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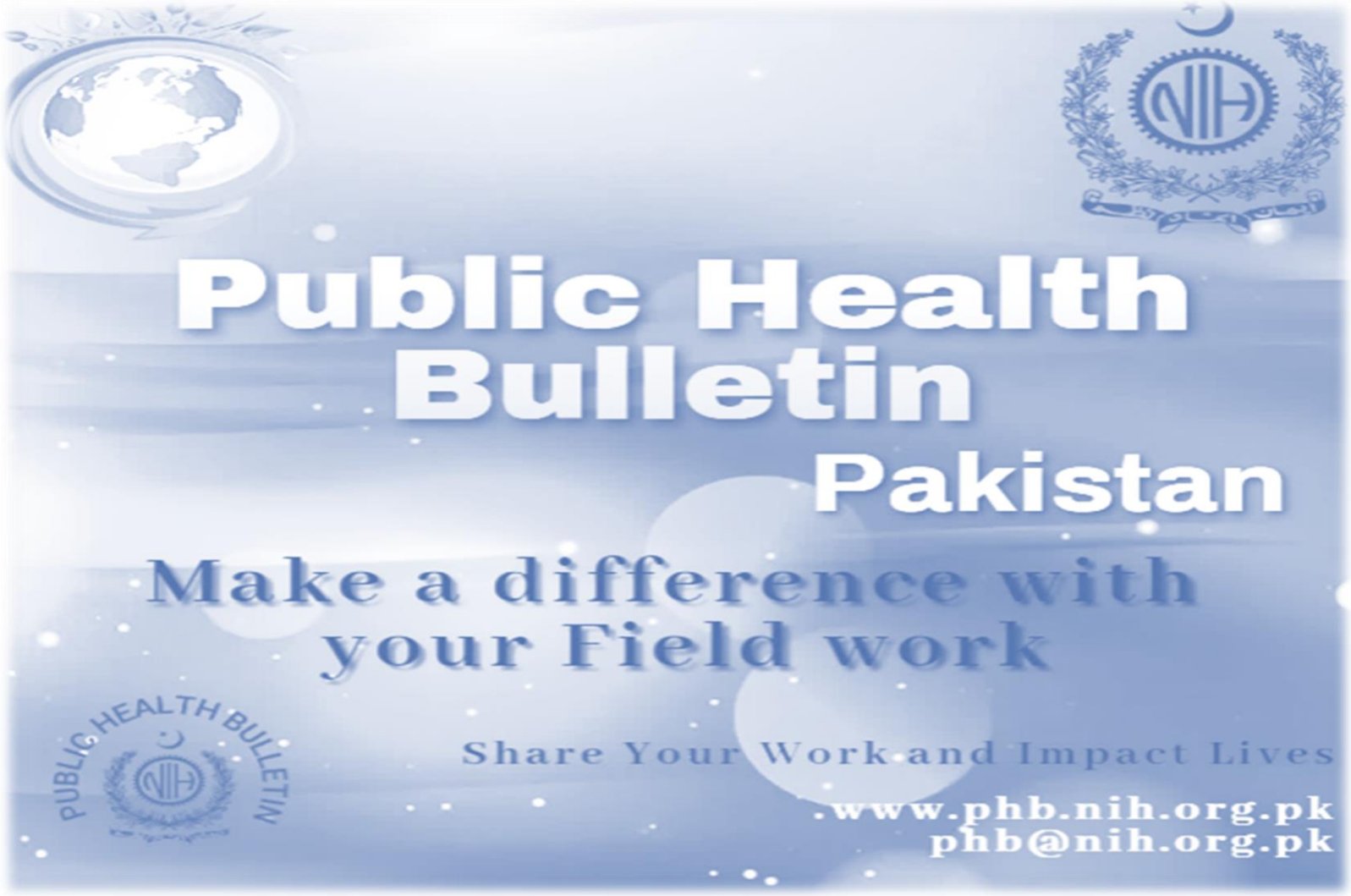
Integrated Disease Surveillance & Response (IDSR) Report

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 05, 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;

- *Strengthening Mortality Surveillance in Pakistan: Expanding Advocacy and Implementation to Punjab*
- *Outbreak Investigation Report of Measles in Village Dribh Kechi, UC Baledai, Taluka Mehar District Dadu, Sindh.*
- *World Neglected Tropical Diseases Day: A Call to Action for Pakistan*

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 05, the most frequently reported cases were of Acute Diarrhea (Non-Cholera) followed by Malaria, ILI, TB, ALRI <5 years, dog bite, B. Diarrhea, VH (B, C & D), Typhoid and SARI.*
- *Twenty (20) cases of AFP reported from KP, fifteen (15) from Punjab, eleven from Sindh and four from AJK.*
- *Eighteen (18) suspected cases of HIV/ AIDS reported from Punjab, eleven (11) from KP and five from Sindh.*
- *Thirteen (13) suspected cases of Brucellosis reported from KP.*
- *Among VPDs, there is an increasing number of cases of Measles, Mumps and Chickenpox this week.*
- *Among water/food borne diseases, there is an increasing number of cases of Acute Diarrhea (Non-Cholera) and Typhoid this week.*
- *Among vector-borne, there is an increasing number of cases of CL this week.*
- *Among other diseases, there is an increasing 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 79%*
- *GB is the top reporting regions with a compliance rate of 92%, followed by AJK & Sindh 90% and KPK 77%.*
- *The lowest compliance rate was observed in ICT 70% and Balochistan 59%.*

Region	Expected Reports	Received Reports	Compliance (%)
Khyber Pakhtunkhwa	2314	1788	77
Azad Jammu Kashmir	404	365	90
Islamabad Capital Territory	36	25	70
Balochistan	1308	784	59
Gilgit Baltistan	405	375	92
Sindh	2096	1902	90
National	6527	5214	79

Public Health Actions

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

Gonorrhea

- **Enhance Case Detection and Reporting:** Strengthen the implementation of gonorrhea surveillance within IDSR by training healthcare providers on case definitions, diagnostics, and reporting protocols.
- **Address Antimicrobial Resistance (AMR):** Establish routine testing for gonorrhea cases and antibiotic susceptibility in gonorrhea cases to monitor resistance trends and guide treatment protocols.
- **Community Awareness:** Leverage local health workers and community influencers to hold community awareness sessions.

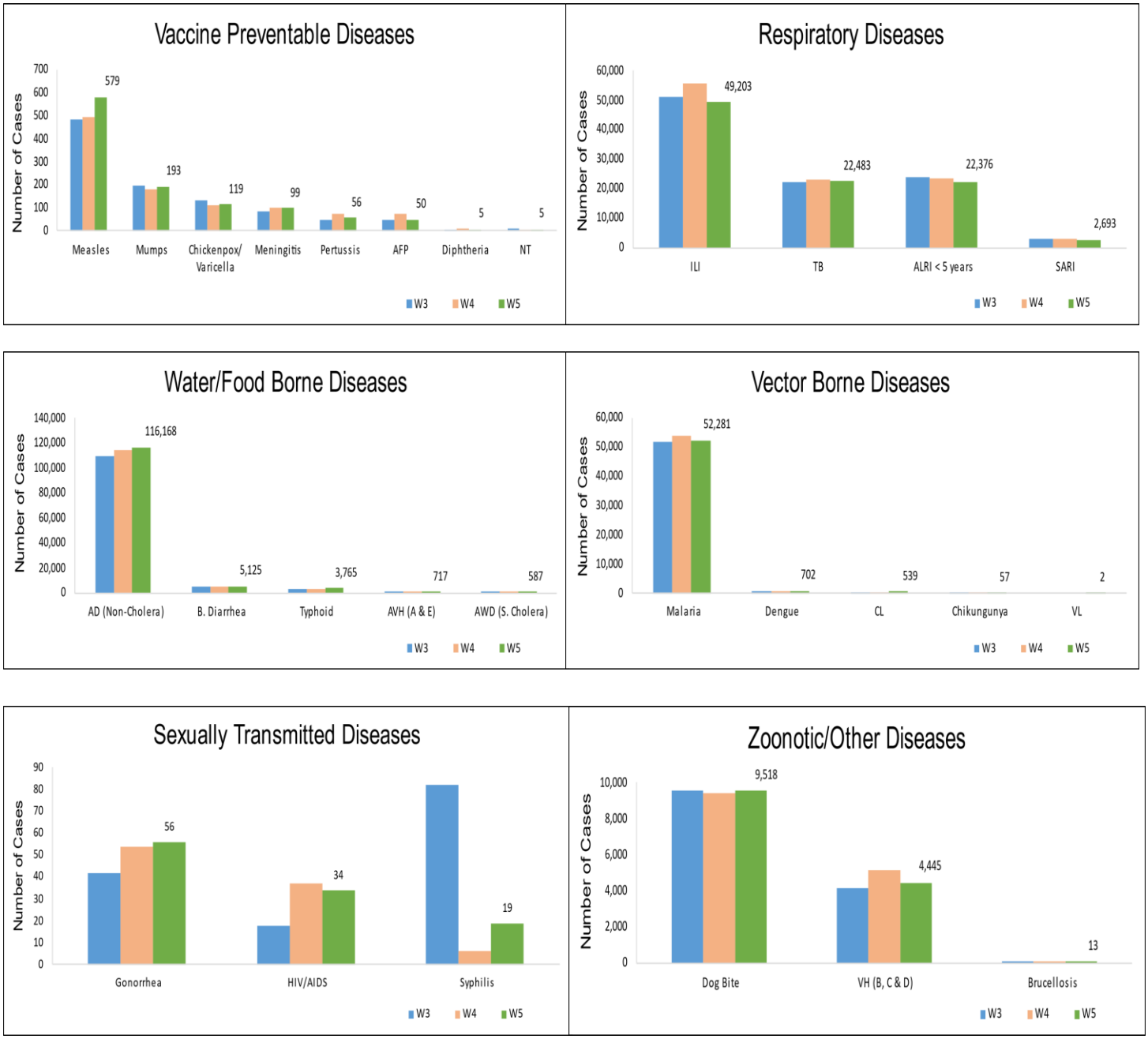
Pertussis

- **Enhance Case Detection and Reporting:** Integrate syphilis surveillance into the IDSR framework by training healthcare providers on case definitions, diagnostic algorithms (including serologic tests like RPR and TPHA), and timely reporting protocols.
- **Strengthen Contact Tracing:** Establish systematic contact tracing mechanisms to identify, test, and treat sexual partners of confirmed syphilis cases, preventing further transmission.
- **Ensure Access to Diagnostics and Treatment:** Ensure the availability of rapid syphilis tests and essential medicines (like penicillin) at all primary healthcare facilities, with clear treatment guidelines for all stages of the disease.
- **Community Awareness**: Collaborate with community health workers and influencers to conduct awareness campaigns about syphilis symptoms, prevention (including condom use), and integrate syphilis screening into routine antenatal care ensuring pregnant women are tested early in pregnancy and receive prompt treatment to prevent congenital syphilis.

Table 1: Province/Area wise distribution of most frequently reported suspected cases during Week 05, Pakistan.

Diseases	AJK	Balochistan	GB	ICT	KP	Punjab	Sindh	Total
AD (Non-Cholera)	1,044	4,204	411	172	15,571	65,076	29,690	116,168
Malaria	0	2,568	0	0	3,412	2,179	44,122	52,281
ILI	2,824	7,584	421	1,132	6,871	3	30,368	49,203
TB	43	97	61	15	432	10,761	11,074	22,483
ALRI < 5 years	1,519	2,010	1,050	13	1,760	2,561	13,463	22,376
Dog Bite	89	155	6	1	805	5,197	3,265	9,518
B. Diarrhea	27	1,024	64	0	822	538	2,650	5,125
VH (B, C & D)	16	89	3	0	136	0	4,201	4,445
Typhoid	15	322	29	0	527	1,970	902	3,765
SARI	364	704	271	0	1,121	0	233	2,693
AVH (A & E)	18	11	5	0	302	0	381	717
Dengue	0	2	0	0	5	662	33	702
AWD (S. Cholera)	3	90	12	0	37	444	1	587
Measles	7	24	3	0	339	128	78	579
CL	0	37	0	0	496	5	1	539
Mumps	5	12	3	2	99	2	70	193
Chickenpox/ Varicella	2	2	5	2	52	9	47	119
Meningitis	1	1	2	0	11	79	5	99
Chikungunya	0	0	0	0	0	0	57	57
Gonorrhea	0	22	0	0	10	0	24	56
Pertussis	0	36	7	0	7	0	6	56
AFP	4	0	0	0	20	15	11	50
HIV/AIDS	0	0	0	0	11	18	5	34
Syphilis	0	0	0	0	1	0	18	19
Brucellosis	0	0	0	0	13	0	0	13
NT	0	0	0	0	5	0	0	5
Diphtheria (Probable)	0	0	0	0	3	2	0	5
VL	0	0	0	0	2	0	0	2

Figure 1: Most frequently reported suspected cases during Week 05, Pakistan.



Sindh

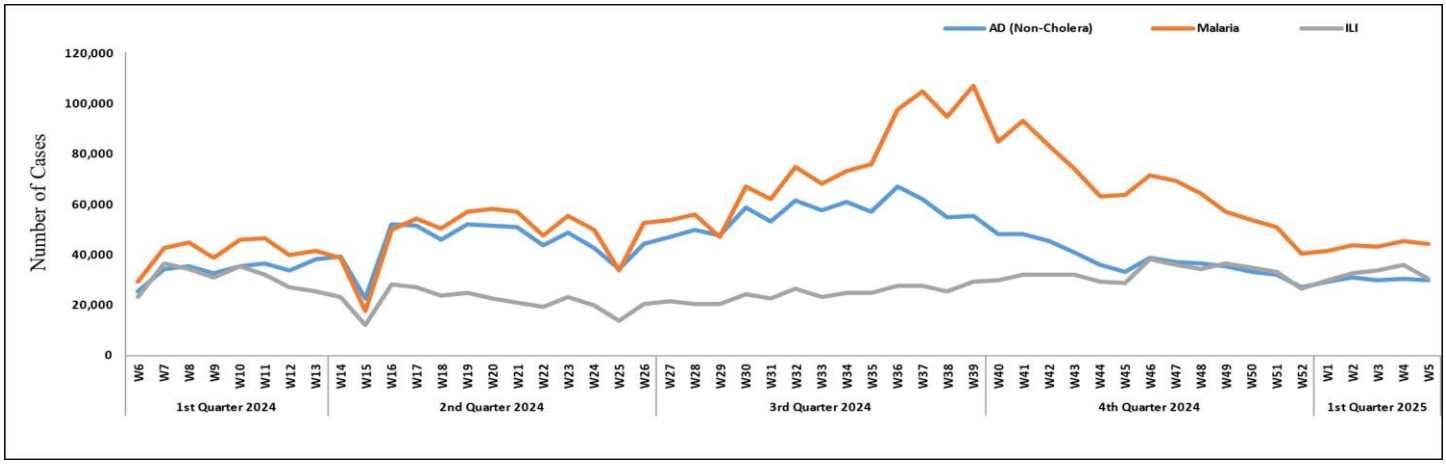
- Malaria cases were maximum followed by ILI, AD (Non-Cholera), ALRI<5 Years, TB, VH (B, C, D), dog bite, B. Diarrhea, Typhoid and SARI.
- Malaria cases are mostly from Larkana, Dadu and Khairpur whereas ILI cases are from Khairpur, Mirpurkhas and Karachi Malir.
- Fifteen suspected cases of HIV/ AIDS reported from Sindh. Field investigation required to verify the case.
- Eight cases of AFP reported from Sindh. All are suspected cases and need field verification.
- There is an increase in number of cases of Malaria, ILI, AD (Non-Cholera), ALRI<5 Years and VH (B, C, D) this week.

Table 2: District wise distribution of most frequently reported suspected cases during Week 05, Sindh

Districts	Malaria	ILI	AD (Non-Cholera)	ALRI < 5 years	TB	VH (B, C & D)	Dog Bite	B. Diarrhea	Typhoid	AVH (A & E)
Badin	1,882	2,625	1,835	638	846	272	159	126	56	2
Dadu	4,066	695	2,539	1,666	499	61	363	465	147	57
Ghotki	670	109	494	650	282	126	242	65	2	3
Hyderabad	429	12	1,028	14	101	58	22	5	4	0
Jacobabad	842	718	498	472	119	243	213	103	33	0
Jamshoro	2,171	372	874	367	626	202	93	110	41	5
Kamber	2,869	0	1,292	336	788	114	268	81	18	0
Karachi Central	3	1,819	576	5	13	5	0	6	50	3
Karachi East	51	526	449	85	18	4	21	14	2	0
Karachi Keamari	3	396	539	54	2	0	0	3	6	0
Karachi Korangi	89	14	405	5	28	1	1	7	5	0
Karachi Malir	194	3,298	1,113	236	115	32	31	33	18	1
Karachi South	2	4	92	0	0	0	0	0	0	0
Karachi West	268	1,191	903	178	121	59	31	19	26	3
Kashmore	1,680	586	329	219	224	15	48	24	3	0
Khairpur	3,733	6,174	1,804	1,143	906	188	230	281	154	3
Larkana	4,533	32	1,364	593	914	53	41	248	6	5
Matiari	2,545	0	929	462	620	394	68	39	1	0
Mirpurkhas	1,638	3,183	1,643	803	718	109	157	60	23	0
Naushero Feroze	520	405	498	389	49	49	212	110	48	0
Sanghar	3,915	100	1,329	756	1,201	1,011	237	99	38	2
Shaheed Benazirabad	1,411	21	1,153	231	259	73	143	43	73	0
Shikarpur	2,392	6	1,016	269	292	223	237	180	5	0
Sujawal	715	0	821	445	142	39	83	84	39	0
Sukkur	1,642	2,195	1,020	324	503	84	152	87	3	0
Tando Allahyar	1,158	1,618	685	356	466	265	80	97	6	0
Tando Muhammad Khan	440	45	566	232	472	2	24	76	0	0
Tharparkar	2,039	2,159	1,703	1,333	455	70	2	100	33	21
Thatta	1,238	2,065	1,107	493	35	112	107	33	29	273
Umerkot	984	0	1,086	709	260	337	0	52	33	3
Total	44,122	30,368	29,690	13,463	11,074	4,201	3,265	2,650	902	381

Figure 2: Most frequently reported suspected cases during Week 05 Sindh

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



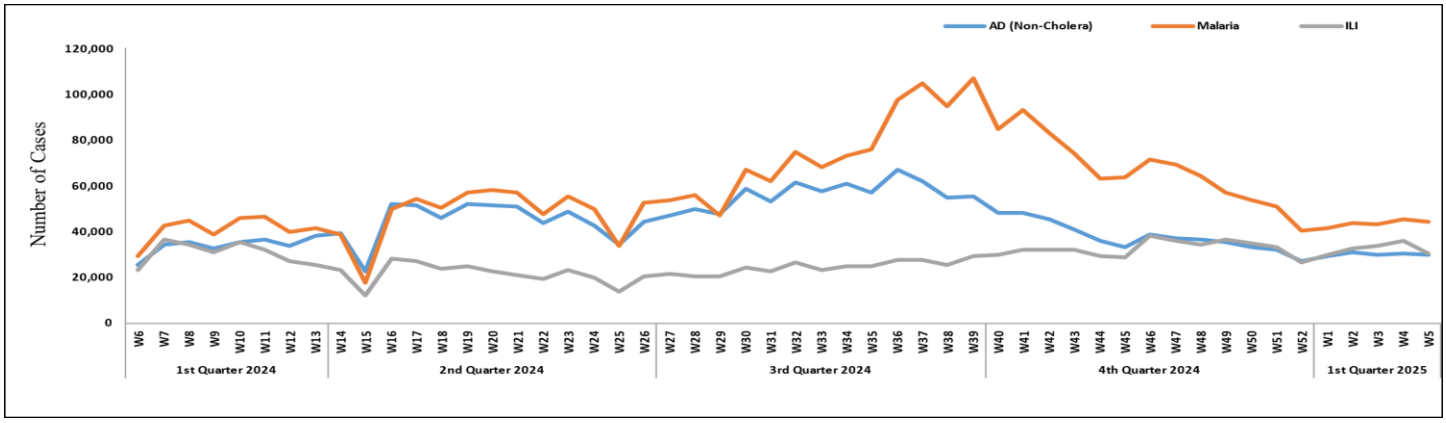
- ILI, AD (Non-Cholera), Malaria, ALRI <5 years, B. Diarrhea, SARI, Typhoid, dog bite, TB and VH (B, C & D) cases were the most frequently reported diseases from Balochistan province.
- ILI cases are mostly reported from Gwadar, Kech (Turbat) and Quetta while AD (Non-Cholera) cases are mostly reported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

Table 3: District wise distribution of most frequently reported suspected cases during Week 05, Balochistan

Districts	ILI	AD (Non-Cholera)	Malaria	ALRI < 5 years	B. Diarrhea	SARI	Typhoid	Dog Bite	TB	AWD (S. Cholera)
Barkhan	64	54	32	9	3	3	22	8	4	0
Chagai	300	88	19	0	21	0	10	0	2	1
Dera Bugti	70	42	47	59	14	0	0	0	0	0
Gwadar	1,749	528	105	22	97	0	23	1	0	0
Harnai	20	107	68	203	74	0	1	3	6	0
Hub	23	39	56	7	13	0	2	0	0	0
Jaffarabad	136	189	233	38	47	17	6	3	33	0
Jhal Magsi	466	172	355	12	0	2	7	10	4	0
Kalat	4	13	6	17	9	5	9	0	0	0
Kharan	595	86	11	0	60	22	3	0	0	0
Khuzdar	284	219	64	12	94	23	6	0	0	39
Killa Saifullah	0	103	108	227	52	42	15	0	0	0
Kohlu	400	167	58	25	64	91	37	NR	1	NR
Lasbella	60	287	316	97	42	13	13	20	0	0
Loralai	431	108	15	39	22	91	22	11	0	0
Mastung	50	63	13	77	10	29	10	3	0	0
MusaKhel	21	16	69	43	3	0	1	0	0	6
Naseerabad	12	297	289	55	11	70	48	78	5	3
Nushki	5	98	8	0	51	0	0	0	0	0
Panjgur	54	55	46	114	5	12	0	0	0	0
Pishin	617	182	14	109	93	56	35	4	0	11
Quetta	1,190	438	11	218	37	54	11	2	3	3
Sibi	115	21	9	6	6	7	0	0	0	0
Sohbat pur	19	148	187	89	65	23	20	3	3	9
Surab	114	35	18	0	0	0	0	0	0	0
Usta Muhammad	183	398	287	173	49	13	5	7	0	0
Washuk	439	169	106	19	69	53	11	2	0	18
Zhob	163	82	18	340	13	78	5	0	36	0
Total	7,584	4,204	2,568	2,010	1,024	704	322	155	97	90

Figure 4: Most frequently reported suspected cases during Week 05, Balochistan

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



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

Table 4: District wise distribution of most frequently reported suspected cases during Week 05, KP

Districts	AD (Non-Cholera)	ILI	Malaria	ALRI < 5 years	SARI	B. Diarrhea	Dog Bite	Typhoid	CL	TB
Abbottabad	376	175	0	54	11	8	92	4	0	14
Bajaur	308	93	111	39	105	74	49	1	20	17
Bannu	537	5	1,351	19	6	42	2	74	0	22
Battagram	127	556	13	11	10	4	1	NR	13	43
Buner	168	0	192	1	0	0	13	1	0	0
Charsadda	1,296	1,495	372	512	5	144	24	106	0	32
Chitral Lower	213	176	3	16	24	6	14	1	11	2
Chitral Upper	40	2	0	3	0	0	3	2	0	0
D.I. Khan	1,172	0	183	41	0	24	10	0	2	48
Dir Lower	905	0	209	19	0	69	41	36	1	10
Dir Upper	484	149	2	96	0	2	29	5	5	26
Hangu	154	321	38	3	0	3	8	4	48	9
Haripur	435	355	0	93	34	1	6	0	0	38
Karak	264	54	85	48	120	9	16	3	118	1
Khyber	359	109	21	87	26	94	53	26	63	11
Kohat	337	85	9	4	34	26	23	5	63	0
Kohistan Lower	58	0	1	0	0	1	1	0	0	0
Kohistan Upper	168	7	0	12	0	7	0	0	0	0
Kolai Palas	42	8	1	4	1	7	0	3	0	2
L & C Kurram	15	9	10	1	0	10	0	0	0	1
Lakki Marwat	552	31	157	26	0	5	37	9	2	4
Malakand	293	53	0	14	19	16		21	40	7
Mansehra	455	311	0	2	0	0	0	0	0	0
Mardan	635	0	4	80	0	20	62	19	0	14
Mohmand	81	159	108	2	171	15	24	1	95	0
North Waziristan	19	0	23	5	4	3	0	4	1	3
Nowshera	1,025	107	23	6	14	32	8	6	1	8
Orakzai	37	21	9	0	0	3	0	0	0	0
Peshawar	2,029	942	41	160	158	110	6	99	1	11
SD Tank	13	2	56	0	0	6	2	0	2	0
Shangla	458	0	237	27	0	4	37	19	0	56
South Waziristan (Lower)	18	280	6	8	55	0	9	7	0	3
SWU	0	1	0	1	7	0	0	0	0	0
Swabi	854	806	35	152	102	3	176	32	0	27
Swat	1,056	158	7	137	4	32	25	9	0	7
Tank	427	114	84	19	0	1	0	25	0	15
Tor Ghar	38	0	13	41	25	20	29	2	10	0
Upper Kurram	122	287	8	17	186	21	5	3	0	1
Total	15,571	6,871	3,412	1,760	1,121	822	805	527	496	432

Figure 6: Most frequently reported suspected cases during Week 05, KP

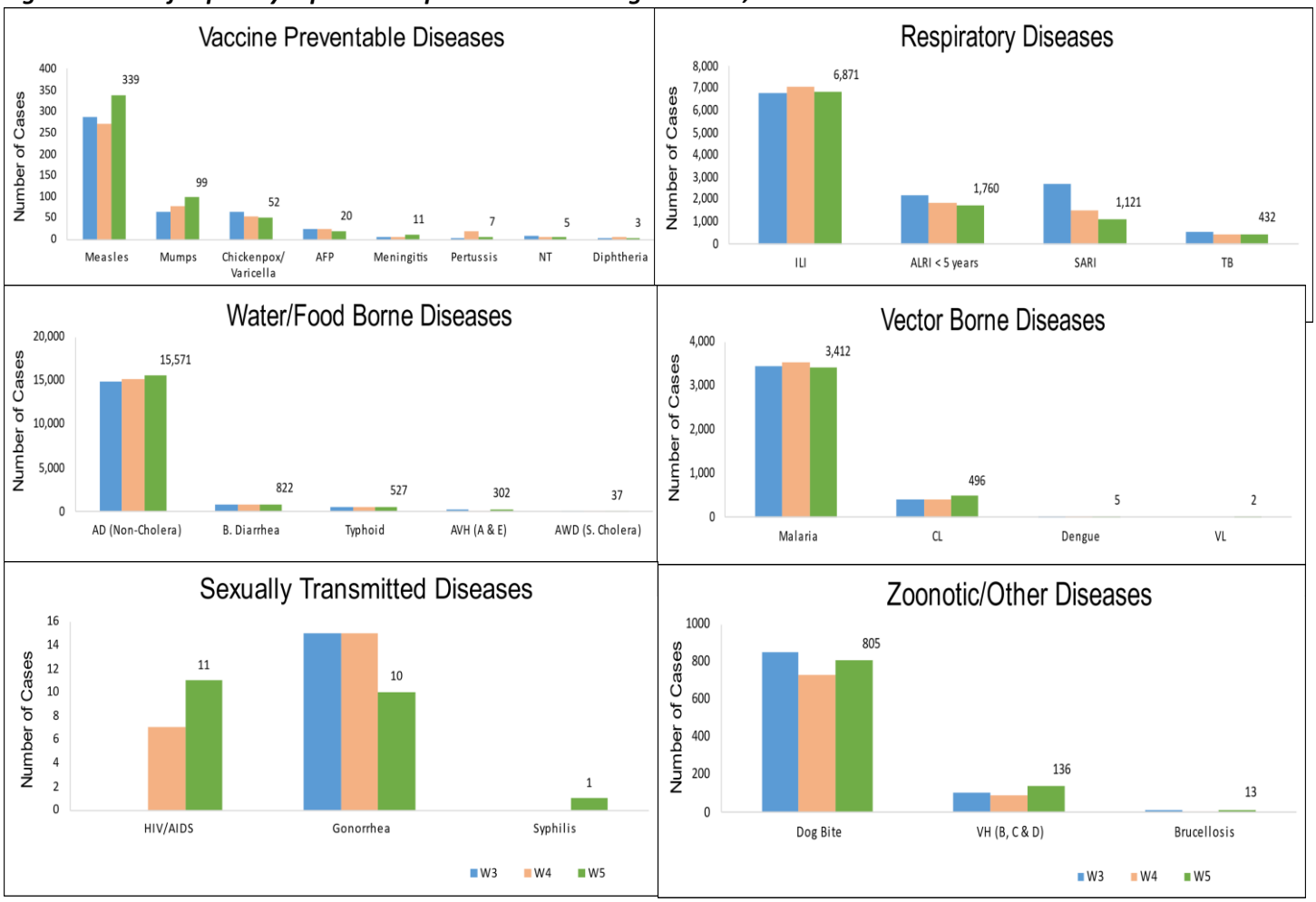
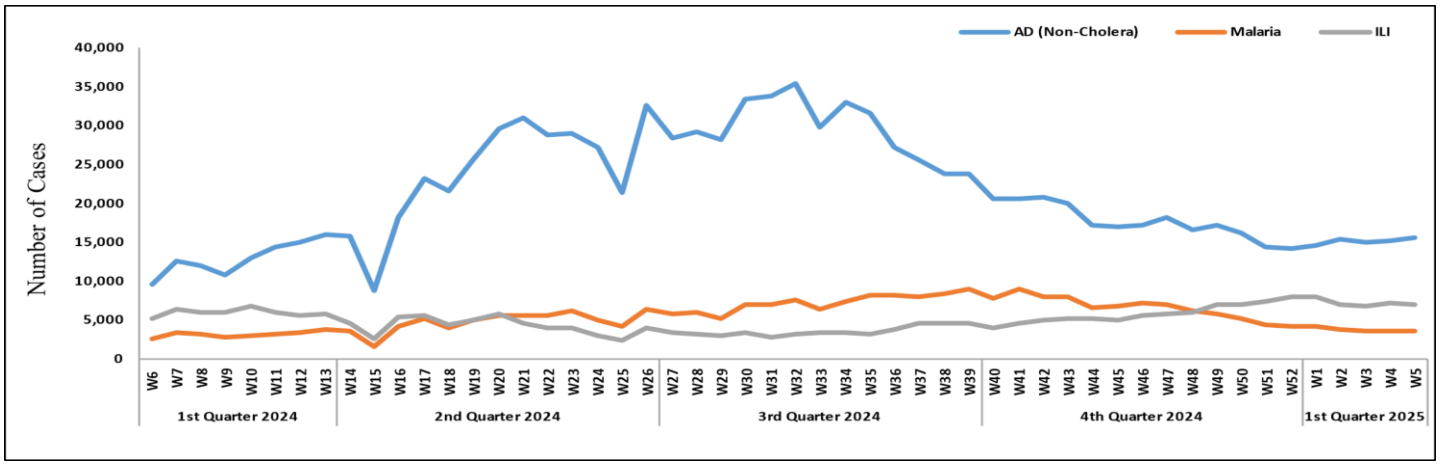


Figure 7: Week wise reported suspected cases Malaria, AD (Non-Cholera) & ILI, KP



Punjab

- AD (Non-Cholera) cases were maximum followed by TB, dog bite, ALRI<5 Years, Malaria, Typhoid, Dengue, B. Diarrhea and AWD (S. Cholera) cases.
- AD (Non-Cholera), dog bite, ALRI<5 Years and Dengue showed an increase in number of cases while TB and Malaria showed a decline in number of cases this week.
- Eighteen suspected cases of HIV/AIDs reported from Punjab. They require field verification.
- Fifteen cases of AFP reported from Punjab. All are suspected cases and need field verification.

Figure 8: Most frequently reported suspected cases during Week 05, Punjab

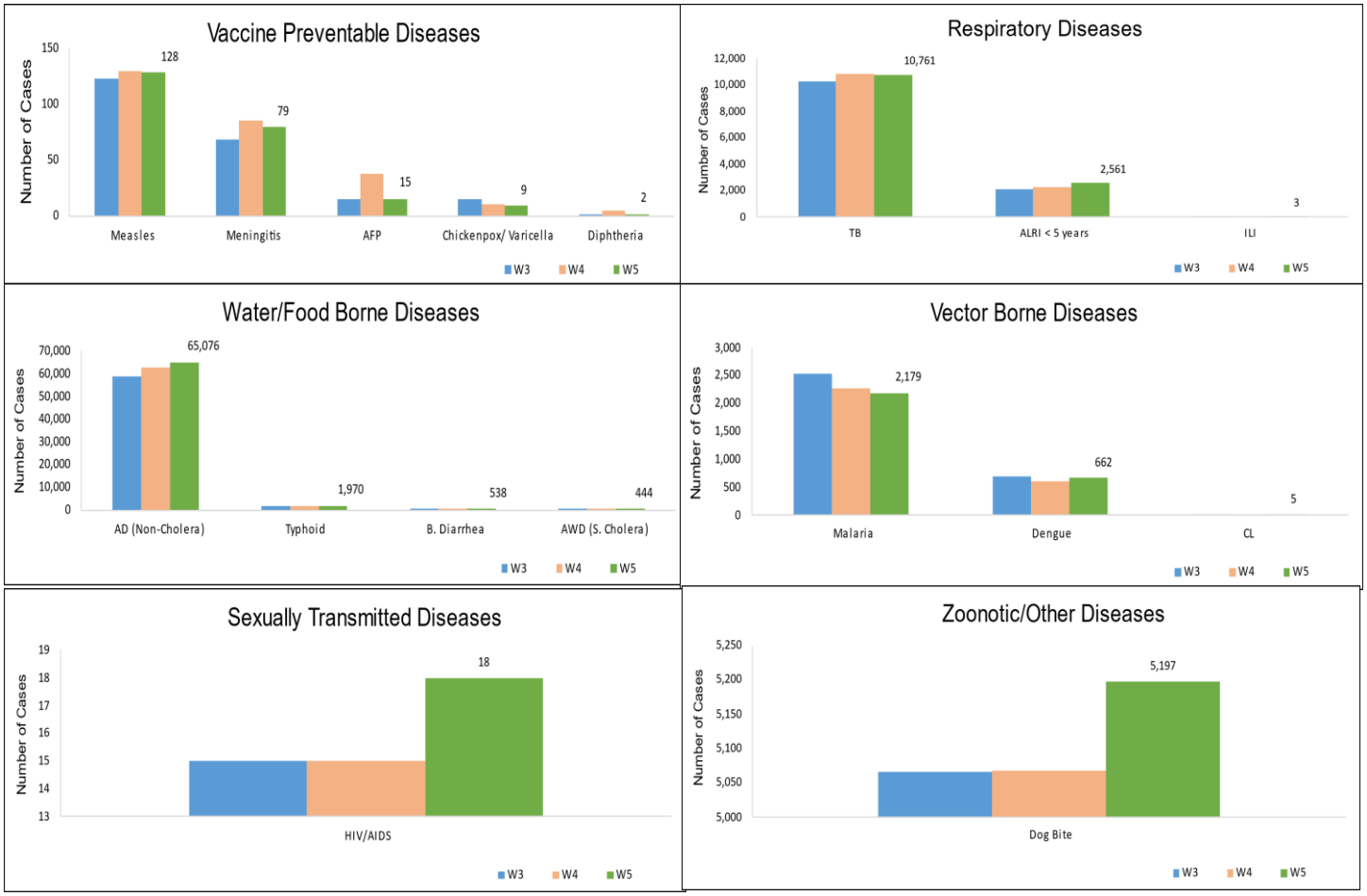
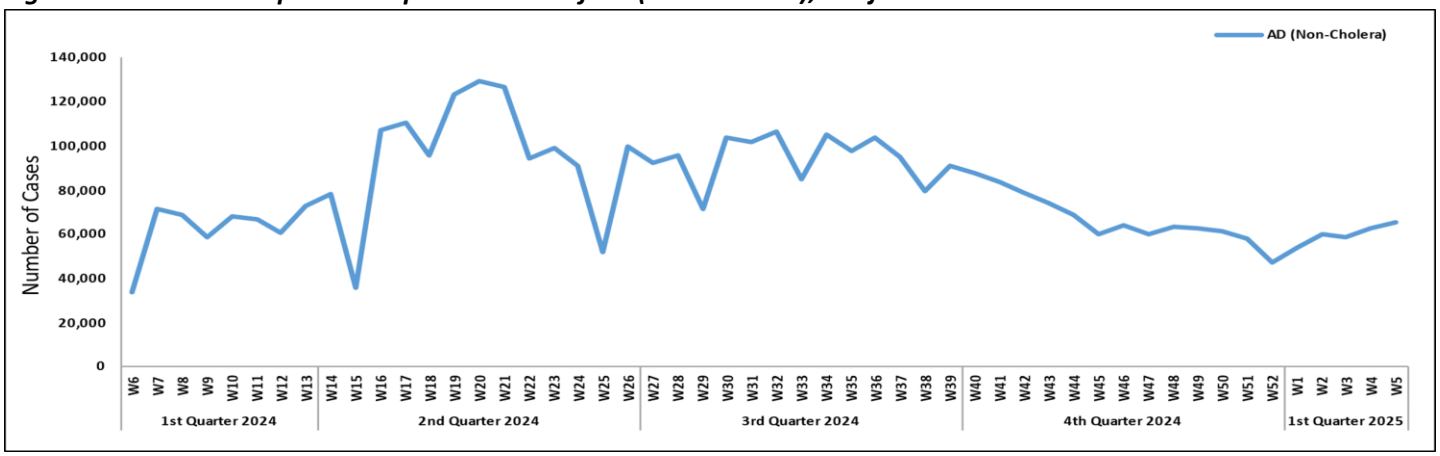


Figure 9: Week wise reported suspected cases of AD (Non-Cholera), Punjab



ICT, AJK & GB

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

AJK: ILI cases were maximum followed by ALRI < 5years, AD (Non-Cholera), SARI, dog bite, TB, B. Diarrhea, AVH (A & E), VH (B, C & D) and Typhoid cases. A decline in cases observed for ILI and dog bite while an increase in cases observed for ALRI < 5years, AD (Non-Cholera), VH (B, C & D) and Typhoid this week. Four cases of AFP reported from AJK. All are suspected cases and need field verification.

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

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Figure 10: Most frequently reported suspected cases during Week 05, AJK

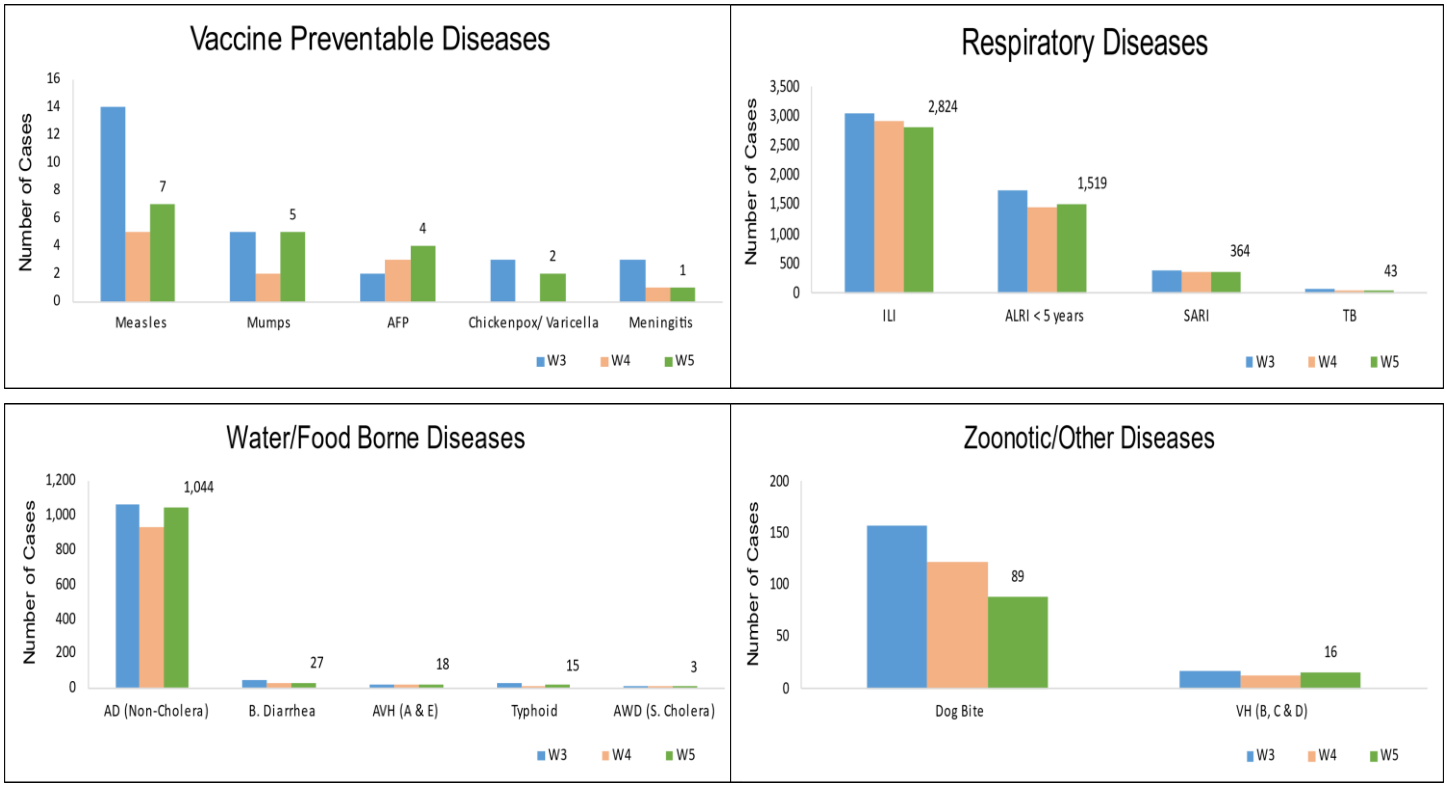


Figure 11: Week wise reported suspected cases of ILI and ARI <5 years, AJK

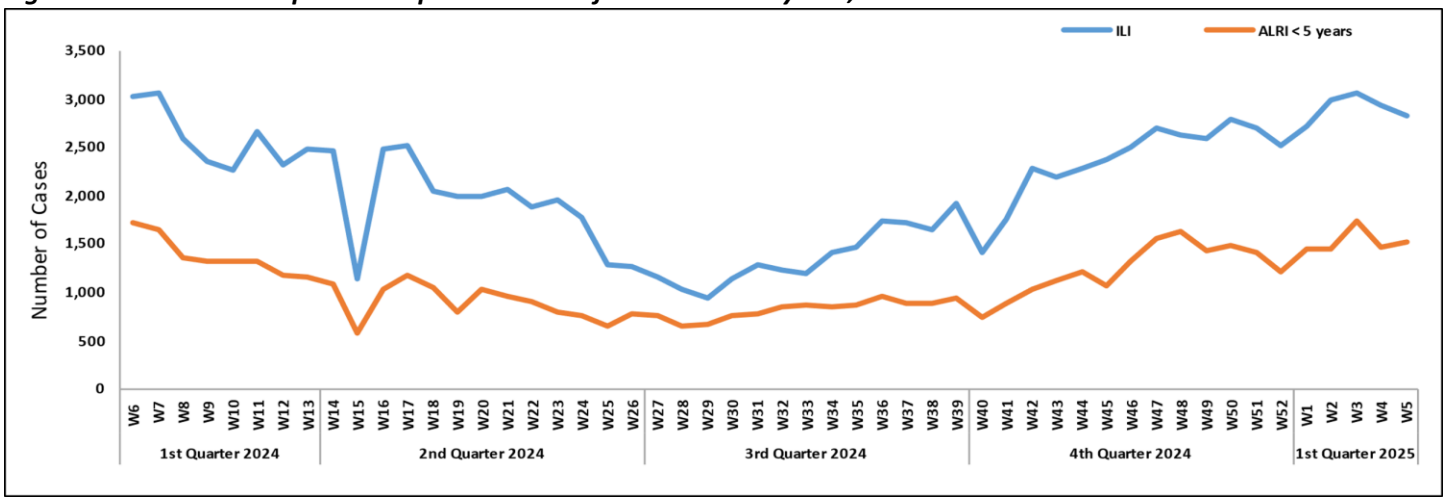


Figure 12: Most frequently reported suspected cases during Week 05, ICT

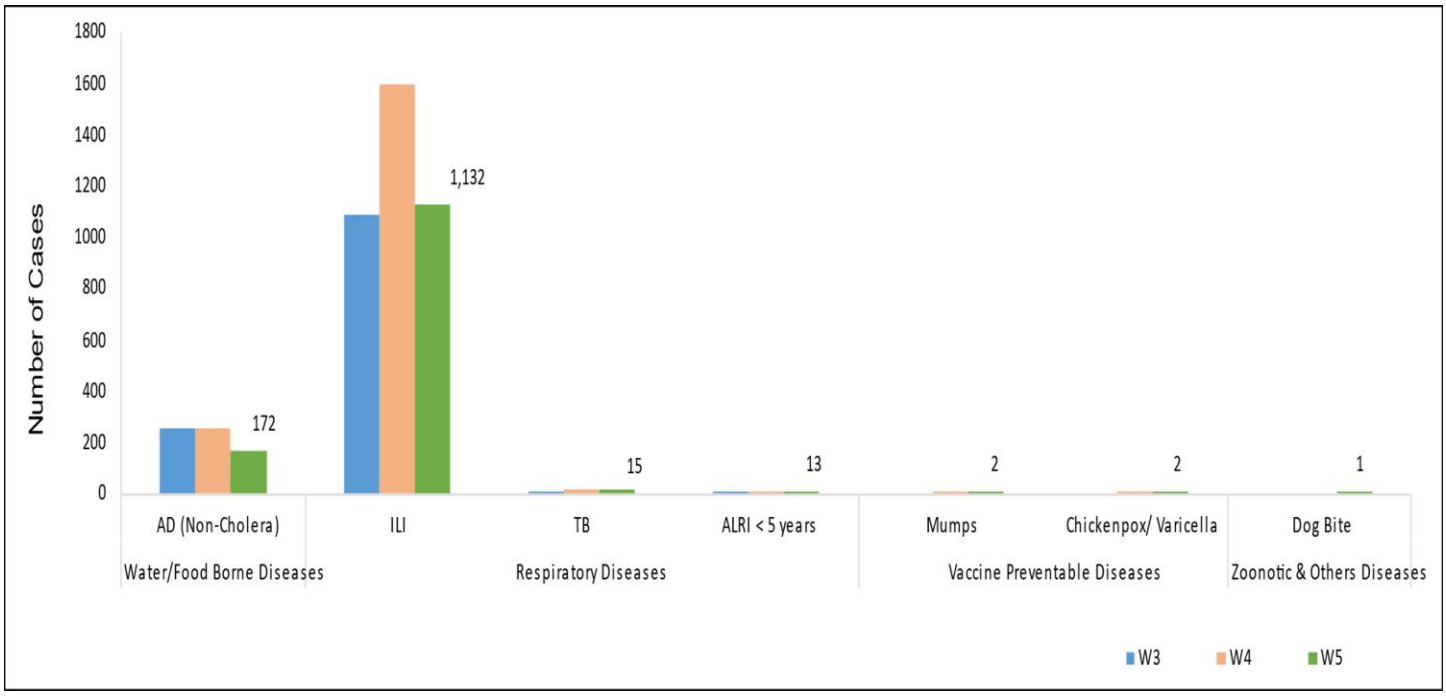


Figure 13: Week wise reported suspected cases of ILI, ICT

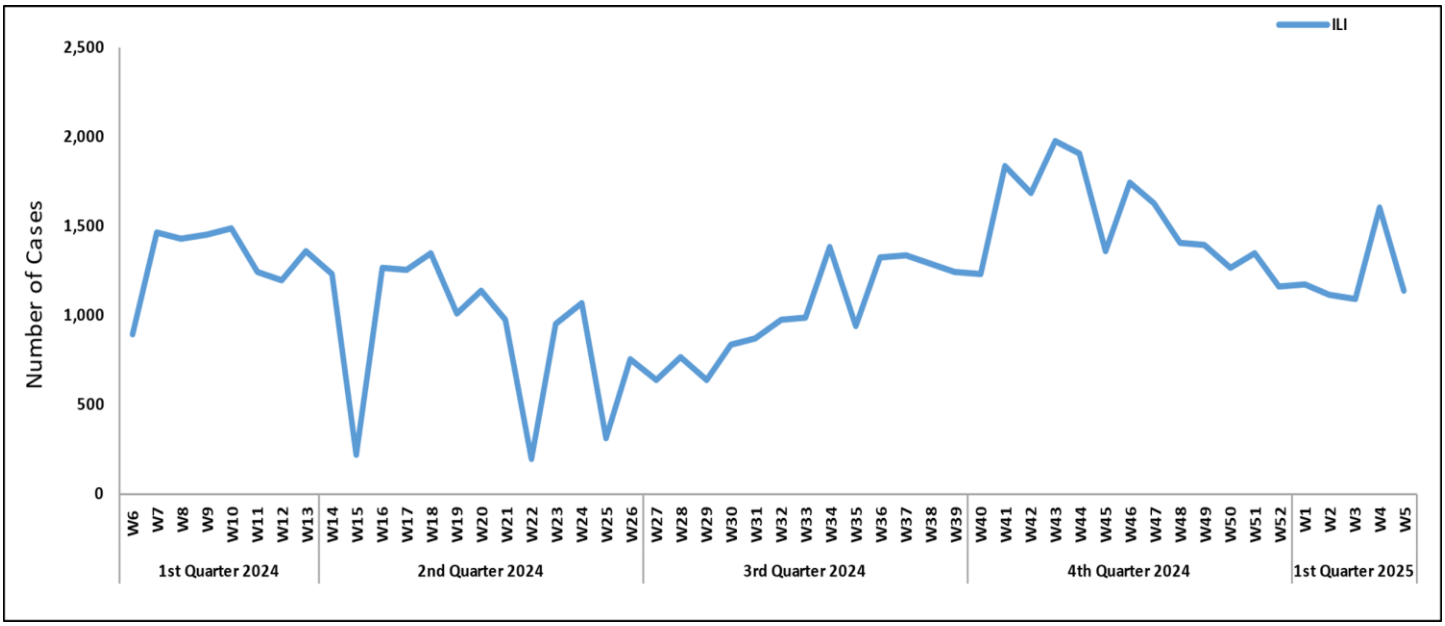


Figure 14: Most frequent cases reported during Week 05, GB

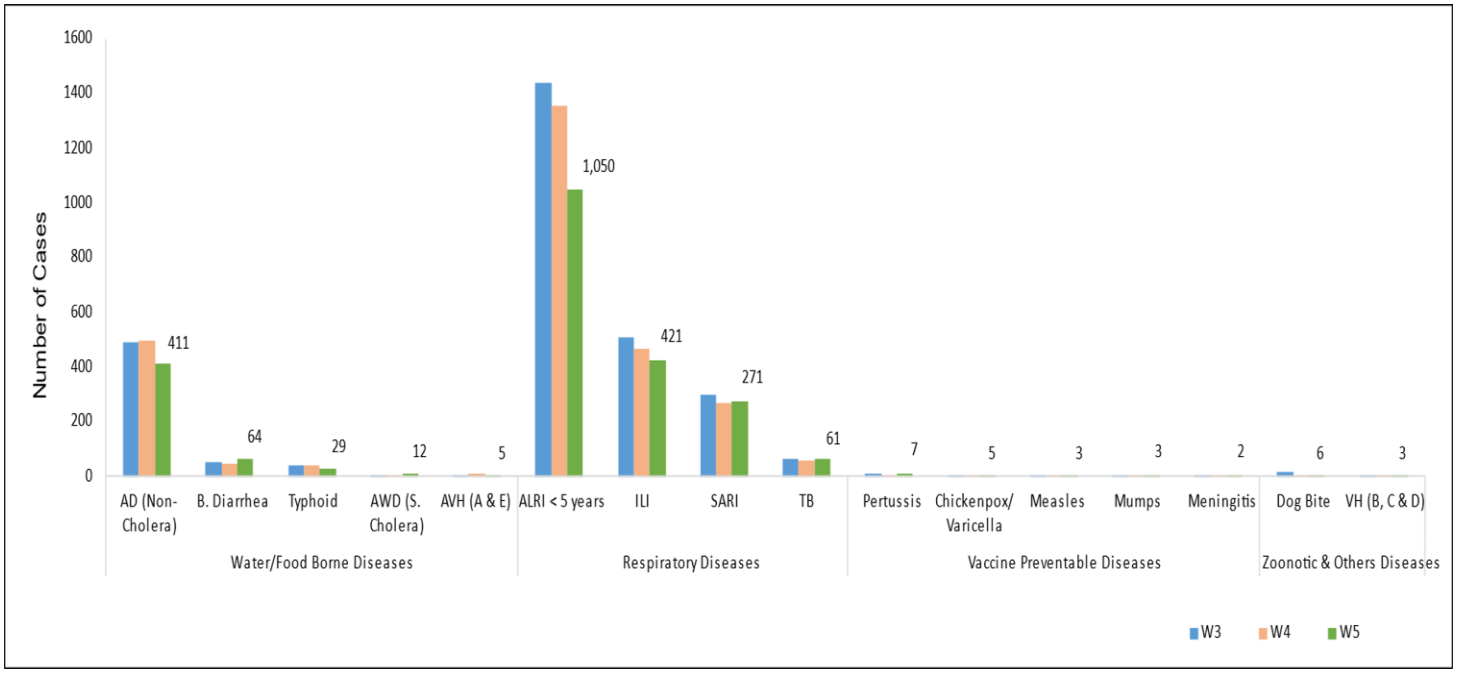


Figure 15: Week wise reported suspected cases of ALRI <5 years, GB

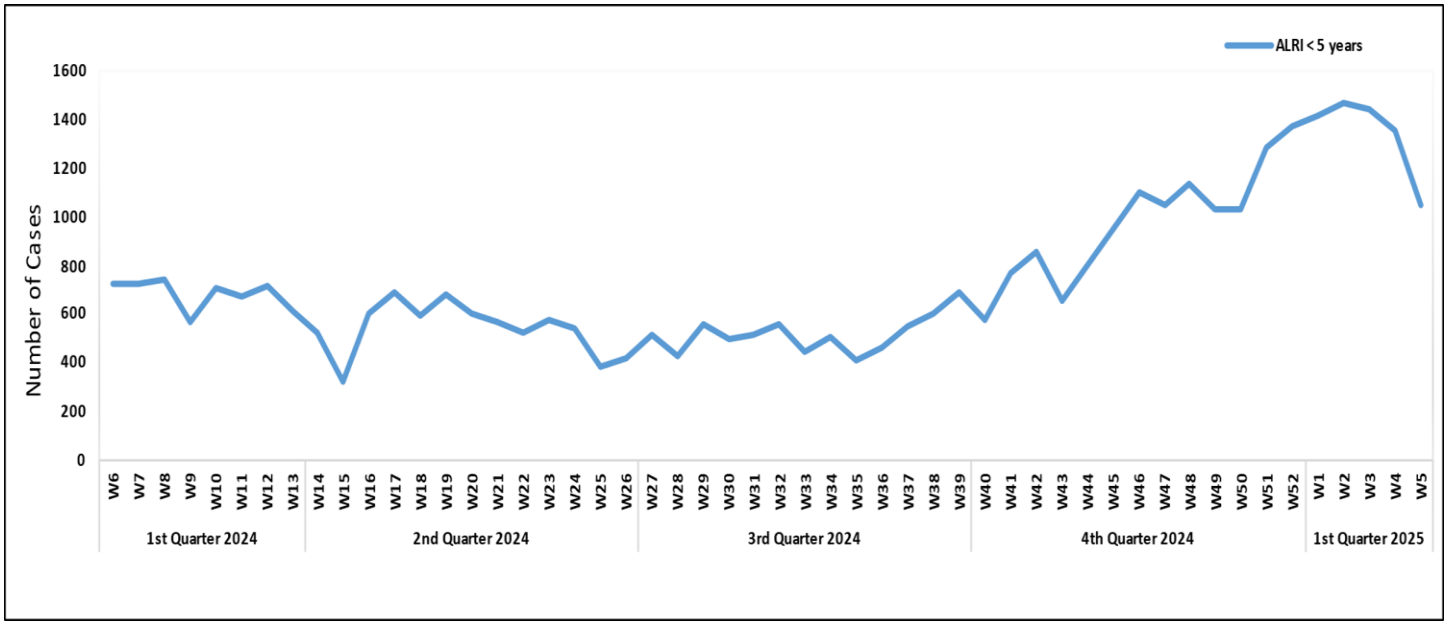


Table 5: Public Health Laboratories confirmed cases of IDSR Priority Diseases during Epid Week 05

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)		120	0	-	-	0	0	-	-	-	-	-	-	0	0
AD (non-cholera)		208	5	-	-	0	0	-	-	-	-	-	-	0	0
Malaria		7661	431	-	-	435	9	-	-	-	-	-	-	53	0
CCHF		0	0	2	0	0	0	1	0	-	-	-	-	0	0
Dengue		1156	128	0	0	22	0	2	0	-	-	-	-	14	0
VH (B)		7819	325	90	66	1,485	11	-	-	-	-	-	-	757	3
VH (C)		9444	987	44	14	1,485	13	-	-	-	-	-	-	759	4
VH (D)		235	74	30	8	0	0	-	-	-	-	-	-	-	-
VH (A)		85	41	-	-	4	0	-	-	-	-	-	-	0	0
VH (E)		90	5	-	-	0	0	-	-	-	-	-	-	0	0
Covid-19		47	1	7	0	14	0	7	0	-	-	-	-	20	0
Chikungunya		16	1	-	-	0	0	-	-	-	-	-	-	0	0
TB		451	56	-	-	9	0	-	-	-	-	-	-	93	2
HIV/ AIDS		2671	16	-	-	667	1	-	-	-	-	-	-	613	0
Syphilis		1158	42	-	-	170	0	-	-	-	-	-	-	3	0
B. Diarrhea		100	0	-	-	0	0	-	-	-	-	-	-	0	0
Typhoid		1,062	15	-	-	68	3	-	-	-	-	-	-	0	0
Diphtheria		6	4	-	-	0	0	-	-	-	-	-	-	0	0
Pneumonial (ALRI)		42	35	-	-	0	0	-	-	-	-	-	-	0	0
Meningitis		8	0	-	-	0	0	-	-	-	-	-	-	0	0
Rubella (CRS)		10	6	-	-	0	0	-	-	-	-	-	-	0	0
Measles		224	103	68	41	308	163	6	3	7	5	175	40	25	10
Rubella		224	9	68	0	308	6	6	0	7	0	175	1	25	0
Covid-19	Out of SARI	2	0	0	0	8	0	159	0	12	0	243	0	0	0
	Out of ILI	6	0	0	0	6	0	70	0	8	0	182	1	0	0
Influenza A	Out of SARI	2	0	0	0	8	0	159	10	12	0	243	32	0	0
	Out of ILI	6	0	0	0	6	0	70	8	8	0	182	30	0	0
Influenza B	Out of SARI	2	0	0	0	8	0	159	6	12	0	243	47	0	0
	Out of ILI	6	0	0	0	6	0	70	5	8	0	182	40	0	0
RSV	Out of SARI	2	0	0	0	8	0	159	61	12	0	243	0	0	0
	Out of ILI	6	0	0	0	6	0	70	9	8	0	182	0	0	0

Table 6: IDSR reporting districts Week 05, 2024

Provinces/Regions	Districts	Total Number of Reporting Sites	Number of Reported Sites for current week	Compliance Rate (%)
Khyber Pakhtunkhwa	Abbottabad	111	104	94%
	Bannu	238	125	53%
	Battagram	59	27	46%
	Buner	34	34	100%
	Bajaur	44	40	91%
	Charsadda	59	56	95%
	Chitral Upper	34	29	85%
	Chitral Lower	35	35	100%
	D.I. Khan	113	113	100%
	Dir Lower	74	74	100%
	Dir Upper	37	30	81%
	Hangu	22	21	95%
	Haripur	72	71	99%
	Karak	36	36	100%
	Khyber	53	40	75%
	Kohat	61	61	100%
	Kohistan Lower	11	11	100%
	Kohistan Upper	20	20	100%
	Kolai Palas	10	10	100%
	Lakki Marwat	70	69	99%
	Lower & Central Kurram	42	7	17%
	Upper Kurram	41	29	71%
	Malakand	42	30	71%
	Mansehra	133	102	77%
	Mardan	80	76	95%
	Nowshera	55	52	95%
	North Waziristan	13	6	46%
	Peshawar	154	128	83%
	Shangla	37	30	81%
	Swabi	64	61	95%
	Swat	77	75	97%
	South Waziristan (Upper)	93	36	39%
	South Waziristan (Lower)	42	18	43%
	Tank	34	32	94%
	Torghar	14	14	100%
	Mohmand	68	64	94%
	SD Peshawar	5	0	0%
	SD Tank	58	10	17%
	Orakzai	69	12	17%
	Mirpur	37	37	100%
	Bhimber	42	20	48%

Azad Jammu Kashmir	Kotli	60	59	98%
	Muzaffarabad	45	43	96%
	Poonch	46	43	93%
	Haveli	39	39	100%
	Bagh	40	40	100%
	Neelum	39	28	72%
	Jhelum Vellay	29	29	100%
Islamabad Capital Territory	Sudhnooti	27	27	100%
	ICT	21	18	86%
Balochistan	CDA	15	7	47%
	Gwadar	26	26	100%
	Kech	44	0	0%
	Khuzdar	74	46	62%
	Killa Abdullah	26	0	0%
	Lasbella	55	55	100%
	Pishin	69	42	61%
	Quetta	55	42	76%
	Sibi	36	4	11%
	Zhob	39	31	79%
	Jaffarabad	16	15	94%
	Naserabad	32	32	100%
	Kharan	30	30	100%
	Sherani	15	0	0%
	Kohlu	75	43	57%
	Chagi	36	20	56%
	Kalat	41	40	98%
	Harnai	17	17	100%
	Kachhi (Bolan)	35	0	0%
	Jhal Magsi	28	28	100%
	Sohbat pur	25	25	100%
	Surab	32	18	56%
	Mastung	45	45	100%
	Loralai	33	21	64%
	Killa Saifullah	28	27	96%
	Ziarat	29	0	0%
	Duki	31	0	0%
	Nushki	32	26	81%
	Dera Bugti	45	25	56%
	Washuk	46	36	78%
	Panjgur	38	10	26%
	Awaran	23	0	0%
	Chaman	24	0	0%
	Barkhan	20	18	90%
	Hub	33	11	33%
	Musakhel	41	17	41%
Gilgit Baltistan	Usta Muhammad	34	34	100%
	Hunza	32	32	100%
	Nagar	25	20	80%
	Ghizer	38	38	100%

	Gilgit	40	40	100%
	Diamer	62	61	98%
	Astore	54	54	100%
	Shigar	27	25	93%
	Skardu	52	52	100%
	Ganche	29	28	97%
Sindh	Kharmang	46	25	54%
	Hyderabad	74	25	34%
	Ghotki	64	64	100%
	Umerkot	43	43	100%
	Naushahro Feroze	107	49	46%
	Tharparkar	276	228	83%
	Shikarpur	61	60	98%
	Thatta	52	52	100%
	Larkana	67	66	99%
	Kamber Shadadkot	71	71	100%
	Karachi-East	23	19	83%
	Karachi-West	20	20	100%
	Karachi-Malir	37	30	81%
	Karachi-Kemari	18	15	83%
	Karachi-Central	12	7	58%
	Karachi-Korangi	18	17	94%
	Karachi-South	4	4	100%
	Sujawal	55	55	100%
	Mirpur Khas	106	101	95%
	Badin	124	124	100%
	Sukkur	64	63	98%
	Dadu	90	90	100%
	Sanghar	100	100	100%
	Jacobabad	44	44	100%
	Khairpur	170	166	98%
	Kashmore	59	59	100%
	Matiari	42	42	100%
	Jamshoro	75	72	96%
	Tando Allahyar	54	53	98%
	Tando Muhammad Khan	41	41	100%
	Shaheed Benazirabad	125	122	98%

Table 7: IDSR reporting Tertiary care hospital Week 05, 2024

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

Strengthening Mortality Surveillance in Pakistan: Expanding Advocacy and Implementation to Punjab

The implementation and advocacy of the National Mortality Surveillance System (MSS) are gaining momentum across Pakistan, transitioning from national-level discussions to provincial implementation. Following the successful advocacy meeting in Khyber Pakhtunkhwa (KP), efforts have now extended to Punjab, reflecting a strong commitment to improving public health through data-driven policies and evidence-based decision-making.

To advance these efforts, the Center for Disease Control (CDC) at the National Institutes of Health (NIH), in collaboration with the Punjab Health Department, successfully organized a consultative workshop on the implementation of a mortality surveillance system. The workshop served as a platform to bring together 40 key stakeholders from various institutions, including Medical Teaching Institutions (MTIs), the Punjab Healthcare Commission, Rescue 1122, the National Database and Registration Authority (NADRA), and other relevant organizations. The goal was to align efforts in establishing a robust and standardized mortality surveillance system that ensures accurate and timely mortality data collection, reporting, and utilization.

The sessions focused on several critical areas, including:

- The importance of a standardized national mortality surveillance system and its alignment with Pakistan's disease surveillance framework to enhance the country's response to public health challenges.
- A comprehensive discussion on the National Mortality Surveillance Framework and Implementation Plan and Mortality Data Reporting tool developed by NIH, providing a structured approach for provinces to follow.
- Identification of provincial priorities and challenges in mortality surveillance, ensuring that implementation strategies are tailored to Punjab's specific needs and capacities.

The workshop provided an opportunity for stakeholders to engage in collaborative discussions and consensus-building, ensuring that all key players are aligned in their roles and responsibilities. By leveraging multi-sectoral coordination and digital health innovations, Punjab aims to create a comprehensive mortality surveillance system that contributes to timely interventions, resource allocation, and policy formulation.

This initiative marks a significant step forward in strengthening mortality data collection and utilization in Pakistan. A well-structured mortality surveillance system is crucial for tracking health trends, identifying emerging health threats, and formulating evidence-based policies to reduce preventable deaths. With Punjab now actively engaged in implementation

efforts, this sets the stage for other provinces to follow suit, contributing to a nationally unified approach toward improved public health surveillance.

Notes from the field:

Outbreak Investigation Report of Measles in Village Dribh Kechi, UC Baledai, Taluka Mehar District Dadu, Sindh.

DDSRU Focal person

Introduction

Measles is a highly contagious viral disease caused by the measles virus (MeV), belonging to the Paramyxoviridae family. Despite the availability of an effective vaccine, measles continues to pose a significant public health challenge, particularly in regions with low immunization coverage. According to the World Health Organization (WHO), measles caused an estimated 128,000 deaths globally in 2021, with outbreaks often occurring in areas with suboptimal vaccination rates. Pakistan remains a high-burden country for measles, with frequent outbreaks reported due to gaps in routine immunization coverage and challenges in surveillance and response systems.

On 26th February 2025, a general practitioner from a private clinic in Taluka Mehar, District Dadu, reported a suspected case of measles in Village Dribh Kechi, UC Baledai. In response, after verifying the suspected case, the DHO activated a rapid response team on 28th February 2025 to conduct an outbreak investigation and implement necessary case response activities.

Objectives

- To determine the magnitude of outbreak
- To evaluate the associated risk factors
- To identify immunization coverage
- To recommend preventive and control measures

Methods

A descriptive outbreak investigation was conducted in village Dribh Kechi where the team visited the household of the initial suspected measles case and recorded family member's accounts. The suspected cases were defined as any person with fever (≥38°C) and a generalized maculopapular rash, along with at least one of the following symptoms: cough, coryza (runny nose), or conjunctivitis (red eyes) residing in Village Dribh Kechi, UC Baledai. Case identification was carried out through active case finding and a review of routine immunization records to identify additional suspected cases in the affected village and surrounding areas. Basic Health Unit (BHU) in Baledai was also visited by the team to review and validate Expanded Program on Immunization (EPI) records to assess vaccination coverage among the affected individuals and sensitize the facility in charge.

Descriptive analysis was conducted to characterize the outbreak in terms of age, sex, and vaccination status, while also identifying associated risk factors.

Results

Total 17 suspected measles cases were identified based on clinical signs and symptoms consistent with the case definition. The highest incidence was observed among children aged 3–5 years, with a disproportionate impact on females. The data revealed that 16 (94%) of the suspected cases were unvaccinated, while one case had received only the first dose of the Measles-Rubella (MR-1) vaccine but had missed the second dose (MR-2). Review of BHU record shows low routine immunization in the community. The primary risk factor identified for measles infection in the village was lack of vaccination. The community had previously refused routine immunization due to fear of fever; however, vaccine acceptance increased

following the outbreak. Poor health-seeking behavior, reliance on traditional healers, and socioeconomic challenges resulted in the underutilization of health services and contributed as risk factors.

Public Health Response

- Mobile medical camps, mop-up vaccination activities, Vitamin A supplementation, health awareness sessions, and outreach immunization campaigns were initiated in the affected village and surrounding areas.

Discussion

The findings of this investigation highlight the critical role of vaccination in preventing measles outbreaks. The majority of suspected cases were unvaccinated, reinforcing well-established evidence that measles susceptibility is highest among individuals who have not received the recommended doses of the measles-containing vaccine (MCV) (1,2). The outbreak predominantly affected children aged 3–5 years, an age group that should have received at least one or both doses of the Measles-Rubella (MR) vaccine, indicating significant gaps in routine immunization coverage. Studies have shown that low measles vaccination coverage is a major risk factor for outbreaks, particularly in settings with weak immunization systems and vaccine hesitancy (3,4).

A notable aspect of this outbreak was the disproportionate impact on females, which may reflect gender-based disparities in healthcare access or sociocultural barriers limiting female child immunization. Previous research has identified gender differences in immunization uptake in some low-resource settings, with female children sometimes being less likely to receive vaccinations due to household decision-making patterns and caregiver preferences (5,6).

The community's historical refusal of routine immunization due to fear of vaccine-related fever was a key determinant of low coverage. Vaccine hesitancy, driven by misinformation and fear of adverse effects, remains a significant global challenge, as reported by the WHO (7). However, the increased acceptance of vaccination following the outbreak suggests that direct exposure to an outbreak can serve as a catalyst for behavioral change. Similar trends have been observed in previous measles outbreaks, where community demand for vaccines surged after witnessing disease severity (8).

Additional factors contributing to measles susceptibility in this community included poor health-seeking behavior, reliance on traditional healers, and socioeconomic barriers. Limited access to healthcare services, financial constraints, and trust in alternative medicine have been documented as impediments to timely vaccination and medical care in various settings (9,10). Addressing these challenges requires targeted community engagement, health education, and strengthening of immunization programs to ensure higher coverage and prevent future outbreaks**.**

Conclusion

The suspected measles outbreak in the village is likely due to low routine immunization coverage, which left a significant proportion of the population vulnerable to infection. The absence of adequate vaccination was identified as the primary risk factor contributing to disease transmission.

Recommendations

1. Strengthen disease surveillance at facility level for early detection and prevention of spread of disease in the community.
2. Implement proper case response activities, including free medical camps, mop-up immunization, and Vitamin A supplementation in the affected village and surrounding areas.

3. Increase efforts to cover refusals, defaulters, and zero-dose children in the affected and neighboring villages.
4. Engage local Lady Health Workers (LHWs) to conduct health education sessions and support maximum routine immunization coverage.

References

1. Perry RT, Gacic-Dobo M, Dabbagh A, Mulders MN, Strebel PM, Okwo-Bele JM, et al. Progress toward regional measles elimination—worldwide, 2000–2016. *MMWR Morb Mortal Wkly Rep*. 2018;67(6):1323–9.
2. World Health Organization. Measles vaccines: WHO position paper—April 2017. *Wkly Epidemiol Rec*. 2017;92(17):205–27.
3. Patel MK, Goodson JL, Alexander JP Jr, Kretsinger K, Sodha SV, Rota PA, et al. Progress toward regional measles elimination—worldwide, 2000–2020. *MMWR Morb Mortal Wkly Rep*. 2021;70(45):1563–9.
4. Durrheim DN, Crowcroft NS, Strebel PM. Measles—the epidemiology of elimination. *Vaccine*. 2014;32(51):6880–3.
5. Babirye JN, Engebretsen IM, Makumbi F, Fadnes LT, Wamani H, Tylleskär T, et al. Timeliness of childhood vaccinations in Kampala, Uganda: a community-based cross-sectional study. *PLoS One*. 2012;7(4):e35432.
6. Puri N, Coomes EA, Haghbayan H, Gunaratne K. Social media and vaccine hesitancy: new updates for the era of COVID-19 and globalized infectious diseases. *Hum Vaccin Immunother*. 2020;16(11):2586–93.
7. World Health Organization. Ten threats to global health in 2019. Geneva: WHO; 2019. Available from: https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019
8. SAGE Working Group on Vaccine Hesitancy. Report of the SAGE Working Group on Vaccine Hesitancy. Geneva: WHO; 2014. Available from: https://www.who.int/immunization/sage/meetings/2014/october/SAGE_working_group_revised_report_vaccine_hesitancy.pdf
9. Obrist B, Iteba N, Lengeler C, Makemba A, Mshana C, Nathan R, et al. Access to health care in contexts of livelihood insecurity: a framework for analysis and action. *PLoS Med*. 2007;4(10):e308.
10. Figueroa JP, Bottazzi ME, Drameh-Avognon O, Gilbert J, Gooden M, Harris T, et al. Urgent needs of low-income and middle-income countries for COVID-19 vaccines and therapeutics. *Lancet*. 2021;397(10274):562–4.

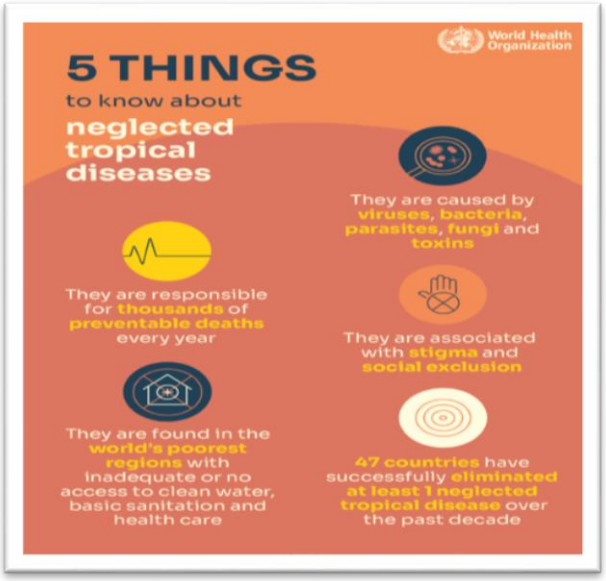
Knowledge Hub

World Neglected Tropical Diseases Day: A Call to Action for Pakistan

Neglected Tropical Diseases (NTDs) are a diverse group of infectious diseases that affect over 1.5 billion people worldwide, predominantly in low-income settings. These diseases, including leprosy, dengue, leishmaniasis, and lymphatic filariasis, thrive in conditions of poverty, inadequate sanitation, and limited healthcare access. World NTD Day, observed annually on January 30, serves as a global platform to raise awareness, mobilize resources, and accelerate efforts towards eliminating NTDs.

The Global Commitment to End NTDs

The World Health Organization (WHO) officially recognized World NTD Day in 2021, underscoring the urgent need for concerted global action. Since the launch of the London Declaration on NTDs in 2012, significant progress has been made in controlling and eliminating several NTDs. WHO's *Roadmap for Neglected Tropical Diseases 2021–2030* outlines ambitious goals, including reducing the number of people requiring interventions for NTDs by 90% and eliminating at least one NTD in 100 countries by 2030. Each year, WHO and its global partners commemorate World NTD Day by organizing various events and campaigns. For instance, in 2025, WHO called on leaders and communities to unite, act, and eliminate NTDs by making bold, sustainable investments to free the estimated 1.5 billion people affected worldwide.



The Burden of NTDs in Pakistan

Pakistan faces a considerable burden of NTDs, particularly leishmaniasis, dengue, rabies, and soil-transmitted helminthiasis. The country's

diverse geography, including flood-prone areas, inadequate vector control, and poor access to healthcare in rural regions, exacerbates the spread of these diseases. Cutaneous leishmaniasis, for instance, remains a major public health concern, especially in Khyber Pakhtunkhwa and Balochistan, where thousands of cases are reported annually.

Pakistan's Efforts and Challenges

Pakistan has taken steps to combat NTDs, including national programs for dengue control and the mass drug administration (MDA) initiative to reduce soil-transmitted helminthiasis. However, challenges such as insufficient funding, lack of intersectoral coordination, and limited community engagement hinder sustained progress.

World NTD Day presents an opportunity to advocate for stronger commitments from policymakers, enhance surveillance systems, and integrate NTD programs within existing healthcare services. Multi-sectoral collaboration involving public health authorities, academia, and civil society is crucial to achieving sustained progress.

Call to Action

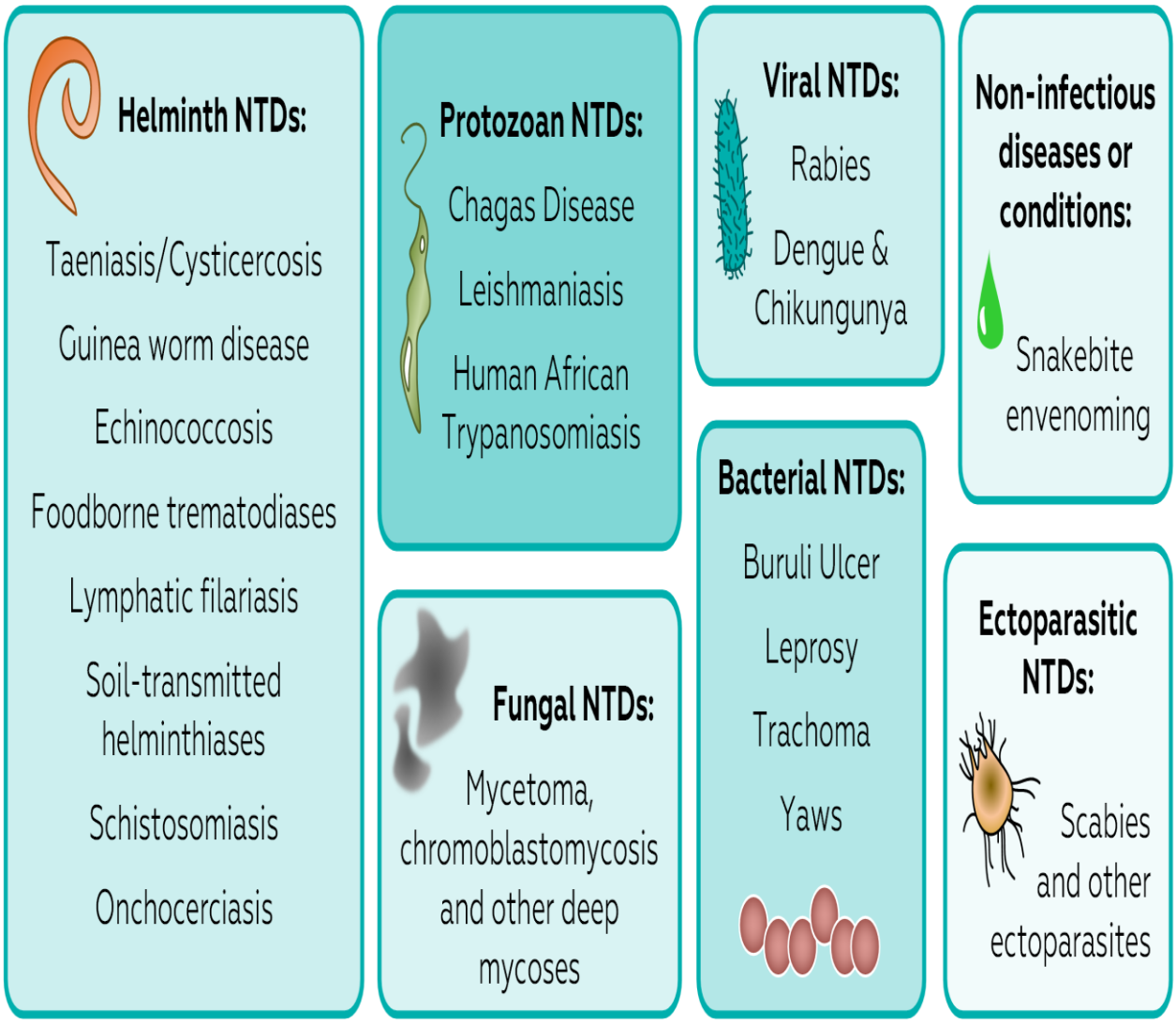
To combat NTDs effectively in Pakistan, the following actions are essential:

1. **Strengthening Surveillance and Research:** Investment in NTD data collection and epidemiological research is vital for evidence-based policymaking.
2. **Enhancing Vector Control Measures:** Improved sanitation, clean water access, and community-based interventions can significantly reduce NTD transmission.
3. **Scaling Up Mass Drug Administration (MDA):** Expanding MDA programs for helminthes infections can alleviate the disease burden among school-age children.
4. **Increasing Public Awareness:** Community engagement through health education campaigns can promote preventive behaviors and reduce stigma.
5. **Securing Sustainable Financing:** Long-term investment in NTD control programs is needed to ensure continuity and effectiveness.

As Pakistan continues its journey toward universal health coverage, addressing NTDs must remain a priority. On this World NTD Day, let us reaffirm our commitment to eliminating these diseases and improving the health and well-being of vulnerable populations across the country.

References

1. World Health Organization. (2021). *Ending the neglect to attain the Sustainable Development Goals: A road map for neglected tropical diseases 2021–2030*. WHO.
2. World Health Organization. (2025). *World NTD Day 2025: Unite, Act, Eliminate*. Retrieved from https://www.who.int/campaigns/world-ntd-day/2025
3. World NTD Day. (2025). *World NTD Day Campaign Overview*. Retrieved from https://worldntdday.org
4. Pakistan Ministry of National Health Services, Regulations & Coordination. (2024). *National Action Plan for the Control of Neglected Tropical Diseases in Pakistan*.
5. WHO EMRO. (2023). *Cutaneous leishmaniasis in Pakistan: Current status and control strategies*. Retrieved from http://www.emro.who.int/neglected-tropical-diseases/countries/pakistan.html



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