NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

BUNDIBUGYO VIRUS DISEASE (BVD) PREPAREDNESS

An update for Physicians, Accident & Emergency Practitioners and Laboratorians

Centre for Emerging Zoonotic and Parasitic Diseases, and Outbreak Response Unit, and
Division of Public Health Surveillance and Response
National Institute for Communicable Diseases
(NICD) 24-hour hotline number: 0800 212 552

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On 15 May 2026, the Democratic Republic of the Congo (DRC) and Uganda announced BVD outbreaks linked to transmission in north-eastern DRC, with Ituri province primarily affected. On 27 August 2026, Uganda declared its BVD outbreak over after 42 days without a new confirmed case. Uganda had reported 20 laboratory-confirmed cases, including 15 imported from the DRC, and two deaths. France reported one imported BVD case from the DRC on 24 June 2026, and the patient recovered.

As of 24 October 2026, health authorities had reported 9964 laboratory-confirmed cases, including 4841 deaths and 2670 recoveries, across eight provinces in north-eastern and north-western DRC. The provinces include Ituri, North Kivu, Haut-Uele, Tshopo, South Kivu, Bas Uele, South Ubangi and North Ubangi. Ituri remains the most affected province with 7179 confirmed cases and 28 of its 36 health zones affected.

As of 23 October 2026, Kenya reported nine laboratory-confirmed BVD cases including two deaths of the index case who was imported via travel from the DRC through Uganda to Nairobi and a family member who developed symptoms while in quarantine. All subsequent cases belong to the same cluster as the first case. All 135 contacts have been traced.

As of 24 October 2026, Nigeria has reported its first laboratory-confirmed BVD case in Abuja. This imported case was a traveller arriving from Uganda through Addis Ababa on 3 October 2026. A total of 53 contacts have been identified and traced.

Despite the low risk of importations to South Africa, healthcare workers countrywide should be on alert for suspected BVD cases (see case definition). It is important to exclude *malaria* in these cases.

BVD case definition:

Suspected case:

Any person presenting with one or more of the following symptoms: an acute onset of fever (≥38°C), nausea, vomiting, diarrhoea, severe headache, muscle pain, abdominal pain, or unexplained haemorrhage; who visited or resided in DRC or Uganda, in the outbreak areas determined, in the 21 days prior to onset of illness and had direct contact with or cared for suspected/confirmed BVD cases in the 21 days prior to onset of illness or has unexplained multisystem illness that is malaria-negative.

Transmission of Bundibudyo virus (BDBV):

As for other ebolaviruses, BDBV is transmitted among humans through **close and direct physical contact** with infected bodily fluids (with blood, faeces and vomit being the most infectious). Health care workers attending to persons with suspected or confirmed BVD should observe strict contact precautions. Health care workers and direct contacts of a BVD case (such as family and friends) are at high risk. Funerals have been reported as high-risk events for transmission.

Specimen collection for confirmation of BVD:

1. Detailed specimen collection and submission guidelines are available on the NICD website.
2. Submit both a clotted blood (red or yellow top tube) and EDTA treated tube (purple top tube) for investigation.
3. The specimens should be packaged in accordance with the international and national regulations for shipment of dangerous biological materials (i.e. triple packaging using absorbent material with appropriate labelling) and transported directly and urgently to:
   Centre for Emerging Zoonotic and Parasitic Diseases, Special Viral Pathogens Laboratory, National Institute for Communicable Diseases (NICD) National Health Laboratory Service (NHLS), Modderfontein Rd. 1, Sandringham, 2131
4. Completed case investigation form accompanies the specimens
5. Samples should be kept cold during transport (cold packs are sufficient for transport within 24 hrs).
6. The NICD offers a full repertoire of laboratory testing for BVD.
   Test requests need only to state for *Ebola/BVD investigation*.
   Refer to NICD website for more information.

Response to a suspected case of BVD:

1. Establish that the patient meets the case definition for a suspected BVD case.
2. Observe appropriate infection control procedures.
3. Standard management for BVD is limited to supportive therapy including fluid management, provision of oxygen, and maintenance of blood pressure and treatment of secondary infections.
4. Inform the NICD hotline (0800 212 552) and notify the local and provincial communicable disease control co-ordinator (CDCC) telephonically.
5. Notify as Category I notifiable medical condition (VHF) using the NMC App
6. Submit samples to NICD for laboratory testing.

Refer to the National Guidelines for Recognition and Management of viral haemorrhagic fevers for more information.

Managing a suspected BVD case

As soon as the decision is made to proceed on the basis of a presumptive diagnosis of BVD, measures should be applied to minimize exposure of medical staff, other patients and relatives.

1. Inform the management and infection control officers at the medical facility concerned of the existence of the suspected case of BVD.
2. Isolate the patient and apply infection precautions.
3. Administer such life-saving therapy as may be necessary and possible. Keep the patient hemodynamically stable and manage fever. Treat for any other life-threatening symptoms as necessary.
4. Take steps to verify the diagnosis.
5. Notify the National Director of Communicable Disease Control (CDC) and the relevant provincial CDCC if not already done.
6. Decide whether the patient is to be retained at the primary hospital (isolation facilities), or whether to seek transfer to an BVD designated hospital.
7. Assess the status of the patient as either low, moderate or high risk (see NICD website).

For more information, visit the NICD website, Bundibugyo webpage.