

Integrated Disease Surveillance & Response (IDSR) Report

Center of Disease Control
National Institutes of Health, Islamabad

Integrated Disease Surveillance & Response (IDSR) Weekly Public Health Bulletin is your go-to resource for disease trends, outbreak alerts, and crucial public health information. By reading and sharing this bulletin, you can help increase awareness and promote preventive measures within your community.



Public Health Bulletin Pakistan

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Public Health Bulletin - Pakistan, Week 32, 2026

Overview

IDSR Reports

Ongoing Events

Field Reports

The **Integrated Disease Surveillance & Response (IDSR) Weekly Public Health Bulletin** is your trusted source for the latest disease trends, outbreak updates, and essential public health information in Pakistan. Published weekly, the bulletin provides **timely, reliable, and evidence-based** information for public health professionals, policymakers, healthcare workers, and the public. It presents key surveillance findings, outbreak investigations, seasonal disease trends, and practical public health recommendations to support informed decision-making and strengthen disease prevention efforts.

The bulletin is developed using verified surveillance data and expert review to ensure its content remains accurate, relevant, and aligned with Pakistan's public health priorities. It also addresses emerging health misinformation by providing factual, science-based information that communities can trust.

This Week's Highlights:

- **Strengthening Genomic Surveillance Capacity: NIH Completes Fifth Hands-on Training Workshop on Next-Generation Sequencing**
- **Knowledge Hub - Understanding Cutaneous Leishmaniasis: A Public Health Priority**

Together, we can strengthen disease surveillance, promote informed action, and build a healthier Pakistan.

By transforming surveillance data into actionable public health intelligence, the IDSR Weekly Public Health Bulletin continues to support evidence-based decision-making and protect communities across Pakistan.

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Stay informed. Stay prepared. Stay healthy.

Note: All reported cases in this report are suspected cases

- During Week 32, the most frequently reported cases were of Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, TB, ALRI <5 years, Animal/ Dog Bite, B. Diarrhea, VH (B, C & D), Typhoid, SARI, AVH (A & E), and AWD (S. Cholera).
- Thirty-one cases of AFP were reported from KP, seven from Sindh, and two from GB.
- Eight suspected cases of HIV/ AIDS reported from Sindh and three from KP.
- Nine suspected cases of Brucellosis were reported from Balochistan and one from KP.
- Among VPDs, there is an increase in the number of cases of Chickenpox, Mumps, Meningitis, AFP, Pertussis, NT, and Rubella this week.
- Among Respiratory diseases, there is an increase in the number of cases of ILI this week.
- Among Water/ Food-borne diseases, there is an increase in the number of cases of AD (Non-Cholera), B. Diarrhea, Typhoid, and AWD (S. Cholera) this week.
- Among Vector-borne diseases, there is an increase in the number of cases of Malaria and Dengue this week.
- Among STDs, there is an increase in the number of suspected cases of HIV/ AIDS and Syphilis this week.
- Among Zoonotic/ Other diseases, there is an increase in the number of cases of Animal/ Dog Bite, VH (B, C & D), and Brucellosis this week.
- Field investigation is required for verification of the alerts and for prevention and control of the outbreaks.

IDSR Compliance Attributes

- The national compliance rate for IDSR reporting in 158 implemented districts is 74%.
- Sindh is the top reporting region with a compliance rate of 98%, followed by GB 89%, ICT 81%, KP 81%, and Balochistan 43%.
- In Week 32, the lowest compliance rate is observed in AJK, 0%, due to the non-availability of internet connection in the region.

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2,277	1,852	81
Azad Jammu Kashmir	476	0	0
Islamabad Capital Territory	36	29	81
Balochistan	1,305	560	43
Gilgit Baltistan	405	359	89
Sindh	2,115	2,066	98
National	6,614	4,866	74

Federal, Provincial, Regional Health Departments and relevant programs may consider following public health actions to prevent and control diseases.

Cutaneous Leishmaniasis

Enhance Case Detection and Reporting: Strengthen cutaneous leishmaniasis surveillance within the Integrated Disease Surveillance and Response (IDSR) system by training healthcare providers on standard case definitions, early recognition, timely notification, and reporting, particularly in endemic and high-risk areas.

Strengthen Laboratory Diagnosis: Improve access to laboratory diagnosis by strengthening microscopy and other appropriate diagnostic capacities at designated facilities to support timely case confirmation and appropriate case management.

Strengthen Case Management and Referral: Ensure availability of appropriate treatment and referral services for suspected and confirmed cases, particularly in endemic and underserved areas, to promote early treatment and reduce complications and permanent scarring.

Implement Integrated Vector Control: Coordinate with relevant health, municipal, and environmental sectors to implement appropriate sandfly control measures, including indoor residual spraying where indicated, environmental management, and reduction of potential sandfly breeding and resting sites.

Raise Community Awareness: Develop culturally appropriate health education campaigns to increase awareness about sandfly bites, use of personal protective measures, early recognition of skin lesions, and the importance of timely healthcare seeking.

Strengthen Outbreak Detection and Response: Monitor geographical and temporal trends to identify clustering or increased transmission, investigate suspected outbreaks promptly, and implement targeted control measures in affected communities.

Dog Bite

Enhance Case Detection and Reporting: Strengthen surveillance and reporting of dog-bite cases within the Integrated Disease Surveillance and Response (IDSR) system to ensure timely notification, particularly in areas with a high burden of dog bites or suspected rabies cases.

Ensure Prompt Post-Exposure Management: Strengthen the capacity of healthcare facilities to provide immediate wound washing, risk assessment, and timely administration of rabies post-exposure prophylaxis (PEP), including rabies vaccine and rabies immunoglobulin where indicated.

Ensure Availability of Rabies Biologicals: Maintain adequate and uninterrupted supplies of quality-assured rabies vaccines and rabies immunoglobulin at designated health facilities, particularly in high-risk and underserved areas.

Strengthen One Health Coordination: Enhance coordination between human health, veterinary, local government, and municipal authorities for surveillance of dog bites and suspected rabies cases, investigation of animal exposures, and implementation of coordinated prevention and control measures.

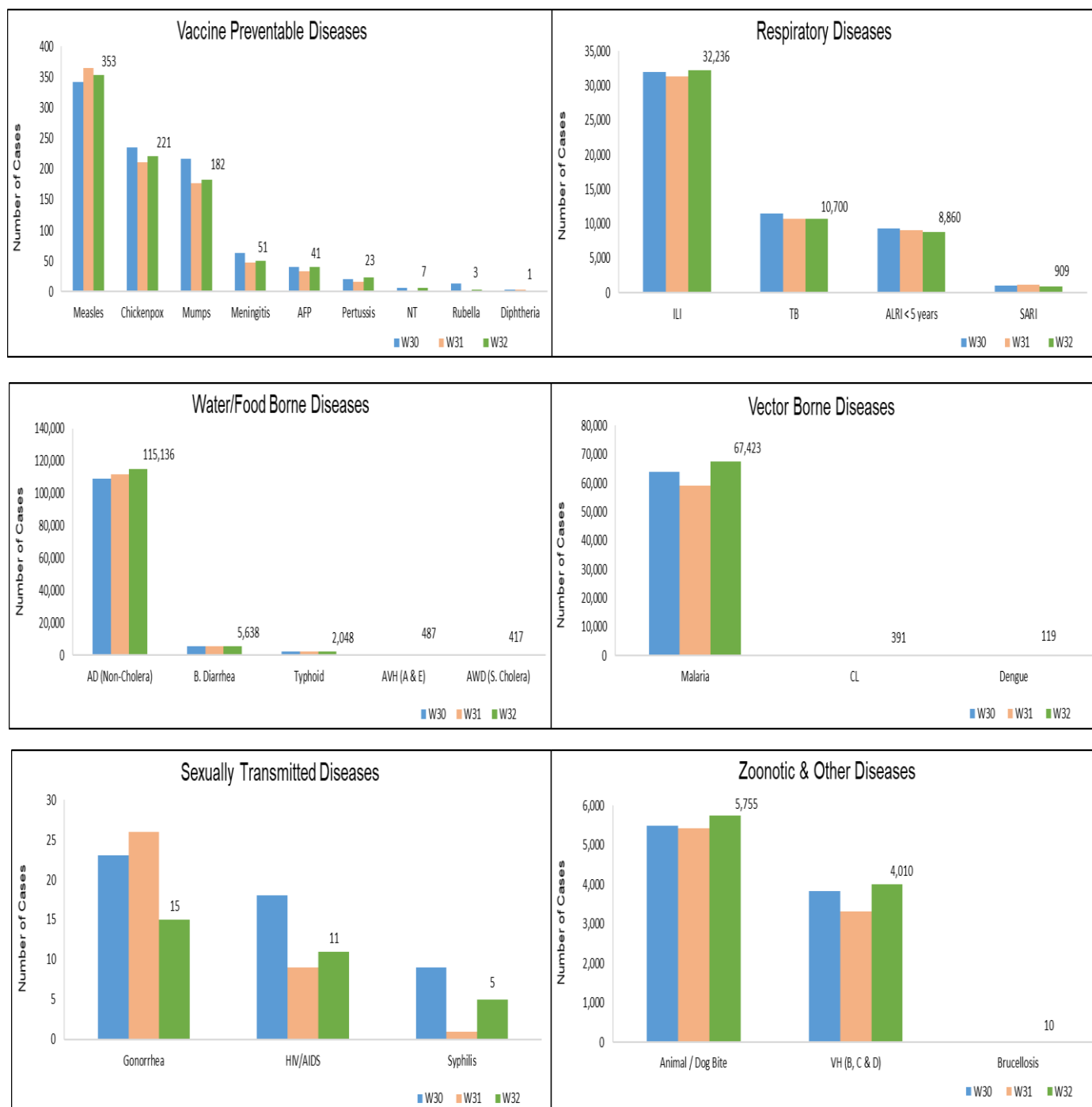
Promote Responsible Dog Ownership and Dog Population Management: Support measures for registration, vaccination, and responsible ownership of dogs, while implementing humane and evidence-based dog population management strategies in collaboration with relevant authorities.

Raise Community Awareness: Conduct targeted risk communication campaigns to educate communities on avoiding dog bites, safe behavior around animals, immediate and thorough washing of bite wounds with soap and water, and the importance of seeking medical care promptly after an animal bite.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 32, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	NR	5,574	1,928	665	51,847	NR	55,122	115,136
Malaria	NR	1,285	0	2	7,164	NR	58,972	67,423
ILI	NR	3,837	239	1,322	3,174	NR	23,664	32,236
TB	NR	19	119	14	315	NR	10,233	10,700
ALRI < 5 years	NR	875	495	2	534	NR	6,954	8,860
Animal / Dog Bite	NR	89	28	0	1,579	NR	4,059	5,755
B. Diarrhea	NR	643	90	4	1,322	NR	3,579	5,638
VH (B, C & D)	NR	105	49	138	173	NR	3,545	4,010
Typhoid	NR	248	119	0	662	NR	1,019	2,048
SARI	NR	304	61	0	338	NR	206	909
AVH (A & E)	NR	3	0	0	183	NR	301	487
AWD (S. Cholera)	NR	150	21	0	226	NR	20	417
CL	NR	24	0	0	362	NR	5	391
Measles	NR	9	4	0	294	NR	46	353
Chickenpox/ Varicella	NR	14	7	0	180	NR	20	221
Mumps	NR	19	3	1	113	NR	46	182
Dengue	NR	3	0	0	65	NR	51	119
Meningitis	NR	1	4	0	6	NR	40	51
AFP	NR	1	2	0	31	NR	7	41
Pertussis	NR	3	0	0	20	NR	0	23
Gonorrhea	NR	2	0	0	2	NR	11	15
HIV/AIDS	NR	0	0	0	3	NR	8	11
Brucellosis	NR	9	0	0	1	NR	0	10
NT	NR	0	0	0	7	NR	0	7
Syphilis	NR	0	0	0	1	NR	4	5
Rubella (CRS)	NR	3	0	0	0	NR	0	3
Diphtheria (Probable)	NR	0	0	0	1	NR	0	1

Figure 1: Most frequently reported suspected cases during Week 32, Pakistan.



- Malaria cases were maximum followed by AD (Non-Cholera), ILI, TB, ALRI <5 Years, Animal/ Dog Bite, B. Diarrhea, VH (B, C & D), Typhoid and AVH (A & E).
- Malaria cases were mostly from Badin, Khairpur, and Umerkot, whereas AD (Non-Cholera) cases were from Badin, Mirpurkhas, and Khairpur.
- Seven cases of AFP were reported from Sindh. They are suspected cases and need field verification.
- There is a decline in the number of cases of TB, ALRI <5 years, AVH (A & E), SARI, and AFP, while an increase in the number of cases of Malaria, AD (Non-Cholera), ILI, Animal/ Dog Bite, B. Diarrhea, VH (B, C & D), Typhoid, Dengue, Measles, Mumps, Meningitis, Chickenpox, AWD (S. Cholera), HIV/ AIDS, CL, and Syphilis this week.

Table 2: District wise distribution of most frequently reported suspected cases during Week 32, Sindh.

Districts	Malaria	AD (Non-Cholera)	ILI	TB	ALRI < 5 years	Animal / Dog Bite	B. Diarrhea	VH (B, C & D)	Typhoid	AVH (A & E)
Badin	4,837	5,697	2,417	827	584	140	350	222	111	14
Dadu	2,921	3,214	452	637	1,159	296	483	222	185	119
Ghotki	3,982	1,784	0	535	368	331	152	563	0	0
Hyderabad	1,042	2,638	1,375	318	140	92	79	93	4	5
Jacobabad	1,224	894	476	192	194	209	109	66	21	0
Jamshoro	2,209	2,506	43	488	244	109	102	109	25	17
Kamber	2,193	1,944	0	687	172	224	120	30	11	0
Karachi Central	2	1,936	1,294	19	3	114	3	20	105	7
Karachi East	115	273	19	9	12	14	6	21	5	1
Karachi Keamari	21	678	510	14	12	9	7	0	8	2
Karachi Korangi	73	421	8	17	0	15	1	0	5	0
Karachi Malir	92	1,133	1,649	74	167	35	30	4	6	1
Karachi South	15	122	5	0	0	0	0	0	0	0
Karachi West	341	849	1,550	85	234	74	14	18	19	0
Kashmore	1,523	485	177	90	63	197	55	10	4	0
Khairpur	4,286	3,370	4,087	877	707	344	321	255	197	23
Larkana	3,352	2,172	113	741	281	110	325	34	4	1
Matiali	3,018	1,583	9	476	143	103	63	90	1	18
Mirpurkhas	3,753	3,494	2,471	607	264	199	169	55	11	9
Naushero Feroze	1,627	1,528	1,224	288	245	256	151	68	94	6
Sanghar	2,709	1,546	54	794	228	266	46	399	20	0
Shaheed Benazirabad	2,712	1,675	2	277	163	190	87	142	117	0
Shikarpur	2,001	1,401	10	182	126	233	202	195	6	0
Sujawal	747	1,934	0	129	111	24	50	10	2	0
Sukkur	2,045	1,684	2,072	319	159	147	131	268	2	0
Tando Allahyar	2,602	1,921	774	303	101	120	86	126	3	1
Tando Muhammad Khan	1,344	1,425	0	427	106	74	127	57	0	0
Tharparkar	1,875	2,689	1,059	462	501	9	157	45	3	13
Thatta	2,069	2,082	1,814	35	175	125	67	352	27	62
Umerkot	4,242	2,044	0	324	292	0	86	71	23	2
Total	58,972	55,122	23,664	10,233	6,954	4,059	3,579	3,545	1,019	301

Figure 2: Most frequently reported suspected cases during Week 32, Sindh.

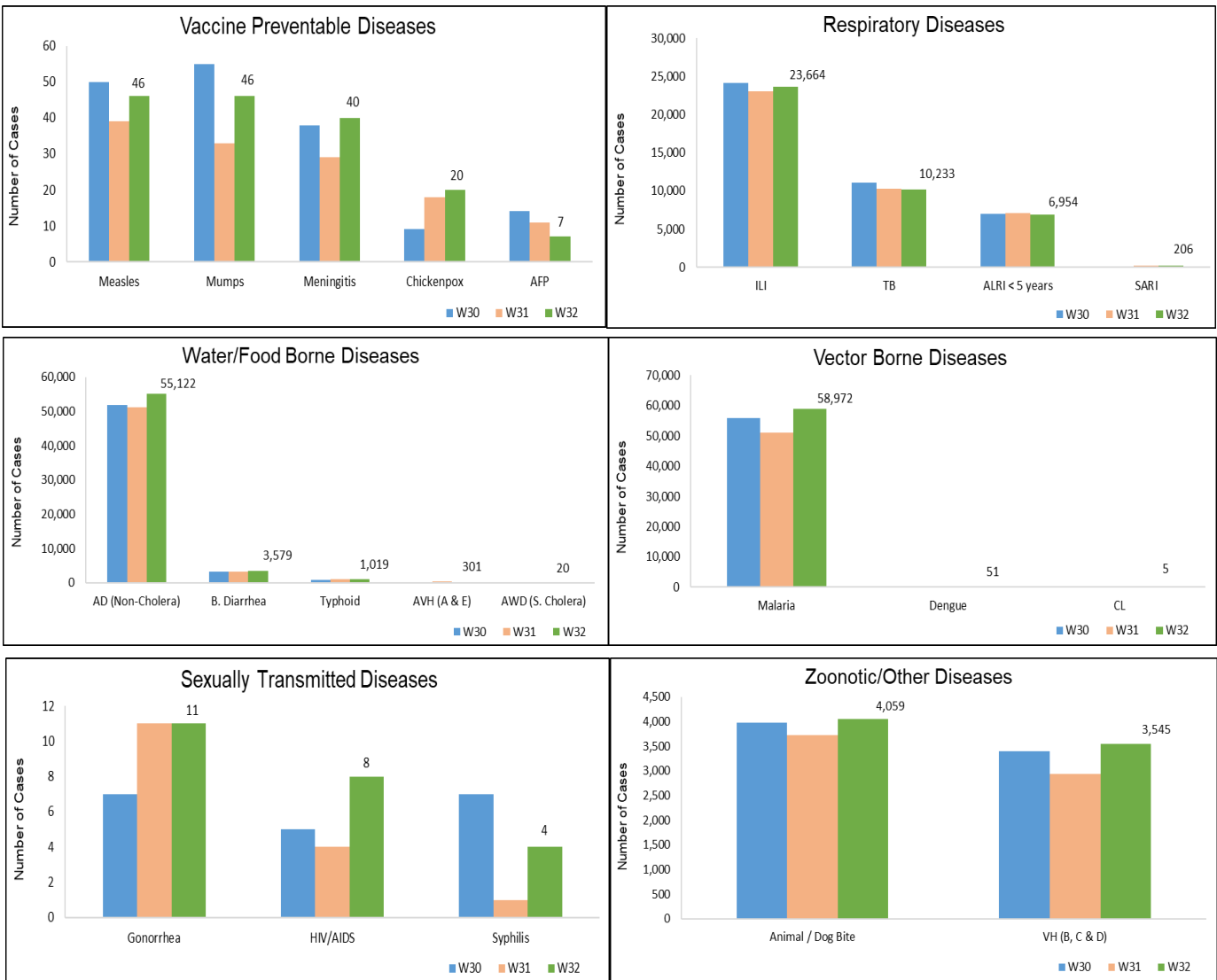
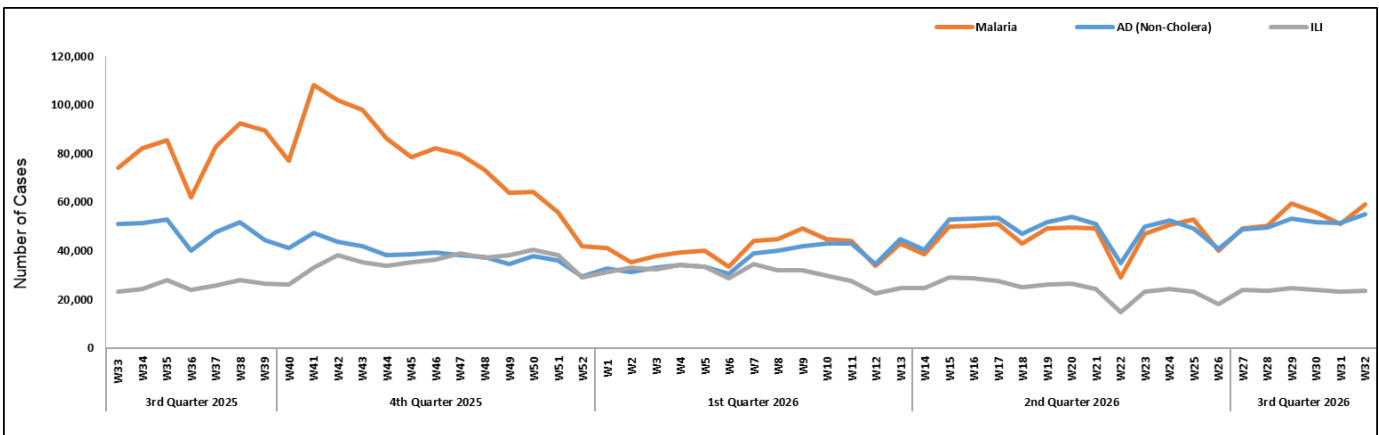


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh.



- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, AWD (S. Cholera), VH (B, C & D), and Animal/ Dog Bite cases were the most frequently reported diseases from Balochistan province.
- AD (non-cholera) cases were mostly reported from Usta Muhammad, Quetta, and Lasbella while ILI cases were mostly reported from Quetta, Kharan, and Ziarat.
- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, Typhoid, VH (B, C & D), CL, TB, Mumps, Chickenpox, Brucellosis, AVH (A & E), Rubella, Dengue, AFP, and Meningitis showed an increase in the number of cases. A decline has been observed in the number of cases of B. Diarrhea, SARI, AWD (S. Cholera), Animal/Dog Bite, Measles, Pertussis, and Gonorrhea this week.

Table 3: District wise distribution of most frequently reported suspected cases during Week 32, Balochistan.

Districts	AD (Non-Cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	AWD (S. Cholera)	VH (B, C & D)	Animal / Dog Bite
Awaran	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Barkhan	64	43	147	24	4	0	22	6	0	11
Chagai	176	206	37	0	34	0	10	0	2	0
Chaman	62	67	0	15	4	0	11	1	0	0
Dera Bugti	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Duki	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Gwadar	197	308	10	NR	4	NR	NR	NR	NR	2
Harnai	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hub	138	50	71	15	1	5	0	0	0	1
Jaffarabad	167	0	63	3	9	0	0	0	0	0
Jhal Magsi	88	140	26	7	0	0	0	0	0	0
Kachhi (Bolan)	154	192	92	17	13	31	NR	19	1	11
Kalat	0	0	0	0	0	0	0	0	0	0
Kech (Turbat)	45	15	2	9	15	8	1	15	3	7
Kharan	235	544	12	0	86	21	3	0	0	0
Khuzdar	59	28	35	0	9	13	24	2	0	0
Killa Abdullah	302	147	23	13	27	45	21	40	0	1
Killa Saifullah	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kohlu	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lasbella	430	61	202	132	26	NR	8	0	0	2
Loralai	420	394	59	35	47	42	23	5	0	2
Mastung	385	281	90	81	36	59	14	0	17	8
MusaKhel	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Naseerabad	306	0	116	13	11	25	58	0	12	36
Nushki	173	0	0	5	48	5	0	0	0	0
Panjgur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Pishin	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Quetta	536	695	19	102	41	21	14	24	0	0
Sherani	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sibi	260	147	126	92	20	24	11	8	0	2
Sohbat pur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Surab	8	31	0	0	0	0	0	0	0	0
Usta Muhammad	988	87	34	163	126	5	2	0	70	3
Washuk	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Zhob	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Ziarat	381	401	121	149	82	0	26	30	0	3
Total	5,574	3,837	1,285	875	643	304	248	150	105	89

Figure 4: Most frequently reported suspected cases during Week 32, Balochistan.

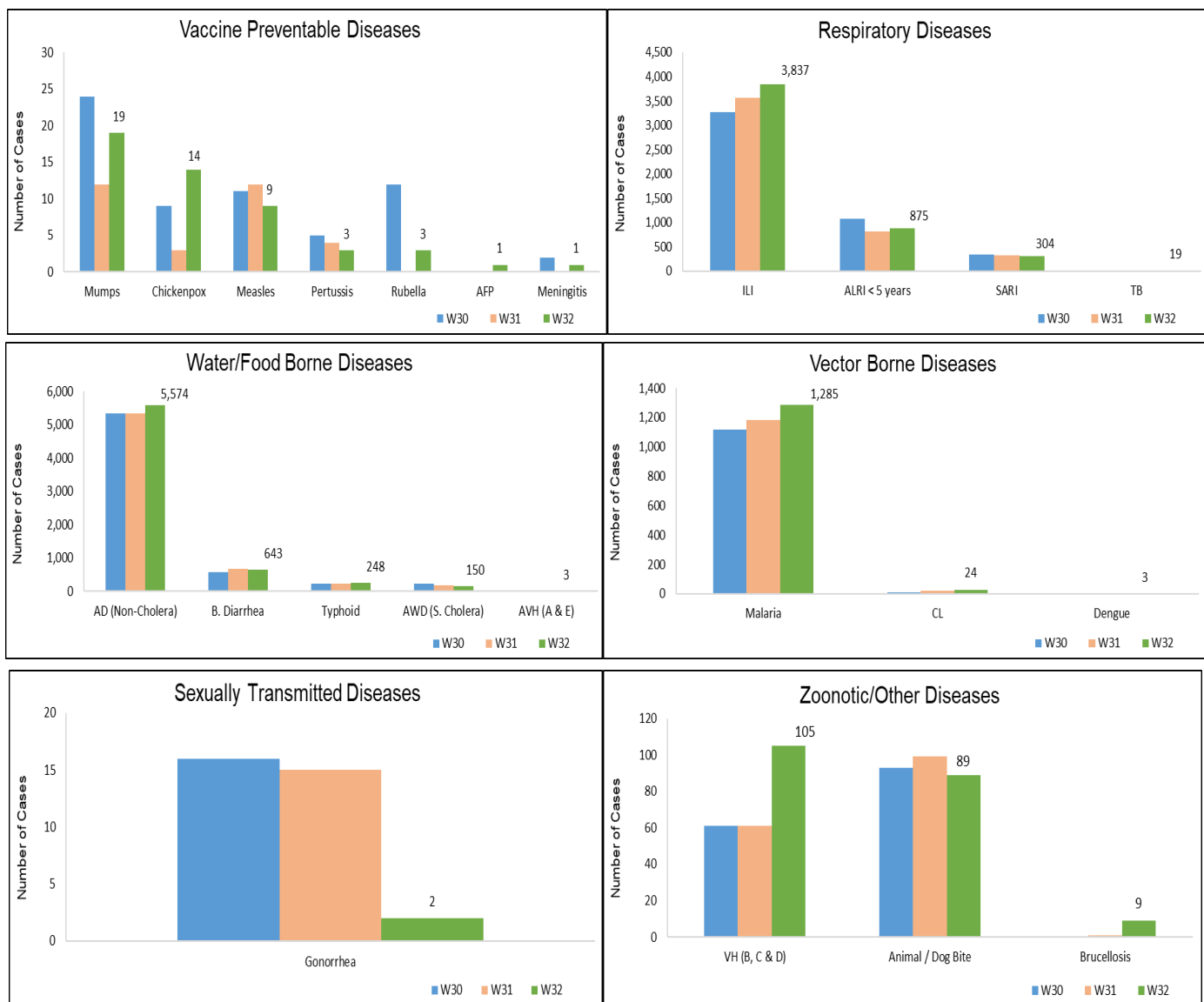
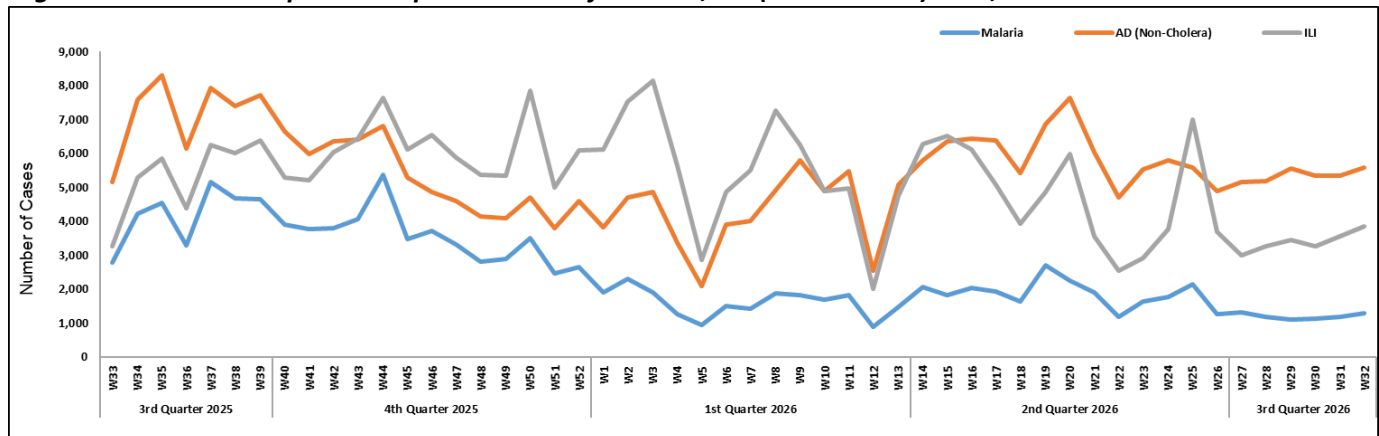


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan.



- Cases of AD (Non-Cholera) were maximum followed by Malaria, ILI, Animal/ Dog Bite, B. Diarrhea, Typhoid, ALRI <5 Years, CL, SARI, and TB.
- AD (Non-Cholera), Malaria, TB, AWD (S. Cholera), Chickenpox, VH (B, C & D), AFP, Pertussis, NT, and Brucellosis cases showed an increase in number while ILI, Animal/ Dog Bite, B. Diarrhea, Typhoid, ALRI <5 Years, CL, SARI, Measles, AVH (A & E), Mumps, Dengue, Meningitis, HIV/ AIDS, Gonorrhea, Syphilis, and Diphtheria showed a decline in number this week.
- Thirty-one cases of AFP were reported from KP. All are suspected cases and need field verification.
- Three cases of HIV/AIDS were reported from KP. Field investigation is required.
- One suspected case of brucellosis was reported from KP, which requires field verification.

Table 4: District wise distribution of most frequently reported suspected cases during Week 32, KP.

Districts	AD (Non-Cholera)	Malaria	ILI	Animal / Dog Bite	B. Diarrhea	Typhoid	ALRI < 5 years	CL	SARI	TB
Abbottabad	3,007	5	47	59	8	6	17	0	14	13
Bajaur	900	368	1	97	65	1	6	26	3	9
Bannu	955	854	6	7	20	64	5	5	0	17
Battagram	806	97	633	2	3	0	0	0	0	0
Buner	709	116	0	31	0	0	0	0	0	0
Charsadda	1,790	337	295	1	49	62	108	0	0	6
Chitral Lower	1,154	14	4	6	30	5	6	6	5	7
Chitral Upper	273	9	9	4	9	13	2	1	2	2
D.I. Khan	1,955	625	0	34	51	6	8	2	0	10
Dir Lower	2,900	149	0	79	103	46	6	10	0	4
Dir Upper	3,216	28	66	27	79	13	74	0	0	3
Hangu	289	104	0	0	23	0	0	3	0	0
Haripur	1,995	2	310	68	0	0	2	0	15	1
Karak	714	283	4	42	53	25	41	75	0	7
Khyber	1,014	564	35	60	190	27	62	85	11	11
Kohat	869	239	0	17	52	33	1	36	0	0
Kohistan Lower	336	0	0	0	2	5	0	0	0	0
Kohistan Upper	343	16	0	0	13	1	5	1	0	0
Kolai Palas	119	0	13	0	1	2	2	0	0	3
L & C Kurram	33	4	2	0	6	1	0	0	0	0
Lakki Marwat	815	346	0	92	0	22	0	0	0	4
Malakand	1,549	63	104	59	0	0	0	0	5	1
Mansehra	1,861	2	396	11	39	17	1	0	0	10
Mardan	2,381	363	74	118	93	58	61	0	0	13
Mohmand	121	147	147	11	3	7	0	52	98	2
North Waziristan	70	139	0	1	0	15	2	0	3	3
Nowshera	3,241	618	14	88	25	8	2	12	15	25
Orakzai	64	6	3	0	1	0	1	0	0	0
Peshawar	5,890	58	155	24	95	55	9	0	0	23
Shangla	2,696	859	0	175	20	62	7	1	0	81
South Waziristan (Lower)	225	179	201	9	87	35	2	34	81	12
SWU	8	23	0	0	0	0	0	0	1	0
Swabi	2,717	140	544	148	13	1	22	0	66	25
Swat	5,949	75	18	264	137	61	74	0	0	8
Tank	413	230	17	9	5	0	4	0	0	5
Tor Ghar	250	89	0	19	33	3	0	13	0	8
Upper Kurram	220	13	76	17	14	8	4	0	19	2
Total	51,847	7,164	3,174	1,579	1,322	662	534	362	338	315

Figure 6: Most frequently reported suspected cases during Week 32, KP.

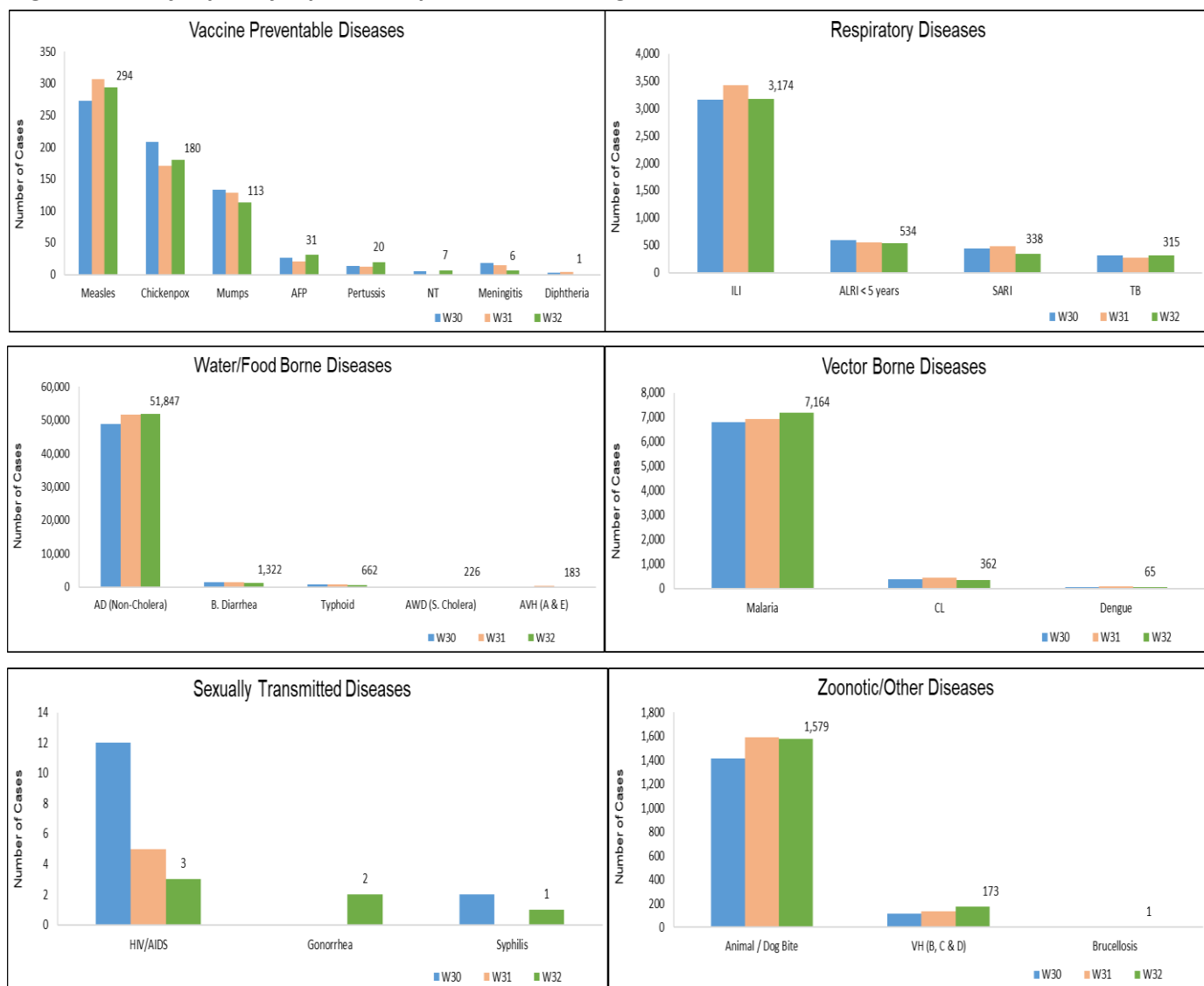
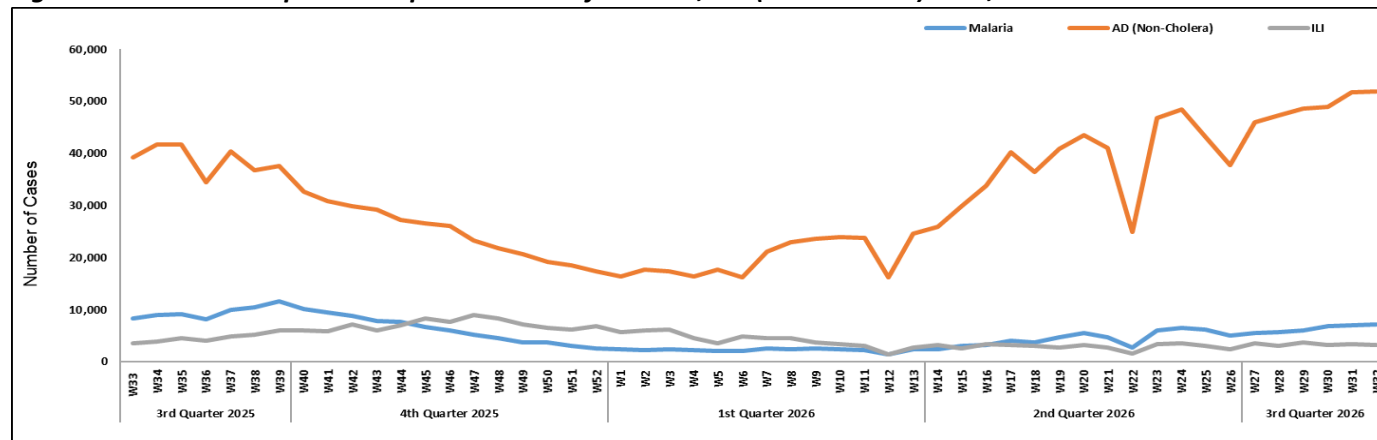


Figure 7: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, KP.



ICT: The most frequently reported cases from Islamabad were ILI followed by AD (Non-Cholera), VH (B, C & D), TB, B. Diarrhea, ALRI <5 Years, Malaria, and Mumps. VH (B, C & D) cases showed a decline in number while an increase in number was observed in ILI, AD (Non-Cholera), TB, B. Diarrhea, ALRI <5 Years, Malaria, and Mumps cases this week.

AJK: Data for Week 32 is not shared due to the non-availability of internet connection in the region.

GB: AD (non-cholera) cases were the most frequently reported disease, followed by ALRI <5 Years, ILI, TB, Typhoid, B. Diarrhea, SARI, VH (B, C & D), Animal/ Dog Bite, and AWD (S. Cholera). An increase in cases is observed for VH (B, C & D), Animal/ Dog Bite, and AWD (S. Cholera), and AFP, while a decline is observed in the number of cases of AD (Non-Cholera), ALRI <5 Years, ILI, TB, Typhoid, B. Diarrhea, SARI, Chickenpox, Measles, and Mumps this week.

NOTE: Due to the political conditions AJK data for Week 32 is not shared.
Figure 8: Most frequently reported suspected cases during Week 22, AJK.

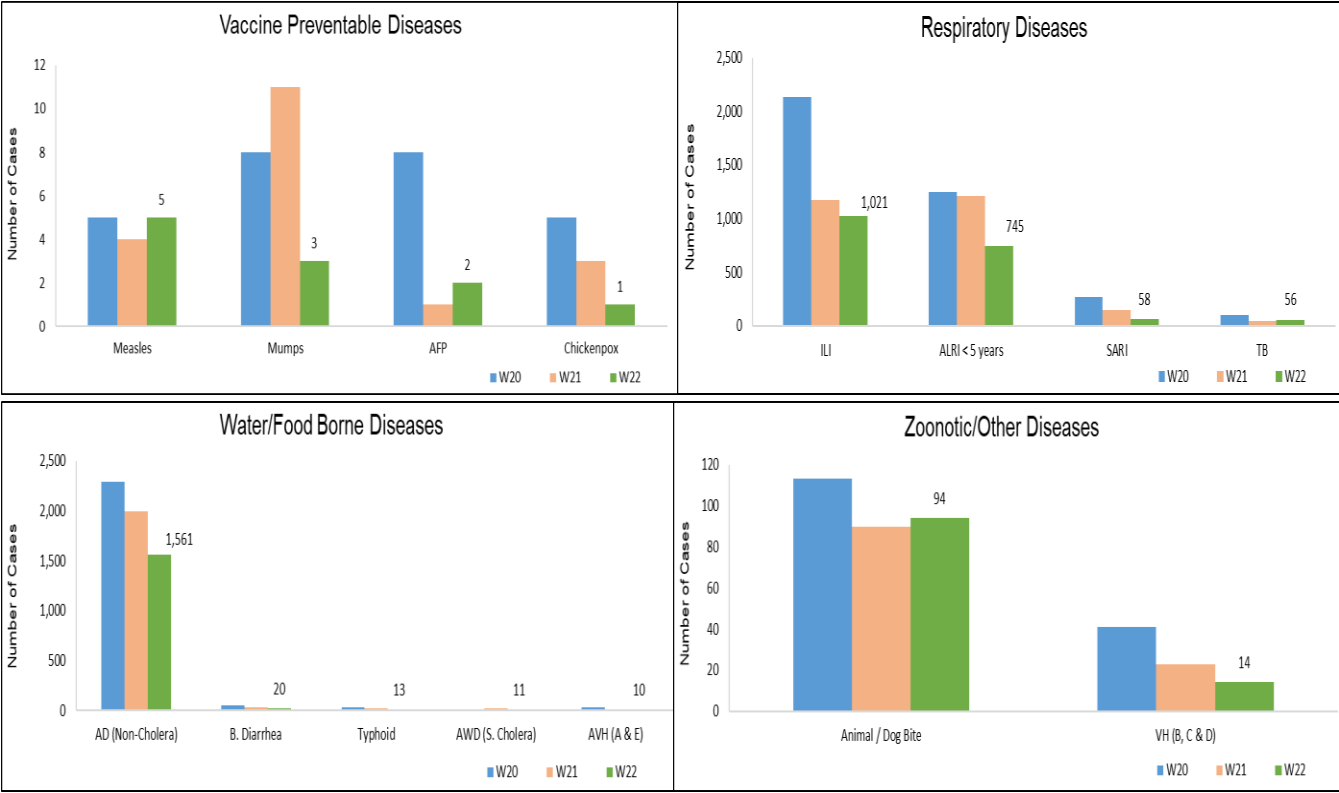


Figure 9: Week wise reported suspected cases of ILI and AD (Non-Cholera), AJK.



Figure 10: Most frequently reported suspected cases during Week 32, ICT.

Figure 11: Week wise reported suspected cases of ILI, ICT.

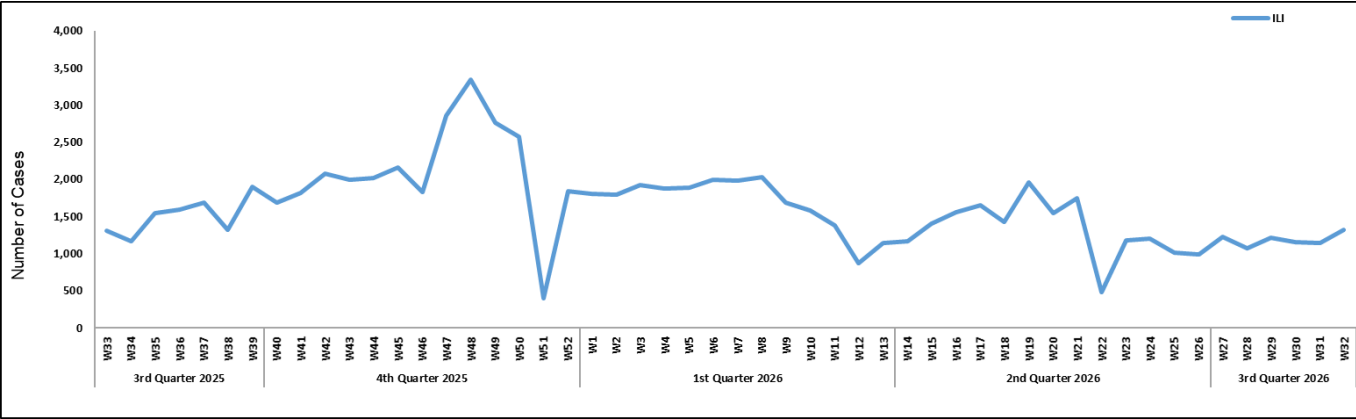


Figure 12: Most frequently reported suspected cases during Week 32, GB.

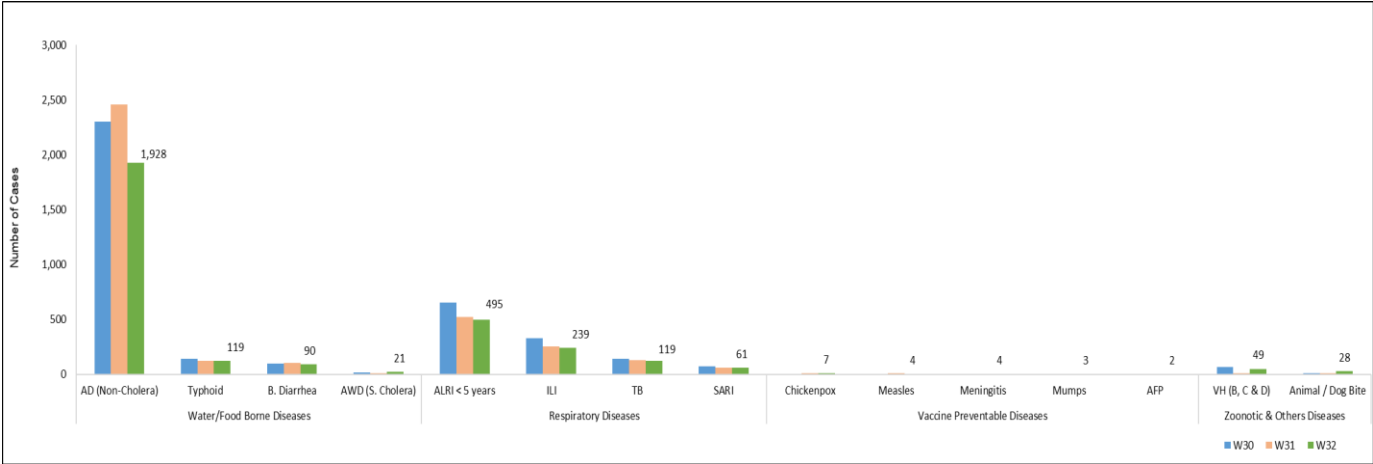
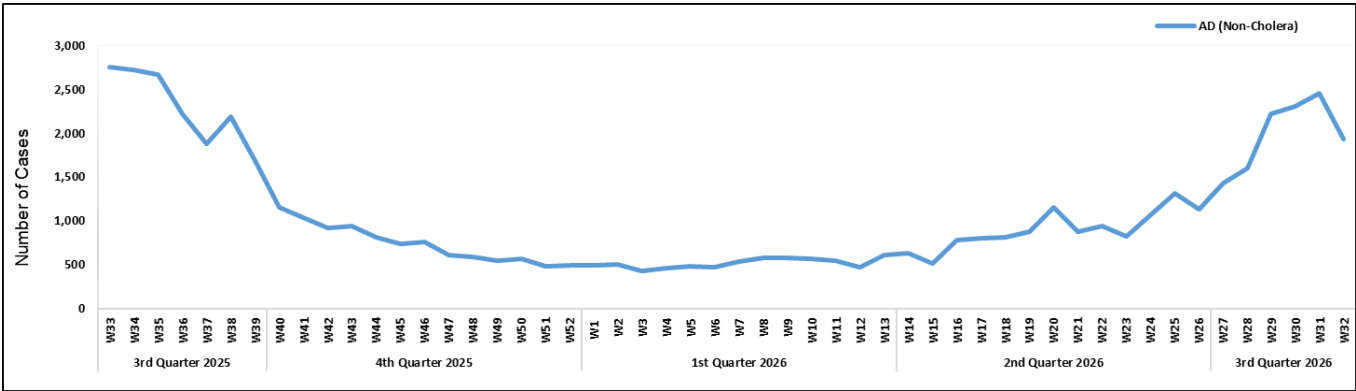


Figure 13: Week wise reported suspected cases of AD (Non-Cholera), GB.



Public Health Laboratories

Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 32, Pakistan.

Diseases		Sindh		Balochistan		KPK		ISL		GB		Punjab		AJK	
		Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos
AWD (S. Cholera)		12	1	-	-	-	-	-	-	-	-	-	-	-	-
Stool culture & Sensitivity		160	0	-	-	-	-	-	-	-	-	-	-	-	-
Malaria		6,412	491	1,276	95	-	-	-	-	212	0	-	-	-	-
CCHF		-	-	13	2	-	-	-	-	-	-	-	-	-	-
Dengue		1,289	77	122	4	-	-	-	-	-	-	-	-	-	-
VH (B)		12,079	194	898	92	-	-	-	-	1,489	16	-	-	-	-
VH (C)		12,443	890	903	62	-	-	-	-	1,505	2	-	-	-	-
VH (D)		306	40	23	7	-	-	-	-	-	-	-	-	-	-
VH (A)		117	46	-	-	-	-	-	-	-	-	-	-	-	-
VH (E)		82	20	-	-	-	-	-	-	-	-	-	-	-	-
TB		574	58	86	11	-	-	-	-	84	0	-	-	-	-
HIV/ AIDS		4,842	41	532	1	-	-	-	-	253	0	-	-	-	-
Syphilis		856	16	205	0	-	-	-	-	198	0	-	-	-	-
Typhoid		130	4	97	15	-	-	-	-	223	0	-	-	-	-
Diphtheria		6	0	-	-	-	-	-	-	-	-	-	-	-	-
ILI		10	1	-	-	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)		152	23	-	-	-	-	-	-	-	-	-	-	-	-
Meningitis		10	0	-	-	-	-	-	-	-	-	-	-	-	-
Measles		95	34	37	16	192	83	13	10	2	2	283	50	2	0
Leishmaniosis (cutaneous)		2	2	5	5	-	-	-	-	3	0	-	-	-	-
Mpox		4	2	-	-	-	-	-	-	-	-	-	-	-	-
SARI		19	5	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	ILI	4	0	-	-	-	-	4	0	-	-	12	0	-	-
	SARI	5	0	-	-	33	0	11	2	-	-	76	2	-	-
Influenza A	ILI	4	0	-	-	-	-	4	0	-	-	12	0	-	-
	SARI	5	0	-	-	33	0	11	0	-	-	76	0	-	-
Influenza B	ILI	4	0	-	-	-	-	4	0	-	-	12	0	-	-
	SARI	5	0	-	-	33	0	11	0	-	-	76	0	-	-
RSV	ILI	4	0	-	-	-	-	4	0	-	-	12	0	-	-
	SARI	5	0	-	-	33	0	11	0	-	-	76	0	-	-

Figure 14: District wise Influenza sentinel sites, Pakistan.

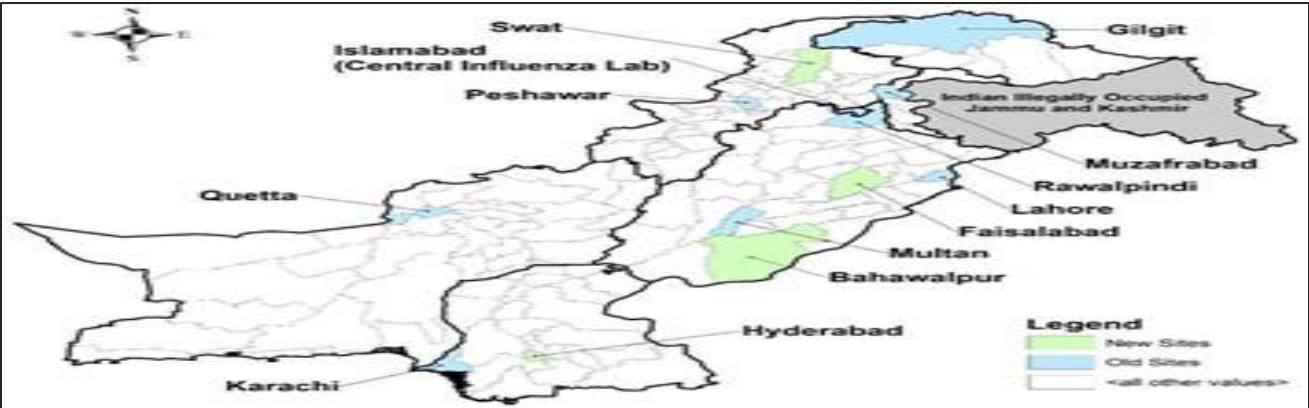


Figure 15: Distribution of suspected samples of ILI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 32, Pakistan.

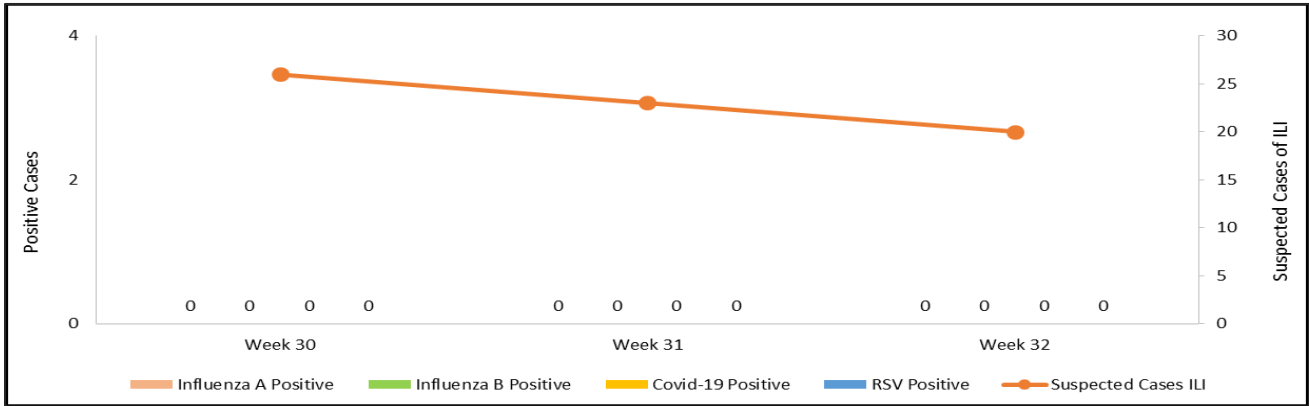
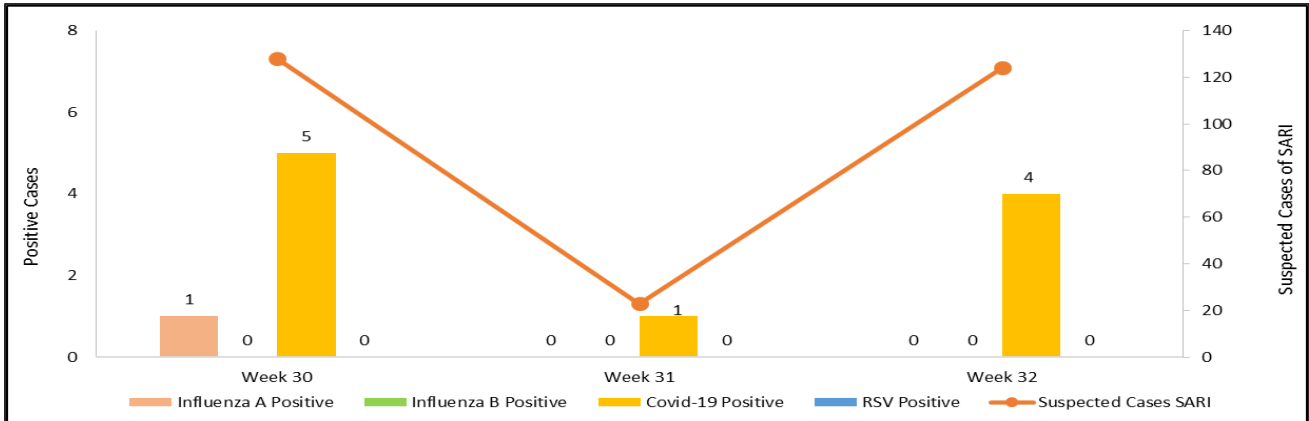


Figure 16: Distribution of suspected samples of SARI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 32, Pakistan.



IDSR Reports Compliance

Out of 158 IDSR-implemented districts, compliance is low in KP, AJK, ICT and Balochistan. Green color highlights >50% compliance, while red color highlights <50% compliance

Table 6: Compliance of IDSR reporting districts Week 32, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	104	94%
	Bannu	228	114	50%
	Battagram	59	44	75%
	Buner	34	34	100%
	Bajaur	43	43	100%
	Charsadda	61	59	97%
	Chitral Upper	31	31	100%
	Chitral Lower	37	36	97%
	D.I. Khan	115	115	100%
	Dir Lower	63	57	90%
	Dir Upper	56	51	91%
	Hangu	22	16	73%
	Haripur	72	71	99%
	Karak	36	35	97%
	Khyber	53	46	87%
	Kohat	61	61	100%
	Kohistan Lower	13	10	77%
	Kohistan Upper	22	15	68%
	Kolai Palas	10	9	90%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	34	13	38%
	Upper Kurram	38	37	97%
	Malakand	42	42	100%
	Mansehra	133	131	98%
	Mardan	82	78	95%
	Nowshera	57	55	96%
	North Waziristan	10	9	90%
	Peshawar	157	128	82%
	Shangla	37	36	97%
	Swabi	65	60	92%
	Swat	75	72	96%
	South Waziristan (Upper)	93	72	77%
	South Waziristan (Lower)	29	28	97%
	Tank	34	33	97%
	Torghar	13	13	100%
	Mohmand	68	19	28%
	Orakzai	69	6	9%
Azad Jammu Kashmir	Mirpur	41	0	0%
	Bhimber	85	0	0%
	Kotli	60	0	0%
	Muzaffarabad	45	0	0%
	Poonch	46	0	0%
	Haveli	39	0	0%
	Bagh	54	0	0%
	Neelum	39	0	0%



	Jhelum Valley	29	0	0%
	Sudhnooti	27	0	0%
Islamabad Capital Territory	ICT	24	23	96%
	CDA	12	6	50%
Balochistan	Gwadar	26	15	58%
	Kech	45	1	2%
	Khuzdar	74	9	12%
	Killa Abdullah	26	23	88%
	Lasbella	55	52	95%
	Pishin	65	0	0%
	Quetta	56	25	45%
	Sibi	36	29	81%
	Zhob	39	0	0%
	Jaffarabad	16	15	94%
	Naseerabad	32	31	97%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	0	0%
	Chagai	36	18	50%
	Kalat	41	40	98%
	Harnai	17	0	0%
	Kachhi (Bolan)	35	18	51%
	Jhal Magsi	28	28	100%
	Sohbat pur	25	0	0%
	Surab	32	5	16%
	Mastung	46	46	100%
	Loralai	33	27	82%
	Killa Saifullah	28	0	0%
	Ziarat	29	28	97%
	Duki	31	0	0%
	Nushki	29	28	97%
	Dera Bugti	45	0	0%
	Washuk	46	0	0%
	Panjgur	38	0	0%
	Awaran	23	0	0%
	Chaman	25	24	96%
	Barkhan	20	19	95%
	Hub	33	15	45%
	Musakhel	41	0	0%
	Usta Muhammad	34	34	100%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	20	20	100%
	Ghizer	38	38	100%
	Gilgit	44	41	93%
	Diamer	62	57	92%
	Astore	55	55	100%
	Shigar	23	11	48%
	Skardu	54	54	100%
	Ganche	29	26	90%

	Kharmang	25	25	100%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	62	97%
	Umerkot	65	65	100%
	Naushahro Feroze	102	101	99%
	Tharparkar	273	272	100%
	Shikarpur	59	59	100%
	Thatta	50	49	98%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	16	76%
	Karachi-West	20	20	100%
	Karachi-Malir	35	26	74%
	Karachi-Kemari	22	21	95%
	Karachi-Central	12	10	83%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	4	67%
	Sujawal	55	49	89%
	Mirpur Khas	106	106	100%
	Badin	123	123	100%
	Sukkur	63	62	98%
	Dadu	90	90	100%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	Khairpur	168	168	100%
	Kashmore	59	59	100%
	Matari	42	42	100%
	Jamshoro	74	74	100%
	Tando Allahyar	54	53	98%
	Tando Muhammad Khan	41	41	100%
	Shaheed Benazirabad	122	122	100%

Table 7: Compliance of IDSR reporting Tertiary care hospitals Week 32, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
AJK	Mirpur	2	0	0%
	Bhimber	1	0	0%
	Kotli	1	0	0%
	Muzaffarabad	2	0	0%
	Poonch	2	0	0%
	Haveli	1	0	0%
	Bagh	1	0	0%
	Neelum	1	0	0%
	Jhelum Vellay	1	0	0%
	Sudhnooti	1	0	0%
Sindh	Karachi-South	3	2	67%
	Sukkur	1	1	100%
	Shaheed Benazirabad	1	1	100%
	Karachi-East	1	1	100%
	Karachi-Central	1	1	100%
KP	Peshawar	3	0	0%
	Swabi	1	0	0%
	Nowshera	1	1	100%
	Mardan	1	0	0%
	Abbottabad	1	1	100%
	Swat	1	1	100%

Strengthening Genomic Surveillance Capacity: NIH Completes Fifth Hands-on Training Workshop on Next Generation Sequencing



The Department of Virology, National Institutes of Health (NIH), Islamabad, has completed the fifth batch of its three-day Hands-on Training Workshop on Next-Generation Sequencing (NGS) and Data Analysis of Viral Pathogens. The training brought together 21 participants, including professionals, researchers, and students from leading academic, research, laboratory, and healthcare institutions across Pakistan.

The workshop was designed to build practical expertise in applying NGS technologies for the detection, characterization, and genomic surveillance of viral pathogens. With the increasing importance of genomic epidemiology in understanding the emergence, transmission, evolution, and geographic spread of infectious diseases, strengthening national capacity in genomic sequencing and bioinformatics remains an important component of Pakistan's public health preparedness.

A key feature of the workshop was its strong emphasis on hands-on learning, enabling

participants to gain practical experience across the complete NGS workflow.

The training also highlighted how genomic data can support public health decision-making, including pathogen identification and characterization, molecular epidemiology, monitoring viral evolution, detection of emerging variants, and strengthening outbreak investigation and surveillance.

Multidisciplinary engagement is particularly valuable for fostering collaboration between laboratory scientists, public health professionals, researchers, and the next generation of genomic epidemiology experts. The workshop represents another step toward expanding national expertise in NGS, bioinformatics, and genomic data interpretation.



The Department of Virology remains committed to strengthening Pakistan's genomic surveillance and laboratory capacity through high-quality practical training, institutional collaboration, knowledge sharing, and continued professional development. By investing in technical capacity and fostering collaboration across institutions, NIH aims to support a stronger and more integrated national framework for genomic surveillance and preparedness against emerging and re-emerging viral threats.

Knowledge Hub

Cutaneous Leishmaniasis (CL): What You Need to Know

It is a parasitic infectious disease caused by protozoan parasites of the genus *Leishmania*. It is transmitted mainly through the bite of infected female phlebotomine sandflies. Cutaneous leishmaniasis is the most common form of leishmaniasis and primarily affects the skin, causing lesions that may ulcerate and leave permanent scars. It is an important public health concern in Pakistan, which is endemic for cutaneous leishmaniasis.

What is Cutaneous Leishmaniasis?

It is a vector-borne parasitic disease that affects the skin. The infection usually begins at the site of a sandfly bite and may develop into a papule, nodule, or ulcer. Lesions commonly occur on exposed parts of the body, such as the face, arms, and legs. The disease is usually not transmitted directly from person to person.

Incubation Period

The incubation period usually lasts from several weeks to months after being bitten by an infected sandfly. The exact incubation period varies depending on the *Leishmania* species, immune status, and other factors.

How Cutaneous Leishmaniasis Spreads to Humans

Sandfly Transmission

Cutaneous leishmaniasis spreads when an infected female sandfly bites a person. The sandfly acquires the parasite when feeding on an infected human or animal and can transmit the parasite during a subsequent bite.

Environmental and Exposure Risk

The risk of infection increases among people living in or travelling to endemic areas, individuals who spend time outdoors from dusk to dawn, people sleeping outdoors or in poorly protected housing, and populations living in areas where sandflies are present.

High-Risk Groups

People at increased risk include people living in endemic areas and people frequently exposed to sandflies, particularly during evening and night-time outdoor activities; people living in poorly constructed or inadequately screened houses; people experiencing population displacement or migration from endemic areas; people with limited access to healthcare, diagnosis and treatment; and individuals with weakened immune systems may have more severe or atypical disease.

Signs & Symptoms

Symptoms of cutaneous leishmaniasis usually develop gradually and may include a small papule or nodule at the site of the sandfly bite with gradual enlargement of the lesion. These are painless skin ulcers, often with raised or indurated edges. There is crusting or scabbing of the lesion. There is one or multiple lesions, commonly affecting the face, arms, hands and legs. Lesions may heal slowly over months or years and can leave permanent scars.

Complications

If left untreated, cutaneous leishmaniasis can lead to complications, including persistent or chronic skin ulcers, secondary bacterial infection of lesions, permanent and disfiguring scars, psychological distress and social stigma, particularly when lesions affect the face. Rarely, more extensive or difficult-to-treat forms of cutaneous disease.

Prevention

It focuses on reducing exposure to infected sandflies, early recognition of lesions, timely diagnosis and appropriate treatment.

Personal Protection

Avoid unnecessary outdoor exposure from dusk to dawn when sandflies are most active. Wear long-sleeved clothing, long trousers and socks when outdoors. Use appropriate insect repellents on exposed skin. Sleep under insecticide-treated bed nets, particularly when sleeping outdoors or in unscreened accommodation. Use appropriately screened doors and windows where feasible. Maintain clean surroundings and support locally recommended vector-control measures.

Early Detection and Treatment

Seek medical evaluation for a skin lesion or ulcer that persists or gradually enlarges. People with suspected CL should be assessed at an appropriate healthcare facility. Early diagnosis and appropriate treatment can reduce prolonged disease and the risk of permanent scarring. Complete the prescribed treatment regimen and attend follow-up appointments as advised by healthcare providers.

Vaccination

There is currently **no vaccine available** to prevent cutaneous leishmaniasis.

Community Awareness

Educate communities about sandfly transmission, protective measures, and early recognition of skin lesions. Encourage timely healthcare seeking, reduce stigma associated with visible skin lesions, and promote

community participation in locally appropriate vector-control activities.

Diagnosis and Treatment

Early diagnosis and appropriate treatment are essential to reduce prolonged disease, complications, and permanent scarring.

Cutaneous leishmaniasis can be diagnosed through:

Clinical assessment of characteristic skin lesions and relevant travel or residence history; demonstration of *Leishmania* parasites by microscopy from appropriate lesion specimens; and Molecular testing such as PCR, where available.

Other laboratory methods, including culture, may be used in specialized settings. Serological tests have limited value for cutaneous leishmaniasis. Parasitological confirmation is important, particularly before systemic or potentially toxic treatment.

Treatment consists of:

Local or systemic antileishmanial treatment depending on the number, size and location of lesions, causative species, geographic setting and patient characteristics. It should be prescribed and monitored by trained healthcare providers. Patients should not self-treat suspected lesions or use unverified medicines or topical preparations. Treatment adherence and follow-up are important to ensure appropriate clinical response. Most cases of cutaneous leishmaniasis can be treated successfully, although healing may take time and scars may remain after the infection has resolved.

More Information

For additional authoritative information on Cutaneous Leishmaniasis (CL), please visit:

1. **World Health Organization (WHO):**
<https://www.who.int/health-topics/leishmaniasis>

2. **World Health Organization – Leishmaniasis Fact Sheet:**
<https://www.who.int/news-room/fact-sheets/detail/leishmaniasis>
3. **WHO Eastern Mediterranean Regional Office (WHO EMRO):**
<https://www.emro.who.int/neglected-tropical-diseases/>
4. **Centers for Disease Control and Prevention (CDC):**
<https://www.cdc.gov/leishmaniasis/>
5. **National Institute of Health (NIH), Pakistan:**
<https://www.nih.org.pk/>

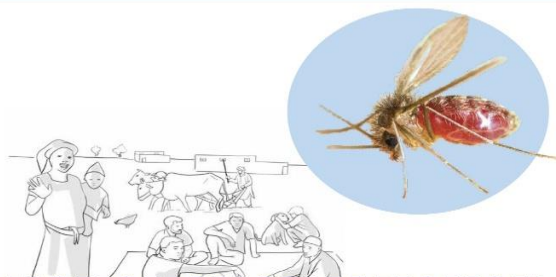


Leishmaniasis

Information for the general public

Source of infection

Vector-borne disease transmitted through the bites of infected female phlebotomine sandflies, which feed on blood to produce eggs.



Type of exposure & prevention

Leishmaniasis is caused by bite of an infected female sandfly (phlebotomine), a tiny 2-3 mm long insect vector. Poverty, poor housing, population mobility, malnutrition and weak immune system increases the risk of developing and transmitting disease. Prevent it by:



Symptoms

Leishmaniasis has three forms: visceral (Kala-Azar, most serious form); cutaneous (most common); and mucocutaneous. Depending upon its type it can be fatal. Symptoms include:

Visceral leishmaniasis



Cutaneous leishmaniasis



Mucocutaneous leishmaniasis



Actions to take in case of symptoms:



Seek medical advice immediately. Early diagnosis and access to safe medicine is important.



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