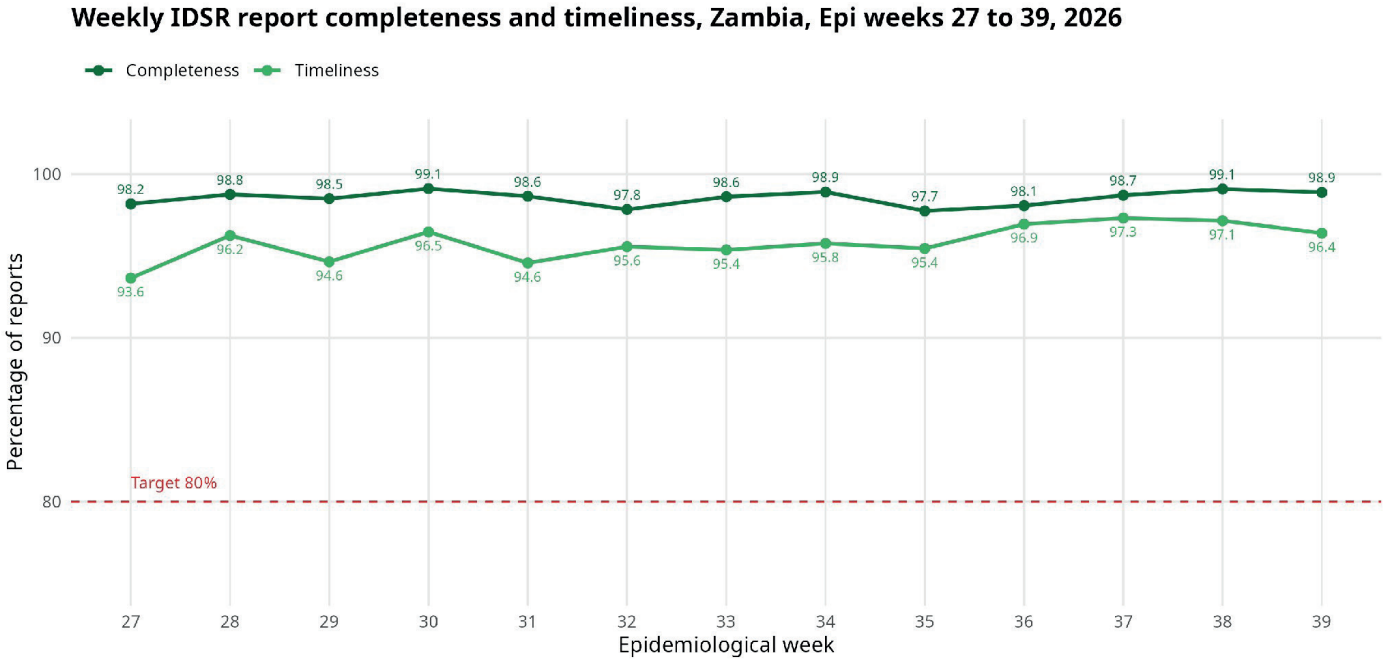
Summary of Priority Diseases and Events In Zambia Quarter 3 2026

Integrated Disease Surveillance Report (IDSR) Timeliness and Completeness

Nationally, 44,937 weekly reports were expected from health facilities and surveillance sites to the IDSR system during Q3 2026 (Weeks 27 to 39, 29 June to 27 September 2026). Of these, 44,279 were received (98.54% completeness) and 42,423 were received on time (95.81% timeliness). Timeliness is calculated using received reports as the denominator, so reports that were never submitted are excluded from its calculation and the percentage should not be read as the proportion of all expected reports received by the deadline; on that basis, 42,423 of 44,937 expected reports (94.41%) were received on time. Reports are received and collated at the district and provincial levels before submission to ZNPHI. Timeliness and completeness of weekly reports are key indicators of reporting performance. Figure 1 summarises completeness and timeliness rates by province for Q3 2026.



Completeness: percentage of expected reports that were received, regardless of submission timing. National target ≥80%.
Timeliness: percentage of received reports that were submitted on time. National target ≥80%.

Figure 1: IDSR report completeness and timeliness rates by province, Q3 2026 (Weeks 27 to 39)

Muchinga Province recorded the highest completeness (100.00%) and timeliness (98.97%), while Northwestern Province had the lowest completeness (96.74%) and Northern Province the lowest timeliness (93.09%). All provinces exceeded the WHO/MOH target of at least 80% for both indicators. Nationally, weekly completeness remained between 97.7% and 99.1% throughout the quarter, and weekly timeliness ranged from 93.6% in Week 27 to 97.3% in Week 37. These findings demonstrate strong reporting completeness and timeliness across provinces. However, continued attention to data accuracy, laboratory confirmation, and the sensitivity of event detection is essential to strengthening the overall performance of the surveillance system.

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 Q3 2026 (Weeks 27 to 39), a total of 264 suspected cholera cases were reported nationally, of which 65 were confirmed (24.62% confirmation rate). Twenty three deaths were recorded, equivalent to 8.71% of all suspected cases. The ratio of deaths to confirmed cases (35.38%) is not presented as a confirmed-case case fatality rate (CFR), because it has not been established that all 23 deaths occurred among the 65 confirmed cases; if deaths included suspected or probable cases, the ratio would be overstated. Lusaka and Central provinces were the primary hotspots, together accounting for 239 (90.5%) of all suspected cases. Lusaka Province alone accounted for 126 suspected cases (47.7%), 37 confirmed cases (56.9%) and 20 deaths (87.0%) (Figure 2). Cases were also reported from Northern (11), Luapula (10), Southern (2), Northwestern (1) and Eastern (1) provinces.

Cholera transmission was low and sporadic from Week 27 to Week 34, with no more than five suspected cases in any week. Cases then increased sharply, from 11 in Week 35 to 47 in Week 37 and 68 in Week 38, reaching a peak of 113 suspected cases in Week 39 (Figure 3). The last three weeks of the quarter accounted for 228 (86.4%) of all suspected cases, and 17 of the 23 deaths were recorded in Week 37. Central Province began reporting cases in Week 35, followed by Luapula in Week 37 and Northern in Week 38. This pattern indicates an escalating outbreak at the end of the quarter.

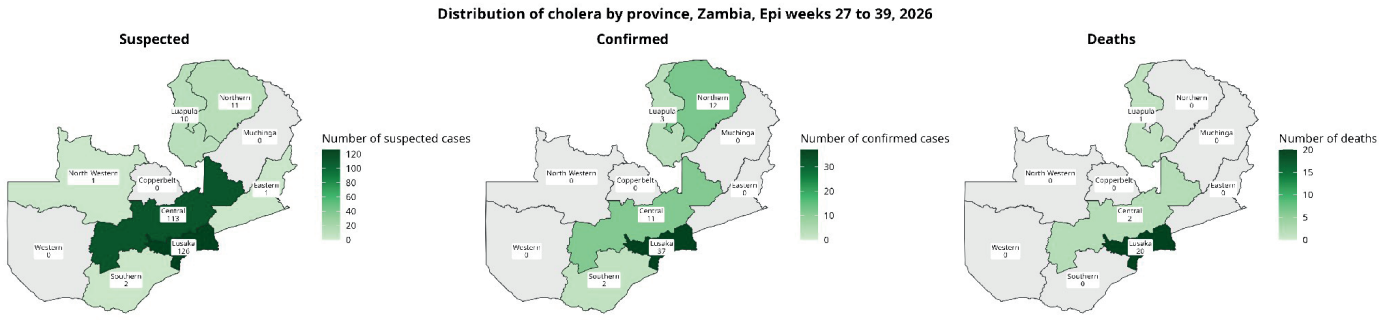


Figure 2: Distribution of suspected cases, confirmed cases and deaths of cholera by province, Q3 2026

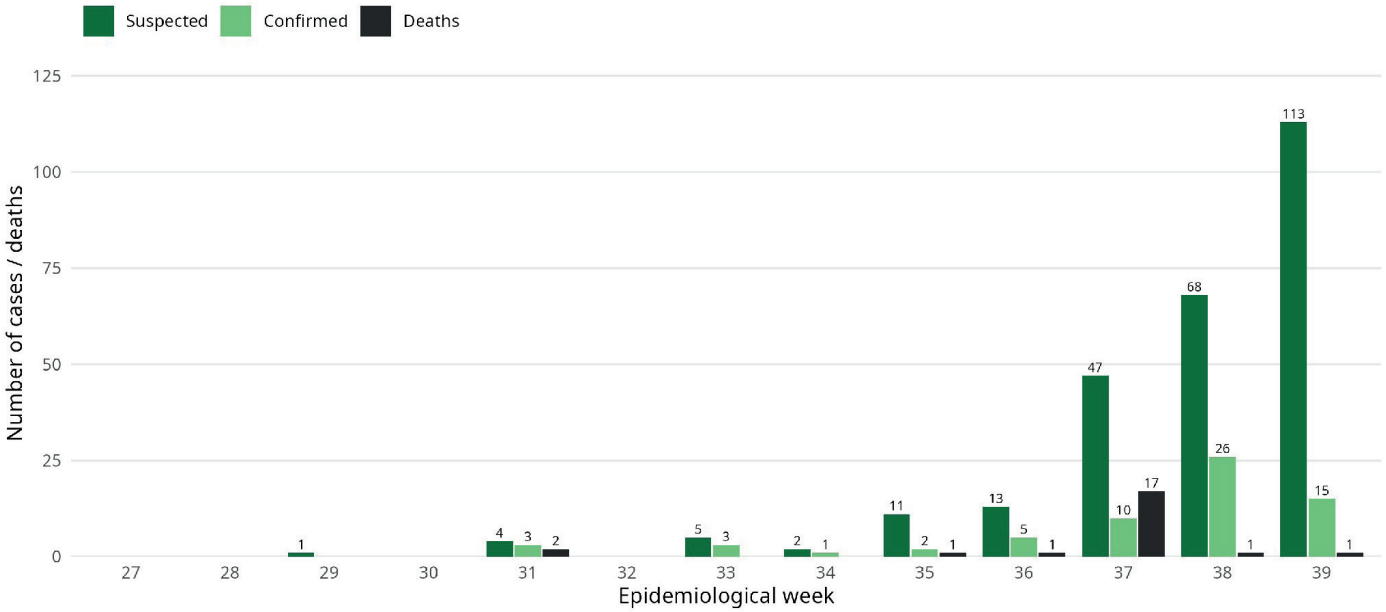


Figure 3: Weekly suspected cholera cases, confirmed cases and deaths, Zambia, Q3 2026

Recommendations

- Provincial and district health teams in Lusaka and Central provinces should intensify active case finding, oral rehydration therapy (ORT) provision, case management and household water treatment promotion in affected communities.
- Provincial and district health teams in Northern, Luapula and other neighbouring provinces should maintain heightened vigilance for early case detection and rapid response.
- Water and sanitation authorities should conduct targeted water quality testing in cholera affected areas of Lusaka and Central provinces to identify contamination sources.
- ZNPHI and provincial teams should review the deaths recorded in Week 37, including community deaths, delays in care seeking and quality of case management.
- Strengthen specimen collection and laboratory confirmation of suspected cases, as fewer than one in four suspected cases were confirmed.
- Consider reactive oral cholera vaccination in the most affected areas, alongside water, sanitation and hygiene interventions.
- 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

1. 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 again the highest burden non-malaria disease in Q3 2026, with 487,117 suspected cases reported nationally. Of these, 6,931 were confirmed (1.42%) and 77 deaths were recorded (CFR 1.11% among confirmed cases). Copperbelt Province recorded the highest number of suspected cases (70,884; 14.6%), followed by Central (68,941; 14.2%) and Eastern (59,812; 12.3%) provinces, while Muchinga Province recorded the lowest (18,061) (Figure 4). Eastern Province accounted for the largest share of deaths (23; 29.9%), and no deaths were recorded in Lusaka and Muchinga provinces.

Unlike Q2 2026, when weekly cases were stable at approximately 25,000 to 26,000, weekly suspected cases rose steadily through the quarter, from 27,290 in Week 27 to a peak of 49,270 in Week 39, an increase of 81% (Figure 5). The last four weeks accounted for 37.0% of all cases in the quarter. The contribution of seasonality, changes in reporting and other possible drivers to this rise cannot be determined from the quarterly data; comparison with data from previous years is needed, and the trend should be monitored closely.

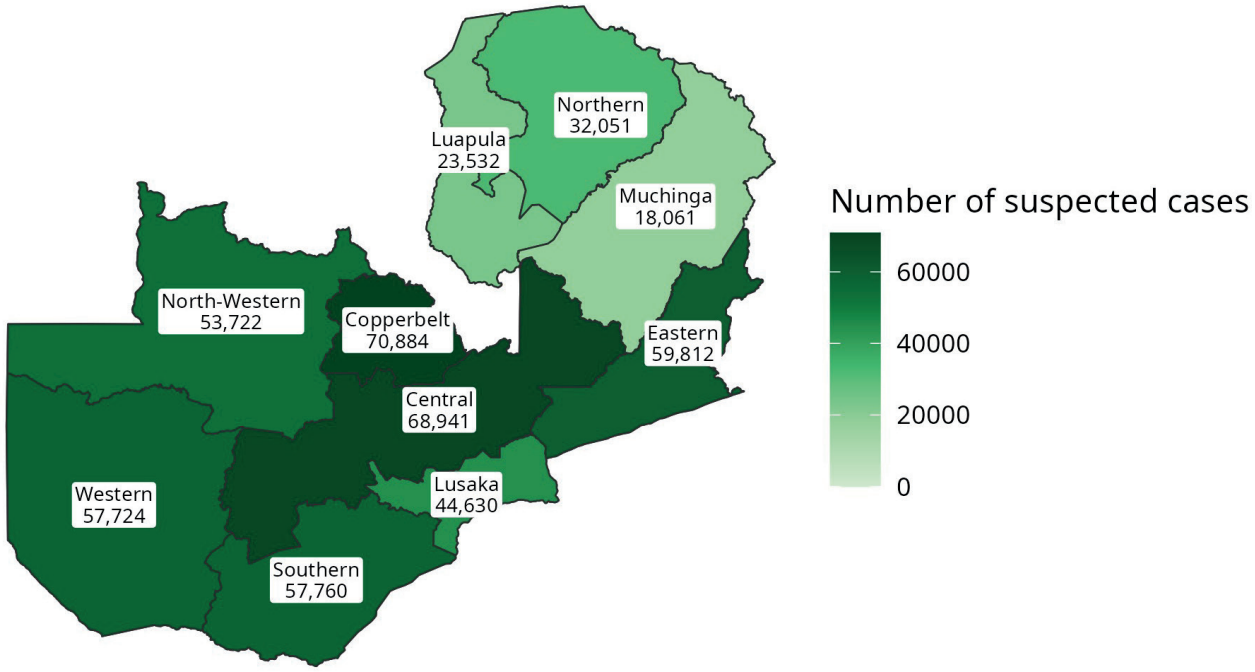


Figure 4: Distribution of suspected non-bloody diarrhoea cases by province, Q3 2026

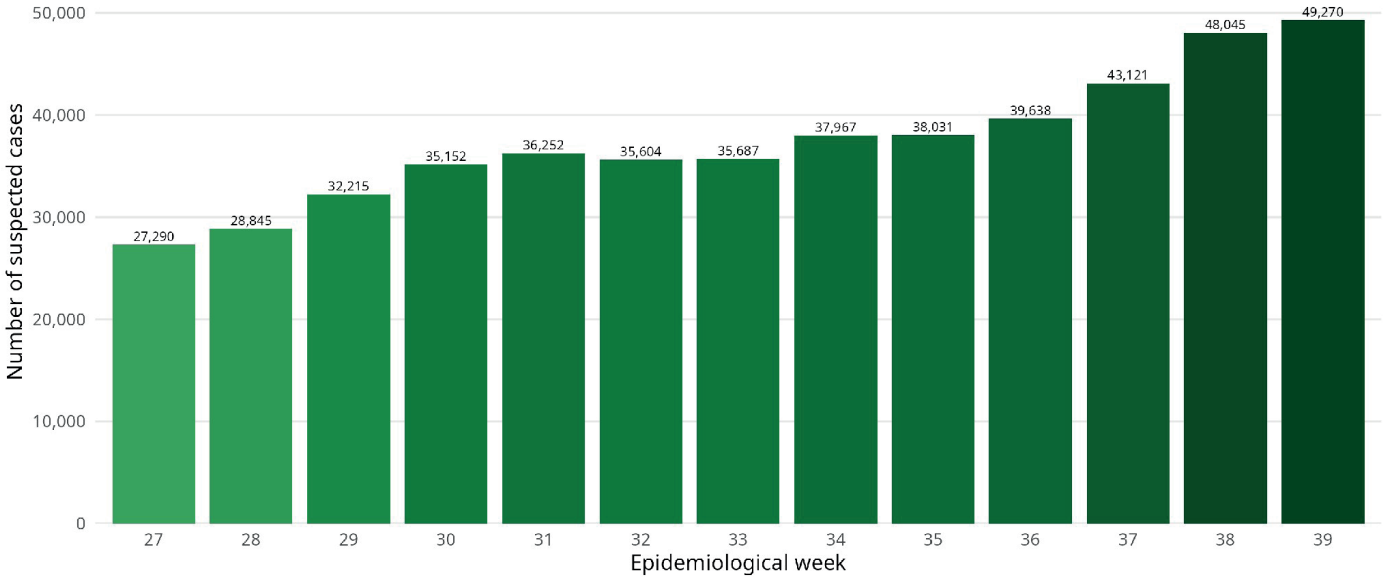


Figure 5: Weekly suspected non-bloody diarrhoea cases, Zambia, Q3 2026

- 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 caseswithin 24 hours per IDSR protocols. More information is available at: www.znphi.co.zm

Recommendations

- Provincial health offices in Copperbelt, Central and Eastern provinces should intensify community water, sanitation and hygiene (WASH) interventions and health education on safe food handling, handwashing with soap and safe water storage.

- Health facilities should maintain adequate stocks of oral rehydration salts, zinc and intravenous fluids in anticipation of the continued rise in cases.

- Eastern Province should review the 23 deaths recorded to identify gaps in care seeking and case management.

- Strengthen stool specimen collection and laboratory testing, as only 1.4% of suspected cases were confirmed.

- Health workers should report all suspected cases within 24 hours per IDSR protocols.

Epidemiological Summary Diarrhoea with Blood

A total of 14,571 suspected bloody diarrhoea (dysentery) cases were reported nationally during Q3 2026, an increase of about 83% compared with the 7,969 cases reported in Q2 2026. As in Q2, zero confirmed cases and no deaths were recorded against this substantial suspected case count. This remains 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. It is not yet known whether specimens were collected, whether laboratory testing was undertaken, which pathogens were included in testing, or whether the zero reflects no positive results, no testing or missing laboratory reporting. These possibilities have different implications for surveillance performance and public health action and should be established. Western (2,541; 17.4%), Eastern (2,154; 14.8%) and Central (2,089; 14.3%) provinces had the highest case concentrations (Figure 6). Weekly suspected cases showed a generally increasing trend, from 825 in Week 27 to 1,525 in Week 39, with a peak of 1,614 in Week 38 (Figure 7). The last four weeks accounted for 39.9% of all cases in the quarter.

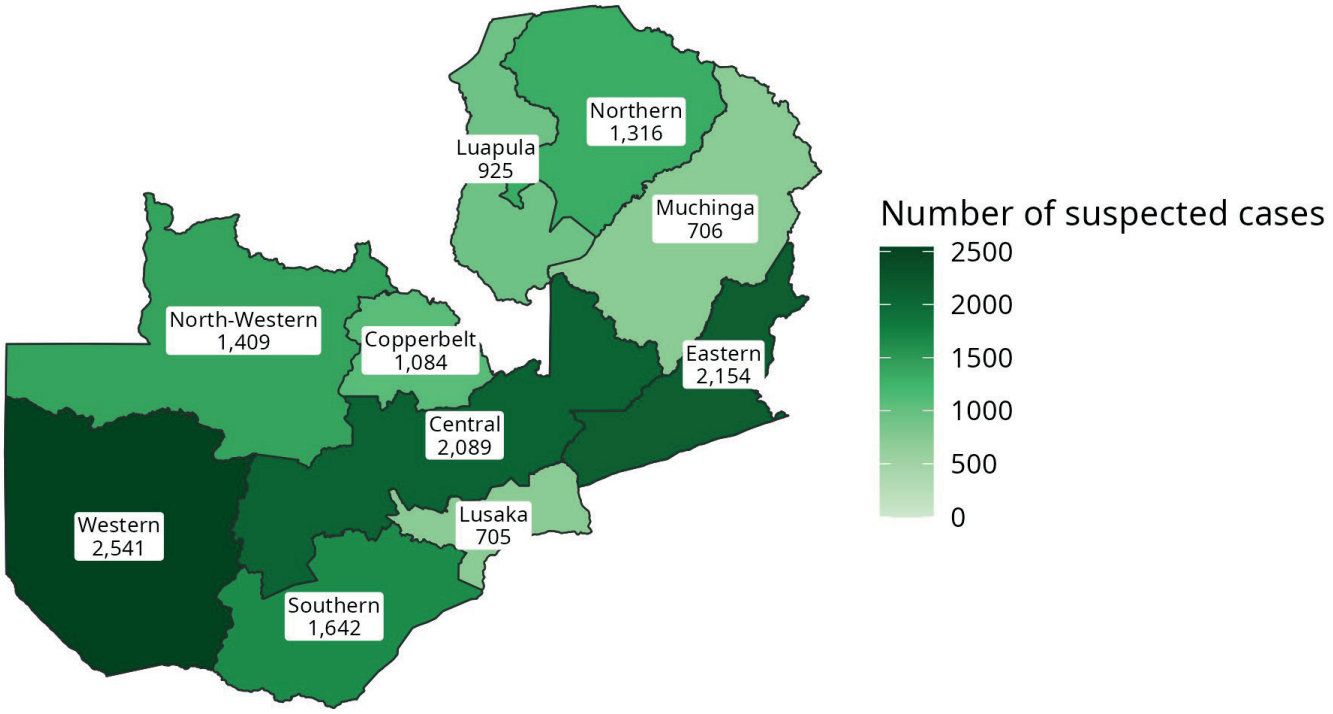


Figure 6: Distribution of suspected bloody diarrhoea cases by province, Q3 2026

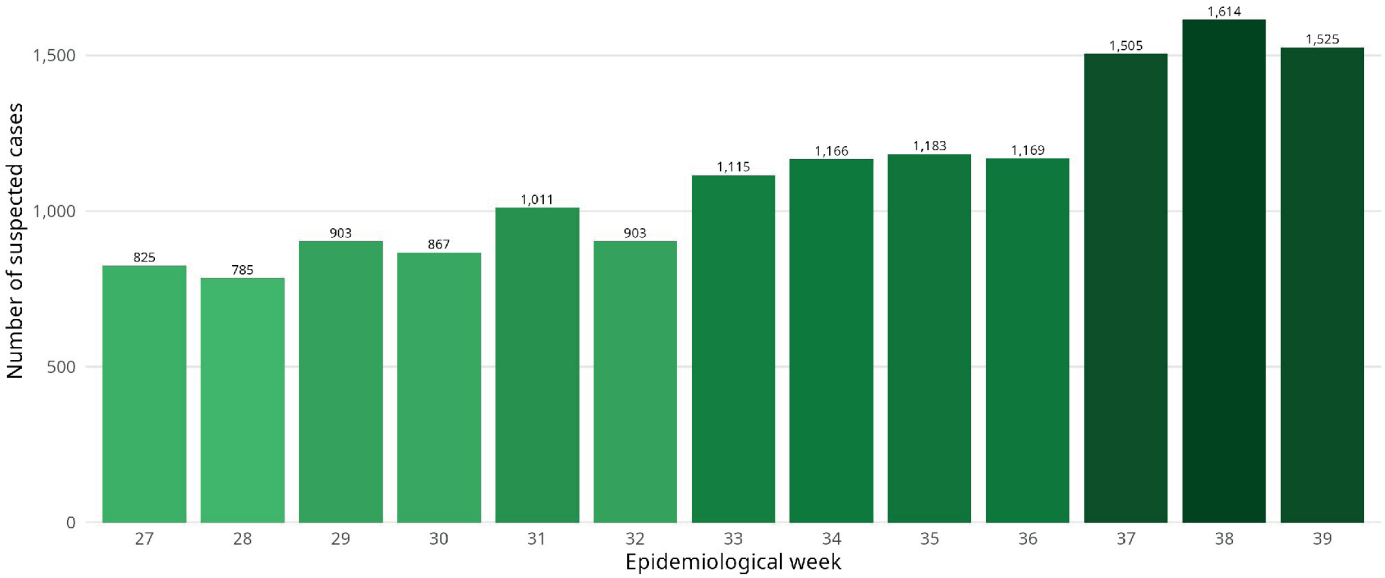


Figure 7: Weekly suspected bloody diarrhoea cases, Zambia, Q3 2026

Recommendations

- Provincial health offices in Western, Eastern 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 establish whether specimens were collected and tested, which pathogens were included in testing, and whether the zero reflects negative results, no testing or missing laboratory reporting, as well as any gap in case definition application.

- Clinicians should collect stool specimens from suspected dysentery cases and submit them to provincial laboratories to improve confirmation rates and guide antimicrobial stewardship.

1. 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 Q3 2026 (Weeks 27 to 39), 74 laboratory confirmed influenza like illness (ILI) cases were reported nationally, with no associated deaths (CFR 0%). Lusaka Province accounted for 59 (79.7%) of the confirmed cases, followed by Northwestern (8), Southern (3), Eastern (3) and Muchinga (1) provinces (Figure 8). Confirmed cases occurred in two waves. The first rose from 5 in Week 31 to 10 in Week 32 and 19 in Week 33, driven mainly by Lusaka Province, then fell to between 2 and 3 cases per week in Weeks 34 to 36. The second rose to 8 in Week 37 and peaked at 20 in Week 38, when Lusaka reported 11 cases and Northwestern reported all 8 of its cases, before dropping to 1 case in Week 39 (Figure 9).

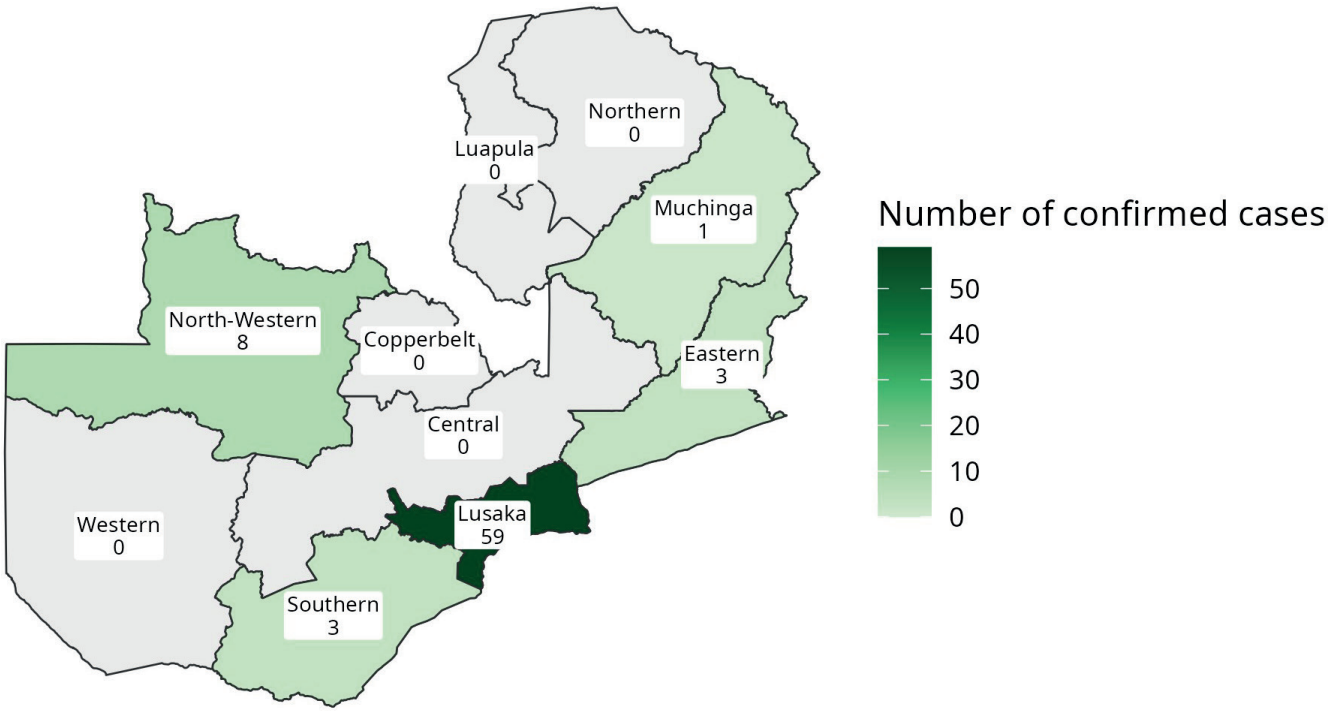


Figure 8: Distribution of confirmed influenza like illness cases by province, Q3 2026

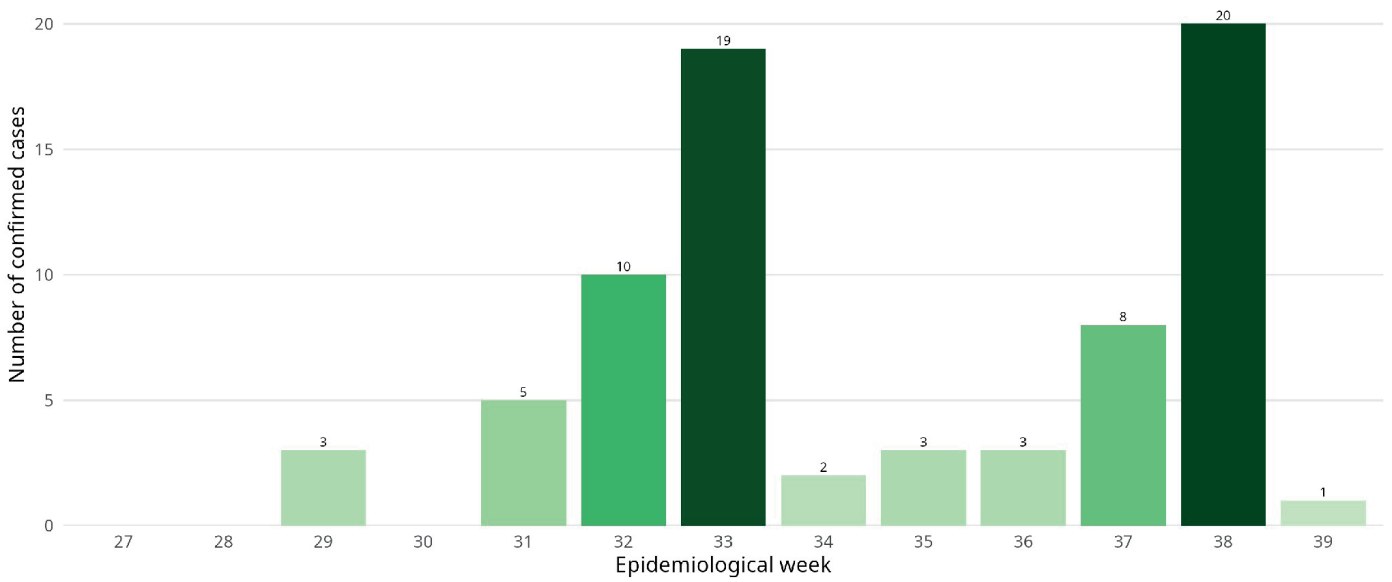


Figure 9: Weekly confirmed influenza like illness cases, Zambia, Q3 2026

Recommendations

- Increase laboratory testing and timely confirmation of suspected ILI cases.
- Strengthen ILI subtype specific influenza surveillance, ensuring routine reporting of influenza A(H3N2) and A(H1N1) through national systems linked to the DHIS2.
- Investigate the Week 32 to 33 and Week 37 to 38 clusters in Lusaka and the Week 38 cluster in Northwestern Province, and implement targeted infection prevention and control (IPC) measures 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.

1. Anthrax
Description

Anthrax is a zoonotic disease caused by Bacillus anthracis, a spore forming bacterium found in soil that mainly affects domestic and wild herbivores such as cattle, goats, sheep and hippopotamuses (9). Humans become infected through contact with infected animals or contaminated animal products, by handling or eating meat from infected carcasses, or by inhaling spores (9). Cutaneous anthrax, which presents as a painless skin lesion that develops a black centre, is the most common form, while gastrointestinal and inhalational forms are less frequent but more severe (9). Person to person transmission is rare (9). Anthrax is endemic in parts of Zambia, with recurrent outbreaks in humans and animals, including Chama District in 2011 and the large multi province outbreak that began in Sinazongwe District of Southern Province and was notified to WHO in November 2023 (10,11).

Epidemiological Summary

During Q3 2026 (Weeks 27 to 39), 79 suspected anthrax cases were reported nationally, of which 1 was confirmed (1.27% confirmation rate), and no deaths were recorded (CFR 0%). Southern Province (47; 59.5%) and Muchinga Province (26; 32.9%) together accounted for 92.4% of suspected cases, followed by Western (5) and Lusaka (1) provinces (Figure 10). The only confirmed case was reported from Muchinga Province in Week 37.

Suspected cases were reported in every week of the quarter. In Southern Province, cases peaked in Weeks 30 and 31 (8 and 7 cases) and again in the final weeks of the quarter, while all 26 cases from Muchinga Province were reported from Week 35 onwards. Weekly suspected cases reached a peak of 15 in Week 36, and the last four weeks accounted for 46 (58.2%) of all cases in the quarter, indicating an increasing trend (Figure 11).

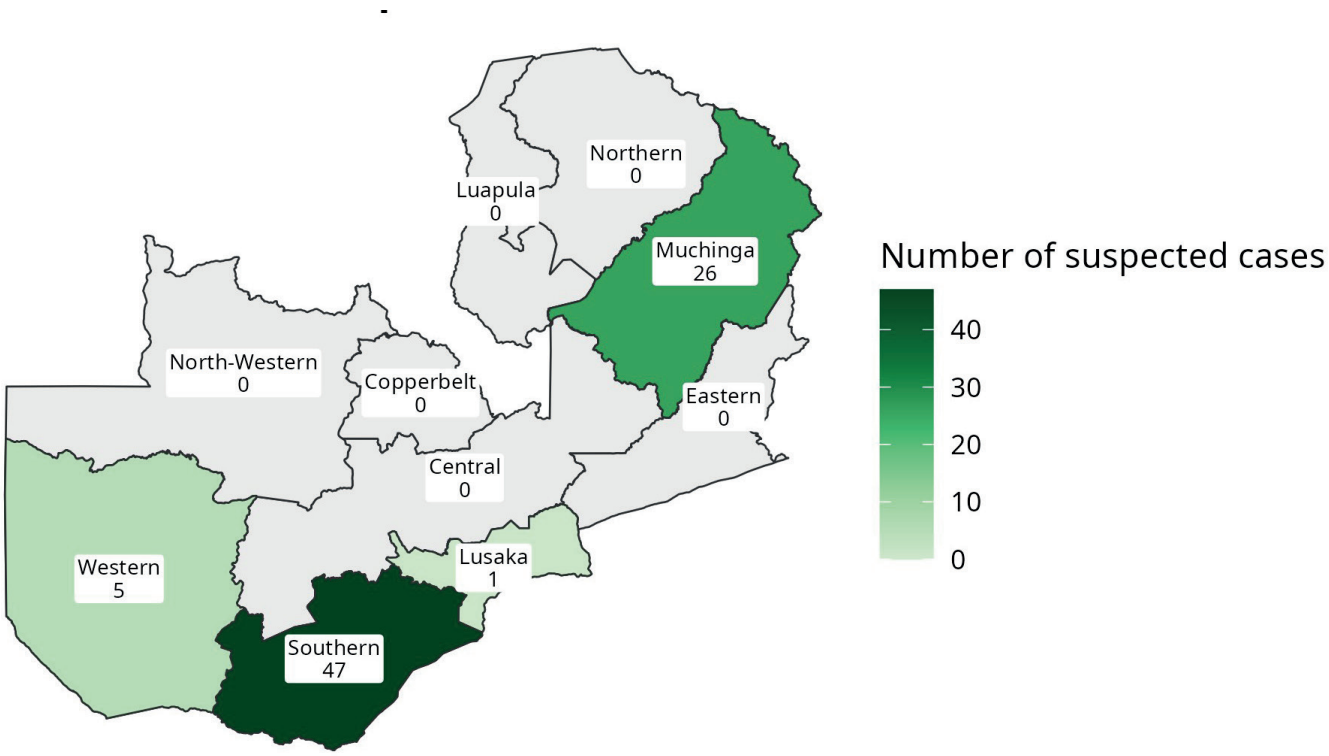


Figure 10: Distribution of suspected anthrax cases by province, Q3 2026

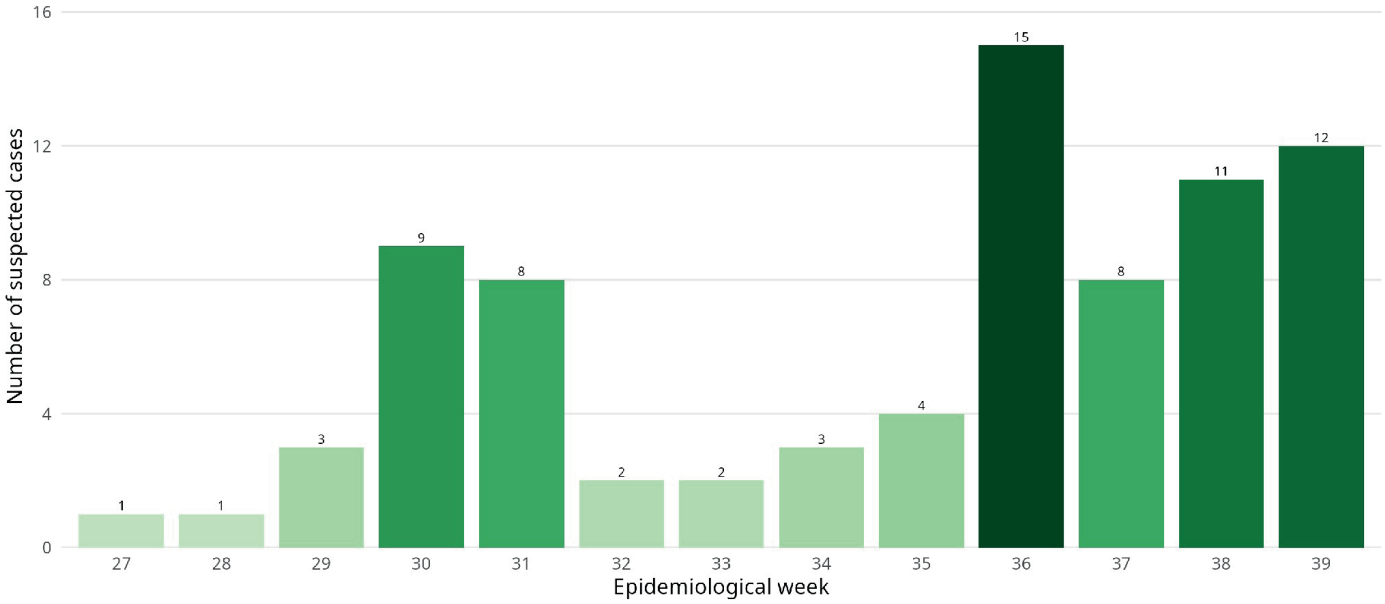


Figure 11: Weekly suspected anthrax cases, Zambia, Q3 2026

Recommendations

- Provincial and district health teams in Southern and Muchinga provinces should investigate all suspected cases, collect specimens for laboratory confirmation and maintain active case finding, as only one suspected case was confirmed.

- Human and animal health authorities should conduct joint One Health investigations of livestock and wildlife deaths and strengthen livestock vaccination in affected districts.
- Communities should be sensitised not to handle, skin or eat meat from animals that died of unknown causes, and to seek care early for any skin lesion after contact with animals or carcasses.
- Clinicians should start appropriate antibiotic treatment promptly for suspected cases, in line with national guidelines.
- Health workers should report all suspected cases within 24 hours per IDSR protocols.

1. 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 (13). The second declaration was ended on 5 September 2025, although continued surveillance and response remain essential (14).

Epidemiological Summary

During Q3 2026 (Weeks 27 to 39), 121 suspected mpox cases were reported nationally, with 2 confirmed (1.65% confirmation rate) and no deaths (CFR 0%). Muchinga Province accounted for the highest number of suspected cases (63; 52.1%), followed by Lusaka (24; 19.8%), Northwestern (10), Western (8) and Central (6) provinces, with smaller numbers in Copperbelt (4), Southern (3), Eastern (2) and Luapula (1) provinces (Figure 12). Both confirmed cases were reported from Copperbelt Province, in Weeks 29 and 35.

Suspected cases peaked at 46 in Week 27, of which 44 were from Muchinga Province, and then declined to between 1 and 10 cases per week through Week 32. A second, smaller peak of 20 cases in Week 33 was entirely from Lusaka Province, after which cases remained low at 2 to 6 per week until the end of the quarter (Figure 13). This suggests that both clusters were contained.

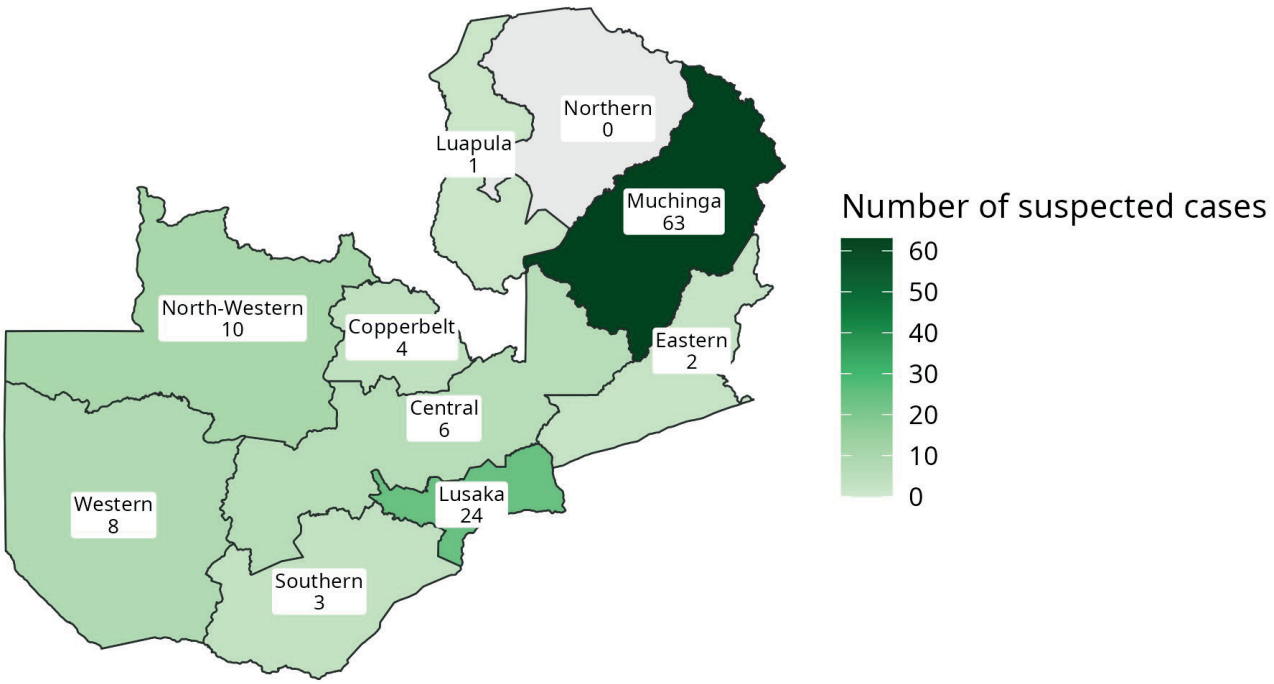


Figure 12: Distribution of suspected mpox cases by province, Q3 2026

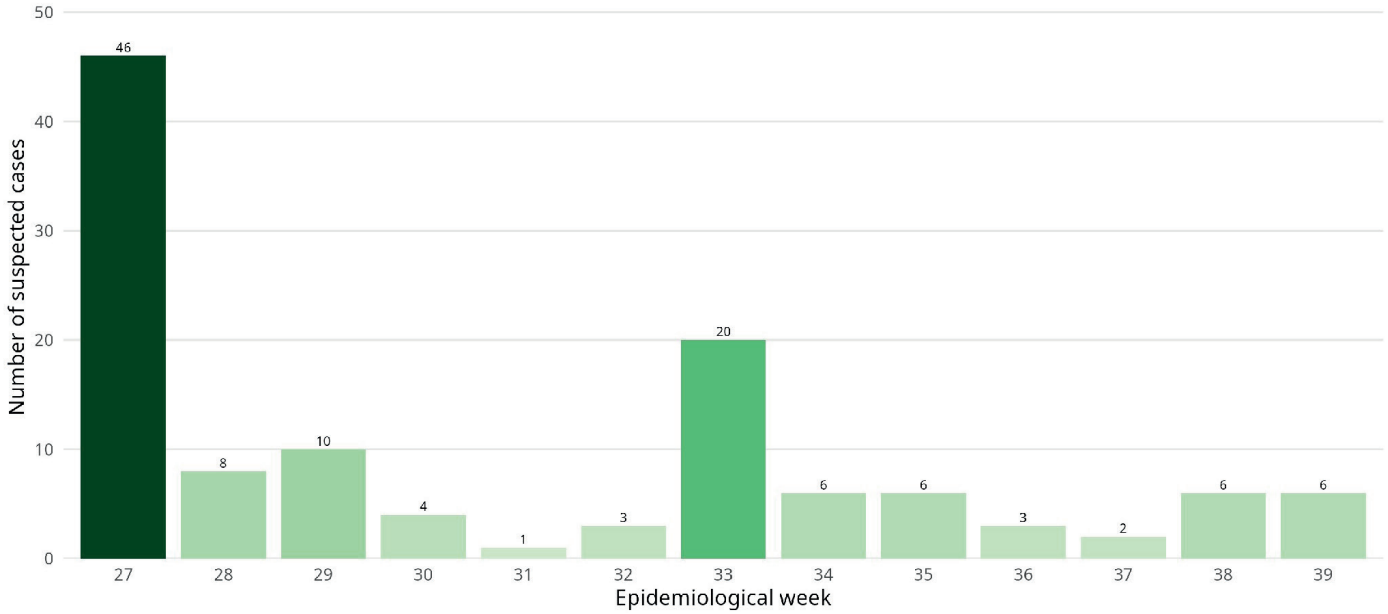


Figure 13: Weekly suspected mpox cases, Zambia, Q3 2026

Recommendations

- Maintain sensitive mpox case detection and verification around the hotspot areas, particularly in Muchinga and Lusaka provinces.
- Investigate the Week 27 cluster in Muchinga and the Week 33 cluster in Lusaka thoroughly, and ensure contact tracing has fully interrupted transmission chains.
- Improve specimen collection and laboratory testing of suspected cases, as only 1.65% of suspected cases were confirmed.
- 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

Disease/ Event	Suspected cases	Confirmed cases	Deaths	CFR*(%)
Acute flaccid paralysis (AFP) (suspected polio)	86	1	—	—
Acute viral hepatitis	23669	1312	9	0.69
Anthrax	71	—	—	—
Adverse event following immunisation (AEFI)	39	12	—	—
Bilharzia (Schistosomiasis)	6910	986	1	0.10
Bloody diarrhoea (dysentery)	14577	—	—	—
Cholera	268	66	23	34.85
Diarrhoea non-bloody	487174	6931	77	1.11
Dog bites	6571	—	—	—
HIV	52422	1252	—	—
Human rabies	18	10	5	50.00
Influenza-like illness (ILI)	—	74	—	—
Malaria	2728054	979631	567	0.06
Measles	2087	82	6	7.32
Meningitis	83	26	2	7.69
Monkeypox (mpox)	121	2	—	—
Mumps	4894	658	10	1.52
Plague	—	—	—	—
Scabies	6472	59	8	13.56
Tuberculosis	9953	413	9	2.18
Typhoid fever	2313	26	5	19.23

** CFR = Case fatality rate: (number of deaths ÷ number of confirmed cases) × 100. '—' indicates insufficientconfirmed case data to calculate a meaningful rate. Case fatality rates above 100% (neonatal tetanus, 500.00%; trypanosomiasis, 177.78%) arise because reported deaths exceed confirmed cases. They are not conventional case fatality rates for a single cohort: deaths may include suspected or probable cases or relate to a different reporting period, and data entry or classification errors are possible, so these values should be verified by the surveillance team and interpreted with caution. Definitions of suspected and confirmed cases and confirmation pathways differ between diseases; where deaths include unconfirmed cases or fall outside the same reporting cohort, the calculated rates may overestimate the true case fatality.*

Table 1: Nationally reported suspected and confirmed cases, deaths, and CFRs by disease/event Q3 2026 (July to September 2026)

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