PUBLIC HEALTH BULLETIN-PAKISTAN

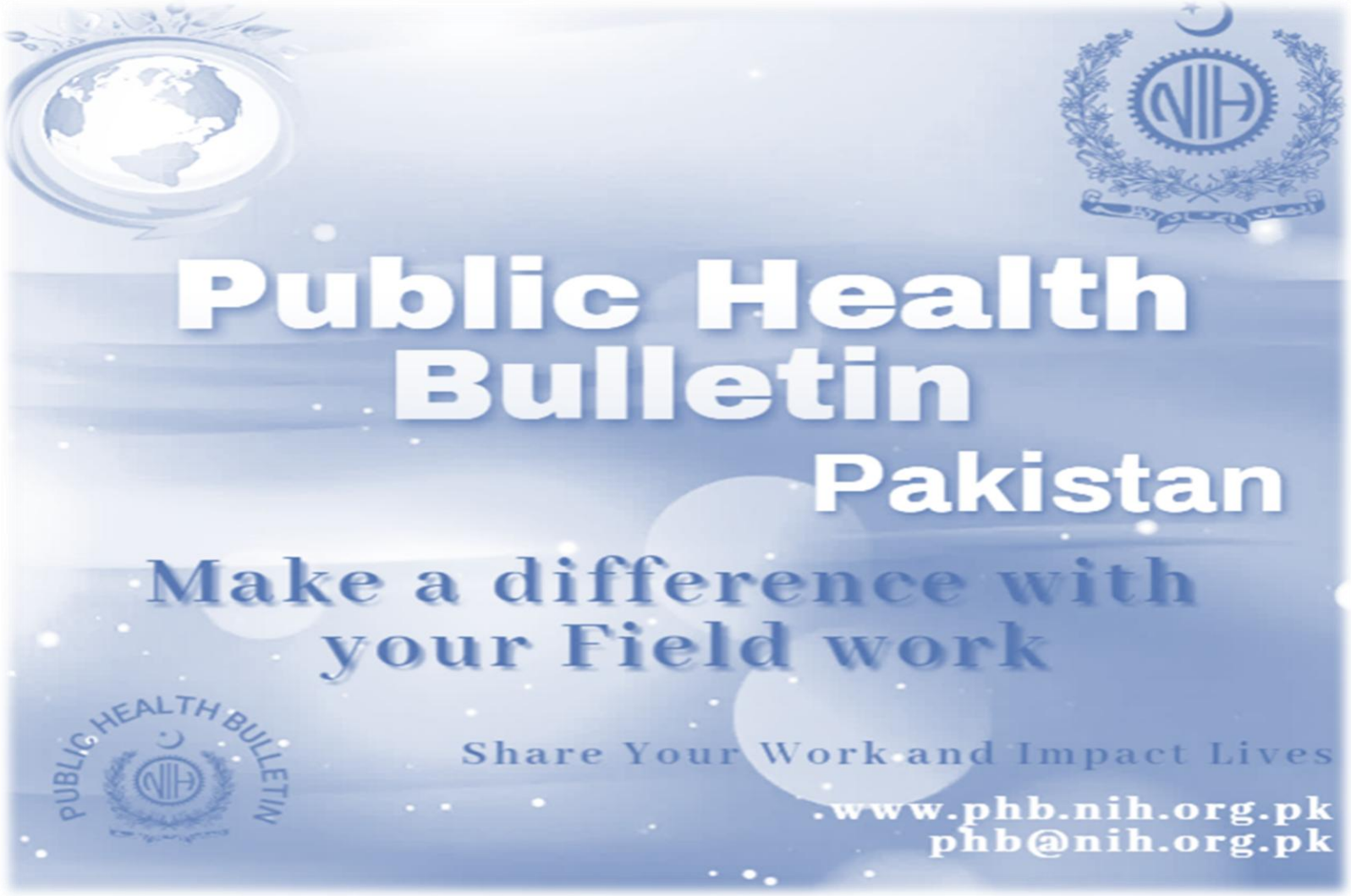
Vol. 5 | Week 26
23rd JUNE – 29th JUNE
08th JULY, 2025

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 26, 2025

The Public Health Bulletin (PHB) provides timely, reliable, and actionable health information to the public and professionals. It disseminates key IDSR data, outbreak reports, and seasonal trends, along with actionable public health recommendations. Its content is carefully curated for relevance to Pakistan's priorities, excluding misinformation. The PHB also proactively addresses health misinformation on social media and aims to be a trusted resource for informed public health decision-making.

This Weeks Highlights include;

- *Outbreak Investigation of a Lab-Confirmed Case of Crimean-Congo Hemorrhagic Fever (CCHF) in Wah, Taxila, Rawalpindi, June 2025*
- *Knowledge hub on Understanding AVH A & E: What you need to know*

By transforming complex health data into actionable intelligence, the Public Health Bulletin continues to be an indispensable tool in our collective journey toward a healthier Pakistan.

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Stay informed. Stay prepared. Stay healthy.

Sincerely,
The Chief Editor

Overview

- *During Week 26, the most frequently reported cases were of Acute Diarrhea (Non-Cholera) followed by Malaria, ILI, TB, ALRI <5 years, B. Diarrhea, VH (B, C & D), Dog Bite, Typhoid and SARI.*
- *Thirteen cases of AFP reported from KP, nine from Sindh and two from AJK.*
- *Twenty suspected cases of HIV/ AIDS reported from Sindh, two from KP and two from Balochistan.*
- *Seven suspected cases of Brucellosis reported from KP.*
- *Among VPDs, the most frequently reported cases were of Measles, Mumps, Chickenpox, Meningitis, Pertussis, AFP and Diphtheria in this week. There is a slight decline in number of cases of VPDs in Week 26.*
- *Among Respiratory diseases, there is a slight increase in number of cases of TB this week. ILI is the most frequently reported disease in Week 26.*
- *Among Water/food-borne diseases, there is a slight decline in number of cases of Acute Diarrhea (Non-Cholera), B. Diarrhea, and AVH (A & E), with a small increase in AWD (S. Cholera) this week.*
- *Among Vector-borne diseases, the most frequently reported disease is Malaria with a slight decline in number of cases this week.*
- *Among STDs, there is an increase in number of cases of Gonorrhea this week.*
- *Among Zoonotic/Other diseases, there is an increase in number of cases of dog bite 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 74%*
- *Sindh is the top reporting region with a compliance rate of 97%, followed by AJK 94%, GB 93% and ICT 76%.*
- *The lowest compliance rate was observed in KP 64% and Balochistan 43%.*

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2704	1737	64
Azad Jammu Kashmir	404	380	94
Islamabad Capital Territory	38	29	76
Balochistan	1308	564	43
Gilgit Baltistan	410	380	93
Sindh	2111	2038	97
National	6975	5128	74

Public Health Actions

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

Bloody Diarrhea

- **Strengthen Surveillance and Case Notification**: Enhance reporting of bloody diarrhea cases through the IDSR system by training healthcare providers on standard case definitions, early detection of clusters, and immediate notification of suspected outbreaks.
- **Improve Laboratory Diagnosis and Antimicrobial Sensitivity Testing**: Expand diagnostic capacity to identify bacterial causes (e.g., *Shigella*, *E. coli* O157:H7, *Entamoeba histolytica*) and conduct antimicrobial resistance testing to guide appropriate treatment.
- **Ensure Effective Case Management**: Train healthcare workers on syndromic management and rational use of antibiotics; ensure availability of essential medicines, ORS, and supportive care at all health facility levels.
- **Promote Water, Sanitation, and Hygiene (WASH)**: Coordinate with WASH stakeholders to improve access to safe water, sanitation infrastructure, and hygiene promotion, particularly in outbreak-prone or underserved communities.
- **Raise Public Awareness and Promote Preventive Behaviors**: Conduct targeted health education on hand hygiene, safe food handling, proper sanitation, and the importance of seeking care promptly in cases of bloody stools especially for young children.
- **Support Outbreak Investigation and Control**: Deploy rapid response teams to investigate suspected outbreaks, identify sources of infection (e.g., contaminated food/water), and implement control measures, including community-level sanitation improvements.

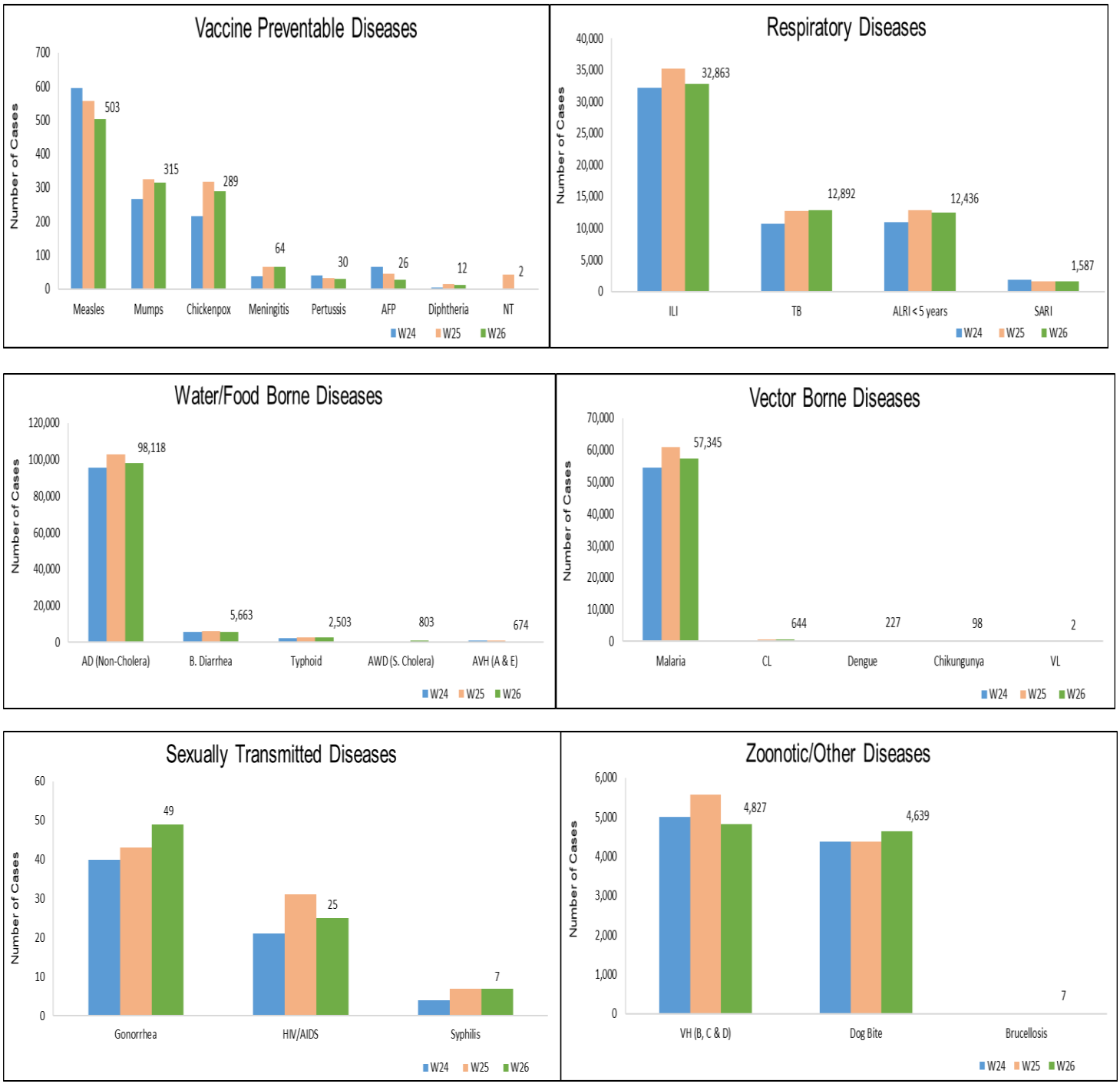
Acute Viral Hepatitis (A & E)

- **Enhance Case Detection and Reporting:** Strengthen AHV (A & E) surveillance in the IDSR system by training health personnel to recognize symptoms and ensure timely reporting, especially during seasonal peaks or in outbreak-prone areas.
- **Strengthen Laboratory Confirmation:** Improve diagnostic capacity by ensuring availability of rapid and confirmatory tests (e.g., IgM for HAV/HEV) at regional laboratories to facilitate timely outbreak response.
- **Improve WASH Infrastructure:** Coordinate with municipal and rural development authorities to upgrade water supply systems, prevent sewage contamination, and promote latrine use to interrupt fecal-oral transmission.
- **Engage in Risk Communication:** Design and disseminate targeted messages through community channels to raise awareness about safe drinking water, personal hygiene, food safety, and the risks of consuming contaminated water or raw produce.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 26, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	2,248	4,428	1,759	385	36,753	NR	52,545	98,118
Malaria	5	1,838	0	0	5,446	NR	50,056	57,345
ILI	1,740	2,757	360	695	3,936	NR	23,375	32,863
TB	99	68	112	5	467	NR	12,141	12,892
ALRI < 5 years	841	1,161	583	0	985	NR	8,866	12,436
B. Diarrhea	45	805	94	0	984	NR	3,735	5,663
VH (B, C & D)	20	27	6	1	91	NR	4,682	4,827
Dog Bite	130	63	13	0	1,113	NR	3,320	4,639
Typhoid	18	273	106	0	752	NR	1,354	2,503
SARI	290	293	143	0	628	NR	233	1,587
AWD (S. Cholera)	9	116	21	0	51	NR	606	803
AVH (A & E)	37	17	0	0	200	NR	420	674
CL	1	37	0	0	596	NR	10	644
Measles	25	11	33	1	328	NR	105	503
Mumps	9	36	6	1	206	NR	57	315
Chickenpox/ Varicella	18	9	10	7	186	NR	59	289
Dengue	1	8	0	1	38	NR	179	227
Chikungunya	0	0	0	0	4	NR	94	98
Meningitis	4	0	4	0	6	NR	50	64
Gonorrhea	0	33	0	0	7	NR	9	49
Pertussis	0	6	12	0	11	NR	1	30
AFP	2	1	1	0	13	NR	9	26
HIV/AIDS	1	2	0	0	2	NR	20	25
Diphtheria (Probable)	0	0	0	0	8	NR	4	12
VL	0	0	0	0	0	NR	2	2
Syphilis	0	0	0	0	0	NR	7	7
Brucellosis	0	0	0	0	7	NR	0	7
NT	0	0	0	0	2	NR	0	2

Figure 1: Most frequently reported suspected cases during Week 26, Pakistan.



Sindh

- AD (Non-Cholera) cases were maximum followed by Malaria, ILI, TB, ALRI<5 Years, VH (B, C, D), B. Diarrhea, Dog Bite, Typhoid and AWD (S. Cholera).
- AD (Non-Cholera) cases are mostly from Karachi South, Badin and Mirpurkhas whereas Malaria cases are from Sanghar, Khairpur and Larkana.
- Nine cases of AFP 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, VH (B, C, D), Measles, Chickenpox, Mumps, AFP, Diphtheria and Pertussis while an increase in number of cases of TB, Dog Bite and Meningitis this week.

Table 2: District wise distribution of most frequently reported suspected cases during Week 26, Sindh

Districts	AD (Non-Cholera)	Malaria	ILI	TB	ALRI < 5 years	VH (B, C & D)	B. Diarrhea	Dog Bite	Typhoid	AWD (S. Cholera)
Badin	3,202	3,185	2,304	854	482	155	207	141	133	0
Dadu	2,778	3,208	603	445	789	64	487	390	121	0
Ghotki	1,578	2,879	35	510	336	527	81	276	0	0
Hyderabad	2,468	784	1,092	322	128	103	46	54	7	0
Jacobabad	679	480	301	106	726	174	103	202	11	0
Jamshoro	1,680	1,527	51	473	221	239	112	80	28	0
Kamber	1,961	3,020	0	888	223	110	105	200	15	0
Karachi Central	1,268	41	1,124	37	52	14	30	0	94	0
Karachi East	345	52	181	24	14	1	2	11	17	1
Karachi Keamari	664	10	301	35	40	0	3	0	5	3
Karachi Korangi	301	87	2	8	3	1	8	4	0	0
Karachi Malir	1,720	217	2,417	260	319	25	71	62	41	0
Karachi South	4,289	149	20	340	123	323	185	256	218	595
Karachi West	820	310	1,085	78	233	27	21	90	25	0
Kashmore	520	1,995	307	276	167	19	103	145	11	0
Khairpur	2,924	4,190	6,479	1,028	861	195	353	250	212	0
Larkana	1,586	3,785	2	739	163	60	278	39	3	0
Matiari	2,038	2,418	0	541	124	383	54	61	0	0
Mirpurkhas	3,029	2,487	1,745	806	300	105	109	88	20	0
Naushero Feroze	1,119	1,320	648	338	241	55	176	192	133	0
Sanghar	2,246	4,404	23	1,203	446	1,122	92	221	30	0
Shaheed Benazirabad	1,773	1,969	2	294	159	59	82	144	116	0
Shikarpur	1,227	1,627	7	240	180	350	187	128	6	0
Sindh Private TCH	97	33	3	8	32	13	3	1	31	7
Sujawal	2,664	882	0	149	298	0	226	73	7	0
Sukkur	1,383	1,933	1,883	371	468	83	101	98	2	0
Tando Allahyar	1,765	1,729	716	455	165	164	96	63	8	0
Tando Muhammad Khan	1,396	835	61	558	153	115	90	17	1	0
Tharparkar	1,903	2,468	1,227	428	419	47	135	0	27	0
Thatta	1,293	681	756	38	675	62	79	34	3	0
Umerkot	1,829	1,351	0	289	326	87	110	0	29	0
Total	52,545	50,056	23,375	12,141	8,866	4,682	3,735	3,320	1,354	606

Figure 2: Most frequently reported suspected cases during Week 26 Sindh

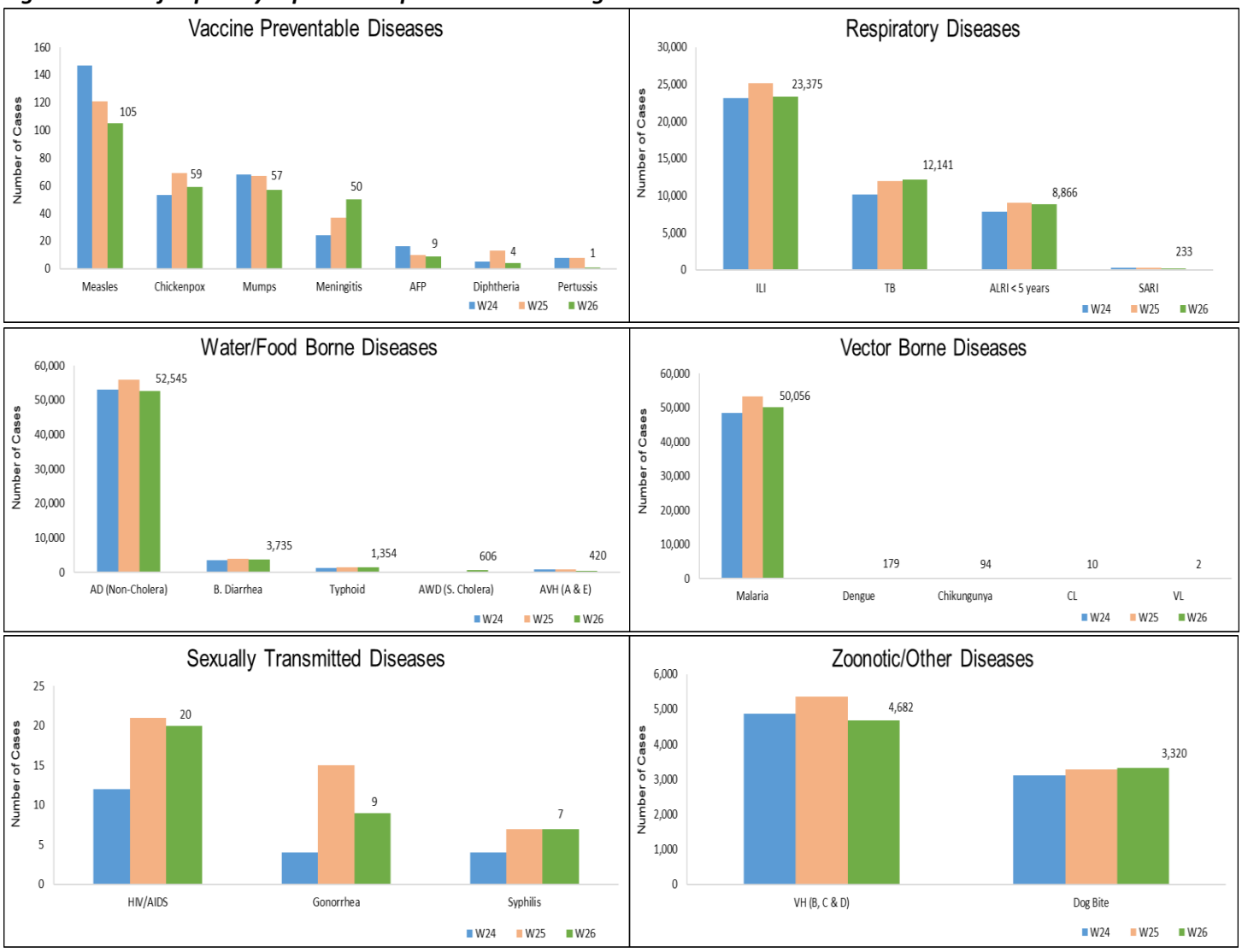
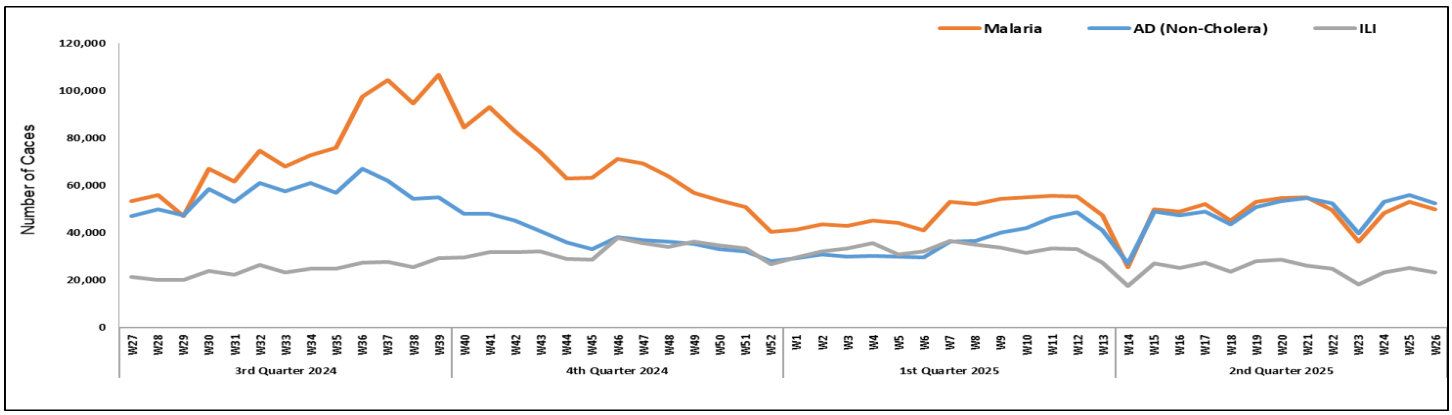


Figure 3: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Sindh



Balochistan

- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, AWD (S. Cholera), TB and Dog Bite cases were the most frequently reported diseases from Balochistan province.
- AD (Non-Cholera) cases are mostly reported from Pishin, Usta Muhammad and Lasbella while ILI cases are mostly reported from Gwadar, Kharan and Pishin.
- Two cases of HIV/AIDs reported from Balochistan. Field investigation is required to confirm the cases.
- B. Diarrhea, AWD (S. Cholera), TB, Dog Bite, Mumps, Chickenpox and Gonorrhea showed an increase in number of cases this week. A decrease in number of cases of ILI, Malaria, ALRI <5 Years, SARI, Measles, Pertussis and HIV/ AIDS is observed.

Table 3: District wise distribution of most frequently reported suspected cases during Week 26, Balochistan

Districts	AD (Non-Cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	AWD (S. Cholera)	TB	Dog Bite
Barkhan	103	30	65	21	4	2	25	4	3	23
Chaman	0	110	26	0	57	0	33	0	0	2
Dera Bugti	63	0	55	0	2	0	0	0	0	0
Gwadar	242	531	123	0	22	0	5	0	0	2
Hub	214	41	129	7	15	0	1	0	0	0
Jaffarabad	0	0	0	0	0	0	0	0	0	0
Jhal Magsi	196	120	199	9	0	1	3	0	0	0
Kalat	72	2	46	6	23	3	24	0	0	0
Kharan	194	415	37	2	87	12	6	0	0	0
Khuzdar	45	28	18	0	14	17	7	1	0	0
Killa Abdullah	123	66	6	4	25	19	5	24	0	3
Kohlu	30	57	22	7	26	4	5	NR	NR	NR
Lasbella	442	40	249	205	32	3	13	0	2	6
Loralai	199	224	32	24	27	76	6	3	0	0
MusaKhel	49	14	114	5	17	0	1	16	0	2
Naseerabad	334	27	93	17	12	7	48	1	5	9
Panjgur	102	84	66	46	30	0	1	23	0	0
Pishin	553	319	54	85	152	25	36	17	0	3
Quetta	110	72	9	97	8	27	6	10	0	0
Sibi	0	6	3	0	1	0	2	2	0	0
Sohbat pur	301	14	144	108	71	1	29	1	3	8
Surab	3	6	2	0	0	0	0	0	0	0
Usta Muhammad	523	128	118	131	73	0	7	0	0	4
Washuk	176	260	146	29	67	35	4	12	0	1
Zhob	354	163	82	358	40	61	6	2	55	0
Total	4,428	2,757	1,838	1,161	805	293	273	116	68	63

Figure 4: Most frequently reported suspected cases during Week 26, Balochistan

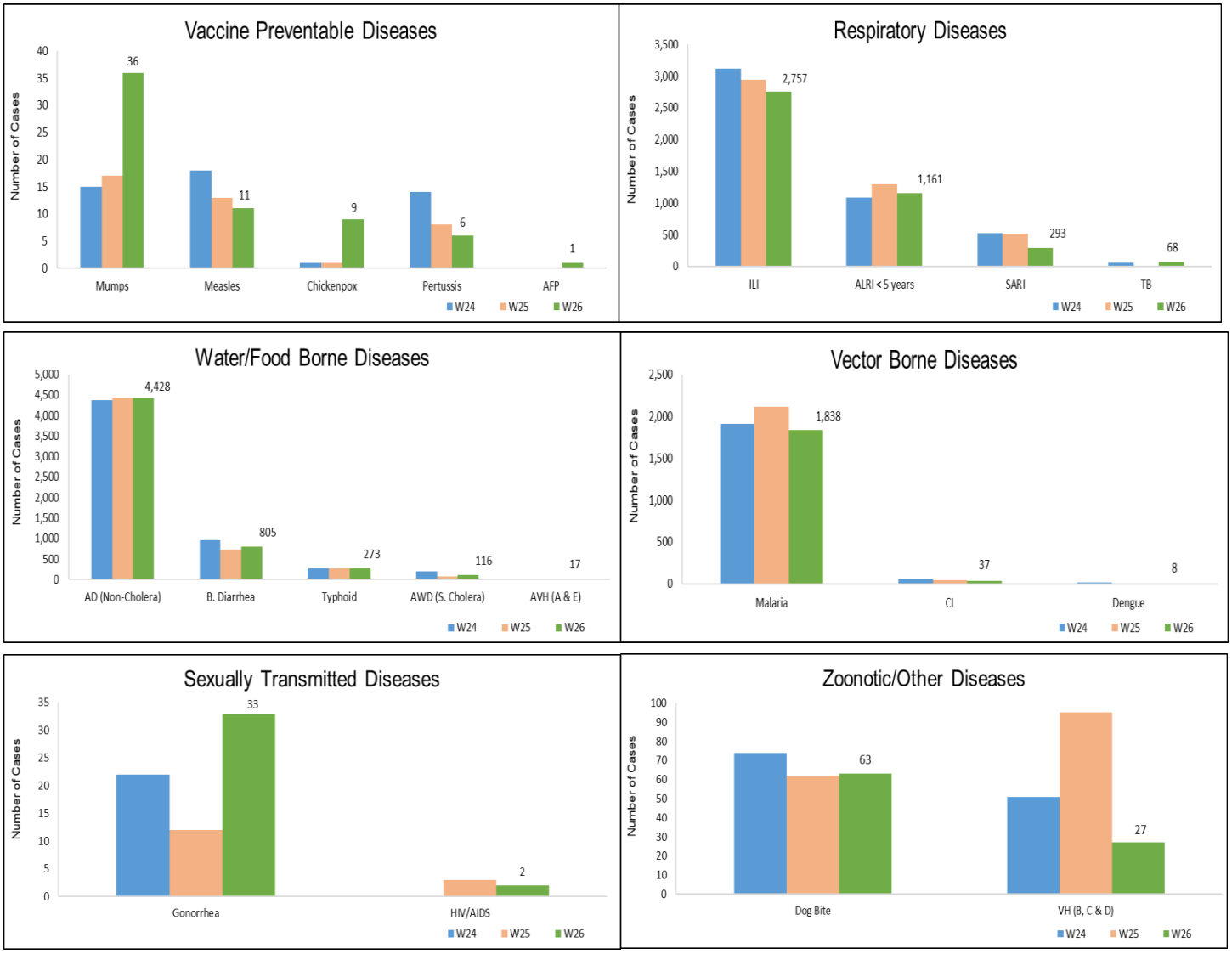
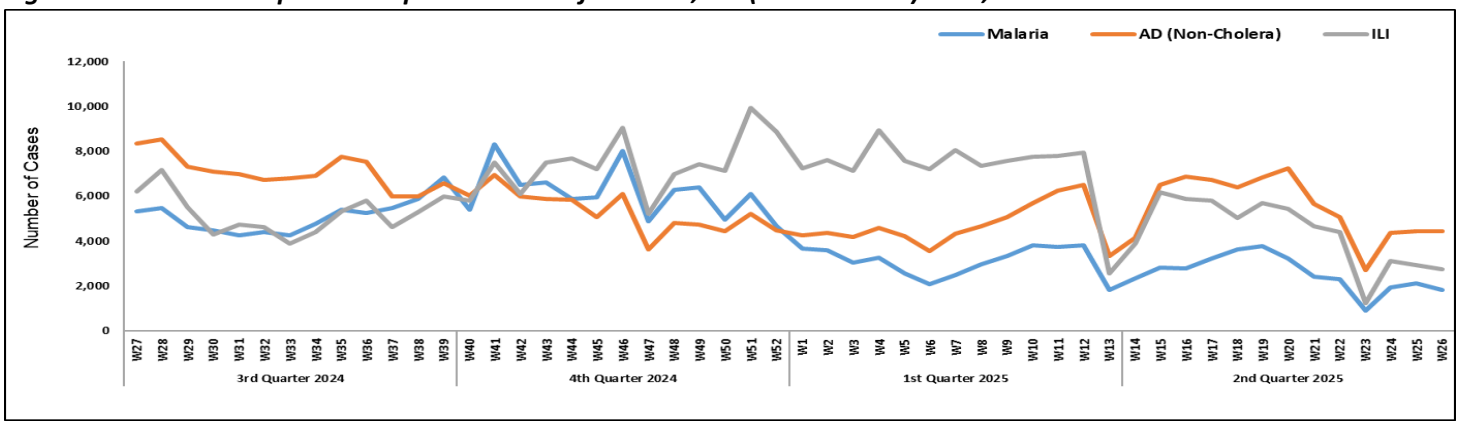


Figure 5: Week wise reported suspected cases of Malaria, AD (Non-Cholera) & ILI, Balochistan



- Cases of AD (Non-Cholera) were maximum followed by Malaria, ILI, Dog Bite, ALRI<5 Years, B. Diarrhea, Typhoid, SARI, CL and TB.
- AD (Non-Cholera), Malaria, ILI, ALRI<5 Years, B. Diarrhea, TB, Measles, Mumps Chickenpox, VH (B, C & D), AFP, Brucellosis and HIV/ AIDS cases showed a decline in number while Dog Bite, SARI, CL and Gonorrhea showed an increase in number this week.
- Thirteen cases of AFP reported from KP. All are suspected cases and need field verification.
- Two cases of HIV/AIDs reported from KP. Field investigation is required.
- Seven suspected cases of Brucellosis reported from KP. They require field verification.

Table 4: District wise distribution of most frequently reported suspected cases during Week 26, KP

Districts	AD (Non-Cholera)	Malaria	ILI	Dog Bite	ALRI < 5 years	B. Diarrhea	Typhoid	SARI	CL	TB
Abbottabad	1,527	0	32	32	14	9	15	7	0	8
Bajaur	880	275	53	72	34	81	11	41	14	14
Bannu	839	1,430	2	4	19	13	60	13	1	14
Battagram	482	46	447	8	1	4	7	2	4	21
Buner	435	322	0	11	0	0	5	0	0	2
Charsadda	2,425	339	1,168	16	341	74	97	4	1	16
Chitral Lower	1,155	14	177	14	18	37	10	14	8	3
Chitral Upper	230	7	39	3	2	10	18	17	0	3
D.I. Khan	1,485	304	0	38	15	44	0	0	1	41
Dir Lower	1,800	257	0	35	10	47	30	0	20	0
Dir Upper	2,023	15	48	24	74	30	21	2	4	22
Hangu	201	88	166	4	46	5	1	0	50	4
Haripur	975	0	16	12	11	0	0	0	0	0
Karak	515	189	32	93	38	9	2	0	265	10
Khyber	803	336	43	36	48	125	61	9	144	23
Kohat	768	88	0	52	10	17	29	0	16	0
Kohistan Lower	133	1	2	0	0	2	0	10	0	0
Kohistan Upper	509	28	0	2	0	23	3	2	0	16
Kolai Palas	73	3	14	0	4	9	1	0	0	2
L & C Kurram	3	0	0	0	0	8	0	0	0	0
Lakki Marwat	841	327	0	62	0	8	20	0	0	6
Malakand	730	34	0	0	0	0	42	0	4	3
Mansehra	1,017	0	155	0	0	4	3	0	0	5
Mardan	1,249	93	119	104	91	17	1	0	2	16
Mohmand	179	191	61	9	0	34	1	97	39	1
North Waziristan	76	88	0	4	11	20	8	108	15	5
Nowshera	2,350	184	104	55	0	22	35	12	2	25
Orakzai	149	20	9	1	0	16	0	0	0	0
Peshawar	4,596	43	426	11	24	126	141	16	1	15
SD Tank	27	12	0	0	3	9	0	0	0	0
Shangla	1,731	173	0	93	10	4	6	0	0	69
South Waziristan (Lower)	36	176	94	8	4	0	12	18	0	10
SWU	43	35	10	0	3	3	0	7	0	0
Swabi	1,345	86	355	188	36	25	42	61	0	47
Swat	4,232	31	108	92	103	52	42	0	0	49
Tank	540	152	72	1	7	9	12	0	0	3
Tor Ghar	123	46	0	21	2	17	2	13	5	8
Upper Kurram	228	13	184	8	6	71	14	175	0	6
Total	36,753	5,446	3,936	1,113	985	984	752	628	596	467

Figure 6: Most frequently reported suspected cases during Week 26, KP

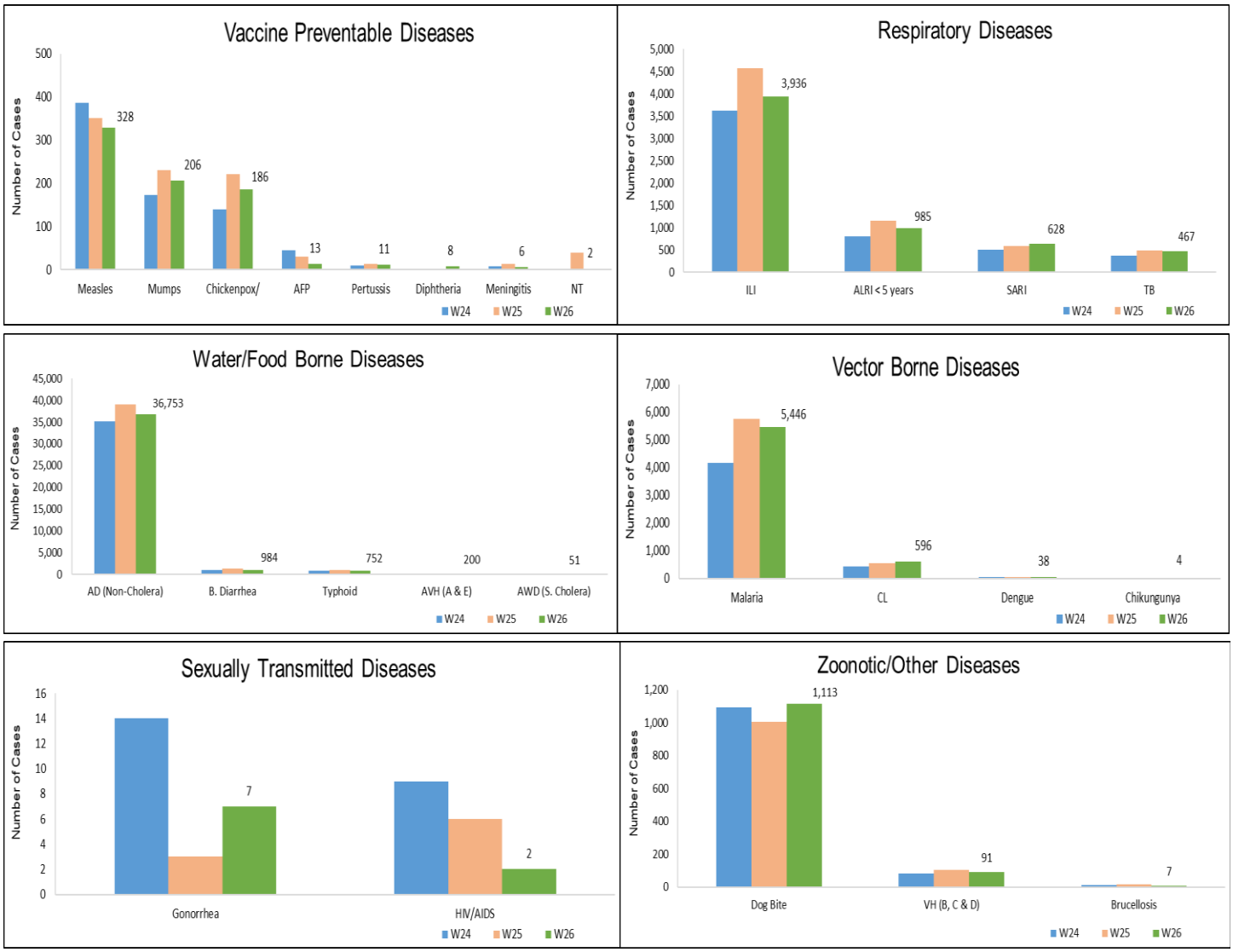
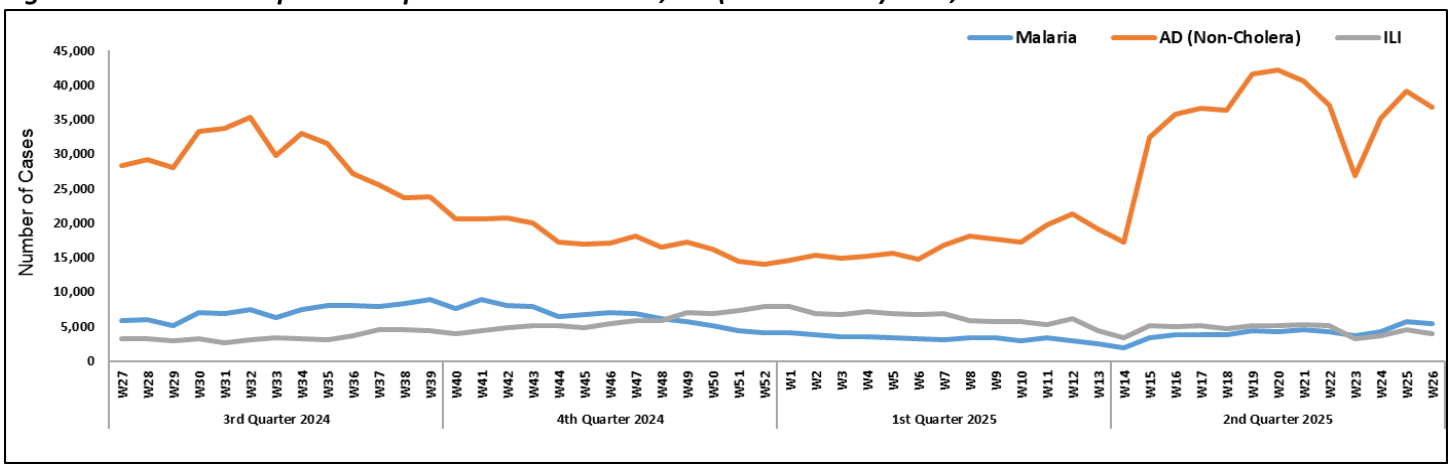


Figure 7: Week wise reported suspected cases Malaria, AD (Non-Cholera) & ILI, KP



PUNJAB

- The most frequently reported cases were of Acute Diarrhea (Non-Cholera) followed by TB, dog bite, ALRI <5 years, Malaria, Typhoid and AWD (S. Cholera) this week.
- There is a decline in cases observed for Acute Diarrhea (Non-Cholera), TB, dog bite, ALRI <5 years, Malaria and Typhoid this week.
- Five cases of AFP reported Punjab this week. They are suspected cases and need field verification.
- Five suspected cases of HIV/ AIDS reported from Punjab this week. They require field investigation.

Figure 8: Most frequently reported suspected cases during Week 14, Punjab

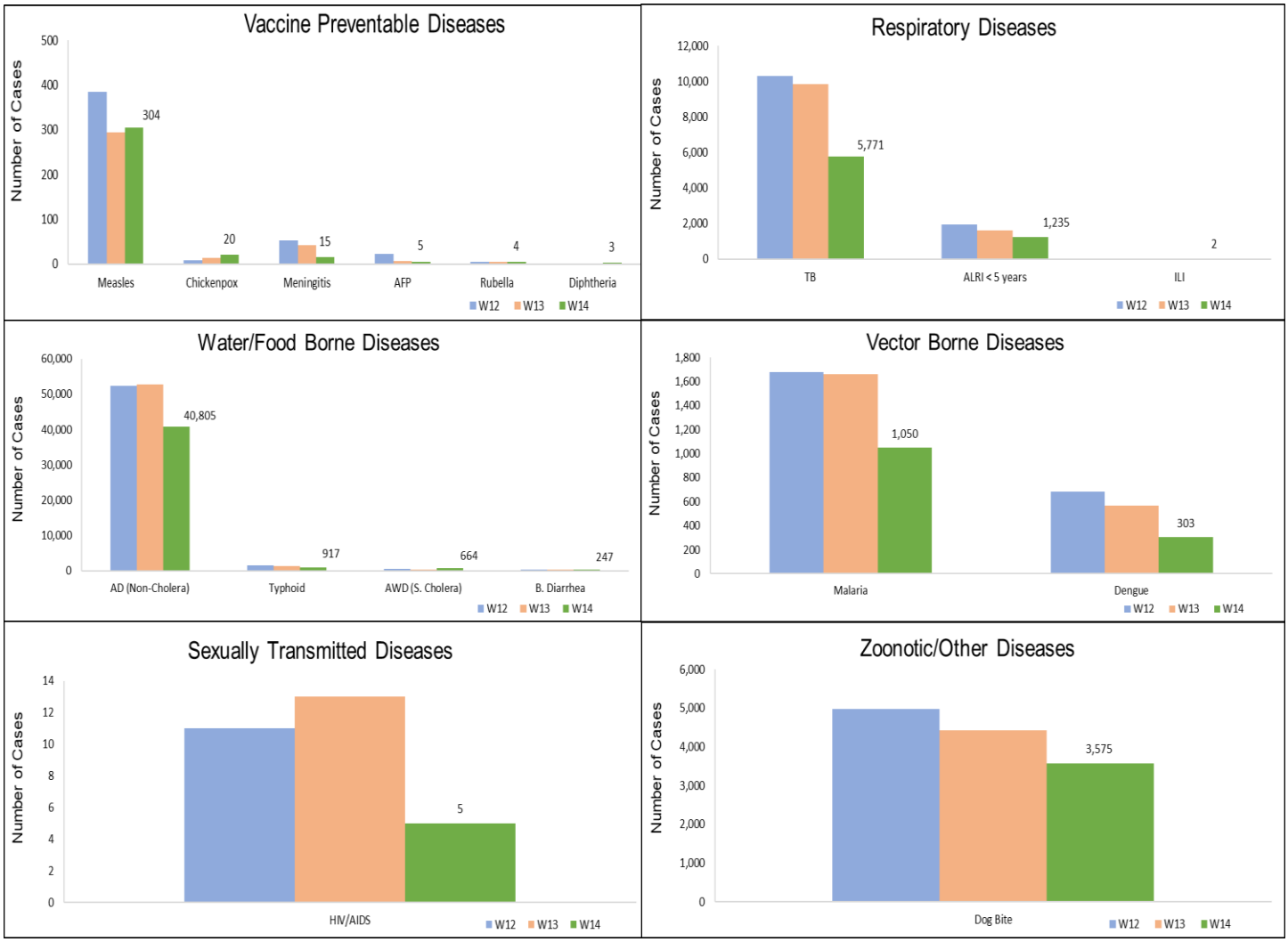
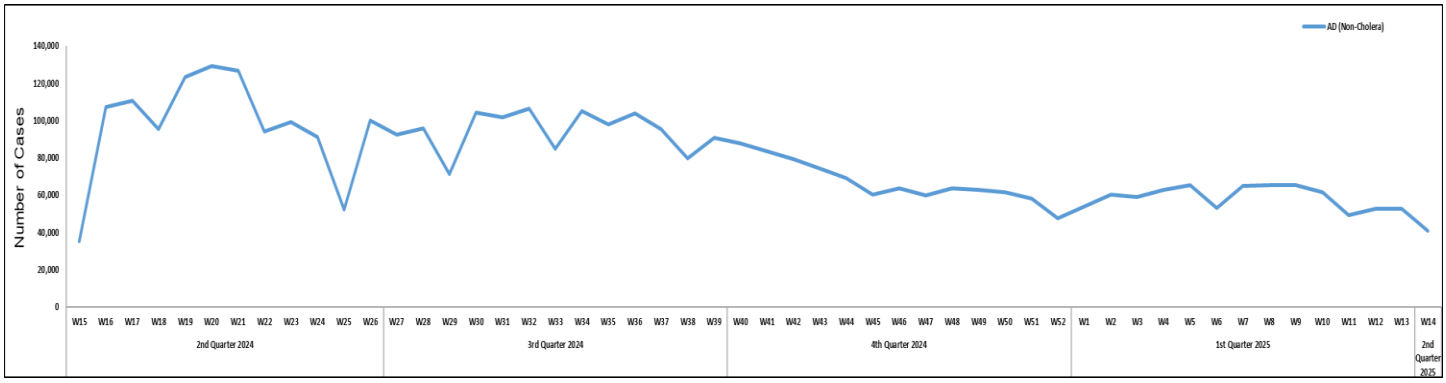


Figure 9: Week wise reported suspected cases of AD (Non-Cholera), Punjab



ICT, AJK & GB

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

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

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

Figure 10: Most frequently reported suspected cases during Week 26, AJK

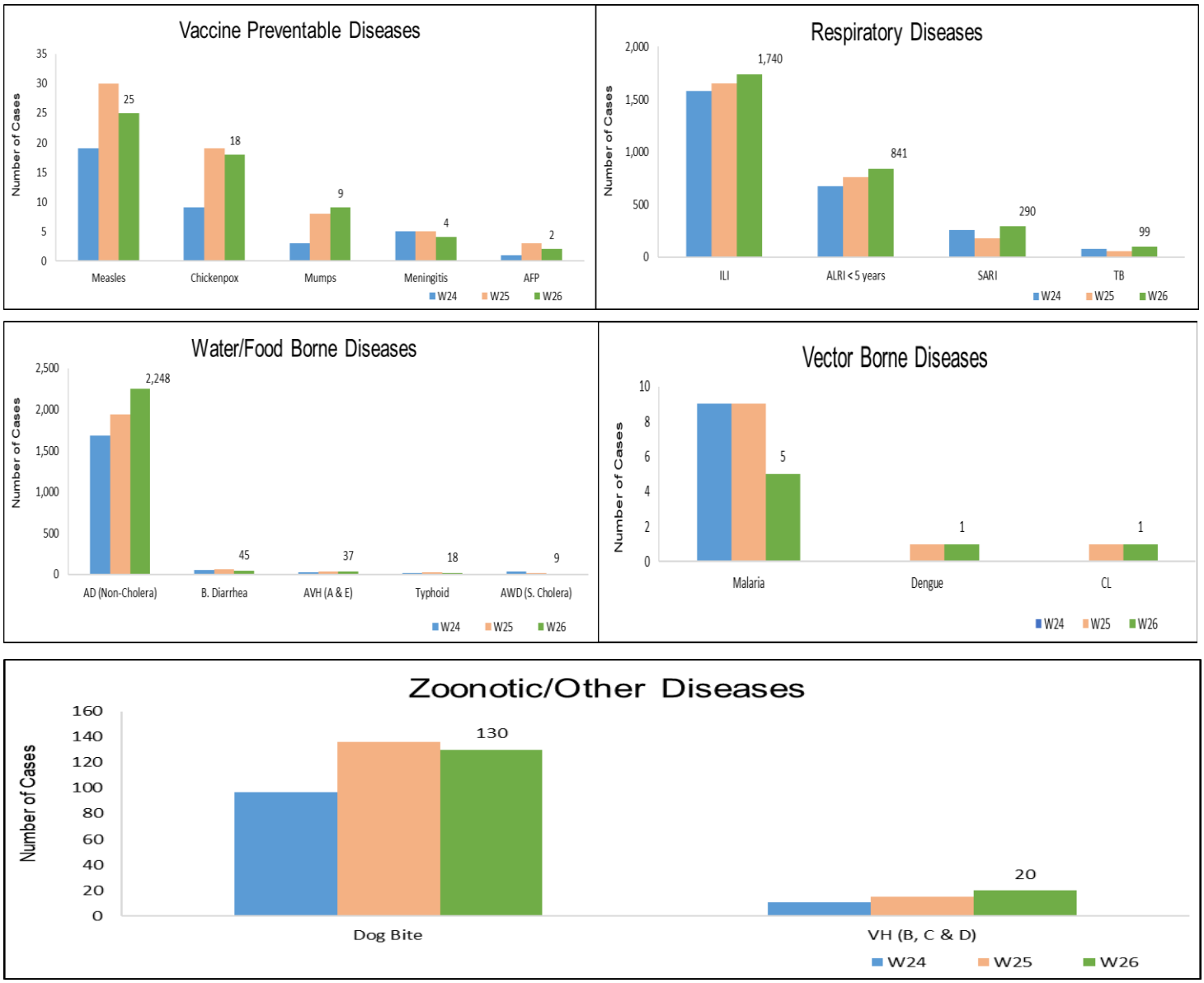


Figure 11: Most frequently reported suspected cases during Week 26, ICT

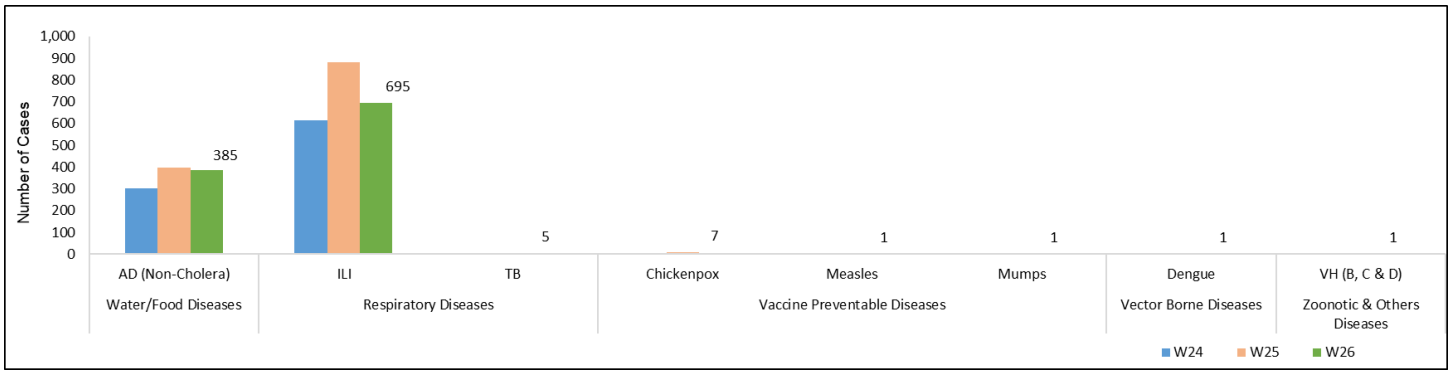


Figure 12: Week wise reported suspected cases of ILI, ICT

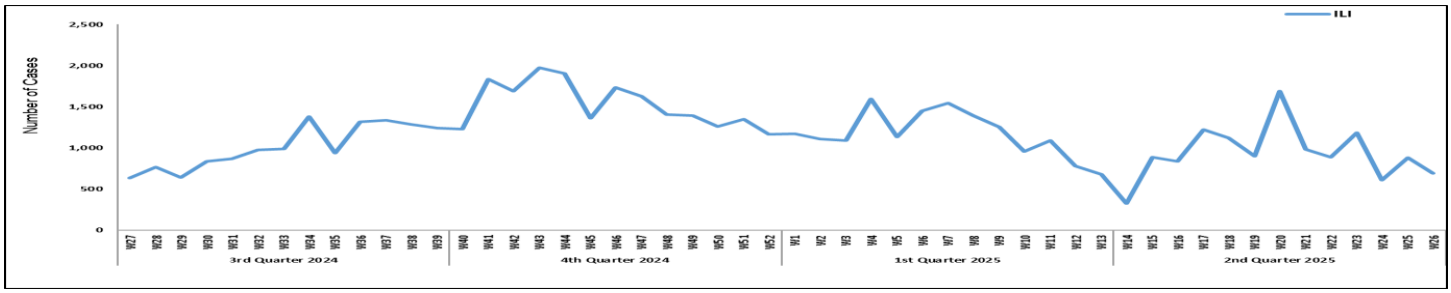


Figure 13: Most frequent cases reported during Week 26, GB

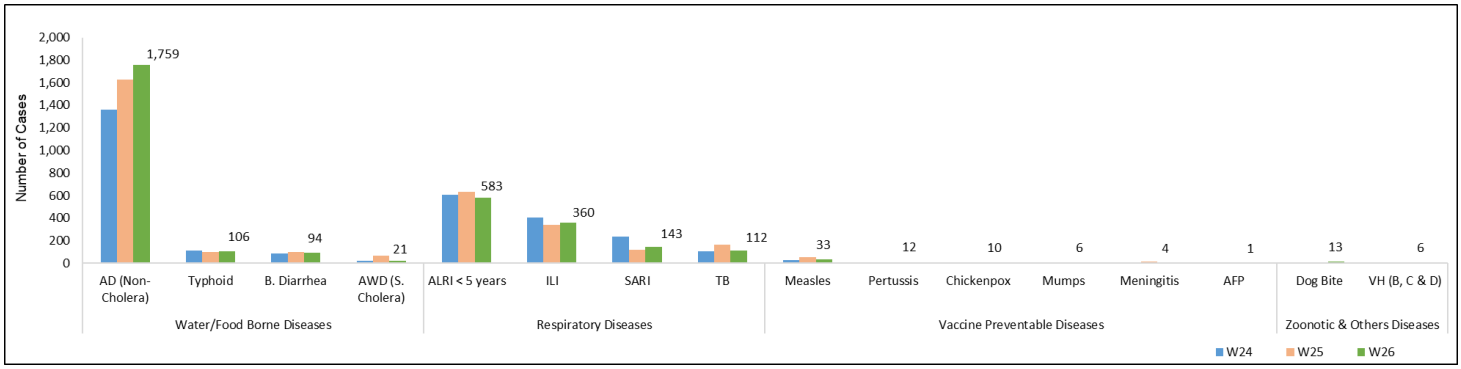


Figure 14: Week wise reported suspected cases of AD (Non-Cholera), GB

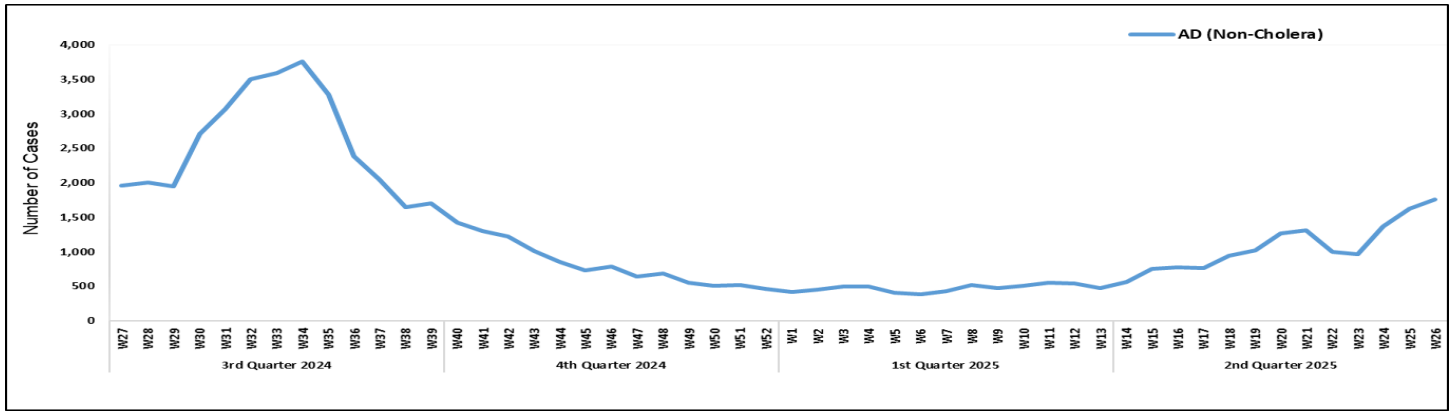


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epid Week 26

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)		53	4	-	-	0	0	-	-	-	-	-	-	-	-
Stool culture & Sensitivity		186	6	-	-	0	0	-	-	-	-	-	-	-	-
Malaria		7,787	745	-	-	389	5	-	-	-	-	-	-	-	-
CCHF		1	0	6	0	0	0	-	-	-	-	-	-	-	-
Dengue		2,551	213			0	0	-	-	-	-	-	-	-	-
VH (B)		15,571	449	117	96	929	4	-	-	103	6	-	-	579	5
VH (C)		15,511	1,165	69	21	840	9	-	-	103	0	-	-	577	13
VH (D)		54	19	0	0	0	0	-	-	-	-	-	-	-	-
VH (A)		301	97	-	-	1	0	-	-	-	-	-	-	-	-
VH (E)		99	28	-	-	0	0	-	-	-	-	-	-	-	-
Covid-19		6	0	2	0	0	0	-	-	-	-	-	-	12	0
TB		439	129	-	-	5	1	-	-	8	1	-	-	43	2
HIV/ AIDS		6,243	41	-	-	919	0	-	-	13	0	-	-	485	1
Syphilis		1,844	26	-	-	382	0	-	-	0	0	-	-	0	0
B. Diarrhea		25	2	-	-	-	-	-	-	0	0	-	-	0	0
Chikungunya		15	12	-	-	-	-	-	-	0	0	-	-	0	0
Typhoid		1,446	57	-	-	-	-	-	-	39	1	-	-	0	0
Diphtheria		4	0	-	-	-	-	-	-	-	-	-	-	-	-
ILI		24	1	1	0	-	-	-	-	-	-	-	-	-	-
M-POX		1	0	-	-	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)		53	18	-	-	-	-	-	-	-	-	-	-	-	-
Meningitis		16	1	-	-	-	-	-	-	-	-	-	-	-	-
Measles		218	94	34	18	249	101	22	7	18	7	637	118	45	20
Rubella		218	7	34	1	249	6	22	0	18	0	637	1	45	1
Rubella (CRS)		4	3	-	-	0	0	-	-	-	-	-	-	0	0
Covid-19	Out of SARI	10	0	-	-	29	3	27	1	-	-	54	0	12	0
	Out of ILI	0	0	-	-	1	0	18	0	-	-	18	0	8	0
Influenza A	Out of SARI	10	0	-	-	29	1	27	0	-	-	54	0	12	0
	Out of ILI	0	0	-	-	1	0	18	1	-	-	18	0	8	0
Influenza B	Out of SARI	10	0	-	-	29	0	27	0	-	-	54	0	12	0
	Out of ILI	0	0	-	-	1	0	18	0	-	-	18	0	8	0
RSV	Out of SARI	10	0	-	-	29	0	27	0	-	-	54	0	12	0
	Out of ILI	0	0	-	-	1	0	18	0	-	-	18	0	8	0

- 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 26, 2024

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	102	92%
	Bannu	238	132	55%
	Battagram	59	37	63%
	Buner	34	20	59%
	Bajaur	44	41	93%
	Charsadda	59	59	100%
	Chitral Upper	34	30	88%
	Chitral Lower	35	34	97%
	D.I. Khan	114	113	99%
	Dir Lower	74	62	84%
	Dir Upper	37	32	86%
	Hangu	22	17	77%
	Haripur	72	71	99%
	Karak	36	36	100%
	Khyber	53	43	81%
	Kohat	61	61	100%
	Kohistan Lower	11	10	91%
	Kohistan Upper	20	17	85%
	Kolai Palas	10	8	80%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	3	7%
	Upper Kurram	41	30	73%
	Malakand	42	19	45%
	Mansehra	133	90	68%
	Mardan	80	56	70%
	Nowshera	56	54	96%
	North Waziristan	13	8	62%
	Peshawar	156	131	84%
	Shangla	37	34	92%
	Swabi	64	63	98%
	Swat	77	76	99%
	South Waziristan (Upper)	93	36	39%
	South Waziristan (Lower)	42	20	48%
	Tank	34	32	94%
	Torghar	14	14	100%
	Mohmand	68	59	87%
	SD Peshawar	5	0	0%
	SD Tank	58	6	10%
	Orakzai	69	12	17%
Azad Jammu Kashmir	Mirpur	37	37	100%
	Bhimber	42	20	48%
	Kotli	60	60	100%
	Muzaffarabad	45	43	96%

	Poonch	46	46	100%
	Haveli	39	39	100%
	Bagh	40	40	100%
	Neelum	39	39	100%
	Jhelum Velley	29	29	100%
	Sudhnooti	27	27	100%
Islamabad Capital Territory	ICT	23	23	100%
	CDA	15	6	40%
Balochistan	Gwadar	26	19	73%
	Kech	44	0	0%
	Khuzdar	74	10	14%
	Killa Abdullah	26	17	65%
	Lasbella	55	55	100%
	Pishin	69	31	45%
	Quetta	55	12	22%
	Sibi	36	20	56%
	Zhob	39	27	69%
	Jaffarabad	16	16	100%
	Naserabad	32	32	100%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	8	11%
	Chagi	36	0	0%
	Kalat	41	40	98%
	Harnai	17	0	0%
	Kachhi (Bolan)	35	0	0%
	Jhal Magsi	28	27	96%
	Sohbat pur	25	25	100%
	Surab	32	2	6%
	Mastung	45	0	0%
	Loralai	33	19	58%
	Killa Saifullah	28	0	0%
	Ziarat	29	0	0%
	Duki	31	0	0%
	Nushki	32	0	0%
	Dera Bugti	45	24	53%
	Washuk	46	26	57%
	Panjgur	38	7	18%
	Awaran	23	0	0%
	Chaman	24	24	100%
	Barkhan	20	18	90%
	Hub	33	30	91%
	Musakhel	41	11	27%
	Usta Muhammad	34	34	100%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	38	100%
	Gilgit	42	41	98%
	Diamer	62	62	100%

	Astore	55	55	100%
	Shigar	27	25	93%
	Skardu	53	53	100%
	Ganche	29	29	100%
	Kharmang	46	25	54%
Sindh	Hyderabad	72	69	96%
	Ghotki	64	64	100%
	Umerkot	62	62	100%
	Naushahro Feroze	107	98	92%
	Tharparkar	276	239	87%
	Shikarpur	60	60	100%
	Thatta	52	50	96%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	15	71%
	Karachi-West	20	20	100%
	Karachi-Malir	35	35	100%
	Karachi-Kemari	22	22	100%
	Karachi-Central	12	11	92%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	6	100%
	Sujawal	55	54	98%
	Mirpur Khas	106	102	96%
	Badin	124	124	100%
	Sukkur	64	63	98%
	Dadu	90	88	98%
	Sanghar	100	98	98%
	Jacobabad	44	44	100%
	Khairpur	170	166	98%
	Kashmore	59	59	100%
	Matiari	42	42	100%
	Jamshoro	75	74	99%
	Tando Allahyar	54	54	100%
	Tando Muhammad Khan	41	41	100%
	Shaheed Benazirabad	122	122	100%

Table 7: IDSR reporting Tertiary care hospital Week 26, 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	1	100%
	Sukkur	1	0	0%
	Shaheed Benazirabad	1	0	0%
	Karachi-East	1	1	100%
	Karachi-Central	1	0	0%

Notes from the field:

Outbreak Investigation of a Lab-Confirmed Case of Crimean-Congo Hemorrhagic Fever (CCHF) in Wah, Taxila, Rawalpindi, June 2025

Dr. Ehsan Ghani (DHO Preventive services)
Dr. Waqar Ahmed (FETP 13th Cohort)

Introduction

Crimean-Congo Hemorrhagic Fever (CCHF) is a severe viral zoonosis caused by a Nairovirus, transmitted primarily through bites from infected Hyalomma ticks or direct contact with the blood and tissues of infected animals. Globally, CCHF is endemic in over 30 countries, particularly in Africa, the Balkans, the Middle East, and Asia, with a case fatality rate ranging from 10% to 40% [1]. In the Eastern Mediterranean region, countries like Pakistan, Iran, and Afghanistan frequently report seasonal CCHF cases, often linked to livestock handling and slaughtering practices [2]. Within Pakistan, sporadic outbreaks are commonly observed around Eid-ul-Azha due to increased human-animal interaction.

On June 15, 2025, a patient with high-grade fever, hemorrhagic symptoms, and severe cytopenia was admitted to THQ Hospital, Hassan Abdal. The case was reported to the Federal Disease Surveillance and Response Unit (FDSRU) on June 18 and was confirmed as Crimean-Congo Hemorrhagic Fever (CCHF) through laboratory testing. An outbreak was officially declared in coordination with the District Health Authority Rawalpindi. A multidisciplinary team comprising public health, epidemiology, and livestock officials initiated a field investigation on June 19th to assess the situation and implement control measures

Objectives:

1. To confirm and investigate the source of CCHF outbreak.
2. To Identify and monitor contacts to prevent secondary transmission.
3. To implement control measures.
4. To propose recommendations for future prevention.

Methods

A descriptive cross-sectional outbreak investigation was conducted from June 15 to 30, 2025, in Wah, Taxila, District Rawalpindi, Punjab, Pakistan. The study population included one laboratory-confirmed case of Crimean-Congo Hemorrhagic Fever (CCHF) and all persons having possible exposure with confirmed case. A suspected case was defined as an individual presenting with high-grade fever, hemorrhagic symptoms, and thrombocytopenia, with a relevant exposure history, and confirmed case was ”any person who is lab confirmed via RT-PCR testing for CCHF”. Data were collected using a structured case investigation form and a contact tracing sheet to collect data on demographic profile, clinical features, hospital and laboratory information. Case finding was performed through a combination of hospital record review and active surveillance in the community. Serum samples were collected from suspected cases using appropriate biosafety precautions and tested at the National Institute of Health (NIH) in Islamabad using RT-PCR.

Data were analyzed to calculate frequencies, age statistics, gender ratios, attack rates, and to describe symptom distribution and potential risk factors.

Results:

A single laboratory-confirmed case of Crimean-Congo Hemorrhagic Fever (CCHF) was identified in a 38-year-old male resident of Model Town, Wah Cantt, Taxila. The patient presented with high-grade fever, body aches, gum bleeding, and hematemesis; laboratory findings revealed severe thrombocytopenia (platelets 4,100/µL), leukopenia (WBC 1.91 x 10^3/µL), and chest X-ray infiltrates. The most probable risk factor was direct exposure to blood and tissues during the slaughter of five sacrificial animals on Eid-ul-Azha (June 7, 2025). Contact tracing identified 20 close contacts, all of whom were quarantined for 14 days; two contacts developed fever but tested negative for CCHF. Additionally, 14 healthcare workers were monitored, all were placed under observation or quarantine as per protocol none of whom developed symptoms.

RT-PCR testing conducted at the National Institute of Health (NIH) Islamabad confirmed the diagnosis on June 18, 2025.

Environmental inspection of the patient's residence revealed no domestic animals in the immediate vicinity, but acaricidal spraying was carried out in and around the household as a precautionary measure due to the patient's recent contact with sacrificial animals.

Public Health Measures Taken:

- **Case Surveillance & Contact Monitoring:** Initiated district-wide active surveillance for Viral Hemorrhagic Fevers (VHFs).
- **Environmental & Vector Control:** Conducted acaricidal spraying at the patient's residence and surrounding areas. Livestock Department set up 25 inter-district and inter-provincial checkpoints across the Potohar region. Deployed 115 staff to apply acaricidal spray on animals at entry and exit points to reduce tick infestation.
- **Health System Strengthening:** Conducted training sessions for healthcare providers on VHF case identification and notification, Clinical management and referral protocols, infection Prevention and Control (IPC) practices.
- **Community Engagement & Risk Communication:** Organized community awareness sessions on CCHF prevention and symptoms, led by social mobilizers , sanitary patrols and by Lady Health Workers (LHWs).

Discussion

The confirmed outbreak of Crimean-Congo Hemorrhagic Fever (CCHF) reported from Wah, Taxila, highlights the recurring seasonal and zoonotic nature of the disease in Pakistan. CCHF is endemic in several parts of the country and shows a predictable increase in incidence around Eid-ul-Azha, when large-scale animal slaughter leads to increased human exposure to blood and tissues of potentially infected livestock [1,4]. The patient, participated in the unsupervised slaughter of goats and bulls, which is consistent with established evidence linking traditional butchering practices to increased risk of CCHF transmission [5,6].

The clinical profile of the patient marked by high-grade fever, mucosal bleeding, and severe thrombocytopenia is characteristic of previously documented CCHF cases in Pakistan and globally [7,8].

Timely environmental and public health measures, including acaricidal spraying, community education, and healthcare worker monitoring, effectively prevented secondary

cases and demonstrated improved outbreak preparedness and coordination [9].

This event highlights the critical need for sustained One Health-based intersectoral collaboration, particularly during high-risk periods such as religious festivals involving animal contact. Strengthening community awareness, enforcing safe animal handling practices, and building capacity for early detection and response remain essential to reducing the burden of CCHF in endemic areas [10].

Conclusion

This outbreak investigation confirmed a single case of CCHF likely linked to direct contact with infected animal blood during Eid-ul-Azha slaughter activities. Early clinical suspicion, prompt laboratory testing, and robust public health response curtailed further spread. However, this case highlights persistent vulnerabilities in traditional animal handling and inadequate awareness among the general population.

Recommendations

Immediate (Short-Term):

- Mandatory acaricidal treatment of sacrificial animal's pre-slaughter.
- Intensify awareness campaigns before Eid targeting high-risk populations (butchers, livestock traders, general public).
- Re-train healthcare providers in CCHF identification, IPC, and PPE use.

Mid-Term:

- Establish local tick control programs in high-risk districts like Rawalpindi.
- Ensure slaughtering during Eid-ul-Azha is supervised at designated slaughter points with trained personnel.
- Sustain One Health interdepartmental coordination for real-time zoonotic disease reporting.

Long-Term:

- Develop a real-time One Health surveillance system linking human, animal, and environmental sectors.
- Enforce legislation for safe animal transport and handling.
- Invest in research on tick ecology and CCHF epidemiology in endemic zones.

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Knowledge Hub

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

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

What are Hepatitis A and Hepatitis E?

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

Hepatitis A: A highly contagious liver infection caused by the Hepatitis A virus (HAV). It is the most common form of viral hepatitis worldwide.

Hepatitis E: A liver infection caused by the Hepatitis E virus (HEV). It is also widespread, particularly in developing countries.

How Hepatitis A and E Spread

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

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

Person-to-Person Contact: Direct contact with an infected person, such as during sex or caring for a sick person, can also spread the virus.

Signs & Symptoms

Symptoms for both Hepatitis A and Hepatitis E are often mild or absent, especially in young children. When symptoms do appear, they are usually the same for both viruses and can include:

- Fever.
- Fatigue.
- Nausea or vomiting.
- Abdominal pain or discomfort, especially in the liver area (upper right side of the belly).
- Dark urine.
- Light-colored stools.
- Jaundice: A yellowing of the skin and eyes.
- Loss of appetite.
- Joint pain.
- Symptoms typically appear about 2-6 weeks after exposure and last for a few weeks to a few months.

Complications

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

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

Hepatitis E: Severe cases can also lead to acute liver failure. This is particularly dangerous for pregnant individuals, for whom Hepatitis E can have a very high fatality rate.

Prevention

Preventing Hepatitis A and E involves both vaccination and good hygiene.

Hepatitis A Prevention

- Vaccination: An effective vaccine is available and recommended for all children and for adults who are at increased risk, such as travelers to high-risk areas, men who have sex with men, and people with chronic liver disease.
- Handwashing: Wash hands with soap and water after using the bathroom, changing diapers, and before preparing or eating food.
- Hepatitis E Prevention
- Vaccination: A vaccine for Hepatitis E is available in some countries but not globally.

- Safe Water: Drink only bottled or boiled water, especially when traveling to areas where Hepatitis E is common.
- Safe Food: Avoid raw or undercooked shellfish, pork, and other meat products.

Diagnosis and Treatment

Diagnosis: Both Hepatitis A and E are diagnosed through a blood test that detects antibodies or the virus itself.

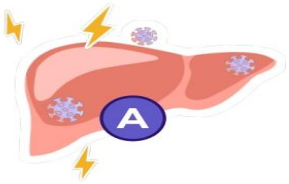
Treatment: There is no specific cure for Hepatitis A or E. Treatment focuses on supportive care to manage symptoms. This includes rest, adequate nutrition, and hydration. A healthcare provider may recommend medications for nausea or other symptoms.

More Information

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

- Centers for Disease Control and Prevention (CDC):
- https://www.cdc.gov/hepatitis/hav/index.htm
- https://www.cdc.gov/hepatitis/hevev/index.htm
- World Health Organization (WHO):
- https://www.who.int/news-room/fact-sheets/detail/hepatitis-a
- https://www.who.int/news-room/fact-sheets/detail/hepatitis-e
- Public Health Agency of Canada (PHAC):
- https://www.canada.ca/en/public-health/services/diseases/hepatitis-a.html
- UK Health Security Agency (UKHSA) / National Health Service (NHS):
- https://www.nhs.uk/conditions/hepatitis/

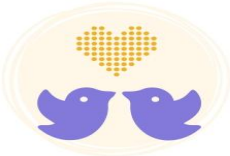
WHAT YOU SHOULD KNOW ABOUT HEPATITIS A



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

HOW DOES IT SPREAD?

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



Having sexual contact with infected partner(s)

Eating or drinking foods contaminated by Hepatitis A

WHAT ARE THE SYMPTOMS?

Throwing up or feeling like throwing up

Yellowing of the eyes and skin

Fever

Other symptoms include:

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

HOW CAN YOU PREVENT IT?

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

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

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

UK Health Security Agency

World Health Organization

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION