Diphtheria, African Region

Date and version of current assessment: 16 March 2026, v2
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Overall risk and confidence*

Overall risk	
Regional	**Global**
Moderate	**Low**

Confidence in available information	
Regional	**Global**
Moderate	Moderate

Risk statement

This WHO Rapid Risk Assessment (RRA, v2) aims to assess the risk of diphtheria at the regional level, considering the public health impact, the risk of geographical spread and the risk of insufficient control capacities with available resources. Diphtheria is a major public health problem in the WHO African Region (AFR) despite significant efforts on immunization in the past decades (e.g. introduction of DTP vaccine in the Expanded Program on Immunisation in 1974). Between 2000 and 2024, 75 789 diphtheria suspected cases were reported across the Region with an average 3 500 cases per year.

Between the beginning of 2025 and as of 1 March 2026, over 29 000 suspected diphtheria cases with 1 420 deaths (CFR 4.9%) have been reported across these eight countries: Algeria, Chad, Guinea, Mali, Mauritania, Niger, Nigeria and South. This represents a 67% increase in the number of suspected cases (11 749 additional cases) and a 59.4% increase in the number of deaths (529 additional deaths) reported since the last WHO RRA (v1) conducted in October 2025, Nigeria continues to account for the majority of suspected cases (62.6%) and deaths (66%) in the Region. Of the 18 130 total confirmed cases (clinically compatible, laboratory-confirmed and epidemiologically linked) across the eight affected countries, 752 (4%) cases were recorded as laboratory-confirmed: Algeria (8), Chad (1), Guinea (48), Mali (66), Mauritania (12), Niger (313), Nigeria (211) and South Africa (93).

Case data trends from 2026 have been difficult to interpret, with extremely delayed case reporting from countries (both to the national and regional levels), and instances of under-reporting also being notified, particularly from humanitarian settings. However, a lower number of cases are being consistently reported than earlier in the outbreak and thus it appears that new cases continue to decline or plateau, as seen in half of the affected countries (Chad, Mali, Mauritania, and Nigeria).

Since the first WHO RRA (v1) conducted in October 2025, the regional CFR remains around 5%. While Guinea continues to report among the highest CFRs in the region at 19%, South Africa's CFR has increased since the last WHO RRA (v1) to 19%. Children aged 5–14 yrs (57%) and females (63%) are the most affected; where information is available on the vaccination status of cases, most cases are unvaccinated, under-vaccinated, or with unknown vaccination status.

While the overall risk was previously assessed as "HIGH" at the regional level in October 2025, it is now considered "MODERATE" due to:

- Overall declining trend in number of weekly cases regionally, with country-specific trends also declining in half of the affected countries (Chad, Mali, Mauritania and Nigeria), and only sporadic cases reported from South Africa.
- Strengthened coordination of public health response through the activation of an Incident Management System (IMS) in most of the affected countries. A joint Regional Office for Africa (AFRO) and WHO headquarters (HQ) IMS structure was activated to support the regional coordination of the response, with high-level ministerial commitment to controlling the outbreaks in the affected countries.
- Implementation of immunization activities as part of the outbreak response in most of the affected countries.

* Confidence refers to the level of confidence in the data/information or the quality of the evidence available at the time the RRA is conducted. Poor quality information may increase the overall perceived risk due to the incertitude in the assessment.

- Strengthening of surveillance, case management, community sensitization, through capacity building activities, and the provision of diphtheria antitoxin (DAT), antibiotics, laboratory supplies, etc.

Nonetheless, some challenges continue to prevent the effective containment of these outbreaks:

- The complex humanitarian situation in many of the affected countries continues to contribute to poor access to immunization and healthcare services for internally displaced persons (IDPs), nomads, miners, and migrants. Unsanitary living conditions (in displacement camps) are also favouring the transmission of diphtheria. These increase the exposure risk of vulnerable groups (particularly women and children) to diseases.
- Limited laboratory confirmation due to lack of reagents, sample transportation challenges and limited available of laboratory capacity.
- In most of the affected countries, the annual coverage for routine diphtheria vaccination remains below the national targets thereby contributing to the resurgence of cases and outbreaks.
- Global scarcity of DAT for the treatment of affected persons.
- High internal and cross-border movements of susceptible individuals (unvaccinated or not fully vaccinated).
- Persistent funding challenges across most affected countries exacerbated by the current challenging international funding landscape.

The overall risk at the global level remains ''LOW'' due to:
The global risk of diphtheria outbreaks from the ongoing multi-country diphtheria outbreak in the African region is assessed as low, given the existence of routine immunization programs in most countries. Nonetheless, the risk posed by international travel of susceptible populations from the WHO African Region cannot be overlooked, highlighting the need to strengthen risk communication, demand generation and reactive immunisation, as well as the need for enhanced data sharing and surveillance globally.

Risk questions

Risk question		Assessment		Risk	Rationale
		Likelihood	Consequences		
Potential risk for human health?	Regional	Unlikely	Moderate	Moderate	Since the last WHO RRA (v1) conducted in October 2025, 11 749 additional cases and 529 additional deaths have been reported from Algeria, Chad, Guinea, Mali, Mauritania, Niger, Nigeria and South Africa. While data from 2026 has been difficult to interpret, with delayed case reporting from countries (both to the national and regional levels), and instances of under-reporting also being notified, particularly from humanitarian settings, a smaller number of weekly cases are being consistently reported across many affected countries (Chad, Mali, Mauritania, Nigeria and South Africa) as compared to earlier in the outbreak. Most suspected cases and deaths continue to be reported from one country, Nigeria, where the most affected states in the northern part of the country are grappling with insecurity, thus hampering response activities. The overall CFR as of March 2026 (4.9%) remains similar to that reported in October 2025 (5.1%); While Guinea continues to report among the highest CFRs in the region at 19%, South Africa's CFR has increased since the last WHO RRA (v1) to 19%. Poor disease risk perception and health seeking behaviour, the presence of comorbidities, late presentation to healthcare facilities, and limited human resource capacity for clinical care of affected individuals contributes to the high CFR estimates. Although significant efforts have been made by WHO and partners to mitigate the global scarcity of DAT, access to DAT
	Global	Unlikely	Minor	Low	

					remains limited, which continues to contribute to increasing the risk of disease complications, including death. The current outbreaks in the WHO African Region remain a low risk for human health at global level.
Risk of event spreading?	Regional	Unlikely	Minor	Low	Delays in case reporting, very limited laboratory confirmation capacity, and sub-optimal information sharing in some affected countries increase the likelihood of outbreaks expanding within and between neighboring countries. In addition, most affected countries (Chad, Mali, Niger, Nigeria, Mauritania, Algeria) share long and porous borders, with significant cross-border movements of susceptible populations reported for political (populations fleeing conflicts), health (population seeking better healthcare), and economic reasons. Nonetheless, the epidemic remains confined to the eight affected countries at the time of the current assessment, and efforts are being made to strengthen cross-border surveillance between countries sharing porous borders (e.g. as part of the zonal containment strategy, cross-border mobile teams will be deployed to provide surge support and prevent cross-border transmission). The current outbreaks in the WHO African Region pose a low risk for the event spreading to a global level.
	Global	Unlikely	Minimal	Low	
Risk of insufficient control capacities with available resources	Regional	Likely	Moderate	High	Partners have mobilised human and financial resources to support the affected countries to respond to the Diphtheria outbreaks. WHO has provided funding to the respective WHO Country Offices (WCOs) through the WHO Contingency Fund for Emergencies (CFE) and additional efforts are being made to mobilise more resources. Mobilisation of resources at national, regional and global levels have contributed to implement response activities. Therefore, immunisation activities as part of the outbreak response have been conducted in most countries, some experts have been deployed on country demand to strengthen coordination, surveillance, and vaccination. Efforts are being made to provide countries with DAT, antibiotics, and vaccines, etc. Nonetheless, underfunding remains a challenge and national authorities, with partners' support, have to scale up resource mobilisation efforts to contain these outbreaks. Additionally, the extremely low global stock of DAT may not be sufficient to address the needs in the affected countries.
	Global	Likely	Minor	Moderate	

Major actions recommended by the risk assessment team

	Action
☐	Refer the event for review by IHR Emergency Committee for consideration as a PHEIC by DG (Art 12, IHR)
☐	Immediate activation of WHO response mechanism as urgent public health response is required
☒	Recommend setting up WHO grading call
☐	Immediate support to response, but no WHO grading recommended at this point in time
☐	Rapidly seek further information and repeat RRA (including field risk assessment)
☒	Support Member State to undertake preparedness measures
☒	Continue to closely monitor
☐	No further risk assessment required for this event, return to routine activities

Immediate actions

WHO Country Offices (WCOs) to:

- Continue supporting partners coordination for a coordinated public health response.

- Continue supporting the development of vaccine requests for supplementary immunization activities where necessary to address immunity gaps.
- Continue supporting national authorities' efforts to strengthen gaps in surveillance, case detection and reporting, laboratory confirmation of cases, case management, infection prevention and control.
- Continue supporting strengthening of community awareness on the ongoing outbreaks as well as prevention measures.
- Continue supporting resource mobilisation for an adequate implementation of response activities.

WHO Regional Office for Africa (AFRO) to support WCOs with:

- Advocacy efforts to improve timely information sharing.
- Regional partners coordination for a coordinated and efficient response.
- Monitoring of diphtheria case trends across the Region, and in-depth risk analytics to identify high-risk areas and guide targeted interventions.
- Establishment of a contingency stock for diphtheria at the Emergency Preparedness and Response Hubs in Dakar and Nairobi (including DAT, antibiotics, and laboratory supplies) to enable rapid distribution to countries when needed.

WHO HQ will support WCOs, and AFRO as needed, including:

- Ensuring an equitable, evidence-based approach to access the WHO DAT emergency stockpile through the existing the DAT allocation mechanism.
- Support for the procurement of DAT for the affected countries.

Supporting information

Hazard assessment

Diphtheria is an infectious disease caused by the bacterium *Corynebacterium diphtheria*, which primarily infects the throat and upper airways, and produces a toxin affecting other organs. The disease can spread from person to person by breathing in the aerosolized secretions from coughs or sneezes of infected individuals. Although transmission from respiratory cases via droplets is the most common mode of infection, cutaneous carriage of *C. diphtheriae* should also be considered as it is an important source of person-to-person transmission of the pathogen, particularly in communities where vaccination coverage is low and/or where hygiene conditions are poor.

The incubation period is typically from 2 to 5 days. The illness has an acute onset, and common symptoms include a sore throat, fever, swelling of the neck glands and weakness. Within 2–3 days from infection, the diphtheria toxin causes a membrane of dead tissue to build up in the respiratory tract, forming a thick, greyish-white coating that can cover tissues in the nose, tonsils and throat, making breathing and swallowing difficult. Some people may not develop disease manifestations but can still transmit the bacteria to others. Following an infection, unvaccinated individuals may present with skin infections (cutaneous diphtheria), classical respiratory diphtheria, and in rare cases, systemic diphtheria. The most common sites of symptomatic as well as asymptomatic infections are the pharynx, larynx, tonsils, nose and skin. The toxin kills tissue at the site of infection and produces systemic effects including myocarditis, nephritis, polyneuropathy and paralysis when absorbed into the bloodstream. For unvaccinated individuals without adequate treatment, diphtheria can be fatal in around 30% of cases, with children younger than 5 years of age at greater risk of dying.

Treatment involves administering diphtheria antitoxin and antibiotics. Diphtheria specific antitoxin (DAT) neutralizes circulation toxin in the blood. DAT must be administered as soon as possible, as early administration is associated with improved clinical outcomes. In patients with suspected or confirmed symptomatic diphtheria, WHO suggests administration of a single dose of diphtheria antitoxin with choice of dose based on disease severity and time since symptom onset. Antibiotics stop bacterial replication and thereby toxin production, preventing further transmission to uninfected individuals, and limiting carriage that can persist even after clinical recovery. However, many current strains of diphtheria have exhibited resistance to some commonly used antimicrobial drugs (e.g. penicillin). In patients with suspected or confirmed diphtheria, WHO recommends using macrolide antibiotics (azithromycin, erythromycin) in preference to penicillin antibiotics.

Diphtheria vaccine is a bacterial toxoid, i.e. a toxin whose toxicity has been inactivated. The vaccine is normally given in combination with other vaccines as DTwP/DTaP vaccine or pentavalent/hexavalent vaccine. For adolescents and adults, the diphtheria toxoid is frequently combined with tetanus toxoid in lower concentration (Td vaccine). WHO recommends a 3-dose primary vaccination series with diphtheria-containing vaccine followed by 3 booster doses. The primary vaccination series should begin as early as 6 weeks of age with subsequent doses given with a minimum interval of 4 weeks between doses. The 3 booster doses should preferably be given during second year of life (12-23 months), 4-7 years and 9-15 years. Ideally, there should be at least four years between booster doses. To further promote immunity against diphtheria, combined diphtheria, and tetanus toxoid vaccine (Td or TD) should be used rather than tetanus toxoid alone. This can be used in pregnancy as well as following injuries.

Unvaccinated and partially vaccinated individuals are at increased risk of infection. There have been resurgences in diphtheria cases any time immunization coverage falls below vaccination threshold for herd immunity. Damaged health infrastructure and health services in countries experiencing or recovering from a natural disaster or conflict interrupt routine immunization. Overcrowding in residential camps increases the risk of infection. Individuals who have been in contact with cases of diphtheria should be treated with antibiotics prophylactically to prevent illness. The immunization status of all contacts should also be checked. Unvaccinated contacts should receive a full course of diphtheria toxoid-containing vaccine and partially vaccinated contacts should receive the doses needed to complete their vaccination series. If vaccination history is unknown, re-vaccination is recommended. High risk groups including pregnant women and health workers working in outbreak settings should ensure their vaccination status is up to date.

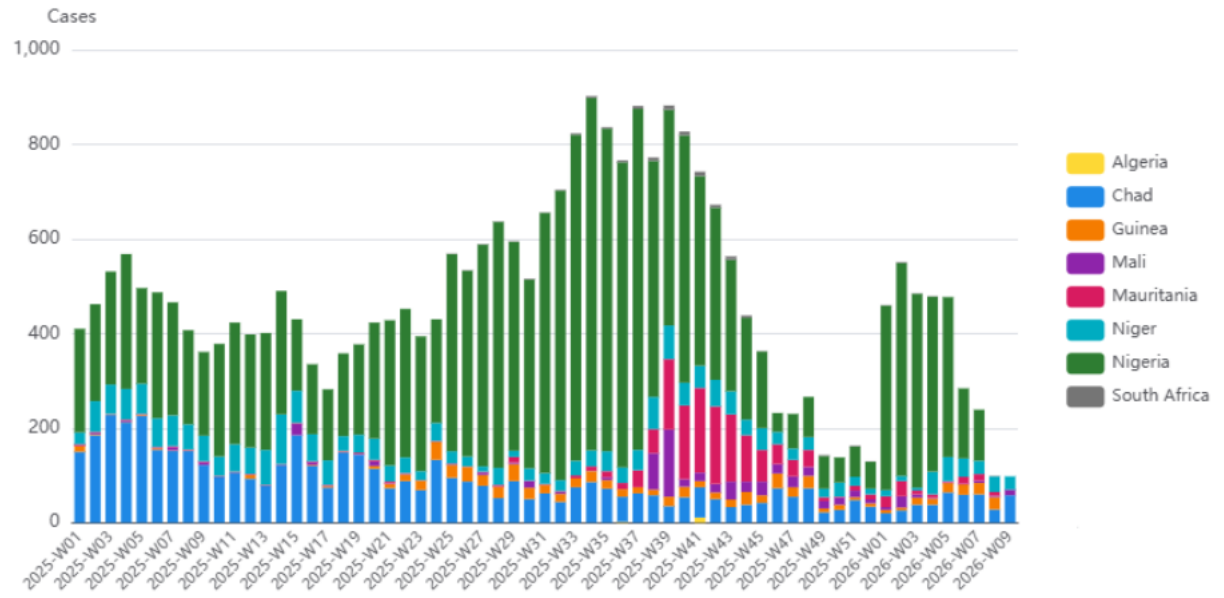
Exposure assessment

Since 2022, the WHO African Region has been experiencing a resurgence of diphtheria. Since the beginning of 2025, eight countries have reported diphtheria outbreaks: Algeria, Chad, Guinea, Mali, Mauritania, Niger, Nigeria, and South Africa. As of 1 March 2026, over 29 000 suspected diphtheria cases with 1 420 deaths have been reported across these eight countries. This represents a 67% increase in the number of suspected cases (11 749 additional cases) and a 59.4% increase in the number of deaths (529 additional deaths) since the last WHO RRA (v1) conducted in October 2025. The regional Case Fatality Ratio (CFR) has remained around 5% (5.1% as of October; 4.9% as of March).

A total of 18 130 confirmed cases (clinically compatible, laboratory-confirmed and epidemiologically linked) have been reported from the eight affected countries, of which 752 (4%) are laboratory-confirmed cases: Algeria (8), Chad (1), Guinea (48), Mali (66), Mauritania (12), Niger (313), Nigeria (211), and South Africa (93).

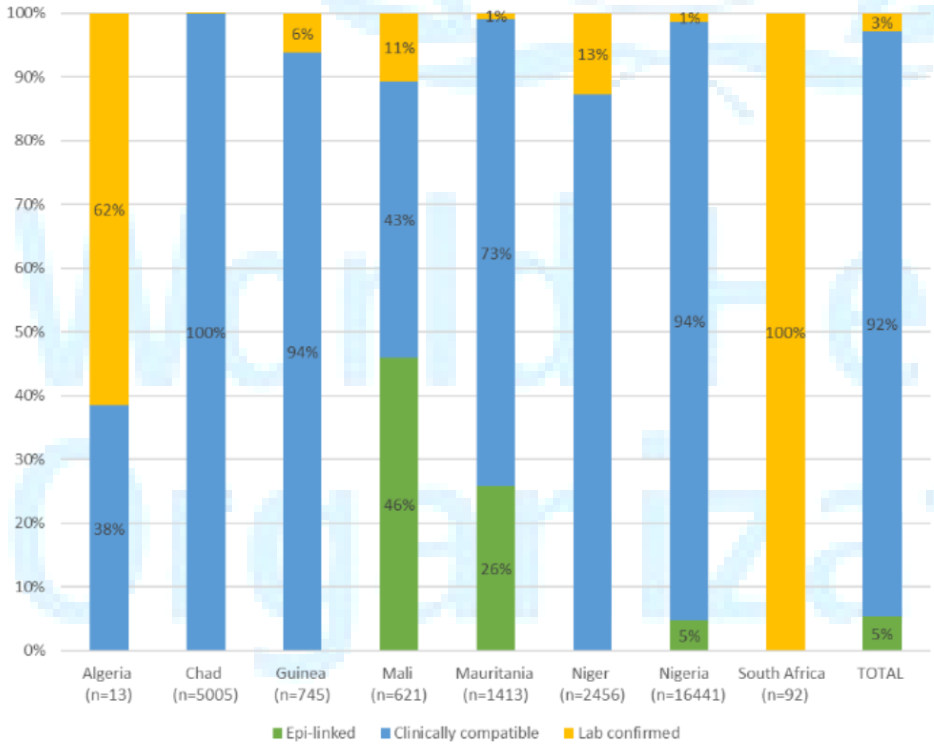
Data from 2026 has been difficult to interpret, with extremely delayed case reporting from countries (both to the national and regional levels), and instances of under-reporting also being notified, particularly from humanitarian settings. However, a lower number of weekly cases are being consistently reported than earlier in the outbreak and thus it appears that new cases continue to decline or plateau as seen in half of the affected countries (Chad, Mali, Mauritania and Nigeria), with South Africa only reporting sporadic cases.

Weekly distribution of Diphtheria suspected cases by country, WHO African region, 1 January 2025 – 1 March 2026

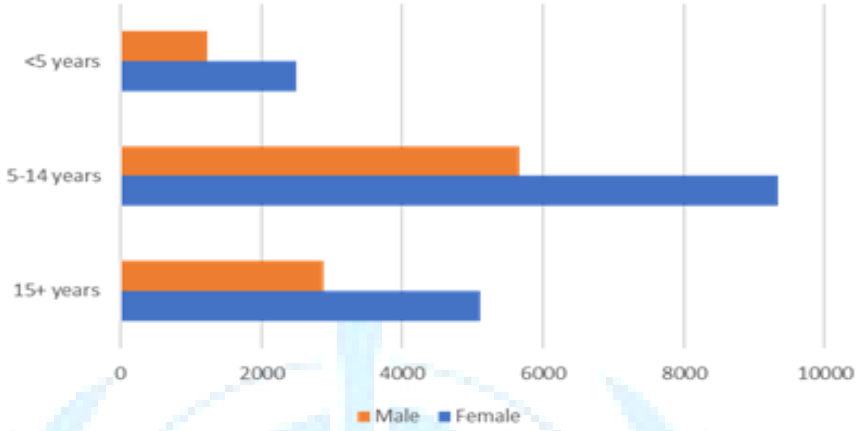


Nigeria accounts for the majority of suspected (62.6%) cases in the WHO African Region, while South Africa and Guinea are reporting the highest CFR of 19% each. Children aged 5–14 yrs (57%) and females (63%) of cases are the most affected; 84–95% of cases are unvaccinated, under-vaccinated, or with unknown vaccination status.

Case classification status, by country: Week 1, 2025 – Week 7, 2026



Age and sex distribution of suspected cases, 1 January 2025 – 19 February 2026

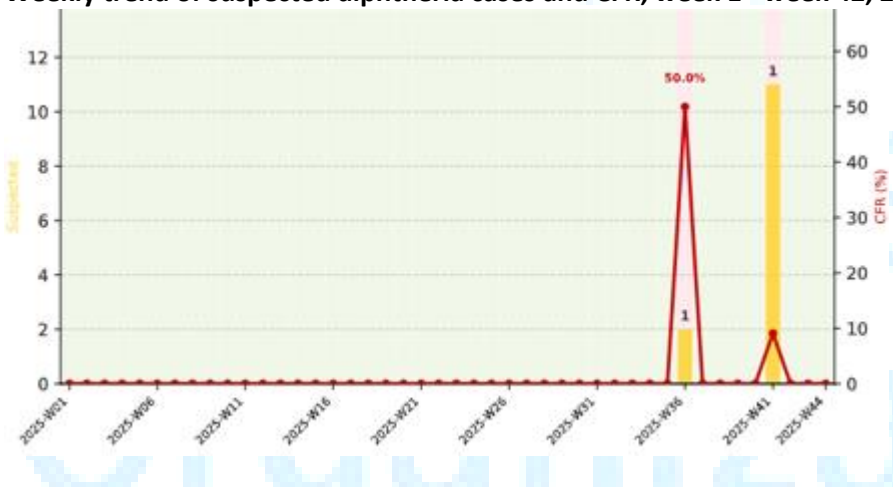


Algeria: In September 2024, an outbreak of diphtheria was reported in three southern wilayas (regions) of Algeria, Tamanrasset, In Guezzam, and Bordj Badji Mokhtar. As of 25 May 2025, 915 suspected cases including 119 deaths (CFR 13%) were reported. Of the 915 suspected cases, 299 were laboratory-confirmed. Seventy-eight percent of cases were nationals of Mali and Niger.

In October 2025, a diphtheria outbreak was reported in the northeastern wilaya of Skikda. From 8 to 19 October 2025, a total of 13 suspected cases with 2 deaths (CFR 15.4%) have been reported from Skikda, Filfila and Hamadi krouma communes. Three of the suspected cases were age 4, 5 and 12 years while the 10 remaining cases were age above 18 years. Of the 13 suspected cases, 8 were laboratory-confirmed by culture and PCR at Institut Pasteur of Algeria. None of the confirmed cases were vaccinated, with males accounting for 62.5% (n=5) of these cases.

No recent data has been shared with WHO by Algeria on the diphtheria situation since October 2025.

Weekly trend of suspected diphtheria cases and CFR, week 1– week 42, 2025, Algeria

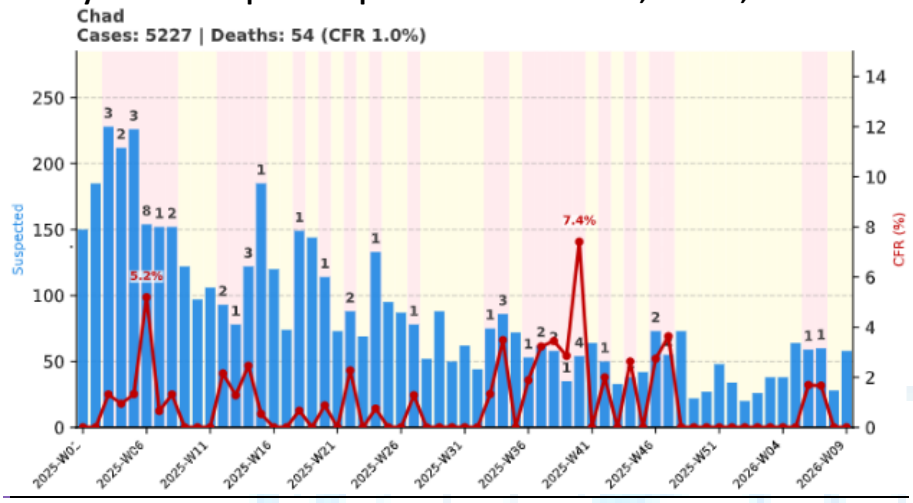


Chad: From 1 January 2025 to 1 March 2026, a total of 5 227 suspected cases of diphtheria with 54 deaths (CFR 1%) were reported from 27 health districts across 7 provincial health delegations of Chad. Between 5 October 2025 (last update for Chad for WHO RRA, v1) and 1 March 2026, there has been a 20.4% (n=886) increase in the number of suspected cases and a 17.4% (n=8) increase in the number of deaths reported from Chad. Since January 2025, and as of 1 February 2026, 57 of 70 samples collected were tested by culture (13 samples were unusable), of which 4 returned positive for *C. acolans* (n=3 samples) and *C. diphteriae gravis* (n=1 sample). In addition, 48 clinically compatible cases were recorded.

Analyses of demographic data collected from 1 762 suspected cases revealed that the most affected age-group was 3-13 years (n=732, 41.5%) followed by 14-24 years (n=445, 25.3%) with a male to female ratio of 0.9. Vaccination status analyzed for 2 069 cases, revealed that 6% (n=126) were vaccinated, 2% (n=46) were not

vaccinated and 92% (n=1 897) had unknown vaccination status. Of the 126 cases vaccinated, 81% (n=102) were aged 1-5 years, while 19% (n=24) were aged more than 5 years.

Weekly trend of suspected diphtheria cases and CFR, week 1, 2025 – week 9, 2026, Chad

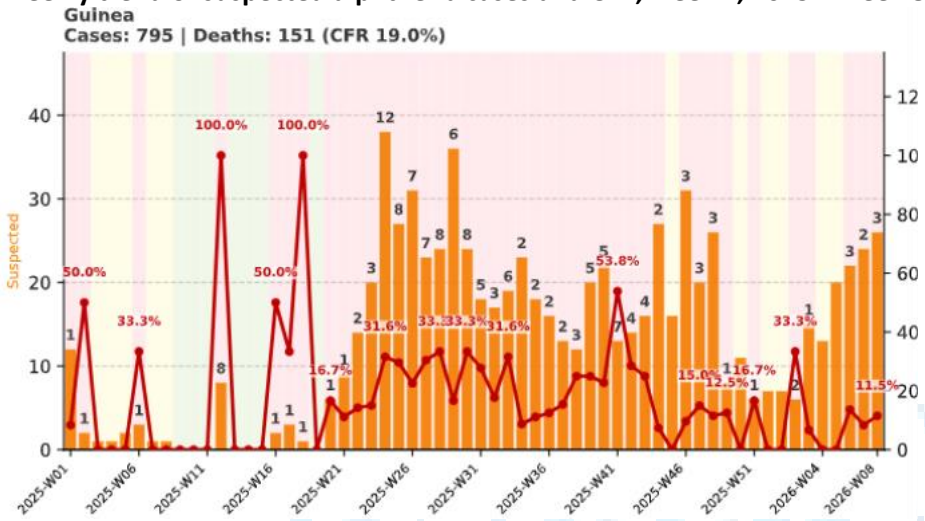


Guinea: In 2025, Guinea experienced a resurgence of diphtheria cases, with a notable increase beginning in June. From 1 January 2025 to 22 February 2026, a total of 795 suspected cases, including 151 deaths (CFR: 19%), were reported across four prefectures: Siguiri, Kankan, and Mandiana in the Kankan region, and Dabola in the Faranah region. From 1 January to 22 February 2026, a total of 133 suspected cases with 11 deaths (CFR 8.3%) were reported from Siguiri and Mandiana in the Kankan region, and Matoto in the Conakry region. The Siguiri district remains the epicenter, accounting for over 80% of both reported cases and fatalities.

Between 12 October 2025 (last update for Guinea for WHO RRA, v1) and 22 February 2026, there has been a 68.4% (n=323) increase in the number of suspected cases and a 36% (n=40) increase in the number of deaths reported from Guinea. An increasing trend in the number of weekly cases has been observed since week 5, 2026 after a plateauing trend between week 49, 2025 and week 4, 2026. Since January 2025, and as of 22 February 2026, 48 cases were laboratory-confirmed, and 561 clinically compatible cases were recorded.

The resurgence of diphtheria cases observed since June 2025 follows a major outbreak first notified in July 2023 in Siguiri district, which subsequently spread to other regions. As of 9 April 2024, 4 517 suspected cases and 105 deaths (CFR: 2.3%) had been reported from six regions: Kankan, Faranah, Labé, Mamou, Conakry, and N'Nzérékoré. The Siguiri health district alone accounted for 98.4% of suspected cases. Among the 4,307 confirmed cases, 29 were laboratory-confirmed, 4 173 were clinically compatible, and 105 were epidemiologically linked. By April 2024, the weekly incidence had declined significantly—from over 200 cases per week in March 2023 to fewer than 15 cases per week—and the number of affected regions had dropped from seven to one.

Weekly trend of suspected diphtheria cases and CFR, week 1, 2025 – week 8, 2026, Guinea

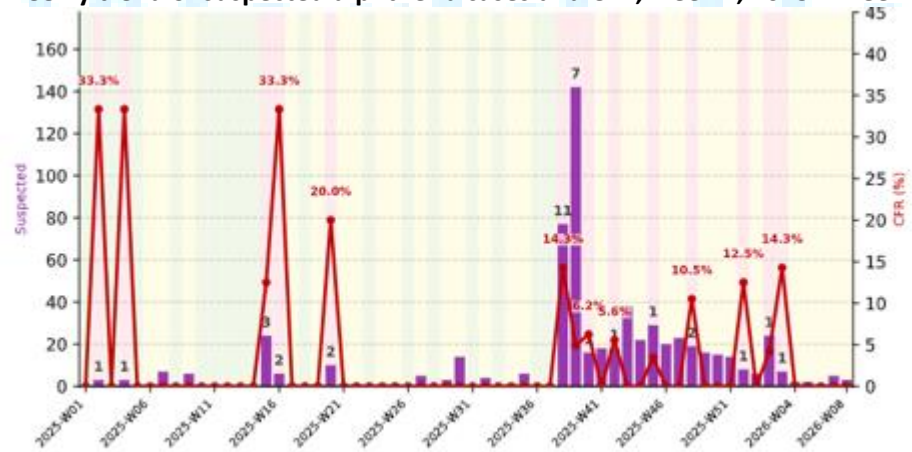


Mali: From 1 January 2025 to 1 March 2026, a total of 636 suspected cases of diphtheria with 35 deaths (CFR 5.5%) have been reported. Cases and deaths have been reported from 37 districts across 9/11 regions, with the majority of suspected cases (67%) and deaths (71.4%) recorded in Segou (144 cases, 10 deaths) and Mopti (282 cases, 15 deaths) regions. Between 19 October 2025 (last update for Mali for WHO RRA, v1) and 1 March 2026, there has been a 72% (266 cases) increase in the number of suspected cases and a 20.7% (6 deaths) increase in the number of deaths reported from Mali.

A total of 371 cases have been confirmed. Of 255 cumulative samples collected and tested at the National Public Health Institute, 66 returned positive for *toxigenic C. diphtheria* on PCR, and 189 tested negative. In addition, 285 epidemiologically linked and 20 clinically compatible cases have been recorded. Confirmed cases have been reported from 21 districts across 7/11 regions (Koulikoro, Sikasso, Segou, Mopti, Tombouctou, Gao and Bamako).

The outbreak has been marked by a rapid geographic expansion with the number of affected districts increasing from 3 in week 40, 2025 to 37 in week 9, 2026. After the number of weekly suspected cases peaked in week 39 of 2025 (140 cases), a plateauing trend in number of weekly cases has been observed between week 40, 2025 and week 3, 2026, followed by a decreasing trend since week 4, 2026.

Weekly trend of suspected diphtheria cases and CFR, week 1, 2025 – week 8, 2026, Mali

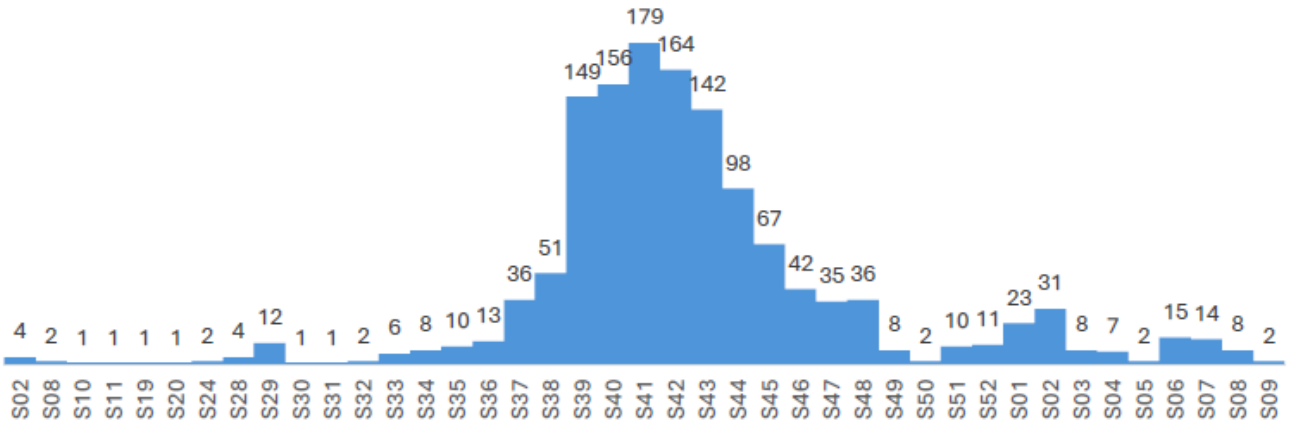


Mauritania: In 2025, an upsurge in the number of weekly diphtheria cases had been observed from week 39, with a peak of 179 cases reported in week 41. From 1 January 2025 to 1 March 2026, a total of 1 415 suspected cases of diphtheria with 54 deaths (CFR 3.8%) were reported. Between 19 October 2025 (last update for Mauritania for WHO RRA, v1) and 1 March 2026, there has been a 168% (n=887) increase in the number of suspected cases and an 80% (n=24) increase in the number of deaths reported from Mauritania. In addition, the number of affected areas increased from 11/63 moughataas (health districts) across 6/15 wilayas (regions) to

34/63 moughataas across 14/15 wilayas since the first RRA in October 2025. Nonetheless, from Week 41, 2025, a steady decrease in the number of suspected cases has been observed.

From 1 January 2025 to week 9, 2026, a total of 1 414 confirmed cases have been reported, including 12 laboratory-confirmed cases, 364 epidemiologically linked, and 1 038 clinically compatible cases have been reported. Socio-demographic analyses for 1 325 cases revealed that females account for 58.6% (n=777) of cases, with the most affected age groups being 5-14 years (643 cases, 48.5%) and 15-24 years (300 cases, 22.6%). Children age less than 5 years account for 7.8% (n=103) of cases.

Weekly trend of suspected diphtheria cases and CFR, week 1, 2025 – week 9, 2026, Mauritania



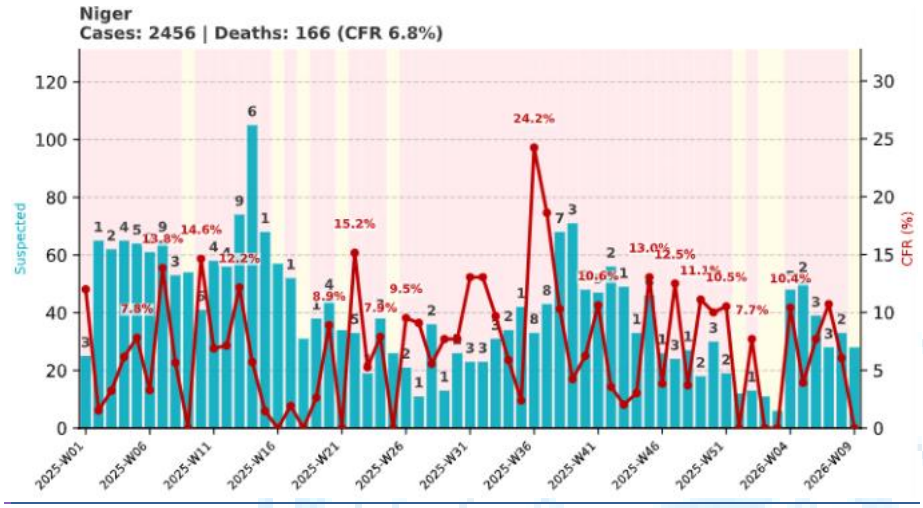
***Graphique 2** : Evolution des cas suspects de la Diphtérie par semaine épidémiologique.*

Niger: From 1 January to 31 December 2025, a total of 2 244 suspected cases of diphtheria with 154 deaths (CFR 6.7%) were reported. This represents a 44% decrease in the number of cases and a 470% increase in the number of deaths reported compared to the total number of cases reported in 2024 when 4002 suspected cases with 27 deaths (CFR 0.7%) were recorded.

From 1 January 2025 to 1 March 2026, a total of 2 456 suspected cases with 166 deaths (CFR 6.8%) were reported. Between 19 October 2025 (last update for Niger for WHO RRA, v1) and 1 March 2026, there has been a 30% increase (569 cases) in the number of suspected cases and a 37% increase (45 deaths) in the number of deaths reported from Niger. From 1 January 2025, and as of 1 March 2026, 34/72 districts across 8 regions of Niger (Agadez, Diffa, Dosso, Maradi, Niamey, Tahoua, Tillaberi and Zinder) have been experiencing outbreaks. An increase in the number of weekly suspected cases has been observed since week 4, 2026, after a decreasing trend was observed between week 39 of 2025 to week 3 of 2026.

Cumulatively since 1 January 2025 and as of 1 March 2026, 313 cases were laboratory-confirmed for *C. diphtheria*. Of 1 627 cases with available socio-demographic data, 44.7% (n=727) are in the age-group 5-14 years, followed by 27.5% (n=448) in the age-group 15-29 years. Women are more affected than men with a female to male ratio at 1.3.

Weekly trend of suspected diphtheria cases and CFR, week 1, 2025 – week 9, 2026, Niger



Nigeria: Nigeria is faced with an increase in the number of weekly of diphtheria cases since 2022. From week 19, 2022 to week 52, 2025, a total of 61 570 suspected cases including 40 142 confirmed cases were reported. Among the confirmed cases, 612 were laboratory-confirmed, 987 were epidemiologically linked and 38 543 were clinically compatible. A total of 2 143 deaths were recorded among the confirmed cases (CFR=5.3%). Confirmed cases have been reported from 300 LGAs across 31 states.

In 2025, a total of 15 273 confirmed cases were reported from 240 LGAs across 25 states. This represents a 42.5% increase in the number of confirmed cases reported compared to 2024 when a total of 10 714 confirmed cases were reported from 122 LGAs across 19 states. In 2025, a total of 872 deaths were recorded among confirmed cases (CFR 5.7%), which represents an 80% increase compared to 2024 when 484 deaths were recorded. In 2025, over 95% of confirmed cases were reported from five states, Kano, Borno, Bauchi, Katsina, and Yobe.

From 1 January 2025 to 15 February 2026, a total of 18 295 suspected cases including 15 273 confirmed cases with 939 deaths (CFR 5.1%) have been reported. Following an increasing case trend in weeks 1 and 2 of 2026, a decreasing case trend has been observed since week 3, 2026.

Weekly trend of suspected diphtheria cases and CFR, week 1, 2025 – week 7, 2026, Nigeria

South Africa: Between January 2024 and 8 March 2026, South Africa reported a total of 96 confirmed respiratory diphtheria cases, 2 probable cases, 4 cutaneous cases, and 62 asymptomatic carriers identified through contact tracing. Nineteen deaths occurred among probable and confirmed respiratory cases, resulting in an overall case fatality ratio of 19% (19/98). Mortality was higher among children and adolescents under 18 years 7/29 (24%) compared to adults 12/69 (17%). The median age of confirmed respiratory cases was 25 years (range 2-55 years),

with most cases 67/96 (70%) occurring in adults. Geographically, the outbreak was concentrated in the Western Cape, which accounted for 77% (122/158) of respiratory cases (confirmed and carriers) and 63% (12/19) of deaths. Smaller numbers were reported in Limpopo, Mpumalanga, Gauteng, and KwaZulu-Natal, with 26 clusters identified across multiple provinces between late 2024 and early 2026. Gaps in vaccination were evident among children: of 22 cases aged 12 years and under, only two were reportedly up to date with their vaccinations.

Table 1. Summary of reported ongoing diphtheria outbreaks in the WHO African region, 1 January 2025– 1 March 2026

Country	Total suspected cases	Total deaths (CFR)	Confirmed cases	Last update
Algeria	13	2 (15.4%)	8 (laboratory-confirmed)	Week 42, 2025
Chad	5 227	54 (1%)	49 1 (2%) laboratory-confirmed; 48 (98%) clinically compatible	Week 9, 2026
Guinea	795	151 (19%)	609 48 (7.9%) laboratory-confirmed; 561 (92.1%) clinically compatible	Week 8, 2026
Mali	636	35 (5.5%)	371 66 (17.8%) laboratory-confirmed; 285 (76.8%) epi-linked; 20 (5.4%) clinically compatible	Week 9, 2026
Mauritania	1 415	54 (3.8%)	1 414 12 (0.8%) laboratory-confirmed; 364 (25.7%) epi-linked; 1 038 (73.4%) clinically compatible	Week 9, 2026
Niger	2 456	166 (6.8%)	313 (laboratory-confirmed)	Week 9, 2026
Nigeria	18 295	939 (5.1%)	15 273 211 (1.4%) laboratory-confirmed; 780 (5.1%) epi-linked; 14 282 (93.5%) clinically compatible	Week 7, 2026
South Africa	404	19/98 (19%) Among probable and confirmed respiratory cases	96 laboratory-confirmed respiratory diphtheria cases	Week 10, 2026
TOTAL	29 241	1 420 (4.9%)	18 133 (752 laboratory-confirmed)	

Context assessment

Diphtheria remains a major public health problem, and one of the high-burden vaccine preventable diseases in the WHO African Region after malaria and measles, despite substantial immunization efforts over the past three decades. Between 2000 and 2024, 75 789 suspected diphtheria cases were reported in the Region, an average 3 500 cases per year. From 2023 to 2024, nine countries (Algeria, Chad, Gabon, Guinea, Mali, Mauritania, Nigeria, Niger, and South Africa) reported a resurgence of diphtheria outbreaks with about 57 000 suspected

cases and 2 000 deaths (CFR of 3.5%) recorded. The most affected countries were Nigeria, Guinea and Niger. Most cases reported were children under fifteen years of age, with a higher proportion among females. Over 50% of the suspected cases were unvaccinated or had unknown vaccination status. The same countries, except Gabon, continue to report outbreaks into 2025–2026.

Following the sharp rise in the number of diphtheria cases in the WHO African Region in September 2025, affected countries, with the support of WHO and other partners, have implemented a range of public health response actions:

- Incident Management Systems (IMS) have been activated in most countries with response pillars in place, led by national authorities with partners' support.
- A grading call was conducted on 31 October 2025 and a grade 2 response level was assigned, prompting IMS activation and establishment of a joint AFRO-HQ Incident Management Support Team (IMST) for regional coordination.
- A high-level meeting between the WHO Regional Director for Africa and Ministers of Health of affected countries was held on 16 December 2025. During that meeting, affected countries were urged to lead national outbreak responses and strengthen routine immunization. The operationalisation of the ministerial directives is ongoing through the activation of three strategic axes for "zonal containment":
    - **Targeted cross-border hotspots** to strengthen response activities at the borders. In Nigeria for instance, transmission dynamics have been mapped at the borders with Niger (e.g. Zinder-Katsina, Zinder-Kano), and an expert has been deployed to strengthen contact tracing activities in these two corridors. In Mauritania and Algeria, cases are detected, treated and vaccinated in border camps hosting migrants and displaced people.
    - **Strengthened diagnosis and treatment** in Guinea and South Africa where laboratory materials and DAT were supplied to tackle critical reagents shortages and high CFR.
    - **Integrated response in complex settings** to mitigate the impact of concurrent disease outbreaks, diphtheria surveillance was integrated into broader humanitarian operations to prevent silent transmission in overwhelmed health systems.
- Surveillance has been enhanced in the affected countries through active case search, contact tracing, in-depth investigations.
- WHO has continually ensured equitable, evidence-based access to the DAT emergency stockpile through an allocation mechanism, which aims to serve outbreak-affected settings. As part of these efforts, a number of vials were dispatched to Chad, Guinea, Mali, and Niger.
- Funding support of over US$ 550 000 has been provided to countries to support the implementation of their respective response; US$300 000 was provided to the affected countries through the WHO Contingency Fund for Emergencies (CFE).
- Logistical support such as laboratory materials, DAT, PPEs, and antibiotics have all been supplied to affected countries.
- Chad, Guinea, Mali, Mauritania, Niger, Nigeria, and South Africa have conducted immunisation activities aimed at closing immunity gaps.

Nonetheless, several challenges are hindering the containment of these outbreaks:

- Within West and Central Africa, the Sahel remains one of the most displacement-affected and crisis-prone regions globally. Persistent insecurity, recurrent climatic shocks, and socioeconomic fragility continue to drive large-scale internal displacement and cross-border refugee movements, particularly across Mali, Niger, Nigeria, Chad, Mauritania, and Guinea. These population movements occur across porous and largely unmonitored borders, sustaining high levels of mobility and compounding humanitarian needs in border regions, transit corridors, and host communities. In this environment, displaced and mobile populations face heightened exposure to preventable diseases risks (including diphtheria) such as barriers and disruptions to health services (including immunization) and overcrowded and unsanitary living conditions.
- Shortage of laboratory and case management stock supplies have hampered the response to the diphtheria outbreaks across the Region. DAT availability across affected countries remains critically low, with current stock levels below minimum operational requirements.

- Concurrent outbreaks (Rift Valley Fever, dengue, measles, etc.) across most affected countries have overwhelmed response capacities already stretched by funding gaps, contributing to delaying the control of diphtheria outbreaks in the Region.

Table 2. Summary of context by country

Country	Context
Algeria	Prolonged geopolitical instability in neighboring countries (Mali, Niger, Mauritania) has led to mass displacements of thousands of people into southern Algeria, with low vaccination coverage often recorded among displaced populations. As part of the Public Health response to the diphtheria outbreak, vaccination campaigns and capacity building activities were conducted in 2024. According to WHO/UNICEF estimates of national immunization coverage (WUENIC), the Diphtheria-Tetanus toxoid-Pertussis (DTP) coverage in 2024 was 98% for the first dose and 92% for the third dose. The current diphtheria situation in Algeria remains unclear. No information has been shared since May 2025 on the outbreak that affected the southern part of the country since September 2024, nor on the outbreak that affected the northeastern wilaya of Skikda in October 2025. Therefore, the exact number of diphtheria outbreaks, cases and deaths recorded since the beginning of 2025 is not known.
Chad	Chad remains one of the most complex and strained humanitarian contexts in the Sahel, affected simultaneously by the Sudan crisis, climate shocks, and recurrent public health emergencies. The country hosts nearly one million Sudanese refugees, in addition to internally displaced populations, with the majority concentrated in Ouaddaï, Wadi Fira, Sila, and Ennedi Est. Continued arrivals throughout late 2025 have further intensified overcrowding in camps and host communities, placing severe pressure on already fragile basic services, including health, WASH, nutrition, and food assistance. Inadequate infrastructure, high population density, and sustained cross-border movement from Sudan continue to heighten the populations vulnerability to communicable diseases. Although cholera transmission was declared over in December 2025, the broader epidemiological environment remains fragile, with multiple epidemic-prone diseases circulating nationally. The convergence of displacement, overstretched services, and access constraints positions Chad as a critical node in the regional humanitarian and displacement landscape, with heightened vulnerability to diphtheria transmission and severe outcomes. WHO, UNICEF, Médecins Sans Frontières (MSF) France and MSF Holland are supporting the diphtheria outbreak response activities in the affected areas: • Capacity building activities in surveillance, case management and laboratory were conducted with the support of partners including WHO, UNICEF, and Africa Centres for Disease Control and Prevention (Africa CDC). • WHO provided case management kits and DAT. • A request has been submitted to GAVI for the supply of vaccines and funding of operational costs for a mass vaccination campaign in 13 districts across the 4 provincial health delegations with active outbreaks. According to WHO/UNICEF estimates of national immunization coverage (WUENIC), the Diphtheria-tetanus toxoid-Pertussis (DTP) coverage in 2024 was 84% for the first dose and 68% for the third dose.
Guinea	Guinea reports a high CFR (19.2%), driven by poor health seeking behaviour, late presentation to health facilities as well as limited case management capacity. In addition, sample collection kits are currently out of stock at the Kankan Regional Hospital Laboratory, which is hindering the biological confirmation of new cases. Critical needs include strengthening case management, expediting the procurement of laboratory consumables and organizing additional rounds of vaccination campaigns targeting children under 15 years of age in all health areas of active districts. Response activities are ongoing in districts with active transmission: • Active case search, investigations, contact tracing, antibiotic prophylaxis of contacts and case management at the Siguiri treatment centre. • 300 vials of DAT were made available at the Siguiri treatment center in February 2026 with

	WHO support. • Routine immunization has been strengthened in the affected districts, and a reactive vaccination campaign was conducted in Siguiri district in February 2026, with a total of 20 639 children age ≤ 15 years vaccinated (8 345 with Pentavalent vaccine and 12 294 with Td). According to WHO/UNICEF estimates of national immunization coverage (WUENIC), the Diphtheria-tetanus toxoid-Pertussis (DTP) coverage in 2024 was 77% for the first dose and 63% for the third dose.
Mali	The humanitarian context in Mali is marked by a complex humanitarian crisis resulting from a volatile security situation in northern and south-central Mali, compounded with recurring health emergencies, unprecedented climate shocks, and insufficient basic social services. In 2025, 6.4 million Malians needed multisectoral humanitarian assistance. Continued armed violence has caused significant internal and cross-border displacement and restricted humanitarian space as well as access to basic services for the most vulnerable populations. This has contributed to lower immunization coverage among displaced populations, thus increasing their susceptibility to vaccine-preventable diseases outbreaks. According to WHO/UNICEF estimates of national immunization coverage (WUENIC), the Diphtheria-tetanus toxoid-Pertussis (DTP) coverage in 2024 was 91% for the first dose and 82% for the third dose. Response activities are ongoing: • Active case search, contact tracing, investigation, case management, and community sensitization. • Distribution of Td vaccines and reactive vaccination campaigns conducted in the 13 affected districts with confirmed outbreaks. • Strengthening of routine immunisation through the big catch up. • Ongoing preparations for a vaccination campaign scheduled for May 2026. Challenges remain, including underfunding of the outbreak response, limited availability of diphtheria antitoxin and antibiotics, and logistical challenges (access challenges and recurring fuel shortages) causing delayed transportation of sampling kits, vaccines, samples, etc.).
Mauritania	Mauritania is home to the largest refugee camp for Malians who have fled their country since 2012 due to violence and instability. Since late 2023, escalating violence in neighbouring Mali has driven more refugees to Mauritania's eastern border. As of 31 January 2026, 184 521 registered refugees (177 409) and asylum seekers (7 112), of which 53% were children and 51% were females, were hosted across 11 regions of Mauritania. Over 90% (166 748) of the refugee population has been recorded in Hodh El Chargui region, with the majority (120 186, 72%) in the Mbera camp in Bassiknou health district in Hodh El Chargui region. Over 80% of the refugee population in the Mbera camp are women and children. The national health authorities officially declared a diphtheria outbreak on 25 September 2025. Between September 2025 and February 2026, Mauritania was faced with concurrent Rift Valley Fever (RVF) and dengue outbreaks as well, with cases being reported in some wilayas also affected by the diphtheria outbreak (Hodh El Gharbi, Brakna, Hodh Chargui), thus affecting the capacity to adequately respond to the increase in the number of diphtheria cases. The RVF and dengue outbreaks were declared over in weeks 5 and 8 of 2026 respectively. Since week 41, 2025, there has been a steady decrease in the number of diphtheria cases reported. Nonetheless, the diphtheria response continues to face numerous challenges. Insecurity and funding gaps limit humanitarian access and reduce health care service availability, increasing refugees' vulnerability to diphtheria and other vaccine-preventable diseases. Sub-optimal active case search, insufficient community sensitization, underreporting and delayed data reporting from routine surveillance contribute to delaying the containment of the diphtheria outbreak. Although reactive vaccination campaigns have been conducted in the five most affected regions (Hodh El Chargui, Hodh El Gharbi, Assaba, Guidimagha, and Brakna), additional vaccination campaigns are needed to ensure a larger immunization coverage across the country. According to WHO/UNICEF estimates of national immunization coverage (WUENIC), the Diphtheria-tetanus toxoid-Pertussis (DTP) coverage in 2024 was 95% for the first dose and 86% for the third dose. Urgent needs include financial support to heighten active case search and community sensitization activities.
Niger	Niger continues to face a complex and protracted humanitarian crisis, fuelled by heightened security challenges, recurring climate shocks, growing economic pressures, mass population displacement and epidemics (diphtheria, meningitis, cholera, ascites syndrome, etc). These shocks have led to significant vulnerability for communities. As of December 31, 2025, the country had 984 366 forcibly displaced persons (refugees and internally displaced persons), an increase of about 12% compared to 2024. In 2025, an estimated 2.6 million people required

	humanitarian assistance in a context of resource scarcity. In 2026, it is estimated that 3 million people will require humanitarian assistance, of which 847 000 will be in need of health assistance. Response activities are ongoing: • Following the increase in the number of diphtheria cases in the country affecting 34 of 72 districts across 8 regions, two round of vaccination campaigns were conducted between September and December 2025 in fifteen affected health districts. Given the geographic expansion of the outbreak, a request has been made to extend vaccination to seventeen additional health districts experiencing outbreaks and to develop a specific plan for the densely populated capital city, Niamey. According to WHO/UNICEF estimates of national immunization coverage (WUENIC), the Diphtheria-tetanus toxoid-Pertussis (DTP) coverage in 2024 was 95% for the first dose and 86% for the third dose. • In addition to heightening response efforts through capacity building of healthcare workers and enhanced risk communication and community engagement, national authorities, with the support of partners, deployed over 620 doses of DAT in the affected LGAs. Current challenges remain hard-to-reach areas, unmonitored migration corridors, and chronic access constraints that continue to hinder vaccination, surveillance, and service delivery. Large zero-dose clusters and persistent displacement have sustained a prolonged diphtheria outbreak since 2022, with children in conflict-affected and flood-prone areas particularly at risk. Shortage of antibiotics and laboratory supplies (reagents, sampling kits, etc) continue to hamper the control of the outbreak.
Nigeria	Nigeria remains one of the countries most affected by internal displacement, with an estimated 2.3 million internally displaced persons, primarily in the north-east. Insecurity continues to prevent displaced populations from returning home in a sustained, large-scale manner, with secondary displacement a frequent occurrence as communities move repeatedly in search of safety and assistance. Nigeria accounts for the majority of suspected and confirmed diphtheria cases across the WHO African Region. According to WHO/UNICEF estimates of national immunization coverage (WUENIC), the Diphtheria-tetanus toxoid-Pertussis (DTP) coverage in 2024 was 71% for the first dose and 67% for the third dose. Response activities are ongoing: • In 2025, vaccination campaigns were organized in Lagos, Imo and Kaduna states with 80 289 individuals vaccinated with Td (71 413) and 8 876 with the Pentavalent vaccine. Of these, 14 102 were health workers and support staff, all in Lagos. • Routine immunization has also been strengthened through the Big Catch-up initiative. • Discussions are ongoing with GAVI regarding the request to organize a vaccination response in additional LGAs affected by the outbreak. The key response challenges remain shortage of DAT and antibiotics, limited supply of consumable and reagents (Diphtheria selective medium and PCR reagents), shortage of case managers to support the treatment of cases in treatment centers, and shortage of Td for reactive immunization activities.
South Africa	According to WHO/UNICEF estimates of national immunization coverage (WUENIC), in 2024, the immunization coverage remains below 80% in most provinces (76% for the first DTP dose and 74% for the third). The most affected province is the Western Cape. Vaccination coverage has consistently been below 80% in most provinces and widening immunity gaps are increasing vulnerability to outbreaks. A national multi-antigen catch-up vaccination campaign targeting children under 15 years was conducted in all provinces except Gauteng in November 2025 in Affected provinces to close immunity gaps. South Africa's diphtheria outbreak response has been affected by several interconnected challenges. Clusters in high-risk settings, such as correctional facilities and densely populated communities, sustained transmission, while declining routine immunisation coverage created immunity gaps, particularly among children and young adults. The response has been further complicated by vaccine hesitancy, misinformation, and delayed healthcare-seeking behaviour, which contributed to more severe disease outcomes. In addition, delayed clinical suspicion among frontline healthcare workers resulted in delayed diagnosis and case management. Coordination across sectors and effective risk communication and community engagement need to be strengthened to enhance collaboration in outbreak response and improve vaccination uptake.

	Detailed case investigations and in-depth risk assessments are needed to guide targeted interventions. There is a need to strengthen capacity for surveillance and clinical management to improve early identification and response to cases. RCCE should be reinforced to address vaccine hesitancy, counter misinformation, VPD outbreaks and promote timely health-seeking behaviour in communities.

Table 3. Summary of vaccination coverage by diphtheria-affected country (WUENIC, 2024)

Vaccination Indicators (WHO/UNICEF)	*Algeria*	*Chad*	*Guinea*	*Mali*	*Mauritania*	*Niger*	*Nigeria*	*South Africa*
DTP-containing vaccine, 1st dose (2024)	*98%*	*84%*	*77%*	*91%*	*95%*	*95%*	*71%*	*76%*
DTP-containing vaccine, 3rd dose (2024)	*92%*	*68%*	*63%*	*82%*	*86%*	*86%*	*67%*	*74%*
Polio, 3rd dose (2024)	*89%*	*67%*	*55%*	*72%*	*85%*	*86%*	*69%*	*74%*
Measles-containing vaccine, 1st dose (2024)	*94%*	*66%*	*60%*	*72%*	*93%*	*81%*	*57%*	*76%*
Measles-containing vaccine, 2nd dose (2024)	*90%*	*46%*	*45%*	*60%*	*59%*	*77%*	*35%*	*82%*

Capacities and vulnerabilities related to the diphtheria outbreak response in the affected countries

Current WHO RRA v2, March 2026	
Capacities	**Vulnerabilities**
Coordination & Leadership • Incident management system in place and response plans developed in most affected countries • Existing sitreps • Strong partners (WHO, UNICEF, GAVI, Africa CDC, MSF, IFRC) support in most affected countries • A joint WHO AFRO-HQ Incident Management Support Team has been activated to coordinate the response across the eight affected countries • AFRO deployed technical experts in countries to strengthen surveillance laboratory, case management. • A regional strategic response plan costed at $5M has been developed to address critical gaps in diagnostics and DAT supply • A high-level ministerial meeting was held on 16 December 2025, followed by the operationalisation of the ministerial directives through the activation of a zonal containment strategy through three strategic axes.	***Coordination & Leadership*** • Incident management system setup delayed in some countries (e.g. Mauritania) • Outbreak not officially declared in some countries (e.g. South Africa) • Limited information sharing (e.g. Algeria) • Underfunded response plans
Resource mobilisation In addition to the initial $80 000 CFE disbursed for the response, $110 000 has been sent to each affected country to support surveillance and RCCE activities	***Resource mobilisation*** Concurrent epidemics have stretched available resources
Surveillance • Case definition and final case classification shared by AFRO with all affected countries • Surveillance has been strengthened in border regions for early detection of cross-border transmission (Mali, Mauritania, Guinea, Niger, Nigeria)	***Surveillance*** • **Underreporting** remains a challenge in some countries (e.g. Mauritania, Nigeria) • **Delayed reporting** – few countries are sharing data (including the number of new cases and deaths) in a timely manner, which makes it challenging to

Current WHO RRA v2, March 2026	
Capacities	**Vulnerabilities**
	accurately interpret trends and ensure an evidence-based outbreak response
Laboratory • Capacity building in sample collection and testing have been conducted in most affected countries	**Laboratory** • Case confirmation rates remain critically low, with only about 3% of suspected cases laboratory confirmed. • Persistent shortages of reagents and sample transport kits prevent the validation of transmission chains, leading to an over-reliance on broad clinical definitions.
Vaccination • Vaccination campaigns have been conducted in all affected countries, with planning for additional campaigns ongoing in some countries (e.g. Nigeria, Niger, Mali)	**Vaccination** • **Low routine immunization coverage** remains a critical challenge. Among the eight diphtheria-affected countries, DTP3 coverage ranges from 63% (Guinea) to 92% (Algeria), with a regional average of 74%. Substantial sub-national variation is also evident. Where information is available on vaccination coverage among cases, most have been among zero-dose and under-immunized children and adolescents.
Clinical management • Webinars on case management and laboratory diagnostics for diphtheria have been held, with over 500 participants in attendance. • DAT has been dispatched to several countries, including Mali, Niger, Guinea, and Chad • Antibiotics valued at approximately $30,000 are being procured and will be shipped to Mali, Chad, and Mauritania, including- orals and IVs	**Clinical management** • **Therapeutic Shortages & Supply Chain Disruptions** - Global scarcity of Diphtheria Antitoxin (DAT) and shortages of some antibiotics, along with inadequate clinical management capacity, continues to drive high case fatality rates. • **Concurrent Epidemics & Health System Strain** - Health systems are severely stretched through several concurrent outbreaks, including **Mpox, dengue, and measles**.
Operations support and Logistics Prepositioning of PPE, DAT, laboratory reagents and antibiotics is ongoing in affected countries	**Operations support and Logistics** • **Insecurity & Humanitarian Access** - Volatile security contexts and humanitarian access constraints, notably in Mali (Kidal, Ménaka), Niger (Diffa), and Chad, impede active surveillance and vaccination. These barriers disrupt access to healthcare facilities, causing significant delays in diagnosis, treatment, and care for vulnerable populations. • **Logistics and administrative bottlenecks:** customs clearance delays, cold chains failure, weak sample transportation systems, etc.

Current WHO RRA v2, March 2026	
Capacities	**Vulnerabilities**
Risk communication & community engagement • RCCE resource materials have been shared by WHO AFRO with affected countries • Community engagement teams have been deployed in some countries (e.g. Guinea/Siguiri) to improve early care-seeking behavior	**Risk communication & community engagement** **Lack of coordinated RCCE interventions and generation of community data** – given the clear nuances amongst the outbreaks (particularly within communities that are nomadic and underserved within the health system), completing holistic contextual analysis and community engagement would allow for more targeted interventions.

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