

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 33, 2026

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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 Pakistan's Frontline Public Health Workforce: 26th Frontline FETP Cohort Completes Final Contact Session in Karachi**
- **Knowledge Hub – AFP surveillance: Foundation of Polio Eradication**

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.

Subscribe to the Weekly Bulletin today!

Stay informed. Stay prepared. Stay healthy.

Sincerely,

Note: All reported cases in this report are suspected cases

- During Week 33, the most frequently reported cases were of Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, TB, ALRI <5 years, B. Diarrhea, Animal/Dog Bite, VH (B, C & D), Typhoid, SARI, AVH (A & E) and CL.
- Eighteen cases of AFP were reported from KP, thirteen from Sindh, one from Balochistan and one from GB.
- Ten suspected cases of HIV/ AIDS reported from Sindh and seven from KP.
- One suspected case of brucellosis was reported from KP and one from Balochistan.
- Among VPDs, there is an increase in the number of cases of Mumps, Meningitis, Pertussis, NT & Rubella this week.
- Among Respiratory diseases, there is an increase in the number of cases of ILI, TB & ALRI<5 years this week.
- Among Water/food-borne diseases, there is an increase in the number of cases of B.Diarrhea this week.
- Among Vector-borne diseases, there is an increase in the number of cases of Malaria this week.
- Among STDs, there is an increase in the number of cases of HIV/AIDs this week.
- Among Zoonotic/Other diseases, there is a decrease in the number of cases of Animal / Dog Bite and VH (B, C & D) 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 75%
- Sindh is the top reporting region with a compliance rate of 98%, followed by GB 89%, KP 79% and ICT 75%.
- The lowest compliance rate was observed in Balochistan, 52% and AJK 0%.

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2,277	1,809	79
Azad Jammu Kashmir	476	0	0
Islamabad Capital Territory	36	27	75
Balochistan	1,305	673	52
Gilgit Baltistan	405	360	89
Sindh	2,115	2,068	98
National	6,614	4,937	75

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

Acute Flaccid Paralysis (AFP)

Strengthen surveillance: Ensure active detection and immediate reporting of all AFP cases, particularly among children under 15 years.

Promptly investigate cases: Document clinical presentation, date of paralysis onset, vaccination status, travel history, and relevant epidemiological information.

Ensure adequate specimen collection: Collect two stool specimens 24–48 hours apart, preferably within 14 days of paralysis onset, with appropriate storage and reverse cold-chain transportation.

Monitor surveillance quality: Regularly review non-polio AFP rates, stool adequacy, investigation timeliness, and geographical surveillance gaps.

Strengthen immunization: Identify areas with low vaccination coverage and ensure eligible children receive polio vaccination according to national guidelines.

Maintain rapid response: Ensure prompt epidemiological assessment and coordinated response to any poliovirus detection.

Chickenpox (Varicella)

Strengthen surveillance: Promptly identify and investigate unusual increases, clusters, or outbreaks, particularly in schools and other congregate settings.

Limit transmission: Keep cases away from school, work, and group settings until all lesions have crusted and reinforce appropriate infection prevention measures.

Protect high-risk groups: Promptly assess exposed pregnant women, newborns, immunocompromised persons, and others at increased risk of severe disease.

Investigate outbreaks: Conduct active case finding, maintain line lists, identify epidemiological links, and monitor transmission.

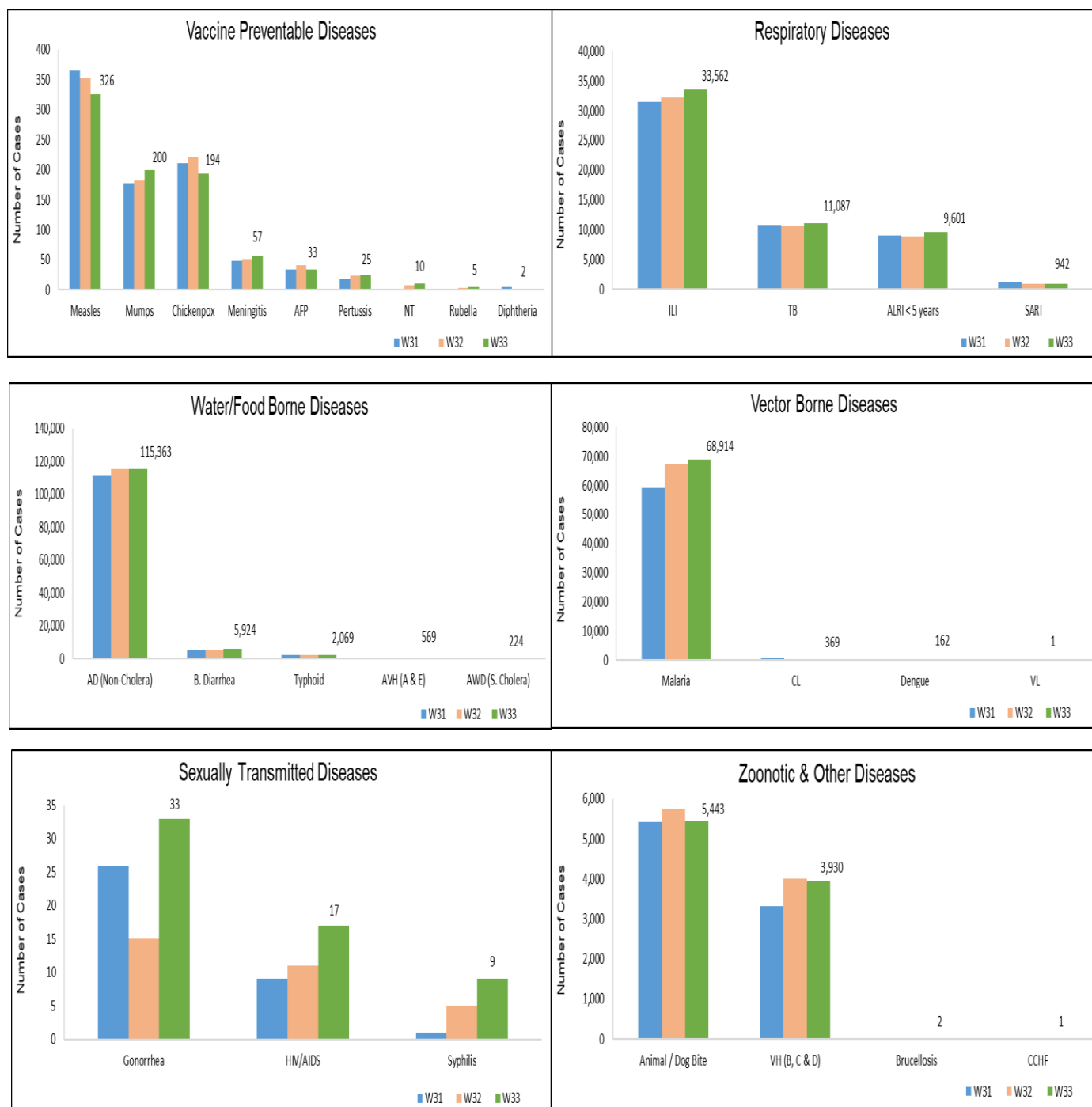
Promote awareness: Educate communities on symptoms, transmission, hand and respiratory hygiene, and when to seek medical care.

Monitor complications: Refer patients with severe fever, breathing difficulty, neurological symptoms, dehydration, or secondary bacterial infection for appropriate clinical management.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 33, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	NR	6,533	2,018	552	48,762	NR	57,498	115,363
Malaria	NR	1,800	0	0	6,548	NR	60,566	68,914
ILI	NR	5,354	199	1,367	3,166	NR	23,476	33,562
TB	NR	8	136	7	264	NR	10,672	11,087
ALRI < 5 years	NR	1,105	484	0	545	NR	7,467	9,601
B. Diarrhea	NR	941	112	7	1,256	NR	3,608	5,924
Animal / Dog Bite	NR	96	11	2	1,484	NR	3,850	5,443
VH (B, C & D)	NR	77	60	120	160	NR	3,513	3,930
Typhoid	NR	326	59	3	731	NR	950	2,069
SARI	NR	319	79	0	399	NR	145	942
AVH (A & E)	NR	2	0	0	292	NR	275	569
CL	NR	14	0	0	339	NR	16	369
Measles	NR	25	7	0	242	NR	52	326
AWD (S. Cholera)	NR	195	12	0	11	NR	6	224
Mumps	NR	39	6	1	117	NR	37	200
Chickenpox/ Varicella	NR	5	2	1	177	NR	9	194
Dengue	NR	2	0	0	88	NR	72	162
Meningitis	NR	0	3	0	12	NR	42	57
AFP	NR	1	1	0	18	NR	13	33
Gonorrhea	NR	20	0	0	4	NR	9	33
Pertussis	NR	12	0	0	10	NR	3	25
HIV/AIDS	NR	0	0	0	7	NR	10	17
NT	NR	1	0	0	7	NR	2	10
Syphilis	NR	0	0	0	0	NR	9	9
Rubella (CRS)	NR	5	0	0	0	NR	0	5
Brucellosis	NR	1	0	0	1	NR	0	2
Diphtheria (Probable)	NR	1	0	0	1	NR	0	2
CCHF	NR	1	0	0	0	NR	0	1
VL	NR	1	0	0	0	NR	0	1

Figure 1: Most frequently reported suspected cases during Week 33, 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 are mostly from Badin, Khairpur and Mirpurkhas whereas ILI cases are from Khairpur, Mirpurkhas and Sukkur.
- Ten cases of AFP reported from Sindh. They are suspected cases and need field verification.
- There is a decline in number of cases of Mumps, Chickenpox, ILI, SARI, Dog Bite and VH (B, C & D), while an increase in the number of cases of Measles, Meningitis, AFP, Pertussis, NT, TB, ALRI <5 years, AD (non- cholera), malaria and HIV/AIDs this week.

Table 2: District wise distribution of most frequently reported suspected cases during Week 33, 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	5,119	6,339	2,213	836	462	161	415	240	82	3
Dadu	2,615	4,309	497	500	1,267	259	331	126	156	98
Ghotki	3,884	1,875	0	557	644	315	110	491	0	0
Hyderabad	1,214	2,697	1,419	330	148	75	98	83	1	4
Jacobabad	1,331	837	481	234	212	217	114	45	28	0
Jamshoro	2,459	2,465	37	613	258	130	107	198	59	13
Kamber	2,191	2,207	0	733	218	200	140	29	14	0
Karachi Central	7	1,713	1,034	12	2	91	2	15	98	5
Karachi East	106	349	15	20	23	15	9	23	6	0
Karachi Keamari	18	552	411	9	14	18	7	0	4	3
Karachi Korangi	55	325	3	22	1	18	2	1	5	2
Karachi Malir	81	1,047	1,645	78	124	28	15	4	8	5
Karachi South	17	111	17	0	0	0	0	0	0	0
Karachi West	253	794	1,233	81	192	85	20	15	20	0
Kashmore	1,513	479	339	84	81	140	64	8	4	0
Khairpur	4,121	3,168	4,122	879	620	327	317	283	180	14
Larkana	3,368	2,156	102	783	291	80	345	25	3	0
Matari	2,913	1,784	21	573	165	133	79	90	0	13
Mirpurkhas	4,118	3,411	2,535	665	266	175	135	35	12	19
Naushero Feroze	1,880	1,778	1,217	291	306	293	112	45	84	11
Sanghar	3,059	1,797	59	871	270	208	54	631	9	2
Shaheed Benazirabad	2,726	1,746	5	278	141	194	98	199	97	0
Shikarpur	1,769	1,400	2	191	146	226	205	219	3	0
Sujawal	1,341	2,312	0	97	146	85	38	102	6	0
Sukkur	1,633	1,508	2,360	283	154	131	185	170	12	0
Tando Allahyar	2,807	2,028	693	348	140	90	83	78	5	0
Tando Muhammad Khan	1,618	1,377	0	447	118	61	135	130	2	0
Tharparkar	2,050	2,849	1,081	499	560	1	176	25	10	17
Thatta	2,308	1,958	1,935	54	222	94	108	162	16	66
Umerkot	3,992	2,127	0	304	276	0	104	41	26	0
Total	60,566	57,498	23,476	10,672	7,467	3,850	3,608	3,513	950	275

Figure 2: Most frequently reported suspected cases during Week 33, Sindh.

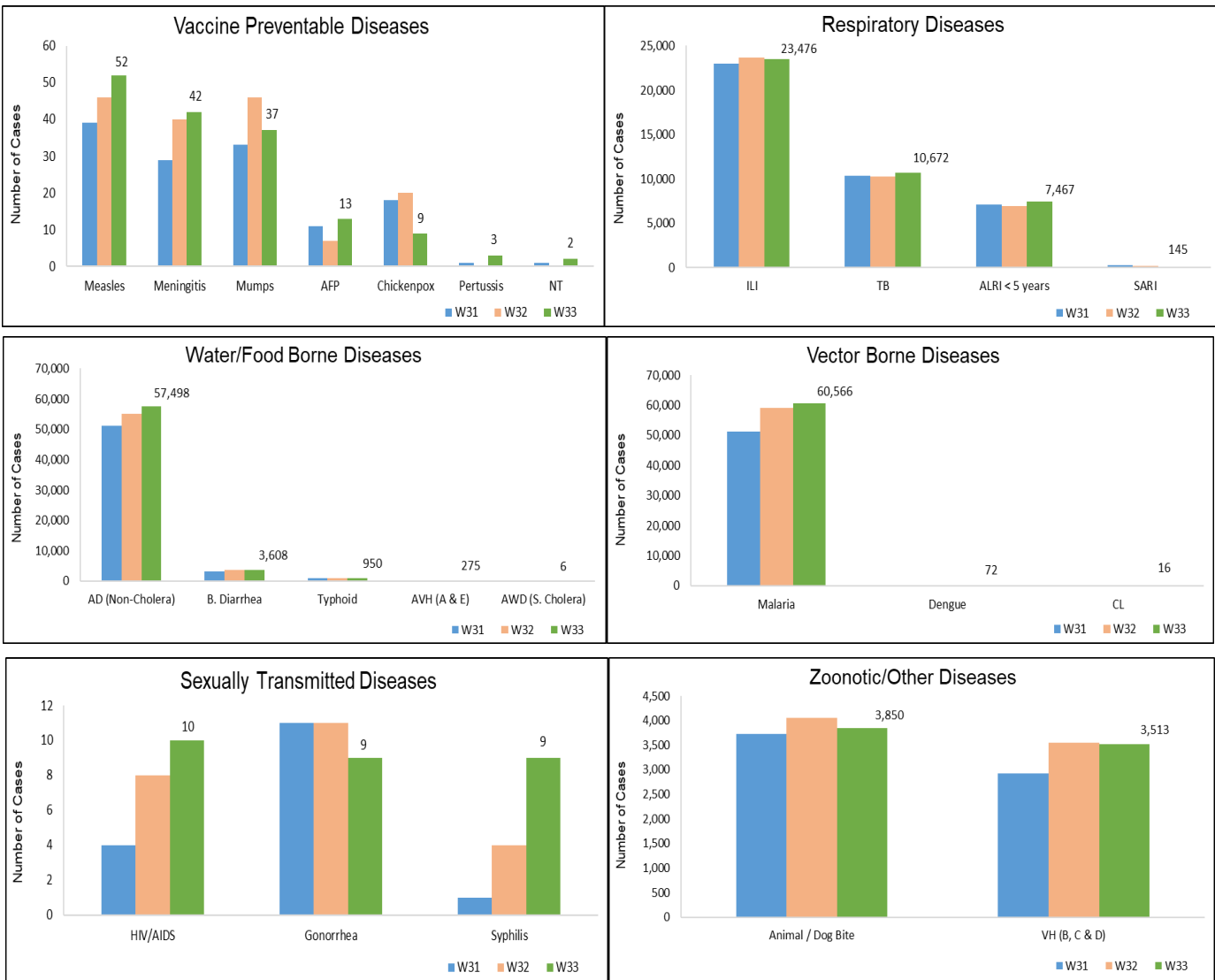
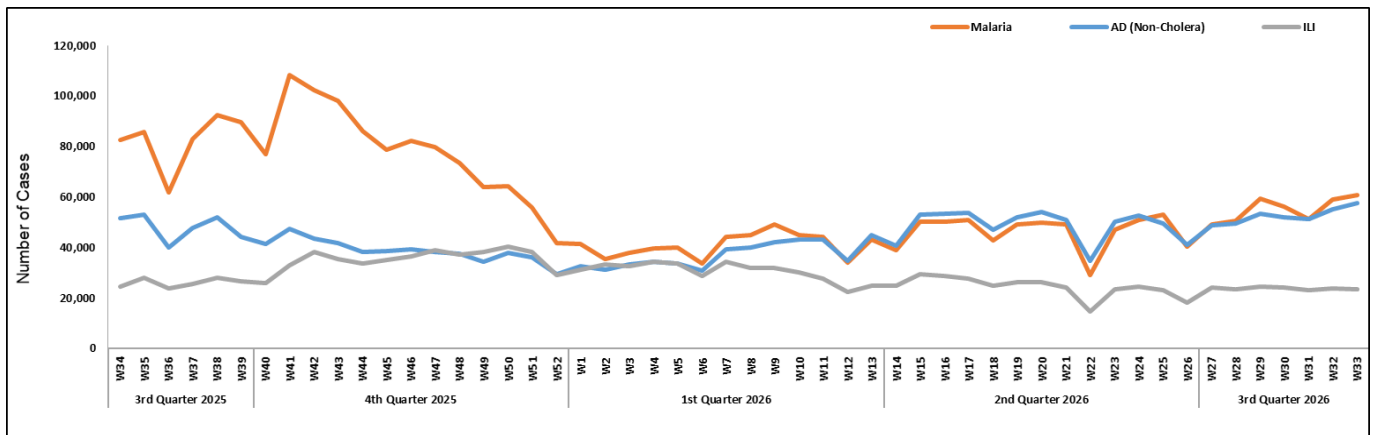


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh.



- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, Typhoid, SARI, AWD (S. Cholera), Animal / Dog Bite and VH (B, C&D) cases were the most frequently reported diseases from Balochistan province.
- ILI cases are mostly reported from Gwadar, Quetta and Kech (Turbat) while AD (Non-Cholera) cases are mostly reported from Usta Mohammad, Gwadar, and Quetta.
- Mumps, Measles, Pertussis, Rubella, NT, Diphtheria, ILI, ALRI <5 years, SARI, AD (Non-Cholera), B.Diarrhea, Typhoid, AWD (S Cholera), Malaria, CCHF and Dog bite cases showed an increase in the number of cases.
- A decline has been observed in Chickenpox, CL, brucellosis, and VH (B, C & D).

Table 3: District wise distribution of most frequently reported suspected cases during Week 33, Balochistan.

Districts	AD (Non-Cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	Typhoid	SARI	AWD (S. Cholera)	Animal / Dog Bite	VH (B, C & D)
Awaran	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Barkhan	109	47	107	32	13	51	11	0	11	0
Chagai	196	321	47	0	63	6	0	0	0	3
Chaman	49	267	16	0	37	46	2	16	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	586	869	40	NR	NR	NR	NR	NR	NR	NR
Harnai	144	0	52	62	36	0	0	0	1	0
Hub	117	37	21	13	1	1	2	0	0	0
Jaffarabad	145	0	97	0	20	0	0	0	5	0
Jhal Magsi	0	0	0	0	0	0	0	0	0	0
Kachhi (Bolan)	167	187	72	10	5	NR	16	11	9	NR
Kalat	11	0	6	0	5	5	0	0	0	0
Kech (Turbat)	351	721	281	19	46	NR	NR	NR	3	NR
Kharan	208	549	9	4	85	8	21	0	0	0
Khuzdar	66	26	27	14	14	16	7	0	0	0
Killa Abdullah	260	167	11	5	51	11	57	22	3	4
Killa Saifullah	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kohlu	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lasbella	487	83	166	232	32	7	0	0	7	20
Loralai	434	420	73	34	78	33	37	3	3	0
Mastung	367	205	66	67	34	14	23	0	11	10
MusaKhel	121	9	172	10	24	17	0	4	1	0
Naseerabad	311	0	142	25	17	64	20	31	29	4
Nushki	138	0	2	0	44	0	2	8	0	0
Panjgur	89	24	72	32	2	0	0	2	0	0
Pishin	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Quetta	495	807	17	130	38	10	39	39	0	0
Sherani	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sibi	280	143	132	52	16	12	22	6	1	0
Sohbat pur	227	5	24	140	74	10	0	17	0	0
Surab	10	34	0	0	0	0	0	0	0	0
Usta Muhammad	804	95	65	165	93	6	0	0	7	36
Washuk	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Zhob	56	49	23	23	5	NR	55	16	NR	NR
Ziarat	305	289	60	36	78	9	5	20	5	0
Total	6,533	5,354	1,800	1,105	941	326	319	195	96	77

Figure 4: Most frequently reported suspected cases during Week 33, Balochistan.

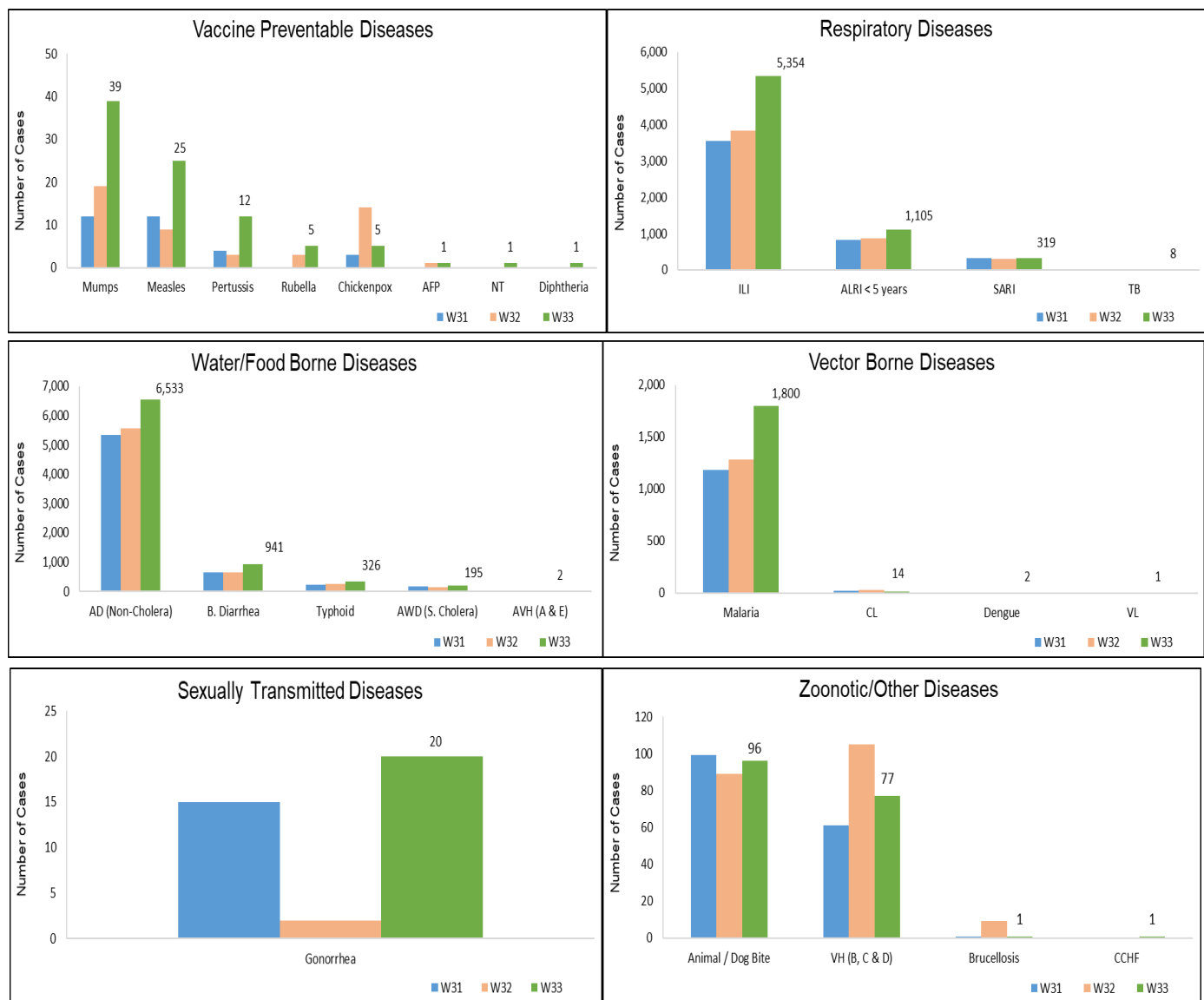
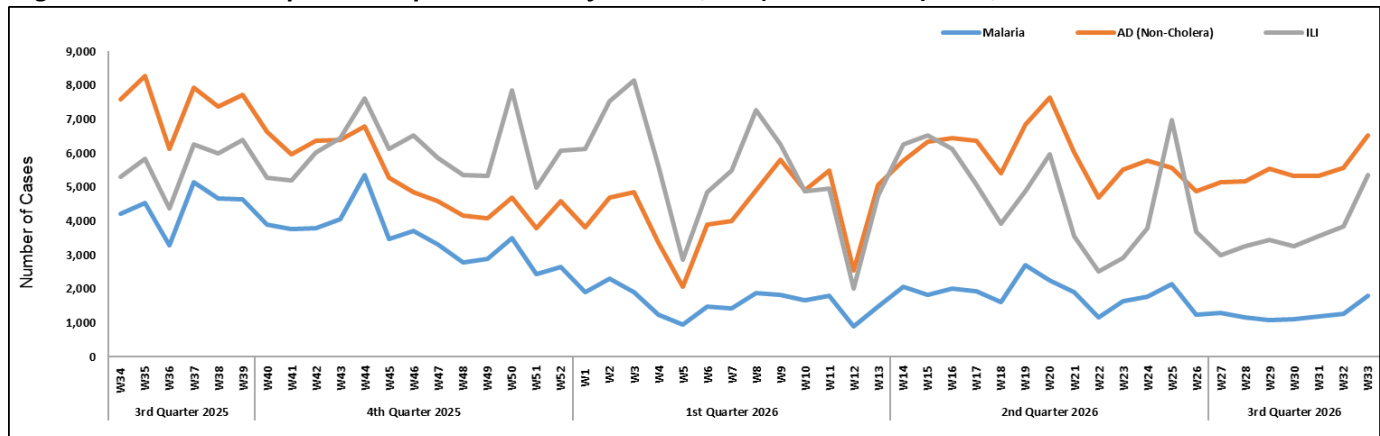


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan.



- Cases of AD (Non-Cholera) were maximum followed by Malaria, ILI, Animal / Dog Bite, B. Diarrhea, Typhoid, ALRI<5 Years, SARI, CL and AVH (A & E).
- Mumps, Meningitis, ALRI < 5years, SARI, Typhoid, AVH (A & E), Dengue, and HIV/AIDs cases showed an increase in number while Measles, Chickenpox, AFP, Pertussis, ILI, TB, AD (Non-Cholera), Malaria, Dog Bite and VH (B, C & D) showed a decline in number this week.
- Eighteen cases of AFP were reported from KP. All are suspected cases and need field verification.
- Seven cases of HIV/AIDs 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 33, KP.

Districts	AD (Non-Cholera)	Malaria	ILI	Animal / Dog Bite	B. Diarrhea	Typhoid	ALRI < 5 years	SARI	CL	AVH (A & E)
Abbottabad	2,355	4	242	54	18	8	49	15	0	0
Bajaur	869	293	0	96	55	0	13	5	27	14
Bannu	892	765	3	1	11	54	2	0	4	0
Battagram	756	76	502	3	0	3	2	0	0	0
Buner	524	123	0	19	0	0	0	0	0	0
Charsadda	2,649	347	360	20	74	82	115	1	0	55
Chitral Lower	885	18	3	8	36	8	5	7	6	1
Chitral Upper	279	8	14	3	6	9	6	6	1	2
D.I. Khan	1,815	639	0	35	31	4	21	0	2	1
Dir Lower	2,492	119	0	56	88	44	5	0	10	10
Dir Upper	2,878	10	52	24	45	11	26	0	0	1
Hangu	299	101	0	0	8	5	0	0	5	0
Haripur	1,703	2	305	70	1	7	25	58	0	9
Karak	732	422	7	49	80	30	40	0	75	22
Khyber	874	569	23	55	167	22	25	10	77	8
Kohat	932	243	0	39	50	16	0	0	26	0
Kohistan Lower	276	1	0	0	2	0	0	0	0	0
Kohistan Upper	465	26	0	0	29	0	4	0	0	0
Kolai Palas	81	2	2	0	0	1	1	0	0	0
L & C Kurram	65	9	3	0	8	1	0	2	0	0
Lakki Marwat	666	326	0	86	3	17	0	0	0	0
Malakand	1,690	36	262	33	0	0	0	10	0	35
Mansehra	1,501	3	266	12	28	21	13	0	0	0
Mardan	2,058	329	25	107	80	55	28	0	0	4
Mohmand	98	177	135	12	1	4	0	83	40	1
North Waziristan	89	131	4	1	5	12	6	8	0	1
Nowshera	2,745	551	11	45	33	4	5	9	18	31
Orakzai	101	6	5	0	0	0	0	0	0	0
Peshawar	5,761	57	129	28	105	51	28	0	0	5
Shangla	2,828	560	0	174	13	76	4	0	0	3
South Waziristan (Lower)	230	184	135	27	83	52	3	89	45	13
SWU	2	8	0	0	0	0	0	0	0	0
Swabi	2,679	70	478	138	10	5	19	68	0	9
Swat	5,639	49	92	255	138	110	78	0	0	64
Tank	378	207	19	0	4	4	10	0	0	1
Tor Ghar	210	71	0	15	28	1	0	0	3	0
Upper Kurram	266	6	89	19	16	14	12	28	0	2
Total	48,762	6,548	3,166	1,484	1,256	731	545	399	339	292

Figure 6: Most frequently reported suspected cases during Week 33, KP.

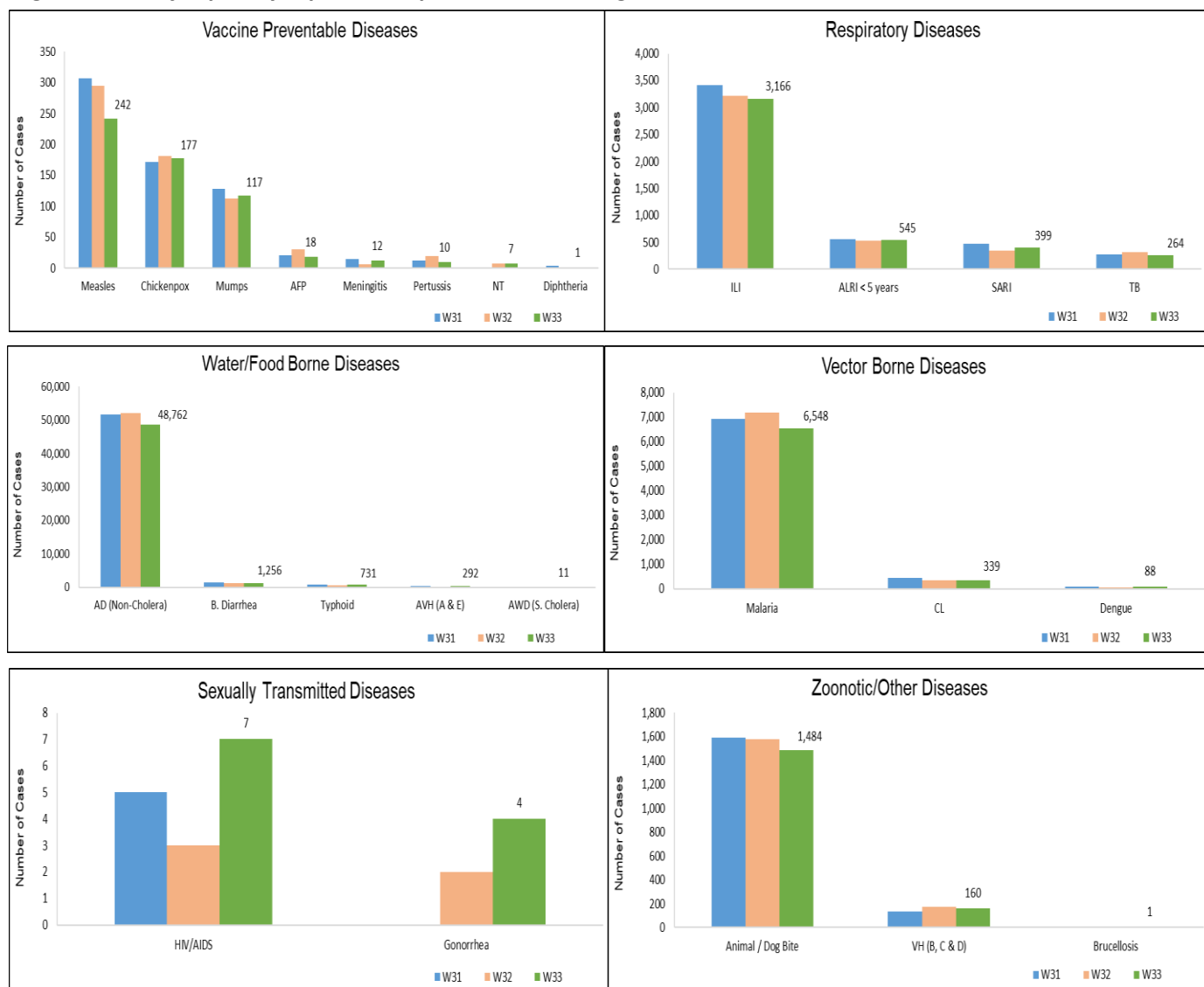
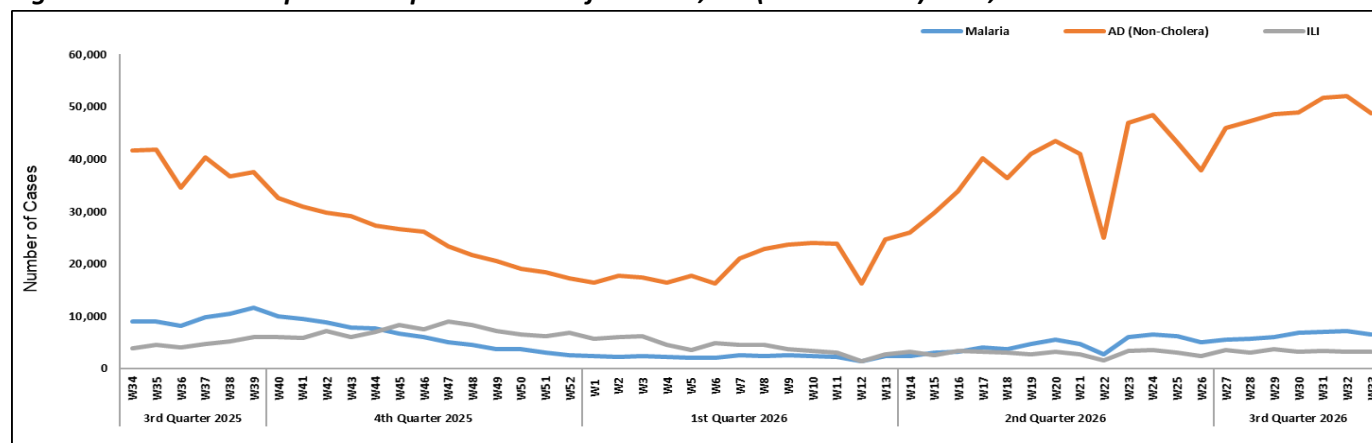


Figure 7: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, KP.



ICT: The most frequently reported cases from Islamabad were ILI followed by AD (Non-Cholera) and VH (B, C & D). AD (non- cholera) and VH(B, C & D) cases showed a decline while ILI cases showed an increase in number this week.

AJK: No reporting from AJK due to political issues.

GB: AD (non-cholera) cases were maximum, followed by ALRI <5 Years and ILI. An increase in cases is observed for AD (non-cholera), B. Diarrhea, TB, SARI, and VH (B, C & D). In contrast, a decline is observed in the number of cases of Typhoid, AWD (S. Cholera), and ILI this week.

NOTE: Due to the political conditions AJK data for Week 33 is not shared.

Figure 8: Most frequently reported suspected cases during Week 22, AJK.

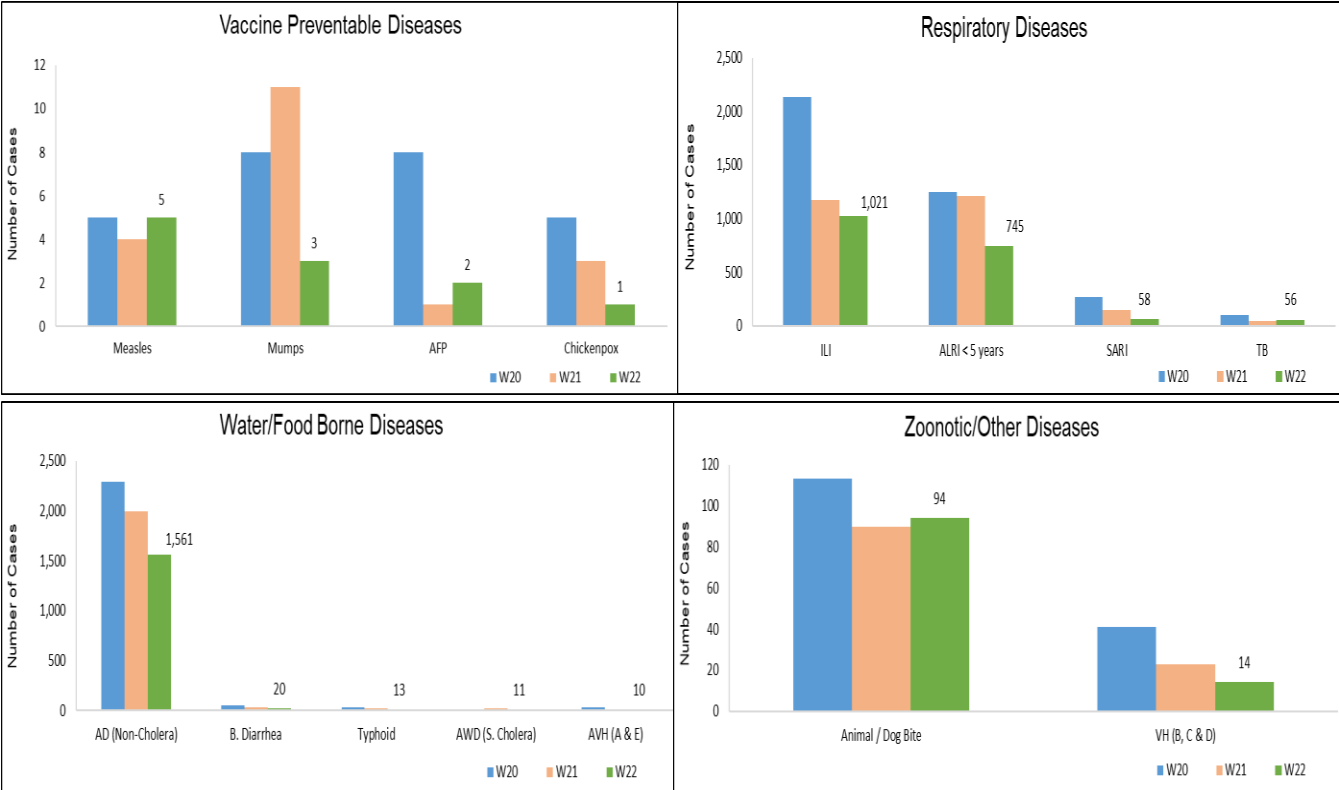


Figure 9: Week wise reported suspected cases of ILI and AD (Non-Cholera), AJK.

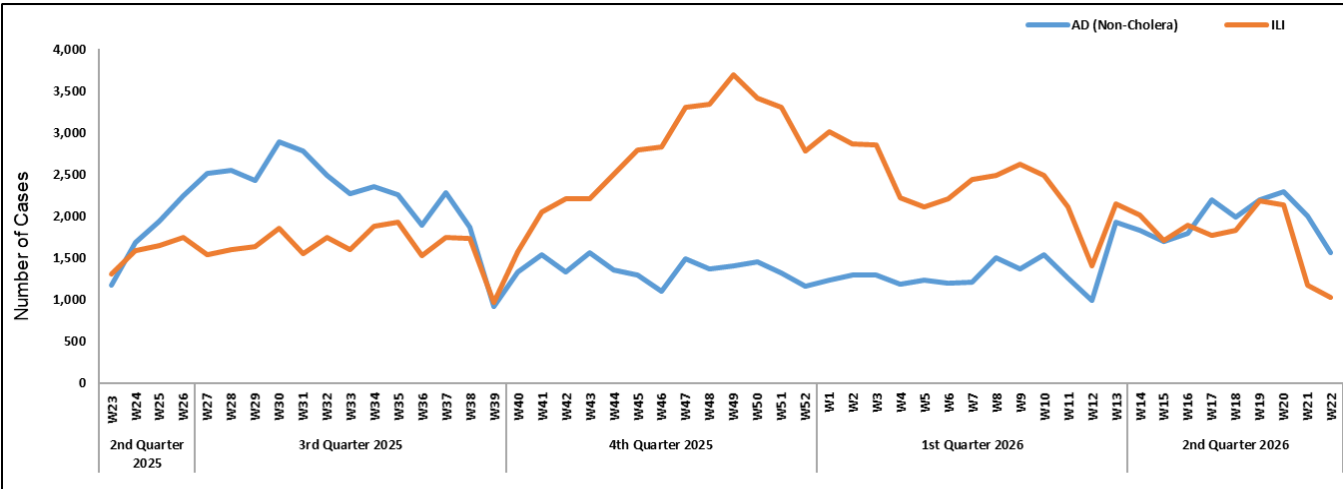


Figure 10: Most frequently reported suspected cases during Week 33, ICT.

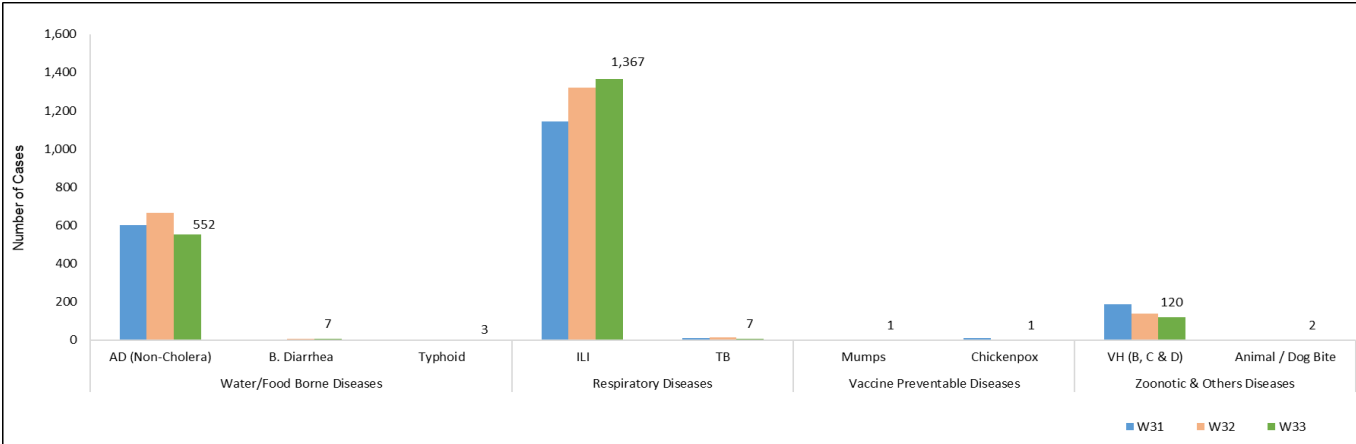


Figure 11: Week wise reported suspected cases of ILI, ICT.

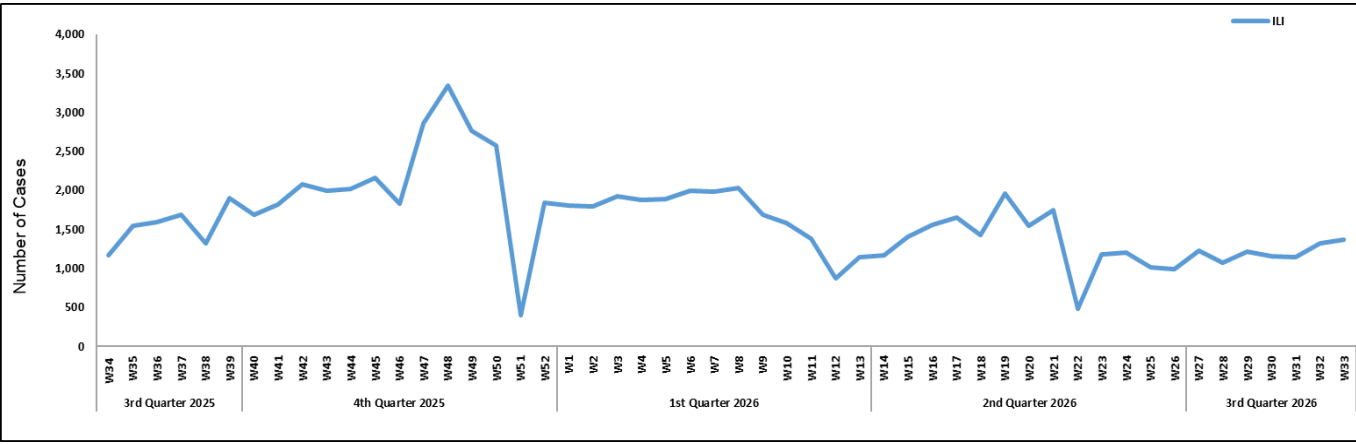


Figure 12: Most frequently reported suspected cases during Week 33, GB.

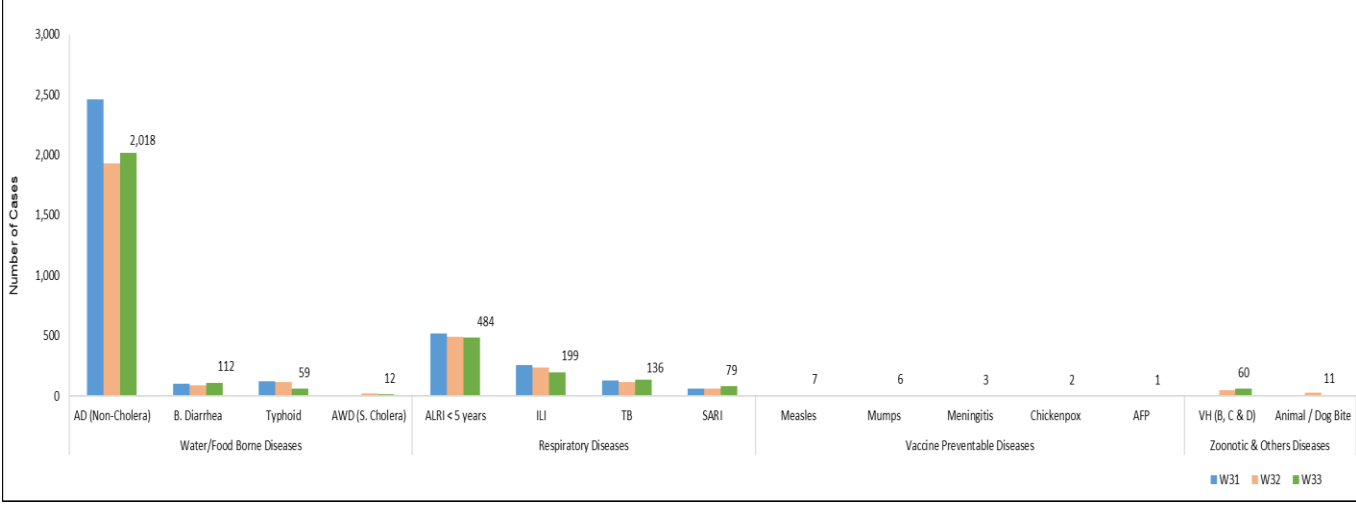
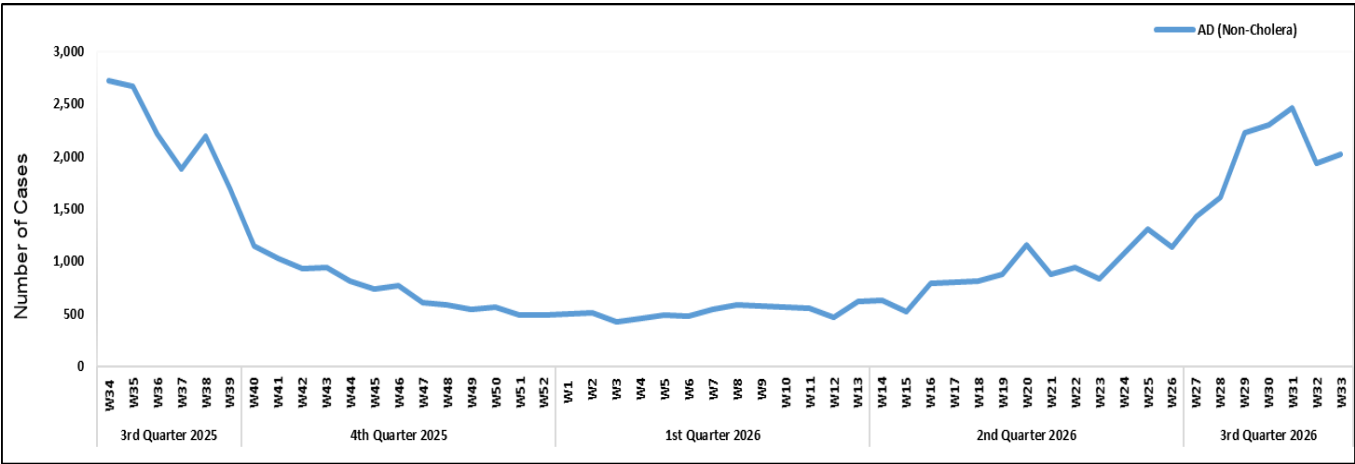


Figure 13: Week wise reported suspected cases of AD (Non-Cholera), GB.



Public Health Laboratories

Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 33, 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)	23	0	-	-	-	-	-	-	1	0	-	-	-	-
Stool culture & Sensitivity	182	0	-	-	-	-	-	-	-	-	-	-	-	-
Malaria	6,758	496	1,370	81	-	-	-	-	251	0	-	-	-	-
CCHF	-	-	34	2	-	-	-	-	-	-	-	-	-	-
Dengue	1,280	80	53	1	-	-	-	-	-	-	-	-	-	-
VH (B)	12,161	242	802	85	-	-	-	-	1,660	15	-	-	-	-
VH (C)	12,547	959	856	60	-	-	-	-	1,720	2	-	-	-	-
VH (D)	156	39	28	9	-	-	-	-	-	-	-	-	-	-
VH (A)	203	82	-	-	-	-	-	-	-	-	-	-	-	-
VH (E)	69	10	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	-	-	1	0	-	-	-	-	-	-	-	-	-	-
TB	629	56	97	15	-	-	-	-	66	1	-	-	-	-
HIV/ AIDS	5,332	36	612	1	-	-	-	-	303	1	-	-	-	-
Syphilis	1,235	19	322	0	-	-	-	-	228	0	-	-	-	-
Typhoid	134	16	48	5	-	-	-	-	246	7	-	-	-	-
Diphtheria	4	2	-	-	-	-	-	-	-	-	-	-	-	-
ILI	5	1	1	1	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)	134	22	-	-	-	-	-	-	-	-	-	-	-	-
Meningitis	19	2	-	-	-	-	-	-	-	-	-	-	-	-
Measles	57	33	21	6	179	110	9	6	6	3	142	26	2	2
Rubella (CRS)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Leishmaniasis (cutaneous)	7	0	3	3	-	-	-	-	2	0	-	-	-	-
Chikungunya	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chickenpox	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Gonorrhea	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Brucellosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mpox	3	2	-	-	-	-	-	-	-	-	-	-	-	-
Leishmaniasis (Visceral)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SARI	11	5	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	ILI	0	0	-	-	2	0	0	0	-	-	14	0	-
	SARI	3	0	-	-	25	0	8	0	-	-	58	1	-
Influenza A	ILI	0	0	-	-	2	0	0	0	-	-	14	0	-
	SARI	3	0	-	-	25	0	8	0	-	-	58	0	-
Influenza B	ILI	0	0	-	-	2	0	0	0	-	-	14	0	-
	SARI	3	0	-	-	25	0	8	0	-	-	58	0	-
RSV	ILI	0	0	-	-	2	0	0	0	-	-	14	0	-
	SARI	3	0	-	-	25	0	8	0	-	-	58	0	-

Integrated Respiratory Viruses Sentinel Surveillance, National Influenza Centre

The National Influenza Centre (NIC) comprises twelve Laboratory-Based sentinel surveillance sites strategically located at major tertiary care hospitals across Pakistan providing comprehensive geographical coverage. These sites collect samples from individuals with Influenza-Like Illness (ILI) and Severe Acute Respiratory Infections (SARI), which are then analyzed for high-impact Respiratory pathogens with epidemic and pandemic potential, including Influenza, SARS-CoV-2, and Respiratory Syncytial Virus.

Figure 14: District wise Influenza sentinel sites, Pakistan.

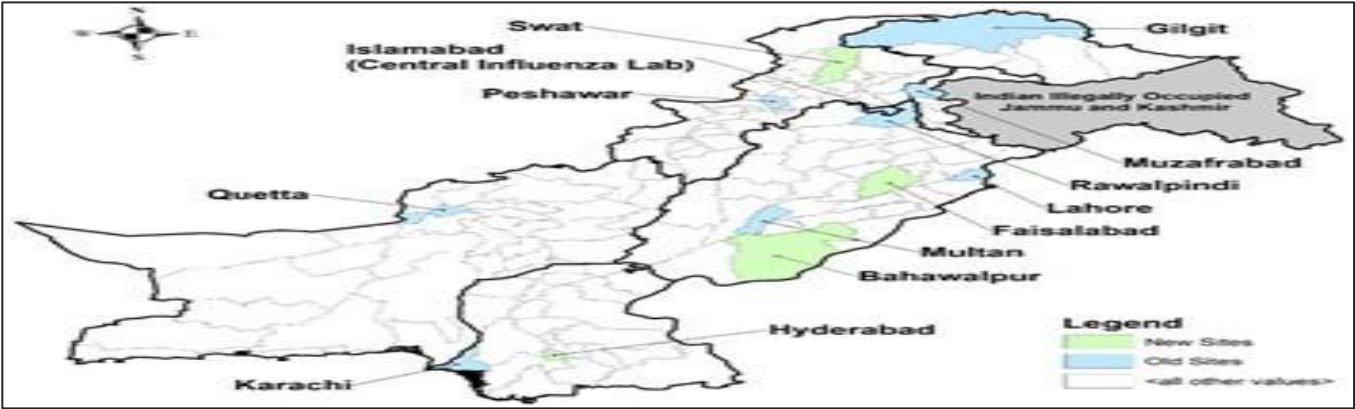


Figure 15: Distribution of suspected samples of ILI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 33, Pakistan.

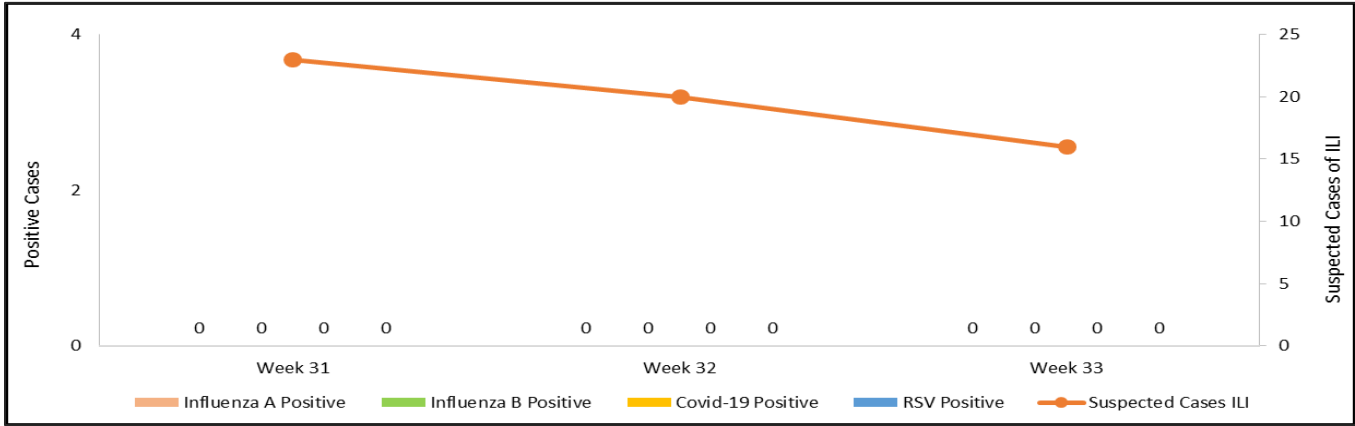
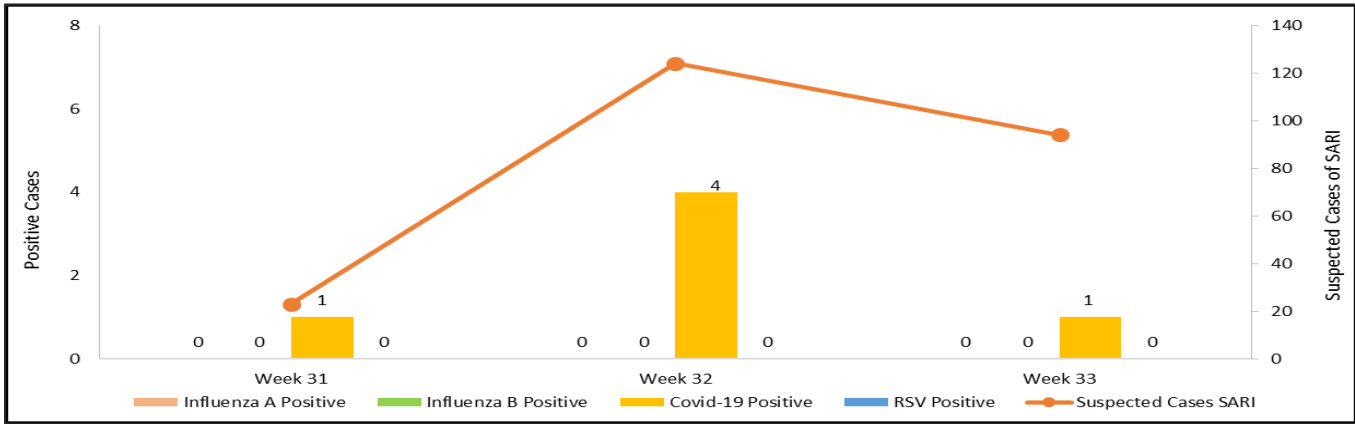


Figure 16: Distribution of suspected samples of SARI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 33, Pakistan.



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 33, 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	113	50%
	Battagram	59	44	75%
	Buner	34	34	100%
	Bajaur	43	43	100%
	Charsadda	61	61	100%
	Chitral Upper	31	31	100%
	Chitral Lower	37	35	95%
	D.I. Khan	115	115	100%
	Dir Lower	63	58	92%
	Dir Upper	56	50	89%
	Hangu	22	14	64%
	Haripur	72	72	100%
	Karak	36	36	100%
	Khyber	53	39	74%
	Kohat	61	61	100%
	Kohistan Lower	13	9	69%
	Kohistan Upper	22	14	64%
	Kolai Palas	10	8	80%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	34	13	38%
	Upper Kurram	38	37	97%
	Malakand	42	42	100%
	Mansehra	133	127	95%
	Mardan	82	74	90%
	Nowshera	57	57	100%
	North Waziristan	10	10	100%
	Peshawar	157	131	83%
	Shangla	37	36	97%
	Swabi	65	62	95%
	Swat	75	73	97%
	South Waziristan (Upper)	93	37	40%
	South Waziristan (Lower)	29	29	100%
	Tank	34	33	97%
	Torghar	13	13	100%
	Mohmand	68	20	29%
	Orakzai	69	5	7%
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 Velley	29	0	0%
	Sudhnooti	27	0	0%
Islamabad Capital Territory	ICT	24	22	92%
	CDA	12	5	42%
Balochistan	Gwadar	26	24	92%
	Kech	45	27	60%
	Khuzdar	74	9	12%
	Killa Abdullah	26	23	88%
	Lasbella	55	55	100%
	Pishin	65	0	0%
	Quetta	56	26	46%
	Sibi	36	30	83%
	Zhob	39	13	33%
	Jaffarabad	16	16	100%
	Naseerabad	32	32	100%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	0	0%
	Chagai	36	25	69%
	Kalat	41	40	98%
	Harnai	17	17	100%
	Kachhi (Bolan)	35	18	51%
	Jhal Magsi	28	14	50%
	Sohbat pur	25	25	100%
	Surab	32	6	19%
	Mastung	46	46	100%
	Loralai	33	28	85%
	Killa Saifullah	28	0	0%
	Ziarat	29	27	93%
	Duki	31	0	0%
	Nushki	29	26	90%
	Dera Bugti	45	0	0%
	Washuk	46	0	0%
	Panjgur	38	6	16%
	Awaran	23	0	0%
	Chaman	25	24	96%
	Barkhan	20	19	95%
	Hub	33	15	45%
	Musakhel	41	18	44%
	Usta Muhammad	34	34	100%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	20	20	100%
	Ghizer	38	38	100%
	Gilgit	44	42	95%
	Diamer	62	59	95%
	Astore	55	55	100%
	Shigar	23	8	35%

	Skardu	54	54	100%
	Ganche	29	27	93%
	Kharmang	25	25	100%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	64	100%
	Umerkot	65	65	100%
	Naushahro Feroze	102	99	97%
	Tharparkar	273	272	100%
	Shikarpur	59	59	100%
	Thatta	50	50	100%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	16	76%
	Karachi-West	20	20	100%
	Karachi-Malir	35	25	71%
	Karachi-Kemari	22	21	95%
	Karachi-Central	12	9	75%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	4	67%
	Sujawal	55	51	93%
	Mirpur Khas	106	106	100%
	Badin	123	123	100%
	Sukkur	63	63	100%
	Dadu	90	90	100%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	Khairpur	168	168	100%
	Kashmore	59	59	100%
	Matiali	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 33, 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	1	100%
	Abbottabad	1	1	100%
	Swat	1	1	100%

Strengthening Pakistan's Frontline Public Health Workforce: 26th Frontline FETP Cohort Completes Final Contact Session in Karachi



The National Institutes of Health (NIH), Pakistan, in collaboration with the World Health Organization (WHO) and the Sindh Health Department, successfully conducted the final contact session of the **26th Frontline Field Epidemiology Training Program (FETP) Cohort** in Karachi from **20–23 July 2026**. The session marked an important milestone in the professional development of **33 public health professionals**, bringing their three-session learning journey closer to completion and graduation.

The Frontline FETP is designed to strengthen the capacity of public health professionals working at the frontline of disease surveillance and response. Through a combination of classroom-based learning, practical exercises, mentorship, and field assignments, the program enables participants to apply epidemiological principles directly within their respective workplaces and communities. This field-based approach ensures that learning extends beyond the classroom and contributes to strengthening routine public health systems.

Throughout the training, participants enhanced their practical knowledge and competencies in **disease surveillance, data collection and analysis, outbreak investigation, applied epidemiology, risk communication, and public health response**. Emphasis was placed on the timely detection and reporting of public health events, systematic analysis and interpretation of surveillance data, and the use of epidemiological evidence to guide appropriate public health action.



A key feature of the cohort was the integration of a **One Health approach**, recognizing the interconnected nature of human, animal, and environmental health. Emerging and re-emerging infectious diseases increasingly require coordinated action across sectors and disciplines. By incorporating One Health principles into field epidemiology training, participants were encouraged to look beyond traditional boundaries and understand how multisectoral coordination can strengthen preparedness, early detection, investigation, and response to health threats.

The successful completion of the 26th Frontline FETP Cohort therefore represents another important step towards strengthening Pakistan's capacity for **health security, epidemic preparedness, and effective public health emergency response**. Equipped with practical epidemiological skills, field experience, and a growing network of colleagues, these professionals will continue to play an important role in protecting the health of communities across the country.

Knowledge Hub

Acute Flaccid Paralysis Surveillance: Foundation of Polio Eradication

Introduction

Acute Flaccid Paralysis (AFP) is a clinical syndrome characterized by the **rapid onset of weakness or paralysis with reduced muscle tone**, without an obvious traumatic cause. Although AFP may occur at any age, surveillance primarily focuses on **children under 15 years**, as AFP surveillance is one of the most important approaches for detecting poliovirus transmission.

AFP is not a diagnosis itself. Several neurological and infectious conditions can cause acute flaccid weakness, with **Guillain-Barré syndrome (GBS)** being one of the most common non-polio causes. Other differential diagnoses include transverse myelitis, traumatic neuritis, acute neuropathies, botulism, and other neuromuscular disorders.

Why is AFP Surveillance Important?

Only a small proportion of poliovirus infections result in paralytic disease. Therefore, surveillance limited to clinically suspected poliomyelitis would risk missing ongoing transmission. AFP surveillance instead uses a highly sensitive approach by identifying and investigating all eligible cases of acute flaccid paralysis.

Every AFP case is therefore an important surveillance event. Even when the final diagnosis is not polio, timely detection, investigation, and specimen collection help demonstrate that the surveillance system is sensitive enough to detect poliovirus circulation.

AFP Case Definition

For surveillance purposes, a suspected AFP case is defined as:

Any child under 15 years of age with acute onset of flaccid paralysis, or any person of any age in whom poliomyelitis is suspected.

Healthcare workers should report cases meeting this definition immediately rather than waiting for a definitive diagnosis or laboratory confirmation.

Investigation and Specimen Collection

Once an AFP case is identified, it should be **reported and investigated promptly**. The investigation includes clinical and epidemiological history, examination of the pattern and progression of paralysis, and assessment of vaccination history.

A critical component is the collection of **two stool specimens, 24–48 hours apart and preferably within 14 days of paralysis onset**. Specimens must be appropriately stored and transported under a maintained reverse cold chain to ensure their quality for laboratory testing.

Where required, a **60-day follow-up examination** is conducted to assess residual paralysis and support final case classification, particularly when adequate specimens were not obtained.

Common Differential Diagnoses

Most AFP cases identified through a sensitive surveillance system are caused by conditions other than poliomyelitis. **Guillain–Barré syndrome** commonly presents with progressive, relatively symmetrical weakness and reduced or absent reflexes. Other causes include transverse myelitis, traumatic neuritis, acute neuropathies, botulism, and other neuromuscular conditions.

Poliomyelitis may characteristically cause **asymmetrical flaccid weakness with reduced or absent reflexes and generally preserved sensation**. However, clinical presentation alone cannot reliably exclude poliovirus infection, making laboratory-supported surveillance essential.

Monitoring AFP Surveillance Quality

The effectiveness of AFP surveillance depends on its ability to detect and investigate cases consistently. Important performance measures include the **non-polio AFP rate** and the proportion of cases with **adequate stool specimens**. Timeliness of notification and investigation, specimen transportation, laboratory testing, and completion of required follow-up are also important measures of surveillance quality.

AFP surveillance is further strengthened by **environmental surveillance**, which detects poliovirus in sewage or wastewater and can provide evidence of community transmission

even when no paralytic cases have been identified.

Role of Healthcare Workers

Healthcare workers are central to maintaining sensitive AFP surveillance. Any child presenting with sudden weakness or paralysis should prompt consideration of AFP and immediate notification through the appropriate surveillance system.

The key principle is:

Detect early → Report immediately → Investigate promptly → Collect adequate specimens

Notification should not be delayed while waiting for specialist assessment, laboratory confirmation, or a final clinical diagnosis.

Conclusion

Continued vigilance among healthcare workers, high-quality specimen collection, laboratory testing, and integration with environmental surveillance are critical to ensuring that poliovirus circulation does not go undetected. **Every AFP case represents an opportunity to strengthen surveillance and protect communities from polio.**

More information:

For additional information on AFP, please visit:

1. **WHO – Acute Flaccid Paralysis (AFP) Surveillance Guidance**
[WHO AFP Surveillance Guidance](#)
2. **CDC – Acute Flaccid Myelitis / AFP Surveillance and Clinical Information**
[CDC Acute Flaccid Myelitis Information](#)
3. **UKHSA – Acute Flaccid Paralysis: Investigation and Reporting**
[UKHSA AFP Guidance](#)



LET'S FIGHT POLIO

We are one step away from eradicating polio in the world, vaccinate your child and **let's make history by ending this disease together!**

Children, from 2 months to 6 years of age, **should complete all doses of polio vaccine** as recommended by their health care provider

This will protect them from **serious illness and death**

And avoid **lifelong paralysis** due to the poliovirus

Talk to your healthcare provider for more information

PAHO   www.paho.org/polio

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