



THREAT ASSESSMENT BRIEF

Importation of Ebola disease cases caused by Bundibugyo virus to Kenya and Nigeria

23 October 2026

Summary

Kenya and Nigeria have recently reported imported Ebola disease cases in their countries. In Kenya, the detection of an imported case was reported in Nairobi, where secondary cases were also reported. In Nigeria, a case in a person with travel history to Uganda was detected in Abuja. This has occurred in the context of the ongoing outbreak of Ebola disease caused by Bundibugyo virus (BDBV) in the Democratic Republic of the Congo (DRC), and cases reported in Uganda this spring.

This Threat Assessment Brief assesses the risk for people from the EU/EEA living in or travelling to the newly affected areas, and the overall risk for the general EU/EEA population. It is intended for public health authorities in the EU/EEA.

Epidemiological situation

On 20 October 2026, Nigeria reported one confirmed Ebola disease case caused by BDBV in a person who travelled from Uganda via an international flight on 3 October 2026. Symptom onset was on 7 October and the person was admitted to hospital on 11 October. The confirmation of Ebola disease caused by BDBV was made on 20 October. Contact tracing is currently under way, with 44 contacts being followed up.

As of 23 October 2026, Kenya has reported nine confirmed Ebola disease cases caused by BDBV, including one death. The first individual, reported on 6 October, developed symptoms while in DRC and travelled to Kenya via Uganda on 3 October. All eight secondary cases (four relatives and four healthcare workers) were linked to the first imported case and were in quarantine when they developed symptoms. Contact tracing activities are ongoing in Kenya, with all listed contacts (135 people) being followed up as of 22 October 2026 [1].

As of 21 October 2026, 9 704 confirmed Ebola disease cases caused by BDBV, including 4 687 deaths, have been reported from eight provinces in DRC (data until 20 October 2026), where community transmission is still ongoing. In Uganda, a total of 20 cases, including two deaths were reported since 15 May 2026. The last confirmed case in Uganda was reported on 21 June 2026.

Risk assessment

The likelihood of infection for people from the EU/EEA living in or travelling to affected areas in Kenya and Nigeria is assessed as **low**, providing they adhere to recommended precautionary measures. Although infection with BDBV leads to severe disease at an individual level, the impact for people from the EU/EEA living in and travelling to affected areas in Kenya and Nigeria is considered **low** at the population level. Therefore, overall, the current risk for people from the EU/EEA living or travelling to affected areas in Kenya and Nigeria is considered **low**.

Based on the experience from the current and previous Ebola disease outbreaks in Africa, it is expected that the importation of cases to Europe will remain rare events and will mainly concern medical evacuations for treatment. The likelihood of secondary transmission of BDBV and sustained transmission within the EU/EEA

following an imported case is considered **very low**, as cases are likely to be promptly identified and isolated, and recommended control measures would be implemented. The population-level public health impact in the EU/EEA is expected to be **very low** as only very few cases are expected. Therefore, the overall risk of BDBV for the general population in the EU/EEA is assessed as **very low**.

Recommendations

EU/EEA countries should remain vigilant, strengthen their preparedness and response capabilities for detecting and managing potential imported Ebola disease cases, and provide travel advice to people living in and travelling to/from affected areas.

ECDC does not recommend any travel restrictions for travellers to or from Kenya and Nigeria. Exit screening from the affected areas and countries, including symptom checks and exposure assessments is an important measure that contributes to reducing the risk by identifying symptomatic travellers before they board, and preventing them travelling while symptomatic.

Entry screening of incoming travellers from areas affected in the current outbreak is not proven to be an efficient measure to detect imported cases, and is also a highly complex public health intervention.

ECDC actions

ECDC continues to monitor the outbreak through its epidemic intelligence activities to provide epidemiological updates, situational awareness reports and risk assessments for the EU/EEA.

ECDC publishes regular updates on this outbreak on its [website](#), as well as [Questions and Answers documents](#) for healthcare providers and the general public, [laboratory guidance](#) and [preparedness](#) and [communication tools](#) for public health authorities.

ECDC is actively liaising with key partners, including Africa CDC, the European Commission, the World Health Organization, the European Union Delegation in Nigeria and Nigeria CDC to provide further support through the EU Health Task Force in response to the ongoing event in Nigeria.

Since 19 May 2026, the EU Health Task Force, in collaboration with the European Civil Protection and Humanitarian Aid Operations (DG ECHO), the Directorate-General for International Partnerships (DG INTPA) and the Global Outbreak Alert and Response Network (GOARN), has been deploying ECDC experts to Addis Ababa (Ethiopia) at Africa CDC's headquarters, Kampala (Uganda), South Sudan and Bunia (DRC).

Epidemiological situation

Nigeria

On 20 October 2026, Nigeria reported one confirmed Ebola disease case caused by Bundibugyo virus (BDBV) [2] in the Federal Capital Territory (FCT). The person travelled from Uganda to Nigeria via an international flight on 3 October 2026, and subsequently developed symptoms on 7 October. The person sought medical care in Abuja in a private healthcare facility on 11 October, and infection with BDBV was confirmed by repeated laboratory testing on 20 October [3,4]. According to media reports, the person is the wife of a European diplomat living in Abuja [5,6]. Although Uganda's Ministry of Health reported that the person previously travelled to the Democratic Republic of the Congo (DRC) [7], this information is not supported by other sources. According to media sources, the case had travelled to Nigeria via Addis Ababa (Ethiopia) [8]. Contact tracing is currently under way, with at least 44 contacts being followed up [2].

Kenya

As of 23 October 2026, Kenya has reported nine confirmed Ebola disease cases caused by BDBV, including one death. The first person, reported on 6 October, developed symptoms while in DRC and travelled to Kenya via Uganda on 3 October. The person died on 5 October [9]. Between 14 and 20 October, eight additional cases were reported, four relatives of the first case and four healthcare workers. All secondary cases were linked to the first imported case and were in quarantine when they developed symptoms [10]. Contact tracing activities are ongoing in Kenya, with all 135 listed contacts followed up as of 22 October 2026 [1].

Event background DRC and Uganda

On 15 May 2026, Africa CDC reported an outbreak of Ebola disease in Ituri Province of DRC [11]. Since then, as of 21 October 2026, 9 704 confirmed Ebola disease cases caused by Bundibugyo virus, including 4 687 deaths, have been reported from eight provinces (data until 20 October 2026) [12]. In Uganda, a total of 20 cases, including two deaths, were reported. The last confirmed case was reported on 21 June 2026 [13]. On 27 August, WHO declared the end of the Ebola disease outbreak in Uganda following 42 consecutive days without a new confirmed case being reported [14].

In the EU/EEA, since the beginning of the outbreak and as of 23 October 2026, an imported case was reported in July 2026 in a healthcare worker in France who had been working in areas of DRC affected by the outbreak [15]. Additionally, three cases have been medically evacuated to Germany and the Netherlands [16].

No licenced vaccines or specific therapeutics are currently available for Ebola disease caused by BDBV. Following the approval to use the rVSV-ZEBOV (Ervebo) vaccine against BDBV under an expanded-access (compassionate-use) protocol, the DRC received an initial allocation of 70 000 doses from the global Ebola vaccine stockpile in August 2026 [17]. In August 2026, vaccination of healthcare and other frontline workers started in DRC [18]. As of 21 October 2026, Africa CDC reported that 12 269 individuals had been vaccinated through the compassionate-use BVD vaccination campaign across 19 health zones, and another 1 262 individuals under the BRAVO study [19] (which aims at investigating the effectiveness of the rVSV-ZEBOV vaccine in 20 000 frontline workers), making a total of 13 531 individuals who have been vaccinated.

ECDC risk assessment for the EU/EEA

This assessment is based on evidence available to ECDC at the time of publication. It follows the ECDC rapid risk assessment methodology, where the overall risk is determined by a combination of the probability of infection and the impact of the disease on the affected population [20]. This assessment carries moderate uncertainty as in-depth investigations of the imported cases in Kenya and Nigeria are still ongoing. ECDC will continue monitoring the event and will reassess the risk depending on how the situation evolves and how response measures are implemented.

What is the risk for people from the EU/EEA living in or travelling to Kenya and Nigeria?

Transmission of BDBV requires direct contact with organs, blood, secretions, or other bodily fluids of dead or living people or animals with the infection. Exposure of this kind is unlikely for travellers from the EU/EEA or people from the EU/EEA living and working in Kenya and Nigeria. Therefore, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is assessed as **low**, provided they adhere to the recommended precautionary measures in both Kenya and Nigeria.

People from the EU/EEA working in the humanitarian or health sectors in the affected areas have a **low to moderate** likelihood of infection. Individuals who were in direct contact with the reported cases in these countries are at increased risk. In the case of Nigeria, media reports suggest the patient may be part of the European diplomatic community. However, epidemiological investigations are ongoing and information remains limited.

Although infection with BDBV leads to severe disease at an individual level, the impact for people from the EU/EEA living and travelling in affected areas in Kenya and Nigeria is considered **low** at the population level.

Therefore, overall, the current risk for people from the EU/EEA living in or travelling to affected areas in Kenya and Nigeria is considered **low**.

What is the risk for the general population in the EU/EEA following the cases in Kenya and Nigeria?

The most likely route of introduction of BDBV in the EU/EEA is through people with the infection travelling from affected areas to an EU/EEA country. From the time of the World Health Organization (WHO) Public Health Emergency of International Concern (PHEIC) declaration for this outbreak [21] until now, three patients with BDBV infection have been medically evacuated to the EU/EEA, and one imported case was recorded in France. All cases occurred in humanitarian healthcare workers and all have been appropriately cared for in high security isolation units in EU countries, and have since recovered. No secondary transmission has been recorded in household or healthcare contacts in the EU.

Considering this data together with the historical experience from the large West Africa Ebola outbreak between 2013 and 2016, which led to a very limited number of imported or medically evacuated cases (n=8) in the EU/EEA (Germany (n=2), Norway (n=1), Spain (n=2), Italy (n=1) and the United Kingdom (n=2)) and locally acquired

infections (n=1, in Spain, nosocomial transmission) [22,23], the likelihood of secondary transmission of BDBV and sustained transmission within the EU/EEA following an imported case is considered **very low**, as possible imported cases are likely to be promptly identified and isolated and recommended control measures would be implemented.

In the instance of the patient in Nigeria who seems to be part of the European diplomatic community in the country, there is a higher likelihood that people from the EU/EEA may have been exposed.

BDBV infection can cause severe disease in affected individuals, and there is a significant operational impact on healthcare facilities caring for such patients. However, the population-level public health impact in the EU/EEA is expected to be **very low** as only very few cases are expected and EU/EEA countries have robust hospital and public health systems.

Therefore, the overall risk of BDBV for the general population in the EU/EEA is assessed as **very low**.

The likelihood of BDBV affecting the substances of human origin donor population in the context of this outbreak in the EU/EEA is currently assessed as **very low**.

The assessment will be reviewed as further epidemiological and virological information becomes available.

ECDC recommendations

Cases of BDBV infection are expected to continue occurring sporadically outside the affected areas in DRC as long as the large outbreak in the country continues. Rapid control of the recent cases in Nairobi, Kenya and Abuja, Nigeria and their contacts, is key to avoid establishing community transmission in these countries. This will also reduce the likelihood of importation to the EU/EEA as both countries have regular flight connections with several EU/EEA cities.

ECDC recommendations following the imported cases of BDBV in Kenya and Nigeria remain essentially the same as outlined in the ECDC Threat Assessment Brief from 21 May 2026, [Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda, 2026](#) [24].

EU/EEA countries should strengthen their preparedness and response capabilities in case of a potential imported Ebola case by focusing on:

- Providing travel advice to people living in and travellers to/from affected areas;
- Preparing for a potential Ebola disease imported case by:
 - increasing awareness among health professionals;
 - reviewing case management protocols and ensuring referral hospitals and designated care teams are trained and ready;
 - reviewing testing capacities and biosafety protocols.

Travel advice to travellers and people living in affected areas

Countries should ensure that clear travel advice is posted at prominent places in international airports (posters, QR codes, etc.) both for departing and returning travellers.

People from the EU/EEA living in or travelling to affected areas should follow the recommendations of local health authorities on the prevention and control of BDBV disease, and always apply the following precautionary measures:

- Avoid contact with symptomatic patients, their bodily fluids, and the bodies or bodily fluids of deceased patients;
- Avoid consumption of bushmeat and avoid contact with wild animals, whether alive or dead;
- Wash and peel fruits and vegetables before consumption;
- Wash hands regularly with soap or antiseptics hand-rubs;
- Engage in safe sexual practices.

Returning travellers, on the other hand, should be provided with information on what to look out for, such as common symptoms of Ebola BDBV and instructions on where they can find more advice (website, telephone, etc.) and where/how they can safely access healthcare services.

ECDC does not recommend any travel restrictions for travellers to or from Kenya and Nigeria. Travel restrictions, such as flight cancellations and general entry restrictions can lead to significant impact in the movement of humanitarian workers, material and pharmaceuticals to the affected areas, hindering the response to the outbreak.

Exit screening from the affected areas and countries is recommended and is important. Exit screening should include symptom checks and exposure assessments and not be based solely on temperature checks. Exit screening also helps dissuade people who are ill from travelling and enhances public and stakeholder confidence. However, exit screening cannot fully prevent the exportation of cases, because the absence of symptoms at departure does not exclude the subsequent onset of disease [24]. National and international public health authorities should consider strengthening and monitoring exit screening procedures from the affected areas.

Screening incoming travellers from areas affected by Ebola disease is not a proven intervention to detect imported cases. It is also a highly complex and resource-consuming public health intervention which requires the involvement of many actors (health, security, transport, public and private, at central and local levels), as well as adherence to careful Standard Operating Procedures and assigning responsibility for resource provision (e.g. personal protective equipment, PPE). An algorithm has been developed by ECDC to provide guidance for EU/EEA public health authorities, decision-makers, and healthcare professionals on risk categorisation and managing individuals potentially exposed to Ebola disease [25]. In addition, ECDC has updated the RAGIDA guidance on Ebola disease to support public health authorities and other competent national authorities in EU/EEA countries to provide actions to consider after the identification of a suspected or confirmed Ebola disease case during or after a flight [26].

Preparedness for a potential Ebola disease imported case

EU/EEA countries should review and strengthen their preparedness plans for responding to a potential imported case(s) of Ebola disease, including raising awareness in healthcare professionals, reviewing case management protocols and laboratory diagnostic capacity.

An operational checklist tool has been published by ECDC addressing the preparedness and response elements for the potential importation of an Ebola disease case into an EU/EEA Member State health system [27].

More tools and resources supporting EU/EEA countries' [public health preparedness](#), [laboratory preparedness](#) and [communication tools](#) in the context of the ongoing Ebola Bundibugyo outbreak can be found on the ECDC website.

Limitations

Despite the large number of cases detected in the DRC, data specific to BDBV disease continue to be limited.

The investigations of imported cases in Kenya and Nigeria regarding their travel routes and contact tracing are ongoing. Therefore additional information which may impact this assessment may become available in the near future.

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