

# 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

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### Public Health Bulletin - Pakistan, Week 12, 2026

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## IDSR Reports

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## Ongoing Events

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## Field Reports

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*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 Report of Mpox, District Peshawar, Pakistan (March 2026)*
- *Knowledge hub on Measles: 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*



*Note: All reported cases in this report are suspected cases*

- During Week 12, the most frequently reported cases were Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, ALRI <5 years, TB, Dog Bite, B. Diarrhea, VH (B, C & D), Typhoid, SARI, and AVH (A & E).
- Six cases of AFP were reported from KP and three from Sindh.
- Three suspected cases of HIV/ AIDS were reported from Sindh and two from KP.
- One suspected case of Brucellosis was reported from KP and one from Balochistan.
- Among VPDs, there is an increase in the number of cases of Rubella, while Measles, Mumps, Meningitis, and Pertussis showed a decrease in number this week.
- Among Respiratory diseases, there is a decrease in the number of cases of ILI, TB, ALRI <5 years and SARI this week.
- Among Water/food-borne diseases, there is a decrease in the number of cases of AD (non – cholera), B. Diarrhea, and Typhoid this week.
- Among Vector-borne diseases, there is a decrease in the number of cases of Malaria this week.
- Among STDs, there is a decline in the number of cases of HIV/AIDs this week.
- Among Zoonotic/Other diseases, there is a decrease in the number of cases of dog bites this week.

## IDSR compliance attributes

- The national compliance rate for IDSR reporting in 158 implemented districts is 77%
- Sindh is the top reporting region with a compliance rate of 98%, followed by GB 88%, AJK 84%, and KP 77%.
- The lowest compliance rate was observed in ICT 71% and Balochistan, 35%.

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2,234	1,729	77
Azad Jammu Kashmir	469	395	84
Islamabad Capital Territory	38	27	71
Balochistan	1,308	455	35
Gilgit Baltistan	417	365	88
Sindh	2,111	2,072	98
National	6,577	5,043	77



## Public Health Actions

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

### Measles

- **Strengthen Surveillance and Case Notification:** Enhance measles case reporting through the IDSR system by training healthcare providers to recognize and report suspected cases (fever with maculopapular rash and cough, coryza, or conjunctivitis). Ensure immediate outbreak alerts.
- **Expand Laboratory Confirmation:** Strengthen laboratory capacity for measles IgM antibody testing and PCR, particularly for outbreak investigations and elimination verification.
- **Improve Immunization Coverage:** Ensure high and equitable coverage of measles-containing vaccines (MCV1 and MCV2) through routine immunization, outreach services, and catch-up campaigns in underserved areas.
- **Conduct Supplemental Immunization Activities (SIAs):** Organize targeted or nationwide campaigns to close immunity gaps, especially during outbreaks or in low-coverage districts.
- **Strengthen Outbreak Preparedness and Response:** Establish rapid response teams for case isolation, contact tracing, and ring vaccination.
- **Raise Public Awareness:** Implement community engagement and communication campaigns to promote vaccine acceptance, early healthcare-seeking, and understanding of measles symptoms and risks.

### Mumps

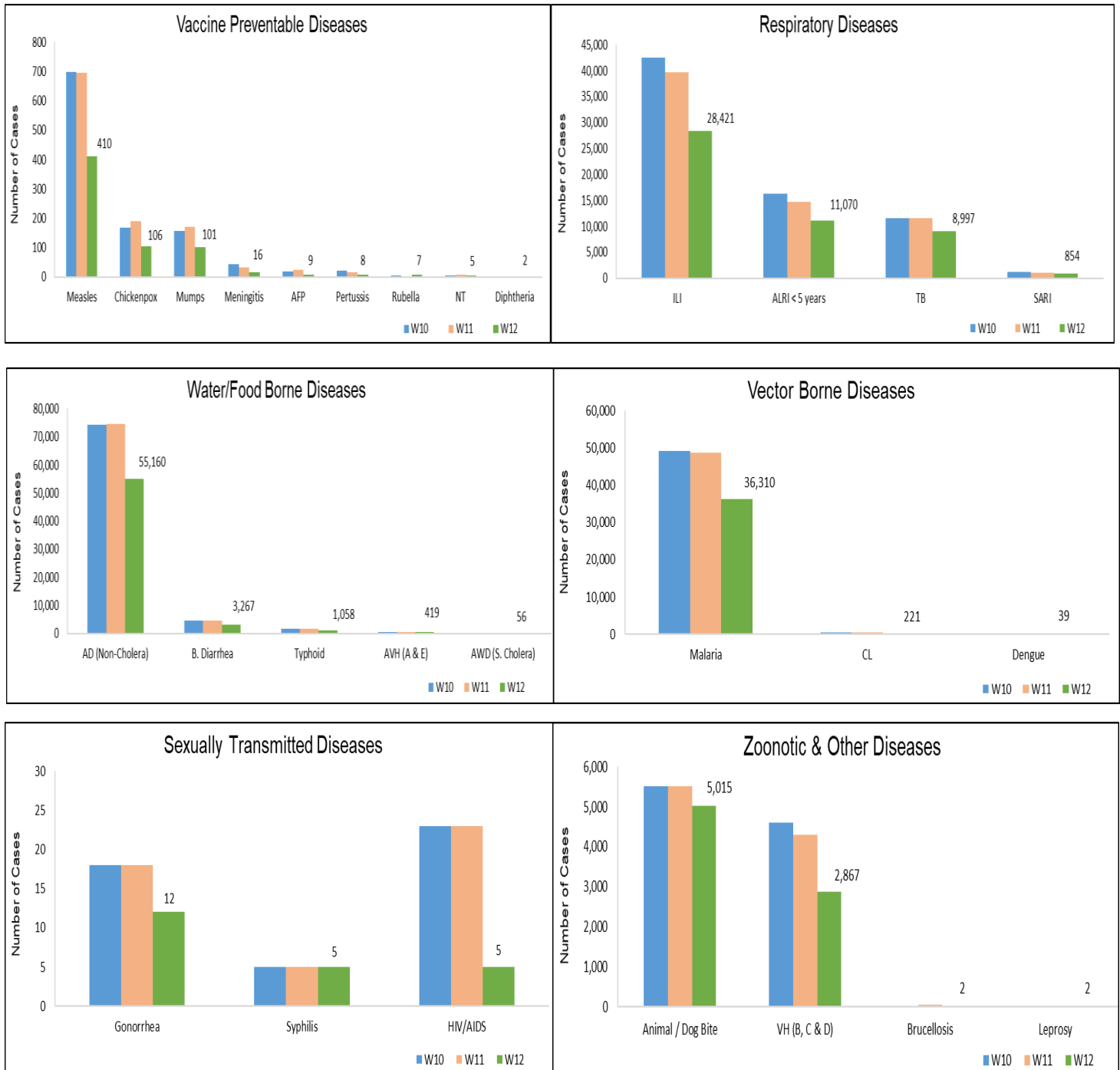
- **Enhance Surveillance and Case Detection:** Strengthen mumps case detection within IDSR by training health workers to apply standard case definitions and promptly report suspected cases, particularly in schools and crowded institutions.
- **Expand Laboratory Capacity:** Support laboratory confirmation through IgM antibody testing and PCR where feasible, especially during outbreaks.
- **Promote Vaccination:** Increase coverage of the Measles-Mumps-Rubella (MMR) vaccine via routine immunization services and supplemental campaigns in high-risk or low-coverage populations.
- **Implement Outbreak Control Measures:** Encourage isolation of suspected cases during the infectious period and conduct contact tracing in schools and workplaces to minimize transmission.
- **Raise Community Awareness:** Disseminate health education materials highlighting mumps symptoms, routes of transmission (respiratory droplets), preventive measures, and importance of vaccination.
- **Strengthen Multi-Sectoral Collaboration:** Work with educational institutions and community leaders to promote vaccination campaigns and enforce outbreak control strategies.



**Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 12, Pakistan.**

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	987	2,547	472	238	16,228	NR	34,688	55,160
Malaria	0	904	0	0	1,430	NR	33,976	36,310
ILI	1,408	2,018	274	877	1,420	NR	22,424	28,421
ALRI < 5 years	739	457	545	2	544	NR	8,783	11,070
TB	40	14	48	3	124	NR	8,768	8,997
Animal / Dog Bite	138	112	0	0	1,034	NR	3,731	5,015
B. Diarrhea	14	297	34	2	459	NR	2,461	3,267
VH (B, C & D)	7	19	1	0	47	NR	2,793	2,867
Typhoid	7	82	52	0	218	NR	699	1,058
SARI	72	194	67	0	354	NR	167	854
AVH (A & E)	7	0	0	0	190	NR	222	419
Measles	0	11	14	0	310	NR	75	410
CL	0	5	0	0	213	NR	3	221
Chickenpox/ Varicella	2	2	1	0	43	NR	58	106
Mumps	1	7	1	0	65	NR	27	101
AWD (S. Cholera)	3	50	1	0	2	NR	0	56
Dengue	0	1	0	0	1	NR	37	39
Meningitis	1	1	4	0	2	NR	8	16
Gonorrhoea	0	4	0	0	0	NR	8	12
AFP	0	0	0	0	6	NR	3	9
Pertussis	0	2	1	0	4	NR	1	8
Rubella (CRS)	0	7	0	0	0	NR	0	7
HIV/AIDS	0	0	0	0	2	NR	3	5
NT	0	0	0	0	4	NR	1	5
Syphilis	0	0	0	0	0	NR	5	5
Brucellosis	0	1	0	0	1	NR	0	2
Diphtheria (Probable)	0	0	0	0	2	NR	0	2
Leprosy	0	2	0	0	0	NR	0	2

**Figure 1: Most frequently reported suspected cases during Week 12, Pakistan.**

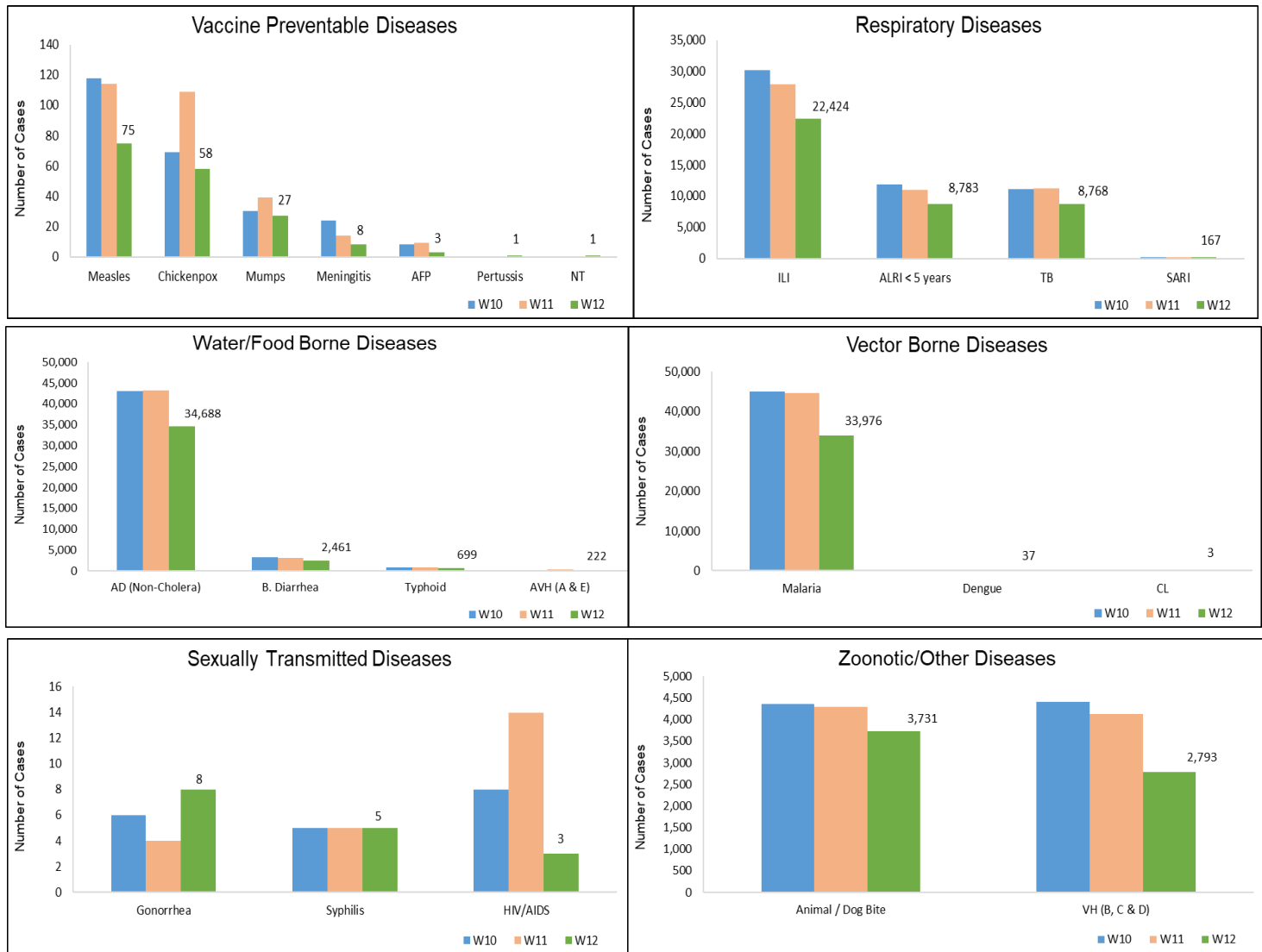


- AD (non-cholera) cases were maximum followed by Malaria, ILI, ALRI<5 Years, TB, Dog bite, VH (B, C, D), B. Diarrhea, Typhoid and AVH (A & E).
- Malaria cases are mostly from Khairpur, Sanghar and Larkana whereas ILI cases are from Khairpur, Badin and Mirpurkhas.
- Three cases of AFP reported from Sindh. They are suspected cases and need field verification.
- There is a decline in number of cases of Measles, Chickenpox, Mumps, Meningitis, AFP, ILI, ALRI<5years, TB, AD (Non-Cholera), B. Diarrhea, Typhoid, Malaria, Dog bite, VH (B, C&D) and HIV/ AIDS while an increase in number of cases of NT and Pertussis this week.

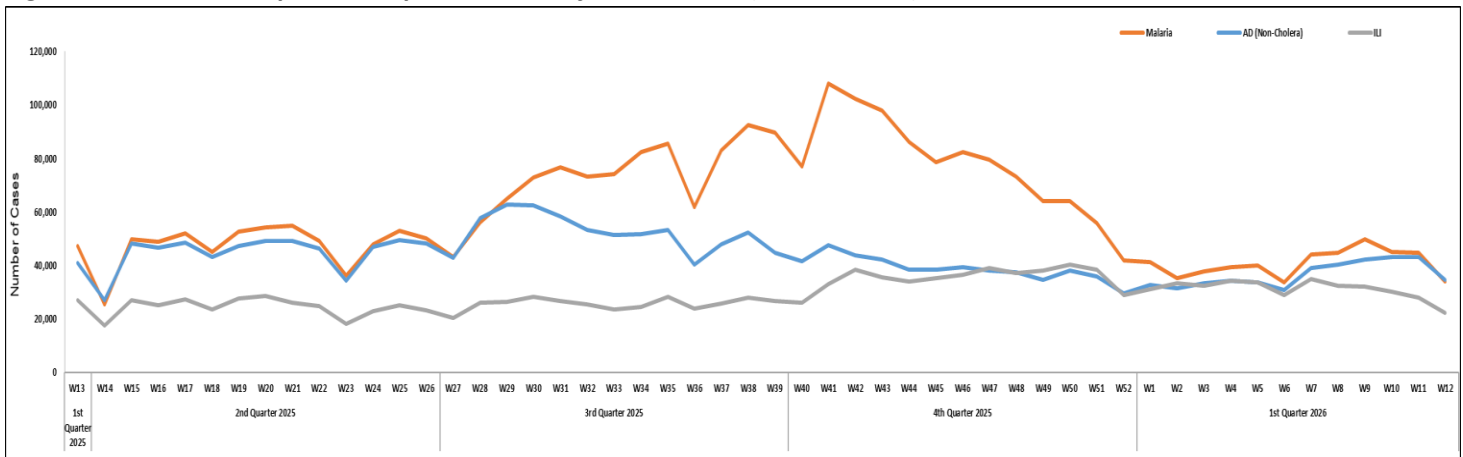
**Table 2: District wise distribution of most frequently reported suspected cases during Week 12, Sindh.**

Districts	AD (Non-Cholera)	Malaria	ILI	ALRI < 5 years	TB	Animal / Dog Bite	VH (B, C & D)	B. Diarrhea	Typhoid	AVH (A & E)
Badin	1,558	1,525	2,469	432	486	103	79	215	101	0
Dadu	1,709	2,254	955	1,253	441	293	60	303	107	43
Ghotki	910	1,627	27	525	394	246	430	79	6	0
Hyderabad	1,628	486	1,982	125	241	49	54	47	8	0
Jacobabad	508	1,473	758	336	191	217	40	62	16	0
Jamshoro	1,444	1,284	99	326	394	91	48	68	23	2
Kamber	1,330	2,146	0	208	618	242	57	79	17	0
Karachi Central	875	8	965	55	274	116	15	0	51	0
Karachi East	223	14	3	12	12	13	0	0	8	8
Karachi Keamari	330	1	158	5	11	16	0	1	0	0
Karachi Korangi	154	40	16	2	27	5	0	4	1	0
Karachi Malir	697	30	1,019	155	37	41	1	27	4	9
Karachi South	51	3	0	0	0	0	0	0	0	0
Karachi West	768	269	1,174	191	67	72	15	17	24	0
Kashmore	262	1,327	182	57	119	155	0	19	0	0
Khairpur	3,203	3,220	4,706	1,105	905	349	136	279	144	5
Larkana	1,189	2,508	0	237	681	68	14	220	0	0
Matiali	1,159	1,248	2	243	460	130	233	59	0	12
Mirpurkhas	2,326	1,115	2,456	338	595	188	30	97	10	49
Naushero Feroze	1,375	1,163	787	304	193	248	47	136	32	0
Sanghar	1,753	2,781	47	305	713	240	983	43	13	1
Shaheed Benazirabad	1,226	1,398	11	146	219	123	89	67	59	0
Shikarpur	789	1,201	3	245	100	263	100	127	3	0
Sujawal	1,381	568	0	268	79	79	40	63	11	8
Sukkur	1,030	1,058	1,803	305	268	137	52	100	9	0
Tando Allahyar	1,217	883	777	110	311	52	104	64	4	0
Tando Muhammad Khan	841	323	62	106	344	104	23	86	0	0
Tharparkar	1,905	1,406	1,057	608	364	0	16	99	13	16
Thatta	1,400	970	906	408	21	91	76	19	6	68
Umerkot	1,447	1,647	0	373	203	0	51	81	29	1
<b>Total</b>	<b>34,688</b>	<b>33,976</b>	<b>22,424</b>	<b>8,783</b>	<b>8,768</b>	<b>3,731</b>	<b>2,793</b>	<b>2,461</b>	<b>699</b>	<b>222</b>

**Figure 2: Most frequently reported suspected cases during Week 12, Sindh.**



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

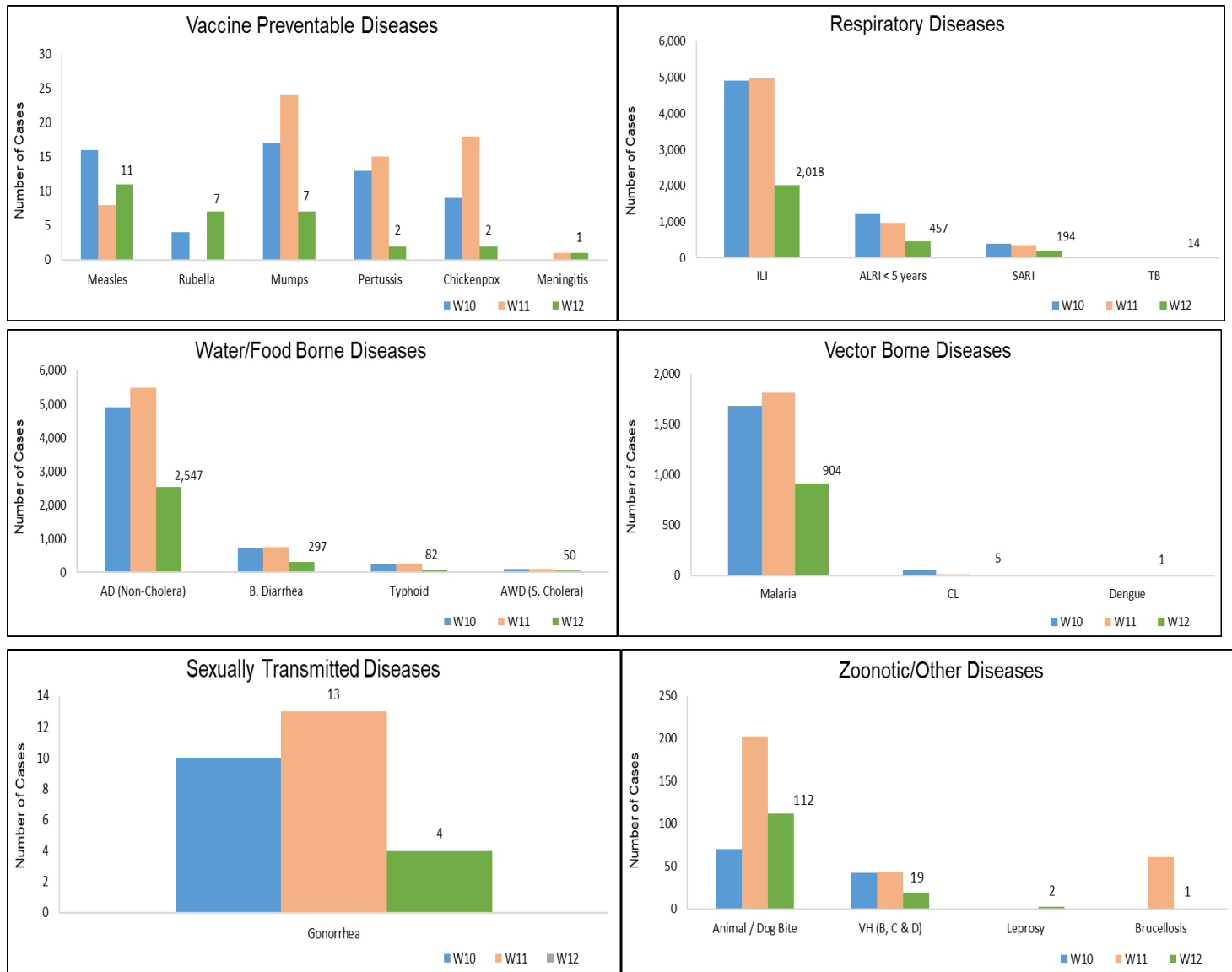


- AD (Non-Cholera), ILI, Malaria, ALRI <5 years, B. Diarrhea, SARI, Dog Bite, Typhoid, AWD (S. Cholera) and VH (B, C & D) cases were the most frequently reported diseases from Balochistan province.
- ILI cases are mostly reported from Kharan, Kachhi (Bolan), and Quetta while AD (Non-Cholera) cases are mostly reported from Usta Muhammad, Sibi and Lasbella.
- One case of Brucellosis reported from Balochistan. Field investigation is required to confirm the case.
- Measles, Rubella and Leprosy showed an increase in the number of cases. At the same time, a decline has been observed in the number of cases of Mumps, Pertussis, Chicken pox, ILI, ALRI, 5years, SARI, AD (Non-Cholera), B. Diarrhea, Typhoid, AWD (S. Cholera), Dog Bite, Malaria, Gonorrhoea and VH (B, C & D).

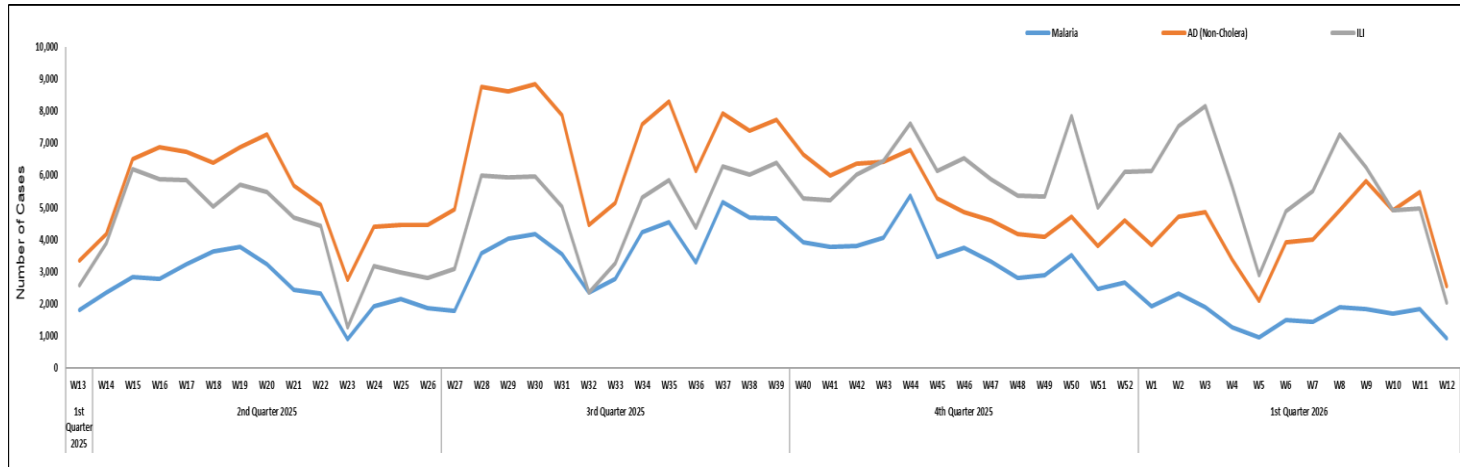
**Table 3: District wise distribution of most frequently reported suspected cases during Week 12, Balochistan.**

Districts	AD (Non-Cholera)	ILI	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Animal / Dog Bite	Typhoid	AWD (S. Cholera)	VH (B, C & D)
Awaran	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Barkhan	19	5	6	10	3	0	0	5	0	0
Chagai	128	189	18	0	33	0	0	9	0	0
Chaman	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Dera Bugti	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Duki	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Gwadar	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Harnai	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hub	75	23	23	4	6	0	4	0	0	0
Jaffarabad	62	2	70	3	5	0	8	2	0	0
Jhal Magsi	0	0	0	0	0	0	0	0	0	0
Kachhi (Bolan)	205	273	340	70	22	6	10	0	12	3
Kalat	5	0	5	2	4	0	0	9	0	0
Kech (Turbat)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kharan	148	296	8	0	58	2	0	1	0	0
Khuzdar	48	15	9	0	6	12	1	4	0	0
Killa Abdullah	44	14	1	0	5	50	1	2	3	0
Killa Saifullah	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kohlu	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lasbella	280	37	99	67	19	0	2	2	0	9
Loralai	91	131	6	6	16	31	0	3	0	0
Mastung	143	150	4	47	42	12	7	2	0	0
MusaKhel	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Naseerabad	277	14	104	46	7	14	55	22	1	2
Nushki	61	0	1	0	1	0	0	0	12	0
Panjgur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Pishin	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Quetta	134	249	0	60	1	10	1	0	0	0
Sherani	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sibi	357	308	113	38	17	32	6	11	20	0
Sohbat pur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Surab	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Usta Muhammad	385	166	79	85	51	12	9	2	0	5
Washuk	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Zhob	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Ziarat	85	146	18	19	1	13	8	8	2	0
<b>Total</b>	<b>2,547</b>	<b>2,018</b>	<b>904</b>	<b>457</b>	<b>297</b>	<b>194</b>	<b>112</b>	<b>82</b>	<b>50</b>	<b>19</b>

**Figure 4: Most frequently reported suspected cases during Week 12, Balochistan.**



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



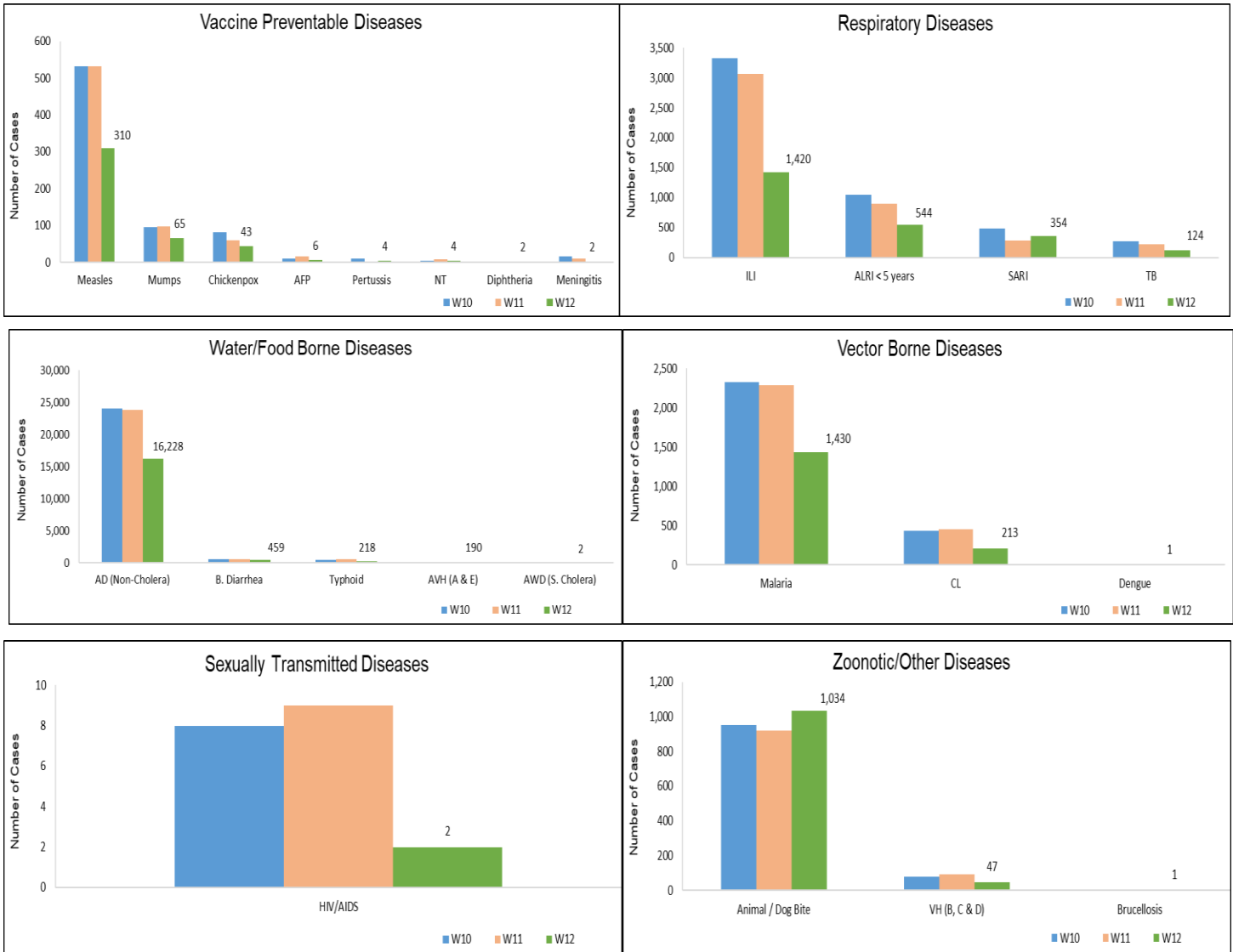
- Cases of AD (Non-Cholera) were maximum followed by Malaria, ILI, Dog Bite, ALRI<5 Years, B. Diarrhea, SARI, Measles, Typhoid, and CL.
- Pertussis, SARI and dog bite cases showed an increase in number while Measles, Mumps, Chickenpox, AFP, NT, ILI, ALRI<5years, TB, AD (non- cholera) Typhoid, Malaria, CL, HIV/AIDs and VH (B, C & D) showed a decline in number this week.
- Six cases of AFP reported from KP. All are suspected cases and need field verification.
- Two cases of HIV/AIDs reported from KP. A field investigation is required.
- One suspected case of Brucellosis was reported from KP, which requires field verification.

**Table 4: District wise distribution of most frequently reported suspected cases during Week 12, KP.**

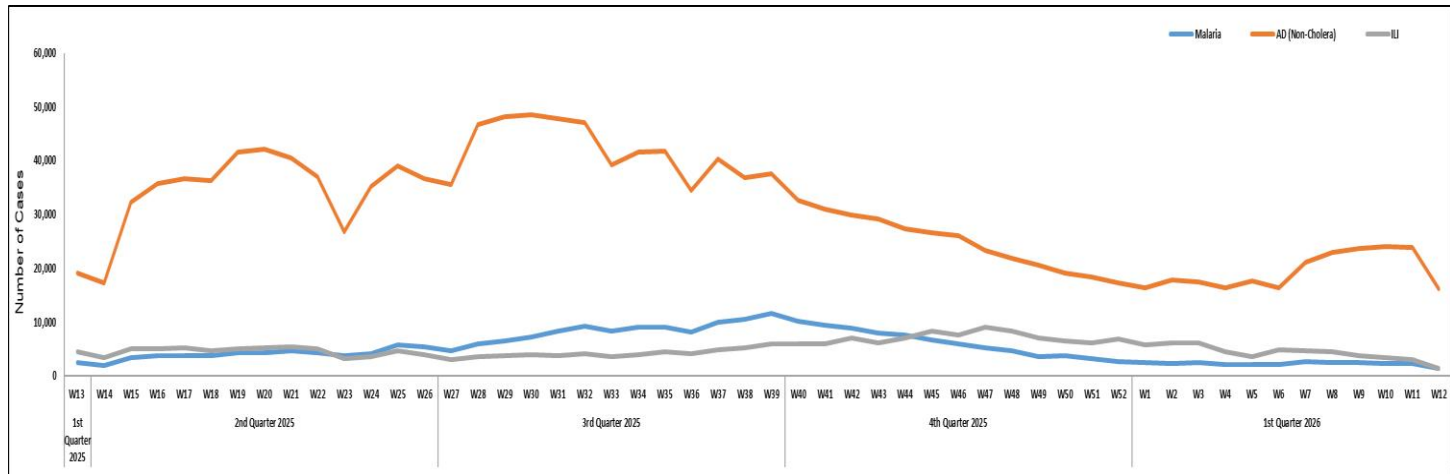
Districts	AD (Non-Cholera)	Malaria	ILI	Animal / Dog Bite	ALRI < 5 years	B. Diarrhea	SARI	Measles	Typhoid	CL
Abbottabad	429	0	77	46	10	3	3	1	1	0
Bajaur	296	52	3	83	7	16	29	2	0	8
Bannu	410	475	3	4	5	9	0	60	50	2
Battagram	104	9	163	10	0	3	0	2	0	0
Buner	111	71	0	0	0	0	0	0	2	0
Charsadda	848	102	157	39	22	46	0	38	18	0
Chitral Lower	334	4	14	11	15	11	9	0	2	3
Chitral Upper	69	1	20	3	1	2	4	0	5	1
D.I. Khan	1,663	57	0	28	17	25	0	50	0	0
Dir Lower	735	24	0	46	4	49	0	17	7	1
Dir Upper	685	3	23	7	52	12	0	1	8	0
Hangu	130	46	1	16	1	16	0	3	1	25
Haripur	654	0	140	68	32	8	4	9	15	0
Karak	213	34	10	23	28	6	0	27	4	107
Khyber	241	45	2	43	9	37	2	1	15	10
Kohat	276	11	0	26	2	8	0	3	5	11
Kohistan Lower	59	0	0	0	0	1	0	0	0	0
Kohistan Upper	212	1	0	0	0	14	0	1	0	0
Kolai Palas	40	0	14	0	4	1	10	0	1	0
L & C Kurram	43	10	5	0	2	3	0	0	3	0
Lakki Marwat	272	45	3	27	0	0	0	1	5	1
Malakand	920	5	23	0	38	0	40	5	0	2
Mansehra	238	0	36	0	0	0	0	0	0	0
Mardan	941	22	37	19	112	26	0	2	0	1
Mohmand	99	42	54	13	1	6	66	0	1	23
North Waziristan	39	30	5	1	25	14	67	12	8	5
Nowshera	877	51	9	15	7	42	7	7	5	8
Orakzai	57	0	1	0	0	8	0	0	0	0
Peshawar	1,971	7	125	9	28	29	0	29	3	0
Shangla	585	181	1	68	12	1	0	6	4	0
South Waziristan (Lower)	24	12	35	12	6	4	30	5	4	2
SWU	10	0	0	0	0	0	0	0	0	0
Swabi	881	25	256	272	34	10	72	22	34	0
Swat	1,369	11	115	124	55	23	1	5	7	0
Tank	237	40	19	0	3	4	0	1	0	0
Tor Ghar	34	6	0	6	6	6	0	0	3	3
Upper Kurram	122	8	69	15	6	16	10	0	7	0
<b>Total</b>	<b>16,228</b>	<b>1,430</b>	<b>1,420</b>	<b>1,034</b>	<b>544</b>	<b>459</b>	<b>354</b>	<b>310</b>	<b>218</b>	<b>213</b>



**Figure 6: Most frequently reported suspected cases during Week 12, KP.**



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

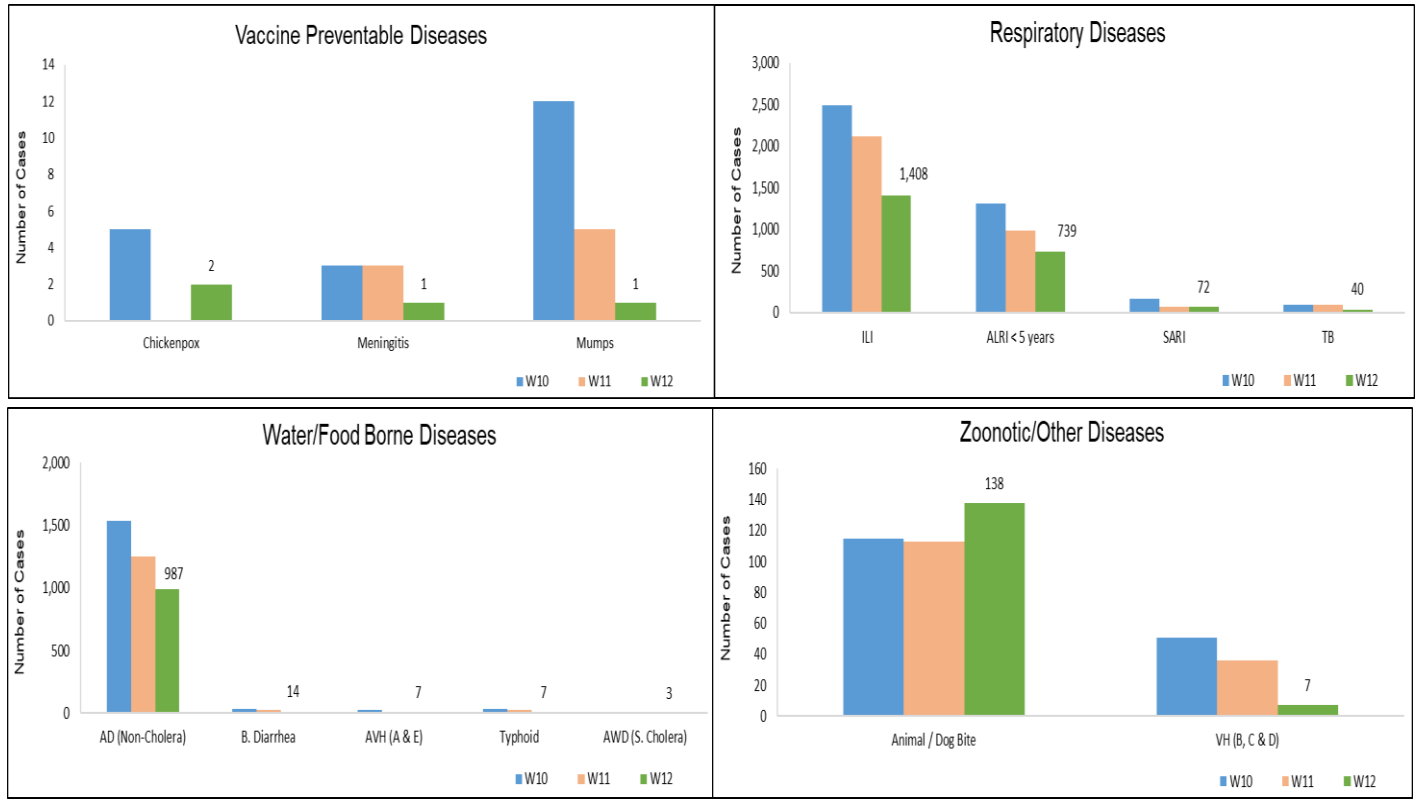


**ICT:** The most frequently reported cases from Islamabad were ILI followed by AD (Non-Cholera). ILI and AD (non – cholera) cases showed a decline in number this week.

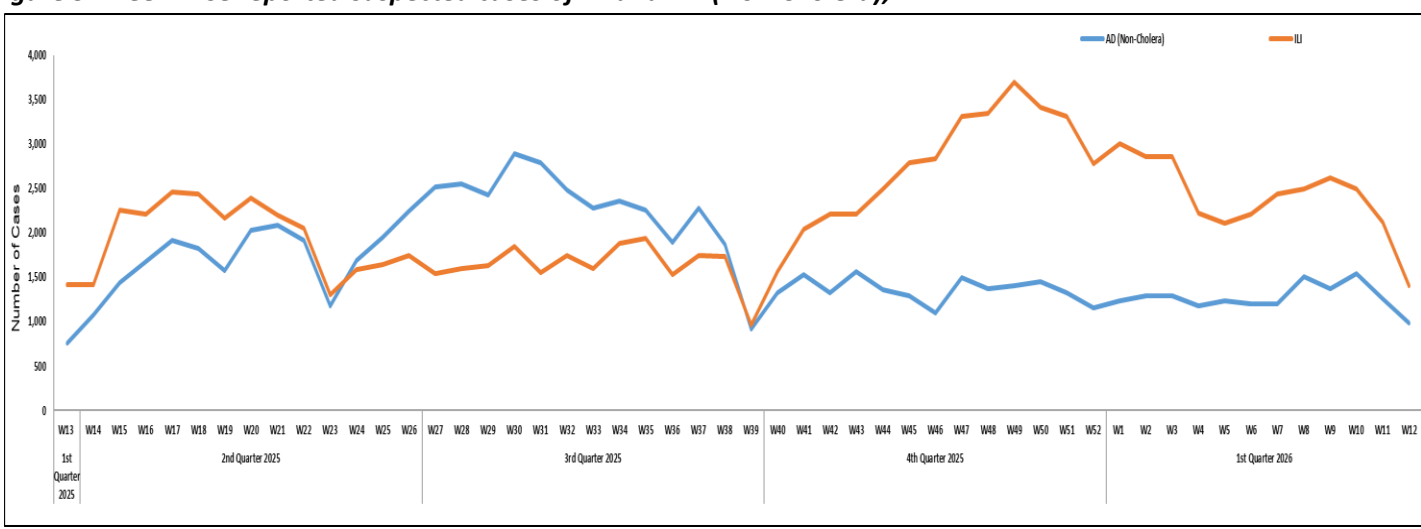
**AJK:** ILI cases were maximum followed by AD (Non-Cholera) and ALRI < 5 years cases. An increase in number of suspected cases was observed for Chicken pox and Dog Bite cases while a decline in cases observed for Meningitis, Mumps, ALRI<5 years, TB, AD (non-cholera), and VH (B, C &D) this week.

**GB:** ALRI <5 Years cases were the most frequently reported diseases, followed by AD (Non-Cholera) and ILI cases. An increase in cases is observed for ILI cases, while a decline is observed in the number of cases of AD (non-cholera), Typhoid, ALRI <5 Years, SARI, TB, and Measles this week.

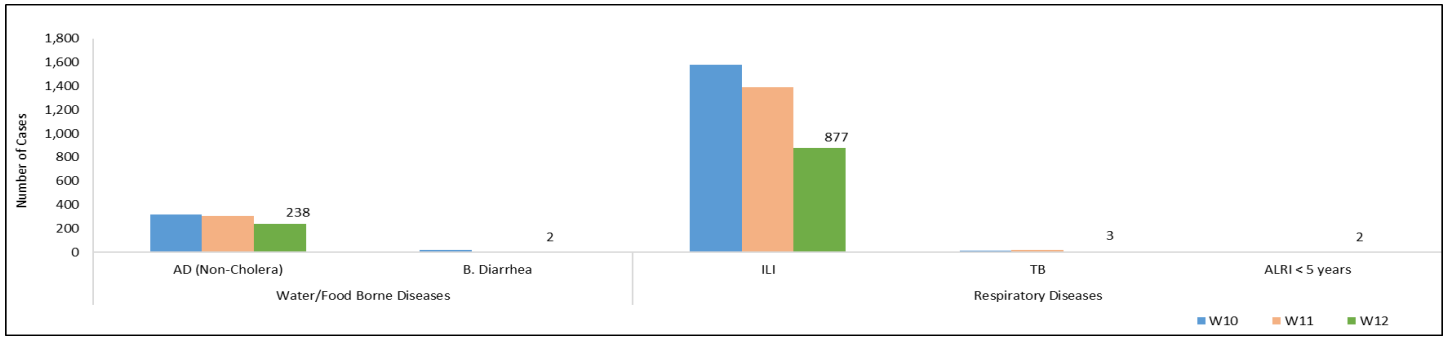
**Figure 8: Most frequently reported suspected cases during Week 12, AJK.**



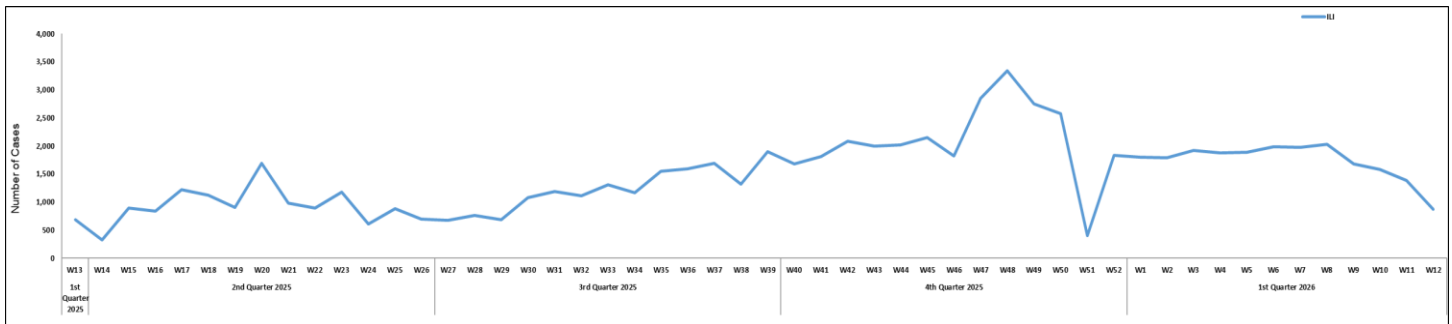
**Figure 9: Week wise reported suspected cases of ILI and AD (Non-Cholera), AJK.**



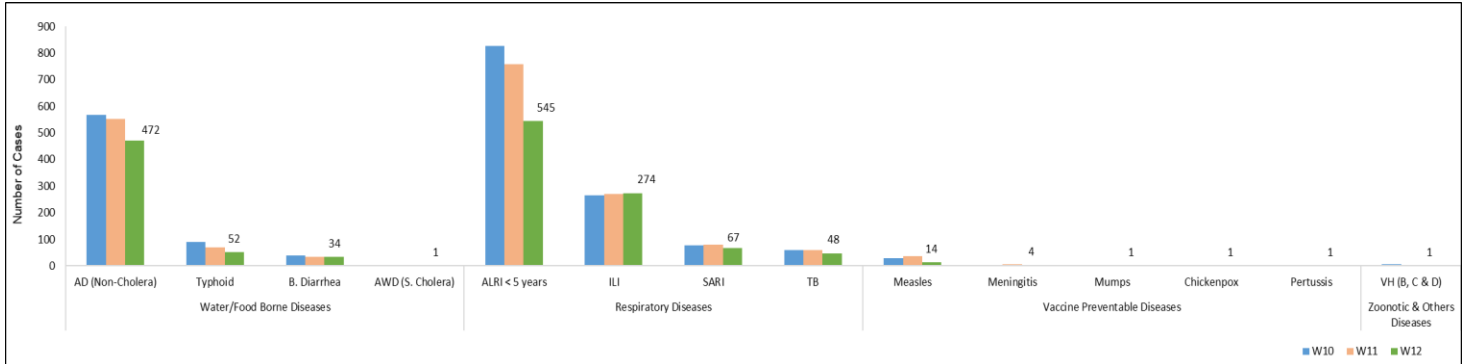
**Figure 10: Most frequently reported suspected cases during Week 12, ICT.**



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



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



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

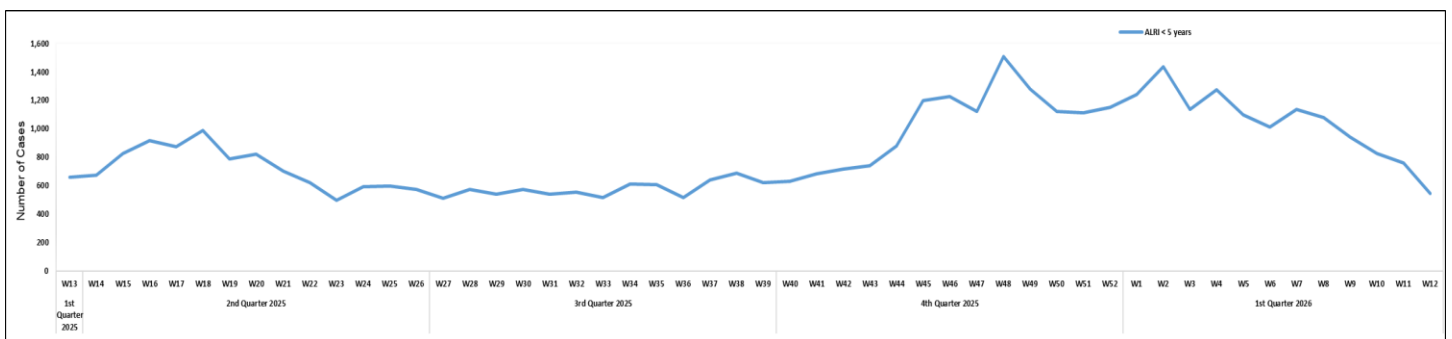


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 12, Pakistan.

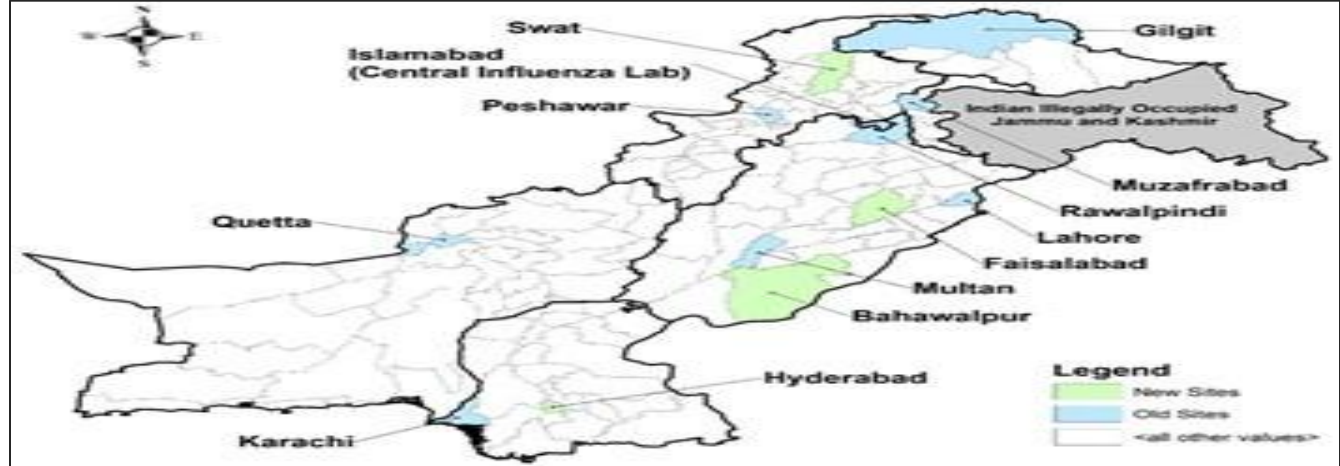
Diseases	Sindh		Balochistan		KPK		ISL		GB		Punjab		AJK	
	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos	Total Test	Total Pos
AWD (S. Cholera)	51	0	-	-	-	-	-	-	-	-	-	-	-	-
Stool culture & Sensitivity	98	1	-	-	-	-	-	-	-	-	-	-	-	-
Malaria	4,314	141	856	55	-	-	-	-	54	0	-	-	7	0
CCHF	-	-	1	0	-	-	-	-	-	-	-	-	-	-
Dengue	561	15	60	5	-	-	-	-	-	-	-	-	3	0
VH (B)	7,149	173	594	42	-	-	-	-	619	9	-	-	241	3
VH (C)	7,350	667	587	52	-	-	-	-	669	1	-	-	239	9
VH (D)	18	8	12	3	-	-	-	-	-	-	-	-	-	-
VH (A)	2	0	-	-	-	-	-	-	-	-	-	-	-	-
VH (E)	1	0	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	-	-	-	-	-	-	-	-	-	-	-	-	8	0
TB	362	36	74	6	-	-	-	-	27	0	-	-	25	0
HIV/ AIDS	2,447	24	452	1	-	-	-	-	78	0	-	-	225	0
Syphilis	693	10	142	0	-	-	-	-	51	0	-	-	-	-
Typhoid	499	5	136	27	-	-	-	-	144	7	-	-	-	-
Diphtheria	7	2	-	-	-	-	-	-	-	-	-	-	-	-
ILI	9	1	-	-	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)	4	4	-	-	-	-	-	-	-	-	-	-	-	-
Meningitis	1	0	-	-	-	-	-	-	-	-	-	-	-	-
Measles	280	89	20	8	244	97	24	11	18	7	367	93	12	2
Rubella (CRS)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Leishmaniosis (cutaneous)	-	-	16	1	-	-	-	-	-	-	-	-	-	-
Chikungunya	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chickenpox	1	0	-	-	-	-	-	-	-	-	-	-	-	-
Mpox	1	1	-	-	-	-	-	-	-	-	-	-	-	-
SARI	20	8	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	ILI	-	-	-	-	-	-	-	-	-	11	0	2	0
	SARI	-	-	-	-	-	6	0	-	-	56	0	8	0
Influenza A	ILI	-	-	-	-	-	-	-	-	-	11	0	2	0
	SARI	-	-	-	-	-	6	0	-	-	56	0	8	0
Influenza B	ILI	-	-	-	-	-	-	-	-	-	11	0	2	0
	SARI	-	-	-	-	-	6	0	-	-	56	1	8	0
RSV	ILI	-	-	-	-	-	-	-	-	-	11	0	2	0
	SARI	-	-	-	-	-	6	0	-	-	56	0	8	0



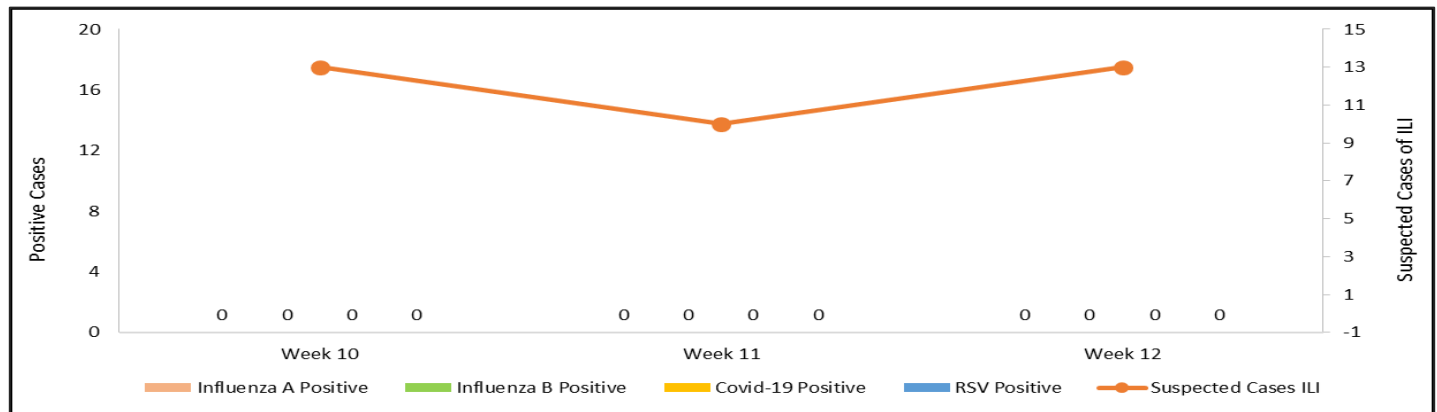
# Integrated Respiratory Viruses Sentinel Surveillance, National Influenza Centre

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 Syncytial Virus.

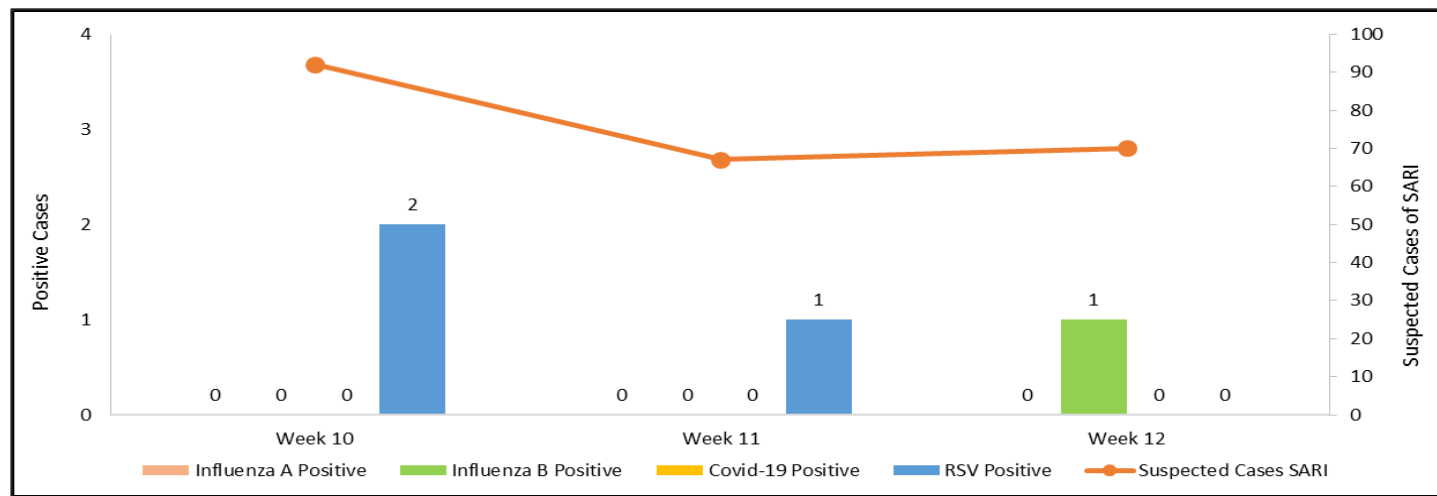
**Figure 14: District wise Influenza sentinel sites, Pakistan.**



**Figure 15: Distribution of suspected samples of ILI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 12, Pakistan.**



**Figure 16: Distribution of suspected samples of SARI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 12, Pakistan.**



# IDSR Reports Compliance

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

**Table 6: Compliance of IDSR reporting districts Week 12, Pakistan.**

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	103	93%
	Bannu	238	120	50%
	Battagram	59	42	71%
	Buner	34	13	38%
	Bajaur	44	42	95%
	Charsadda	59	57	97%
	Chitral Upper	34	30	88%
	Chitral Lower	35	34	97%
	D.I. Khan	114	114	100%
	Dir Lower	74	61	82%
	Dir Upper	37	31	84%
	Hangu	22	16	73%
	Haripur	72	72	100%
	Karak	36	36	100%
	Khyber	53	39	74%
	Kohat	61	61	100%
	Kohistan Lower	12	9	75%
	Kohistan Upper	20	13	65%
	Kolai Palas	10	10	100%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	17	40%
	Upper Kurram	41	36	88%
	Malakand	42	24	57%
	Mansehra	133	124	93%
	Mardan	80	74	93%
	Nowshera	56	50	89%
	North Waziristan	13	10	77%
	Peshawar	156	117	75%
	Shangla	37	32	86%
	Swabi	66	59	89%
	Swat	77	74	96%
	South Waziristan (Upper)	93	37	40%
	South Waziristan (Lower)	42	29	69%
Tank	34	32	94%	
Torghar	14	13	93%	
Mohmand	68	21	31%	
Orakzai	69	8	12%	
Azad Jammu Kashmir	Mirpur	39	39	100%
	Bhimber	92	41	45%
	Kotli	60	60	100%
	Muzaffarabad	45	45	100%
	Poonch	46	46	100%
	Haveli	39	39	100%



	Bagh	54	30	56%
	Neelum	39	39	100%
	Jhelum Velly	29	29	100%
	Sudhnooti	27	27	100%
<b>Islamabad Capital Territory</b>	ICT	24	22	92%
	CDA	15	5	33%
<b>Balochistan</b>	Gwadar	26	0	0%
	Kech	44	0	0%
	Khuzdar	74	7	9%
	Killa Abdullah	26	7	27%
	Lasbella	55	55	100%
	Pishin	69	0	0%
	Quetta	55	13	24%
	Sibi	36	26	72%
	Zhob	39	0	0%
	Jaffarabad	16	15	94%
	Naserabad	32	31	97%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	10	0%
	Chagi	36	18	50%
	Kalat	41	40	98%
	Harnai	17	0	0%
	Kachhi (Bolan)	35	18	51%
	Jhal Magsi	28	28	100%
	Sohbat pur	25	0	0%
	Surab	32	0	0%
	Mastung	46	45	98%
	Loralai	33	15	45%
	Killa Saifullah	28	0	0%
	Ziarat	29	21	72%
	Duki	31	0	0%
	Nushki	32	29	91%
	Dera Bugti	45	0	0%
	Washuk	46	0	0%
	Panjgur	38	0	0%
	Awaran	23	0	0%
	Chaman	24	0	0%
	Barkhan	20	3	15%
	Hub	33	20	61%
Musakhel	41	0	0%	
Usta Muhammad	34	34	100%	
<b>Gilgit Baltistan</b>	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	38	100%
	Gilgit	44	44	100%
	Diامر	62	54	87%
	Astore	55	55	100%
	Shigar	27	16	59%



	Skardu	53	52	98%
	Ganche	29	29	100%
	Kharmang	46	25	54%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	64	100%
	Umerkot	62	62	100%
	Naushahro Feroze	107	102	95%
	Tharparkar	276	266	96%
	Shikarpur	60	59	98%
	Thatta	52	49	94%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	17	81%
	Karachi-West	20	20	100%
	Karachi-Malir	35	30	86%
	Karachi-Kemari	22	21	95%
	Karachi-Central	12	11	92%
	Karachi-Korangi	18	18	100%
	Karachi-South	6	4	67%
	Sujawal	55	55	100%
	Mirpur Khas	106	105	99%
	Badin	124	122	98%
	Sukkur	64	63	98%
	Dadu	90	90	100%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	Khairpur	170	168	99%
	Kashmore	59	59	100%
	Matiari	42	42	100%
	Jamshoro	75	74	99%
	Tando Allahyar	54	54	100%
Tando Muhammad Khan	41	41	100%	
Shaheed Benazirabad	122	122	100%	



**Table 7: Compliance of IDSR reporting Tertiary care hospitals Week 12, 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	0	0%
	Mardan	1	0	0%
	Abbottabad	1	1	100%
	Swat	1	1	100%



## Notes from the field:

### Outbreak Investigation Report of Mpox, District Peshawar, Pakistan (March 2026)

#### Introduction

Mpox is a zoonotic viral disease caused by the Monkeypox virus, belonging to the Orthopoxvirus genus. It is characterized by fever, rash, and lymphadenopathy, and may lead to complications in severe cases. Globally, Mpox has re-emerged as a public health concern, particularly following multi-country outbreaks reported since 2022, affecting both endemic and non-endemic regions. The disease is primarily transmitted through close contact with infected individuals, bodily fluids, lesions, or contaminated materials. In the Eastern Mediterranean Region, sporadic cases and outbreaks have been reported, raising concerns regarding surveillance gaps and cross-border transmission.

In Pakistan, Mpox remains a relatively rare but high-priority disease due to its epidemic potential and public health implications. Early detection, isolation, and contact tracing are critical to prevent onward transmission. This report describes the investigation of a confirmed Mpox case in District Peshawar, Khyber Pakhtunkhwa.

#### Objectives

- To determine the magnitude of Mpox outbreak
- To identify potential risk factors and modes of transmission associated with the case
- To propose evidence-based recommendations for containment and prevention of future outbreaks

#### Methods

A descriptive outbreak investigation was conducted. The study population included the confirmed case and all identified close contacts in District Peshawar. The investigation was carried out in Kohati Gate and associated healthcare facilities, including Lady Reading

Hospital and Hayatabad Medical Complex, from 13 March to 28 March 2026. A suspected case was defined as “any individual presenting with acute onset of fever followed by rash or skin lesions suggestive of Mpox”, while a confirmed case was defined as “a suspected case with laboratory confirmation through PCR”.

Data were collected using a structured case investigation form, including demographic, clinical, and exposure history. Active case finding and contact tracing were conducted in the community and among healthcare contacts, alongside hospital record reviews. Laboratory samples (skin lesion specimens) were collected and sent for testing at the Public Health Reference Laboratory, Khyber Medical University using PCR. Data were analyzed descriptively.

#### Results

A total of one confirmed case of Mpox was identified during the investigation period. The patient was an 18-year-old male, residing in Kohati Gate, Peshawar. No additional cases were detected among identified contacts.

Clinically, the patient presented with fever, headache, and progressive skin lesions, initially vesicular, later becoming pustular and crusted. Lesions were primarily located in the pelvic region and subsequently increased in number and size.

Risk factor assessment did not identify any history of travel, animal exposure, or sexual contact, suggesting an unclear source of infection. Multiple healthcare visits prior to diagnosis indicated delays in clinical suspicion and referral.

Laboratory testing confirmed Mpox infection through PCR at the Public Health Reference Laboratory, KMU. All identified close contacts were traced and monitored, with no positive cases detected during the follow-up period.

#### Discussion



This investigation confirmed a single sporadic case of Mpox in District Peshawar with no evidence of secondary transmission. The absence of additional cases suggests limited spread, likely due to eventual isolation and effective contact tracing. However, the delay in diagnosis highlights gaps in clinical awareness and early detection at primary and tertiary healthcare levels. Similar challenges have been documented in other non-endemic settings, where atypical presentations and low index of suspicion contribute to delayed recognition.

The patient's unclear exposure history indicates the possibility of undetected transmission chains or environmental exposure, necessitating strengthened surveillance systems. The repeated healthcare visits before confirmation also underscore deficiencies in referral pathways and isolation capacity, particularly in high-burden tertiary hospitals.

Despite these challenges, timely laboratory confirmation and rapid public health response, including isolation and contact tracing, were critical in preventing further spread. Strengthening integrated disease surveillance and response systems remains essential to detect and respond to such emerging infections promptly.

### Conclusion

A single confirmed case of Mpox was identified in District Peshawar with no secondary transmission. Delays in diagnosis and limited isolation facilities were observed; however, effective laboratory confirmation, isolation, and contact tracing successfully contained the outbreak.

### Recommendations

- Strengthen surveillance systems for early detection of Mpox at all healthcare levels.
- Enhance isolation capacity and preparedness in tertiary care hospitals.
- Improve clinical awareness and training of healthcare providers for early recognition and referral.

- Ensure strict adherence to infection prevention and control measures in healthcare settings.
- Continue active contact tracing and monitoring of exposed individuals for at least 21 days.
- Promote community awareness regarding symptoms, transmission, and prevention of Mpox.
- Strengthen coordination between surveillance systems, laboratories, and healthcare facilities for timely reporting and response.

### References

1. World Health Organization. Mpox (monkeypox) fact sheet. Geneva: WHO; 2023.
2. Centers for Disease Control and Prevention. Monkeypox: Clinical recognition. Atlanta: CDC; 2023.
3. World Health Organization. Multi-country outbreak of mpox, External situation report. Geneva: WHO; 2022.
4. Ministry of National Health Services, Regulations and Coordination Pakistan. National guidelines for Mpox preparedness and response. Islamabad: MoNHSR&C; 2023.

## Knowledge Hub

### Measles: What You Need to Know

#### What is Measles?

Measles is caused by a virus in the paramyxovirus family. It's a vaccine-preventable disease. Before the MMR (Measles, Mumps, and Rubella) vaccine became widely available, measles was a common childhood illness. It's now rare in many parts of the world due to high vaccination rates, but outbreaks can still happen in communities where people are unvaccinated.

#### How Measles Spreads

Measles is one of the most contagious diseases known. It spreads through the air when



an infected person coughs or sneezes. The virus can remain in the air and on surfaces for up to two hours after the infected person has left.

An infected person can spread the virus for four days before the rash appears and four days after the rash appears.

### Signs & Symptoms

Symptoms usually begin 7-14 days after exposure to the virus.

Initial symptoms include:

- High fever
- Cough
- Runny nose
- Red, watery eyes
- **Koplik spots:** tiny white spots with bluish-white centers found inside the mouth on the inner cheek. These appear 2-3 days before the rash.

The characteristic measles rash appears 3-5 days after the first symptoms:

- It starts as flat, red spots on the face, along the hairline, and behind the ears.
- The rash then spreads down the body to the trunk, arms, and legs.
- The spots may become slightly raised and can merge together.

### Complications

Measles can lead to severe complications, especially in young children and adults.

Common complications:

- Ear infections
- Diarrhea
- Pneumonia: The most common cause of death from measles in young children.

More severe complications (less common):

- **Encephalitis:** Swelling of the brain, which can lead to deafness or intellectual disability.
- **Subacute Sclerosing Panencephalitis (SSPE):** A very rare, but fatal degenerative disease of the central nervous system that can develop years after a measles infection.

- **Pregnancy complications:** Measles during pregnancy can lead to premature birth or low birth weight.

### Prevention

The best way to prevent measles is through **vaccination** with the MMR vaccine.

- **Children:** The CDC and WHO recommend two doses: the first at 12-15 months of age and the second at 4-6 years of age.
- **Adults:** Adults who are not sure about their vaccination status or have certain risk factors may need one or two doses.

### Diagnosis and Treatment

- **Diagnosis:** Measles is diagnosed by a doctor based on symptoms, vaccination history, and laboratory tests (blood or swab tests).
- **Treatment:** There is no specific antiviral treatment for measles. Care focuses on supportive measures to relieve symptoms:
  - Rest and plenty of fluids.
  - Fever reducers like acetaminophen (paracetamol). Do **NOT** give aspirin to children or teenagers due to the risk of Reye's syndrome.
  - Vitamin A supplementation for all children diagnosed with measles, as it can reduce the risk of severe outcomes.

### More Information

For additional authoritative information on measles, please visit:

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



# MEASLES

## IT ISN'T JUST A LITTLE RASH



Measles can be dangerous, especially for babies and young children.

Measles symptoms typically include:



**High fever**  
(may spike to more than 104°F)



**Cough**



**Runny nose**



**Red and/or watery eyes**



**Rash**  
(breaks out 3-5 days after symptoms begin)

### Measles can be serious.

Measles can cause severe health complications, including pneumonia, swelling of the brain (encephalitis) and death.



**1 out of 5** people who get measles will be hospitalized.



**1 out of every 20** children with measles will get pneumonia, the most common cause of death from measles in young children.



**1 out of every 1,000** people with measles will develop brain swelling, which may lead to brain damage.



**1 to 3 out of 1,000** people with measles will die.

#### Long-term complications

A very rare, but deadly disease called subacute sclerosing panencephalitis can develop 7 to 10 years after a person has recovered from measles.



[www.cdc.gov/measles](http://www.cdc.gov/measles)



### You have the power to protect your child.

Provide your children with safe and long-lasting protection against measles by making sure they get the measles-mumps-rubella (MMR) vaccine. Talk to your healthcare provider.

	<a href="https://phb.nih.org.pk/">https://phb.nih.org.pk/</a>		<a href="https://twitter.com/NIH_Pakistan">https://twitter.com/NIH_Pakistan</a>
	<a href="mailto:idsr-pak@nih.org.pk">idsr-pak@nih.org.pk</a>		<a href="https://www.facebook.com/NIH.PK/">https://www.facebook.com/NIH.PK/</a>