ASEAN Biological Threats Surveillance Centre

Situation Report of Ebola Disease Outbreak caused by the Bundibugyo virus (BDBV) in the Democratic Republic of the Congo

November 6, 2026

With Support by:

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) in the Democratic Republic of the Congo (DRC) 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.
- **As of November 3**, a total of 10,668 cases with 5,198 deaths **(CFR: 48.7%)** have been confirmed in DRC across 67 health zones in eight provinces. A total of 2,881 patients recovered, representing a recovery rate of 27%.

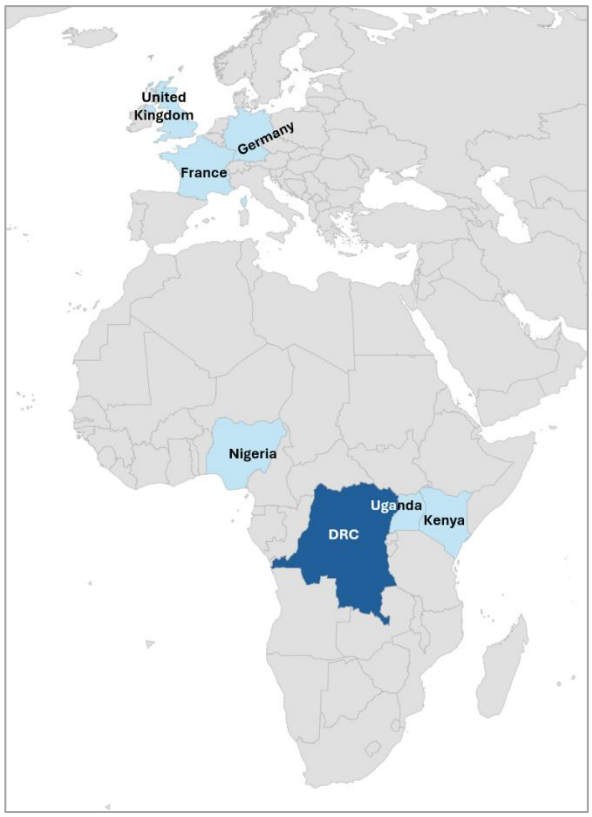


Figure 1. Map of countries reporting confirmed cases of BDBV as of November 5, 2026

- From **October 6 to 20, Kenya** reported nine confirmed BDBV cases, including one death, all linked to an imported case in a traveler returning from the DRC via Uganda, while **Nigeria** reported its first imported BDBV case in a traveler with recent travel history to Uganda on October 20. Contact tracing and response activities are ongoing in both countries, with no evidence of wider community transmission reported in Kenya.
- **On November 4, the United Kingdom (UK) reported a healthcare worker who tested positive for Ebola disease while supporting outbreak response activities in the DRC** and was medically evacuated to the UK for treatment.
- Since the start of the outbreak, **six countries have reported imported BVD cases linked to affected areas**, highlighting the risk of international spread. **Uganda, France, Germany, and the UK** reported cases associated with travel to the DRC, while **Kenya** reported imported cases linked to travel from the DRC via Uganda. **Nigeria** subsequently reported an imported case in a traveler returning from Uganda.

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.
- **Between July 9 and October 16**, the outbreak expanded beyond the initial affected provinces, with **Tshopo** and **Haut-Uélé** added on 9 July, followed by **Bas-Uélé** (12 August), **Sud-Ubangi** (10 September), and **Nord-Ubangi** (16 October), increasing the number of affected provinces from three to eight.
- **By November 3,** DRC confirmed a total of 10,668 cases and 5,198 deaths (CFR=48.7%) from 67 health zones in eight provinces.

Table 1. Distribution of Confirmed BDBV cases in the Democratic Republic of the Congo (DRC), as of November 3, 2026

Province	Health Zones Affected	Cases	Deaths	CFR (%)
Ituri	28	7,485	3,532	47.2
Nord-Kivu	17	2,593	1,422	54.8
Haut-Uele	7	470	208	44.3
Tshopo	7	94	29	30.9
Sud-Kivu	1	3	1	33.3
Bas Uele	4	13	4	30.8
Sud-Ubangi	1	2	1	50.0
Nord-Ubangi	2	8	1	12.5
Total	**67**	**10,668**	**5,198**	**48.7**

Source: Institut National De Sante Publique DRC

The BVD outbreak continued to expand in the DRC, driven by sustained transmission across affected provinces. Weekly reported cases increased from 8 cases in epidemiological week (EW) 19 to 296 cases in EW23, before briefly declining in EW24. Transmission subsequently intensified, with weekly case counts generally exceeding 300 from EW25 onward and peaking at 856 cases in EW29 (July 19 to 25), the highest weekly total reported during the outbreak. Although case counts declined thereafter, transmission remained substantial, with 375–651 cases reported weekly between EW30 and EW42. In EW43, 503 cases were reported, while 201 cases had been reported in EW44 as of November 1–3, 2026. As the latest data represent only three days of reporting, they are therefore not directly comparable with complete epidemiological weeks (Figure 2).

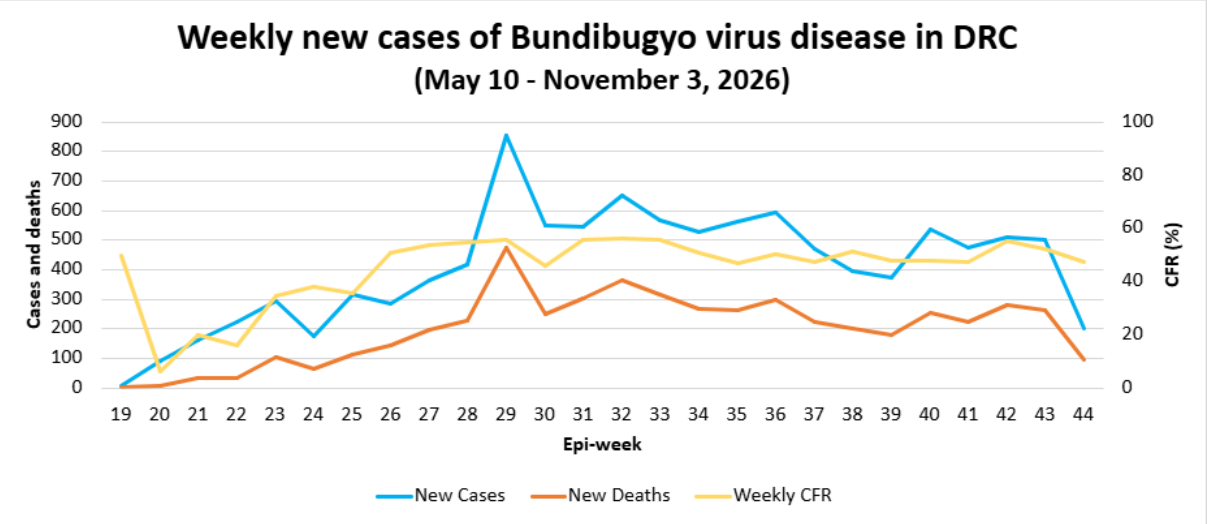


Figure 2. Weekly new cases of BVD in the DRC (May 10 – November 3, 2026)
(Source: Institut National De Sante Publique DRC)

Similar patterns were observed in mortality trends. Weekly deaths increased from 4 in EW19 to a peak of 475 in EW29, before declining in subsequent weeks. A secondary peak of 365 deaths was observed in EW32, followed by fluctuating but persistently elevated mortality. Deaths increased again to 280 in EW42, before declining to 262 in EW43. In EW44, 95 deaths had been reported as of November 1–3. The weekly case fatality ratio (CFR) fluctuated throughout the outbreak, remaining above 45% from late June onward and peaking at 56.1% in EW32, underscoring the continued severity of the outbreak.

Ituri Province remains the most affected province, accounting for 70.2% of all confirmed cases reported to date. The highest proportions of confirmed cases were reported from Rwampara (11.3%), Bunia (8.9%), Nizi (8.0%), and Mongbwalu (6.8%). Together, these four health zones accounted for approximately 35.0% of all confirmed cases, highlighting the concentration of transmission in a limited number of persistent hotspots.

Outside Ituri, North Kivu accounted for 24.3% of confirmed cases, followed by Haut-Uélé (4.4%). The remaining affected provinces contributed relatively small proportions of cases, each accounting for 0.1%–0.9% of the cumulative total, indicating that transmission remains concentrated in a limited number of provinces and health zones.

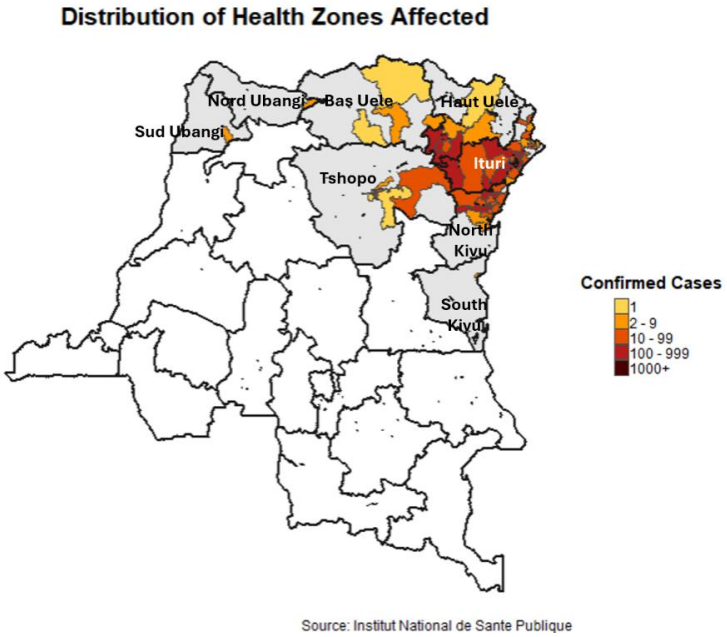


Figure 3. Distribution of Health Zones affected, as of November 3, 2026

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 confirmed case of BVD in a traveler from the DRC. Laboratory confirmation was obtained on 15 May, and the patient subsequently died. The last confirmed case was reported on 21 June 2026. **By July 28, 2026, Uganda officially declared the end of the Ebola outbreak 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.

Kenya

- **On October 6, 2026**, Kenya reported its first imported BDBV case in a traveler returning from the DRC via Uganda, who died on October 5. A second epidemiologically linked case was confirmed in a household contact under quarantine on October 14.
- **As of October 23**, Kenya reported nine confirmed cases, including two deaths, with all cases linked to the initial importation event. There was no evidence of wider community transmission.
- **By November 3,** five remaining patients discharged and 46 contacts were released from quarantine. No new cases have been reported since 19 October 2026.

Nigeria

- **On October 20, 2026**, Nigeria reported its first imported case of Ebola disease caused by Bundibugyo virus (BDBV) in a woman with a recent travel history to Uganda. No further cases were reported in the country.

The United Kingdom

- **On November 4, 2026**, the United Kingdom reported a healthcare worker who tested positive for Ebola disease while supporting outbreak response activities in the DRC and was medically evacuated to the UK for specialist treatment. The patient was reported to be in stable condition, and UK authorities assessed the risk to the public as low.

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.
- The outbreak has now surpassed DRC's 2018–2020 outbreak in deaths and is the largest Ebola outbreak ever reported in DRC.

Response Operations

Democratic Republic of the Congo

- Response activities continued across affected provinces. 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.
- Following confirmation of the second BDBV case on 14 October 2026, Kenya intensified contact tracing and quarantine measures. Of the 128 contacts identified from the index case, 113 had been traced, including 108 contacts placed under quarantine and daily monitoring in Kenya, while relevant authorities were notified for five contacts located abroad. Efforts to locate the remaining contacts continue.
- On October 15, 2026, WHO reaffirmed its support to Kenya's Ebola response following confirmation of a second BDBV case. Response efforts have focused on surveillance, contact tracing, case management, and infection prevention and control (IPC).

United Kingdom

- The British Government arranged the patient's medical evacuation from the DRC to the UK for specialist treatment at a high-consequence infectious disease (HCID) unit, with transfer by specialist ambulance upon arrival. British authorities stated that the National Health Service (NHS) has procedures in place to manage suspected and confirmed Ebola infections.

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

Currently, there are no direct (non-stop) flights from the outbreak source airport (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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