Situation at a Glance

- On May 17, 2026, the World Health Organization (WHO) officially declared the Ebola disease outbreak caused by the Bundibugyo virus (BDBV) a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations (2005).
- On August 14, WHO reassessed the outbreak risk and maintained its previous assessment: very high in the DRC, high in countries sharing land borders with the DRC, and low in the rest of the African Region and globally.

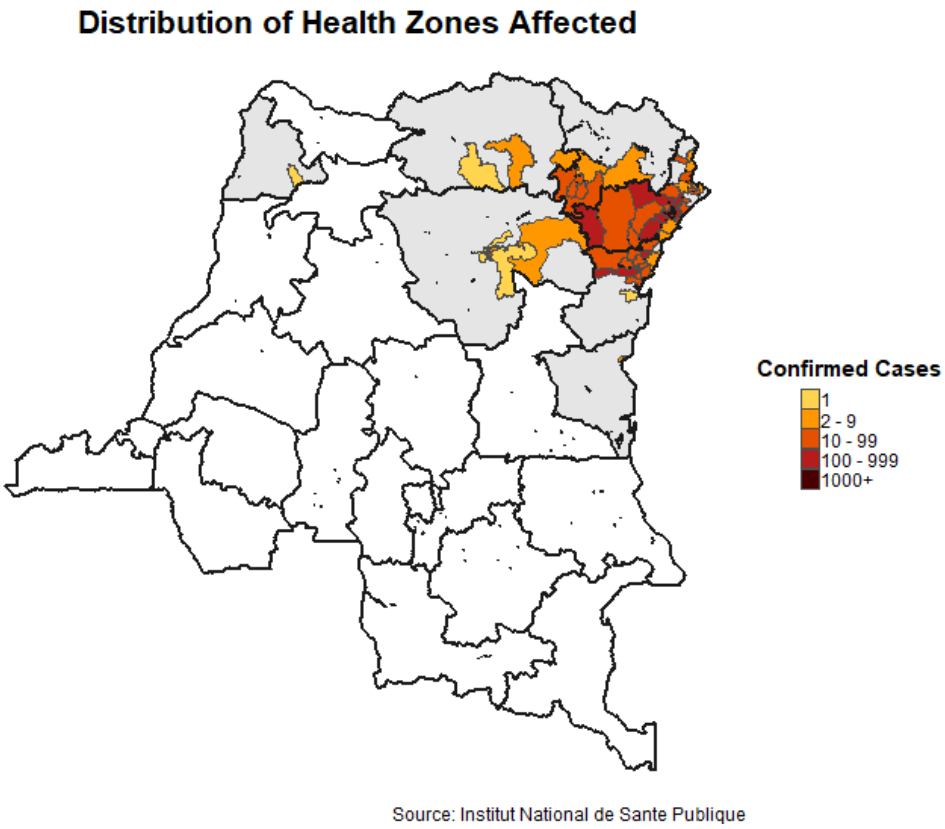

Figure 1. Distribution of Health Zones affected, as of September 16, 2026

- **As of September 16**, a total of 7,475 cases with 3,605 deaths **(CFR: 48.2%)** have been confirmed across 62 health zones in seven provinces. A total of 1,798 patients recovered, representing a recovery rate of 24.1%.
- A total of 159 healthcare worker infections had been reported across three provinces as of 7 August 2026, mostly occurring in Ituri Province. No further updates on healthcare worker infections or associated deaths were reported in subsequent situation reports.

Table 1. Distribution of Confirmed BDBV cases in the Democratic Republic of the Congo (DRC), as of September 16, 2026

Province	Health Zones Affected	Cases	Deaths	CFR (%)
Ituri	28	5,792	2,642	45.6
Nord-Kivu	16	1,350	828	61.3
Haut-Uele	6	292	118	40.4
Tshopo	7	30	11	36.7
Sud-Kivu	1	3	1	33.3
Bas Uele	3	7	4	57.1
Sud Ubangi	1	1	1	100.0
Total	**62**	**7,475**	**3,605**	**48.2**

Source: Institut National De Sante Publique DRC

Situation Update

Democratic Republic of the Congo

- **On May 5**, 2026, WHO received an alert regarding a high-mortality outbreak in Mongbwalu Health Zone, Ituri Province, including four healthcare worker deaths within four days. Retrospective investigations identified the earliest suspected case as a healthcare worker who developed fever, bleeding, vomiting, and severe malaise on 24 April and later died in Bunia.
- **On May 15,** Laboratory testing confirmed Bundibugyo virus disease (BVD), and the Ministry of Health officially declared the country's 17th Ebola outbreak. At the time, 246 suspected cases and 80 deaths had been reported across Rwampara, Mongbwalu, and Bunia health zones.
- **On May 24**, the outbreak expanded to 11 health zones across Ituri, North Kivu, and South Kivu, with 105 confirmed cases and 10 deaths (CFR: 9.5%), alongside 906 suspected cases and 223 suspected deaths.
- **Between June 14 to 20,** the country reported 174 new cases and 66 deaths (CFR: 37.9%), bringing cumulative totals to 1,094 confirmed cases and 277 deaths.
- **On July 9**, the DRC Ministry of Public Health officially expanded the list of affected provinces including **Tshopo** and **Haut-Uele**.
- **On August 12,** a further case of death was confirmed in the province of **Bas Uele**, bringing the total number of affected provinces to six.
- **On September 10,** a first confirmed case, resulting in death, was reported in **Sud-Ubangi**, bringing the total number of affected provinces to seven.
- **By September 16, DRC** confirmed a total of 6,843 cases and 3,310 deaths (CFR=48.4%). The number of recoveries was 1,611, representing 23.5% of confirmed cases.

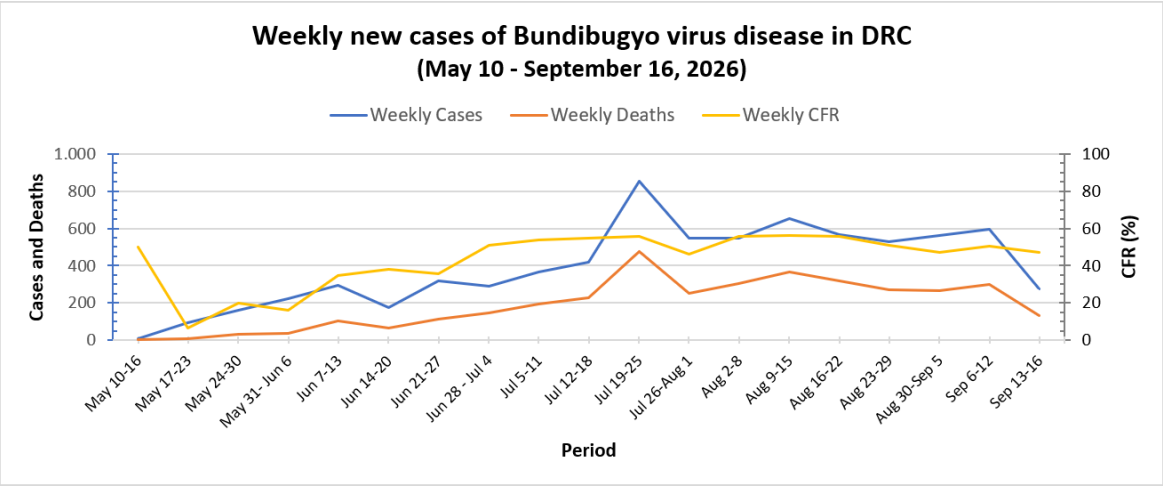

Figure 2. Weekly new cases of BVD in the DRC (May 10 – September 16, 2026)
(Source: Institut National De Sante Publique DRC)

The BVD outbreak continued to expand in DRC, driven by sustained transmission in the country. Weekly reported cases increased from 8 during May 10–16 to a peak of 856 during July 19–25, reflecting widespread transmission across affected provinces. From September 6-8, there were 239 additional cases confirmed (Figure 2).

Similar patterns were observed in mortality trends, with a rise from four deaths during May 10–16 to a peak of 475 deaths during July 19–25 and declined the following week. However, a slight surge occurred with 365 deaths reported during August 9-15 before gradually decreasing to week ending September 5. The weekly CFR fluctuated throughout the outbreak, remaining above 45% since late June, peaking at 56.07% during September 13-16.

Overall, the outbreak remains active in the DRC, with ongoing transmission, high mortality, and continued geographic spread reported across affected provinces, as shown in Figure 2. Although response measures have been intensified in affected areas, new cases continue to be reported, indicating that transmission has not yet been fully contained.

Ituri remains the most affected province, contributing 77.48% of all confirmed cases reported to date (Figure 1). Specifically, the highest proportions of cases were recorded in Bunia (21.7%), followed by Rwampara (13.8%), Nizi (9.9%), and Mongbalu (9.0%). Together, these four health zones accounted for 54.4% of all confirmed cases, demonstrating a limited number of geographic hotspots.

Meanwhile, cases reported from other provinces indicate that transmission is not confined to Ituri alone and that the risk of further spread persists. Continued population movement, challenges in accessing healthcare services, and delays in detection may contribute to ongoing transmission and the emergence of new affected areas.

Uganda

- **On May 11, 2026,** Uganda reported its first case of BVD in an elderly traveller from the DRC. He was hospitalized in Kampala and died on May 14. Laboratory testing confirmed BDBV infection on 15 May, and the body was repatriated to the DRC the same day. The last confirmed case was reported on 21 June 2026, and transmission remained limited in Kampala. **By July 28, 2026, Uganda officially declared the end of the Ebola outbreak after completing the required period of enhanced surveillance with no further transmission detected**. Overall, the outbreak resulted in 20 confirmed cases and two deaths (CFR: 10.0%), with 18 patients recovering (90.0%).

France

- **On June 24, 2026,** France reported an imported laboratory-confirmed BDBV case in a physician returning from a humanitarian mission in Ituri Province, DRC. The patient was isolated after self-reporting symptoms upon arrival on June 23. PCR testing confirmed infection, and five contacts identified from the flight were placed under monitoring. No secondary cases have been reported.

Germany

- **On July 13, 2026,** an imported BVD case involving a United States humanitarian worker was medically evacuated from the DRC to Germany after testing positive for BDBV. At the time of reporting, no evidence of local transmission or secondary cases had been reported in Germany.

Epidemiology

- Bundibugyo virus disease (BVD) is a severe Ebola disease caused by the Bundibugyo virus, an Orthoebolavirus. The current event is the 17th Ebola outbreak reported in the DRC since 1976. It is transmitted through direct contact with infected bodily fluids. The incubation period is 2–21 days, and symptoms range from fever and fatigue to severe gastrointestinal illness and haemorrhagic manifestations. Differentiating BVD from other common febrile diseases is challenging without laboratory testing.
- Effective outbreak control depends on early case identification, isolation of patients, contact tracing, safe burial procedures, adherence to IPC protocols, and strong community engagement, as there are currently no licensed vaccines or specific antiviral treatments for BVD.
- The outbreak has now surpassed DRC's 2018–2020 outbreak in deaths and is the largest Ebola outbreak ever reported in DRC.

Response Operations

- Response activities continued across affected provinces, including case management, surveillance, risk communication and community engagement (RCCE), infection prevention and control (IPC), and safe and dignified burial (SDB) operations. Surveillance at points of entry and points of control (PoE/PoC) remained active, while RCCE interventions supported community awareness, contact tracing, and outbreak response efforts.
- Logistics operations continued to support the response through personnel training, the delivery of nutrition and IPC supplies, and fuel distribution. Efforts to strengthen response capacity also included ongoing monitoring of patients in isolation, as well as continued construction and expansion of Ebola Treatment Centres (CTEs) and associated isolation facilities.
- On August 18–20, 2026, WHO reported progress in the development of BVD medical countermeasures, including human trials for two candidate vaccines, continued enrollment in the therapeutic trial, and the allocation of Ebola vaccine doses to the DRC by the International Coordinating Group (ICG) on Vaccine Provision to support outbreak response and generate evidence on vaccine safety and effectiveness against Bundibugyo ebolavirus.
- As of September 13, of 11,703 targeted healthcare and frontline workers (19.7%) had been vaccinated in Tshopo Province. Additional doses were deployed to Bas-Uélé, and vaccination of frontline workers in Bunia, Ituri, was scheduled to begin on September 15, although vaccine uptake remained suboptimal in some areas.

The WHO Recommendations

- On August 24, 2026, following the second meeting of the IHR Emergency Committee, WHO reaffirmed that the BVD outbreak continues to constitute a PHEIC and issued updated Temporary Recommendations for affected and at-risk countries.
- WHO stressed the importance of building community trust, expanding engagement with community leaders and local networks, and improving acceptance of public health measures, including early detection, case referral, contact tracing, and safe burial practices.
- WHO highlighted the importance of community trust and cross-border collaboration through strengthened surveillance, information sharing, and preparedness for imported cases, while continuing to advise against travel or trade restrictions, flight suspensions, or border closures. WHO also underscored the need to accelerate research on BVD vaccines and therapeutics while maintaining core outbreak-control measures, including surveillance, contact tracing, clinical care, IPC, and community engagement.

Risk to the ASEAN Region (Based on Flight Connectivity from Ebola Outbreak Areas)

Currently, there are no direct (non-stop) flights from the outbreak source airports (Kinshasa – DRC) to all ASEAN Member States (AMS). This allows for significant reduction on immediate importation risk, as passenger volume is diluted across connecting routes, and additional screening opportunities exist at transit hubs. Despite no direct flights, all ASEAN-bound travel requires 1-stop connections, primarily through major global hubs. Further details on flight connectivity can be accessed in the Situation Report of Ebola Disease Outbreak in The Democratic Republic of the Congo and Uganda - 18 May 2026.

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