World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Kenya | Nigeria

Weekly External Situation Report 27, Data as of 15 November 2026

8 Provinces **68 Health Zones** Affected	**5** Provinces **52 Health Zones** Active Transmission*	**3 109** Cases Recovered	**49.7%** Bed Occupancy	**35 559** Contacts under follow up
1 681 Active Cases in Isolation	**396** Health Worker Cases	**59** Health Worker Deaths	**1 792** Bed Capacity	**30** Testing Laboratories

Note: Health zones with active transmission have reported at least one case in the last 21 days. Active cases in isolation include both suspected and confirmed cases and are as of 14 November (SitRep N°184); bed capacity and occupancy are from the latest complete bed census (7 November). Health worker cases and deaths are derived from the DHIS2 line list (occupation recorded as health worker or frontline worker; extract of 17 November). Weekly and three-week figures in this report are sums of the daily counts published in the national sitreps, as on the COUSP dashboard; epidemiological weeks run from Monday to Sunday.

Summary of Bundibugyo Virus Disease cases by country of reporting

Country	New Confirmed Cases (Last 7 days of reporting)	New Confirmed Deaths (Last 7 days of reporting)	Confirmed Cases (Total)	Confirmed Deaths (Total)	CFR (%) Confirmed	Status
Democratic Republic of the Congo	442	239	11 432	5 593	48.9%	Active
Kenya	0	0	9	2	22.2%	Active
Nigeria	0	0	1	0	0.0%	Active
Uganda	0	0	20	2	10.0%	Ended
France	0	0	1	0	0.0%	Ended

Event description

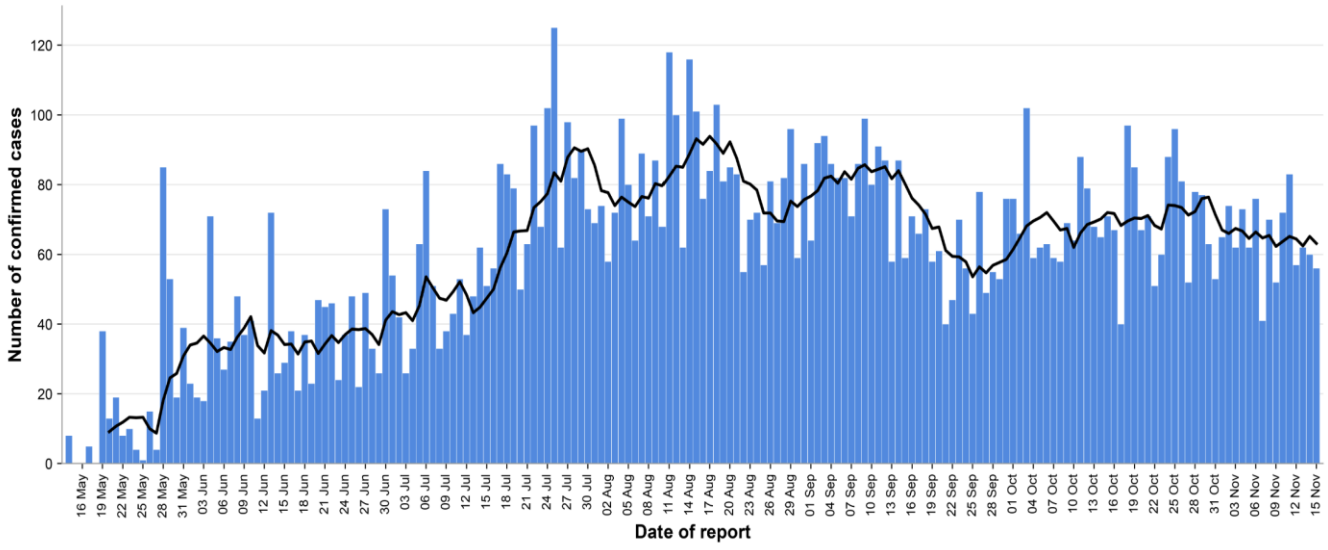
The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo continues at a high and sustained level of transmission. During epidemiological week 46 (9 – 15 November 2026), 442 confirmed cases and 239 confirmed deaths were reported, compared with 458 cases and 228 deaths in week 45; the national seven-day average has remained between 62 and 65 cases per day, and a new health zone, Watsa in Haut-Uélé, reported its first confirmed cases. Over three epidemiological weeks (weeks 44 – 46 compared with weeks 41 – 43), reported cases decreased by 6.7% and deaths by 4.6%, with a decline in Ituri partly offset by continued intense transmission in Nord-Kivu, where Beni remains the health zone with the most cases, and by rising incidence in Mangala, Mambasa and Mutwanga. Deaths in treatment centres increased in week 46 and the proportion of deaths occurring in the community fell to 59% (142 of 239), its lowest weekly level since August. In Kenya, the last patient was discharged on 11 November, and all contacts have completed their follow-up; the 42-day countdown is under way, and the event has not yet been declared over. In Nigeria, all 62 contacts completed their 21-day follow-up on 13 November and no secondary case was identified; surveillance continues in both countries. Additionally, Nigeria started the 42 days countdown on 27 Oct after the case was medically evacuated to Switzerland on the 26 October 2026.
In the Democratic Republic of the Congo, insecurity in Beni, Mabalako and Bafwasende, strikes over unpaid salaries in several provinces and community resistance to safe burials continue to constrain surveillance and response operations.

Democratic Republic of the Congo

As of 15 November 2026, the BVD outbreak in the Democratic Republic of the Congo has affected 68 health zones and 248 health areas across eight provinces. One new health zone, Watsa in Haut-Uélé, was affected during the reporting period (two confirmed cases reported on 11 November and seven on 13 November). Since ***External Situation Report #26***, (data as of 7 November), an additional 512 confirmed cases and 270 confirmed deaths have been reported between 8 and 15 November, of which 442 cases and 239 deaths during epidemiological week 46 (9 – 15 November). The cumulative total is 11 432 confirmed cases, including 5 593 confirmed deaths [crude case fatality ratio (CFR) 48.9%]. Among cases with a documented outcome (5 593 deaths and 3 109 recoveries), the case fatality ratio is 64.3%; the outcome of the remaining 2 730 cases is still pending or not yet recorded. Transmission remains highly heterogeneous across affected areas. Ituri continues to account for the largest proportion of cumulative confirmed cases (68.9%) and accounted for 227 of the 442 cases reported in week 46 (51.4%), while Nord-Kivu (25.3% of cumulative cases; CFR 55.4%) accounted for 169 (38.2%). Transmission persists at lower levels in Haut-Uélé (35 cases; 7.9%), Tshopo (10; 2.3%) and Nord-Ubangi (one case).

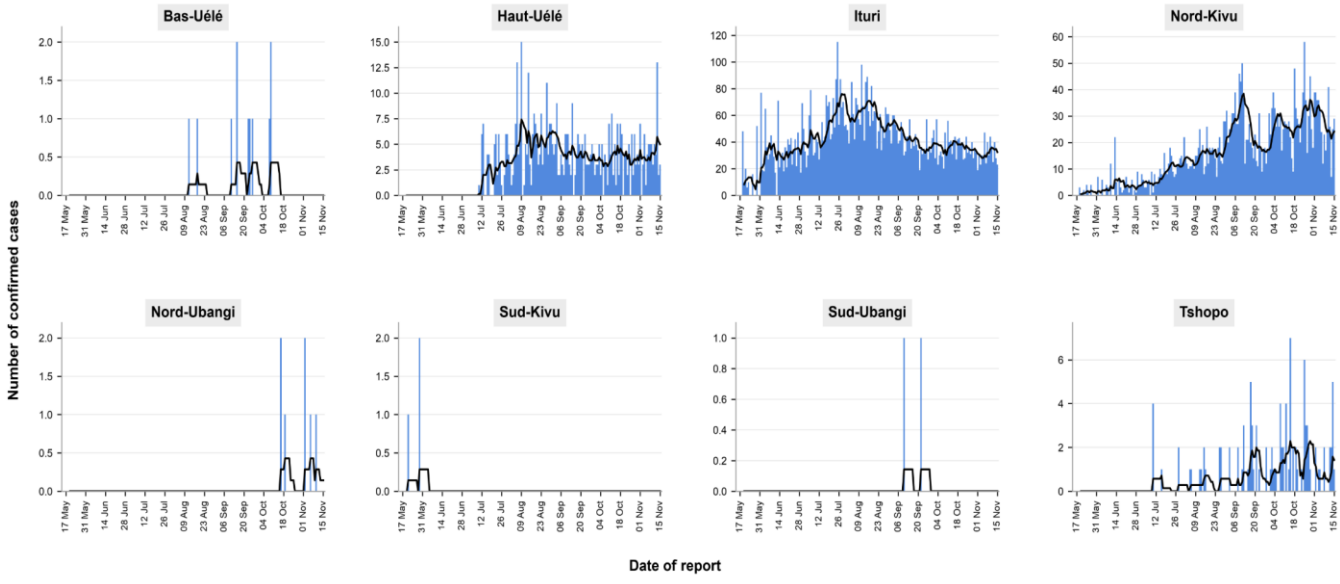
National daily incidence rose steadily from May to its highest levels in late July and mid-August, declined through late September and has fluctuated at a high plateau since early October. The seven-day moving average ranged between 62 and 65 confirmed cases per day during week 46 (63.1 on 15 November, compared with 65.4 on 8 November), well below the mid-August peak of 94 but with no downward trend over the last six weeks. Provincial trends diverged. Ituri reported 227 cases in week 46 compared with 223 in week 45 (seven-day average of 32 cases per day on 15 November), with Mandima, Bunia, Mangala and Mambasa reporting the most cases, while Nord-Kivu reported 169 cases compared with 202 (24 cases per day on 15 November, down from 29 on 8 November), Beni still reporting the largest numbers in the province. Haut-Uélé reported 35 cases compared with 24 (13 of them on 13 November, seven in the newly affected Watsa Health Zone), Tshopo 10 compared with six, and Nord-Ubangi one case in Wapinda. Bas-Uélé, Sud-Kivu and Sud-Ubangi have reported no case in the last 21 days (Figures 1 and 2). By week of symptom onset (Figure 3), confirmed cases recorded in the DHIS2 line list peaked between late July and mid-August, remained above 400 per week until mid-September and have declined gradually since, to 370 in week 43 and 306 in week 44; weeks 44 to 46 are still incomplete because of the delay between symptom onset and reporting (median five days, 90th percentile 14 days).

Figure 1. Daily national trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 15 November 2026



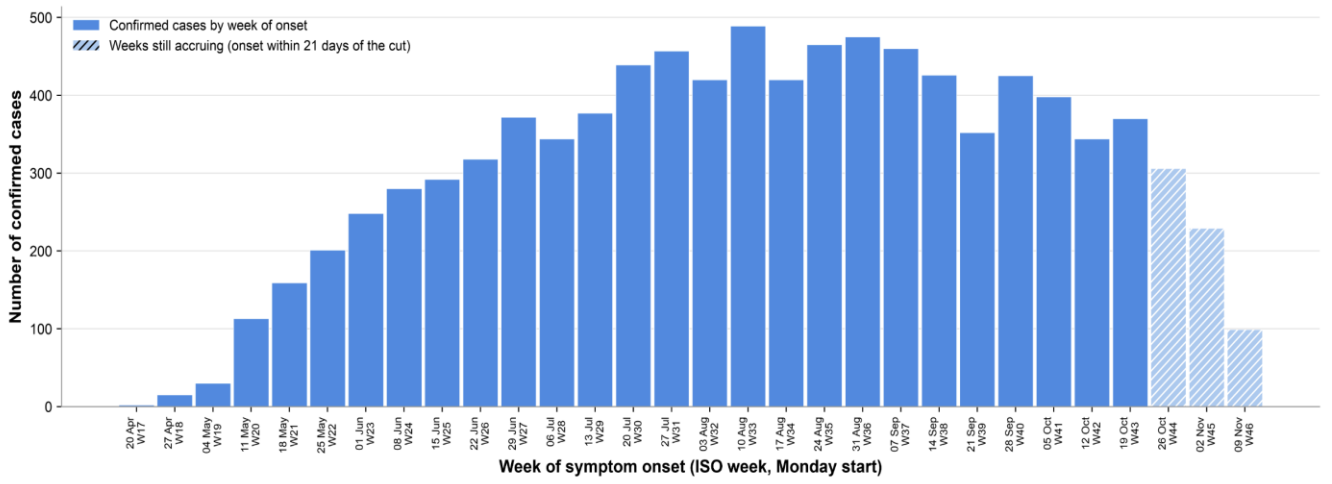
Bars show daily confirmed cases; black line shows the 7-day moving average. Data through 15 November 2026 (SitRep N°185), epidemiological week 46.

Figure 2. Daily provincial trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 15 November 2026



Bars show daily confirmed cases; black line shows the 7-day moving average; note the different y-axis scales. Data through 15 November 2026 (SitRep N°185), epidemiological week 46.

Figure 3. Confirmed Bundibugyo virus disease cases by week of symptom onset, Democratic Republic of the Congo, DHIS2 line list extract of 17 November 2026 (weeks 44 – 46 incomplete)



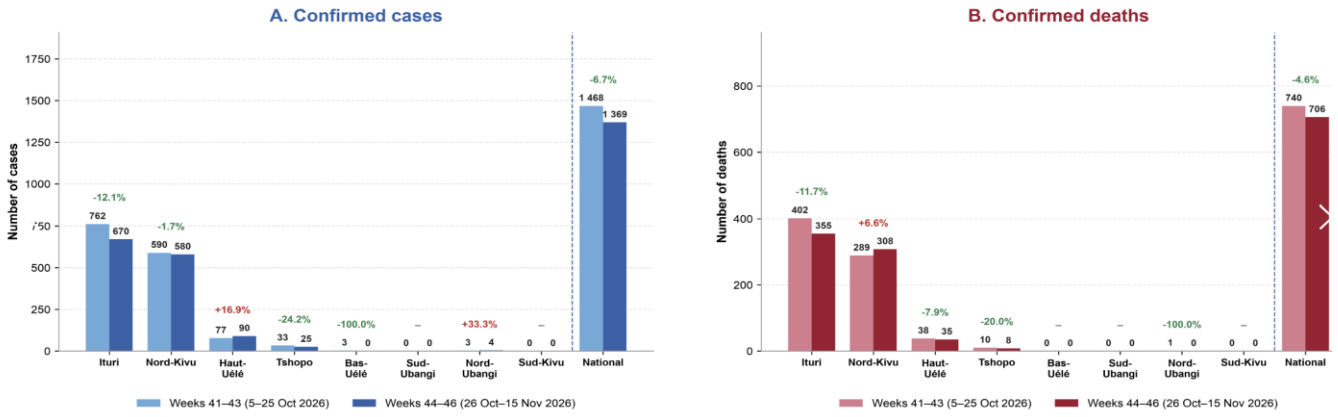
DHIS2 line list extract of 17 November 2026: 9 325 of 11 104 confirmed cases with a recorded onset date on or before 15 November 2026 (84%). Median onset-to-report delay 5 days (90th percentile 14 days) so recent weeks are incomplete.

Trend Analysis (21-day comparison):

During the most recent three epidemiological weeks (weeks 44 – 46, 26 October – 15 November 2026), a total of 1 369 confirmed cases were reported nationally, compared with 1 468 during the preceding 21 days (weeks 41 – 43, 5 – 25 October), a decrease of 99 cases (−6.7%). Cases in Ituri decreased from 762 to 670 (−12.1%), accounting for 48.9% of national cases during the latest period, and in Nord-Kivu from 590 to 580 (−1.7%), accounting for 42.4%. Haut-Uélé increased from 77 to 90 cases (+16.9%; 6.6% of national cases) and Nord-Ubangi from three to four, while Tshopo decreased from 33 to 25 (−24.2%). Bas-Uélé, which reported three cases in the preceding period, reported none; Sud-Kivu and Sud-Ubangi reported no case in either period. These weekly and three-week figures are sums of the daily counts published in the national sitreps, as on the COUSP dashboard; the corresponding differences in cumulative counts (1 372 and 1 457 cases) differ slightly because retrospectively added cases enter the cumulative totals only.

During the same period, 706 confirmed deaths were reported nationally, compared with 740 during weeks 41 – 43 (−4.6%). Deaths decreased from 402 to 355 (−11.7%) in Ituri, from 38 to 35 in Haut-Uélé and from 10 to eight in Tshopo, but increased from 289 to 308 (+6.6%) in Nord-Kivu, which now accounts for 43.6% of newly reported deaths (39.1% in the preceding period) against 50.3% for Ituri. Nord-Ubangi, which reported one death in the preceding period, reported none. In Nord-Kivu, deaths rose while cases fell slightly, consistent with the province's higher case fatality ratio (55.4%).

Figure 4. Bundibugyo virus disease cases and deaths by province across consecutive three-week periods, epidemiological weeks 41 – 43 (5 – 25 October 2026) compared with weeks 44 – 46 (26 October – 15 November 2026), Democratic Republic of the Congo



Transmission remained active in more than two-thirds of the health zones affected since the start of the outbreak. Of the 68 health zones affected to date, 48 (70.6%) in five provinces reported at least one new confirmed case during weeks 44 – 46 (26 October – 15 November): 21 in Ituri, 14 in Nord-Kivu, six in Haut-Uélé, five in Tshopo and two in Nord-Ubangi. The comparison between the two 21 days periods covers the 54 health zones that reported at least one case in either period: incidence increased in 22, decreased in 28 and was unchanged in four (Mahagi and Nyankunde in Ituri, Alimbongo in Nord-Kivu and Wapinda in Nord-Ubangi); the remaining 14 zones reported no case in either period.

The largest absolute increase occurred in Beni, Nord-Kivu (228 to 273 cases; +19.7%), followed by Mutwanga, Nord-Kivu (28 to 71; +153.6%), Mangala, Ituri (22 to 63; +186.4%), Mambasa, Ituri (46 to 76; +65.2%), Oicha, Nord-Kivu (43 to 57; +32.6%), Mongbwalu, Ituri (10 to 22), Isiro, Haut-Uélé (7 to 18), Pawa, Haut-Uélé (19 to 29) and Masereka, Nord-Kivu (7 to 16). Watsa in Haut-Uélé (nine cases), Kilo (five), Drodro and Kambala (one each) in Ituri and Yakoma in Nord-Ubangi (four) reported cases after none in the preceding period (Figure 5). Conversely, the largest decreases were observed in Mandima (257 to 202), Rwampara (71 to 48), Bunia (170 to 149), Nia-Nia (27 to 8), Aru (17 to 1) and Komanda (18 to 2) in Ituri; Butembo (52 to 23), Katwa (61 to 36) and Mabalako (54 to 34) in Nord-Kivu; and Wamba (47 to 23) in Haut-Uélé. In week 46, Beni (71 cases), Mandima (65) and Bunia (51) reported the most cases, followed by Mangala (31), Oicha (25) and Mambasa (24). Zone-level figures are differences in cumulative confirmed cases between SitReps N°143, N°164 and N°185 and reconcile to the national totals.

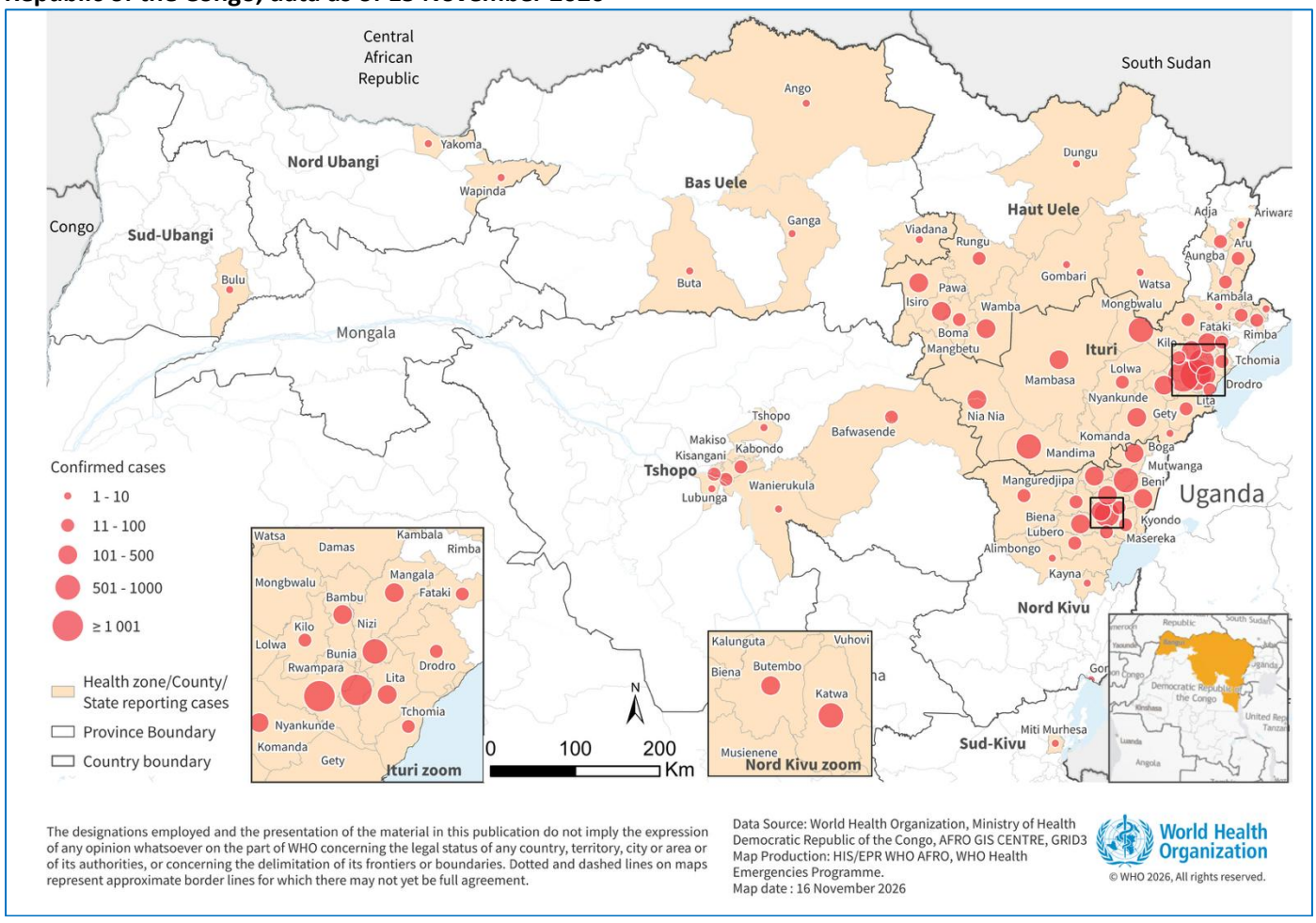
There were 20 health zones without a new case during weeks 44 – 46: Adja, Ariwara, Aungba, Boga, Damas, Gety and Logo in Ituri; Goma, Kayna and Manguredjipa in Nord-Kivu; Dungu and Gombari in Haut-Uélé; Lubunga and Wanie-Rukula in Tshopo; Miti-Murhesa in Sud-Kivu; Buta, Dakwa, Ganga and Viadana in Bas-Uélé; and Bulu in Sud-Ubangi. Six of them (Damas, Gety and Logo in Ituri, Manguredjipa in Nord-Kivu, and Dakwa and Ganga in Bas-Uélé) had reported cases during weeks 41 – 43.

Figure 5. Health zones reporting an increase in confirmed cases between consecutive three-week periods (epidemiological weeks 41 – 43 compared with weeks 44 – 46, 2026), Democratic Republic of the Congo, data as of 15 November 2026

Province	Health zone	Weeks 41–43 (5–25 Oct 2026) (cases)	Weeks 44–46 (26 Oct–15 Nov 2026) (cases)	% change
Ituri	Drodro	0	1	New
	Fataki	1	3	+200.0%
	Kambala	0	1	New
	Kilo	0	5	New
	Lita	28	29	+3.6%
	Mambasa	46	76	+65.2%
	Mangala	22	63	+186.4%
	Mongbwalu	10	22	+120.0%
Nord-Kivu	Beni	228	273	+19.7%
	Biena	4	5	+25.0%
	Kalunguta	30	32	+6.7%
	Masereka	7	16	+128.6%
	Mutwanga	28	71	+153.6%
	Oicha	43	57	+32.6%
Haut-Uélé	Boma Mangbetu	2	6	+200.0%
	Isiro	7	18	+157.1%
	Pawa	19	29	+52.6%
	Rungu	2	5	+150.0%
	Watsa	0	9	New
Tshopo	Kabondo	11	13	+18.2%
	Makiso-Kisangani	6	8	+33.3%
Nord-Ubangi	Yakoma	0	4	New

Only health zones with an increase in confirmed cases between the two periods are shown (22 of 68 affected health zones).
Periods are epidemiological weeks 41–43 (5–25 Oct) and 44–46 (26 Oct–15 Nov); zone values are differences in cumulative confirmed cases between SitReps N°143, N°164 and N°185.

Figure 6. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 15 November 2026



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

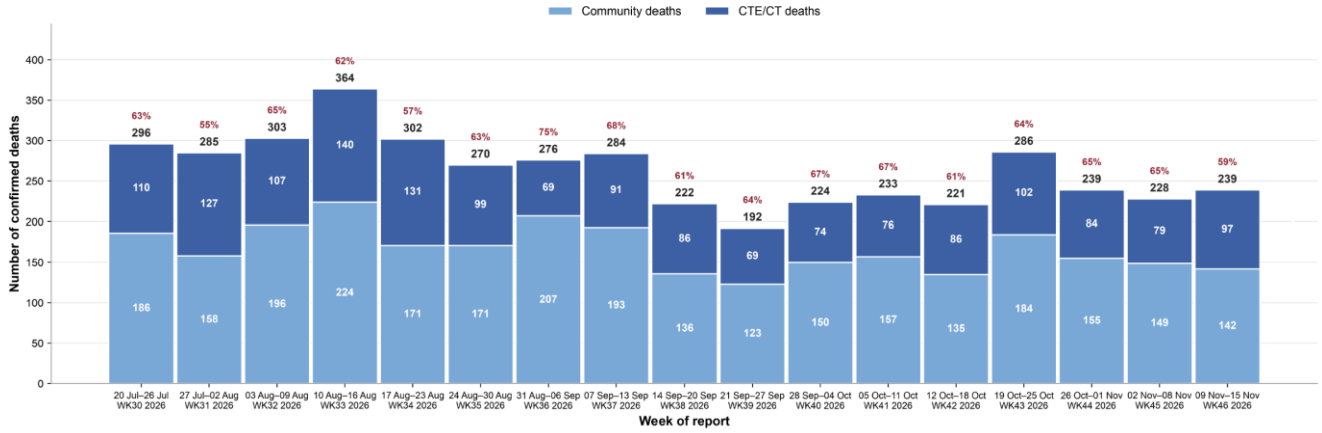
Data Source: World Health Organization, Ministry of Health Democratic Republic of the Congo, AFRO GIS CENTRE, GRID3
Map Production: HIS/EPR WHO AFRO, WHO Health Emergencies Programme.
Map date : 16 November 2026

World Health Organization

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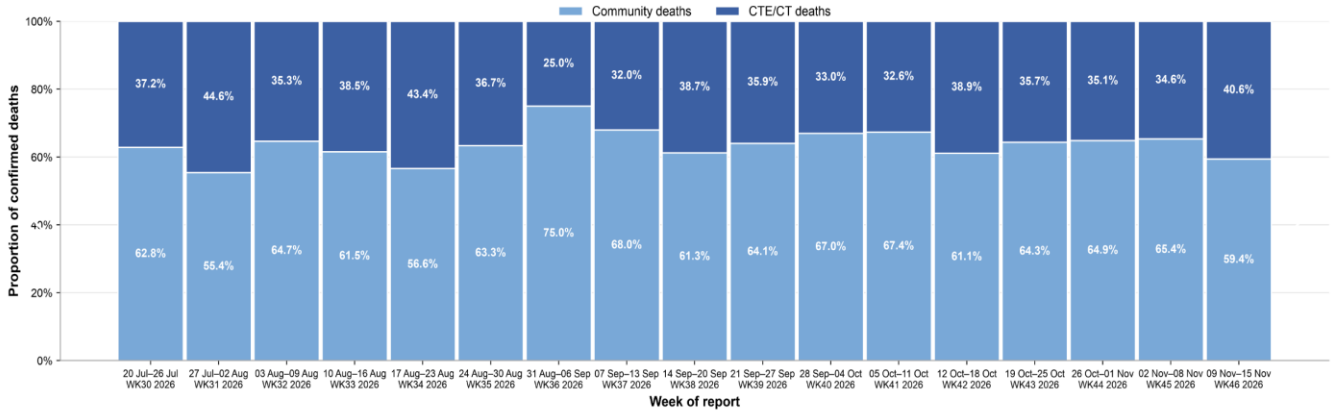
Weekly confirmed deaths (Figure 7) have fluctuated between 220 and 290 since mid-October: 286 in week 43 (19 – 25 October), 239 in week 44, 228 in week 45 and 239 in week 46 (9 – 15 November), an increase of 4.8% over the preceding week. Community deaths decreased from 149 in week 45 to 142 in week 46 while deaths in treatment facilities rose from 79 to 97, so that the proportion of deaths occurring in the community fell from 65.4% to 59.4%, the lowest weekly share since the week of 17 – 23 August (Figure 8). On 15 November, 18 of the 25 confirmed deaths (72%) occurred in the community. Although the shift in week 46 suggests that more patients reached treatment facilities before dying, three in five confirmed deaths still occur outside treatment facilities, and the increase in deaths in treatment centres also points to late presentation.

Figure 7. Weekly number of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological weeks 30 – 46, 2026



Numbers within bars show deaths by place of death; numbers above bars show weekly totals; red percentages show the share of weekly deaths occurring in the community. Source: DRC SitReps (WHE-HQ aggregate tracker), weeks of report.

Figure 8. Weekly proportion of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological weeks 30 – 46, 2026

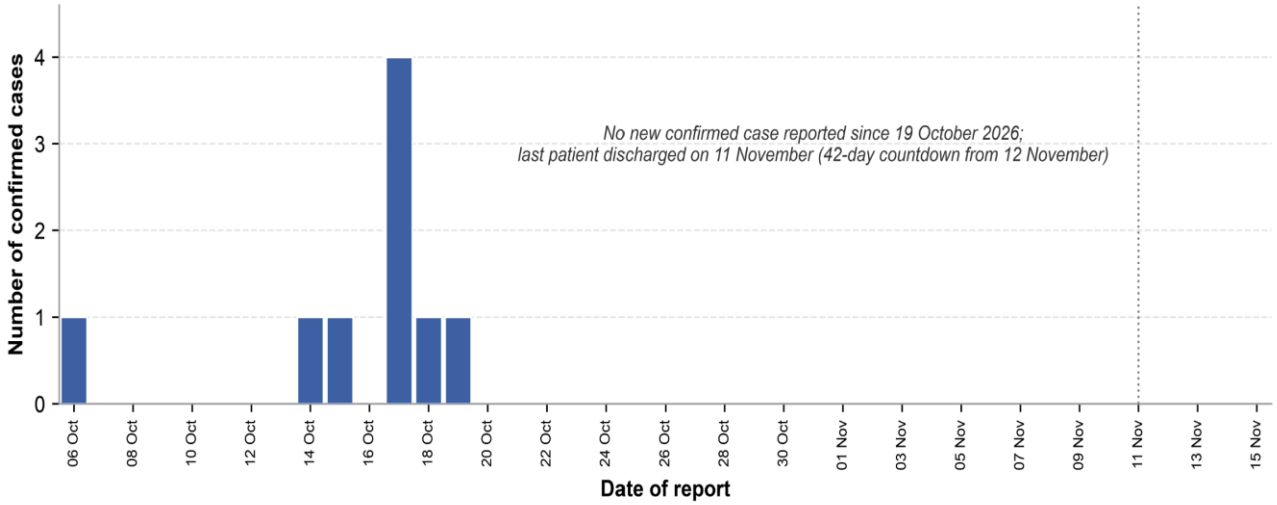


Percentages show the share of each week's confirmed deaths occurring in the community (light blue) and in treatment centres (dark blue). Source: DRC SitReps (WHE-HQ aggregate tracker), weeks of report.

Kenya

Since the previous report, Kenya has reported no new confirmed case of BVD. The cumulative total remains nine confirmed cases, including two deaths (CFR 22.2%), all belonging to a single chain of transmission linked to the imported index case; the last confirmed case was reported on 19 October 2026. On 11 November 2026, the Ministry of Health announced the discharge of the last patient under treatment, the seventh survivor, after two consecutive negative tests, and the final 11 contacts completed their 21-day monitoring and were released from quarantine on the same day. For the first time since the first case was confirmed, Kenya has no patient under treatment and no contact under follow-up. The 42-day countdown started on 12 November 2026; the end of the event will be declared by the Government if no new case is detected during that period. Surveillance, screening at points of entry and survivor follow-up continue.

Figure 9. Confirmed Bundibugyo virus disease cases in Kenya by date of report, 06 October – 15 November 2026



Nigeria

Nigeria has reported a single confirmed case of BVD, confirmed on 20 October 2026 in the Federal Capital Territory, Abuja, in a traveller from Uganda. The patient was medically evacuated to Switzerland on 26 October and discharged from the Geneva University Hospitals on 11 November 2026 after full recovery; the 42-day countdown is counted from 27 October, the day after the evacuation. No secondary case has been identified. On 13 November 2026, the Nigeria Centre for Disease Control and Prevention (NCDC) announced that all 62 contacts of the index case had completed their 21-day follow-up; 13 contacts who developed fever or non-specific symptoms during monitoring tested negative, as did seven suspected cases reported from Adamawa, Borno, Ekiti, Lagos and Rivers states over the preceding three weeks. The 62 contacts include the companion evacuated with the patient, whose follow-up in Switzerland was due to end on 16 November according to the Swiss IHR National Focal Point. The Emergency Operations Centre remains activated and surveillance continues; the completion of contact monitoring does not constitute a declaration of the end of the event, which will follow WHO criteria. Two lessons stand out from this event: the rapid activation of the incident management system and of response activities once the case was notified and confirmed, and the 12-day interval between symptom onset and notification, eight days of which were spent in a private health facility, which underlines the need for a high index of suspicion among clinicians for travellers from affected areas.

Public health response

Coordination

- Joint WHO–Africa CDC–partner coordination continues through the Continental Incident Management Support Team (CIMST), with increasing emphasis on translating epidemiological intelligence into coordinated operational action across affected countries.
- The CIMST has initiated an assessment of the collective response performance to identify operational gaps and lessons learned, strengthen accountability, and reassess preparedness and response priorities in affected and at-risk countries, particularly in light of the recent international spread.
- In the Democratic Republic of the Congo, the Government continues to implement a recently adopted 180-day

multisectoral response plan which provides an operational framework for a six-month period. The plan prioritizes surveillance and contact tracing, clinical care, community engagement and risk communication, logistics, and preparedness in at-risk areas, with estimated implementation requirements of US$1.3 billion. A national incident management team led by the government with support from WHO and partners continue to coordinate response activities.

- In Kenya, the national task force and the Incident Management Team remain in place, and the Public Health Emergency Operations Centre remains activated to coordinate surveillance during the 42-day countdown that started on 12 November, with heightened surveillance in all counties, rapid response teams on alert and continued screening at points of entry. The Ministry of Health has indicated that no quarantine or 'Ebola-free' certificates will be issued to travellers, in line with the International Health Regulations.
- In Nigeria, the National Incident Management System remains activated at level 3 under the leadership of the NCDC and the Coordinating Minister of Health and Social Welfare. Following the completion of contact monitoring on 13 November, the Emergency Operations Centre continues to coordinate surveillance, point-of-entry measures and preparedness in high-risk states.
- A broad network of partners continues to support response operations across affected and at-risk countries, including UNICEF, the International Organization for Migration (IOM), Médecins Sans Frontières (MSF), the Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Samaritan's Purse, the European Union, the Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams and StandBy partners. Support includes surveillance, clinical care, laboratory services, logistics, technical assistance and specialist deployments.

Surveillance

Democratic Republic of the Congo

- Surveillance activities continued across affected and at-risk areas, including active case finding, alert management and investigation, contact tracing, mortality surveillance, community-based surveillance, and surveillance at points of entry (PoEs) and points of control (PoCs).

- During epidemiological week 46 (9 – 15 November 2026), a total of 26 919 alerts were reported, averaging 3 846 alerts per day, an increase of 4.1% from 25 853 (3 693 per day) during week 45. Alert verification remained close to complete (99.9%). A total of 3 384 alerts (12.6%) were validated as suspected cases and 3 310 suspected cases were investigated. On the six days of the week for which the complete alert cascade was published (9 – 14 November), 1 488 of 2 942 investigated suspected cases (50.6%) were isolated and transferred to a treatment centre within 24 hours, compared with 51.0% during 1 – 7 November. Half of investigated suspected cases are still not isolated and transferred within 24 hours, which remains the main weakness of the alert-management cascade.

- During week 46, an average of 34 521 contacts required daily follow-up, compared with 36 005 during week 45 (−4.1%). Follow-up performance improved, from 79.9% of contacts seen during week 45 to 82.9%, with daily performance ranging from 79.7% on 9 November to 85.5% on 10 November; on 15 November, 30 243 of the 35 559 contacts under follow-up in the five provinces that transmitted data were seen (85.1%). Weekly follow-up improved in every province with a large contact workload but remained lowest in Tshopo (78.1%, up from

56.9%) and Nord-Kivu (78.8%, up from 75.4%), compared with 87.5% in Haut-Uélé (83.5% in week 45), 88.3% in Ituri (86.7%), 98.2% in Sud-Ubangi and 98.9% in Nord-Ubangi. All provinces with a large contact workload remain below the ≥95% operational target and, nationally, close to one in six contacts was not reached each day; the WHO Director-General noted on 11 November that more than 1 000 contacts had been lost to follow-up and that three confirmed cases remained unaccounted for.

- At points of entry (PoEs) and points of control (PoCs), 145 sites reported to the national database during week 46. From 9 to 14 November (the six days available in the database at the time of writing), 1 848 794 travellers were recorded, of whom 97.1% were screened, 97.1% washed their hands and 99.0% received sensitization messages, compared with 1 965 729 travellers (97.2% screened, 97.1% hand-washed and 98.4% sensitized) over the seven days of week 45. Screening coverage ranged from 95.6% in Sud-Ubangi and 96.2% in Ituri, where half of all travellers are recorded, to 97.7% in Nord-Kivu and 98.6 – 99.2% in Bas-Uélé, Haut-Uélé, Sud-Kivu and Tshopo. Thirty-four alerts were detected at PoEs and PoCs during 9 – 14 November (22 living travellers and 12 bodies in transit), compared with 24 (18 and six) in week 45; all were isolated, seven were referred to a treatment centre and none tested positive (one in week 45). A joint site assessment was conducted at the Boh PoC in Haut-Uélé with the Kibali gold mine ahead of its activation, and construction of control points and temporary isolation facilities continued in Sud-Ubangi (Bokuda and Karawa) and at Beni airport with the support of IOM and World Vision. Operational challenges persist: the Avakubi PoC (Nia-Nia, Ituri) and the Butuhe PoC (Nord-Kivu) remain closed because of insecurity, several PoCs in Ituri and Bas-Uélé were on strike over delayed payment of allowances, refusals of screening and hand washing remain high in Sud-Ubangi, and isolation facilities are lacking at ports in Sud-Kivu.

Kenya

- Kenya has maintained nationwide surveillance for suspected BVD since May 2026, with 28 counties having submitted samples for testing; as of 2 November, 611 samples had been tested, of which nine (1.5%) were positive. No new alert was validated during the reporting period. Heightened surveillance is being maintained in all counties for the duration of the 42-day countdown, with rapid response teams on alert, and a five-day training on Ebola surveillance and response for county teams from Busia, Bungoma, Trans Nzoia, Nairobi and Migori was held in Nakuru from 9 to 13 November. Another five-day training is underway in Naivasha covering Mombasa, Makueni, Taita Taveta, Nakuru and Machakos County rapid response teams. Another five-day training is underway in Naivasha covering Mombasa, Makueni, Taita taveta, Nakuru and Machakos County rapid response teams

- A total of 135 contacts were listed, including 46 airport staff, 45 hospital staff, 26 passengers, 14 relatives and four flight crew members. Eight contacts tested positive for BVD during quarantine (four relatives and four hospital staff) and nine passengers who travelled outside Kenya were followed up through bilateral engagement with the countries concerned. All contacts have now completed their 21 days of monitoring; the last 11 were released from quarantine on 11 November 2026 (Ministry of Health, 11 November 2026).

- Border screening continues nationwide at points of entry in Kenya: 804 751 travellers had been screened at 26 points of entry since May 2026 as of 16 November 2026 (760 415 as of 5 November). No suspected case was

identified at points of entry during the period.

Nigeria

- On 13 November 2026, the NCDC announced that all 62 contacts listed for the index case had completed the mandatory 21-day follow-up, the last of them on 13 November; 26 had exited quarantine by 8 November and 52 by 11 November. The companion evacuated to Switzerland with the patient is counted among the 62 and was followed up by the Swiss authorities until 16 November. None developed BVD: 13 contacts who presented fever or non-specific symptoms during monitoring tested negative. Seven suspected cases notified through the alert system over the preceding three weeks from Adamawa, Borno, Ekiti, Lagos and Rivers states also tested negative.

Laboratory

Democratic Republic of the Congo

- Diagnostic capacity remains substantially expanded and decentralized, from two laboratories at the onset of the outbreak to 30 laboratories with testing capacity, of which 27 report results daily, using open RT-PCR and near-point-of-care PCR platforms with a combined reported testing capacity of over 5000 samples per day; decentralization continues, with new laboratories to be set up in Yakoma and Pawa. During week 46 (9 – 15 November), 3 975 new samples were tested nationally, of which 444 (11.2%) were positive, compared with 3 627 samples and 449 positives (12.4%) in week 45; positivity among new samples has fallen from 16.3% in week 44 to 12.4% in week 45 and 11.2% in week 46. On 15 November, 435 samples were analysed and 56 (12.9%) were positive. Positivity among all samples tested during 9 – 13 November, including re-samples and post-mortem swabs, ranged from 8.9% in Tshopo and 12.1% in Nord-Kivu to 15.8% in Ituri, 24.6% in Haut-Uélé and 28.9% at the Biakato laboratory (Mandima). According to the national sitrep, the Yakoma laboratory in Nord-Ubangi was not yet operational on 14 November, with samples pending referral, and 118 samples were pending in Nord-Kivu.

- Laboratory validation of candidate BVD diagnostics under the BRIDGE-Access initiative is ongoing at the Institut National de Recherche Biomédicale (INRB) in Kinshasa, following its initiation on 14 September. The work is evaluating BDBV-specific and broader filovirus assays, including near-point-of-care diagnostics, to generate the clinical evidence required to inform future deployment, procurement and regulatory pathways.

- The priority is increasingly shifting from expansion to consolidation and sustained performance of the decentralized laboratory network. This includes implementation of the updated decentralization plan; maintaining reliable supplies and functional equipment; strengthening training, supervision and quality assurance; and improving specimen management, turnaround-time monitoring and partner reporting. WHO is supporting these efforts through the procurement of over US$3 million (excluding in-kind contributions) in laboratory supplies and critical equipment for new and existing laboratories. WHO shared forecasts of laboratory needs for the next six months with partners to inform coordinated planning and resource mobilization.

Nigeria

- Laboratory confirmation of the index case was reported by the NCDC National Reference Laboratory on 20 October 2026, and phylogenetic sequencing has been concluded by the National Reference Laboratory and the African Centre of Excellence for Genomics of Infectious Diseases (ACEGID). As of 8 November, 27 samples had been tested at the National Reference Laboratory (one positive, the index case; 26 negative, including 22 from contacts and four from suspected cases), and samples from suspected cases subsequently reported in

Adamawa, Borno, Ekiti, Lagos and Rivers states also tested negative. Standard operating procedures (SOPs) and job aids on sample reception, molecular detection and genomic sequencing have been validated; testing capacity is being expanded across the laboratory network, prioritizing states with international points of entry and the Lagos laboratory, while uninterrupted testing and confirmation are maintained at the National Reference Laboratory; 500 donated test kits have been added to the stockpile and additional reagents and commodities are being positioned.

Case Management

Democratic Republic of the Congo

- Case-management demand remains high: 1 681 patients (confirmed and suspected) were in isolation or treatment nationally on 14 November 2026 (SitRep N°184), compared with 1 010 on 7 November. The daily number fluctuated between 651 and 1 681 during the week, reflecting the admission and discharge of large numbers of suspected cases and variable reporting completeness; the largest caseloads remain in Nord-Kivu and Ituri.

- Bed occupancy in treatment centres varies considerably by region. Across the 90 treatment and isolation facilities reporting bed data on 7 November (the latest complete bed census), 890 of 1 792 beds (49.7%) were occupied, ranging from 8.8% in Tshopo and 22.5% in Haut-Uélé to 41.0% in Ituri, 70.2% in Nord-Kivu and 79.4% in Bas-Uélé. In Nord-Kivu, 78 patients were admitted and 141 discharged on 14 November, and 153 patients were managed in health facilities outside dedicated treatment centres.

- Operational constraints remain important: a substantial share of patients in Nord-Kivu continues to be managed outside dedicated treatment centres; suspected cases in Bas-Uélé are isolated in health facilities in the absence of a functional treatment centre, the Buta CTE being still under construction; response activities in Bafwasende (Tshopo) remain suspended; and construction of the Makiso isolation centre and the extension of the Météo CTE in Tshopo have started.

- Cumulative recoveries increased to 3 109 as of 15 November, from 2 940 on 7 November (+169), including 158 during week 46; 26 recoveries were reported on 15 November.

- Training of clinical teams continues to strengthen the quality and consistency of care in dedicated treatment centres. The multi-sectoral, multi-partner training programme initiated in September has continued to build the pool of trained personnel supporting case management.

- The survivor-care programme established in Bunia continues to provide follow-up and address the specific medical needs of people recovering from BVD, with expansion to additional sites planned to improve access to survivor services.

Research and Development

- Ervebo® vaccination of frontline and healthcare workers is conducted by the national immunization programme under a compassionate-use protocol, separately from the research studies. No consolidated national total has

been published; the provincial cumulative figures reported in the national sitreps are 3 352 people vaccinated in Nord-Kivu as of 14 November (3 235 frontline workers and 117 contacts in Beni, Oicha, Mabalako, Kalunguta and Mutwanga), 3 930 in Ituri as of 12 November (1 686 women and 2 244 men, with the support of MSF), 1 809 in Haut-Uélé as of 12 November (72% of the active frontline-worker target, in Isiro, Wamba, Pawa and Rungu, with extension to Gombari) and 2 260 doses used of 2 500 received in Bas-Uélé as of 12 November (Bili and Buta), about 11 350 people in total. In Nord-Kivu, 247 of the 3 600 doses received remained in stock on 14 November and the province has requested 10 000 additional doses; one non-serious adverse event following immunization was reported there, and 50 adverse events (five of them serious) had been reported in Ituri as of 9 November.

- Research continues alongside: the BRAVO observational study of vaccine effectiveness among healthcare workers in Ituri, the TUMAINI project evaluating candidate Bundibugyo virus vaccines and Ervebo®, the PARTNERS therapeutic trial, which has expanded to Beni, the EBO-PEP post-exposure prophylaxis trial and the ORACLE and EBOPALU protocols. In Tshopo, 68 confirmed patients had received candidate therapeutics (65 remdesivir and three MBP134) and 628 people had received post-exposure prophylaxis as of 12 November, for a cumulative 709 recipients as of 14 November.

Infection Prevention and Control (IPC)

- IPC performance in healthcare facilities remained a major concern. During week 46 (9 – 15 November), 95 healthcare facilities were assessed nationally with the IPC-WASH scorecard, of which five scored above 80%. On 14 November, an IPC scorecard assessment at the Cité 2 facility in Nord-Ubangi scored 37.9%; in Bas-Uélé, 33 providers and seven hygienists were briefed on the use of personal protective equipment, waste management, triage and hand hygiene and bio-cleaning was carried out in four of the ten buildings of the Viadana general referral hospital; and in Tshopo, the re-assessment of health facilities showed improved scores after mentoring. In Sud-Ubangi, most health facilities lack waste sorting and waste areas, water supply and storage and adequate sanitation, and the three-bucket technique is not applied. Infections among health and frontline workers continue to be recorded: 396 confirmed cases and 59 deaths among health and frontline workers are recorded in the DHIS2 line list (extract of 17 November; occupation recorded as health worker or frontline worker), a definition that differs from the figure of 158 carried unchanged in the national sitrep since 17 August.

- IPC activities continued but remained uneven. During week 46, 252 IPC rings were opened nationally (213 in week 45) and 681 of 874 targeted households (77.9%) were decontaminated, compared with 530 of 673 (78.8%) in week 45. On 14 November, in Nord-Kivu, eight of 30 identified rings (26.7%) were opened, 13 of 31 identified households (41.9%) and 18 of 21 health facilities (85.7%) were decontaminated; in Ituri, 31 of 51 rings were opened and 60 of 70 households and 11 of 13 health facilities were decontaminated; and in Haut-Uélé, two rings were opened in Pawa and 17 households and six health facilities were decontaminated.

- Safe and dignified burial (SDB) completion was unchanged during week 46, with 1 226 of 1 356 requests (90.4%) completed, compared with 1 247 of 1 379 (90.4%) in week 45, while refusals fell from 151 to 52. Completion was highest in Ituri (679 of 718; 94.6%) and Nord-Kivu (489 of 555; 88.1%, down from 93.5%), lower in Haut-Uélé (35 of 40; 87.5%) and Tshopo (23 of 37; 62.2%, up from 34.7%), and none of the six requests in Bas-Uélé was completed. On 14 November, SDB teams in Ituri completed 55 burials for 73 death alerts (including carry-overs), with 44 bodies swabbed and 23 failures or refusals; in Nord-Kivu, 53 of 59 death alerts led to an SDB, with 50 bodies swabbed and 20 burials postponed; in Haut-Uélé two SDBs were performed and one could not be performed in Isiro because of community resistance; and in Bas-Uélé, 22 bodies were swabbed in Dakwa and Buta but none of the four community deaths notified that day was managed by the SDB teams.

- Operational constraints continued to undermine IPC implementation. Insecurity remains a major constraint: on 8 November, an attack attributed to the ADF in Mabalako Health Zone, with 44 bodies recorded, and an attempted arson of the Beni treatment centre were reported in Nord-Kivu; response activities remain suspended in Bafwasende (Tshopo), where threats against response teams were also reported in Kabondo and Mangobo; and insecurity persists on the Bolebole axis in Haut-Uélé. Strikes over unpaid salaries and allowances affected health workers and PoC staff in several provinces, including Bas-Uélé, Ituri (Tchomia and Kasenyi) and Tshopo. Community resistance and rumours (refusal of swabbing and isolation, 'Ebola is a business') continued to affect safe burials and the management of community death alerts, as illustrated by the failed or refused SDBs in Ituri, Tshopo and Isiro and the four unmanaged community deaths in Bas-Uélé on 14 November.

- Material and infrastructure gaps persisted across affected provinces. In Nord-Kivu, deliveries of IPC supplies, nutrition kits (Kalunguta) and demarcation material to operational areas continued; in Haut-Uélé, construction of the Bolebole CTE was completed and its electrification and water supply started, works continued in Pawa, and WHO provided five computers and FHI 360 300 litres of fuel to support coordination; in Ituri, fuel for the incinerator and generator and a solar regulator were procured with the support of JHPIEGO; in Tshopo, works started on the Makiso isolation centre and 1 200 litres of fuel were received for the incinerator; and in Nord-Ubangi, poor communication networks, insufficient communication credit for contact follow-up and active case search, and shortages of basic supplies in Wapinda continue to hamper operations.

Risk Communication and Community Engagement (RCCE)

Democratic Republic of the Congo

- Community engagement activities continued across affected provinces. On 14 November 2026, in Nord-Kivu, 2 711 household visits reached 86 788 people, 8 221 educational discussions reached 140 121 people and 108 mass communication activities reached 12 649 people, with 100% of newly confirmed cases covered by mental health and psychosocial support. In Ituri, 10 527 household visits reached 27 135 people, educational discussions continued, and a community forum was held in Mangala (Ngbadhebu/Mandje) with ALIMA. In Tshopo, 5 677 households were visited, 182 educational discussions were held and mass sensitization continued in Tshopo, Makiso-Kisangani and Lubunga health zones, and community teams supported contact listing around newly confirmed cases.

- RCCE continued to support surveillance, contact tracing, case management and safe and dignified burials, including the pre-listing of 1 885 contacts and the accompaniment of 36 household decontaminations around confirmed cases in Ituri, support to contact listing and to the acceptance of decontamination and vaccination in Tshopo, and the announcement of 66 laboratory results (two positive) in Tshopo with psychological preparation of patients and families. Community alerts remain an important source of detection; 18 community alerts were notified in Bulu (Sud-Ubangi) on 14 November.

- Community resistance and rumours continue to affect the response. On 14 November, 23 SDB attempts failed or were refused in Ituri, five bodies could not be swabbed in Tshopo, one SDB was refused in Isiro (Haut-Uélé) and four community deaths in Bas-Uélé were not managed by the SDB teams, while refusals of screening and hand washing remain high at PoCs in Sud-Ubangi. Insecurity and threats against response teams in Bafwasende, Kabondo and Mangobo (Tshopo) and in Beni further limit community engagement, underlining the need for sustained dialogue through trusted local actors and the rapid management of community concerns.

- Community engagement continued across the other affected provinces. In Haut-Uélé, 530 household visits, 54 educational discussions and nine mass activities were conducted on 14 November and 250 education actors were briefed in Isiro on BVD prevention in schools. In Bas-Uélé, 82 household visits (1 492 people), 25

educational discussions (820 people), 14 mass sensitization sessions (5 596 people) and 15 radio broadcasts (Titule, Ganga, Koteli and Ango) were conducted and communication materials were provided by UNICEF. In Nord-Ubangi, sensitization reached 512 pupils and six teachers at the Ndonga/Kimbanguiste primary school in Yakoma, and in Sud-Ubangi 264 households (1 320 people) were visited in Bulu Health Zone (Mondosa, Akula, Gwaka mission and Kuma).

Preventing and Responding to Sexual Exploitation, Abuse, and Harassment (PRSEAH)

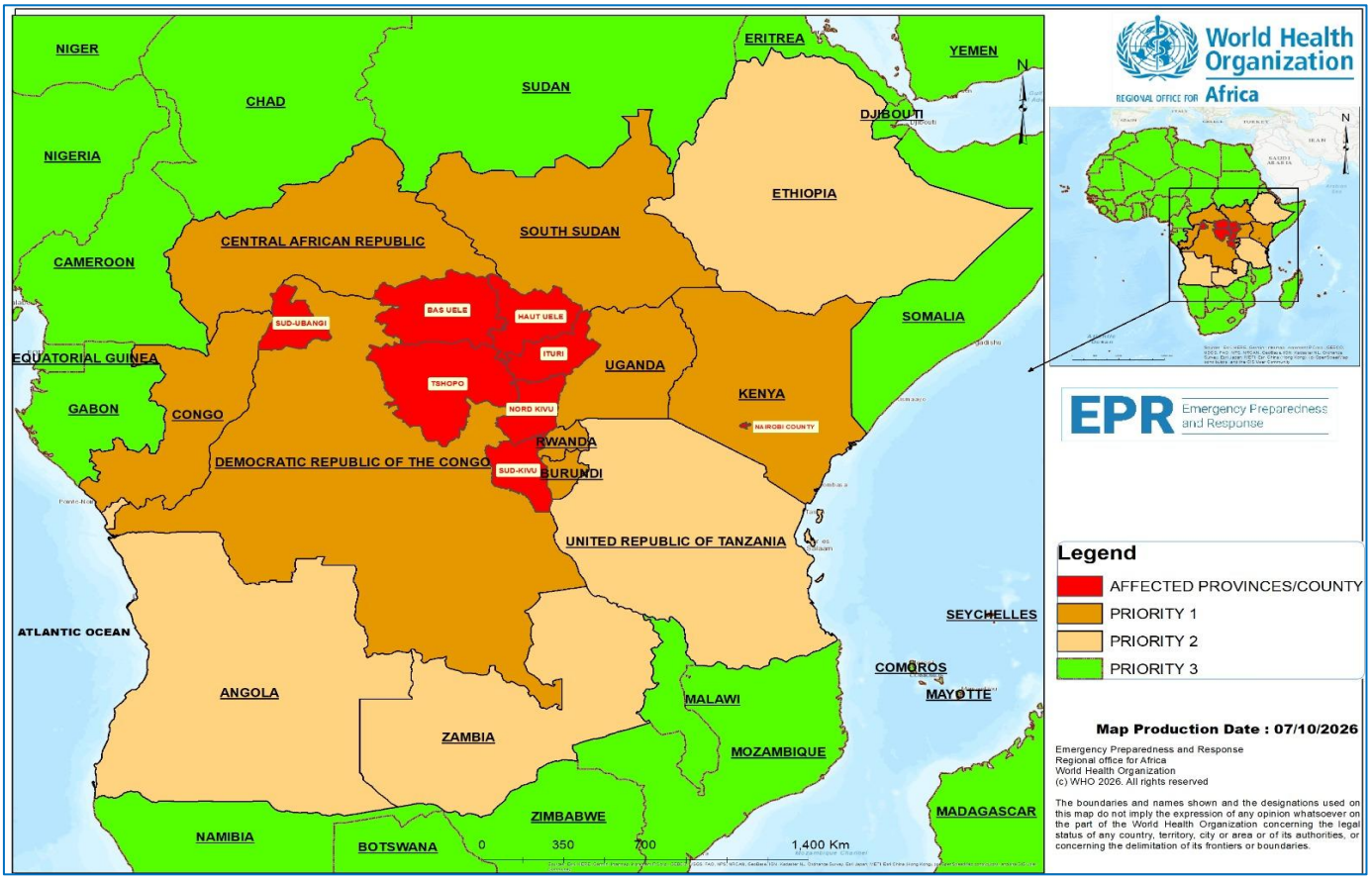
- PRSEAH sensitization continued across the response. On 14 November 2026, PSEA briefings and reminders of the toll-free reporting numbers (495555 and 151) were conducted in Nord-Kivu; sensitization sessions and signatures of the code of conduct took place in Pawa and Isiro (Haut-Uélé); and PSEA briefings and training sessions continued in Ituri. Only three of the eight affected provinces reported PSEA activities on 14 November.

Public health preparedness

Operational Readiness

- Based on regional cross-border risk modelling and the evolving epidemiological situation, countries have been recategorized by priority for response and preparedness. The Democratic Republic of the Congo and Kenya are classified as the response countries (Priority 1A); Uganda, Central African Republic, South Sudan, Republic of the Congo, Burundi and Rwanda as Priority 1B countries; and Angola, Ethiopia, United Republic of Tanzania, and Zambia as Priority 2 countries.

Figure 10. Regional prioritization of countries for Bundibugyo virus disease preparedness and response, as of 18 October 2026



- High-priority countries completed repeat readiness assessments, reflecting continued efforts to strengthen national preparedness capacities as well as readiness assessments in high risk subnational units. Activities from their contingency plans are being implemented to support critical readiness pillars.
- Regional technical deployments continued to support preparedness and response capacity in affected and high-risk Member States, including Central African Republic, Democratic Republic of the Congo, Kenya, South Sudan and Uganda including support visits to cross border areas where recent exportation occurred to strengthen capacities. IHR coordination and cross border meetings are being supported to strengthen inter-country information sharing.

Border Health, Travel and Mass Gatherings

- Surveillance and public health measures have been reinforced at airports, high-risk border crossings, major ports and internal transit routes in the Democratic Republic of the Congo and Uganda, Kenya, Nigeria National authorities, IOM, and partners continue to support the implementation of WHO border health guidance, strengthen cross-border coordination, and facilitate the timely detection, reporting and referral of suspected cases at PoEs and PoCs along priority travel corridors.

- Cross-border preparedness and response are being strengthened through enhanced coordination among the Democratic Republic of the Congo, Uganda, the Central African Republic, South Sudan and other neighbouring countries to improve the early detection of cases and reduce the risk of cross-border spread. Priority actions include strengthening coordinated cross-border disease surveillance, event-based surveillance, active case finding, joint investigations and contact tracing where required, and real-time information sharing through regular cross-border coordination meetings and harmonized reporting mechanisms.

- Priority operational actions include rapid assessments and mapping of PoEs, particular attention continues to be given to high- volume mobility corridors, including river, road and air transport networks connecting affected and at-risk areas, including informal crossings, and major congregation points; and ensuring readiness capacities through the provision of trained personnel, equipment, PPE, referral mechanisms, disinfectants, risk communication materials, contingency plans and simulation exercises to support surveillance, safe management of suspected cases, infection prevention and control, environment hygiene and sanitation, sensitization of travellers, and engagement of border communities.

- The postponement of mass gatherings is advised in areas with documented BVD transmission until transmission is interrupted. Event-specific risk assessments should be conducted using the WHO all-hazards mass gathering risk assessment tool. These assessments should be complemented by implementation of measures before, during, and after events, as outlined in WHO guidance for mass gatherings attended by individuals from areas with documented Bundibugyo virus detection, including the establishment of referral pathways and RT-PCR testing capacity.

  Event organisers should distribute participant information to all attendees before and during the event, covering BVD symptoms, what to do if feeling unwell, and available health services, in line with WHO guidance for mass gathering events attended by individuals from areas with documented BDBV detection. With several major mass gathering events taking place or upcoming in the Region, including the Youth Olympic Games held in Senegal from 31 October to 13 November, the evolving BVD situation underscores the importance of maintaining enhanced vigilance and proportionate, risk-based preparedness and response measures, consistent with WHO guidance.

Situation interpretation

The BVD outbreak in the Democratic Republic of the Congo remains at a critical juncture six months after its declaration. Transmission is broadly stable at a high level: 442 confirmed cases and 239 deaths were reported in epidemiological week 46, the national seven-day average has held between 61 and 76 cases per day since the beginning of October, and the three-week totals fell marginally, from 1 468 to 1 369 cases (−6.7%) and from 740 to 706 deaths (−4.6%). The decrease is driven by Ituri, where Mandima, Bunia and Rwampara reported fewer cases, while Mangala and Mambasa in Ituri and Mutwanga and Oicha in Nord-Kivu are intensifying, Beni remains the largest focus, Haut-Uélé reported a new health zone (Watsa), and sporadic transmission continued in Tshopo and Nord-Ubangi. The response is still not reaching the performance required to interrupt transmission: only half of investigated suspected cases are isolated within 24 hours, close to one in six contacts is not seen each day, more than 1 000 contacts have been lost to follow-up, and three in five deaths still occur in the community, although the share of community deaths fell in week 46 and safe burial refusals decreased. Insecurity in Beni, Mabalako and Bafwasende, strikes over unpaid salaries and shortages of vaccine doses in Nord-Kivu further constrain operations. In Kenya, where eight secondary cases occurred in a single chain, all contacts have completed follow-up and the 42-day countdown is under way; in Nigeria, contact monitoring

ended on 13 November with no secondary case identified. Neither event has been declared over and surveillance continues in both countries. Priorities remain reinforcing response capacity in the most active health zones of Nord-Kivu (Beni, Mutwanga, Oicha) and Ituri (Mandima, Bunia, Mangala, Mambasa), investigating the new focus in Watsa, improving the timeliness of isolation of suspected cases and the completeness of contact follow-up, maintaining safe burial performance, securing vaccine supply for frontline workers, and maintaining cross-border surveillance and information sharing.

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