



Review

An Overview of Antimicrobial Stewardship Optimization: The Use of Antibiotics in Humans and Animals to Prevent Resistance

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Abstract: Antimicrobials are a type of agent widely used to prevent various microbial infections in humans and animals. Antimicrobial resistance is a major cause of clinical antimicrobial therapy failure, and it has become a major public health concern around the world. Increasing the development of multiple antimicrobials has become available for humans and animals with no appropriate guidance. As a result, inappropriate use of antimicrobials has significantly produced antimicrobial resistance. However, an increasing number of infections such as sepsis are untreatable due to this antimicrobial resistance. In either case, life-saving drugs are rendered ineffective in most cases. The actual causes of antimicrobial resistance are complex and versatile. A lack of adequate health services, unoptimized use of antimicrobials in humans and animals, poor water and sanitation systems, wide gaps in access and research and development in healthcare technologies, and environmental pollution have vital impacts on antimicrobial resistance. This current review will highlight the natural history and basics of the development of antimicrobials, the relationship between antimicrobial use in humans and antimicrobial use in animals, the simplistic pathways, and mechanisms of antimicrobial resistance, and how to control the spread of this resistance.

Keywords: antimicrobial resistance; human; infection; sanitation; control; public health



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1. Introduction

The advancement of antimicrobials in the 1940s was a giant forward leap in public health [1]. The far-reaching use and abuse of these agents have brought about the advancement of resistant organisms [2]. Internationally, antibiotic resistance is seen today as a significant danger to overall well-being. Without immediate compositional action by several collaborators, the environment is set toward a post-anti-microbial stage in which routinely treated contaminations can destroy [3,4].

The impact of anti-infective overuse, according to the European Commission (EC), is significant. As a result, more than 70% of bacteria responsible for intra-hospital infection were discovered to be resistant to at least one antibiotic structure. AMR is also responsible for about 25,000 human deaths per year in the EU and 700,000 worldwide, and it is expected to kill more people by 2050 than cancer. Since resistance has been recorded for practically all antibiotic structures, databases and surveillance systems from both the human health and veterinary sectors are becoming increasingly abundant in the data. The Population Correction Unit (PCU), Romania's major indicator for antimicrobial consumption in the veterinary sector, reported in 2015 that the consumed amount of antibiotics was $100.5 \text{ mg PCU}^{-1}$, practically identical to the EU average ($100.6 \text{ mg PCU}^{-1}$). Only a quarter of nations have adopted a national policy to tackle AMR, despite the fact that global antimicrobial consumption in the cattle sector is predicted to increase by 70% between 2010 and 2030 [5]. Antibiotic resistance genes, modes of action, resistance profile, and ontology are all tracked in this database. There was no such system when the Antibiotic Resistance Database (ARDB) was founded in 2009. Resistance data is available for 13,293 genes, 377 antibiotic classes, 632 genomes, 933 species, and 124 genera in the ARDB. The Comprehensive Antibiotic Resistance Database (CARD), a biological database that collects and organizes information on resistance genes, proteins, and antimicrobial resistance phenotypes, recently received all the data from the ARDB. The database contains information on all drug classes and resistance mechanisms, and it is organized using ontology [6]. As a result, one of the most significant goals of many governments and the World Health Organization is to develop antimicrobial stewardship programs (ASPs) (WHO). One of the ASPs' strategies is to conduct extensive antibiotic usage monitoring. Among the various measurements, defined daily doses (DDD)/100 bed-days stand out as the most popular source of information for this purpose [7]. Veterinarians frequently encounter the necessity to treat cats with infectious diarrhea. The significance of enteropathogenic bacteria in this disease, however, is unclear. *Salmonella* spp. are common causes of feline diarrhea, although their clinical evidence in cats is masked by the fact that these bacteria are found in the indigenous intestinal microflora of many other animals. Other zoonotic pathogenic pathogens in cats (e.g., *Clostridium perfringens* type A, *Clostridium difficile*, *Campylobacter upsaliensis*, *C. helveticus*, and *C. jejuni*) can cause symptoms ranging from moderate diarrhea to severe necrohemorrhagic enteritis. Despite current worries about other bacteria, *Salmonella* remains one of the most common causes of food-borne illness worldwide. Salmonellosis can cause a wide range of illnesses in humans and animals, including acute gastrointestinal enteritis, bacteremia, and extraintestinal localized infections affecting a variety of organs. *Salmonella* spp. infections in humans are linked to severe food-borne illnesses, including acute gastroenteritis, which is caused by consuming contaminated water and food products. The most popular pet animals are cats and dogs. However, the presence of *Salmonella* in these animals is unknown, and the risk to the owner's health is uncertain. Cats who are allowed to roam freely outside and scavenge or hunt for food of unknown quality are particularly vulnerable to *Salmonella* spp. transmission. Subclinical infections in carrier animals can lead to bacterial transmission to people, which is a far more serious issue [8].

The therapeutic use of penicillin and the start of thorough screening of actinomycetes are achievements in the "Golden Era" of antibiotic research [9]. In the late stages of a microbial stationary growth cycle, antibiotics are developed, and decoupled from the replication of time, which means that they are not required for sustaining the organism's survival [10]. Currently, antibiotics that are market available are either supplied through microbial fermentation or measured using the latest antibiotic spine structure through a semi-synthetic process. They are characterized into various chemically defined groups. A critical number of these antimicrobials influence cell walls (e.g., β -lactam and glycopeptides), while a few others apply their antibacterial action by focusing on protein engineered apparatus using association with ribosomal subunits, and these incorporate anti-infection agents, for example, macrolides, chloramphenicol, antibiotic medication, linezolid, and aminoglycosides [10]. The term 'antimicrobial stewardship' is experienced in a developing

number and progressively assorted scope of settings, from antimicrobial stewardship programs in clinics and the local area [11,12] to veterinary antimicrobial stewardship [13,14], one health antimicrobial stewardship [15,16], and the World Health Organization (WHO) globally stewardship structure [17]. Antimicrobial stewardship has been conceptualized from numerous points of view, including as a bunch of facilitated mediations, as a program, as a way of thinking, and as an ethic. The root of the term ‘stewardship’ lies in everyday activities that are frequently multifaceted: the steward of a vast family unit cautiously and dependably deals with the family [18]. Antimicrobial stewardship is a lucid arrangement of activities that advance utilizing antimicrobials in manners that guarantee maintainable admittance to powerful treatment for all who require them [16,19]. This concept can be extended from intervention at individual levels to global activities and in the fields of human, animal, and environmental health. Putting less accentuation on individual prescriptions assists with underscoring a more extensive idea of antimicrobial administration that qualifies the commitments of Non-prescribers [20]. Secondly, the relationship between antibiotic uses in humans and animals is also a threat due to irrational uses of the Antibiotic. Thirdly, antibiotic resistance has different pathways and mechanisms. A road map is therefore required to control the unreasonable services of antibiotics, in both humans and animals.

2. The Natural History of Antibiotics

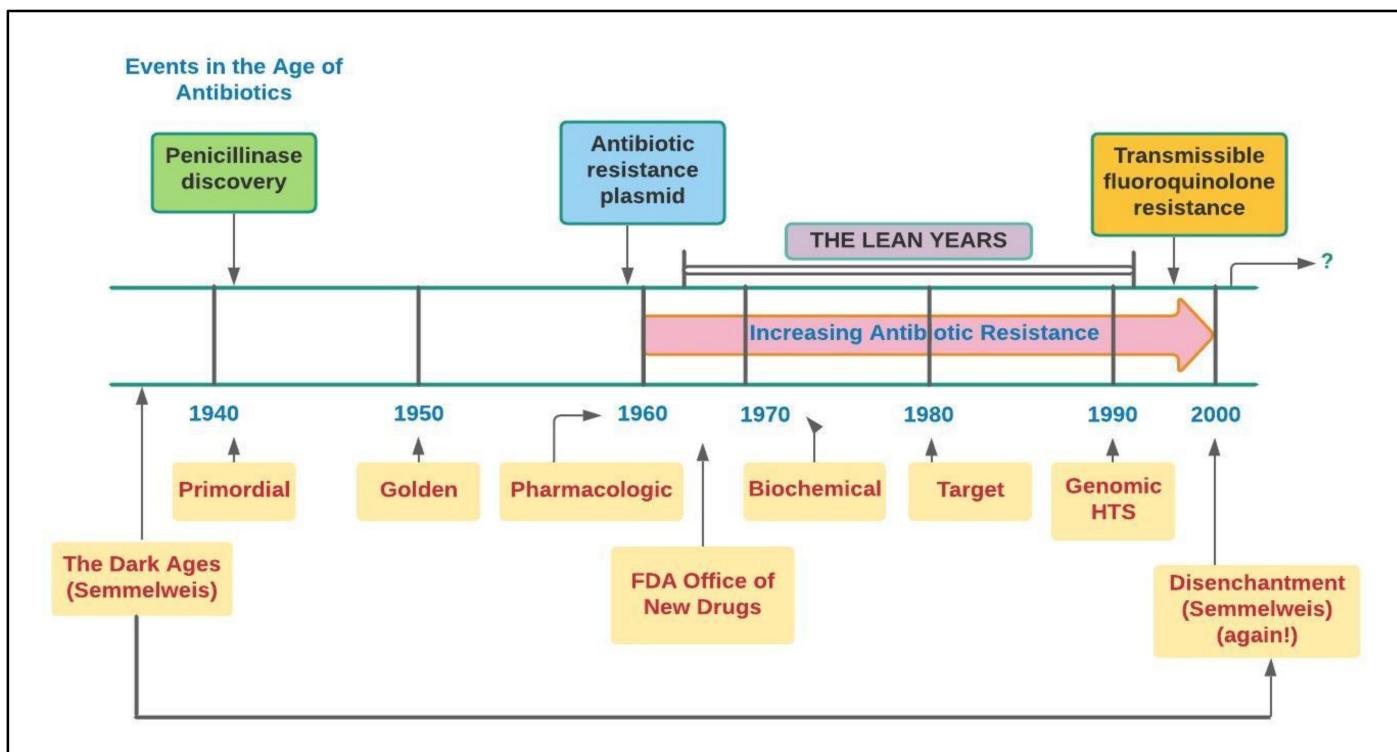
In 1947, S.A. Waksman characterized the expression “antibiotic” as follows: “A chemical material, which is produced by microorganisms, is an antibiotic that keeps back bacteria and other microorganisms, and even kills them” [21]. In a real sense, antibiotics signify “against life”; for this situation, against organisms. There are numerous anti-infection agents: anti-bacterial, anti-viral, anti-fungal, and anti-parasitic [22]. Nowadays, “antibiotic” has innumerable implications: (I) an organic compound of synthetic or natural source that restrains or kills pathogenic microscopic organisms; (II) any antimicrobial compound, or (III) restricted to microbial substances of microbial origin in the Waksman convention [23].

1928: Alexander Fleming found the main anti-microbial, penicillin. In any regard, penicillin was controlled for more than 10 years before it was introduced as a microbial illness therapy [24]. The 1930s: The first widely used antimicrobial was Prontosil, a sulfonamide synthesized by German organic biochemist Gerhard Domagk [25]. 1945: Penicillin was initially used to treat bacterial infections on a large scale. Florey and Chain’s attempts to refine the antibiotic and scale-up manufacturing made this feasible. 1940–1962: The golden era of antibiotics. The largest number of antibiotic classes that we are using today as antimicrobials were established and familiarized with the market. Each class usually comprises a few antimicrobials that have been discovered over time or are modified adaptations of previous types. There are, for instance, various β -lactams (articulated beta-lactams), for example, multiple penicillin and cephalosporin [24]. Antimicrobial groups based on their mode of action are shown in Table 1, and the discovery of antibiotics and the subsequent development of resistance to antibiotics are shown in Figure 1.

The discovery and development of antibiotic resistance progressed as follows: Dark Ages, also called the pre-antibiotic period; Primordial Age, the emergence of chemotherapy, through sulfonamides; Halcyon years, the golden era, when the majority of the currently-used antibiotics were developed; Lean or Modest years, the downward spiral in the discovery and development of antibiotics; Pharmacologic period, efforts to understand and better use antibiotics through dose, administration, and so on, were made; Biochemical period, understanding of the biochemical activities of antibiotics and resistance mechanisms resulted in investigations of functionalization to prevent resistance; Target era, the mechanism of action and genetic research prompted initiatives for the development of new chemical compounds; Genomic/HTS era, the approach of genomic sequencing was utilized to forecast key objectives for implementation in high-performance screening tests; Disenchantment phase, many organizations stopped their discovery initiatives due to the failure of their massive investment in genome-based approaches [27].

Table 1. Antimicrobial groups based on their mode of action [26].

No.	Mode of Action	Antimicrobial Groups
1	Cell wall synthesis inhibitor	β -lactams: Penicillin, Cephalosporins, monobactams, carbapenems Glycopeptides: Vancomycin
2	Depolarization of cell membrane	Lipopeptide Bind to 30 s ribosomal subunit:
3	Protein synthesis inhibitors	<ul style="list-style-type: none"> • Aminoglycosides • Tetracyclines • Bind to 50 s ribosomal subunit:
4	Nucleic acid synthesis inhibitor	Macrolides
5	Inhibitors of metabolic pathways	Chloramphenicol Lincosamides Quinolones, Fluoroquinolones Sulfonamides, Trimethoprim

**Figure 1.** Background of discovery of antibiotics and the subsequent development of resistance to antibiotics.

3. Methodologies for Detecting the Human Gut Resistome

All available methods for identifying the human gut resistome in terms of antibiotic resistance gene type and quantity are inadequate for characterizing the repository of resistant genes and the genetic variables linked with resistant genes. As a result, if one wants to define the human gut resistome properly, a mix of various methods should be utilized [28]. Human gut resistome identification procedure from feces sample that contains resistance gene are shown in Figure 2.

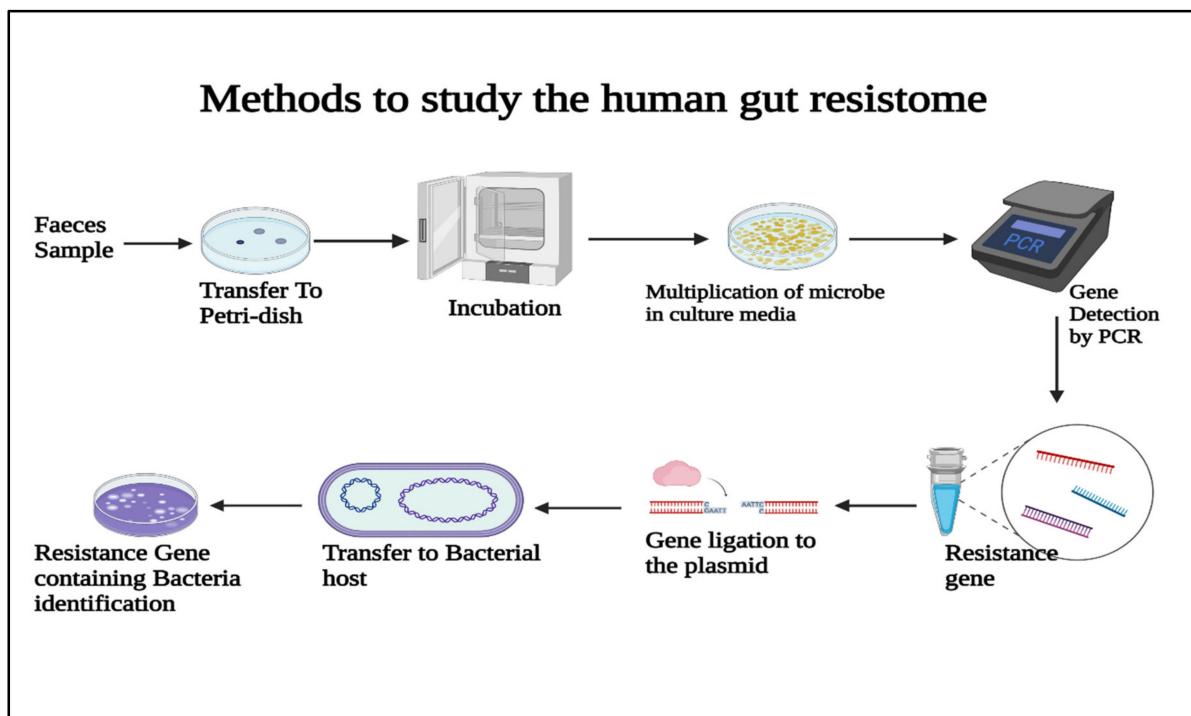


Figure 2. Human gut resistome identification procedure from feces sample that contains resistance gene [28].

4. The Antibiotic Resistome

All genetic factors that potentially confer drug resistance are included in the antibiotic resistome [29]. Resistomes can be related to particular medications [29], such as all the genes imparting resistance to β -lactam antibiotics, specific geographic regions, such as genes in soil, hospital, or agricultural microbiomes [30], and individual organism [31]. The resistome can be further divided into two general components. The first is “intrinsic resistance,” which is imparted by genes essential to an organism’s core genome. The second form of resistance is called “gained resistance”, which occurs when genes are introduced into a susceptible organism through the acquisition of mobile genetic elements.

A component of the acquired resistome in Enterobacteriaceae is the Metallo-lactamase NDM-1, which provides carbapenem resistance [30]. The existence of a cadre of multidrug efflux pumps and an impermeable outer membrane, that represent parts of *Pseudomonas aeruginosa*’s intrinsic resistome, is primarily responsible for this organism’s inherent resistance to several antibiotics. If persistent selection pressure is applied throughout time, acquired resistance can permanently link to the genome and take on inherent resistance features. Intrinsic resistance is a critical obstacle in the development of antibiotics [31,32]. Gram-negative bacteria are normally resistant to multiple antimicrobials due to the biology of their cell envelope, which is made up of two concentric membrane surfaces. This barrier, however, can be overcome by introducing a benzylic primary amino group, resulting in ampicillin, which overcomes both Gram-positive and Gram-negative intrinsic insensitivity [33,34]. Gram-negative bacteria have an innate resistance to several drugs thanks to multidrug efflux pumps. The inner membrane, outer membrane, and connecting components of the tripartite resistance-nodulation-division (RND) pumps, in particular, move foreign molecules from the cytosol and periplasm to the cell’s exterior [35,36], as shown in Figure 3.

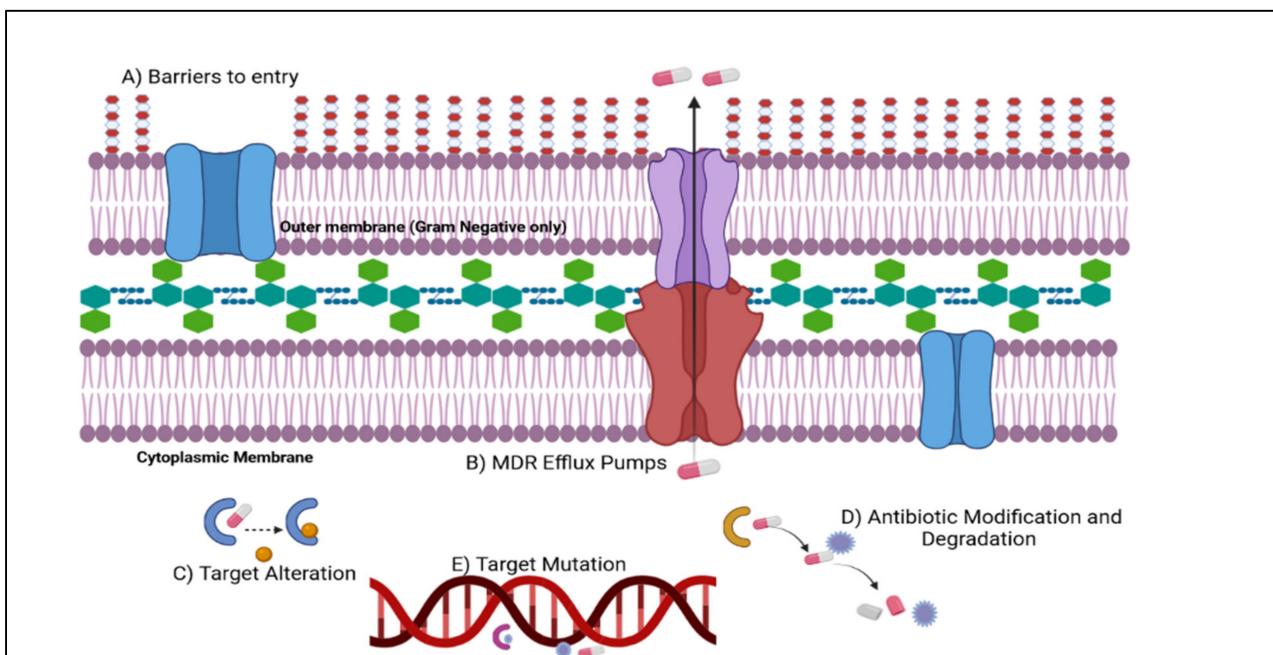


Figure 3. Intrinsic and acquired antibiotic resistance in bacteria. (A) Barriers to entry include the outer membrane of Gram-negative bacteria and associated protein pores; (B) efflux pumps; (C) target alteration; (D) antibiotic modification and degradation; (E) antibiotic target mutation.

In addition to efflux systems, Gram-positive and Gram-negative bacteria use a variety of intrinsic resistance mechanisms that have just lately been discovered. Because antibiotic production must have evolved alongside self-protection mechanisms in bacteria, antibiotic resistance is at least as old as antibiotics themselves. Serine-lactamases are considered to have originated nearly two billion years ago and have subsequently developed into the three Ambler class branches of the serine-lactamase phylogenetic tree [37,38]. The primitive difference between these genes and clinically relevant -lactamases is shown by sequencing and phylogenetic analyses of the -lactamases, demonstrating the ancient origin of -lactamase resistance and its widespread geographical expansion [39].

5. Resistance to Antibiotics

Antibiotic resistance is now becoming a more serious concern around the world. In addition to phenotypically resistant bacteria, isolates with silent but intact antibiotic resistance genes may constitute a great concern. Antimicrobial resistance (AR) can be transferred across bacteria via genetic elements, resulting in the rapid creation of multidrug resistance (MDR) in germs from animals, posing a risk to human health [40]. Table 2 shows some resistant genes and associated antimicrobials along with their structures. Antibiotic resistance occurs as germs such as bacteria and fungi can destroy antibiotic ingredients. This means that the germs are not killed and are still rising. Contaminations caused by antibiotic-resistant bacteria are difficult to handle and, at times, nonsensical. Antibiotic-resistant infections often necessitate more extended hospital stays, more doctor appointments, and expensive and risky alternative treatments. Resistance to antibiotics does not indicate a body's resistance to antibiotics because bacteria are immune to the antibiotics meant to kill them [41]. Anti-microbials are medications used to prevent and treat bacterial contaminations. Antimicrobial tolerance occurs as microscopic species become resistant to antibiotics because of their application. Antibiotic resistance develops in microbes, not humans or animals. These microbes can infect people or livestock, and the infections they cause are more difficult to cure than those caused by bacteria that are not immune [42].

Table 2. Antimicrobials and the associated genes that confer resistance to those antimicrobials.

No.	Name of Antimicrobials	Structure	Genes	Reference
1	Rifampicin		<i>drrABC</i>	[43]
			<i>rpoB</i>	[44]
2	Benzothiazinones		<i>dprE1</i>	[45]
3	Ethambutol		<i>aftA</i>	[46]
4	Para-aminosalicylic acid (PASA)		<i>embABC</i>	[47]
			<i>ubiA</i>	[46]
			<i>thyA</i>	[48]
5	D-cycloserine		<i>ribD</i>	
			<i>folC</i>	
			<i>ald</i>	[49]
			<i>ddl</i>	[50]
			<i>alr</i>	[51]

Table 2. Cont.

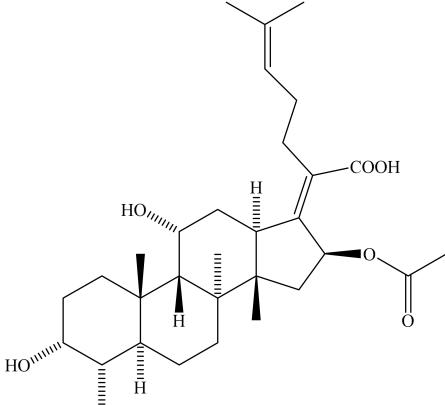
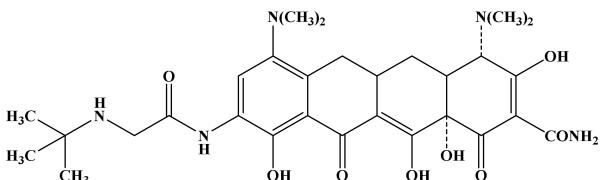
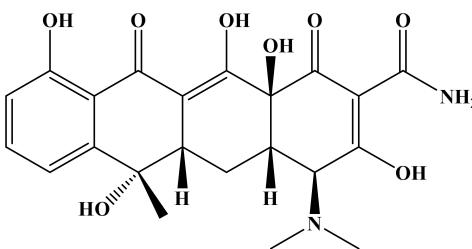
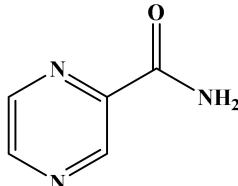
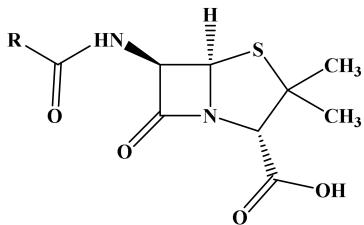
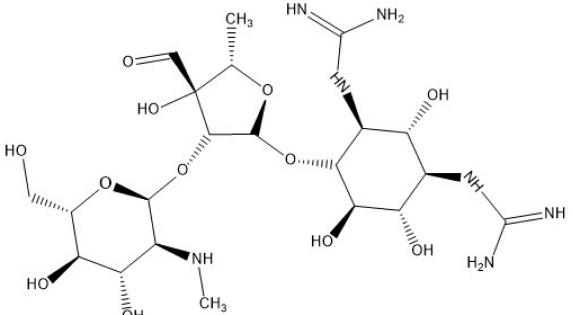
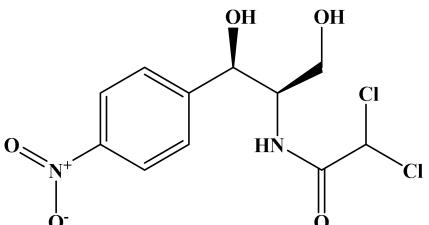
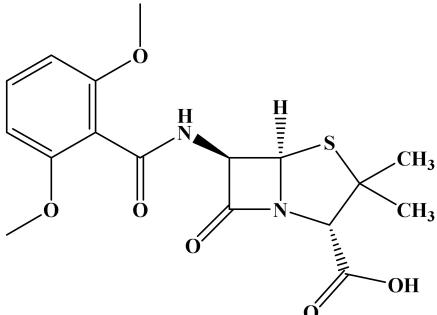
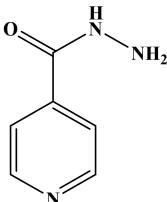
No.	Name of Antimicrobials	Structure	Genes	Reference
6	Fucidic acid		<i>far1/fusB</i>	[52]
7	Glycylcycline		<i>tetK</i>	[52]
8	Ethionamide		<i>mshC</i>	[53]
9	Tetracycline		<i>tetM</i>	[52]
10	Pyrazinamide		<i>pncA</i>	[54]
11	Penicillin		<i>blaZ</i>	[52]

Table 2. Cont.

No.	Name of Antimicrobials	Structure	Genes	Reference
12	Streptomycin		<i>aadA1</i>	[55]
13	Chloramphenicol		<i>cat</i>	[52]
14	Methicillin		<i>mecA</i>	[52]
15	Isoniazid		<i>katG</i> <i>inhA</i> <i>fabG1</i>	[56] [57] [58]

6. Mechanisms of Antimicrobial Resistance

Antimicrobials are specialists who execute or hinder microorganisms' development and envelop anti-infection agents, antifungals, and antivirals [2]. Antimicrobial resistance (AMR) is created when microorganisms adjust and fill within sight of antimicrobials, when delivering therapy with an antimicrobial medication [2,59]. The elements prompting AMR are complex and multifactorial. Resistance happens because of a characteristic developmental cycle that outfits the microorganisms with mechanisms to balance the antimicrobials' impacts. Antimicrobial resistance can occur, for instance, when an organism develops an enzyme that wrecks the medication in a straightforward manner (for example, β -lactamases, which corrupt β -lactam antimicrobials) [60]. Antibiotics that follow up on the cell wall by restraining peptidoglycan synthesis incorporate β -lactams and glycopeptides. β -Lactams include penicillin, cephalosporin, monobactams, and carbapenems [61]. Antimicrobial resistance mechanisms are classed into four main categories: (1) limiting uptake of a drug;

(2) altering a drug target; (3) inactivating a drug; (4) active drug efflux [26]. General mechanisms of antimicrobial resistance are shown in Figure 4. Table 3 shows the mechanisms of resistance of some common antibiotics.

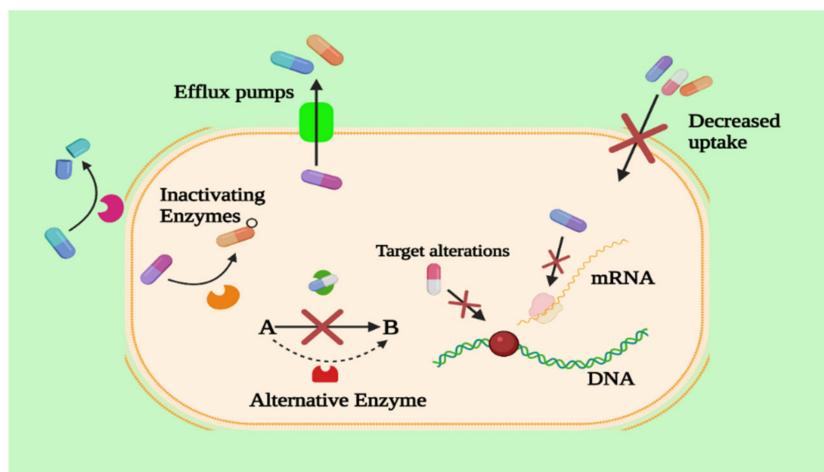


Figure 4. General mechanisms of antimicrobial resistance [62].

Table 3. The mechanisms of resistance of some common antibiotics [63].

Antimicrobial Groups	Examples	Mechanism of Resistance
<i>beta – lactams</i>	Penicillins, Cephalosporins, Carbapenems, Monobactams	Hydrolysis, efflux, altered target
Aminoglycosides	Streptomycin, Gentamycin	Altered target, acetylation, efflux
Tetracyclines	Minocycline, Tigecycline	Efflux, altered target, hydrolysis
Lincosamides	Clindamycin	Efflux, altered target
Macrolides	Erythromycin, azithromycin	Hydrolysis, efflux, altered target
Phenols	Chloramphenicol	Acetylation, efflux, altered target
Quinolones	Ciprofloxacin	Acetylation, efflux, altered target
Pyrimidines	Trimethoprim	Efflux, altered target
Sulfonamides	Sulfamethoxazole	Efflux, altered target

7. Relationship between Antibiotic Use in Animals and Antibiotic Use in Humans

Antibiotics are primarily used in animals for three purposes: surgical treatment of sick animals, prophylactic infection prevention, and growth promoters to increase feed use and development. However, preventive therapy entails treating human animals with antibiotic doses that surpass the pathogen's minimum inhibitory concentration for a limited period. In addition, therapeutic medication is often given to intensively farmed livestock in the form of feed or drinking water; however, because sick animals may not drink or eat, this procedure can be unsuccessful in some situations. Furthermore, prophylactic therapy includes giving a group of animals low to heavy doses of antibiotics in their feed or drink for a set amount of time. Antibiotics used as growth promoters are often fed to whole herds and flocks at sub-therapeutic doses for long periods and are available over the counter from feed producers and growers [64,65].

8. Development of Antimicrobial Resistance in Human and Animal Healthcare

Antimicrobial resistance poses severe threats to human and animal healthcare. The speedy elevation and expansion of resistant microbes and ARGs in populations, animals, and the climate is regarded as a severe global issue [66]. Fundamentally, resistance emerges from a natural evolving phase that assists microorganisms with pathways to combat the antimicrobials impact [60]. Antimicrobial resistance tries to intimidate to overturn the progress of antimicrobials with modern medications [67]. Antibiotic resistance is caused by excessive usage and improper usage (inappropriate selections, insufficient dosing, and

unclear obedience to medication guidance). However, human medication in the population and clinics, in animal farming and agricultural sectors, and in the environment are the four major sectors that influence the emergence of antibiotic resistance, according to research findings [68,69]. AMR may lead to increases in-patient death rates and the duration of hospitalized stay and has numerous social and financial consequences. Any drug-resistant microbes necessitate physical separation from the community to prevent infection, resulting in lost work and family periods for patients. Additionally, the patient could be charged with further physician visits and hospitalization, as well as potential second-line therapies, laboratory examinations, and other diagnostic expenses [3,70].

8.1. New Antibiotics

Plazomicin is a chemically synthesized aminoglycoside [71] that inhibits bacterial protein synthesis and has dose-dependent bactericidal efficacy in vitro [72]. Plazomicin was certified by the FDA in 2018 for the treatment of cUTI and pyelonephritis at a dosage of 15 mg/kg IV, QD. The FDA package insert for plazomicin mentions nephrotoxicity and ototoxicity as potential adverse effects.

Plazomicin is more effective than other aminoglycosides against colistin-resistant Enterobacteriales (including those with MCR-1 genes), with 89.5% of isolates susceptible (compared to amikacin, gentamicin, and tobramycin, which are effective against 16.8%, 47.4%, and 63.2 percent of isolates, respectively) [73]. In two clinical studies, plazomicin 15 mg/kg IV, QD was compared to meropenem 1 g IV, TID [74], and levofloxacin 750 mg IV, QD in patients with complicated urinary tract infections (UTI) (Table 4) for up to 10 days [75]. Clinical trials in complicated urinary tract infections (UTI) are shown in Table 4.

Table 4. Clinical trials in complicated urinary tract infection (UTI).

First Author (Ref)	Resistant Microorganisms	Dose New Antibiotic (n Patient)	Comparator, Dose (n Patient)	Definition Outcome	Timing Assessment of Outcomes	Outcomes (New Antibiotics vs. Comparator)
A comparative study with Plazomicin						
Wagenlehner [74]	ESBL 26.5% CRE 4.8%	15 mg/kg IV, QD (<i>n</i> = 306)	Meropenem 1 g IV, TID (<i>n</i> = 303)	Clinical cure and microbiological response	15 to 19 days after the start of therapy	81.7% vs. 70.1%
Conolly [75]	Ceftazidime non-susceptible 17.6%	15 mg/kg IV, QD (<i>n</i> = 51)	Levofloxacin 750 mg IV, QD (<i>n</i> = 29)	Microbiological eradication rate	12 days after the last dose	60.8% vs. 58.6%
A comparative study with Eravacycline						
Clinical trial identifier NCT03032510	No information	1.5 mg/kg IV, QD + levofloxacin PO (<i>n</i> = 603).	Ertapenem 1 g IV, QD + levofloxacin PO (<i>n</i> = 602).	Clinical cure and microbiological response	14 to 17 days post randomization	84.8% vs. 94.8%
Clinical trial identifier NCT01978938	No information	1.5 mg/kg IV, QD (<i>n</i> = 455).	Levofloxacin 750 mg IV, QD (<i>n</i> = 453).	Clinical cure and microbiological response	Post-treatment visit	60.4% vs. 66.9%
A comparative study with Cefiderocol						
Portsmouth [76]	No information	2 g IV, TID (<i>n</i> = 252)	Imipenem- cilastatin 1 g IV, TID (<i>n</i> = 119)	Clinical cure and microbiological response	7 ± 2 days after the end of antibiotic treatment	73% vs. 55%
A comparative study with Ceftazidime/avibactam						
Carmeli [77] ^a	Ceftazidime non-susceptible Enterobacteriales or <i>P.</i> <i>aeruginosa</i> 100%	2 g/500 mg IV, TD (<i>n</i> = 165)	Best available therapy (97% carbapenems) (<i>n</i> = 168)	Clinical response	7 to 10 days after the last infusion	91% vs. 91%

Table 4. Cont.

First Author (Ref)	Resistant Microorganisms	Dose New Antibiotic (n Patient)	Comparator, Dose (n Patient)	Definition Outcome	Timing Assessment of Outcomes	Outcomes (New Antibiotics vs. Comparator)
Wagenlehner [78]	Ceftazidime non-susceptible 19.6%	2 g/500 mg IV, TD (n = 393)	Doripenem 500 mg IV, TD (n = 417)	Clinical cure and microbiological response	21 to 25 days post-randomization	71.2% vs. 64.5%
Popejoy [79]	ESBL 11.1%	1 g/500 mg IV, TD (n = 54)	Levofloxacin 750 mg IV, QD (n = 46) Meropenem 1 g, IV, TD (n = 26)	Clinical cure	5 to 9 days post therapy	95.8% vs. 82.6% (p = 0.01)
Wagenlehner [80]	ESBL 14.8%	1 g/500 mg IV, TD (n = 398)	Levofloxacin 750 mg IV, QD (n = 402)	Clinical cure and microbiological response	5 to 9 days post-therapy	76.9% vs. 68.4%
Kaye [81]	Piperacillin/tazobactam-resistant <i>E. coli</i> and <i>K. pneumoniae</i> 15%	2 g/2 g IV, TD (n = 274)	Piperacillin/tazobactam 4 g/500 mg IV, TD (n = 276)	Clinical cure and microbiological response	End of intravenous treatment	98.4% vs. 94.0%
Wunderink [82] ^b	Multicenter study (27 CRE 78.7%)	2 g/2 g IV, TD (n = 32)	Best available therapy (n = 15) (46.7% dual therapy)	Cure rates	At day 28	65.6% vs. 33.3% (95% CI: 3.3. to 61.3)
Motsch [83] ^c	Imipenem-nonsusceptible microorganisms 100%	500 mg/250 mg IV, QD (n = 31)	Comparative study with Imipenem+ cilastatin/ relebactam Colistimethate Sodium + imipenem + cilastatin loading dose 300 mg colistin base activity, followed by maintenance doses up to 150 mg colistin base activity, IV, BD (n = 16)	Clinical and microbiological response Survival (HAP/VAP) Clinical response (cIAI)	On therapy visit (cUTI) On day 28 (HAP/VAP and cIAI)	71.4% vs. 70.0% Favorable overall response against <i>P. aeruginosa</i> : 81% vs. 63%

Abbreviation: IV, intravenous; PO, oral; BD, twice daily; TID, three times daily; QD, once a day. CRE, carbapenem-resistant Enterobacteriales; cUTI, complicated urinary tract infection; cIAI, complicated intra-abdominal infection; HAP/VAP, hospital-acquired pneumonia/ventilator-associated pneumonia; ESBL, extended-spectrum beta-lactamases; cUTI, complicated urinary tract infection; cIAI, complicated intra-abdominal infection; HAP/VAP, hospital-acquired pneumonia/just ESBL or CRE data is stated; if entire data is not accessible, only new antibiotic data is included; ^a Patients with severe intra-abdominal infection (10%) were included; ^b 34% of cUTI patients had HAP/VAP and 46.8% had bacteremia; ^c 51.6% of cUTI patients had HAP/VAP and 12.9% had cIAI.

Eravacycline is a tetracycline-class fluorocycline. It suppresses bacterial protein production, just like other tetracyclines. Eravacycline was authorized by the FDA in 2018 for the treatment of cIAI at a dosage of 1 mg/kg IV, BD for a total of 4 to 14 days. According to surveillance studies [84], eravacycline is active against *E. coli* (MIC50/90: 0.12/0.5), including ESBL *E. coli* (0.25/0.5), and *K. pneumonia* (0.25/0.5), including ESBL *K. pneumoniae* (0.06/0.5) [84].

Temocillin is a derivative of ticarcillin, a penicillin antibiotic that primarily targets PBP3 and was developed and marketed in the United Kingdom in the 1980s, but was quickly abandoned due to its lack of activity against Gram-positive bacteria, non-fermenters (such as *A. baumannii* and *P. aeruginosa*), and anaerobes [85]. Given the increasing prevalence of

infections caused by Enterobacteriales that are resistant to third-generation cephalosporins, there has been increased interest in this antibacterial drug in recent decades as a carbapenem-sparing alternative. ESBL and AmpC do not affect temocillin, whereas OXA-48 and MBL do [85–88].

Cefiderocol is a catechol-substituted siderophore that has recently been discovered [89]. In 2019, the FDA authorized it at a dosage of 2 g IV. Cefiderocol has a MIC₅₀/90 of 2/8 mg/L for Enterobacteriales with ESBL and AmpC [90]. It is active against >90% of Enterobacteriales isolates. It also kills over 90% of *Acinetobacter* spp. and *Pseudomonas aeruginosa* isolates [91], including carbapenem-resistant strains [92]. *E. coli* and *Klebsiella* spp. were the most frequent pathogens in this investigation (There was no information supplied on their sensitivity to third-generation cephalosporins), with *P. aeruginosa* accounting for 7%. A recently published RCT compared cefiderocol 2 g IV, TID in 145 patients with meropenem 2 g IV, and TID in 146 nosocomial pneumonia patients and found similar mortality at day 14, 12.4% vs. 11.6% [93].

8.2. Beta-Lactam/Beta-Lactamase Inhibitor

Antibiotics that combine a cephalosporin or carbapenem antibiotic with a beta-lactamase inhibitor are listed below (BLI). The companion beta-lactam antibiotic can reach its objective, penicillin-binding proteins, via inhibiting beta-lactamases (PBPs). Tazobactam (partner to ceftolozane), avibactam (to ceftazidime), vaborbactam (to meropenem), and sulbactam are the BLIs that are coupled with the novel beta-lactam antibiotics described here (to imipenem-cilastatin). Another example is the use of sulbactam, which boosts imipenem's action against most Enterobacteriales (lowering the MIC by 2- to 128-fold) and *P. aeruginosa* (lowering the MIC by 8-fold) [94]. The addition of vaborbactam decreases the MIC 2- to > 1024-fold and increases meropenem's effectiveness against most Enterobacteriales species [94].

Ceftazidime/avibactam was authorized by the FDA in 2015 for the treatment of cIAI (in combination with metronidazole) and cUTI at a dosage of 2.5 g IV, TD, and was later extended to HAP/VAP in 2018. Ceftazidime/avibactam had similar potential adverse effects to ceftazidime alone, according to the FDA package insert. Ceftazidime/avibactam has the most clinical evidence among the “novel” antibiotics discussed in this paper. It was proven to be non-inferior to the best-available medication (mainly carbapenem) in treating cUTI caused by ceftazidime-resistant Enterobacteriales and *Pseudomonas aeruginosa* (Table 1) [71]. Approximately 10% of the participants in this trial had cIAI.

Ceftolozane/tazobactam is a combination of antipseudomonal cephalosporins and BLI tazobactam. In 2014, the FDA authorized this antibiotic combination (brand name Zerbaxa) for cUTI and cIAI indications at a dosage of 1.5 g IV, TD. In 2019, the indication was expanded to include HAP/VAP. Ceftolozane has already been shown to be effective against ESBL Enterobacteriales and carbapenem-resistant *P. aeruginosa* [95]. Its effectiveness against carbapenem-resistant *Acinetobacter* spp. [96] and Enterobacteriales [97] is modest.

Meropenem/vaborbactam (Vabomere) was authorized by the FDA to treat cUTI at a dosage of 4 g (meropenem 2 g and vaborbactam 2 g) IV, TD. Carbapenem-resistant Enterobacteriales, especially those that contain KPCs, benefit from the addition of vaborbactam. However, as previously stated, it has little activity against MBL and OXA-positive isolates [98]. Meropenem's action against *A. baumannii* and *P. aeruginosa* is unaffected by the addition of vaborbactam [94].

9. Alternatives to Antibiotics

Antibiotic overuse in people and animals has contributed significantly to the rise of AMR and has also resulted in the buildup of these substances in the environment by selecting resistant bacteria and transforming the environment into a vast reservoir for AMR genes [99]. Furthermore, the abuse of antibiotics in animal production, as well as the EU restriction on their use in feed (Regulation EC/1831/2003), has resulted in a rise in the incidence of livestock disease and economic loss.

Antimicrobial peptides are among the most effective antibiotic substitutes. Due to their capability to heal bacterial infections, especially those induced by multidrug-resistant diseases, many antimicrobial peptides have been reported, with varied activity spectra and mechanisms of action. Hundreds of AMPs have been found to exhibit antibacterial action in vivo against bacteria that are resistant to antibiotics [100]. A new piscidin-like peptide from black sea bass fish was recently revealed to have broad-spectrum antibacterial action against many bacteria, particularly Gram-positive infections [101]. Similarly, jelling-I, a tiny AMP made up of eight amino acids, kills Gram-negative and Gram-positive bacteria by compromising the cell membrane's integrity [102]. Furthermore, another new defensin-like peptide with an antibacterial action against Gram-positive bacteria such as *Staphylococcus aureus*, *Staphylococcus carnosus*, Nocardia asteroides, and one Gram-negative bacterium, Psychrobacter faecalis, was recently reported [103].

Antimicrobial lipids, such as medium-chain fatty acids (MCFAs) and monoglycerides, might be used instead of antibiotics. MCFAs are a key component of the innate immune system in mammalian breast milk, skin, and mucosa, and they can trigger the development of host defense peptides in humans and animals [104]. The antibacterial activity of lauric acid (LA) and its monoglyceride derivative, monolaurin (glycerol monolaurate, GML), is the greatest among MCFAs. Although the positive effects of MCFAs and LA are progressively becoming acknowledged, nothing is known about their content in insects. Because of their outstanding nutritional characteristics and possible impacts on animal health, insects have recently received a lot of interest as new alternative feed additives.

10. Lack of Awareness

Antibiotics have a broad spectrum of applications, but their misuse can also result in a massive array of infections and bacterial resistance [105]. When antibiotics for particular bacteria are overutilized or misused, the antibiotics against this kind of microbe become less feasible. Therefore, Antibiotics should always be used rationally [106]. Unfinished prescription reporting is one of the leading causes of the use of excess antibiotics in our society. Several aspects of the prescription could be incomplete, where some parts are insufficient or absent in medications, which may contribute to overdose and toxicity by abusing drugs in human beings [107]. However, according to a research analysis on prescribing antibiotics in pediatric patients, 76 out of 100 children have recommended antibiotics in prescriptions while 24 children do not have recommended antibiotics. Forty-eight patients have been rationally recommended antibiotics in those 76 children, whereas 28 have irrationally recommended antibiotics. These 28 children did not require antibiotics because they were suffering from viral infections, and most had mild infections that required essential antibiotics. Still, a high range of antibiotics was recommended to them [108]. Misuse of antibiotics is widespread in our culture in older people due to self-medication. On the other hand, drug stores provide non-prescription antibiotics. The most severe underlying cause of bacterial resistance is that the full course of antibiotics is often not taken by patients. Antibiotic management is, therefore, necessary if the usable agents are to be effective and extended. A coordinated battle for a diversified approach at the global, national, and organizational levels is essential, and this task must be faced together.

11. Prevention of Antimicrobial Resistance in Human and Animal Healthcare

Given the degree and reality of the test of antimicrobial obstruction, the way that WHO Member States are currently executing public activity plans because of the WHO's global action plan on AMR is an indication of progress [109]. To help accelerate these endeavors, the Wellcome Trust facilitated an interdisciplinary worldwide culmination in April 2016 that united policymakers and researchers from more than 30 nations to audit and examine an assortment of 25 approach alternatives. The culmination's conversations mirrored the multifaceted danger that antimicrobial opposition presents. Human and creature well-being and food creation measures have social, financial, and ecological dimensions [110], and anti-infection use in medical care is intensely impacted by open perspectives and

behaviors [111]. Antimicrobial obstruction procedures should be similarly comprehensive. The meaning of ‘One Health’ catches this extension by recognizing the reliance on human, rural, and creature well-being, just like the climate. Antimicrobial obstruction can utilize an assortment of assets and an expanding information base accessible to public chiefs, regardless of how lack of proof has been distinguished as a snag to action [112].

In the first place, anti-infection agents should be eliminated from horticulture without risking the food framework’s capacity to satisfy rising worldwide needs. Anti-toxins ought to be stopped for better creature cultivation techniques for the development of advancement and sickness counteraction. Given the expected economic effect of such mediations, especially in low- and center-pay nations, protection plans could shield ranchers from the danger of losing pay because of lower profitability during the progress. To help decrease anti-microbial use in agribusiness, a further examination into elective treatments and cultivation rehearses is required. Additionally, food handling cycles can accomplish more to shield shoppers from drug-safe organisms.

Second, in both human and creature medication, we need to understand better medication opposition levels and anti-toxin use at the nearby level. Observation and checking are required to acquire a reasonable image of neighborhood conditions and evaluate the impact of intercessions. Anti-infection use and obstruction information should be incorporated in more prominent detail. Quantitative information would empower policymakers to screen the effects of projects and set objectives to motivate conduct upgrades while additionally expanding straightforwardness.

12. Poor Provider Knowledge and Lack of Guidelines

Improper anti-infection use is exacerbated by helpless supplier schooling and an absence of care rules. It is imperative to give excellent instruction to medical services suppliers, ranchers, veterinarians, and other animal well-being experts. Other significant territories incorporate creating or refreshing rules and guaranteeing admittance to excellent fundamental antimicrobials and diagnostics [113].

13. Awareness in the Community

Because anti-microbial obstruction has consistently been a significant worry for bioMérieux, the organization contributes fundamentally to public mindfulness and instructive endeavors. For quite a long while, bioMérieux has vivaciously supported World Antibiotic Awareness Week to help in the worldwide fight against antimicrobial obstruction (coordinated by the World Health Organization). To underwrite a One Health Approach covering antimicrobial opposition in human and creature wellbeing and horticulture, the WAAW lobby’s extension was stretched out in 2020, and its accentuation moved from “anti-toxins” to “antimicrobials.” Organizing mindfulness programs for medical care professionals, the overall population, and bioMérieux laborers are essential for our organization. We additionally supply informational materials for the type of messages, recordings, tributes, and online classes that are disseminated worldwide to bring issues to light about antimicrobial opposition and the fundamental part of diagnostics [114].

14. Regulate the Sale and Use of Antibiotics through Prescription

In 1997, the worldwide interest in anti-toxins was USD 17 billion (GBP 10.6 billion), with around 818 billion remedies for respiratory plot contaminations. While the market is increasing in size (it was USD 15 billion in 1993), the quantity of treatments remains the same. Nonetheless, in the period 1980–1991, the all-out ascent in anti-microbial solutions in England was 46%, which was still lower than the pace of development in France [115,116]. The rise in anti-microbial costs could be impacted by various factors [116–118]. Two attributes of anti-toxin recommendation have appeared to raise the danger of obstruction choice, specifically the utilization of too few dosages or too long treatments [119]. The terrible implementation of the utilization of profoundly specific specialists presently cannot seem to be resolved as far as their natural impacts. Seventy-five percent of populace

remedies are for respiratory infections [117,118]. The most widely recognized explanation for these is tonsillopharyngitis, along with bronchitis. Anti-microbials are given to around 90% of tonsillopharyngitis patients in both France and the United Kingdom. This creates 9 million solutions in France each year. The conference rate in France is several times that of the United Kingdom [116,117]. A quick indicative test for bunch A streptococci with 90% affectability is available [120]. However, it is not generally utilized and is not covered by the French medical care framework. For this reason, 35% of patients have been polluted with bunch A streptococci [121]; a fast test may save around 6 million anti-toxin solutions.

15. Global Action Plan on Antimicrobial Resistance

Procedures that are crucial for healthcare services would be inaccessible or dangerous without antibiotics, as detailed by the WHO [122]. Critical operations, cancer care, and prophylaxis during cesarean are examples of facilities that can no longer be administered efficiently without appropriate antibiotics. The foundation for improving WHO health programs recognize the building blocks of a healthcare system relating to administration, funding processes, medications and technology, health information programs, human resources, and the provision of health services [123]. With the scale and intensity of the antimicrobial resistance challenge, there has been some improvement in developing national initiative plans by member countries of the WHO [124]. The overarching aim of the action strategy is to assure the potential to cure and avoid contagious diseases by reliable and secure, quality-assured drugs, which are used sensibly and are available to anyone that needs them, and this should be continued as long as possible [125]. Antibiotics can be used in favor of better animal breeding methods to develop growth and prevent disease progressively. For each human and animal medication, it is necessary to gain even more knowledge of the extent of resistant strains and the usage of antibiotics. Public health services must optimize their use of antibiotics to decrease the impact of the disease. In line with the objectives for sustainable improvement, the focus should be put on improving sanitation and the availability of safe water, promoting handwashing habits, and better protection and treatment of infection in clinics [126].

16. Role of Pharmacists in Combating Resistance to Antimicrobials

Pharmacists are critical participants of the healthcare system and play a vital role in using medications and the delivery of medical guidance [127]. They are in an excellent position to recognize antibiotics better and educate their intelligent use in society and hospitals through direct communication with the patient [128,129]. The utilization of antibiotics among medical practitioners, patients in the various areas of the care community, and the general consumers is one of the significant results of improved pharmacists' responsibilities [130]. Hospital pharmacists can supervise the clinical setting by controlling compliance with common treatment protocols, including the appropriate antibiotics prescribed by physicians through their formulation and testing [131,132]. In the context of antimicrobial stewardship, pharmacists and nurses can cooperate successfully to minimize antimicrobial usage and fight antimicrobial resistance [132]. Community pharmacists could convince patients that antibiotics are ineffective for viral infections, and they could suggest people consult with a registered physician for alternative therapy for a mild infection. They should be diligent in compliance with legislation and not allow antibiotics to be sold over the counter [131]. Academic pharmacists play an important part in teaching pharmacists and other medical professionals about the appropriate use of drugs and the concept of antimicrobial stewardship [133]. Pharmacists could also develop national legislation, regulations, and directives that encourage the proper use and application of antimicrobials, where available [134]. They could, in turn, cooperate in the development and facilitation of training and behavioral actions that help the appropriate use of antimicrobials with the support of society and health professional groups.

17. Types of Intervention

Interventions usually fall into six different categories: norms and standards (acknowledgment, directives, public scrutiny, limit OTC sales, control of prescription); information interventions (observation, response); support for decision-making (algorithm, etiology); sequence of distribution (decentralized supply, delivery of medications); economy (financial support, strategic pricing, wellbeing insurance); and management processes (necessary policy on medicine, programs for stewardship) [135]. The more successful they are when they plan the interventions, compared to a national facility or level, the closer they are geared towards the supplier/prescriber of antibiotics. It is also necessary to realize how one intervention can affect other circumstances.

Persuasive intervention: Persuasive intervention is used to disseminate education services, to remember, audit, and discussion or educational provision. The ongoing training of medical professionals will help keep workers up-to-date, educate them about policies and improvements to pharmacotherapy, and encourage them to express perspectives and learn from discussions with their peers [136]. Passive education should preferably be paired with active interventions; passive education yields only modest results as an independent program [137,138].

Restrictive intervention: Restrictive interventions are initiatives that restrict the prescriber's freedom to select such antibiotics. For example, targeted antibiotics may require approval by a specialist in infectious diseases and may be replaced by a pharmacist or be fully limited in the treatment [139–141].

18. Prescribing and Intervention Context

A few investigations depicted the context of interventions to deal with the availability of antibiotics in medical clinics, primary care, and pharmacies, including public, private, and casual suppliers. Some studies concentrated on drug stores, local-area drug specialists, and informal doctors in villages [135]. A better and faster decision by medical professionals associated with drug prescription may lead to substantial patient outcome changes and better use of healthcare costs. While there have been recent changes in the spread of evidence in practice, the prescription practice of medical professionals tends to differ. Due to this variance and the ability to damage the reputation of new medicines that often have a minimal benefit compared existing treatments [142], we must understand which interventions in the change of prescription are successful in improving patient results, thus minimizing healthcare costs [143].

19. Knowledge of Antimicrobial Resistance and Appropriate Antibiotics Use

Antibiotics have become a productive and proactive tool against many pathogens over the last four or five decades. The growth of antibiotic-resistant and propagated pathogens in the community is a significant problem globally that poses an important public health danger, particularly in developing areas, in the current era [144,145]. Concepts as to why and what should be done with antibiotic resistance are not the most significant basis for developing interventions to change prescriber execution in antibiotic prescriptions. A conceptual approach is required to choose and execute the procedures to change the medication [146]. The leading causes of antimicrobial resistance increase and spread may be self-medication, illegal prescription, improper use, and unnecessary use of such antimicrobial drugs [147–149]. This rise in antibiotic resistance gradually decreases their therapeutic efficacy and leads to more severe diseases with higher death rates. It will place a heavy strain on the global economy and various healthcare organizations [150].

Many studies accurately found that antibiotics had been appropriately administered to treat bladder or urinary tract infections (72% where $n = 93$), skin or wound infections (67% where $n = 87$), and gonorrhea (39% where $n = 51$) [151], as shown in Figure 5.

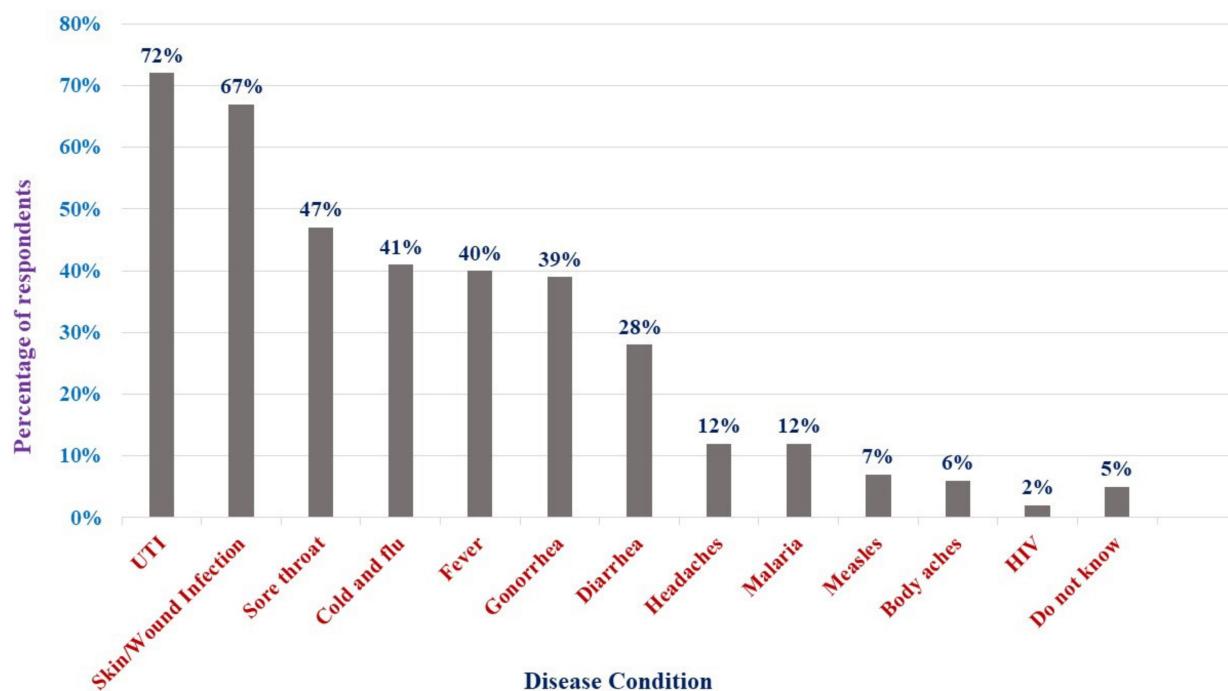


Figure 5. Percentages of participants who reported acceptable antibiotic usage in the different circumstances of the illness. HIV, human immunodeficiency virus; UTI, urinary tract infection.

20. Practical Concerns and Diverse Influences on Antibiotic Prescribing

Prescription is a crucial procedure in medical practice. In general, infections are regularly introducing issues, and antibiotics are among the most habitually recommended drugs. For a long time, antibiotics have been an essential aspect of prescription research. Apart from the availability of drugs, several more subtle factors tend to be involved. The following variables were found to impact prescription in doctoral research: insufficient diagnostic services, the inadequacy of instructions on antibiotics, complications to tracking patient conditions, low intensive treatment services in rural areas, patients wanting immediate relief, patient prospects perceived from previous recommendations, usage of stored up medication, and fear that patients will be lost in rivalry [152–154].

21. The Most Current Antimicrobial Stewardship Programs

The WHO published its Global Implementation Plan on Antimicrobial Resistance in 2015, outlining a comprehensive set of goals and priorities for its own member countries targeted at eliminating AMR [124]. The plan outlined five major targets, each with suggestions for activities by member countries, the administration, and partner organizations. One of them is to set up antimicrobial stewardship programs that include both animal and human usage. The most recent AMR programs are mentioned here.

21.1. The Southeast Asia Region Antimicrobial Stewardship 2022 Webinar Series (24 March–7 December 2022)

Widespread accessibility to elevated, inexpensive antimicrobials is a vital part of universal health coverage (UHC). The accessibility of high-quality, cheap antimicrobials to prevent contagious infections is a concern in many contexts, impacting the effectiveness of healthcare services. Antimicrobial stewardship (AMS) is defined by the WHO as a comprehensive set of coordinated strategies that enhance the responsible and proper use of antimicrobials to assist in better health outcomes throughout the care continuum. The webinar series was developed in response to a request from several member countries for assistance on how to execute comprehensive and coordinated national antimicrobial stewardship efforts in a programmatic framework based on public health guidelines.

The Objectives of the webinar series are to improve the perception of antimicrobial stewardship (AMS) initiatives and their significance to public health in the fight against antimicrobial resistance, to increase listeners' knowledge and capabilities in establishing regional and health facility AMS programs in the WHO Southeast Asia Region countries utilizing the WHO AMS toolbox, to train people to give technical help to national and local counterparts in developing/maintaining successful AMS programs, connected with other strategies and initiatives to optimize antibiotic usage and decrease the risk of bacterial resistance at the national/local level, and to encourage the prudent use of antimicrobials [155].

The webinar series is available to the public. This guidance is primarily intended for state policymakers at Ministries of Health as well as national AMR-organizing authorities such as national AMR steering or coordinating panels, as well as health professionals, infectious disease doctors, pharmacists, and midwives engaged in antibiotic clinical management and usage [155].

21.2. European Society of Clinical Microbiology and Infectious Diseases (ESCMID) AMS Certificate (2022–2024)

ESCMID's fundamental objectives are to promote positive, interdisciplinary, and scientifically proven antimicrobial stewardship programs (ASP) in Europe. Education is critical to achieving this goal. A pan-European competency in AMS is required to face the difficulties of minimizing antimicrobial misuse. The importance of diagnostics in antimicrobial stewardship is recognized in the ESCMID AMS certificate program. The curriculum will last two years and will involve face-to-face practice, virtual learning modules, and study projects. Every face-to-face session will be followed by examinations. All course organizers are advised to design their courses with the following objectives in mind: (1) Wisdom, (2) Abilities, (3) Behavior on their part [156].

The program's intended users are infectious disease doctors, professional microbiologists, medical pharmacologists, intensive care unit (ICU) doctors, internists, specialist midwives, pediatricians, and other medical specialties. Doctors who are nearing the end of their training are also welcome [156].

Participants of the program will have gained the information, abilities, and behaviors essential to make a substantial contribution to this extremely significant specialized area. Members in the curriculum are prepared for research roles, academic and/or instructing professions, jobs in domestic and global AMS organizations, work in application service providers of healthcare facilities, and government jobs. Learners will be capable of actively boosting the AMS movement whether they are beginning, maintaining, or expanding their careers in medical infectious diseases [156].

22. Current Situation of Antibiotic Resistance in Bangladesh and Treatment Difficulty and Rising Costs

22.1. Treatment Pattern, Use

Multiple small-scale studies on antibiotic prescribing and usage were published, with results differing by age and gender. Antimicrobials were prescribed more frequently to children (66%) than to adults (44%) [157], and the incidence of prescribing antimicrobials was greater at the extremes of age [158] and for men [159]. Higher-generation antimicrobials (e.g., ceftriaxone, ciprofloxacin, azithromycin) were often recommended [158,160], particularly by doctors [160]. Research from a Dhaka slum found that antimicrobial awareness education can promote rational usage by lowering antibiotic prescription and/or irrational use [161]. According to studies, two or more antimicrobials are regularly administered at the same time in Bangladesh [158,159,162–168], and hospital settings prescribe more antimicrobials than community settings [169]. Due to a shortage of testing facilities, prescribing antibiotics without laboratory tests was relatively widespread in Bangladesh [162,163,165]. Furthermore, qualified prescribers (e.g., in-service trainee doctors at a medical college hospital) have been seen to feel confident in selecting a suitable antibiotic and prescribing the proper dose and duration based on clinical diagnosis [170]. This was confirmed in a simulated patient trial in which antimicrobials were prescribed (71%) based on clinical

knowledge [171]. The treatment guidelines were known by qualified prescribers from several secondary and tertiary level hospitals [172], but not by those from Upazila (sub-district) hospitals [173]. Standard treatment recommendations were not always accessible [174]. Fever, common cold, cough, diarrhea, and ARI are all common reasons antibiotics were prescribed [160,163,173].

22.2. Self-Treatment and Non-Compliance

Noncompliance with prescribed doses by patients, which facilitates the emergence of AMR, was a regular occurrence in the literature reviewed [175]. Patients used to discontinue taking antimicrobials as soon as their symptoms went away, thus this number may be as high as 50% [162]. Patients frequently viewed doctors as inept when recommended antimicrobials failed to work in a short period of time [176]. Self-treatment (taking medicine without contacting a qualified physician) was shown to be relatively common in the literature review [177–182]. It was shown to be prevalent for disorders such as dysentery, diarrhea, and food poisoning (36%); cold, cough, and fever (28%); and suspected infection of some type (13%) [178]. Advice from traditional healers (41%), experience with the particular antibiotic for the particular ailment (33%), knowledge of antibiotics (17.5%), and waiving doctor's consultation fees (1%) were all reasons for self-treatment by the people in Bangladesh. Furthermore, self-medication has also been linked to poverty [182].

22.3. Antimicrobial Resistance and Sensitivity

Antibiotic susceptibility testing and resistance trends were discussed in ten studies. Uropathogens have been discovered to be resistant to medicines such as imipenem [183]. Susceptibility studies of clinical isolates revealed that many common bacteria, such as *E. coli* and *S. Typhi*, are resistant to low-cost, routinely used antibiotics [184–187]. Mannan et al. [184] collected 70 types of clinical isolates from blood, sputum, urine, and pus samples and discovered that 64 percent of isolated *S. Typhi* were multiple antibiotic-resistant. Resistance to older and regularly used antimicrobials was found in 50% of *E. coli*, *S. aureus*, *Pseudomonas*, and *Klebsiella* infections in a research carried out in three tertiary level hospitals in Dhaka [185]. Uncertainty regarding diagnosis was also a factor in giving too many antibiotics in 70% of cases. Antimicrobial sensitivity tests on 2016 culture-positive urine samples from a tertiary medical college hospital in Bangladesh revealed *E. coli* in 84% of cases, with 82% of those resistant to amoxicillin [186].

Another investigation comprising isolates from public and private hospitals, clinics, and diagnostic centers in Dhaka city found similar results of minimal sensitivity of *E. coli* to amoxicillin [187]. *Salmonella typhi* was shown to be responsive to amikacin (70%), azithromycin (73%), ceftazidime (63%), ceftriaxone (67%), and ciprofloxacin (87%) in recent research by Tarana et al. [188]. Another research (2017) discovered *E. coli* in 86% of urine samples obtained from a private medical college hospital in Dhaka [189], with *E. coli* being extremely resistant to amoxicillin (95%). More than 80% of MRSA isolates are susceptible to certain macrolides (tobramycin, gentamycin) and carbapenems (meropenem) while the remaining were resistant to ampicillin, amoxicillin, cefixime, and azithromycin [190].

Over the three years (2016–2018), an antibiogram from a private sector tertiary hospital revealed that the last-resort antimicrobials (Polymyxin B and Colistin) maintained their high sensitivity to *Klebsiella*, *Psudomonosis*, and the *E. coli* [191]. GARP's Bangladesh National Working Group conducted an assessment that included a descriptive analysis of the AMR status in several sectors as well as suggestions [192].

22.4. Food Production and Food Animals, Fisheries, and the Environment, and the Spread of AMR

Antimicrobial residues such as tetracycline, ciprofloxacin, enrofloxacin, and amoxicillin were identified in a significant percentage of poultry meat and eggs intended for human consumption [193,194]. Antibiotic residues were found in over 60% of the liver, kidney, and egg samples and about 50% of breast and thigh samples [193]. In Bangladesh, 3079 metric tons of poultry manure are generated each day, with 50% of this being utilized

directly in aquaculture [195] Detectable amounts of oxytetracycline residues, for example, were found in 25% of Pangas fish samples from Sylhet Sadar [196]. *Salmonella* species were discovered in 60 to 78% of street meals in Chittagong, with multidrug-resistant *Salmonella* found in every food item tested [197]. Dhaka's hospitals are also adding to the problem by dumping untreated medical waste into the water, resulting in high levels of resistant *E. coli*. Waterborne *E. coli* [198–202] contributes to wildlife infections from people and animals, e.g., the occurrence of multidrug-resistant enterococcus in free-range wildlife and Shiga Toxin-generating *E. coli* in Buffalo feces [203].

22.5. Bangladesh's Current Antimicrobial Resistance Policies and Initiatives

From the updated National Drug Policy (2016) [204], the Government Republic of Bangladesh established major policy guidelines and documents to control and prevent AMR in humans: (i) for monitoring the sale and dispense of the drugs without prescription, the Government of Bangladesh established the pharmacovigilance and Adverse Drug Reaction (ADR) policy 2017; (ii) Standard Treatment Guideline (STG) for rational uses of antibiotics in sub-districts; (iii) a guideline for antimicrobial stewardship development. These policy publications covered a variety of topics related to AMR prevention and control in healthcare settings.

The Ministry of Fisheries and Livestock (MoFL) issued the National Livestock Development Policy in 2007, citing insufficient veterinary services and weak regulatory framework execution as hurdles to addressing AMR in this industry. Antimicrobials, growth hormones, and pesticides were all outlawed in 2010 under specific rules governing various parts of food animals and fish. A person who breaks this legislation might face a year in jail or a fine of up to BDT 50,000 (USD 650).

Finally, the Disease Control Unit of the Director-General of Health Services, MoHFW, has created a National Action Plan 2017–2022 for limiting AMR in Bangladesh, along with a road map for its execution in line with the worldwide plan [202]. Through the development of standard treatment guidelines, antibiotic stewardship, the development of reference laboratories, Good Manufacturing Practice (GMP), Good Pharmacy Practice (GPP), and infection prevention and control, and the establishment of a comprehensive surveillance system, the document emphasizes the rational use of antibiotics in all sectors.

22.6. Treatment Cost

Due to a lack of public awareness, unnecessarily prescribed antibiotics, especially in rural areas, non-human antibiotic use, and flexibility of the government law, AMR has gradually increasing in Bangladesh; at present the government have taken some initiative to mitigate this problem, but this initiative is less to control AMR. Furthermore, treating individual infected patients with resistant pathogens is connected with greater expenditures because it necessitates further examinations and a longer stay in hospital. In Bangladesh, the healthcare system is mixed and both public and private treatment costs vary from public to private. Treatment cost in a private hospital is higher compared to a public hospital. Human antibiotic consumption in Bangladesh is estimated to be valued at roughly Tk. 3500 crore per year, making it the second-largest therapeutic category in the pharmaceutical business, accounting for 16% of the entire market. Antibiotic use in our country is growing by roughly 13 to 16% per year, which is concerning. These figures indicate that day-by-day costs of treatment are increasing tremendously due to resistance to pathogen, which, in a middle-income country, is concerning because it affects people's ability to fulfill basic needs. During and after the COVID-19 pandemic, treatment costs doubled due to increasing self-medication, and also hypothetically prescribing different types of antibiotics, especially ivermectin (77%) and azithromycin (54%).

According to recent research by the International Center for Diarrheal Disease Research, Bangladesh (ICDDR'B), roughly 6.4 million individuals in Bangladesh, or 4% of the population, become poorer every year owing to high health expenditures [205]. According to the study, the lowest 20% of the population spent 16.5% of their family income on direct

healthcare expenditures, while the wealthiest 20% paid just 9.2%. Households paid 64% of direct health expenditures out of pocket, with the balance coming from the government and other sources [205]. This is an unreasonably high burden for many households in a country where the average annual per capita income is less than USD 1000 [206].

23. Antimicrobial Stewardship in Bangladesh

Antimicrobial resistance is a high-profile global health issue that is rapidly expanding throughout the globe. It causes a great deal of morbidity and mortality. Bangladesh is a South Asian country with a dense population. Antibiotic overuse is a hot topic in this country. This topic is not well understood by prescribers, the ordinary public, and stakeholders. As a result, Bangladesh's antibiotic resistance dilemma is becoming an insurmountable problem, and the list of accessible last-line possible treatments is shrinking by the day. Unfortunately, there is no national antimicrobial surveillance data, and neither government nor private hospitals have active antibiotic stewardship programs [207].

Bangabandhu Sheikh Mujib Medical University (BSMMU) was one of the hospitals in Bangladesh that took the initiative and produced a few stewardship principles at the institution level a few years ago. Unfortunately, prescribers do not follow these standards, and they are only available on their website, and there was no monitoring because the standards were not followed. Antibiotic usage is still not prudently applied by prescribers in Bangladesh, both rural and urban, and people are mainly uninformed of the associated danger of antibiotic resistance in their current lives and future generations. Overall, practicing doctors, stakeholders, and policymakers have expressed a desire to implement a stewardship-like program at the institution level, but it is still not happening at this alarming time of AMR [207].

Square Hospital, on the other hand, began developing a stewardship program with the primary purpose of establishing a realistic relationship between antibiotic prescribing and stewardship goals from the outset. Antimicrobial stewardship is now only operational in Square hospital in Bangladesh, out of all the private and governmental hospitals in the country. Bangladesh is not a particularly forward-thinking country in this sense, but the government and foreign organizations (UN, UN/FAO, UNFPA, USAID, UKAID, WHO, and MSH) are striving to create it, including a few recent projects [207].

24. Concluding Remarks and Future Perspectives

AMR is increasing at an alarming rate around the world. Currently, it is widely recognized as a global public health issue that requires immediate attention. New resistance mechanisms are continuously arising and spreading across the globe, posing a threat to our ability to treat various infectious diseases. Though its resistance mechanism is complex and challenging to understand, we must take the necessary initiatives to provide more fundamental research and developmental data to control resistance. The major challenge of antibiotic resistance is exacerbated by medication abuse and overuse, as well as inadequate infection prevention and management. It is increasing day by day all over the world. To minimize the impact and spread of resistance, necessary efforts can be taken at all levels of society. We should take the necessary steps included in all sectors and increase knowledge to prevent the spread of antibiotic resistance. Traditional practices in infection control, antibiotic stewardship, and novel antibiotic development are all foundations of society's strategy for resistance prevention, and they must be maintained. Future research should be intensified to provide strong information on the healthcare field via multi-sectoral and interdisciplinary collaboration. A worldwide endeavor should develop a reliable standard method for evaluating observational data on antibiotic use in animals, and the effect on human health is crucial. Inter-sectoral coordination should be prioritized by lawmakers, animal healthcare staff, pharmaceutical industries, regulatory agencies, and medication distributors to limit improper antimicrobial usage in animals. Antimicrobial dosing control should be optimized, which will play a pivotal role in optimum antimicrobial therapy.

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