

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 Q2 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 Q2 2026.

Table 1: IDSR report completeness and timeliness rates by province Q2 2026 April–June 2026)

Province	Expected Reports (N)	Completeness n (%)	Timeliness n (%)	Met ≥80% Target?
Central	4821	4774 (99.03%)	4623 (96.84%)	Yes
Copperbelt	5473	5401 (98.68%)	5355 (99.15%)	Yes
Eastern	5575	5543 (99.43%)	5248 (94.68%)	Yes
Luapula	4210	4181 (99.31%)	4122 (98.59%)	Yes
Lusaka	2964	2904 (97.98%)	2744 (94.49%)	Yes
Muchinga	2210	2209 (99.95%)	2189 (99.09%)	Yes
Northern	4199	4179 (99.52%)	4053 (96.98%)	Yes
Northwestern	4615	4424 (95.86%)	4170 (94.26%)	Yes
Southern	6019	5932 (98.55%)	5727 (96.54%)	Yes
Western	4680	4530 (96.79%)	4246 (93.73%)	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%.

Muchinga Province recorded the highest completeness (99.95%) and timeliness (99.09%), while Western had the lowest completeness (96.79%) and North-Western the lowest timeliness (94.26%). All provinces nonetheless exceeded the WHO/MOH target of at least 80% for both indicators.

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 Q2 2026 (Weeks 14 - 26), a total of 261 suspected cholera cases were reported nationally, of which 93 were confirmed (35.63% confirmation rate). 14 deaths were recorded, representing a case fatality rate (CFR) of 5.36%. Lusaka Province was the primary hotspot, accounting for most confirmed cases and deaths (Figure 1). Cholera transmission was most intense during Weeks 14 and 15, with a peak of 64 suspected cases in Week 9, before declining in the rest of the quarter (Figure 2).



Figure 1: Distribution of suspected cholera cases by province, Q2 2026.

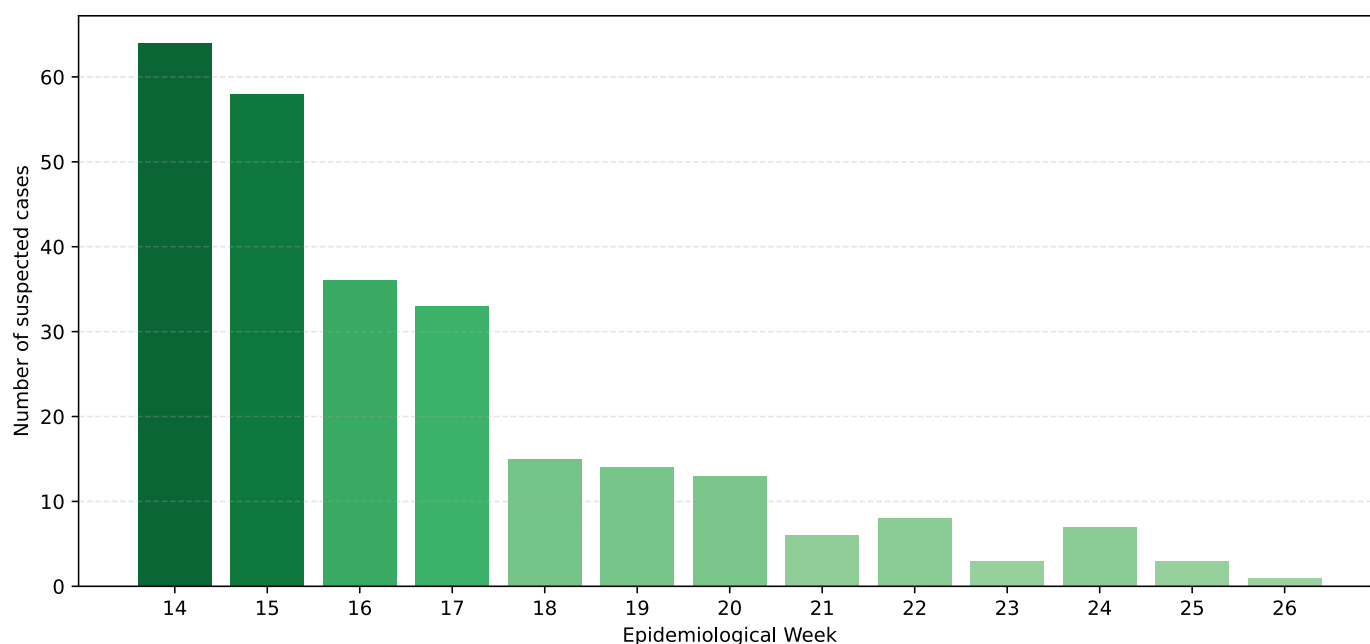


Figure 2: Weekly suspected cholera cases, Zambia, Q2 2026.

Recommendations

- Provincial and district health teams in Lusaka should maintain 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 (Lusaka) 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 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 on Diarrhoea Non-Bloody

Non-bloody diarrhoea was the highest-burden non-malaria disease in Q2 2026, with 351,542 suspected cases reported nationally. Of these, 6,363 were confirmed and 7 deaths were recorded (CFR 0.11%). Copperbelt Province recorded the highest case concentration, followed by Central Province (Figure 3). Case counts remained consistently high throughout the quarter (approximately 25,000 – 26,000 cases per week), suggesting sustained endemic transmission rather than a discrete outbreak (Figure 4).

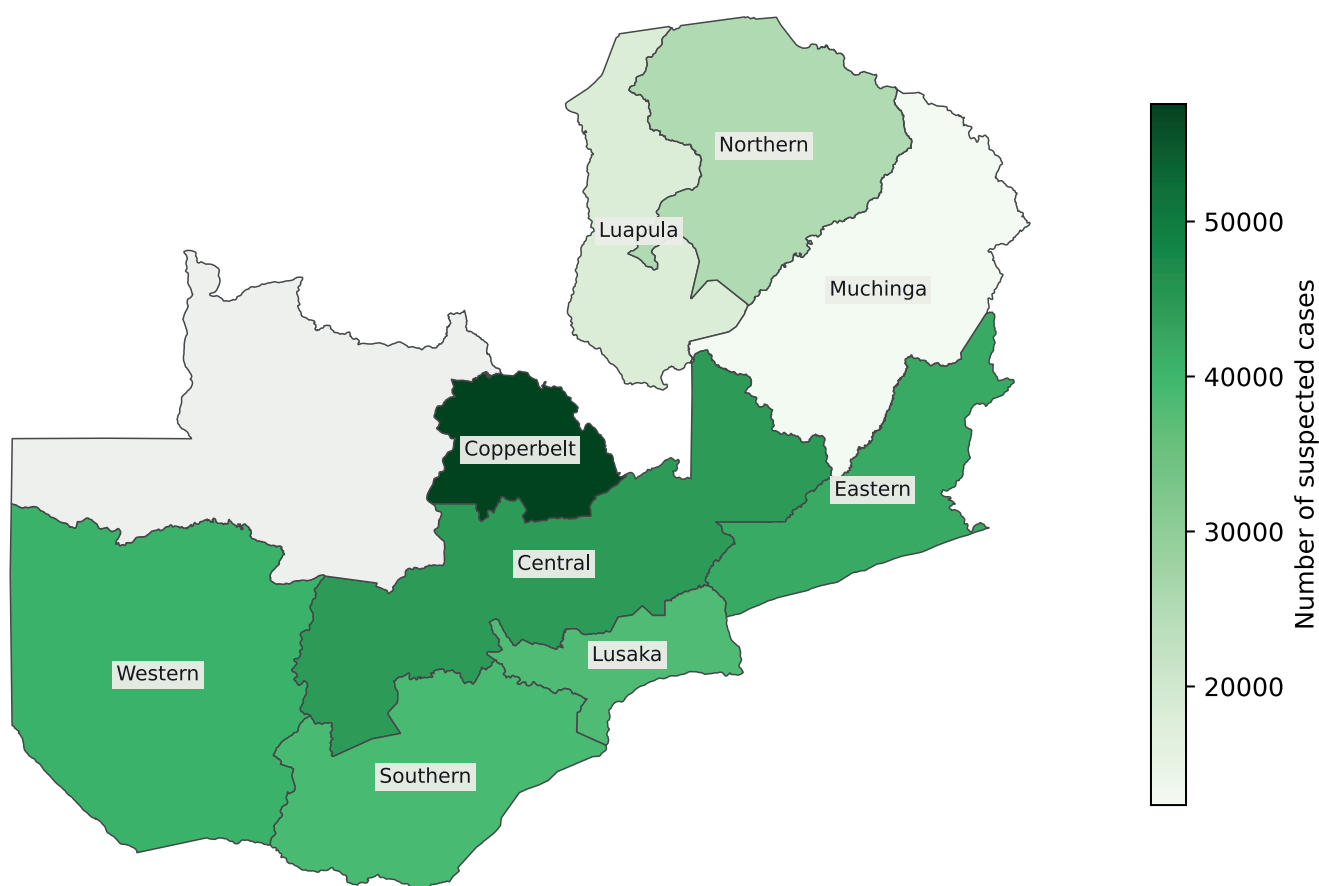


Figure 3: Distribution of suspected non-bloody diarrhoea cases by province, Q2 2026

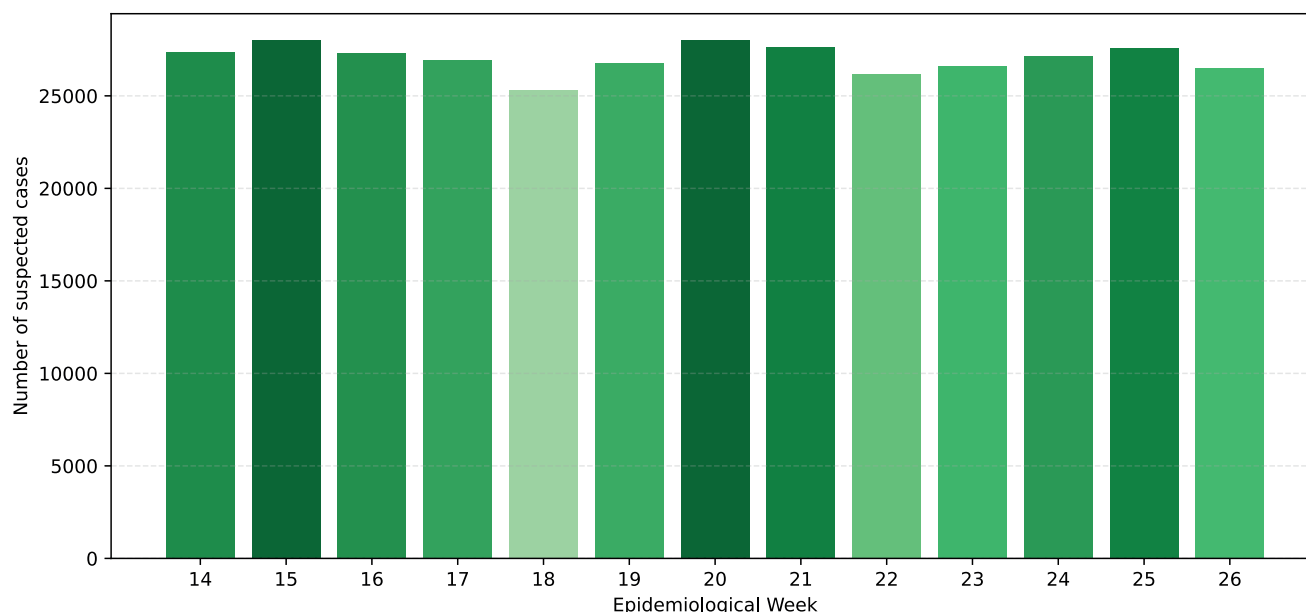


Figure 4: Weekly suspected non-bloody diarrhoea cases, Zambia, Q2 2026

Recommendations

Epidemiological Summary Diarrhoea with Blood

A total of 7969 suspected bloody diarrhoea (dysentery) cases were reported nationally during Q2 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. Western and Central provinces showed the highest case concentrations (Figure 5). The number of suspected diarrhoea with blood cases shows a generally increasing trend from epidemiological week 14 to week 26, with a more pronounced rise from about week 21 towards the end of the quarter (Figure 6).

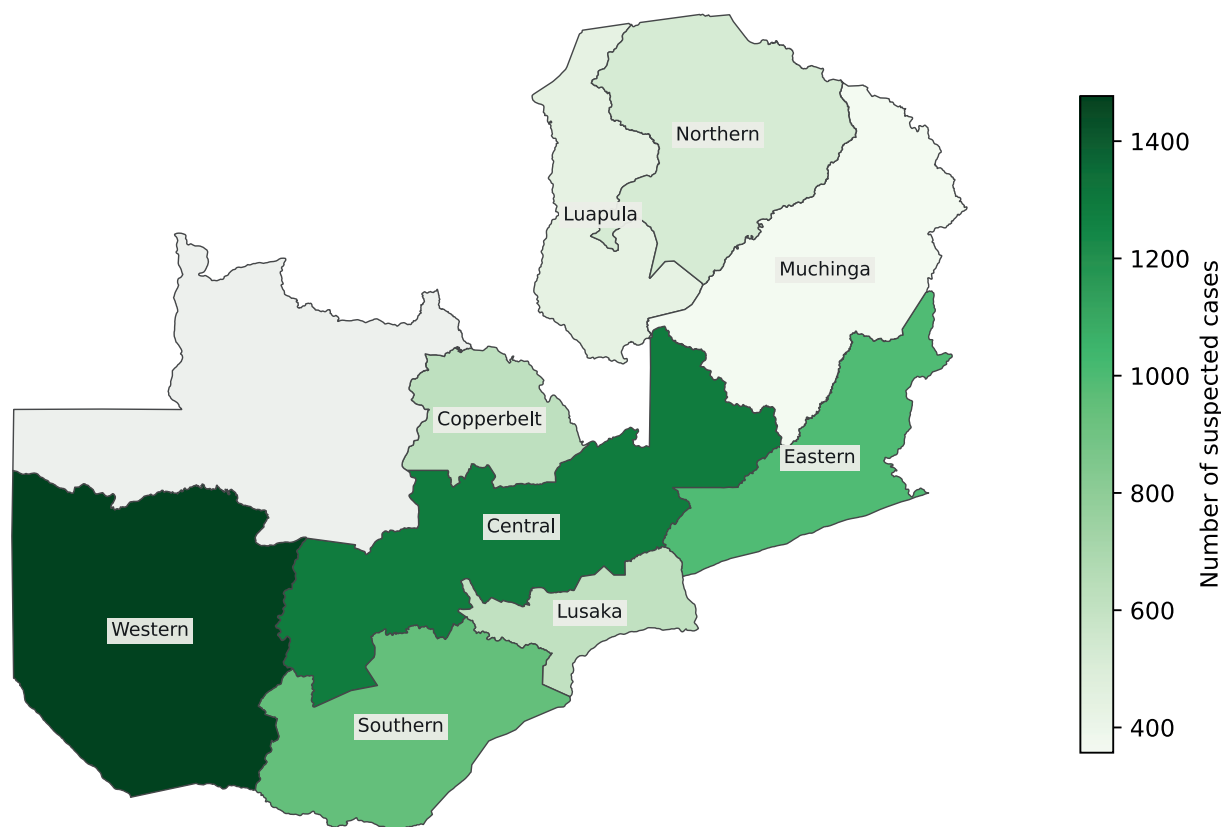


Figure 5: Distribution of suspected bloody diarrhoea cases by province, Q2 2026

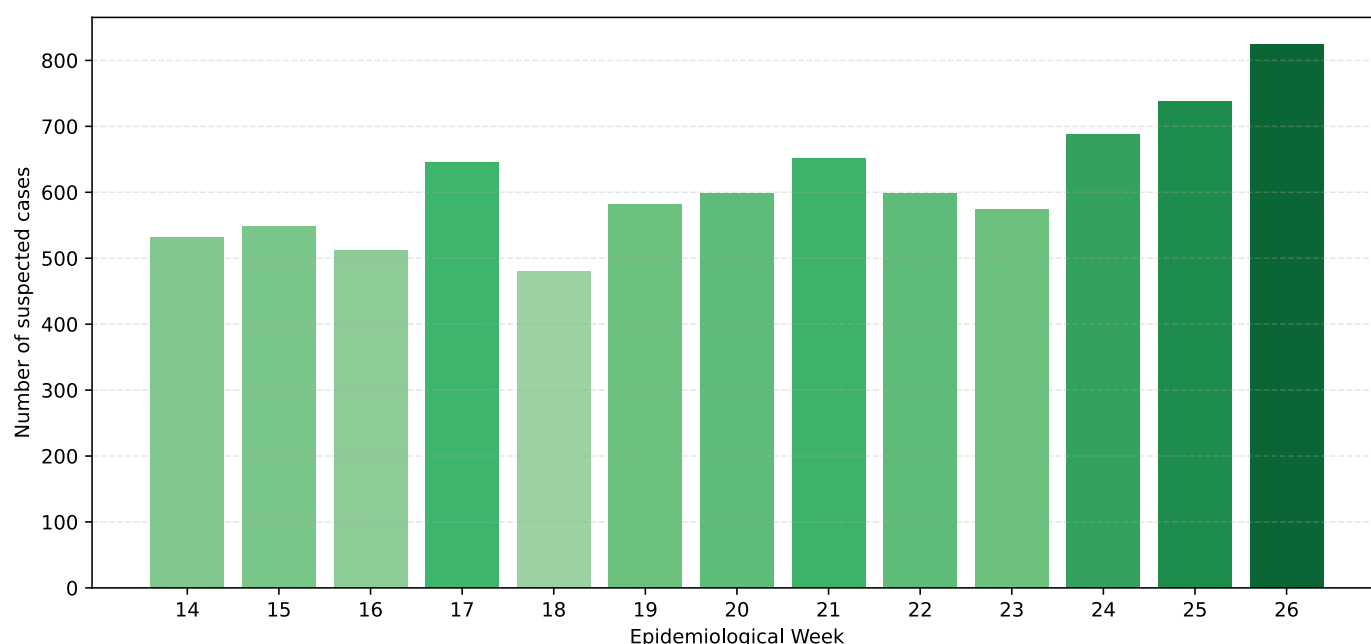


Figure 6: Weekly suspected bloody diarrhoea cases, Zambia, Q 2026

Recommendations

- Provincial health offices in Western and Central 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. Influenza Like Illness

Description

Influenza is an acute respiratory illness caused by influenza A and B viruses, which spread mainly through droplets generated when infected individuals cough, sneeze, or talk (7). In Africa influenza A (particularly subtypes such as H3N2 and H1N1) and influenza B co-circulate and are responsible for most seasonal outbreaks, with varying predominance by strain and year (8). Children under five years of age, pregnant women, older adults, and individuals with underlying chronic conditions (such as HIV, asthma, or cardiovascular disease) are at highest risk of complications, severe disease, and death. Zambia experiences seasonal influenza transmission, with peaks typically observed during cooler months and in association with changing rainfall and humidity patterns.

Epidemiological Summary

During Q2 2026, 920 suspected influenza-like illness (ILI) cases were reported nationally, with 4 confirmed cases and no associated deaths (CFR 0%) (Figure 7). Weekly suspected influenza cases fluctuate between roughly 45 and 65 from weeks 14–23, then drop sharply in weeks 24–25 before rebounding to high levels again in week 26, suggesting a brief interruption followed by renewed transmission (Figure 8).



Figure 7: Distribution of suspected influenza cases by province, Q2 2026

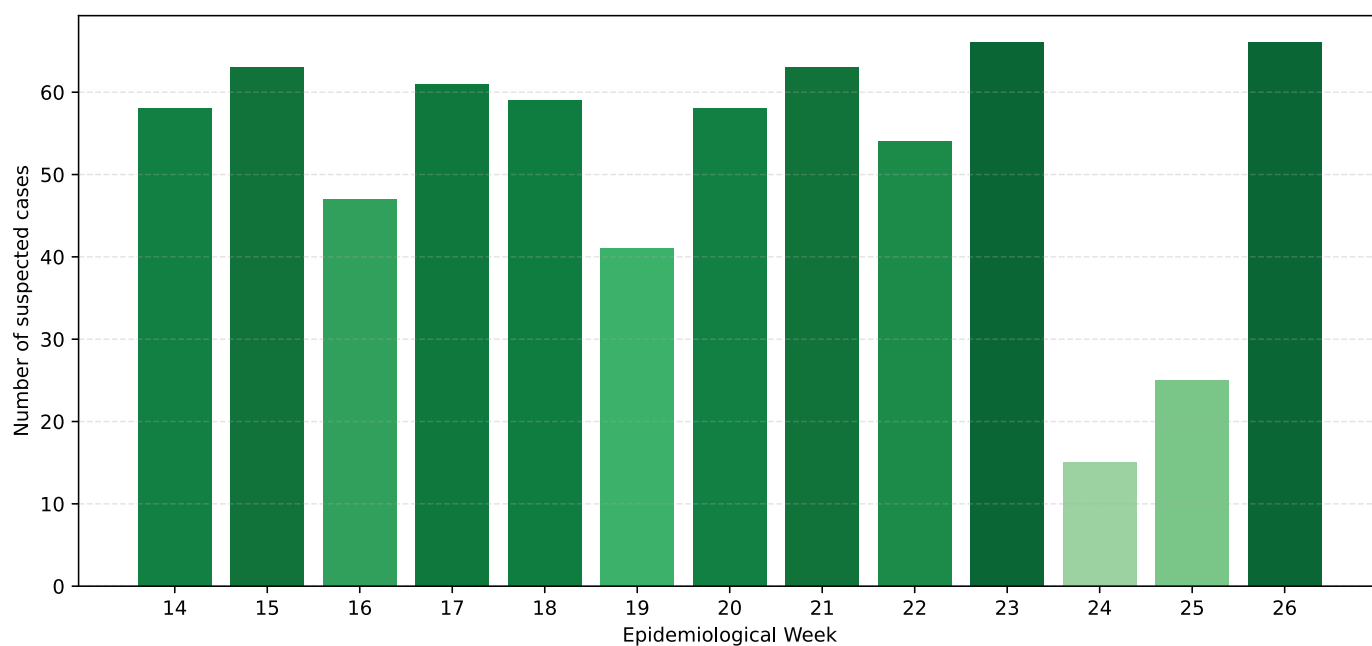


Figure 8: Weekly suspected influenza cases, Zambia, Q2 2026.

Recommendations

- Increase laboratory testing and timely confirmation of suspected ILI as well as
- Strengthen ILI subtype-specific influenza surveillance, ensuring routine reporting of influenza A(H3N2) and A(H1N1) through national systems linked to the DHIS2
- Investigate surges and implement targeted IPC where clusters are detected.
- Intensify risk communication on respiratory hygiene for high risk groups.
- Use weekly ILI trends to guide seasonal preparedness and resource planning.

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 Q2 2026, 581 suspected measles cases were reported nationally, with 61 confirmed and 4 deaths (CFR 2.76%). Western Province continues to be the primary hotspot, accounting for the majority of cases nationally (Figure 9). Measles suspected cases remained low and relatively stable through weeks 14–21, then rise sharply from week 22 onward, with a steep, continuous increase peaking in week 26, suggesting an escalating outbreak.



Figure 9: Distribution of suspected measles cases by province, Q2 2026. Western Province recorded the highest burden, indicating a localised vaccination gap

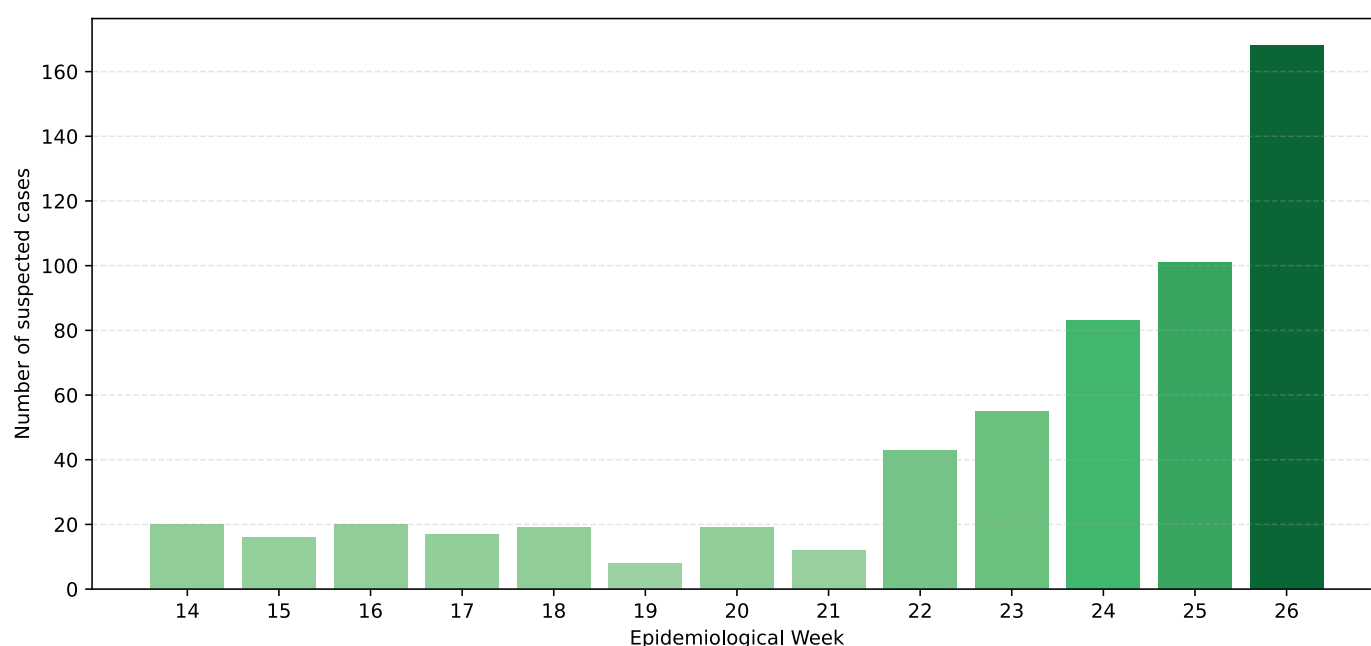


Figure 10: Weekly suspected measles cases, Zambia, Q1 2026.

Recommendations

- Investigate the outbreak rapidly and target response to affected districts.
- Conduct urgent, high-coverage measles vaccination campaigns in Western Province.
- Strengthen routine two-dose measles vaccination coverage nationally.
- Improve measles case-based surveillance and timely laboratory confirmation.
- Intensify risk communication and infection prevention measures in communities and health facilities.

5. 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 Q2 2026, 37 suspected mpox cases were reported nationally, with 1 confirmed and no death reported (CFR 0%). Southern Province accounted for the highest number of suspected cases, with Western and Lusaka provinces also reporting clusters (Figure 11). Mpox suspected cases show a short-lived peak around week 19 followed by a steady decline to very low levels by week 25, suggesting that the initial surge was contained and transmission reduced.

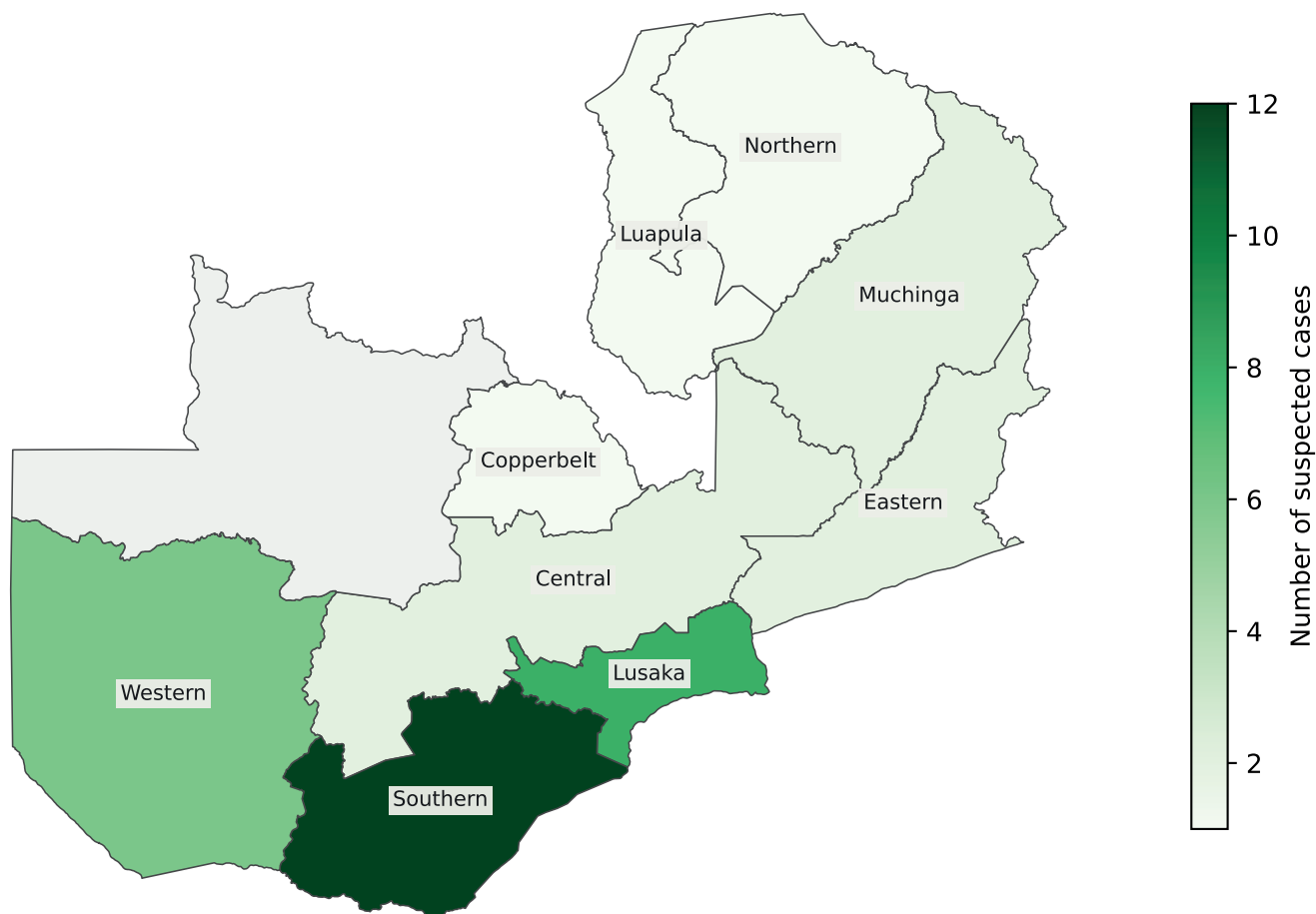


Figure 11: Distribution of suspected mpox cases by province, Q2 2026.

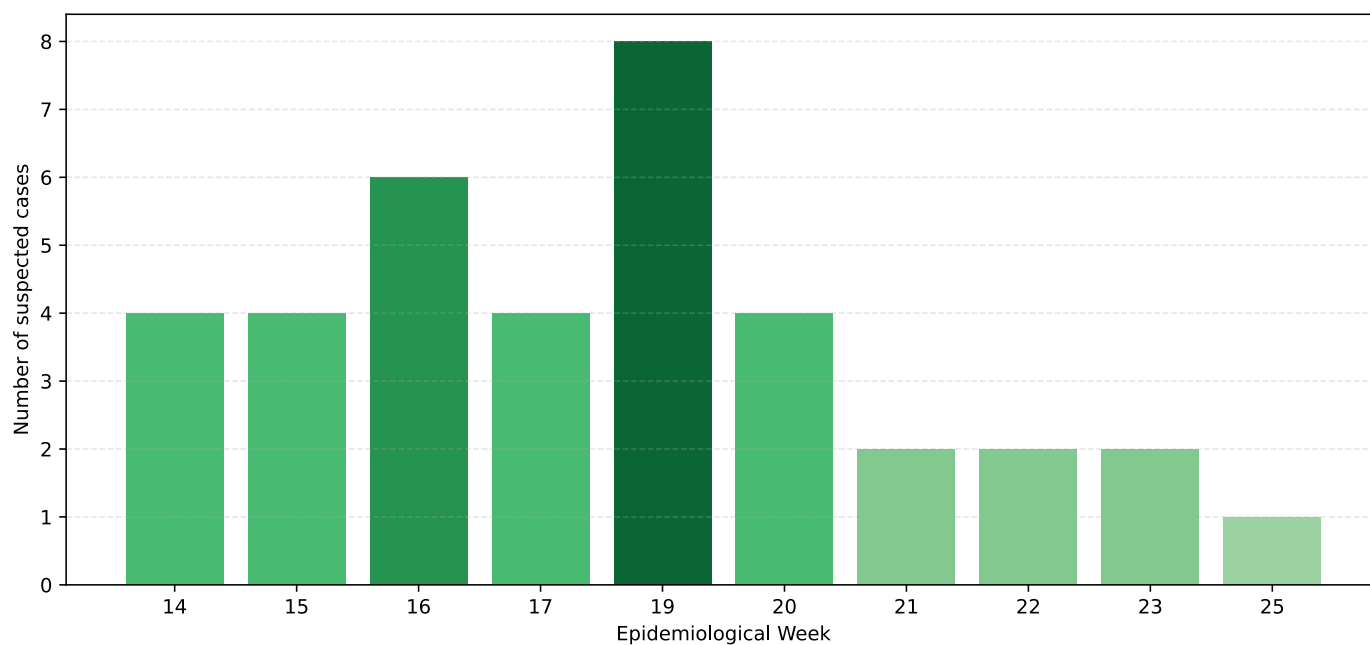


Figure 12: Weekly suspected mpox cases, Zambia, Q2 2026.

Recommendations

- Maintain sensitive Mpox case detection and verification around the hotspot areas.
- Investigate the week 19 surge thoroughly and ensure contact tracing has fully interrupted transmission chains.
- Sustain IPC measures and clinical readiness for Mpox despite declining case numbers.
- Continue targeted risk communication to at risk groups on symptom recognition and care seeking.

Table of Reported Cases and Events

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)	133	2	9	6.77
Acute viral hepatitis	27045	1651	11	0.04
Adverse event following immunisation (AEFI)	19	8	—	—
Bilharzia (Schistosomiasis)	55	1	—	—
Bloody diarrhoea (dysentery)	6518	802	1	0.06
Cholera	7969	—	—	—
Diarrhoea non-bloody	319	1	—	—
Dog bites	261	93	14	5.36
HIV	45811	1142	8	0.07
Human rabies	24	5	8	133.70
Influenza-like illness (ILI)	920	14	—	—
Malaria	4855459	2741433	962	0.08
Measles	581	61	4	2.76
Meningitis	231	43	22	38.20
Monkeypox (mpox)	37	1	—	—
Mumps	5114	694	8	0.63
Neonatal tetanus	17	2	5	117.97
Plague	6	—	—	—
Scabies	7129	158	1	0.06
Trypanosomiasis	29	5	—	—
Tuberculosis	9350	226	1	0.04
Typhoid fever	1871	52	—	—

* 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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