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 20, 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 17**, a total of 11,613 cases with 5,678 deaths **(CFR: 48.9%)** have been confirmed in DRC across 68 health zones in eight provinces. A total of 3,148 patients recovered, representing a recovery rate of 27.2%.

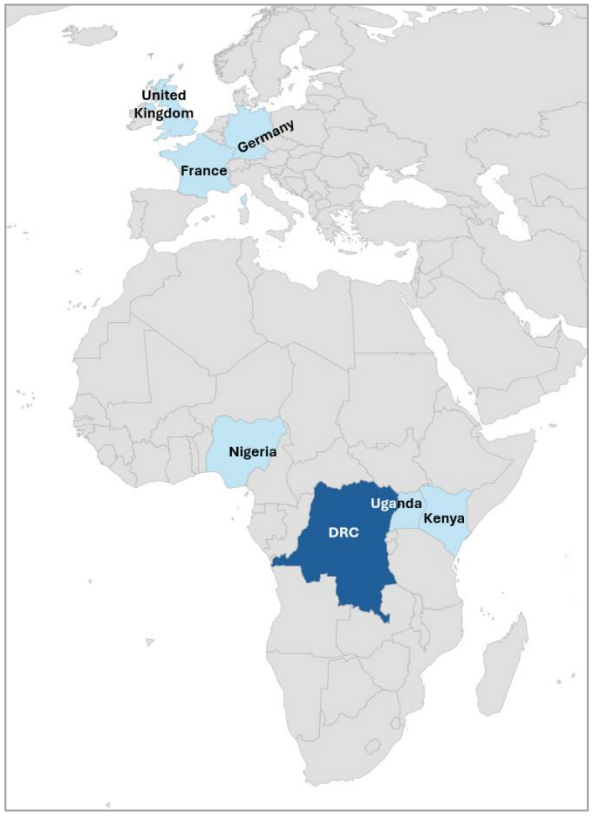


Figure 1. Map of countries reporting confirmed cases of BDBV as of November 20, 2026

- 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 17,** DRC confirmed a total of 11,613 cases and 5,678 deaths (CFR=48.9%) from 68 health zones in eight provinces.

Table 1. Distribution of Confirmed BDBV cases in the Democratic Republic of the Congo (DRC), as of November 17, 2026

Province	Health Zones Affected	Cases	Deaths	CFR (%)
Ituri	28	7,946	3,751	47.2
Nord-Kivu	17	2,996	1,654	55.2
Haut-Uele	8	534	231	43.3
Tshopo	7	109	35	32.1
Sud-Kivu	1	3	1	33.3
Bas Uele	4	13	4	30.8
Sud-Ubangi	1	2	1	50.0
Nord-Ubangi	2	10	1	10.0
Total	**68**	**11,613**	**5,678**	**48.9**

Source: Institut National De Sante Publique DRC

The BVD outbreak in the DRC continued to be characterized by sustained transmission and high mortality. Weekly reported cases increased from 8 cases in epidemiological week (EW) 19 to a peak of 856 cases in EW29, reflecting rapid expansion of the outbreak across affected provinces (Figure 2). Although case counts subsequently declined, transmission remained substantial, with weekly totals largely exceeding 375 cases from EW30 onward. Cases decreased from 509 in EW42 to 456 in EW45, suggesting a modest downward trend. Preliminary data for EW46 (15–17 November) recorded 237 cases, suggesting continuous transmissions.

Mortality trends followed a similar pattern. Weekly deaths increased from 4 deaths in EW19 to a peak of 475 deaths in EW29, before declining in subsequent weeks. Despite this decline, mortality remained persistently high, with weekly deaths ranging from 179 to 365 between EW30 and EW44. As of November 16, DRC had reported 62 deaths in the incomplete EW46 reporting period. The weekly case fatality ratio (CFR) fluctuated throughout the outbreak, remaining above 45% since EW30 and peaking at 56.1% in EW32, indicating continued high mortality among reported cases.

Overall, although weekly case counts and deaths have declined from the peaks observed in late July and early August, transmission remains active across affected provinces. The continued reporting of hundreds of new cases and deaths each week indicates that the outbreak remains a significant public health threat. The apparent decline observed in EW45 should be interpreted cautiously, as the reporting period covers only four days (Figure 2).

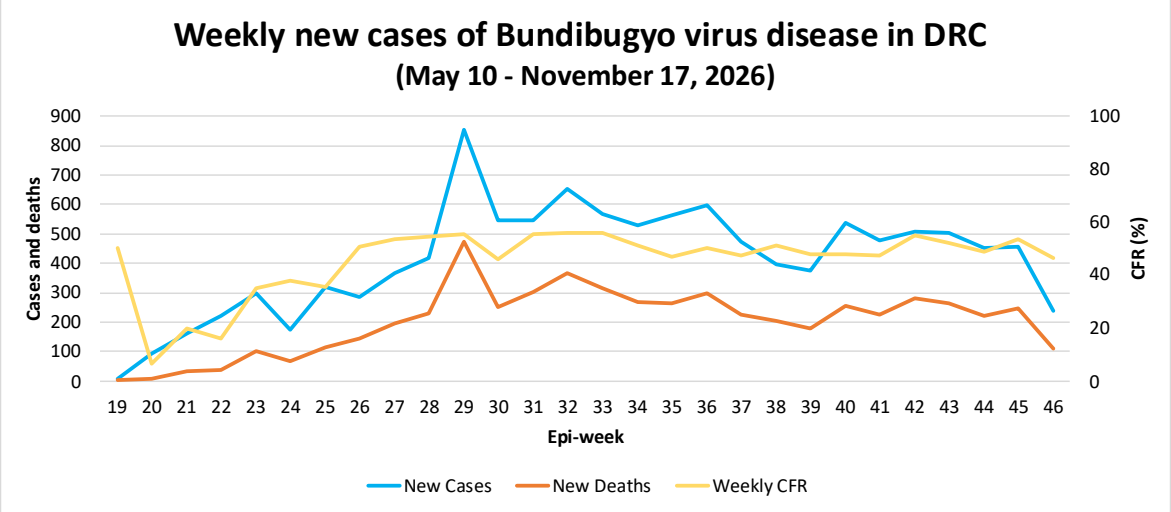


Figure 2. Weekly new cases of BVD in the DRC (May 10 – November 17, 2026)
(Source: Institut National De Sante Publique DRC)

Ituri remains the most affected province, accounting for 68.4% of all confirmed cases reported to date. The highest proportions of confirmed cases were reported from Rwampara (11.3%), Bunia (18.2%), Nizi (7.6%), and Mongbwalu (6.4%) in Ituri, as well as Beni (8.0%) in North Kivu. Together, these five health zones accounted for 50.1% of all confirmed cases, indicating that transmission remains concentrated in a limited number of persistent hotspots.

Outside Ituri, North Kivu accounted for 25.8% of confirmed cases, followed by Haut-Uélé (4.6%). The remaining affected provinces each contributed 0.1%–1.0% of the cumulative caseload, suggesting that the outbreak remains largely concentrated in a small number of provinces and health zones.

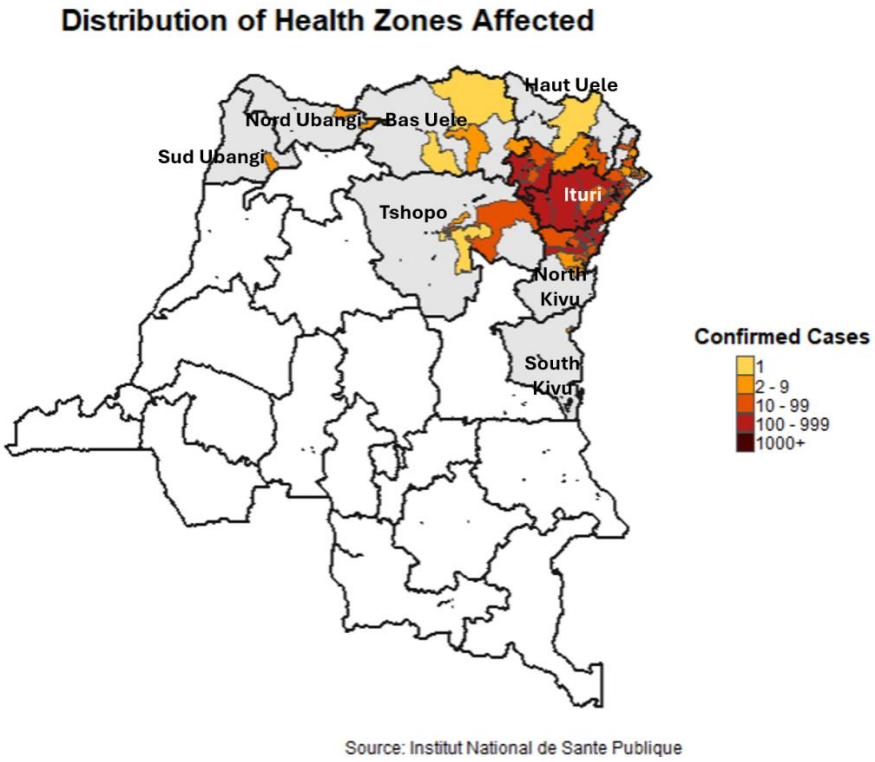


Figure 3. Distribution of Health Zones affected, as of November 17, 2026

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 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 11,** Kenya's last Ebola patient has been discharged, with all 135 contacts completing monitoring and no community transmission recorded. The 42-day countdown towards declaring Kenya Ebola-free begins on November 12.

Nigeria

- **On October 20, 2026**, Nigeria reported its first imported BDBV case in a Swiss national with recent travel history to Uganda. On October 26, Switzerland reported the medical evacuation of the patient, who remains in isolation at Geneva University Hospital. Her spouse has since been discharged from hospital. No information on the patient's clinical condition has been released due to data protection requirements, and no additional cases have been reported in Nigeria.

The United Kingdom

- **On November 5, 2026,** the United Kingdom reported the evacuation of a healthcare worker who tested positive for Ebola disease while supporting outbreak response activities in the DRC. 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.
- 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. 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.
- Despite ongoing response efforts, several operational indicators remain below target. Contact follow-up and timely isolation of suspected cases remain suboptimal, more than 1,000 contacts have been lost to follow-up, and a substantial proportion of deaths continue to occur in the community. Insecurity, health-worker strikes, operational disruptions, and vaccine supply constraints in some areas continue to hinder outbreak control efforts.

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 community trust, engagement with community leaders and local networks, and 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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