Emergency Operations Centre
Division of Public Health Surveillance and Response
publichealthintelligence@nicd.ac.za
(NICD) 24-hour hotline number: 0800 212 552

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Executive summary

As of 29 October 2026, the Bundibugyo virus disease (BVD) outbreak remains active in the Democratic Republic of the Congo (DRC), with imported cases and linked transmission reported in Kenya and an imported case detected in Nigeria. The latest NICD update, published on 28 October and using data through 26 October, reports 10141 laboratory-confirmed cases and 4928 deaths in the DRC. Kenya has reported nine confirmed cases, including two deaths, all linked to the imported index case. The Nigerian patient was medically evacuated to Switzerland; contact follow-up and investigation continue. WHO advises against restrictions on travel to or trade with affected countries. [1–3]

Cholera remains a multi-country outbreak. The latest ECDC monitoring update, published on 27 October, reports 291272 cases and 2471 deaths globally since 1 January 2026. For countries relevant to Southern Africa, the update gives cumulative totals through 11 October of 50923 cases and 1338 deaths in the DRC; 7892 cases and 66 deaths in Mozambique; and 1773 cases and 37 deaths in Zambia. The same update reports no new information from Zimbabwe since 28 September; therefore, the older Zimbabwe figures should not be presented as current totals. Country totals are not directly comparable because reporting periods, case definitions and completeness vary. [4]

The immediate South African intelligence priorities are to maintain readiness for rapid recognition and isolation of suspected BVD cases; ensure exposure-based contact assessment and cross-border information sharing; and maintain cholera preparedness, particularly for imported cases and water- and sanitation-associated risks. The NICD hotline logged 29 queries during 15–21 October 2026. Patient investigations and rabies post-exposure prophylaxis each accounted for seven queries (24.14%); the private sector generated 21 queries (72.41%). Hotline activity describes service demand and is not a proxy for disease incidence. [1,5]

1. Bundibugyo virus disease: DRC and regional spread

1.1 Current epidemiological situation

Democratic Republic of the Congo

The BVD outbreak was declared in the DRC on 15 May 2026. As of 26 October, the latest NICD update reports 10141 laboratory-confirmed cases, including 4928 deaths, and 2708 recoveries across eight provinces: Ituri, North Kivu, South Kivu, Tshopo, Haut-Uélé, Bas-Uélé, South Ubangi and North Ubangi. Ituri remains the most affected province, with 7247 confirmed cases. These figures are cumulative and may be revised as national surveillance data are updated. [1,2]

Kenya

Kenya reported its first imported case on 6 October 2026 in a traveller who had travelled from the DRC through Uganda. As of 26 October, nine confirmed cases, including two deaths, had been reported. All cases were linked to the initial imported case, and no wider community transmission had been reported. WHO and ECDC report that the last confirmed case was reported on 20 October. On 26 October, 20 contacts had completed the 21-day follow-up period and 98 remained under monitoring; these categories do not account for all 135 contacts initially identified. [2,3]

Nigeria and Switzerland

Nigeria confirmed one imported case in Abuja on 20 October in a patient with recent travel history from Uganda. The patient developed symptoms on 7 October and tested positive on 20 October. By 26 October, 54 contacts had been traced and were under follow-up. ECDC reported that the patient had subsequently been medically evacuated to Switzerland. Investigations into the exposure source and travel history were ongoing. The case does not, by itself, establish local transmission in Nigeria. [2]

Uganda and France

Uganda declared the end of its outbreak on 27 August 2026 after completing 42 days without a new confirmed case; it had reported 20 confirmed cases and two confirmed deaths, plus one probable case and death. France had previously reported one imported case in a healthcare worker returning from the DRC; the patient recovered, and no secondary transmission was reported. These historical events remain relevant to the regional epidemiological record but are not evidence of ongoing local transmission in those countries. [3,6]

1.2 Response and countermeasure developments

Response activities in the DRC include case investigation, laboratory testing, isolation and clinical management, contact tracing, infection prevention and control (IPC), safe and dignified burials, community engagement and surveillance at points of entry. In Kenya, authorities have managed the linked cluster through isolation, contact tracing, quarantine or monitoring of contacts, and IPC measures. Nigeria activated its incident management arrangements and is conducting case investigation, contact tracing and IPC activities with partner support. [2,3]

The WHO outbreak update of 23 October stated that the risk assessment was being revised in light of the evolving situation. WHO advises against restrictions on travel to or trade with affected countries. This does not preclude targeted public-health measures for suspected cases and identified contacts, consistent with national law and outbreak-specific guidance. [3]

1.3 Regional and South African implications

The importation events in Kenya and Nigeria demonstrate that infected travellers may move through regional aviation hubs before diagnosis. South Africa should maintain a complete recent travel and exposure history for patients with compatible illness, including transit countries, healthcare contacts, funeral exposures and contact with body fluids. Temperature screening alone cannot exclude infection in an asymptomatic person during the incubation period. Suspected cases should be notified immediately, isolated promptly and assessed under current national viral haemorrhagic fever guidance. [1,3]

Preparedness should prioritise clinician awareness, access to appropriate personal protective equipment, referral pathways, laboratory coordination, contact tracing capacity and clear communication with Port Health Services and neighbouring countries. Blanket travel restrictions are not supported by WHO's current advice. Any compulsory isolation or quarantine measure must be based on the applicable South African legal framework and individual public-health circumstances.

1.4 Public health intelligence assessment

Indicator	Assessment as of 29 October 2026
DRC outbreak	Ongoing; 10141 confirmed cases and 4928 deaths reported through 26 October.
Regional spread	Imported cases with linked transmission reported in Kenya; one imported case detected in Nigeria.
Kenya cluster	Nine confirmed cases, two deaths; all linked to the index case; no wider community transmission reported.
Nigeria	One imported case; patient medically evacuated to Switzerland; 54 contacts under follow-up as of 26 October.
South Africa	No confirmed case identified in the cited NICD and international updates; maintain preparedness and rapid detection.
WHO travel advice	WHO advises against restrictions on travel to or trade with affected countries.

Intelligence assessment: Watch – escalating regional relevance. This is an operational assessment for South African preparedness, not a WHO risk category. The outbreak remains concentrated in the DRC, but imported cases in Kenya and Nigeria reinforce the need for vigilance, travel-history assessment and response readiness. [1–3]

2. Cholera in Southern and Central Africa

2.1 Overview and background

Cholera is an acute diarrhoeal infection caused by ingestion of food or water contaminated with toxigenic Vibrio cholerae. Severe illness can cause rapid dehydration and death without prompt rehydration and appropriate treatment. Transmission is associated with unsafe water, inadequate sanitation and hygiene, and conditions that disrupt water and

health services. Case and death totals published by different countries are affected by differing case definitions, surveillance capacity, reporting delays and under-ascertainment. [4,7]

The ECDC global monitoring update published on 27 October 2026 reports 291272 cholera cases and 2471 deaths worldwide from 1 January to 27 October. For the period 28 September to 27 October, 42136 new cases and 501 new deaths were reported. These global aggregates include data from multiple surveillance systems and should be interpreted with the source's stated limitations. [4]

2.2 Current epidemiological situation

Democratic Republic of the Congo

The ECDC update reports 50923 cumulative cases and 1338 deaths from 1 January to 11 October 2026. Between 13 September and 11 October, 9236 cases and 288 deaths were reported. These figures indicate substantial ongoing reported burden; they are not a count through 27 October. [4]

Mozambique

The ECDC update reports 7892 cumulative cases and 66 deaths from 1 January to 11 October 2026. Seventy-eight new cases were reported between 13 September and 11 October. The update does not provide a later national cumulative total through 27 October. [4]

Zambia

The ECDC update reports 1773 cumulative cases and 37 deaths from 1 January to 11 October 2026, including 699 cases and 18 deaths reported between 13 September and 11 October. Other reports published later in October have cited higher totals, but they do not use the same reporting cut-off. The 11 October figures are therefore retained here as the latest internally consistent country data in the ECDC update, not as the current total on 29 October. [4]

Zimbabwe

The ECDC update states that no new information had been reported from Zimbabwe since 28 September. The latest detailed information identified in the previous surveillance review was an IFRC emergency overview dated 8 September, which described reported cases in Manicaland and Midlands provinces. Because that report is dated and does not provide a national total current to late October, those figures are not presented as the current cumulative burden. Updated national surveillance data are required. [4,8]

Angola and other countries in the region

The ECDC update also records cholera activity in Angola and several other African countries. For Angola, it reports 6940 cumulative cases and 132 deaths from 1 January to 11 October 2026, including 289 cases and five deaths between 13 September and 11 October. These data are included as regional context; the report does not imply that all listed countries share the same outbreak source or transmission chain. [4]

2.3 Response and countermeasure developments

The regional response to cholera includes case detection and management, laboratory confirmation where available, oral rehydration and intravenous fluids for severe dehydration, safe water provision, water treatment, sanitation, hygiene promotion, risk communication and oral cholera vaccination where indicated. Response activities and vaccination progress vary by country and reporting period; allocations of vaccine doses should not be interpreted as doses administered or as population coverage. [4,7]

WHO's 8 October 2026 rapid risk assessment characterised cholera as a significant regional public-health concern. The assessment is regional and should not be interpreted as a specific risk rating for South Africa. [5]

2.4 Regional and South African implications

Mozambique, Zimbabwe and Zambia are relevant to South Africa because of geographic proximity, cross-border movement and shared regional transport and trade links. The DRC and Angola also contribute to the wider regional picture. These factors make imported cases plausible, but the available regional data do not quantify the probability of importation into South Africa. No South African outbreak or local transmission should be inferred from neighbouring-country reports alone.

South African preparedness should include clinician awareness of acute watery diarrhoea and relevant travel or exposure histories; timely notification and investigation of suspected cases; laboratory readiness; access to appropriate rehydration

and treatment; and coordination between Port Health, provincial and district teams. Water and sanitation monitoring remains important where local conditions suggest exposure risk. Safe-water messaging should follow advice from the responsible water services and public-health authorities. [5,7]

2.5 Public health intelligence assessment

Indicator	Assessment as of 29 October 2026
Regional situation	Ongoing multi-country cholera activity; ECDC reported 291272 cases and 2471 deaths globally through 27 October.
Southern/Central African burden	Latest internally consistent country data in the ECDC update are through 11 October for DRC, Mozambique, Zambia and Angola.
Zimbabwe data	No new update reported to ECDC since 28 September; the last detailed source identified is dated 8 September.
South African relevance	Importation is plausible given regional movement; no inference of local transmission is warranted from regional data alone.
Key information gap	Updated primary national surveillance reports are needed to establish country totals after the ECDC data cut-off.

Intelligence assessment: Watch. Regional cholera transmission and uneven access to safe water and sanitation warrant continued surveillance and preparedness. The assessment is based on the documented regional burden and proximity of affected countries; it is not a formal WHO risk category for South Africa. [4,5]

3. Cross-event public health intelligence priorities

Priority	Operational intelligence requirement
Verification	Use the latest dated national surveillance updates; retain the reporting cut-off and case definition for every figure.
Clinical readiness	Ensure clinicians can recognise suspected BVD and cholera, notify promptly and initiate appropriate infection prevention or rehydration pathways.
Travel and exposure histories	For suspected BVD, document countries visited, transit points, healthcare contact, funeral exposure and other relevant contact with body fluids. For cholera, assess travel and water/food exposures.
Laboratory coordination	Maintain referral pathways and communicate specimen handling and testing requirements through the responsible national reference laboratories.
Cross-border information sharing	Maintain information exchange with neighbouring countries, Port Health and regional surveillance partners.
Water, sanitation and hygiene	Monitor reported water-quality failures and sanitation disruptions; align public messaging with competent water and health authorities.
Data quality	Do not compare cumulative totals with different cut-off dates as if contemporaneous; distinguish confirmed, suspected and probable cases, and do not calculate CFRs from mismatched denominators.

4. NICD hotline activity: 15–21 October 2026

A total of 29 queries were logged on the NICD Query Logging System during 15–21 October 2026. Patient investigations requiring diagnostic or clinical advice and rabies post-exposure prophylaxis each accounted for seven queries (24.14% each). Administrative queries and requests for results accounted for five each (17.24% each). Infection-control enquiries

accounted for two queries (6.90%), while vaccine-related enquiries and requests concerning a laboratory-confirmed case for clinical or public-health management each accounted for one query (3.45%).
Gauteng contributed 10 queries (34.48%), followed by the Western Cape with seven (24.14%) and KwaZulu-Natal with six (20.69%). The private sector accounted for 21 queries (72.41%), compared with eight (27.59%) from the public sector. These data describe hotline workload for the specified period; they are not a measure of disease incidence and do not establish a relationship between hotline calls and the BVD or cholera events discussed in this report.

Table 1. Summary of NICD hotline queries, 15–21 October 2026

Category	Number	Percentage (%)
Disease query		
Patient investigation (diagnostic/clinical advice)	7	24.14
Rabies post-exposure prophylaxis	7	24.14
Administrative	5	17.24
Results	5	17.24
Infection control	2	6.90
Vaccine-related enquiry	1	3.45
Laboratory-confirmed case for clinical/public-health management	1	3.45
Animal/environmental health	1	3.45
Province		
Gauteng	10	34.48
Western Cape	7	24.14
KwaZulu-Natal	6	20.69
Limpopo	2	6.90
Mpumalanga	2	6.90
North West	1	3.45
Eastern Cape	1	3.45
Sector		
Private	21	72.41
Public	8	27.59
Total	29	100.00

5. Overall public health intelligence assessment

The BVD outbreak remains active in the DRC, with linked transmission in Kenya and an imported case detected in Nigeria. The latest available data support continued South African preparedness focused on early recognition, immediate isolation of suspected cases, contact management, travel and exposure histories, and coordination across national and regional response systems. WHO advises against restrictions on travel to or trade with affected countries. [1–3]
Cholera continues to affect multiple countries, including countries in Southern and Central Africa. The latest ECDC country figures for several countries are based on data through 11 October, while no newer update was reported for Zimbabwe. These cut-offs must remain visible in any onward use of the figures. For South Africa, the principal implications are readiness to detect imported cases, clinical and laboratory preparedness, and surveillance of relevant water, sanitation and hygiene risks. The sources cited do not establish a direct epidemiological link between the BVD and cholera events. [4,5]
Overall assessment: maintain heightened surveillance and response readiness for BVD and cholera, with disease-specific operational measures and routine review as new official data become available.

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