

Figure 1: A UNICEF and MoH team visiting a CTC at Chaisa, Lusaka. (UNICEF

ZAMBIA

Cholera Outbreak

Flash update # 1

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Reporting Period: 7 October to 16 November 2026

Highlights

- **Outbreak Overview**: As of 16 November 2026, ZNPHI reported 3,099 cases and 68 deaths (CFR 2.2%) across 27 districts in seven provinces since 28 July. Children under 15 make up 24.9% of cases with age data (available for ~78.5% of cases).
- **Lusaka and Chibombo** are the current hotspots accounting for 75.2% of cases (1,959 and 371 respectively).
- **Community engagement and communication**: UNICEF-supported household visits reached over 1.2 million people, while dialogues engaged a further 30,000 people and 1,390 gatekeepers and influencers. This was reinforced by 31,600 communication materials (distribution underway) and a media campaign with an estimated potential audience of 7.8 million.
- **OCV**: 701,354 vaccinations supported in Lusaka, Chibombo and Chongwe (23–26 October 2026).
- **WASH:** UNICEF delivered 20 AWD kits to five districts and two tents to Chibombo for cholera treatment centres. It supported three inline chlorinators in Chibombo and WASH/IPC supplies to 20 health facilities in Chibombo and to treatment facilities in four Luapula districts.
- **Funding:** UNICEF's cholera response 2026/27 is only 9% funded, with a US$2.95 million gap (91%); Health has the largest gap (US$1.64 million). Urgent funding is needed to replenish WASH supplies and scale up treatment and community case finding before the rainy season.

Situation in Numbers (Since 28 July 2026)

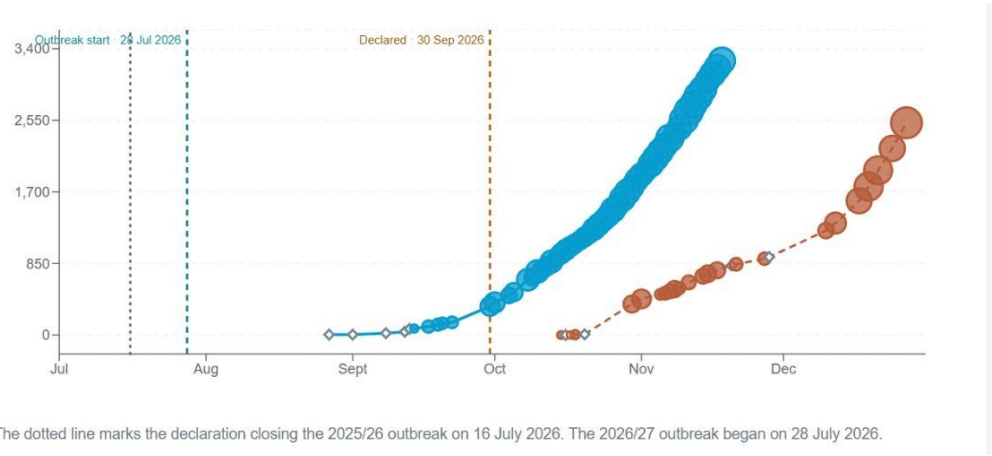
- **437 Laboratory c**onfirmed cases
- **3,099** Cumulative cases (605 among children under 15, including 321 under five)
- **68** Cumulative deaths
- **36** facility & **32** community deaths
- **2.2%** case fatality ratio
- **74** new cases in the last 24 hours
- **101** currently admitted
- **27** affected districts across **7** provinces
- **UNICEF Funding Gap: US$2.95 million (91%)**

Source: ZNPHI Cholera Surveillance Updates

Situation Overview & Humanitarian Needs

On 30 September 2026, the acting Minister of Health declared a cholera outbreak in Zambia, following cases reported since 28 July 2026. On 13 November, the Minister issued a follow-up statement noting that the “country is in deep trouble” and cautioned that the situation could rapidly deteriorate once heavy rains set in. According to ZNPHI, between 28 July and 16 November 2026, **Zambia recorded 3,099 cumulative cholera cases**, comprising 437 laboratory-confirmed and 2,662 suspected cases and **68 deaths**. The outbreak affected 27 districts across seven provinces: Lusaka, Central, Luapula, Northern, Southern, Copperbelt and North-Western. The overall case fatality ratio was 2.2%. In the preceding 24 hours, 74 new cases and two facility deaths were reported, while the seven-day average stood at 85 cases per day. A total of 101 patients remained admitted and 2,930 had been discharged.

The current burden is substantially higher than that reported around the same time in previous outbreaks. On 21 November 2025, the Ministry of Health reported 569 cases and nine deaths since the outbreak began on 5 August 2025. During the October-onward wave that developed into the 2023/24 epidemic, ZNPHI recorded 728 cases and 14 deaths by 15 November 2023, approximately one month after the first Lusaka case was identified on 14 October. Current totals are approximately 4.3 times the cases and 4.9 times the deaths recorded in that November 2023 snapshot. These comparisons describe the burden at similar calendar dates; the outbreaks had different starting dates and reporting periods.



The dotted line marks the declaration closing the 2025/26 outbreak on 16 July 2026. The 2026/27 outbreak began on 28 July 2026.

Among the 2,432 cases with recorded age and sex, 1,355 (55.7%) were male and 1,077 (44.3%) female, indicating a higher proportion of reported cases among males. Children under 15 accounted for 605 cases (24.9% of cases with recorded data), comprising 357 boys and 248 girls; 321 were children under five. Age and sex information remained unavailable for 667 cases, limiting assessment of the full burden among children. Under-15 figures do not capture all children under 18, and a cumulative child-death total was not provided in the latest bulletin.

Nearly half of all deaths, that is 32 of 68 (47.1%) occurred in the community before patients reached care, underscoring the need for early detection, prompt care-seeking, timely referral and accessible treatment close to affected communities. The approaching rainy season could increase transmission through flooding, contamination of water sources and disruption of water and sanitation services.

An initial reactive oral cholera vaccination (OCV) campaign was conducted in October following ICG approval for 782,146 doses across 16 targeted areas in Lusaka, Chibombo, Chongwe and Chikankata. 701,354 vaccinations were reported across Lusaka, Chibombo and Chongwe. A further application, submitted on 13 November, requests 1,930,096 doses for people aged one year and above in 31 targeted areas across seven districts, with implementation proposed from 20 November, subject to ICG approval. The application also reports 500,000 doses pre-positioned in-country to initiate vaccination in priority Lusaka areas once approval is secured.

Affected children and caregivers urgently need timely access to treatment, safe drinking water, hygiene supplies, nutrition screening and referral, and protection support, and the community deaths show that too many are still not reaching care in time. Understanding the barriers to care, and giving families clear, accessible information on symptoms, immediate action and where to seek treatment, is therefore essential.

Immediate priorities are case-area targeted interventions that combine household visits for hygiene promotion, risk communication and community engagement, household water treatment and water-quality monitoring. These will be linked to community-based surveillance, early treatment, stronger referral pathways and essential treatment supplies, with nutrition screening, child protection referrals and targeted school interventions built into the response. UNICEF will

continue supporting government-led incident management structures to strengthen coordination, interrupt transmission, prevent avoidable deaths and sustain essential services, reviewing geographic priorities as the outbreak evolves.

Government response plan:

The **Cholera National Incident Action Plan** covers 15 November 2026 to 9 January 2027. It is built around a planning scenario of approximately 10,000 cumulative cholera cases to guide response capacity and resource mobilization, with lower and higher scenarios of approximately 6,000 and 25,000 cases. These are planning scenarios, not forecasts, and they underline the need to accelerate targeted prevention, treatment and community response before the rainy season.

Summary Analysis of Programme Response

Under the leadership of the Ministry of Health and ZNPHI, UNICEF is supporting the Government-led response through the provision of pre-positioned WASH and Health supplies and integrated community interventions spanning risk communication and community engagement, hygiene promotion, community-based surveillance, case management and referral.

UNICEF is working with government authorities, civil society organizations and the private sector to support an integrated response across health, WASH/IPC, risk communication and community engagement, education, nutrition and child protection. Technical support is provided through national and subnational coordination structures. Rapid assessments were conducted in Chibombo, including Mwanjuni Rural Health Centre, and in Mandevu sub-district, Lusaka, covering Chaisa Cholera Treatment Unit (CTU), a Cholera Treatment Centre (CTC) and an Oral Rehydration Point (ORP). Findings are informing targeted support to address facility and community response gaps.

UNICEF Zambia has 11 staff dedicated to the cholera response, including emergency focal points in (WASH, Health, Education, SBC, Nutrition, Social Policy, PME, CAPE and Child Protection), with field presence in (Lusaka, Chibombo and Luapula). Through partners, UNICEF is supporting 20 community volunteers and 7 health workers deployed for household visits, community-based surveillance and referral.

WASH/IPC

During the reporting period, UNICEF delivered 20 acute watery diarrhoea (AWD) kits to five districts and two tents to Chibombo. In collaboration with Lukanga Water Utility, UNICEF supported installation of inline chlorinators at three health facilities in Chibombo District. UNICEF also provided IPC-WASH supplies through Chibombo District Health Office to support 20 health facilities and distributed supplies to health facilities treating cholera cases in Mwense, Mwansabombwe, Nchelenge and Chiengi districts in Luapula Province. These supplies support water treatment, safe water storage, hand hygiene and infection prevention and control, and reached an estimated 12,000 affected and at-risk households across the targeted districts. A further 70 AWD kits remain in stock.

UNICEF currently has limited WASH supplies, including liquid chlorine, sufficient to support about 5,000 households for two weeks. Without immediate replenishment, UNICEF's capacity to respond to the expanding outbreak will be significantly constrained.



Figure 2: Handing over of AWD kits and WASH/IPC supplies to Luapula Provincial Health Office

UNICEF continued to support WASH Cluster and IPC-WASH Pillar coordination through information sharing, technical discussions and joint analysis. Operational gaps include limited partner capacity, inadequate water and sanitation services in affected communities and health facilities, insufficient supplies and constrained frontline delivery capacity. Reported gaps in water trucking and intermittent utility water supply in Lusaka hotspots require follow-up with utilities and district authorities to improve safe-water availability, water-quality monitoring and household water treatment.

The UNICEF team visited Chaisa, one of the cholera hotspots in Mandevu, and observed poor environmental sanitation, uncontrolled waste disposal and inadequate latrine facilities. The community relies on public taps managed by Chaisa Water Trust for drinking water, which

is reportedly available for only nine hours per day. Community members reported that the tariff of K1 per 20 litres is unaffordable for vulnerable households. As a result, many households continue to use potentially unsafe shallow wells for cooking, handwashing and washing utensils, increasing the risk of cholera transmission. Options to improve affordable access to safe water for vulnerable households require follow-up with the utility and district authorities.

The Minister of Health's emphasis on safe-water access reinforces the need for coordinated follow-up by health authorities, water and sanitation authorities, commercial utilities and district teams. Priority actions include identifying underserved communities, addressing interruptions in safe-water provision and linking household prevention messages with access to the supplies and services needed to practise them.

Risk Communication and Community Engagement

UNICEF continues to co-chair the Cholera Risk Communication and Community Engagement (RCCE) Pillar, which has met every two weeks since the onset of the outbreak in July. In this role, UNICEF supported the pillar to map partners using the 5Ws (who, what, where, when and for whom) matrix, which showed that only seven of the more than 22 pillar partners are actively engaged in the current outbreak response. UNICEF also supported the review, updating and costing of the national Cholera RCCE incident action plan (IAP) for all pillar partners, which requires K45.1 million (approximately US$2.2 million), of which only K2.7 million (6.0%) has been mobilized, leaving a deficit of K42.4 million. This national pillar requirement is separate from UNICEF's own SBC requirement of US$352,000.



Figure 3: Men participating in cholera sensitization using a 3Cs poster at a bus stop in Ndola, Copperbelt Province

Using the 3Cs (clean and safe drinking water, clean hands and early care) behaviour change package, UNICEF and partners reached over 1.2 million people through door-to-door sensitization and a further 30,000 at-risk community members through community dialogue meetings. Men, who are among the most affected and at-risk groups in the current outbreak, have also been engaged and sensitized.

To complement these community-based efforts, UNICEF supported a one-month mass media campaign between September and October, airing cholera prevention and early care-seeking messages on one national television station and 15 radio stations (two national and 13 provincial and community stations), with an estimated potential audience of 7.8 million people. In parallel, community feedback mechanisms were strengthened through national call centres and community-level channels, with over 3,000 cholera-related feedback inputs documented to date via the Childline call centre and affected households. In addition, 1,390 community gatekeepers and influencers have been reached with 3Cs messages. This feedback continues to guide adjustments to messaging and to address misinformation and barriers to prevention and treatment.

UNICEF also supported the printing of 31,600 cholera social and behavioural change materials, comprising 3Cs adult and child-friendly posters, 3Cs sign language and foreign language posters, and oral rehydration point (ORP), oral cholera vaccine (OCV) and general cholera job aids. The Ministry of Health and partners are distributing these materials, with Nakonde as the main distribution point, across 16 hotspot and at-risk districts (Chibombo, Chiengi, Mwansabombwe, Mwense, Nchelenge, Chilanga, Chongwe, Lusaka, Mpulungu, Nsama, Mbala, Chikankata, Monze, Kalomo, Nakonde and Mpika), as well as in Makyukwayukwa in Kaoma District and Meheba Refugee Camp in Kalumbila and Solwezi districts.

The two rapid assessments in Lusaka and Chibombo identified three priorities: (1) stronger engagement with influential community leaders and community security structures, as crime is discouraging people from seeking care at night; (2) sustained behaviour change messaging on sanitation and hygiene at household and community level, including correct use of chlorine and ORS; and (3) stronger collection and use of community feedback and Social and Community Listening (SCL) at health facility level to adjust response activities in real time.

Health

UNICEF supports coordination, planning and situation monitoring through the national Incident Management System (IMS) and the surveillance and case management technical working groups. Support prioritizes community-based case finding and prompt referral to treatment, given the high proportion of community deaths. UNICEF provided resources for integrated community response activities in Lusaka and Chibombo and delivered 20 Acute Watery Diarrhoea (AWD) kits to five districts (Chibombo, Chiengi, Mwense, Mwansabombwe and Nchelenge) with four kits per district. Two tents were also provided to Chibombo for cholera treatment, helping maintain essential health services. UNICEF retains 70 AWD kits in stock to support further response needs and reduce pressure on routine medical supplies.

In Mandevu, Chaisa CTU had five beds and reported receiving approximately seven patients daily, with no dedicated paediatric beds. The CTC visited had 15 beds and reported receiving 20–30 cases on some days. Additional cholera beds, including paediatric beds, a larger treatment tent and continued on-site technical support were identified as urgent priorities.

Following the October Oral Cholera Vaccination (OCV) reactive campaign, for which the ICG approved 782,146 doses, Zambia's application dated 13 November requests a further 1,930,096 doses for people aged one year and above in 31 targeted areas across Lusaka, Chibombo, Nchelenge, Mwansabombwe, Mpulungu, Nsama and Mpongwe districts. The application reports 500,000 doses already pre-positioned in-country to initiate vaccination in priority Lusaka areas, with implementation proposed from 20 November, subject to ICG approval. The available documentation does not establish cumulative doses received or administered; these figures remain pending confirmation.

Education

UNICEF is supporting the Ministry of Education to establish and strengthen epidemic preparedness and response committees. This support focuses on preparedness; implementation results will be reported as they become available.

Nutrition

The Mandevu assessment found that nutrition was largely absent from community response activities and case management. Priority needs include screening for acute malnutrition, referral and age-appropriate feeding guidance at treatment facilities, alongside nutrition messaging at ORPs and through community outreach. Nutrition response activities have not yet started due to lack of funding.

UNICEF plans to orient community-based volunteers and health workers on screening children under five, Infant and Young Child Feeding in Emergencies and the Family MUAC approach, which enables caregivers to screen children using mid-upper arm circumference. Planned support also includes pre-positioning and last-mile distribution of nutrition commodities to health facilities.

Child Protection

Child protection priorities include ensuring that affected children and caregivers can safely access treatment, information and supplies. Planned actions include identifying and referring vulnerable children, supporting family tracing and reunification where needed, and linking families to case management and mental health and psychosocial support (MHPSS). Child safeguarding, gender-based violence (GBV) risk mitigation and protection from sexual exploitation and abuse (PSEA) will be integrated into community engagement and supply distribution. Implementation results will be reported as activities commence and verified data become available.

Continuity of Essential Social Services

UNICEF continues to support government and partners to maintain essential services during the cholera response, including education, primary health care (including routine immunization), maternal and child health, nutrition and child protection

Communication

During the reporting period, UNICEF shared cholera prevention and early care-seeking messages through Facebook, X and Instagram. Content included Ministry of Health updates, demonstrations of correct household water chlorination, safe water storage and handling, and documentation of UNICEF-supported WASH/IPC supply deliveries in Luapula. Sign-language content supported accessibility. Selected posts are linked below.

1. UNICEF amplified a Ministry of Health update on the evolving cholera outbreak: 3Cs to stop Cholera
2. UNICEF also published and boosted cholera prevention content to increase its reach among online audiences, reinforcing key messages on how individuals and families can protect themselves and their communities. The content includes a sign-language version to ensure inclusivity of the messages: 3Cs to stop cholera, with sign-language version.
3. Content included a video demonstrating how to correctly chlorinate drinking water at household level, supporting wider efforts to promote safe water treatment and reduce cholera transmission: 6 steps to keep your water safe and prevent cholera.
4. A social media post highlighted the role of Community-Based Volunteers in supporting an integrated cholera response, featuring quotes from Collins Nkoma, a Community-Based Volunteer, and Racheal Phiri, a community member in Chainda, Lusaka.
5. UNICEF documented the handover of essential WASH and infection prevention and control (IPC) supplies in Luapula.
6. UNICEF supported cholera prevention by disseminating key Ministry of Health messages on safe household water chlorination, storage and handling.

Content was cross posted across UNICEF Zambia's digital channels to reinforce consistent cholera prevention and response messages.

Humanitarian Leadership and Coordination

UNICEF supports the government-led cholera response under the leadership of the Ministry of Health and ZNPHI, working with relevant ministries, WHO and other partners. UNICEF co-chairs the RCCE Pillar and contributes technical and operational support across WASH/IPC, surveillance, case management, supplies and continuity of essential services.

UNICEF is working with the Ministry of Water Development and Sanitation, commercial utilities and provincial focal persons to strengthen IPC-WASH coordination. WASH Cluster meetings held on 29 October and 5 November identified the need to broaden participation and strengthen follow-up on agreed actions to address service and supply gaps.

Limited partner presence in the assessed locations in Mandevu highlights the need for additional operational support, sustained on-site technical assistance and coordinated coverage across treatment services, ORPs, community surveillance, RCCE and WASH.

Funding Overview and Partnerships

The overall Cholera Preparedness and Response Plan for the 2026/27 outbreak season is costed at US$3,243,211.13. To date, US$290,898 (9%) has been mobilized, leaving a funding gap of US$2,952,313.13 (91%). Health accounts for the largest share of the gap at US$1.64 million, followed by WASH (US$645,426) and SBC (US$289,000). Plan is being adjusted as outbreak evolves.

UNICEF expresses its sincere appreciation to ECHO for its contributions, and to the Government of Zambia and partners for their continued collaboration. Additional funding is urgently needed to scale up the response in hotspots areas as well as readiness in high-risks districts.

Next Steps

- Scale up case-area targeted interventions in hotspot communities, linking household visits, hygiene promotion and household water treatment with community-based surveillance and timely referral.

- Replenish WASH supplies, including liquid chlorine, and support additional cholera beds, including paediatric beds, in Mandevu.
- Orient community volunteers and health workers on nutrition screening, Infant and Young Child Feeding in Emergencies and the Family MUAC approach, subject to funding.
- Begin identification and referral of vulnerable children and link families to case management and MHPSS services, subject to funding.
- Mobilize more RCCE pillar partners and expand engagement with community leaders and security structures to reduce barriers to seeking care at night.
- Follow up with utilities and district authorities on safe-water availability and affordability in Lusaka hotspots.

Next Sitrep: 1 December 2026

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