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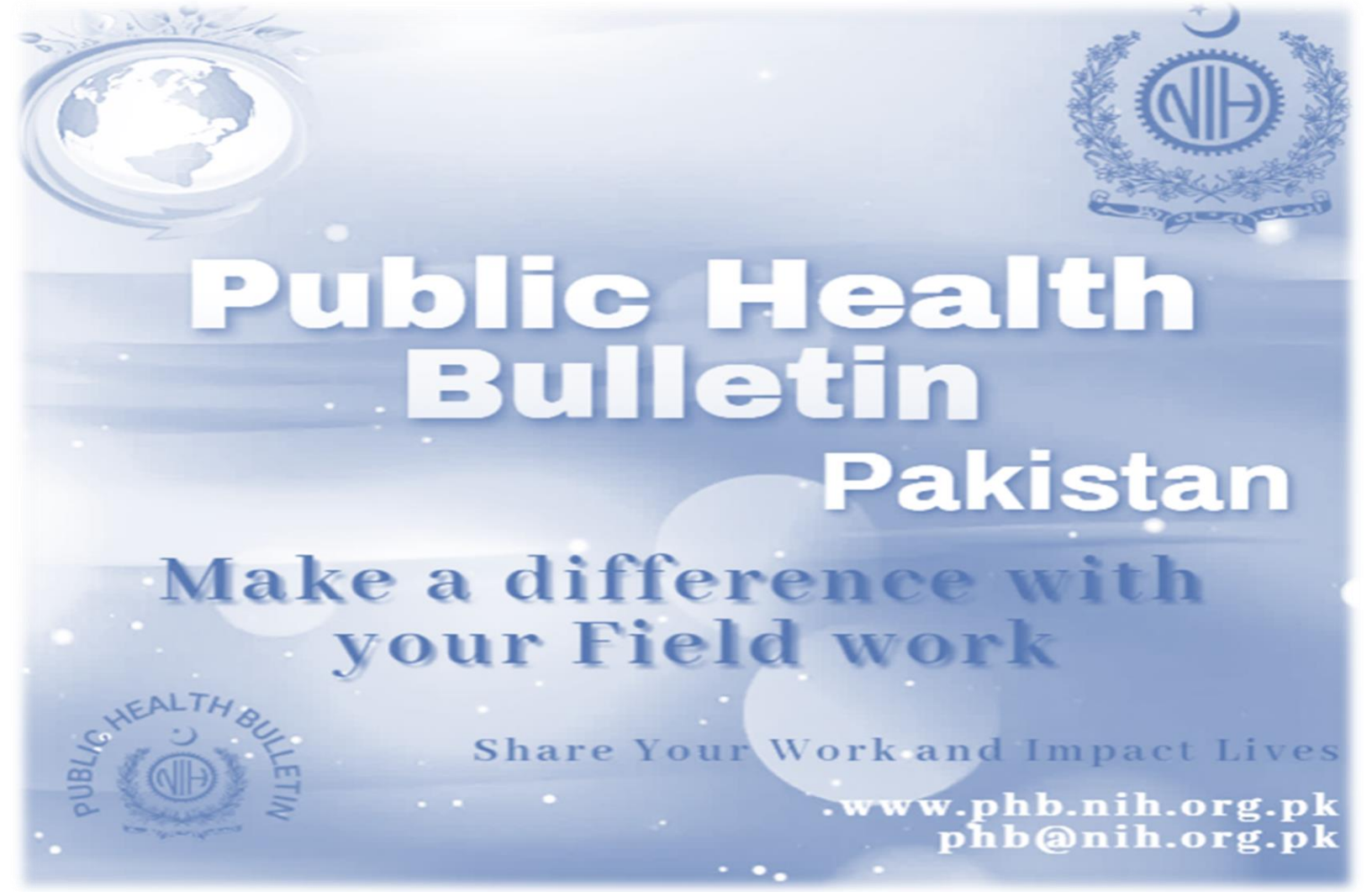
Integrated Disease Surveillance & Response (IDSR) Report

Center of Disease Control
National Institute of Health, Islamabad

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

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



Public Health Bulletin - Pakistan, Week 21, 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 to be relevant to Pakistan's priorities and free of 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;

- *Crimean Congo Haemorrhagic Fever Case Investigation Report, Loralai District, Balochistan, March 2026*
- *Knowledge hub on Understanding CCHF: A Public Health Priority*

By transforming complex health data into actionable intelligence, the Public Health Bulletin remains 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

- *During Week 21, 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, and Measles.*
- *Twenty-two cases of AFP were reported from KP, twenty from Sindh, and one from AJK.*
- *Nine suspected cases of HIV/ AIDS were reported from KP and six from Sindh.*
- *Two suspected cases of Brucellosis were reported from KP.*
- *Among VPDs, there is an increase in the number of cases of Chickenpox, NT, and Diphtheria this week.*
- *Among Respiratory diseases, there is a decrease in the number of cases of ILI, TB, ALRI <5 years, and SARI this week.*
- *Among Water/food-borne diseases, there is an increase in the number of cases of B. Diarrhea and AWD (S. Cholera) this week.*
- *Among Vector-borne diseases, there is an increase in the number of cases of CL, Chikungunya, and VL this week.*
- *Among STDs, there is a decline in the number of cases of HIV/AIDS this week.*
- *Among Zoonotic/Other diseases, there is an increase in the number of cases of 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 77%.*
- *AJK is the top reporting region with a compliance rate of 97%, followed by Sindh 95%, GB 90%, ICT 79%, and KP 75%.*
- *In Week 21, the lowest compliance rate is observed in Balochistan, 40%.*

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2,277	1,711	75
Azad Jammu Kashmir	476	464	97
Islamabad Capital Territory	38	30	79
Balochistan	1,303	520	40
Gilgit Baltistan	405	365	90
Sindh	2,111	2,012	95
National	6,610	5,102	77

Public Health Actions

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

Crimean-Congo Hemorrhagic Fever (CCHF)

Strengthen Surveillance and Reporting: Enhance surveillance for early detection and timely reporting of suspected CCHF cases, particularly during high-risk periods and in endemic areas; integrate human and animal health surveillance through a One Health approach.

Improve Laboratory Capacity and Biosafety: Expand access to diagnostic testing, including RT-PCR and serological testing, and ensure safe specimen collection, transport, and handling according to biosafety guidelines.

Enhance Infection Prevention and Control (IPC): Ensure availability and proper use of personal protective equipment (PPE) in healthcare facilities; strengthen IPC measures to prevent healthcare-associated transmission.

Promote Safe Livestock Handling and Tick Control: Collaborate with livestock and veterinary departments to implement tick control measures, regulate livestock movement, and educate farmers, butchers, and animal handlers on safe animal handling practices.

Raise Public Awareness: Conduct risk communication and community engagement activities on prevention of tick bites, safe slaughtering practices, early recognition of symptoms, and prompt healthcare seeking.

Dog Bite / Rabies

Strengthen Surveillance and Reporting: Establish and strengthen integrated surveillance systems for dog bites and suspected rabies cases to facilitate timely reporting, investigation, and response.

Ensure Availability of Post-Exposure Prophylaxis (PEP): Maintain uninterrupted supplies of rabies vaccines and rabies immunoglobulin at designated health facilities and ensure timely administration according to national guidelines.

Enhance Dog Population Management and Vaccination: Collaborate with local government and veterinary authorities to implement mass dog vaccination campaigns and humane dog population management programs.

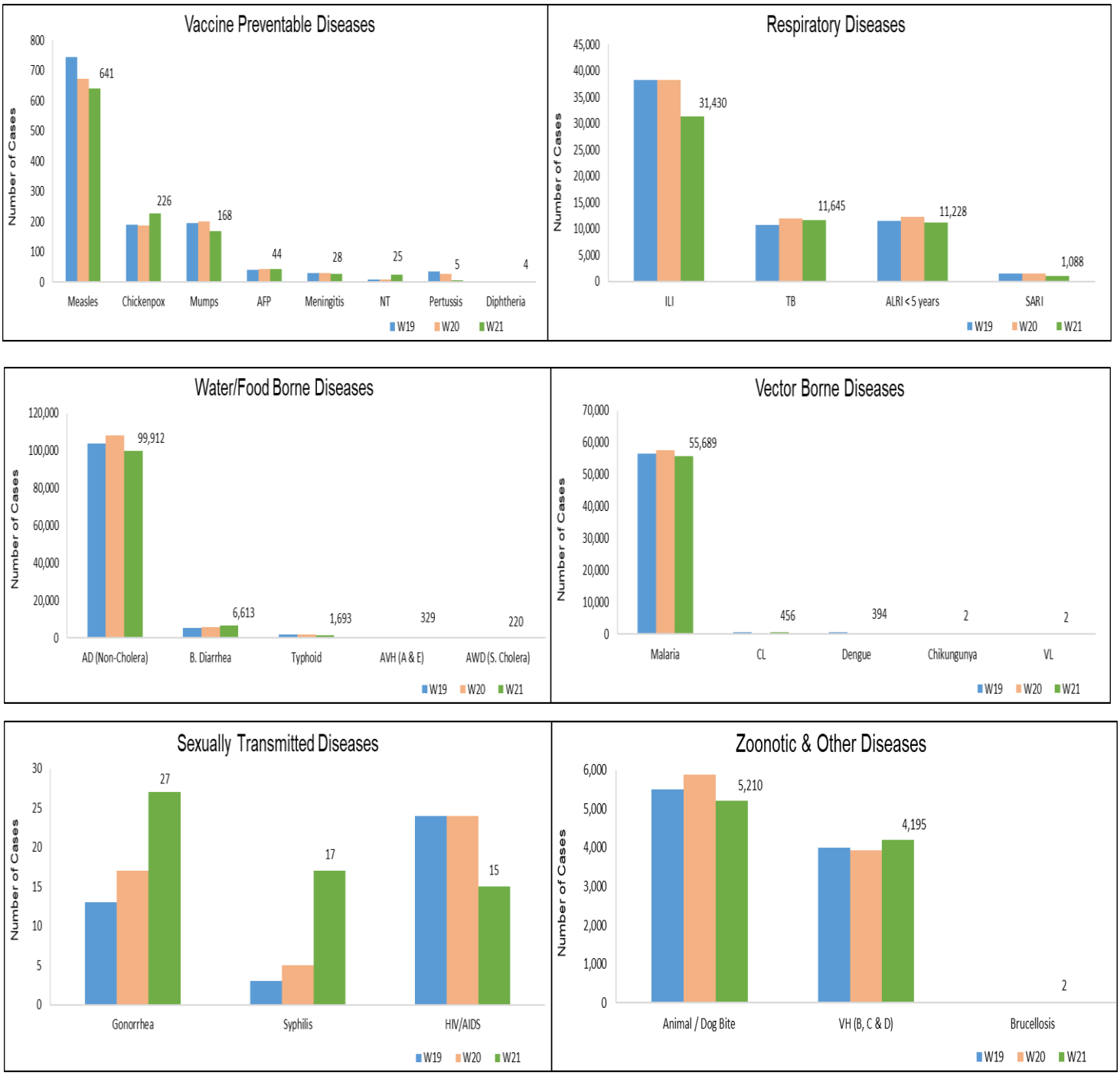
Improve Healthcare Worker Capacity: Train healthcare providers on proper wound management, risk assessment, case management, and administration of rabies post-exposure prophylaxis.

Raise Community Awareness: Conduct public education campaigns on responsible pet ownership, avoidance of stray animals, immediate wound washing after dog bites, and the importance of seeking medical care promptly following an animal bite.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 21, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	1,833	5,464	874	27	40,808	NR	50,906	99,912
Malaria	0	1,862	0	0	4,714	NR	49,113	55,689
ILI	1,159	3,144	246	67	2,648	NR	24,166	31,430
TB	42	13	62	0	255	NR	11,273	11,645
ALRI < 5 years	1,142	863	685	0	672	NR	7,866	11,228
B. Diarrhea	35	715	53	0	2,341	NR	3,469	6,613
Animal / Dog Bite	83	119	3	0	1,331	NR	3,674	5,210
VH (B, C & D)	17	59	0	0	97	NR	4,022	4,195
Typhoid	22	240	74	2	461	NR	894	1,693
SARI	146	244	78	0	487	NR	133	1,088
Measles	4	11	7	0	511	NR	108	641
CL	0	32	1	0	407	NR	16	456
Dengue	0	226	0	0	30	NR	138	394
AVH (A & E)	15	8	0	0	113	NR	193	329
Chickenpox/ Varicella	3	5	7	0	154	NR	57	226
AWD (S. Cholera)	17	164	2	0	0	NR	37	220
Mumps	11	14	3	3	91	NR	46	168
AFP	1	1	0	0	22	NR	20	44
Meningitis	1	0	4	0	7	NR	16	28
Gonorrhea	0	10	0	0	3	NR	14	27
NT	0	0	0	0	13	NR	12	25
Syphilis	0	0	0	0	2	NR	15	17
HIV/AIDS	0	0	0	0	9	NR	6	15
Pertussis	0	4	0	0	1	NR	0	5
Diphtheria (Probable)	0	0	0	0	4	NR	0	4
Brucellosis	0	0	0	0	2	NR	0	2
Chikungunya	0	0	0	0	0	NR	2	2
VL	0	0	0	0	2	NR	0	2

Figure 1: Most frequently reported suspected cases during Week 21, Pakistan.



Sindh

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

Table 2: District wise distribution of most frequently reported suspected cases during Week 21, Sindh.

Districts	AD (Non-Cholera)	Malaria	ILI	TB	ALRI < 5 years	VH (B, C & D)	Animal / Dog Bite	B. Diarrhea	Typhoid	AVH (A & E)
Badin	4,468	3,528	3,203	855	1,058	195	126	403	101	0
Dadu	2,161	2,212	432	452	727	47	189	273	93	15
Ghotki	1,506	2,564	0	482	438	657	242	132	0	0
Hyderabad	2,517	678	1,034	327	139	94	76	60	4	6
Jacobabad	822	1,525	743	335	319	110	272	131	25	0
Jamshoro	1,876	1,920	81	571	300	152	122	87	35	3
Kamber	2,112	2,850	0	755	235	66	284	167	21	0
Karachi Central	2,121	17	1,429	171	107	27	101	1	105	18
Karachi East	448	66	9	22	19	9	2	3	5	0
Karachi Keamari	637	11	448	17	13	1	14	10	1	0
Karachi Korangi	446	66	0	65	1	1	10	8	3	2
Karachi Malir	1,504	67	1,762	71	173	3	46	37	7	4
Karachi South	100	16	0	0	0	0	0	0	0	0
Karachi West	1,046	309	1,664	103	214	14	81	29	24	0
Kashmore	432	1,518	145	112	110	14	138	53	7	0
Khairpur	3,314	4,257	5,550	882	970	282	249	395	225	15
Larkana	1,980	2,924	0	778	253	30	105	303	6	1
Matiari	1,722	2,661	56	701	159	268	97	65	0	16
Mirpurkhas	3,184	1,993	2,741	693	243	52	133	100	10	3
Naushero Feroze	1,582	1,602	950	379	309	138	258	226	51	0
Sanghar	1,632	3,057	26	782	270	891	195	49	17	1
Shaheed Benazirabad	1,769	2,199	0	287	178	109	175	88	79	0
Shikarpur	1,336	1,635	3	290	194	138	275	183	4	0
Sujawal	2,235	673	0	103	98	60	78	67	6	0
Sukkur	1,637	1,345	1,889	399	149	103	127	145	4	0
Tando Allahyar	1,956	1,782	624	408	109	275	103	101	9	3
Tando Muhammad Khan	992	684	0	430	105	5	80	75	0	0
Tharparkar	2,037	1,904	834	386	514	39	0	97	8	27
Thatta	1,826	1,731	543	77	297	144	96	46	12	77
Umerkot	1,508	3,319	0	340	165	98	0	135	32	2
Total	50,906	49,113	24,166	11,273	7,866	4,022	3,674	3,469	894	193

Figure 2: Most frequently reported suspected cases during Week 21, Sindh.

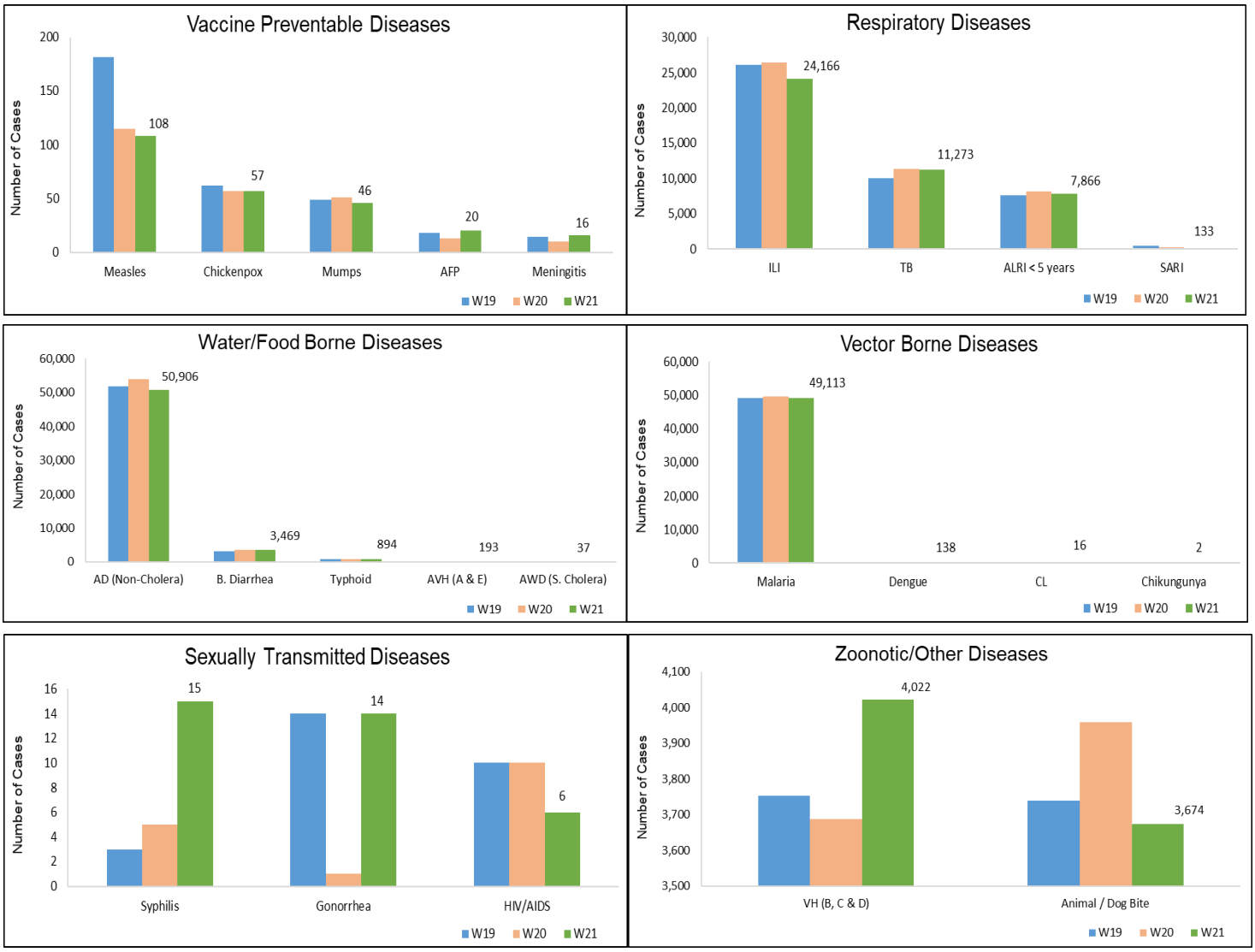
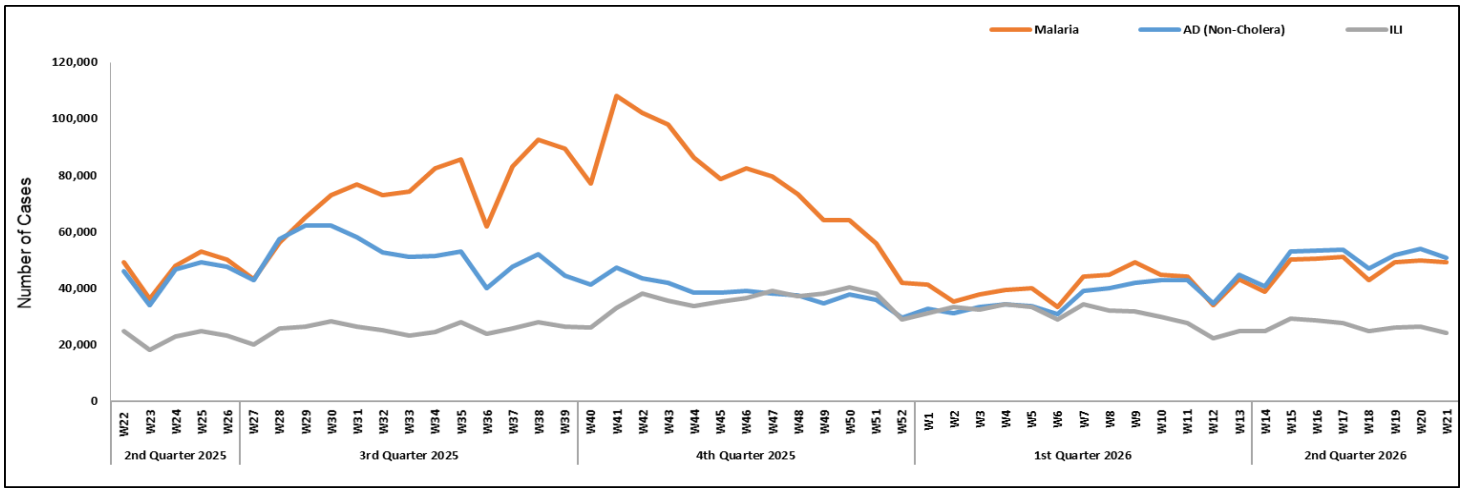


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh.



Balochistan

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

Table 3: District wise distribution of most frequently reported suspected cases* during *Week 21, Balochistan.

Districts	AD (non-cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	Dengue	AWD (S. Cholera)	Animal / Dog Bite
Awaran	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Barkhan	80	48	52	16	9	2	42	0	68	21
Chagai	174	188	55	0	30	0	6	0	0	0
Chaman	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Dera Bugti	3	0	3	0	1	0	0	0	0	0
Duki	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Gwadar	518	599	17	NR	22	NR	NR	129	NR	NR
Harnai	228	6	76	178	66	0	4	0	0	5
Hub	99	26	40	7	0	0	0	0	0	6
Jaffarabad	151	24	133	3	17	0	3	0	0	12
Jhal Magsi	0	0	0	0	0	0	0	0	0	0
Kachhi (Bolan)	210	201	175	88	30	12	NR	NR	14	18
Kalat	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kech (Turbat)	354	494	281	4	54	NR	NR	54	NR	NR
Kharan	282	469	36	0	97	17	6	0	2	0
Khuzdar	119	84	43	0	18	6	32	0	0	0
Killa Abdullah	275	121	23	14	53	76	18	0	49	10
Killa Saifullah	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kohlu	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lasbella	528	77	354	165	38	2	10	43	0	15
Loralai	332	314	47	23	49	23	16	0	2	0
Mastung	507	204	35	128	73	23	8	0	1	12
MusaKhel	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Naseerabad	306	0	190	27	28	32	69	0	1	11
Nushki	26	0	0	0	3	0	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	52	48	0	46	11	10	10	0	7	0
Sherani	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sibi	300	115	156	34	18	29	14	0	20	0
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	920	126	146	130	98	12	2	0	0	9
Washuk	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Zhob	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Ziarat	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Total	5,464	3,144	1,862	863	715	244	240	226	164	119

Figure 4: Most frequently reported suspected cases during Week 21, Balochistan.

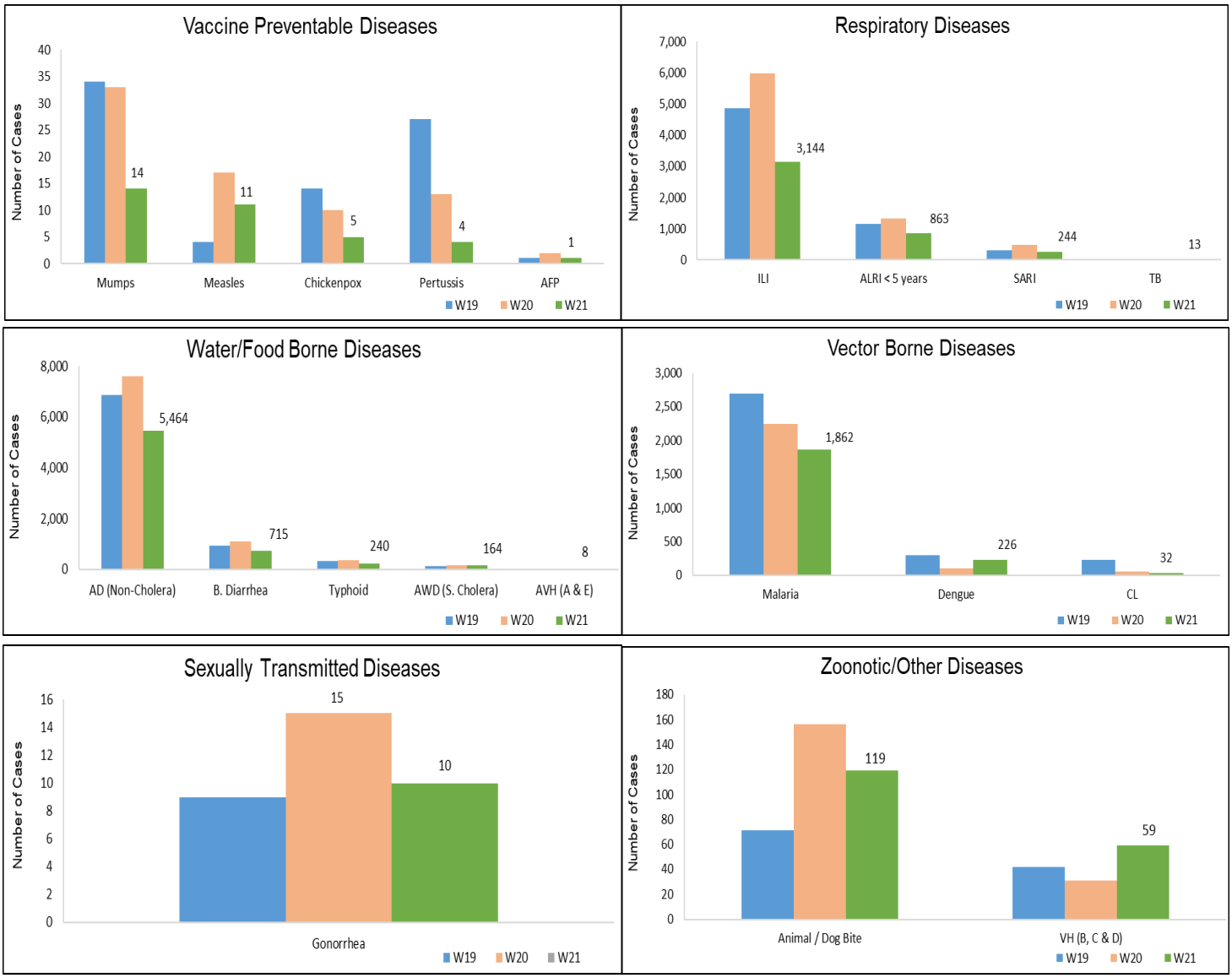
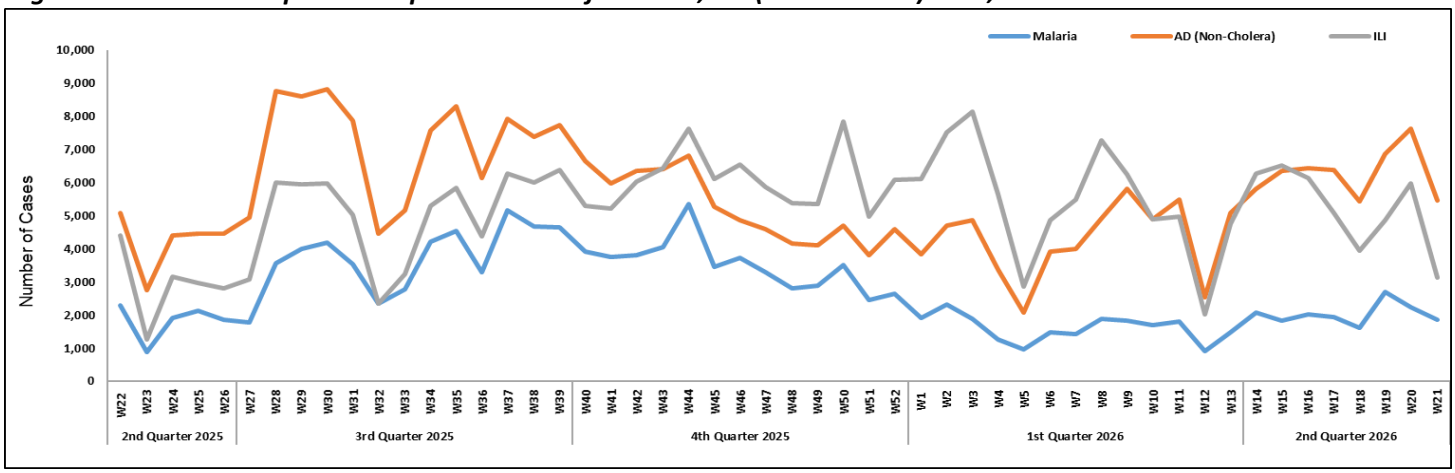


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan.



UK Health Security Agency

World Health Organization

U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

Khyber Pakhtunkhwa

- Cases of AD (Non-Cholera) were maximum followed by Malaria, ILI, B. Diarrhea, Animal/ Dog Bite, ALRI<5 Years, Measles, SARI, Typhoid, and CL.
- B. Diarrhea, SARI, CL, Chickenpox, AFP, NT, HIV/ AIDS, Diphtheria, and Syphilis cases showed an increase in number while AD (Non-Cholera), Malaria, ILI, Animal/ Dog Bite, ALRI<5 Years, Measles, Typhoid, TB, AVH (A & E), VH (B, C, & D), Mumps, Dengue, Meningitis, Gonorrhea, and Pertussis showed a decline in number this week.
- Twenty-two cases of AFP were reported from KP. All are suspected cases and need field verification.
- Nine cases of HIV/AIDS were reported from KP. Field investigation is required.
- Two 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 21, KP.

Districts	AD (Non-Cholera)	Malaria	ILI	B. Diarrhea	Animal / Dog Bite	ALRI < 5 years	Measles	SARI	Typhoid	CL
Abbottabad	1,131	4	32	10	55	23	15	14	8	1
Bajaur	910	207	2	49	77	17	15	37	1	23
Bannu	1,068	885	2	21	2	7	110	6	91	3
Battagram	399	54	523	0	4	10	10	0	0	0
Buner	490	113	0	0	0	0	0	0	0	0
Charsadda	2,214	324	314	126	43	125	9	0	108	0
Chitral Lower	654	19	15	41	3	19	5	7	2	8
Chitral Upper	198	7	9	4	2	2	0	6	13	1
D.I. Khan	2,580	435	0	39	37	14	102	0	0	1
Dir Lower	1,962	107	0	90	57	3	17	0	32	1
Dir Upper	1,282	8	21	31	21	89	8	0	21	0
Hangu	283	114	0	26	27	0	1	0	2	13
Haripur	1,947	5	116	0	79	21	5	0	0	0
Karak	729	187	18	1,175	33	37	22	0	7	153
Khyber	731	315	16	179	34	23	7	5	19	23
Kohat	821	113	0	56	13	1	1	0	15	58
Kohistan Lower	63	1	0	2	0	0	0	0	0	0
Kohistan Upper	451	7	0	18	4	0	1	0	1	0
Kolai Palas	88	0	7	1	0	1	0	2	0	0
L & C Kurram	17	0	0	2	0	0	0	0	0	0
Lakki Marwat	773	215	6	7	91	2	5	0	14	0
Malakand	1,795	21	53	0	0	6	16	7	0	4
Mansehra	1,077	0	120	27	0	7	0	0	17	0
Mardan	2,059	222	1	53	33	66	5	0	0	2
Mohmand	151	72	157	5	5	0	4	127	5	39
North Waziristan	69	85	7	6	0	13	9	14	16	0
Nowshera	2,587	326	26	33	111	20	29	12	11	28
Orakzai	130	6	4	9	8	0	0	0	0	0
Peshawar	5,525	41	226	92	19	11	50	0	20	0
Shangla	1,092	331	0	3	240	6	4	0	5	0
South Waziristan (Lower)	83	96	153	34	0	21	20	144	3	39
SWU	53	17	9	0	0	2	0	0	0	0
Swabi	2,690	111	441	32	33	26	37	74	7	0
Swat	3,779	21	176	106	257	66	1	0	35	0
Tank	485	163	18	6	0	6	2	0	0	0
Tor Ghar	214	61	0	29	15	8	0	0	3	10
Upper Kurram	228	21	176	29	28	20	1	32	5	0
Total	40,808	4,714	2,648	2,341	1,331	672	511	487	461	407

Figure 6: Most frequently reported suspected cases during Week 21, KP.

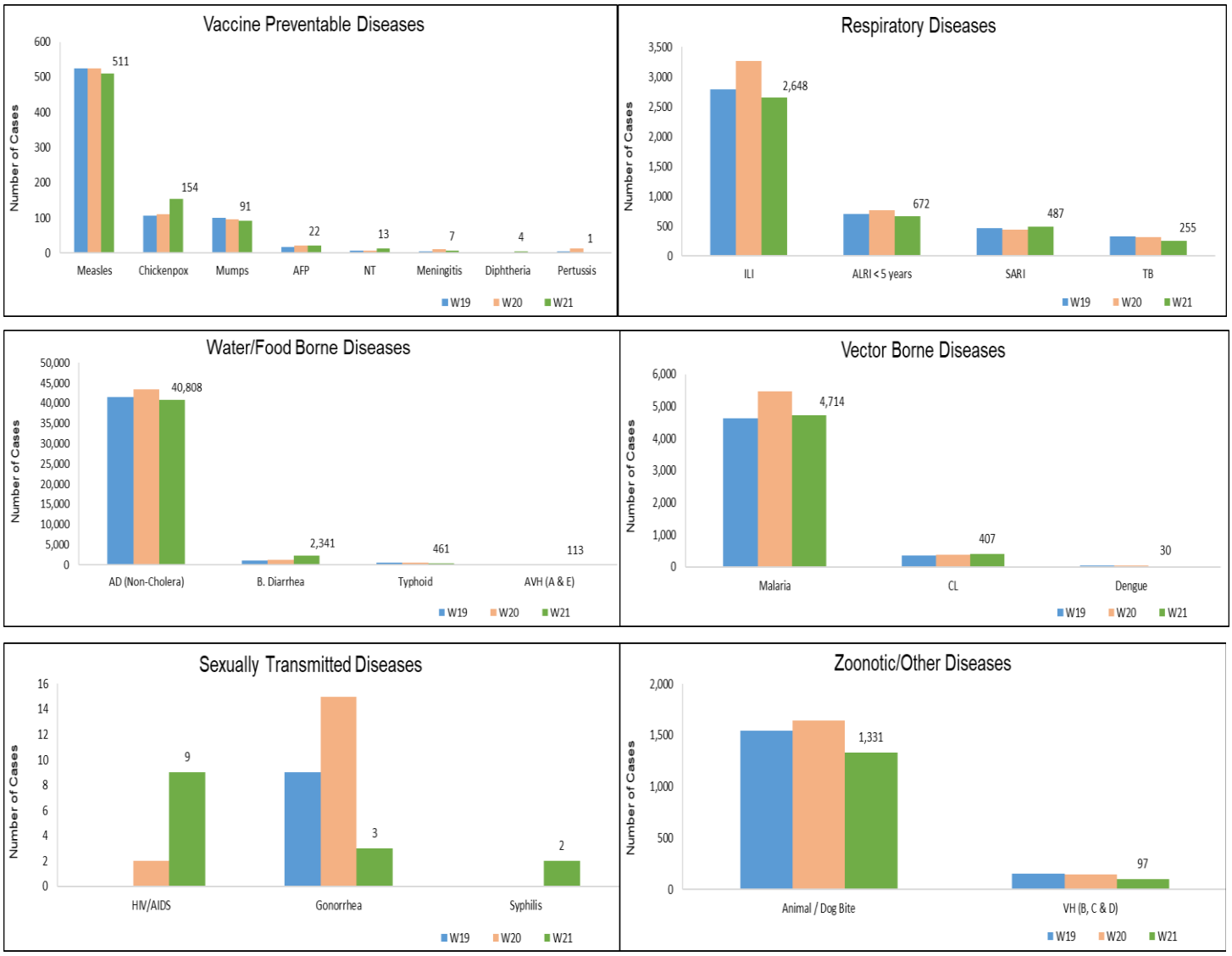
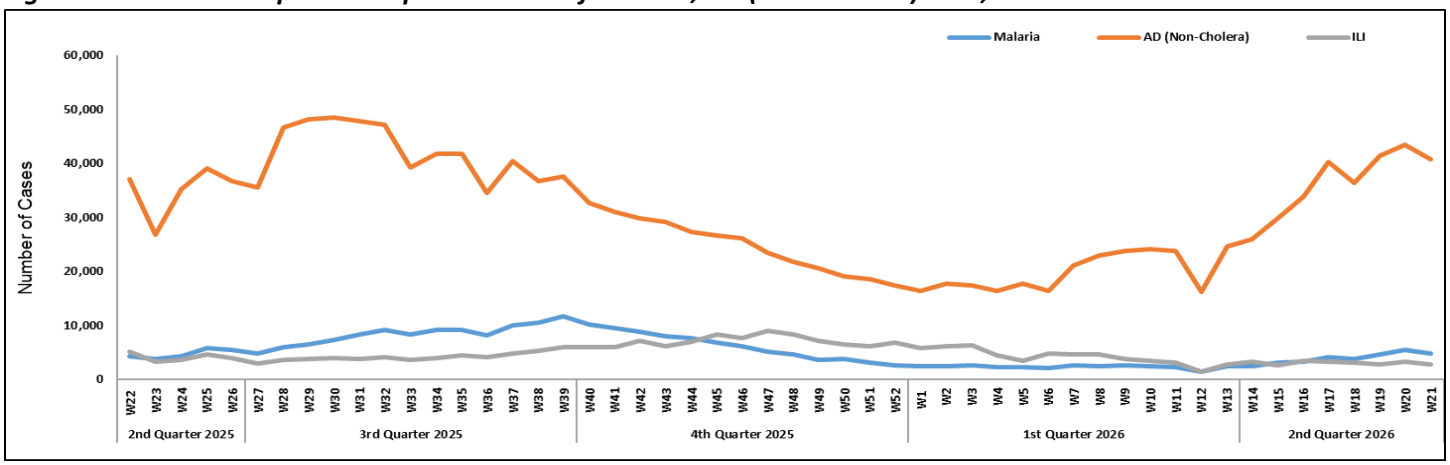


Figure 7: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, KP.



ICT, AJK & GB

ICT: The most frequently reported cases from Islamabad were ILI followed by AD (Non-Cholera), Mumps, and Typhoid. ILI, AD (Non-Cholera), Mumps, and Typhoid cases showed a decline in number this week.

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

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

Figure 8: Most frequently reported suspected cases during Week 21, AJK.

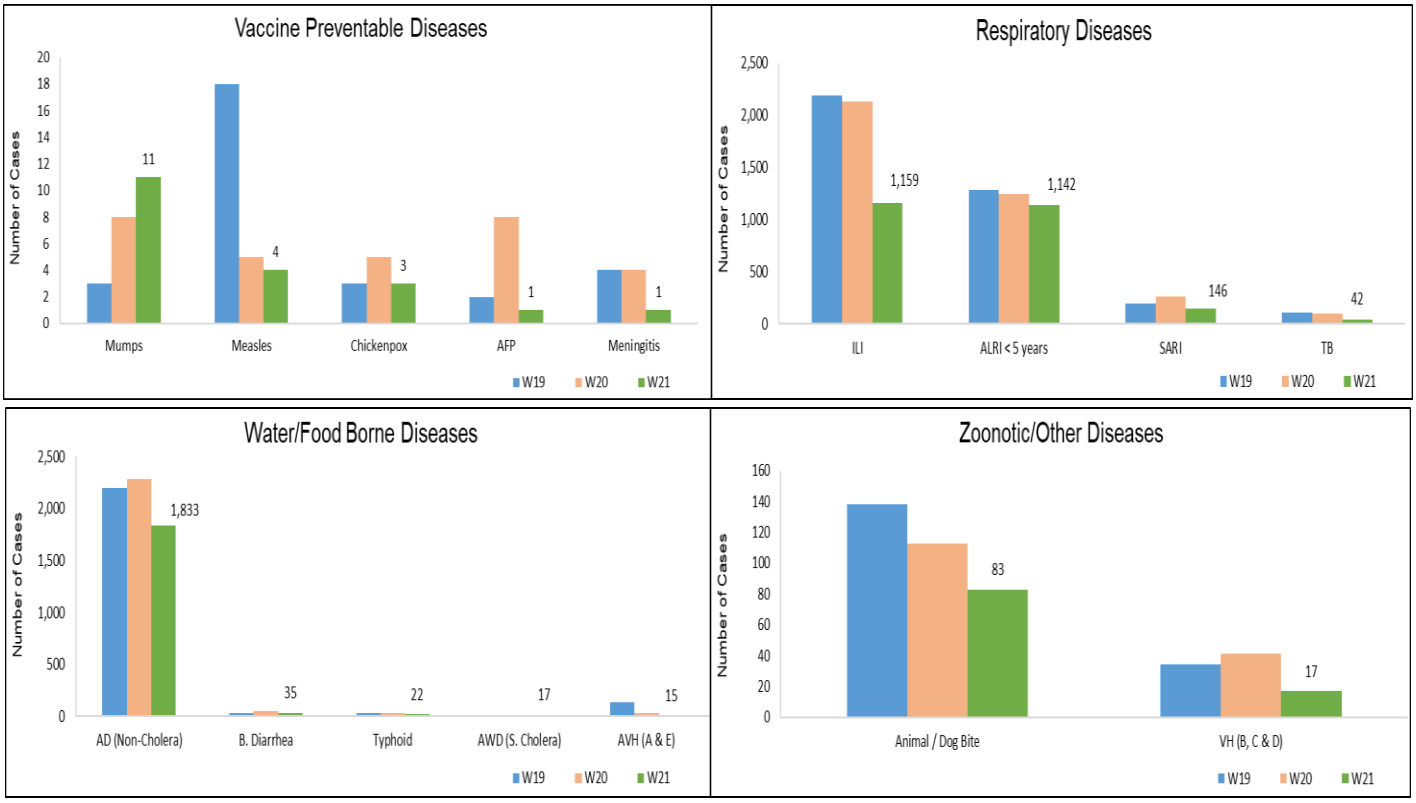


Figure 9: Week wise reported suspected cases of ILI and AD (Non-Cholera), AJK

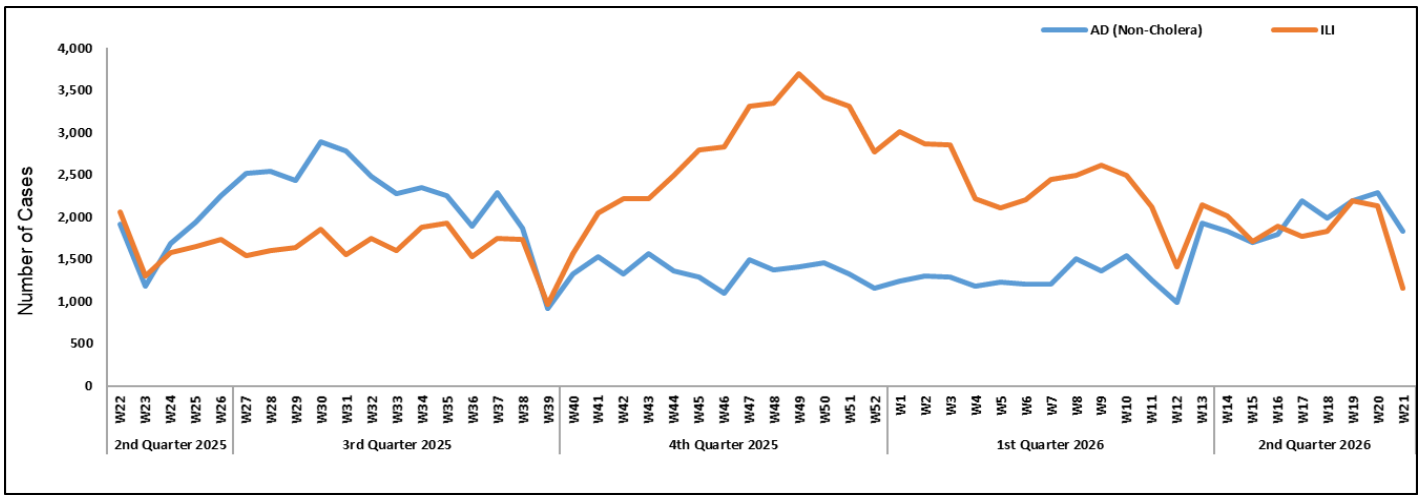


Figure 10: Most frequently reported suspected cases during Week 21, ICT.

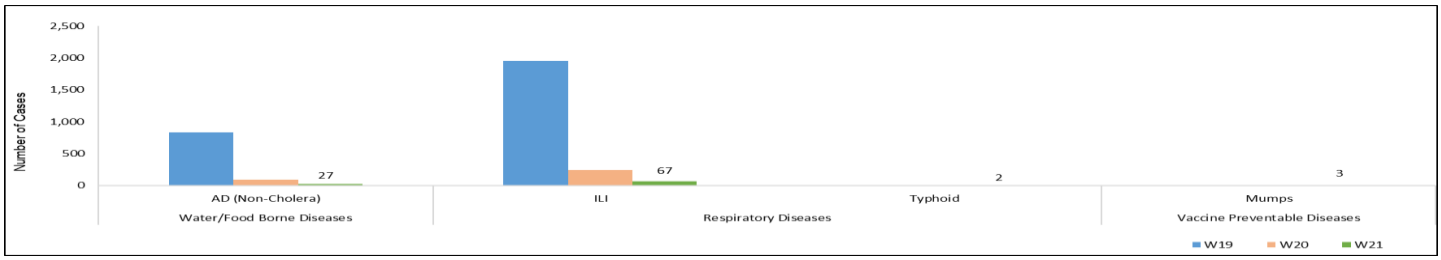


Figure 11: Week wise reported suspected cases of ILI, ICT.

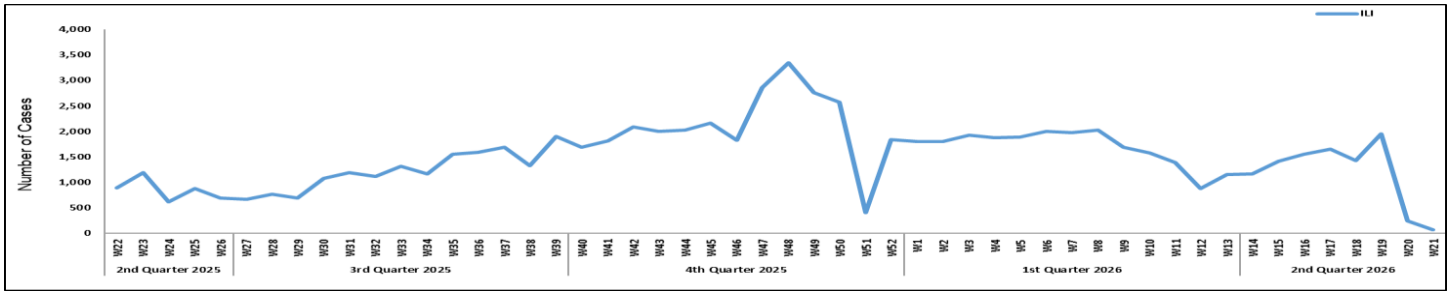


Figure 12: Most frequently reported suspected cases during Week 21, GB.

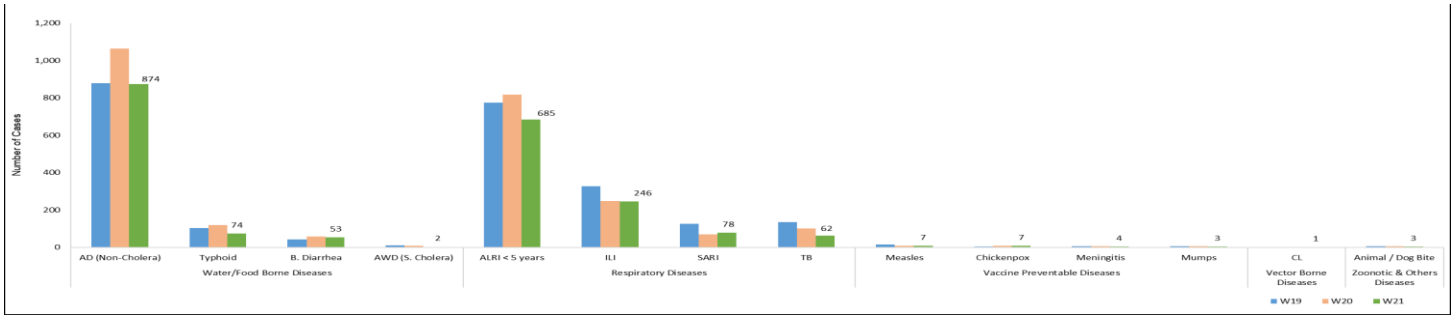


Figure 13: Week wise reported suspected cases of AD (Non-Cholera), GB.

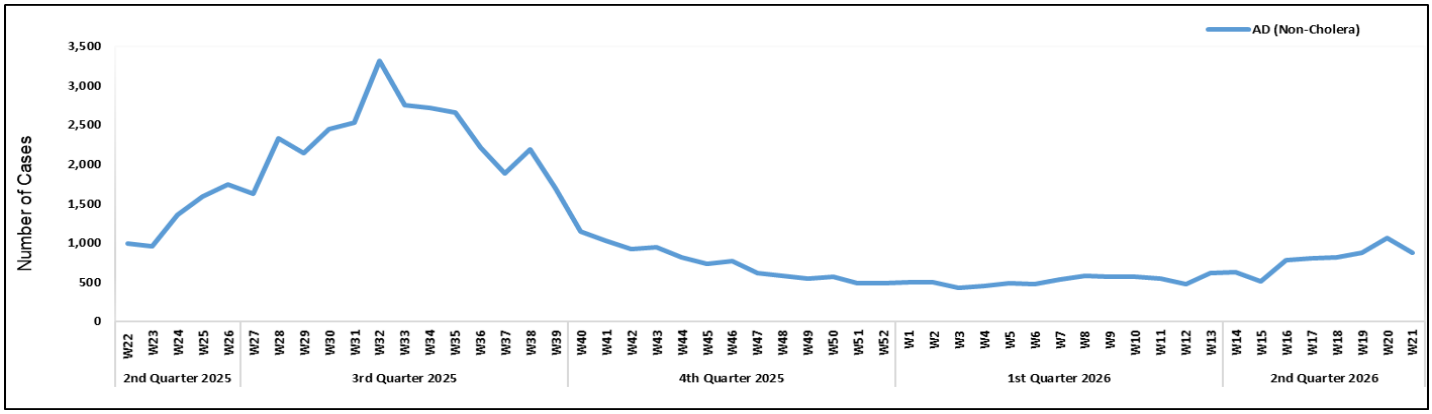


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 21, Pakistan.

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)		49	11	-	-	-	-	-	-	-	-	-	-	-	-
Stool culture & Sensitivity		177	1	-	-	-	-	-	-	-	-	-	-	-	-
Malaria		5,095	288	1,674	159	125	18	-	-	215	1	-	-	14	0
CCHF		5	0	3	0	-	-	-	-	-	-	-	-	-	-
Dengue		959	71	501	37	2	0	-	-	4	0	-	-	2	0
VH (B)		11,860	296	766	92	62	0	-	-	665	15	-	-	176	2
VH (C)		12,202	846	697	33	62	0	-	-	684	7	-	-	176	5
VH (D)		239	56	28	6	-	-	-	-	-	-	-	-	-	-
VH (A)		194	83	-	-	-	-	-	-	-	-	-	-	-	-
VH (E)		115	18	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19		3	0	-	-	-	-	-	-	-	-	-	-	9	0
TB		603	63	84	13	12	2	-	-	77	0	-	-	37	7
HIV/ AIDS		3,149	27	258	1	35	0	-	-	239	0	-	-	176	1
Syphilis		1,015	22	174	0	4	0	-	-	189	0	-	-	-	-
Typhoid		140	3	-	-	-	-	-	-	354	2	-	-	-	-
Diphtheria		3	0	-	-	-	-	-	-	-	-	-	-	-	-
ILI		8	0	-	-	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)		107	12	-	-	-	-	-	-	-	-	-	-	-	-
Meningitis		13	0	-	-	-	-	-	-	-	-	-	-	-	-
Measles		433	146	58	20	558	198	24	17	5	3	632	114	22	3
Leishmaniosis (cutaneous)		-	-	2	2	4	2	-	-	2	0	-	-	-	-
Chikungunya		-	-	2	0	-	-	-	-	-	-	-	-	-	-
Chickenpox		3	0	-	-	-	-	-	-	-	-	-	-	-	-
Mpox		4	0	-	-	-	-	-	-	-	-	-	-	-	-
SARI		11	4	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	ILI	-	-	-	-	-	-	-	-	-	-	8	0	-	-
	SARI	-	-	-	-	-	-	-	-	-	-	53	0	-	-
Influenza A	ILI	-	-	-	-	-	-	-	-	-	-	8	0	-	-
	SARI	-	-	-	-	-	-	-	-	-	-	53	0	-	-
Influenza B	ILI	-	-	-	-	-	-	-	-	-	-	8	0	-	-
	SARI	-	-	-	-	-	-	-	-	-	-	53	0	-	-
RSV	ILI	-	-	-	-	-	-	-	-	-	-	8	0	-	-
	SARI	-	-	-	-	-	-	-	-	-	-	53	0	-	-

Figure 14: District wise Influenza sentinel sites, Pakistan.

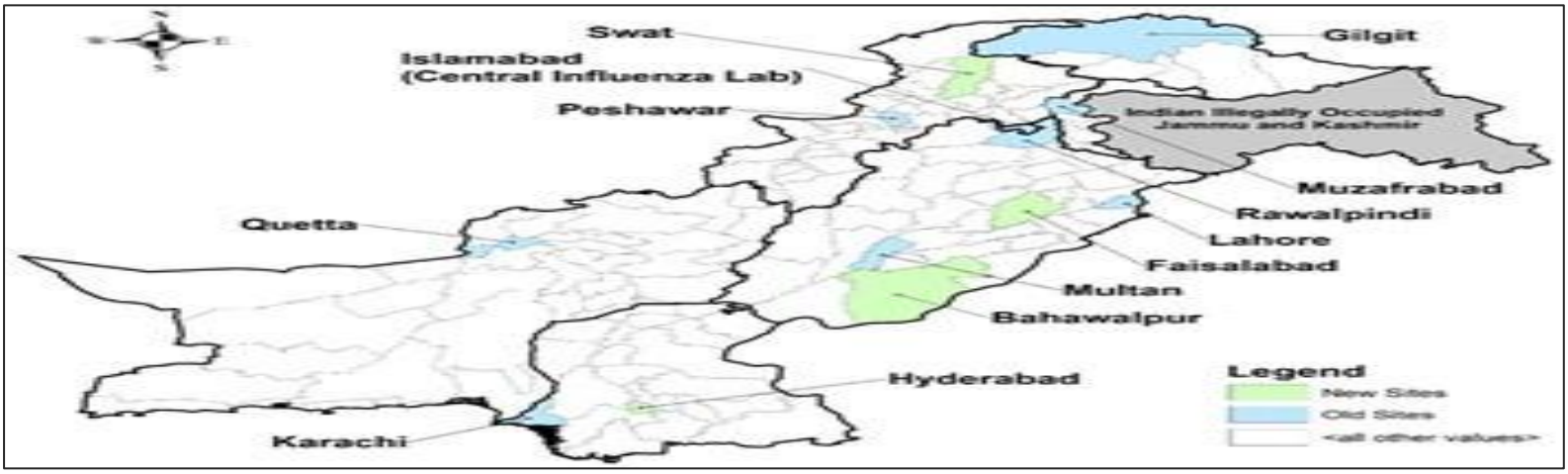
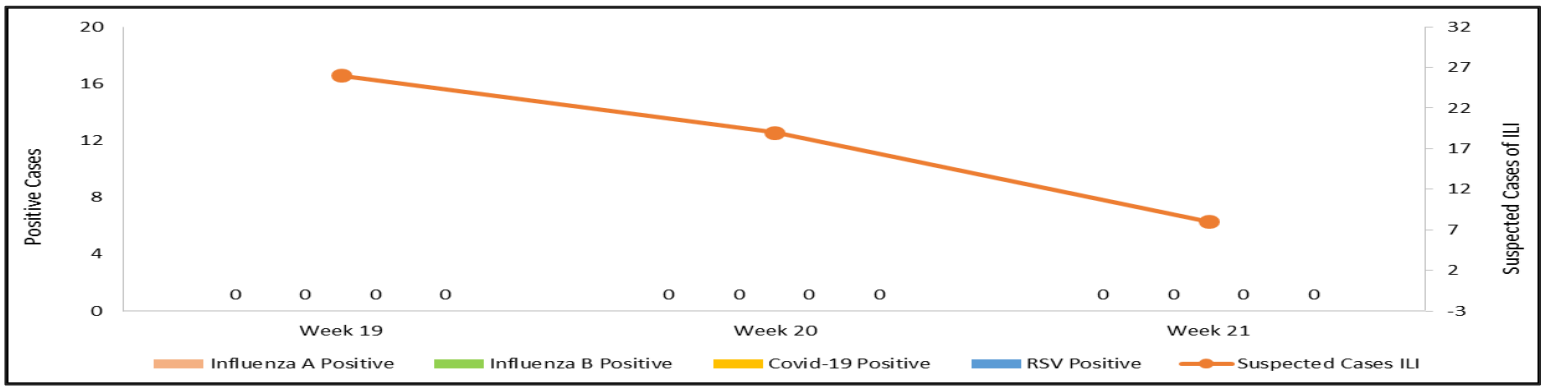


Figure 15: Distribution of suspected samples of ILI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 21, Pakistan.



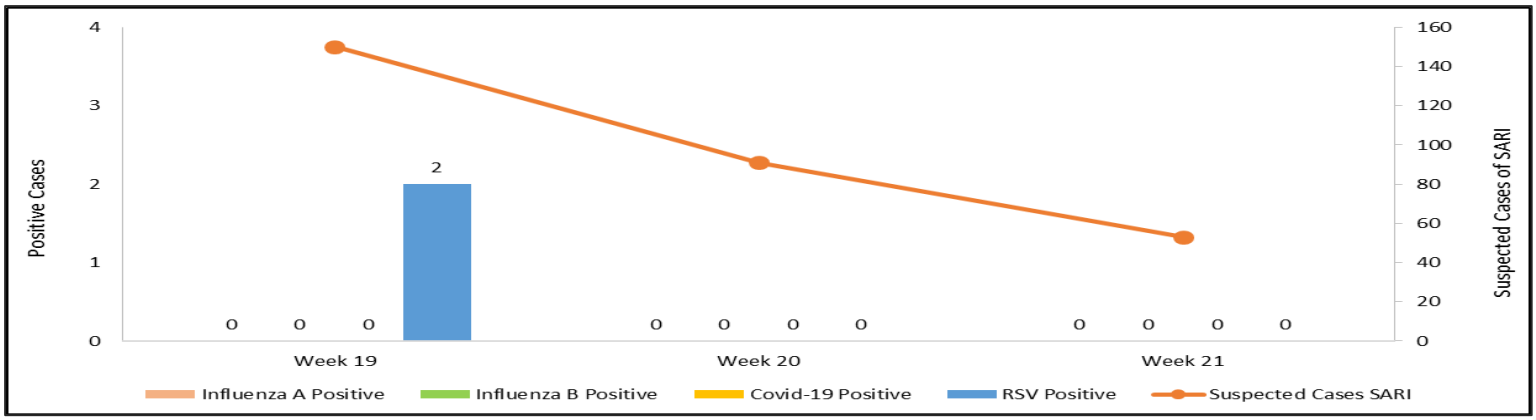


Figure 16: Distribution of suspected samples of SARI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 21, Pakistan.

Table 6: Compliance of IDSR reporting districts Week 21, 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	241	123	51%
	Battagram	59	44	75%
	Buner	34	34	100%
	Bajaur	44	41	93%
	Charsadda	61	60	98%
	Chitral Upper	31	28	90%
	Chitral Lower	37	36	97%
	D.I. Khan	115	114	99%
	Dir Lower	63	63	100%
	Dir Upper	56	36	64%
	Hangu	23	20	87%
	Haripur	72	72	100%
	Karak	36	36	100%
	Khyber	53	39	74%
	Kohat	61	61	100%
	Kohistan Lower	13	7	54%
	Kohistan Upper	22	15	68%
	Kolai Palas	10	8	80%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	6	14%
	Upper Kurram	38	37	97%
	Malakand	41	41	100%
	Mansehra	133	90	68%
	Mardan	82	68	83%
	Nowshera	57	51	89%
	North Waziristan	12	9	75%
	Peshawar	157	113	72%
	Shangla	37	31	84%
	Swabi	65	61	94%
	Swat	77	70	91%
	South Waziristan (Upper)	93	36	39%
	South Waziristan (Lower)	29	16	55%
	Tank	34	33	97%
	Torghar	13	13	100%
	Mohmand	68	17	25%
	Orakzai	69	9	13%
Azad Jammu Kashmir	Mirpur	41	41	100%
	Bhimber	85	84	99%
	Kotli	60	60	100%
	Muzaffarabad	45	45	100%
	Poonch	46	46	100%
	Haveli	39	39	100%
	Bagh	54	54	100%

	Neelum	39	39	100%
	Jhelum Velley	29	29	100%
	Sudhnooti	27	27	100%
Islamabad Capital Territory	ICT	24	24	100%
	CDA	14	6	43%
Balochistan	Gwadar	26	15	58%
	Kech	44	25	57%
	Khuzdar	74	15	20%
	Killa Abdullah	26	25	96%
	Lasbella	55	55	100%
	Pishin	65	0	0%
	Quetta	56	18	32%
	Sibi	36	27	75%
	Zhob	39	0	0%
	Jaffarabad	16	16	100%
	Naseerabad	32	28	88%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	0	0%
	Chagai	36	20	56%
	Kalat	41	40	0%
	Harnai	17	17	100%
	Kachhi (Bolan)	35	19	54%
	Jhal Magsi	28	14	50%
	Sohbat pur	25	0	0%
	Surab	32	0	0%
	Mastung	46	46	100%
	Loralai	33	26	79%
	Killa Saifullah	28	0	0%
	Ziarat	29	0	0%
	Duki	31	0	0%
	Nushki	29	3	10%
	Dera Bugti	45	1	2%
	Washuk	46	0	0%
	Panjgur	38	0	0%
	Awaran	23	0	0%
	Chaman	25	0	0%
	Barkhan	20	19	95%
	Hub	33	28	85%
	Musakhel	41	0	0%
	Usta Muhammad	34	33	97%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	20	18	90%
	Ghizer	38	37	97%
	Gilgit	44	43	98%
	Diamer	62	53	85%
	Astore	55	55	100%
	Shigar	23	21	91%
	Skardu	54	54	100%
	Ganche	29	27	93%

	Kharmang	25	25	100%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	64	100%
	Umerkot	65	64	98%
	Naushahro Feroze	102	102	100%
	Tharparkar	273	266	97%
	Shikarpur	59	59	100%
	Thatta	50	50	100%
	Larkana	67	54	81%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	17	81%
	Karachi-West	20	20	100%
	Karachi-Malir	35	29	83%
	Karachi-Kemari	22	20	91%
	Karachi-Central	12	11	92%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	4	67%
	Sujawal	55	23	42%
	Mirpur Khas	106	105	99%
	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%
	Matiari	42	41	98%
	Jamshoro	74	74	100%
	Tando Allahyar	54	53	98%
	Tando Muhammad Khan	41	26	63%
	Shaheed Benazirabad	122	122	100%

Table 7: Compliance of IDSR reporting Tertiary care hospitals Week 21, 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	0	0%
	Abbottabad	1	1	100%
	Swat	1	0	0%

Notes from the field:

Crimean-Congo Hemorrhagic Fever (CCHF) Case Investigation Report, Loralai District, Balochistan, Pakistan, March 2026

Dr Aneela Habib (SMO)
Dr Israr Ahmed (Veterinary Medical Officer)
Dr Mohammad Ali (Deputy Director, Environment)

Introduction

Crimean-Congo Hemorrhagic Fever (CCHF) is a severe viral zoonotic disease caused by the Crimean-Congo Hemorrhagic Fever virus, a member of the genus Orthonairovirus. The disease is primarily transmitted through bites of infected Hyalomma ticks, contact with infected animal blood or tissues during slaughtering, and exposure to bodily fluids of infected persons. CCHF has a wide geographic distribution across Africa, Asia, the Middle East, and Eastern Europe, with an estimated case fatality rate ranging from 10% to 40%, although higher mortality has been reported in resource-limited settings. Pakistan remains an endemic country for CCHF, with sporadic cases and outbreaks reported annually, particularly in Balochistan due to extensive livestock movement and favorable ecological conditions for tick vectors. Loralai district is considered a high-risk area because of its large livestock population and frequent animal trading. On 29 March 2026, a laboratory-confirmed CCHF case from Loralai district was reported to the World Health Organization Provincial Office, Balochistan, prompting a field investigation using a One Health approach.

Objectives

1. To conduct a detailed investigation of CCHF cases admitted to the isolation ward of Fatima Jinnah Hospital.
2. To investigate possible sources of infection.
3. To enlist all close contacts of the patient to assess their health status to rule out possibilities of disease transmission.

Methods

A descriptive case study was conducted from 30 March to 9 April 2026 following the notification of a confirmed CCHF case from Loralai district, Balochistan. The study population comprised residents of Nawakilli Pathankot, Loralai, with an estimated population of 272,432. The investigation focused on the confirmed case admitted to the isolation ward of Fatima Jinnah Hospital, Quetta.

A suspected case was defined as “any person presenting with acute fever and hemorrhagic manifestations or thrombocytopenia with a history of exposure to livestock, ticks, or confirmed CCHF cases during the preceding two weeks”. Confirmation was based on laboratory testing conducted at Fatima Jinnah Hospital.

Data were collected using the Integrated Disease Surveillance and Response System (IDSRS) CCHF Case Investigation form through face-to-face interviews with the patient and attendants. Medical records from local healthcare facilities, Sandeman Provincial Hospital Quetta, and Fatima Jinnah Hospital were reviewed to document the clinical course and management of the patient. Active case finding and contact tracing were conducted among household members and healthcare workers to identify additional cases and monitor symptoms.

Blood samples were collected for laboratory confirmation and serial monitoring of hematological and biochemical parameters,

including complete blood counts and liver function tests. Data were analyzed descriptively to summarize demographic characteristics, clinical manifestations, exposure history, laboratory findings, and potential risk factors associated with infection.

Results

A total of one laboratory-confirmed CCHF case was identified during the investigation. The patient was a 26-year-old male resident of Nawakilli Pathankot, Loralai district.

The patient developed high-grade fever on 22 March 2026, followed by chills, generalized body aches, and headache. He initially sought treatment from a local practitioner on 23 March 2026 and was managed symptomatically. Due to worsening symptoms and severe thrombocytopenia, he was referred to Sandeman Provincial Hospital, Quetta on 26 March 2026 and subsequently to Fatima Jinnah Hospital on 27 March 2026.

The patient required multiple platelet transfusions and admission to an isolation ward for management.

Investigation of exposure history revealed significant occupational risk factors. The patient had been working as a butcher in a slaughterhouse for the previous 12 years. He reported handling and slaughtering livestock without personal protective equipment. The animal involved had been transported from Sindh Province on 17 March 2026 and reportedly had visible tick infestation. No veterinary inspection of the animal was conducted before slaughtering. The patient slaughtered the animal on 20 March 2026 without protective measures, representing the most likely source of infection.

Laboratory findings demonstrated marked thrombocytopenia and Leukopenia. Elevated liver enzymes were detected. Following supportive treatment and repeated platelet transfusions, platelet counts improved, accompanied by clinical recovery.

No secondary transmission was detected among healthcare workers, attendants, or household contacts during the monitoring period.

Discussion

This investigation identified a laboratory-confirmed case of CCHF in a young male butcher from Loralai district, Balochistan. The patient's occupation placed him at increased risk of exposure to infected animal blood and tissues, which is consistent with established epidemiological patterns reported from endemic countries. Slaughterhouse workers, livestock handlers, veterinarians, and farmers are recognized as high-risk occupational groups for CCHF infection (1,2,4).

The patient's history of handling and slaughtering a tick-infested animal without personal protective equipment strongly suggests occupational exposure as the source of infection. Similar findings have been documented in previous investigations from Pakistan, where inadequate biosafety practices during animal handling and slaughtering have contributed significantly to disease transmission (3,5)

Clinical manifestations observed in this patient, including fever, thrombocytopenia, hemorrhagic signs, leukopenia, and elevated liver enzymes, are characteristic of CCHF infection and align with published literature (1,2,3). Early recognition, prompt referral, isolation, and supportive treatment likely contributed to the favorable outcome observed in this case, as recommended in national and international guidelines (1,2,5)

The absence of secondary cases among healthcare workers and household contacts highlights the effectiveness of infection prevention and control measures implemented at Fatima Jinnah Hospital. Previous studies have shown that strict adherence to infection prevention and control protocols can substantially reduce the risk of nosocomial transmission of CCHF (2,5).

Nevertheless, the identification of a tick-infested animal originating from another province emphasizes the importance of strengthening livestock surveillance, veterinary inspection systems, and intersectoral coordination under the One Health framework. Effective collaboration among public health, veterinary, and environmental sectors is essential for the prevention and control of CCHF in endemic settings (4,5).

Conclusion

A confirmed case of Crimean-Congo Hemorrhagic Fever was identified in a 26-year-old butcher from Loralai district, Balochistan. Occupational exposure during slaughtering of a tick-infested animal without protective equipment was identified as the most probable source of infection. Prompt diagnosis, isolation, clinical management, and contact monitoring prevented secondary transmission. The investigation highlights the ongoing risk posed by livestock-associated exposures and the need for integrated human, animal, and environmental health interventions.

Recommendations

Strengthen surveillance for CCHF in high-risk districts, particularly before and during periods of increased livestock movement.

Ensure mandatory use of personal protective equipment by butchers, slaughterhouse workers, veterinarians, and livestock handlers.

Implement routine veterinary inspection and tick control measures for livestock before transportation and slaughter.

Enhance public awareness regarding CCHF transmission, prevention, and early healthcare-seeking behavior.

Strengthen infection prevention and control practices in healthcare facilities, including isolation procedures and appropriate PPE use.

Conduct regular training of healthcare workers on recognition and management of CCHF cases.

Improve coordination between public health, livestock, and environmental sectors through a One Health approach.

Establish routine monitoring and acaricide treatment programs to reduce tick infestation among livestock.

References

1. World Health Organization. Crimean-Congo haemorrhagic fever (CCHF) [Internet]. Geneva: WHO; 2025 [cited 2026 Jun 17]. Available from: https://www.who.int/news-room/fact-sheets/detail/crimean-congo-haemorrhagic-fever
2. Centers for Disease Control and Prevention. Crimean-Congo Hemorrhagic Fever (CCHF) [Internet]. Atlanta (GA): CDC; 2025 [cited 2026 Jun 17]. Available from: https://www.cdc.gov/vhf/crimean-congo
3. Khan E, Hasan R, Mehraj V, Nasir A, Siddiqui J, Hewson R. Crimean-Congo hemorrhagic fever in Pakistan: case series and review of literature. BMC Infect Dis. 2013;13:89.
4. Nasirian H. Crimean-Congo hemorrhagic fever (CCHF) outbreak in Asia and neighboring regions. J Arthropod Borne Dis. 2019;13(3):211-226.
5. National Institute of Health Pakistan. Guidelines for Prevention and Control of Crimean-Congo Hemorrhagic Fever. Islamabad: NIH Pakistan; 2024.

Knowledge Hub

Crimean-Congo Hemorrhagic Fever (CCHF): What You Need to Know

It is a severe viral disease caused by the Crimean-Congo Hemorrhagic Fever Virus (CCHFV), which belongs to the Nairovirus genus. The disease primarily affects humans and is transmitted through infected ticks or contact with infected animal or human blood and body fluids. CCHF is widely distributed across Africa, Asia, the Middle East, and Eastern Europe, including Pakistan. It is characterized by sudden onset of fever and, in severe cases, bleeding manifestations that can lead to death.

What is Crimean-Congo Hemorrhagic Fever?

It is a zoonotic disease, meaning it can spread from animals to humans. Domestic and wild animals such as cattle, sheep, goats, and camels can carry the virus without showing signs of illness. Humans become infected through tick bites or exposure to infected blood and tissues.

Incubation period:

- Tick bite: 1–3 days (up to 9 days).
- Blood/tissue contact: 5–6 days (up to 13 days).

How CCHF Spreads to Humans

Tick Bites

The most common mode of transmission is through the bite of an infected Hyalomma tick.

Contact with Infected Animals

Handling blood, tissues, or body fluids of infected livestock during farming, veterinary procedures, or slaughtering.

Exposure during animal transport, slaughter, and meat processing.

Human-to-Human Transmission

Contact with blood, secretions, organs, or other bodily fluids of infected persons.

Healthcare-associated infections can occur through contaminated medical equipment or inadequate infection prevention and control practices.

Occupational Exposure

People at high risk include:

Farmers, livestock handlers, butchers and slaughterhouse workers, veterinarians, healthcare workers, and laboratory personnel

Signs & Symptoms

They usually appear within 1–13 days after exposure and often begin suddenly.

Common symptoms include:

High fever, severe headache, muscle aches, back and Joint pain, fatigue, weakness, dizziness, neck pain and stiffness, sensitivity to light, nausea and vomiting, and sore throat. As the disease progresses, patients may develop abdominal pain and diarrhea, mood changes, and confusion, bruising under the skin, nosebleeds, and bleeding gums, blood in vomit, urine, or stool, severe bleeding, and shock

Complications

CCHF can result in serious complications, particularly in severe cases. Severe internal and external bleeding, liver, kidney, and respiratory failure, Shock, and Multi-organ Failure
The case fatality rate ranges from 10% to 40%, making early diagnosis and treatment critical.

Diagnosis and Treatment

Early diagnosis is essential for patient management and outbreak control.
It is confirmed through:
Reverse Transcription Polymerase Chain Reaction (RT-PCR) testing and ELISA for

antibody detection, antigen detection tests and virus isolation in specialized laboratories
There is no specific universally approved antiviral treatment for CCHF.
It mainly consists of:
Early supportive care, Intravenous fluids, and electrolyte management. Blood and blood product transfusions when required.
Treatment of complications such as shock and organ failure. Strict infection prevention and control measures.
Early recognition and prompt medical care significantly improve survival.

Prevention

It focuses on reducing exposure to ticks, infected animals, and infected persons.

Personal Protection

• Wear long-sleeved clothing and long trousers when working with livestock.
• Use tick repellents on skin and clothing.
• Regularly inspect clothing and skin for ticks.
• Remove attached ticks safely and promptly.

Safe Animal Handling

• Wear gloves and protective clothing when handling livestock or animal tissues.
• Avoid direct contact with blood and body fluids of animals.
• Use personal protective equipment (PPE) during slaughtering and meat processing.

Infection Prevention and Control

• Isolate suspected or confirmed patients.
• Use appropriate PPE when caring for patients.
• Follow standard, contact, and droplet precautions in healthcare settings.

Community Awareness

• Educate communities about tick-bite prevention and safe livestock handling.
• Seek medical care immediately if symptoms develop after tick exposure or contact with livestock.

More Information

For additional authoritative information on Crimean-Congo Hemorrhagic Fever (CCHF), please visit:

1. World Health Organization (WHO): https://www.who.int/news-room/fact-sheets/detail/crimean-congo-haemorrhagic-fever
2. Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/crimean-congo/index.html
3. National Institute of Health (NIH), Pakistan: https://www.nih.org.pk
4. World Organisation for Animal Health (WOAH): https://www.woah.org/en/disease/crimean-congo-haemorrhagic-fever
5. European Centre for Disease Prevention and Control (ECDC): https://www.ecdc.europa.eu/en/crimean-congo-haemorrhagic-fever

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UK Health Security Agency

World Health Organization

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION