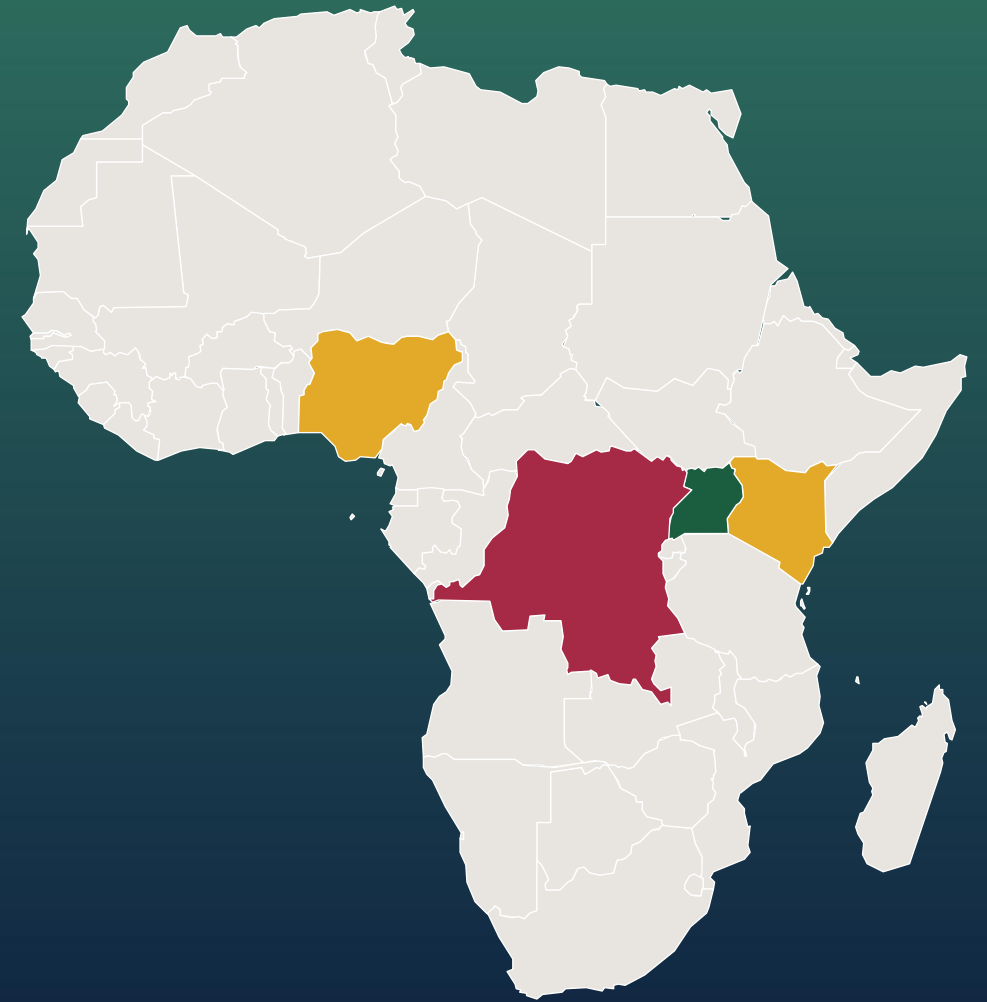


EBOLA 2026: **FROM A NATIONAL** **OUTBREAK TO A** **CONTINENTAL HEALTH** **SECURITY TEST**



Ministerial meeting, 28 October 2026

H.E. Dr. Jean Kaseya
Director General, Africa CDC



AfricaCDC
Centres for Disease Control
and Prevention

Joint BVD Continental IMST

PRESENTATION

- 1. EPIDEMIOLOGY IN AFRICA**
- 2. EPIDEMIOLOGY IN DRC**
- 3. KENYA, NIGERIA...AND RISK OF SPREADING ACROSS AFRICA**
- 4. WHERE ARE WE WITH RESEARCH AND DEVELOPMENT?**
- 5. IMPLICATIONS AND RECOMMENDATIONS TO AFRICAN UNION
MEMBER STATES**

EPIDEMIOLOGY IN AFRICA

10,091 confirmed cases across five reporting countries with 4 African countries (3 African regions)

10,172

confirmed cases

4,932

confirmed deaths

48.5%

crude case fatality

2,727

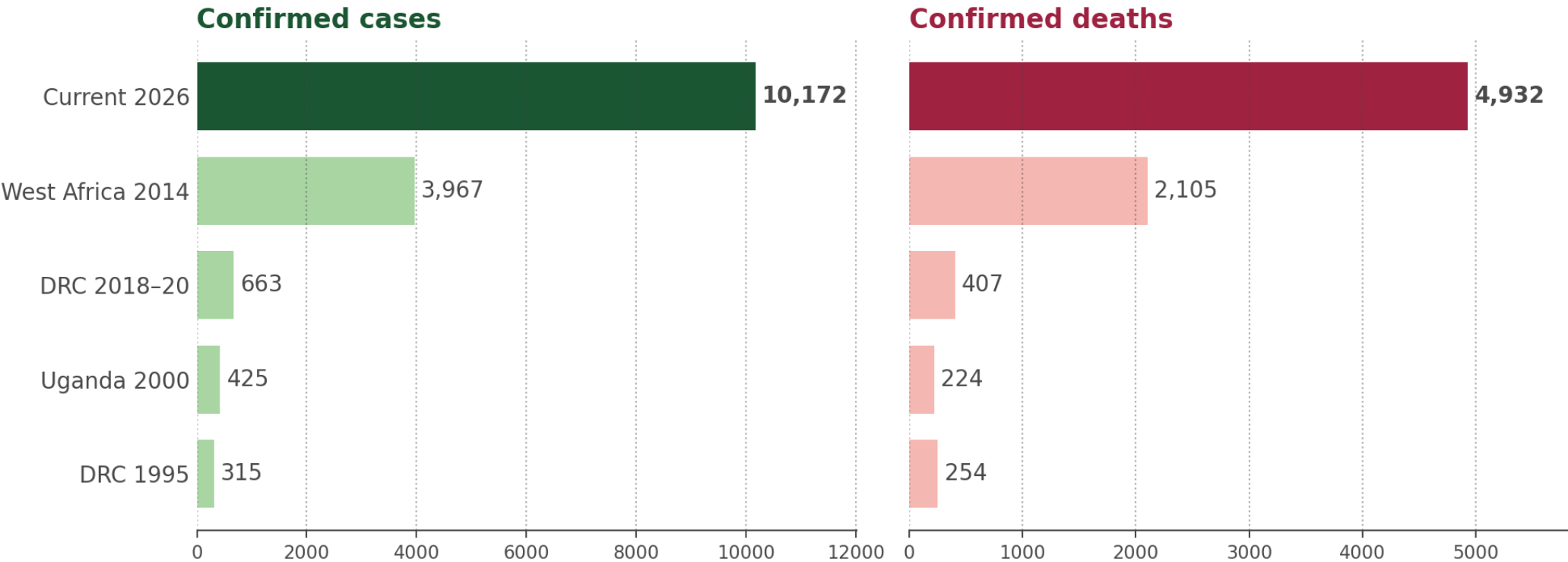
reported recoveries

Country	Cases	Deaths	Current situation
DRC	10,141	4,928	Ongoing community transmission
Uganda	20	2	Outbreak ended; vigilance continues
Kenya	9	2	One linked cluster; contacts under monitoring
Nigeria	1	0	Imported case; medical care in Switzerland
France	1	0	Imported case recovered

Common cumulative baseline: 25 October 2026

At 166 days, this outbreak is 2.6x larger than the West African one (for the same period from declaration)

Reported cases and deaths at a comparable stage



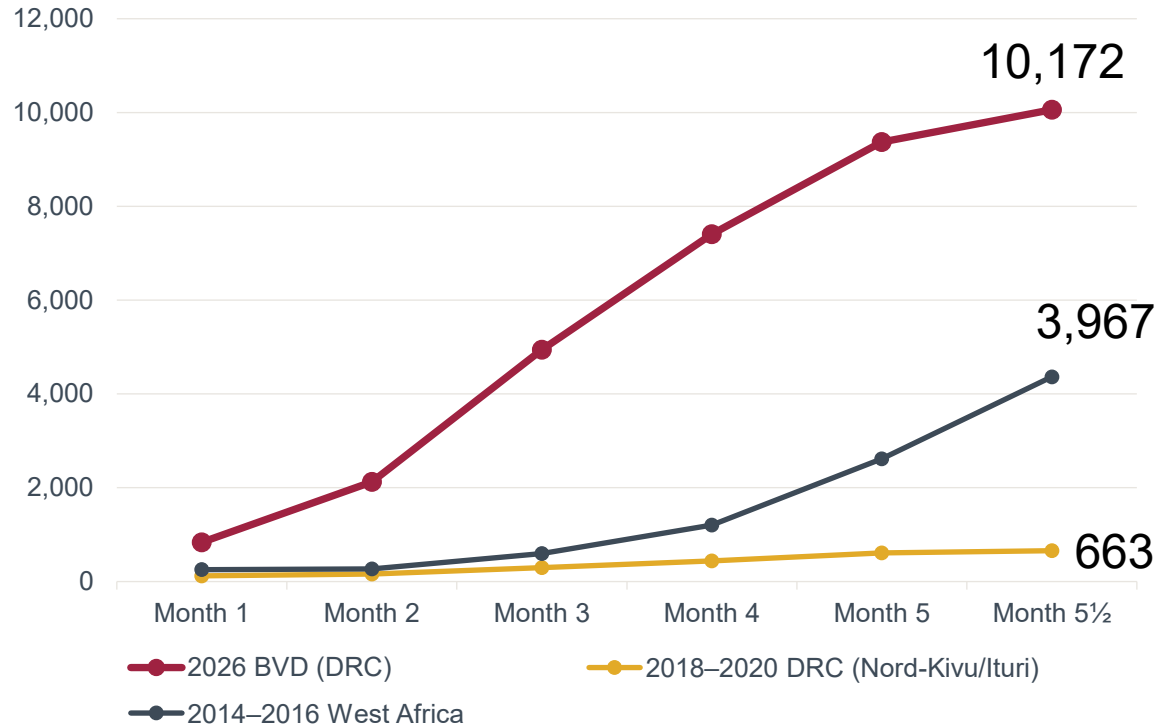
2.6x more cases and 2.3x more deaths than the next-highest comparator at week 24

Current 2026: 10,172 cases / 4,932 deaths (week 24, 166 days since declaration 2026-05-15; affected: Uganda, Kenya and DRC). Case ref: West Africa 2014; death ref: West Africa 2014.

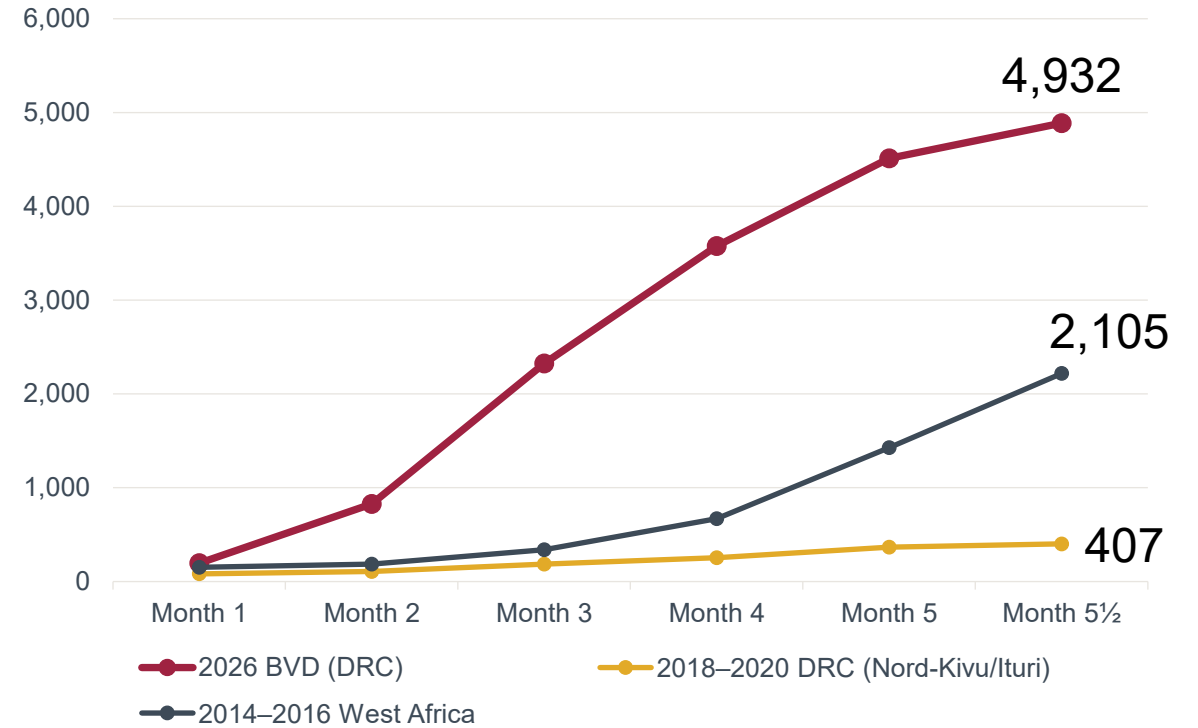
Same clock, three outbreaks: 2026 is far ahead of 2018–2020 and 2014–2016 every month

Cumulative cases and deaths at the end of each month after declaration · month 5½ ≈ 165 days

CONFIRMED CASES



CONFIRMED DEATHS



3× to 7× more cases from month 1

15× Nord-Kivu, >2× West Africa

12× more deaths than 2018–2020

2026: INSP/INRB daily sitreps, confirmed cases and deaths in DRC (plus 31 exported cases and 4 deaths in Uganda, Kenya, Nigeria and France = 10,091 / 4,891). 2018–2020: WHO/DRC MoH, confirmed + probable (declared 1 Aug 2018). 2014–2016: WHO DONs, suspected + probable + confirmed (declared 23 Mar 2014). Month 5½ ≈ 165 days.

Comparison of the 2014 – 2016 West Africa Ebola "Zaire" outbreak with the 2026 Ebola "Bundibugyo" outbreak

West Africa (2014–2016)

Duration

2 years 6 months

Countries with cases

10 (3 intense)

Confirmed cases

15,261

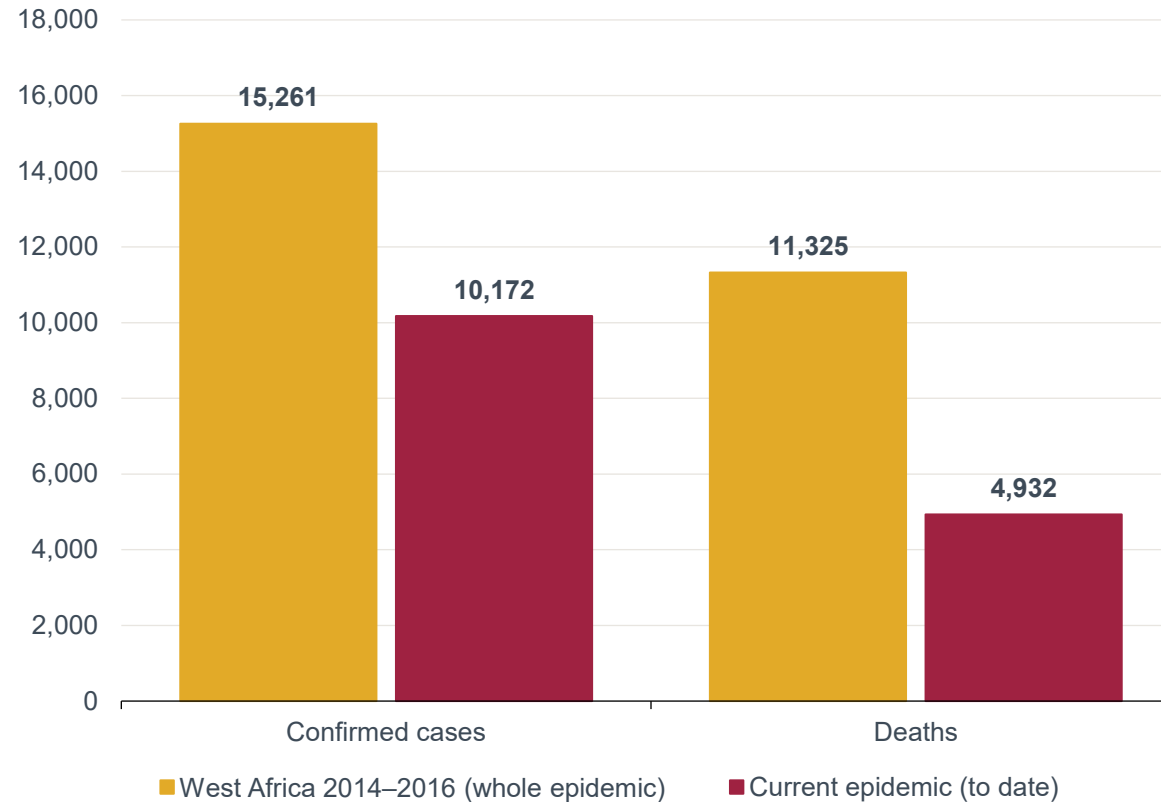
Deaths (all cases)

11,325

Case fatality (all cases)

~40%

CONFIRMED CASES AND DEATHS



West Africa: WHO final figures (28,616 total cases of which 15,261 laboratory-confirmed; 11,325 deaths).
Current epidemic: confirmed cases and deaths as of 25 Oct 2026 (DRC, Uganda, Kenya, Nigeria, France).

Current epidemic (2026)

Duration so far

5½ months

Countries with cases

5 in 3 regions

Confirmed cases

10,172

Deaths

4,932

Case fatality

48.5%



EPIDEMIOLGY IN DEMOCRATIC REPUBLIC OF CONGO (DRC)

Ebola's socioeconomic toll in West Africa 2014-2016

West Africa's experience and the risks facing the current outbreak

Guinea, Liberia and Sierra Leone



Liberia, 2014



Sierra Leone, 2015

US\$2.8bn **5 million** **~23,000**

estimated GDP
losses¹

children kept
out of school²

children lost a parent
or primary caregiver³

1. Trade slowed
2. disrupted markets and supply chain
3. Interrupted routine care
4. more preventable deaths.
5. Missed learning
6. Family separation
7. Lower Income Household
8. Insecurity

Sources: ¹ World Bank (2021). ² UNICEF (2015). ³ UNICEF (2017). Current context: WHO, 23 Oct 2026. Photo credits and evidence in notes.

DRC: expansion across eight provinces

May 15, 2026

Cases: 8
Deaths: 4



1 province and 3 Health zones affected

Jul 15, 2026

Cases: 2,124
Deaths: 828



3 provinces and 46 Health zones affected

Sep 15, 2026

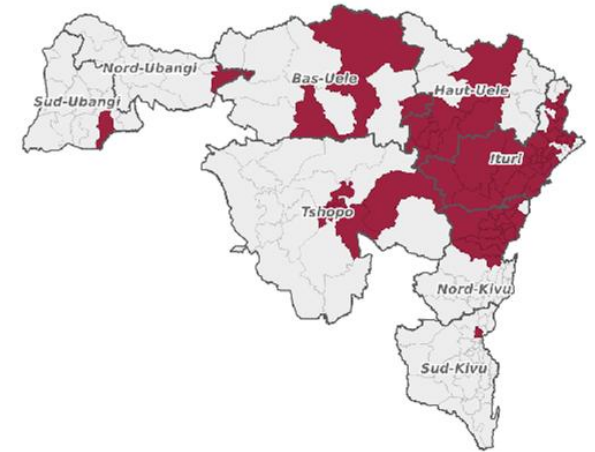
Cases: 7,404
Deaths: 3,577



7 provinces and 62 Health zones affected

Oct 25, 2026

Cases: 10,060
Deaths: 4,887



10 provinces and 66 Health zones affected

■ Affected health zones □ Province boundaries

[Historical geographic snapshots. Latest cumulative endpoint: 25 Oct 2026. Sources: INSP; supplied Africa CDC maps.](#)

16 of 66 health zones have had no case for 21 days; 50 remain active

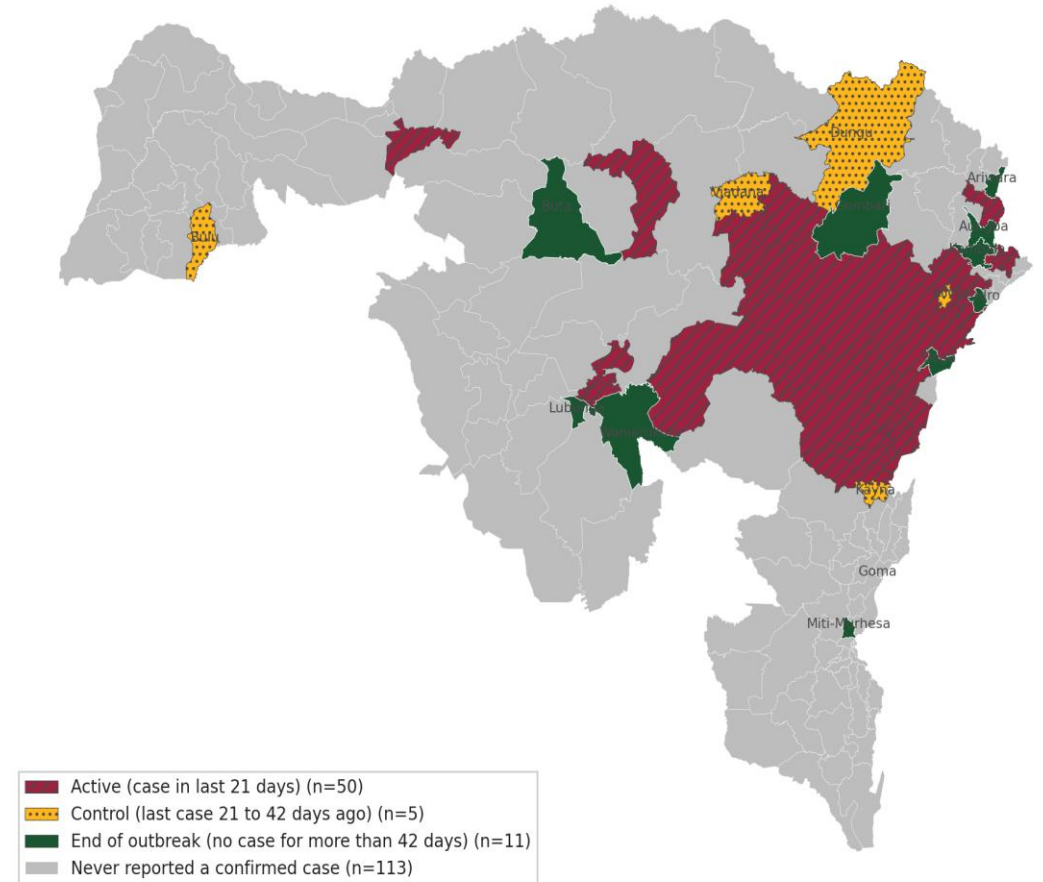
Cadre	Rule	Zones
Active	last confirmed-case rise within 21 days	50
Control	last report 21 to 42 days ago	5
Sustained Controlled area	last report more than 42 days ago	11

Control zones (21–42 d): Kilo, Kayna, Viadana, Bulu, Dungu

Resurgent (≥ 21 d gap, rise in last 21 d): Aru, Kabondo, Tshopo, Tchomia, Mahagi, Bafwasende, Damas, Ganga, Adja, Logo

Sustained controlled (>42 d): Ariwara, Aungba, Boga, Buta, Drodoro, Goma, Gombari, Kambala, Lubunga, Miti-Murhesa, Wanierukula. SitRep N°142 not available. Dakwa is absent from the boundary file.

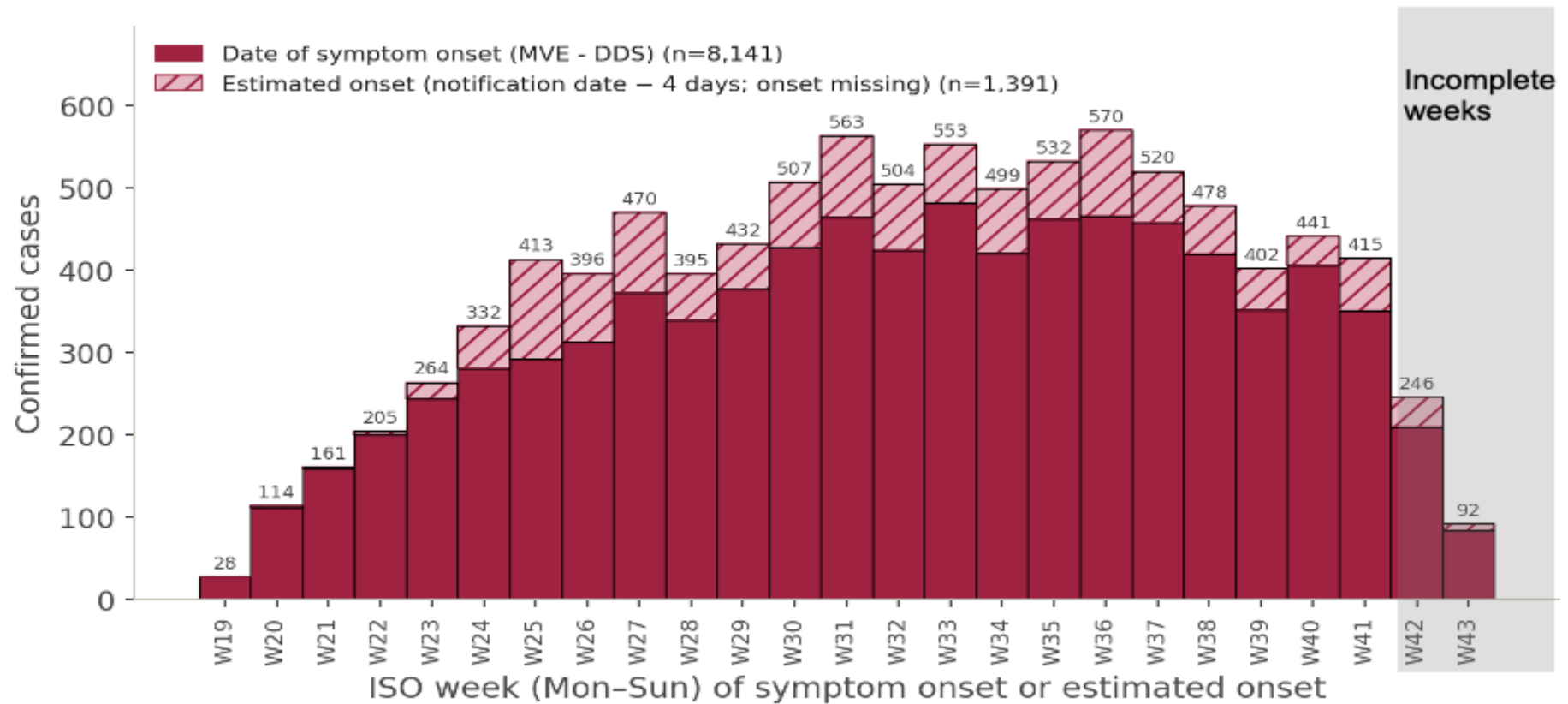
Affected provinces, transmission cadre, as at 25 October 2026



Weekly Trend of BVD cases in DRC based on Date of Onset -EW43

AFRICA CDC

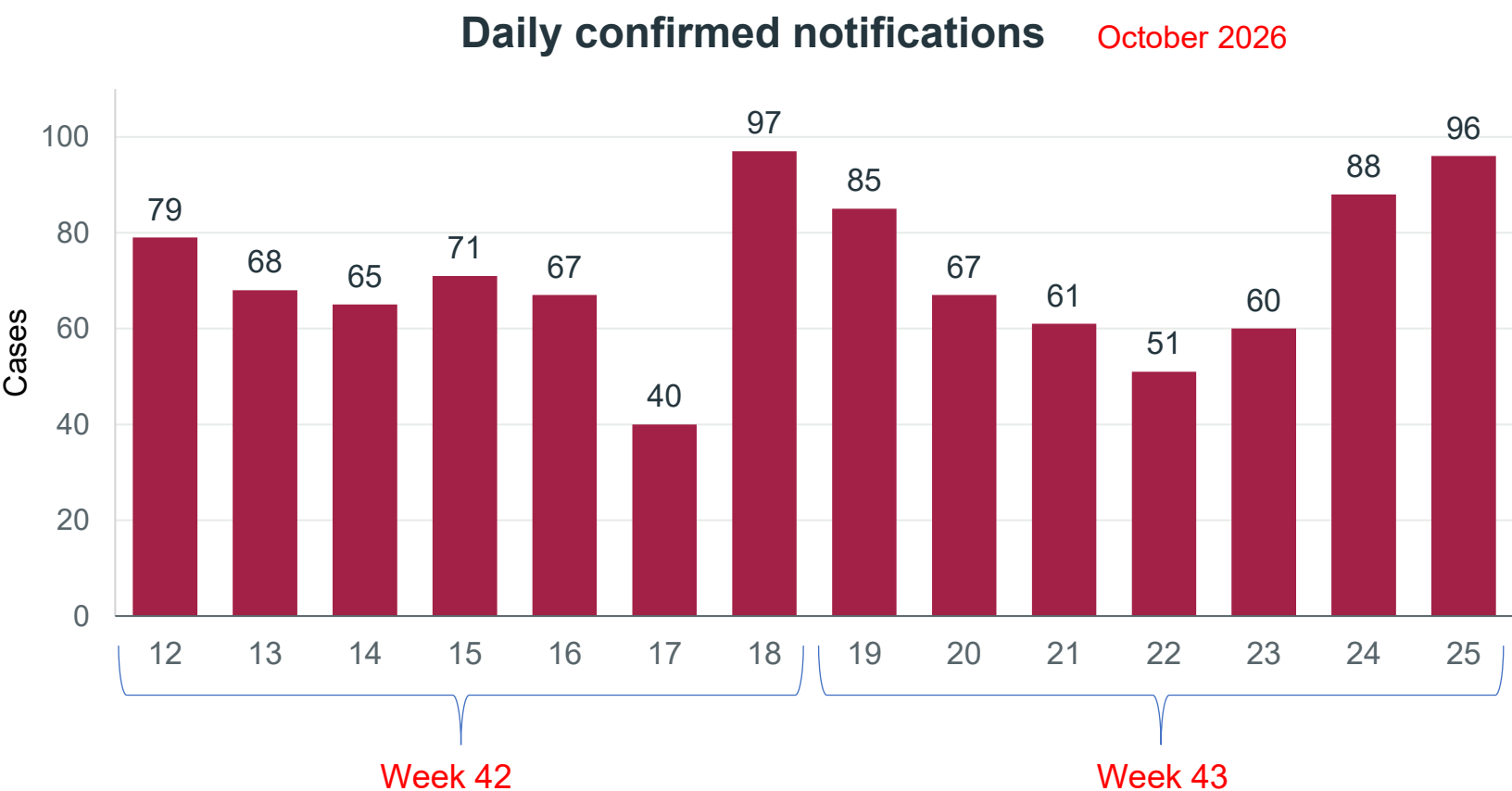
Confirmed BVD cases by onset date, DRC



Safeguarding Africa's Health

DRC continues to report substantial numbers of new cases

Reported additions to the cumulative case count, 12–25 October 2026



508
cases in 19–25 Oct
72.6 per day on average

96
new cases on 25 Oct
Nord-Kivu 58, Ituri 32, Tshopo 6

Source: INSP daily SitReps 151–164. Recent notification counts do not estimate the reproduction number.

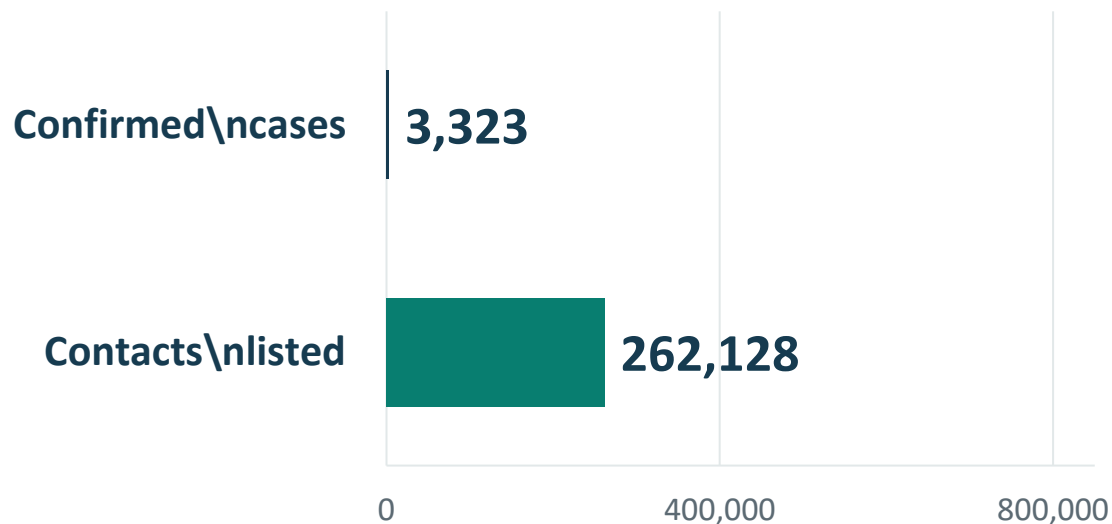
Ebola cases and contact listing

MINISTERIAL MEETING
28 OCT 2026

Comparison of the 2018–2020 outbreak with 2026

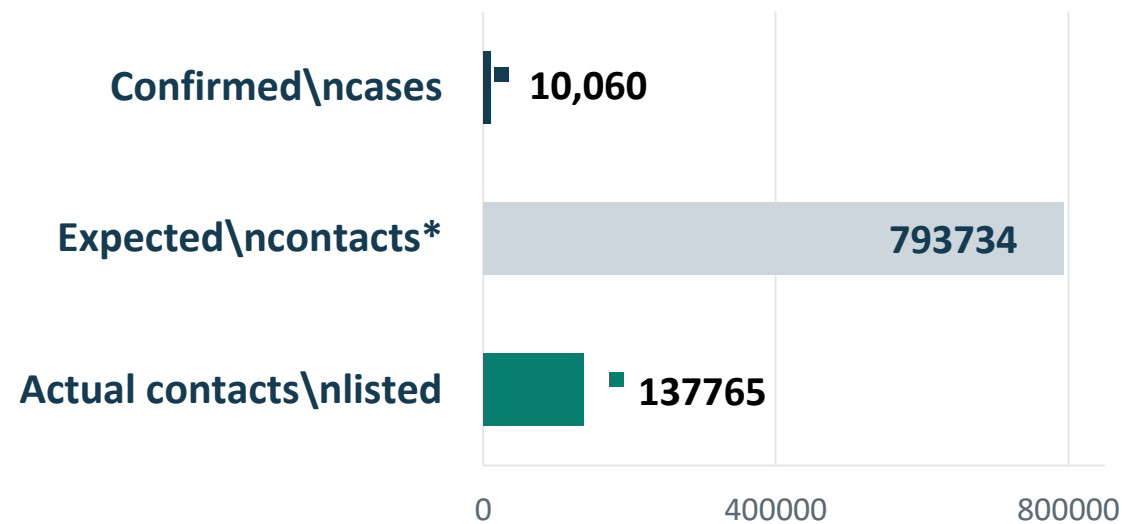
DRC 2018–2020

78.9 contacts listed per confirmed case



2026 outbreak

Actual contact list: 17.3% of the historical benchmark



Consequence:

- More than 80% of new cases are coming from communities ... out of the contact list
- More than 65% of deaths are coming from communities

Five reasons the epidemic is not yet under control

Evidence from DRC SitRep N°164 (data to 25 Oct 2026), WHO DON 622 and Africa CDC analyses

1 Transmission is still intense and still spreading

~400–550

confirmed cases per week by onset date since EW31 — no sustained decline over 11 weeks

- 96 new confirmed cases and 46 deaths on 25 Oct alone
- 50 of 66 health zones active in the last 21 days; 10 zones resurgent after ≥21 days without a case
- 8 provinces now affected, some far from epicentre

2 Most chains of transmission are invisible

< 15%

of new cases come from known contacts — control requires ≥ 95%

- Contacts listed per case are ~23% of the 2018–2020 benchmark
- Contact follow-up 82–89% vs 95% target for identified contacts
- WHO estimates true cases are 2–4 times more than the reported number

3 Deaths happen in the community, not in care

~65%

of confirmed deaths occur outside treatment centres (40 of 46 deaths on 25 Oct)

- Community deaths mean unsafe burials and undetected chains
- Median delay from onset to notification 4 days; 10% take 11+ days
- **Case fatality 48.6%, higher than any Ebola outbreak of the last decade**

4 The virus is crossing borders

4

countries with exported cases (Uganda, Kenya, Nigeria, France);

- Kenya: 8 secondary cases, 2 deaths, 98 still in quarantine
- Nigeria: case detected only 13 days after onset in private hospitals
- Genomes link the Kenyan and Nigerian cases through unsampled chains

5 Response capacity is stretched

Only US\$1 B

of US\$ 3 B pledged has been disbursed; lack of traceability of funds from some partners

- Insecurity: many rebels groups operating. A nurse killed in Bafwasende on 24 Oct
- Humanitarian situation: people in camps without water, foods, health...
- No licensed vaccine or treatment for Bundibugyo; trials only started

Community deaths show persistent delays in reaching care

Both snapshots show a major burden outside treatment centres

6–20 October

63.7%

of reported deaths in the community

307 community deaths
175 deaths in treatment centres

25 October

87.0%

of that day's confirmed deaths

40 community deaths
6 deaths in treatment centres

Earlier detection, rapid referral and community trust remain essential to reduce these deaths.

Sources: WHO DON622, 23 Oct (6–20 Oct interval); INSP SitRep164 (25 Oct). The two periods are not a trend comparison.

Known contact among confirmed cases

Confirmed cases by ISO week of symptom onset, EW17-EW42; recent weeks may be incomplete owing to onset-to-confirmation delay

Upper panel: share of confirmed cases who were a known contact. Hollow point = week with <10 cases.



% known contact = Known contact ÷ all confirmed cases per ISO week. N = 7,705 confirmed cases; 922 (12.0%) known contacts.

Source: DHIS2 Line List; symptom onset 20 Apr-18 Oct 2026.

Safeguarding Africa's Health

- Earlier series: confirmed cases among known contacts were generally below 20%.
- 22 Oct follow-up: 25,005/28,067 contacts seen (89.1%), up from 84.8%, below the 95% target.

The hidden toll: essential PHC services in Ituri, 2026 vs 2025

Change in routine primary health care indicators in the affected Ituri health zones

Indicator (Ituri health zone →)	Bunia	Rwampara	Nizi	Mongbwalu	Mangala	Lita	Nia Nia
Deliveries with a skilled attendant	-6%	+0%	-18%	-14%	-24%	+7%	-37%
Deliveries	-7%	+0%	-17%	-13%	-28%	+7%	-37%
Caesarean sections	-3%	-37%	-27%	-43%	-49%	-21%	-2%
ANC 1st visit	+6%	-11%	-3%	+12%	-11%	+21%	-37%
Maternal deaths	+75%	–	+75%	–	–	–	–
DTP1–DTP3 dropout rate (%)	+1.8 pt	+0.2 pt	+1.4 pt	-1.6 pt	+7.3 pt	+1.2 pt	+9.7 pt
DTP-HepB-Hib 3 (immunisation)	-3%	-7%	-16%	-23%	-18%	+8%	-42%
New curative consultations	-13%	-9%	-7%	-1%	+7%	+8%	-38%
Measles vaccine 1st dose	-1%	-5%	-5%	-13%	-1%	-15%	-48%

Improvement Deterioration Not comparable

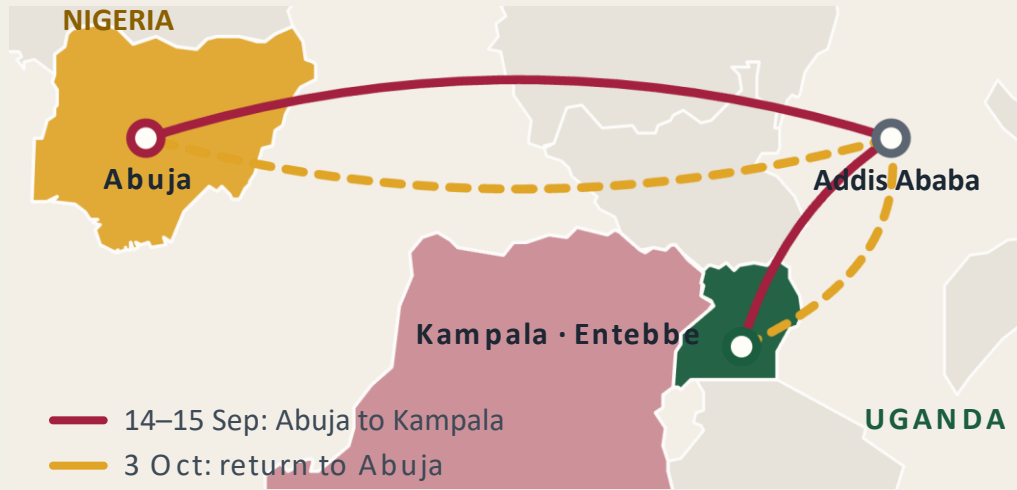
Source: DHIS2 / provincial health divisions



KENYA, NIGERIA...AND RISK OF SPREADING ACROSS AFRICA

Nigeria's imported case: September

Abuja → Kampala → Abuja · symptom onset 6 October · confirmed 19 October



18 days

in Uganda, 15 Sep to 3 Oct, all within the exposure window

6 Oct

onset of symptoms; care first sought 10
Ebola confirmed 19 Oct

15 Sep – 4 Oct

possible exposure window: 2 to 21 days
before onset

Next step

Uganda to trace household, hotel, mall
airport contacts, with Nigeria and Africa

Family home, Kampala · 15–24 Sep

Hotel, Kampala · 24 Sep – 2 Oct

Abuja · 3–6 Oct

Onset
6 Oct

14–15 Sep

Travel to Uganda

Travelled alone by Abuja,
Ababa and Entebbe;
00:55 on 15 Sep.

15–24 Sep

Family home

With her mother and five
siblings, mostly indoors.
illness reported.

25 Sep

Husband joins

The couple move to a Le
Village Kampala hotel and
until 2 Oct.

28 Sep

Shopping trip

Visit to a Kampala
mall for a family birthday.
Other contacts not

1 Oct

Father arrives

From Arua, near the DRC
No symptoms reported. Flight
home 3 Oct.

BVD IN NIGERIA · SITUATION (NCDC SITREP, 24 OCT)

One imported case (from Uganda); 53 contacts, none symptomatic; patient evacuated 26 Oct

CONFIRMED CASE

1

42-year-old female, Abuja; confirmed 20 Oct; sequencing 21 Oct

CLOSE CONTACTS

53

Primary contacts (HCWs, spouse, domestic and lab staff); 0 symptomatic

PATIENT STATUS

Evacuated

to Geneva on 26 Oct; no active case in Nigeria

FEDERAL MINISTRY OF HEALTH Nigeria | NCDC

UPDATE ON EBOLA VIRUS DISEASE (EVD)

Confirmed Case in FCT

What You Need to Know

20 October 2026

KEY HIGHLIGHTS

- Confirmed case**
One Ebola case confirmed in the FCT on 20 October 2026, following laboratory confirmation.
- Patient**
A woman who recently arrived from Uganda on an international flight. She was cared for at a private hospital for several days before diagnosis. She is now in isolation.
- Contact tracing**
Started, with 44 close contacts identified so far, including healthcare workers, patients, caregivers and travel contacts.
- Response**
The Health Minister, NCDC and FCT Health Services Secretariat are coordinating. Surveillance has been intensified, and the hospital is getting support to strengthen infection prevention and control.
- Call to facilities**
All public and private health facilities should be on high alert, keep a high index of suspicion, isolate suspected cases promptly, observe strict IPC, and report immediately.

PUBLIC MESSAGES

- Ebola spreads through direct contact with blood or body fluids of a sick or deceased person, or contaminated materials. A person cannot spread it before symptoms begin.
- Stay calm and vigilant; no need for panic.
- Practise hand hygiene and avoid body fluids of suspected cases.
- Watch for fever, severe weakness, headache, vomiting and diarrhoea, especially after possible exposure.
- Report any exposure immediately, even if well. If symptomatic, avoid close contact and call public health authorities before going to a facility.
- Cooperate with contact tracers, including relevant airline passengers.
- Avoid rumours and stigma; use only official sources.

REASSURANCE

Nigeria contained Ebola in 2014 and has the experience and systems to respond. Updates will come from the Presidential Taskforce on EVD and NCDC.

Together we can stop Ebola

NCDC TOLL-FREE 6232 24/7

STAY INFORMED | STAY SAFE | PROTECT YOURSELF AND OTHERS

Nigeria Stronger Together

WHAT WE KNOW SO FAR

3 Oct

Entebbe → Abuja

7 Oct

Developed symptoms

11 Oct

Admitted, private facility; NCDC notified 19 Oct

20 Oct

Confirmed for BVD

WHAT IS NOT YET KNOWN ???

Where, when, how and by whom the person was contaminated.

Exact source of exposure: genome sits in the Kenyan cluster (one substitution from the Kenyan index case)

Travel Route of Ebola Case Prior to Death in Kenya

Illustrative movement pathway based on confirmed chronology as of 6 October 2026

DRC → UGANDA → KENYA



KEY POINTS

- **26 Aug to 14 Sep:** work travel in Bas-Uele (Buta, Aketi Health Zone, then Likati).
- **15–16 Sep:** malaise, treated at home; **17–19 Sep:** admitted to Tongo Etandi Health Centre, Bongo.
- **More than 10 days** in Kisangani seeking care (20 Sep to 1 Oct).
- **1 Oct:** exited DRC at Kasindi–Mpondwe; **3 Oct:** flew Entebbe to Nairobi; **died 5 Oct** (~23:30).

NAIROBI DETAIL · STEPS 11 TO 14



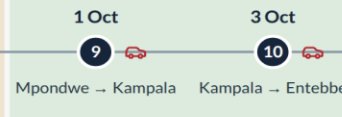
LEGEND

- Flight (blue arrow with plane icon)
- Stop in travel sequence (numbered circle)
- Land border crossing (yellow diamond)
- Mode not reported (dashed line)
- Road (taxi, car) (red dashed arrow with car icon)
- Health facility (red building icon)
- International boundary (solid line)

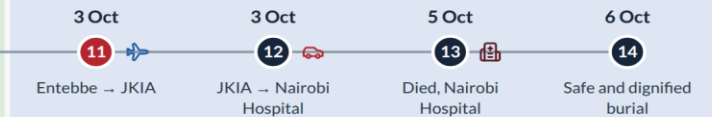
DRC



UGANDA



KENYA



Source: Confirmed multi-country chronology, as of 6 October 2026

Route lines are illustrative and do not show exact roads or flight paths. Boundaries are indicative.

2,300 km travelled: enough to cross 11 European, 8 West African or 6 Gulf countries

Straight-line distance between the case's stops (Likati- Aketi- Buta → Kisangani → Beni → Kasindi → Kampala → Entebbe → Nairobi) ≈ 2,300 km, laid over three other regions

Europe · 11 countries

Vienna → Athens ≈ 2,250 km



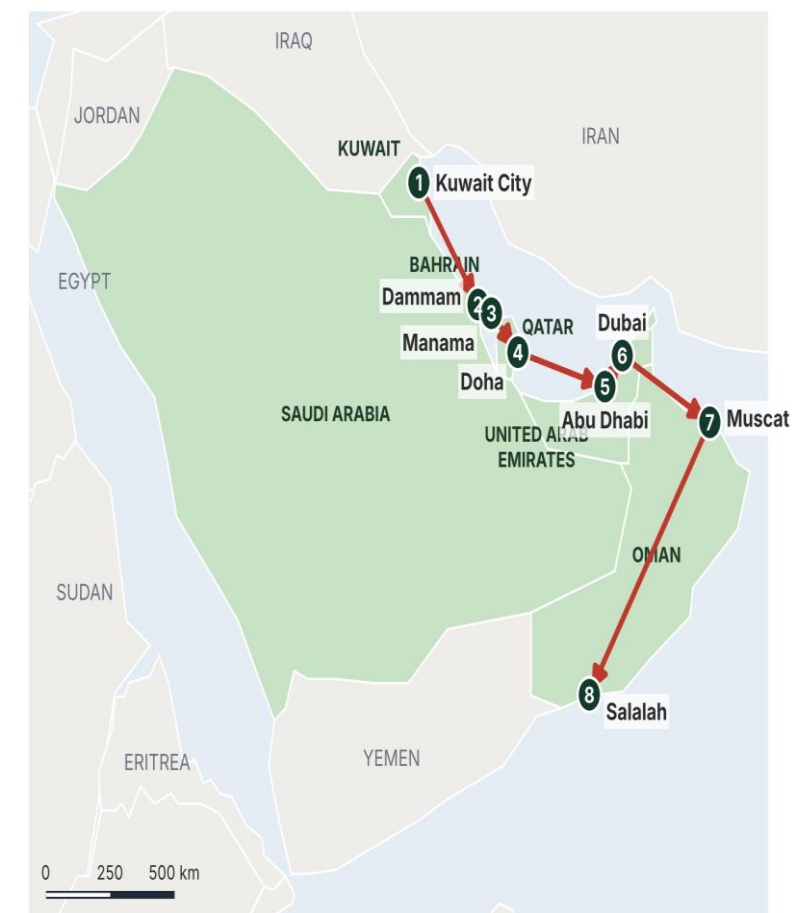
West Africa · 8 countries (+ Ghana)

Dakar → Abidjan ≈ 1,950 km

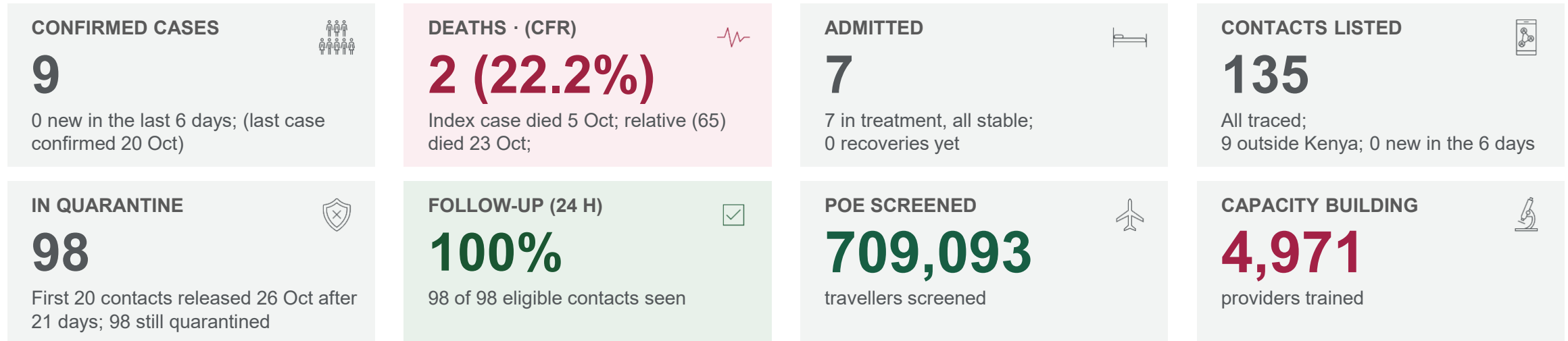


Gulf · 6 countries

Kuwait City → Salalah ≈ 2,250 km



BVD IN KENYA · AT A GLANCE



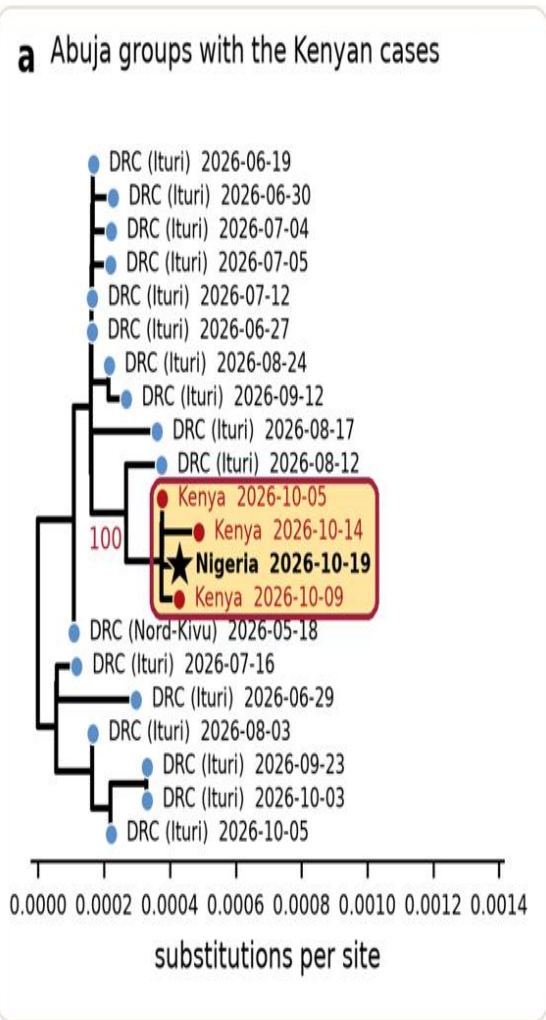
Isolation	Laboratory	Surge and coordination
211 beds	5 testing labs; 6–12 h turnaround	343 surge responders
Dedicated referral capacity	Mobile labs at Busia and Lwakhakha	11 county PHEOCs being established

Minister Duale will talk about the preparedness of Kenya and how it is driving the response there and saving the economy and stability of the country

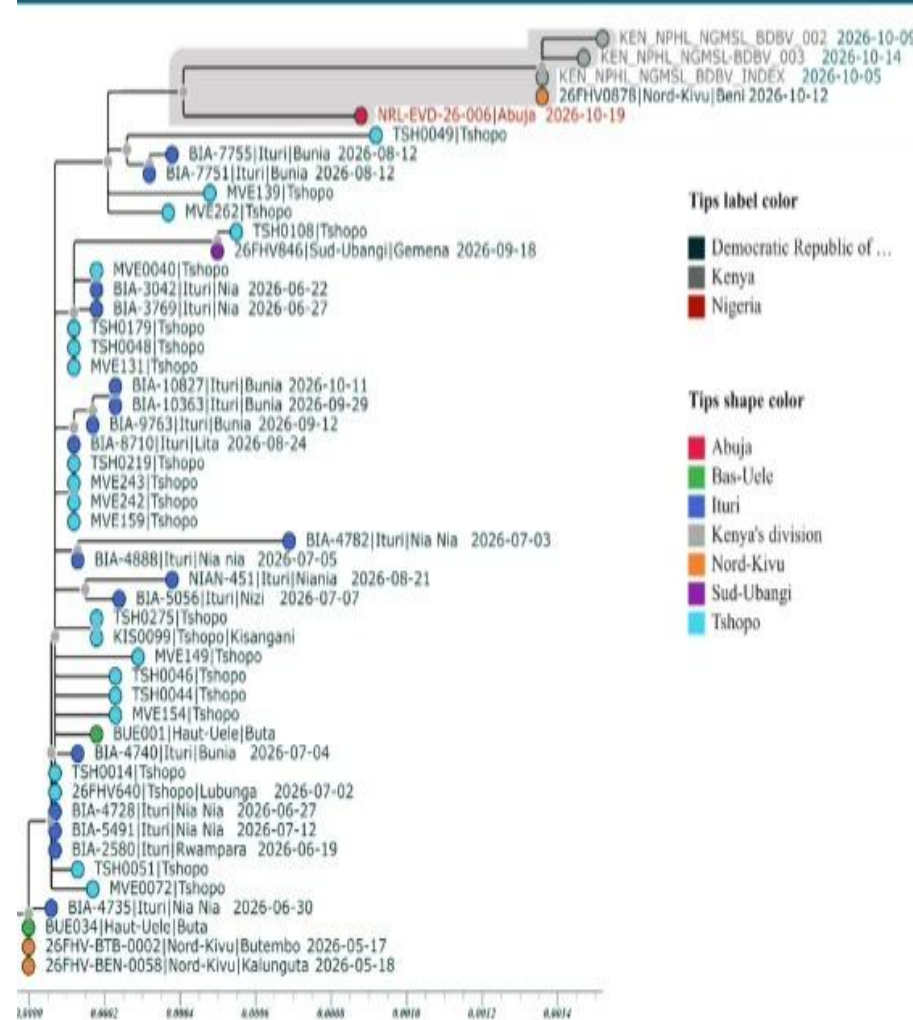
WHERE ARE WE WITH RESEARCH AND DEVELOPMENT?

What the genome is telling us? Report from the Joint genomic assessment group (DR Congo, Uganda, Kenya and Nigeria)

Earlier tree



More recent sequencing



How the work was done

- Convened at the request of H.E. Dr Jean Kaseya, Director-General, Africa CDC.
- Chaired by Prof. Jean-Jacques Muyembe, Director-General, INRB Kinshasa.
- 22 participants from the Africa CDC and the 4 countries — INRB (DRC), NHLDS-CPHL (Uganda), NGMSL (Kenya), ACEGID / NCDC (Nigeria).
- Each team presented its data; the group jointly reviewed sequences and methods and reached consensus.

The question put to the group

Is the Nigeria case a new importation out of DRC or a downstream case of the Kenyan chain?

All 4 countries released a total of **1,126 genomes** assessed. data provided promptly, enabling a regional answer within a couple of days of the Abuja detection

What the genome is tells us? Report from the Joint genomic assessment group (DR Congo, Uganda, Kenya and Nigeria)

WHAT THE DATA CAN SETTLE

1. The 3 genomes (Kenya, Nigeria and Beni in DRC - 12 October) form a single clade at 88% bootstrap support.
2. The Beni genome carries the Kenya–Nigeria barcode at all 11 called positions, including 2038 T→A, carried by no other genome of virus in DRC.
3. Every other genome from cases in DRC is ≥ 4 substitutions from Kenya and ≥ 5 from Nigeria cases.

The wider picture

1. One spillover, not many — all 2026 sequences trace to a single introduction, then sustained human-to-human spread.
2. Kenya and Nigeria cases are not from Uganda's known chains — neither virus carries Uganda's May–June markers.
3. Kenya: one introduction with local onward transmission; the three genomes differ by 1–3 changes.

WHAT THE DATA CAN NOT SETTLE

1. Where, when and from whom either patient was infected. Genomes identify a chain, not a place, a moment or a person — and cannot locate transmission at any venue unless the genome data is combined with epidemiologic and contact tracing information.
2. Whether the Abuja patient was infected by the Kenyan index case or chain, or both shared one unrecognized source is not clear.
3. Whether an unsampled chain was circulating in Uganda during the transit window cannot be excluded.
4. Whether paucisymptomatic presentations permit cryptic cross-border transmission.

WAY FORWARD and RECOMMENDATIONS FROM THE GROUP

- ❖ **All four Member States.** Reconstruct both patients' routes, dates and symptom onset; establish whether the itineraries overlapped and trace fellow travellers if they did.
- ❖ **DR Congo.** Increase sequencing volume, extend to unsequenced provinces and health zones, reinforce screening at road borders and points of entry.
- ❖ **Kenya.** Continue sequencing the identified chain to define the full extent of the introduction.

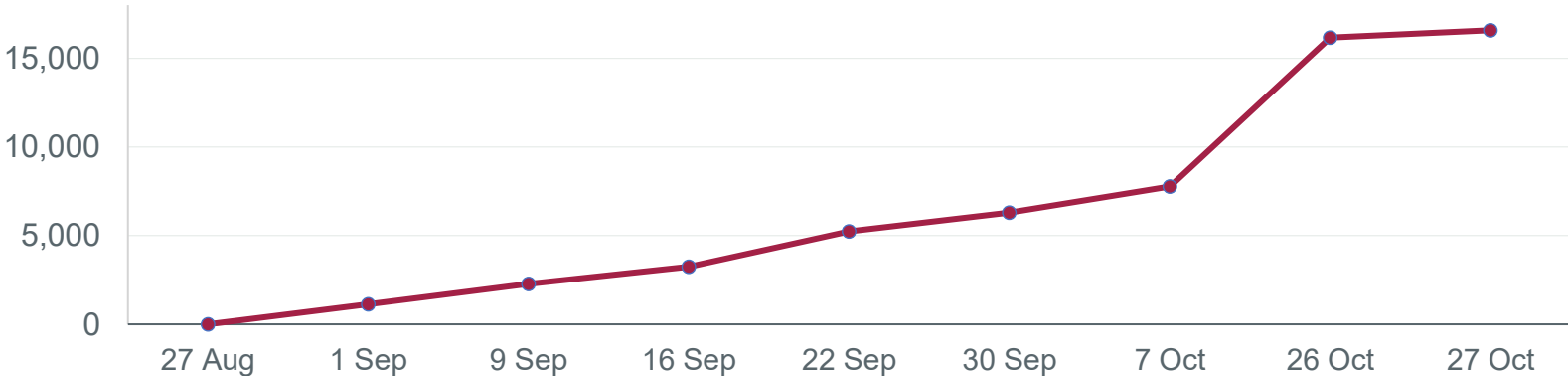
- ❖ **Uganda.** Strengthen surveillance in border districts and among travellers to test for an unrecognised derived chain.
- ❖ **Nigeria.** Sequence any further Abuja-linked case if any; a second genome would show at once whether transmission continues.
- ❖ **Africa CDC.** Continue to coordinate joint technical analysis through regular meetings and updates.

Vaccination is proceeding under research and access protocols

Ervebo is licensed for Zaire ebolavirus. Protection against Bundibugyo is being evaluated.

Protocol	Allocated doses	Purpose
Compassionate use	30,000	Monitored access for frontline and at-risk groups
BRAVO	20,000	Observational vaccine study in frontline workers
TUMAINI	20,000	Phase 2/3 ring-vaccination efficacy trial

Cumulative frontline workers vaccinated



16,585

frontline workers vaccinated

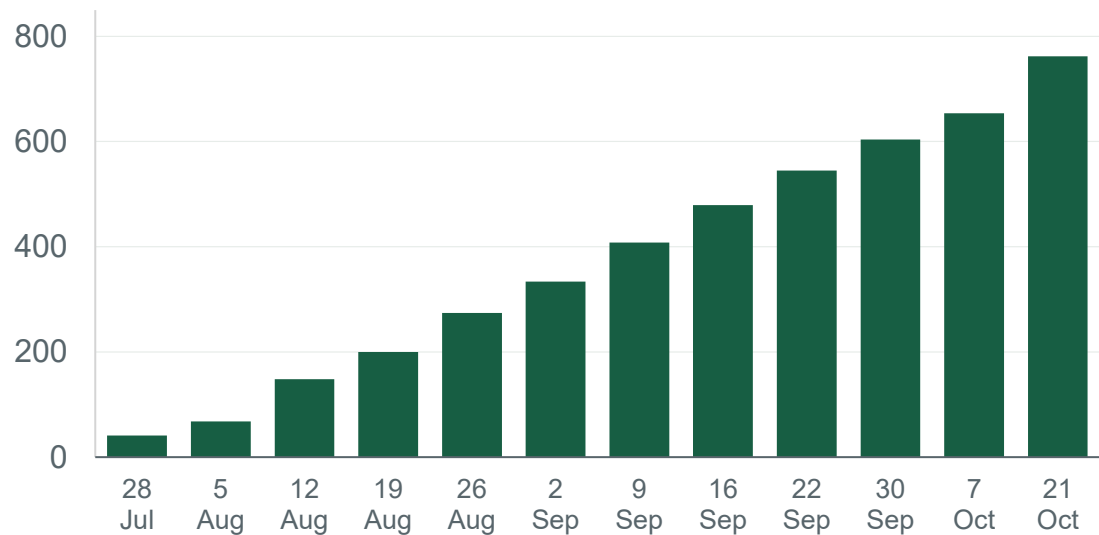
Compassionate use + BRAVO
As reported on 27 October

Sources: [supplied vaccination update \(26–27 Oct\)](#); [WHO and CEPI on TUMAINI launch \(23 Oct\)](#). No proven BVD efficacy is assumed.

Therapeutic and post-exposure trials continue

Enrolment as of 21 October 2026, using the supplied trial updates

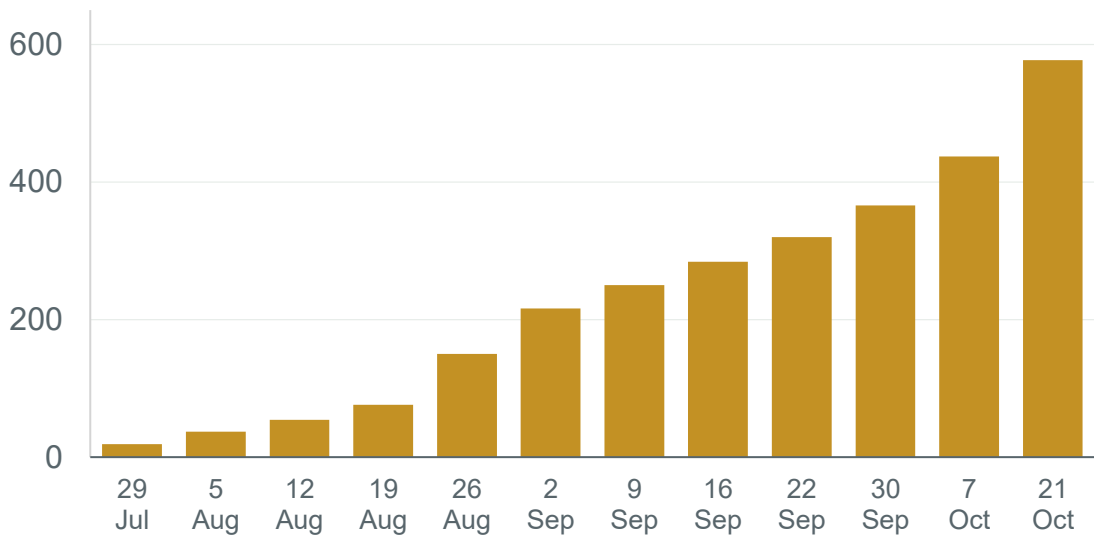
Remdesivir + MBP134



762 enrolled

Target: 1,500–2,500 participants
51% of lower target; 30% of upper target

Obeldesivir post-exposure prophylaxis



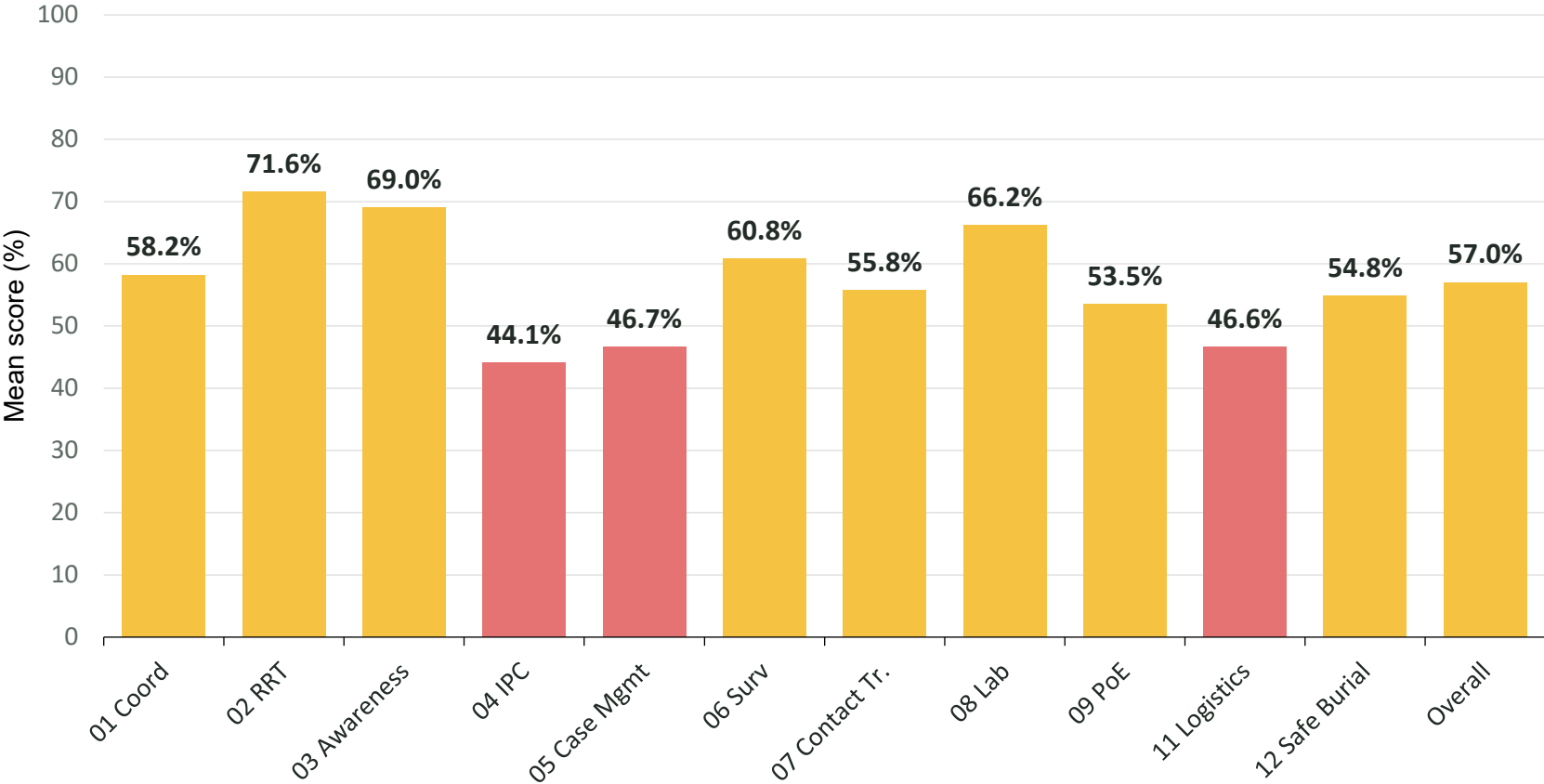
577 enrolled

Target: 1,000 participants
58% of target

Source: supplied trial-pillar update. Enrolment is not evidence of efficacy. Trials require their own follow-up and analysis.

IMPLICATIONS AND RECOMMENDATIONS TO AFRICAN UNION MEMBER STATES

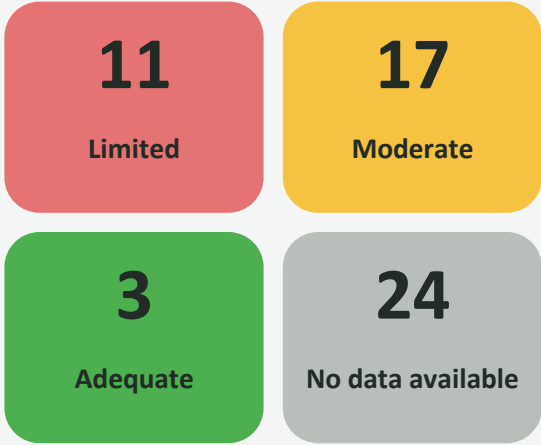
Status and Preparedness for Filovirus – Average Pillar Score Across 31 Countries (2026)



Score bands

- Limited: below 50%
- Moderate: 50% to <80%
- Adequate: 80% and above

Countries by overall score



The 31 countries and the quarter of their latest data (all 2026) are: Angola (Q3), Benin (Q4), Botswana (Q3), Burundi (Q3), Cameroon (Q2), Cape Verde (Q2), Central African Republic (Q3), Chad (Q2), Comoros (Q2), Côte d’Ivoire (Q2), Eswatini (Q3), Kenya (Q3), Lesotho (Q2), Liberia (Q2), Madagascar (Q4), Malawi (Q3), Mali (Q2), Namibia (Q2), Niger (Q2), Nigeria (Q2), Republic of Congo (Q3), Rwanda (Q3), Senegal (Q2), Seychelles (Q2), South Africa (Q2), South Sudan (Q4), Tanzania (Q3), Togo (Q2), Uganda (Q3), Zambia (Q3) and Zimbabwe (Q3).

Recommendations to African Ministers

Government-led coordination with communities at the centre

1 Cross-border Surveillance

Strengthen cross-border coordination through MoU with joint surveillance, information sharing and contact tracing.

3 Increase preparedness score

Mobilize national preparedness, especially in countries at risk of importation.

5 Keep country borders open

Reject unnecessary travel and trade restrictions and promote evidence-based public health measures

2 More funding for preparedness

Ensure funding transparency and accountability, with resources reaching frontline responders.

4 Support Research and Development

Support accelerated MCM research and access, through coordinated African scientific and regulatory mechanisms.

6 Coordination and accountability

Use one response framework, clear responsibilities and transparent financial tracking.

THANK YOU



AfricaCDC
Centres for Disease Control
and Prevention



**World Health
Organization**

African Region