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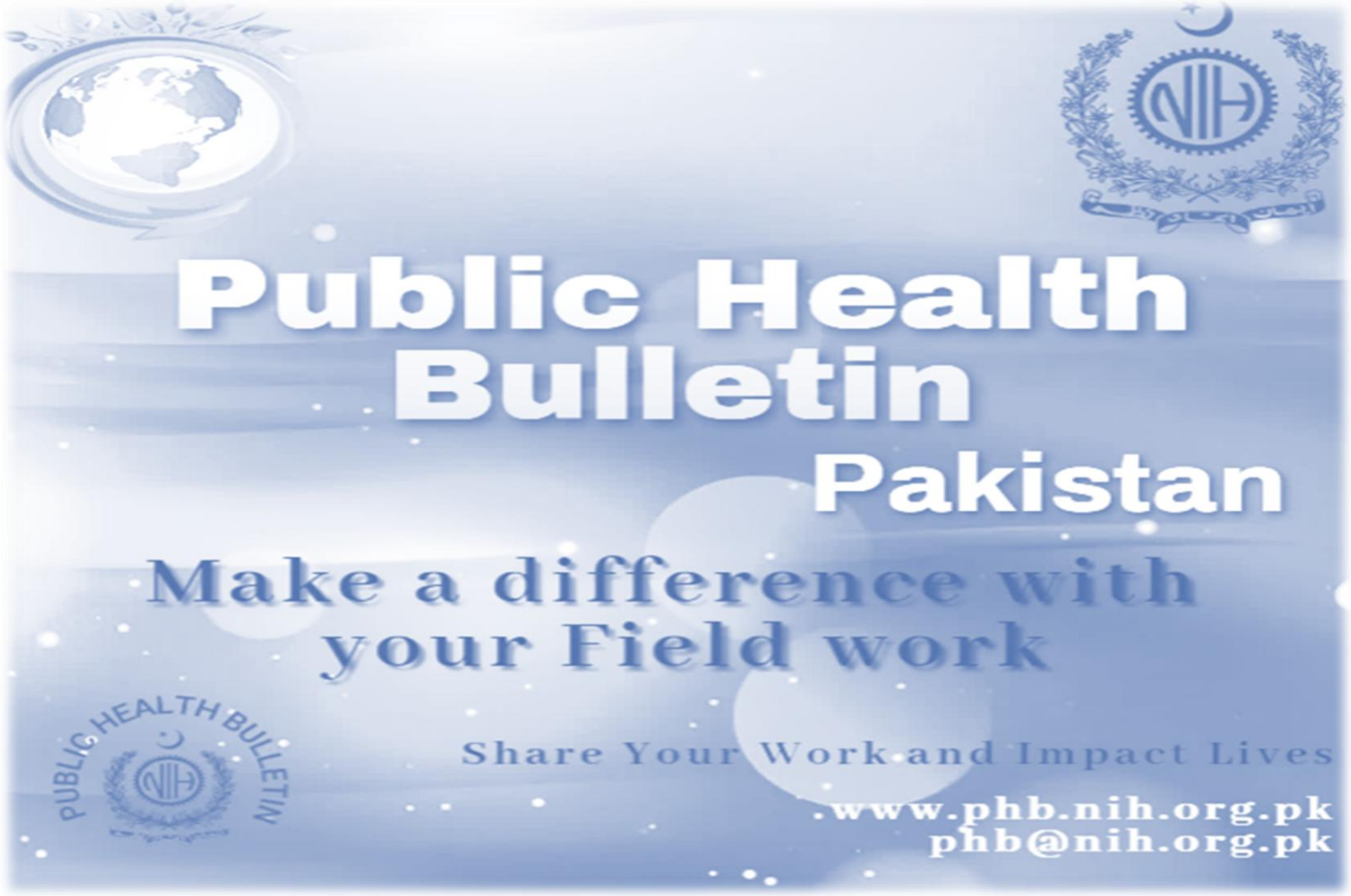
Integrated Disease Surveillance & Response (IDSR) Report

Center of Disease Control
National Institute of Health, Islamabad

http:/www.phb.nih.org.pk/

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, Week 20, 2025

The Public Health Bulletin (PHB) provides timely, reliable, and actionable health information to the public and professionals. It disseminates key IDSR data, outbreak reports, and seasonal trends, along with actionable public health recommendations. Its content is carefully curated for relevance to Pakistan's priorities, excluding misinformation. The PHB also proactively addresses health misinformation on social media and aims to be a trusted resource for informed public health decision-making.

This Weeks Highlights include;

- *Letter to Editor - The Silent Pandemic – Confronting Antimicrobial Resistance in Pakistan*
- *Knowledge hub on Syphilis: What You Need to Know*

By transforming complex health data into actionable intelligence, the Public Health Bulletin continues to be an indispensable tool in our collective journey toward a healthier Pakistan.

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Stay informed. Stay prepared. Stay healthy.

Sincerely,
The Chief Editor

Note: All reported cases in this report are suspected cases

- *During Week 20, the most frequently reported cases were of Acute Diarrhea (Non-Cholera) followed by Malaria, ILI, ALRI <5 years, TB, B. Diarrhea, VH (B, C & D), dog bite, Typhoid and SARI.*
- *Fifteen cases of AFP reported from KP, five from Sindh, four from AJK and one each from Balochistan and GB.*
- *Fifty-five suspected cases of HIV/ AIDS reported from Sindh and three from KP.*
- *Four suspected cases of Brucellosis reported from KP.*
- *One suspected case each of CCHF reported from Balochistan and Sindh.*
- *Among VPDs, there is an increase in number of cases of Chickenpox, Mumps, Pertussis and NT this week.*
- *Among Respiratory diseases, there is an increase in number of cases of ILI, ALRI< 5 years, TB and SARI this week.*
- *Among Water/food-borne diseases, there is an increase in number of cases of Acute Diarrhea (Non-Cholera), B. Diarrhea and AWD (S. Cholera) this week.*
- *Among Vector-borne diseases, there is an increase in number of cases of Malaria this week.*
- *Among STDs, there is an increase in number of cases of HIV/AIDs 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 80%*
- *Sindh is the top reporting regions with a compliance rate of 95%, followed by AJK 94%, GB 92% and ICT 80%.*
- *The lowest compliance rate was observed in KP 73% and Balochistan 57%.*

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	*2315*	*1699*	*73*
Azad Jammu Kashmir	*404*	*380*	*94*
Islamabad Capital Territory	*36*	*28*	*80*
Balochistan	*1304*	*702*	*57*
Gilgit Baltistan	*405*	*374*	*92*
Sindh	*2108*	*2011*	*95*
National	*6572*	*5194*	*79*

Public Health Actions

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

Syphilis

- **Strengthen Surveillance and Case Notification:** Strengthen syphilis reporting into the IDSR system by training healthcare providers on syndromic management and laboratory-based case definitions, with emphasis on antenatal screening and high-risk populations.
- **Improve Diagnostic Capacity:** Expand availability of rapid diagnostic tests (RDTs) and confirmatory testing (e.g., RPR, TPHA) at primary and secondary health facilities respectively to enable early diagnosis and linkage to care.
- **Ensure Access to Treatment:** Guarantee timely availability of Benzathine penicillin and other recommended antibiotics; train providers on national treatment protocols and partner notification.
- **Prevent Congenital Syphilis:** Scale up routine syphilis screening for all pregnant women and ensure prompt treatment of positive cases to prevent vertical transmission.
- **Raise Awareness and Promote Safer Behaviors:** Conduct community outreach and behavior change communication to promote condom use, reduce stigma, and encourage timely care-seeking, particularly in adolescents and key populations (e.g., sex workers, MSM).

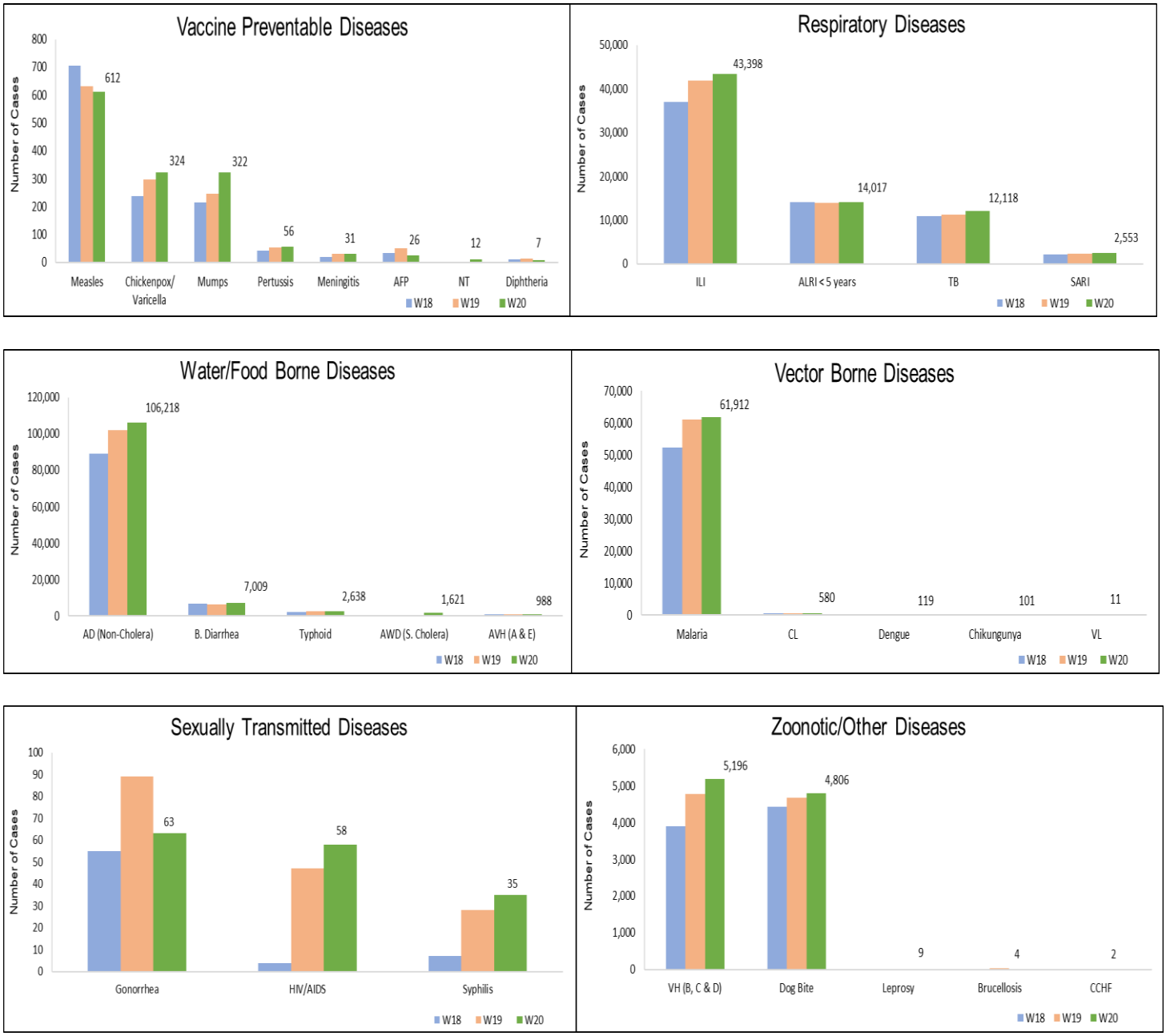
Gonorrhea

- **Enhance Surveillance and Reporting**: Strengthen gonorrhea into STI surveillance systems within IDSR, emphasizing syndromic management and laboratory-confirmed reporting, especially in urban and high-risk areas.
- **Improve Laboratory Capacity for Diagnosis and Resistance Monitoring**: Expand access to microscopy, culture, and NAAT (nucleic acid amplification tests); support antimicrobial resistance surveillance for gonorrhea to inform treatment guidelines.
- **Ensure Syndromic and Etiologic Management**: Train healthcare providers in syndromic case management while encouraging lab-based confirmation where possible; ensure availability of recommended dual therapy antibiotics.
- **Strengthen Youth-Friendly and Key Population Services**: Improve access to confidential, stigma-free STI services for adolescents and key populations through dedicated clinics and outreach activities.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 20, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (non-cholera)	2,025	7,226	1,265	591	42,195	NR	52,916	106,218
Malaria	0	3,210	0	1	4,224	NR	54,477	61,912
ILI	2,391	5,428	369	1,690	5,127	NR	28,393	43,398
ALRI < 5 years	1,045	1,640	821	9	1,487	NR	9,015	14,017
TB	60	83	116	15	412	NR	11,432	12,118
B. Diarrhea	77	1,262	67	4	1,526	NR	4,073	7,009
VH (B, C & D)	22	81	4	0	100	NR	4,989	5,196
Dog Bite	146	99	6	2	1,001	NR	3,552	4,806
Typhoid	8	562	96	1	817	NR	1,154	2,638
SARI	256	698	312	2	978	NR	307	2,553
AWD (S. Cholera)	17	66	18	0	41	NR	1,479	1,621
AVH (A & E)	31	4	4	0	235	NR	714	988
Measles	10	26	13	0	421	NR	142	612
CL	1	45	0	0	519	NR	15	580
Chickenpox/ Varicella	0	19	28	12	147	NR	118	324
Mumps	4	72	6	0	162	NR	78	322
Dengue	1	23	0	0	23	NR	72	119
Chikungunya	0	1	0	0	0	NR	100	101
Gonorrhea	0	46	0	0	8	NR	9	63
HIV/AIDS	0	0	0	0	3	NR	55	58
Pertussis	0	34	8	0	13	NR	1	56
Syphilis	0	0	0	0	4	NR	31	35
Meningitis	1	0	1	0	2	NR	27	31
AFP	4	1	1	0	15	NR	5	26
NT	0	0	0	0	3	NR	9	12
VL	0	0	0	0	0	NR	11	11
Leprosy	0	0	0	0	9	NR	0	9
Diphtheria (Probable)	0	0	0	0	4	NR	3	7
Brucellosis	0	0	0	0	4	NR	0	4
CCHF	0	1	0	0	0	NR	1	2

Figure 1: Most frequently reported suspected cases during Week 20, Pakistan.



Sindh

- Malaria cases were maximum followed by AD (Non-Cholera), ILI, TB, ALRI<5 Years, VH (B, C, D), B. Diarrhea, dog bite, AWD (S. Cholera) and Typhoid.
- Malaria cases are mostly from Larkana, Khairpur and Sanghar whereas AD (Non-Cholera) cases are from Karachi South, Badin and Khairpur.
- Fifty-five suspected cases of HIV/ AIDS reported from Sindh. They need field investigation.
- Five cases of AFP reported from Sindh. They are suspected cases and need field verification.
- One case of CCHF reported from Sindh. It is suspected case and requires field verification.

Table 2: District wise distribution of most frequently reported suspected cases during Week 20, Sindh

Districts	Malaria	AD (non-cholera)	ILI	TB	ALRI < 5 years	VH (B, C & D)	B. Diarrhea	Dog Bite	AWD (S. Cholera)	Typhoid
Badin	3,438	3,640	2,721	778	407	332	238	184	4	45
Dadu	3,512	2,838	426	410	534	142	615	616	0	123
Ghotki	1,149	1,001	85	275	362	105	64	156	0	0
Hyderabad	818	2,831	1,364	266	101	115	66	73	0	7
Jacobabad	752	746	714	174	476	185	144	229	0	28
Jamshoro	1,975	1,660	13	536	300	198	127	84	0	22
Kamber	3,845	2,118	0	701	236	98	160	218	0	17
Karachi Central	3	823	747	9	2	6	1	0	0	64
Karachi East	26	302	197	22	4	3	4	3	1	13
Karachi Kemari	6	429	221	28	27	1	2	0	0	4
Karachi Korangi	65	400	3	14	2	0	6	0	0	2
Karachi Malir	214	1,983	3,272	188	297	35	44	51	0	32
Karachi South	111	3,674	61	244	65	210	125	298	1,443	227
Karachi West	324	818	1,138	103	171	39	20	96	0	26
Kashmore	2,281	611	636	257	170	39	98	120	0	2
Khairpur	4,893	3,433	7,319	1,007	1,267	263	358	230	0	259
Larkana	5,397	2,266	45	1,052	304	75	366	38	0	9
Matiari	2,560	1,845	1	546	214	431	54	49	0	2
Mirpurkhas	2,225	3,053	2,373	705	391	203	102	111	0	16
Naushero Feroze	1,237	1,080	718	374	387	66	183	187	0	55
Sanghar	4,071	2,022	37	1,172	456	1,238	145	197	0	59
Shaheed Benazirabad	2,337	1,915	1	346	185	71	80	126	0	94
Shikarpur	2,496	1,343	3	268	207	530	178	159	0	4
Sujawal	985	2,255	0	150	273	52	220	71	0	5
Sukkur	1,683	1,534	2,314	361	423	55	138	84	0	7
Tando Allahyar	2,054	2,075	722	416	203	264	131	65	0	10
Tando Muhammad Khan	926	1,160	41	401	121	64	95	22	31	0
Tharparkar	2,231	1,659	1,314	330	558	57	109	0	0	17
Thatta	1,373	1,698	1,907	25	471	27	96	85	0	2
Umerkot	1,490	1,704	0	274	401	85	104	0	0	3
Total	54,477	52,916	28,393	11,432	9,015	4,989	4,073	3,552	1,479	1,154

Figure 2: Most frequently reported suspected cases during Week 20 Sindh

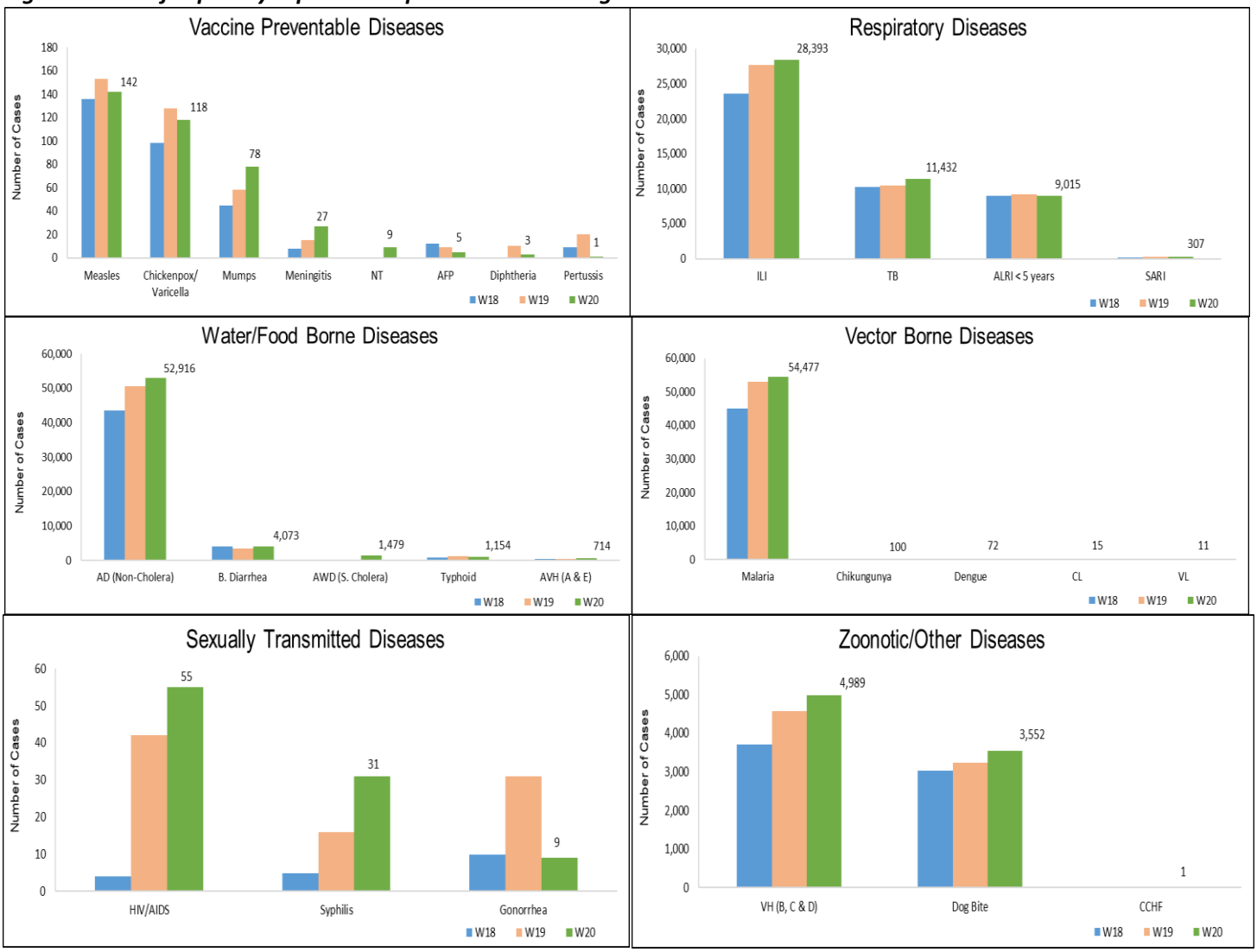
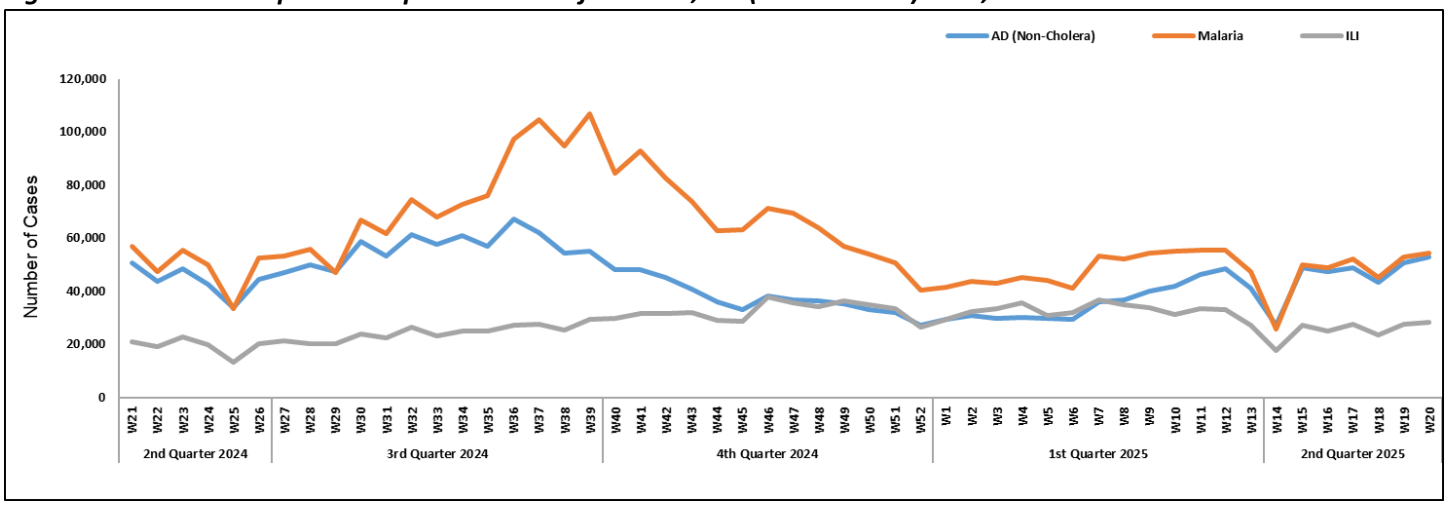


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh



- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, dog bite, TB and VH (B, C & D) cases were the most frequently reported diseases from Balochistan province.
- AD (Non-Cholera) cases are mostly reported from Usta Muhammad, Quetta and Gwadar while ILI cases are mostly reported from Gwadar, Quetta and Pishin.
- One suspected case of AFP reported from Balochistan. It requires field investigation.
- One case of CCHF reported from Balochistan. It is suspected case and needs field verification.

Table 3: District wise distribution of most frequently reported suspected cases during Week 20, Balochistan

Districts	AD (non-cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	Dog Bite	TB	VH (B, C & D)
Barkhan	103	92	61	26	8	5	43	1	2	0
Chagai	154	197	24	0	31	0	11	0	0	0
Dera Bugti	91	3	68	4	8	0	7	0	0	0
Gwadar	541	969	96	34	57	0	85	2	0	2
Hub	174	48	130	7	10	2	1	1	1	0
Jhal Magsi	269	152	264	69	0	1	39	10	6	0
Kachhi (Bolan)	149	46	161	30	52	139	19	0	1	0
Kalat	50	3	47	10	22	0	20	5	2	0
Kharan	222	466	44	20	72	0	10	0	0	0
Khuzdar	59	82	59	0	28	0	7	0	0	0
Killa Abdullah	122	54	5	7	10	40	3	2	1	0
Killa Saifullah	201	0	212	80	90	32	19	0	0	2
Kohlu	165	252	122	13	54	21	10	NR	NR	NR
Lasbella	443	52	338	216	41	4	14	35	2	2
Loralai	251	410	43	39	44	81	11	2	0	0
Mastung	239	161	97	45	68	114	30	0	9	13
MusaKhel	40	14	54	14	6	0	6	0	0	0
Naseerabad	382	26	305	18	8	0	61	18	8	24
Nushki	182	0	23	0	53	0	0	0	0	0
Panjgur	35	52	62	64	32	0	1	0	0	0
Pishin	529	573	47	82	161	41	37	2	2	0
Quetta	783	733	18	177	44	71	20	0	0	0
Sibi	177	238	23	22	5	17	41	0	1	0
Sohbat pur	318	38	371	161	96	16	37	7	3	3
Surab	46	179	20	0	0	0	0	0	0	0
Usta Muhammad	1,032	157	299	171	109	0	7	14	1	34
Washuk	178	282	157	4	109	17	16	0	2	0
Zhob	291	149	60	327	44	97	7	0	42	1
Total	7,226	5,428	3,210	1,640	1,262	698	562	99	83	81

Figure 4: Most frequently reported suspected cases during Week 20, Balochistan

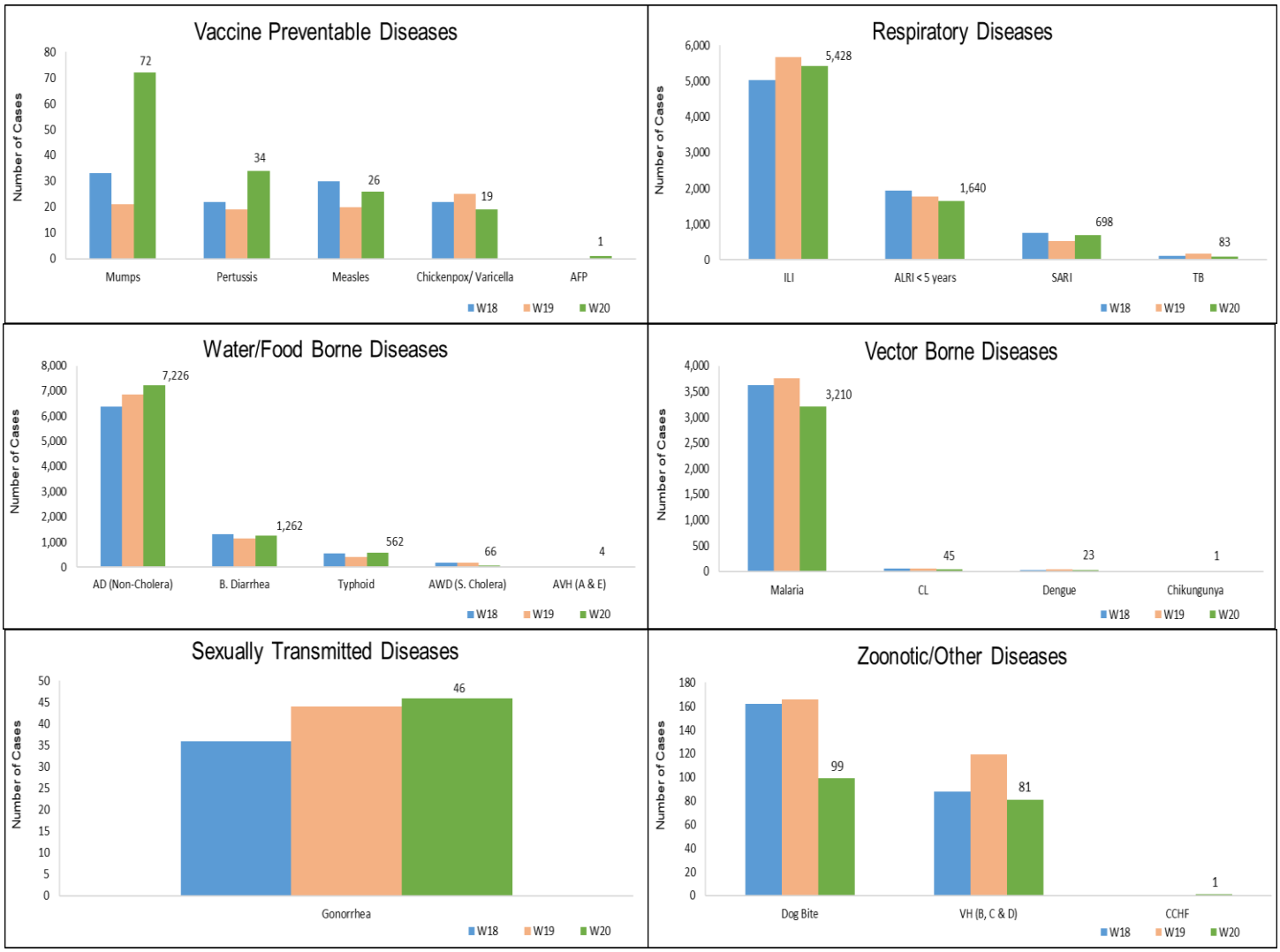
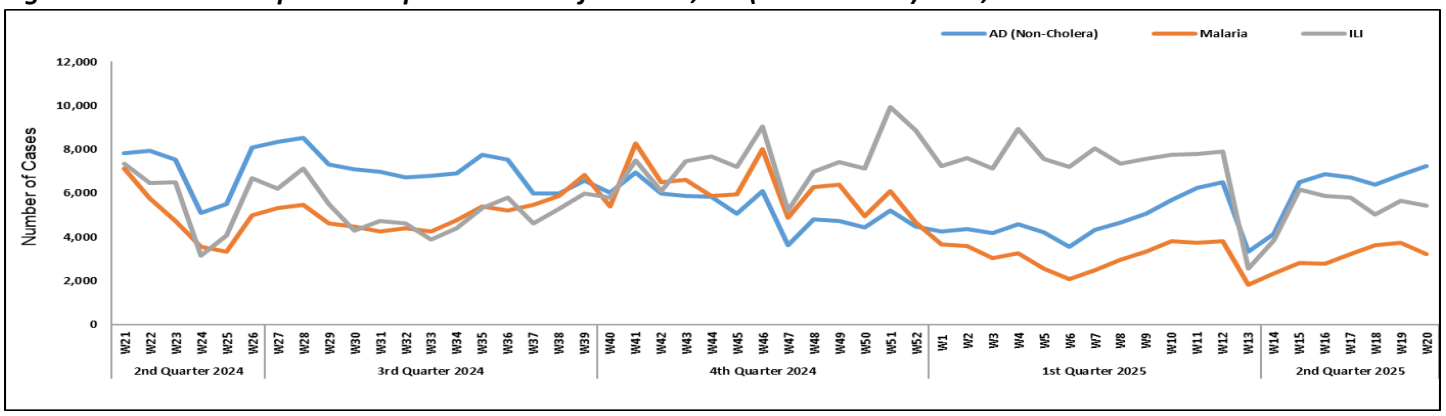


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan



Khyber Pakhtunkhwa

- Cases of AD (Non-Cholera) were maximum followed by ILI, Malaria, B. Diarrhea, ALRI<5 Years, dog bite, SARI, Typhoid, CL and Measles.
- AD (Non-Cholera), ILI, B. Diarrhea, ALRI<5 Years, HIV/AIDs and VPDs including Mumps, Chickenpox, Pertussis, Diphtheria and NT showed an increase in number of cases while Malaria, dog bite, SARI, CL and Measles showed a decline in number of cases this week.
- Fifteen cases of AFP reported from KP. All are suspected cases and need field verification.
- Four suspected cases of Brucellosis reported from KP. They require field verification.
- Three cases of HIV/AIDs reported from KP. They are suspected cases and need field verification.

Table 4: District wise distribution of most frequently reported suspected cases during Week 20, KP

Districts	AD (non-cholera)	ILI	Malaria	B. Diarrhea	ALRI < 5 years	Dog Bite	SARI	Typhoid	CL	Measles
Abbottabad	1,585	192	0	20	8	47	5	27	0	2
Bajaur	779	68	252	92	12	51	76	10	26	30
Bannu	428	3	777	45	11	1	0	38	0	4
Battagram	338	612	34	6	8	10	NR	NR	4	NR
Buner	383	0	303	1	0	11	0	5	0	0
Charsadda	3,575	1,272	381	302	375	11	7	139	3	67
Chitral Lower	896	153	11	24	14	20	15	4	12	1
Chitral Upper	235	17	2	4	8	0	20	14	0	0
D.I. Khan	2,104	0	224	26	25	44	0	0	3	78
Dir Lower	2,218	0	168	101	7	103	0	26	0	15
Dir Upper	1,090	75	28	2	8	9	0	4	12	4
Hangu	156	72	51	12	0	0	0	2	0	0
Haripur	1,872	200	7	0	36	15	8	13	0	5
Karak	875	73	184	75	54	43	21	4	274	25
Khyber	744	70	160	125	481	39	7	20	79	9
Kohat	1,197	4	87	74	4	28	0	31	18	0
Kohistan Lower	102	0	1	5	0	0	0	0	1	0
Kohistan Upper	533	0	4	35	4	4	0	0	0	3
Kolai Palas	118	0	0	7	0	0	0	2	0	0
L & C Kurram	6	3	0	15	0	0	0	2	0	0
Lakki Marwat	1,023	0	230	16	2	60	0	26	0	10
Malakand	1,863	49	26	0	0	0	64	78	0	9
Mansehra	1,351	495	2	6	0	0	19	11	0	0
Mardan	1,151	80	98	38	136	81	0	9	4	14
Mohmand	228	128	170	41	6	3	116	8	59	9
North Waziristan	131	5	222	27	2	1	6	5	5	12
Nowshera	3,321	4	107	18	9	70	22	41	5	10
Orakzai	164	17	24	13	0	2	0	0	0	0
Peshawar	5,574	466	35	194	86	7	31	142	0	72
SD Tank	20	0	16	7	0	1	0	0	2	1
Shangla	850	0	264	7	2	26	256	7	0	5
South Waziristan (Lower)	53	172	84	0	8	6	46	9	11	3
SWU	46	64	36	2	0	0	12	0	0	1
Swabi	2,097	419	49	22	42	181	14	70	0	21
Swat	4,197	108	27	63	119	84	41	46	0	3
Tank	606	102	97	17	11	4	0	8	0	4
Tor Ghar	103	1	42	34	4	30	13	3	1	3
Upper Kurram	183	203	21	50	5	9	179	13	0	1
Total	42,195	5,127	4,224	1,526	1,487	1,001	978	817	519	421

Figure 6: Most frequently reported suspected cases during Week 20, KP

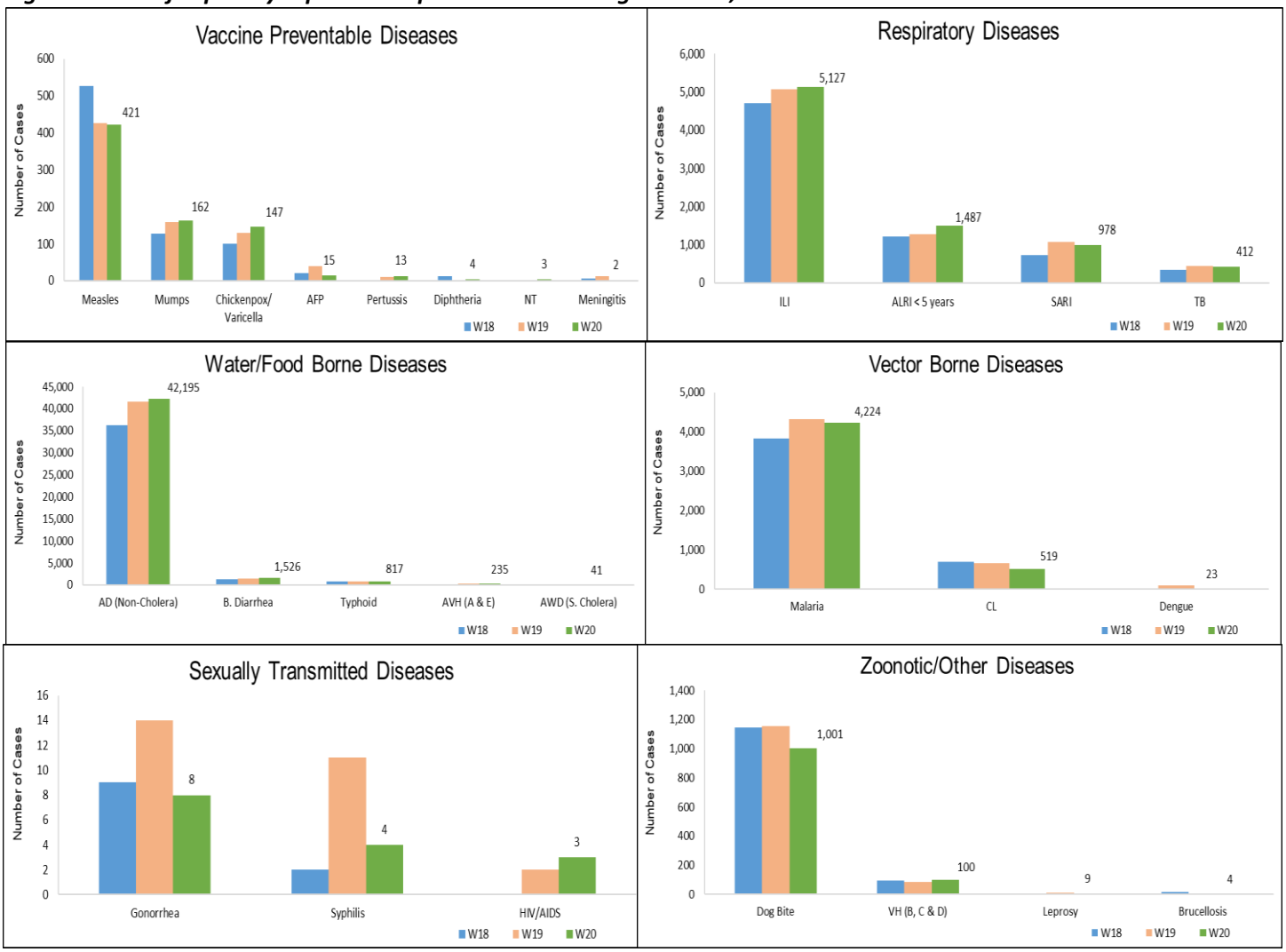
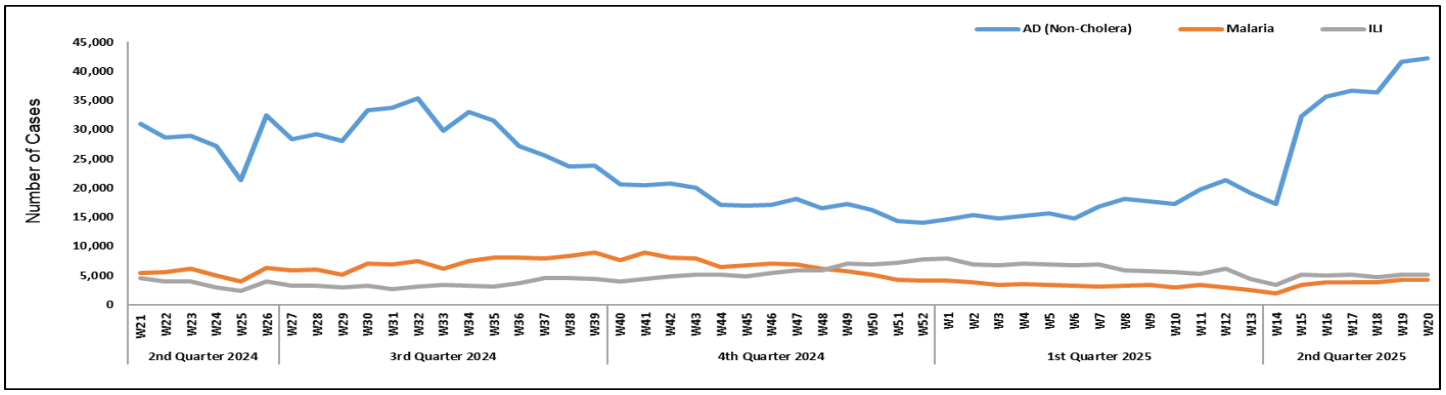


Figure 7: Week wise reported suspected cases Malaria, AD (Non-Cholera) & ILI, KP



ICT, AJK & GB

ICT: The most frequently reported cases from Islamabad were ILI and AD (Non-Cholera). ILI and AD (Non-Cholera) cases showed an increase in number this week.

AJK: ILI cases were maximum followed by AD (Non-Cholera), ALRI < 5years, SARI, dog bite, B. Diarrhea, TB, AVH (A & E), VH (B, C & D) and AWD (S. Cholera) cases. An increase in cases observed for ILI, AD (Non-Cholera), ALRI < 5years, SARI, dog bite, B. Diarrhea, TB, AVH (A & E), VH (B, C & D) and VPDs including Measles, AFP and Mumps this week. Four cases of AFP reported from AJK. They require field investigation.

GB: AD (Non-Cholera) cases were the most frequently reported diseases followed by ALRI <5 Years, ILI, SARI, TB, Typhoid, B. Diarrhea and Chickenpox cases. One suspected case of AFP reported from GB. It requires field investigation.

Figure 10: Most frequently reported suspected cases during Week 20, AJK

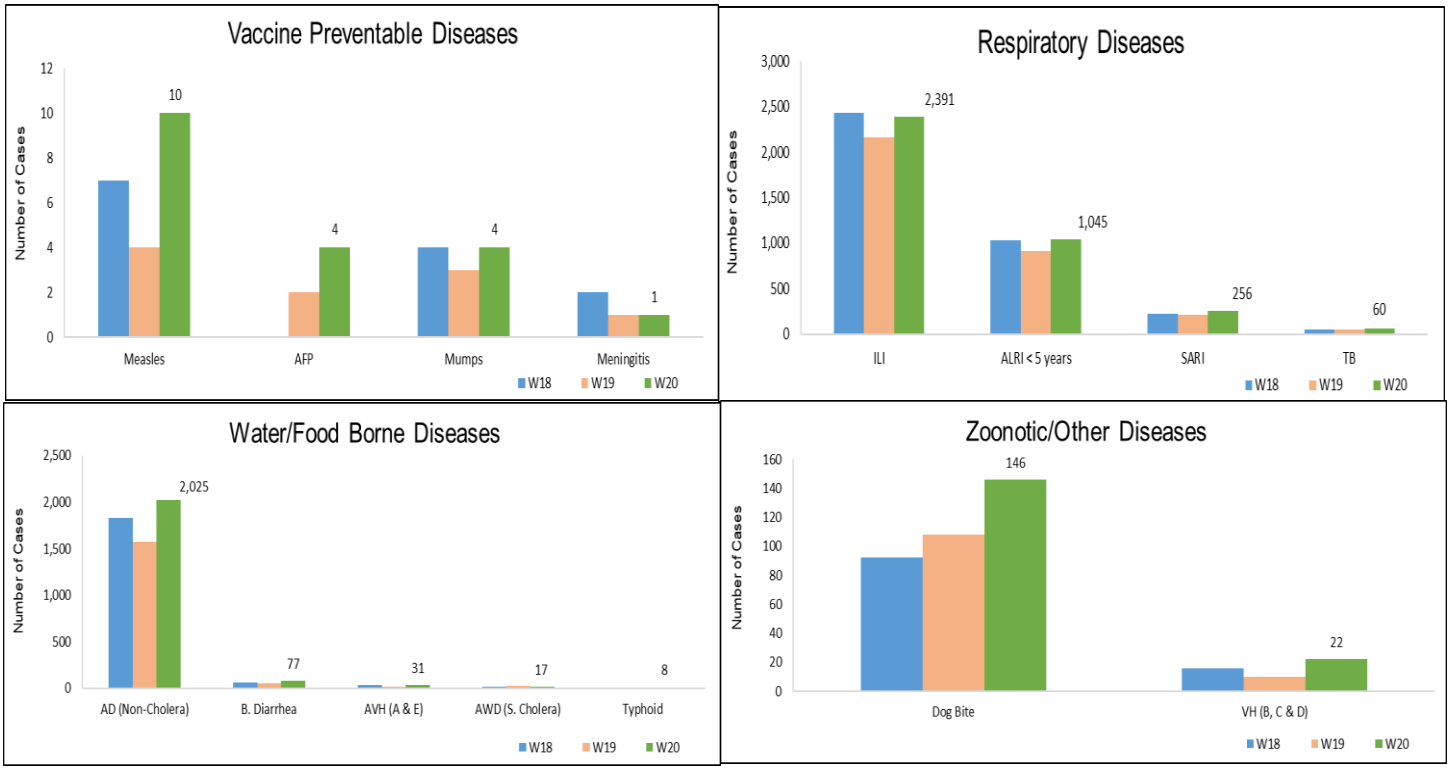


Figure 11: Week wise reported suspected cases of ILI and ARI <5 years, AJ

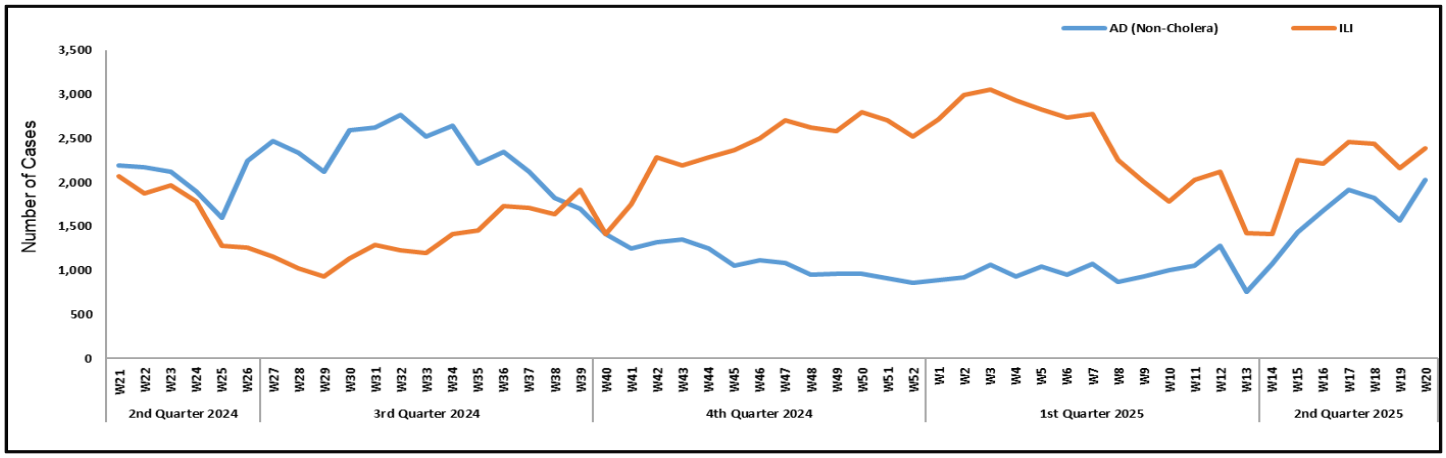


Figure 12: Most frequently reported suspected cases during Week 20, ICT

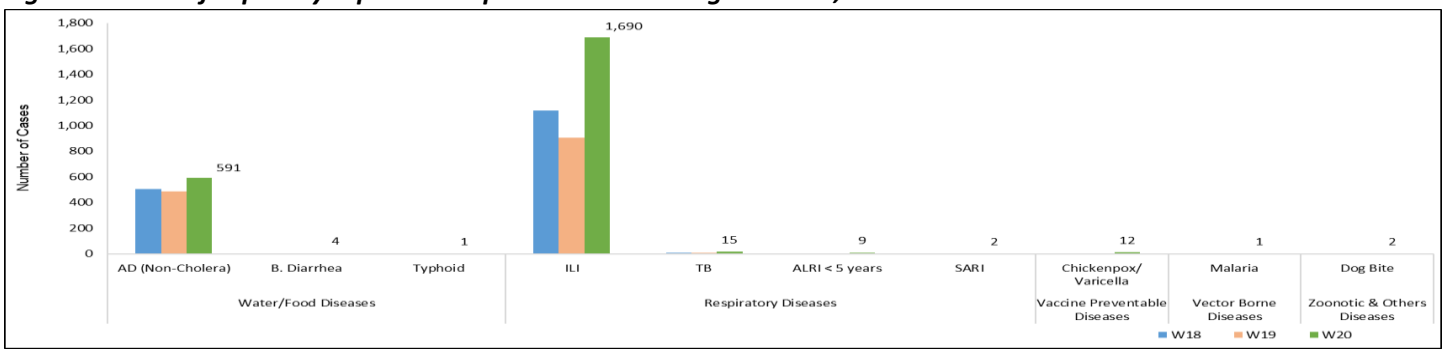


Figure 13: Week wise reported suspected cases of ILI, ICT

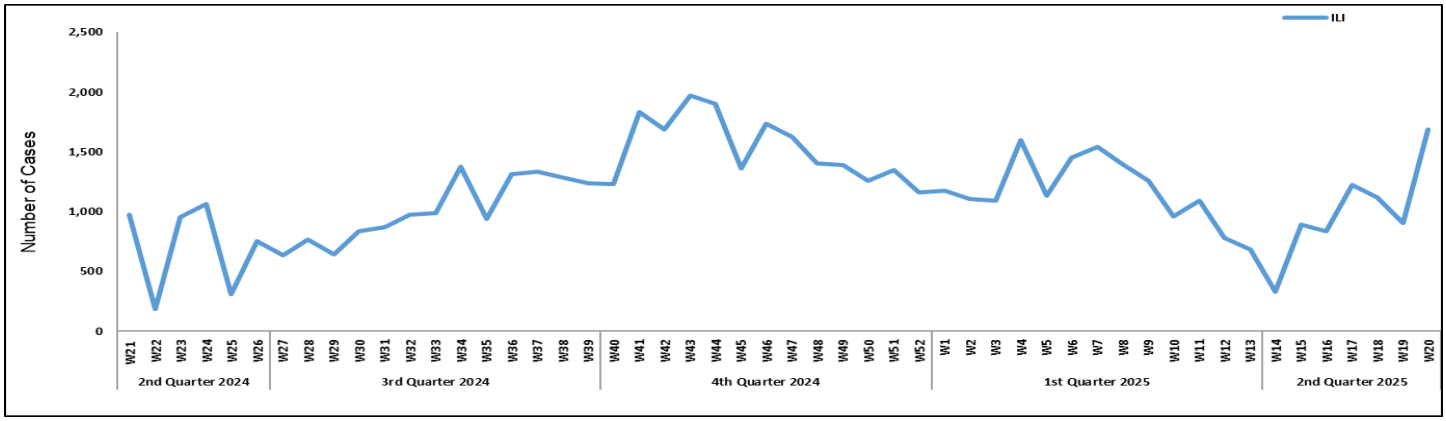


Figure 14: Most frequent cases reported during Week 20, GB

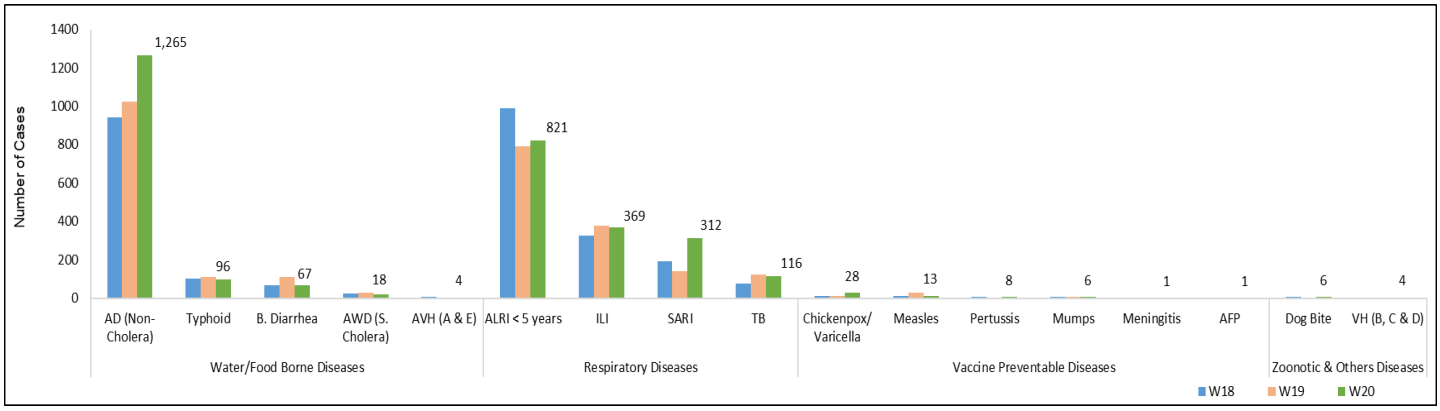


Figure 15: Week wise reported suspected cases of ALRI <5 years, GB

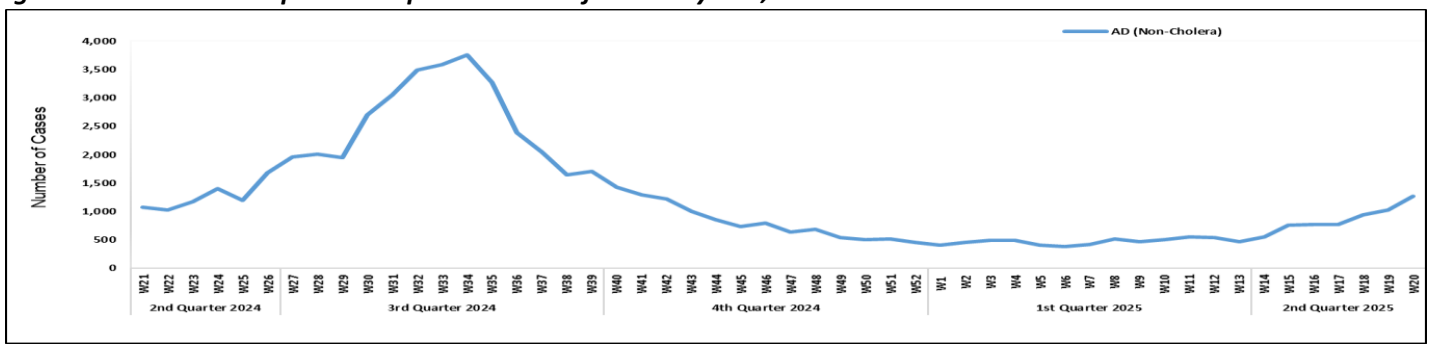


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epid Week 20

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)		75	1	-	-	0	0	-	-	-	-	-	-	0	0
AD (non-cholera)		192	0	-	-	0	0	-	-	-	-	-	-	0	0
Malaria		8,632	537	-	-	107	0	-	-	-	-	-	-	1	0
CCHF		0	0	13	1	0	0	-	-	-	-	-	-	0	0
Dengue		1,853	136	3	0	2	0	-	-	-	-	-	-	1	0
VH (B)		15,982	399	117	96	120	1	-	-	-	-	-	-	28	0
VH (C)		16,286	1,550	86	35	120	2	-	-	-	-	-	-	198	1
VH (D)		83	16	80	8	0	0	-	-	-	-	-	-	170	0
VH (A)		10	0	-	-	5	1	-	-	-	-	-	-	0	0
VH (E)		30	9	-	-	0	0	-	-	-	-	-	-	0	0
Covid-19		28	9	8	0	0	0	-	-	-	-	-	-	0	0
Chikungunya		6	2	3	0	0	0	-	-	-	-	-	-	0	0
TB		546	56	-	-	11	0	-	-	-	-	-	-	41	4
HIV/ AIDS		5,700	48	0	0	67	0	-	-	-	-	-	-	63	0
Syphilis		1,342	26	-	-	0	0	-	-	-	-	-	-	0	0
B. Diarrhea		32	0	-	-	0	0	-	-	-	-	-	-	0	0
Typhoid		1,258	29	-	-	0	0	-	-	-	-	-	-	0	0
Diphtheria		8	2	-	-	0	0	-	-	-	-	-	-	0	0
ILI		28	3	1	0	0	0	-	-	-	-	-	-	0	0
Meningitis		10	1	-	-	0	0	-	-	-	-	-	-	0	0
Measles		446	223	54	34	434	179	9	6	30	21	780	225	13	2
Rubella		446	4	54	3	434	6	9	0	30	0	780	11	13	0
Covid-19	Out of SARI	7	2	0	0	15	1	41	10	4	0	99	15	5	1
	Out of ILI	4	0	0	0	6	0	40	8	3	0	38	5	4	0
Influenza A	Out of SARI	7	0	0	0	15	0	41	0	4	0	99	0	5	0
	Out of ILI	4	0	0	0	6	0	40	0	3	0	38	0	4	0
Influenza B	Out of SARI	7	0	0	0	15	0	41	0	4	0	99	0	5	0
	Out of ILI	4	0	0	0	6	0	40	0	3	0	38	0	4	0
RSV	Out of SARI	7	0	0	0	15	0	41	1	4	0	99	0	5	0
	Out of ILI	4	0	0	0	6	0	40	0	3	0	38	0	4	0

Table 6: IDSR reporting districts Week 20, 2025

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	102	92%
	Bannu	238	116	49%
	Battagram	59	30	51%
	Buner	34	21	62%
	Bajaur	44	41	93%
	Charsadda	59	57	97%
	Chitral Upper	34	29	85%
	Chitral Lower	35	34	97%
	D.I. Khan	113	113	100%
	Dir Lower	74	63	85%
	Dir Upper	37	28	76%
	Hangu	22	14	64%
	Haripur	72	72	100%
	Karak	36	36	100%
	Khyber	53	43	81%
	Kohat	61	61	100%
	Kohistan Lower	11	8	73%
	Kohistan Upper	20	17	85%
	Kolai Palas	10	10	100%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	6	14%
	Upper Kurram	41	30	73%
	Malakand	42	21	50%
	Mansehra	133	90	68%
	Mardan	80	48	60%
	Nowshera	55	52	95%
	North Waziristan	13	7	54%
	Peshawar	155	129	83%
	Shangla	37	32	86%
	Swabi	64	62	97%
	Swat	77	76	99%
	South Waziristan (Upper)	93	37	40%
	South Waziristan (Lower)	42	21	50%
	Tank	34	29	85%
	Torghar	14	14	100%
	Mohmand	68	62	91%
	SD Peshawar	5	0	0%
	SD Tank	58	7	12%
	Orakzai	69	12	17%
Azad Jammu Kashmir	Mirpur	37	37	100%
	Bhimber	42	20	48%

	Kotli	60	60	100%
	Muzaffarabad	45	43	96%
	Poonch	46	46	100%
	Haveli	39	39	100%
	Bagh	40	40	100%
	Neelum	39	39	100%
	Jhelum Velley	29	29	100%
	Sudhnooti	27	27	100%
Islamabad Capital Territory	ICT	21	20	95%
	CDA	15	8	53%
Balochistan	Gwadar	26	21	81%
	Kech	44	22	50%
	Khuzdar	74	10	14%
	Killa Abdullah	26	19	73%
	Lasbella	55	55	100%
	Pishin	65	40	62%
	Quetta	55	32	58%
	Sibi	36	19	53%
	Zhob	39	29	74%
	Jaffarabad	16	15	94%
	Naserabad	32	32	100%
	Kharan	30	30	100%
	Sherani	15	1	7%
	Kohlu	75	13	17%
	Chagi	36	22	61%
	Kalat	41	40	98%
	Harnai	17	0	0%
	Kachhi (Bolan)	35	0	0%
	Jhal Magsi	28	27	96%
	Sohbat pur	25	25	100%
	Surab	32	12	38%
	Mastung	45	41	91%
	Loralai	33	26	79%
	Killa Saifullah	28	3	11%
	Ziarat	29	0	0%
	Duki	31	0	0%
	Nushki	32	0	0%
	Dera Bugti	45	33	73%
	Washuk	46	28	61%
	Panjgur	38	7	18%
	Awaran	23	0	0%
	Chaman	24	0	0%
	Barkhan	20	20	100%
	Hub	33	29	88%
	Musakhel	41	18	44%
	Usta Muhammad	34	33	97%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	38	100%

	Gilgit	40	40	100%
	Diamer	62	60	97%
	Astore	54	54	100%
	Shigar	27	25	93%
	Skardu	52	52	100%
	Ganche	29	28	97%
	Kharmang	46	25	54%
Sindh	Hyderabad	73	72	99%
	Ghotki	64	64	100%
	Umerkot	62	62	100%
	Naushahro Feroze	107	97	91%
	Tharparkar	276	217	79%
	Shikarpur	60	60	100%
	Thatta	52	52	100%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	16	76%
	Karachi-West	20	20	100%
	Karachi-Malir	35	34	97%
	Karachi-Kemari	18	18	100%
	Karachi-Central	12	7	58%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	5	83%
	Sujawal	55	55	100%
	Mirpur Khas	106	105	99%
	Badin	124	123	99%
	Sukkur	64	63	98%
	Dadu	90	82	91%
	Sanghar	100	99	99%
	Jacobabad	44	43	98%
	Khairpur	170	169	99%
	Kashmore	59	59	100%
	Matiari	42	42	100%
	Jamshoro	75	74	99%
	Tando Allahyar	54	54	100%
	Tando Muhammad Khan	41	41	100%
	Shaheed Benazirabad	122	122	100%

Table 7: IDSR reporting Tertiary care hospital Week 20, 2025

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

Letter to the Editor

The Silent Pandemic – Confronting Antimicrobial Resistance in Pakistan

Dear Editor,

A silent, yet increasingly devastating, pandemic is unfolding across Pakistan: Antimicrobial Resistance (AMR). This phenomenon, where bacteria, viruses, fungi, and parasites evolve to withstand the medications designed to kill them, poses an existential threat to modern medicine. In Pakistan, the consequences are particularly dire, with NCDs and AMR collectively threatening to cripple our healthcare system and economy. [1]

The alarming statistics underscore the urgency. Bacterial AMR was directly responsible for an estimated 1.27 million global deaths in 2019 and contributed to 4.95 million, with low- and middle-income countries like Pakistan bearing a disproportionate burden. [2] Worryingly, a 2019 WHO report identified Pakistan among the top five nations experiencing the highest rates of neonatal mortality attributed to resistant bacteria. [1]

The rise of "superbugs" is no longer a distant threat; it is a grim reality. We are witnessing the emergence of extensively drug-resistant (XDR) strains of common infections, most notably XDR typhoid. Pakistan, particularly Sindh province, has become an epicenter of XDR typhoid, a strain resistant to multiple first-line antibiotics. [3, 4] This means that infections once easily treated with readily available antibiotics now require more potent, expensive, and often intravenously administered drugs, or, in the worst cases, become untreatable. [4] The economic fallout is substantial, increasing healthcare costs for patients and straining an already overburdened system. [5, 6]

The contributing factors to Pakistan's AMR crisis are well-documented:

Irrational use of antibiotics: Over-prescription by healthcare providers, self-medication by the public (often for viral infections where antibiotics are ineffective), and the easy availability of antibiotics without prescription are rampant. [1, 5, 7]

Poor infection prevention and control (IPC): Inadequate hygiene practices in homes and healthcare settings, coupled with poor water, sanitation, and hygiene (WASH) infrastructure, facilitate the spread of resistant pathogens. [1, 4, 8]

Antibiotic use in livestock and agriculture: The widespread use of antibiotics in livestock for growth promotion and disease prevention also contributes significantly to the development and spread of resistant bacteria, which can then enter the food chain. [1]

Pakistan has recognized the urgency, endorsing its second National Action Plan (NAP 2.0) on AMR (active until 2028), with support from international partners. [9] This revised NAP emphasizes a "One Health" approach, recognizing the interconnectedness of human, animal, and environmental health, and aims to strengthen governance, data submission, and interventions across sectors. [9, 10] However, effective implementation remains critical.

To truly combat AMR and protect our future, we must:

Strengthen Regulatory Frameworks: Enforce strict regulations on the sale and prescription of antibiotics, ensuring they are only available with a valid prescription and discouraging self-medication and quackery. [1, 5]

Implement Robust Antimicrobial Stewardship Programs (ASPs): Hospitals and primary care facilities must adopt and enforce guidelines for appropriate antibiotic prescribing, supported by diagnostic facilities to guide treatment decisions. [7, 8]

Improve Infection Prevention and Control (IPC): This includes promoting stringent hand hygiene, sterilization, and isolation practices in healthcare settings, alongside significant investment in clean water, sanitation, and waste management infrastructure in communities. [1, 4, 8]

Enhance Surveillance and Research: Continuous monitoring of resistance patterns and antibiotic consumption is crucial to inform policy and guide effective interventions. [1, 7]

Public Awareness and Education: Launch targeted campaigns to educate the public about the dangers of antibiotic misuse, the importance of completing prescribed courses, and the distinction between bacterial and viral infections. [5, 8]

Promote the "One Health" Approach: Foster collaboration between human health, animal health, and environmental sectors to control antibiotic use across all domains and prevent the spread of resistance. [9, 10]

The battle against AMR, and especially against formidable superbugs like XDR typhoid, is a race against time. Our collective health and future prosperity depend on immediate, coordinated, and sustained action.

Sincerely,

Dr. Shafiq Ur Rehman Napar

Senior Scientific Officer, CDC-NIH

References:

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Knowledge Hub

Syphilis: What You Need to Know

Syphilis is a sexually transmitted infection (STI) caused by a bacterium called *Treponema pallidum*. It can cause serious health problems if not treated. Syphilis develops in stages, and symptoms vary with each stage.

What is Syphilis?

Syphilis is a bacterial infection that is typically spread through sexual contact. If left untreated, syphilis can lead to severe and potentially life-threatening health complications, affecting the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints.

How Syphilis Spreads

Syphilis is spread through direct contact with a syphilis sore (called a chancre) during vaginal, anal, or oral sex. Sores are typically firm, round, and painless. They can be found on or around the penis, vagina, anus, rectum, lips, or mouth.

Syphilis can also be spread from a pregnant person to their baby during pregnancy or childbirth, which is known as **congenital syphilis**.

Syphilis **cannot** be spread by casual contact with objects like toilet seats, doorknobs, swimming pools, hot tubs, bathtubs, or shared clothing or eating utensils.

Stages of Syphilis

Syphilis progresses through distinct stages, each with different signs and symptoms.

1. Primary Syphilis

Symptoms: Usually characterized by the appearance of a single, small, firm, round, and **painless** sore called a **chancre**.

The chancre appears at the site where the bacteria entered the body (e.g., genitals, anus, rectum, lips, mouth).

It typically appears 3 to 4 weeks after infection but can range from 10 to 90 days.

Duration: The chancre usually lasts 3 to 6 weeks and heals on its own, regardless of whether a person is treated.

Note: Even though the chancre heals, the infection is still present and will progress to the next stage if not treated.

2. Secondary Syphilis

Symptoms: This stage typically begins as the primary chancre is healing or several weeks after it has healed. Symptoms can include:

Skin rash: Non-itchy, reddish-brown, often rough or sometimes faint rashes that can appear anywhere on the body, including the palms of the hands and soles of the feet.

Sores in the mouth, anus, or vagina (mucous patches).

Fever.

Swollen lymph glands.

Sore throat.

Patchy hair loss.

Headaches.

Weight loss.

Muscle aches.

Duration: These symptoms may come and go over time.

Note: Like the chancre, these symptoms will also resolve on their own without treatment, but the infection remains.

3. Latent Syphilis

Symptoms: This stage begins when the primary and secondary symptoms disappear. There are no visible signs or symptoms during this stage.

Duration: The latent stage can last for years.

Classification: It is divided into "early latent" (within 12 months of infection) and "late latent" (more than 12 months after infection).

Note: The infection remains in the body and can still progress to the tertiary stage if left untreated.

4. Tertiary (Late) Syphilis

Symptoms: This is the most serious stage and can occur 10-30 years after the initial infection if not treated. It can lead to severe damage to:

The brain and nervous system (neurosyphilis), causing stroke, meningitis, hearing loss, vision problems (including blindness), dementia, or loss of coordination.

The heart and blood vessels (cardiovascular syphilis), potentially leading to aneurysms or heart valve problems.

Bones, joints, or other organs.

Note: Tertiary syphilis can be disabling and life-threatening.

Congenital Syphilis

Congenital syphilis occurs when a pregnant person with syphilis passes the infection to their baby during pregnancy or childbirth. This can lead to:

Miscarriage.

Stillbirth.

Prematurity.

Low birth weight.

Severe health problems in the baby, including bone deformities, severe anemia, liver and spleen enlargement, jaundice, nerve problems (like blindness or deafness), or brain damage.

Some babies may not have symptoms at birth but develop them later if not treated.

All pregnant individuals should be tested for syphilis early in their pregnancy and again in the third trimester and at delivery if at high risk.

Complications if Untreated

If left untreated, syphilis can cause:

Severe damage to major organs, including the brain, heart, blood vessels, and nervous system.

Blindness.

Deafness.

Paralysis.

Dementia.

Death.

Increased risk of acquiring or transmitting HIV.

Prevention

Abstinence: Not having vaginal, anal, or oral sex.

Condoms: Use latex condoms correctly every time you have sex. Condoms can prevent the spread of syphilis by covering sores, but they only work if the condom covers the sore.

Limit partners: Having fewer sexual partners reduces your risk.

Get tested: Regular STI testing, especially if you are sexually active or have new partners.

Talk to partners: Discuss STI status with new partners before engaging in sexual activity.

Avoid sharing needles.

Diagnosis

Syphilis is diagnosed with a **blood test**. Sometimes, fluid from a chancre can also be tested.

Treatment

Syphilis is curable with the right antibiotics.

Early syphilis (primary, secondary, or early latent) is treated with a single dose of penicillin G administered by injection.

Late syphilis requires multiple doses of penicillin G.

Neurosyphilis requires intravenous (IV) penicillin.

It is crucial to complete the entire course of medication prescribed by your healthcare provider. Treatment will cure the infection, but it cannot repair any damage already done by the disease.

After treatment, follow-up blood tests are often needed to ensure the infection is gone.

Partner Notification

If you are diagnosed with syphilis, it is important to notify your sexual partners so they can also get tested and treated. This prevents reinfection and further spread. Health departments often provide confidential partner notification services.

More Information

For additional authoritative information on syphilis, please visit:

Centers for Disease Control and Prevention (CDC):

https://www.cdc.gov/std/syphilis/default.htm

World Health Organization (WHO):

https://www.who.int/news-room/fact-sheets/detail/syphilis

Public Health Agency of Canada (PHAC):

https://www.canada.ca/en/public-health/services/diseases/syphilis.html

UK Health Security Agency (UKHSA) / National Health Service (NHS):

https://www.nhs.uk/conditions/syphilis/

UK Health Security Agency (UKHSA) / National Health Service (NHS):

https://www.nhs.uk/conditions/mumps/

LET'S TALK ABOUT SYPHILIS

Tips for health professionals on the screening and management of syphilis in Canada

Health professionals play a pivotal role in the prevention and control of syphilis

WHAT YOU CAN DO AS A HEALTH PROFESSIONAL

TALK — Normalize sexual health discussions

Sexual health and STBBI* prevention are an integral part of everyone's health care. Provide culturally aware and trauma-informed care when counselling people about syphilis.

SCREEN — Prevent transmission and complications

Adults and adolescents	High prevalence groups**	In pregnancy
• Screen all sexually active persons with a new or multiple partners, and/or upon request of the individual. • Screen those with multiple partners every 3 to 6 months.	• Consider targeted "opt-out" screening as frequently as every 3 months. • Consult the NAC-STBBI syphilis screening recommendations for more information.	• Screen in the first trimester or at the first prenatal visit. • Re-screen at 28 to 32 weeks and during labour in areas with outbreaks and for people at ongoing risk for infection.

*STBBI: Sexually transmitted and blood-borne infections

**** Population groups and/or communities experiencing high prevalence of syphilis include:** Gay, bisexual and other men who have sex with men; people living with HIV; people who are or have been incarcerated; people who use substances or addiction services; and some Indigenous communities. When determining which groups/communities to prioritize, consider local epidemiology. For specific individuals, consider travel history and patient risk factors.

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	https://phb.nih.org.pk/		https://twitter.com/NIH_Pakistan
	idsr-pak@nih.org.pk		https://www.facebook.com/NIH.PK/

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CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION