

Summary of Priority Diseases and Events in Zambia

Integrated Disease Surveillance Report (IDSR) Timeliness and Completeness

Nationally, 44,512 health facilities and surveillance sites were expected to report to the IDSR system during Q1 2026. Reports are received and collated at the district and provincial levels before submission to ZNPHI. Timeliness and completeness of weekly reports are the primary indicators of surveillance system quality. Table 1 summarises completeness and timeliness rates by province for Q1 2026.

Table 1: IDSR report completeness and timeliness rates by province Q1 2026 (January–March 2026)

Province	Expected Reports (N)	Completeness* n (%)	Timeliness† n (%)	Met ≥80% Target?
Central	4758	4,689 (98.55%)	4,462 (93.78%)	Yes
Copperbelt	5473	5,381 (98.32%)	5,245 (95.83%)	Yes
Eastern	5473	5,414 (98.92%)	5,146 (94.03%)	Yes
Luapula	4199	4,137 (98.52%)	4,061 (96.71%)	Yes
Lusaka	2951	2,862 (96.98%)	2,632 (89.19%)	Yes
Muchinga	2184	2,184 (100.0%)	2,121 (97.12%)	Yes
Northern	4225	4,086 (96.71%)	3,803 (90.01%)	Yes
Northwestern	4602	4,461 (96.94%)	3,991 (86.72%)	Yes
Southern	6045	5,907 (97.72%)	5,679 (93.95%)	Yes
Western	4602	4,469 (97.11%)	4,176 (90.74%)	Yes

* *Completeness*: percentage of expected reporting health facilities/surveillance sites that submitted data regardless of submission timing. National target ≥80%.

† *Timeliness*: percentage of reporting health facilities/surveillance sites that submitted reports on time. National target ≥80%.

All 10 provinces met the ≥80% WHO/MOH target for both completeness and timeliness. Nationally, completeness was 97.9% and timeliness was 92.8%. Muchinga Province achieved the highest completeness at 100.0%, while North-Western Province recorded the lowest timeliness at 86.7%, though still well above the 80% threshold. These results indicate a high-quality surveillance system capable of reliably detecting and tracking disease events across Zambia.

Featured Diseases

1. Cholera

Description

Cholera is an acute diarrhoeal disease caused by infection with the bacterium *Vibrio cholerae* (1). It is transmitted through contaminated water and food and can cause severe dehydration and death within hours if untreated. Children, the elderly, and those with underlying health conditions are most at risk (1). Zambia has experienced recurrent cholera outbreaks, particularly in peri-urban areas with limited access to safe water, sanitation, and hygiene (WASH) infrastructure (2). Surveillance is essential to enable rapid case detection, outbreak response, and interruption of transmission (2).

Epidemiological Summary

During Q1 2026 (Weeks 1–13), a total of 768 suspected cholera cases were reported nationally, of which 150 were confirmed (19.5% confirmation rate). Thirteen deaths were recorded, representing a case fatality rate (CFR)

of 8.67% (13/150). Lusaka Province was the primary hotspot, accounting for the majority of confirmed cases and deaths (Figure 1). Northern Province recorded a smaller cluster of cases. Cholera transmission was most intense during Weeks 3-11, with a peak of 145 suspected cases in Week 9, before declining toward the end of the quarter (Figure 2).



Figure 1: Distribution of suspected cholera cases by province, Q1 2026. Lusaka Province recorded the highest burden

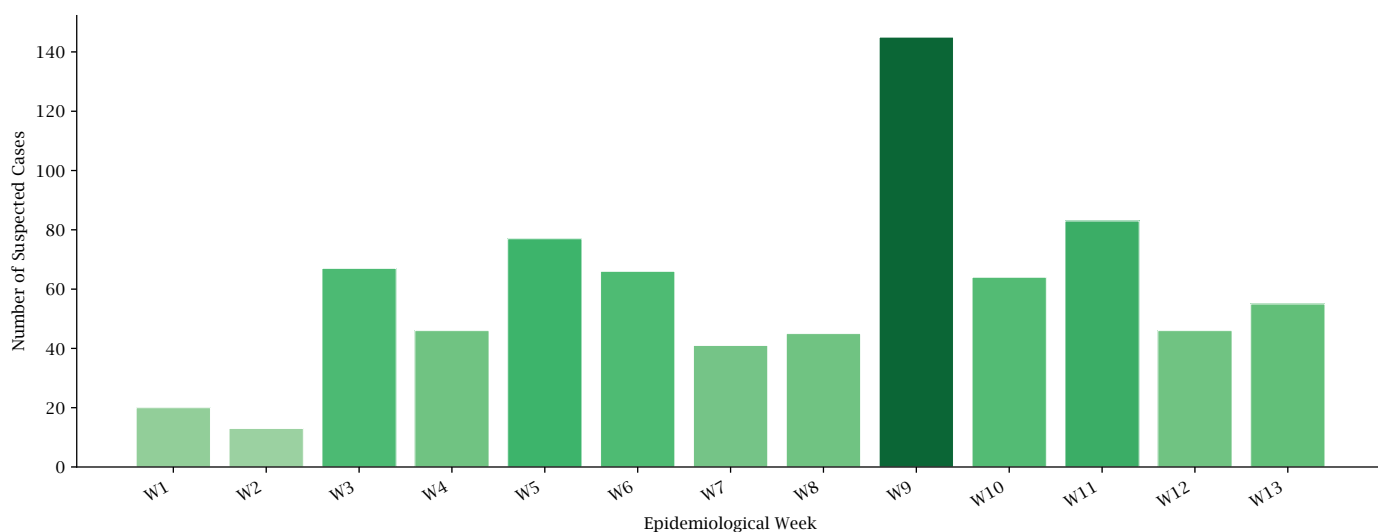


Figure 2: Weekly suspected cholera cases, Zambia, Q1 2026. Peak transmission was observed in Week 9.

Recommendations

- Provincial and district health teams in Lusaka should intensify active case finding, oral rehydration therapy (ORT) provision, and household water treatment promotion in affected communities.
- Water and sanitation authorities should conduct targeted water quality testing in cholera-affected areas to identify contamination sources.
- Health workers are advised to enforce standard precautions and report all suspected cases within 24 hours per IDSR protocols. More information is available at: www.znphi.co.zm

2. Diarrhoeal Diseases (Non-Bloody and Bloody)

Diarrhoeal diseases both non-bloody (acute watery diarrhoea) and bloody (dysentery) represent a significant proportion of the communicable disease burden in Zambia (3). Non-bloody diarrhoea is most commonly caused by viral and bacterial pathogens transmitted via the faecal-oral route, contaminated water, and poor food hygiene (4,5). Bloody diarrhoea (dysentery) is typically caused by *Shigella* species or enterohaemorrhagic *Escherichia coli*, and is associated with higher morbidity and risk of complications (6). Children under five years of age and communities with limited WASH access are most vulnerable (6). Both conditions share the same underlying risk factors and prevention strategies (4,5,6).

Epidemiological Summary Non-Bloody Diarrhoea

Non-bloody diarrhoea was the highest-burden non-malaria disease in Q1 2026, with 392,829 suspected cases reported nationally. Of these, 8,315 were confirmed and 21 deaths were recorded (CFR 0.25%). Copperbelt Province recorded the highest case concentration, followed by Eastern and Western provinces (Figure 3). Case counts remained consistently high throughout the quarter (approximately 27,000–34,000 cases per week), suggesting sustained endemic transmission rather than a discrete outbreak (Figure 4).

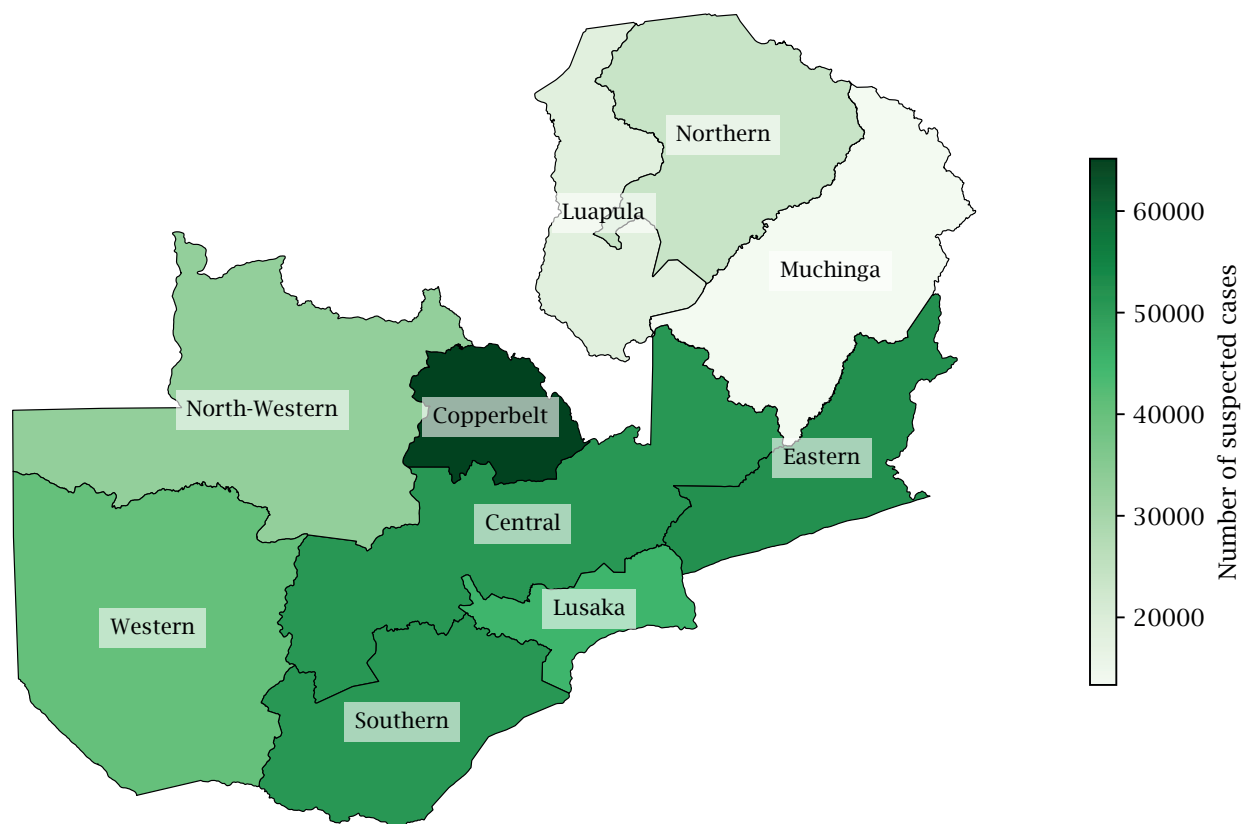


Figure 3: Distribution of suspected non-bloody diarrhoea cases by province, Q1 2026. Copperbelt Province recorded the highest burden.

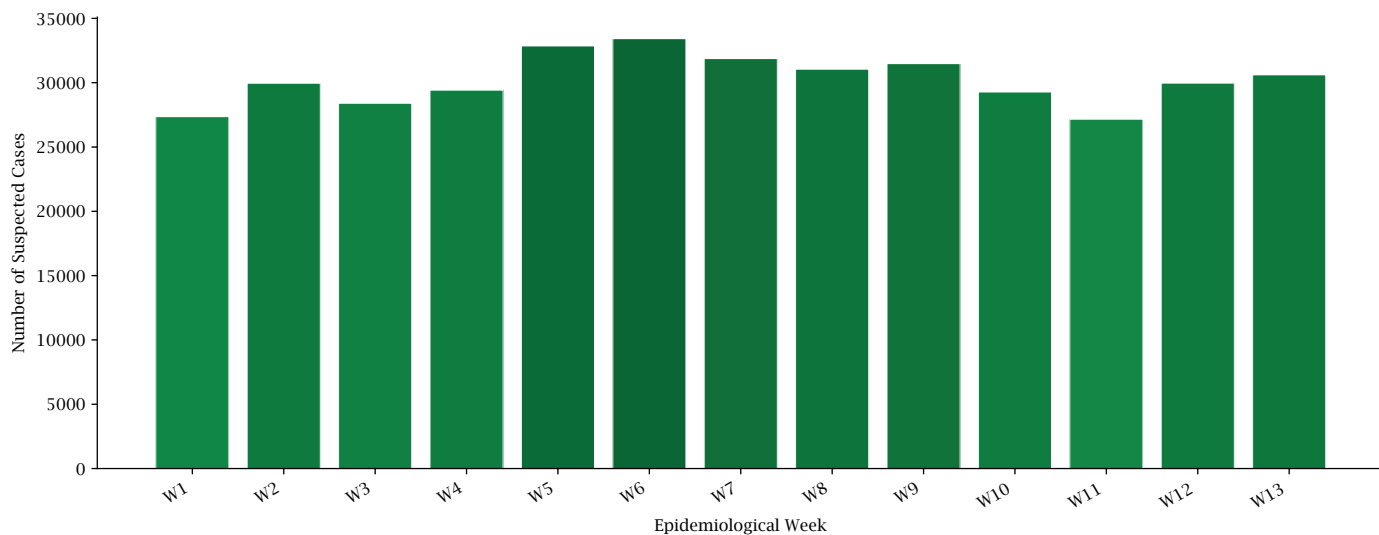


Figure 4: Weekly suspected non-bloody diarrhoea cases, Zambia, Q1 2026. Case counts remained consistently elevated throughout the quarter.

Epidemiological Summary Bloody Diarrhoea (Dysentery)

A total of 10,902 suspected bloody diarrhoea (dysentery) cases were reported nationally during Q1 2026. Notably, zero confirmed cases were recorded against this substantial suspected case count. This is an important surveillance signal that requires investigation; it may indicate a laboratory confirmation gap, inconsistent application of the case definition at facility level, or specimen collection and transport challenges. Eastern and Southern provinces showed the highest case concentrations (Figure 5). Cases were highest in Weeks 1-4 and declined progressively through the quarter (Figure 6).

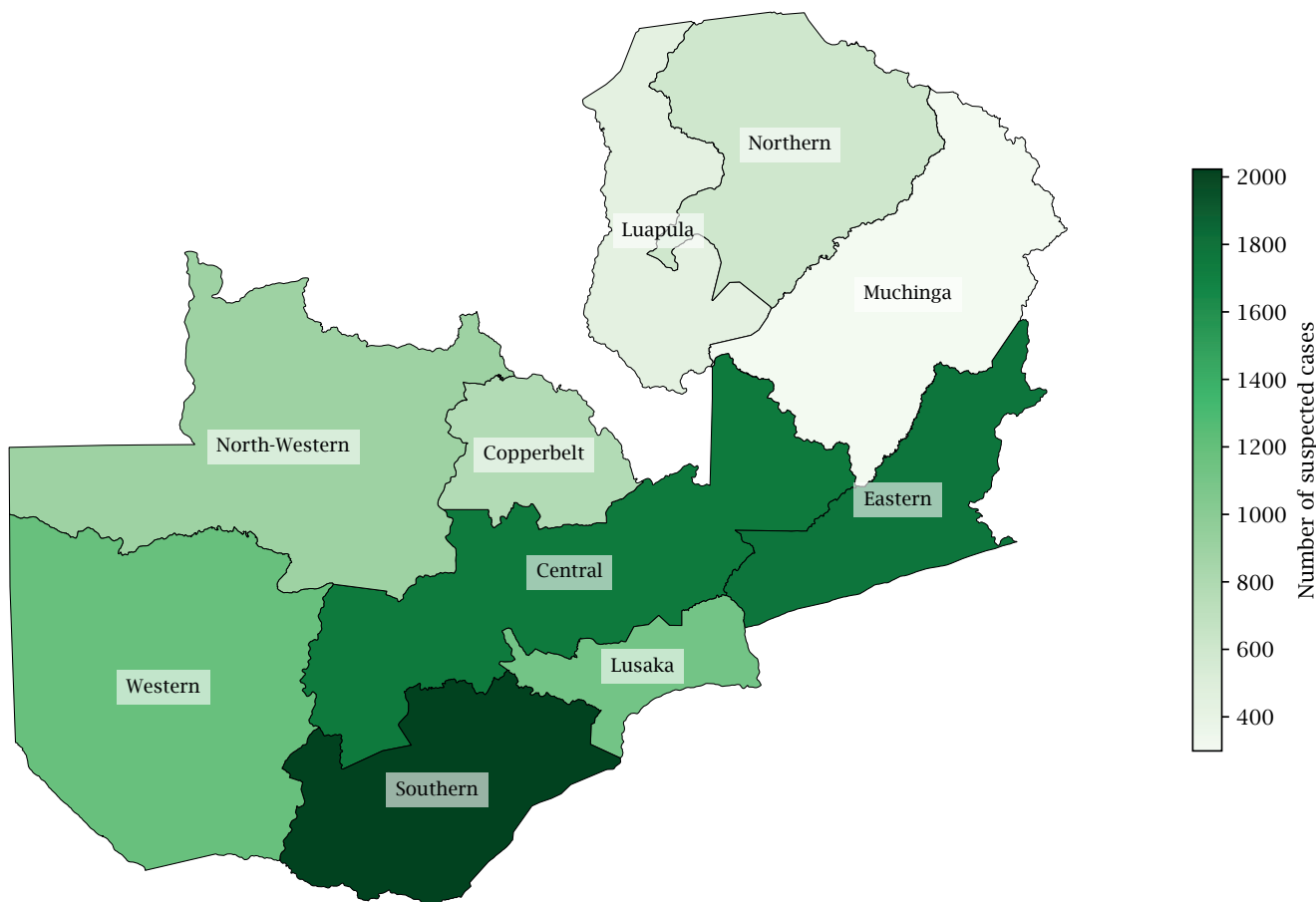


Figure 5: Distribution of suspected bloody diarrhoea cases by province, Q1 2026. Southern Province recorded the highest burden.

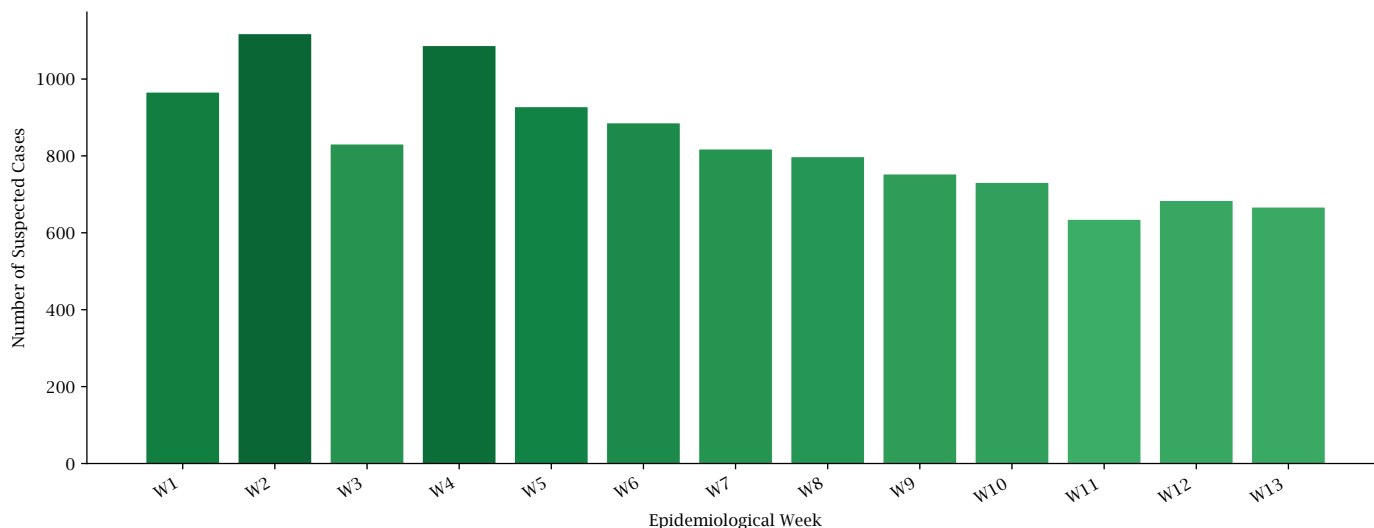


Figure 6: Weekly suspected bloody diarrhoea cases, Zambia, Q1 2026. A declining trend was observed from Week 2 onward

Recommendations

- Provincial health offices in Copperbelt, Eastern, and Southern provinces should intensify community WASH interventions and health education targeting safe food handling, handwashing with soap, and safe water storage.
- ZNPHI should investigate the zero-confirmation rate for bloody diarrhoea to determine whether it reflects a true epidemiological situation or a surveillance gap in laboratory testing and case definition application.
- Clinicians should collect stool specimens from suspected dysentery cases and submit to provincial laboratories to improve confirmation rates and guide antimicrobial stewardship.

3. Malaria

Description

Malaria is a life-threatening disease caused by Plasmodium parasites transmitted through the bites of infected female Anopheles mosquitoes (7). In Zambia, Plasmodium falciparum is the predominant species and is responsible for the most severe forms of the disease (8). Children under five years of age and pregnant women are at highest risk of severe malaria and death (9). Zambia's malaria transmission is seasonal, with peak transmission occurring during the rainy season (October to April) (8). Malaria remains the leading cause of morbidity and mortality in Zambia and is a priority disease under the National Malaria Elimination Programme (10).

Epidemiological Summary

Malaria was the dominant disease reported in Q1 2026, with 4,629,503 suspected cases, 2,480,259 confirmed cases (53.6% test positivity rate), and 272 deaths (CFR 0.01%). Copperbelt and North-Western provinces recorded the highest burden of suspected cases, while Lusaka and Southern provinces had relatively lower case counts (Figure 7). The weekly trend shows a progressive increase from approximately 265,000 suspected cases in Week 1 to a peak of approximately 415,000 in Week 9, consistent with the trajectory of Zambia's peak rainy season transmission. A slight decline was observed from Week 10 onward, signalling the beginning of the post-peak period (Figure 8).

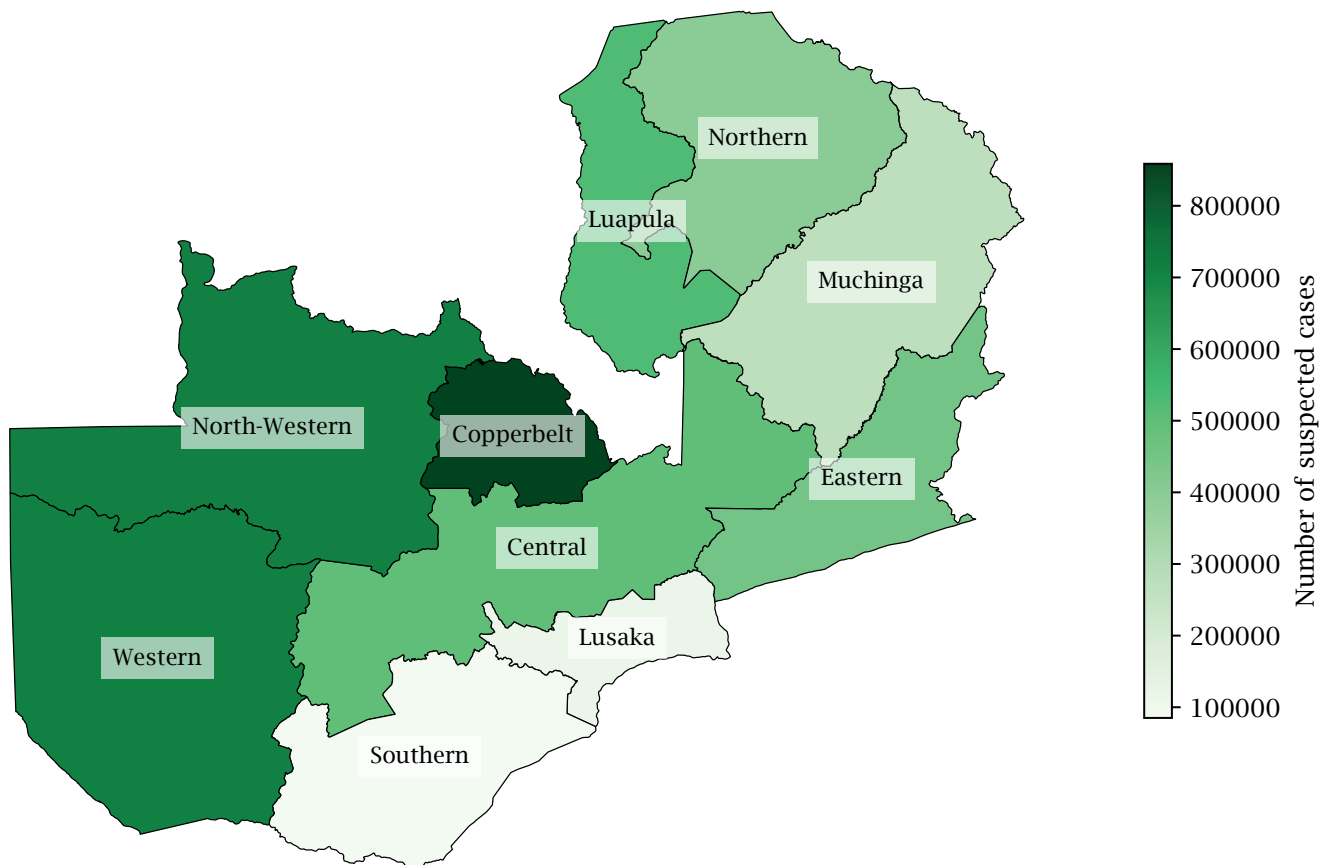


Figure 7: Distribution of suspected malaria cases by province, Q1 2026. Copperbelt and North-Western provinces recorded the highest burden.

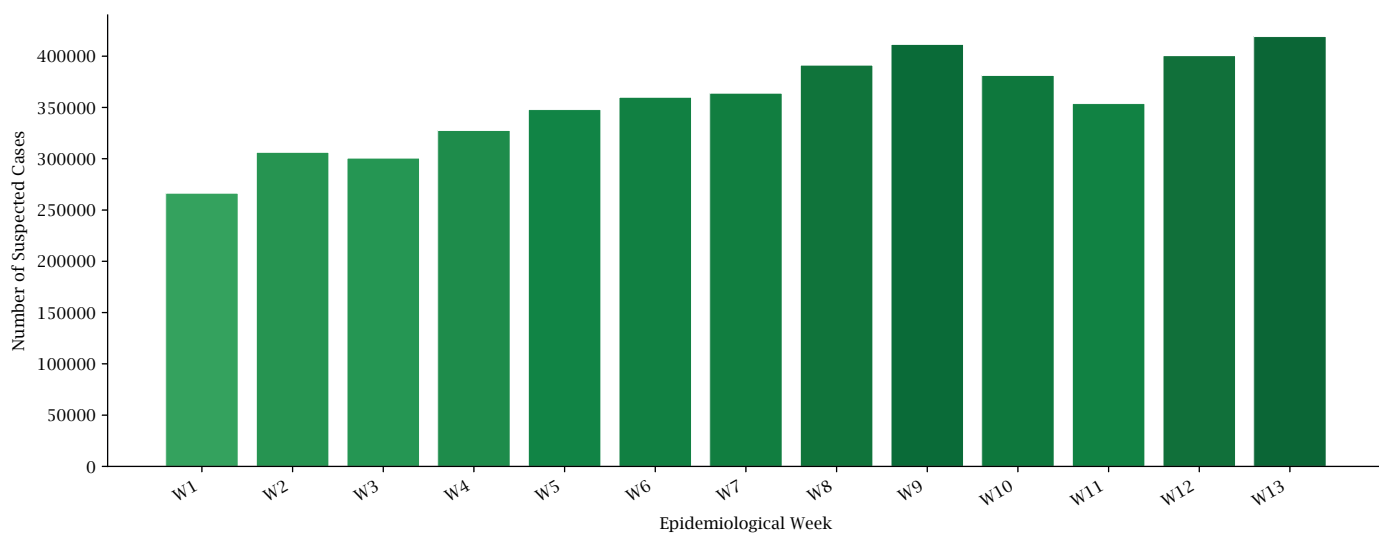


Figure 8: Weekly suspected malaria cases, Zambia, Q1 2026. Cases peaked in Week 9, consistent with peak rainy season transmission.

Recommendations

- Health facilities in high-burden provinces (Copperbelt, North-Western, Luapula, Western) should ensure adequate stocks of rapid diagnostic tests (RDTs) and artemisinin-based combination therapies (ACTs) ahead of the continued transmission season.
- Community health workers should reinforce insecticide-treated bed net (ITN) use and promote indoor residual spraying (IRS) uptake in targeted districts.
- Pregnant women and children under five should be prioritised for preventive interventions including

intermittent preventive treatment in pregnancy (IPTp) and seasonal malaria chemoprevention (SMC) where applicable.

4. Measles

Description

Measles is a highly contagious viral disease caused by the measles virus (genus Morbillivirus) (11). It is transmitted via respiratory droplets and can cause severe complications including pneumonia, encephalitis, and death, particularly in young children and immunocompromised individuals (11). Zambia is committed to the WHO African Region measles elimination target, and sustained measles transmission signals a vaccination coverage gap that requires urgent programmatic action (12). All suspected measles cases in children under 15 years are notifiable under Zambia's Integrated Disease Surveillance and Response (IDSR) system.

Epidemiological Summary

During Q1 2026, 912 suspected measles cases were reported nationally, with 34 confirmed and 2 deaths (CFR 5.88%). Western Province was the primary hotspot, accounting for the majority of cases consistent with the distribution seen in the province-level choropleth (Figure 9). The weekly epi curve shows two notable surges: a peak of 329 suspected cases in Week 3 and a second surge of 258 cases in Week 8, with relative decline in between and a third smaller increase in Week 13 (Figure 10). This bimodal pattern suggests either multiple transmission chains or incomplete outbreak containment following the initial surge.



Figure 9: Distribution of suspected measles cases by province, Q1 2026. Western Province recorded the highest burden, indicating a localised vaccination gap.

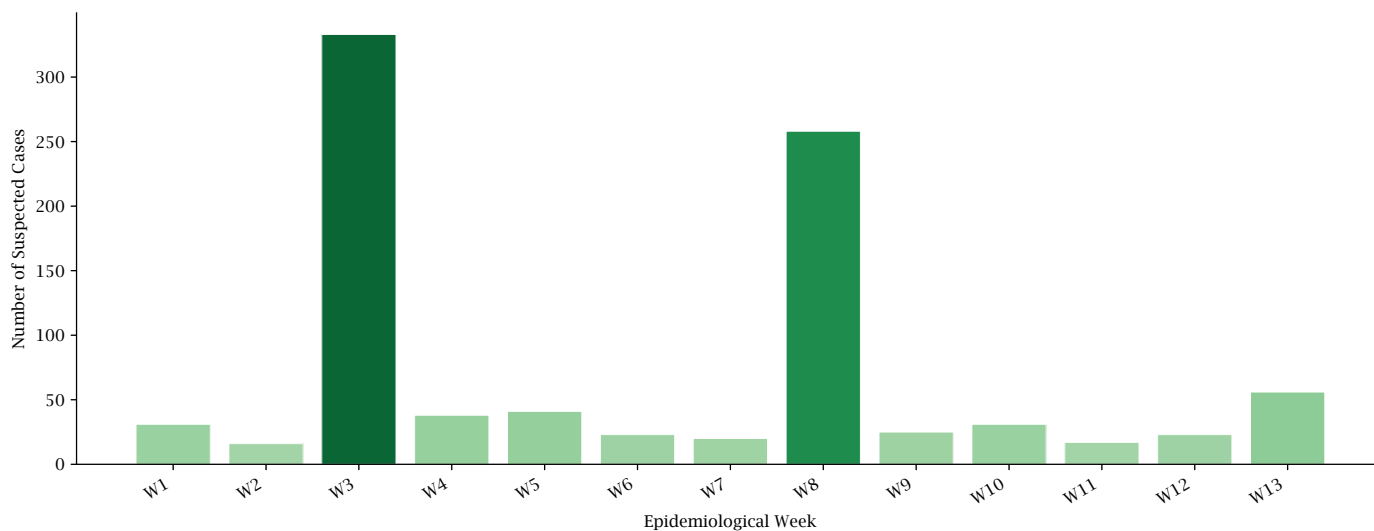


Figure 10: Weekly suspected measles cases, Zambia, Q1 2026. A bimodal pattern with peaks in Weeks 3 and 8 suggests ongoing transmission chains.

Recommendations

- The Western Province Health Office should conduct an immediate vaccination coverage assessment to identify under immunised populations and implement a targeted supplementary immunisation activity (SIA).
- All confirmed measles cases should be reported to ZNPHI within 24 hours and blood samples collected for laboratory confirmation and genotyping to characterise the circulating strain.
- Health workers are advised to administer vitamin A supplementation alongside measles treatment to reduce severity and mortality, per WHO guidelines (www.who.int/health-topics/measles).

5. Monkeypox (Mpox)

Description

Monkeypox (Mpox) is a viral zoonotic disease caused by the monkeypox virus (genus Orthopoxvirus) (13). It is transmitted to humans from animals (particularly rodents and primates) through direct contact with infected animals, contaminated materials, or through close human-to-human contact via respiratory droplets, skin lesions, or bodily fluids (13). Clinical presentation includes fever, rash, and lymphadenopathy (13). In July 2022 and again in August 2024, the WHO Director-General declared mpox a Public Health Emergency of International Concern (PHEIC) under the IHR, requiring heightened surveillance, case investigation, and reporting (14).

Epidemiological Summary

During Q1 2026, 128 suspected mpox cases were reported nationally, with 8 confirmed and 1 death (CFR 12.50%). Muchinga Province accounted for the highest number of suspected cases, with Western and Lusaka provinces also reporting clusters (Figure 11). The weekly epi curve reveals highest transmission in Weeks 1 and 3 (approximately 18-19 cases per week), with a general declining trend through to Week 11 (3 cases), followed by a resurgence in Week 12 (17 cases) (Figure 12). This resurgence warrants continued surveillance and investigation to identify whether it represents a new transmission chain.

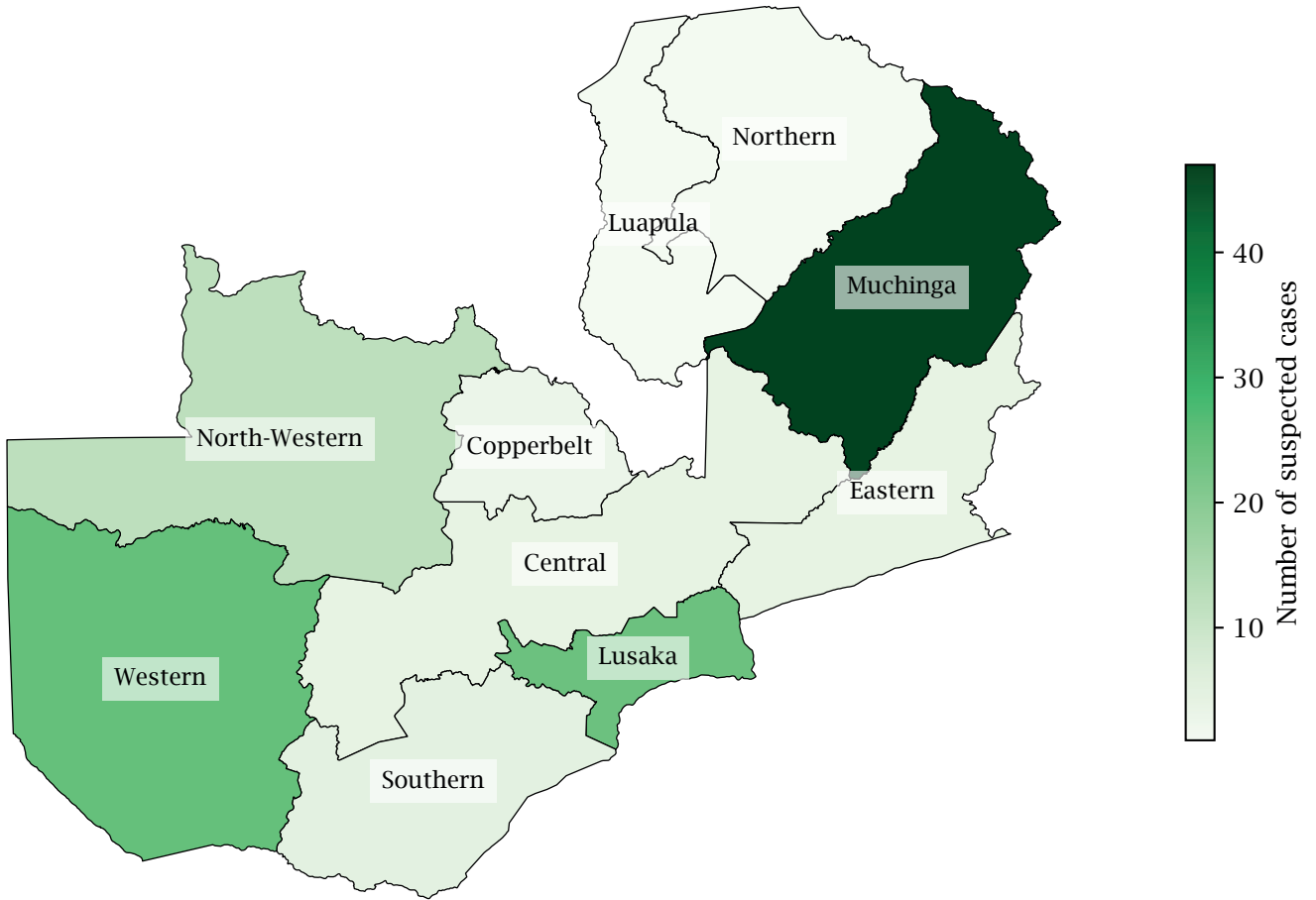


Figure 11: Distribution of suspected mpox cases by province, Q1 2026. Muchinga Province recorded the highest concentration of cases.

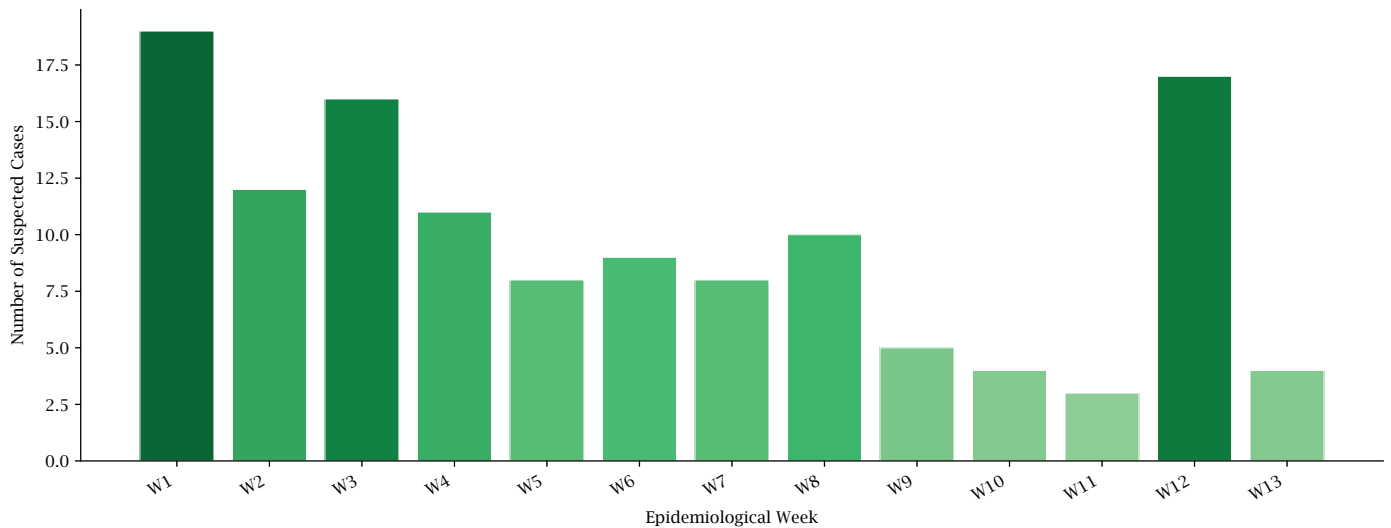


Figure 12: Weekly suspected mpox cases, Zambia, Q1 2026. A resurgence in Week 12 warrants continued surveillance.

Recommendations

- Muchinga Province health authorities should investigate the Week 12 resurgence to determine transmission source, identify new cases, and initiate contact tracing per ZNPHI mpox response guidelines.
- All suspected mpox cases must be reported to ZNPHI within 24 hours as required under the IHR. Specimens should be collected and submitted to the national reference laboratory for PCR confirmation.
- Health workers should implement standard infection prevention and control (IPC) measures including personal protective equipment (PPE) when managing suspected cases. For guidance, consult: www.who.int/health-topics/monkeypox.

Table of Reported Cases and Events

Table 2 provides a complete reference of all nationally reported IDSR diseases and events for Q1 2026 (Weeks 1-13, 29 December 2025–29 March 2026). Diseases are listed in alphabetical order. Case fatality rates are calculated as the number of deaths divided by the number of confirmed cases, multiplied by 100. A dash (...) indicates insufficient confirmed case data to calculate a meaningful rate.

Table 2: Nationally reported suspected and confirmed cases, deaths, and CFRs by disease/event Q1 2026 (January–March 2026)

Disease / Event	Suspected Cases	Confirmed Cases	Deaths	CFR* (%)
Acute flaccid paralysis (AFP) (suspected polio)	152	—	—	—
Acute viral hepatitis	27,388	1,472	12	0.82
Adverse event following immunisation (AEFI)	28	10	0	0.00
Anthrax	94	—	—	—
Bilharzia (Schistosomiasis)	6,663	776	0	0.00
Bloody diarrhoea (dysentery)	10,902	—	—	—
COVID-19	322	26	0	0.00
Cholera	768	150	13	8.67
Diarrhoea Non-Bloody	392,829	8,315	21	0.25
Dog bites	7,222	—	—	—
HIV	61,858	1,493	8	0.54
Human rabies	27	—	—	—
Influenza-like illness (ILI)	1,818	5	0	0.00
Malaria	4,629,503	2,480,259	272	0.01
Measles	912	34	2	5.88
Meningitis	135	31	13	41.94
Monkeypox (mpox)	128	8	1	12.50
Mumps	7,004	2,077	0	0.00
Neonatal tetanus	27	1	7	700.00
Plague	9	—	—	—
Scabies	8,887	205	0	0.00
Trypanosomiasis	248	23	1	4.35
Tuberculosis	8,637	261	2	0.77
Typhoid fever	2,085	76	1	1.32

* CFR = Case fatality rate: (number of deaths ÷ number of confirmed cases) × 100. '—' indicates insufficient confirmed case data to calculate a meaningful rate.

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A microscopic view of cells, likely a honeycomb-like structure, with a central cell in focus. The background is a warm, orange-yellow glow.

Data used was extracted from eIDSR on 21st April, 2026.

About eIDSR

The Electronic Integrated Disease Surveillance and Response System (eIDSR) is a disease surveillance system that is used to continuously and systematically collect, analyse, interpret, and visualize public health data. Data is collected at facility level and captured by district surveillance officers. The data reported in this bulletin was extracted from the system (except where indicated otherwise) on the aforementioned date.

For more information you can email healthpress@znphi.co.zm