

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

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Overview

IDSR Reports

Ongoing Events

Field Reports

Public Health Bulletin - Pakistan, Week 01, 2024

Evolving from a basic disease registry, Pakistan's Public Health Bulletin has become an indispensable tool for safeguarding public health. By meticulously tracking disease trends, the Bulletin serves as an early warning system, enabling timely interventions to prevent outbreaks.

This Weeks Highlights include;

- *Operationalizing One Health in Pakistan: A Multi-sectoral Collaborative Workshop to Establish Federal and Provincial Governance Structures*
- *Cutaneous Leishmaniasis Medical Camps at KUL Tangi UC Wanki Siraj Khel - District Karak*
- *Outbreak Investigation of Scabies*
- *Knowledge review on Typhoid*

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*



All reported cases in this report are suspected cases

- During week 01, the most frequently reported cases were of Acute Diarrhea (Non-Cholera) followed by Malaria, ILI, ALRI <5 years, TB, dog bite, B. Diarrhea, VH (B, C & D), Typhoid and SARI.
- Sixteen cases of AFP reported from KP, ten from Punjab, nine from Sindh and eight from AJK.
- Twenty-one suspected cases of HIV/ AIDS reported from Punjab and four from Sindh.
- Fourteen suspected cases of Brucellosis reported from KP.
- Among VPDs, there is an increase in number of cases of Measles, Meningitis and Chicken pox this week.
- Among respiratory diseases, there is an increase in number of cases of ILI, ALRI< 5 years and TB this week.
- Among water/food borne diseases, there is an increase in number of cases of Acute Diarrhea (Non-Cholera) this week.
- Among other diseases, there is an increase in number of cases of 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 81%
- Gilgit Baltistan , Sindh are the top reporting regions with a compliance rate of 93%, followed by AJK 91% and KP 78%.
- The lowest compliance rate was observed in ICT 75% and Balochistan 62%.

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2319	1808	78
Azad Jammu Kashmir	404	369	91
Islamabad Capital Territory	36	27	75
Balochistan	1307	810	62
Gilgit Baltistan	405	375	93
Sindh	2090	1948	93
National	6561	5337	81



Public Health Actions

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

ALRI in children < five years

- **Enhance Surveillance:** Strengthen the surveillance of ALRI cases at public health facilities and incorporate data from private sector as well, especially during flu seasons.
- **Strengthen Lab Systems:** Enhance the capacity of laboratory systems to easily detect the circulating strains in the population.
- **Promote Hygiene Practices:** Launch health education campaigns on proper respiratory hygiene (Covering coughs, frequent hand washing).
- **Enhance vaccination:** Vaccination in high-risk groups (asthmatics, children < 5) for ALRI is advised.

HIV/AIDS

- **Expand HIV Screening and Testing:** Increase access to screening and testing, particularly in high-risk populations.
- **Ensure Access to ART:** Provide immediate access to antiretroviral therapy (ART) for individuals living with HIV.
- **Strengthen Community Awareness Programs:** Continue community awareness and health education programs, focusing on high-risk populations and areas for prevention of HIV/AIDS, including counseling regarding stigmatization associated with the disease.

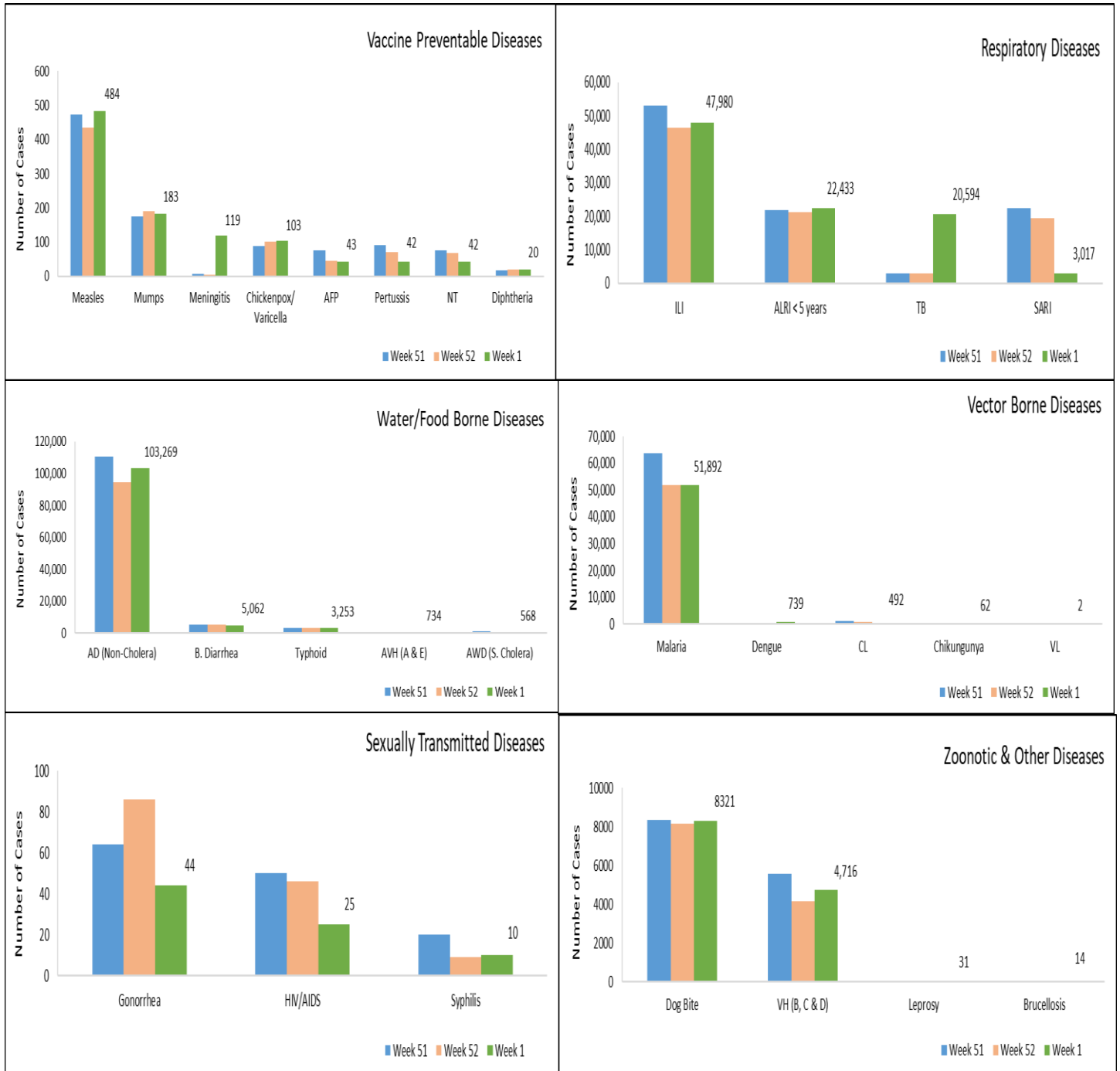


Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 01, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	891	4,266	414	224	14,609	54,047	28,818	103,269
Malaria	0	3,678	0	0	4,117	2,674	41,423	51,892
ILI	2,715	7,235	406	1,175	7,913	6	28,530	47,980
ALRI < 5 years	1,441	2,257	1,416	15	2,402	1,999	12,903	22,433
TB	36	107	50	5	459	9,456	10,481	20,594
Dog Bite	83	136	3	2	730	4,350	3,017	8,321
B. Diarrhea	12	997	52	0	888	434	2,679	5,062
VH (B, C & D)	12	62	0	0	107	0	4,535	4,716
Typhoid	11	399	36	0	561	1,508	738	3,253
SARI	212	637	270	2	1,745	0	151	3,017
Dengue	0	3	0	0	12	685	39	739
AVH (A & E)	12	0	3	0	243	0	476	734
AWD (S. Cholera)	3	47	9	0	54	434	21	568
CL	0	59	0	0	429	4	0	492
Measles	3	47	2	0	249	154	29	484
Mumps	3	32	5	0	83	3	57	183
Meningitis	1	0	0	0	15	83	20	119
Chickenpox/ Varicella	2	3	12	0	46	16	24	103
Chikungunya	0	5	0	0	0	0	57	62
Gonorrhoea	0	25	0	0	11	0	8	44
AFP	8	0	0	0	16	10	9	43
Pertussis	0	23	9	0	7	1	2	42
Leprosy	0	0	0	0	31	0	0	31
HIV/AIDS	0	0	0	0	0	21	4	25
Diphtheria	0	0	0	0	13	6	1	20
Brucellosis	0	0	0	0	14	0	0	14
Syphilis	0	0	0	0	0	0	10	10
NT	0	0	0	0	7	1	0	8
VL	0	1	0	0	1	0	0	2



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



- Malaria cases were maximum followed by AD (Non-Cholera), ILI, ALRI<5 Years, TB, VH (B, C, D), dog bite, B. Diarrhea, Typhoid and AVH (A & E).
- Malaria cases are mostly from Larkana, Dadu and Khairpur whereas AD (Non-Cholera) cases are from Badin, Khairpur and Dadu.
- Nine cases of AFP reported from Sindh. All are suspected cases and need field verification.
- Four suspected cases of HIV/ AIDS reported from Sindh. Field investigation required to verify the case.
- There is an increasing number of cases of Malaria, AD (Non-Cholera), ILI, TB, VH (B, C, D) and dog bite this week.

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

Districts	Malaria	AD (Non-Cholera)	ILI	TB	ALRI < 5 years	VH (B, C & D)	B. Diarrhea	Dog Bite	Typhoid	AVH (A&E)
Badin	1,471	1,774	2,787	543	743	183	53	115	26	12
Dadu	4,252	1,733	546	1,457	391	37	369	430	106	41
Ghotki	895	440	75	502	217	215	232	46	0	3
Hyderabad	228	871	10	7	85	51	0	0	8	0
Jacobabad	1,067	526	849	387	97	208	205	86	68	0
Jamshoro	1,639	946	328	460	509	194	60	70	73	2
Kamber	2,338	1,134	0	351	739	127	231	88	13	0
Karachi Central	2	396	1,070	0	8	6	1	1	11	0
Karachi East	45	419	509	66	35	6	21	9	1	0
Karachi Keamari	0	398	386	66	0	0	3	3	4	0
Karachi Korangi	84	306	10	2	12	1	0	3	0	0
Karachi Malir	256	1,095	3,276	307	113	33	41	48	22	3
Karachi South	14	87	2	0	0	0	0	0	0	0
Karachi West	249	838	1,296	137	134	75	30	29	25	2
Kashmore	2,320	310	648	224	278	28	124	51	3	0
Khairpur	4,020	1,746	5,796	1,099	887	161	292	242	131	1
Larkana	4,366	1,533	15	603	844	66	61	369	4	6
Matari	1,551	838	3	517	577	265	54	37	8	6
Mirpurkhas	1,479	1,814	2,580	739	586	124	133	104	7	4
Naushero Feroze	1,859	1,024	1,146	472	474	46	211	123	39	0
Sanghar	3,524	1,403	148	841	1001	1,409	183	99	28	4
Shaheed Benazirabad	1,210	1,198	16	262	212	87	164	22	79	5
Shikarpur	1,954	923	0	236	251	663	213	165	6	0
Sujawal	580	938	8	174	181	51	62	34	5	15
Sukkur	1,795	813	1,826	709	395	82	74	96	9	0
Tando Allahyar	874	701	1,547	369	517	245	58	116	7	0
Tando Muhammad Khan	366	546	37	184	436	0	31	62	0	0
Tharparkar	1,131	1,772	1,911	1,095	430	58	3	108	15	30
Thatta	767	1,126	1,705	572	29	48	108	57	17	340
Umerkot	1,087	1,170	0	522	300	66	0	66	23	2
Total	41,423	28,818	28,530	12,903	10481	4,535	3,017	2,679	738	476



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

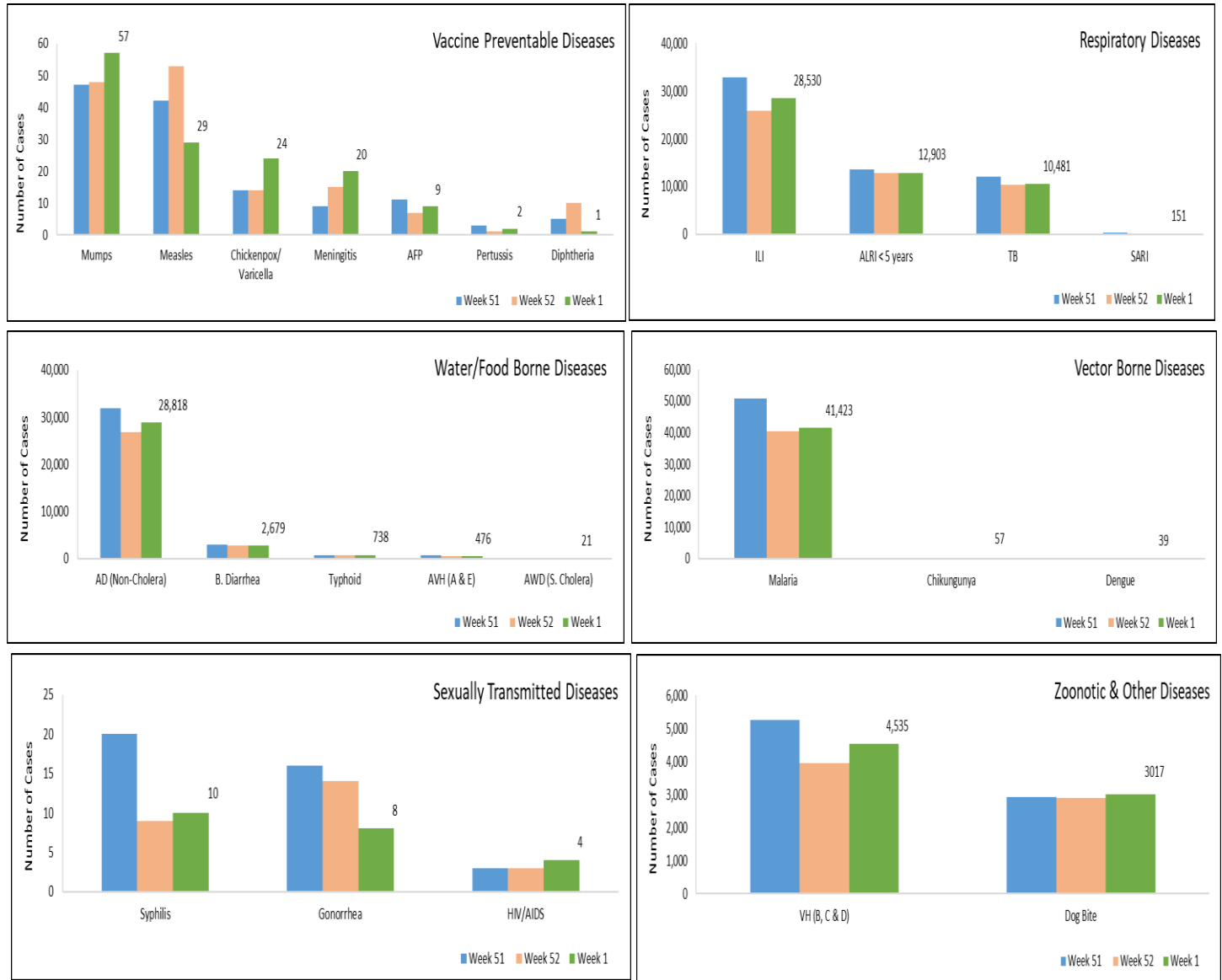
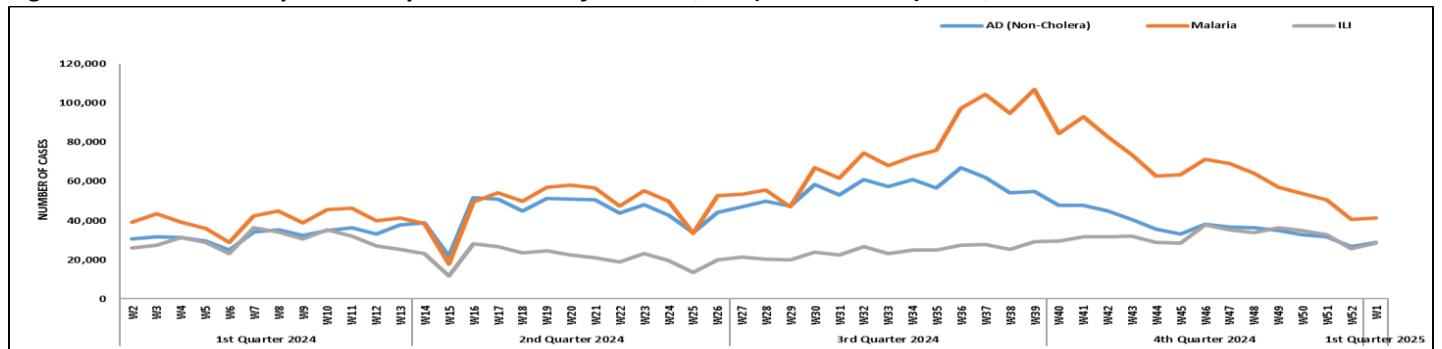


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh



- ILI, Malaria, AD (Non-Cholera), ALRI <5 years, B. Diarrhea, SARI, Typhoid, TB, dog bite and VH (B, C & D) cases were the most frequently reported diseases from Balochistan province.
- ILI cases are mostly reported from Kech (Turbat), Quetta and Pishin while Malaria cases are mostly reported from Gwadar, Usta Muhammad and Quetta.
- ILI, Malaria, AD (Non-Cholera), B. Diarrhea, Typhoid, TB and VH (B, C & D) showed a decline in cases while an increase in cases observed for ALRI <5 years and dog bite this week.

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

Districts	AD (Non-Cholera)	Malaria	ILI	B. Diarrhea	ALRI < 5 years	Typhoid	SARI	AWD (S.Cholera)	TB	CL
Barkhan	48	54	36	38	3	0	20	11	0	0
Chagai	209	58	23	0	26	0	8	0	1	0
Dera Bugti	51	31	42	48	10	2	0	0	0	0
Gwadar	497	443	157	3	124	0	11	0	0	0
Harnai	22	72	46	186	71	0	0	2	2	2
Jaffarabad	169	194	248	8	29	12	2	4	35	0
Jhal Magsi	398	254	560	298	3	4	7	11	8	0
Kalat	4	21	8	19	9	4	23	0	1	0
Kech (Turbat)	1,160	259	556	22	34	7	2	NR	1	0
Kharan	648	96	19	0	32	4	2	0	0	0
Khuzdar	380	242	85	4	171	53	26	0	0	0
Killa Saifullah	0	92	64	236	25	42	7	1	0	2
Kohlu	352	131	51	16	32	62	35	NR	NR	NR
Lasbella	59	297	326	105	38	10	17	25	0	0
Loralai	355	91	24	39	20	67	17	19	0	0
Mastung	27	108	11	6	9	7	13	6	0	0
Naseerabad	62	288	349	43	16	19	65	51	8	55
Nushki	51	74	2	3	16	1	0	0	0	0
Panjgur	7	12	9	3	6	11	0	0	0	0
Pishin	737	179	14	145	62	31	30	2	0	0
Quetta	938	345	13	177	40	89	18	0	0	0
Sherani	17	7	0	0	0	17	0	0	0	0
Sibi	57	192	322	226	29	64	51	0	0	1
Sohbat pur	20	145	318	114	47	17	15	1	4	2
Surab	231	60	17	21	0	0	0	0	0	0
Usta Muhammad	215	356	265	212	55	32	10	2	1	0
Washuk	355	117	98	0	77	11	14	1	0	0
Zhob	166	48	15	285	13	71	6	0	46	0
Total	7,235	4,266	3,678	2,257	997	637	399	136	107	62



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

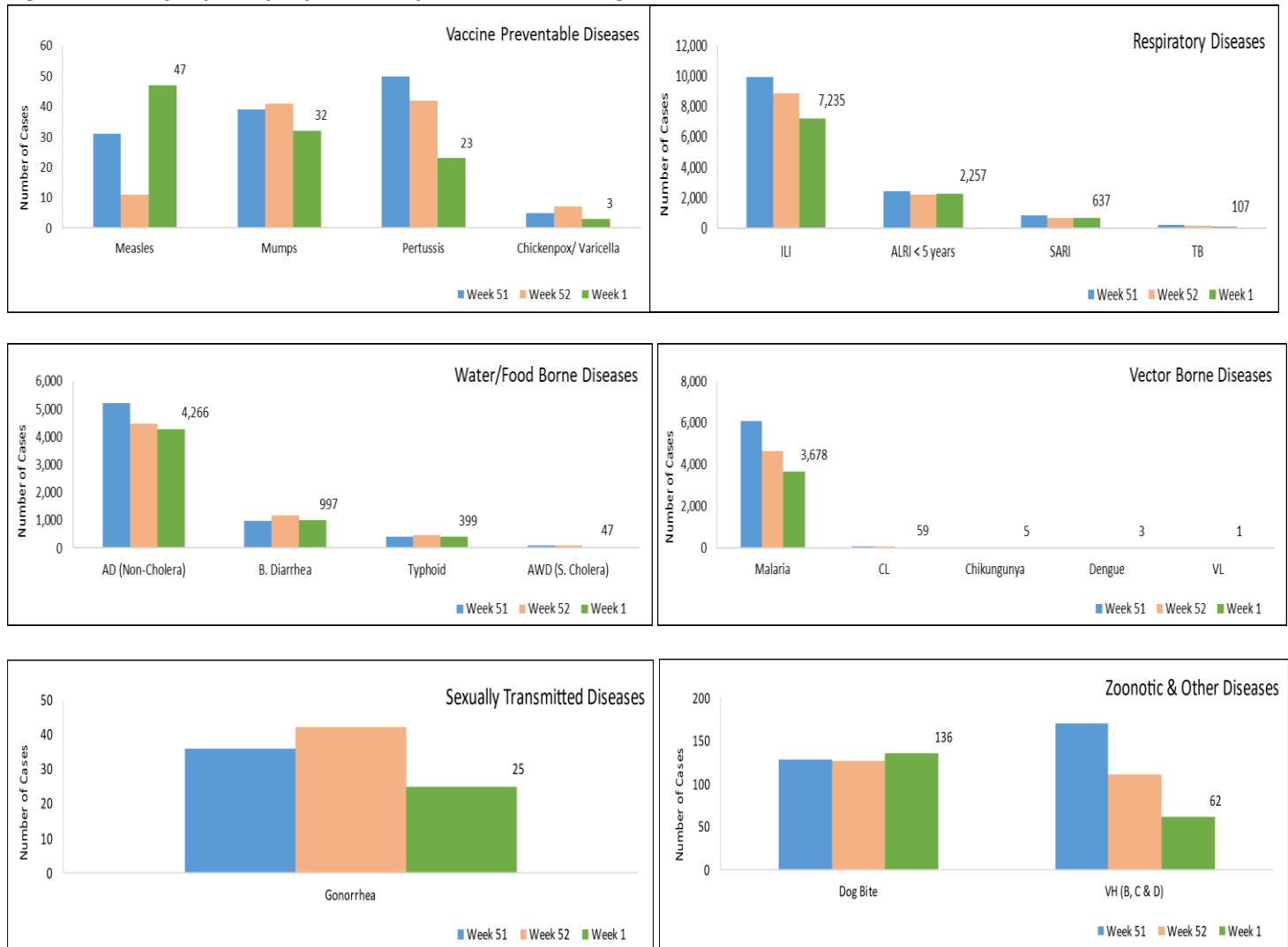
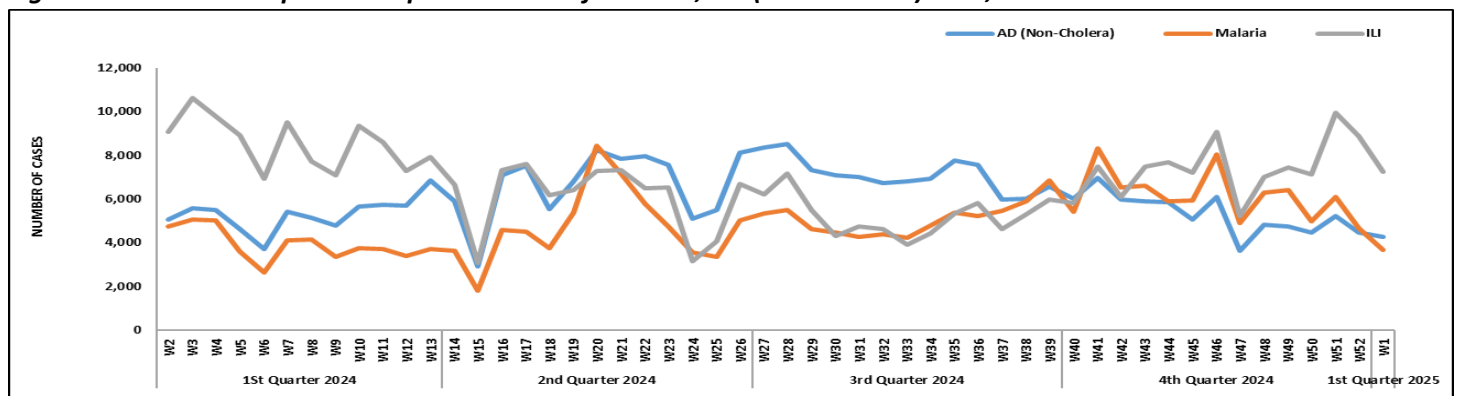


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan



- Cases of AD (Non-Cholera) were maximum followed by ILI, Malaria, ALRI<5 Years, SARI, B. Diarrhea, dog bite, Typhoid, TB and CL cases.
- Malaria and dog bite cases showed a decline in number while AD (Non-Cholera), ILI, ALRI<5 Years, SARI, TB and CL cases showed an increase in number this week.
- Sixteen cases of AFP reported from KP. All are suspected cases and need field verification.
- Fourteen suspected cases of Brucellosis reported from KP. They require field verification.

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

Districts	AD (Non-Cholera)	Malaria	ILI	B.Diarrhea	SARI	ALRI <5 Years	Typhoid	Dog Bite	TB	AVH (A&E)
Abbottabad	388	168	0	75	28	5	47	28	8	0
Bajaur	299	126	138	42	141	50	57	2	12	21
Bannu	594	7	1,360	18	0	34	3	88	17	0
Battagram	137	642	14	39	0	NR	1	0	42	NR
Buner	135	0	107	0	0	0	13	4	1	0
Charsadda	1,148	1,589	395	833	41	188	16	44	8	0
Chitral Lower	214	214	5	31	21	10	13	1	1	3
Chitral Upper	61	18	0	5	0	0	1	7	0	0
D.I. Khan	1,033	0	245	21	0	21	12	0	47	1
Dir Lower	819	4	129	27	0	52	24	32	9	0
Dir Upper	464	124	4	16	0	0	3	2	20	8
Hangu	72	245	158	21	18	10	3	0	3	6
Haripur	482	385	0	48	5	1	8	11	46	0
Karak	262	16	45	23	50	8	7	2	2	100
Khyber	474	304	480	160	119	156	45	86	28	142
Kohat	255	30	21	7	15	15	13	5	0	2
Kohistan Lower	69	0	0	0	0	5	0	0	1	0
Kohistan Upper	275	0	11	13	0	9	0	0	14	0
Kolai Palas	63	8	1	1	4	5	0	1	1	0
L & C Kurram	3	14	9	0	8	13	0	1	0	0
Lakki Marwat	461	21	145	33	0	13	38	4	5	1
Malakand	349	120	11	55	31	49	0	16	2	32
Mansehra	395	406	1	20	243	2	0	0	4	0
Mardan	526	0	6	72	27	15	66	18	8	0
Mohmand	108	171	108	3	203	19	14	4	0	93
North Waziristan	2	0	6	2	13	1	0	1	0	0
Nowshera	829	55	25	8	13	26	7	7	12	5
Orakzai	20	13	3	0	0	6	18	0	1	0
Peshawar	1,712	1,201	5	196	285	107	6	57	29	0
SD Tank	9	2	7	0	0	0	0	0	0	0
Shangla	534	0	142	64	0	1	48	4	54	2
South Waziristan (Lower)	17	243	18	8	74	2	4	7	4	0
SWU	10	19	6	0	15	0	0	0	0	0
Swabi	739	1,029	48	342	74	6	177	40	45	0
Swat	999	271	29	176	10	13	41	46	14	0
Tank	502	151	417	18	0	3	0	35	17	1
Tor Ghar	37	0	17	3	35	14	32	5	1	12
Upper Kurram	112	317	1	22	272	29	13	3	3	0
Total	14,609	7,913	4,117	2,402	1,745	888	730	561	459	429



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

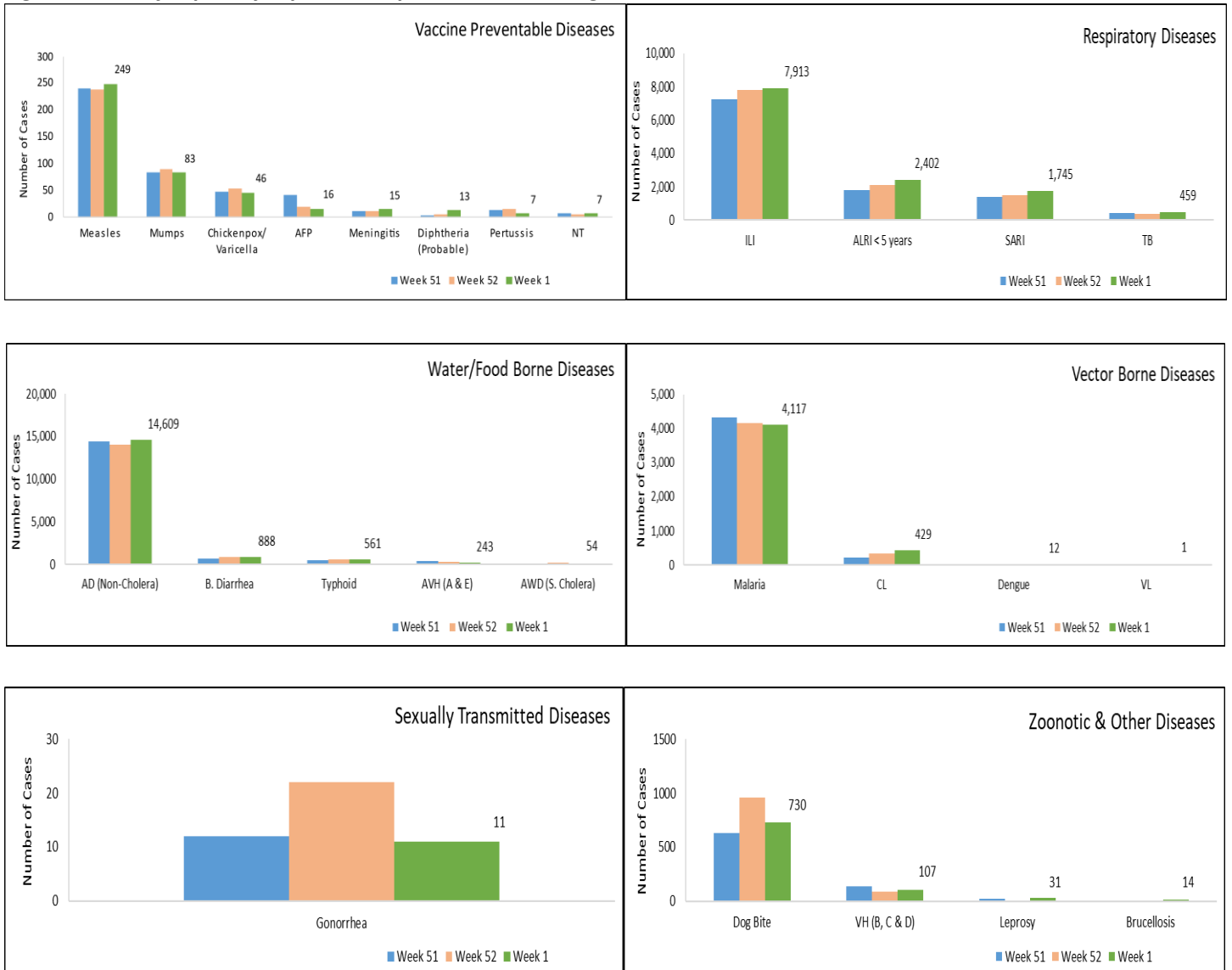
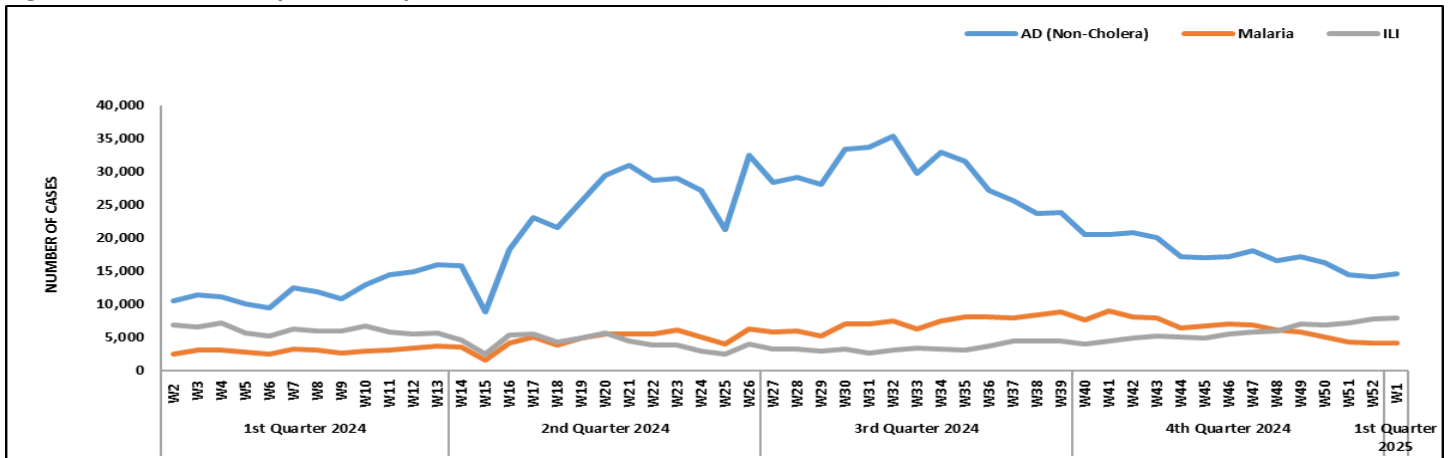


Figure 7: Week wise reported suspected cases Malaria, AD (Non-Cholera) & ILI, KP



ICT: The most frequently reported cases from Islamabad were ILI followed by AD (Non-Cholera) and ALRI <5 years. ILI and ALRI <5 years cases showed an increase in number while AD (Non-Cholera) cases showed a decline this week.

AJK: ILI cases were maximum followed by ALRI <5 years, AD (Non-Cholera), SARI, dog bite, TB, VH (B, C & D), AVH (A & E) and B. Diarrhea cases. Eight cases of AFP reported from AJK. All are suspected cases and need field verification.

GB: ALRI <5 Years cases were the most frequently reported diseases followed by AD (Non-Cholera), ILI, SARI, B. Diarrhea, TB and Typhoid cases. An increasing number of cases observed for ALRI <5 years and B. Diarrhea while a decline in number of cases observed for AD (Non-Cholera), ILI, SARI, TB and Typhoid this week.

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

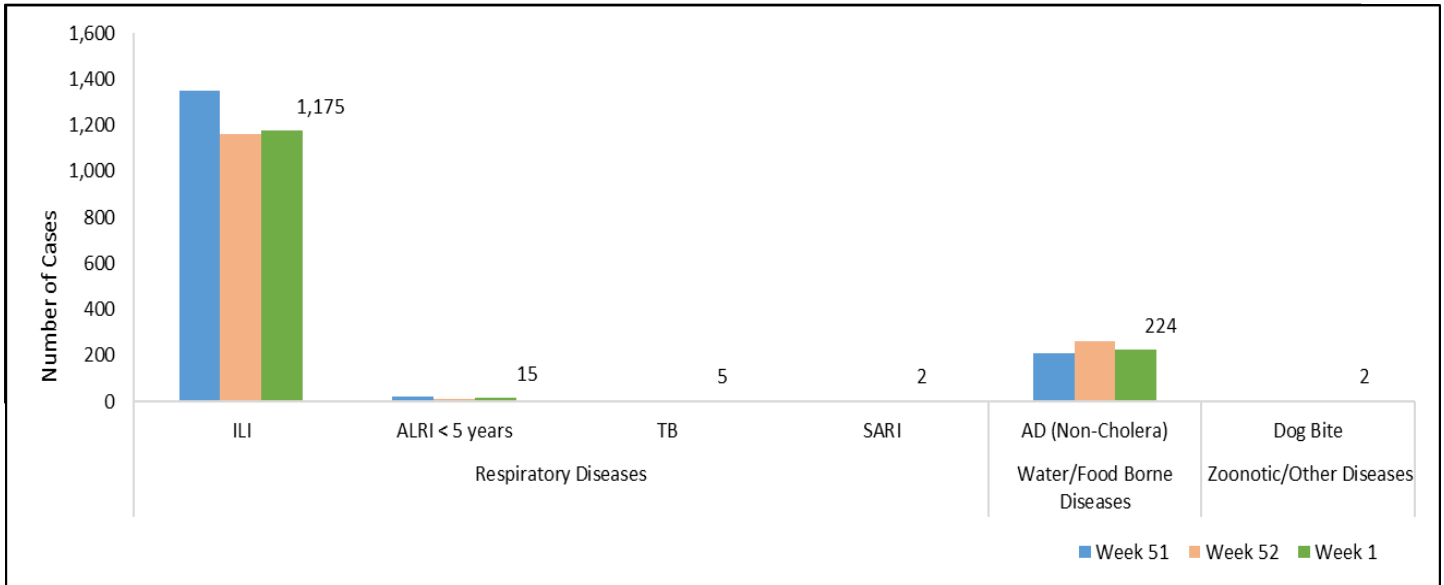


Figure 9: Week wise reported suspected cases of ILI, ICT

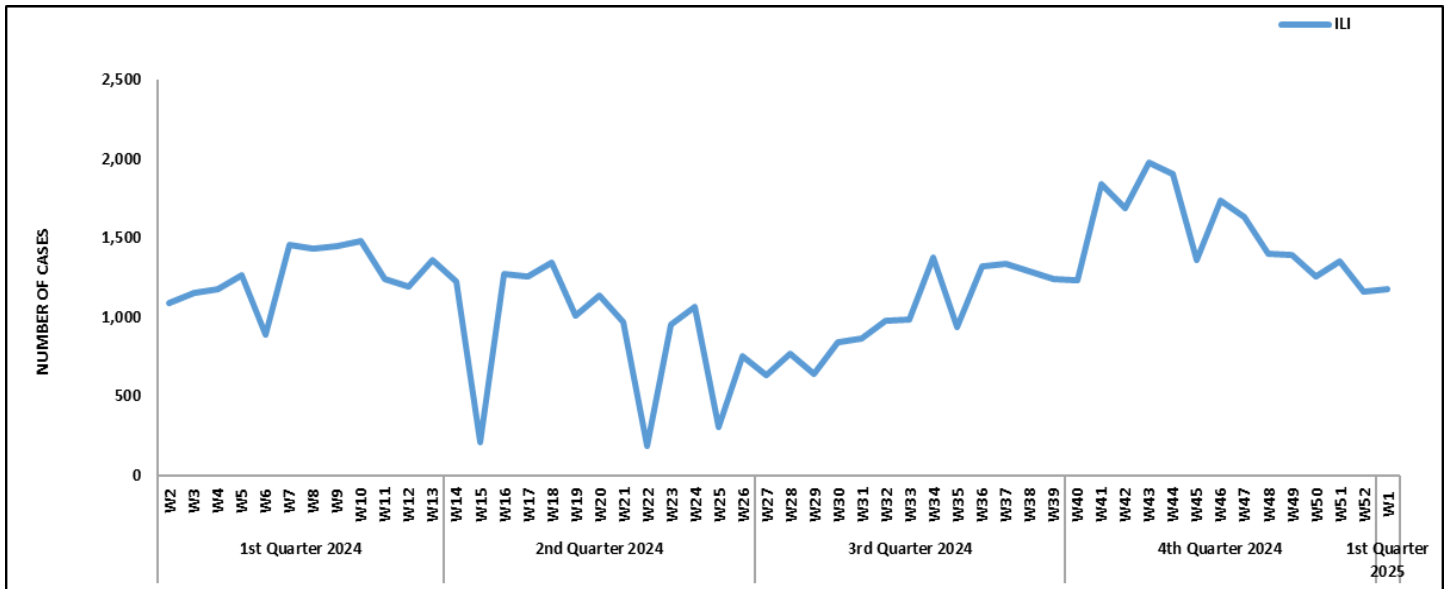


Figure 10: Most frequently reported suspected cases during Week 01, AJK

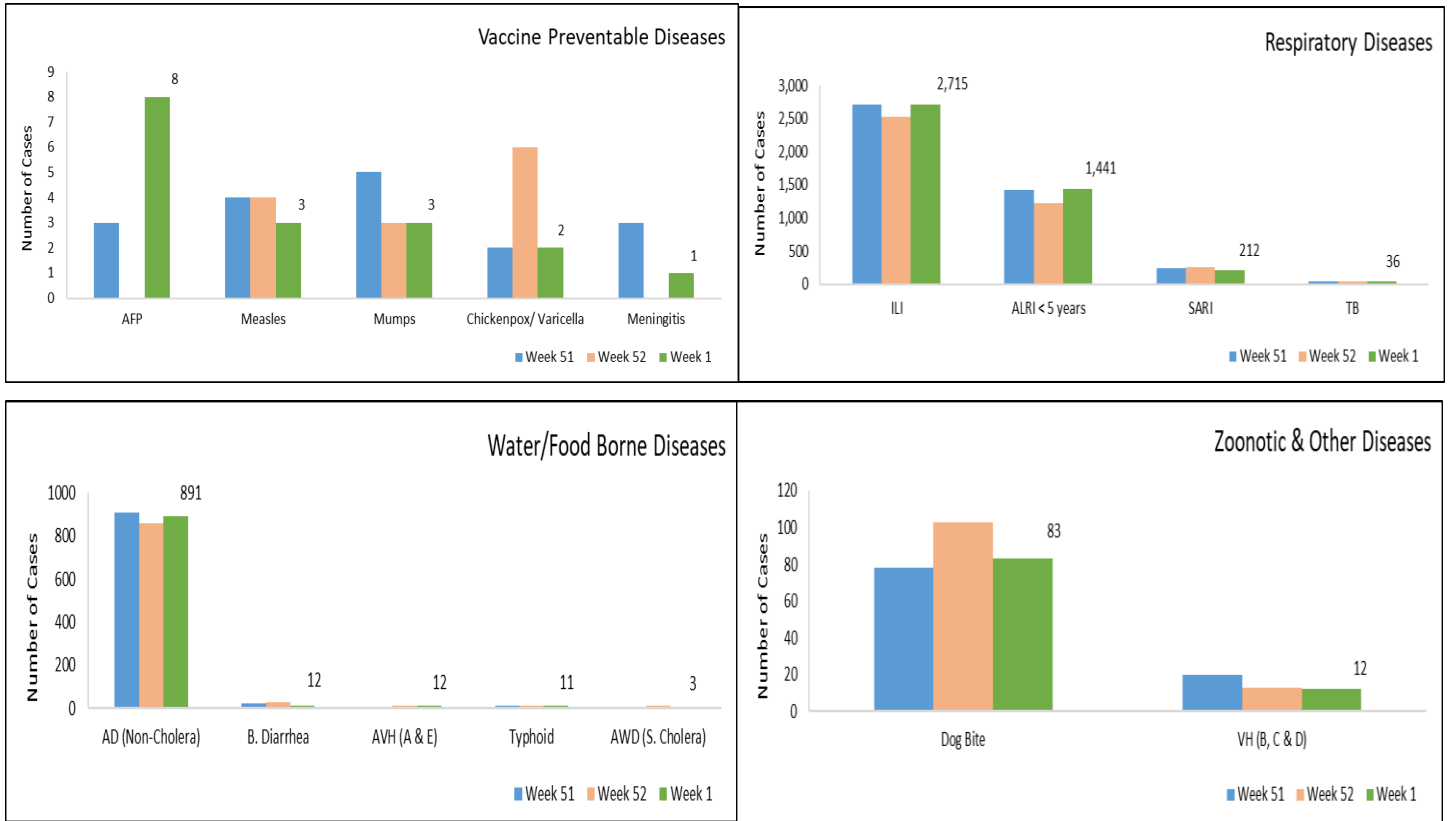


Figure 11: Week wise reported suspected cases of ILI and ARI < 5 years, AJK

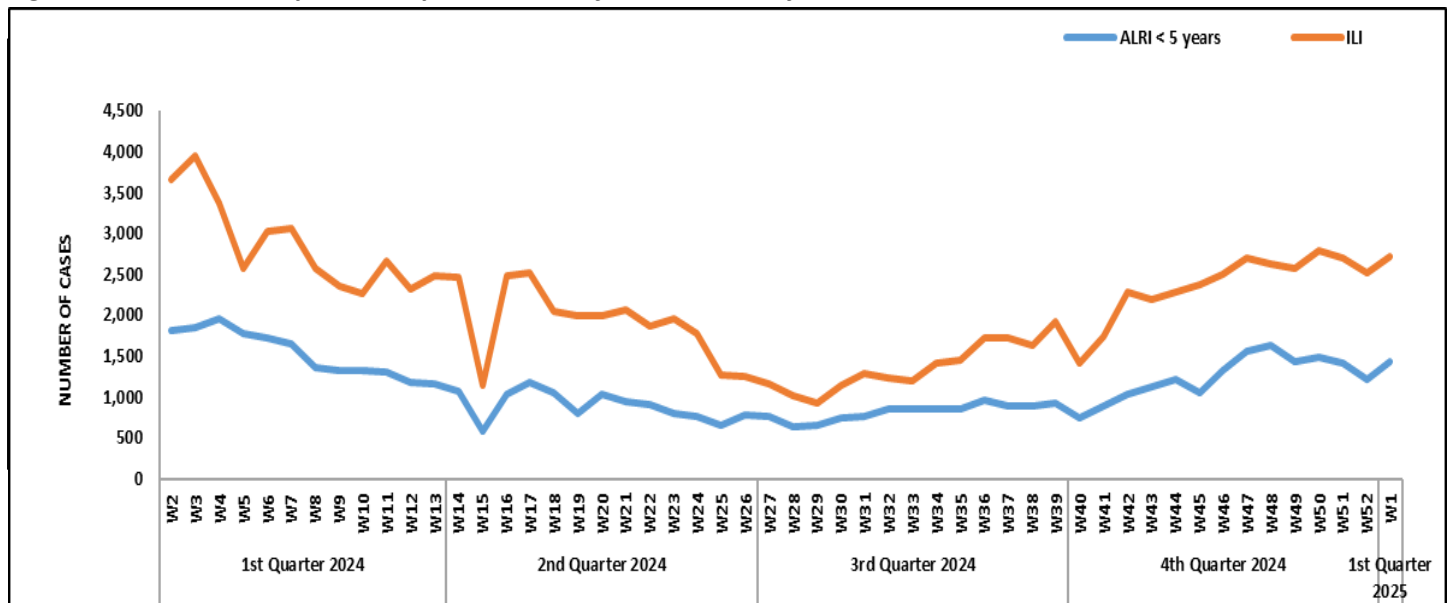


Figure 12: Most frequent cases reported during Week 01, GB

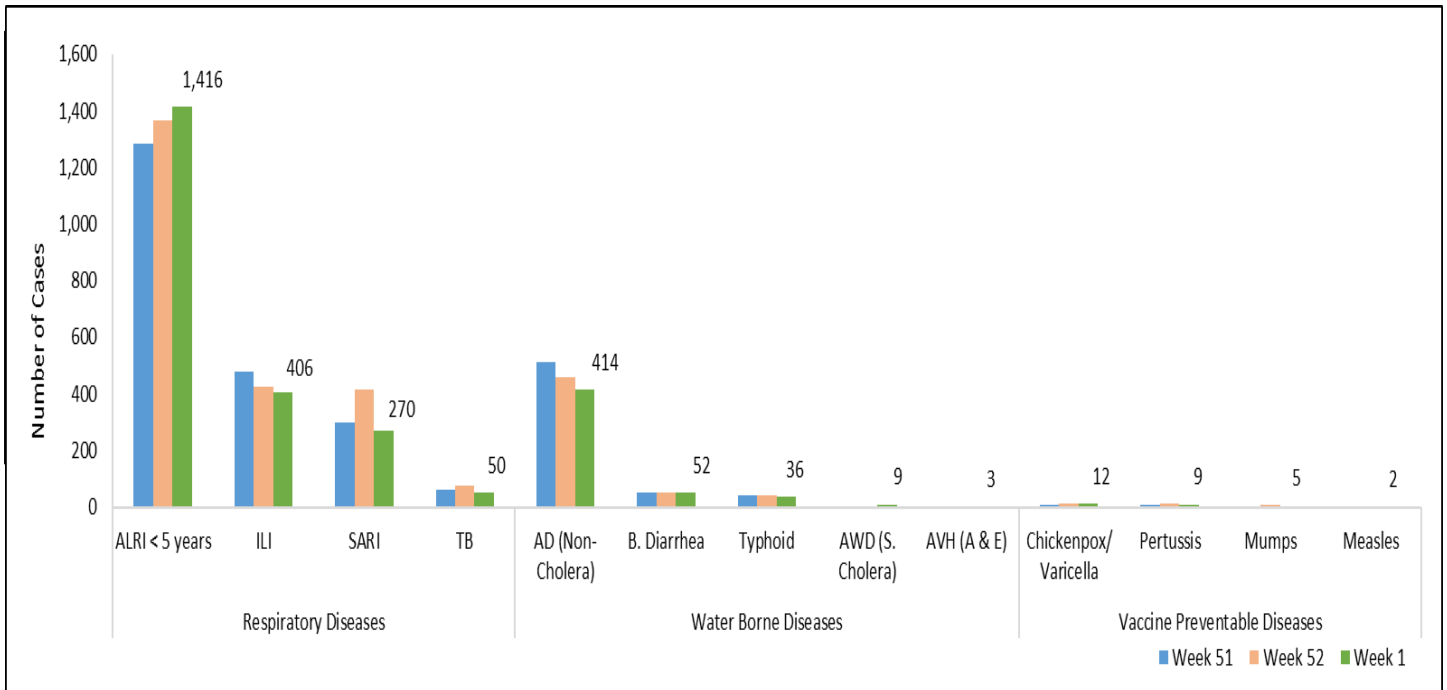
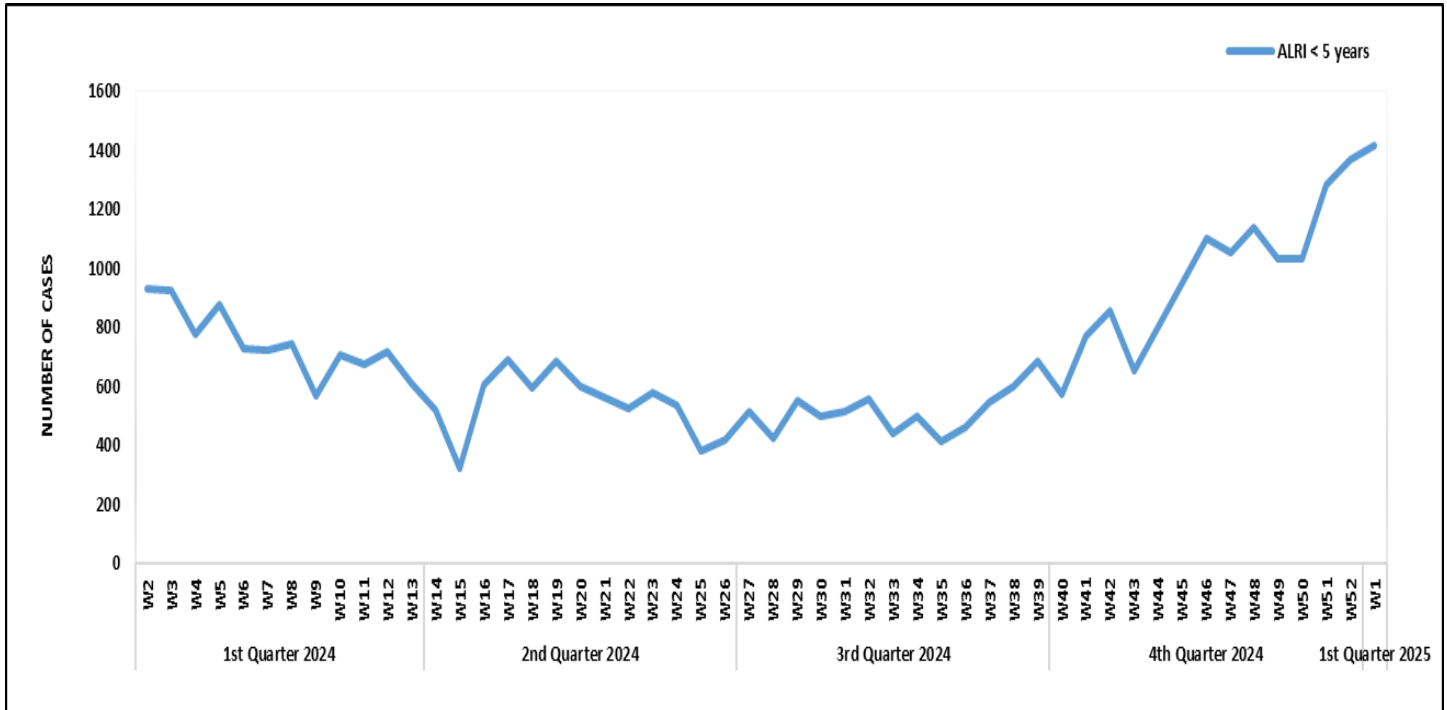


Figure 13: Week wise reported suspected cases of ALRI < 5 years, GB



- AD (Non-Cholera) cases were maximum followed by TB, dog bite, Malaria, ALRI<5 Years, Typhoid, B. Diarrhea, AWD (S. Cholera), Measles and Dengue cases.
- AD (Non-Cholera), TB, dog bite, Malaria, ALRI<5 Years, Measles and Dengue showed an increase in number of cases this week.
- Twenty-one suspected cases of HIV/ AIDS reported from Punjab. Field investigation required to verify the cases.
- Ten cases of AFP reported from Punjab. All are suspected cases and need field verification.

Figure 14: Most frequently reported suspected cases during Week 01, Punjab.

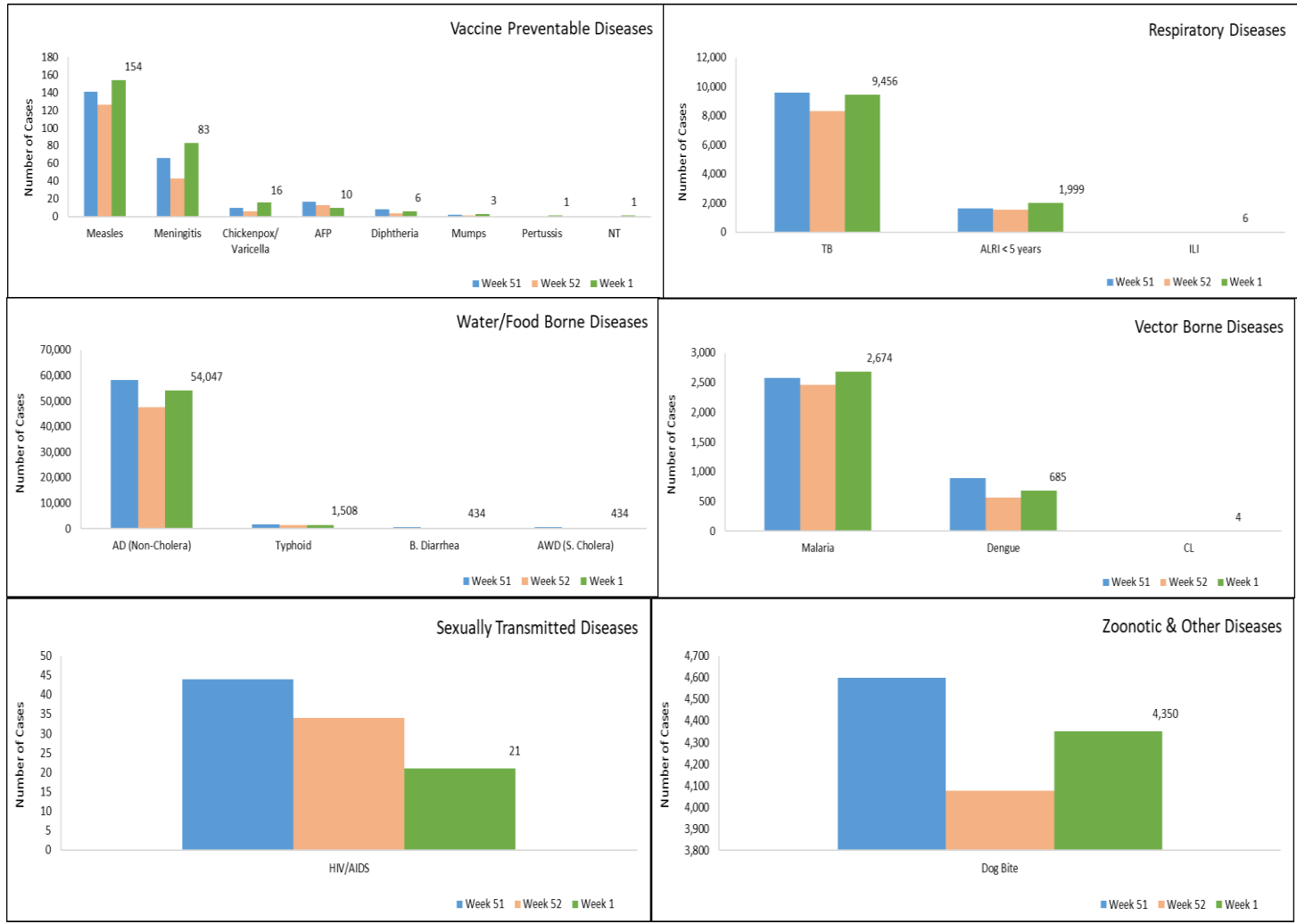


Figure 15: Week wise reported suspected cases of AD (Non-Cholera), Punjab.

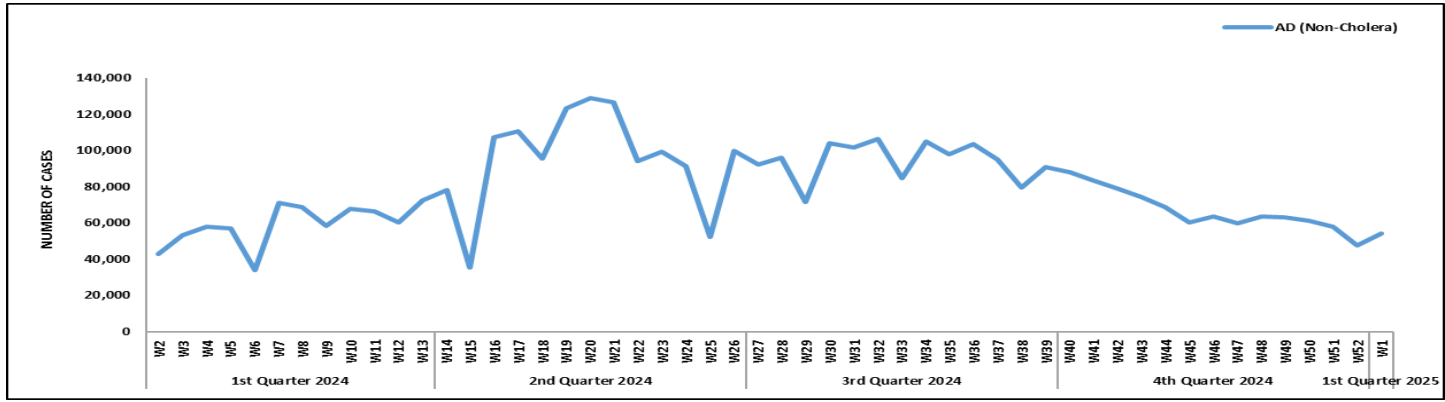


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epid Week 01

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	-	-	0	0	-	-	-	-	-	-	0	0	
AD (Non-Cholera)	66	1	-	-	0	0	-	-	-	-	-	-	0	0	
Malaria	683	23	-	-	1,424	19	-	-	-	-	-	-	37	1	
CCHF	-	-	3	0	0	0	1	0	-	-	-	-	0	0	
Dengue	462	5	0	0	703	18	1	0	-	-	-	-	10	0	
VH (B)	2,706	69	115	82	2,065	43	-	-	-	-	-	-	200	7	
VH (C)	2,731	278	71	27	2,359	64	-	-	-	-	-	-	205	3	
VH (A & E)	-	-	-	-	434	20	-	-	-	-	-	-	0	0	
Covid-19	-	-	-	-	96	2	1	0	-	-	-	-	0	0	
Chikungunya	-	-	-	-	0	0	-	-	-	-	-	-	0	0	
TB	-	-	-	-	127	6	-	-	-	-	-	-	60	10	
HIV/ AIDS	-	-	-	-	1,908	5	-	-	-	-	-	-	63	0	
Syphilis	-	-	-	-	223	0	-	-	-	-	-	-	0	0	
B. Diarrhea	-	-	-	-	0	0	-	-	-	-	-	-	0	0	
Typhoid	493	11	-	-	172	12	-	-	-	-	-	-	1	0	
Diphtheria (Probable)	-	-	-	-	0	0	-	-	-	-	-	-	0	0	
Pertussis	-	-	-	-	0	0	-	-	-	-	-	-	0	0	
M-POX	-	-	-	-	0	0	0	0	-	-	-	-	0	0	
Leishmaniasis (cutaneous)	-	-	-	-	94	35	-	-	-	-	-	-	0	0	
Meningitis	-	-	-	-	0	0	-	-	-	-	-	-	0	0	
Pneumonia (ALRI)	-	-	-	-	230	32	-	-	-	-	-	-	0	0	
Brucellosis	-	-	-	-	12	0	-	-	-	-	-	-	0	0	
Measles	67	38	22	14	212	99	2	0	5	3	128	37	3	3	
Rubella	67	0	22	0	212	8	2	0	5	0	128	1	3	0	
Covid-19	Out of SARI	15	0	0	0	17	0	123	0	10	0	210	0	0	0
	Out of ILI	10	0	0	0	7	0	36	0	7	0	170	0	0	0
Influenza A	Out of SARI	15	1	0	0	17	2	123	9	10	1	210	30	0	0
	Out of ILI	10	2	0	0	7	2	36	5	7	1	170	20	0	0
Influenza B	Out of SARI	15	1	0	0	17	2	123	6	10	2	210	30	0	0
	Out of ILI	10	1	0	0	7	3	36	3	7	1	170	24	0	0
RSV	Out of SARI	15	0	0	0	17	0	123	35	10	0	210	0	0	0
	Out of ILI	10	0	0	0	7	0	36	1	7	0	170	0	0	0



IDSR Reports Compliance

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

Table 6: IDSR reporting districts Week 01, 2024

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	101	91%
	Bannu	238	140	59%
	Battagram	62	34	55%
	Buner	34	32	94%
	Bajaur	44	41	93%
	Charsadda	59	58	98%
	Chitral Upper	34	24	71%
	Chitral Lower	35	35	100%
	D.I. Khan	114	113	99%
	Dir Lower	74	72	97%
	Dir Upper	37	30	81%
	Hangu	22	17	77%
	Haripur	72	65	90%
	Karak	36	36	100%
	Khyber	53	41	77%
	Kohat	61	61	100%
	Kohistan Lower	11	11	100%
	Kohistan Upper	20	20	100%
	Kolai Palas	10	10	100%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	9	21%
	Upper Kurram	41	26	63%
	Malakand	42	28	67%
	Mansehra	136	129	95%
	Mardan	80	76	95%
	Nowshera	55	49	89%
	North Waziristan	13	2	15%
	Peshawar	152	132	87%
	Shangla	37	29	78%
	Swabi	64	63	98%
	Swat	77	72	94%
	South Waziristan (Upper)	93	36	39%
	South Waziristan (Lower)	42	20	48%
	Tank	34	33	97%
Torghar	14	14	100%	
Mohmand	68	64	94%	
SD Peshawar	5	0	0%	
SD Tank	58	5	9%	
	Orakzai	69	11	16%
	Mirpur	37	37	100%
	Bhimber	42	20	48%



Azad Jammu Kashmir	Kotli	60	60	100%
	Muzaffarabad	45	42	93%
	Poonch	46	46	100%
	Haveli	39	39	100%
	Bagh	40	40	100%
	Neelum	39	29	74%
	Jhelum Vellay	29	29	100%
Islamabad Capital Territory	Sudhnooti	27	27	100%
	ICT	21	19	90%
Balochistan	CDA	15	8	53%
	Gwadar	25	20	80%
	Kech	44	28	64%
	Khuzdar	74	54	73%
	Killa Abdullah	26	0	0%
	Lasbella	55	55	100%
	Pishin	69	41	59%
	Quetta	55	31	56%
	Sibi	36	36	100%
	Zhob	39	27	69%
	Jaffarabad	16	16	100%
	Naserabad	32	29	91%
	Kharan	30	30	100%
	Sherani	15	9	60%
	Kohlu	75	45	60%
	Chagi	36	14	39%
	Kalat	41	40	98%
	Harnai	17	16	94%
	Kachhi (Bolan)	35	0	0%
	Jhal Magsi	28	28	100%
	Sohbat pur	25	25	100%
	Surab	32	29	91%
	Mastung	45	45	100%
	Loralai	33	29	88%
	Killa Saifullah	28	25	89%
	Ziarat	29	0	0%
	Duki	31	0	0%
	Nushki	32	28	88%
	Dera Bugti	45	21	47%
	Washuk	46	33	72%
	Panjgur	38	3	8%
	Awaran	23	0	0%
	Chaman	24	0	0%
Barkhan	20	19	95%	
Hub	33	0	0%	
Musakhel	41	0	0%	
Gilgit Baltistan	Usta Muhammad	34	34	100%
	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	38	100%



	Gilgit	40	40	100%
	Diامر	62	61	98%
	Astore	54	54	100%
	Shigar	27	25	93%
	Skardu	52	52	100%
	Ganche	29	29	100%
Sindh	Kharmang	46	24	52%
	Hyderabad	72	25	35%
	Ghotki	64	64	100%
	Umerkot	43	43	100%
	Naushahro Feroze	107	96	90%
	Tharparkar	276	233	84%
	Shikarpur	60	59	98%
	Thatta	52	52	100%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	18	86%
	Karachi-West	20	20	100%
	Karachi-Malir	37	23	62%
	Karachi-Kemari	18	15	83%
	Karachi-Central	11	7	64%
	Karachi-Korangi	18	16	89%
	Karachi-South	4	4	100%
	Sujawal	55	55	100%
	Mirpur Khas	106	103	97%
	Badin	124	124	100%
	Sukkur	64	63	98%
	Dadu	90	87	97%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	Khairpur	170	168	99%
	Kashmore	59	59	100%
	Matari	42	42	100%
	Jamshoro	75	74	99%
Tando Allahyar	54	53	98%	
Tando Muhammad Khan	41	41	100%	
Shaheed Benazirabad	125	122	98%	



Table 7: IDSR reporting Tertiary care hospital Week 01, 2024

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	1	0	0%
	Sukkur	1	0	0%
	Shaheed Benazirabad	1	1	100%
	Karachi-East	1	1	100%
	Karachi-Central	1	0	0%



Operationalizing One Health in Pakistan: A Multi-sectoral Collaborative Workshop to Establish Federal and Provincial Governance Structures

National Institute of Health, in collaboration with US-CDC, successfully hosted a pivotal workshop focused on operationalizing the One Health approach and establishing a comprehensive governance structure in Pakistan. The event brought together 43 participants, including representatives from federal and provincial ministries, as well as development partners such as the World Health Organization (WHO), the Food and Agriculture Organization (FAO), the UKHSA, JSI, Fleming Fund and JHPEIGO.



The primary objective of the workshop was to design a clear and effective governance structure for implementing One Health principles at both federal and provincial levels.

Over the course of two days, the workshop featured updates from federal ministries on their existing One Health initiatives, providing valuable context for the governance design process. International development partners complemented these updates by sharing insights from their ongoing One Health projects in Pakistan, offering examples of best practices and lessons learned from global and local contexts.

The interactive format of the workshop encouraged active engagement, with participants dividing into working groups to collaboratively design governance structures. On the first day, the groups developed a federal-level governance

structure to ensure coordinated leadership, resource allocation, and oversight of One Health initiatives across the country. On the second day, the focus shifted to provincial-level governance structures, emphasizing the need for context-specific strategies while maintaining alignment with the overarching federal governance structure. This dual approach ensures that national priorities are effectively translated into actionable plans at the provincial level.



The workshop achieved its key objective of creating actionable and inclusive governance structures that will enhance collaboration across the human, animal, and environmental health sectors. These structures are expected to improve coordination among stakeholders, streamline decision-making processes, and enable a more integrated response to shared health challenges.

Notes from the field:

Outbreak Investigation of Scabies Outbreak in Prison Barracks, Dist. Quetta, 12th December 2024.

Dr. Abdul Kareem Qazi- FETP Fellow PDSRU

Dr. Olas Yar- FETP Alumni PDSRU Quetta

Introduction:

Scabies is a highly transmissible skin condition caused by the infestation of the mite *Sarcoptes scabiei*, primarily transmitted

through prolonged skin-to-skin contact. Globally, scabies affects more than 200 million people at any given time, with outbreaks frequently occurring in overcrowded and resource-limited settings such as prisons, refugee camps, and care homes. Contributing factors such as shared bedding, clothing, and inadequate sanitation often amplify its spread in such environments.

On December 12, 2024, the Provincial Disease Surveillance and Response Unit (PDSRU) in Balochistan was alerted through media reports about approximately 350 suspected scabies cases in District-Prison in Quetta. Subsequent verification by prison authorities confirmed 90 suspected cases. A joint investigation team comprising members of the PDSRU and a dermatologist from Sandeman Provincial Hospital (SPH) Quetta was dispatched by department of health, Balochistan to District Prison Quetta the same day to assess the situation, confirm the outbreak, and implement appropriate response measures.

Objectives

- To determine the magnitude of the disease (Scabies).
- To identify the risk factors associated with Scabies in prison barracks Quetta, Balochistan.
- To formulate the recommendations to contain the outbreak.

Methods

A descriptive outbreak investigation was conducted in prison barracks following reports of a scabies outbreak. The study population included inmates within the prison from June 2, 2024 to December 12, 2024. A suspected case was defined as any individual presenting with itching, skin rash, superficial burrows, skin lesions, crusting, or fever lasting at least two to three weeks during the above mentioned period. Data were collected using a structured questionnaire, which captured information on clinical signs and symptoms, demographic characteristics (age and sex), living conditions and hygiene practices of

suspected cases. Descriptive analysis was performed to assess the distribution of cases by time, place and person, identify risk factors, and calculate the overall attack rate to determine the magnitude of the outbreak.

Results

A total of 44 confirmed scabies cases were identified, with 90% being males and 10% females. The most number of cases was reported from age group 11–20 years (39%), followed by 31–40 years (23%). All cases presented with itching and skin rash, while 75% exhibited superficial burrows, followed by fever (40%), skin lesions (32%), and crusting (32%). The date wise distribution showed two peaks, with the highest number of cases reported on November 14 and November 21, 2024. The overall attack rate was 4 per 100 individuals. Environmental assessment of the barracks revealed overcrowding and poor hygiene as key risk factors with the lack of isolation facilities, limited access to clean water and soap, and a shortage of medical supplies and trained healthcare staff.

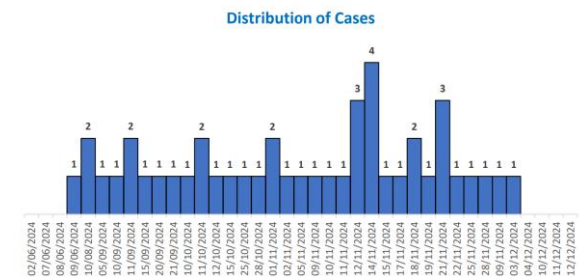


Figure 1: Date wise distribution of cases

Discussion:

The scabies outbreak at District Prison Quetta highlights the vulnerabilities of correctional facilities to communicable diseases due to overcrowding, inadequate hygiene, and limited healthcare infrastructure. Scabies, caused by *Sarcoptes scabiei*, thrives in conditions of close human contact and poor sanitation, which are characteristic of prisons globally [1,2].

The most affected age group being 11–20 years reflects a greater susceptibility among younger inmates due to less developed immunity or behavioral factors leading to



closer contact. This finding aligns with previous studies identifying young age as a risk factor for scabies in institutional outbreaks [4].

The lack of isolation facilities in the prison posed a significant challenge, as scabies outbreaks require rapid isolation of affected individuals to limit transmission [5]. Limited access to clean water and soap further exacerbated the situation, highlighting the critical need for basic hygiene resources in correctional settings. Similar barriers to effective outbreak management have been reported in other low-resource environments [6]. Furthermore, the shortage of medical supplies and trained healthcare staff impeded timely diagnosis and treatment, prolonging the outbreak duration.

This outbreak underscores the need for systemic reforms in correctional facilities to reduce disease vulnerability. Regular health screening, improved sanitation, adequate staffing, and training for healthcare providers are essential components of a comprehensive outbreak prevention strategy [7].

Conclusion:

Although the immediate response helped mitigate the spread, systemic challenges such as overcrowding, inadequate isolation measures, and limited access to clean water and medical resources must be addressed to prevent recurring outbreaks and ensure the health and well-being of inmates. The scabies outbreak at District Prison Quetta emphasizes the urgent need to enhance hygiene practices, sanitation, and healthcare infrastructure in correctional facilities.

Recommendations

- Provide sufficient soap, clean water, and sanitation supplies.
- Conduct regular cleaning and disinfection of prison facilities.
- Educate prison staff on the proper cleaning of inmates' clothes and bed sheets on a daily basis.

- Address overcrowding by transferring inmates to other facilities or reviewing cases for early release.
- Conduct regular health check-ups to identify and treat infectious diseases promptly.
- Train prison staff on identifying and managing scabies outbreaks and other contagious diseases.
- Ensure adequate stockpiles of scabies treatment supplies and general medical supplies.
- Invest in better healthcare infrastructure and facilities within the prison.

References

1. Engelman D, Cantey PT, Marks M, et al. The public health control of scabies: priorities for research and action. *Lancet*. 2019;394(10192):81-92.
2. Romani L, Steer AC, Whitfield MJ, Kaldor JM. Prevalence of scabies and impetigo worldwide: a systematic review. *Lancet Infect Dis*. 2015;15(8):960-967.
3. Chosidow O. Scabies and pediculosis. *Lancet*. 2000;355(9206):819-826.
4. Currie BJ, McCarthy JS. Permethrin and ivermectin for scabies. *N Engl J Med*. 2010;362(8):717-725.
5. Heukelbach J, Feldmeier H. Scabies. *Lancet*. 2006;367(9524):1767-1774.
6. Chandler DJ, Fuller LC. A review of scabies: an infestation more than skin deep. *Dermatology*. 2019;235(2):79-90.
7. Salavastru CM, Chosidow O, Janier M, Tiplica GS. European guideline for the management of scabies, 2017. *J Eur Acad Dermatol Venereol*. 2017;31(8):1248-1253.

Cutaneous Leishmaniasis Medical Camps at KUL Tangi UC Wanki Siraj Khel -District Karak

Cutaneous Leishmaniasis (CL) is a vector-borne infection caused by flagellated parasitic protozoans of the genus *Leishmania*. In District Karak, particularly in certain areas, CL has emerged as a significant public health threat. This infection is endemic to tropical and subtropical regions of the district and exhibits a wide geographical distribution.

During a medical camp held on January 8, 2025, in UC Wanki Siraj Khel, District Karak, 73 suspected cases of CL were identified. The high prevalence observed in the region emphasizes the widespread nature of the outbreak, particularly in areas like Kul Tangi



within UC Wanki Siraj Khel. The presence of infected individuals in otherwise non-endemic areas poses a substantial risk of further transmission, as the sandfly vector is present in these locations, including UC Wanki Siraj Khel, Tehsil Takhti-e-Nasrati, District Karak.

Currently, patients from Wanki Siraj Khel are receiving treatment at the KGN Bannu MSF-supported Leishmaniasis Center. However, this facility is facing a critical shortage of Injection Glucantime (1.5g/5ml), which is essential for the treatment of CL. The situation calls for an immediate response from healthcare authorities to ensure an adequate supply of Glucantime through IVC/MCP and support from the District Administration. Additionally, extensive awareness campaigns involving all relevant departments of District Karak are urgently needed to prevent further outbreaks.

The treatment for cutaneous Leishmaniasis typically requires daily injections for a duration of three to eight weeks, depending on the severity of the disease. Unfortunately, many patients are unable to complete their treatment due to the financial burden or difficulty of traveling to healthcare facilities for daily injections. Body parts affected by CL in UC Wanki Siraj Khel, District Karak, require timely and comprehensive medical attention to prevent long-term complications and further spread of the disease.

Affected body parts

Belly, Face, Hand, Leg, Lips, Mouth, Neck, Nose, All Body etc.

Details of Leishmaniasis Cases of UC Wanki Siraj Khel District Karak Dated 08/01/2025

S.No	UC	Area	No. of Patients
1	Wanki Siraj Khel	Kul Tangi	73

Activities Conducted in the Endemic Area

Medical Camps with provision of injection Glucantime, Antibiotics, Indoor Residual Spray in infected Houses, Social mobilization

regarding disease prevention, Entomological Assessment for identification of Sand fly and involvement of LHW/LHSs for Awareness.

Challenges

- Partially availability of Injection Glucantime 1.5g/5ml
- Non availability of Proper Leishmaniasis Centre.
- Non Availability of Proper Staff Trained on IRS activities.
- Outbreak Vehicle Occupied by RDG South.

Way forward

- Provision of Proper Leishmaniasis center along with proper equipped.
- Need Capacity Building training for IRS Staff.
- Provision of dedicated Vehicle for outbreak activities.



Knowledge Hub

Knowledge Review: Cutaneous Leishmaniasis Introduction

Cutaneous leishmaniasis (CL) is a parasitic disease caused by protozoa of the genus *Leishmania* and transmitted to humans through the bites of infected female phlebotomine sandflies. It is one of the most common forms of leishmaniasis, primarily affecting the skin and occasionally mucous membranes. This disease is endemic in over 90

countries, predominantly in tropical and subtropical regions, posing significant public health challenges.

Epidemiology

CL is distributed across diverse geographic regions, with high prevalence in parts of South America, the Middle East, North Africa, and Central Asia. According to the World Health Organization (WHO), approximately 600,000 to 1 million new cases of leishmaniasis occur annually, with CL accounting for the majority. Risk factors for CL include environmental changes, urbanization, deforestation, population displacement, and climate change, all of which affect the distribution of sandflies and reservoirs.

Pathogenesis and Clinical Features

The *Leishmania* parasite is introduced into the skin via the bite of an infected sandfly. Once inside the host, the parasite invades macrophages and replicates intracellularly, leading to the formation of skin lesions. Clinical manifestations of CL vary from self-healing ulcers to chronic, disfiguring scars. Lesions often appear on exposed body parts, such as the face, arms, and legs, and can range from single ulcers to multiple disseminated lesions.

Diagnosis

The diagnosis of CL involves a combination of clinical evaluation, epidemiological context, and laboratory tests. Microscopic examination of skin smears, culture, polymerase chain reaction (PCR), and serological tests are commonly used to confirm the presence of *Leishmania*. Accurate diagnosis is essential for effective treatment and control.

Treatment

Treatment options for CL depend on the causative species, geographic location, and severity of the disease. First-line treatments include pentavalent antimonials, such as sodium stibogluconate and meglumine antimoniate. Alternative therapies include liposomal amphotericin B, miltefosine, and azole antifungals. Topical treatments, such as

thermotherapy and cryotherapy, are used for localized lesions.

Prevention and Control

Prevention of CL relies on integrated vector management, personal protective measures, and community education. Key strategies include:

Vector control: Using insecticide-treated bed nets, indoor residual spraying, and environmental management to reduce sandfly populations.

Personal protection: Wearing protective clothing and applying insect repellents.

Reservoir control: Targeting animal reservoirs through vaccination or culling in certain regions.

Awareness campaigns: Educating communities about sandfly habitats and preventive measures.

Public Health Significance

CL has profound implications for public health, particularly in endemic areas. The disease often affects marginalized populations with limited access to healthcare. Furthermore, the social stigma associated with disfiguring scars can lead to psychological distress and economic burdens. Addressing CL requires a One Health approach, integrating human, animal, and environmental health to tackle its multifaceted drivers.

Key Takeaways

- Cutaneous leishmaniasis is a neglected tropical disease with a wide geographic distribution and significant public health impact.
- Early and accurate diagnosis is critical for effective treatment and reducing morbidity.
- A combination of vector control, personal protection, and community education forms the cornerstone of CL prevention.



- A One Health approach is essential to address the interconnected factors driving CL transmission.
- Continued research and investment in diagnostics, treatment, and vaccines are crucial for advancing CL control.

References

1. World Health Organization. (2023). Leishmaniasis. Retrieved from <https://www.who.int/>
2. Centers for Disease Control and Prevention. (2023). Parasites - Leishmaniasis. Retrieved from <https://www.cdc.gov/>
3. Public Health Agency of Canada. (2023). Leishmaniasis - Pathogen Safety Data Sheet. Retrieved from <https://www.canada.ca/>



Leishmaniasis

Information for internally displaced persons and refugees

Source of infection

Vector-borne disease transmitted through the bites of infected female phlebotomine sandflies, which feed on blood to produce eggs.



Type of exposure & prevention

It is caused by bite of an infected female sandfly (phlebotomine), a tiny 2-3 mm long insect vector. Internally displaced persons and refugees are at high risk of leishmaniasis because of increased chances of contact with sandflies. Control it by:



Remaining vigilant of sandflies, especially when outdoors



Keeping your home clean from waste and sewerage



Covering windows to avoid sandflies from entering



Avoiding sleeping outside or on ground



Destroying sandfly breeding sites through use of insecticides



Covering Full body with clothing and using insecticide-treated nets to avoid sandfly bites

Symptoms

Leishmaniasis has three forms: visceral (Kala-Azar, most serious form); cutaneous (most common); and mucocutaneous. Depending upon its type it can be fatal. Symptoms include:

Visceral leishmaniasis



Irregular Fever



Anaemia



Weight loss



Spleen and liver enlargement



Rash usually on face, upper arms, trunk and other parts of the body

Cutaneous leishmaniasis



Ulcers on exposed parts of the body (face, arms and legs)



Disfigured skin lesions after recovery

Mucocutaneous leishmaniasis



Lesions in the mucous membranes (nose, throat or mouth)

Actions to take in case of symptoms:



Treatment is complex and should be administered by highly experienced health personnel. See a doctor in case of symptoms.



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