PUBLIC HEALTH BULLETIN-PAKISTAN

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Integrated Disease Surveillance & Response (IDSR) Report

Center of Disease Control
National Institute of Health, Islamabad

PAKISTAN

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 15, 2026

The Public Health Bulletin (PHB) provides timely, reliable, and actionable health information to the public and professionals. It disseminates key IDSR data, outbreak reports, and seasonal trends, along with actionable public health recommendations. Its content is carefully curated 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*
- *Laboratory-Confirmed Mpox Case – District Swabi, Pakistan*
- *Knowledge hub on Typhoid Fever: 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

Note: All reported cases in this report are suspected cases

- *During week 15, the highest number of cases were of Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, ALRI <5 years, TB, Dog Bite, B. Diarrhea (5,266), VH (B, C & D) (5,210), Typhoid and SARI.*
- *• A total of forty-five cases of AFP were reported, including twenty-one from KP, twenty from Sindh, three from AJK and one from GB.*
- *• Fifteen suspected cases of HIV/AIDS were reported, including nine from Sindh, four from KP and two from Balochistan.*
- *• Two suspected cases of Brucellosis were reported from KP.*
- *Among VPDs, there is an increase in number of cases of Measles, Mumps, Pertussis and Rubella (CRS) this week.*
- *Among Respiratory diseases, there is an increase in number of cases of ALRI <5 years and SARI this week.*
- *Among Water/food-borne diseases, there is an increase in number of cases of AVH (A & E) and AWD (S. Cholera) this week.*
- *Among Vector-borne diseases, there is an increase in number of cases of Chikungunya this week.*
- *Among STDs, there is a decline in number of cases of HIV/AIDs this week.*

IDSR compliance attributes

- *The national compliance rate for IDSR reporting in 158 implemented districts is 84%*
- *Sindh is the top reporting regions with a compliance rate of 97%, followed by GB 86%, AJK 86% and ICT 76%.*
- *The lowest compliance rate was observed in KP 77% and Balochistan 57%.*

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2,234	1,722	77
Azad Jammu Kashmir	469	405	86
Islamabad Capital Territory	38	29	76
Balochistan	1,308	648	57
Gilgit Baltistan	417	359	86
Sindh	2,111	2,081	99
National	6,577	5,214	84

UK Health Security Agency

World Health Organization

CDC
U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

Public Health Actions

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

Typhoid

- **Enhance Case Detection and Reporting:** Strengthen typhoid surveillance within the Integrated Disease Surveillance and Response (IDSR) system by training healthcare providers on standard case definitions, timely notification, and outbreak detection, particularly in high-burden and underserved areas.
- **Improve Laboratory Diagnosis:** Expand laboratory diagnostic capacity for typhoid by supporting culture and sensitivity testing for MDR and XDR detection at district and provincial levels to confirm cases and guide antimicrobial stewardship.
- **Promote Water, Sanitation, and Hygiene (WASH):** Collaborate with relevant sectors to ensure access to safe drinking water, improve sanitation infrastructure, and promote hygiene practices, especially handwashing with soap.
- **Implement Vaccination Strategies:** Support the scale-up of Typhoid Conjugate Vaccine (TCV) through routine immunization and targeted campaigns in high-risk populations.
- **Raise Community Awareness:** Develop culturally appropriate health education campaigns to inform communities about transmission routes, preventive behaviors (e.g., safe food handling and hygiene), and the importance of early care-seeking.

Acute Viral Hepatitis (A & E)

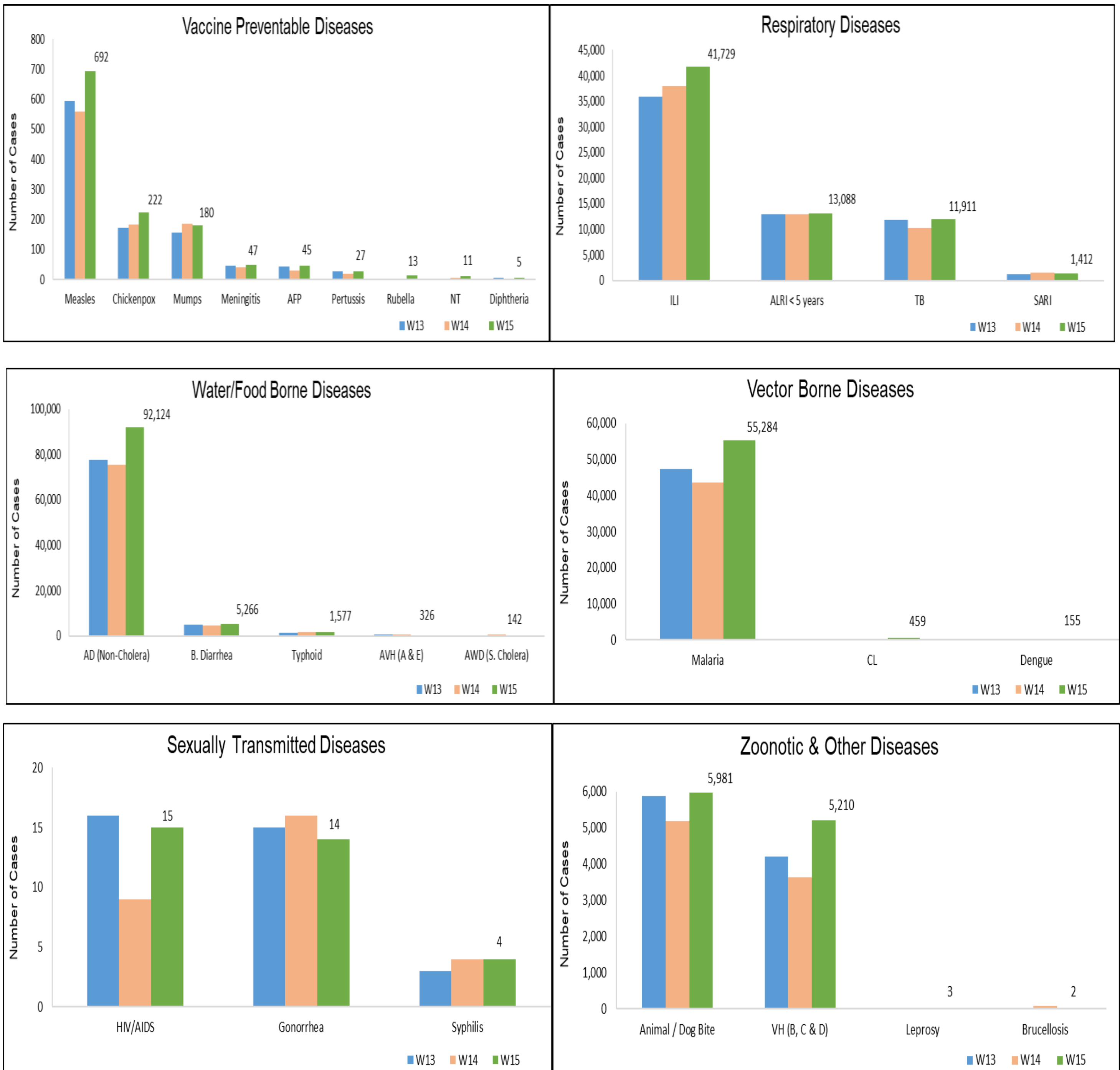
- **Enhance Case Detection and Reporting:** Strengthen AHV (A & E) surveillance in the IDSR system by training health personnel to recognize symptoms and ensure timely reporting, especially during seasonal peaks or in outbreak-prone areas.
- **Strengthen Laboratory Confirmation:** Improve diagnostic 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.

Pakistan

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 15, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	1,695	6,349	518	503	29,809	NR	53,250	92,124
Malaria	0	1,833	0	0	2,976	NR	50,475	55,284
ILI	1,706	6,517	164	1,408	2,526	NR	29,408	41,729
ALRI < 5 years	1,041	1,265	550	2	696	NR	9,534	13,088
TB	81	19	65	13	221	NR	11,512	11,911
Animal / Dog Bite	115	142	4	1	1,341	NR	4,378	5,981
B. Diarrhea	46	755	44	1	781	NR	3,639	5,266
VH (B, C & D)	21	34	2	0	150	NR	5,003	5,210
Typhoid	24	276	73	0	410	NR	794	1,577
SARI	159	582	45	0	259	NR	367	1,412
Measles	19	12	3	1	528	NR	129	692
CL	0	23	0	0	429	NR	7	459
AVH (A & E)	19	3	0	0	102	NR	202	326
Chickenpox/ Varicella	4	12	2	1	98	NR	105	222
Mumps	8	24	2	0	94	NR	52	180
Dengue	0	68	0	0	0	NR	87	155
AWD (S. Cholera)	4	101	4	0	2	NR	31	142
Meningitis	3	0	7	0	23	NR	14	47
AFP	3	0	1	0	21	NR	20	45
Pertussis	0	24	0	0	3	NR	0	27
HIV/AIDS	0	2	0	0	4	NR	9	15
Gonorrhea	0	7	0	0	1	NR	6	14
Rubella	0	3	0	0	2	NR	8	13
NT	0	0	0	0	2	NR	9	11
Diphtheria	0	1	0	0	4	NR	0	5
Syphilis	0	0	0	0	0	NR	4	4
Leprosy	0	3	0	0	0	NR	0	3
Brucellosis	0	0	0	0	2	NR	0	2

Figure 1: Most frequently reported suspected cases during Week 15, Pakistan.



Sindh

- The most frequently reported cases were of Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, TB, ALRI <5 years, VH (B, C & D), Dog Bite, B. Diarrhea, Typhoid and SARI.
- Acute Diarrhea (Non-Cholera) and ILI cases were mainly reported from Khairpur, Mirpurkhas and Badin, while Malaria cases were concentrated in Khairpur, Sanghar and Dadu
- TB and ALRI <5 years cases were higher in Khairpur, Sanghar and Dadu, whereas VH (B, C & D) cases were predominantly reported from Sanghar, Ghotki and Matiari; SARI cases were reported from Khairpur, Sujawal and Sukkur.

Table 2: District wise distribution of most frequently reported suspected cases during Week 15, Sindh.

Districts	AD (Non-Cholera)	Malaria	ILI	TB	ALRI < 5 years	VH (B, C & D)	Animal / Dog Bite	B. Diarrhea	Typhoid	SARI
Badin	3,809	2,591	3,200	746	347	206	113	361	88	0
Dadu	2,108	3,207	879	489	1,086	87	304	353	95	0
Ghotki	1,129	2,490	12	485	391	633	297	111	0	0
Hyderabad	2,999	668	1,671	369	180	113	74	78	1	0
Jacobabad	708	1,664	823	220	301	140	230	88	18	0
Jamshoro	2,172	2,204	88	563	411	137	119	102	53	2
Kamber	1,668	3,142	0	723	252	88	238	138	16	0
Karachi Central	1,781	15	1,912	260	235	17	137	1	88	0
Karachi East	403	22	15	21	14	3	4	13	0	0
Karachi Keamari	762	14	510	14	49	0	9	25	6	0
Karachi Korangi	404	61	19	67	2	0	7	11	0	0
Karachi Malir	1,562	78	2,179	100	262	8	50	62	7	4
Karachi South	94	14	0	0	0	0	0	0	0	0
Karachi West	880	317	1,280	87	238	19	73	15	19	3
Kashmore	349	1,773	241	118	43	9	255	24	3	0
Khairpur	3,187	4,311	5,761	938	1,159	256	442	397	174	112
Larkana	1,825	3,556	4	675	309	31	101	292	2	0
Matiari	2,234	2,351	72	673	309	451	133	82	0	0
Mirpurkhas	4,002	1,688	4,049	739	459	47	212	156	17	0
Naushero Feroze	1,535	1,898	1,100	399	401	71	305	234	43	1
Sanghar	2,732	4,036	68	971	427	1,784	237	93	23	0
Shaheed Benazirabad	1,980	2,131	2	291	196	108	191	112	78	0
Shikarpur	1,285	1,819	4	248	254	103	277	175	4	3
Sujawal	2,441	944	0	158	149	45	80	101	9	126
Sukkur	1,410	1,395	1,957	397	287	132	206	117	5	103
Tando Allahyar	2,565	1,581	1,047	394	168	135	62	113	6	0
Tando Muhammad Khan	1,405	725	90	508	137	96	136	138	0	0
Tharparkar	2,335	2,054	1,171	478	707	63	0	142	13	12
Thatta	1,465	1,471	1,254	50	527	185	86	15	6	1
Umerkot	2,021	2,255	0	331	234	36	0	90	20	0
Total	53,250	50,475	29,408	11,512	9,534	5,003	4,378	3,639	794	367

Figure 2: Most frequently reported suspected cases during Week 15, Sindh.

Vaccine Preventable Diseases

Number of Cases

140 120 100 80 60 40 20 0

129 105 52 20 14 9 8

Measles Chickenpox Mumps AFP Meningitis NT Rubella

W13 W14 W15

Respiratory Diseases

Number of Cases

35,000 30,000 25,000 20,000 15,000 10,000 5,000 0

29,408 11,512 9,534 367

ILI TB ALRI < 5 years SARI

W13 W14 W15

Water/Food Borne Diseases

Number of Cases

60,000 50,000 40,000 30,000 20,000 10,000 0

53,250 3,639 794 202 31

AD (Non-Cholera) B. Diarrhea Typhoid AVH (A & E) AWD (S. Cholera)

W13 W14 W15

Vector Borne Diseases

Number of Cases

60,000 50,000 40,000 30,000 20,000 10,000 0

50,475 87 7

Malaria Dengue CL

W13 W14 W15

Sexually Transmitted Diseases

Number of Cases

12 10 8 6 4 2 0

9 6 4

HIV/AIDS Gonorrhea Syphilis

W13 W14 W15

Zoonotic/Other Diseases

Number of Cases

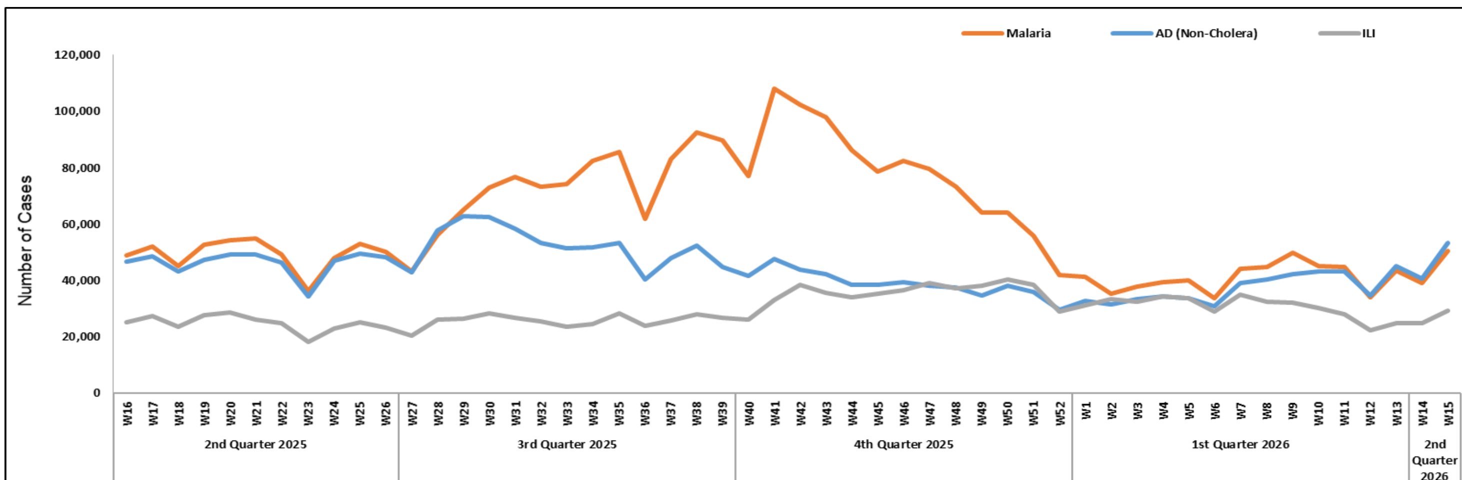
6,000 5,000 4,000 3,000 2,000 1,000 0

5,003 4,378

VH (B, C & D) Animal / Dog Bite

W13 W14 W15

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



Balochistan

- The most frequently reported cases were of ILI, followed by Acute Diarrhea (Non-Cholera), Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, Animal/Dog Bite and AWD (Suspected Cholera).
- ILI and Acute Diarrhea (Non-Cholera) cases were predominantly reported from Gwadar, Quetta and Sibi, while Malaria cases were concentrated in Sibi, Lasbella and Kachhi (Bolan).
- ALRI <5 years cases were higher in Lasbella, Usta Muhammad and Quetta, whereas SARI cases were mainly reported from Killa Abdullah, Sibi and Loralai; AWD (Suspected Cholera) cases were reported from Sibi, Kachhi (Bolan) and Ziarat.

Table 3: District wise distribution of most frequently reported suspected cases **during** ***Week 15, Balochistan.***

Districts	ILI	AD (Non-Cholera)	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	Animal / Dog Bite	AWD (S. Cholera)	ILI
Awaran	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Barkhan	45	78	34	32	8	0	24	4	3	45
Chagai	253	197	35	0	57	0	9	0	0	253
Chaman	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Dera Bugti	0	1	0	1	0	0	0	0	0	0
Duki	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Gwadar	1,281	777	69	4	100	NR	35	NR	NR	1,281
Harnai	118	169	57	7	49	0	0	2	0	118
Hub	84	240	73	14	14	0	3	1	0	84
Jaffarabad	52	134	104	2	4	0	2	0	0	52
Jhal Magsi	49	106	68	67	0	0	0	0	0	49
Kachhi (Bolan)	255	222	215	71	32	9	0	28	20	255
Kalat	0	17	0	12	0	0	1	0	0	0
Kech (Turbat)	560	407	198	4	60	NR	8	NR	NR	560
Kharan	510	224	7	3	80	46	10	0	0	510
Khuzdar	57	67	27	9	31	0	14	0	0	57
Killa Abdullah	175	232	4	28	34	120	18	20	17	175
Killa Saifullah	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Kohlu	59	30	NR	13	10	7	7	NR	NR	59
Lasbella	68	548	267	226	42	3	3	15	0	68
Loralai	463	282	20	60	41	95	27	3	0	463
Mastung	289	268	23	77	43	71	15	12	0	289
MusaKhel	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Naseerabad	9	371	186	40	17	16	41	11	0	9
Nushki	0	105	3	5	31	0	0	0	0	0
Panjgur	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Pishin	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Quetta	1,012	420	2	145	23	54	9	0	5	1,012
Sherani	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sibi	670	604	297	124	33	118	32	5	35	670
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	198	588	109	186	44	6	5	24	0	198
Washuk	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Zhob	58	75	NR	43	2	29	1	2	3	58
Ziarat	252	187	18	92	0	8	12	15	18	252
Total	6,517	6,349	1,833	1,265	755	582	276	142	101	6,517

Figure 4: Most frequently reported suspected cases during Week 15, Balochistan.

Vaccine Preventable Diseases
Number of Cases
50
40
30
20
10
0
Pertussis 24
Mumps 24
Measles 12
Chickenpox 12
Rubella 3
Diphtheria 1
W13 W14 W15

Respiratory Diseases
Number of Cases
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
ILI 6,517
ALRI < 5 years 1,265
SARI 582
TB 19
W13 W14 W15

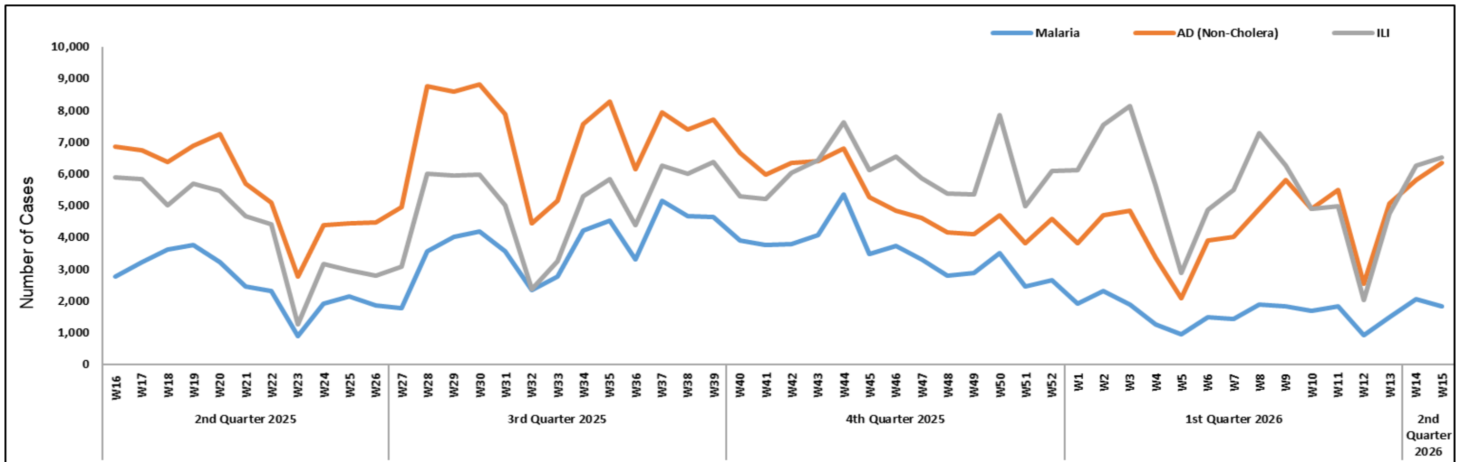
Water/Food Borne Diseases
Number of Cases
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
AD (Non-Cholera) 6,349
B. Diarrhea 755
Typhoid 276
AWD (S. Cholera) 101
AVH (A & E) 3
W13 W14 W15

Vector Borne Diseases
Number of Cases
2,500
2,000
1,500
1,000
500
0
Malaria 1,833
Dengue 68
CL 23
W13 W14 W15

Sexually Transmitted Diseases
Number of Cases
14
12
10
8
6
4
2
0
Gonorrhea 12 7
HIV/AIDS 0 2
W13 W14 W15

Zoonotic/Other Diseases
Number of Cases
250
200
150
100
50
0
Animal / Dog Bite 142
VH (B, C & D) 34
Leprosy 3
W13 W14 W15

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



Khyber Pakhtunkhwa

- The most frequently reported cases were of Acute Diarrhea (Non-Cholera), followed by Malaria, ILI, Animal/Dog Bite, B. Diarrhea, ALRI <5 years, Measles, CL, Typhoid and SARI.
- Acute Diarrhea (Non-Cholera) cases were predominantly reported from Peshawar, D.I. Khan and Swat, while Malaria cases were concentrated in Bannu, Shangla and Charsadda; ILI cases were higher in Swabi, Charsadda and Abbottabad.
- Animal/Dog Bite cases were mainly reported from Swabi, Swat and Shangla, whereas Measles cases were higher in Bannu, D.I. Khan and Peshawar; SARI cases were reported from Upper Kurram, South Waziristan (Lower) and Bajaur.field verification.

Table 4: District wise distribution of most frequently reported suspected cases during Week 15, KP.

Districts	AD (Non-Cholera)	Malaria	ILI	Animal / Dog Bite	B. Diarrhea	ALRI < 5 years	Measles	CL	Typhoid	SARI
Abbottabad	842	3	277	60	0	41	7	0	10	26
Bajaur	585	100	3	97	28	7	19	28	0	39
Bannu	825	891	3	4	7	8	103	16	73	0
Battagram	276	23	316	0	10	12	0	0	2	0
Buner	240	28	0	0	0	0	0	0	3	0
Charsadda	1,949	315	352	36	119	129	28	1	60	2
Chitral Lower	516	6	20	14	22	14	0	5	6	9
Chitral Upper	101	1	18	5	5	5	0	0	8	4
D.I. Khan	2,508	187	0	28	39	29	84	4	0	0
Dir Lower	1,233	32	0	56	59	7	26	3	19	0
Dir Upper	1,107	6	32	9	13	34	5	0	9	2
Hangu	402	85	9	15	76	1	0	18	3	0
Haripur	1,515	0	243	81	0	67	4	0	9	24
Karak	477	55	14	33	21	45	33	162	7	0
Khyber	618	144	23	51	82	10	1	61	35	4
Kohat	583	43	0	68	18	3	0	65	11	0
Kohistan Lower	102	3	0	0	11	0	0	1	2	0
Kohistan Upper	378	1	0	2	22	5	0	0	0	0
Kolai Palas	91	0	4	0	1	2	0	0	0	0
L & C Kurram	6	10	1	0	11	3	0	0	2	0
Lakki Marwat	670	143	0	67	3	0	7	0	10	0
Malakand	387	17	53	0	0	13	6	1	0	6
Mansehra	166	0	6	0	0	0	0	0	4	0
Mardan	1,808	42	9	13	28	51	28	1	29	0
Mohmand	99	54	12	1	2	0	3	53	1	13
North Waziristan	54	64	3	3	8	18	15	1	10	9
Nowshera	2,099	146	28	63	26	21	40	3	6	1
Orakzai	100	6	4	4	4	0	0	0	0	0
Peshawar	4,694	13	229	12	56	30	70	0	27	0
Shangla	825	343	0	167	6	4	4	0	18	0
South Waziristan (Lower)	69	22	110	20	1	32	3	0	23	42
SWU	39	11	7	3	0	1	0	0	1	6
Swabi	1,335	48	507	191	8	16	33	0	6	27
Swat	2,351	14	80	191	46	77	4	0	11	0
Tank	448	86	23	0	6	2	5	0	0	0
Tor Ghar	80	18	0	15	14	6	0	6	1	0
Upper Kurram	231	16	140	32	29	3	0	0	4	45
Total	29,809	2,976	2,526	1,341	781	696	528	429	410	259

Figure 6: Most frequently reported suspected cases during Week 15, KP.

Vaccine Preventable Diseases

Number of Cases

Measles 528; Chickenpox 98; Mumps 94; Meningitis 23; AFP 21; Diphtheria 4; Pertussis 3; NT 2; Rubella (CRS) 2

W13 W14 W15

Respiratory Diseases

Number of Cases

ILI 2,526; ALRI < 5 years 696; SARI 259; TB 221

W13 W14 W15

Water/Food Borne Diseases

Number of Cases

AD (Non-Cholera) 29,809; B. Diarrhea 781; Typhoid 410; AVH (A & E) 102; AWD (S. Cholera) 2

W13 W14 W15

Vector Borne Diseases

Number of Cases

Malaria 2,976; CL 429

W13 W14 W15

Sexually Transmitted Diseases

Number of Cases

HIV/AIDS 4; Gonorrhea 1

W13 W14 W15

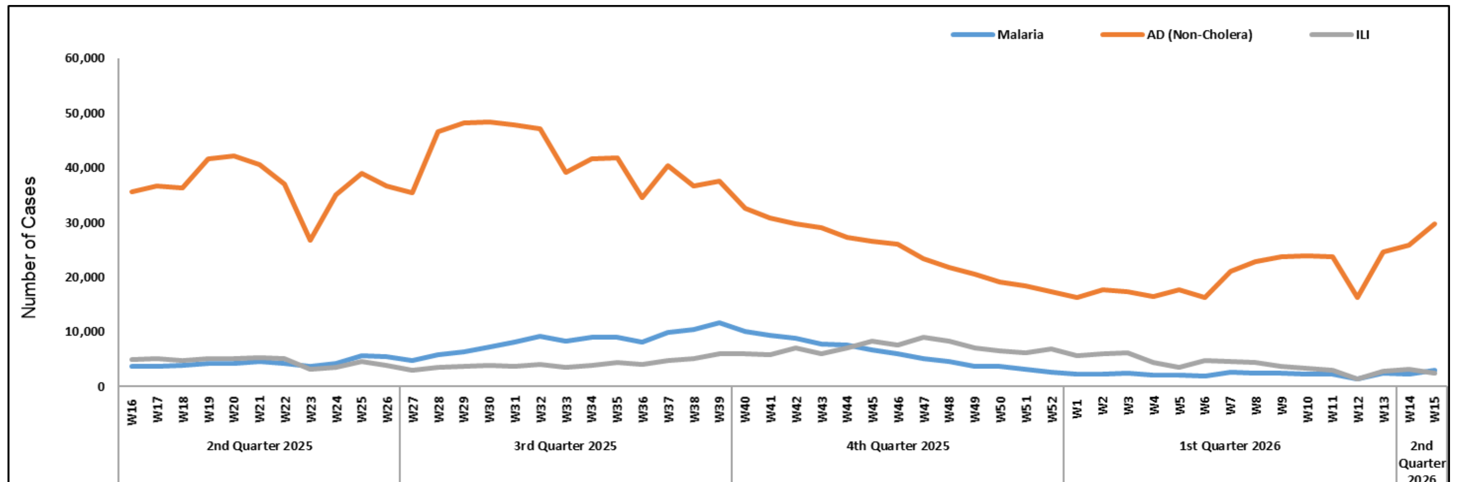
Zoonotic/Other Diseases

Number of Cases

Animal / Dog Bite 1,341; VH (B, C & D) 150; Brucellosis 2

W13 W14 W15

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



ICT, AJK & GB

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

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

GB: ALRI <5 Years cases were the most frequently reported diseases followed by AD (Non-Cholera), ILI, SARI, TB, Typhoid, B. Diarrhea, Chickenpox/ Varicella, AVH (A & E), VH (B, C & D), Measles and Pertussis cases. An increase in cases is observed for

Figure 8: Most frequently reported suspected cases during Week 15, AJK.

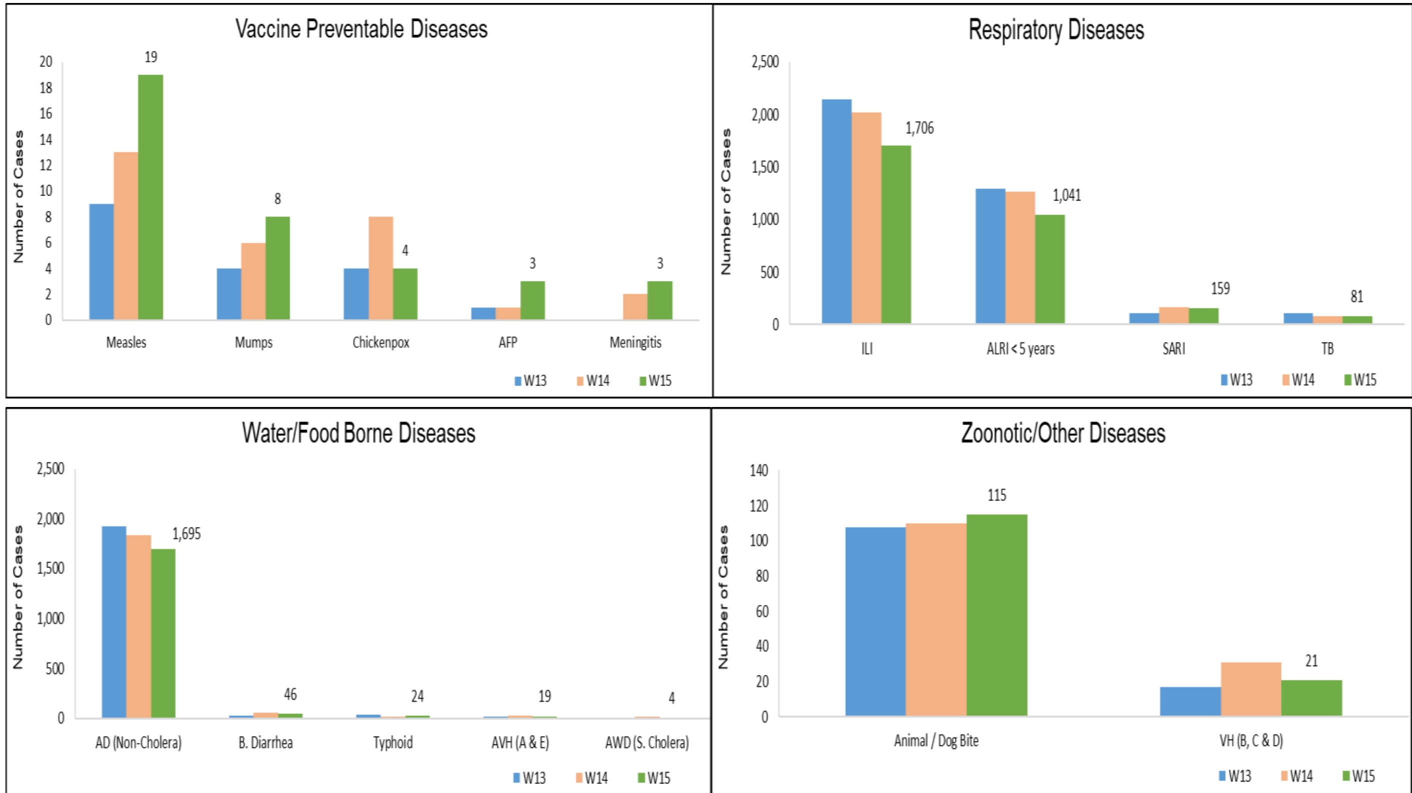


Figure 9: Week wise reported suspected cases of ILI and AD (Non-Cholera), AJK.

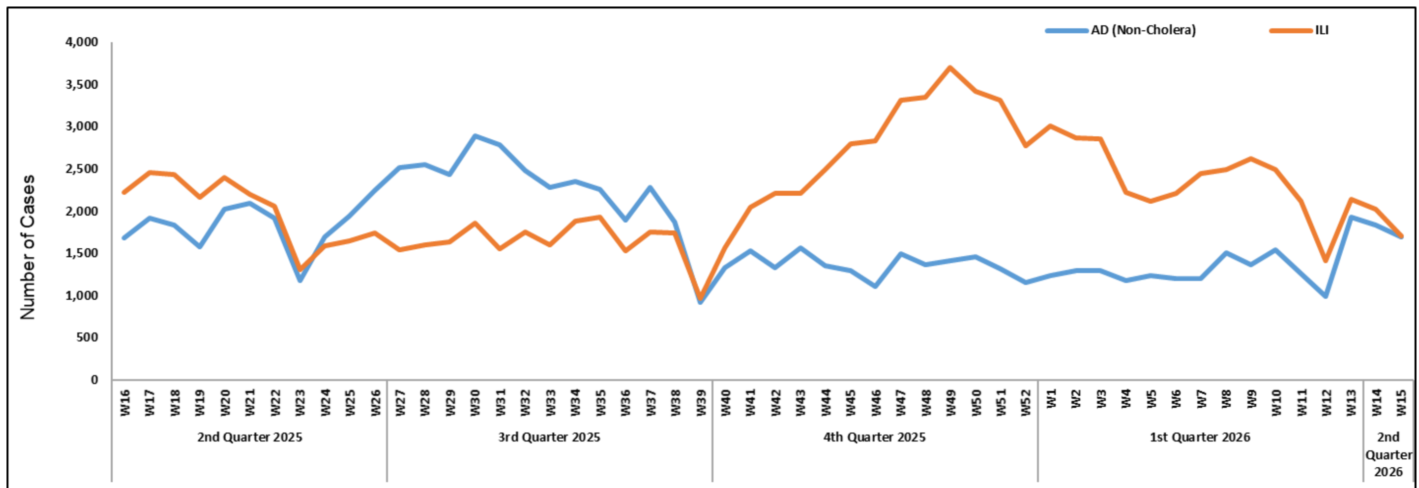


Figure 10: Most frequently reported suspected cases during Week 15, ICT.

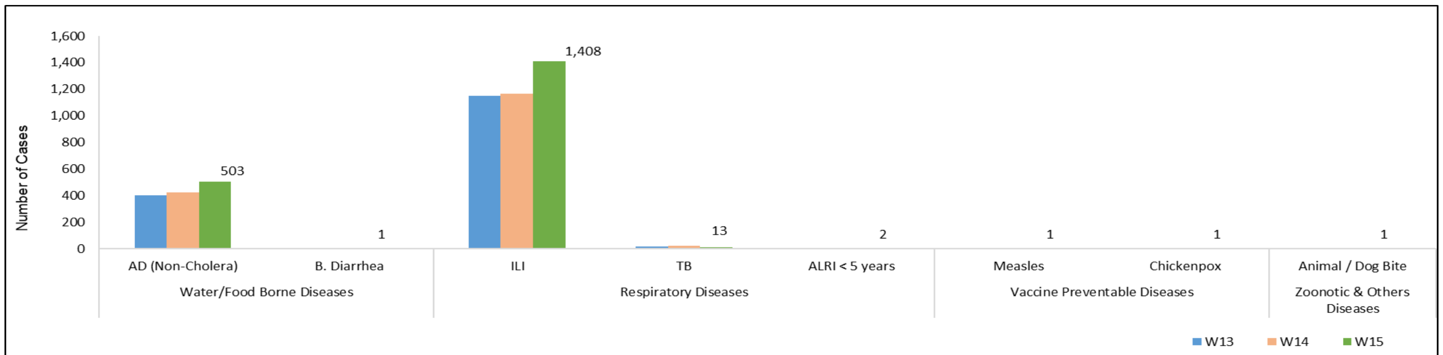


Figure 11: Week wise reported suspected cases of ILI, ICT.

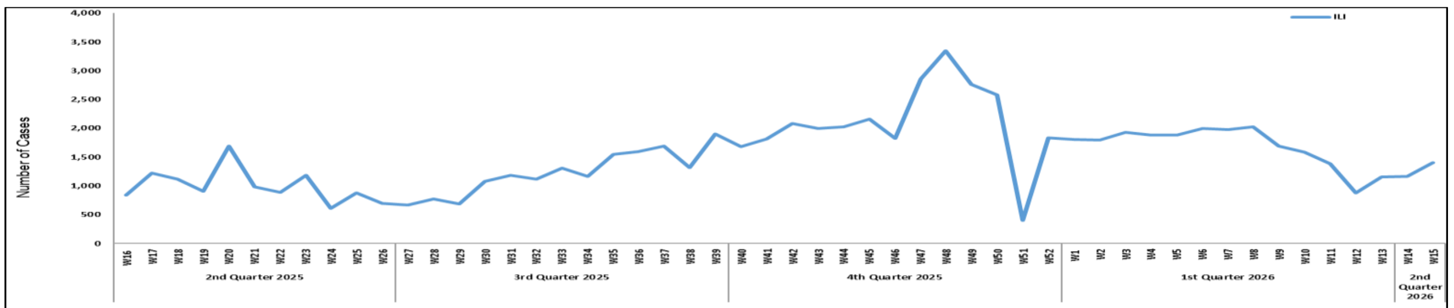


Figure 12: Most frequently reported suspected cases during Week 15, GB.

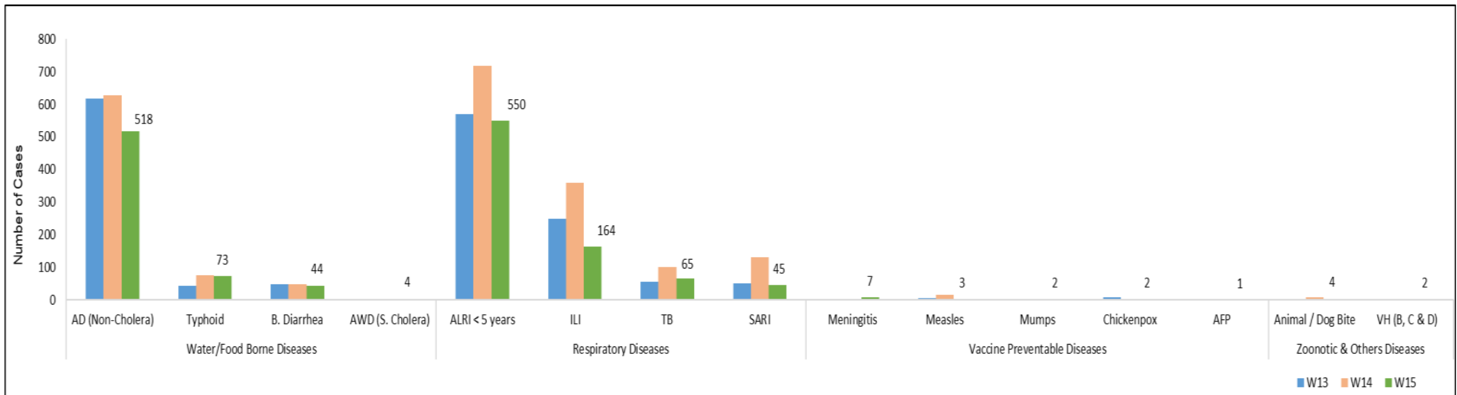


Figure 13: Week wise reported suspected cases of AD (Non-Cholera), GB.

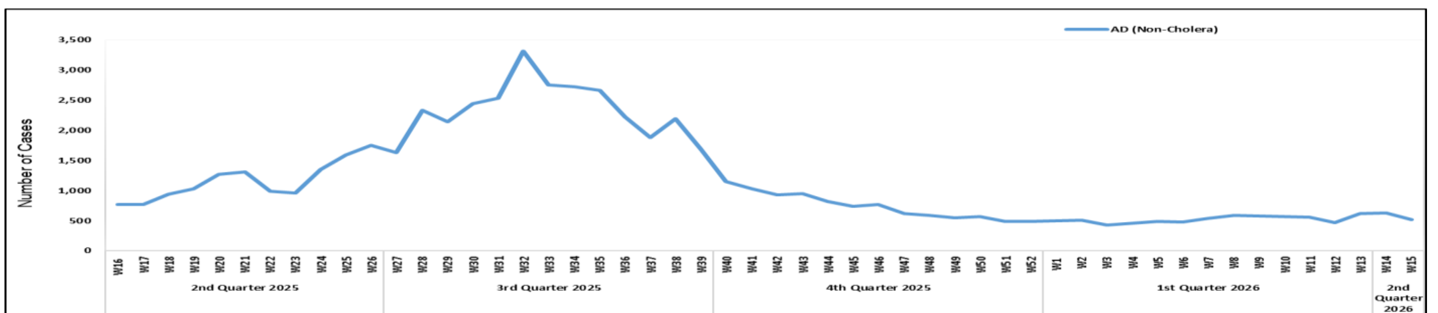


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Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epi Week 15, Pakistan.

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)		67	2	-	-	-	-	-	-	-	-	-	-	-	-
Stool culture & Sensitivity		274	2	-	-	10	0	-	-	-	-	-	-	-	-
Malaria		6,671	291	2,414	129	8	0	-	-	188	0	-	-	20	0
CCHF		-	-	5	1	-	-	-	-	-	-	-	-	-	-
Dengue		1,529	52	632	65	2	0	-	-	-	-	-	-	12	0
VH (B)		17,192	473	1,194	112	-	-	-	-	1,639	14	-	-	729	4
VH (C)		17,503	1,735	1,117	91	-	-	-	-	1,725	5	-	-	728	18
VH (D)		60	12	-	-	-	-	-	-	-	-	-	-	-	-
VH (A)		137	34	-	-	-	-	-	-	-	-	-	-	-	-
VH (E)		33	7	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19		1	0	3	0	-	-	-	-	-	-	-	-	4	2
TB		1,063	106	226	25	-	-	-	-	133	2	-	-	7	1
HIV/ AIDS		5,844	41	813	2	-	-	-	-	268	0	-	-	619	0
Syphilis		1,496	23	125	1	-	-	-	-	184	0	-	-	-	-
Typhoid		761	11	90	8	-	-	-	-	186	6	-	-	-	-
Diphtheria		3	0	-	-	-	-	-	-	-	-	-	-	-	-
ILI		13	1	3	0	-	-	-	-	-	-	-	-	-	-
Pneumonia (ALRI)		116	21	1	1	-	-	-	-	-	-	-	-	-	-
Meningitis		7	0	-	-	-	-	-	-	-	-	-	-	-	-
Measles		278	133	16	7	331	160	14	6	12	6	317	73	23	9
Rubella (CRS)		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Leishmaniosis (cutaneous)		2	0	97	44	-	-	-	-	-	-	-	-	-	-
Chikungunya		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chickenpox		3	1	-	-	-	-	-	-	-	-	-	-	-	-
Mpox		4	2	-	-	-	-	-	-	-	-	-	-	-	-
SARI		28	12	-	-	-	-	-	-	-	-	-	-	-	-
Covid-19	ILI	3	0	-	-	-	-	-	-	-	-	13	0	1	0
	SARI	3	0	-	-	-	-	8	0	-	-	43	0	10	0
Influenza A	ILI	3	0	-	-	-	-	-	-	-	-	13	0	1	0
	SARI	3	0	-	-	-	-	8	0	-	-	43	0	10	0
Influenza B	ILI	3	0	-	-	-	-	-	-	-	-	13	0	1	0
	SARI	3	0	-	-	-	-	8	0	-	-	43	0	10	0
RSV	ILI	3	0	-	-	-	-	-	-	-	-	13	0	1	0
	SARI	3	0	-	-	-	-	8	0	-	-	43	3	10	0

- 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.

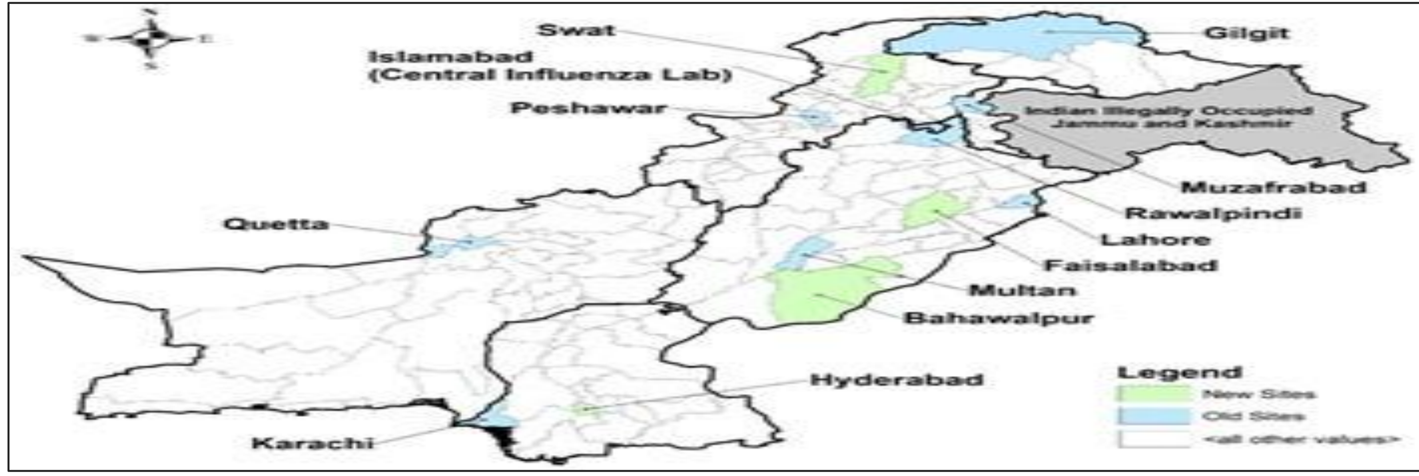


Figure 15: Distribution of suspected samples of ILI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 15, Pakistan.

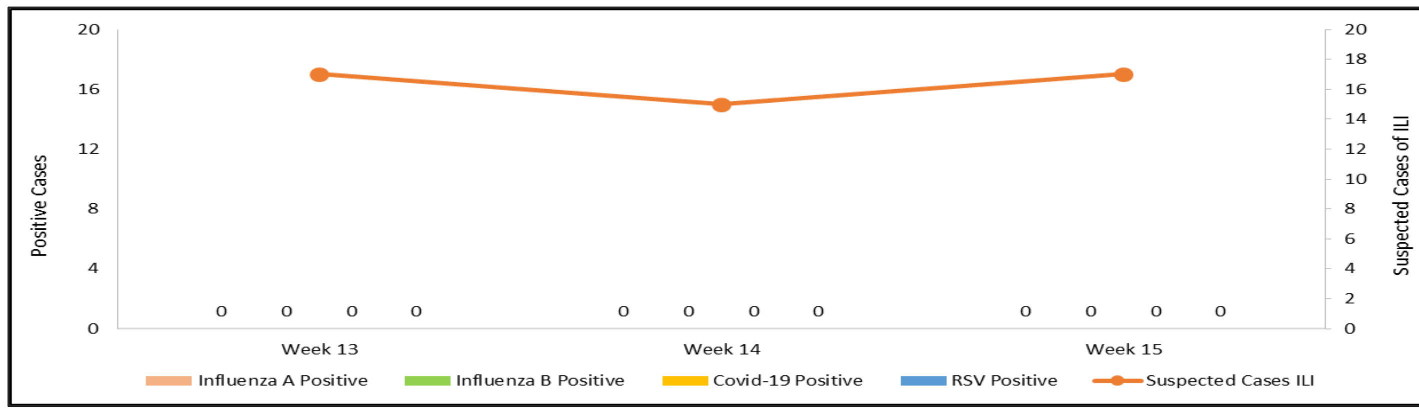
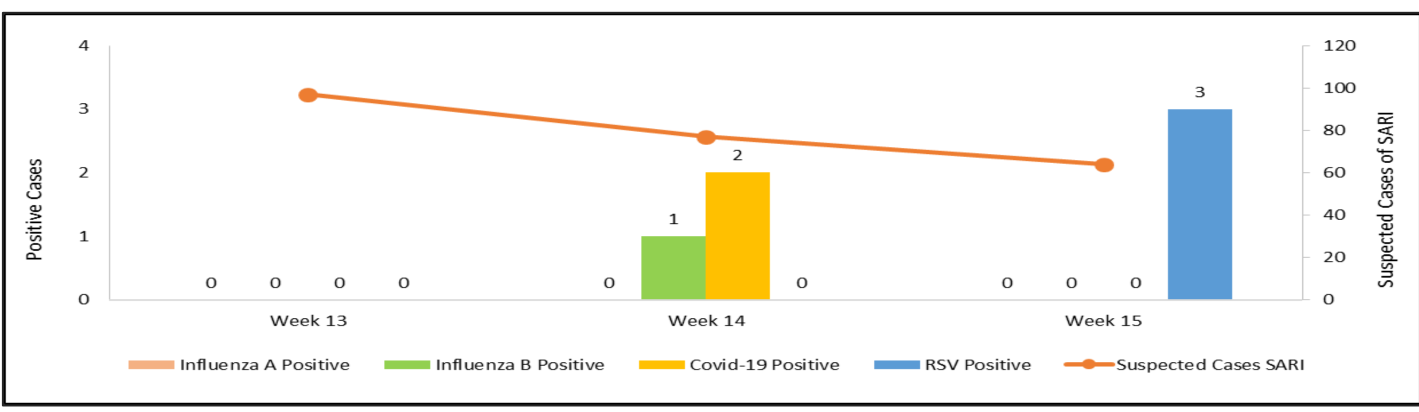


Figure 16: Distribution of suspected samples of SARI and positive cases of Influenza A, Influenza B, COVID-19 and RSV, Week 15, Pakistan.



- 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: Compliance of IDSR reporting districts Week 15, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	105	95%
	Bannu	238	132	55%
	Battagram	59	43	73%
	Buner	34	18	53%
	Bajaur	44	43	98%
	Charsadda	61	61	100%
	Chitral Upper	34	30	88%
	Chitral Lower	35	35	100%
	D.I. Khan	115	114	99%
	Dir Lower	74	60	81%
	Dir Upper	37	36	97%
	Hangu	22	19	86%
	Haripur	72	72	100%
	Karak	36	36	100%
	Khyber	53	41	77%
	Kohat	61	61	100%
	Kohistan Lower	12	11	92%
	Kohistan Upper	20	18	90%
	Kolai Palas	10	10	100%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	11	26%
	Upper Kurram	41	35	85%
	Malakand	42	28	67%
	Mansehra	133	39	29%
	Mardan	80	73	91%
	Nowshera	56	54	96%
	North Waziristan	13	9	69%
	Peshawar	156	136	87%
	Shangla	37	30	81%
	Swabi	66	62	94%
	Swat	77	75	97%
	South Waziristan (Upper)	93	38	41%
	South Waziristan (Lower)	42	29	69%
	Tank	34	33	97%
	Torghar	14	13	93%
	Mohmand	68	35	51%
	Orakzai	69	8	12%
Azad Jammu Kashmir	Mirpur	39	39	100%
	Bhimber	92	38	41%
	Kotli	60	60	100%
	Muzaffarabad	45	45	100%
	Poonch	46	46	100%
	Haveli	39	39	100%
	Bagh	54	43	80%
	Neelum	39	39	100%
	Jhelum Velley	29	29	100%

	Sudhnooti	27	27	100%
Islamabad Capital Territory	ICT	24	24	100%
	CDA	15	5	33%
Balochistan	Gwadar	26	24	92%
	Kech	44	20	45%
	Khuzdar	74	11	15%
	Killa Abdullah	26	24	92%
	Lasbella	55	55	100%
	Pishin	69	0	0%
	Quetta	55	23	42%
	Sibi	36	33	92%
	Zhob	39	12	31%
	Jaffarabad	16	16	100%
	Naserabad	32	32	100%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	8	11%
	Chagi	36	20	56%
	Kalat	41	40	98%
	Harnai	17	16	94%
	Kachhi (Bolan)	35	18	51%
	Jhal Magsi	28	28	100%
	Sohbat pur	25	0	0%
	Surab	32	0	0%
	Mastung	46	46	100%
	Loralai	33	28	85%
	Killa Saifullah	28	0	0%
	Ziarat	29	23	79%
	Duki	31	0	0%
	Nushki	32	29	91%
	Dera Bugti	45	1	2%
	Washuk	46	0	0%
	Panjgur	38	0	0%
	Awaran	23	0	0%
	Chaman	24	0	0%
	Barkhan	20	18	90%
	Hub	33	30	91%
	Musakhel	41	0	0%
	Usta Muhammad	34	33	97%
Gilgit Baltistan	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	38	100%
	Gilgit	44	44	100%
	Diamer	62	58	94%
	Astore	55	55	100%
	Shigar	27	7	26%
	Skardu	53	52	98%
	Ganche	29	28	97%

	Kharmang	46	25	54%
Sindh	Hyderabad	72	72	100%
	Ghotki	64	64	100%
	Umerkot	62	62	100%
	Naushahro Feroze	107	102	95%
	Tharparkar	276	272	99%
	Shikarpur	60	59	98%
	Thatta	52	49	94%
	Larkana	67	67	100%
	Kamber Shadadkot	71	71	100%
	Karachi-East	21	16	76%
	Karachi-West	20	20	100%
	Karachi-Malir	35	33	94%
	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	106	100%
	Badin	124	123	99%
	Sukkur	64	63	98%
	Dadu	90	90	100%
	Sanghar	100	99	99%
	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 15, Pakistan.

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
AJK	Mirpur	2	2	100%
	Bhimber	1	1	100%
	Kotli	1	1	100%
	Muzaffarabad	2	2	100%
	Poonch	2	2	100%
	Haveli	1	1	100%
	Bagh	1	1	100%
	Neelum	1	1	100%
	Jhelum Vellay	1	1	100%
	Sudhnooti	1	1	100%
Sindh	Karachi-South	3	2	67%
	Sukkur	1	1	100%
	Shaheed Benazirabad	1	1	100%
	Karachi-East	1	1	100%
	Karachi-Central	1	1	100%
KP	Peshawar	3	0	0%
	Swabi	1	0	0%
	Nowshera	1	1	100%
	Mardan	1	1	100%
	Abbottabad	1	1	100%
	Swat	1	0	0%

Notes from the field:

Outbreak Investigation of Laboratory-Confirmed Mpox Case – District Swabi, Pakistan

Introduction

Mpox (formerly Monkeypox) is a zoonotic viral disease caused by an Orthopoxvirus, clinically resembling smallpox but with lower mortality. Globally, mpox has re-emerged as a public health concern, particularly following the multi-country outbreaks reported since 2022, affecting both endemic and non-endemic regions. Transmission occurs through close contact with infected individuals, contaminated materials, or respiratory droplets. In the Eastern Mediterranean Region, sporadic imported and locally transmitted cases have been reported, highlighting gaps in surveillance and border health security. Pakistan has reported limited but significant imported cases, often linked with international travel. The risk of local transmission remains due to delayed detection and limited awareness. In January 2026, a suspected case was identified in District Swabi, Khyber Pakhtunkhwa, prompting an outbreak investigation to assess transmission dynamics and containment measures.

Objectives

- To determine the magnitude of the outbreak.
- To identify potential risk factors associated with the transmission of the disease.
- To propose recommendations for containment and prevention of future outbreaks.

Methods

A descriptive outbreak investigation was conducted. The population under study included the index case and his household contacts in Maini village, District Swabi. The investigation area was confined to the patient's residence and A suspected case was defined as "any individual presenting with fever and characteristic vesicular or pustular rash, while a confirmed case was defined as a suspected case with laboratory confirmation via PCR. Data were collected using a structured case investigation form, including demographic, clinical, travel, and exposure history. Active case finding was conducted through household visits and contact tracing, supplemented by hospital record review at BKMC/GKMC MTI Swabi.

Biological samples (lesion swabs) were collected and sent to the Public Health Reference Laboratory (PHRL) for confirmation. Contact sampling was attempted; however, initial refusal delayed specimen collection. Data were analyzed descriptively, focusing on person, place, and time distribution.

Results

A total of one laboratory-confirmed case of mpox was identified. The patient was a 32-year-old male with a recent travel history to Dammam, Saudi Arabia. Symptom onset began with lesions on the left eye prior to arrival in Pakistan, followed by progression to the right eye, both hands, and abdomen on 2nd January 2026.

One suspected secondary case (wife) was identified with similar papular lesions on hands. The affected area was limited to a single household in Maini village, District Swabi..

Clinical presentation included fever and vesicular-pustular skin lesions involving ocular and peripheral body regions. The primary risk factor identified was recent international travel to a region with reported mpox activity. Close household contact was identified as a potential source of secondary transmission.

Laboratory testing confirmed mpox infection in the index case on 16th January 2026. A contact sample from the spouse was collected on 21st January; results were pending at the time of reporting.

Discussion

This investigation identified an imported case of mpox with probable secondary household transmission. The epidemiological link to travel

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history is consistent with previously reported mpox cases in non-endemic countries, where international mobility plays a critical role in disease spread. The delayed healthcare-seeking behavior and initial reluctance for contact sampling represent challenges to early detection and containment.

The presence of symptoms in the spouse indicates possible human-to-human transmission through close contact, which aligns with established transmission pathways. Limited geographic spread suggests that early isolation and response measures were partially effective. However, gaps in risk communication and community engagement were evident, particularly in initial refusal for testing.

The findings underscore the importance of strengthening surveillance at points of entry, rapid response mechanisms, and public awareness regarding emerging infectious diseases.

Conclusion

A single imported laboratory-confirmed case of mpox with a suspected secondary household case was identified in District Swabi. Prompt response limited further spread; however, delays in detection and contact compliance posed challenges.

Recommendations

- Integrate mpox surveillance into existing IDSR systems.
- Strengthen screening and surveillance at international points of entry for early detection of imported cases.
- Enhance community awareness regarding symptoms and transmission of mpox to improve early reporting and compliance.
- Ensure strict adherence to Infection Prevention and Control (IPC) measures at household and healthcare levels.
- Improve contact tracing mechanisms and ensure timely collection of samples from all contacts.
- Build laboratory capacity for rapid diagnosis and decentralize testing facilities where feasible.
- Conduct training of healthcare workers on identification and management of emerging zoonotic diseases.

References

1. World Health Organization. Mpox (Monkeypox) Fact Sheet. Geneva: WHO; 2024.
2. Centers for Disease Control and Prevention. Mpox: Epidemiology and Transmission. Atlanta: CDC; 2024.
3. World Health Organization. Multi-country mpox outbreak: situation update. Geneva: WHO; 2023.
4. Ministry of National Health Services Regulations and Coordination. National Guidelines for Mpox Preparedness and Response. Islamabad: Government of Pakistan; 2023.

Knowledge Hub

Typhoid Fever: What You Need to Know

Typhoid fever is a serious bacterial infection caused by ***Salmonella Typhi***. It is primarily spread through **contaminated food or water** and is common in areas with poor sanitation. Typhoid fever can lead to high fever, fatigue, and abdominal pain. If left untreated, it can be fatal.

What is Typhoid Fever?

Typhoid fever is an illness caused by a specific type of bacteria, ***Salmonella Typhi***. It is different from the more common types of *Salmonella* that cause typical food poisoning. Typhoid fever is a systemic infection, meaning it spreads throughout the body, and is generally more severe.

How Typhoid Fever Spreads

Typhoid fever is spread through the **fecal-oral route**. The bacteria are passed in the feces (poop) of infected people and then contaminate food or water, which is then ingested by others.

Transmission occurs through:

- **Contaminated Food or Water:** This is the most common way, often when water supplies are exposed to sewage or when food is handled by an infected person who did not wash their hands thoroughly.

- **Chronic Carriers:** Some people can continue to shed the bacteria in their feces for years after recovering, unknowingly spreading the infection.

Signs & Symptoms

Symptoms typically appear **6 to 30 days after exposure**. The illness is characterized by a gradual onset of severe symptoms.

Common symptoms include:

- **Sustained High Fever:** The fever often gradually increases over several days.
- Weakness and fatigue.
- Headache.
- Abdominal pain.
- Loss of appetite.
- **Constipation** or, less commonly, diarrhea.
- Rash (small, rose-colored spots on the chest and abdomen, appearing in some cases).

Complications

Without prompt treatment, typhoid fever can lead to severe, life-threatening complications:

- **Intestinal Perforation:** A hole in the intestine that allows contents to leak into the abdominal cavity, causing peritonitis (a severe infection). This requires emergency surgery.
- **Intestinal Hemorrhage:** Severe bleeding in the intestines.
- **Neuropsychiatric symptoms:** Including delirium and confusion.
- **Death:** About 10-30% of untreated cases can be fatal.

Prevention

Prevention of typhoid fever focuses on vaccination, safe food/water practices, and good hygiene.

- **Vaccination:** Typhoid vaccines are recommended for **travelers** to areas where typhoid fever is common, and for people with known exposure risk. Both injectable and oral vaccines are available.
- **Safe Food and Water Practices:** When traveling or in high-risk areas, drink only boiled or bottled water. Eat only thoroughly cooked food that is served hot, and avoid raw fruits and vegetables you cannot peel yourself.
- **Good Hygiene: Wash hands thoroughly with soap and water** before eating, preparing food, and after using the toilet.

Diagnosis and Treatment

- **Diagnosis:** Typhoid fever is usually confirmed by a **blood culture** to isolate the *Salmonella Typhi* bacteria. Stool and urine cultures may also be used.
- **Treatment:** Typhoid fever is treated with **antibiotics**. Early diagnosis is crucial.
    - The choice of antibiotic depends on the region where the infection was acquired due to rising rates of **antibiotic resistance**.
    - It is vital to complete the full course of prescribed antibiotics to eliminate the bacteria and prevent relapse or becoming a chronic carrier.
    - Severe cases require hospitalization and intravenous fluids/antibiotics.

More Information

For additional authoritative information on typhoid fever, please visit:

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

قومی ادارہ صحت، پاکستان

ٹائیفائیڈ بخار کیا ہے

ٹائیفائیڈ بخار ایک وبائی مرض ہے جو ایک مخصوص جرثومے سے لاحق ہوتا ہے۔ یہ مرض زیادہ تر آلودہ خوراک یا آلودہ پانی کے استعمال اور حفظان صحت کے اصولوں پر عمل نہ کرنے سے پھیلتا ہے۔ خاص طور پر قوت مدافعت کی کمی کے شکار افراد کو اس مرض سے جلد متاثر ہونے کا خدشہ ہوتا ہے۔
اس مرض کی اہم علامات میں تیز بخار (103 ڈگری فارن ہائیٹ سے زیادہ)، بھوک کا نہ لگنا، پیٹ میں درد، متلی قبض یا دست اور کمزوری محسوس ہونا شامل ہیں جبکہ مرض کی شدت میں انتڑیوں میں سوراخ بھی ہو سکتے ہیں۔ ان علامات کی موجودگی کی صورت میں فوراً مستند ڈاکٹر سے رجوع کریں تاکہ ٹائیفائیڈ بخار کی بروقت تشخیص کی جا سکے۔

ٹائیفائیڈ بخار سے بچاؤ

ہاتھوں کی صفائی کا خیال رکھیں خاص طور پر کھانا کھانے سے پہلے اور بیت الخلاء استعمال کرنے کے بعد ہاتھوں کو اچھی طرح صابن اور صاف پانی سے دھوئیں۔

پانی ہمیشہ ابال کر پئیں۔

پانی کو صاف کرنے کیلئے کلورین (مجوزہ مقدار) کا استعمال کریں۔

ہمیشہ تازہ اور صاف ستھری غذا کا استعمال کریں۔

باہر کے کھلے (غیر معیاری) کھانے اور مشروبات سے گریز کریں۔

سبزی اور پھل کو دھو کر استعمال کریں۔

ٹائیفائیڈ بخار سے پیشگی بچاؤ کے لئے ڈاکٹر کے مشورے سے ٹائیفائیڈ ویکسین لگوائیں۔

اہم ہدایات

یاد رہے کہ پاکستان میں ٹائیفائیڈ بخار کے علاج کے لئے استعمال ہونے والی بیشتر اینٹی بائیوٹک ادویات غیر موثر ہو چکی ہیں۔ اس لیے ضروری ہے کہ مستند ڈاکٹر کے مشورے سے اینٹی بائیوٹک ادویات استعمال کریں تاکہ ادویات مزاحم ٹائیفائیڈ سے بچا جا سکے۔

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