# Lassa Fever Burden and Reported Case Fatality in Nigeria from 2024 To Epidemiological Week 31 Of 2026: The Public Health Lessons

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***Abstract***
***Background***: *Lassa fever remains an important public health challenge in Nigeria. We assessed changes in reported disease burden, geographical distribution and case fatality between 2024 and epidemiological week 31 of 2026.*
***Methods***: *We conducted a retrospective descriptive analysis of aggregate national surveillance data from Nigeria Centre for Disease Control and Prevention Lassa fever situation reports. Indicators included suspected and confirmed cases, deaths among confirmed cases, the confirmed-to-suspected case proportion, and affected states and local government areas. Case-fatality ratios (CFRs) were calculated with Wilson 95% confidence intervals (CIs). Exploratory two-sided pooled two-proportion z-tests compared CFRs. Epidemiological weeks 1–31 of 2025 and 2026 were compared to reduce bias from unequal observation periods.*
***Results***: *Confirmed cases decreased by 12.3%, from 1,309 in 2024 to 1,148 in 2025, whereas deaths remained similar at 214 and 215. CFR increased from 16.35% (95% CI 14.44–18.45%) to 18.73% (16.58–21.09%; p = 0.121). By week 31 of 2026, 1,017 confirmed cases and 239 deaths were reported, yielding a CFR of 23.50% (21.00–26.20%). Compared with weeks 1–31 of 2025, confirmed cases increased by 21.7% and deaths by 53.2%; CFR increased from 18.66% to 23.50% (p = 0.011). The 2026 report attributed approximately 86% of confirmed cases to Ondo, Bauchi, Taraba, Edo and Benue.*
***Conclusion***: *Reported Lassa fever fatality increased in early 2026, including in a comparison of equivalent surveillance periods. These findings support strengthening timely diagnosis, referral, supportive care and outcome surveillance, particularly in high-burden states. Aggregate data cannot establish the causes of the increase.*

***Keywords***: *Lassa fever; Nigeria; surveillance; case-fatality ratio; public health; geographical distribution.*

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## 1 Background of the study

Lassa fever is a zoonotic viral illness endemic in parts of West Africa, including Nigeria. Human infection commonly follows exposure to food or household materials contaminated by infected rodents, while transmission between people can occur through contact with infectious body fluids, particularly where infection prevention measures are inadequate. The clinical spectrum and the concentration of severe presentations among patients who reach diagnostic services make the interpretation of reported fatality dependent on how cases are detected and followed [1].

For public health planning, surveillance should describe both the number of detected cases and the outcomes among those cases. A reduction in confirmed notifications can coexist with an unchanged or increasing number of deaths. Such divergence can arise from changes in transmission, detection of mild illness, access to care, case severity or completeness of reporting. Reported case-fatality ratios therefore provide a useful warning signal, but do not measure mortality among all infected people or establish the causes of a change in outcomes.

Nigeria's Lassa-specific surveillance summaries recorded 1,309 confirmed cases and 214 deaths in 2024 and 1,148 confirmed cases and 215 deaths in 2025. The decline in confirmed cases was accompanied by an increase in the reported CFR. By epidemiological week 31 of 2026, the disease-specific report recorded 1,017 confirmed cases and 239 deaths [2–4]. These observations warrant a structured assessment of burden and fatality. However, comparing a partial year with a complete year can be misleading, especially when the seasonal composition of cases and the time available for outcome reporting differ.

The geographical distribution of notifications is also relevant to resource allocation. A high concentration of cases in a few states can identify locations where additional diagnostic and referral capacity may be valuable, but case shares are influenced by population size and surveillance coverage. Similarly, the age and sex distributions of confirmed cases describe those detected by surveillance and should not be interpreted as population susceptibility without appropriate denominators. An integrated description of these indicators can inform more focused investigations while preserving the limits of aggregate data.

Clinical evidence provides a rationale for investigating the connection between surveillance and care. The LASCOPE prospective cohort in Nigeria identified associations of mortality with clinical and laboratory characteristics, including older age, renal impairment and severity at presentation [5]. National aggregate summaries cannot assess these mechanisms directly. Their contribution is to identify patterns that justify linkage of surveillance records with clinical, laboratory and healthcare-access information.

The present study addresses the need to distinguish changes in detected disease burden from changes in reported fatality during 2024–2026. It combines comparisons of complete annual surveillance periods with a separate comparison of equivalent weeks in 2025 and 2026, describes geographical and demographic patterns, and evaluates the sensitivity of annual mortality comparisons to conflicting official source totals. The effective endpoint for 2026 is 2 August, corresponding to the end of epidemiological week 31; no observations are extrapolated to the later review cutoff of 15 August.

## 2 Aim and objectives

### 2.1 Aim

To assess the reported burden, geographical and demographic distribution, and case fatality of Lassa fever in Nigeria from 2024 to epidemiological week 31 of 2026, with separate comparisons of equivalent surveillance periods**.**

### 2.2 Specific objectives

1. Describe suspected, confirmed and probable cases, deaths among confirmed cases, and the number of affected states and local government areas in each reporting period.
2. Estimate confirmed-to-suspected case proportions and CFRs, with 95% confidence intervals, and quantify changes between 2024 and 2025.
3. Compare weeks 1–31 of 2025 and 2026 using absolute differences, relative changes, crude odds ratios and exploratory tests of proportions.
4. Summarise the geographical distribution of confirmed cases by geopolitical zone and state for 2024, and describe the leading state contributions reported for subsequent periods.
5. Describe the reported age and sex characteristics without inferring population-level susceptibility from case distributions.
6. Evaluate how alternative official 2025 death totals affect the annual CFR comparison and identify data limitations relevant to interpretation.

## 3.0 Methodology

### 3.1 Study design and setting

This was a retrospective descriptive and comparative analysis of publicly available aggregate Lassa fever surveillance data for Nigeria. National summaries were the primary units of reporting; state and geopolitical-zone summaries were used for geographical description. No participants were recruited and no specimens were collected for this analysis.

### 3.2 Observation periods

The analysis included cumulative epidemiological weeks 1–52 of 2024 and 2025, and weeks 1–31 of 2026. The respective terminal reporting weeks ended on 29 December 2024, 28 December 2025 and 2 August 2026 [2–4]. “Annual” refers to the week-52 cumulative surveillance period rather than all calendar dates. The 2025 week-31 comparator was obtained from the comparison table within the 2026 week-31 report. The later review cutoff of 15 August 2026 did not extend the observed dataset.

### 3.3 Data sources and eligibility

Primary sources were the NCDC Lassa fever situation reports for week 52 of 2024, week 52 of 2025 and week 31 of 2026 [2–4]. The NCDC general Weekly Epidemiological Report for week 52 of 2025 was examined to assess the effect of a conflicting annual death total [6]. Eligible observations were cumulative national counts and descriptive state, age and sex summaries pertaining to the defined periods. Individual weekly counts were not summed with cumulative totals. Probable cases were retained as a separate descriptive category and were not added to the confirmed-case CFR denominator.

### 3.4 Data extraction and validation

Variables extracted were reporting period, suspected cases, confirmed cases, probable cases, deaths among confirmed cases, affected states and LGAs, and available demographic summaries. The supplied 2024 state table was checked against the primary report and its totals recalculated: 10,098 suspected and 1,309 confirmed cases. State counts were aggregated into Nigeria’s six geopolitical zones, assigning the Federal Capital Territory to North Central. Calculated percentages were derived from unrounded counts. No missing counts were imputed and rounded state shares were not converted into invented exact case counts.

### 3.5 Source hierarchy and discrepancy handling

The disease-specific Lassa reports were used consistently for the primary analysis. The 2025 disease-specific report records 215 deaths, whereas the general report records 178 deaths among the same 1,148 confirmed cases [3,6]. Neither figure was silently substituted for the other. A sensitivity analysis recalculated the 2025 CFR and its comparison with 2024 under both totals. This approach documents the analytical consequence of the discrepancy; it does not resolve which source total is definitive.

### 3.6 Operational definitions

A suspected, confirmed or probable case was accepted as categorised in the source surveillance report; no case was reclassified. CFR was defined as reported deaths among confirmed cases divided by confirmed cases, multiplied by 100. The confirmed-to-suspected case proportion was confirmed cases divided by suspected cases, multiplied by 100. It was not assumed to equal laboratory test positivity because a unique tested-person denominator and complete testing coverage were unavailable. An affected administrative unit was one reporting at least one confirmed case. A state or zone case share was its confirmed count divided by the national confirmed count, multiplied by 100.

### 3.7 Statistical analysis

Counts and proportions summarised each period. Absolute changes were calculated as the later count minus the earlier count, and relative changes as 100 × (later − earlier)/earlier. Differences between percentages were expressed in percentage points. Wilson score 95% confidence intervals were calculated for CFRs and confirmed-to-suspected case proportions. Two-sided pooled two-proportion z-tests compared each indicator between 2024 and 2025 and, separately, between weeks 1–31 of 2025 and 2026. The equivalent Pearson chi-square statistic was z squared with one degree of freedom, without continuity correction. These equivalent statistics were not treated as independent tests.

### 3.8 Effect estimates and analytical boundaries

For each comparison, the later period was the exposed category and the earlier period the reference. Crude odds ratios used the reported event count and denominator minus event count; log-Wald intervals were calculated from the four cell counts. Confidence intervals for differences in proportions used the independent-binomial Wald approximation. For CFR comparisons, confirmed cases minus reported deaths were labelled “not reported dead at the cutoff”, not confirmed survivors. Inference was exploratory, two-sided and unadjusted for multiple comparisons, with $p < 0.05$ used as a descriptive threshold. Calculations assumed independent observations and did not adjust for state or facility clustering, reporting revisions or differences in case mix. They therefore do not constitute adjusted estimates of individual mortality risk. Calculations were performed in Python using SciPy and the standard math library.

### 3.9 Analyses not supported by the available data

Population incidence, state-specific CFRs without death denominators, adjusted mortality models, time-to-event analyses, seasonality, environmental associations and formal spatial clustering were not estimated. Age- and sex-specific tests were not reconstructed from rounded ratios. Comparisons of complete 2024 or 2025 periods with partial 2026 were descriptive only. The

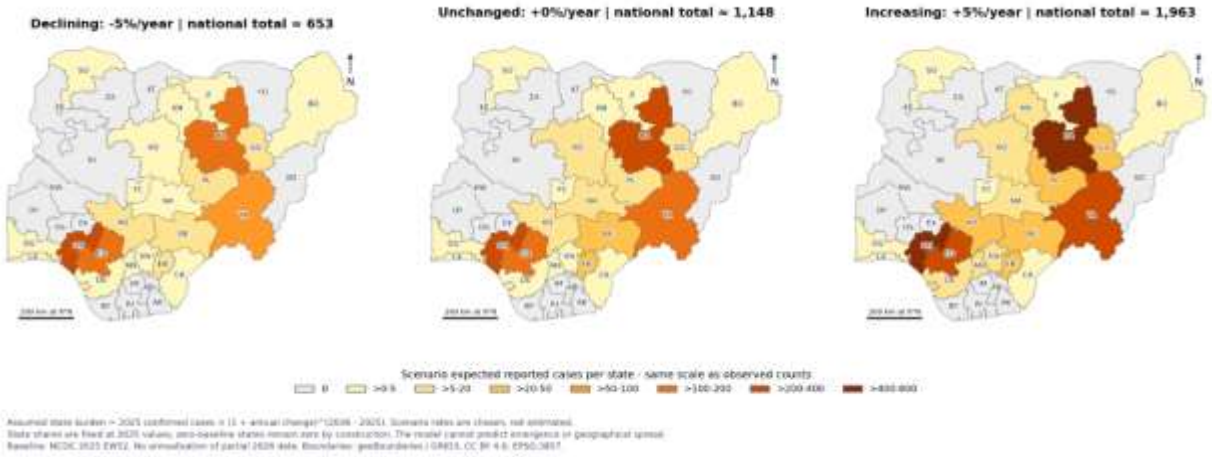
annual and matched-period datasets were analysed separately because the 2025 weeks 1–31 counts form a subset of the 2025 annual counts.

### 3.10 Ethical considerations

The analysis used publicly available aggregate surveillance summaries. No identifiable patient data were accessed, no individuals were contacted and no intervention was administered.

## Results

The GIS analysis showed geographical concentration of reported Lassa fever cases across the study periods. In 2024, Ondo, Edo, Bauchi, Taraba and Benue accounted for 1,118 of 1,309 confirmed cases (85.4%). In 2025, Ondo, Bauchi, Edo and Taraba contributed 1,018 of 1,148 cases (88.7%). By epidemiological week 31 of 2026, Ondo, Bauchi, Taraba, Edo and Benue accounted for 875 of 1,017 confirmed cases (86.0%). These distributions represent reported case burden rather than population incidence or statistically significant spatial clusters. Illustrative projections for 2027–2036, calculated from the complete 2025 baseline using assumed annual changes of −5%, 0% and +5%, yielded approximately 653, 1,148 and 1,963 expected reported cases nationally in 2036, respectively. State shares remained unchanged by construction because the same multiplier was applied to every state; these outputs are conditional scenarios rather than validated forecasts.




## Discussion

This analysis identifies a divergence between reported Lassa fever case counts and deaths in Nigeria. Confirmed cases declined between 2024 and 2025, but deaths did not decrease, resulting in a higher observed CFR. The increase in fatality was more pronounced in 2026, when the cumulative CFR reached 23.50% by epidemiological week 31. A comparison of equivalent periods showed that confirmed cases and deaths both increased relative to weeks 1–31 of 2025, with deaths increasing more rapidly. Together, these observations suggest that a reduction in diagnosed cases in one reporting year should not be interpreted as sufficient evidence of sustained improvement in disease control or clinical outcomes [1–3].

The annual comparison requires statistical restraint. The difference between the 2024 and 2025 CFRs was not statistically significant in the exploratory two-proportion analysis ($p = 0.121$). It is therefore more appropriate to describe a numerical increase than to claim a demonstrated change in mortality risk between those years. The comparisons of 2026 with the complete 2024 and 2025 reporting periods produced smaller p-values, but unequal observation windows limit their epidemiological comparability. Differences in seasonal case mix, reporting delays and outcome

ascertainment could contribute to the observed contrasts. Statistical significance cannot remove these design limitations.

The matched-period comparison provides stronger descriptive evidence of a worsening situation in 2026. Between weeks 1–31 of 2025 and the corresponding period of 2026, confirmed cases increased from 836 to 1,017 and deaths from 156 to 239. The CFR increased by 4.84 percentage points, from 18.66% to 23.50% (exploratory $p = 0.011$). Thus, the higher 2026 CFR cannot be attributed solely to comparing a partial year with a complete year. Nevertheless, equivalent calendar coverage does not ensure equivalent case ascertainment, patient characteristics or completeness of outcome reporting. This analysis establishes a surveillance signal requiring investigation rather than an adjusted causal estimate of a change in individual mortality risk.

Several explanations should be examined. Delays in recognising illness, accessing testing or reaching designated care could lead to a greater proportion of patients presenting with advanced disease. Alternatively, reduced detection of mild infections could increase the observed CFR even without a change in disease severity among all infected people. Differences in age, comorbidity, pregnancy status, referral patterns and treatment capacity may also affect the national ratio. These mechanisms were not measured in the present dataset and should remain hypotheses. In particular, the results do not establish increased viral virulence, treatment failure or deterioration in clinical practice. Clinical evidence from Nigeria helps identify variables for subsequent investigation. In the prospective LASCOPE cohort, older age, clinical severity, renal impairment, elevated alanine aminotransferase and lower diagnostic RT-PCR cycle threshold values were independently associated with mortality [4]. This supports linking surveillance records to clinical and laboratory information rather than relying on annual totals alone. Priority variables include symptom-onset date, first healthcare contact, sample collection, result availability, referral, admission, renal function, severity at presentation and final outcome. Such linkage would help distinguish changes in the population detected from changes in outcomes within comparable patient groups. The cohort findings do not, however, demonstrate that these factors caused the national increase observed here. The reduction in geographical reporting during 2025 also requires careful interpretation. The number of affected states declined from 28 to 22, and affected local government areas from 139 to 107. This indicates a smaller documented geographical footprint, but does not establish interruption of transmission in locations without confirmed cases. Counts of affected administrative units are sensitive to surveillance activity, diagnostic access and the detection of even a single case. Moreover, the matched-period comparison showed more affected states and local government areas in 2026 than in 2025. These findings support maintaining national detection capacity while concentrating additional resources in areas with a sustained high reported burden. The persistence of Ondo, Edo and Bauchi among major contributors, with Taraba and Benue also prominent, indicates a geographically concentrated reported burden. The 2026 week-31 report attributed approximately 86% of confirmed cases to these five states [3]. This pattern supports targeted planning for sample transport, referral networks, treatment capacity and community engagement. It also shows why Lassa fever prevention should address affected communities in both northern and southern Nigeria. However, the observed concentration could reflect differences in population size and detection capacity as well as exposure. Without population denominators, environmental measurements and formal spatial analysis, these results do not establish higher population incidence or statistically significant spatial clustering.

The confirmed-to-suspected case proportion declined from 12.96% in 2024 to 12.23% in 2025 and increased to 14.25% by week 31 of 2026. These proportions describe the relationship between surveillance categories; they are not estimates of infection prevalence in the general population.

They should also not be described as laboratory test positivity unless the number of people tested, completion of testing and handling of repeat samples are established. Changes may reflect underlying transmission, the breadth of clinical suspicion, competing febrile illnesses or access to confirmation. Recording the proportion of suspected cases tested and diagnostic turnaround times would improve interpretation of future comparisons.

The predominance of the 21–30-year age group is relevant for public health communication and service planning, but does not demonstrate that young adults have the highest population risk. Age-specific case counts need to be related to population size and patterns of testing. Similarly, approximately balanced male-to-female distributions do not establish equal susceptibility or outcomes. Exposure opportunities, healthcare use and case ascertainment may differ between groups. The present aggregate data therefore support inclusive prevention messages and more detailed demographic analysis, rather than claims of biological susceptibility or protective effects associated with age or sex. The findings have practical implications for the connection between surveillance and care. Improving notification alone will not necessarily reduce deaths unless suspected cases can access timely assessment, diagnostic confirmation and appropriate clinical support. Referral systems should be evaluated alongside laboratory services, and treatment centres should monitor severity, complications and outcomes consistently. WHO identifies early intensive supportive care as important and notes substantial uncertainty about ribavirin efficacy [5]. The present analysis contains no treatment information and cannot evaluate antiviral effectiveness. Recommendations should consequently emphasise timely evidence-informed care and rigorous therapeutic research rather than attribute the observed CFR to a particular drug or regimen.

Prevention should complement clinical improvements. Measures that reduce opportunities for rodent contamination of food and households, together with infection prevention in healthcare settings, remain relevant to Lassa fever control [5]. The concentration of reported cases provides a basis for prioritising implementation and evaluation in high-burden communities. It does not demonstrate that a particular environmental condition caused the observed distribution. Assessments linking human surveillance with household exposure, rodent ecology and local service access would be needed to test those explanations and guide interventions more precisely.

Several limitations affect interpretation. The analysis uses aggregate reported data and cannot adjust for clinical severity, demographic composition, comorbidities or treatment. Surveillance CFR represents deaths reported among confirmed cases, not mortality among all infections. Cases with unresolved outcomes at a reporting cutoff and delays between diagnosis and death can bias cumulative ratios. Probable cases were excluded from the confirmed-case denominator, and no assumption was made about unreported deaths. Binomial confidence intervals and two-proportion tests do not account for clustering within states or facilities, temporal dependence or systematic reporting error; the p-values are exploratory and unadjusted for multiple comparisons. The 2026 findings cover weeks 1–31 only and were not extrapolated to a full year or to the later review cutoff. Source consistency is an additional limitation. The Lassa-specific 2025 week-52 situation report records 215 deaths and an 18.7% CFR, whereas the general week-52 Weekly Epidemiological Report lists 178 deaths and a 15.5% CFR for the same annual confirmed-case total [2,6]. This analysis consistently uses the disease-specific report, but the discrepancy should be reconciled with the reporting authority before definitive annual mortality comparisons are published. The matched-period comparison reproduced within the 2026 Lassa-specific report remains useful, although its underlying records also require routine validation. Future work should use a documented data version, a clear source hierarchy and, where possible, validated records with completed outcomes.

The contribution of this analysis is to identify a separation between changes in detected burden and changes in reported fatality, while demonstrating why matched surveillance periods and consistent denominators matter. It brings mortality, geographical concentration and diagnostic ascertainment into a single descriptive assessment. It does not identify patient-level predictors or causal drivers. Its principal value is to define a focused investigation: whether changes in detection, presentation severity, referral access, clinical support or outcome reporting explain the higher reported fatality in 2026.

The repeated concentration of reported cases in Ondo, Bauchi, Edo and Taraba, with substantial contributions from Benue, supports prioritizing these locations for diagnostic access, referral services, clinical preparedness and community prevention while maintaining surveillance nationally. Nevertheless, differences in population size, healthcare access and case ascertainment could contribute to the geographical pattern; the maps therefore cannot independently establish differences in infection risk or identify environmental causes. The ten-year scenarios illustrate how sustained changes in reported burden could affect future service requirements, but their spatial consistency is an imposed assumption rather than evidence that the same states will remain dominant. Similarly, states with no confirmed cases in the baseline remain at zero mechanically, which must not be interpreted as protection against future emergence. Given the availability of only two complete annual observations and an incomplete 2026 period, reliable geographical forecasting would require a longer series of state- or LGA-level observations, relevant population denominators, assessment of reporting completeness and validation against subsequently observed outcomes.

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## Conclusion

The epidemiological maps identified a concentrated reported Lassa fever burden involving several recurrent high-burden states in Nigeria. This distribution provides a practical basis for targeted resource allocation alongside nationwide detection and response capacity. The 2027–2036 maps offer transparent planning scenarios under specified assumptions, but do not predict geographical spread, changing state rankings or individual infection risk. Longer surveillance series and validated spatiotemporal models are needed before these scenarios can be replaced by defensible forecasts with quantified prediction uncertainty.

Nigeria experienced a decline in reported confirmed Lassa fever cases between 2024 and 2025 without a corresponding reduction in reported deaths. By epidemiological week 31 of 2026, both

cases and deaths exceeded the corresponding 2025 totals, and the reported CFR was higher. The concentration of confirmed cases in a small number of states supports targeted strengthening of diagnostic access, referral, and clinical support, while maintaining national surveillance. These aggregate findings do not establish increased viral severity or identify the causes of the mortality pattern. Consistent source reconciliation, completed outcome follow-up, and linked patient-level analyses are needed to determine the mechanisms and evaluate interventions. The epidemiological maps identified a concentrated reported Lassa fever burden involving several recurrent high-burden states in Nigeria. This distribution provides a practical basis for targeted resource allocation alongside nationwide detection and response capacity. The 2027–2036 maps offer transparent planning scenarios under specified assumptions, but do not predict geographical spread, changing state rankings or individual infection risk. Longer surveillance series and validated spatiotemporal models are needed before these scenarios can be replaced by defensible forecasts with quantified prediction uncertainty.

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**References**

1. Nigeria Centre for Disease Control and Prevention. Lassa fever situation report. Epidemiological week 52, 2024. https://ncdc.gov.ng/themes/common/files/sitreps/a45a720bd6ddd1e75a5a3e7e6195e412.pdf
2. Nigeria Centre for Disease Control and Prevention. Lassa fever situation report. Epidemiological week 52, 2025. https://zadmin.ncdc.gov.ng/themes/common/files/sitreps/04beb529df54f4ceb99ac291842640b4.pdf
3. Nigeria Centre for Disease Control and Prevention. Lassa fever situation report. Epidemiological week 31, 2026. https://ncdc.gov.ng/themes/common/files/sitreps/a373aae5ca8b3ff2346793d5bbed5cbb.pdf
4. Duvignaud A, Jaspard M, Etafo IC, et al. Lassa fever outcomes and prognostic factors in Nigeria (LASCOPE): a prospective cohort study. Lancet Glob Health. 2021;9(4):e469–e478. doi:10.1016/S2214-109X(20)30518-0.
5. World Health Organization. Lassa fever. https://www.who.int/news-room/fact-sheets/detail/lassa-fever (accessed 25 October 2026).
6. Nigeria Centre for Disease Control and Prevention. Weekly Epidemiological Report. Volume 15, number 52. Week 52, 2025. https://ncdc.gov.ng/themes/common/docs/wers/661_1772120299.pdf

**Supplementary Table S1 State distribution of Lassa fever cases in 2024**

| State or FCT | Suspected | Confirmed | National case share % | Confirmation % |
|---|---|---|---|---|
| Abia | 20 | 0 | 0.00 | 0.00 |
| Adamawa | 21 | 3 | 0.23 | 14.29 |
| Akwa Ibom | 8 | 0 | 0.00 | 0.00 |
| Anambra | 47 | 4 | 0.31 | 8.51 |
| Bauchi | 1,143 | 253 | 19.33 | 22.13 |
| Bayelsa | 27 | 2 | 0.15 | 7.41 |
| Benue | 1,072 | 64 | 4.89 | 5.97 |
| Borno | 13 | 0 | 0.00 | 0.00 |
| Cross River | 64 | 8 | 0.61 | 12.50 |
| Delta | 100 | 5 | 0.38 | 5.00 |
| Ebonyi | 382 | 53 | 4.05 | 13.87 |
| Edo | 3,103 | 289 | 22.08 | 9.31 |
| Ekiti | 17 | 0 | 0.00 | 0.00 |
| Enugu | 126 | 15 | 1.15 | 11.90 |
| FCT | 76 | 2 | 0.15 | 2.63 |
| Gombe | 64 | 5 | 0.38 | 7.81 |
| Imo | 41 | 3 | 0.23 | 7.32 |
| Jigawa | 26 | 2 | 0.15 | 7.69 |
| Kaduna | 127 | 15 | 1.15 | 11.81 |
| Kano | 58 | 1 | 0.08 | 1.72 |
| Katsina | 24 | 1 | 0.08 | 4.17 |
| Kebbi | 8 | 0 | 0.00 | 0.00 |
| Kogi | 158 | 37 | 2.83 | 23.42 |
| Kwara | 10 | 0 | 0.00 | 0.00 |
| Lagos | 49 | 1 | 0.08 | 2.04 |
| Nasarawa | 72 | 5 | 0.38 | 6.94 |
| Niger | 13 | 3 | 0.23 | 23.08 |
| Ogun | 39 | 1 | 0.08 | 2.56 |
| Ondo | 2,613 | 400 | 30.56 | 15.31 |
| Osun | 8 | 0 | 0.00 | 0.00 |
| Oyo | 41 | 1 | 0.08 | 2.44 |
| Plateau | 115 | 17 | 1.30 | 14.78 |
| Rivers | 75 | 6 | 0.46 | 8.00 |
| Sokoto | 10 | 0 | 0.00 | 0.00 |
| Taraba | 301 | 112 | 8.56 | 37.21 |
| Yobe | 24 | 1 | 0.08 | 4.17 |
| Zamfara | 3 | 0 | 0.00 | 0.00 |
| Nigeria | 10,098 | 1,309 | 100.00 | 12.96 |

***Source**: cumulative state table in the 2024 week-52 report [2]. State rows were checked against the primary table and the national totals recalculated. Zero confirmed cases means no reported confirmed case in this table, not demonstrated absence of infection.*