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Event-Based Surveillance 15 May 2026

Contents

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Africa

Ebola Virus Disease (EVD) Outbreak detected in Ituri Province, Democratic Republic of the Congo, 15 May 2026

Overview and Background: On 15 May 2026, the Africa Centres for Disease Control and Prevention (Africa CDC) confirmed a new outbreak of Ebola Virus Disease (EVD) in the Ituri Province of the Democratic Republic of the Congo (DRC). Preliminary laboratory results from the National Institute for Biomedical Research (INRB) in Kinshasa detected Ebola virus in 13 of 20 samples tested. Initial molecular characterization suggests a non-Zaire ebolavirus species, such as *Sudan ebolavirus* or *Bundibugyo ebolavirus*, with genetic sequencing ongoing to confirm the specific strain. As of 15 May 2026, 246 suspected cases and 65 deaths have been reported, primarily concentrated in the Mongwalu and Rwampara health zones. Four deaths have been confirmed among the laboratory-positive cases [Case fatality rate (CFR) = 4/13; 30.77%], while suspected cases in the provincial capital, Bunia, are currently pending validation.

This event follows the recent conclusion of the 16th recorded Ebola outbreak in the DRC, which occurred in the Bulape Health Zone, Kasai Province. That outbreak was declared on 4 September 2025 and was caused by the Zaire strain. The index case was identified as a 34-year-old pregnant woman whose death in late August triggered community transmission among close contacts and healthcare workers. A total of 64 cases were recorded (53 laboratory-confirmed, 11 probable) with 45 deaths, resulting in a high CFR of 70.3%. Following a 42-day countdown after the last patient was discharged, the outbreak was declared over on 1 December 2025 (Africa CDC, 2025; WHO, 2025).

The DRC is currently transitioning through its rainy season, which typically lasts from October to May in the central and southern regions. This period impacts public health logistics and disease dynamics by complicating the physical delivery of medical supplies and the mobility of rapid response teams (RRTs). Heavy rainfall frequently renders unpaved roads impassable, delaying the transport of laboratory samples from remote areas like Mongwalu to central testing facilities. Additionally, the season alters disease dynamics; high absolute humidity and lower temperatures increase the environmental stability of ebolaviruses on surfaces and in droplets, while flooding can lead to the contamination of water sources (Ng et al., 2014; Westhoff Smith et al., 2016). The increase in other seasonal illnesses during this time, such as malaria and respiratory infections, often creates a diagnostic "masking" effect, where early Ebola symptoms are mistaken for more common febrile conditions, leading to delays in isolation and increased community transmission. Because early Ebola symptoms are easily mistaken for these more common febrile conditions, there are frequent delays in patient isolation, which contributes to increased community transmission (NICD, 2024; WHO, 2011).

About Ituri Province, DRC

Ituri Province is situated in the north-eastern DRC, bordered by Uganda to the east and South Sudan to the north. The region is characterized by a diverse topography consisting of dense tropical rainforests, particularly the Ituri Forest, as well as savannahs and highlands. The environment serves as a natural habitat for various wildlife, including fruit bats of the *Pteropodidae* family, which are recognized as the primary natural reservoir for Ebola viruses (WHO, 2011). The potential cause of spillover into human populations is often linked to the bushmeat trade or contact with infected animals such as non-human primates or forest antelopes. The province's economy includes artisanal mining, particularly in the Mongwalu area, and agriculture. These activities increase human encroachment into primary forests, heightened by the province's population growth and the rapid expansion of urban centers like Bunia (Mecsas & Olson, 2021).

The public health landscape in Ituri is challenged by limited infrastructure and ongoing insecurity, which hampers access to formal healthcare facilities. Much of the population depends on subsistence farming, and rural areas often experience low health literacy regarding preventive measures such as safe burial practices and vaccination (Africa CDC, 2026). The crude mortality rates in these regions are exacerbated by high rates of malnutrition and endemic diseases like tuberculosis, HIV, and various neglected tropical diseases. In the context of EVD, the environmental stability of the virus is higher in the shaded, humid forest floor, making localized transmission cycles difficult to break without intensive community engagement and infection prevention and control (IPC) measures (Westhoff Smith et al., 2016).

Ebola outbreaks in the DRC: The DRC has historically experienced a higher frequency of Ebola outbreaks than any other nation, with documented events dating back to the first recognized emergence of the virus. The inaugural outbreak occurred in 1976 in Yambuku, involving the Zaire strain, and resulted in a case fatality rate (CFR) of 88% (Rosello et al., 2015). Subsequent major events include the 2014 outbreak in Boende (CFR=74.2%) and the tenth outbreak between 2018 and 2020 in North Kivu and Ituri, which stands as the most extensive in its history with 3 470 cases and 2 280 deaths (CFR=66%) (Africa CDC, 2026). In recent years, the frequency has remained high, with the 11th outbreak in Mbandaka (2020) recording 130 cases and the 14th outbreak (2022) resulting in 5 deaths for its 5 recorded cases. The most recent 16th outbreak in Bulape (2025) concluded with 64 cases and 45 deaths (WHO, 2025).

EVD signs and symptoms: The clinical presentation of EVD is characterized by a sudden and severe onset of illness following an incubation period that typically ranges from 2 to 21 days (NICD, 2021; WHO, 2024). Initially, patients present with non-specific, "flu-like" symptoms including a fever greater than 38.5°C, intense fatigue, muscle pain (myalgia), severe headache, and a sore throat. As the disease progresses rapidly, these early signs are followed by gastrointestinal distress such as vomiting, abdominal pain, and profuse diarrhoea.

In advanced stages, the virus causes systemic failure, which may manifest as a maculopapular rash and impaired kidney and liver function. In some cases, internal and external bleeding occurs, which can include oozing from the gums, blood in the stools (melaena), or bleeding into the skin (purpura) and eyes (Africa CDC, 2026; NICD, 2021). Laboratory findings at this stage often show low white blood cell and platelet counts alongside elevated liver enzymes. Because these symptoms mirror other endemic diseases like malaria and typhoid fever, early clinical diagnosis remains a significant challenge (WHO, 2024).

Public health actions: Africa CDC has convened high-level coordination meetings with health authorities from the DRC, Uganda, and South Sudan to synchronize cross-border surveillance. INRB teams have been deployed to the affected zones to conduct real-time genomic sequencing. Authorities have advised against contact with the deceased and are implementing safe and dignified burial protocols. Emergency medical supplies and PPE are being mobilized for Bunia to support the local clinical response (Africa CDC, 2026)

Implications for South Africa: South Africa remains at a low risk of importing EVD cases through air travel and trade. While the outbreak is currently rural, the potential for undetected cases to reach urban transit hubs like Kinshasa remains a concern. Historical data shows consistent travel between the nations via OR Tambo and Cape Town. While EpiRisk analysis suggests a low immediate probability (0.03%) of importation, the unknown nature of a non-Zaire species necessitates enhanced surveillance and diagnostic readiness to identify strains that may not respond to Zaire-specific medical countermeasures (Epirisk, 2024; NICD, 2026).

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Cholera Outbreak Situation in the Southern African Development Community (SADC) Region and Implications for South Africa, 2026

The Southern African Development Community (SADC) region continues to experience ongoing cholera outbreaks in 2026, with several countries reporting sustained transmission linked to flooding, population displacement, inadequate water and sanitation infrastructure, and cross border population movement. According to the World Health Organization (WHO), cholera cases in Southern Africa increased more than seven fold during the first six weeks of 2026 compared with the same period in 2025 (World Health Organization [WHO], 2026a). WHO further reported that between 1 January and 15 February 2026, the Southern African region recorded 4,320 cholera cases and 56 deaths across five countries in the region (WHO, 2026a).

Angola continues to report one of the largest cholera outbreaks within the SADC region. According to Reuters, by March 2025 Angola had reported 6,564 cholera cases and 237 deaths, with transmission continuing into

2026, particularly in provinces bordering Namibia (Reuters, 2025). WHO regional situation updates continued to identify Angola among countries experiencing active cholera transmission during 2026 (WHO, 2026a).

Malawi also continues to experience ongoing cholera transmission. The Public Health Institute of Malawi reported that as of 16 February 2026, the country had recorded 828 suspected cholera cases, including 87 laboratory confirmed cases and two deaths. The outbreak has mainly affected the districts of Chikwawa, Blantyre, Lilongwe, and Kasungu (Public Health Institute of Malawi, 2026).

Mozambique is currently the most affected country in the SADC region during 2026. WHO reported that Mozambique accounted for approximately 90% of cholera cases reported in Southern Africa during the early part of the year, largely following severe flooding and cyclone related displacement (WHO, 2026b). According to the Africa Centres for Disease Control and Prevention (Africa CDC), Mozambique reported 2 496 new cholera cases and 20 deaths between February and March 2026 (Africa CDC, 2026).

Namibia has also reported renewed cholera activity after nearly a decade without confirmed cases. Reuters reported that Namibia confirmed its first cholera case in ten years in March 2025 in the Kunene region bordering Angola (Reuters, 2025). Between 1 January - 29 March 2026, the ministry of health has reported 213 cases and 57 deaths, WHO and the European Centre for Disease Prevention and Control (ECDC) continued to identify Namibia among countries with active cholera transmission during 2026 (WHO, 2026b; ECDC, 2026).

Tanzania continues to report sporadic cholera transmission in 2026. According to the World Health Organization multi country cholera epidemiological updates between 1 January to 29 March 2026 and 27 March 2026. No new cases were reported in the past 28 days (WHO, 2026a; WHO, 2026b).

Zambia remains affected by an ongoing cholera outbreak that was first detected in August 2025. According to the Zambia Ministry of Health, as of 3 February 2026 the country had recorded 861 cumulative cholera cases and 16 deaths, with cases reported across 20 districts in eight provinces. Northern Province, particularly Mpulungu District, remained the epicentre of the outbreak (Zambia Ministry of Health, 2026).

Zimbabwe also continued to report low level cholera transmission in 2026. WHO regional reporting indicated that Zimbabwe was among the Southern African countries reporting active outbreaks between 1 January and 29 March 2026. During this period, a combined total 32 cholera cases and 2 deaths were reported (WHO, 2026c).

Public health actions: World Health Organization has identified 27 high risk zones across five Southern African countries, driven by vulnerabilities such as inadequate water, sanitation and hygiene infrastructure and the recurrence of cholera outbreaks. The organisation has called for the urgent expansion of public health interventions, including oral cholera vaccination, strengthened disease surveillance, and improvements in water and sanitation services, to prevent further escalation of the outbreaks (WHO, 2026a).

WHO has also highlighted several key response priorities for affected countries, including enhancing epidemiological surveillance systems, strengthening laboratory diagnostic capacity, improving access to quality treatment and case management, implementing effective water, sanitation and hygiene (WASH) and infection prevention and control (IPC) measures, promoting community engagement in cholera prevention activities, and supporting access to and rollout of oral cholera vaccine campaigns (WHO, 2026b). Furthermore, WHO warned that without timely and coordinated interventions centred on surveillance, case management, vaccination,

WASH measures, and cross border collaboration, cholera transmission is likely to continue spreading across the region (WHO, 2026b).

Africa CDC has similarly advocated for comprehensive cholera prevention and control strategies, including strengthened surveillance, improved access to safe water and sanitation, enhanced hygiene practices, social mobilisation, effective clinical management, and the use of oral cholera vaccines (Africa CDC, 2026). In collaboration with WHO, Africa CDC launched the Continental Cholera Emergency Preparedness and Response Plan for Africa 1.0 and established a Continental Cholera Incident Management Support Team operating under the "4 One" principle of one team, one plan, one budget, and one monitoring framework. The initiative aims to reduce cholera related deaths by 90% and eliminate cholera in more than 20 African countries by 2030 (Africa CDC & WHO, 2025).

Implications for South Africa: South Africa is not currently experiencing any active cholera outbreak, continued transmission in neighbouring SADC countries presents an ongoing risk of importation through cross border travel and population movement. Border provinces and districts with high mobility may remain particularly vulnerable, especially in areas with inadequate sanitation and limited access to safe water. Continued surveillance, laboratory preparedness, health promotion activities, water quality monitoring, and strengthened cross border collaboration remain essential to prevent, rapidly detect, and respond to imported cholera cases. According to the Africa Centres for Disease Control and Prevention, the risk to South Africa is assessed as high due to the potential importation of cholera cases from other neighbouring countries in Southern Africa, particularly in the context of ongoing cross border population movement.

Cholera is not endemic in South Africa but occurs in episodic outbreaks, typically linked to unsafe water systems and sanitation breakdowns rather than sustained community transmission. All suspected and confirmed cholera cases are classified as notifiable medical conditions (NMC) and are subject to immediate mandatory reporting, investigation and public health response through national surveillance systems coordinated by the Department of Health within 24 hours of clinical suspicion or laboratory confirmation (NDoH, 2023a; NICD, 2024). The most recent major cholera outbreak in South Africa occurred in 2023, with highest cumulative numbers identified in Hammanskraal, Tshwane, Gauteng Province. Between 1 February and 4 July 2023, 198 laboratory confirmed cases were reported nationally, with 47 associated deaths from both confirmed and suspected cases (NDoH, 2023a; NDoH, 2023b).

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South Africa

Avian Influenza Virus Detected in a Cape Fur Seal in the Western Cape, South Africa

Overview: On 8 May 2026, media reports confirmed that a Cape fur seal from Mossel Bay in the Western Cape tested positive for highly pathogenic avian influenza (HPAI), marking the first documented detection of avian influenza virus in a seal in South Africa. The infected seal was captured at The Point, Mossel Bay, on 9 April 2026 after presenting with respiratory distress and abnormal behaviour. Following euthanasia, samples tested positive for both rabies and HPAI (Mossel Bay Advertiser, 2026).
The detection occurs in the context of ongoing HPAI activity in South Africa, including outbreaks among poultry and wild seabirds in several provinces, particularly the Western Cape. Previous avian influenza outbreaks in the province resulted in significant mortality among seabirds, especially Cape cormorants and other coastal bird species. Seal deaths associated with avian influenza were previously investigated during the 2021 Western Cape seabird outbreak, although laboratory confirmation in seals had not been documented at that time (CapeNature, 2021).

Globally, HPAI H5N1 clade 2.3.4.4b has increasingly demonstrated spillover into mammalian species, including seals, sea lions, foxes, cats, cattle, and other wildlife species. Large scale mortality events among marine mammals linked to avian influenza have previously been reported in South America and other regions (Food and Agriculture Organization [FAO], 2025).

Public Health Actions
Veterinary and wildlife authorities collected samples from the affected seal for diagnostic testing following its capture and euthanasia. The case was investigated collaboratively by veterinary services, marine wildlife rescue

organisations, and animal health authorities. Public messaging was issued warning residents and beach visitors to avoid direct contact with seals, dead seabirds, or stranded marine mammals (Mossel Bay Advertiser, 2026). Authorities and wildlife rescue organisations further advised the public to:

- Avoid handling sick or dead seals and seabirds
- Keep pets away from marine mammals and bird carcasses
- Report unusual wildlife illness or mortality events to veterinary or conservation authorities
- Ensure the use of appropriate personal protective equipment (PPE) by individuals involved in animal rescue or carcass handling activities (Mossel Bay Advertiser, 2026)

South Africa continues active and passive surveillance for HPAI in poultry and wildlife populations. Ongoing outbreak response measures include quarantine of affected poultry farms, culling of infected birds, movement restrictions, and enhanced surveillance in high risk areas (Department of Agriculture, Land Reform and Rural Development [DALRRD], 2026).

Implications for South Africa: The confirmation of HPAI infection in a Cape fur seal raises concern regarding interspecies transmission and adaptation of avian influenza viruses to mammalian hosts. The Western Cape coastline hosts large populations of seabirds and marine mammals, creating opportunities for continued spillover events where infected birds and seals interact in shared coastal ecosystems.

Although the current public health risk to the general population is considered low, occupational groups such as veterinarians, wildlife rescue personnel, conservation workers, and individuals involved in handling infected animals may face increased exposure risk. The concurrent detection of rabies and HPAI in the same seal further complicates wildlife health management and highlights the importance of a coordinated One Health response involving animal, environmental, and human health sectors (Mossel Bay Advertiser, 2026). The event also has potential implications for biodiversity conservation, tourism, and marine ecosystem health in South Africa. Previous international outbreaks of HPAI among marine mammals have resulted in reported mortality events, emphasizing the importance of strengthened surveillance and rapid response mechanisms. The Garden Route and West Coast are major tourism corridors. Seal colonies at Mossel Bay, Plettenberg Bay, and Hout Bay attract significant visitor numbers raising concerns of potential exposure. Continued monitoring of wild birds and marine mammals along the South African coastline will be essential to detect additional cases and assess the potential for sustained mammalian transmission (FAO, 2025).

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NICD Hotline

Period: 30 April – 06 May 2026

Statistics of Calls:
Total calls: 16 queries logged on the Query Logging System (QLS).
Table 1. Summary of queries

Disease Query	Number	Percentage (%)
Rabies post-exposure prophylaxis	9	60.00
Patient(s) investigation (diagnostic/clinical advise)	3	20.00
Administrative	2	13.33
Non-rabies post-exposure prophylaxis	1	6.67
Province		
Western cape	6	40.00
Gauteng	5	33.33
Eastern Cape	2	13.33
North West	1	6.67
Kwa-Zulu Natal	1	6.67
Sector		
Private	8	53.33
Public	7	46.67
Total	15	100

Unfolding events

Severe weather resulting in fatalities, mass displacement, and ongoing recovery efforts, Western Cape, 15 May 2026

Overview: As of 15 May 2026, the Western Cape Department of Health and Wellness (WCDHW) confirmed that the cumulative death toll from the severe storm systems has reached 10 fatalities (SA News, 2026). The initial weather warnings were issued by the South African Weather Service (SAWS) on 10 May 2026. The arrival of a cut-off low-pressure system (primary driver of the Orange Level 8 warnings), a phenomenon characterized by a slow-moving, intense rainfall profile, has resulted in the displacement of approximately 83 184 residents in the province (Cape {town} Etc, 2026; ReliefWeb, 2026). Following the declaration of a National State of Disaster on 11 May 2026, authorities mandated province-wide school closures to mitigate the risk to learners and staff from navigating submerged or unstable road networks (Daily Maverick, 2026; Western Cape Government, 2026). Informal settlements in Khayelitsha, Lwandle, and Gugulethu remain the most severely impacted areas, with approximately 21 000 dwellings sustaining notable structural damage (Ground News, 2026).

The evolving conditions carry public health implications. Extensive flooding and infrastructure damage led to contamination of water sources and disruption of essential health services. In rural and farming communities, where drainage systems are often vulnerable, stagnant water increases the risk of water-borne diseases such as cholera and typhoid (CDC, 2017; NICD, 2026). Additionally, respiratory illnesses are a heightened risk, as cold temperatures and increased indoor crowding in emergency shelters can facilitate the transmission of respiratory viruses, such as influenza (Eccles, 2005). Vulnerable populations are at the greatest risk (WHO, 2011), as indoor crowding facilitates the transmission of viruses through droplets and aerosols (CDC, 2023),

with some viruses showing increased stability in colder, less humid environments (Mecsas & Olson, 2021). The suspension of school-based feeding programmes and the loss of household food reserves may also exacerbate nutritional vulnerabilities among learners in lower-income households.

Public health actions: Provincial disaster management teams remain fully activated to coordinate emergency relief for isolated communities. The WCDHW and the Western Cape Education Department (WCED) have prioritised communication with households to prevent stranded learners and reduce travel during hazardous conditions (Makhoba, 2026). Local health authorities have been alerted to monitor for potential increases in gastrointestinal illnesses following the contamination of local runoff water and sewage overflows (NICD, 2026). Healthcare facilities in affected districts have been placed on heightened alert for potential spikes in clinical presentations, while critical reservoirs, including the Clanwilliam Dam, are being monitored as they exceed 103% capacity (SA News, 2026).

Implications for South Africa: Under the Disaster Management Act, this event highlights the critical intersection between climate shifts and public health resilience. The frequency of these closures and mass displacements reflects a growing requirement for climate-resilient infrastructure. According to the Africa CDC risk algorithm, the current situation in the Western Cape is graded as low risk for a large-scale infectious disease outbreak; however, it remains a high-priority localised humanitarian and environmental health emergency requiring sustained inter-sectoral coordination (Africa CDC, 2026).

Recommendations: Authorities should continue to strengthen inter-sectoral coordination between education, health, and disaster management. Residents in the affected districts are urged to avoid low-lying routes and treat all non-piped water during the recovery phase. Health facilities in the Cape Winelands, Central Karoo, and Eden districts should maintain diagnostic readiness for climate-sensitive diseases associated with post-flood conditions and provide psychological support services for residents facing displacement-related trauma (Bhekisisa, 2026).

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