

Noma in Africa: A Neglected Disease of Poverty

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Executive summary

Noma is a preventable, treatable disease that still kills or disfigures young children across Africa because it is caught too late. It is a fast-moving gangrene of the mouth and face that strikes mainly children aged 2 to 6 living in extreme poverty. Untreated, it has been estimated to kill about 90% of those it affects.

The tools to stop it are cheap and already exist: early recognition, common antibiotics, oral hygiene and nutrition. What is missing is detection, data and funding. The only global burden estimate dates to 1998 (140,000 new cases a year), and most cases are never recorded.

WHO added noma to its list of neglected tropical diseases in December 2023. That decision creates an opening to fold noma into existing programs for child nutrition, immunization, primary care and NTD control. This paper sets out the disease, its burden, the response so far, the gaps, and practical recommendations for governments, donors, NGOs and health systems.

What noma is

Noma (also called cancrum oris or gangrenous stomatitis) is a gangrenous disease that begins as a gum sore and can destroy the soft tissue, bone and skin of the face within days. It is not caused by a single germ. It is linked to a mix of ordinary mouth bacteria that turn destructive when a child's defenses are low ([WHO](#)).

Noma is considered opportunistic and non-contagious; there is no documented person-to-person spread. It mainly affects children aged 2 to 6, but it can also occur in adults with weakened immune systems, including from HIV or leukemia.

Risk factors

- **Malnutrition**, the most consistently reported driver
- **Recent infections** such as measles, malaria and severe diarrhea, which weaken immunity
- **Poor oral hygiene** and limited access to clean water
- **Extreme poverty**, which ties the factors above together

Clinical stages (WHO)

WHO uses clinical criteria to stage the disease; there is no point-of-care test.

0. Simple gingivitis (gum inflammation)
1. Acute necrotizing gingivitis: the key window for cheap, effective treatment
2. Edema: swelling of the cheek or lip
3. Gangrene: dead tissue, often a hole through the face
4. Scarring
5. Sequelae: lasting disfigurement and loss of function

Treatment

Caught early, noma responds to widely available antibiotics, oral hygiene support, antiseptic mouthwash (salt water or chlorhexidine) and nutritional supplements, and can heal without lasting damage. Once gangrene sets in, survivors usually need complex reconstructive surgery and long-term rehabilitation.

Burden and geography in Africa

Africa is the most affected continent, but nobody knows how many children noma reaches today. The most cited figures are WHO's 1998 estimates ([WHO](#)):

Measure	1998 WHO estimate
New cases per year	140,000
People living with noma (prevalence)	770,000
Case-fatality rate, untreated	90%

WHO itself notes these figures have methodological limits. Newer evidence suggests the fatality rate may now be below 90% and falls sharply with early treatment.

The disease is concentrated in the "noma belt," a band of Africa running from Mauritania to Ethiopia across the Sahel. More than 13,000 cases have appeared in the scientific literature since the early 2000s, including in African countries outside the belt and in Asia, the Americas, the Middle East and Europe.

Why the data are so weak

- The disease moves fast and kills quickly, often before a child reaches a clinic.
- Surveillance systems in affected areas are thin, and definitions have varied.

- Stigma leads families to hide affected children.
- Many health workers and caregivers do not recognize early-stage noma.

Human, social and economic impact

For survivors, noma is a lifelong disability rooted in a few weeks of untreated infection. WHO describes lasting disfigurement and impaired breathing, swallowing, speaking and vision ([WHO](#)).

- **Health:** many survivors cannot open their jaw fully, which makes eating and dental care hard and worsens malnutrition.
- **Social:** facial disfigurement brings stigma, isolation and discrimination. Children are often kept out of school, and families may hide them.
- **Economic:** survivors' chances of education and work shrink, and reconstructive surgery requires scarce surgical teams, long hospital stays and repeated operations.
- **Rights:** in 2012 the UN Human Rights Council acknowledged that neglect of noma may amount to a violation of basic child rights.

Noma is also a marker of absolute poverty. Where it appears, it signals that the same children face malnutrition, missed vaccinations and limited primary care.

Global response to date

The 2023 NTD listing was a breakthrough, but it has not yet turned into routine care, surveillance or dedicated funding. Key milestones, newest first:

Date	Milestone
Jul 2026	MSF calls for urgent action, noting noma remains largely absent from routine child health programs in Nigeria (MSF via The Binoculist)
Mar 2026	PathNoma research alliance funded (University of Liverpool, LSTM, ISGlobal, CaixaResearch, MSF) to study causes and early detection (University of Liverpool)
2025	US government withdraws NTD donations; it had supplied almost 40% of NTD funding in 2023 (Lancet Global Health)
Dec 2023	WHO adds noma to its NTD list, after a Nigeria-led request backed by MSF (MSF)

Date	Milestone
2014	MSF begins supporting Nigeria's Noma Children's Hospital in Sokoto
2012	UN Human Rights Council says neglect of noma may violate basic child rights (WHO)
1994	WHO launches its noma control program; a regional program later covers 11 priority African countries

Nigeria as the leading example

Nigeria reports more cases than other countries, likely because it has specialist hospitals and a government-led response, not because its burden is uniquely higher ([Africanews/AP](#)). At the Sokoto hospital, MSF teams performed 1,645 reconstructive surgeries on 1,078 patients between 2014 and 2025, and the hospital cared for 1,034 patients in 2025 alone ([MSF](#)).

Funding headwinds

Overall NTD funding fell 41%, from US\$440 million in 2018 to US\$260 million in 2023, before the 2025 US withdrawal ([Lancet Global Health](#)). Noma, the newest NTD, enters the list as the money shrinks.

Gaps and barriers

The central failure is late detection: children reach care after the cheap, curable stage has passed. MSF reports that many patients arrive at specialist centers badly deteriorated after visiting several facilities, including higher-level hospitals, where noma was not recognized ([MSF via The Binoculist](#)).

- **Data:** the only global estimate is from 1998. Cases are mostly found through active searching, and there are essentially no data from conflict zones ([Lancet Global Health](#)).
- **Recognition:** frontline health workers and caregivers often do not know the early signs.
- **Integration:** noma is largely missing from primary care, surveillance systems and financing frameworks, even in Nigeria ([MSF](#)).
- **Science:** the causes and disease mechanisms are still poorly understood, and there is no point-of-care diagnostic test.

- **Surgical capacity:** reconstruction depends on a handful of specialist centers and visiting NGO teams.
- **Funding:** NTD budgets are shrinking just as noma joins the list.
- **Conflict and displacement:** insecurity in the Sahel deepens malnutrition and cuts off care in the areas at highest risk.

Recommendations

The highest-return move is to catch noma at the gum stage by building it into programs that already reach young children. Noma does not need a stand-alone system; it needs a place in existing ones.

For African governments and ministries of health

1. Make noma a notifiable disease and add it to Integrated Disease Surveillance and Response reporting.
2. Adopt national action plans using WHO's step-by-step guide, linked to existing NTD and child-health programs.
3. Add noma screening to malnutrition clinics, immunization days and routine child visits.
4. Stock first-line antibiotics, chlorhexidine and nutrition supplements at primary care level.

For donors and funders

1. Fund noma within integrated NTD and child-nutrition budgets rather than as a niche add-on.
2. Finance a modern burden study to replace the 1998 estimate.
3. Support research on causes, early diagnosis and a point-of-care test, building on efforts such as PathNoma.
4. Co-fund regional surgical centers and training so reconstruction does not depend on a few visiting teams.

For NGOs and community organizations

1. Train community health workers, traditional healers and caregivers to spot early warning signs.
2. Run awareness campaigns that also tackle stigma.
3. Provide survivor support: mental health care, schooling and livelihood help.
4. Share case data with ministries so it enters national surveillance.

For health systems and professional bodies

1. Add noma to the training curricula of doctors, nurses and dental workers in endemic countries.
2. Use existing tools, such as the free WHO OpenWHO noma course and the WHO SkinNTD app, for frontline training.
3. Set referral pathways from primary care to surgical centers.

Measures of progress

- Share of noma cases detected at stage 0 or 1
- Number of endemic countries with noma in national surveillance and action plans
- A published, updated burden estimate
- Survivors reached with surgery and rehabilitation

Conclusion

Noma is one of the clearest cases in global health where a child's fate turns on a few days and a few dollars. The science of early treatment is settled; the gap is recognition, reach and money. Folding noma into the child-health, nutrition and NTD programs already working across Africa is the fastest way to turn the 2023 WHO listing into lives saved.

Sources

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