PUBLIC HEALTH BULLETIN-PAKISTAN

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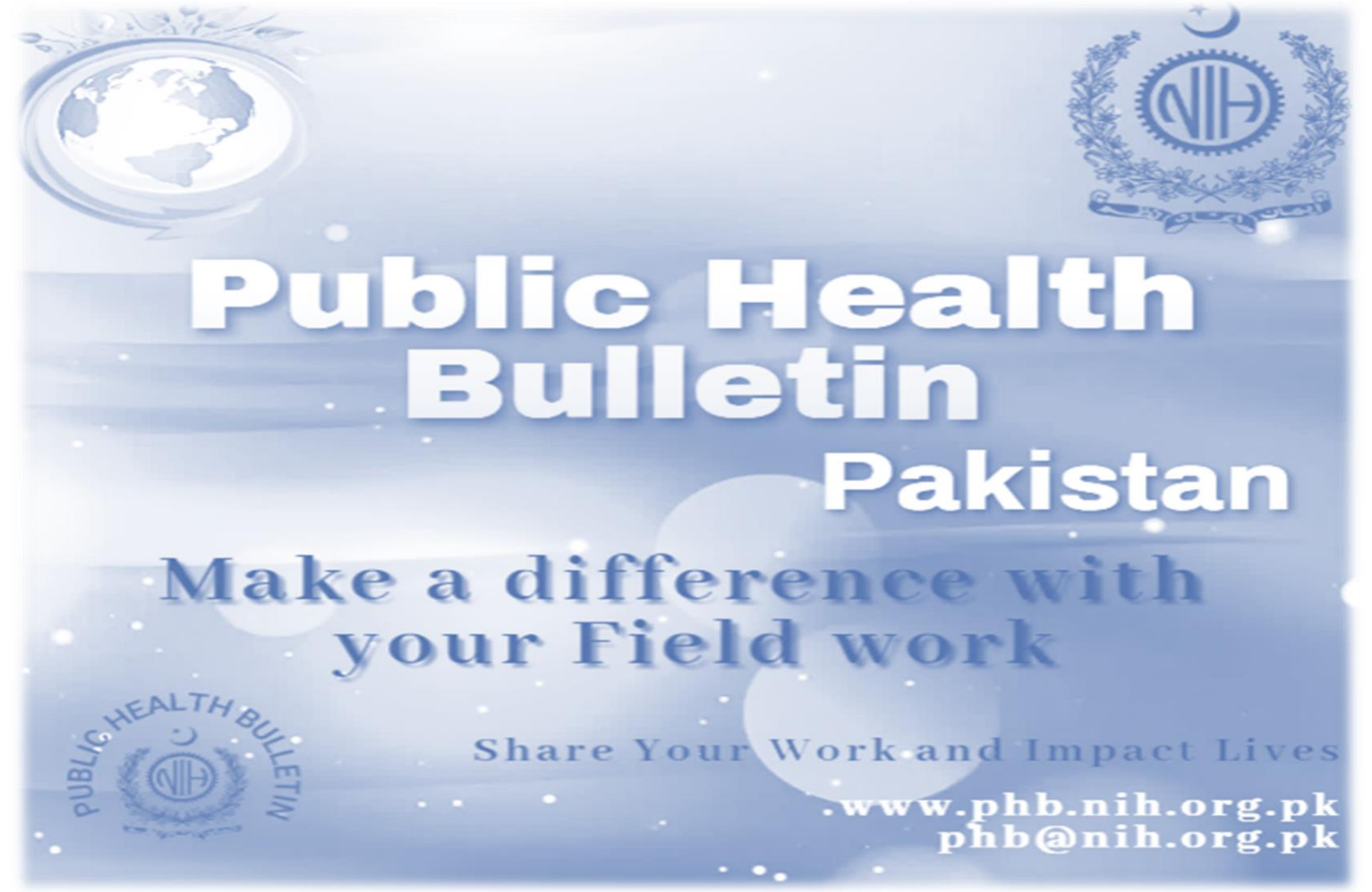
Integrated Disease Surveillance & Response (IDSR) Report

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.



Overview

IDSR Reports

Ongoing Events

Field Reports

Public Health Bulletin - Pakistan, Week 01, 2026

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 Week's Highlights include;

- *Strengthening Local Capacities for Timely Outbreak Detection & Response in KP – Khyber Pakhtunkhwa*
- *Case Report of Mpox – District Bara – Khyber Pakhtunkhwa*
- *Knowledge hub on Understanding of Hepatitis A & E: A Public Health Priority*

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

Overview

- *During Week 01, the most frequently reported cases were of Acute Diarrhea (Non-Cholera), followed by ILI, Malaria, ALRI <5 years, TB, Dog Bite, B. Diarrhea, VH (B, C & D), SARI, Typhoid, and Measles.*
- *Seventeen cases of AFP were reported from KP, seven from Sindh, and one from Balochistan.*
- *Thirteen suspected cases of HIV/ AIDS were reported from Sindh, and five from KP. *The number of HIV/AIDS cases in Balochistan in Week 1 is zero. This has been verified by the province after completion of the data analysis and will be rectified in next week's data.*
- *Five suspected cases of Brucellosis were reported from Balochistan and three from KP.*
- *Among VPDs, there is an increase in the number of cases of Measles, Pertussis, Meningitis, and AFP this week.*
- *Among Respiratory diseases, there is an increase in the number of cases of ILI, ALRI <5 years, and TB this week.*
- *Among Water/food-borne diseases, there is an increase in the number of cases of AD (Non-Cholera) and B. Diarrhea this week.*
- *Among Vector-borne diseases, there is a decrease in the number of cases of Malaria, CL, and Dengue this week.*
- *Among STDs, there is a decline in the number of cases of Syphilis this week.*
- *Among Zoonotic/Other diseases, there is an increase in the number of cases of Dog Bite and Leprosy this week.*

IDSR compliance attributes

- *The national compliance rate for IDSR reporting in 158 implemented districts is 78%.*
- *Sindh is the top reporting region with a compliance rate of 98%, followed by GB 86%, AJK 85%, ICT 76%, and KP 74%.*
- *In Week 1, the lowest compliance rate was observed in Balochistan 47%.*

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2229	1660	74
Azad Jammu Kashmir	469	400	85
Islamabad Capital Territory	38	29	76
Balochistan	1308	621	47
Gilgit Baltistan	417	357	86
Sindh	2111	2059	98
National	6572	5126	78

Public Health Actions

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

Meningitis

- **Strengthen Surveillance and Outbreak Detection:** Enhance meningitis case reporting under IDSR by training healthcare providers on syndromic case definitions and ensuring rapid notification of suspected cases and clusters.
- **Improve Laboratory Confirmation:** Improve diagnostic capacity for cerebrospinal fluid (CSF) analysis, including culture, Gram stain, latex agglutination, and PCR to identify causative organisms (Neisseria meningitidis, Streptococcus pneumoniae, Haemophilus influenzae).
- **Ensure Prompt Case Management:** Train healthcare workers to recognize early signs of meningitis and provide immediate treatment with appropriate antibiotics; ensure availability of essential medicines at all levels.
- **Support Preventive Vaccination:** Promote meningococcal, pneumococcal, and Hib vaccines through routine immunization and outbreak response vaccination campaigns in high-risk populations.
- **Raise Public Awareness and Risk Communication**: Conduct community education on early symptoms (sudden fever, stiff neck, altered consciousness), importance of early care-seeking, and preventive practices during outbreaks (avoiding overcrowding).

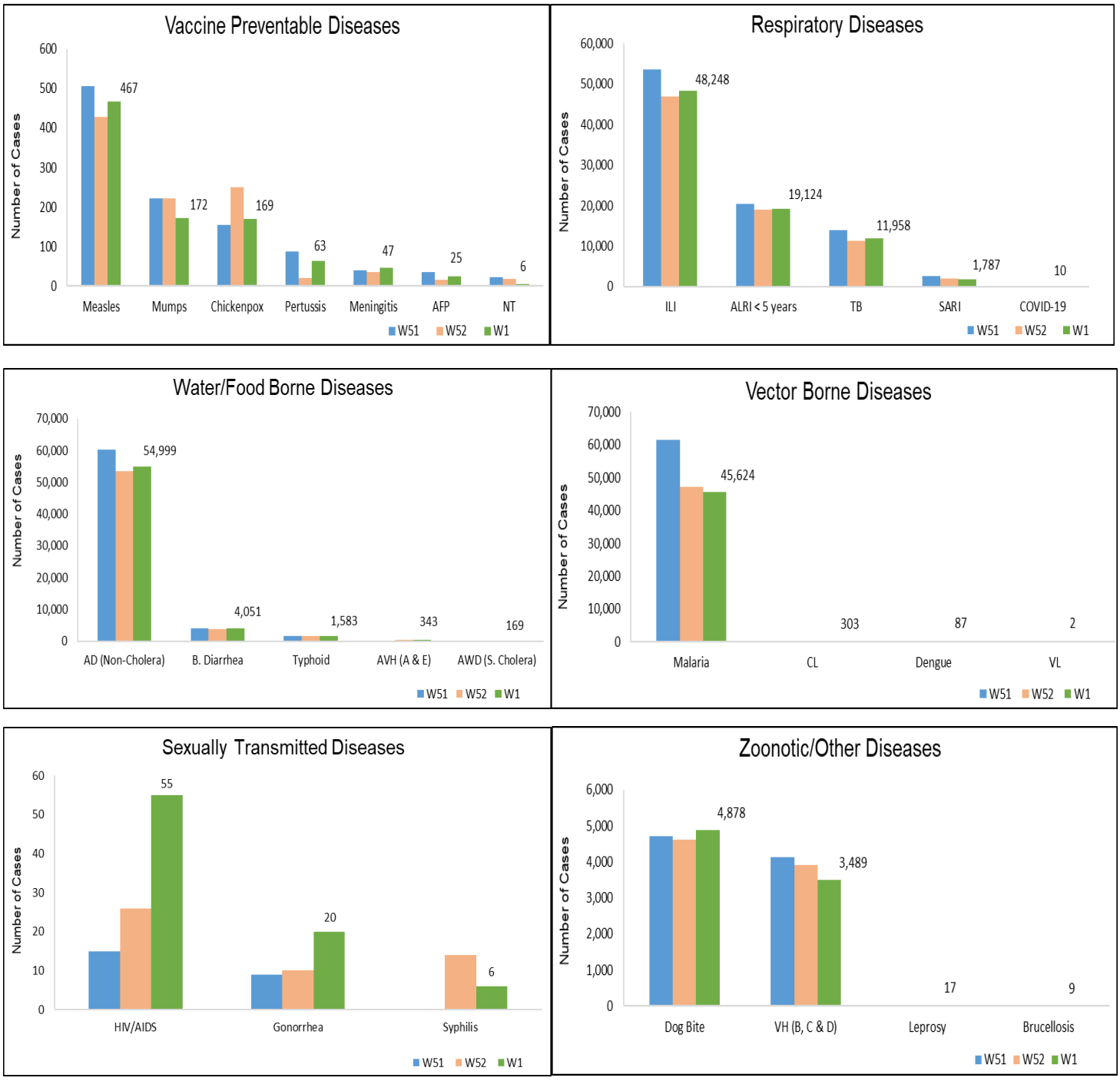
Neonatal Tetanus (NT)

- **Strengthen Surveillance and Case Detection:** Strengthen neonatal tetanus surveillance in IDSR by active case finding in high-risk areas and immediate notification of suspected cases.
- **Ensure Maternal Immunization**: Scale up coverage of tetanus toxoid (TT) vaccination among pregnant women and women of childbearing age through routine immunization and supplemental campaigns.
- **Promote Clean Delivery and Cord Care:** Train skilled birth attendants and community health workers in clean delivery practices and hygienic cord care; discourage harmful traditional practices.
- **Ensure Prompt Case Management:** Strengthen referral systems and availability of tetanus antitoxin (TAT), antibiotics, and supportive care for suspected cases.
- **Conduct Community Awareness Campaigns:** Educate families and communities on the importance of maternal immunization, safe delivery, and hygienic newborn care to prevent tetanus.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 01, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (non-cholera)	1,238	3,825	497	294	16,374	NR	32,771	54,999
ILI	3,006	6,086	344	1,804	5,704	NR	31,304	48,248
Malaria	5	1,915	0	0	2,366	NR	41,338	45,624
ALRI < 5 years	1,564	2,114	1,240	17	1,649	NR	12,540	19,124
TB	111	32	62	4	240	NR	11,509	11,958
Dog Bite	100	287	4	1	964	NR	3,522	4,878
B. Diarrhea	33	811	59	6	535	NR	2,607	4,051
VH (B, C & D)	14	24	0	0	105	NR	3,346	3,489
SARI	230	730	127	0	548	NR	152	1,787
Typhoid	19	242	70	0	573	NR	679	1,583
Measles	8	20	3	0	387	NR	49	467
AVH (A & E)	15	9	0	0	109	NR	210	343
CL	0	53	0	0	250	NR	0	303
Mumps	7	52	3	0	83	NR	27	172
AWD (S. Cholera)	3	139	1	0	25	NR	1	169
Chickenpox/ Varicella	3	14	10	1	112	NR	29	169
Dengue	0	4	0	0	5	NR	78	87
Pertussis	0	53	0	0	7	NR	3	63
HIV/AIDS	3	34	0	0	5	NR	13	55
Meningitis	2	4	4	0	9	NR	28	47
AFP	0	1	0	0	17	NR	7	25
Diphtheria (Probable)	0	3	0	0	13	NR	6	22
Gonorrhea	0	19	0	0	0	NR	1	20
Leprosy	0	0	0	0	8	NR	9	17
COVID-19	0	0	0	0	10	NR	0	10
Brucellosis	0	5	1	0	3	NR	0	9
NT	0	0	0	0	6	NR	0	6
Syphilis	0	0	0	0	0	NR	6	6
VL	0	2	0	0	0	NR	0	2

Figure 1: Most frequently reported suspected cases during Week 01, Pakistan.



Sindh

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

Table 2: District wise distribution of most frequently reported suspected cases during Week 01, Sindh.

Districts	Malaria	AD (non-cholera)	ILI	ALRI < 5 years	TB	Dog Bite	VH (B, C & D)	B. Diarrhea	Typhoid	AVH (A & E)
Badin	1,948	1,745	2,241	605	784	112	295	151	29	0
Dadu	3,573	1,984	1,063	1,385	504	280	104	324	105	71
Ghotki	2,270	692	28	883	434	271	372	72	0	0
Hyderabad	432	2,029	1,886	192	322	67	69	92	3	2
Jacobabad	786	502	1,175	478	192	226	120	66	44	0
Jamshoro	1,662	1,198	160	448	542	134	124	62	13	4
Kamber	1,822	1,282	2	295	737	273	78	90	16	0
Karachi Central	13	1,522	2,221	13	234	44	21	0	62	0
Karachi East	34	211	3	14	14	0	4	1	2	0
Karachi Keamari	2	501	201	13	12	1	0	0	0	0
Karachi Korangi	100	373	11	2	42	17	1	9	3	0
Karachi Malir	28	499	2,080	146	76	27	0	17	9	0
Karachi South	15	71	2	0	0	0	0	0	0	0
Karachi West	344	760	1,193	277	73	63	23	18	20	0
Kashmore	2,002	238	778	154	94	97	4	33	2	1
Khairpur	3,798	2,510	5,541	1,293	1,014	262	197	227	152	11
Larkana	2,944	1,156	0	308	685	50	17	206	5	0
Matiari	2,003	1,061	18	287	663	75	96	42	2	1
Mirpurkhas	1,530	2,246	4,738	725	905	199	24	138	16	93
Naushero Feroze	1,096	1,211	687	633	155	259	82	241	39	0
Sanghar	3,300	1,413	91	661	1,137	309	1,149	70	24	2
Shaheed Benazirabad	1,846	1,157	4	260	309	132	55	73	72	0
Shikarpur	1,994	755	11	167	224	262	168	124	2	0
Sujawal	563	959	0	217	146	60	0	92	7	0
Sukkur	1,500	797	2,068	286	382	113	14	101	3	0
Tando Allahyar	1,089	693	1,534	212	383	74	139	81	2	3
Tando Muhammad Khan	405	727	103	236	563	35	89	89	0	0
Tharparkar	1,696	2,038	2,177	1,138	573	1	48	108	13	17
Thatta	957	1,151	1,285	645	79	79	42	11	0	0
Umerkot	1,586	1,290	3	567	231	0	11	69	34	5
Total	41,338	32,771	31,304	12,540	11,509	3,522	3,346	2,607	679	210

Figure 2: Most frequently reported suspected cases during Week 01, Sindh.

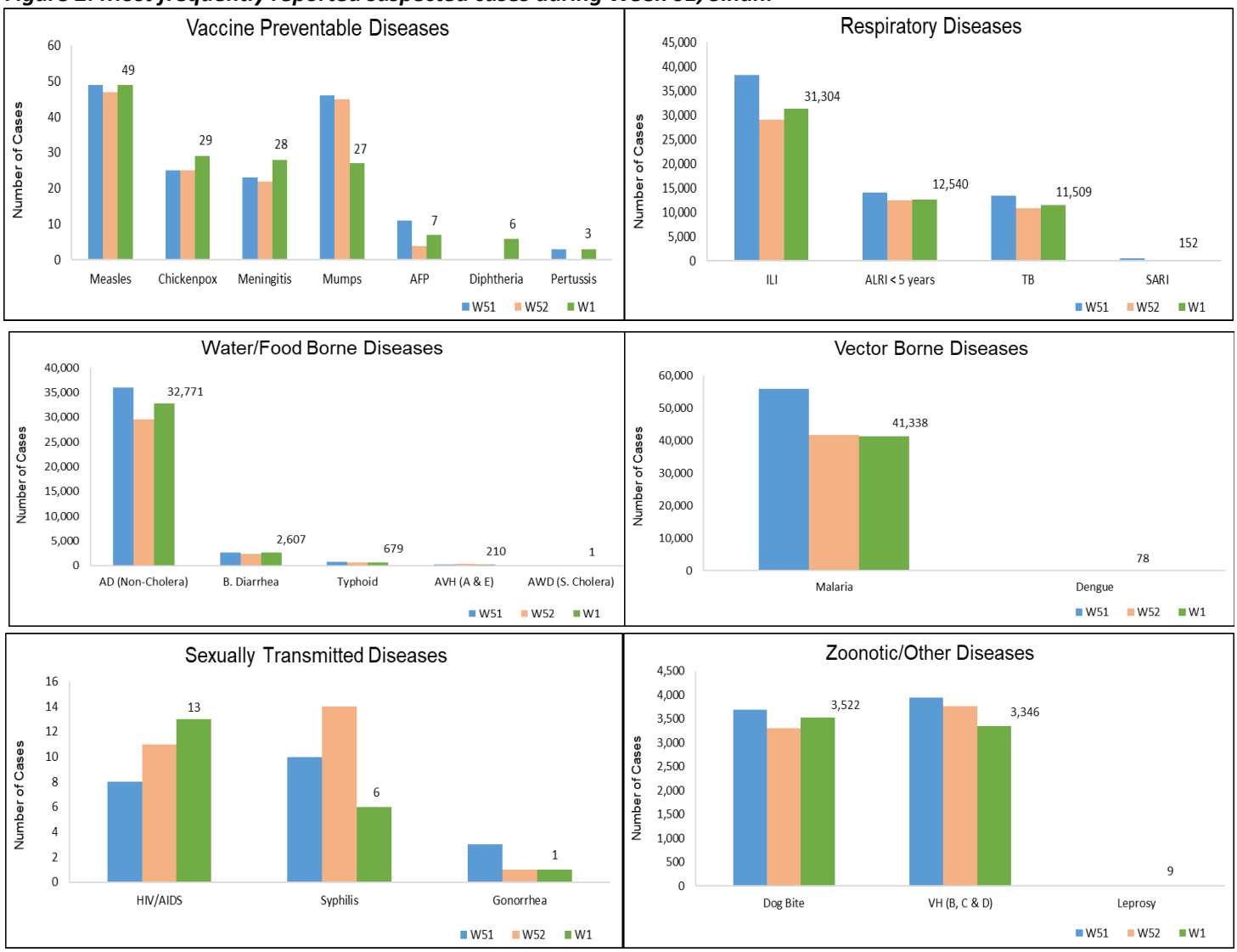
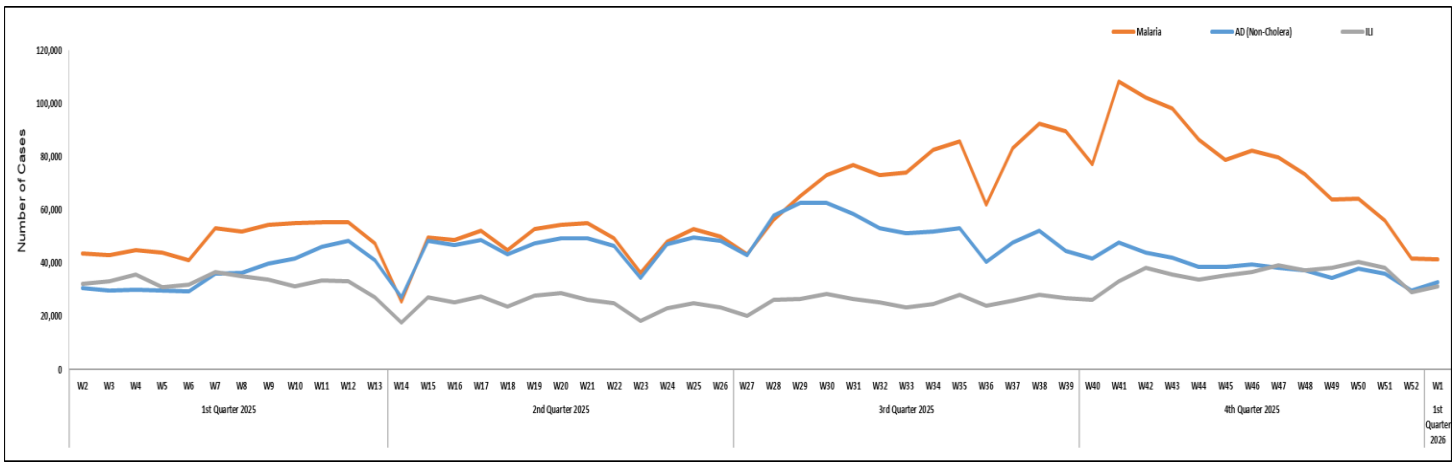


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh.



Balochistan

- ILI, AD (Non-Cholera), ALRI <5 years, Malaria, B. Diarrhea, SARI, Dog Bite, Typhoid, AWD (S. Cholera) and CL cases are the most frequently reported diseases from Balochistan province.
- ILI cases are mostly reported from Sibi, Pishin, and Loralai while AD (Non-Cholera) cases are mostly reported from Usta Muhammad, Sibi, and Lasbella.
- One case of AFP is reported from Balochistan. Field investigation is required to confirm the cases.
- Dog Bite, CL, Pertussis, Mumps, Measles, Chickenpox, Brucellosis, Meningitis, Dengue, and Diphtheria showed an increase in the number of cases. At the same time, a decline has been observed in the number of cases of ILI, AD (Non-Cholera), ALRI <5 years, Malaria, B. Diarrhea, SARI, Typhoid, AWD (S. Cholera), TB, and VH (B, C & D) in Week 01.
- *The number of HIV/AIDS cases in Week 1 is zero. This has been verified by the province after completion of the data analysis and will be rectified in next week's data.

Table 3: District wise distribution of most frequently reported suspected cases during Week 01, Balochistan.

Districts	ILI	AD (non-cholera)	ALRI < 5 years	Malaria	B. Diarrhea	SARI	Dog Bite	Typhoid	AWD (S. Cholera)	CL
Awaran	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Barkhan	36	57	5	17	12	0	30	15	0	3
Chagai	197	69	0	12	21	0	0	8	0	0
Chaman	390	65	71	1	54	41	2	38	6	4
Dera Bugti	0	14	42	1	0	0	0	6	0	0
Duki	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Gwadar	18	14	1	12	4	0	3	2	2	0
Harnai	0	145	199	53	53	0	1	0	0	0
Hub	195	132	57	75	18	0	3	0	0	1
Jaffarabad	127	150	21	187	55	45	0	4	0	0
Jhal Magsi	138	120	91	178	0	6	2	8	0	0
Kachhi (Bolan)	410	268	82	408	123	0	4	0	36	13
Kalat	0	0	0	0	0	0	0	0	0	0
Kech (Turbat)	197	83	NR	26	20	NR	NR	NR	NR	NR
Kharan	569	134	0	9	51	27	0	4	0	0
Khuzdar	35	16	0	11	5	11	0	7	0	0
Killa Abdullah	221	113	14	2	27	82	7	3	21	2
Killa Saifullah	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kohlu	59	12	NR	12	3	NR	NR	5	NR	NR
Lasbella	120	305	167	209	21	1	26	4	0	11
Loralai	585	192	75	8	52	98	0	17	0	0
Mastung	208	130	137	26	15	22	9	3	3	0
MusaKhel	34	70	10	48	17	1	0	6	5	0
Naseerabad	16	269	54	191	8	42	123	34	12	6
Nushki	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Panjgur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Pishin	618	193	184	8	93	116	5	20	12	7
Quetta	512	199	145	7	9	30	1	15	20	0
Sherani	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sibi	785	340	203	240	39	172	9	24	22	6
Sohbat pur	5	198	204	45	33	1	3	8	0	0
Surab	54	16	0	0	0	0	0	0	0	0
Usta Muhammad	278	464	294	100	48	8	35	1	0	0
Washuk	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Zhob	22	20	18	0	2	26	0	5	0	0
Ziarat	257	37	40	29	28	1	24	5	0	0
Total	6,086	3,825	2,114	1,915	811	730	287	242	139	53

Figure 4: Most frequently reported suspected cases during Week 01, Balochistan.

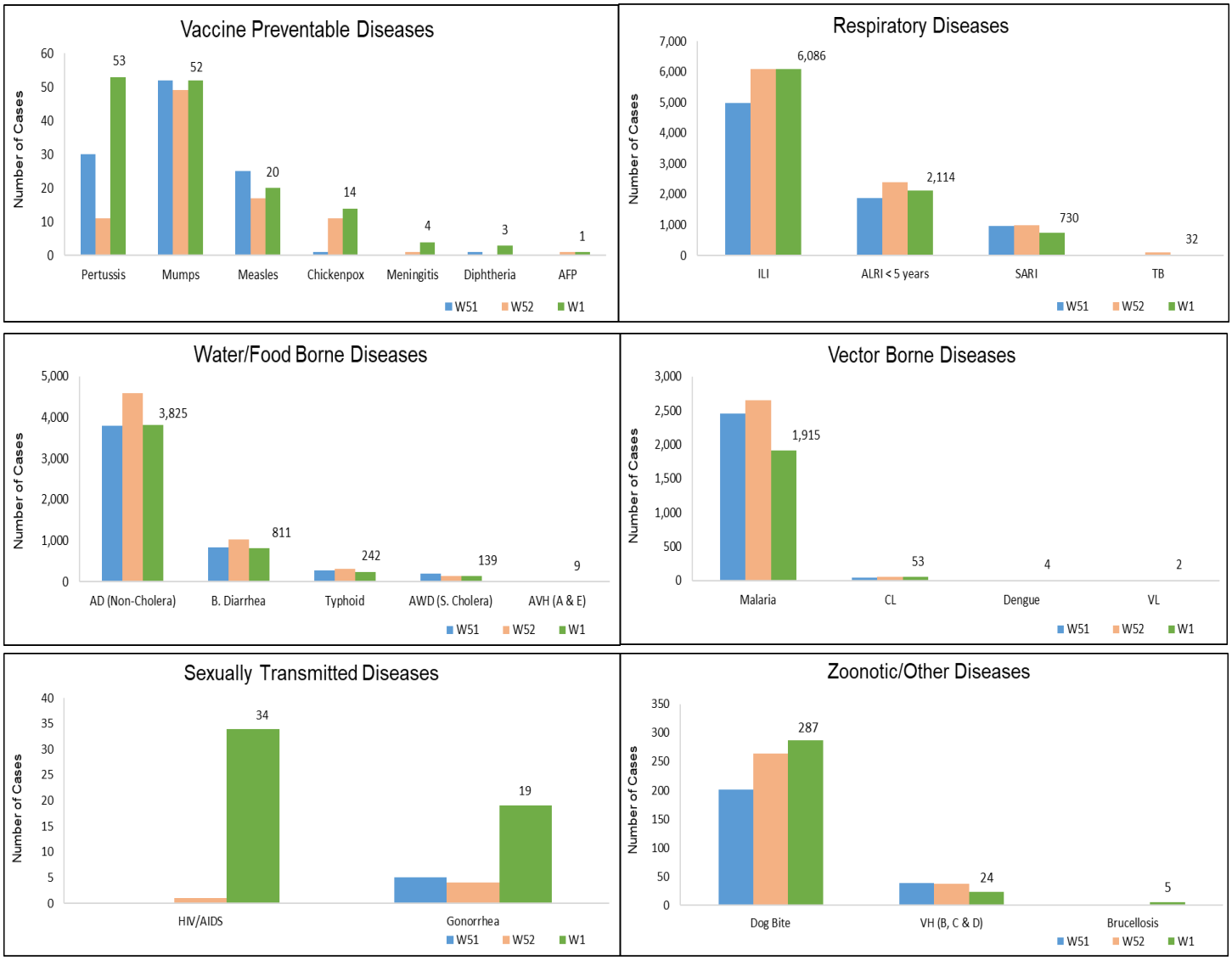
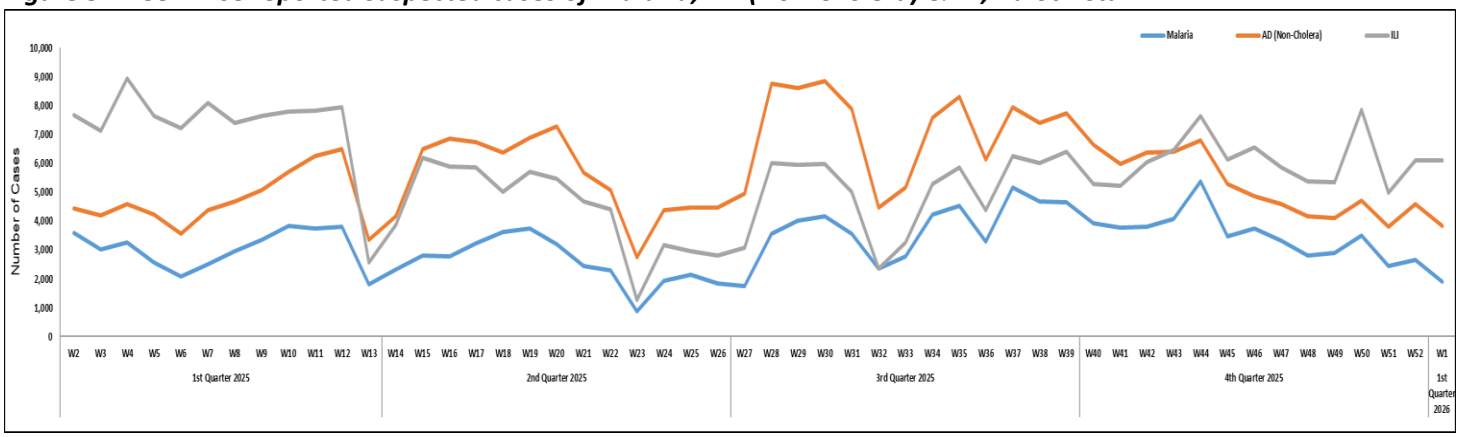


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan.



Khyber Pakhtunkhwa

- Cases of AD (Non-Cholera) are maximum followed by ILI, Malaria, ALRI<5 Years, Dog Bite, Typhoid, SARI, B. Diarrhea, Measles and CL.
- Dog Bite, Measles, TB, VH (B, C & D), AWD (S. Cholera), AFP, Diphtheria, COVID-19, Meningitis, Dengue, and Brucellosis cases showed an increase in number while AD (Non-Cholera), ILI, Malaria, ALRI<5 Years, Typhoid, B. Diarrhea, CL, Chickenpox, AVH (A & E), Mumps, Pertussis, and NT showed a decline in number this week.
- Seventeen cases of AFP are reported from KP. All are suspected cases and need field verification.
- Five cases of HIV/AIDs are reported from KP. A field investigation is required.
- Three suspected cases of Brucellosis are reported from KP, which require field verification.

Table 4: District wise distribution of most frequently reported suspected cases during Week 01, KP.

Districts	AD (non-cholera)	ILI	Malaria	ALRI < 5 years	Dog Bite	Typhoid	SARI	B. Diarrhea	Measles	CL
Abbottabad	557	255	0	30	118	19	10	1	6	0
Bajaur	410	0	76	22	88	1	65	23	4	8
Bannu	506	3	795	13	0	83	0	8	73	0
Battagram	201	532	27	11	7	3	NR	7	16	NR
Buner	128	0	149	0	8	5	0	0	0	0
Charsadda	1,231	1,626	190	525	0	57	3	64	29	1
Chitral Lower	259	22	9	30	15	5	24	11	0	7
Chitral Upper	90	18	5	7	3	7	6	3	0	1
D.I. Khan	1,356	0	164	40	9	2	0	23	21	0
Dir Lower	792	0	65	7	56	18	0	53	22	0
Dir Upper	635	76	11	106	17	8	0	14	7	0
Hangu	190	0	64	0	16	3	0	0	7	17
Haripur	740	997	0	113	17	45	60	10	4	0
Karak	239	79	55	37	25	3	0	8	18	73
Khyber	305	0	91	44	42	55	0	47	0	31
Kohat	274	0	43	22	37	8	0	5	0	13
Kohistan Lower	58	0	0	0	0	0	0	15	2	0
Kohistan Upper	187	1	2	0	0	0	0	8	6	0
Kolai Palas	70	4	0	0	0	0	5	2	0	0
L & C Kurram	17	0	9	0	0	0	0	6	0	0
Lakki Marwat	203	14	161	14	69	3	0	3	2	0
Malakand	340	130	18	19	0	0	28	0	10	2
Mansehra	355	120	NR	15	NR	42	NR	NR	NR	NR
Mardan	673	76	13	186	29	12	0	14	21	2
Mohmand	45	181	77	1	11	5	185	6	7	53
North Waziristan	53	0	50	7	0	37	29	13	15	5
Nowshera	811	64	32	19	9	4	14	20	5	12
Orakzai	36	7	1	0	0	0	0	1	0	0
Peshawar	2,429	436	9	118	9	22	16	38	42	0
Shangla	511	0	58	26	46	18	0	1	3	0
South Waziristan (Lower)	42	117	12	12	18	7	30	37	3	22
SWU	23	2	11	6	0	0	16	2	0	0
Swabi	826	589	45	100	162	41	45	13	43	0
Swat	1,292	216	8	91	130	48	0	45	19	0
Tank	308	31	96	7	0	0	0	5	0	0
Tor Ghar	50	11	12	13	10	3	0	6	0	3
Upper Kurram	132	97	8	8	13	9	12	23	2	0
Total	16,374	5,704	2,366	1,649	964	573	548	535	387	250

Figure 6: Most frequently reported suspected cases during Week 01, KP.

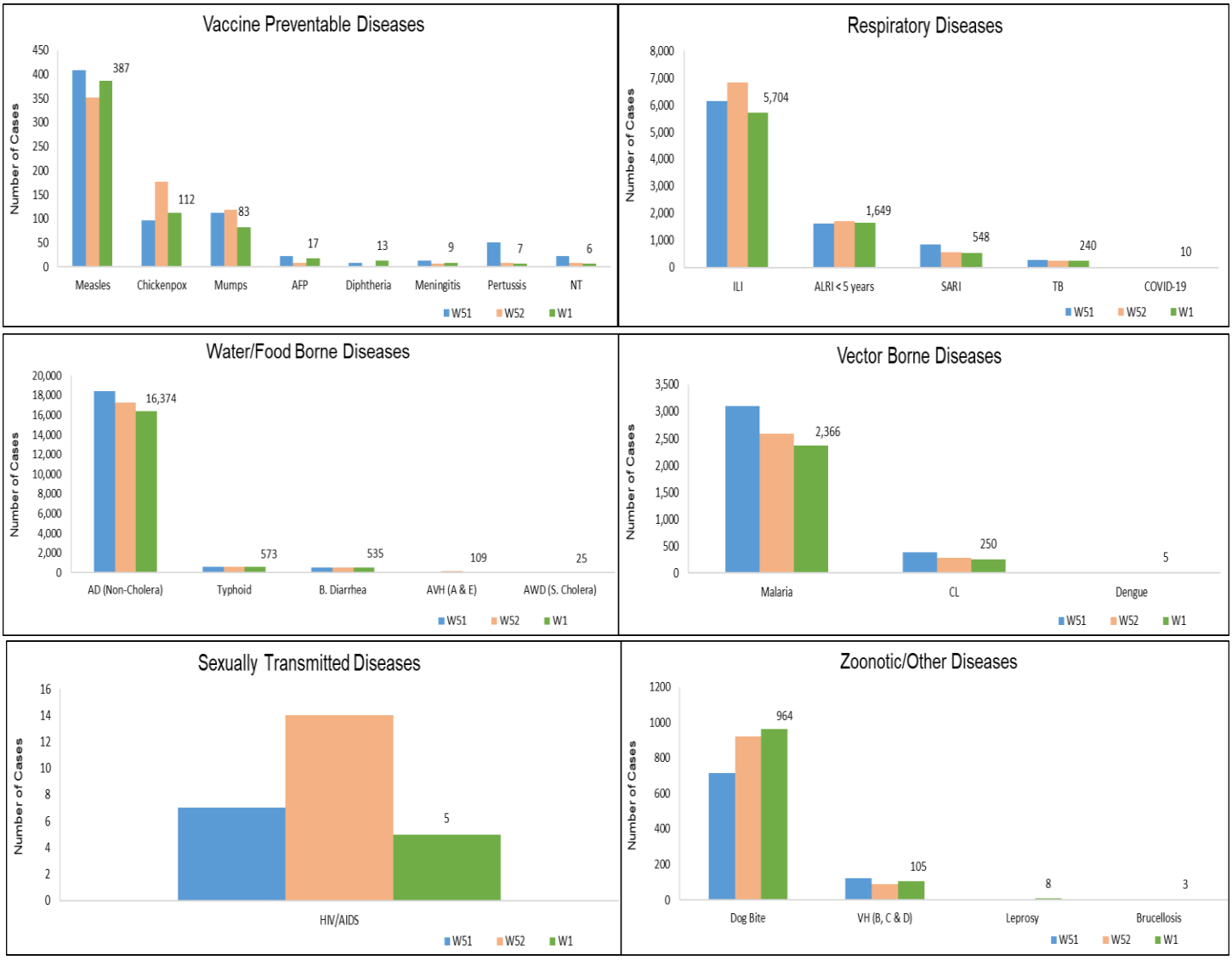
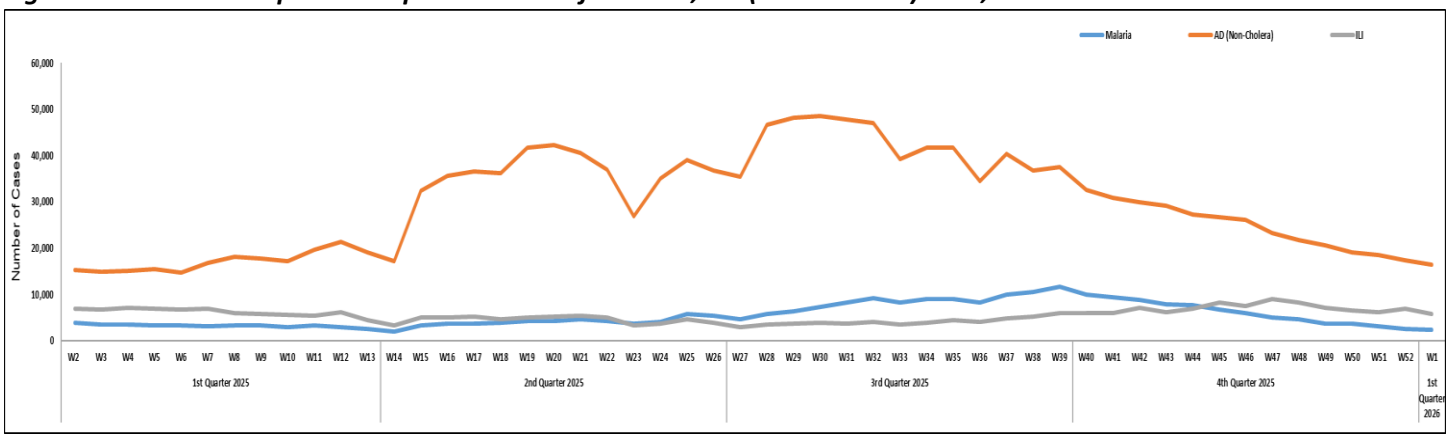


Figure 7: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, KP.



ICT, AJK & GB

ICT: The most frequently reported cases from Islamabad are of ILI followed by AD (Non-Cholera), ALRI <5 Years, B. Diarrhea, TB, Dog Bite, and Chickenpox. ILI, TB, and Chickenpox cases showed a decline in number while an increase in number was observed in AD (Non-Cholera), ALRI <5 Years, B. Diarrhea, and Dog Bite cases this week.

AJK: ILI cases are maximum followed by ALRI < 5years, AD (Non-Cholera), SARI, TB, Dog Bite, B. Diarrhea, Typhoid, AVH (A & E), VH (B, C & D), Measles, Mumps, and Malaria cases. An increase in the number of suspected cases is observed for ILI, ALRI < 5years, AD (Non-Cholera), SARI, TB, B. Diarrhea, Typhoid, and Malaria, while a decline in cases is observed for Dog Bite, AVH (A & E), VH (B, C & D), AWD (S. Cholera), Chickenpox/ Varicella, and Meningitis this week.

GB: ALRI <5 Years cases are the most frequently reported disease, followed by AD (Non-Cholera), ILI, SARI, Typhoid, TB, B. Diarrhea, Chickenpox/ Varicella, Dog Bite, Meningitis, Mumps, and Measles cases. An increase in cases is observed for ALRI <5 Years, AD (Non-Cholera), ILI, Typhoid, TB, B. Diarrhea, Meningitis, and Mumps, while a decline is observed in the number of cases of SARI, Chickenpox/ Varicella, and Measles this week.

Figure 8: Most frequently reported suspected cases during Week 01, AJK.

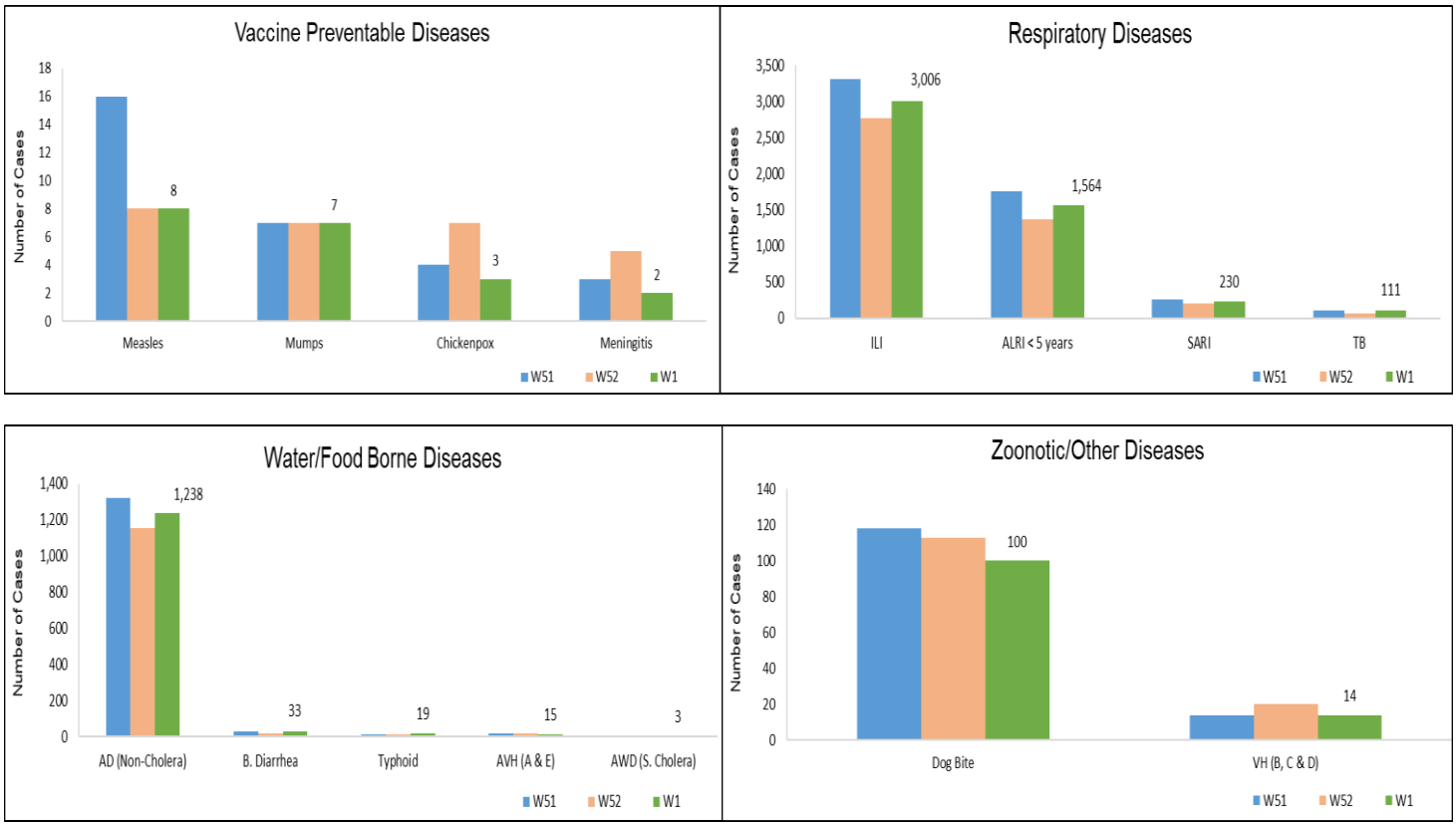


Figure 9: Week wise reported suspected cases of ILI and ALRI < 5 years, AJK.

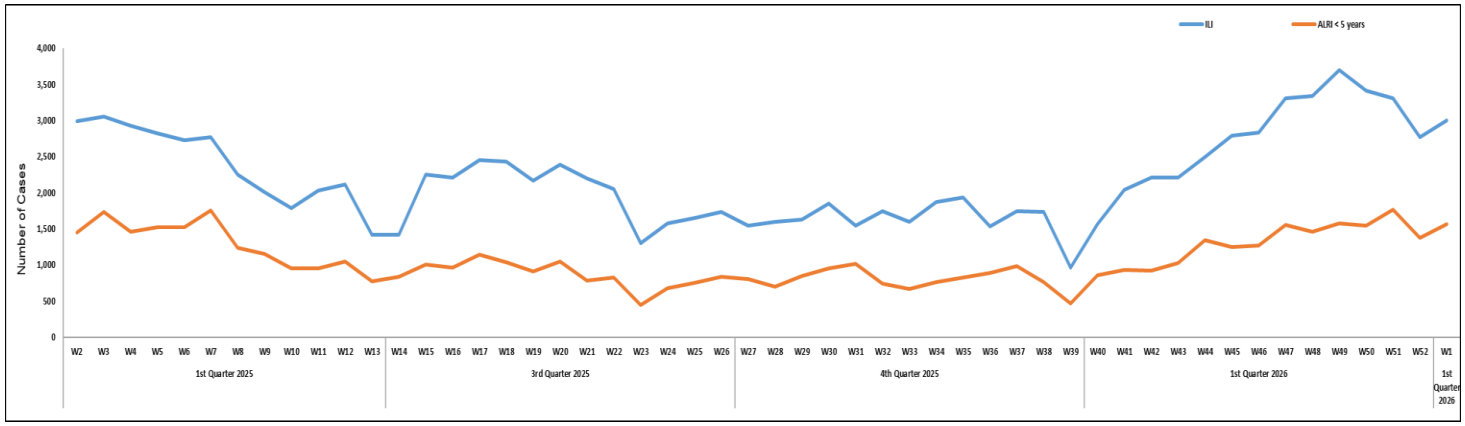


Figure 10: Most frequently reported suspected cases during Week 01, ICT.

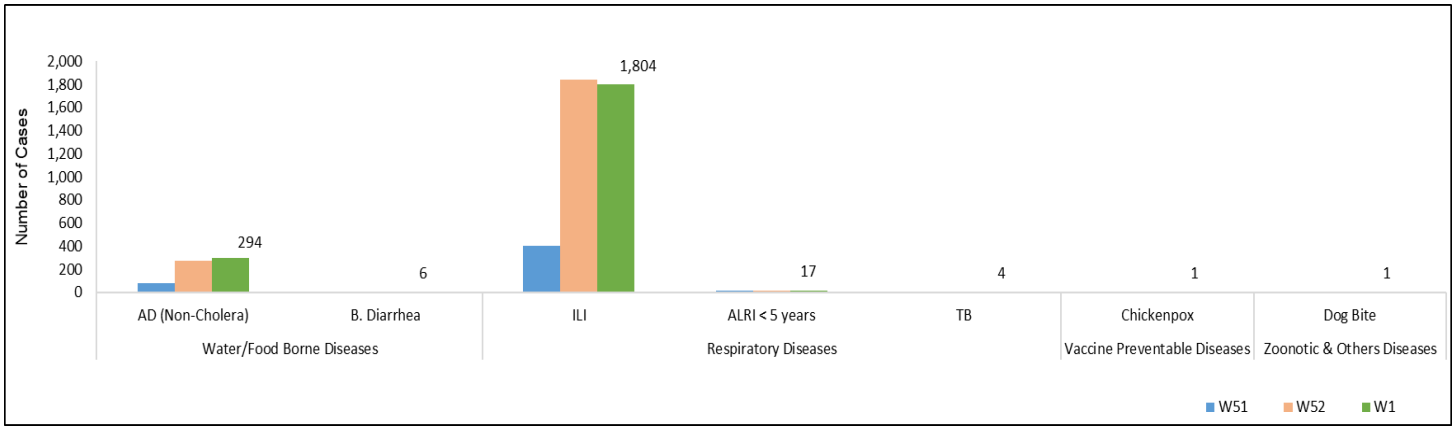


Figure 11: Week wise reported suspected cases of ILI, ICT.

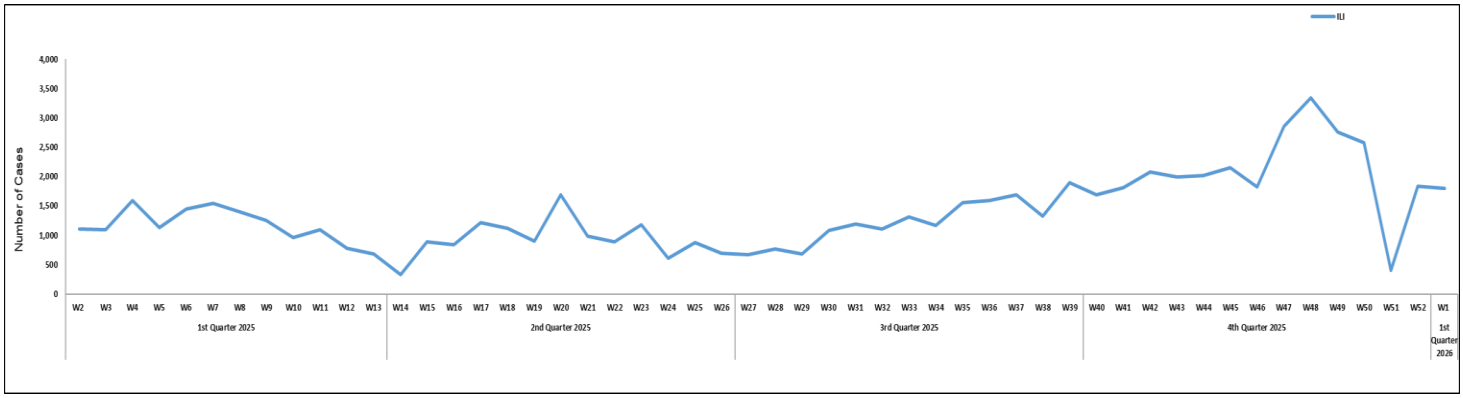


Figure 12: Most frequently reported suspected cases during Week 01, GB.

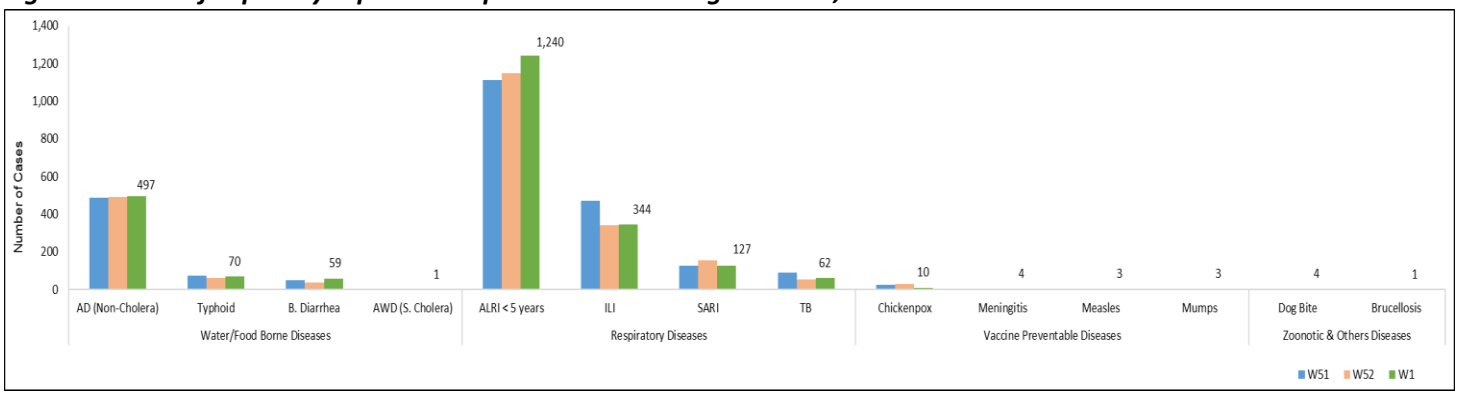


Figure 13: Week-wise reported suspected cases of ALRI < 5 years, GB.

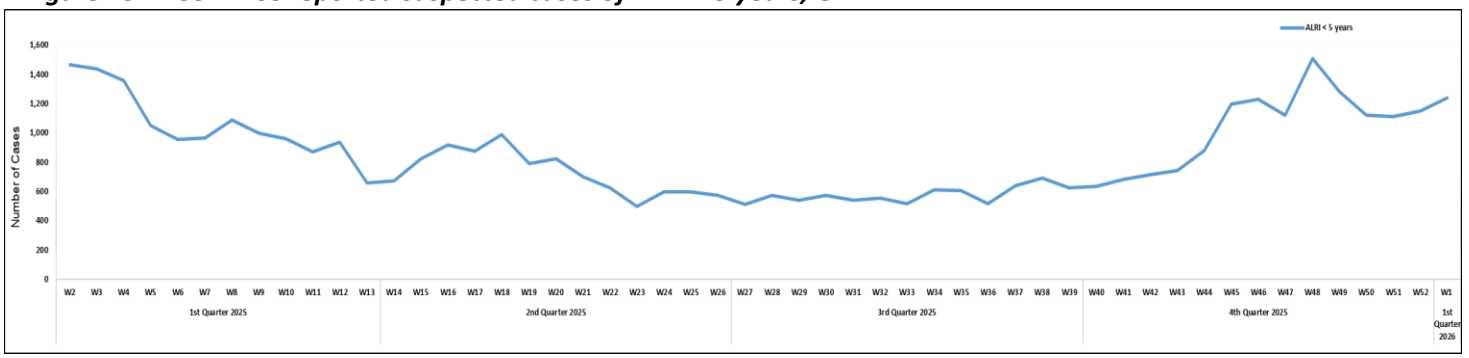


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 01, Pakistan.

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)		155	0	-	-	-	-	-	-	-	-	-	-	-	-
Stool culture & Sensitivity		391	2	-	-	-	-	-	-	-	-	-	-	-	-
Malaria		9014	284	898	171	422	8	-	-	72	0	-	-	1	0
CCHF		1	0	-	-	-	-	-	-	-	-	-	-	-	-
Dengue		3796	354	16	5	41	0	-	-	-	-	-	-	-	-
VH (B)		15191	462	827	61	98	11	-	-	748	9	-	-	344	4
VH (C)		15496	1280	860	42	126	15	-	-	818	2	-	-	344	8
VH (D)		220	44	45	5	-	-	-	-	-	-	-	-	-	-
VH (A)		272	70	1	0	-	-	-	-	2	0	-	-	-	-
VH (E)		118	19	5	0	-	-	-	-	-	-	-	-	-	-
Covid-19		46	0	2	0	31	1	-	-	-	-	-	-	12	0
TB		1020	109	161	36	10	4	-	-	100	1	-	-	67	8
HIV/ AIDS		4490	44	557	1	322	2	-	-	155	1	-	-	333	3
Syphilis		1571	19	38	0	-	-	-	-	68	0	-	-	-	-
Typhoid		2427	33	157	34	-	-	-	-	116	8	-	-	-	-
Diphtheria		6	1	-	-	-	-	-	-	-	-	-	-	-	-
ILI		75	9	4	0	31	0	-	-	-	-	-	-	-	-
Pneumonia (ALRI)		549	133	2	1	-	-	-	-	-	-	-	-	-	-
Meningitis		56	6	-	-	-	-	-	-	-	-	-	-	-	-
Measles		165	78	22	13	310	128	50	38	4	1	397	116	15	5
Rubella (CRS)		165	1	22	1	310	12	50	3	4	0	397	5	15	0
Leishmaniosis (cutaneous)		9	0	47	25	14	4	-	-	-	-	-	-	1	1
Gonorrhea		115	0	-	-	-	-	-	-	-	-	-	-	-	-
Brucellosis		1	0	-	-	-	-	-	-	-	-	-	-	-	-
Mpox		-	-	-	-	1	1	-	-	-	-	-	-	-	-
Leishmaniosis (Visceral)		9	0	-	-	-	-	-	-	-	-	-	-	-	-
SARI		77	31	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	ILI	2	0	-	-	-	-	48	0	2	0	31	0	-	-
	SARI	3	0	-	-	44	0	312	0	8	0	135	0	-	-
Influenza A	ILI	2	0	-	-	-	-	48	4	2	0	31	0	-	-
	SARI	3	0	-	-	44	1	312	10	8	0	135	4	-	-
Influenza B	ILI	2	0	-	-	-	-	48	0	2	0	31	0	-	-
	SARI	3	0	-	-	44	0	312	1	8	0	135	0	-	-
RSV	ILI	2	0	-	-	-	-	48	13	2	0	31	0	-	-
	SARI	3	0	-	-	44	3	312	174	8	0	135	0	-	-

IDSR Reports Compliance

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

Table 6: Compliance of IDSR reporting districts, Week 01, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for the current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	98	88%
	Bannu	238	128	54%
	Battagram	59	35	59%
	Buner	34	18	53%
	Bajaur	44	39	89%
	Charsadda	59	59	100%
	Chitral Upper	34	30	88%
	Chitral Lower	35	33	94%
	D.I. Khan	114	113	99%
	Dir Lower	74	61	82%
	Dir Upper	37	35	95%
	Hangu	22	18	82%
	Haripur	72	68	94%
	Karak	36	36	100%
	Khyber	53	43	81%
	Kohat	61	61	100%
	Kohistan Lower	11	8	73%
	Kohistan Upper	20	12	60%
	Kolai Palas	10	10	100%
	Lakki Marwat	70	68	97%
	Lower & Central Kurram	42	5	12%
	Upper Kurram	41	31	76%
	Malakand	42	22	52%
	Mansehra	133	70	53%
	Mardan	80	64	80%
	Nowshera	56	51	91%
	North Waziristan	13	8	62%
	Peshawar	156	132	85%
	Shangla	37	34	92%
	Swabi	64	61	95%
	Swat	77	75	97%
	South Waziristan (Upper)	93	37	40%
	South Waziristan (Lower)	42	28	67%
	Tank	34	31	91%
	Torghar	14	13	93%
	Mohmand	68	17	25%
	Orakzai	69	8	12%
Azad Jammu Kashmir	Mirpur	37	37	100%
	Bhimber	92	69	75%

	Kotli	60	60	100%
	Muzaffarabad	45	45	100%
	Poonch	46	46	100%
	Haveli	39	39	100%
	Bagh	54	23	43%
	Neelum	39	25	64%
	Jhelum Velley	29	29	100%
	Sudhnooti	27	27	100%
Islamabad Capital Territory	ICT	23	23	100%
	CDA	15	6	40%
Balochistan	Gwadar	26	2	8%
	Kech	44	8	18%
	Khuzdar	74	6	8%
	Killa Abdullah	26	23	88%
	Lasbella	55	55	100%
	Pishin	69	31	45%
	Quetta	55	24	44%
	Sibi	36	34	94%
	Zhob	39	10	26%
	Jaffarabad	16	16	100%
	Naserabad	32	32	100%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	4	5%
	Chagi	36	15	42%
	Kalat	41	40	98%
	Harnai	17	17	100%
	Kachhi (Bolan)	35	18	51%
	Jhal Magsi	28	27	96%
	Sohbat pur	25	21	84%
	Surab	32	8	25%
	Mastung	46	45	98%
	Loralai	33	29	88%
	Killa Saifullah	28	0	0%
	Ziarat	29	7	24%
	Duki	31	0	0%
	Nushki	32	0	0%
	Dera Bugti	45	17	38%
	Washuk	46	0	0%
	Panjgur	38	0	0%
	Awaran	23	0	0%
	Chaman	24	24	100%
	Barkhan	20	11	55%
	Hub	33	24	73%
	Musakhel	41	10	24%
	Usta Muhammad	34	33	97%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	38	100%

	Gilgit	44	44	100%
	Diamer	62	53	85%
	Astore	55	55	100%
	Shigar	27	21	78%
	Skardu	53	52	98%
	Ganche	29	29	100%
	Kharmang	46	13	28%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	64	100%
	Umerkot	62	62	100%
	Naushahro Feroze	107	100	93%
	Tharparkar	276	267	97%
	Shikarpur	60	59	98%
	Thatta	52	49	94%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	13	62%
	Karachi-West	20	20	100%
	Karachi-Malir	35	22	63%
	Karachi-Kemari	22	21	95%
	Karachi-Central	12	11	92%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	4	67%
	Sujawal	55	55	100%
	Mirpur Khas	106	105	99%
	Badin	124	121	98%
	Sukkur	64	63	98%
	Dadu	90	90	100%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	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: Compliance of IDSR reporting Tertiary care hospitals Week 01, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for the current week	Compliance Rate (%)
AJK	Mirpur	2	0	0%
	Bhimber	1	0	0%
	Kotli	1	0	0%
	Muzaffarabad	2	1	50%
	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	0	0%
	Karachi-Central	1	1	100%
	Peshawar	3	0	0%
	Swabi	1	0	0%
	Nowshera	1	1	100%

Strengthening Local Capacities for Timely Outbreak Detection and Response in Khyber Pakhtunkhwa

The National Institute of Health (NIH) Pakistan, with the support of the **7-1-7 Alliance** and **Resolve to Save Lives (RTSL)**, successfully conducted a **two-day 7-1-7 Implementation Workshop** in **Khyber Pakhtunkhwa (KP)** as part of ongoing efforts to enhance Pakistan's public health emergency preparedness and response capacity.

The workshop aimed to strengthen the technical and operational skills of **district-level health staff** by providing **hands-on training** in the core components of the 7-1-7 framework: **event detection within 7 days, notification within 1 day, and initiation of effective response within 7 days**. This approach is globally recognized as a practical benchmark for assessing and improving the timeliness of outbreak detection and response.

Participants engaged in interactive sessions, case-based exercises, and group work focused on **early event detection, rapid risk assessment, timely reporting through surveillance systems, and coordinated outbreak response**. Emphasis was placed on translating the 7-1-7 methodology into routine district-level practice, enabling frontline teams to identify and respond to public health threats before they escalate.

The workshop also provided a platform for dialogue between provincial and district health teams, fostering a shared understanding of roles, responsibilities, and coordination mechanisms during public health emergencies. By strengthening local capacities, the initiative supports **provincial and national health security objectives**, ensuring faster containment of outbreaks and reduced impact on communities.

This capacity-building effort reflects NIH Pakistan's continued commitment to **strengthening surveillance, preparedness, and response systems** in alignment with the **Integrated Disease Surveillance and Response System (IDSRS)** and international health security priorities. The collaboration with 7-1-7 Alliance and Resolve to Save Lives underscores the importance of **partnerships** in advancing resilient health systems capable of responding effectively to emerging and re-emerging public health threats.

Notes from the field:

Case Report of Mpox (Bara District, Khyber Pakhtunkhwa)

Dr Fozia Afridi

Introduction

Mpox (monkeypox) is a re-emerging zoonotic viral disease with increasing global public health significance due to international travel and potential for human-to-human transmission. The disease typically presents with fever, myalgia, lymphadenopathy, and a characteristic vesiculopustular rash. In February 2025, a confirmed case of Mpox was detected in Bara District, Khyber, Pakistan, highlighting the importance of vigilant surveillance, rapid laboratory confirmation, and coordinated outbreak response to prevent further transmission.

Methods

An epidemiological investigation was conducted on 22 February 2025 by a Field Epidemiology and Laboratory Training Program (FELTP) Fellow (16th Cohort) in collaboration with the District Khyber Response Team. The investigation included case verification, clinical assessment, exposure history review, and active contact tracing. Laboratory confirmation was performed by the Public Health Reference Laboratory (PHRL), Peshawar. Clinical specimens were

collected from the patient and a suspected secondary case following standard biosafety procedures. Infection prevention and control (IPC) measures, isolation, community risk communication, and coordination with district health authorities were implemented as part of the response.

Results

The confirmed case was a 32-year-old married female resident of Speen Qambar Sorakhel Sepah, Bara District, Khyber, reported on 21 February 2025. She presented with fever, generalized body aches, widespread vesicular rash, and oral lesions. The diagnosis was clinically suspected and subsequently confirmed by PHRL Peshawar. The patient's husband, who had recently returned from Jeddah, Saudi Arabia, and was symptomatic, was identified as a suspected Mpox case, and his samples were sent for laboratory confirmation. Both individuals were advised to maintain strict isolation. The confirmed case was isolated and managed at THQ Hospital Dogra under medical supervision. Close contacts, including relatives and neighboring households, were screened, and expanded contact tracing remains ongoing at the time of reporting.

Discussion

The detection of a confirmed Mpox case with a suspected secondary case linked to international travel highlights the risk of importation and local transmission. This investigation demonstrates the effectiveness of rapid field investigation, laboratory confirmation, and multisectoral coordination in controlling emerging infectious diseases. Strengthening surveillance systems, enforcing IPC practices, and timely risk communication are essential to interrupt transmission chains, particularly in resource-limited and border-adjacent settings.

Recommendations

Based on the epidemiological findings and response actions, the following recommendations were proposed:

1. **Continuous Monitoring:** Maintain isolation and regular health assessments of the confirmed and suspected cases until clinical resolution.
2. **Expanded Contact Tracing:** Continue active screening and follow-up of all primary and secondary contacts to ensure early detection of additional cases.
3. **Community Awareness and IPC:** Strengthen community-level education on Mpox transmission, early symptom recognition, and infection prevention practices.
4. **Intersectoral Coordination:** Sustain close collaboration between FELTP, district health authorities, laboratories, and healthcare facilities to ensure timely reporting and coordinated response measures.

Conclusion

This confirmed case of Mpox in Bara District, Khyber, highlights the critical importance of early detection, prompt laboratory confirmation, and coordinated public health response. Ongoing monitoring, comprehensive contact tracing, and community engagement are vital to preventing further spread. Strengthening surveillance and preparedness for emerging and re-emerging infectious diseases remains essential to protect public health in Pakistan.

References

1. World Health Organization. **Mpox (monkeypox): Key facts**. Geneva: World Health Organization; 2024.
2. Centers for Disease Control and Prevention. **Mpox (Monkeypox): Clinical overview**. Atlanta: CDC; 2024.
3. World Health Organization. **Surveillance, case investigation, and contact tracing for Mpox**. Interim guidance. Geneva: WHO; 2023.
4. Public Health Reference Laboratory (PHRL). **Laboratory confirmation report of Mpox, Khyber**. Peshawar: NIH Pakistan; 2025.

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Knowledge Hub

Acute Viral Hepatitis A & E: What You Need to Know

Acute viral hepatitis is an inflammation of the liver caused by a virus. Hepatitis A and Hepatitis E are two types of viral hepatitis that are very similar. They both cause an acute (short-term) illness and are spread through contaminated food or water. These viruses do not cause chronic (long-term) liver disease

What are Hepatitis A and Hepatitis E?

Hepatitis A and Hepatitis E are two different viruses, but they cause a similar type of illness. Both viruses infect the liver, causing inflammation and impairing its function. The illness is typically self-limiting, meaning it resolves on its own over time.

Hepatitis A and E both cause liver infection. Hepatitis A is the most common form of viral hepatitis worldwide.

Hepatitis E is also widespread, particularly in developing countries.

How Hepatitis A and E Spread

Both viruses spread through the fecal-oral route. This means a person becomes infected by ingesting something contaminated with an infected person's faeces.

Contaminated food or water is the most common mode of transmission. Food can become contaminated if it is handled by an infected person who has not washed their hands properly. Water can be contaminated if it is exposed to sewage.

Direct contact with an infected person can also spread the virus.

Signs & Symptoms

Symptoms for both Hepatitis A and Hepatitis E are often mild or absent, especially in young children. When symptoms do appear, they are usually the same for both viruses. They may include fever, fatigue, nausea or vomiting, abdominal discomfort or pain, dark urine, light-colored stools, jaundice, loss of appetite, and joint pains.

Symptoms typically appear about 2-6 weeks after exposure and last for a few weeks to a few months.

Complications

Most people who get Hepatitis A or E recover completely with no lasting liver damage. However, in some cases, complications may occur.

Very rarely, Hepatitis A can lead to acute liver failure, which is a life-threatening condition. This is more common in older adults and people with other liver diseases.

Severe cases of hepatitis E infection may also lead to acute liver failure, which is particularly dangerous for pregnant women, leading to a high fatality rate.

Prevention

Prevention of infection relies primarily on vaccination and strengthening water, sanitation, and hygiene (WASH) practices.

An effective vaccine against Hepatitis A is widely available and is recommended for children and high-risk groups, while the vaccine for Hepatitis E is available in some countries only.

WASH interventions are critical for both infections and include ensuring access to safe drinking water through boiling or bottled sources, promoting regular handwashing with

soap after toilet use and before food handling, improving sanitation facilities, and practicing food safety by avoiding raw or undercooked shellfish, pork, and other meat products, particularly in endemic or outbreak-prone areas.

Diagnosis and Treatment

Both Hepatitis A and E are diagnosed through blood tests, including Anti-IgM antibodies (for acute infection) and Anti- IgG antibodies (for past infection).

There is no specific cure for Hepatitis A or E. Treatment focuses on supportive care to manage symptoms. This includes rest, adequate nutrition, and hydration. A healthcare provider may recommend medications for nausea or other symptoms as needed.

More Information

For additional authoritative information on Hepatitis A and E, please visit:

• Centers for Disease Control and Prevention (CDC):

https://www.cdc.gov/hepatitis/hevev/index.htm

• World Health Organization (WHO):

• https://www.who.int/news-room/factsheets/detail/hepatitis-a

• https://www.who.int/news-room/factsheets/detail/hepatitis-e

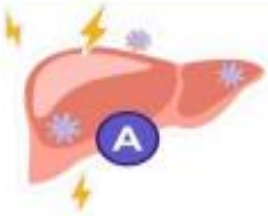
• Public Health Agency of Canada (PHAC):

•https://www.canada.ca/en/publichealth/services/diseases/hepatitisa.html

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

• https://www.nhs.uk/conditions/hepatit is/

WHAT YOU SHOULD KNOW ABOUT HEPATITIS A



A highly contagious liver disease caused by a virus spread from person to person. The illness can last for weeks to months.

HOW DOES IT SPREAD?

Forgetting to wash your hands after using the bathroom or changing diapers

Having sexual contact with infected partner(s)

Eating or drinking foods contaminated by Hepatitis A

WHAT ARE THE SYMPTOMS?

Throwing up or feeling like throwing up

Yellowing of the eyes and skin

Fever

Other symptoms include:

- Dark pee
- Grey poop
- Joint pain
- Diarrhea
- Feeling tired
- Loss of appetite
- Stomach pain

HOW CAN YOU PREVENT IT?

Get vaccinated.
Call 2-1-1 for information on where to get shots

Wash hands with soap and warm water before eating/preparing food and after using the bathroom/changing diapers

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

UK Health Security Agency

World Health Organization

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION