

THE EMERGING GLOBAL THREAT OF *CANDIDA AURIS*: A CALL FOR ENHANCED PUBLIC HEALTH POLICY AND REGIONAL COORDINATION

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ABSTRACT

Antimicrobial resistance represents a paramount challenge to global public health in the 21st century. The multidrug-resistant fungal pathogen *Candida auris* poses a critical and escalating threat to global public health. Characterized by rapid nosocomial transmission, persistent environmental contamination, and resistance to multiple antifungal classes, *C. auris* challenges healthcare systems worldwide. Its independent emergence across distinct geographic clades and exponential rise in cases, exacerbated by the COVID-19 pandemic, underscore the urgent need for robust, coordinated response. This review synthesizes the current knowledge on *C. auris* with a focus on its implications for public health policy, particularly in the European and Balkan healthcare settings, where surveillance gaps and cross-border transmission risks remain pronounced. We analyze the key drivers of spread, including diagnostic misidentification, extensive antifungal resistance, and lapses in infection control, and evaluate the strain on surveillance and hospital preparedness. Effective mitigation is fundamentally dependent on implementing comprehensive, multi-faceted infection prevention and control strategies, guided by antifungal stewardship and rapid diagnostics. We conclude that addressing the *C. auris* threat requires an urgent, coordinated international and regional response focused on strengthening surveillance networks, standardizing diagnostic and infection prevention and control protocols, and fostering data sharing across borders to contain this resilient pathogen.

Keywords: *Candida auris*, antifungal resistance, infection prevention and control, public health policy, nosocomial outbreaks

INTRODUCTION

Fungi have emerged as a substantial threat to global public health. Although vital within ecosystems, a number of species are pathogenic for the human population, causing a spectrum of diseases, from superficial to fatal systemic infections. Current estimates indicate that life-threatening fungal diseases affect more than 6.55 million individuals annually, resulting in over 3.75 million deaths. These figures highlight the critical necessity for enhanced research focused on fungal pathogenicity, epidemiology, and therapeutic development [1].

Initially reported in Japan in 2009, and later isolated retrospectively from 1996, *Candida auris* achieved a global presence by 2018, with cases documented across all inhabited continents [2]. *C. auris* is an alarming example of an emerging multidrug-resistant fungal pathogen of critical global public health concern, distinguished by its capacity for causing outbreaks in hospitals and long-term care facilities, persistent environmental contamination, antifungal resistance and intrinsic tolerance to common disinfectants [2].

This review synthesizes the current knowledge on the risk factors, epidemiology, diag-

nostic challenges and therapeutic limitations of *C. auris* to inform and advocate for urgent, evidence-based policy actions. We focus on the critical need for enhanced surveillance, rapid diagnostic capacity, standardized IPC (infection prevention control) protocols, and regional cooperation, which are the key pillars for mitigating this formidable threat within the European and Balkan healthcare infrastructures.

RISK FACTORS

The most concerning is the atypical behavior of *C. auris*, which demonstrates a pronounced capacity for skin colonization (predominantly axillae, groin) and persistence on abiotic surfaces [3], unlike *C. albicans*, which colonizes the gastrointestinal tract [4], thus enabling silent spread within healthcare environments reminiscent of bacterial “superbugs”. Invasive infection most commonly presents as candidemia, occurring in 5–10% of the colonized patients, with risk exceeding 25% within 60 days of colonization detection. Hematogenous dissemination can also lead to severe infections such as meningitis, endocarditis, and osteomyelitis [5]. Risk factors for *C. auris* mirror those for other nosocomial pathogens and invasive candidiasis: advanced age, indwelling devices, major comorbidities (diabetes, chronic kidney disease and neoplastic disorders), immunocompromised states (neutropenia, glucocorticoid use or solid-organ transplantation), recent surgery, and prolonged ICU stays, especially due to severe COVID-19 [6, 7]. Mortality rates for invasive infections with *C. auris* are high, often exceeding 50–60%. A critical and modifiable risk factor is the prior exposure to broad-spectrum antibiotics and antifungals, which exerts selective pressure favoring resistant strains like *C. auris*.

The unique epidemiological threat from *C. auris* lies in its transmissibility. Transmission can occur rapidly, colonization has been documented after only four hours of exposure, and invasive infection within 48 hours of ICU admission. Patients remain colonized for weeks to months, shedding the pathogen and contaminating their environment extensively, as confirmed by studies detecting *C. auris* on high-touch surfaces around patient beds, which creates a persistent reservoir that fuels outbreaks [3, 7].

EPIDEMIOLOGY

Genomic analyses confirm the nearly simultaneous, independent emergence of *C. auris* across six distinct geographic clades worldwide, followed by rapid clonal expansion within each region [8]. These clades exhibit significant phenotypic differences in outbreak potential and antifungal resistance profiles, complicating a unified global response [9]. The pattern of initial importation followed by rampant local transmission is exemplified in the United States. Since its first report in 2016, clinical cases escalated from 479 in 2019 to 4,514 in 2023, with most intense outbreaks clustered in long-term care facilities [10]. Recognized as an “urgent antimicrobial resistance threat” by the Center for Disease Control and Prevention (CDC) in 2019 [11], and a “critical priority” pathogen by the WHO [12], *C. auris* has achieved near-global distribution since its first identification in 2009 [2]. The rise of *C. auris* is facilitated by a convergence of factors: widespread antimicrobial use, increasing populations of immunocompromised hosts, global travel and patient transfers, and significant gaps in infection prevention and control (IPC) [9]. For the healthcare systems in Europe and the Balkan region, the threat is immediate. Significant outbreaks have been documented across Europe, straining hospital resources and highlighting vulnerabilities in cross-border health security. Between 2013 and 2023, EU/EEA countries reported a total of 4,012 cases of colonisation or infection [13]. The first case reported between 2013–2023 in the EU/EEA was in 2014 in France [13, 14], followed by an initial peak of cases in 2017, mainly related to an outbreak in Spain. Since 2020, case numbers have been increasing rapidly, peaking at 1,346 annual cases reported by 18 EU/EEA countries in 2023 alone. The five countries with the highest numbers of reported cases, from 2013 to 2023, were Spain (n=1 807), followed by Greece (n=852), Italy (n=712), Romania (n=404) and Germany (n=120). However, these figures likely represent only a fraction of the true burden. The latest survey documented distinct outbreaks in 3 countries (Cyprus, France and Germany) [13]. Meanwhile, health author-

ities in Greece, Italy, Romania, and Spain have noted that the pathogen is now so widespread at a regional or national level that tracking individual outbreaks has become impossible. For Greece, Italy, and Spain, the progression from the first documented case to this state of regional endemicity took only 5-7 years, illustrating the alarming speed at which *C. auris* can disseminate through hospital networks. This rapid spread is a serious concern, indicating a high risk for continued expansion across the European healthcare systems [13]. While the previous three *C. auris* surveys from ECDC were limited to the EU/EEA countries, the EU enlargement countries of the Western Balkans and Türkiye were also invited to participate in *C. auris* survey 2024. Six of the seven invited EU enlargement countries also replied to the survey and reported a total of 121 cases of *C. auris*, between 2013–2023. Most cases were reported by Türkiye (n=114), Kosovo (n=6) and Bosnia and Herzegovina (n=1) [13]. In a recent public journal report from Croatia, *C. auris* was suspected in a patient transferred from a European hospital at the Zagreb Clinical Hospital, and was also discovered at the Split Clinical Hospital at the end of August 2025, where two patients were infected, also confirmed in the Croatian Institute of Public Health laboratory. But, Croatia, despite being in the region, was not listed as a participant in the published summary of the

ECDC participation 2024 survey. Slovenia has reported one case in 2023. Bulgaria also did not detect any *C. auris* cases during 2013-2023 which is covered by the *C. auris* 2024 survey, but registered 4 cases in 2025. Serbia reported 8 cases for 2024 outside of the period formally covered by the survey. Montenegro and North Macedonia also replied to the survey but had not detected any cases. Albania did not respond to the survey [13]. The ECDC consistently note that the true number of cases is likely underestimated because many countries, including some in Europe, lack comprehensive national surveillance systems for *C. auris*. Concurrently, major outbreaks were documented in South America (Venezuela, Colombia), Asia (India), and Africa (South Africa, Kenya), establishing *C. auris* as a leading cause of candidemia in some endemic regions [15-20]. Global distribution of *Candida auris* cases by country are shown in Figure 1.

As case numbers rise and geographic distribution widens, achieving sustained control will become increasingly challenging. The 2024 ECDC survey also highlighted persistent gaps in national preparedness, particularly in establishing surveillance systems and developing specific infection prevention and control guidance [13]. Despite the increasing infections, only 17 out of 36 participating countries have implemented nationwide surveillance for *C. auris*. Just 15 countries have established spe-

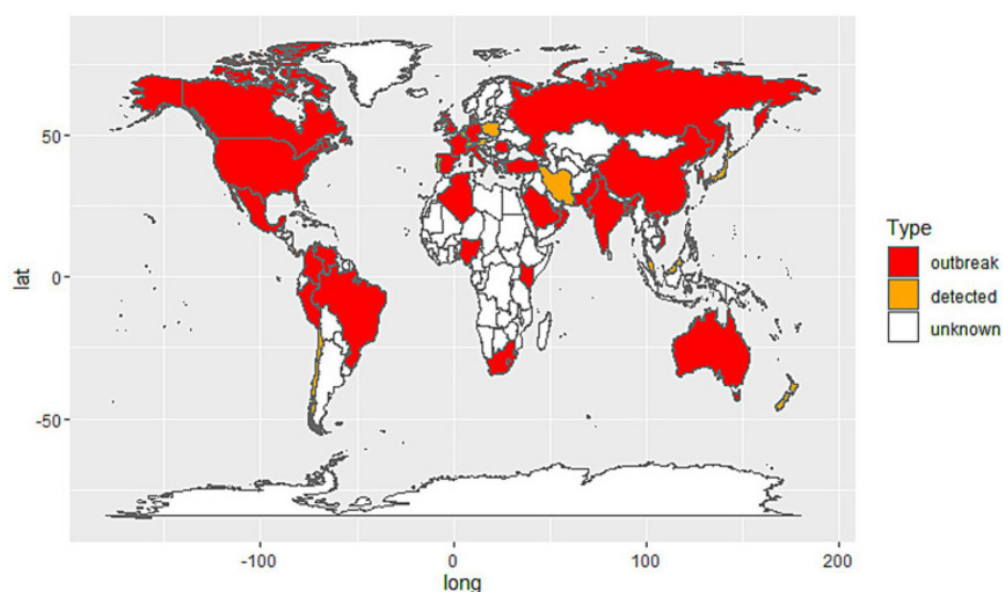


Figure 1. Global distribution of *Candida auris* cases by country. Red: Countries with documented outbreaks (confirmed local transmission). Orange: Countries where *C. auris* has been detected but no outbreaks reported. White: Countries with no reported cases or insufficient data. Adapted from Zhang et al. (2025).

cific national guidelines for infection prevention and control. Laboratory capacity appears more robust, with 29 countries reporting access to a specialist mycology or reference laboratory and 23 countries providing reference testing services to hospitals [13]. There were large differences regarding the setup of surveillance systems (voluntary or mandatory surveillance) and the case definition (all *C. auris* cases, only *C. auris* infections or only *C. auris* bloodstream infections) or the definition of outbreaks. Nevertheless, national efforts focused on early detection, robust surveillance, and the swift implementation of IPC measures remain crucial to contain, delay, and mitigate the impact of *C. auris* on hospitalized patients in Europe. The pathogen's frequent misidentification by standard laboratory methods and its multidrug resistance further complicate timely response and effective treatment of infections with *C. auris*. Given its rapid dissemination and potential to undermine healthcare safety, a shift from a purely clinical to a strengthened public health policy perspective is imperative.

A country can be considered endemic for *C. auris* when the fungus demonstrates persistent, uncontrolled transmission within its healthcare networks, rather than just sporadic imported cases. By this definition, at least 13 nations across different continents should be considered endemic [21]. These include Italy, Spain, Greece, Romania, and the United Kingdom in Europe; the United States and Colombia in the Americas; Saudi Arabia, Oman, Kuwait, Qatar, India,

and Pakistan in Asia; and South Africa in Africa. Additionally, other countries have documented substantial case numbers (over 100 infections or colonizations), signifying either emerging or contained spread. These include Brazil, China, Israel, Kenya, Panama, Russia, and South Korea (Figure 2) [21].

The COVID-19 pandemic acted as a potent accelerator for the spread of all multidrug-resistant (MDR) organisms [22, 23]. Healthcare system strain correlated with increased transmission of MDR microbes, and mortality rates rose from a pre-pandemic range of 50–65% to 60–80% during the COVID-19 pandemic period. Post-pandemic surveillance in China, revealed a dramatic increase in both case numbers and geographic distribution of *C. auris* infections, alongside rising resistance to amphotericin B and echinocandins [24].

While comprehensive surveillance data from the Balkans is still developing, the documented spread across Europe and the constant movement of patients and healthcare workers across borders presents a clear and immediate risk to regional healthcare systems, necessitating proactive surveillance and preparedness [25].

DIAGNOSTIC CHALLENGES AND PUBLIC HEALTH IMPLICATIONS

Accurate and timely identification of *C. auris* remains a critical barrier to containment,

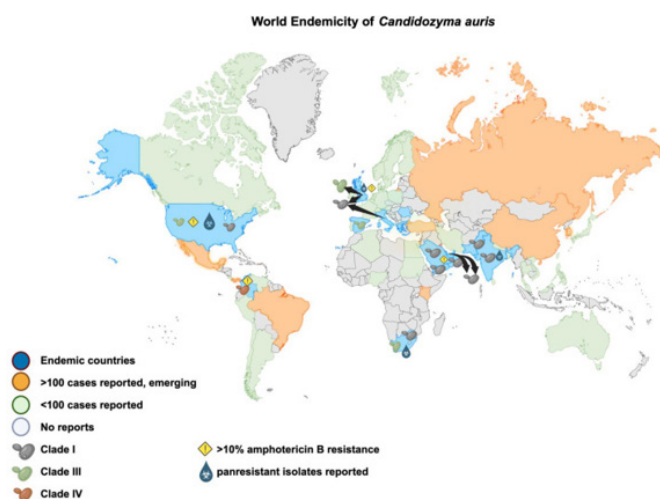


Figure 2. Endemicity of *Candida auris* globally based on surveys from 2009 to 2025.

*Adapted from Salmanton-García et al. (2026)

as misdiagnosis delays isolation and fuels outbreaks. Conventional culture and biochemical methods frequently fail, often misidentifying *C. auris* as related species like *C. haemulonii* [26]. This unreliability underscores why phenotypic identification alone is insufficient for public health response. To address this, selective and chromogenic media have been developed as practical, first-line screening tools, especially for surveillance and in resource-varied settings. Media formulations leveraging organism's thermotolerance and halotolerance (CHROMagar™ Candida Plus) offer improved presumptive identification, though confirmation with advanced methods is still required [27, 28]. These media represent a crucial, scalable step for laboratories without immediate access to molecular technology. Definitive identification of *C. auris* relies on advanced technologies. Matrix-assisted laser desorption/ionization time-of-flight mass spectrometry (MALDI-TOF MS) has become the cornerstone for accurate identification in clinical laboratories, provided spectral databases are regularly updated [29]. For rapid screening and outbreak management, molecular methods are indispensable. Both PCR and loop-mediated isothermal amplification (LAMP) assays can detect *C. auris* directly from surveillance swabs within hours, enabling real-time infection control decisions [30, 31]. A 2025 review of commercial and laboratory-developed PCR tests reported sensitivities and specificities consistently above 94% and 98%, respectively, highlighting their reliability for public health use [31].

In 2014, the U.S. Food and Drug Administration (FDA) approved the T2 Magnetic Resonance (T2MR) assay, a fully automated qualitative diagnostic test performed on the T2Dx instrument, for detection of candidemia. The T2MR assay is capable of detecting five key *Candida* species: *C. albicans*, *C. glabrata*, *C. parapsilosis*, *C. tropicalis* and *C. krusei*. Validation studies of T2MR using axilla/groin swab samples reported a sensitivity of 89% and a specificity of 98%. The subsequent T2Cauris panel was developed to extend detection capabilities to include *C. auris*, *C. haemulonii*, *C. duobushaemulonii* and *C. lusitaniae* in both blood and environmental specimens [32]. Presently, this assay is designated for research use only and has not yet received regulatory approval for clinical diagnostic application.

POLICY IMPERATIVES FOR *C. AURIS* DIAGNOSTICS

Addressing *C. auris* requires specific policy actions to overcome diagnostic hurdles. Healthcare systems must ensure that reference and major hospital laboratories have access to MALDI-TOF MS with validated databases or validated molecular assays. Public health agencies should advocate for and disseminate standardized testing algorithms that combine efficient screening (with chromogenic media) with mandatory confirmatory testing for suspected isolates. For outbreak response and high-risk patient screening (international transfers), protocols utilizing rapid molecular tests are essential to break chains of transmission. This diagnostic investment is a foundational public health priority for containing antimicrobial resistance and healthcare safety policy.

ANTIFUNGAL TREATMENT AND ANTIFUNGAL RESISTANCES

Treatment decisions for confirmed infections with *C. auris* rely on several drug classes: azoles, polyenes, echinocandins, and nucleoside analogues. The most challenging aspect of managing invasive *C. auris* infections is the level of drug resistance and the ability of *C. auris* to develop drug resistance to the 3 main classes of antifungals [33]. According to the Centers for Disease Control and Prevention (CDC), *C. auris* found in non-invasive sites (respiratory tract, urine, or skin) should not be treated without clear evidence of an active infection. Misguided treatment of colonization wastes resources and promotes further resistance [34]. The choice of treatment depends on the infection type, anatomical site, and specific susceptibility. Notably, the CDC recommends echinocandins as the first-line empirical therapy for *C. auris* while awaiting definitive antifungal susceptibility test results. A high proportion of isolates of this fungus demonstrate resistance to fluconazole, with variable but significant resistance to amphotericin B. While echinocandin resistance remains less common, it is emerging and of big concern, with some strains resistant to all three major antifungal

classes [33]. This resistance is driven by specific genetic mutations, such as in the ERG11 gene (conferring azole resistance) and the FKS1 gene (conferring echinocandin resistance). There are currently no established *C. auris*-specific susceptibility breakpoints; therefore, breakpoints are defined based on those established for closely related *Candida* species and on expert opinion. Given the high resistance rates for *C. auris*, antifungal susceptibility testing with determination of MIC with EUCAST (European Committee on Antimicrobial Susceptibility Testing) or CLSI (Clinical and Laboratory Standards Institute) is routinely recommended to guide therapy [35]. According to the CDC's latest upgrade, in the United States, about 90% of *C. auris* isolates have been resistant to fluconazole, about 30% have been resistant to amphotericin B and less than 5% have been resistant to echinocandins [36]. A study from India investigated the susceptibility patterns of 350 *C. auris* isolates and showed that 90% were resistant to azoles (fluconazole), 8% were resistant to polyene (amphotericin B), and 2% were resistant to echinocandins (anidulafungin and micafungin [37]).

Consequently, the challenge of treating *C. auris* extends beyond managing individual cases. It demands comprehensive antimicrobial stewardship, assured laboratory capacity for antifungal susceptibility testing, and strict compliance with the treatment guidelines to conserve the effectiveness of the current antifungal drugs.

INFECTION PREVENTION AND CONTROL

Proactive screening is strongly recommended for high-risk patients, specifically those transferred from foreign hospitals that have recently experienced *C. auris* transmission. The International Society for Antimicrobial Chemotherapy Working Group on Infection Prevention and Control recently issued guidance advising routine screening for patients with a recent intensive care unit stay in an endemic country, as well as those transferred from facilities known to harbor *C. auris* [37]. Considering the pathogen's global spread, potential laboratory misidentification, and possible delays in case reporting, almost any international healthcare facility could be affected without its knowledge. Therefore,

screening all patients referred from a healthcare facility abroad may be a prudent precautionary measure.

IN-HOSPITAL SCREENING CONTACT TRACING AND SCREENING PROTOCOLS

When *C. auris* is identified in a non-isolated patient within a healthcare facility, immediate screening of all close contacts is warranted. This includes individuals who shared the same room or equipment with the index case. In the absence of conclusive data regarding the duration of the contact required for transmission, a prudent approach is to screen all close contacts from the time of the index patient's admission onward. This protocol should be expanded to include all current ward mates if the index case was identified while in an intensive care unit without isolation. Upon identification, all close contacts should be placed under pre-emptive contact precautions, ideally in a single room or grouped together in a room with multiple beds. Pre-emptive precautions may be discontinued following three consecutive negative screening results, obtained at a minimum of 24-hour intervals. However, given the limited evidence that a 24-hour interval sufficiently rules out colonization, it's recommended that any de-isolated contacts who remain hospitalized undergo weekly screening until discharge to ensure safety. If two or more cases are detected, a more extensive response is required. Screening must be extended to all current and former roommates of the infected individuals. Additionally, ward-wide screening should be initiated to include any patient who had significant exposure, such as through shared medical equipment.

CORE INFECTION PREVENTION AND CONTROL MEASURES

Given its transmissibility and capacity for environmental persistence, stringent infection control measures are paramount to contain *C. auris*. A successful strategy necessitates a multi-modal approach, as reliance on any single intervention is often insufficient. *C. auris* spreads

efficiently via direct contact with infected or colonized patients or indirectly via contaminated surfaces and equipment. Asymptomatic colonization of skin, axillae and groin is a primary reservoir. Therefore, immediate placement of patients with confirmed *C. auris* in a single-patient room with dedicated hand hygiene sink and toilet is essential. When single rooms are unavailable, cohorted nursing with a dedicated healthcare team for positive patients is a critical alternative. Dedicated, disposable, or terminally disinfected patient-care equipment (blood pressure cuffs, thermometers, glucometers, ventilators) must be used. Personal protective equipment (gloves and gowns) must be donned upon room entry and discarded before exit to prevent clothing and hand contamination. This remains in effect for the duration of the patient's stay, as colonization can persist indefinitely. *C. auris* exhibits remarkable resilience on abiotic surfaces, surviving for weeks and demonstrating tolerance to many commonly used hospital disinfectants. Therefore, daily cleaning must utilize a disinfectant effective against *Clostridioides difficile* spores or a product with specific label claims against *C. auris*. Quaternary ammonium compounds alone are frequently ineffective. Preferred agents include hydrogen peroxide-based disinfectants, chlorine-based products (sodium hypochlorite), and peracetic acid. Attention must be paid to high-touch surfaces (bed rails, over-bed tables, door handles, infusion pumps) and shared mobile equipment. Adherence should be verified through regular auditing, which may include fluorescent marker systems or adenosine triphosphate bioluminescence assays. In outbreak settings, Ultraviolet-C systems may be considered as adjuncts to manual cleaning. Hands of healthcare workers are also a primary vector for patient-to-patient transmission. Therefore, a strict adherence to the WHO's "Five Moments" for hand hygiene is critical. Alcohol-based hand rub with at least 60% alcohol is the preferred method for routine decontamination, as it is more effective and accessible than soap and water. However, soap and water must be used when hands are visibly soiled or after caring for a patient with diarrhea, as the alcohol-based hand rub has limited efficacy against *C. difficile* spores, which may co-occur. Hand hygiene must be performed immediately before and after patient contact, after contact with the patient's immediate environment, and after glove removal [6].

SUPPORTING SURVEILLANCE, STEWARDSHIP, AND DECOLONIZATION STRATEGIES

Silent transmission from asymptomatically colonized patients is a key driver of outbreaks. Also, standard microbiological methods often misidentify *C. auris*. Active surveillance cultures are a cornerstone of containment [28]. Screening should target high-risk patients, including contacts of newly identified *C. auris* patients, and patients with recent hospitalization or stays in long-term care facility in areas with known transmission. Specimens from patients on units experiencing an outbreak (ICU, burn, transplant) should be obtained via axillary and groin composite swabs. Laboratories must employ matrix-assisted laser desorption/ionization time-of-flight (MALDI-TOF) mass spectrometry with updated databases or molecular methods (PCR) for accurate identification [29-31]. Immediate notification of infection prevention and control teams upon identification is mandatory to trigger interventions. Public health authorities should be notified as per local regulations. The widespread use of broad-spectrum antimicrobials creates an ecological niche that favors multidrug-resistant organisms like *C. auris* by suppressing competing flora. Therefore, programs must advocate for the prudent use of broad-spectrum antibiotics and antifungals. This includes de-escalating therapy based on culture results and antimicrobial susceptibility testing, avoiding unnecessary empiric use of antifungal agents, particularly echinocandins and azoles, to which *C. auris* often shows resistance. Routine antifungal susceptibility testing for all *C. auris* isolates to guide therapy and inform local resistance patterns. While evidence for eradication of colonization is limited, reducing the cutaneous bioburden may decrease environmental shedding and transmission risk. Therefore, daily bathing of colonized/infected patients with 2% or 4% chlorhexidine gluconate is a common practice in outbreak settings, particularly in ICUs. Still, according to Elbahr, daily bathing with 4% chlorhexidine is not very effective in decolonizing *C. auris* carriers, but it is not completely ineffective [39]. Probably this should be accompanied by daily chlorhexidine gluconate-impregnated cloths for skin cleansing. It is critical to note that decolonization is not the primary goal; the objective is source control

to aid outbreak termination. Regimens involving topical antimicrobials (nystatin, iodine) or oral antifungals are not routinely recommended and require specialist consultation, as they may promote further resistance.

CONCLUSION AND POLICY CALL TO ACTION

Containing *Candida auris* demands immediate, coordinated investment in surveillance, diagnostics, and infection control across the Balkan region and Europe. The global dissemination of *Candida auris* represents a critical convergence of antimicrobial resistance, healthcare-associated transmission, and diagnostic failure. Its trajectory, from sporadic cases to sustained outbreaks across continents, signals a systemic failure in our preparedness for novel multidrug-resistant pathogens. The accumulated evidence mandates a paradigm shift for the European and Balkan healthcare systems, from reactive response to proactive containment. Controlling this threat requires a fundamental shift to proactive, coordinated public health governance, anchored in three strategic pillars. First, a regional surveillance and data sharing requires establishing a mandatory, real-time Balkan and European surveillance network for *C. auris* is paramount. This system must standardize the reporting of cases and resistance patterns to track cross-border transmission and direct resources effectively. Second, there is a need for investment in the diagnostic and laboratory infrastructure. National health policies must prioritize funding for confirmatory diagnostic capacity, specifically MALDI-TOF MS and molecular assays, in reference and sentinel hospitals. Implementing rapid diagnostic protocols for high-risk patients is essential to enable pre-emptive isolation and break chains of transmission. Third, a standardized, evidence-based infection prevention and control meaning that ministries of health must adopt and enforce harmonized IPC guidelines for *C. auris*, mandating stringent contact precautions, environmental disinfection with sporicidal agents, and robust antifungal stewardship programs. Success depends on dedicated funding for IPC teams and continuous, mandatory staff training.

The window for containment is narrowing. The persistent spread of *C. auris* is not merely a

clinical challenge but a definitive test of regional health security. A fragmented, national approach will fail. Only through sustained political will, dedicated resources, and unwavering regional cooperation can the healthcare systems of the Balkans and Europe safeguard patients and turn the tide against this formidable pathogen.

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Резиме

ГЛОБАЛНА ЗАКАНА ОД *CANDIDA AURIS*: ПОВИК ЗА ЗАСИЛЕНА ПОЛИТИКА ЗА ЈАВНО ЗДРАВЈЕ И РЕГИОНАЛНА КООРДИНАЦИЈА

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Антимикробната резистенција претставува најголем предизвик за глобалното јавно здравје во 21 век. Мултирезистентната *Candida auris* претставува критична и ескалирачка закана за глобалното јавно здравје. Карактеризиран со брз нозокомијален пренос, перзистентна контаминација на животната средина и отпорност на повеќе класи антифунгални агенси, *C. auris* претставува предизвик за здравствените системи во светот. Нејзината независна појава преку различни географски **клади** и експоненцијалниот пораст на случаите, потенцирани од пандемијата на COVID-19, ја нагласуваат итната потреба од опсежен и координиран одговор. Овој преглед ги синтетизира моменталните сознанија за *C. auris*, со фокус на нејзините импликации за јавноздравствената политика, особено во европските и во балканските здравствени установи, каде што празнините во надзорот и ризиците од прекугранично пренесување остануваат изразени. Ги анализираме клучните двигатели на ширењето, вклучувајќи ја погрешната дијагностичка идентификација, обемената антифунгална резистенција и пропустите во контролата на инфекциите, и го проценуваме притисокот врз надзорот и подготвеноста на болниците. Ефективното ублажување фундаментално зависи од спроведувањето на сеопфатни, повеќестрани стратегии за превенција и контрола на инфекции, водени од антифунгално управување и брза дијагностика. Заклучуваме дека справувањето со заканата од *C. auris* бара итен, координиран меѓународен и регионален одговор, фокусиран на засилување на мрежите за надзор, стандардизирање на протоколите за дијагностика и превенција и контрола на инфекции и поттикнување на споделување на податоци преку границите за да се сопре овој отпорен патоген.

Клучни зборови: *Candida auris*, антифунгална резистенција, превенција и контрола на инфекции, јавноздравствена политика, нозокомијални епидемии