ISSUE
05/2025
January-June 2025

SEMI-ANNUAL BULLETIN

NARSNET Sites

1. LHMC and Associated Hospitals, Delhi
2. VMMC and SJ Hospital, Delhi
3. SMS Medical College, Jaipur, Rajasthan
4. BJ Medical College, Ahmedabad, Gujarat
5. BJ Medical college, Pune, Maharashtra
6. Government Medical college, Chandigarh
7. MMCRI, Mysuru, Karnataka
8. GSVM Medical College, Kanpur, Uttar Pradesh
9. Gauhati Medical College & Hospital, Guwahati, Assam
10. KAP V. GMC, Tiruchirappalli, Tamil Nadu
11. NEIGRIHMS, Shillong, Meghalaya
12. Govt. Medical College, Thiruvananthapuram, Kerala
13. MGM College and Hospital, Indore, Madhya Pradesh
14. IGMC, Shimla, Himachal Pradesh
15. GMC & Hospital, Aurangabad, Maharashtra
16. Osmania Medical College, Hyderabad, Telangana
17. Govt. Medical College & Hospital, Jammu, J&K
18. Agartala Govt. Medical College, Agartala, Tripura
19. Guntur Medical College, Guntur, Andhra Pradesh
20. SCB Medical College & Hospital, Cuttack, Odisha
21. Pt. JLNM Medical College, Raipur, Chhattisgarh
22. RIMS, Ranchi, Jharkhand
23. Pt. BDS PGIMS Rohtak, Haryana
24. IGIMS, Sheikpura, Patna, Bihar
25. Government Medical College, Haldwani, Uttarakhand
26. Gandhi Medical College, Bhopal, Madhya Pradesh
27. Calcutta STM, Kolkata, West Bengal
28. LLRM Medical College, Meerut, Uttar Pradesh
29. GMERS Medical College & Civil Hospital, Valsad, Gujarat
30. Coimbatore Medical College & Hospital, Coimbatore, Tamil Nadu
31. KIMS, Hubli, Karnataka
32. IGMCRI, Puducherry
33. NAMO MERI, Silvassa, Dadra & Nagar Haveli
34. MAMC & Associated Hospitals, Delhi
35. SPMC & Associated Hospital, Bikaner, Rajasthan
36. Goa Medical College & Hospital, Bambolim, Goa
37. STNM Medical College & Hospital, Gangtok, Sikkim
38. Government Medical College, Patiala, Punjab
39. Zoram Medical College, Falkawn, Mizoram
40. Andaman & Nicobar Islands Institute of Medical Sciences, Andaman & Nicobar Islands
41. RNT Medical College, Udaipur, Rajsthan
42. JNIMS, Imphal, Manipur
43. GMC, Srinagar, Jammu & Kashmir
44. AMC, Vishakhapatnam, Andhra Pradesh
45. VIMS, Ballari, Karnataka
46. BMC & Hospital, Burdwan, West Bengal
47. GGMC & JJ Grp of Hospitals, Mumbai, Maharshtra
48. Pt. RMMC & Hospital, Baripada, Odisha
49. UCMS & Associated GTB Hospital, Delhi
50. Pt. DDUMC, Rajkot, Gujarat
51. GMC Thrissur, Kerala
52. SVMC Tirupati, Andhra Pradesh
53. Jorhat Med College & Hospital, Jorhat, Assam
54. NSCBMC, Jabalpur, Madhya Pradesh
55. Toma Riba Institute of Health and Medical Sciences, Naharlugan, Arunachal Pradesh
56. Bangalore Medical College and Research Institute, Bengaluru, Karnataka
57. Kakatiya Medical College, Warangal, Telangana
58. Madras Medical College, Chennai, Tamil Nadu
59. Gajra Raja Medical College, Gwalior, Madhya Pradesh

National Antimicrobial Resistance Surveillance Data

National AMR Surveillance Network (NARS-Net)

Antimicrobial resistance (AMR) has emerged as one of the most pressing global health challenge of the 21st century. The rise of AMR threatens to undermine decades of medical progress, making common infections harder to treat. Procedures such as surgery, cancer therapy, and organ transplantation also become riskier without effective antimicrobials and minor infections could become fatal. Addressing AMR requires urgent, coordinated global action through surveillance, stewardship, innovation, and awareness.

AMR surveillance plays a pivotal role in protecting global health security. It provides vital insights into how resistance emerges, evolves, and spreads, enabling health systems to stay ahead of this rapidly escalating threat. Surveillance helps to identify resistant pathogens, detect unusual trends, and assess the effectiveness of existing treatments. Data generated through surveillance supports the development of new diagnostics, vaccines, and therapeutics by highlighting gaps in current treatment options.

The "National Programme on Antimicrobial Resistance Containment", launched by the Government of India and 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 developed the National AMR Surveillance Network (NARS-Net) to systematically track resistance patterns across diverse pathogens and identify emerging threats proactively and prevent their spread by timely action. By aligning surveillance data with clinical practice, the programme strengthens India's ability to contain resistant infections and preserve the efficacy of existing antimicrobials.

The sentinel sites submit the antimicrobial susceptibility testing (AST) data to NCDC monthly, adhering to programme standard operating procedures including internal quality control (IQC). The sites also participate in National level External Quality Assessment Schemes (EQAS).

The network sites used WHONET 2025, offline data management software, to collect, collate and analyze AST data of their laboratories. Data quality was monitoried closely, and analysis was done after data validation and de-duplication.

National Programme on AMR Containment,
National Centre for Disease Control (NCDC), Directorate General of Health Services,
Ministry of Health & Family Welfare, Government of India

NCDC prepares annual reports and semi-annual bulletins after collating data for priority bacterial pathogens from defined specimen types. The compiled data is also part of the country data submitted to Global AMR and use Surveillance System (GLASS).

This fifth semi-annual bulletin is a representation of AMR data from 59 state govt. medical college laboratories in 27 states and 6 UTs enrolled under NARS-Net submitted from 1st January 2025 to 30th June 2025 . (Fig. 1).

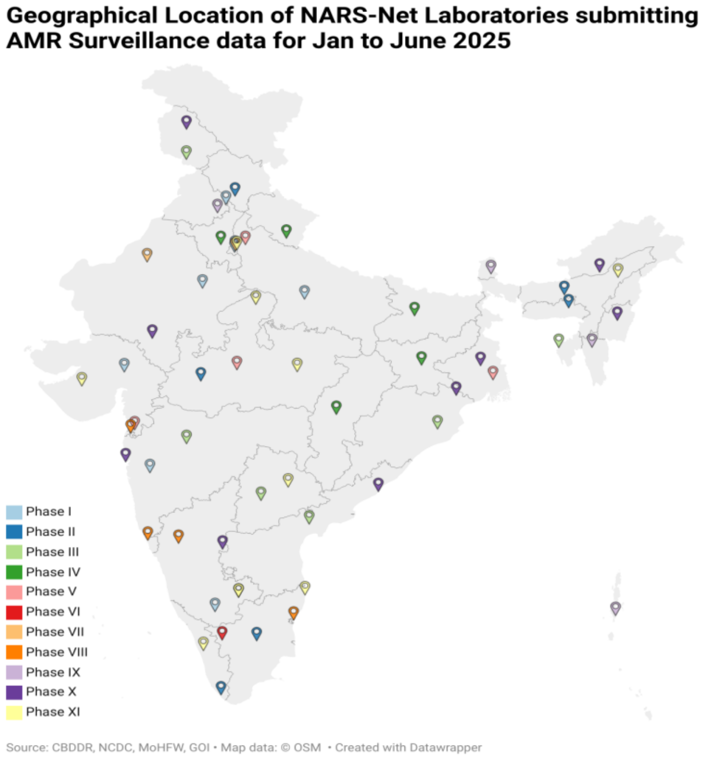


Fig. 1- Geographic location of NARS-Net Laboratories submitting AMR data for January-June 2025

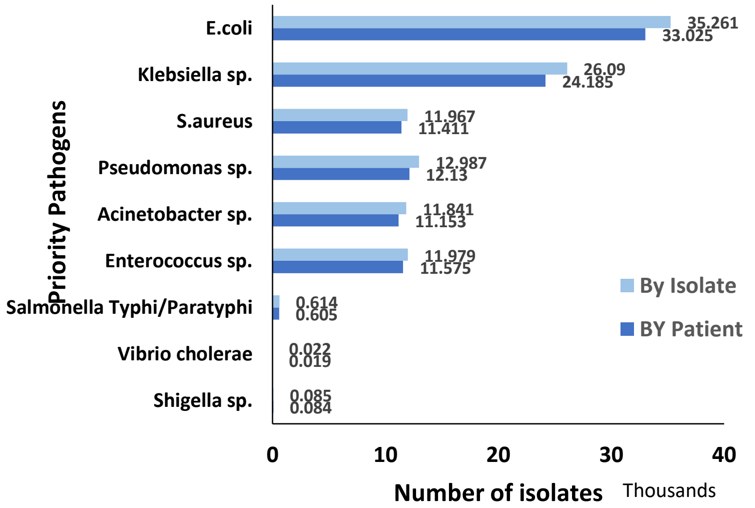


Fig. 2- Distribution of priority pathogen isolates and Unique patient isolates

AMR Surveillance Findings

In this six-monthly bulletin, AMR data of 1,04,187 unique patients has been reported after de-duplication of the 1,10,846 isolate data. (Fig.2). Of 1,04,187 unique patients, 53% were male and 47% female patients (Fig.4). As per the age category, 29% of the patients belonged to age group 25-44 and 26.5% to age group 45-64 whereas least was reported from children in age group of 1-4 years of age (Fig. 5).

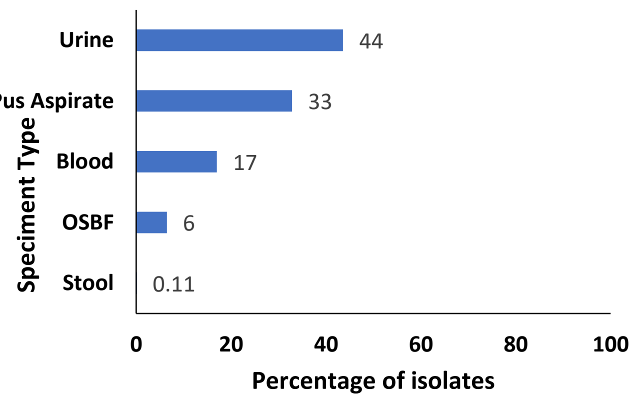


Fig. 3- Percentage Distribution of priority pathogen isolates based on specimen type, NARS-Net (January - June 2025)

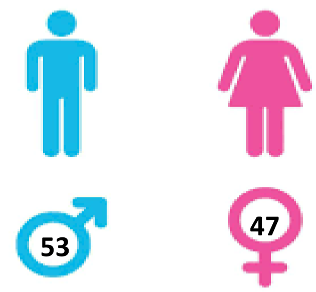


Fig.4- Gender-wise distribution of all priority pathogen isolates (%)

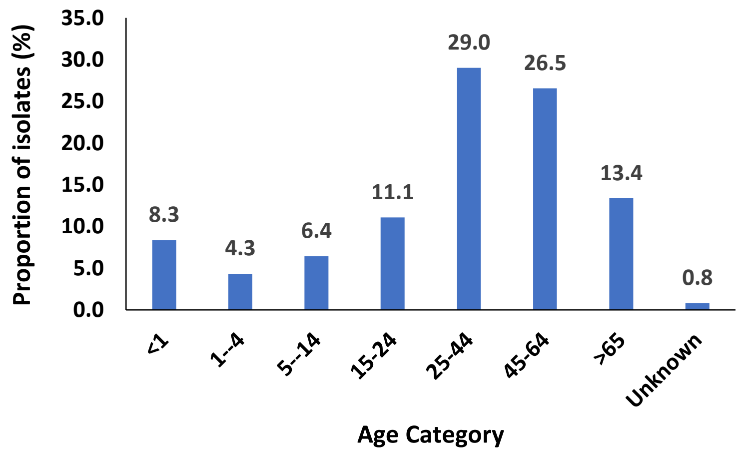


Fig. 5- Distribution of all priority pathogen isolates by age category (N=1,04,187)

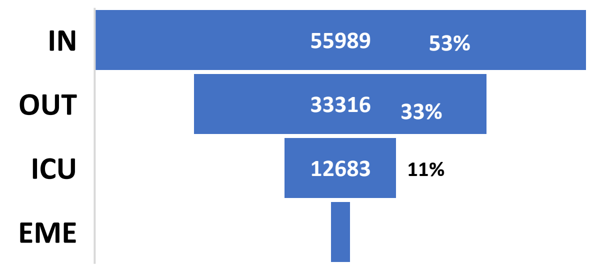


Fig. 6- Distribution of priority pathogen isolates by location type (N=1,04,187)

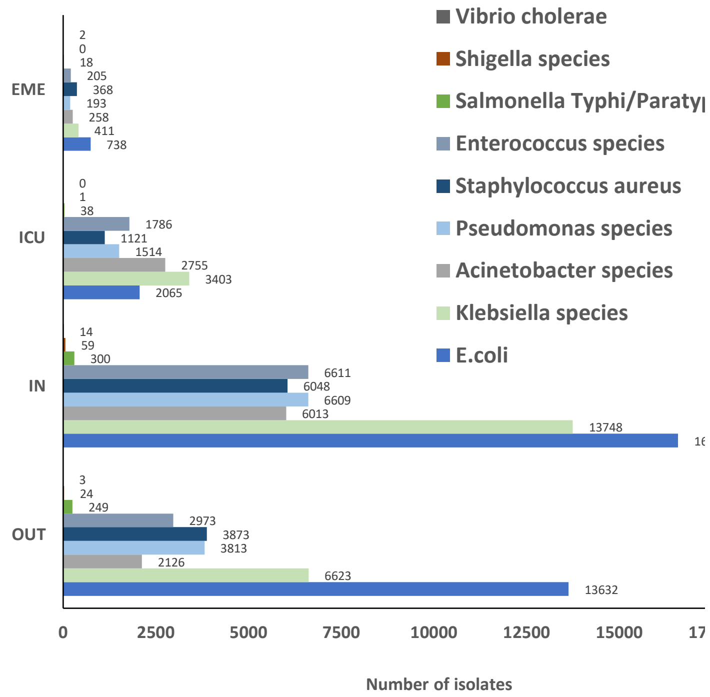


Fig. 7- Distribution of priority pathogen isolates by location-type

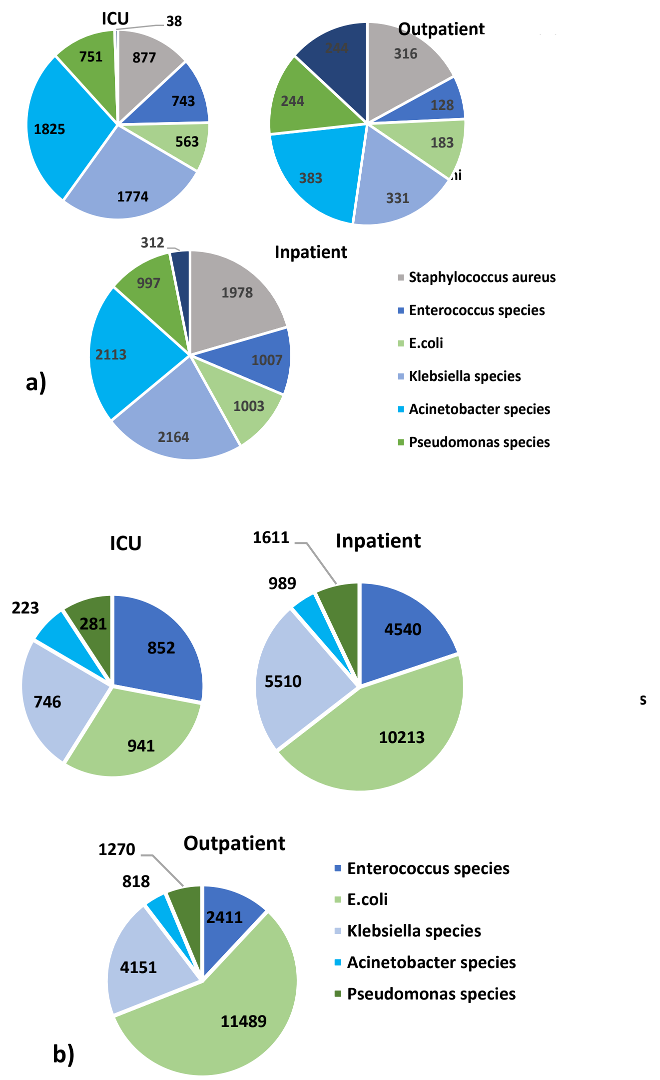


Fig.8- Location-typewise distribution of prority pathogens isolated from a) blood and b) urine

Table 1- Isolation of priority pathogens by specimen type

Priority Specimen	Blood (N=17,974)		OSBF (N=6,644)		Pus Aspirate (N=33,409)		Urine (N=46,046)		Stool (N=114)		Total	
	Number Tested	%	Number Tested	%	Number Tested	%	Number Tested	%	Number Tested	%		%
E.coli	1749	9.7	1409	21.2	7223	21.6	22644	49.2	x	x	33025	32
***Klebsiella* species**	4269	23.8	1650	24.8	7859	23.5	10407	22.6	x	x	24185	23
***Acinetobacter* species**	4321	24	1480	22.3	3322	9.9	2030	4.4	x	x	11153	11
***Pseudomonas* species**	1992	11.1	1022	15.4	5954	17.8	3162	6.9	x	x	12130	12
Salmonella Typhi	510	2.8	X	X	X	X	X	X	6	5.3	516	0.5
Salmonella Paratyphi	84	0.5	X	X	X	X	X	X	5	4.4	89	0.09
***Shigella* species**	X	X	X	X	X	X	X	X	84	73.7	84	0.08
Vibrio cholerae	X	X	X	X	X	X	X	X	19	16.7	19	0.02
Staphylococcus aureus	3171	17.6	476	7.2	7764	23.2	X	X	x	x	11411	11
***Enterococcus* species**	1878	10.4	607	9.1	1287	3.9	7803	16.9	x	x	11575	11

AMR Surveillance Priority pathogens

During January to June 2025 data reporting period, the most commonly isolated priority bacterial pathogen was *E. coli* (32%), which is similar to the previous years, followed by *Klebsiella* species (23%), *Pseudomonas* species (12%), *Acinetobacter* species (11%), *Enterococcus* species (11%), *Staphylococcus aureus* (11%) and and *Salmonella enterica* serovar Typhi and Paratyphi (0.58%), *Vibrio cholerae* (0.02%) and *Shigella* species (0.08%) (Table1).

The majority of isolates were from patients admitted in hospital wards (IPD- 53%) whereas almost a third of the isolates (33%) were from patients visiting the outpatient clinics. Eleven 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 *Acinetobacter* spp. (Fig. 7)

AMR Surveillance Resistance Profile

Gram-positive bacterial pathogens

In this six month reporting period, Gram-positive bacteria viz. *S.aureus* and *Enterococcus* species constituted 22% isolates data among all the priority pathogens isolates.

Staphylococcus aureus

Fifty five percent of *S.aureus* isolates were found to be MRSA. Of 59 sites, 46 sites are performing vancomycin agar screen (VAS) test for *S.aureus*. None of the isolates showed growth on VAS plate. *S.aureus* isolates from blood showed almost similar resistance to linezolid (0.17%) as compared to the previous six months (0.14%).

***Enterococcus* species**

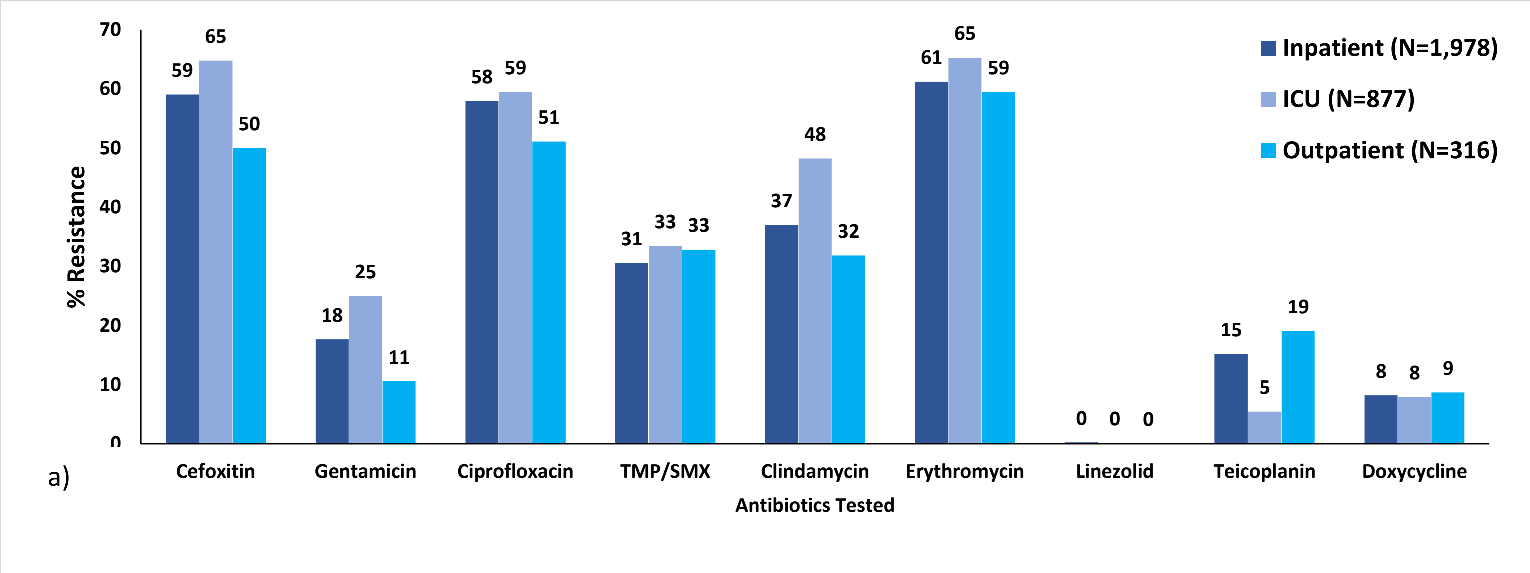
Enterococcus species was most commonly isolated from urine (67%) followed by blood (16%), pus aspirates (11%) and other sterile body fluids (5%). Isolates from blood showed 20% resistance to vancomycin and 2.2% resistance to linezolid. The proportion of VRE is consistently increasing from last 3 years.

Table 2- Resistance profile of *Staphylococcus aureus* (N=11,411)

Antibiotic Tested	Blood (N=3,171)		OSBF (N=476)		PA (N=7,764)	
	Number tested	%R	Number tested	%R	Number tested	%R
Cefoxitin	2595	60	402	54	6404	54
Gentamicin	2547	19	407	16	6194	20
Ciprofloxacin	2443	58	404	60	5917	76
Trimethoprim/Sulfamethoxazole	2365	32	396	22	6204	22
Clindamycin	2678	40	427	34	6989	29
Erythromycin	2889	62	445	56	7272	54
Linezolid	2888	0.17	448	0	7182	0.14
Teicoplanin	556	13	122	10	1128	9
Doxycycline	2319	8	344	4	5085	4

Table 3- Resistance profile of *Enterococcus* species (N=11,575)

Antibiotic Tested	Blood (N=1,878)		OSBF (N=607)		PA (N=1,287)		Urine (N=7,803)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Ampicillin	1495	70	410	65	972	47	5934	57
Gentamicin-High	1597	50	544	37	1059	31	6540	49
Erythromycin	1615	79	531	73	1071	71	x	x
Linezolid	1719	2.2	562	2.3	1180	1.2	7392	0.5
Vancomycin	1751	20	570	15	1145	9	7396	9
Teicoplanin	1364	24	452	20	829	18	5035	15
Doxycycline	1267	30	402	29	853	28	2352	40
Ciprofloxacin	x	x	x	x	x	x	5995	81
Tetracycline	x	x	x	x	x	x	4306	75
Fosfomycin	x	x	x	x	x	x	3433	50
Nitrofurantoin	x	x	x	x	x	x	6718	37



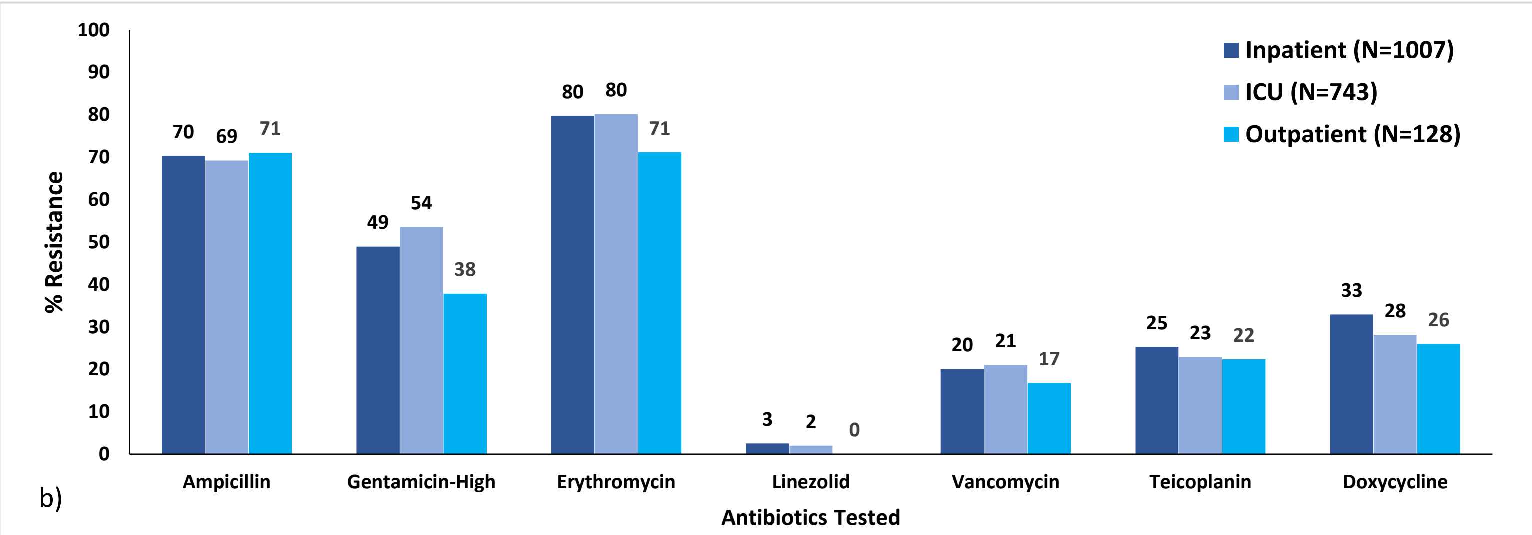


Fig. 8- Resistance profile of a) *S.aureus* (N=3,171) and b) *Enterococcus* spp. (N=1,878) in blood by location type

Gram-Negative Pathogens

AST data of 86,900 isolates of Gram-negative bacterial pathogens have been reported from 81,201 unique patients. Of the Gram-negative pathogens, Enterobacteriaceae accounted for 71% (57,899) of unique patient isolates. 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 unique patient AST data (33,025) (Fig. 1). *E coli* was most commonly isolated from urine samples (69%) followed by pus aspirates (22%), blood (5%) and sterile body fluids (4%) (Table 1). Of 33,025 *E.coli* isolates, 16,726 were tested for colistin using broth microdilution (BMD) method. Only 11 (0.1%) were confirmed as colistin resistant *E.coli* isolates.

Klebsiella species

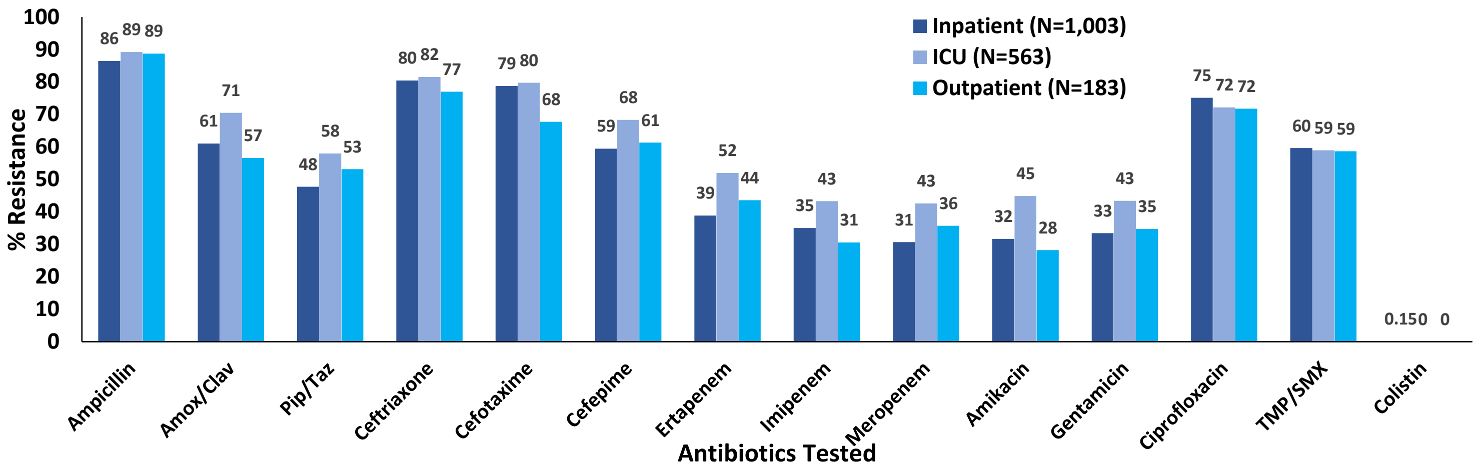
Klebsiella species accounted for 23% of unique patient isolates. Notably, a high resistance to carbapenems was observed among blood isolates of *Klebsiella* species (59%-60%). Excepting aminoglycosides, all other tested antibiotics had more than 50% resistance against *Klebsiella* species. Of 24,185 *Klebsiella* isolates, 12,410 were tested for colistin using BMD method. Seventy two isolates (0.6%) were confirmed at NRL as colistin resistant *Klebsiella* species.

Table 4- Resistance Profile of *E.coli* (N=33,025)

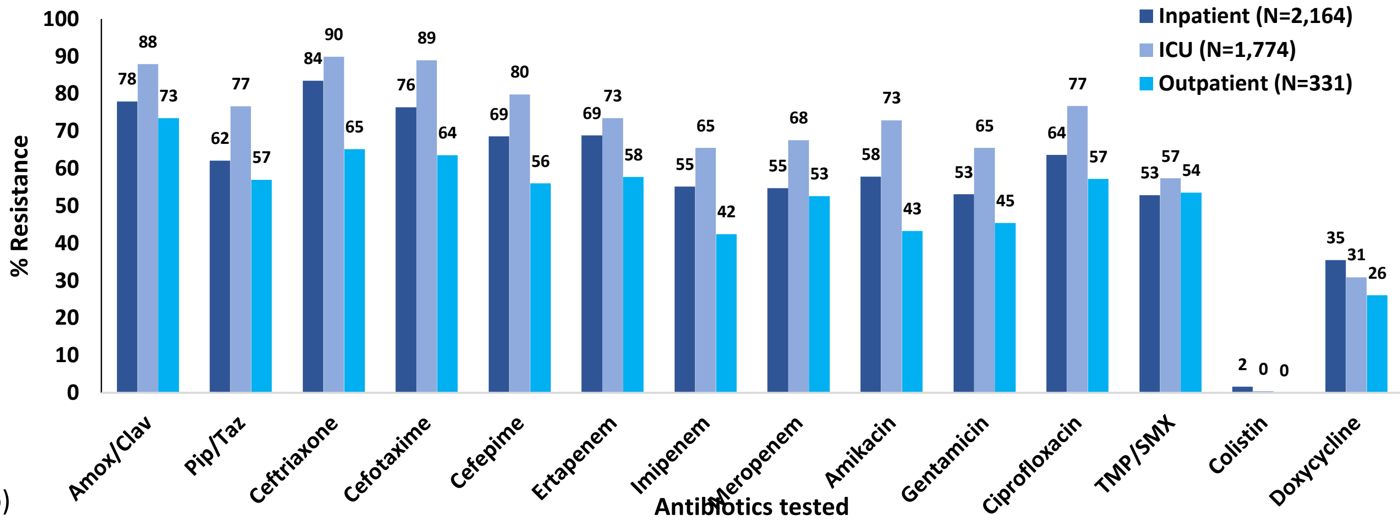
Antibiotic Tested	Blood (N=1,749)		OSBF (N=1,409)		PA (N=7,223)		Urine (22,644)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Ampicillin	1050	88	833	91	4273	89	16479	88
Amoxicillin/Clavulanic acid	1313	64	988	69	5490	65	15278	60
Piperacillin/Tazobactam	1593	52	1213	55	6273	47	18832	43
Ceftriaxone	1239	81	937	85	4693	78	12895	72
Cefotaxime	871	78	754	80	4559	78	16590	74
Cefepime	1434	63	1129	61	5434	59	14770	52
Ertapenem	896	44	734	45	3860	35	10018	24
Imipenem	1462	37	1138	38	5904	30	16015	24
Meropenem	1345	35	1024	38	5623	28	13737	21
Amikacin	1588	36	1227	28	6223	26	17559	26
Gentamicin	1489	37	1117	34	5601	33	18487	31
Ciprofloxacin	1494	74	1125	77	5853	76	17767	73
Trimethoprim/Sulfamethoxazole	1378	59	1033	57	5506	58	18377	55
Colistin	1104	0.09	828	0.12	3853	0.03	10941	0.07
Doxycycline	x	x	491	47	1949	39	x	x
Fosfomycin	x	x	x	x	x	x	13644	5
Nitrofurantoin	x	x	x	x	x	x	20808	20

Table 5- Resistance profile of *Klebsiella* species (N=24,185)

Antibiotic Tested	Blood (N=4,269)		OSBF (N=1,650)		PA (N=7,859)		Urine (N=10,407)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Amoxicillin/Clavulanic acid	3144	82	1176	71	5765	73	7233	67
Piperacillin/Tazobactam	3690	68	1412	57	6734	60	8833	53
Ceftriaxone	2828	85	1093	77	4919	76	5947	67
Cefotaxime	2163	81	861	74	5157	75	7256	70
Cefepime	3138	73	1224	65	5769	65	6565	60
Ertapenem	1873	71	827	52	3821	52	4556	43
Imipenem	3325	59	1265	46	6088	45	7186	38
Meropenem	2997	60	1186	48	6169	48	6671	37
Amikacin	3760	63	1427	48	6601	50	8348	43
Gentamicin	3328	58	1304	47	5797	51	8477	43
Ciprofloxacin	3417	69	1286	67	6180	69	7637	65
Trimethoprim/Sulfamethoxazole	3168	55	1221	56	5794	58	8207	54
Colistin	2439	1.03	938	0.85	3928	0.43	5105	0.43
Doxycycline	1214	33	524	36	1843	37	x	x
Nitrofurantoin	x	x	x	x	x	x	9383	56



a)



b)

Fig. 9- Resistance Profile of *E.coli* (N=1,749) and *Klebsiella* species (N=4,269) in blood by location type

Klebsiella species had higher resistance than *E.coli* amongst all specimen types. ICU units had higher resistance rates than inpatient and outpatient units.

Salmonella Typhi and Paratyphi

A total of 605 isolates of *Salmonella enterica* sero. Typhi and Paratyphi isolates were received, of which 594 were from blood and 11 were from stool specimens. Of 594 blood isolates, 510 were S. *enterica* sero. Typhi and 84 were S. Paratyphi. Surprisingly, seventeen blood isolates of *Salmonella enterica* sero. Typhi and one of Paratyphi were found to be resistant to ceftriaxone. Of these three were imipenem resistant as well. Additionally, three isolates of S.typhi were found to be azithromycin resistant. One isolate of *Salmonella* Paratyphi was resistant to both ceftriaxone and imipenem.

Table 6- Resistance profile of *S. Typhi* and *S. Paratyphi* (N=594) in blood isolates

Antibiotic Tested	Salmonella Typhi (N=510)		Salmonella Paratyphi (N=84)	
	Number Tested	%R	Number Tested	%R
Ampicillin	414	10.4	71	4.2
Ceftriaxone	484	3.5	80	1.3
Cefixime	292	6.2	55	12.7
Imipenem	488	1.0	82	1.2
Ciprofloxacin	482	39.2	75	21.3
Pefloxacin	317	93.1	56	92.9
TMP/SMX	475	6.5	64	3.1
Azithromycin	417	1.0	x	x
Chloramphenicol	401	6.2	68	1.5

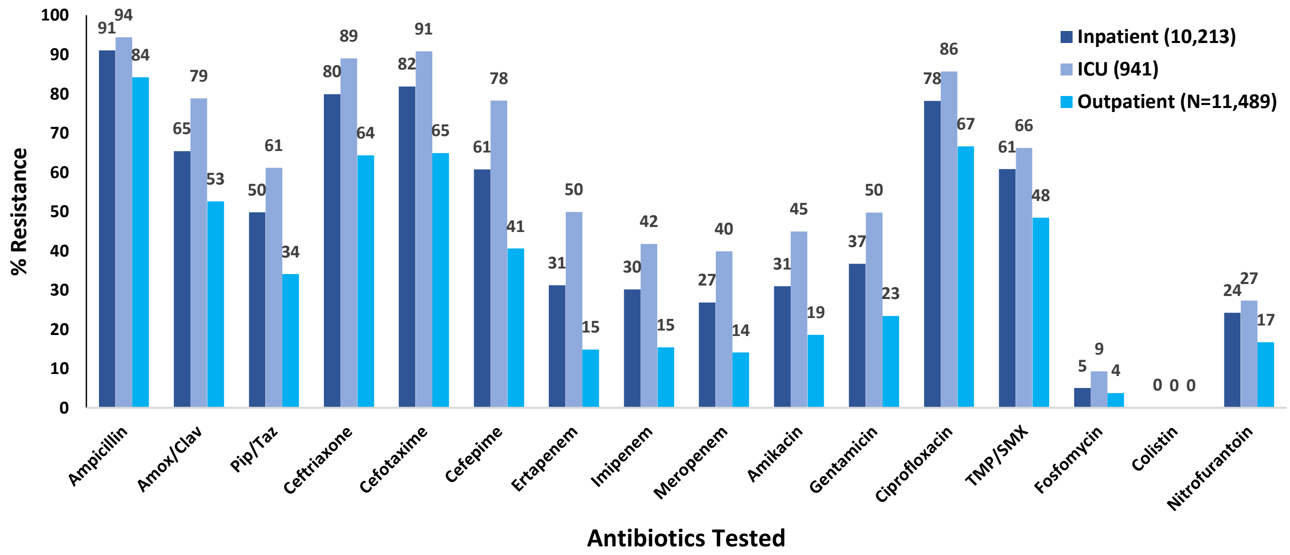


Fig. 10- Resistance Profile of *E.coli* (N=1,749) in urine by location type

Shigella species

Between January and June 2025,, 84 isolates of *Shigella* species from stool specimen were confirmed at AMR-NRL and were considered for analysis. Highest resistance rates were observed against ciprofloxacin and ampicillin and lowest against chloramphenicol. (Table 7)

Table 7- Resistance profile of *Shigella* species (N=84)

Antibiotic Tested	Number Tested	% Resistant
Ampicillin	78	81
Trimethoprim/Sulfamethoxazole	74	55
Azithromycin	72	35
Chloramphenicol	66	5
Ceftriaxone	81	44
Ciprofloxacin	74	81

Non- Fermenting Gram Negative Bacilli (NFGNB)

NFGNB accounted for 22% of the total unique patients isolates. *Pseudomonas* species was most frequently isolated from pus aspirates (49%) followed by urine (26%).Majority isolates of *Acinetobacter* species were from blood (39%) and pus aspirates (30%) respectively.

A total of 12,130 *Pseudomonas* species were reported in this current period, of which 6,577 were tested for colistin using BMD.The resistance to colistin amongst Pseudomonas spp isolates was 1.2% (79 isolates) Approx. 30% of blood isolates and 40% of urine isolates were found resistant to carbapenems (Table 8).

Acinetobacter species from blood, OSBF and pus aspirates showed >60% resistance to all the tested antibiotics excepting colistin and minocycline. Resistance to minocycline (40-47%) was observed to be increased from previous six months report (28-32%). Moreover, resistance to carbapenem has been consistently increasing from last 3 years. Of 5893 isolates tested for colistin, 18 (0.3%) showed resistance. (Table 9)

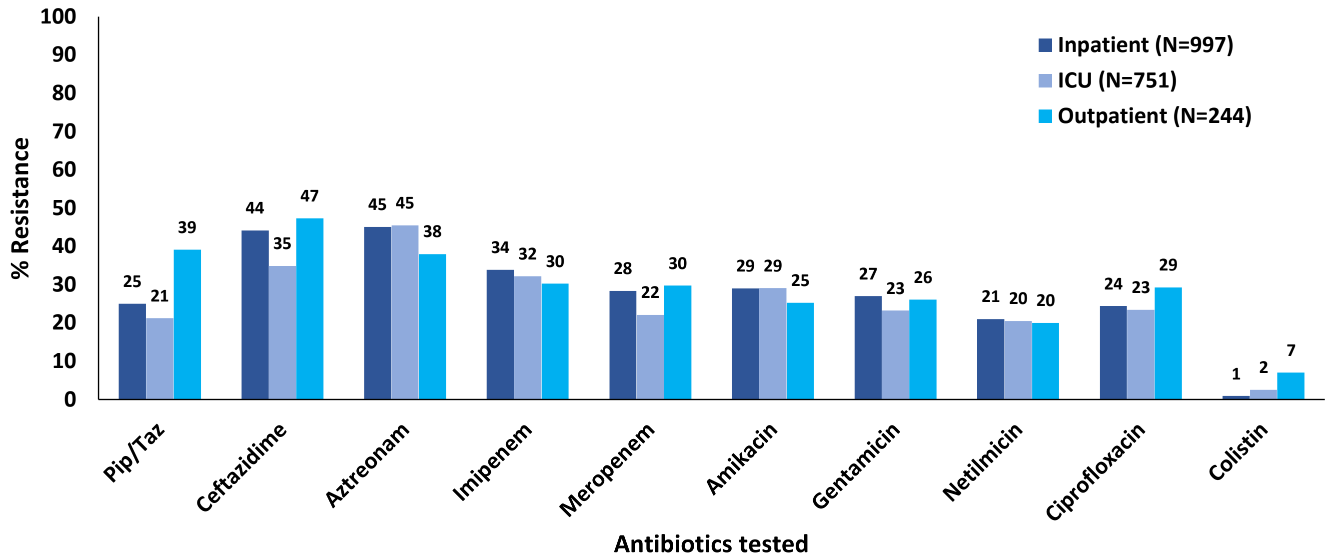
Among blood isolates of ICU patients, *Acinetobacter* species had >70% resistance to most of the 1 and 2nd choice antibiotics including aminoglycosides, third generation cephalosporins, carbapenems .

Table 8- Resistance profile of *Pseudomonas* species (N=12,130)

Antibiotic Tested	Blood (N=1,992)		OSBF (N=1022)		PA (N=5,954)		Urine (N=3,162)	
	Number tested	%R	Number tested	%R	Number tested	%R	Number tested	%R
Piperacillin/Tazobactam	1786	25	884	24	5313	26	2863	31
Ceftazidime	1712	41	908	38	5240	42	2789	55
Aztreonam	1229	45	682	31	3767	27	2112	39
Imipenem	1712	33	872	33	4994	27	2475	42
Meropenem	1570	26	684	30	4776	26	2008	41
Amikacin	1564	29	809	26	4486	30	2632	40
Gentamicin	1215	25	642	28	3368	36	1937	45
Netilmicin	975	21	504	26	2994	31	1525	43
Ciprofloxacin	1694	25	831	37	4722	42	2509	54
Colistin	1192	2.2	625	2.1	3049	0.7	1711	1.1

Table 9- Resistance profile of *Acinetobacter* species (N=11,153)

Antibiotic Tested	Blood (N=4,321)		OSBF (N=1,480)		PA (N=3,322)		Urine (N=2,030)	
	Number Tested	%R	Number Tested	%R	Number Tested	%R	Number Tested	%R
Ampicillin/Sulbactam	1931	69	739	59	1763	68	701	56
Piperacillin/Tazobactam	3668	66	1291	59	2873	70	1596	45
Ceftazidime	3437	76	1182	69	2449	76	1561	65
Imipenem	3492	69	1041	62	2610	67	1340	44
Meropenem	2934	67	1063	60	2589	66	980	41
Amikacin	3639	63	1296	56	2686	68	1344	44
Gentamicin	3249	64	1269	54	2667	66	1473	44
Ciprofloxacin	3393	64	1076	60	2581	72	1506	54
Trimethoprim/Sulfamethoxazole	3078	58	1019	58	2238	71	1398	48
Colistin	2369	0.55	936	0.11	1815	0.22	773	0
Minocycline	2481	47	984	40	1840	45	811	43
Tetracycline	X	X	x	x	x	x	705	44



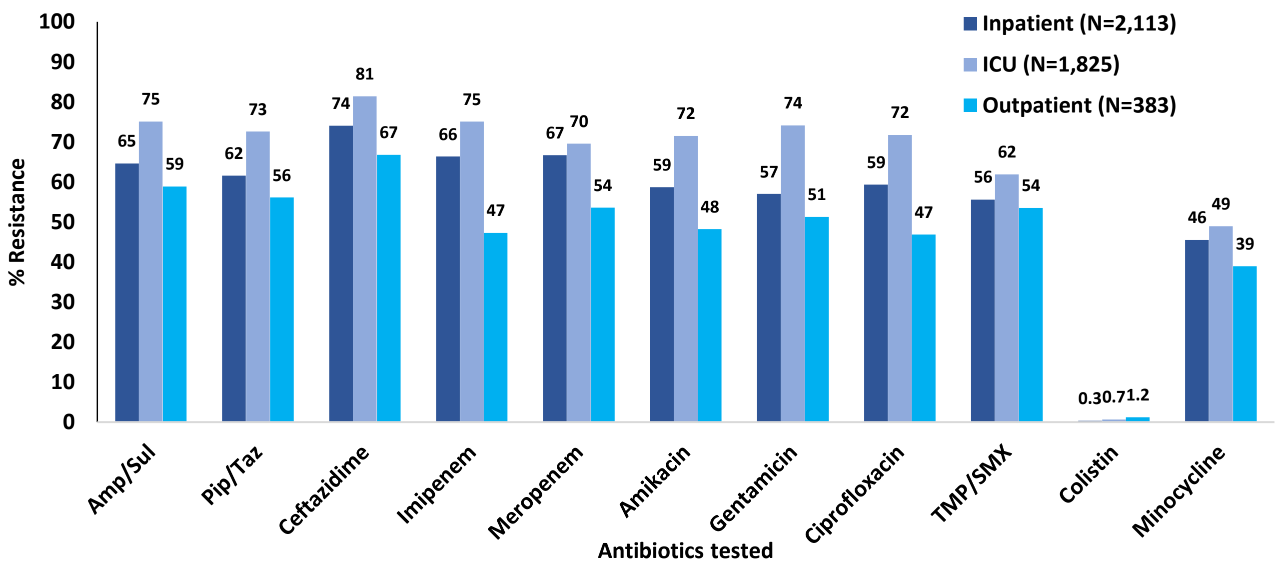


Fig. 11- Resistance Profile of *Pseudomonas* species (N=1,992) and *Acinetobacter* species (N=4,321) in blood by location type

Table 10- Resistance profile of *V.cholerae* (N=19)

Antibiotic Tested	Number Tested	Number of isolates resistant
Ampicillin	15	5
Trimethoprim/Sulfamethoxazole	18	7
Azithromycin	11	0
Chloramphenicol	9	0
Doxycycline	14	1
Tetracycline	16	2

Vibrio cholerae

In the current reporting period, data of 19 isolates of *Vibrio cholerae* confirmed at AMR-NRL has been analyzed. No resistance was observed against chloramphenicol and azithromycin.(Table 10).

Discussion and Conclusion

This is the fifth semi-annual bulletin on AMR surveillance. During this reporting period from January to June 2025, AMR Surveillance data from 59 sites was collated, validated and analysed. Significant improvements in data quality have been observed over the past year, driven by the combined efforts of onsite visits, lab trainings on broth microdilution, strengthened data management practices, and regular monthly virtual monitoring calls with each site. The proportion of MRSA among blood isolates remained almost same this year (55%), which was 54% during the last 6-month reporting period. Similarly, VRE isolation from blood specimens also remained similar in this data reporting period (20%) to that of previous reporting period (20%). Whereas linezolid resistance among blood *Enterococcus* isolates showed slight increase from 1.5% during previous data reporting period (July-Dec 2024) to 2.2% in the current reporting period (Jan-June 2025).

Notably, in the current reporting reporting period, rate of resistance to colistin among *Pseudomonas* species is of concern. There is an increase in resistance to colistin from 0.4% (previous 6 month reporting period) to 2.2% (current reporting period) among *Pseudomonas* species isolated from blood. The increasing resistance highlights the need for implementation of Antimicrobial stewardship practices at healthcare settings to reduce the inadvertent use of last resort antibiotics.

Salmonella Typhi isolates reported from blood were slightly higher in the current reporting period (510) as compared to the that in previous bulletin (434). A notable finding amongst the *Salmonella* Typhi isolates is the slight increase in resistance rates observed against Ceftriaxone (3.5 % in comparison to 1.5% in the last bulletin).

Among the pathogens reported from stool specimens in this bulletin, *Shigella spp*. was most commonly isolated (84) followed by *Vibrio cholerae* (19).The resistance in *Shigella spp.* against ciprofloxacin (81%) was similar to that in the previous bulletin. The resistance rates have marginally increased for Amicillin (81%), Trimethoprim/Sulfamethoxazole (55%), Azithromycin (35%) and Ceftriaxone (44%).

In conclusion, AMR surveillance data is the cornerstone in the fight against antimicrobial resistance—informing decisions, guiding interventions, and protecting communities. The data generated through surveillance not only provides insights into local and regional resistance trends but also contributes to shaping national and global strategies. By highlighting high-risk pathogens and vulnerable areas, AMR surveillance enables targeted responses that can reduce the burden of resistant infections. These insights are indispensable for shaping policies, directing resources, and protecting vulnerable populations. However, data gains value only when translated into action. To truly contain AMR, surveillance must lead to responsible antimicrobial stewardship, strong infection prevention and control practices and continuous investment in research and innovation. Containing AMR is not a choice but a necessity — it demands global collaboration, continuous vigilance, and responsible action to preserve the power of antibiotics for the future.

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