

Integrated Disease Surveillance & Response (IDSR) Report

Center of Disease Control
National Institutes of Health, Islamabad

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



Public Health Bulletin Pakistan

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Public Health Bulletin - Pakistan, Week 39, 2026

Overview

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The **Integrated Disease Surveillance & Response (IDSR) Weekly Public Health Bulletin** is your trusted source for the latest disease trends, outbreak updates, and essential public health information in Pakistan. Published weekly, the bulletin provides **timely, reliable, and evidence-based** information for public health professionals, policymakers, healthcare workers, and the public. It presents key surveillance findings, outbreak investigations, seasonal disease trends, and practical public health recommendations to support informed decision-making and strengthen disease prevention efforts.

The bulletin is developed using verified surveillance data and expert review to ensure its content remains accurate, relevant, and aligned with Pakistan's public health priorities. It also addresses emerging health misinformation by providing factual, science-based information that communities can trust.

This Week's Highlights:

- **Diphtheria Cluster in Shadi Khal, Hangu District, Khyber Pakhtunkhwa, Pakistan, August 2026**
- **Knowledge Hub - Influenza-Like Illness (ILI): What You Need to Know**

Together, we can strengthen disease surveillance, promote informed action, and build a healthier Pakistan.

By transforming surveillance data into actionable public health intelligence, the IDSR Weekly Public Health Bulletin continues to support evidence-based decision-making and protect communities across Pakistan.

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- During Week 39, the most frequently reported cases were of Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, ALRI <5 years, TB, B. Diarrhea, Animal/Dog Bite, VH (B, C & D), Typhoid, SARI, Dengue, and AVH (A & E).
- Twenty-two cases of AFP were reported from KP, sixteen from Sindh, and three from GB.
- Eighteen suspected cases of HIV/ AIDS were reported from Sindh and six from KP.
- Four suspected cases of Brucellosis were reported from KP.
- Among VPDs, there is an increase in the number of cases of Measles 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 Typhoid this week.
- Among Vector-borne diseases, there is an increase in the number of cases of Malaria and Dengue this week.
- Among STDs, there is an increase in the number of suspected cases of Gonorrhea, HIV/ AIDS, and Syphilis this week.
- Among Zoonotic/Other diseases, there is an increase in the number of cases of Animal/ Dog Bite and VH (B, C & D) this week.
- Field investigation is required for verification of the alerts and for prevention and control of the outbreaks.

IDSR Compliance Attributes

- The national compliance rate for IDSR reporting in 158 implemented districts is 86%.
- Sindh is the top reporting region with a compliance rate of 100%, followed by AJK 97%, GB 94%, KP 81%, and Balochistan 71%.
- In Week 39, the lowest compliance rate is observed in ICT, at 56%.

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2,281	1,853	81
Azad Jammu Kashmir	480	464	97
Islamabad Capital Territory	66	37	56
Balochistan	1,317	931	71
Gilgit Baltistan	405	379	94
Sindh	2,067	2,057	100
National	6,616	5,721	86

Public Health Actions

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

Influenza-Like Illness (ILI)

- **Strengthen Surveillance and Reporting:** Enhance ILI surveillance through IDSR and sentinel sites to monitor seasonal trends, detect unusual increases in respiratory illness, and support early outbreak detection.
- **Improve Laboratory Diagnosis:** Strengthen specimen collection, transport, and laboratory testing for influenza and other respiratory viruses to support timely identification of circulating pathogens.
- **Promote Infection Prevention and Control (IPC):** Reinforce hand hygiene, respiratory etiquette, adequate ventilation, and appropriate use of masks in healthcare facilities and crowded settings.
- **Promote Vaccination:** Encourage seasonal influenza vaccination among healthcare workers, older adults, pregnant women, and individuals with chronic illnesses, in accordance with national recommendations.
- **Raise Community Awareness:** Disseminate public health messages on respiratory infection prevention, appropriate home care, and timely healthcare-seeking for persistent or worsening symptoms.

Acute Lower Respiratory Infection (ALRI) in Children Under Five Years

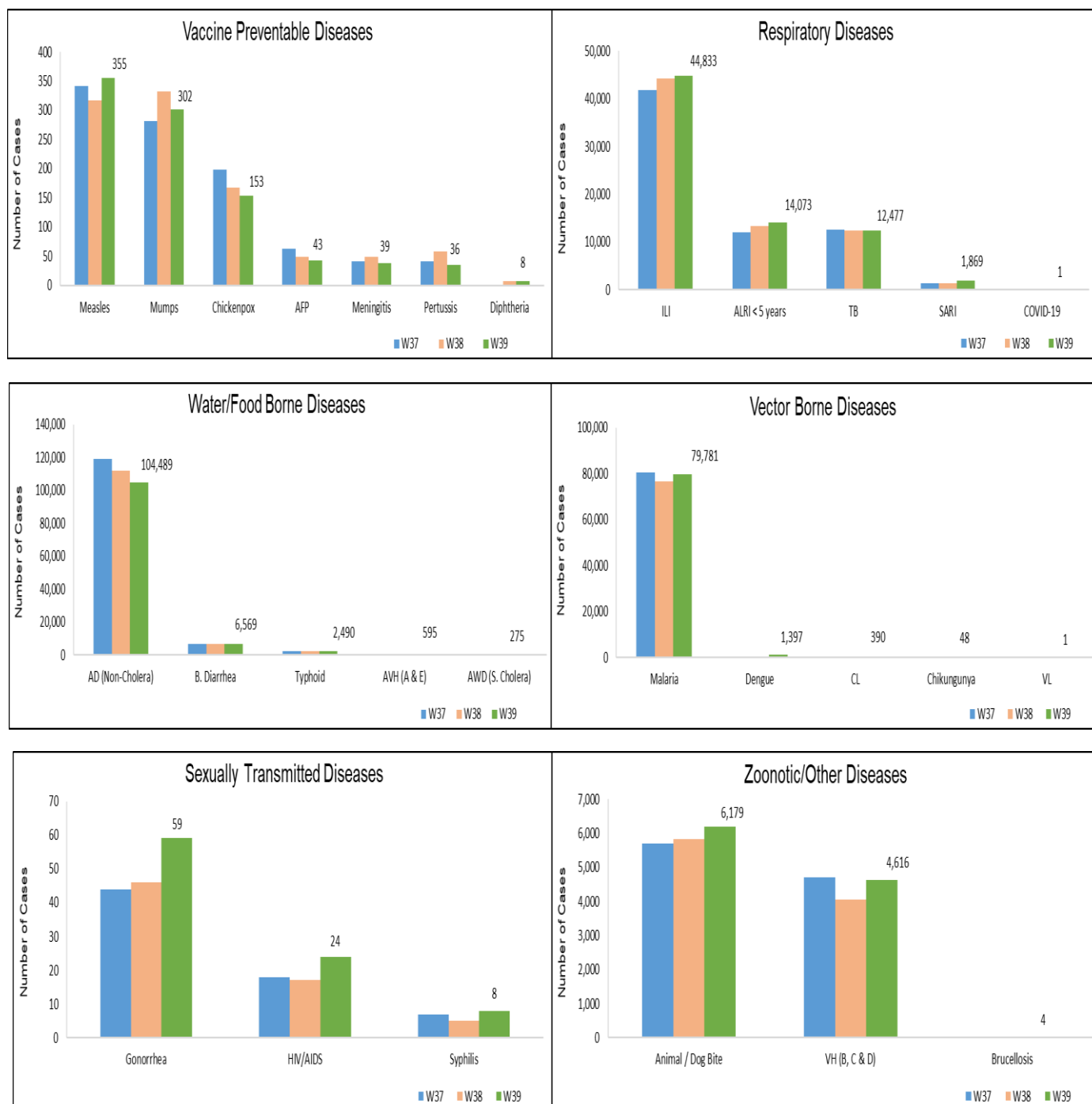
- **Strengthen Surveillance and Early Detection:** Enhance ALRI surveillance among children under five through standardized case definitions, timely reporting, and monitoring of pneumonia trends and unusual clusters.
- **Improve Diagnosis and Case Management:** Train healthcare workers to recognize and manage pneumonia promptly, including identifying danger signs such as fast breathing, chest indrawing, and difficulty breathing, in accordance with national guidelines.
- **Ensure Availability of Essential Care:** Maintain adequate supplies of essential medicines, pulse oximeters, oxygen therapy, and referral services to support the timely management of children with severe respiratory infections.
- **Strengthen Routine Immunization:** Improve coverage of vaccines that prevent respiratory infections, including pneumococcal conjugate vaccine (PCV), Hib, pertussis, and measles vaccines, through routine immunization and targeted outreach in underserved communities.
- **Promote Preventive Practices:** Promote exclusive breastfeeding for the first six months, adequate nutrition, hand hygiene, improved household ventilation, and reduced exposure to tobacco smoke and indoor air pollution.
- **Raise Caregiver Awareness:** Educate parents and caregivers to recognize danger signs, including difficulty breathing, chest indrawing, inability to feed, and lethargy, and to seek immediate medical care when these symptoms occur.



Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 39, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	1,542	8,384	1,180	525	40,325	NR	52,533	104,489
Malaria	12	3,183	2	10	8,779	NR	67,795	79,781
ILI	1,918	8,134	328	1,971	3,929	NR	28,553	44,833
ALRI < 5 years	1,149	2,215	768	4	649	NR	9,288	14,073
TB	34	19	105	22	278	NR	12,019	12,477
B. Diarrhea	26	1,501	61	10	1,130	NR	3,841	6,569
Animal / Dog Bite	101	96	6	1	1,404	NR	4,571	6,179
VH (B, C & D)	13	43	16	40	141	NR	4,363	4,616
Typhoid	28	425	88	9	764	NR	1,176	2,490
SARI	68	862	122	0	381	NR	436	1,869
Dengue	1	3	0	2	1,150	NR	241	1,397
AVH (A & E)	9	20	0	0	186	NR	380	595
CL	0	35	0	0	344	NR	11	390
Measles	3	24	11	0	266	NR	51	355
Mumps	8	67	8	2	178	NR	39	302
AWD (S. Cholera)	15	226	22	0	8	NR	4	275
Chickenpox/ Varicella	5	7	7	2	121	NR	11	153
Gonorrhea	0	42	0	0	5	NR	12	59
Chikungunya	0	1	0	0	31	NR	16	48
AFP	1	0	3	1	22	NR	16	43
Meningitis	2	2	3	0	10	NR	22	39
Pertussis	0	30	0	0	6	NR	0	36
HIV/AIDS	0	0	0	0	6	NR	18	24
Diphtheria (Probable)	1	5	0	0	2	NR	0	8
Syphilis	0	0	0	0	2	NR	6	8
Brucellosis	0	0	0	0	4	NR	0	4
Rabies	0	3	0	0	0	NR	0	3
COVID-19	0	0	0	1	0	NR	0	1
VL	0	0	0	0	1	NR	0	1

Figure 1: Most frequently reported suspected cases during Week 39, Pakistan.



- Malaria cases were maximum followed by AD (Non-Cholera), ILI, TB, ALRI<5 Years, Animal/ Dog Bite, VH (B, C & D), B. Diarrhea, Typhoid and SARI.
- Malaria cases were mostly from Sanghar, Badin, and Larkana whereas AD (Non-Cholera) cases were from Badin, Dadu, and Khairpur.
- Sixteen 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), ILI, B. Diarrhea, Mumps, Meningitis, Chikungunya, Chickenpox, CL, and AWD (S. Cholera), while an increase in the number of cases of Malaria, TB, ALRI<5 Years, Animal/ Dog Bite, VH (B, C & D), Typhoid, SARI, AVH (A & E), Dengue, Measles, HIV/ AIDS, AFP, Gonorrhea, NT, and Syphilis this week.

Table 2: District wise distribution of most frequently reported suspected cases during Week 39, Sindh.

Districts	Malaria	AD (Non-Cholera)	ILI	TB	ALRI < 5 years	Animal / Dog Bite	VH (B, C & D)	B. Diarrhea	Typhoid	SARI
Badin	5,133	5,334	3,128	982	795	158	372	670	95	0
Dadu	3,742	3,533	948	687	1,794	394	280	465	306	255
Ghotki	4,123	1,617	505	557	645	331	317	164	4	7
Hyderabad	1,434	2,450	1,207	448	224	80	82	70	6	0
Jacobabad	2,024	765	495	288	266	216	200	123	37	13
Jamshoro	2,774	2,189	16	668	337	161	153	143	61	3
Kamber	3,462	1,854	13	799	275	231	36	112	11	0
Karachi Central	225	1,474	2,445	130	118	153	58	19	162	0
Karachi East	87	315	25	23	23	20	7	10	3	0
Karachi Keamari	21	585	678	18	14	11	0	4	1	0
Karachi Korangi	70	433	20	28	2	4	1	20	0	0
Karachi Malir	232	1,292	3,189	152	192	60	7	35	27	0
Karachi South	21	126	13	0	0	0	0	3	0	0
Karachi West	300	1,125	1,996	128	214	91	17	61	24	6
Kashmore	1,754	388	210	105	78	165	11	61	0	0
Khairpur	3,923	2,984	3,788	784	699	295	223	290	155	142
Larkana	4,335	2,346	86	837	353	85	29	382	0	0
Matari	3,562	1,784	10	804	198	165	187	85	1	0
Mirpurkhas	3,217	2,736	1,951	658	381	170	59	132	9	0
Naushero Feroze	1,582	1,257	1,311	275	296	378	55	115	91	2
Sanghar	5,175	2,014	132	1,035	423	355	863	42	31	1
Shaheed Benazirabad	2,372	1,870	5	281	219	264	128	85	89	0
Shikarpur	2,449	1,413	3	200	108	267	289	165	1	3
Sujawal	1,123	2,424	0	77	76	63	59	18	0	0
Sukkur	2,495	1,465	2,707	359	185	107	271	147	4	0
Tando Allahyar	2,703	1,681	939	348	135	179	335	77	3	0
Tando Muhammad Khan	1,728	1,334	0	525	187	49	84	78	0	0
Tharparkar	2,020	2,145	536	451	575	0	42	110	9	0
Thatta	1,637	1,626	2,197	94	153	119	137	50	18	4
Umerkot	4,072	1,974	0	278	323	0	61	105	28	0
Total	67,795	52,533	28,553	12,019	9,288	4,571	4,363	3,841	1,176	436

Figure 2: Most frequently reported suspected cases during Week 39, Sindh.

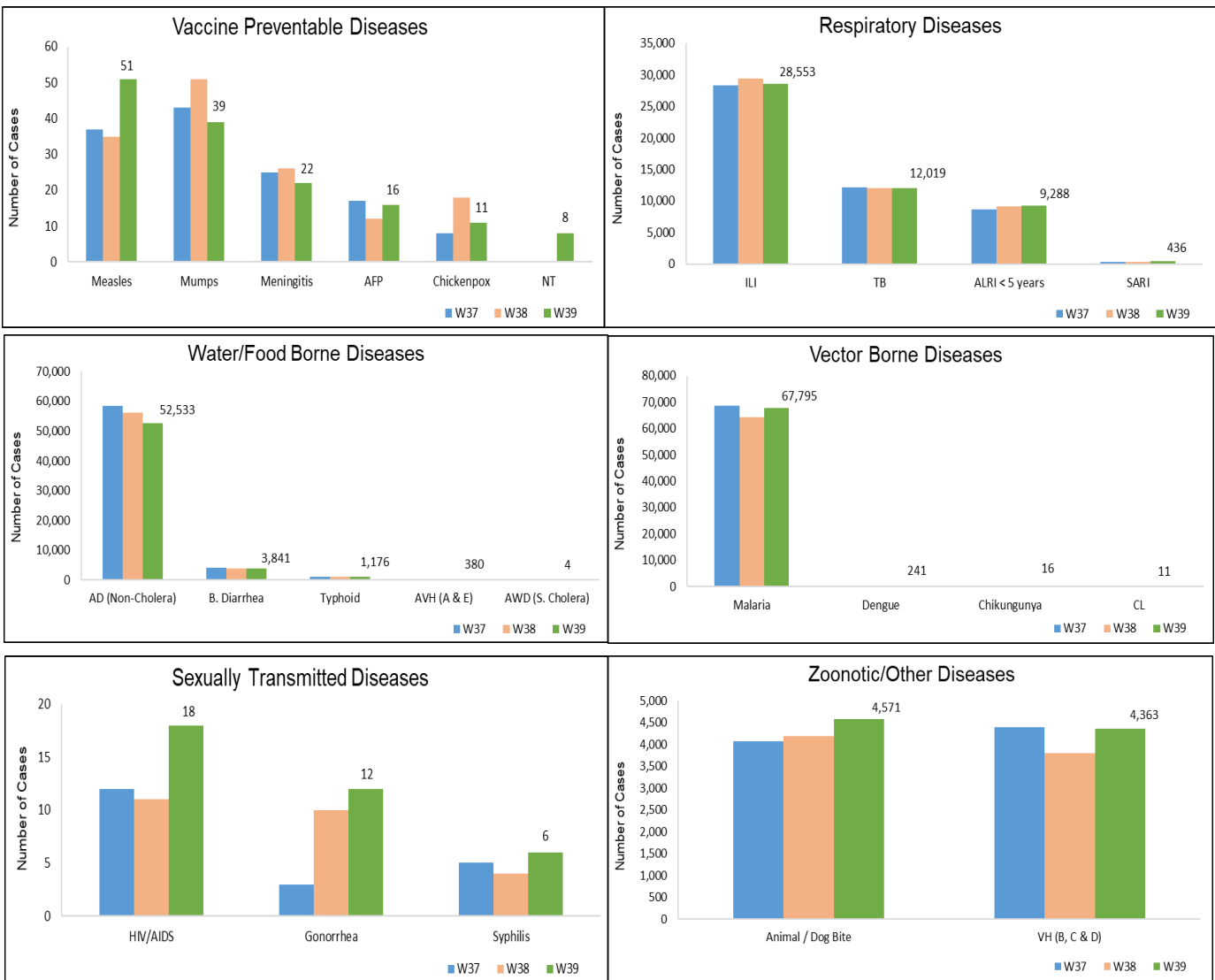
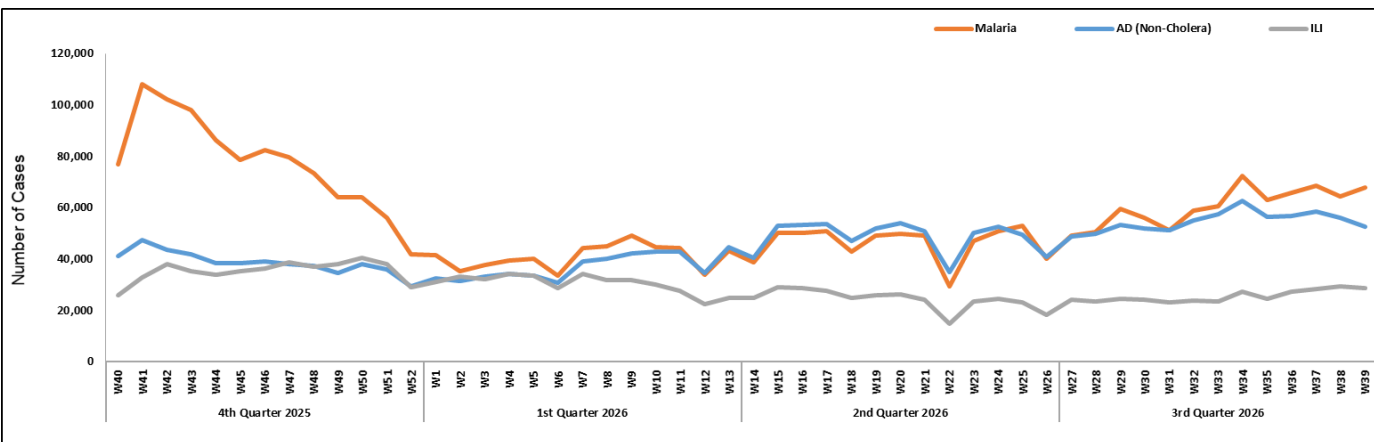


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh.



- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, AWD (S. Cholera), Animal/ Dog Bite, and Mumps cases were the most frequently reported diseases from Balochistan province.
- AD (Non-Cholera) cases were mostly reported from Usta Muhammad, Gwadar, and Lasbella while ILI cases were mostly reported from Gwadar, Kech (Turbat), and Quetta.
- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, Mumps, Gonorrhea, CL, Pertussis, Measles, AVH (A & E), TB, Chickenpox, Diphtheria, Dengue, Rabies, and Meningitis showed an increase in the number of cases. A decline has been observed in AWD (S. Cholera), Animal/ Dog Bite, and VH (B, C & D) cases.

Table 3: District wise distribution of most frequently reported suspected cases during Week 39, Balochistan.

Districts	AD (Non-Cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	AWD (S. Cholera)	Animal / Dog Bite	Mumps
Awaran	13	5	33	3	5	0	11	2	2	3
Barkhan	71	43	132	21	3	6	38	4	11	0
Bashore	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Chagai	175	303	36	0	41	0	7	0	0	0
Chaman	159	252	3	13	40	71	36	3	0	0
Dera Bugti	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
DBS	93	33	82	27	9	0	10	0	0	0
Duki	27	77	27	0	0	0	0	0	0	0
Gwadar	660	1,058	43	4	33	0	7	1	4	1
Harnai	241	3	83	201	80	0	0	0	2	0
Hub	217	71	176	13	14	0	0	0	2	1
Jaffarabad	91	35	79	0	15	0	0	0	0	0
Jhal Magsi	166	97	124	28	0	0	0	0	0	0
Kachhi (Bolan)	140	121	53	8	15	116	NR	22	12	NR
Kalat	0	0	0	0	0	0	0	0	0	0
Kech (Turbat)	454	942	385	28	65	1	4	NR	NR	1
Kharan	241	618	29	5	90	37	4	0	0	0
Khuzdar	124	113	73	22	55	5	26	1	0	0
Killa Abdullah	235	168	6	2	48	48	9	56	5	2
Killa Saifullah	185	0	188	182	93	30	20	0	0	0
Kohlu	237	271	64	12	16	8	38	0	0	0
Lasbella	494	97	222	230	30	0	12	0	17	5
Loralai	415	546	77	44	69	88	20	0	5	2
Mastung	318	326	326	100	20	36	28	0	3	2
MusaKhel	66	33	239	13	14	5	35	5	0	0
Naseerabad	261	0	162	32	10	31	24	0	15	0
Nushki	162	0	0	2	41	0	0	0	0	0
Panjgur	131	69	198	104	58	15	2	0	0	25
Pishin	405	479	11	50	162	48	11	32	0	0
Quetta	440	820	0	94	45	33	0	28	0	2
Sherani	31	44	24	29	25	21	0	0	0	2
Sibi	323	253	120	69	20	41	16	17	2	8
Sohbat pur	198	15	25	152	46	9	9	0	0	1
Surab	26	101	0	0	0	0	0	0	0	0
Tump	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Usta Muhammad	844	205	73	270	133	0	1	0	5	0
Washuk	182	368	138	5	68	24	22	5	0	9
Zhob	293	121	107	348	61	117	2	16	0	2
Ziarat	266	447	99	104	77	72	33	34	11	1
Total	8,384	8,134	3,183	2,215	1,501	862	425	226	96	67

Figure 4: Most frequently reported suspected cases during Week 39, Balochistan.

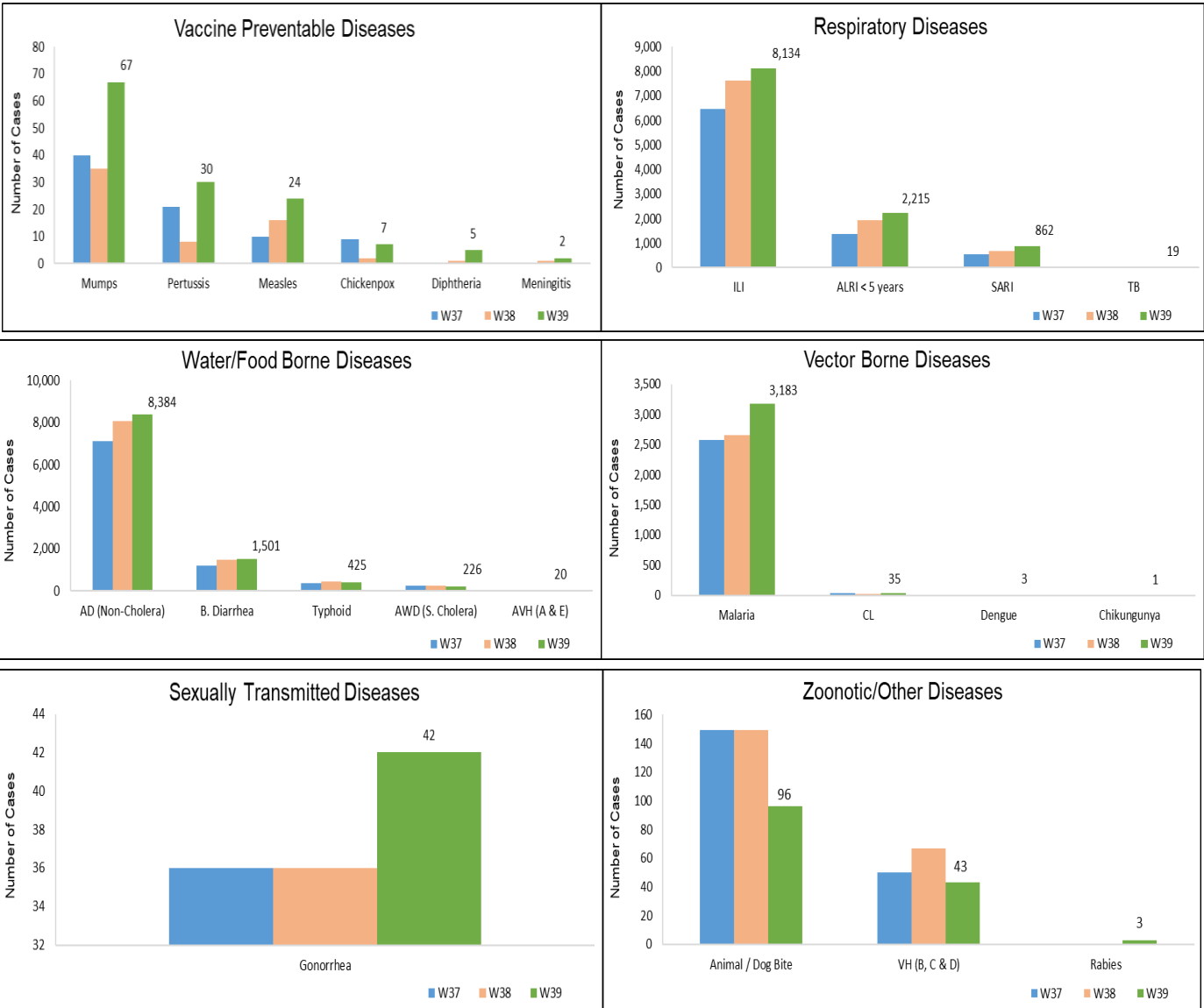
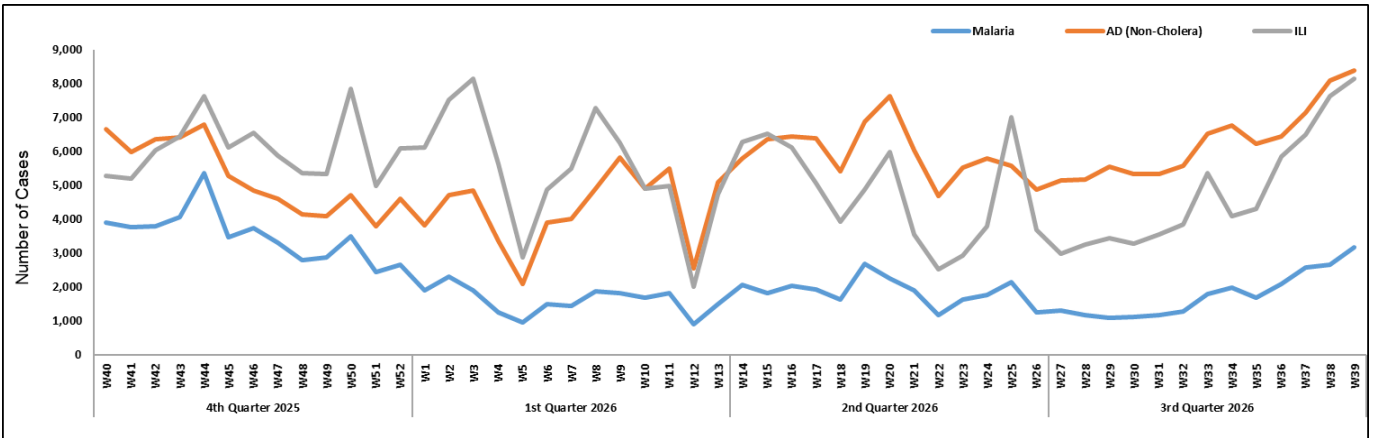


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan.



- Cases of AD (Non-Cholera) were maximum followed by Malaria, ILI, Animal/ Dog Bite, Dengue, B. Diarrhea, Typhoid, ALRI <5 Years, SARI, and CL.
- ILI, Animal/ Dog Bite, Dengue, Typhoid, TB, Measles, Mumps, VH (B, C & D), AWD (S. Cholera), Pertussis, HIV/ AIDS, Gonorrhea, Diphtheria, Syphilis, and VL cases showed an increase in number while AD (Non-Cholera), Malaria, B. Diarrhea, ALRI <5 Years, CL, AVH (A & E), Chickenpox, Chikungunya, AFP and Meningitis cases showed a decline in number this week.
- Twenty-two cases of AFP were reported from KP. All are suspected cases and need field verification.
- Six cases of HIV/ AIDS 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 39, KP.

Districts	AD (Non-Cholera)	Malaria	ILI	Animal / Dog Bite	Dengue	B. Diarrhea	Typhoid	ALRI < 5 years	SARI	CL
Abbottabad	1,218	3	75	60	8	8	18	13	3	0
Bajaur	602	292	0	115	3	41	1	12	5	30
Bannu	990	1,078	0	1	188	11	105	5	5	7
Battagram	389	56	645	19	0	0	0	0	0	0
Buner	442	296	0	21	0	19	0	0	0	0
Charsadda	2,557	367	669	8	461	41	71	111	4	0
Chitral Lower	482	23	5	10	2	21	3	16	11	8
Chitral Upper	187	5	13	3	0	5	4	4	6	0
D.I. Khan	2,086	664	0	37	3	45	6	20	0	3
Dir Lower	2,204	135	3	69	2	88	49	6	2	0
Dir Upper	2,432	28	50	23	0	20	22	25	0	0
Hangu	378	155	0	6	0	0	30	0	0	10
Haripur	1,583	4	525	20	21	0	7	9	0	0
Karak	826	543	7	58	12	42	14	71	0	74
Khyber	933	771	20	42	37	166	35	30	9	108
Kohat	927	311	13	36	243	26	16	2	0	26
Kohistan Lower	251	1	0	4	0	7	4	0	1	0
Kohistan Upper	405	14	0	0	0	5	0	1	0	0
Kolai Palas	59	0	6	0	0	0	0	1	0	0
L & C Kurram	34	5	0	0	0	6	0	0	0	0
Lakki Marwat	870	287	0	111	61	2	23	10	0	0
Malakand	1,764	49	100	25	0	120	0	0	5	0
Mansehra	922	301	482	0	10	13	2	10	0	0
Mardan	1,300	791	31	183	4	33	63	53	0	0
Mohmand	73	174	132	1	2	6	14	0	119	41
North Waziristan	65	118	0	1	0	2	15	6	13	1
Nowshera	2,240	1,205	10	13	17	18	18	9	23	21
Orakzai	121	8	9	0	0	0	0	0	0	0
Peshawar	5,948	104	223	5	64	134	71	25	0	0
Shangla	1,596	342	0	201	0	14	11	19	0	0
South Waziristan (Lower)	140	163	110	6	2	57	25	9	68	14
SWU	38	2	6	0	0	0	0	0	0	0
Swabi	1,761	169	578	142	4	14	5	47	92	0
Swat	3,622	49	77	160	6	109	120	104	0	0
Tank	481	135	17	0	0	4	0	11	0	0
Tor Ghar	164	119	0	14	0	32	2	3	0	1
Upper Kurram	235	12	123	10	0	21	10	17	15	0
Total	40,325	8,779	3,929	1,404	1,150	1,130	764	649	381	344

Figure 6: Most frequently reported suspected cases during Week 39, KP.

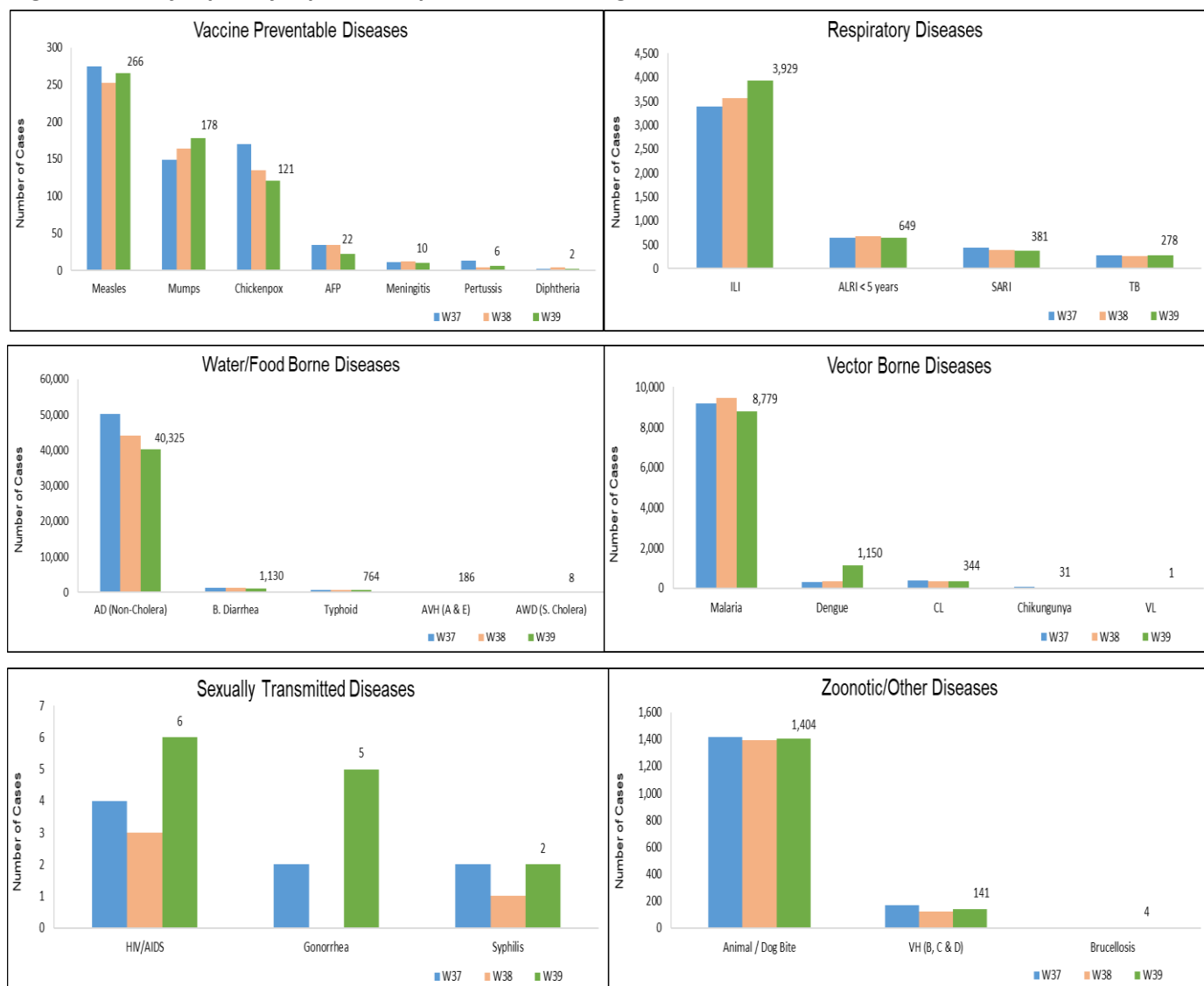
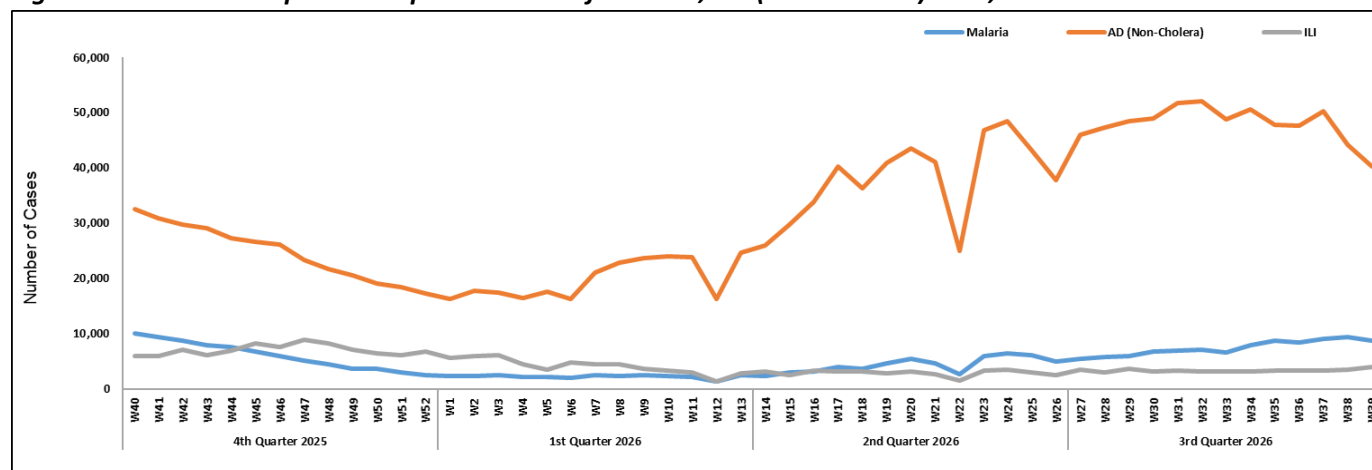


Figure 7: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, KP.



ICT: The most frequently reported cases from Islamabad were ILI followed by AD (Non-Cholera), VH (B, C & D), TB, B. Diarrhea, Malaria, Typhoid, ALRI <5 Years, Mumps, Chickenpox, Dengue, COVID-19, AFP, and Animal/ Dog Bite. AD (Non-Cholera) and Typhoid cases showed a decline in number while an increase in number was observed in ILI, VH (B, C & D), TB, B. Diarrhea, Malaria, Mumps, Chickenpox, COVID-19, and Animal/ Dog Bite cases this week.

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

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

Figure 8: Most frequently reported suspected cases during Week 39, AJK.

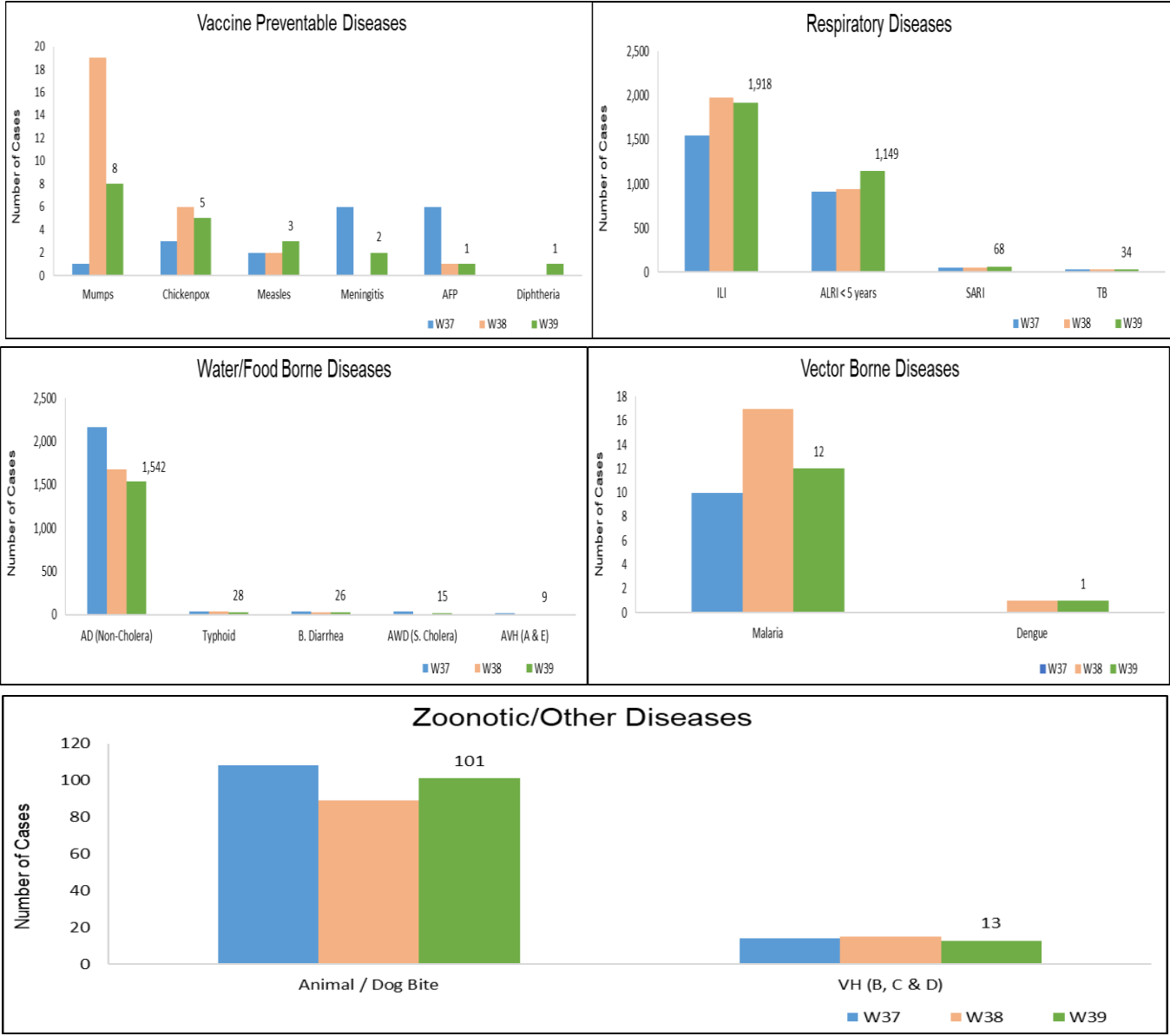


Figure 9: Week wise reported suspected cases of ILI and AD (Non-Cholera), AJK.

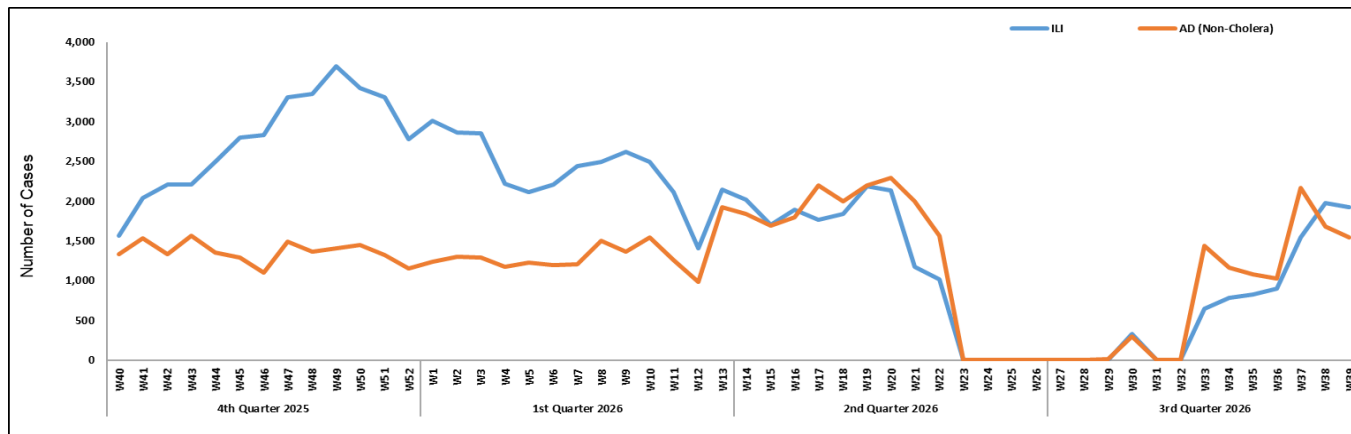


Figure 10: Most frequently reported suspected cases during Week 39, ICT.

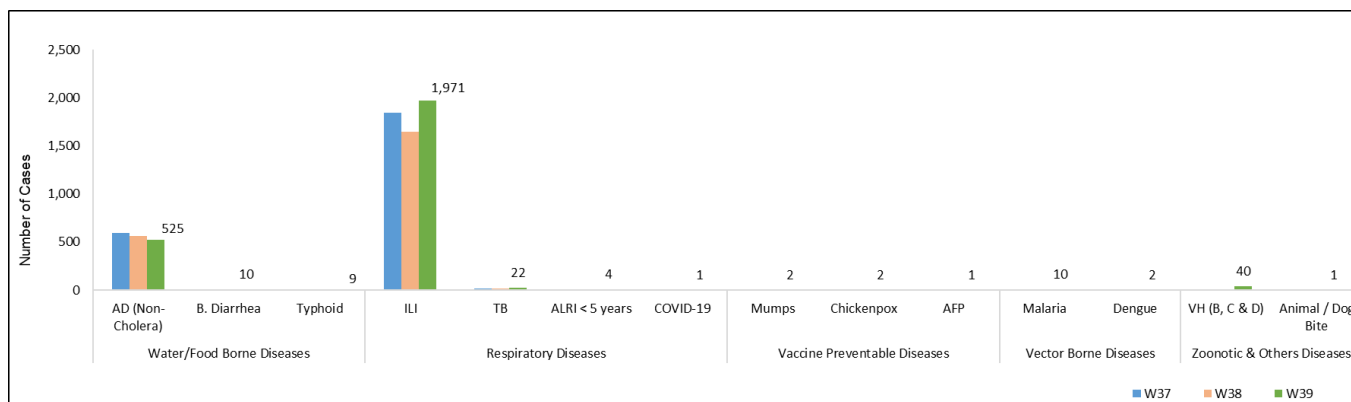


Figure 11: Week wise reported suspected cases of ILI, ICT.

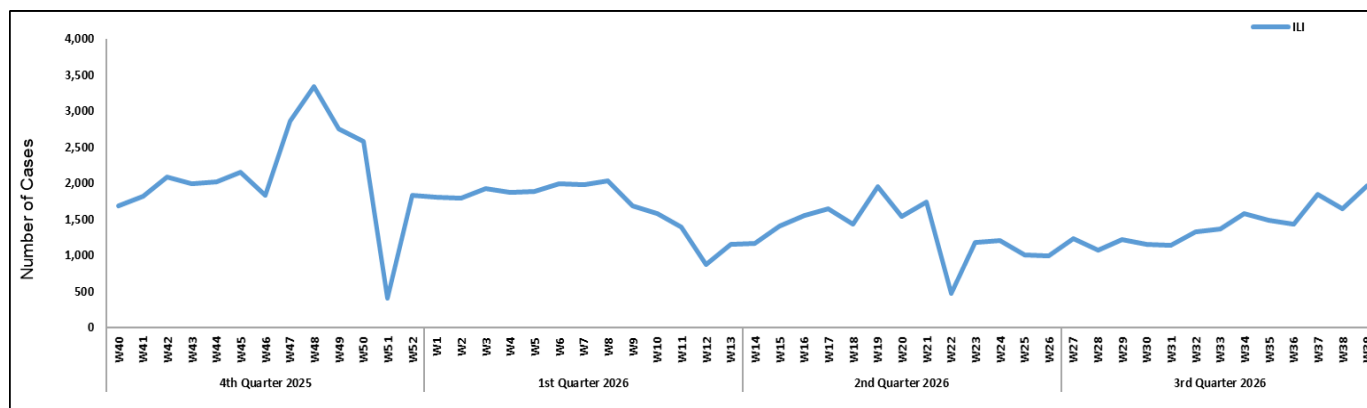


Figure 12: Most frequently reported suspected cases during Week 39, GB.

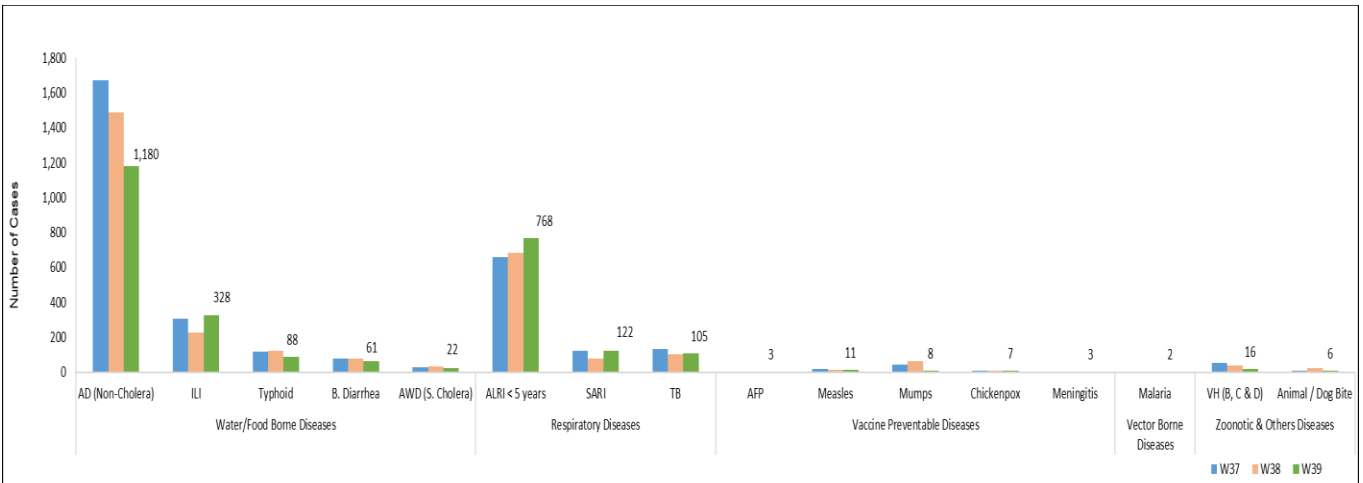
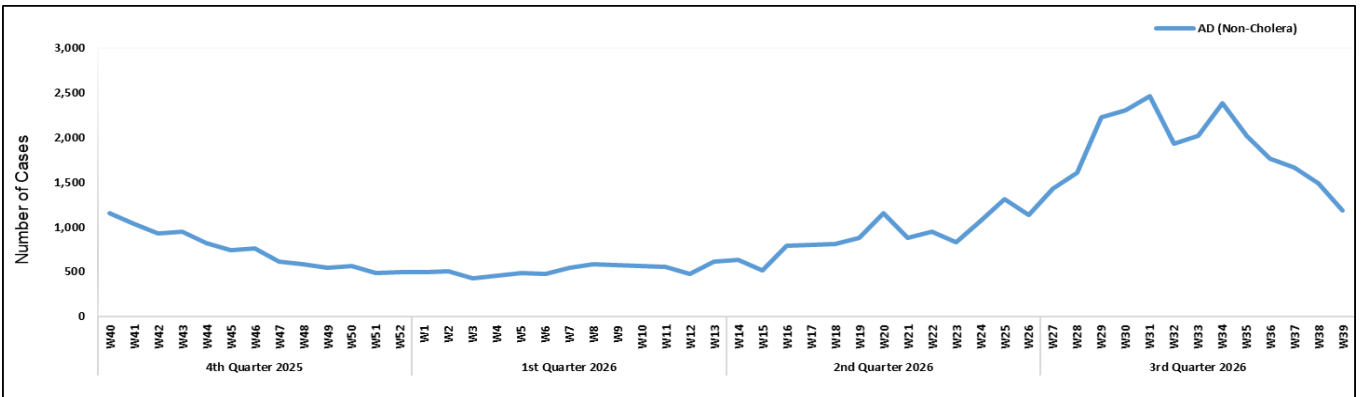


Figure 13: Week wise reported suspected cases of AD (Non-Cholera), GB.



Public Health Laboratories

Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 39, 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)	18	3	-	-	-	-	-	-	-	-	-	-	-	-
Stool culture & Sensitivity	198	3	-	-	-	-	-	-	-	-	-	-	-	-
Malaria	7,173	460	1,262	90	-	-	-	-	176	0	-	-	1	0
CCHF	0	0	4	0	-	-	-	-	-	-	-	-	-	-
Dengue	2,652	234	40	1	-	-	-	-	-	-	-	-	1	0
VH (B)	11,496	236	566	89	-	-	-	-	1,943	18	-	-	38	1
VH (C)	12,102	846	565	50	-	-	-	-	1,725	3	-	-	34	1
VH (D)	183	33	93	18	-	-	-	-	-	-	-	-	-	-
VH (A)	251	60	-	-	-	-	-	-	-	-	-	-	-	-
VH (E)	85	4	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	19	0	4	0	-	-	-	-	-	-	-	-	-	-
TB	809	69	162	15	-	-	-	-	29	0	-	-	-	-
HIV/ AIDS	6,022	48	396	2	-	-	-	-	216	0	-	-	30	0
Syphilis	1,715	18	18	0	-	-	-	-	159	0	-	-	-	-
Typhoid	213	28	77	10	-	-	-	-	185	4	-	-	6	0
Diphtheria	6	0	-	-	-	-	-	-	-	-	-	-	-	-
ILI	16	9	4	1	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)	218	46	4	1	-	-	-	-	-	-	-	-	-	-
Meningitis	25	10	-	-	-	-	-	-	-	-	-	-	-	-
Measles	39	15	34	22	239	123	5	2	0	0	115	19	8	3
Rubella (CRS)	0	0	-	-	-	-	-	-	-	-	-	-	-	-
Leishmaniasis (cutaneous)	0	0	7	4	-	-	-	-	2	0	-	-	-	-
Chikungunya	2	0	-	-	-	-	-	-	-	-	-	-	-	-
Mpox	4	2	-	-	-	-	-	-	-	-	-	-	-	-
Mumps	9	9												
NT	9	9												
SARI	34	18	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	ILI	-	-	-	-	-	9	0	18	0	4	0	-	-
	SARI	2	0	-	-	2	2	20	1	58	0	11	0	3
Influenza A	ILI	-	-	-	-	-	9	0	18	3	4	2	-	-
	SARI	2	0	-	-	2	0	20	1	58	1	11	6	3
Influenza B	ILI	-	-	-	-	-	9	0	18	0	4	0	-	-
	SARI	2	0	-	-	2	0	20	0	58	0	11	1	3
RSV	ILI	-	-	-	-	-	9	0	18	0	4	0	-	-
	SARI	2	0	-	-	2	0	20	0	58	0	11	0	3

Integrated Respiratory Viruses Sentinel Surveillance, National Influenza Centre

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

Figure 14: District wise Influenza sentinel sites, Pakistan.

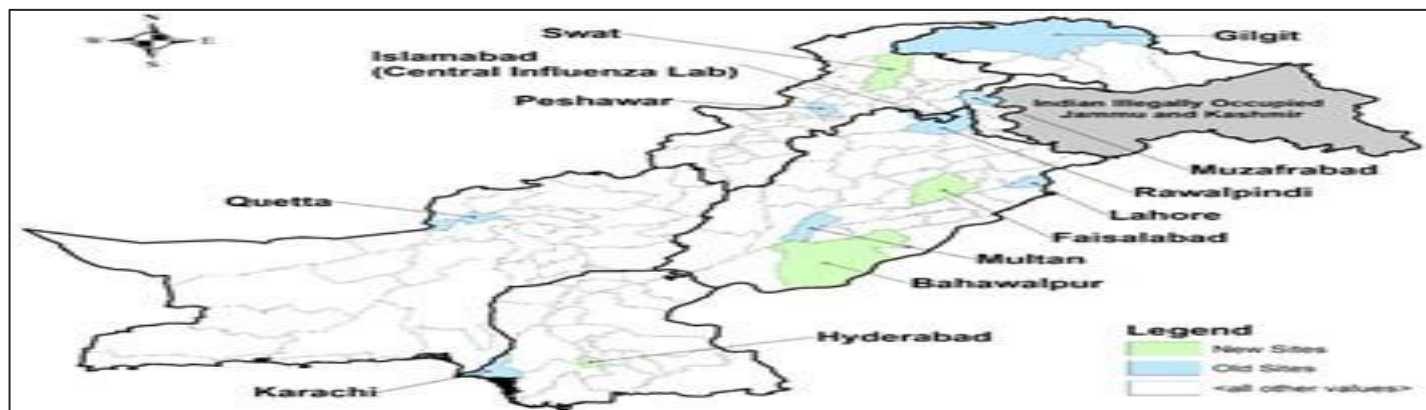


Figure 15: Distribution of suspected samples of ILI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 39, Pakistan.

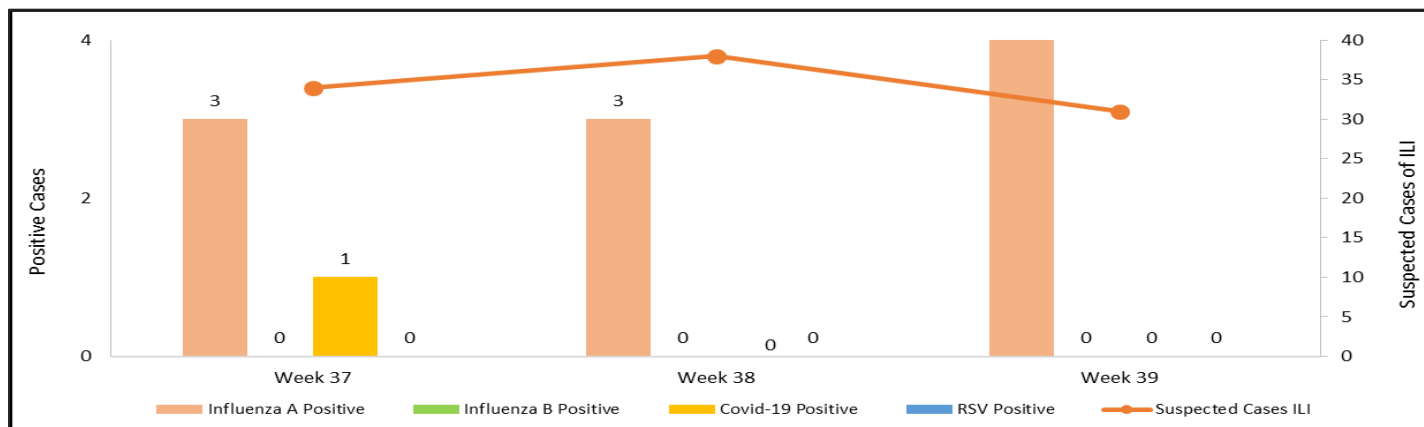
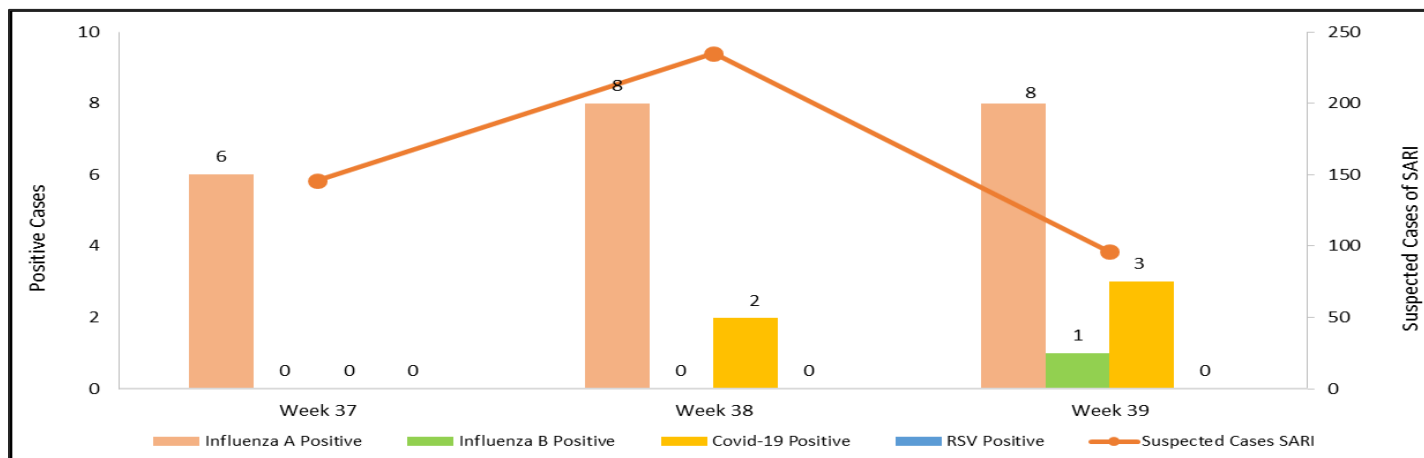


Figure 16: Distribution of suspected samples of SARI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 39, Pakistan.



IDSR Reports Compliance

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

Table 6: Compliance of IDSR reporting districts Week 39, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	105	95%
	Bannu	228	131	57%
	Battagram	59	43	73%
	Buner	34	34	100%
	Bajaur	43	41	95%
	Charsadda	61	61	100%
	Chitral Upper	31	31	100%
	Chitral Lower	37	36	97%
	D.I. Khan	115	115	100%
	Dir Lower	63	60	95%
	Dir Upper	56	48	86%
	Hangu	22	21	95%
	Haripur	72	72	100%
	Karak	36	36	100%
	Khyber	53	42	79%
	Kohat	61	61	100%
	Kohistan Lower	13	13	100%
	Kohistan Upper	22	16	73%
	Kolai Palas	10	8	80%
	Lakki Marwat	70	68	97%
	Lower & Central Kurram	34	11	32%
	Upper Kurram	38	36	95%
	Malakand	42	41	98%
	Mansehra	133	131	98%
	Mardan	81	52	64%
	Nowshera	57	55	96%
	North Waziristan	12	9	75%
	Peshawar	157	131	83%
	Shangla	37	36	97%
	Swabi	65	61	94%
	Swat	75	74	99%
	South Waziristan (Upper)	93	79	85%
	South Waziristan (Lower)	29	28	97%
	Tank	34	32	94%
	Torghar	13	13	100%
	Mohmand	68	17	25%
	Orakzai	69	5	7%
Azad Jammu Kashmir	Mirpur	41	41	100%
	Bhimber	85	83	98%
	Kotli	60	60	100%
	Muzaffarabad	49	47	96%

	Poonch	46	46	100%
	Haveli	39	39	100%
	Bagh	54	54	100%
	Neelum	39	39	100%
	Jhelum Valley	29	28	97%
	Sudhnooti	27	27	100%
Islamabad Capital Territory	ICT	24	24	100%
	CDA	12	9	75%
Balochistan	Gwadar	26	26	100%
	Kech	45	27	60%
	Khuzdar	74	20	27%
	Killa Abdullah	26	24	92%
	Lasbella	55	55	100%
	Pishin	65	15	23%
	Quetta	56	27	48%
	Sibi	36	34	94%
	Zhob	39	36	92%
	Jaffarabad	16	16	100%
	Naseerabad	32	30	94%
	Kharan	30	30	100%
	Sherani	15	4	27%
	Kohlu	75	56	75%
	Chagai	36	21	58%
	Kalat	41	40	98%
	Harnai	17	17	100%
	Kachhi (Bolan)	35	18	51%
	Jhal Magsi	28	28	100%
	Sohbat pur	35	25	71%
	Surab	32	19	59%
	Mastung	46	46	100%
	Loralai	33	31	94%
	Killa Saifullah	28	15	54%
	Ziarat	29	27	93%
	Duki	31	10	32%
	Nushki	29	29	100%
	Dera Bugti North	32	0	0%
	Dera Bugti South	21	20	95%
	Washuk	46	17	37%
	Panjgur	38	21	55%
	Awaran	23	1	4%
	Chaman	27	26	96%
	Barkhan	20	19	95%
	Hub	33	28	85%
	Musakhel	41	37	90%
	Bashore	17	0	0%
	Tump	9	0	0%
	Usta Muhammad	34	34	100%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	20	20	100%

	Ghizer	38	37	97%
	Gilgit	44	43	98%
	Diamer	62	62	100%
	Astore	55	54	98%
	Shigar	23	23	100%
	Skardu	54	54	100%
	Ganche	29	29	100%
	Kharmang	25	25	100%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	64	100%
	Umerkot	65	65	100%
	Naushahro Feroze	102	89	87%
	Tharparkar	273	272	100%
	Shikarpur	59	59	100%
	Thatta	50	50	100%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	15	71%
	Karachi-West	20	20	100%
	Karachi-Malir	35	25	71%
	Karachi-Kemari	22	21	95%
	Karachi-Central	12	10	83%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	4	67%
	Sujawal	55	50	91%
	Mirpur Khas	106	106	100%
	Badin	123	123	100%
	Sukkur	63	63	100%
	Dadu	90	89	99%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	Khairpur	168	168	100%
	Kashmore	59	59	100%
	Matari	42	42	100%
	Jamshoro	74	74	100%
	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 39, 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 Field

Diphtheria Cluster in Shadi Khal, Hangu District, Khyber Pakhtunkhwa, Pakistan, August 2026

Introduction

Diphtheria is an acute, vaccine-preventable bacterial disease caused by toxin-producing *Corynebacterium diphtheriae*, primarily affecting the upper respiratory tract and occasionally the skin. Transmission occurs mainly through respiratory droplets and close contact, and severe disease may cause airway obstruction, myocarditis, neurological complications, and death. Despite the availability of effective vaccines, diphtheria continues to cause outbreaks in populations with inadequate immunization coverage; WHO estimated that 85% of infants worldwide received three doses of diphtheria-containing vaccine in 2025, leaving approximately 20 million infants unvaccinated or incompletely vaccinated. [1] The WHO Eastern Mediterranean Region and neighboring regions remain vulnerable to outbreaks where immunity gaps, population movement, and delayed diagnosis facilitate transmission. [1,2] In Pakistan, gaps in routine immunization and incomplete vaccination schedules create opportunities for diphtheria transmission among susceptible children. In August 2026, a cluster of three laboratory-positive diphtheria cases was documented in Shadi Khal, Union Council Togh Sarai, Tehsil Hangu, District Hangu, Khyber Pakhtunkhwa, including one fatal case in an unvaccinated 13-year-old male. The investigation was undertaken to characterize the outbreak, identify immunization gaps and potential risk

factors, and implement measures to prevent further transmission.

Objectives

1. To determine the magnitude and epidemiological distribution of diphtheria cases and deaths
2. To identify vaccination gaps and potential risk factors
3. To recommend evidence-based measures for interrupting transmission, closing immunization gaps, and preventing future outbreaks.

Methods

A descriptive outbreak investigation was conducted following notification of a diphtheria case in Shadi Khal, Union Council Togh Sarai, Tehsil Hangu, District Hangu, Khyber Pakhtunkhwa, Pakistan. The investigation covered affected households, the school attended by the reported patient, household members, and the surrounding community during August 2026. A suspected case was defined as “any person presenting with an upper respiratory tract illness characterized by pharyngitis, nasopharyngitis, tonsillitis, or laryngitis accompanied by an adherent pseudomembrane of the pharynx, tonsils, larynx, or nose in shadi khel area from 1st august to 28 august”. A laboratory-confirmed case was defined as “a person in whom *Corynebacterium* spp. was isolated from a clinical specimen” and an epidemiologically linked case was defined as “a person meeting the suspected case definition who had an epidemiological link to a laboratory-confirmed case”. [2] Data were collected through household investigations, clinical assessment, contact tracing, vaccination-record review, and assessment of the patient's school. Active case



finding was conducted across a 30-household cluster, including household contacts and members of the surrounding community. Vaccination histories were reviewed to identify zero-dose, under-immunized, and defaulter children. Close contacts were traced, provided appropriate prophylaxis, and monitored for the development of symptoms. Catch-up and outbreak-response vaccination activities were undertaken, and community elders and religious leaders were engaged for risk communication. Symptomatic individuals were assessed, and throat swab specimens were collected and referred to the National Institute of Health (NIH), Islamabad, for laboratory investigation available epidemiological information was analyzed descriptively to summarize case counts, deaths, demographic characteristics, geographic distribution, vaccination status, laboratory findings, and response activities.

Results

A total of three laboratory-positive diphtheria cases were documented in Shadi Khal, Union Council Togh Sarai, Tehsil Hangu, District Hangu, Khyber Pakhtunkhwa, during August 2026, with one reported death. The fatal case was a 13-year-old male who developed symptoms on 20 August 2026, was admitted to hospital on 23 August 2026, and was notified on 24 August 2026. Laboratory confirmation was received on 31 August 2026, and the patient died at North West General Hospital, Peshawar, on the same date. The patient had no documented doses of a diphtheria, tetanus, and pertussis (DTP)-containing vaccine. The investigation included a 30-household cluster assessment and examination of the school attended by the reported patient. Active case finding identified four additional zero-dose children, indicating further immunization gaps in the affected

community. Vaccination-record review also revealed gaps in coverage, particularly for later vaccine doses. Three laboratory-positive cases were recorded in the cluster.

Discussion

This investigation identified a localized cluster of three laboratory-positive diphtheria cases in Shadi Khal, District Hangu, with one reported death.

Diphtheria remains a potentially fatal disease despite the availability of effective vaccines. WHO emphasizes that multiple doses of diphtheria-containing vaccine and subsequent booster doses are necessary to establish and maintain protection. [1,3] The absence of documented vaccination in the fatal case and the identification of additional zero-dose children indicate that routine immunization and catch-up mechanisms require close examination in the affected locality. The reported gaps in later vaccine doses also suggest that the problem may extend beyond children who have never been vaccinated.

The identification of additional zero-dose children through active case finding demonstrates the value of investigating households and associated community settings rather than restricting the response to the initially reported patient.

Conclusion

The investigation documented three laboratory-positive diphtheria cases in Shadi Khal, District Hangu, during August 2026, with one reported death. The fatal case was a 13-year-old male with no documented DTP-containing vaccine doses, and four additional zero-dose children were identified through active case finding. The findings indicate important immunization gaps in



the affected community and the need for sustained surveillance and preventive measures. Continued identification and vaccination of susceptible children, prompt management of suspected cases, and systematic follow-up of contacts are essential to prevent further transmission.

Recommendations

1. Continue active case finding in Shadi Khal and neighboring localities, including households, schools, and health facilities, with immediate investigation of suspected cases.
2. Promptly assess and isolate suspected cases as appropriate, and initiate recommended treatment without waiting for laboratory confirmation when clinical suspicion is high.
3. Identify and vaccinate all zero-dose, under-immunized, and defaulter children through routine immunization, catch-up vaccination, and outbreak-response activities.
4. Ensure timely collection, transport, testing, and reporting of appropriate specimens, with documentation of laboratory results and toxigenicity testing where indicated.
5. Engage LHWs, school administrations, community elders, religious leaders, and other local stakeholders to promote vaccination and early reporting of compatible illness.
6. Assess barriers to routine immunization and strengthen defaulter tracking, outreach sessions, and follow-up for children who miss scheduled doses.

References

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Knowledge Hub

Influenza-Like Illness (ILI): What You Need to Know

Influenza-Like Illness is often referred to as acute respiratory infection, a medical term used by



public health agencies to track viral respiratory outbreaks in communities before specific laboratory test results are returned.

What is ILI?

ILI is defined clinically by a specific cluster of symptoms rather than a single virus. Standard public health surveillance definitions require:

1. **Fever:** Measured temperature of 100°F (37.8°C) or higher, or feeling feverish with chills.
2. **Respiratory Symptoms:** A cough and/or a sore throat.

Common Pathogens Causing ILI

While influenza viruses (Types A and B) are the classic cause, several other respiratory viruses produce identical clinical symptoms:

- **Influenza Viruses (A & B):** Primary cause during seasonal epidemics.
- **SARS-CoV-2:** The virus responsible for COVID-19.
- **Respiratory Syncytial Virus (RSV):** A major cause of severe respiratory illness in young infants and older adults.
- **Human Parainfluenza Viruses (HPIVs):** Frequently associated with croup, bronchitis, and pneumonia.
- **Adenoviruses & Rhinoviruses:** Common causes of upper respiratory tract infections that can present with fever.

How It Spreads

Most ILI-causing pathogens spread through respiratory secretions:

- **Airborne Droplets:** Expelled when an infected individual coughs, sneezes, speaks, or breathes.
- **Surface Contact (Fomites):** Touching contaminated surfaces (such as doorknobs or mobile devices) and subsequently touching the eyes, nose, or mouth.
- **Close Contact:** Prolonged proximity in crowded or poorly ventilated indoor spaces.

Signs & Symptoms

ILI symptoms typically feature a sudden, abrupt onset. While overlapping significantly with the common cold, ILI is distinguished by higher fevers and more severe systemic symptoms.

- **Fever:** Usually 100°F (37.8°C) or higher, often accompanied by chills or night sweats.
- **Cough:** Prominent and typically dry at the onset, which can become severe or prolonged.
- **Muscle & Body Aches:** Severe generalized myalgia, particularly in the back and legs.
- **Fatigue:** Moderate to extreme exhaustion that can last for two to three weeks.
- **Sore Throat & Headaches:** Common initial complaints that accompany nasal congestion.

Complications

While most healthy individuals recover within 1 to 2 weeks, high-risk groups (elderly adults, young children, pregnant women, and



individuals with chronic illness) are at elevated risk for complications:

- **Secondary Bacterial Pneumonia:** Severe infection of the lungs requiring antibiotics.
- **Exacerbation of Chronic Conditions:** Worsening of underlying asthma, COPD, or congestive heart failure.
- **Acute Otitis Media & Sinusitis:** Bacterial complications following viral inflammation.
- **Sepsis & Myocarditis:** Severe systemic inflammatory responses or heart muscle inflammation.

Prevention

- **Vaccination:** Annual flu vaccines, updated COVID-19 vaccines, and RSV immunizations (for eligible infants and older adults) offer the strongest protection against severe illness.
- **Hand Hygiene:** Wash hands thoroughly with soap and water for at least 20 seconds, or use alcohol-based hand sanitizer.
- **Respiratory Etiquette:** Cover coughs and sneezes into a tissue or the inner elbow.
- **Stay Home When Sick:** Isolate during acute illness to protect vulnerable community members.

Diagnosis and Treatment

- **Diagnosis:** Rapid molecular assays (PCR) and antigen tests (swabs) are used by healthcare providers to differentiate between Influenza, COVID-19, and RSV.
- **Treatment:**

- **Supportive Care:** Adequate hydration, rest, and over-the-counter antipyretics (**acetaminophen** or **ibuprofen**) for fever and pain management.
- **CRITICAL WARNING: Avoid Aspirin in children or teenagers** with fever due to the risk of **Reye's syndrome**, a potentially fatal disorder affecting the liver and brain.

More Information

For real-time epidemiological tracking, weekly surveillance reports, and clinical guidance, visit:

- **Centers for Disease Control and Prevention (CDC) - FluView:**
<https://www.cdc.gov/flu/weekly/index.htm>
- **World Health Organization (WHO) - Global Influenza Programme:**
<https://www.who.int/teams/global-influenza-programme/surveillance-and-monitoring>
- **UK Health Security Agency (UKHSA) - National Surveillance Reports:**
<https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports>
- **Public Health Agency of Canada (PHAC) - FluWatch:**
<https://www.canada.ca/en/public-health/services/diseases/flu-influenza/influenza-surveillance.html>





Seasonal Flu موسمی فلو



موسمی فلو ایک قابل علاج بیماری ہے عام طور پر بزرگ چھوٹے بچے حاملہ خواتین، قوت مدافعت میں کمی اور دائمی بیماریوں کا شکار (کینسر، ذیابیطس، دل یا سانس کی شدید بیماریوں میں مبتلا مریض وغیرہ) کو اس بیماری سے جلد متاثر ہونے کا خطرہ ہے۔ اس بیماری کا وائرس کھلی فضا میں کھانسنے یا چھٹکائی کی وجہ سے مریض کے ہاتھوں کے ذریعے ارد گرد کی جگہوں پر پھیل جاتا ہے اور جب کوئی صحت مند شخص وہاں سانس لیتا ہے یا متاثرہ چیزوں کو چھوتا ہے تو وائرس اس تک منتقل ہو جاتا ہے۔

استعمال کے فوراً بعد ڈسٹو پیپر کو محفوظ طریقے سے ٹھکانے لگائیں۔ 	کھانسنے یا چھٹکاتے وقت منہ اور ناک کو کبھی سے ڈھانپ لیں۔ 
فلو کی صورت میں ماسک کا استعمال کریں۔ 	اپنے ہاتھ صاف پانی اور صابن کے ساتھ اچھی طرح دھوئیں۔ 
پچھیدگی کی صورت میں فوراً مستند معالج سے رابطہ کریں۔ 	فلو کی صورت میں گھر پر آرام کریں اور لوگوں سے کیل جوں میں احتیاط کریں۔ 

اس بیماری سے بچاؤ کے لیے معمول کی ویکسینیشن (Flu Vaccination) کروائی جاسکتی ہے۔ خاص طور پر قوت مدافعت کی کمی کا شکار، حاملہ خواتین اور دائمی بیماری (ذیابیطس، ہمدردی، کمرے میں رہنے والے افراد، ویکسینیشن سے محروم افراد) کو۔

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