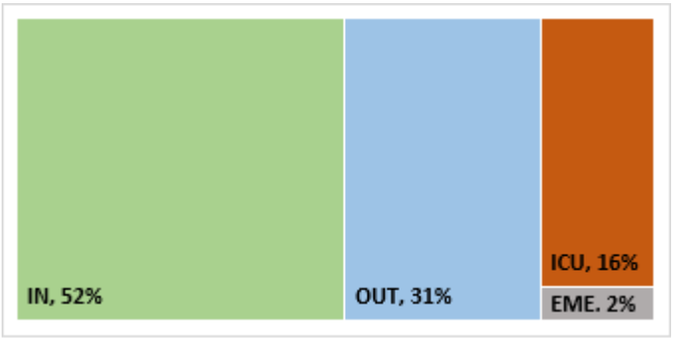
* Gender unknown/missing for 78 (0.1%) unique patients

Fig.4- Gender distribution among unique patients included in the gender analysis (N=1,38,788)



*Age unknown/missing for 0.7% of unique patients.

Fig. 5- Age distribution among unique patients included in the age analysis (N=1,39,687).



*Location type was unknown for 14 isolates.

Fig. 6- Distribution of priority pathogen isolates by location type (N=1,50,081)

AMR Surveillance Priority pathogens

During January to June 2026 data reporting period, the most commonly isolated priority bacterial pathogen was *E. coli* (36%), which is almost similar to the previous years, followed by *Klebsiella* species (23%), *Pseudomonas* species (11%), *Enterococcus* species (11%), *Acinetobacter* species (9%), *Staphylococcus aureus* (9%). During this reporting period, the proportion of *Salmonella* Typhi and Paratyphi isolates increased from 0.94% in the previous six months to 1.02%. *Shigella* spp. constituted 0.07% of isolates during the current reporting period, compared with 0.05% in the previous six months. However, only 2 *Vibrio cholerae* isolates have been reported during this period (Table 1).

The majority of isolates were from patients admitted in hospital wards (52%) whereas almost a third of the isolates (31%) were from outpatient clinics. Sixteen percent of priority pathogens were isolated from ICU settings (Fig. 6). Amongst the IPD and OPD, the most commonly isolated priority pathogen was *E. coli* followed by *Klebsiella* spp. However, in ICU settings *Klebsiella* spp. was the most commonly isolated pathogen followed by *Esch. coli* & *Acinetobacter* spp. (Fig. 7)

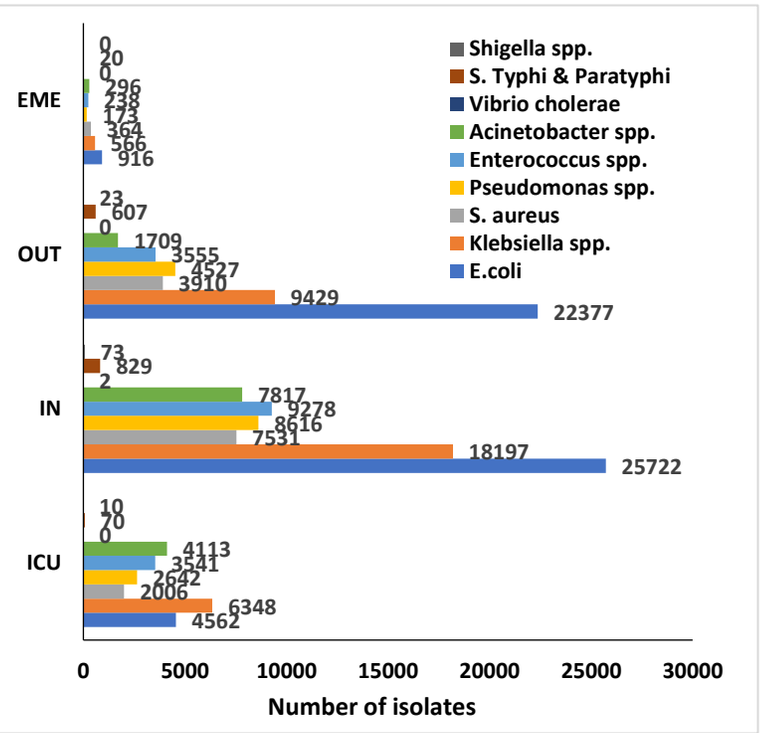


Fig. 7- Distribution of priority pathogen isolates by location-type

Table 1- Isolation of priority pathogens by specimen type

Priority Specimen	Blood (N=27,341)		OSBF (N=9,626)		Pus Aspirate (N=39,592)		Urine (N=73,381)		Stool (N=141)		Total (N=150081)	
	Number Tested	%	Number Tested	%	Number Tested	%	Number Tested	%	Number Tested	%	Number Tested	%
E.coli	4099	15	2146	22	9230	23	38109	52	x	x	53584	36
***Klebsiella* species**	6297	23	2566	27	9082	23	16596	23	x	x	34541	23
***Acinetobacter* species**	5572	20	1890	20	4215	11	2258	3	x	x	13935	9
***Pseudomonas* species**	2685	10	1494	16	6397	16	5385	7	x	x	15961	11
Salmonella Typhi	1157	4	x	x	x	x	x	x	7	5	1164	0.78
Salmonella Paratyphi	337	1	x	x	x	x	x	x	26	18	363	0.24
***Shigella* species**	x	x	x	x	x	x	x	x	106	75	106	0.07
Vibrio cholerae	x	x	x	x	x	x	x	x	2	1	2	-
Staphylococcus aureus	4062	15	695	7	9056	23	x	x	x	x	13813	9
***Enterococcus* species**	3132	11	835	9	1612	4	11033	15	x	x	16612	11

AMR Surveillance Resistance Profile

Gram-positive bacterial pathogens

In this six-month reporting period, Gram-positive bacteria viz. *S.aureus* and *Enterococcus* species constituted 20% of the reported priority pathogen isolates.

Of the 62 NARS-Net sites, 52 sites have started performing vancomycin agar screen method. AMR Programme unit at NCDC has provided broth microdilution training to all 70 NARS-Net sites in April 2026. Only the AMR Alert isolates confirmed at the NRL have been included in this bulletin.

Staphylococcus aureus

Sixty percent of *S. aureus* isolates from blood were found to be MRSA. Of the 102 sites, 54 sites are performing vancomycin agar screen (VAS) test for *S. aureus*. Of the 9,119 isolates tested by VAS method, none of the isolates showed resistance to vancomycin. *S. aureus* isolates from blood (0.13%) and other sterile body fluids (0.15%) showed similar resistance, while pus aspirates showed 0.09% resistance to linezolid, which has slightly decreased from previous six months (Table 2; Fig. 8a). Identification based only on coagulase test continues to challenge accurate identification of *Staph aureus*.

Table 2- Resistance profile of *Staphylococcus aureus* (N=13,813)

Antibiotic Tested	Blood (N=4062)		OSBF (N=695)		PA (N=9056)	
	Number tested	%R	Number tested	%R	Number tested	%R
Cefoxitin	3494	60	592	57	7120	57
Gentamicin	3592	21	630	19	7827	22
Ciprofloxacin	3593	59	595	72	7742	76
Trimethoprim/Sulfamethoxazole	3377	29	616	30	7899	22
Clindamycin	3786	34	645	27	8533	26
Erythromycin	3893	60	653	54	8834	53
Linezolid	3882	0.13	659	0.15	8157	0.09
Teicoplanin	807	6	263	2	2244	3
Doxycycline	2832	12	387	8	5382	6

Enterococcus species

Enterococcus species was most commonly isolated from urine (66.4%) followed by blood (18.9%), pus aspirates (9.7%) and other sterile body fluids (5%). Isolates from blood showed 23% resistance to vancomycin. Resistance to linezolid in this reporting period was observed to be 3%. (Table 3; Fig. 8b).

Table 3- Resistance profile of *Enterococcus* species (N=16,612)

Antibiotic Tested	Blood (3132)		OSBF (835)		PA (1612)		Urine (11033)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Ampicillin	2255	70	532	63	1220	44	8207	62
Gentamicin-High	2541	52	675	41	1390	35	9617	52
Erythromycin	2870	79	769	77	1439	75	x	x
Linezolid	2894	3	775	3	1431	1	10246	2
Vancomycin	2887	23	765	17	1454	11	10106	11
Teicoplanin	2296	23	602	17	1122	14	7698	15
Doxycycline	1712	33	414	43	915	38	3459	45
Ciprofloxacin	x	x	x	x	x	x	9537	84
Fosfomycin	x	x	x	x	x	x	4451	53
Nitrofurantoin	x	x	x	x	x	x	9269	37
Tetracycline	x	x	x	x	x	x	6301	81

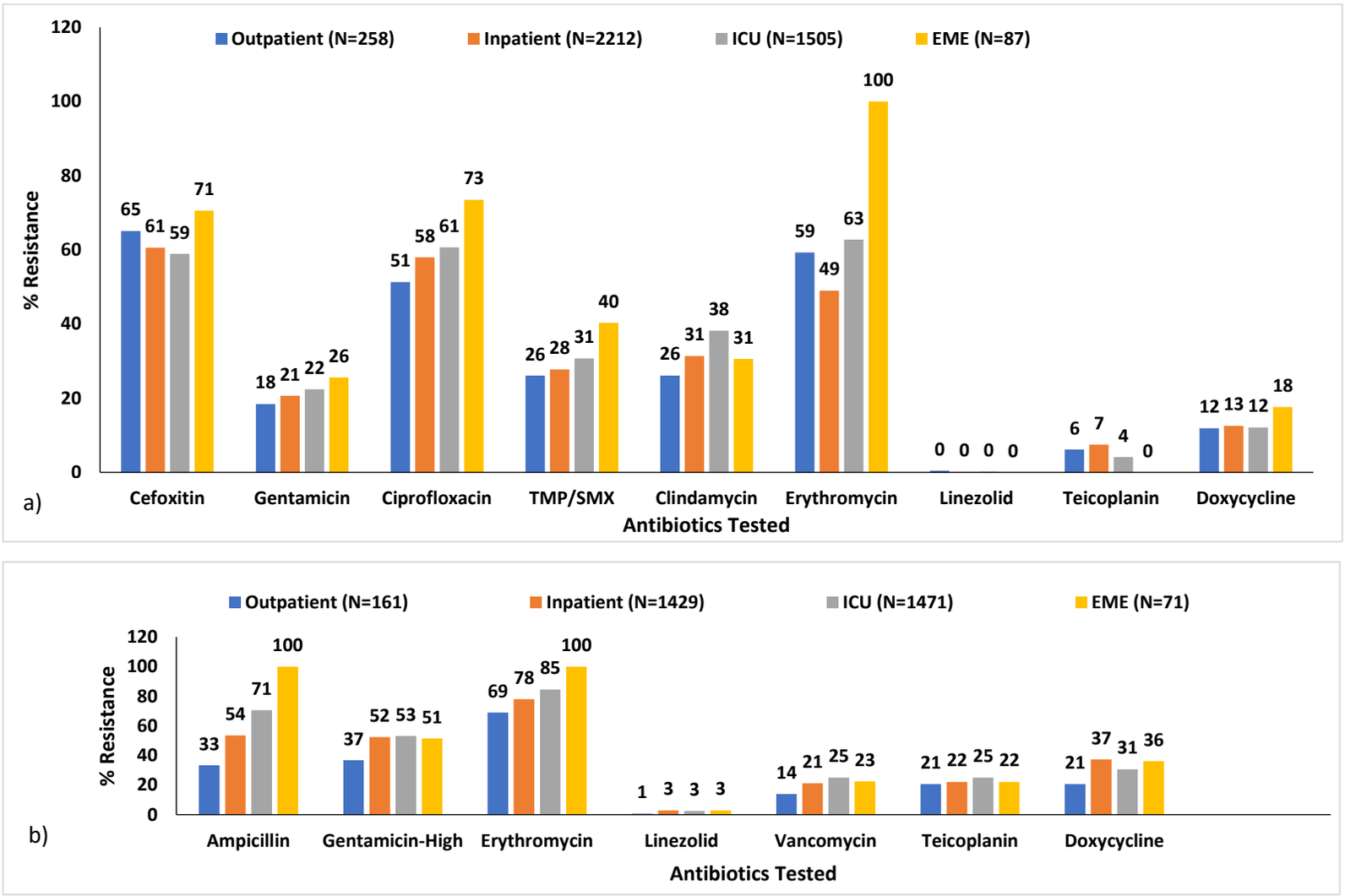


Fig. 8- Resistance profile of a) *S.aureus* (N=4,062) and b) *Enterococcus* spp. (N=3,132) in blood by location type

Gram-Negative Pathogens

In this six-month reporting period, Gram-negative bacteria constituted 80% of the reported priority pathogen isolates. Enterobacteriaceae accounted for 59.8% of the total priority pathogen isolates reported in this bulletin. All the colistin resistant isolates were confirmed using broth microdilution at AMR-NRL at NCDC.

Escherichia coli

E. coli contributed to one-third of the data in the current bulletin (53,584; 36%). Majority of *E. coli* isolates were from urine samples (71.1%) followed by pus aspirates (17.2%), blood (7.6%) and sterile body fluids (4%) (Table 1). Of 53,584 *E.coli* isolates, 33,547 were tested for colistin using broth microdilution (BMD) method and Colistin agar test.

Total of 33 (0.10%) *E.coli* isolates were confirmed as colistin resistant. Carbapenem resistance among blood isolates was found to be 29%-35% whereas among urine isolates it was 19%-22%. ESBL producing *E.coli* among blood isolates was 79%-80% and among urine isolates was 71%-73% (Table 4).

Klebsiella species

Klebsiella spp. contributed to 23% of the data during the current reporting period. ESBL producers among blood isolates was 79%-80% and among urine isolates was 68%-69%. Carbapenem resistance among blood isolates was found to be 61%-67%. Of 34,541 *Klebsiella* isolates, 22,405 were tested for colistin using BMD method/Colistin agar test (Table 5). Seventy-three isolates (0.32%) of *Klebsiella* species were confirmed to be colistin resistant at AMR-NRL at NCDC.

Table 4- Resistance Profile of *E.coli* (N=53,584)

Antibiotic Tested	Blood (4099)		OSBF (2146)		PA (9230)		Urine (38109)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Ampicillin	2076	92	1090	92	4777	90	22399	88
Amoxicillin/Clavulanic acid	2932	59	1599	67	7272	65	31010	54
Piperacillin/Tazobactam	3841	44	1957	55	8384	50	33878	35
Cefuroxime	2548	82	1116	82	5436	79	22177	73
Ceftriaxone	3131	80	1518	83	6592	79	26264	71
Cefotaxime	1905	79	1098	82	5420	79	24268	73
Cefepime	3749	61	1846	62	7785	59	30864	51
Ertapenem	2332	35	1168	40	5356	34	21634	22
Imipenem	3766	29	1785	33	8112	30	30033	21
Meropenem	3517	29	1820	32	8062	29	30256	19
Amikacin	3845	22	1927	23	8228	26	34343	22
Gentamicin	3710	32	1947	33	8222	32	30609	28
Ciprofloxacin	3618	77	1868	81	8167	78	32760	74
Trimethoprim/Sulfamethoxazole	3627	57	1923	56	8109	58	34656	53
Colistin	2785	0.1	1407	0	5612	0.02	23743	0.13
Doxycycline	x	x	566	51	2063	49	x	x
Nitrofurantoin	x	x	x	x	x	x	32852	19
Fosfomycin	x	x	x	x	x	x	25170	5

Table 5- Resistance profile of *Klebsiella* species (N=34,541)

Antibiotic Tested	Blood (6297)		OSBF (2566)		PA (9082)		Urine (16596)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Amoxicillin/Clavulanic acid	4956	78	1927	70	7397	73	13826	64
Piperacillin/Tazobactam	5708	69	2370	61	8328	64	14943	54
Cefuroxime	3465	81	1384	78	5491	75	9894	69
Ceftriaxone	4704	80	1825	76	6652	74	11575	68
Cefotaxime	2926	79	1385	72	5633	73	10356	69
Cefepime	5641	75	2207	67	7788	68	13542	60
Ertapenem	3642	67	1411	59	5269	52	9552	45
Imipenem	5615	61	2118	53	8053	51	13134	41
Meropenem	5212	62	2161	53	8064	51	13750	41
Amikacin	5730	61	2290	50	8026	54	15088	44
Gentamicin	5501	54	2255	48	8060	50	13407	43
Ciprofloxacin	5394	72	2129	67	7910	71	13905	67
Trimethoprim/Sulfamethoxazole	5356	53	2280	56	7907	57	14940	53
Colistin	4371	1.4	1713	0.9	5715	0.5	10606	0.6
Doxycycline	1465	33	556	37	2111	41	x	x
Nitrofurantoin	x	x	x	x	x	x	13599	63

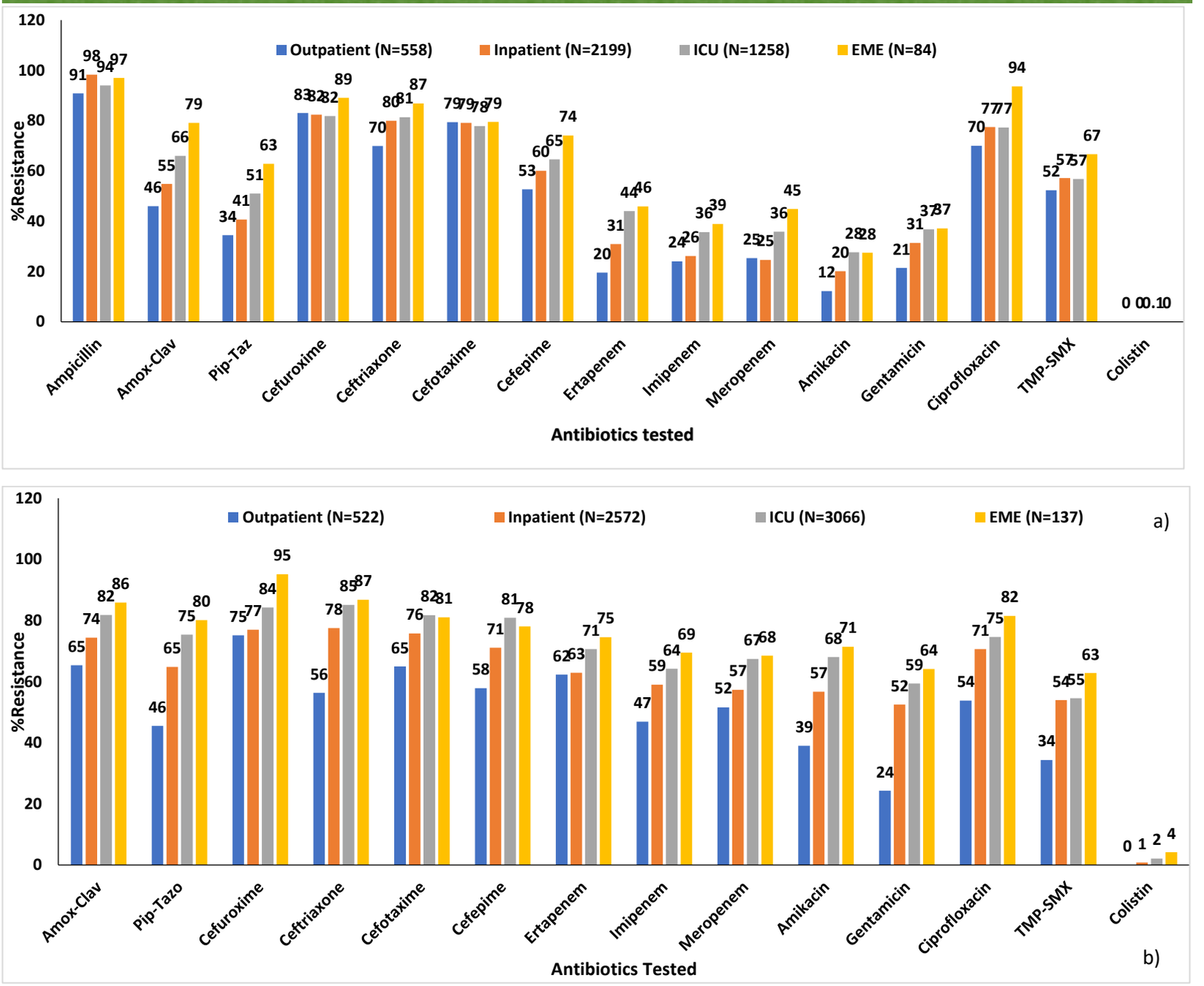


Fig. 9- Resistance Profile of a) *E.coli* (N=4,099) and b) *Klebsiella* species (N=6,297) in blood by location type

Klebsiella species showed higher resistance than *E.coli* to most of the tested antibiotics {Fig. 9(a) and 9(b)}.

Salmonella **Typhi and Paratyphi**

A total of 1,494 isolates of *Salmonella enterica* sero. Typhi and Paratyphi were received from blood, out of which 1,157 were *S. enterica* sero. Typhi and 337 were *S.* Paratyphi. Thirty-three blood isolates of *Salmonella enterica* sero. Typhi and 7 isolates of Paratyphi were found to be resistant to ceftriaxone. Four isolates of *S.* Typhi were azithromycin resistant (Table 6).

Table 6- Resistance profile of *S.* Typhi and *S.* Paratyphi (N=1,494) in blood isolates

Antibiotic Tested	Salmonella Typhi (N=1157)		Salmonella Paratyphi (N=337)	
	Number Tested	%R	Number Tested	%R
Ampicillin	892	8	213	4.6
Ceftriaxone	1071	3	316	2.2
Cefixime	283	0	95	0
Imipenem	902	0	252	0
Ciprofloxacin	1124	50	317	79
Pefloxacin	374	94	57	95
Azithromycin	907	2.5	x	x
Chloramphenicol	923	5	229	4

Shigella species

In this reporting period, AMR data of 106 isolates of *Shigella* species from stool specimen was analyzed. Highest resistance was observed against ciprofloxacin and ampicillin (Table 7).

Table 7- Resistance profile of *Shigella* species (N=106)

Antibiotic Tested	Number Tested	% Resistant
Ampicillin	81	77
Ceftriaxone	97	45
Ciprofloxacin	97	87
Trimethoprim/Sulfamethoxazole	102	39
Azithromycin	82	34
Chloramphenicol	71	14

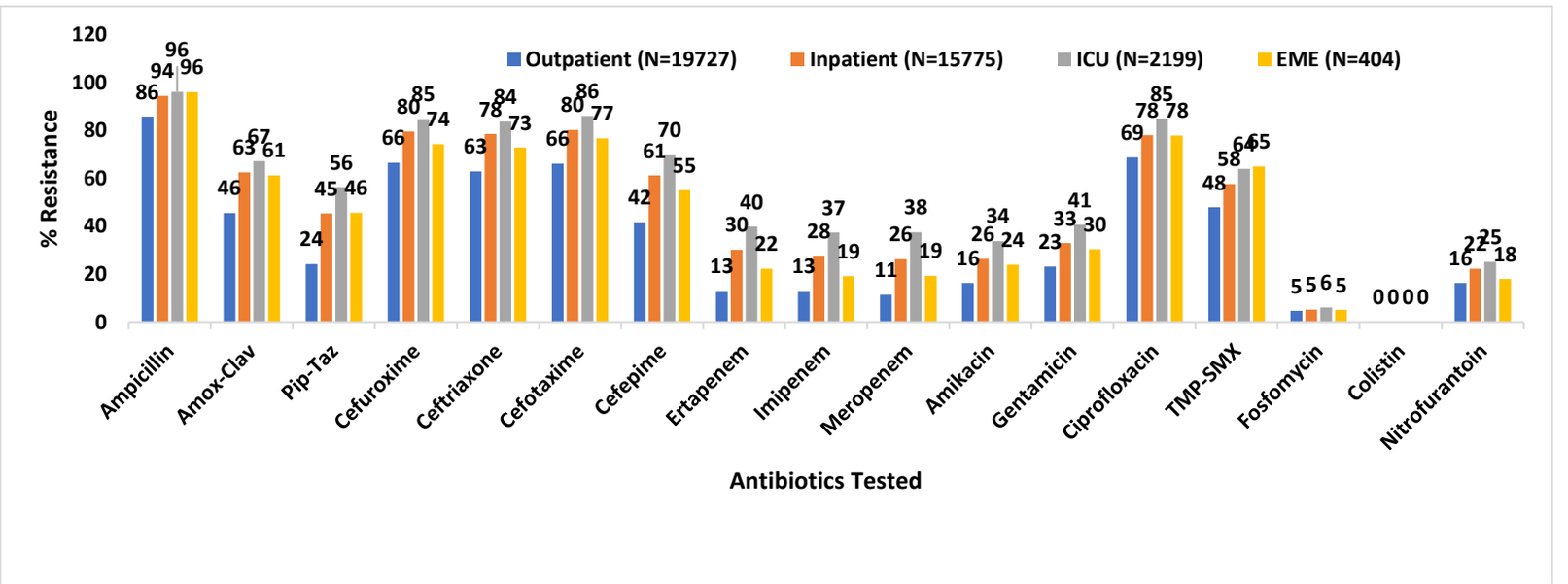


Fig. 10 Resistance Profile of E.coli (N=38,105*location type was unknown for 4 isolates) in urine by location type

Non- Fermenting Gram Negative Bacilli (NFGNB)

NFGNB accounted for 21% of the total unique patients isolates. *Pseudomonas* species was most frequently isolated from pus aspirates (40%) followed by urine (34%). Majority isolates of *Acinetobacter* species were from blood (40%) and pus aspirates (30%).

Pseudomonas species

A total of 15,961 *Pseudomonas* species were reported in this current period, of which 10,039 were tested for colistin using BMD.

The resistance to colistin amongst *Pseudomonas* spp. isolates was 0.2 % (23 isolates), Carbapenem resistance was found in 26% - 32% of blood isolates and 43% of urine isolates were found resistant to carbapenems {Table 8; Fig. 11(a)}.

Acinetobacter species

Acinetobacter species from blood, OSBF and pus aspirates showed >50% resistance to all the tested antibiotics excepting colistin and minocycline. Resistance to minocycline (38-51%) was observed to be almost similar from previous six months report (36-49%).

High resistance to carbapenem is consistent with observations of previous years. Of 8,288 isolates tested for colistin, 13 (0.15%) showed resistance (Table 9).

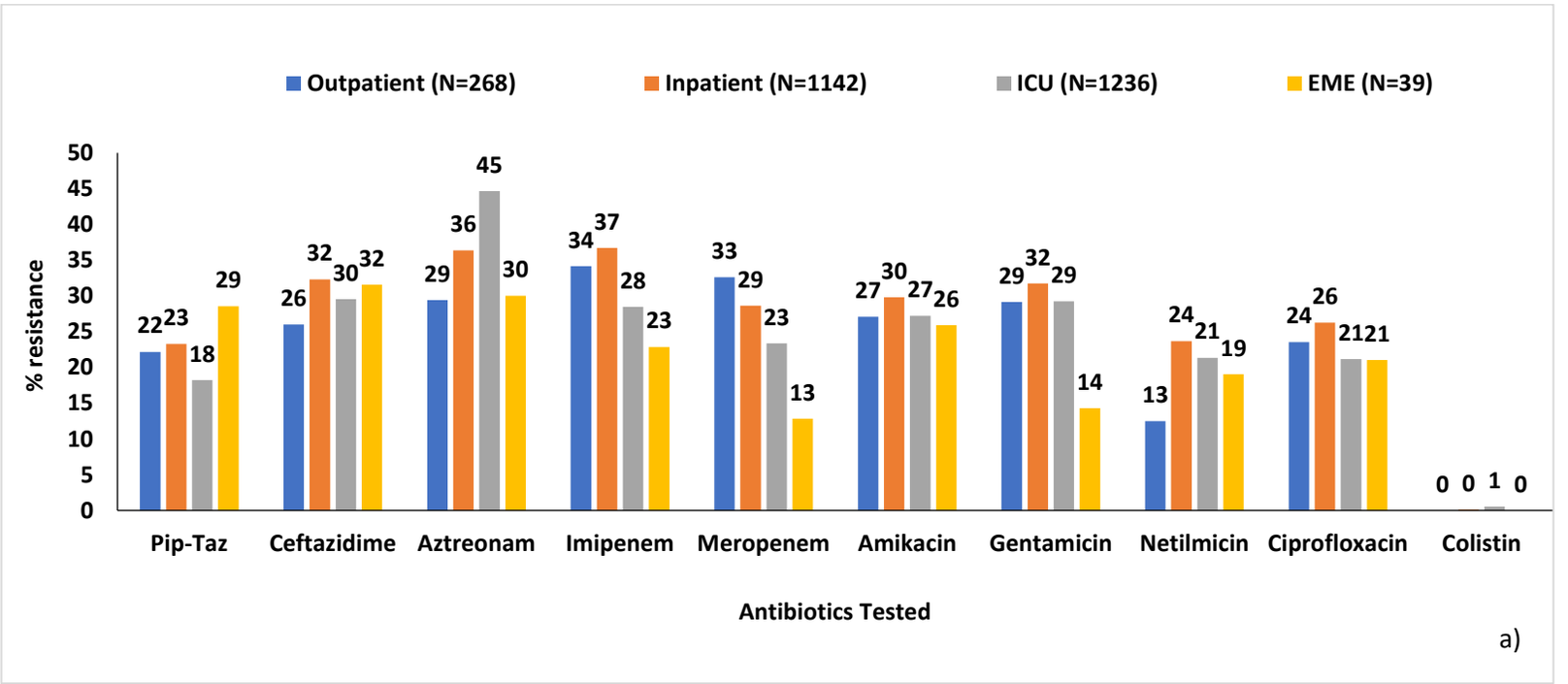
Among blood isolates of ICU patients, *Acinetobacter* species showed >70% resistance to most of the Tier 1 and Tier 2 antibiotics including aminoglycosides, third generation cephalosporins and carbapenems {Fig. 11(b)}.

Table 8- Resistance profile of *Pseudomonas* species (N=15,961)

Antibiotic Tested	Blood (2685)		OSBF (1494)		PA (6397)		Urine (5385)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Piperacillin/Tazobactam	2514	21	1431	27	6022	30	5016	37
Ceftazidime	2527	30	1385	35	5881	41	4734	49
Aztreonam	1913	40	906	29	4599	31	3412	39
Imipenem	2423	32	1273	32	5760	30	4517	43
Meropenem	2220	26	1138	35	5708	30	4419	43
Amikacin	2187	28	1125	23	4833	36	4895	41
Gentamicin	1664	30	785	25	3614	37	2486	44
Netilmicin	1352	22	677	22	3075	32	2531	40
Ciprofloxacin	2348	24	1293	34	5671	46	4717	54
Colistin	1779	0.2	976	0.1	3905	0.2	3379	0.3

Table 9- Resistance profile of *Acinetobacter* species (N=13,935)

Antibiotic Tested	Blood (5572)		OSBF (1890)		PA (4215)		Urine (2258)	
	Number Tested	%R	Number Tested	%R	Number Tested	%R	Number Tested	%R
Ampicillin/Sulbactam	2596	70	946	66	2367	81	1035	58
Piperacillin/Tazobactam	4893	69	1781	69	3826	78	1934	46
Ceftazidime	4621	79	1512	74	3319	85	1640	64
Imipenem	4780	74	1567	71	3746	76	1757	50
Meropenem	4123	69	1598	69	3631	73	1576	47
Amikacin	5213	66	1756	64	3704	79	1991	48
Gentamicin	4431	66	1710	65	3521	75	1781	46
Ciprofloxacin	4449	68	1475	70	3600	81	1755	53
Trimethoprim/Sulfamethoxazole	4322	57	1547	63	3289	74	1791	48
Colistin	3339	0.1	1215	0.2	2426	0.1	1308	0.1
Minocycline	3202	45	1168	49	2482	51	1159	38
Tetracycline	x	x	x	x	x	x	789	42



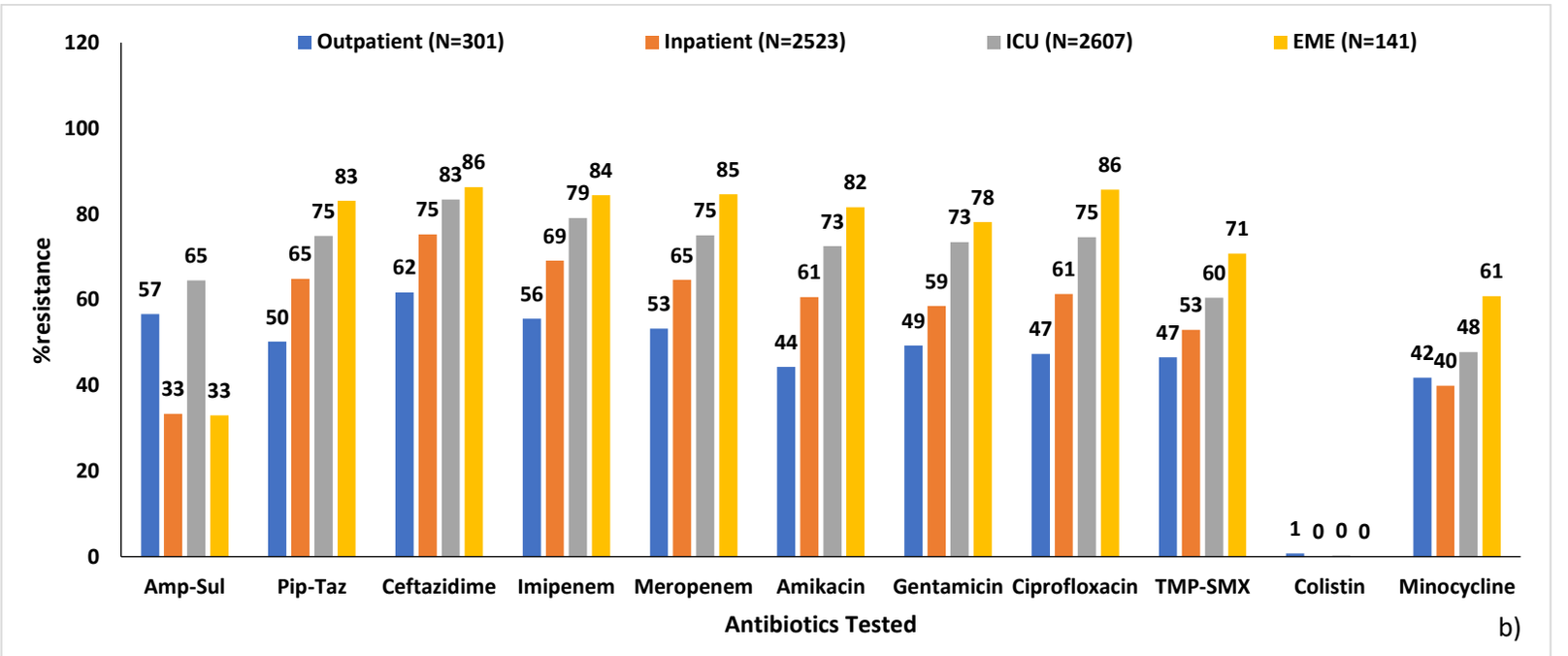


Fig. 11- Resistance Profile of a) *Pseudomonas* species (N=2,685) and b) *Acinetobacter* species (N=5,572) in blood by location type

Vibrio cholerae

In the current reporting period, data of 02 isolates of *Vibrio cholerae* confirmed at AMR-NRL have been analyzed. No resistance was observed against chloramphenicol, doxycycline and tetracycline.

Discussion and Conclusion

This bulletin presents the seventh semi-annual report on AMR surveillance. During the reporting period from January-June 2026, data from 102 surveillance sites, including 62 NARS-Net sites and 40 sites under State AMR Surveillance Networks, was collated, validated, and analyzed. For the state surveillance network, only data from NABL-accredited laboratories were included in the analysis to ensure their participation in EQAS. While interpreting comparisons in AMR data during previous reporting periods, changes in the number and composition of reporting laboratories should be considered, as these may influence pooled resistance percentages.

The proportion of MRSA among blood isolates was 60% in the current reporting period, compared with 56% in the previous six-month reporting period. Vancomycin resistance among *Enterococcus* spp. blood isolates was 23% versus 21% previously, while linezolid resistance was 3% versus 4%.

Among blood isolates, 1,157 *Salmonella* Typhi and 337 *Salmonella* Paratyphi isolates were reported in the current period, compared with 1,083 and 258, respectively, in the previous bulletin.

Amongst stool specimens reported in this bulletin, *Shigella spp.* was predominantly isolated (106). The resistance rates of *Shigella spp.* against Ciprofloxacin (87%) were similar to the previous bulletin (88%) while the rates have slightly increased for Ampicillin (from 68% in previous reporting period to 77% during current reporting period) and in this reporting period), while the resistance rate for Trimethoprim/Sulfamethoxazole has decreased from 48% in previous reporting period to 39% in this reporting period.

The AMR surveillance data of NARS-Net, like previous years, continues to have the limitation that referral of clinical specimens for culture and sensitivity testing is mostly from patients not responding to the prescribed antibiotics which the potential to skew the AMR trends to higher side than the actual trends.

In conclusion, the findings in this bulletin highlight the need for implementation of antimicrobial stewardship practices in healthcare settings to promote the judicious use of antimicrobials, particularly last-resort antibiotics.

AMR surveillance data support evidence-based policy formulation, resource prioritization, and targeted public health interventions. Nevertheless, the true impact of surveillance depends on the translation of evidence into meaningful action. Effective integration of surveillance findings with antimicrobial stewardship programmes, robust infection prevention and control practices, public awareness initiatives, and continued research efforts is critical for addressing the growing threat of AMR. Long-term commitment and coordinated action across all sectors are crucial for safeguarding the effectiveness of antimicrobials and protecting public health.

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