Africa Infodemic Response Alliance
A WHO-HOSTED NETWORK

Introduction

What is this report about ?

This report aims to provide infodemic managers, communicators, and public health professionals with key insights on the infodemic that can help guide public communication, media production, or risk communication and community engagement (RCCE) in ways relevant to community needs, as well as inform public health policies and programs. This report is produced every two weeks by the Africa Infodemic Response Alliance (AIRA), a network hosted by WHO that brings together international and regional organizations with the objective of detecting and countering health mis-disinformation and improving information ecosystems in the African Region.

What did we find during this period ?

Between **1 and 15 March 2026**, we monitored a body of content published online, including news articles and posts from several social media platforms. Based on the monitoring volumes available, the most active topics during the period were **mpox (245 articles published, 96 social media interactions on articles), measles (57 articles published, 56 social media interactions on articles), and meningitis (47 articles published, 17 social media interactions on articles).**

On social media, the available platform-level interaction data (1) indicate that conversations were concentrated mainly on **Facebook and X/Twitter** across all three topics. For meningitis, interactions reached **10.4k on Facebook and 27.7k on X/Twitter. For measles, they reached 11.1k on Facebook and 289.9k on X/Twitter. For mpox, they reached 106.3k on Facebook and 345k on X/Twitter.**

In line with AIRA's methodology, the data collected were filtered, analysed, and then coded by type of infodemic issue (2)(**disinformation, misinformation, information gaps, concerns, requests for clarification, institutional distrust, etc.**) and grouped by health topics according to our taxonomy. This period was characterized by conversations particularly concentrated around **meningitis in Nigeria**, especially around seasonal alerts, risk maps, high-risk states, and vaccine requests; by strong polarization around measles, marked by the normalization of the disease, diagnostic confusion, and narratives of vaccine distrust; and by the persistence of mistrust around **mpox vaccination in Madagascar**, fuelled by "guinea pig" narratives, comparisons with COVID-19, and questions about the targeting of beneficiaries. This does not mean that similar exchanges did not take place elsewhere: interactions vary depending on internet access, platform use, the health situation in each country, and other factors (3).

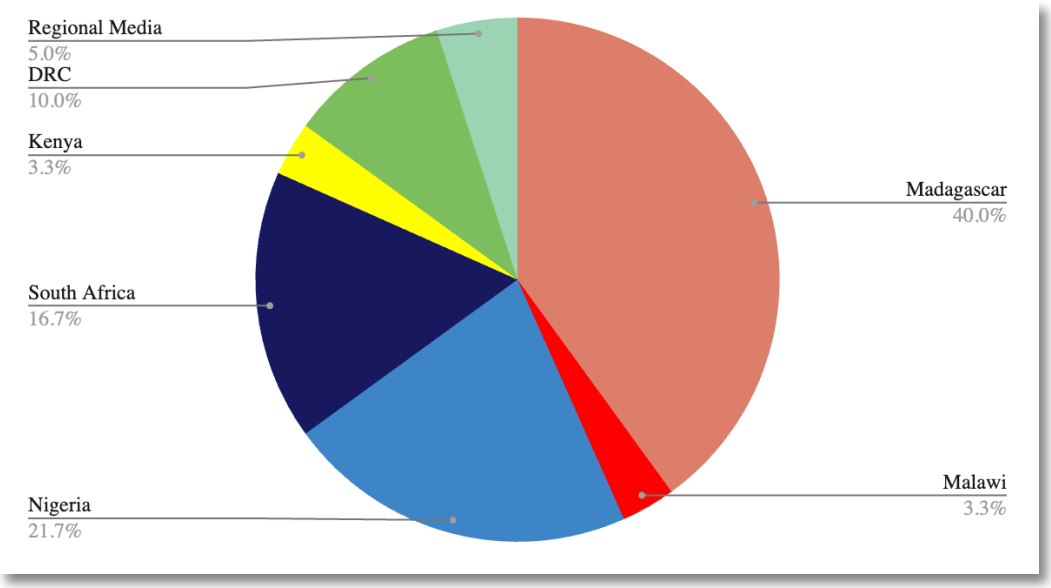


Figure 1 : Geographical distribution of the data scanned for this reporting period (%) of countries (by source of media or social media page) identified in our data for the same period (4)

The most frequently discussed topics during this period include (5) :

1) **Meningitis,** which highlighted communication challenges around dry-season alerts, the identification of high-risk states, understanding the roles of the institutions involved, vaccine availability, and the clarity of prevention messages;

2) **Measles,** which revealed communication challenges related to the normalization of the disease, doubts about its severity, confusion around symptoms and diagnosis, particularly with chickenpox, as well as the circulation of vaccine misinformation narratives;

3) **Mpox,** around which communication problems persist regarding vaccine safety, the identification of priority groups, access to vaccination centres, and fears of experimentation on the population.

Overview per public health priority

This section presents an overview of the most relevant issues identified in our data, classified according to the main public health emergencies. While other topics were noted, we focus on those whose frequency and relevance allow for informed discussion and operational guidance.

PUBLIC HEALTH EMERGENCIES

MENINGITIS (6)

Meduim risk

Nigeria, DRC, across the African region

Meningitis remains a recurring seasonal topic in the region, particularly in countries located within the African meningitis belt, which stretches from **Senegal to Ethiopia**. In this zone, outbreaks and epidemics occur most often during the dry season, generally from December to June, with a **frequent peak between March and April**, when dusty winds, low humidity, cold nights, respiratory infections, and overcrowding increase the risk of transmission. Nigeria is part of this belt, which provides strong contextual grounding for the prevention messages circulated during the reporting period [link].

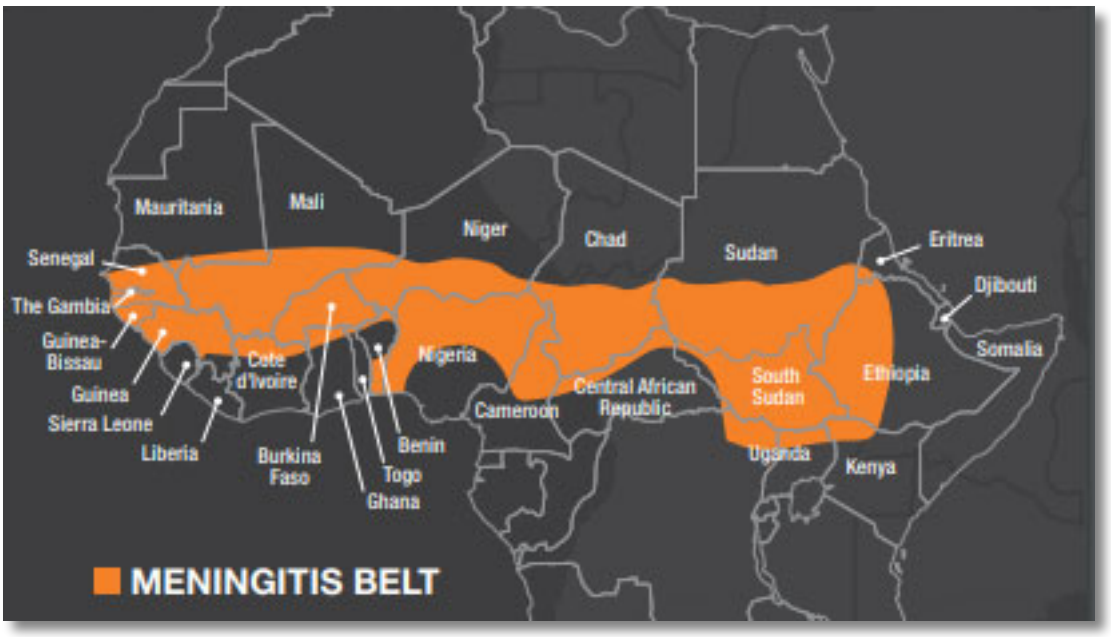


Figure 2 : Meningitis Belt [Link]

Meningitis remained a widely discussed topic, mainly in Nigeria, following the publication by the Nigeria Centre for Disease Control and Prevention (NCDC), on **3 March 2026,** of a **public health advisory on cerebrospinal meningitis**, reminding the public that risk increases during the dry season and calling for heightened vigilance [link].

Conversations were then reignited by the circulation in Nigeria of a **12 March 2026** alert from the Nigerian Meteorological Agency (NiMet), indicating that **11 states : Sokoto, Zamfara, Kebbi, Katsina, Kano, Jigawa, Bauchi, Yobe, Borno, Gombe, and Adamawa**, were at high risk of meningitis due to the prevailing atmospheric conditions. This alert, widely republished by the media, helped amplify public attention around the link between **heat, dust**, and meningitis [link] [link].

At the regional level, discussions were also fuelled by conversations coming from the **Democratic Republic of the Congo**. **The Africa CDC weekly bulletin for 9–15 March 2026** mentioned a Meningococcal Meningitis outbreak, a bacterial form of meningitis, caused in this case by Neisseria meningitidis (serogroup W) in the **Mangembohealth zone in Kongo Central**. A few days later, on 24 March 2026, the US CDC published a travel health notice about the same outbreak and reminding the public that, in this case, vaccination was the best protection [link].

Following these events, we identified a moderate but persistent level of public concern around meningitis, making it one of the most discussed topics during the reporting period.

Dominant narratives associated meningitis with extreme heat, dust, poorly ventilated housing, overcrowding, and inadequate electricity supply.

Another highly visible theme concerned vaccine demand. Several reactions suggested that, if the risk was serious enough to justify national and media alerts, then vaccination should be made more visible, accessible, and explicitly organized. This concern may also reflect a communication gap: Nigeria's childhood routine immunization schedule has historically included a meningococcal vaccine targeting serogroup A, while the recent outbreak has been driven mainly by serogroups C and W. As a result, public expectations about "**the meningitis vaccine**" may not match the specific vaccine response required for the strains currently circulating. Most communication messages do not clearly explain this distinction, nor do they make it explicit that not all forms of meningitis, or not all circulating meningococcal strains, are covered in the same way by existing vaccines.

In Nigeria, we also observed **confusion over NiMet's role in communicating about meningitis**, arguing that this topic should be handled solely by the national health authority. This reaction appears to have been triggered by the communication sequence itself: an initial health advisory from the NCDC, followed by a risk alert issued by a meteorological agency. For part of the public, this articulation was not sufficiently explained, shifting the discussion away from prevention and toward questions about the legitimacy of the messenger.

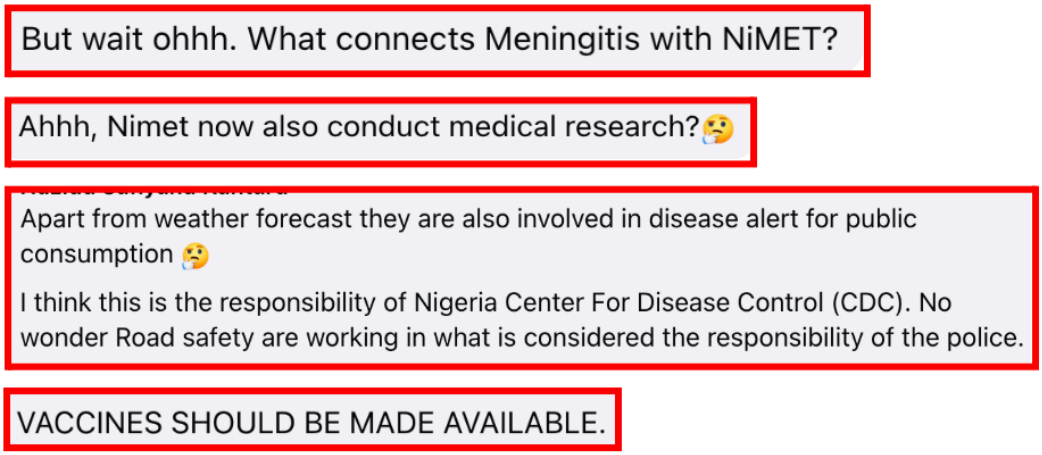
In addition, **several comments downplayed the seriousness of meningitis in comparison with other difficulties considered more immediate, particularly heat, lack of electricity, living conditions, or insecurity.** This does not necessarily indicate rejection of the risk, but rather a ranking of threats based on daily lived experience. In a context where prevention recommendations may seem difficult to implement, for example, avoiding overcrowding or improving ventilation in constrained housing, the health message may be perceived as poorly adapted to lived realities. This tension is consistent with the structural factors described by WHO for countries in the meningitis belt, where overcrowding and certain environmental conditions favour seasonal outbreaks.

Finally, comments revealed expressions of religious fatalism, signs of concern without immediate practical guidance, as well as presence of unverified treatments or opportunistic promotional messages. This type of reaction tends to emerge when alerts heighten the perception of danger without, at the same time, providing sufficiently clear service information on warning symptoms, treatment sites, or access to vaccination.

Why is this concerning?

This trend is concerning because the confusion does not mainly relate to the existence of the disease, but rather to the system's ability to concretely protect the population. If the public mainly retains that the risk is high, that several institutions are speaking in parallel, that access to vaccines is unclear, and that recommendations seem difficult to apply under real-life conditions, this can weaken trust and reduce the effectiveness of prevention messages.

Below or some illustrative comments :



What could we do about it?

It would be useful to systematically **clarify who is speaking on behalf of what in each public message**; to link each alert with **precise service information on what to do**, warning symptoms, treatment sites, and possible access to vaccination; to produce simple content explaining why the **dry season** increases risk without leaving the impression that the weather alone "causes" the disease; and to better address practical concerns linked to living conditions, so that recommendations appear more credible and more feasible.

IMMUNIZATION

MEASLES (7)

Meduim risk

South Africa, DRC, Nigeria,

Measles remained a widely discussed topic during the reporting period, with three main dynamics: **the resurgence of cases in South Africa, epidemic alerts and vaccination campaigns in the DRC, and vaccination mobilization efforts in Nigeria.** In South Africa, the rise in discussions was fuelled by the confirmation of an outbreak in **Tshwane/Pretoria**, in a context where national surveillance had already been reporting an increase in measles cases across several provinces since late December 2025 [link]. In the DRC, discussions were driven by alerts on the rise in casesand deaths, and by vaccination campaigns that followed in North Kivu [link]. In Nigeria, institutional content around the measles-rubella campaign in Lagos mainly generated exchanges about vaccination and its usefulness.

In South Africa, conversations peaked after the circulation of articles reporting a measles outbreak in Pretoria/Tshwane. **On 11 March 2026**, Rekord reported that **16 laboratory-confirmed cases in Tshwane**, including 10 in the previous four weeks, in a context where the country had recorded 491 confirmed cases between 29 December 2025 and 1 March 2026. The NICD weekly report for week 10 of 2026 confirmed **the continuation of the national increase, with clusters in the Western Cape and Gauteng** in particular [link]. These announcements, combined with l posts from government agencies reminding the public of the signs of measles and the importance of catching up on missed doses, fuelled strong activity in the comments [link].

In the DRC, the increase in conversations is first explained by a visible worsening of the epidemic situation. **On 29 January 2026, Radio Okapi reported that at least 24 deaths and 1,912 cases had been recorded in one week, with a particularly critical situation in North Kivu and South Kivu, alongside the announcement of a large-scale vaccination campaign planned for March**. A few weeks later, on 17 March 2026, Radio Okapi announced the launch of a campaign targeting 260,000 children aged 6 to 59 months in the health zones of Goma, Karisimbi, and Nyiragongo, in collaboration with MSF. This sequence, worsening of the epidemic and the announcement of a vaccination response, strongly shaped the reactions observed around the severity of the disease, the protection of children, and the health response .

In Nigeria, discussions were mainly stimulated by official communications around the measles-rubella campaign in Lagos. Content published by Lagos State on the awareness walk ahead of the 2026 rollout, and then on the launch of the campaign from 27 January 2026, helped increase the visibility of the issue and brought vaccination back to the centre of public discussion. These publications appear to have served as an entry point for comments combining support for vaccination, practical questions, and narratives expressing doubt about the usefulness of the vaccine.

Following these events, we observed persistent public concern around the true severity of measles and vaccination across the three countries covered. However, the trivialization of measles as a "normal" childhood illness and the tendency to downplay its severity were especially visible in South Africa and in the social media discussions reviewed from Nigeria, while in the DRC the conversations were more strongly shaped by the scale of the outbreak, deaths, and the vaccination response.

Another highly visible theme **concerns confusion around vaccination**. In South Africa as in Nigeria and the DRC, institutional messages urged the public either to check vaccination status or to take part in ongoing campaigns. Yet part of the reactions questioned the effectiveness of the vaccine itself, asking why an outbreak would occur if vaccination exists, or suggesting that the vaccination response was disproportionate to what they believed the actual level of risk to be. These reactions appear to have been directly triggered by the intensification of campaign messages and vaccination reminders, without always being accompanied by simple explanations about coverage gaps, the consequences of missed catch-up doses, or the need to maintain high collective immunity.

We also observed **persistent confusion around symptoms**. Institutional and media content highlight **fever, rash, cough, runny nose, and red eyes as common symptoms**, generating many exchanges in which internet users compared measles with other rash illnesses, particularly chickenpox. This confusion was likely reinforced by the circulation of images of lesions and by community discussions in which users attempted to identify the disease themselves on the basis of visible signs, without immediate recourse to a health professional.

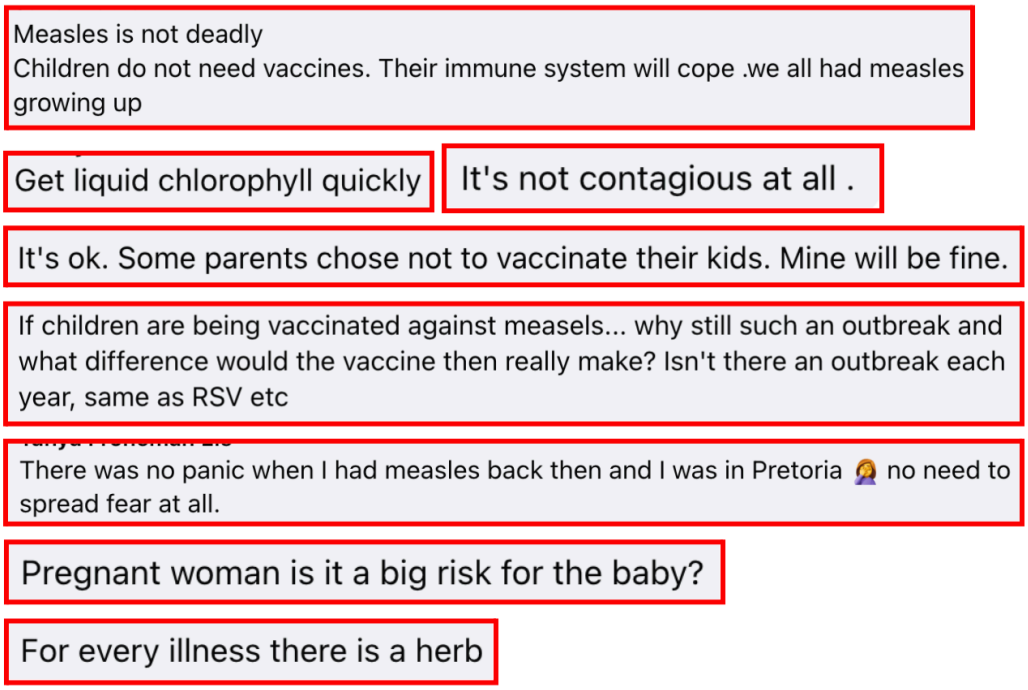
Lastly, several reactions seem to fit into a broader **information fatigue** regarding health messages and vaccination campaigns. In the DRC, the announcement that millions of children would be targeted by the national March campaign generated a mixture of concern and expectation; in South Africa, media framing around "**panic**" in Pretoria may have amplified polarized reactions; in Nigeria, mobilization messages revived older debates about trust in vaccines. **These reactions show that measles-related publications** add to recent memories of health crises and to previous experiences with vaccination.

Conclusion: The evidence shows a frequent trivialization of measles; a minimization of its severity despite reported outbreaks and deaths; confusion about the usefulness of vaccination; confusion with other infectious diseases; and a simultaneous circulation of legitimate questions and narratives of vaccine misinformation.

Why is this concerning?

This trend is concerning because the observed reactions **tend to normalize doubt. When a confirmed outbreak, deaths, and vaccination campaigns are met with comments that minimize the disease, downplay the usefulness of vaccination, or shift the diagnosis to other conditions, this can delay care-seeking, reduce vaccine uptake, and weaken the health response.**

Below or some illustrative comments :



What could we do about it?

It could be useful to investigate further to understand the levers of measles vaccine hesitancy and vaccine coverage gaps in Nigeria, South Africa and the DRC. Collaboration with fact-checkers could also inform if some of the anti-vaxx narratives seen online are part of a larger disinformation campaign or not.

In the meantime, efforts could be strengthened to fill the information gaps about measles symptoms, how measles is different from other infectious diseases, and why a very high vaccine coverage is essential to maintain herd immunity. It could also be relevant to accompany vaccination campaigns with more visible service information, locations, target age groups, schedule, and catch-up opportunities, in order to reduce the space left for misinterpretation and distrust.

Trend to watch : persistent mistrust of the mpox vaccine in Madagascar (8)

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What is happening?

Mpox continues to occupy an important place in the conversations in Madagascar where community transmission is high and 94 confirmed cases were reported between January and December 2025 [link]. However, the discussion is no longer focused only on the disease itself. It is increasingly centred on vaccination. Indeed, media coverage and social engagement were recently reignited by the **launch of the mpox vaccination campaign.** WHO indicates that an allocation of **30,000 doses of MVA-BN** vaccine was granted to Madagascar on 28 January 2026, and then delivered on 21 February 2026. The launch of vaccination on 5 March 2026, **with priority given to health workers and the most exposed groups, increased the visibility of the issue**. Announcements about the first people vaccinated, official communications, and explanations of the strategy directly triggered a wave of comments that were both mistrustful and practical.

Discussions were also fuelled by the **gradual opening of vaccination centres**, particularly in Analamanga, followed by the extension of the campaign to other regions. Locally relayed posts announced the opening of several sites on 24 March 2026, while WHO Madagascar also communicated about the regional launch in Analanjirofo, stating that 164 people had been vaccinated on the first day, mainly health workers. These announcements gave the campaign greater visibility, but they also raised new questions: **who is being targeted, where people can get vaccinated, why certain groups are prioritized, and why this is not a vaccination campaign open to everyone.**

Following these events, we observed sustained **public concern about the mpox vaccine**, making it one of the most discussed issues related to mpox during the period. **The most visible narrative was the idea that vaccinated people were being treated as "guinea pigs,"** with several internet users suggesting that the campaign was a form of experimentation. Other comments revived mistrust shaped during the COVID-19 period, with some people portraying the mpox vaccine as another version of vaccination strategies they had already viewed with suspicion. Discussions also reflected doubts about the **vaccine's safety, questions about whether vaccination was really necessary, and unease about why certain groups were being prioritized.** This pattern is not unique to Madagascar. In South Africa, for example, the arrival of Imvanex doses and the launch of a targeted campaign in the most affected provinces also triggered questions about why vaccination was being introduced after only a small number of new cases, suggesting that many people did not fully understand the logic of vaccinating populations considered to be at higher risk. [link].

Similarly, the experience of Kenya shows that mistrust can be partially mitigated when the campaign is accompanied by visible efforts in community engagement and practical information. **Kenya's September 2025 campaign targeted high-risk groups such as truck drivers, sex workers, and health workers, using mobile sites, consent information, and community-based communication [link].** This example is useful for Madagascar because it shows that a targeted campaign can be better understood when the public clearly sees who is being prioritized, **why, and how to access the vaccine .**

In other words, targeted vaccination remains difficult for part of the public to understand when it is announced without enough explanation about the logic of prioritization, the limited availability of doses, and the concrete modalities of access. It is this lack of clarity that can fuel narratives of mistrust, mockery, and suspicion.

Overview of infodemic insights : The main insights point to a persistent fear of experimentation on the population, often expressed through the "**guinea pig**" narrative; a direct reactivation of mistrust rooted in COVID-19; doubts about the safety and usefulness of the vaccine; questions about the targeting of beneficiaries and the logic of prioritization; a need for service information on centres, access, and criteria; and a still partial understanding of the difference between targeted vaccination and mass vaccination.

Resource box

- Meningitis **:** WHO Regional Office for Africa, Meningococcal Meningitis: useful for the meningitis belt, seasonality, serogroups, and the available vaccines.
- **Measles** : WHO, Measles fact sheet: a key reference on the severity of measles, its contagiousness, the complications, and the importance of high vaccination coverage.
- **Mpox** : WHO, Mpox questions and answers: useful for explaining the disease, transmission, prevention, and the logic of targeted vaccination.

Methodology & Footnotes

What is our methodology?

AIRA's methodology combines regional-level online social listening with offline data whenever available, depending on the local data-collection capacity of AIRA members. Online monitoring is complemented by systematic offline surveillance in the DRC, Kenya, and Nigeria to detect viral content circulating within communities. AIRA also relies on a broad network of more than 350 infodemic managers, RCCE practitioners, and fact-checkers who share relevant information, which is recorded for analysis.

Social media and online monitoring are supported by tools such as NewsWhip (Spike) and Google Trends. The analysis of online conversations relies on performance indicators such as engagement rate (number of likes, comments, reactions, shares). However, these indicators have limits: they do not always reflect the total reach or the intent behind responses. To address this, the team carries out a qualitative analysis of comments and assesses risks in light of emerging narratives, public health priorities, and the potential to disrupt operational response.

Footnotes

1. Platform-level interaction figures and the "social media interactions on articles" totals reflect different units of measurement and should not be added together. They are used to indicate where attention and engagement were most concentrated.

2. These infodemic data points include misinformation, disinformation, information gaps, concerns, claims or requests, expressions of support or positive reactions, and instances of inaccurate, incomplete, or misleading reporting in the media.

3. These data are not intended to represent the entire infodemic landscape in the WHO African Region. Rather, they provide a snapshot of the most visible and relevant themes identified through AIRA's monitoring approach during the reporting period.

4. These data are not intended to represent the entire infodemic landscape in the WHO African Region; rather, they provide a snapshot of the main countries represented in the conversations, identified using the same methodology.

5. The topics highlighted in this report were selected on the basis of their visibility in the monitored dataset and their operational relevance for public health communication during the reporting period.

6. A total of 47 publications identified between March 1 and 15, 2026, generated 17 social media interactions on articles and contained relevant infodemic information after a preliminary search using the following keywords: ("meningitis" OR "cerebrospinal meningitis" OR "CSM" OR "meningococcal meningitis" OR "outbreak" OR "epidemic" OR "dry season" OR "NiMet" OR "NCDC" OR "high-risk states" OR "vaccination" OR "meningitis belt"), applied to content in all languages published in Africa. This search initially yielded 47 news articles related to meningitis during the reporting period.

7. A total of 57 publications identified between March 1 and 15, 2026, containing relevant infodemic information, were retained after a preliminary search using the following keywords: ("measles" OR "rubella" OR "measles-rubella" OR "rash" OR "fever" OR "outbreak" OR "epidemic" OR "vaccination" OR "catch-up dose" OR "immunization campaign" OR "childhood illness" OR "chickenpox"), applied to content in all languages published in Africa. This search yielded 57 news articles and 56 social media interactions on articles during the reporting period.

8. A total of 245 publications identified between March 1 and 15, 2026, containing relevant infodemic information, were retained after a preliminary search using the following keywords: ("mpox" OR "monkeypox" OR "poxvirus" OR "rash" OR "skin lesions" OR "vaccination" OR "mpox vaccine" OR "MVA-BN" OR "vaccination campaign" OR "health workers" OR "priority groups" OR "vaccination centres"), applied to content in all languages published in Africa. This search yielded 245 news articles and 96 social media interactions on articles during the reporting period.OR "artemisinin-based combination therapy" OR "R21" OR "RTS,S" OR "malaria vaccine" OR "mosquito control"), applied to content in all languages published in Africa.