Vol. 5 | Week 13
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PUBLIC HEALTH BULLETIN-PAKISTAN

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.

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Overview

IDSR Reports

Ongoing Events

Field Reports

Public Health Bulletin - Pakistan, Week 13, 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;

- *Mpox Outbreak Investigation Report, District Chitral, KP- (February 2026).*
- *Knowledge hub on Understanding Mpox: 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

Note: All reported cases in this report are suspected cases

- *During Week 13, the most frequently reported cases were of Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, ALRI <5 years, TB, Animal/ Dog Bite, B. Diarrhea, VH (B, C & D), Typhoid, SARI, and Measles.*
- *Twenty-five cases of AFP were reported from KP, fifteen from Sindh, and one from AJK, GB, and Balochistan each.*
- *Ten suspected cases of HIV/ AIDS were reported from Sindh and five from KP.*
- *Four suspected cases of Brucellosis were reported from KP.*
- *Among VPDs, there is an increase in the number of cases of Measles, Chickenpox, Mumps, Meningitis, AFP, Pertussis, and Diphtheria this week.*
- *Among Respiratory diseases, there is an increase in the number of cases of ILI, ALRI <5 years, TB, and SARI this week.*
- *Among Water/food-borne diseases, there is an increase in the number of cases of Acute Diarrhea (Non-Cholera), B. Diarrhea, Typhoid, and AWD (S. Cholera) this week.*
- *Among Vector-borne diseases, there is an increase in the number of cases of Malaria, 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 Animal/ Dog Bite, VH (B, C & D), and Brucellosis this week.*
- *Field investigation is required for verification of the alerts and for prevention and control of the outbreaks.*

IDSR compliance attributes

- *The national compliance rate for IDSR reporting in 158 implemented districts is 79%.*
- *Sindh is the top reporting region with a compliance rate of 98%, followed by AJK 90%, KP 81%, ICT 79%, and GB 77%.*
- *In Week 13, the lowest compliance rate is observed in Balochistan, 43%.*

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2,234	1,806	81
Azad Jammu Kashmir	469	420	90
Islamabad Capital Territory	38	30	79
Balochistan	1,308	560	43
Gilgit Baltistan	417	321	77
Sindh	2,111	2,076	98
National	6,577	5,213	79

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Public Health Actions

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

Mpox

- **Strengthen Surveillance and Case Detection:** Enhance Mpox surveillance through the Integrated Disease Surveillance and Response (IDSR) system by training healthcare workers to identify suspected cases (fever, rash, lymphadenopathy) and ensure timely reporting and alert generation.
- **Improve Laboratory Capacity:** Strengthen laboratory diagnostic capacity for Mpox confirmation using PCR testing. Ensure proper specimen collection, storage, and transport systems, especially during suspected outbreaks.
- **Enhance Case Management and Infection Prevention:** Establish standard protocols for isolation, clinical management, and infection prevention and control (IPC) in healthcare settings. Ensure availability of personal protective equipment (PPE) for healthcare workers.
- **Promote Risk Communication and Community Engagement:** Implement public awareness campaigns to educate communities about Mpox transmission, symptoms, prevention measures, and the importance of early healthcare-seeking behavior while addressing stigma.
- **Ensure Safe Animal and Environmental Practices:** Promote safe handling of animals and animal products, particularly in areas where zoonotic transmission risk exists. Strengthen coordination between human and animal health sectors under a One Health approach.
- **Strengthen Points of Entry Screening:** Enhance screening and preparedness at airports and border crossings for early detection of suspected Mpox cases, especially during international outbreaks.

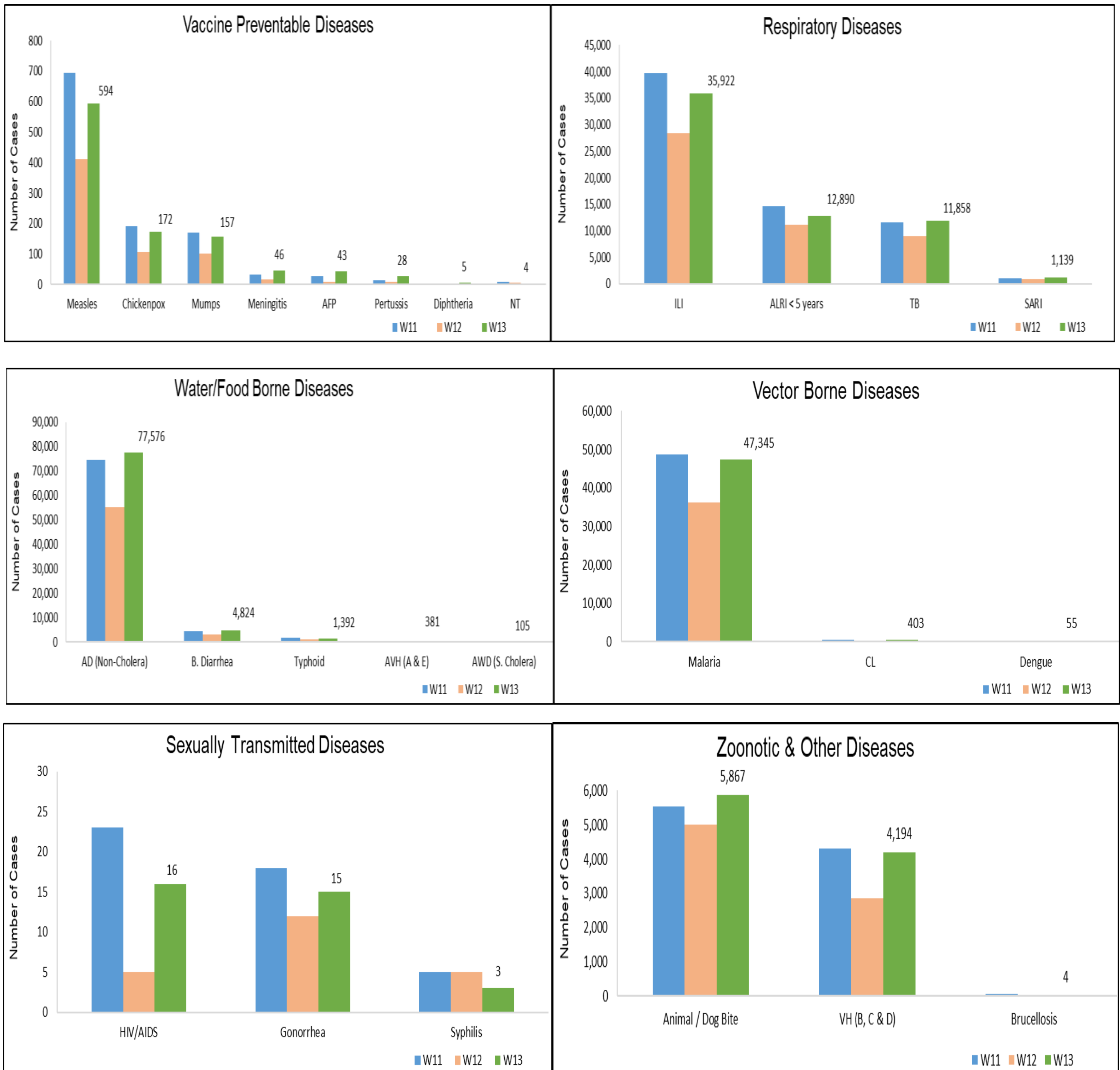
Brucellosis

- **Strengthen Surveillance and Reporting**: Integrate human and animal brucellosis surveillance within the One Health framework to ensure early detection, reporting, and response to outbreaks.
- **Improve Laboratory Diagnosis:** Expand laboratory capacity for serological and molecular confirmation at district and provincial levels; ensure biosafety standards in sample handling.
- **Enhance Intersectoral Collaboration**: Coordinate with livestock and agriculture departments for joint outbreak investigations, animal vaccination campaigns, and control of infection sources.
- **Promote Safe Animal Handling Practices**: Educate farmers, veterinarians, and abattoir workers on safe handling of livestock, proper disposal of animal products, and use of protective gear.
- **Raise Public Awareness:** Conduct community education on avoiding consumption of unpasteurized dairy products and promoting early care-seeking for prolonged fever or joint pain.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 13, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	1,934	5,079	577	403	24,629	NR	44,954	77,576
Malaria	0	1,487	0	0	2,456	NR	43,402	47,345
ILI	2,145	4,742	226	1,150	2,798	NR	24,861	35,922
ALRI < 5 years	1,292	820	566	1	782	NR	9,429	12,890
TB	106	18	56	16	230	NR	11,432	11,858
Animal / Dog Bite	108	218	0	0	1,226	NR	4,315	5,867
B. Diarrhea	30	720	47	2	696	NR	3,329	4,824
VH (B, C & D)	17	73	2	0	102	NR	4,000	4,194
Typhoid	36	223	44	0	390	NR	699	1,392
SARI	114	458	49	0	354	NR	164	1,139
Measles	9	6	6	0	457	NR	116	594
CL	1	13	0	0	384	NR	5	403
AVH (A & E)	17	3	0	0	137	NR	224	381
Chickenpox/ Varicella	4	12	7	4	61	NR	84	172
Mumps	4	30	2	1	76	NR	44	157
AWD (S. Cholera)	2	85	3	0	6	NR	9	105
Dengue	0	9	0	0	1	NR	45	55
Meningitis	0	0	4	0	30	NR	12	46
AFP	1	1	1	0	25	NR	15	43
Pertussis	0	17	0	0	11	NR	0	28
HIV/AIDS	0	1	0	0	5	NR	10	16
Gonorrhea	0	7	0	0	1	NR	7	15
Diphtheria (Probable)	0	0	0	0	5	NR	0	5
Brucellosis	0	0	0	0	4	NR	0	4
NT	0	0	0	0	4	NR	0	4
Syphilis	0	0	0	0	1	NR	2	3

Figure 1: Most frequently reported suspected cases during Week 13, Pakistan.



Sindh

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

Table 2: District wise distribution of most frequently reported suspected cases during Week 13, Sindh.

Districts	AD (Non-Cholera)	Malaria	ILI	TB	ALRI < 5 years	Animal / Dog Bite	VH (B, C & D)	B. Diarrhea	Typhoid	AVH (A & E)
Badin	3,035	2,086	3,154	704	377	101	209	221	45	2
Dadu	1,962	2,708	923	592	1,216	364	58	317	101	39
Ghotki	1,090	2,153	26	464	418	306	612	106	2	0
Hyderabad	2,368	657	1,519	328	143	77	84	68	9	1
Jacobabad	651	1,479	818	287	345	247	28	110	20	0
Jamshoro	2,029	1,750	93	539	386	110	96	112	37	0
Kamber	1,641	2,689	0	743	242	324	90	111	18	0
Karachi Central	1,148	16	1,419	204	88	106	11	3	65	0
Karachi East	308	32	6	20	16	2	1	0	0	0
Karachi Keamari	553	3	201	39	86	16	0	2	0	1
Karachi Korangi	322	45	28	74	2	19	9	12	1	0
Karachi Malir	871	24	1,228	77	183	40	2	9	1	0
Karachi South	82	6	0	0	0	1	0	0	0	0
Karachi West	578	248	933	55	185	54	13	15	18	0
Kashmore	368	1,504	267	119	93	158	1	21	0	0
Khairpur	3,356	4,024	5,324	1,017	1,189	326	152	342	168	6
Larkana	1,665	2,982	0	678	245	110	21	305	2	0
Matiari	1,691	1,996	68	568	312	157	272	112	0	5
Mirpurkhas	3,397	1,622	2,921	828	553	203	34	177	10	67
Naushero Feroze	1,181	1,451	1,090	231	308	255	98	218	29	0
Sanghar	2,338	3,364	74	1,105	440	315	1,374	66	25	2
Shaheed Benazirabad	1,832	2,038	0	406	215	165	123	99	74	1
Shikarpur	1,044	1,515	4	222	291	319	185	158	6	0
Sujawal	1,309	644	0	103	255	84	0	73	20	8
Sukkur	1,370	1,253	1,870	386	350	151	76	137	1	0
Tando Allahyar	1,865	1,193	1,128	423	158	54	103	95	6	2
Tando Muhammad Khan	1,277	658	60	500	148	149	93	108	0	9
Tharparkar	2,498	1,785	1,164	456	705	0	34	231	13	13
Thatta	1,257	1,307	543	32	216	102	179	12	6	65
Umerkot	1,868	2,170	0	232	264	0	42	89	22	3
Total	44,954	43,402	24,861	11,432	9,429	4,315	4,000	3,329	699	224

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Figure 2: Most frequently reported suspected cases during Week 13, Sindh.

Vaccine Preventable Diseases

Number of Cases

140 120 100 80 60 40 20 0

116 84 44 15 12

Measles Chickenpox Mumps AFP Meningitis

W11 W12 W13

Respiratory Diseases

Number of Cases

30,000 25,000 20,000 15,000 10,000 5,000 0

24,861 11,432 9,429 164

ILI TB ALRI < 5 years SARI

W11 W12 W13

Water/Food Borne Diseases

Number of Cases

50,000 45,000 40,000 35,000 30,000 25,000 20,000 15,000 10,000 5,000 0

44,954 3,329 699 224 9

AD (Non-Cholera) B. Diarrhea Typhoid AVH (A & E) AWD (S. Cholera)

W11 W12 W13

Vector Borne Diseases

Number of Cases

50,000 45,000 40,000 35,000 30,000 25,000 20,000 15,000 10,000 5,000 0

43,402 45 5

Malaria Dengue CL

W11 W12 W13

Sexually Transmitted Diseases

Number of Cases

16 14 12 10 8 6 4 2 0

10 7 2

HIV/AIDS Gonorrhea Syphilis

W11 W12 W13

Zoonotic/Other Diseases

Number of Cases

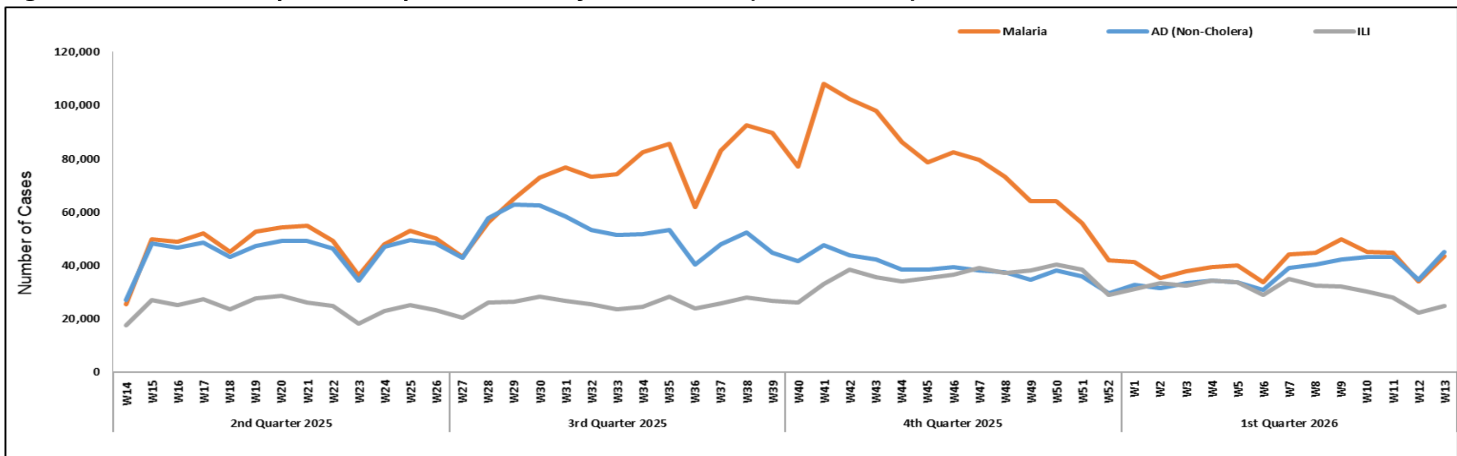
5,000 4,500 4,000 3,500 3,000 2,500 2,000 1,500 1,000 500 0

4,315 4,000

Animal / Dog Bite VH (B, C & D)

W11 W12 W13

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



Balochistan

- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, Animal/ Dog Bite, AWD (S. Cholera) and VH (B, C & D) cases were the most frequently reported diseases from Balochistan province.
- AD (Non-Cholera) cases were mostly reported from Gwadar, Sibi, and Usta Muhammad while ILI cases were mostly reported from Gwadar, Kech (Turbat) and Quetta.
- One case of AFP was reported from Balochistan. Field investigation is required to confirm the case.
- One case of HIV/ AIDS was reported from Balochistan which requires field investigation.
- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, Animal/ Dog Bite, AWD (S. Cholera), VH (B, C & D), Mumps, TB, Pertussis, CL, Chickenpox, Dengue, Gonorrhea, AVH (A & E), and AFP showed an increase in the number of cases. At the same time, a decline has been observed in the number of cases of Measles.

Table 3: District wise distribution of most frequently reported suspected cases during ***Week 13, Balochistan.***

Districts	AD (non-cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	Animal / Dog Bite	AWD (S. Cholera)	VH (B, C & D)
Awaran	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Barkhan	59	36	25	23	9	0	20	3	0	0
Chagai	193	201	23	0	50	0	12	0	0	1
Chaman	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Dera Bugti	14	0	13	6	3	0	1	0	0	0
Duki	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Gwadar	671	1,033	62	44	136	0	46	3	1	1
Harnai	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hub	178	30	52	8	2	2	3	1	0	28
Jaffarabad	128	3	133	2	13	0	1	11	0	0
Jhal Magsi	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kachhi (Bolan)	216	223	194	86	26	9	0	9	13	8
Kalat	0	0	0	0	0	0	0	0	0	0
Kech (Turbat)	462	861	161	5	88	NR	NR	NR	NR	4
Kharan	185	393	9	2	80	19	4	0	0	0
Khuzdar	84	56	26	0	17	7	7	1	0	0
Killa Abdullah	123	140	1	15	25	95	9	9	19	0
Killa Saifullah	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kohlu	33	51	16	21	12	3	7	NR	NR	NR
Lasbella	474	59	175	107	25	0	4	20	0	11
Loralai	184	277	8	27	23	74	10	0	0	0
Mastung	225	198	6	38	24	21	15	13	3	0
MusaKhel	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Naseerabad	290	11	156	26	18	2	47	116	4	11
Nushki	100	7	4	7	19	9	0	0	0	0
Panjgur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Pishin	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Quetta	323	544	3	89	31	36	5	0	0	0
Sherani	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sibi	578	361	330	81	59	92	31	2	30	1
Sohbat pur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Surab	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Usta Muhammad	475	202	89	195	56	13	1	30	0	8
Washuk	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Zhob	84	56	1	38	4	76	NR	NR	15	NR
Ziarat	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Total	5,079	4,742	1,487	820	720	458	223	218	85	73

Figure 4: Most frequently reported suspected cases during Week 13, Balochistan.

Vaccine Preventable Diseases

Number of Cases

35
30
25
20
15
10
5
0

30
17
12
6
1

Mumps
Pertussis
Chickenpox
Measles
AFP

W11 W12 W13

Respiratory Diseases

Number of Cases

6,000
5,000
4,000
3,000
2,000
1,000
0

4,742
820
458
18

ILI
ALRI < 5 years
SARI
TB

W11 W12 W13

Water/Food Borne Diseases

Number of Cases

6,000
5,000
4,000
3,000
2,000
1,000
0

5,079
720
223
85
3

AD (Non-Cholera)
B. Diarrhea
Typhoid
AWD (S. Cholera)
AVH (A & E)

W11 W12 W13

Vector Borne Diseases

Number of Cases

2,000
1,500
1,000
500
0

1,487
13
9

Malaria
CL
Dengue

W11 W12 W13

Sexually Transmitted Diseases

Number of Cases

14
12
10
8
6
4
2
0

7

Gonorrhea

W11 W12 W13

Zoonotic/Other Diseases

Number of Cases

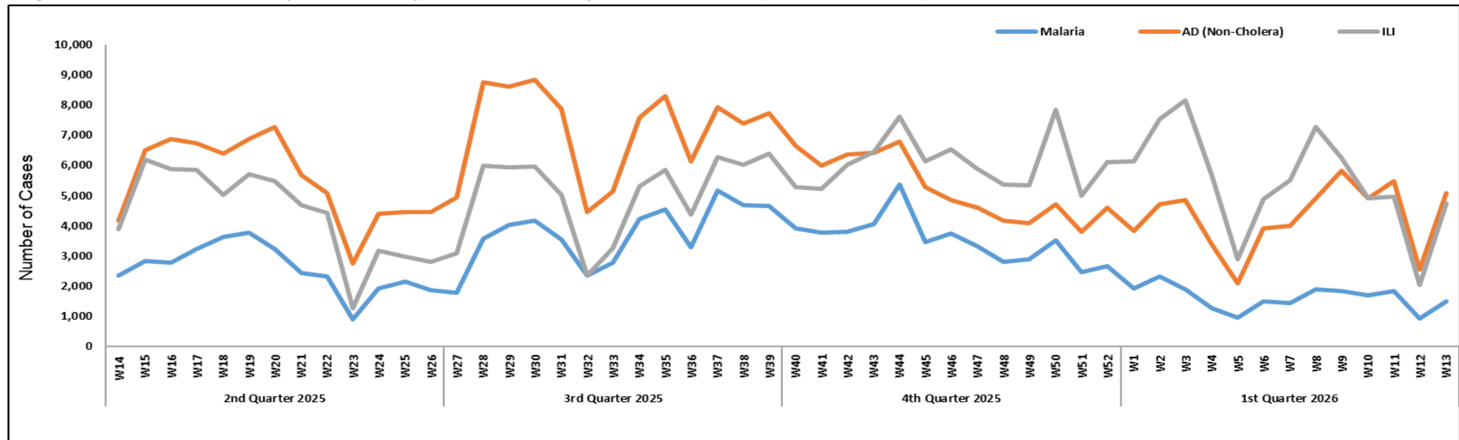
250
200
150
100
50
0

218
73

Animal / Dog Bite
VH (B, C & D)

W11 W12 W13

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



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Khyber Pakhtunkhwa

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

Table 4: District wise distribution of most frequently reported suspected cases during Week 13, KP.

Districts	AD (Non-Cholera)	ILI	Malaria	Animal / Dog Bite	ALRI < 5 years	B. Diarrhea	Measles	Typhoid	CL	SARI
Abbottabad	813	264	0	89	32	0	21	9	1	24
Bajaur	481	5	84	113	20	27	5	0	42	34
Bannu	745	4	795	2	5	17	75	74	2	0
Battagram	270	416	18	7	9	4	8	7	2	0
Buner	242	0	63	13	0	0	0	5	0	0
Charsadda	1,349	453	317	32	131	74	27	69	0	0
Chitral Lower	448	18	5	12	10	16	0	3	2	3
Chitral Upper	148	27	3	13	3	4	1	14	0	7
D.I. Khan	2,275	0	106	26	11	37	57	0	1	0
Dir Lower	1,155	0	51	52	5	57	18	11	1	0
Dir Upper	965	52	13	15	95	18	9	11	0	1
Hangu	309	5	62	20	0	52	2	2	31	0
Haripur	1,572	96	11	25	71	8	1	6	0	0
Karak	361	4	22	27	47	15	26	2	139	0
Khyber	457	18	104	52	25	58	1	25	43	3
Kohat	377	0	16	42	0	21	0	7	34	0
Kohistan Lower	114	0	1	0	0	5	0	2	0	0
Kohistan Upper	289	0	0	0	27	11	2	2	0	0
Kolai Palas	63	10	0	0	1	5	0	0	0	0
L & C Kurram	41	6	11	1	4	3	0	3	0	0
Lakki Marwat	537	9	121	84	0	0	7	8	2	0
Malakand	599	60	7	0	10	0	8	0	1	3
Mansehra	424	33	0	0	7	1	0	5	0	0
Mardan	1,017	64	20	14	89	23	29	16	2	0
Mohmand	97	44	52	15	2	8	3	1	44	60
North Waziristan	95	5	45	2	10	11	10	8	1	22
Nowshera	1,469	23	111	29	19	47	36	16	18	7
Orakzai	86	4	6	3	0	8	0	0	0	0
Peshawar	3,255	206	13	8	23	62	44	10	0	32
Shangla	576	0	209	125	17	3	8	11	0	0
South Waziristan (Lower)	45	31	23	20	25	7	7	4	11	59
SWU	23	0	12	0	2	0	0	0	0	13
Swabi	1,280	616	56	203	34	6	39	34	0	78
Swat	2,082	200	26	163	25	56	10	17	0	0
Tank	275	23	52	0	4	3	3	0	0	0
Tor Ghar	100	0	12	10	3	5	0	2	7	0
Upper Kurram	195	102	9	9	16	24	0	6	0	8
Total	24,629	2,798	2,456	1,226	782	696	457	390	384	354

Figure 6: Most frequently reported suspected cases during Week 13, KP.

Vaccine Preventable Diseases

Number of Cases

Measles 457; Mumps 76; Chickenpox 61; Meningitis 30; AFP 25; Pertussis 11; Diphtheria 5; NT 4

W11 W12 W13

Respiratory Diseases

Number of Cases

ILI 2,798; ALRI < 5 years 782; SARI 354; TB 230

W11 W12 W13

Water/Food Borne Diseases

Number of Cases

AD (Non-Cholera) 24,629; B. Diarrhea 696; Typhoid 390; AVH (A & E) 137; AWD (S. Cholera) 6

W11 W12 W13

Vector Borne Diseases

Number of Cases

Malaria 2,456; CL 384; Dengue 1

W11 W12 W13

Sexually Transmitted Diseases

Number of Cases

HIV/AIDS 5; Gonorrhea 1; Syphilis 1

W11 W12 W13

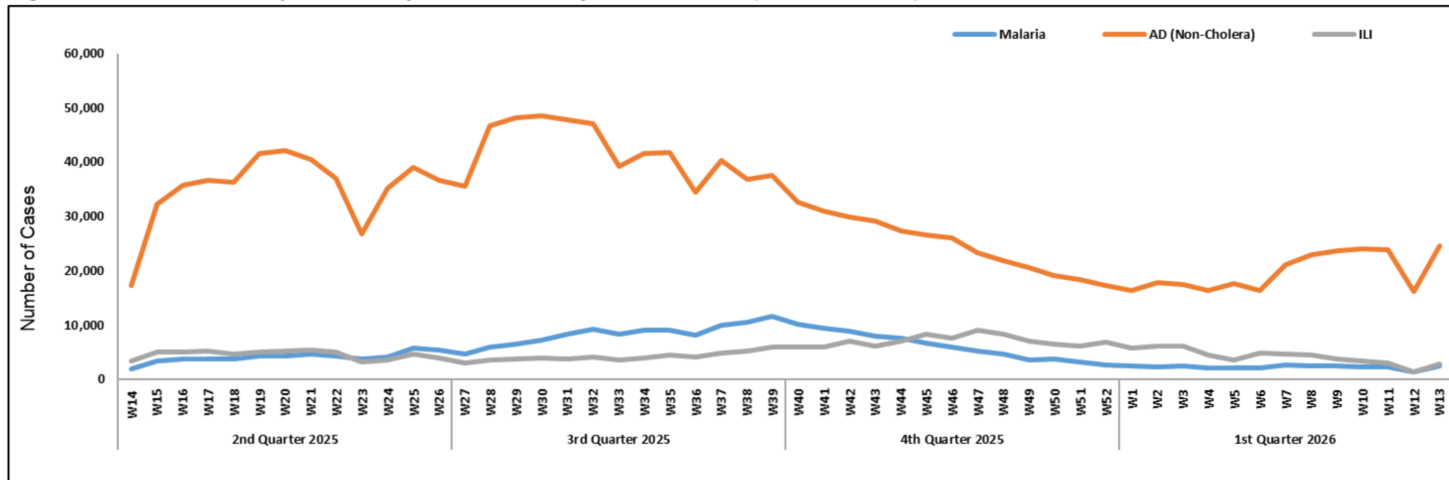
Zoonotic/Other Diseases

Number of Cases

Animal / Dog Bite 1,226; VH (B, C & D) 102; Brucellosis 4

W11 W12 W13

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 were ILI followed by AD (Non-Cholera), TB, Chickenpox, B. Diarrhea, ALRI < 5years, and Mumps. ALRI < 5years cases showed a decline in number while an increase in number was observed in ILI, AD (Non-Cholera), TB, Chickenpox, and Mumps cases this week.

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

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

Figure 8: Most frequently reported suspected cases during Week 13, AJK.

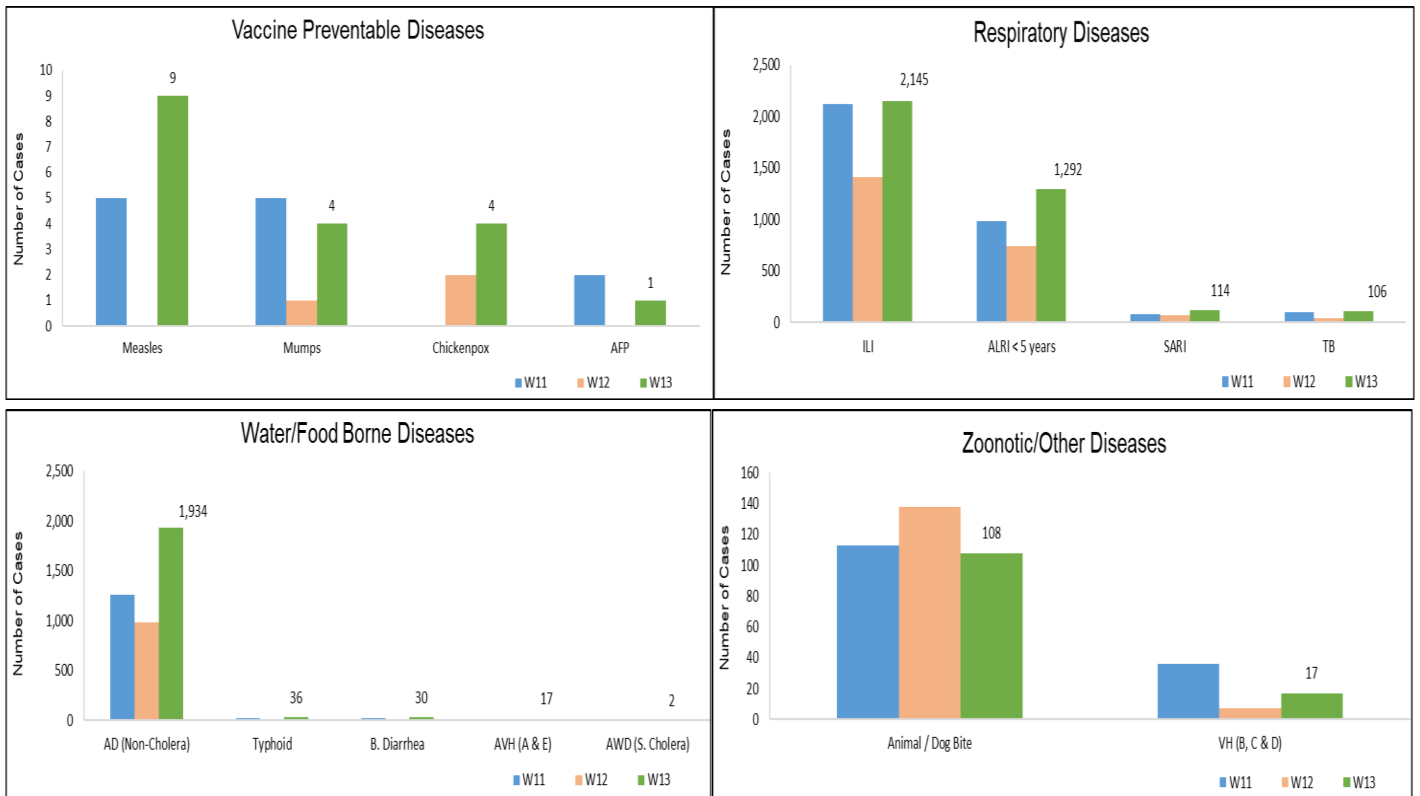


Figure 9: Week wise reported suspected cases of ILI and AD (Non-Cholera), AJK.

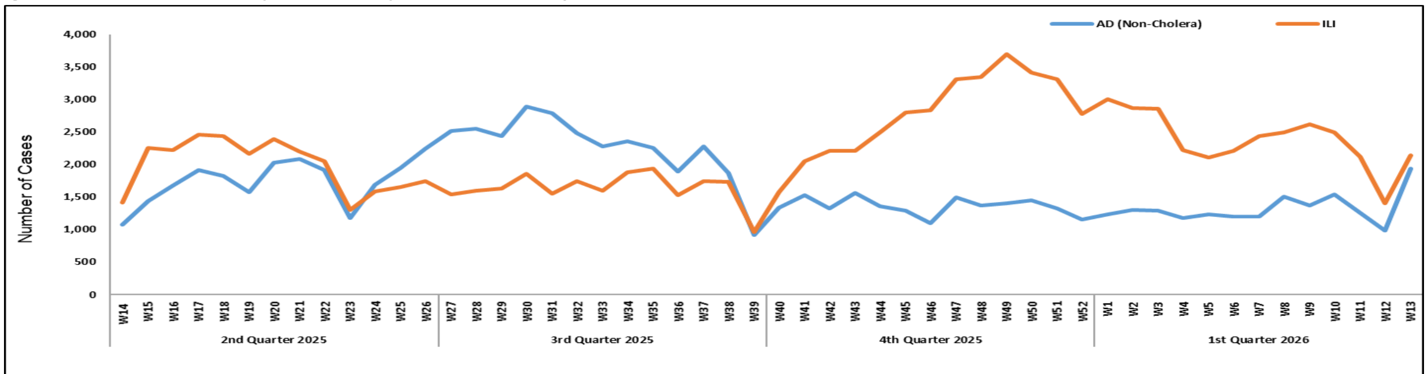


Figure 10: Most frequently reported suspected cases during Week 13, ICT.

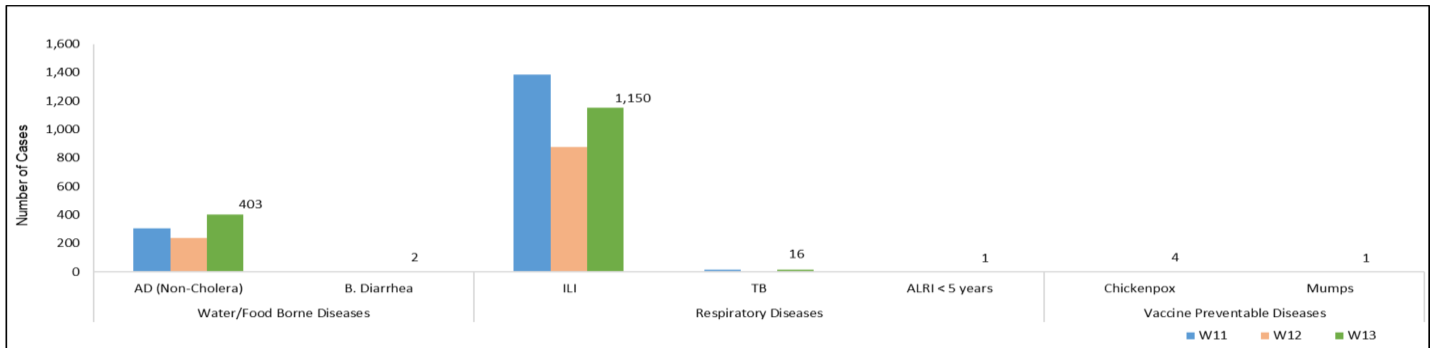


Figure 11: Week wise reported suspected cases of ILI, ICT.

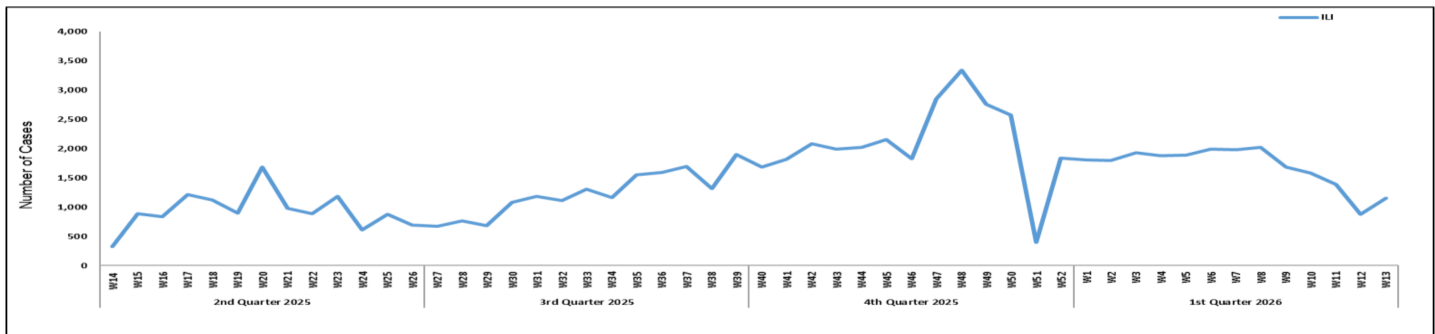


Figure 12: Most frequently reported suspected cases during Week 13, GB.

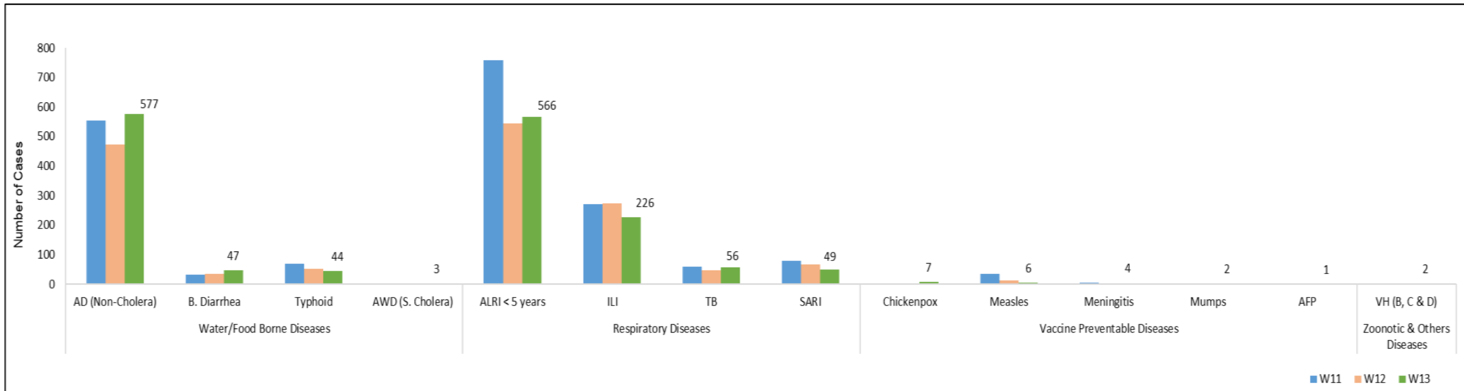


Figure 13: Week wise reported suspected cases of ALRI < 5 years, GB.

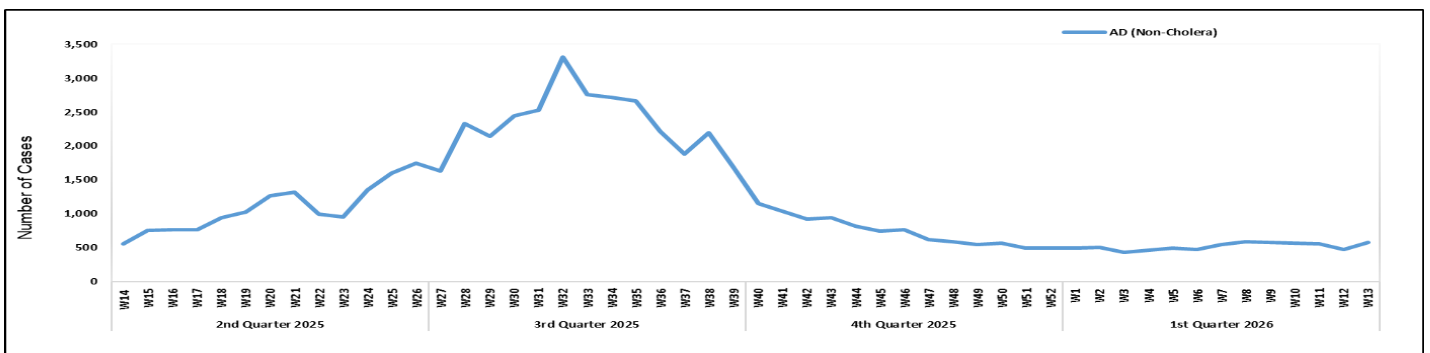
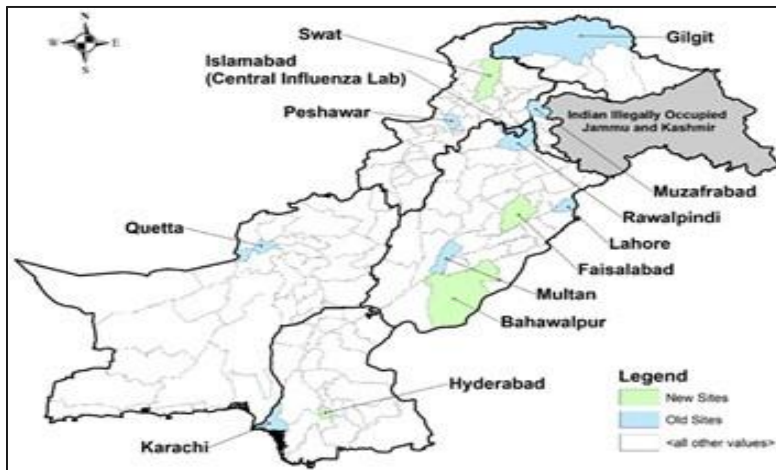


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 13, Pakistan.

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)	62	4	-	-	-	-	-	-	-	-	-	-	-	-
Stool culture & Sensitivity	294	4	-	-	-	-	-	-	-	-	-	-	2	0
Malaria	5,568	226	1,430	97	12	5	-	-	217	1	-	-	16	0
CCHF	-	-	3	1	-	-	-	-	-	-	-	-	-	-
Dengue	1,343	33	322	38	5	0	-	-	-	-	-	-	12	0
VH (B)	13,714	280	901	96	23	10	-	-	1,308	15	-	-	522	7
VH (C)	13,435	1,135	842	90	32	2	-	-	1,367	3	-	-	523	12
VH (D)	74	19	16	4	-	-	-	-	-	-	-	-	-	-
VH (A)	135	35	-	-	4	4	-	-	-	-	-	-	-	-
VH (E)	73	18	-	-	9	4	-	-	-	-	-	-	-	-
Covid-19	-	-	3	0	-	-	-	-	-	-	-	-	6	0
TB	655	71	148	23	4	0	-	-	30	0	-	-	70	13
HIV/ AIDS	5,544	35	569	0	10	0	-	-	259	2	-	-	485	1
Syphilis	1,581	23	189	3	-	-	-	-	213	1	-	-	-	-
Typhoid	606	8	134	19	-	-	-	-	101	2	-	-	-	-
Diphtheria	13	2	-	-	-	-	-	-	-	-	-	-	-	-
ILI	5	0	3	0	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)	197	54	3	2	-	-	-	-	-	-	-	-	-	-
Meningitis	30	1	-	-	-	-	-	-	-	-	-	-	-	-
Measles	200	99	33	12	242	124	8	4	4	4	345	76	15	6
Leishmaniosis (cutaneous)	-	-	32	9	-	-	-	-	2	0	-	-	1	1
Chikungunya	-	-	3	0	-	-	-	-	-	-	-	-	-	-
Chickenpox	4	0	-	-	-	-	-	-	-	-	-	-	-	-
Brucellosis	-	-	-	-	1	0	-	-	-	-	-	-	-	-
Mpox	5	0	-	-	-	-	-	-	-	-	-	-	-	-
SARI	16	10	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19 ILI	6	0	-	-	-	-	-	-	-	-	9	0	2	0
Covid-19 SARI	8	0	-	-	18	0	9	0	-	-	54	0	8	0
Influenza A ILI	6	0	-	-	-	-	-	-	-	-	9	0	2	0
Influenza A SARI	8	0	-	-	18	0	9	0	-	-	54	0	8	0
Influenza B ILI	6	0	-	-	-	-	-	-	-	-	9	0	2	0
Influenza B SARI	8	0	-	-	18	0	9	0	-	-	54	0	8	0
RSV ILI	6	0	-	-	-	-	-	-	-	-	9	0	2	0
RSV SARI	8	0	-	-	18	0	9	0	-	-	54	0	8	0

Figure 14: District wise Influenza sentinel sites, Pakistan.



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 15: Distribution of suspected samples of ILI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 13, Pakistan.

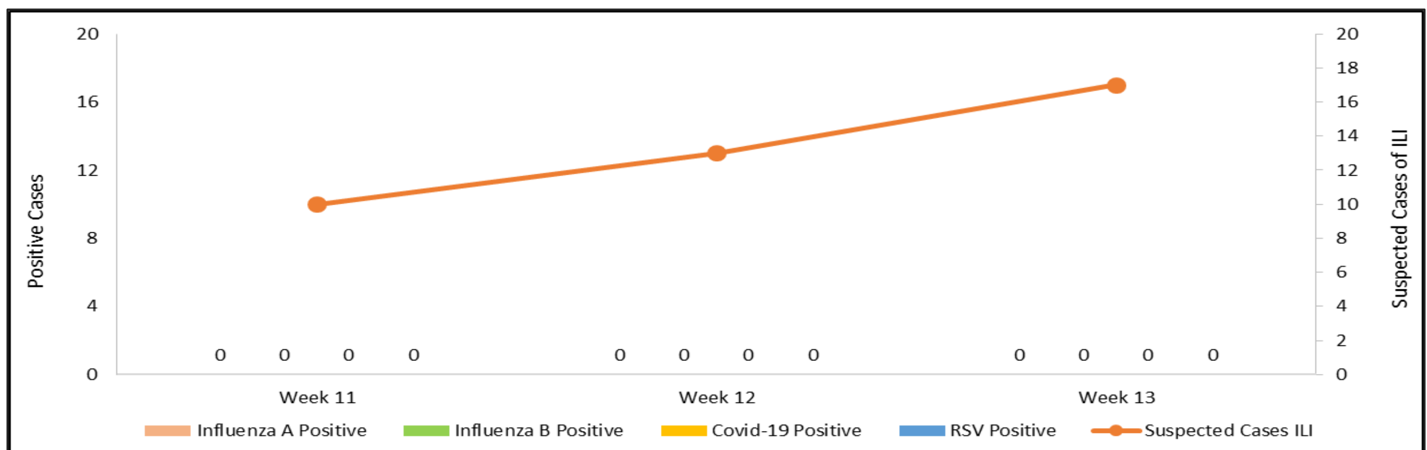
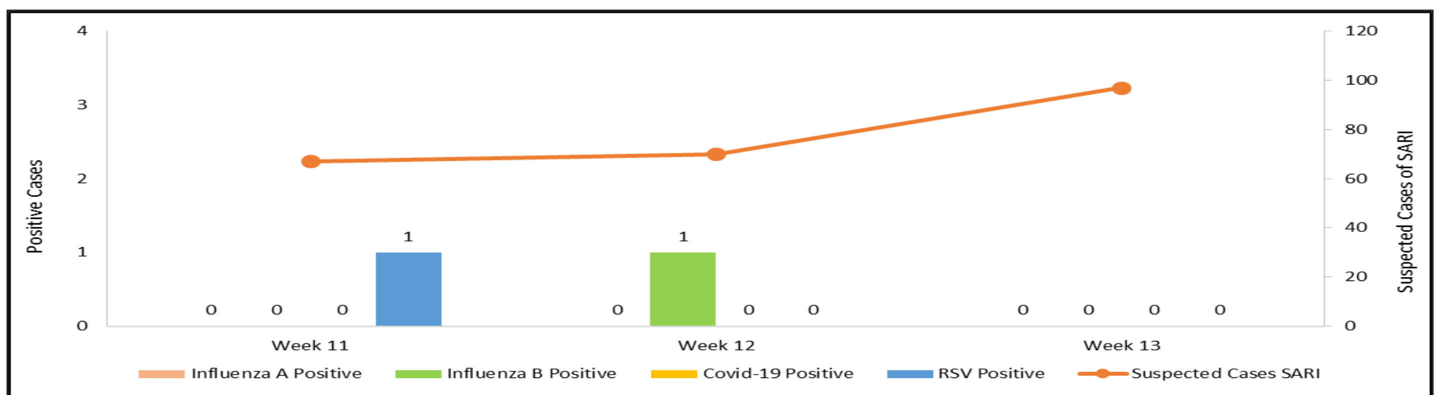


Figure 16: Distribution of suspected samples of SARI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 13, Pakistan.



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- 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 13, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	107	96%
	Bannu	238	132	55%
	Battagram	59	45	76%
	Buner	34	18	53%
	Bajaur	44	43	98%
	Charsadda	59	59	100%
	Chitral Upper	34	30	88%
	Chitral Lower	35	35	100%
	D.I. Khan	114	114	100%
	Dir Lower	74	61	82%
	Dir Upper	37	36	97%
	Hangu	22	20	91%
	Haripur	72	72	100%
	Karak	36	36	100%
	Khyber	53	40	75%
	Kohat	61	61	100%
	Kohistan Lower	12	12	100%
	Kohistan Upper	20	14	70%
	Kolai Palas	10	9	90%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	16	38%
	Upper Kurram	41	37	90%
	Malakand	42	29	69%
	Mansehra	133	130	98%
	Mardan	80	70	88%
	Nowshera	56	55	98%
	North Waziristan	13	11	85%
	Peshawar	156	130	83%
	Shangla	37	27	73%
	Swabi	66	62	94%
	Swat	77	75	97%
	South Waziristan (Upper)	93	38	41%
	South Waziristan (Lower)	42	29	69%
	Tank	34	33	97%
	Torghar	14	13	93%
	Mohmand	68	30	44%
	Orakzai	69	8	12%
Azad Jammu Kashmir	Mirpur	39	39	100%
	Bhimber	92	62	67%
	Kotli	60	60	100%
	Muzaffarabad	45	45	100%
	Poonch	46	46	100%
	Haveli	39	39	100%

	Bagh	54	35	65%
	Neelum	39	38	97%
	Jhelum Velley	29	29	100%
	Sudhnooti	27	27	100%
Islamabad Capital Territory	ICT	24	24	100%
	CDA	15	6	40%
Balochistan	Gwadar	26	25	96%
	Kech	44	34	77%
	Khuzdar	74	13	18%
	Killa Abdullah	26	21	81%
	Lasbella	55	55	100%
	Pishin	69	0	0%
	Quetta	55	26	47%
	Sibi	36	35	97%
	Zhob	39	10	26%
	Jaffarabad	16	16	100%
	Naserabad	32	32	100%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	8	11%
	Chagi	36	21	58%
	Kalat	41	40	98%
	Harnai	17	0	0%
	Kachhi (Bolan)	35	18	51%
	Jhal Magsi	28	0	0%
	Sohbat pur	25	0	0%
	Surab	32	0	0%
	Mastung	46	46	100%
	Loralai	33	22	67%
	Killa Saifullah	28	0	0%
	Ziarat	29	0	0%
	Duki	31	0	0%
	Nushki	32	28	88%
	Dera Bugti	45	6	13%
	Washuk	46	0	0%
	Panjgur	38	0	0%
	Awaran	23	0	0%
	Chaman	24	0	0%
	Barkhan	20	18	90%
	Hub	33	22	67%
	Musakhel	41	0	0%
	Usta Muhammad	34	34	100%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	0	0%
	Gilgit	44	44	100%
	Diamer	62	56	90%
	Astore	55	55	100%
	Shigar	27	18	67%

	Skardu	53	52	98%
	Ganche	29	19	66%
	Kharmang	46	25	54%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	64	100%
	Umerkot	62	62	100%
	Naushahro Feroze	107	102	95%
	Tharparkar	276	272	99%
	Shikarpur	60	59	98%
	Thatta	52	48	92%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	17	81%
	Karachi-West	20	20	100%
	Karachi-Malir	35	28	80%
	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	106	100%
	Badin	124	123	99%
	Sukkur	64	63	98%
	Dadu	90	90	100%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	Khairpur	170	168	99%
	Kashmore	59	59	100%
	Matiari	42	42	100%
	Jamshoro	75	74	99%
	Tando Allahyar	54	54	100%
	Tando Muhammad Khan	41	40	98%
	Shaheed Benazirabad	122	122	100%

Table 7: Compliance of IDSR reporting Tertiary care hospitals Week 13, Pakistan.

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	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%

Notes from the field:

Mpox Case Report, District Chitral, Khyber Pakhtunkhwa, Pakistan (February 2026)

Dr Arsalan Khan - Surveillance Officer

Dr Nouman Gowhar- Surveillance Coordinator PDSRU KP

Introduction

Mpox (formerly known as monkeypox) is a zoonotic viral disease caused by the mpox virus, a member of the Orthopoxvirus genus. It presents with fever, rash, and lymphadenopathy and can lead to complications, particularly in immunocompromised individuals. Globally, mpox has gained attention due to outbreaks beyond endemic regions, particularly after the 2022 multi-country outbreak. The disease remains endemic in parts of Central and West Africa, with sporadic cases reported worldwide. In the Eastern Mediterranean Region, including Pakistan, mpox cases are rare but pose a public health concern due to increasing international travel and local transmission risks. Pakistan has reported sporadic imported and locally transmitted cases, necessitating strong surveillance and rapid response mechanisms. This report describes the investigation of a confirmed mpox case reported from District Chitral, Khyber Pakhtunkhwa.

Objectives

1. To determine the magnitude of the outbreak.
2. To identify potential risk factors associated with the case.
3. To propose recommendations for containment and prevention of future outbreaks.

Methods

A descriptive outbreak investigation was conducted in Village Shishikok, Drosh (Lower Chitral), Islamabad, and Peshawar from 19 to 27 February 2026. The study population included the confirmed case and close contacts.

A suspected case was defined as “any individual presenting with fever and vesicular or pustular rash with lymphadenopathy”. In contrast, a confirmed case was defined as “a suspected case with laboratory confirmation of mpox virus by PCR”. Data were collected using a structured questionnaire covering demographic details, clinical presentation, travel, and exposure history. Active case finding was conducted through contact tracing, including household members and cohabitants. A record review was performed at Pakistan Institute of Medical Sciences (Islamabad) and Lady Reading Hospital (Peshawar).

Laboratory samples (lesion samples) were collected and tested at the Public Health Reference Laboratory (KMU), which confirmed the diagnosis. Descriptive analysis was performed.

Results

A total of one confirmed case of mpox was identified during the investigation. The patient was a 24-year-old male. The case was a resident of Village Shishikok, Lower Chitral, currently working in Islamabad, with exposure history in Islamabad and Peshawar.

No secondary cases were identified among close contacts, including family members and a cohabiting friend.

Risk factor assessment revealed a history of sexual contact in Islamabad one week before symptom onset and close contact with a friend during the symptomatic phase. No international travel history was reported.

Laboratory analysis confirmed mpox infection through PCR testing conducted at the Public Health Reference Laboratory. All identified contacts remained asymptomatic during the observation period.

Discussion

This investigation identified a single confirmed case of mpox with no secondary transmission among close contacts, indicating limited spread. The findings are consistent with

global evidence suggesting that mpox transmission occurs primarily through close physical or intimate contact rather than casual exposure. During the 2022 multi-country outbreak, the majority of cases were linked to close or sexual contact, highlighting the importance of these transmission pathways (2,6).

A systematic review reported that most cases during recent outbreaks occurred among males and were strongly associated with sexual networks (5,7). Similarly, surveillance data from outbreak settings have shown that intimate contact remains the most commonly reported exposure (2,6). This supports the likelihood that the infection in this case was acquired through close or sexual contact.

The absence of secondary cases among household and close contacts in this investigation is also consistent with published evidence. Studies have demonstrated relatively low secondary attack rates in non-sexual household settings, suggesting that transmission in such environments is less efficient, particularly when infection prevention measures are implemented (6,8). Evidence indicates that early case identification, isolation, and contact tracing are critical in interrupting transmission chains in mpox outbreaks (3,6). In this investigation, prompt response by the Rapid Response Team and implementation of IPC measures likely contributed to preventing secondary cases.

Additionally, the movement of the patient across multiple cities highlights the potential role of population mobility in disease spread, as observed in recent outbreaks (4,7). However, the absence of further cases demonstrates the effectiveness of coordinated surveillance and response systems when implemented in a timely manner.

Conclusion

A single confirmed case of mpox was investigated with no evidence of secondary transmission. The outbreak was contained effectively through timely response, isolation, and contact monitoring. However, the presence of risk factors such as close contact and mobility highlights the ongoing risk of mpox transmission in Pakistan.

Recommendations

1. **Strengthen surveillance systems** for early detection and reporting of suspected mpox cases.
2. **Enhance awareness** among healthcare workers regarding case identification and IPC measures.
3. **Promote public awareness** on modes of transmission, especially high-risk groups.
4. **Ensure strict adherence to IPC practices** in healthcare and community settings.
5. **Strengthen contact tracing and monitoring** mechanisms.
6. **Establish better coordination** between provincial and federal health authorities for rapid outbreak response.

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1. World Health Organization. Mpox (monkeypox) fact sheet. Geneva: WHO; 2025.
2. Centers for Disease Control and Prevention. Mpox: Clinical recognition. Atlanta: CDC; 2025.
3. World Health Organization Eastern Mediterranean Region. Mpox situation update. Cairo: WHO EMRO; 2025.
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Knowledge Hub

Mpox (Monkeypox)

What is Mpox?

Mpox is a viral zoonotic disease caused by the mpox virus, a member of the Orthopoxvirus genus. The virus is characterized

by two distinct genetic clades: clade I and clade II. Clade I is associated with more severe disease, in contrast to Clade II.

Transmission of Mpox:

1. Close physical contact: Transmission occurs through direct contact with skin lesions, bodily fluids, respiratory droplets, or contaminated objects (fomites).

2. Zoonotic transmission: Infection can spread from animals to humans through bites, scratches, or handling infected animal products.

3. Human-to-human transmission: Includes prolonged face-to-face, skin-to-skin, or mucosal contact (e.g., mouth-to-mouth or mouth-to-skin).

4. Vertical transmission: Rare transmission from an infected mother to the fetus or newborn during or after childbirth.

Disease Progression:

Incubation period: Usually 5–21 days (commonly 6–13 days) before symptoms appear.

Early (febrile) stage: Fever, swollen lymph nodes, headache, chills, sore throat, and fatigue lasting 1–4 days. **Rash (exanthem) stage:** Skin rash appears and progresses, lasting about 2–4 weeks. **Recovery:** Most patients recover within a few weeks after the rash resolves.

Symptoms:

Mpox usually begins with early symptoms such as fever, chills, muscle aches, back pain, swollen lymph nodes, and fatigue. Within 1–3 days of fever onset, a rash appears and progresses through stages from flat spots to raised bumps, fluid-filled blisters, pus-filled lesions, and finally scabs. The lesions are typically deep, firm, well-defined, and often have a central depression. The rash mainly affects the face, hands, and feet, including the palms and soles, with fewer lesions on the trunk. Unlike Chickenpox, lesions show a synchronous development pattern all over the body.

Prevention of Mpox:

- **Avoid contact:** Avoid close contact with infected individuals and animals.
- **Hand hygiene:** Wash hands regularly with soap and water or use alcohol-based sanitizers.
- **Use PPE:** Wear appropriate protective equipment when caring for suspected or confirmed cases.
- **Safe animal handling:** Properly handle and thoroughly cook animal products.
- **Isolation:** Isolate infected individuals to prevent further spread.

Treatment of Mpox:

- **Self-limiting illness:** Most patients recover within 2–4 weeks.
- **Supportive care:** Ensure adequate hydration, nutrition, and rest.
- **Symptom management:** Treat fever, pain, and any secondary infections.
- **Antiviral treatment:** Consider drugs like tecovirimat in severe or high-risk cases.
- **Isolation:** Patients should remain isolated until all lesions heal completely.
- **Infection control:** Proper handling and disposal of contaminated materials is essential to prevent spread.

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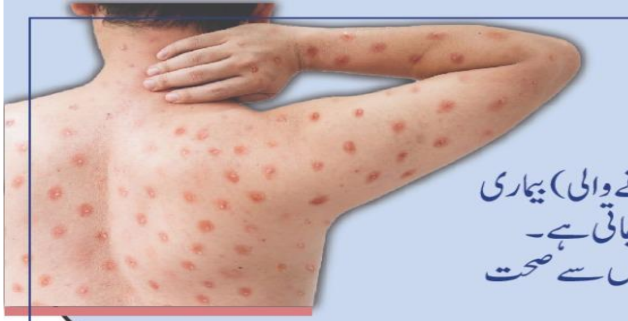

ایم پاکس کیسے پھیلتا ہے

- متاثرہ افراد سے جنسی رابطے، سانس کے قطروں، یا متاثرہ شخص کی جسمانی رطوبتوں کے ذریعے
- وائرس سے آلودہ اشیاء کے ساتھ براہ راست رابطہ سے
- وہ افراد جو ایم پاکس سے متاثرہ شخص کے ساتھ رہتے ہیں یا ان کے ساتھ قریبی رابطے یا سفر میں ہوتے ہیں، ان میں وائرس کے پھیلنے کا خطرہ ہوتا ہے

Centre for Diseases Control (CDC)
National Institute of Health
Ministry of National Health Services Regulations and Coordination

Phone: 0519255237
Fax-No: 051-9255299
Email: fedsd@nih.org.pk
Website: www.nih.org.pk
National Institute of Health
@NIH_Pakistan

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