

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 30, 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 27**, a total of 10,193 cases with 4,960 deaths (**CFR: 48.7%**) have been confirmed in DRC across 66 health zones in seven provinces. A total of 2,749 patients recovered, representing a recovery rate of 27%.
- 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.
- 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 27, 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 27**, DRC confirmed a total of 10,193 cases and 4,960 deaths (CFR=48.7%) 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 27, 2026

Province	Health Zones Affected	Cases	Deaths	CFR (%)
Ituri	28	7,278	3,407	46.8
Nord-Kivu	17	2,361	1,325	56.1
Haut-Uele	7	444	194	43.7
Tshopo	7	89	27	30.3
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	10,193	4,960	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 declining briefly in EW24. Transmission then intensified, with weekly cases generally exceeding 300 from EW25 onward and reaching a peak of 856 cases in EW29, the highest weekly total reported during the outbreak. Although case counts subsequently declined, transmission remained substantial, with weekly totals ranging from 395 to 651 cases from EW30 to EW42. In the most recent reporting period, 229 cases had been reported in EW43; however, this figure covers only 25–27 October and is therefore not directly comparable with complete epidemiological weeks (Figure 2).

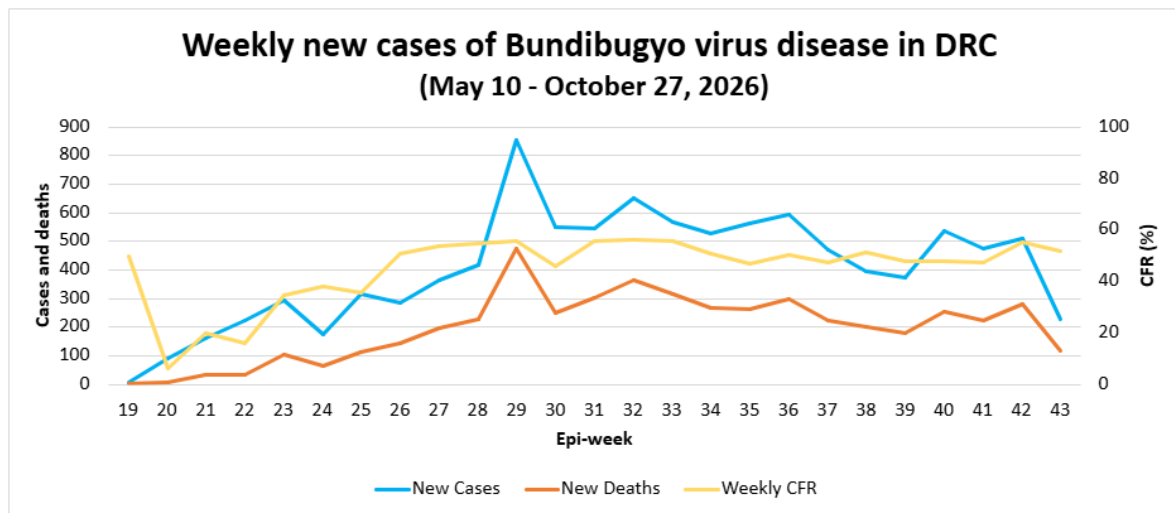


Figure 2. Weekly new cases of BVD in the DRC (May 10 – October 27, 2026)
(Source: Institut National De Sante Publique DRC)

Mortality trends closely mirrored case patterns. Weekly deaths increased from 4 in EW19 to 103 in EW23, before rising further to a peak of 475 deaths in EW29. While deaths declined thereafter, mortality remained high, with weekly totals generally exceeding 200 deaths throughout much of August and September. A secondary increase was observed in EW32 (365 deaths), followed by a gradual decline to 179 deaths in EW39. However, deaths rose again in EW40–42, reaching 280 deaths in EW42. As of 27 October, 119 deaths had been reported in the incomplete EW43.

The weekly case fatality ratio (CFR) fluctuated considerably throughout the outbreak. Following an initial decline from 50.0% in EW19 to below 20% during EW20–22, the CFR increased steadily and remained above 44% from EW26 onward. The highest weekly CFR was recorded in EW32 (56.1%), while most subsequent weeks reported CFRs between 47% and 55%, indicating persistently high mortality among reported cases.

Overall, despite fluctuations in weekly incidence and mortality, the outbreak has remained characterized by sustained transmission and elevated mortality. While recent weeks suggest a possible reduction in transmission intensity compared with the peak observed in late July, ongoing case reporting across affected provinces indicates

that the outbreak remains active. The current EW43 figures should be interpreted cautiously, as they represent only a partial reporting period (25–27 October).

Ituri Province remains the most affected province, accounting for 71.4% of all confirmed cases reported to date. The largest shares of confirmed cases were reported from Bunia (19.3%), Rwampara (11.7%), Nizi (8.3%), and Mongbwalu (7.0%). Together, these four health zones accounted for nearly half of all confirmed cases, highlighting the concentration of transmission in a limited number of geographic hotspots.

North Kivu contributed 23.2% of all 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.

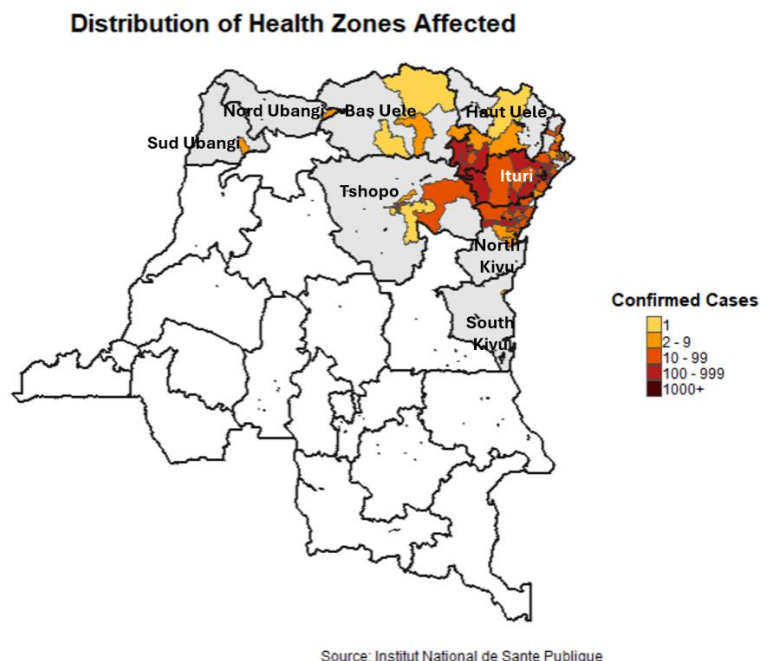


Figure 3. Distribution of Health Zones affected, as of October 27, 2026

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. 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. As of October 22, 2026, a total of 709,000 travellers had been screened at PoE 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.
- On October 27, the first 20 contacts completed 21-day monitoring and had returned home in good health.
- 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.

Nigeria

- the Nigeria Centre for Disease Control and Prevention (NCDC) activated national and state Incident Management Systems to coordinate the response. Health authorities, supported by WHO and partners, are strengthening case investigation, contact tracing, infection prevention and control (IPC), and healthcare worker protection through the provision of personal protective equipment and other essential supplies.

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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