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Event-Based Surveillance Report 29 May 2026

Contents

Africa

Nigeria Cholera Outbreak 2026

Overview

Nigeria is experiencing an escalating cholera outbreak in Borno State, northeastern Nigeria, with 2 715 suspected cases and 27 deaths reported across five Local Government Areas (LGAs) during the first 24 days of May 2026. The outbreak has spread to 29 wards and 124 communities, with Maiduguri Metropolitan Council identified as the primary epicentre accounting for over half of reported cases (Premium Times, 2026). Health officials cautioned that the true burden is likely higher because reports from several Cholera Treatment Centres (CTCs) and Oral Rehydration Points (ORPs) had not yet been fully integrated into official surveillance systems. The outbreak is occurring during the onset of the rainy season, a known peak period for cholera transmission in Nigeria. At national level, the Nigeria Centre for Disease Control and Prevention (NCDC) issued a cholera preparedness alert in April 2026, placing ten states on high alert due to anticipated flooding and heavy rainfall. The Borno outbreak therefore reflects broader national resurgence rather than an isolated event (New Dawn Nigeria, 2026).

Background and context

Cholera is an acute diarrhoeal disease caused by ingestion of food or water contaminated with Vibrio cholerae. Severe disease can rapidly lead to dehydration and death if untreated. Cholera remains endemic in Nigeria and is strongly associated with poor water, sanitation, and hygiene (WASH) infrastructure. Nigeria has experienced recurrent major outbreaks since 1970. In 2024 alone, over 10,800 suspected cases and 359 deaths were reported nationally, representing substantial increases compared with 2023 (Outbreak News Today, 2024).

Recently, cholera activity intensified again in 2024, with over 10,800 suspected cases and 359 deaths by September, representing substantial increases compared to 2023. Borno State remains highly vulnerable due to prolonged Boko Haram insurgency, large internally displaced populations, overcrowded settlements and IDP camps, poor sanitation and unsafe water access, and limited healthcare access caused by insecurity. These factors create conditions conducive to sustained cholera transmission.

Epidemiological situation

As of 24 May 2026, Borno State had reported 2,715 suspected cholera cases and 27 deaths, corresponding to an approximate case fatality ratio (CFR) of 1.0%. This CFR is close to the WHO emergency threshold of above 1%, indicating significant public health concern. Officials warned that surveillance data remain incomplete and that the true burden is likely underestimated because not all treatment centres had fully submitted reports (Sahara Reporters, 2026). Affected LGAs include Maiduguri Metropolitan Council, Jere, Mafa, Konduga, Monguno, Ngala, and Magumeri. Transmission has spread across 124 communities and 29 wards, suggesting multiple concurrent transmission chains associated with contaminated water sources and flooding.

The outbreak emerged within a broader national preparedness context. In April 2026, the NCDC identified Adamawa, Enugu, Kaduna, Kogi, Niger, Osun, Oyo, Plateau, Taraba, and Kwara states as high risk areas due to

anticipated flooding and heavy rainfall. The NCDC also noted that surveillance data already demonstrated increasing cholera activity nationally before the Borno outbreak escalated (New Dawn Nigeria, 2026).

Risk factors and transmission drivers

The outbreak is driven primarily by longstanding deficits in water, sanitation, and hygiene (WASH) infrastructure. Open defecation, limited access to safe drinking water, poor sanitation systems, and flooding related contamination of water sources continue to facilitate widespread community transmission. Delayed healthcare seeking behaviour further increases the risk of severe disease and death (Agboeze et al., 2024; Igwe et al., 2025).

The prolonged Boko Haram insurgency has resulted in large internally displaced populations residing in overcrowded camps with inadequate sanitation and water infrastructure. Insecurity also restricts the movement of response teams and disrupts supply chains for medical and WASH commodities, limiting effective outbreak response activities (Igwe et al., 2025; ReliefWeb, 2026).

Seasonal and climatic factors are contributing significantly to outbreak escalation. Cholera transmission in Nigeria typically peaks during the rainy season between April and October, when flooding contaminates water sources and displaces vulnerable populations into congested settlements (Agboeze et al., 2024; NCDC, 2026).

The approaching Eid-el-Kabir festive period presents an additional public health risk due to increased travel, mass gatherings, and communal food sharing, all of which may accelerate transmission and geographic spread (Blueprint Newspapers, 2026).

Response measure and operational challenges

Response measures currently include the activation of Cholera Treatment Centres (CTCs) and Oral Rehydration Points (ORPs) across affected LGAs. These facilities are providing oral rehydration therapy, intravenous fluids, and case management services for severe disease. Additional activities include surveillance strengthening, active case finding, risk communication, laboratory support, and WASH interventions coordinated through the Nigeria Centre for Disease Control and Prevention (NCDC) Cholera Technical Working Group with support from WHO, UNICEF, and humanitarian partners (NCDC, 2026; ReliefWeb, 2026).

Despite these efforts, a major operational concern remains the absence of an official public outbreak declaration by the Borno State Ministry of Health. Multiple media sources reported unsuccessful attempts to contact the Commissioner for Health. The lack of formal public communication may delay protective community behaviours, reduce healthcare seeking, weaken emergency coordination, and contribute to further outbreak spread during upcoming Eid-el-Kabir mass gatherings (Premium Times, 2026; Sahara Reporters, 2026).

Risk assessment Implications for South Africa

The risk to South Africa is assessed as moderate to high due to the potential importation of cholera cases from Nigeria and other African countries experiencing active outbreaks. South Africa maintains strong travel, trade, and migration links with Nigeria through direct air travel and regional mobility networks. Previous cholera

importations linked to travel from outbreak affected countries have been documented, highlighting the continued risk of travel associated transmission during active outbreaks (NICD, 2019; Smith et al., 2023).

The regional risk is further amplified by ongoing cholera outbreaks across the Southern African Development Community (SADC) region. Since 2022, sustained transmission has been reported in Malawi, Mozambique, Zambia, Zimbabwe, and Namibia, with flooding, displacement, and inadequate water and sanitation infrastructure contributing to continued outbreaks (WHO AFRO, 2026). Between January and February 2026 alone, more than 4,300 cholera cases and 56 deaths were reported across affected Southern African countries. Mozambique accounted for the majority of cases following severe flooding and large scale displacement (WHO AFRO, 2026).

Cholera is not endemic in South Africa but occurs in episodic outbreaks, typically linked to unsafe water systems and sanitation breakdowns rather than sustained community transmission. All suspected and confirmed cholera cases are classified as notifiable medical conditions (NMC) and are subject to immediate mandatory reporting, investigation and public health response through national surveillance systems coordinated by the Department of Health within 24 hours of clinical suspicion or laboratory confirmation (NDoH, 2023a; NICD, 2024). The most recent major cholera outbreak in South Africa occurred in 2023, with highest cumulative numbers identified in Hammanskraal, Tshwane, Gauteng Province. Between 1 February and 4 July 2023, 198 laboratory confirmed cases were reported nationally, with 47 associated deaths from both confirmed and suspected cases (NDoH, 2023a; NDoH, 2023b).

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South Africa

NICD Hotline

Table 1. Summary of queries captured on the Query Logging System, 21-27 May 2026

Disease Query	Number	Percentage (%)
Patient(s) investigation (diagnostic/clinical advice)	20	62.50
Rabies post-exposure prophylaxis	6	18.75
Administrative	3	9.36
Infection Control	2	6.25
Vaccine related enquiry	1	3.13
Province		
Gauteng	15	46.88
Western Cape	8	25.00
Free State	4	12.50
North West	2	6.45
Northern Cape	1	3.13
KwaZulu Natal	1	3.13
Mpumalanga	1	3.13
Sector		
Private	24	75.00
Public	8	25.00
Total	32	100