Situational Report, Week 8 2026
Toxigenic *Corynebacterium diphtheriae* Disease in South Africa in 2024-2026

Date of report: 27 February 2026
Reporting period: 1 January 2024 to 22 February 2026
Report compiled by: Centre for Respiratory Diseases and Meningitis (CRDM), National Institute for Communicable Diseases (NICD)

Highlights

- Since the last situational report (week 7, 2026), the following updates are included in this report
  - No new laboratory-confirmed case of toxigenic diphtheria.
  - No new asymptomatic carriers of toxigenic *C. diphtheriae*.

Table 1: Number of suspected, probable and confirmed cases of toxigenic respiratory and cutaneous diphtheria in South Africa, 1 January 2024 to 22 February 2026[1]

Case definition	Number	Provincial distribution
Laboratory-confirmed toxigenic respiratory diphtheria	93	Gauteng (4/93, 4%) KwaZulu-Natal (3/93, 3%) Limpopo (9/93, 10%) Mpumalanga (8/93, 9%) Western Cape (69/93, 74%)
Probable respiratory diphtheria cases	2	Limpopo (1/2, 50%) Western Cape (1/2, 50%)
Laboratory-confirmed toxigenic cutaneous diphtheria	4	Gauteng (3/4, 75%) Western Cape (1/4, 25%)
Suspected diphtheria cases with specimens sent to exclude diphtheria and tested negative	403	Eastern Cape (4/403, 1%) Free State (5/403, 1%) Gauteng (52/403, 13%) KwaZulu-Natal (11/403, 3%) Limpopo (11/403, 3%) Mpumalanga (33/403, 8%) Northern Cape (1/403, 0%) North West (4/403, 1%) Western Cape (282/403, 70%)
Asymptomatic carriers of toxigenic *C. diphtheriae* identified during contact tracing	62	Gauteng (2/62, 3%) KwaZulu-Natal (2/62, 3%) Limpopo (5/62, 8%) Mpumalanga (3/62, 5%) Western Cape (50/62, 81%)
Deaths in probable and laboratory-confirmed toxigenic respiratory diphtheria cases	19	Gauteng (2/19, 11%) KwaZulu-Natal (1/19, 5%) Limpopo (1/19, 5%) Mpumalanga (3/19, 16%) Western Cape (12/19, 63%)

[1]For case definitions, please see Table 3 at the end of this report.

Public health actions instituted

For every case, a public health response has been initiated. Public health response includes swabbing of close contacts, the isolation of contacts, the provision of prophylaxis, and vaccination of contacts. These public health actions are instituted for contacts in all settings, including households, workplaces, healthcare facility staff and emergency medical services staff. Additional vaccination campaigns have been conducted in schools and communities in the Western Cape and Limpopo.

Epidemiology of respiratory diphtheria cases and asymptomatic carriers, 1 January 2024 - 22 February 2026

Between 1 January 2024 and 22 February 2026, 93 confirmed cases of respiratory diphtheria, two probable respiratory diphtheria cases and 62 asymptomatic carriers of toxigenic *C. diphtheriae*, detected during contact tracing, have been identified in South Africa. The majority of confirmed cases and carriers (77%, 119/155) were from the Western Cape, comprising 69 respiratory diphtheria cases and 50 asymptomatic carriers (Figure 1, Table 1). The median age for cases of confirmed respiratory diphtheria was 25 years (range: 2-55 years), with 69% (64/93) being 18 years and older. The overall case-fatality ratio (CFR) among probable and confirmed respiratory diphtheria cases was 20% (19/95). Among children and adolescents under 18 years, the CFR was 25% (7/28), compared to 18% (12/67) among adults.

In the first half of 2024, two confirmed respiratory diphtheria cases were reported—one in **KwaZulu-Natal** and one in the **Western Cape**. Between week 31 (week starting 29 July 2024) and week 37 (week starting 9 September 2024), a cluster of three respiratory diphtheria cases and seven asymptomatic carriers was identified in a school-linked community in the Western Sub-District of Cape Town. Additionally, two sporadic confirmed respiratory diphtheria cases were reported in Cape Town during this period, unrelated to this cluster.

Since epidemiologic week 46 of 2024, **26 diphtheria clusters** have been identified across South Africa: **16 in the Western Cape, five in Limpopo, two in Gauteng, one in KwaZulu-Natal, and one in Mpumalanga** (Table 2). One cluster spanning **Limpopo and Mpumalanga** was reported in week 11, 2025. Outside these clusters, **50 sporadic respiratory cases** with no known epidemiologic links were reported: **40 in the Western Cape, six in Mpumalanga, three in Limpopo, and one in KwaZulu-Natal**.

Cutaneous toxigenic diphtheria cases

Between 1 January 2024 and 22 February 2026, four cutaneous toxigenic diphtheria cases have been identified, three from Gauteng and one from the Western Cape.

Notified suspected cases of diphtheria from 1 January 2024 to 22 February 2026

From 1 January 2024 to 22 February 2026, 403 individuals have been reported as suspected diphtheria cases and tested negative for *C. diphtheriae*. Alternative diagnoses became available for some of the individuals with suspected diphtheria, and included *Streptococcus pyogenes and Corynebacterium* spp. NOT *diphtheriae*, Ludwig's angina, retrobulbar abscess or respiratory viruses including influenza, respiratory syncytial virus, or SARS-CoV-2.

Non-toxigenic diphtheria

From 1 January 2024 to 22 February 2026, 35 individuals with non-toxigenic *C. diphtheriae* (24 cutaneous, three respiratory, six asymptomatic contacts, two infective endocarditis), three with *C. belfantii* (two respiratory, one bacteraemia and respiratory) and one with *C. ulcerans* (cutaneous) have been detected.

Table 2. Summary of diphtheria clusters reported in South Africa from November 2024 to 22 February 2026

Cluster No.	Week (week start date)[1]	Province (City)	Details	Cluster type
1	50 - 51 (9 - 16 December 2024)	Western Cape (Cape Town)	1 respiratory case 12 asymptomatic carriers	Correctional facility
2	1 - 2 (30 December 2024 - 6 January 2025)	Western Cape (Cape Town)	3 respiratory cases	Community
3	2 (13 January 2025)	Gauteng (Tshwane)	2 respiratory cases	Household/family
4	7-9 (10 - 25 February 2025)	Western Cape (Cape Town)	2 respiratory cases 14 asymptomatic carriers	Correctional facility
5	6 - 8 (3 - 17 February 2025)	Western Cape (Cape Town)	1 respiratory case, 1 asymptomatic carrier	Household/family
6	8 - 9 (17 - 25 February 2025)	Western Cape (Cape Town)	1 respiratory case 1 asymptomatic carrier	Household/family
7	9 - 10 (25 February - 3 March 2025)	Mpumalanga (eMalahleni)	1 respiratory case 1 asymptomatic carrier	Community
8	10 (3 March 2025)	Limpopo -Mpumalanga (Bushbuckridge)	1 probable case (travelled from Limpopo to Mpumalanga after symptom onset) 1 respiratory case 2 asymptomatic carriers in Mpumalanga	Household/family
9	14 - 15 (7 - 14 April 2025)	Limpopo (Ba-Phalaborwa)	1 respiratory case, 1 asymptomatic carrier	Community
10	14 - 15 (7 - 14 April 2025)	Limpopo (Ba-Phalaborwa)	1 respiratory case 1 asymptomatic carrier	Community
11	15 - 17 (7 - 21 April 2025)	Limpopo (Ba-Phalaborwa)	1 respiratory case 1 asymptomatic carrier	Community
12	16 - 17 (14 - 21 April 2025)	Limpopo (Ba-Phalaborwa)	1 respiratory case 1 asymptomatic carrier	Community
13	16 - 17 (14 - 21 April 2025)	KwaZulu-Natal (Empangeni)	1 respiratory case 2 asymptomatic carriers	Community
14	20 - 21 (12 - 19 May 2025)	Limpopo (Ba-Phalaborwa)	1 respiratory case 1 asymptomatic carrier	Household/family
15	20 - 22 (12 - 26 May 2025)	Western Cape (Cape Town)	1 respiratory case 3 asymptomatic carriers	Community
16	29 (14 July 2025)	Gauteng (Tshwane)	2 respiratory cases 2 asymptomatic carriers	Household/family
17	29 - 30 (14 - 21 July 2025)	Western Cape (Cape Town)	1 respiratory case 2 asymptomatic carriers	Correctional facility
18	33 - 34 (11 - 18 August 2025)	Western Cape (Cape Town)	3 respiratory cases	Household/family
19	37 (8 September 2025)	Western Cape (Cape Town)	2 respiratory cases 1 asymptomatic carrier	Household/family
20	41 (6 October 2025)	Western Cape (Cape Town)	1 respiratory case 2 asymptomatic carriers	Household/family
21	41 (6 October 2025)	Western Cape (Cape Town)	1 respiratory case 1 asymptomatic carrier	Household/family
22	44 - 45 (27 October– 3 November 2025)	Western Cape (Cape Town)	1 respiratory case 1 probable case	Household/family
23	49 (1 December 2025)	Western Cape (Cape Town)	2 respiratory cases 3 asymptomatic carriers	Correctional facility
24	50 - 51 (8 – 15 December 2025)	Western Cape (Cape Town)	1 respiratory case 1 asymptomatic carrier	Household/family
25	3 (12 January 2026)	Western Cape (Cape Town)	1 respiratory case 1 asymptomatic carrier	Household/family
26	4 (19 January 2026)	Western Cape (Cape Town)	1 respiratory case 1 asymptomatic carrier	Household/family

[1]Period between the first recorded infection and the last observed infection within each cluster, expressed in weeks. Each week starts on a Monday and is labelled by its start date, following the ISO 8601 standard. Based on the date of clinical presentation or sample collection.

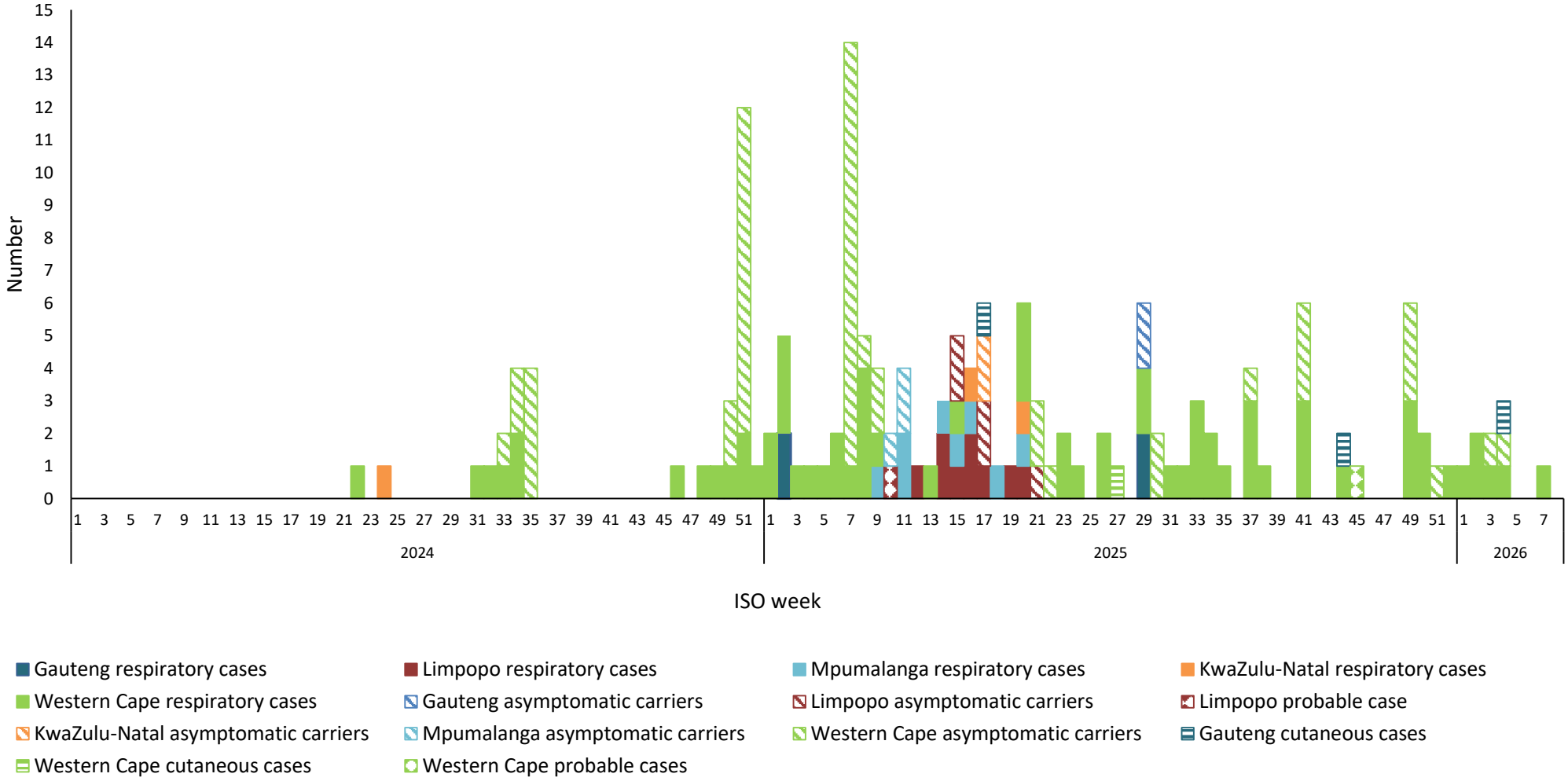

Figure 1: Number of individuals testing positive for toxigenic *C. diphtheriae* (respiratory diphtheria cases, asymptomatic carriers and cutaneous cases) and probable cases, South Africa, 1 January 2024 and 22 February 2026. Based on the date of sample collection or clinical presentation.

Microbiology

Among the 159 toxigenic *C. diphtheriae* infections identified, 51/159 (32%) were detected by PCR only. The remaining 108 infections were culture-confirmed; of these, nine isolates lost viability, leaving 99 isolates for further phenotypic and genotypic characterisation.

The phenotypic Elek test to confirm toxin production showed 100% agreement with the toxin-gene PCR among isolates tested by both methods (n = 95). To date, no non-toxigenic toxin-gene–bearing (NTTB) isolates have been identified; such isolates would be Elek-negative but PCR-positive for the toxin gene.

Antimicrobial susceptibility testing was performed on 95 isolates using the disc diffusion method in accordance with European Committee on Antimicrobial Susceptibility Testing (EUCAST) guidelines. All tested isolates were susceptible to penicillin, with increased exposure (zone diameter [ZD] range 18–27 mm) and susceptible to erythromycin (ZD range 28–34 mm) (Figure 2)(1,2).

To date, 89 toxigenic *C. diphtheriae* isolates have been submitted for sequencing, with results available for 87 isolates. One isolate repeatedly failed sequencing runs and yielded no result, and one is pending sequencing results. All Western Cape Province isolates sequenced to date are sequence type (ST) 906 (n = 72), the same lineage first detected in 2023 and currently appearing to be localised within this province. Sequenced isolates from Mpumalanga (n = 4) and Limpopo (n = 5) belong to a different lineage, ST824. Four isolates—two from KwaZulu-Natal (KZN) and two from Gauteng—are ST378, the lineage previously associated with the 2015 KZN outbreak. An additional isolate from KZN is ST905. One cutaneous diphtheria isolate from Gauteng is ST447, a sequence type not previously detected in South Africa but reported elsewhere, including Yemen, Germany, and Belgium.

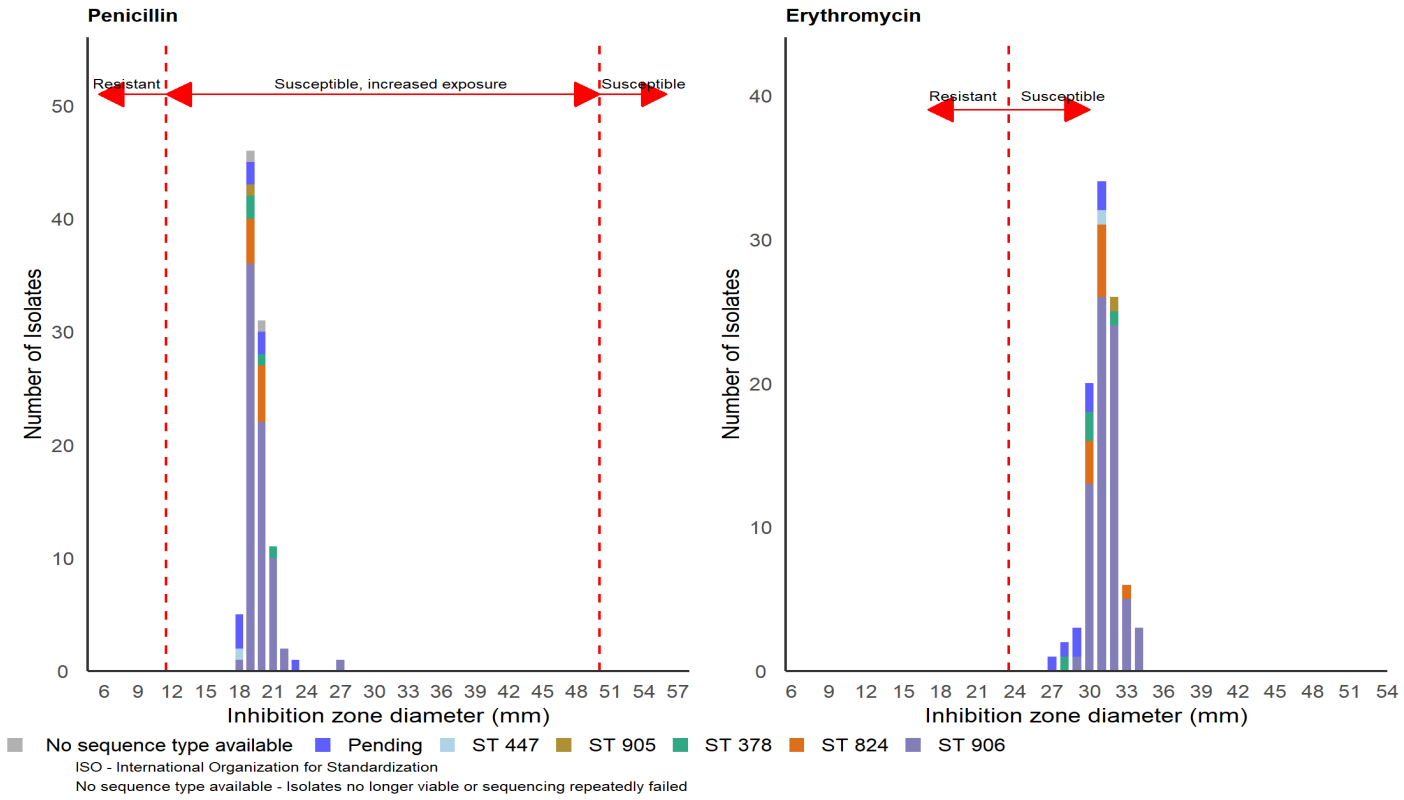

Figure 2. Antimicrobial susceptibility testing for toxigenic *C. diphtheriae* isolates from respiratory diphtheria cases, asymptomatic carriers, and cutaneous cases, South Africa, 2024-2026 (N = 95). The red vertical dashed lines indicate the clinical breakpoints defined by the European Committee on Antimicrobial Susceptibility Testing (EUCAST). Arrows represent the inhibition zone diameter ranges at which *C. diphtheriae* is classified as susceptible, "susceptible at increased exposure", or resistant to each antibiotic.

Vaccination status among respiratory diphtheria cases

Of the 93 respiratory diphtheria cases, 22 (24%) occurred among children aged 12 years and under. Vaccine history was available for seven of these cases. One case (aged eight years) had received four infant doses, but no booster; two cases (aged nine and ten years) had received three infant doses and no booster; two cases were reported as unvaccinated, and two cases (aged six and 12 years) were reported to be up to date with their vaccinations.

Historical epidemiology of diphtheria in South Africa 2015-2023

Between 2015 and 2023, the National Institute for Communicable Diseases (NICD) confirmed 42 toxigenic *C. diphtheriae* infections, comprising 26 respiratory diphtheria cases, 14 asymptomatic carriers detected through contact tracing, and two cases of cutaneous diphtheria. All respiratory cases were reported from the Western Cape (n=9) or KwaZulu-Natal (n=17). The highest annual totals occurred in 2015 (n=11) and 2023 (n=6), while other years reported between 0 and 4 cases.

Information for clinicians

Clinical presentation of respiratory diphtheria

Respiratory diphtheria is a vaccine-preventable illness caused by toxigenic *C. diphtheriae* (and more rarely *C. ulcerans* or *C. pseudotuberculosis*), and can occur in persons of all ages.
The clinical presentation includes the following signs and symptoms:

- sore throat
- low-grade fever
- AND an adherent membrane of the nose, pharynx, tonsils, or larynx (Figure 3) - the membrane is greyish-white and firmly adherent to the tissue
- AND/OR enlarged glands in the neck (bull neck)
- toxin-mediated systemic signs, including myocarditis, polyneuropathy and renal damage

Figure 3: Example of the adherent membrane of diphtheria

Patient management

Treatment includes antibiotics (azithromycin or penicillin) to clear the organism from the throat and prevent onward transmission, and diphtheria anti-toxin (DAT) to neutralise unbound toxin. The dosage of DAT is determined by the duration and severity of illness. **Treatment, contact tracing and chemoprophylaxis should be started before laboratory confirmation**. Early administration of DAT may be life-saving and should not be delayed in cases with a high index of suspicion. Supportive care is primarily focused on airway management and includes the provision of oxygen, electrocardiogram monitoring, and, if necessary, intubation or tracheostomy.

DAT is available in South Africa through provincial pharmacies, although stocks are limited. Clinicians and pharmacists are advised to secure a source of DAT and set up emergency supply lines. Clinicians may refer to "Guidelines for diagnosis, testing, and treatment of diphtheria" https://www.nicd.ac.za/diseases-a-z-index/diphtheria/. Advice is available from the NICD doctor-on-call on 080 021 2552. The NICD doctor on call is able to link clinicians to infectious disease experts to discuss individual cases. Advice is available from the NICD doctor-on-call at 080 021 2552. The doctor-on-call can connect clinicians with infectious disease experts to discuss individual cases, if needed. Additional resources include: https://iris.who.int/bitstream/handle/10665/375887/WHO-DIPH-Clinical-2024.1-eng.pdf.

Laboratory confirmation of *C. diphtheriae*

Most commonly, a throat swab should be collected, from below the membrane if possible, using a Dacron, Rayon or nylon-flocked swab. Respiratory lesions may be pharyngeal, tonsillar, laryngeal or nasal. Swabs need to be taken from relevant lesions. Ideally, the swab should be placed in Amies or modified Stuart's transport medium (this can be obtained from your local National Health Laboratory Service (NHLS) or private laboratory). However, it is possible to send a dry swab if the transport medium is unavailable. The specimen should immediately be transported to the nearest diagnostic laboratory for primary culture on blood agar and ideally on selective and differential media like Hoyle's agar. All isolates and/or clinical specimens (including other *Corynebacterium* spp., e.g., *C. ulcerans* and *C. pseudotuberculosis*) should be sent to the National Institute for Communicable Diseases (NICD) to confirm identification and toxin production. Please alert NICD before sending and label specimens clearly: "suspected diphtheria". Laboratory managers may refer to the NICD recommendations for diagnosis, testing, and treatment of diphtheria at https://www.nicd.ac.za/diseases-a-z-index/diphtheria/ for additional information.

Notification of cases and public health response.

Respiratory diphtheria is a **highly contagious vaccine-preventable illness** caused by the toxin-producing strains of *C. diphtheriae* and occasionally *C. ulcerans* and *C. pseudotuberculosis.* **Primary prevention is through vaccination**, including the infant vaccine course (six, tenand 14 weeks) with boosters at 18 months, six years and 12 years of age. Individuals of all ages can seek assistance at public health care clinics (or private facilities) to review their vaccine status and receive booster dose/s as indicated. Health-care workers are reminded to review vaccination records/status of individuals of all ages and recommend the vaccine as indicated.

Respiratory and cutaneous diphtheria is a Category 1 notifiable condition and should be notified within 24 hours.

All suspected cases should be notified urgently to the district or provincial Communicable Disease Coordinators (CDCCs) as per the notifiable medical condition notification procedures. Contact tracing, including throat swabs, administration of prophylaxis (azithromycin) with or without catch-up vaccination, should start prior to laboratory confirmation. Vaccine campaigns and reassessment of vaccine status should be considered for all patients presenting to primary health care (regardless of symptoms). Additional school and community-based vaccine campaigns should also be considered. https://www.nicd.ac.za/nmc-overview/notification-process/

Table 3: Case definitions for respiratory and cutaneous diphtheria, South African notifiable medical conditions' flipchart

Suspected case	A person meeting the **clinical criteria** for **classic respiratory diphtheria**
Probable case*	Any person meeting the **clinical criteria** for **classic respiratory diphtheria** **AND** with an **epidemiological link** to a confirmed case, but **no diphtheria testing** was performed **OR** Any person meeting the **clinical criteria** for **classic respiratory diphtheria** **AND** **Laboratory confirmation of the organism,** but **toxin production has not been confirmed**.
Confirmed case	Any person meeting the clinical criteria for at least **one of the clinical forms of diphtheria** **AND** **Laboratory confirmation of the organism and toxin production**
Asymptomatic carrier	A person with **no symptoms** **AND** **Laboratory confirmation of the organism and toxin production**

Clinical criteria

Any person with at least one of the following clinical forms:

Classic respiratory diphtheria: An upper-respiratory tract illness characterised by sore throat, low-grade fever AND a typical adherent membrane of the nose, pharynx, tonsils, or larynx

Mild respiratory diphtheria: An upper respiratory tract illness with laryngitis or nasopharyngitis or tonsillitis WITHOUT an adherent membrane/pseudo membrane.

Cutaneous diphtheria: Skin lesion consistent with diphtheria

Diphtheria of other sites: Lesion of the conjunctiva or mucous membranes consistent with diphtheria

Laboratory criteria

Laboratory confirmation of the organism: *C. diphtheriae*, *C. ulcerans,* or *C. pseudotuberculosis* isolated from a clinical specimen or detected by polymerase chain reaction (PCR)

Laboratory confirmation of toxin production: laboratory confirmation of diphtheria (as above) and also confirmed to be *tox* gene positive by PCR, and toxin producing by Elek testing (if an isolate is available).

Additional notes

Clinicians who suspect diphtheria should contact the NICD 24-hour hotline **(0800-212-552)** for assistance with specimen collection and diagnosis. It is essential to: 1) collect a throat swab from suspected cases using the correct procedures, and 2) complete a case investigation to provide authorities with information to identify contacts and implement prevention measures. See resources below.

Additional resources

A case-investigation form (CIF), frequently asked questions document (FAQ), Guidelines for the management and public health response to diphtheria (2018), and specimen collection guidelines are available at http://www.nicd.ac.za/diseases-a-z-index/diphtheria/.

References

1. EUCAST. Antimicrobial susceptibility testing: EUCAST disk diffusion method. Version 11.0. 2023. http://www.eucast.org/ast_of_bacteria/ disk_diffusion_methodology/
2. Corynebacterium diphtheriae and Corynebacterium ulcerans: development of EUCAST methods and generation of data on which to determine breakpoints. Berger A, Badell E, Åhman J, Matuschek E, Zidane N, Kahlmeter G, Sing A, Brisse S. J Antimicrob Chemother. 2024 May 2;79(5):968-976. doi: 10.1093/jac/dkae056. PMID: 38497937