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BUNDIBUGYO VIRUS DISEASE IN NIGERIA: PUBLIC HEALTH IMPLICATIONS AND REGIONAL LESSONS



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NIGERIA'S FIRST IMPORTED CASE OF BUNDIBUGYO VIRUS DISEASE

Overview of the Outbreak

Bundibugyo virus disease (BVD) is a severe infectious disease caused by Bundibugyo virus, first identified during an outbreak in Uganda in 2007 in Bundibugyo district (Towner et al., 2008).

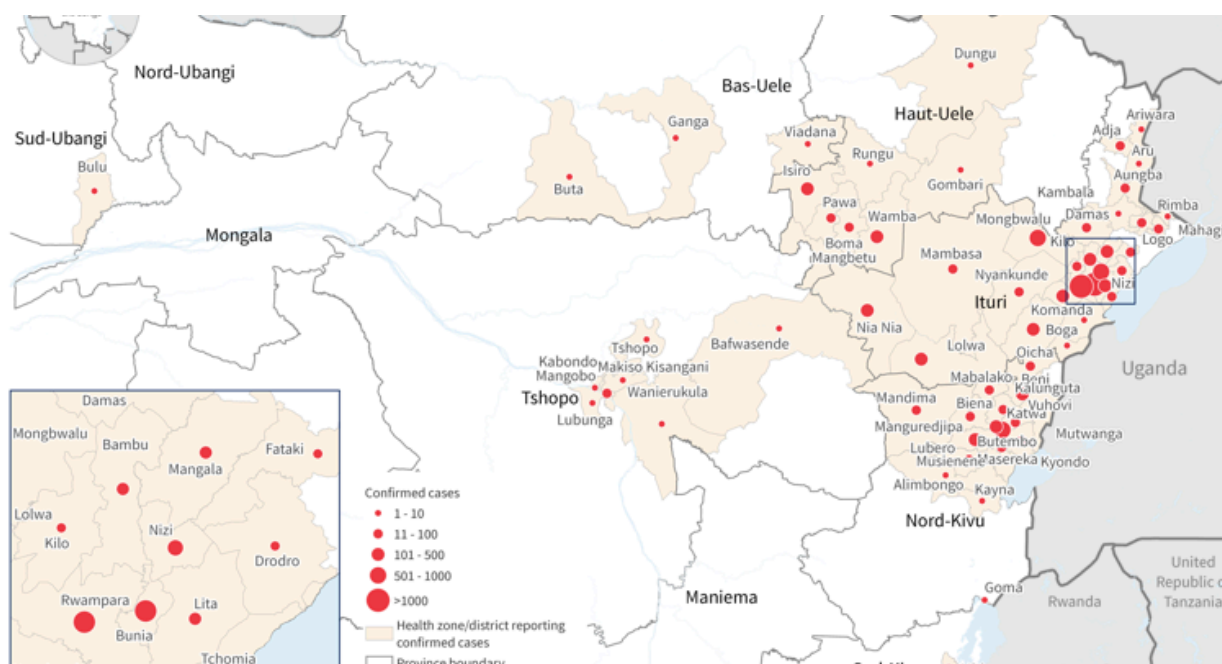
The current outbreak was declared in the Democratic Republic of the Congo (DRC) on 15 May 2026, following laboratory confirmation in Ituri Province, which remains the outbreak's epicentre. Since then, transmission has spread beyond Ituri to seven other provinces: North Kivu, South Kivu, Haut-Uélé, Bas-Uélé, Tshopo, South Ubangi and North Ubangi. As of 23 September, the World Health Organization (WHO) had recorded cases across 63 health zones in seven provinces; by 18 October, the outbreak had reached eight provinces and the DRC had reported 9,552 laboratory-confirmed cases, including 4,602 deaths (WHO, 25 September 2026; NICD, 20 October 2026).

Uganda also reported cases linked to the regional outbreak, including in Kampala, but declared its outbreak over on 27 August 2026. In view of the outbreak's scale and risk of international spread, WHO declared it a Public Health Emergency of International Concern (PHEIC) on 17 May 2026 (WHO, 17 May 2026).

Democratic Republic of the Congo

Confirmed Cases	Confirmed Deaths
9,552	4,602 deaths CFR: 48.2%)

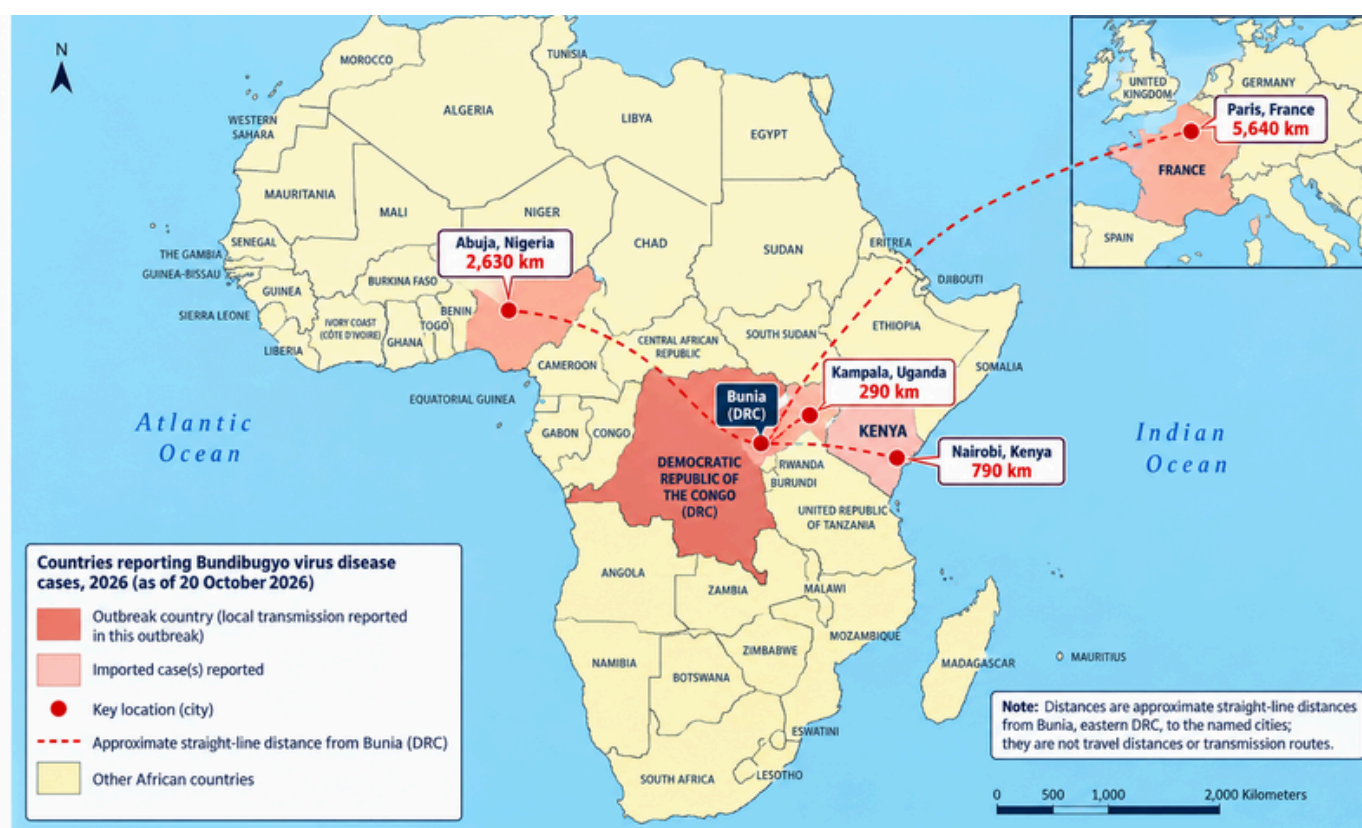
Figure 1. Distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, as of 6 October 2026



International Spread

Beyond the DRC and Uganda, imported cases linked to the outbreak have been reported in France, Kenya and Nigeria. (WHO, 17 July 2026; WHO, 6 October 2026; WHO, 20 October 2026). France confirmed one imported case in June 2026; the report says the patient recovered. Kenya confirmed its first case on 6 October in a patient who is a resident of DRC and had travelled to Nairobi via Uganda; cases identified subsequently in Kenya have been linked to the same cluster (WHO, 6 October 2026). On 20 October, Nigeria confirmed its first imported case in Abuja, involving a woman with a recent travel history to Uganda. At the time of confirmation, 44 contacts had been identified for monitoring, while investigations into the source of infection continued (WHO, 20 October 2026).

Figure 2. Geographic distribution of Bundibugyo virus disease cases and distances from Bunia, DRC, to selected cities.



Nigeria: First Imported Case

On 20 October 2026, the World Health Organization (WHO, 2026a) confirmed Nigeria's first imported case of Bundibugyo virus disease in the Federal Capital Territory (FCT), Abuja. According to the Federal Ministry of Health and Social Welfare (2026), the patient was a woman who had recently travelled to Nigeria from Uganda. She developed symptoms on 7 October and sought medical attention at a private hospital in Abuja on 11 October. Laboratory testing at the Nigeria Centre for Disease Control and Prevention's National Reference Laboratory in Gaduwa, Abuja, confirmed the infection on 20 October (Voice of Nigeria, 2026).

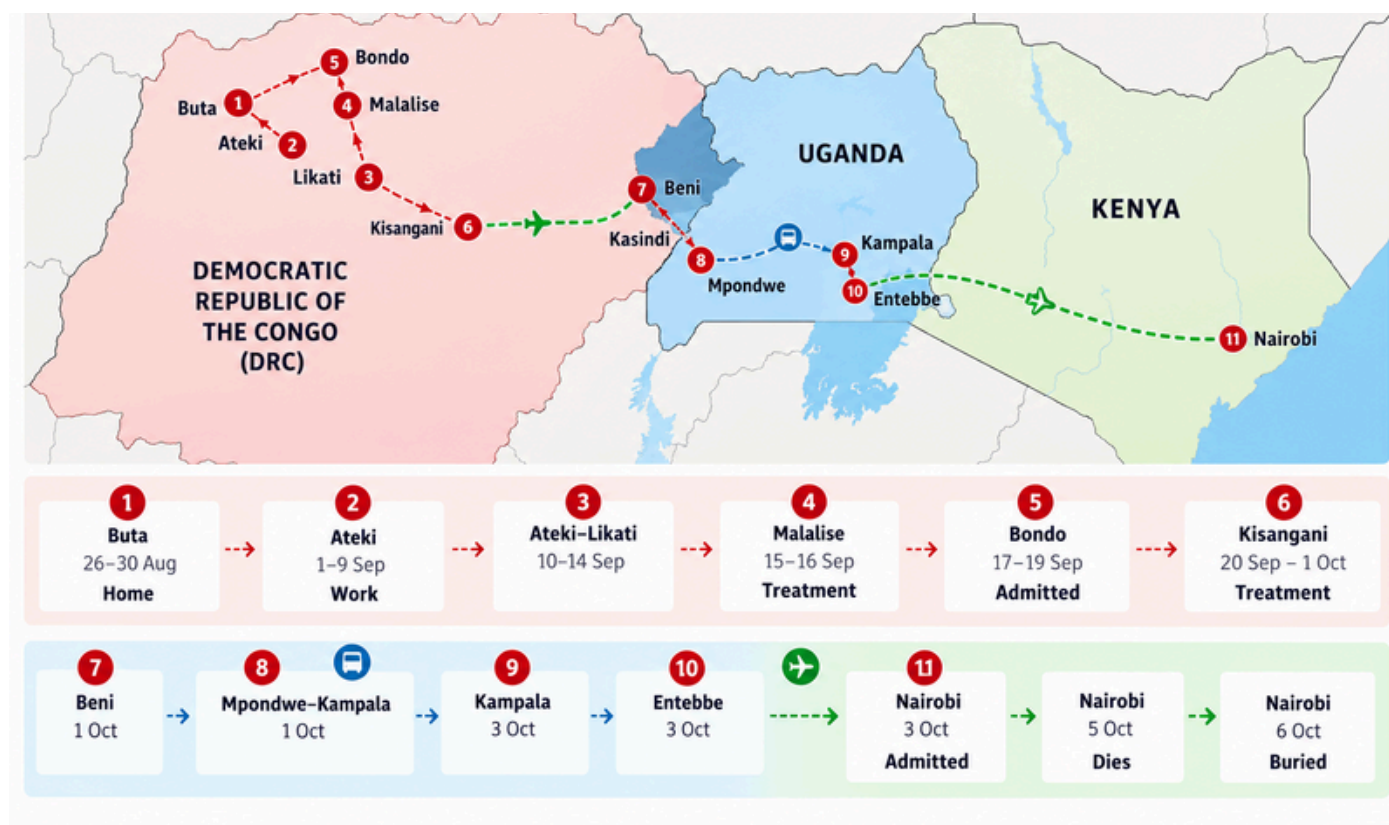
Following confirmation, the patient was isolated for treatment, and public health authorities initiated contact tracing, identifying 44 contacts for monitoring. Response measures also included enhanced surveillance and support for infection prevention and control at the affected health facility (WHO, 2026a). Although the patient had recently travelled from Uganda, the location where she acquired the infection had not been established in the reports reviewed.

Kenya: Imported Case and Transmission

Kenya confirmed its first imported case of Bundibugyo virus disease on 6 October 2026 in a Kenyan man who had been living in the Democratic Republic of the Congo (DRC) (Kenya Ministry of Health, 2026). The patient had reportedly been ill for about a month and had received treatment at several health facilities in the DRC before travelling through Uganda to Nairobi, arriving on 3 October. Laboratory tests conducted by the National Virology Reference Laboratory and the Kenya Medical Research Institute confirmed the infection. He died on 5 October (World Health Organization [WHO], 2026a).

Authorities initially identified 28 contacts, including family members and healthcare workers. Further cases were subsequently detected among people linked to the index patient, and contact tracing was expanded. By 20 October, Kenya had reported nine confirmed cases, including one death. The eight surviving patients were reported to be stable and responding to treatment. All nine cases remained linked to the same cluster, with no evidence of transmission beyond it reported at the time (Centers for Disease Control and Prevention [CDC], 2026; WHO, 2026b).

Figure 3. Travel history and timeline of Kenya's first reported imported Bundibugyo virus disease case.



Comparative Analysis: Kenya and Nigeria

The experiences of Kenya and Nigeria offer important insights into the challenges of responding to imported cases of Bundibugyo virus disease. Although both countries detected cases linked to the regional outbreak, the subsequent course of events has differed. Kenya recorded additional infections among people linked to its first patient, while Nigeria's investigation was still at an early stage following confirmation of its first case on 20 October 2026. The comparison below distinguishes what has been established from the lessons these developments hold for Nigeria.

Kenya confirmed its first imported case of Bundibugyo virus disease on 6 October 2026 in a man who had been living in the Democratic Republic of the Congo (DRC). He travelled through Uganda to Nairobi, arriving on 3 October, and died on 5 October. Laboratory testing by the National Virology Reference Laboratory and the Kenya Medical Research Institute confirmed the infection. Authorities initially identified 28 contacts, including passengers and crew members on the same flight ([Kenya Ministry of Health](#)).

Nigeria confirmed its first imported case on 20 October in a woman with a recent travel history involving Uganda. Her symptoms began on 7 October, and she sought care at a private health facility in Abuja on 11 October. Following laboratory confirmation, she was isolated for treatment, and 44 contacts were identified for monitoring. Investigations into her travel and exposure history remained ongoing ([WHO Nigeria](#)).

By the latest reporting cut-off, Kenya had recorded nine confirmed cases, including one death. The additional cases were linked to the initial patient and included relatives and healthcare workers. Of the 135 contacts identified, 134 had reportedly been traced and quarantined, with no evidence of transmission beyond the identified cluster ([CDC](#); [Nairametrics](#)).

At the same stage of reporting, Nigeria had one confirmed case and 44 identified contacts. The available reports had not established where the patient acquired the infection or provided sufficient follow-up information to determine whether secondary transmission had occurred. The difference in case numbers should be interpreted in light of the different stages of the two investigations, not as evidence that one country's response was more effective.

Recommendations for Nigeria

Strengthen contact tracing and follow-up. Nigeria should ensure that all identified contacts are reached and monitored for the recommended period. Anyone who develops compatible symptoms should be assessed promptly and tested in accordance with national protocols. Kenya's experience demonstrates why monitoring must continue after the initial patient has been identified.

Prevent transmission in healthcare facilities. The infections among healthcare workers in Kenya highlight the importance of strict infection prevention and control. Nigerian authorities should ensure that potentially exposed healthcare workers, patients and caregivers are identified and followed up, and that appropriate protective equipment and safe clinical procedures are consistently applied.

Review the pathway to diagnosis. The Nigerian investigation should document the intervals between symptom onset, the first healthcare visit, consideration of a possible filovirus infection, sample collection and laboratory confirmation. This review could identify opportunities to improve clinical recognition and reduce delays in future cases.

Maintain surveillance beyond points of entry. Traveller screening should be complemented by vigilance in health facilities and communities. Public and private healthcare providers should be alert to compatible symptoms and relevant travel or exposure histories, with clear procedures for reporting, referral, testing and isolation.

Communicate findings clearly and consistently. Public updates should distinguish confirmed cases from suspected cases, report contact-tracing progress and explain new findings without compromising patient confidentiality. Continued information-sharing with WHO, Africa CDC and regional public health authorities will also support coordinated action.

Evaluate the response using comparable indicators. Nigeria should assess its response using measures such as the time from symptom onset to isolation and confirmation, the proportion of contacts successfully traced and monitored, and the detection of secondary cases. These indicators would provide a more meaningful assessment than a comparison of cumulative case counts alone.

Guidance for the Public

1. **Maintain good hand hygiene:** Wash your hands frequently with soap and water or use an alcohol-based hand sanitiser.
2. **Avoid contact with body fluids:** Do not touch the blood, vomit, stool, urine or other body fluids of anyone suspected or confirmed to have the disease.
3. **Recognise symptoms early:** Symptoms may include fever, headache, fatigue, muscle pain, sore throat, vomiting and diarrhoea. Unexplained bleeding may also occur, but is not present in every case.
4. **Seek medical advice promptly:** Anyone who develops compatible symptoms, particularly after possible exposure, should contact a healthcare provider or the relevant public health authority immediately. Call ahead and disclose any travel or exposure history.
5. **Cooperate with contact tracing:** Anyone identified as a contact should follow public health instructions, attend monitoring appointments and report symptoms immediately. Contact monitoring generally continues for 21 days after the last exposure.
6. **Avoid unsafe handling of deceased persons:** Do not touch or handle the body of someone who died with suspected or confirmed Bundibugyo virus disease. Burials should be managed by trained response teams.
7. **Practise food and wildlife safety:** Avoid handling sick or dead wild animals, particularly bats and non-human primates. Do not consume raw or inadequately cooked meat.
8. **Follow official public health guidance:** Obtain updates from the NCDC, Federal and State Ministries of Health, and WHO. Avoid spreading unverified reports or stigmatising people based on their nationality or travel history.

The Global Emerging Pathogens Treatment Consortium (GET) was established in 2014 as a direct response to the 2014-2016 Ebola virus disease outbreaks in West Africa. GET is legally registered in Nigeria, Accra, Ghana, Sierra Leone, and the United States of America. Our primary purpose is to develop African-led and Afrocentric strategies within an international context to address emerging biosecurity threats effectively.



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