

ASEAN Biological Threats Surveillance Centre
**Situation Report of Ebola Disease Outbreak
caused by the Bundibugyo virus (BDBV)**
in the Democratic Republic of the Congo
October 23, 2026



With Support by:
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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 October 20**, a total of 9,704 cases with 4,687 deaths (**CFR: 48.3%**) have been confirmed in DRC across 66 health zones in seven provinces. A total of 2,595 patients recovered, representing a recovery rate of 26.7%.
- 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. A second case was identified among household contacts under quarantine, while ongoing contact tracing found no evidence of wider community transmission.
- On October 20**, Nigeria reported its first imported BDBV case in a woman with recent travel history to Uganda. Public health authorities identified 44 contacts for follow-up and intensified infection prevention and control measures at the health facility where the patient sought care.
- Since the start of the outbreak, five other countries have reported imported BVD cases linked to affected areas**, highlighting the risk of international spread. **Uganda, France, and Germany** reported cases associated with travel to the DRC, while **Kenya** reported imported cases linked to travel from the DRC through Uganda. **Nigeria** subsequently reported an imported case in a traveler returning from Uganda.



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

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 October 20**, DRC confirmed a total of 9,704 cases and 4,687 deaths (CFR=48.3%) from 66 health zones in eight provinces.

Table 1. Distribution of Confirmed BDBV cases in the Democratic Republic of the Congo (DRC), as of October 20, 2026

Province	Health Zones Affected	Cases	Deaths	CFR (%)
Ituri	28	7,040	3,271	46.5
Nord-Kivu	17	2,146	1,199	55.9
Haut-Uele	7	421	183	43.5
Tshopo	7	76	27	35.5
Sud-Kivu	1	3	1	33.3
Bas Uele	4	13	4	30.8
Sud-Ubangi	1	2	1	50.0
Nord-Ubangi	1	3	1	33.3
Total	66	9,704	4,687	48.3

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 during May 10–16 to a peak of 856 during July 19–25, reflecting widespread transmission. Since the week ending September 19, however, a gradual decline in weekly case counts has been observed, with 375 new cases reported in the week ending October 3. However, cases re-emerged with 536 cases in the following week. Preliminary data for the current reporting period indicates that 168 new cases were reported from October 11 to 12, suggesting that transmission remains (Figure 2).

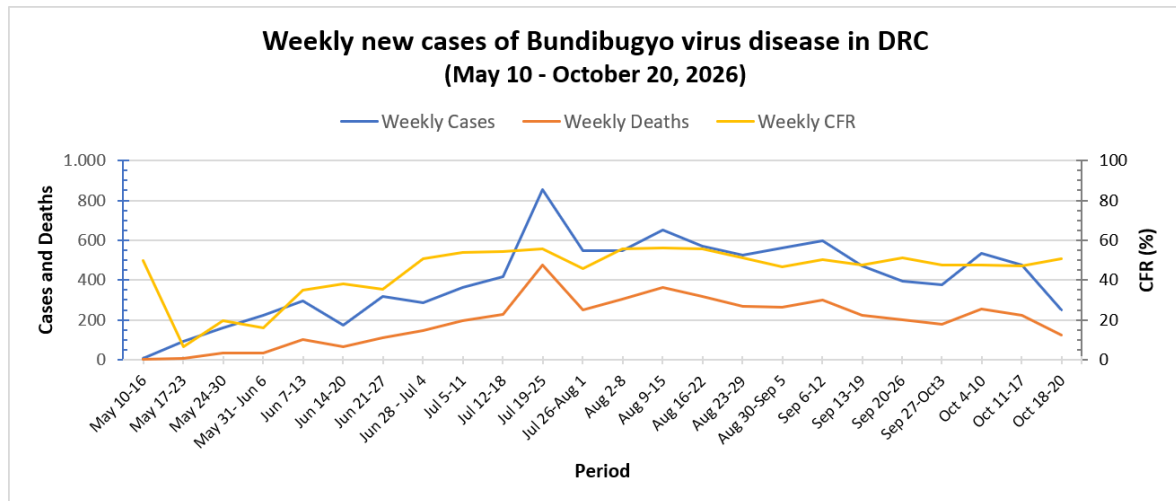


Figure 2. Weekly new cases of BVD in the DRC (May 10 – October 20, 2026)
(Source: Institut National De Sante Publique DRC)

Mortality trends followed a similar pattern, increasing from four deaths during May 10–16 to a peak of 475 deaths during July 19–25, before declining in subsequent weeks. A secondary peak of 365 deaths was observed during August 9–15, followed by a gradual decline. Deaths increased again to 300 during September 6–12 before falling to 179 in the week ending October 3, then rising in the following weeks. A primary finding this week between October 18-20 confirmed 126 deaths. The weekly CFR fluctuated throughout the outbreak, remaining above 44% since late June and peaking at 56.1% during August 9–15.

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 3. 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 72.5% of all confirmed cases reported to date. Specifically, the highest proportions of cases were recorded in Bunia (19.7%), followed by Rwampara (12.1%), Nizi (8.6%), and Mongbalu (7.4%). Together, these four health zones accounted for nearly half of all confirmed cases, demonstrating a limited number of geographic hotspots.

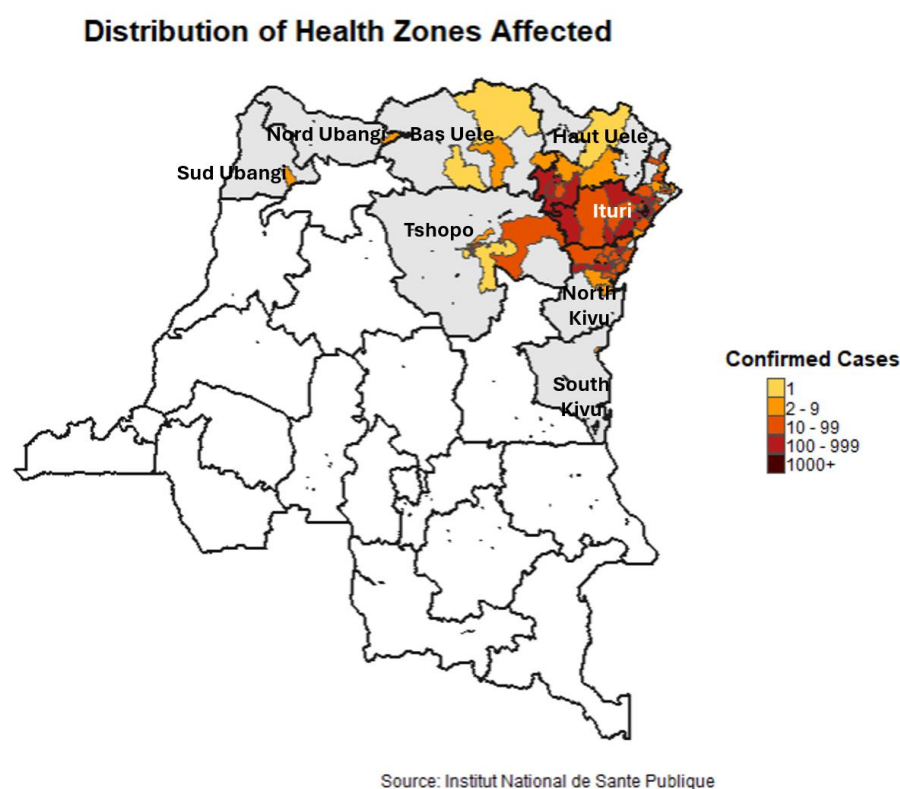


Figure 3. Distribution of Health Zones affected, as of October 20, 2026

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.

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 20**, Kenya had reported nine confirmed cases, including one death, with all cases linked to the initial importation event. Contact tracing and monitoring remain ongoing, with no evidence of wider community transmission.

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. Currently, 44 contacts have been identified and are being. Infection prevention and control measures are being ramped up in the private health facility where the patient sought care.

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.

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).

Kenya

- Screening at points of entry (PoE) continues. On October 19, 2026, a total of 2,990 travellers were screened at PoE, including 2,849 arriving from Uganda and 141 from DRC, bringing the cumulative number screened to 701,989 since May. Risk Communication and Community Engagement (RCCE) coordination and public communication have been intensified, with daily partner coordination, activation of the RCCE technical working group
- Five laboratories have been designated for BVD diagnosis, comprising the National Virology Reference Laboratory, Kenya Medical Research Institute laboratories in Nairobi and Kisumu, and two mobile laboratories at the Busia and Lwakhakha border points.
- WHO has delivered five PCR machines and 20 diagnostic kits, sufficient for approximately 2000 tests, to the Ministry of Health to expand diagnostic capacity.

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 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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