

NOVEMBER, 2026

BUNDIBUGYO VIRUS DISEASE

OUTBREAK SITUATION UPDATE: EPIDEMIOLOGICAL DEVELOPMENTS AND VACCINE RESEARCH

GET Global Emerging Pathogens Treatment Consortium

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Epidemiological Overview of the Bundibugyo Virus Disease Outbreak

Overview of the Outbreak

As of 16 November 2026, the Democratic Republic of the Congo (DRC) had reported 11,376 confirmed cases of Bundibugyo virus disease (BVD), including 5,568 deaths, based on epidemiological data available through 10 November.

Community transmission remains ongoing, with the outbreak affecting 67 of 178 health zones across eight provinces. A total of 3,031 patients had recovered, while 981 were hospitalised in isolation facilities. Contact follow-up coverage across affected provinces stood at 85.5%.

Democratic Republic of the Congo

The DRC continues to account for the overwhelming majority of cases and deaths recorded during the outbreak. Ituri remains the most affected province, with 7,728 confirmed cases and 3,655 deaths reported across 28 of its 36 health zones. North Kivu follows with 2,761 cases and 1,523 deaths across 17 of 34 health zones. Haut-Uélé has recorded 499 cases and 216 deaths across seven of its 13 health zones.

Other affected provinces include Tshopo, with 98 cases and 32 deaths; Bas-Uélé, with 13 cases and four deaths; North Ubangi, with 10 cases and one death; South Kivu, with three cases and one death; and South Ubangi, with two cases and one death.

Between the reporting periods ending 9 and 10 November, an additional 72 confirmed cases and 46 deaths were reported. The new cases occurred in Ituri (44), North Kivu (24), Haut-Uélé (three) and North Ubangi (one). Although Ituri retains the highest cumulative case burden, continued transmission in North Kivu remains a major concern. The reported figures are subject to ongoing review and harmonisation by the DRC health authorities.

Confirmed Cases	Confirmed Deaths
11,376	**5,568 deaths | CFR:48.9%**

Figure 1. Distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, as of 16 November 2026

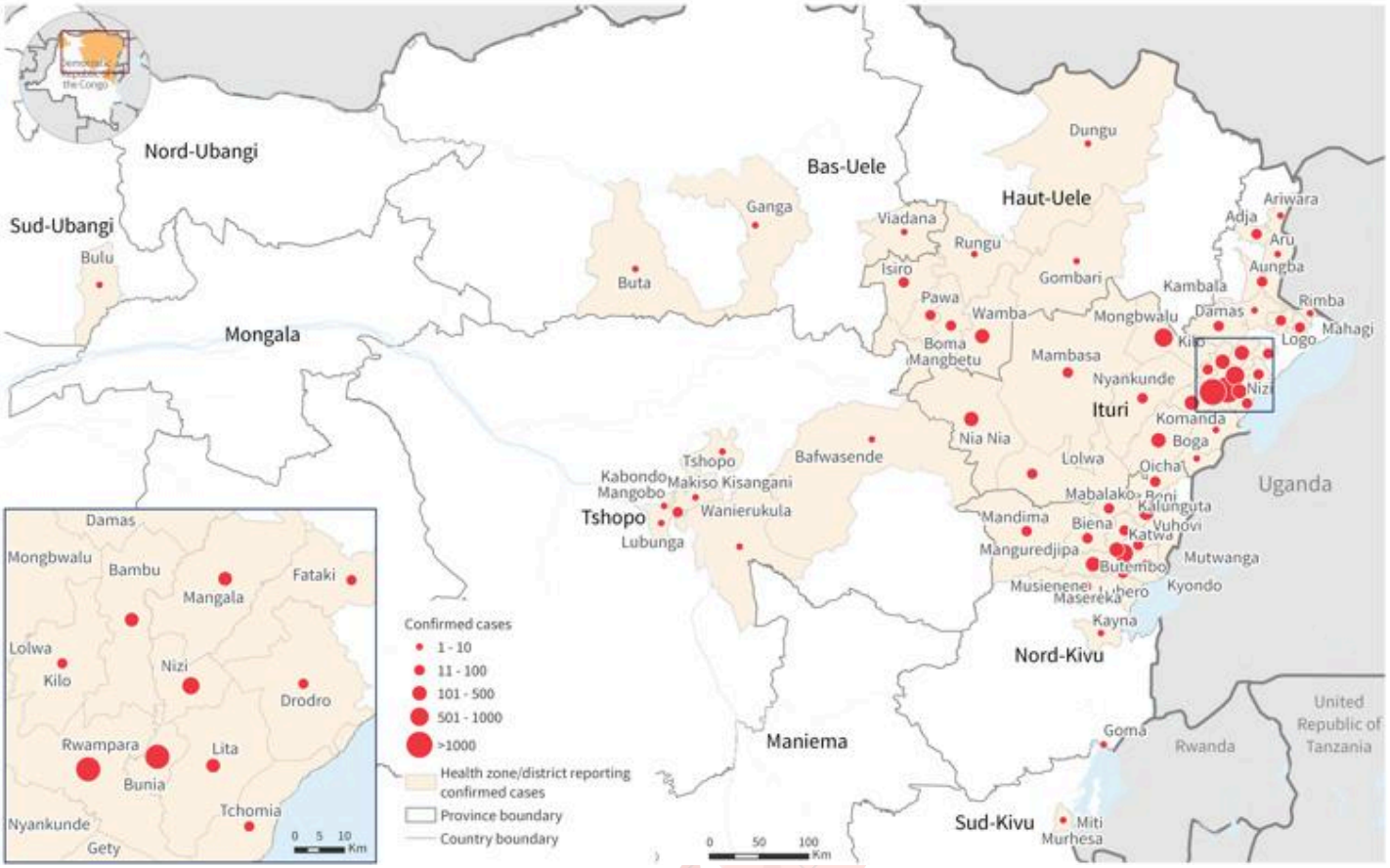


Figure 2. Classification of health zones reporting Bundibugyo virus disease cases in the Democratic Republic of the Congo as of 3 November 2026. Source: World Health Organization (WHO), 6 November 2026.

Kenya

Kenya has reported nine confirmed cases, including two deaths, all epidemiologically linked to the initial imported case. The last confirmed case was reported on 20 October 2026, and no further cases have been identified since then.

As of 11 November, seven patients had recovered, including the last patient, who was discharged from care on that date. All identified contacts under monitoring had also completed the 21-day quarantine period. These developments indicate progress towards interrupting transmission, although continued surveillance remains necessary.

Nigeria

Nigeria has reported one confirmed imported case, identified on 20 October 2026. The patient had travelled from Uganda through Addis Ababa, Ethiopia, before arriving in Nigeria. She developed symptoms on 7 October and sought medical attention in Abuja on 11 October. Following confirmation of the infection, she was medically evacuated to Switzerland on 26 October for treatment in Geneva.

As of 8 November, no additional cases had been reported in Nigeria. A total of 62 contacts were identified, with seven having completed the 21-day follow-up period by 5 November. Contact tracing and monitoring remain part of the country's response, with the monitoring period expected to end on 13 November if no further cases are identified.

Uganda

Uganda previously recorded 20 confirmed cases and two deaths during the outbreak. The last confirmed case was reported on 21 June, and WHO declared the outbreak over in the country on 27 August after 42 days without a new confirmed case.

Although no active cases have been reported, Uganda continues to coordinate with neighbouring countries on cross-border surveillance. On 25 October, 60 contacts linked to the Kenyan case who had travelled through Uganda completed the 21-day follow-up period. Additional screening measures were also introduced at points of entry and along the Uganda–DRC border.

Cases and Medical Evacuations outside Africa

Several confirmed cases among people who had worked in affected areas of the DRC have been medically evacuated to Europe for specialist treatment. On 5 November, a British healthcare worker who tested positive while working in the DRC was evacuated to the United Kingdom for treatment in a specialist high-level isolation unit. Earlier evacuations included patients transferred to the Netherlands and Germany. The confirmed case reported in Nigeria was also evacuated to Switzerland.

France also reported one imported case in June 2026 involving a doctor returning from a humanitarian mission in the DRC. The patient recovered, and no further transmission was reported.

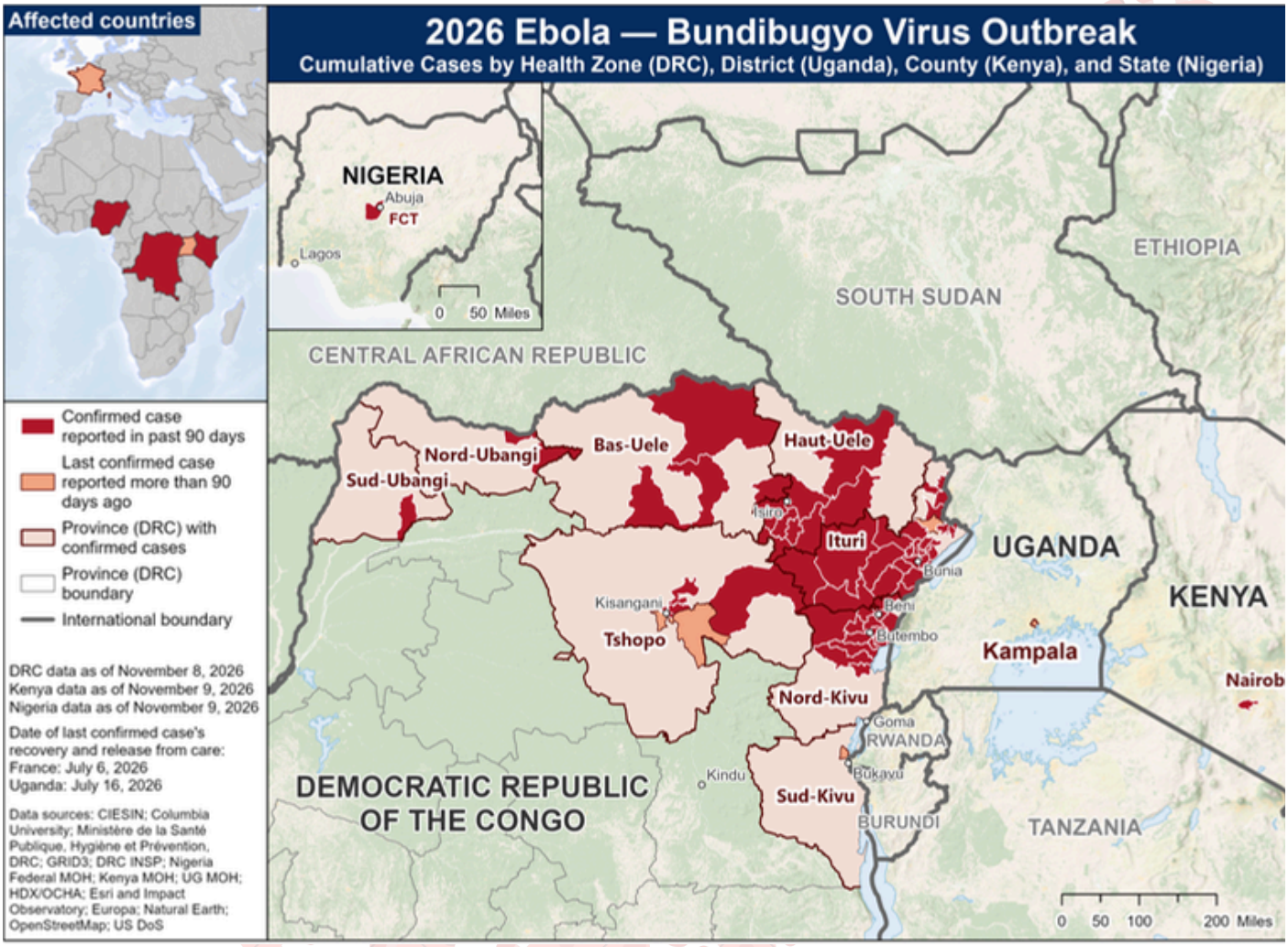


Figure 3. Geographical distribution of reported Bundibugyo virus disease cases across the Democratic Republic of the Congo, Uganda, Kenya, Nigeria, and France.

Research, Development and Medical Countermeasures

Overview of Bundibugyo Vaccine Development

There is currently no licensed vaccine specifically targeting Bundibugyo virus. Ervebo, the licensed Ebola vaccine, protects against Zaire ebolavirus, but its effectiveness against Bundibugyo virus in humans has not been established. Two vaccines developed specifically against Bundibugyo virus, ChAdOx1 BDBV and mRNA-1469, have entered human clinical trials. Both are undergoing Phase 1 evaluation to assess their safety and ability to stimulate an immune response.

WHO Recommendation on Vaccine Candidates

On 4 November 2026, the World Health Organization (WHO) recommended ChAdOx1 BDBV and mRNA-1469 for inclusion in the Phase 2/3 Tumaini clinical trial in the Democratic Republic of the Congo (DRC). The recommendation followed a review of preclinical and early clinical findings by WHO's Technical Advisory Group on Candidate Vaccine Prioritization. The trial will evaluate the candidates further during the ongoing outbreak. Their inclusion is subject to national regulatory approval. Neither vaccine has been licensed for public use.

Bundibugyo-Specific Vaccine Candidates

ChAdOx1 BDBV

ChAdOx1 BDBV is an adenovirus-vectored vaccine developed by the University of Oxford in collaboration with the Serum Institute of India (SII). It uses a modified chimpanzee adenovirus to deliver genetic instructions for a Bundibugyo virus antigen, prompting the body to develop an immune response.

The vaccine entered Phase 1 clinical evaluation in the United Kingdom in July 2026, followed by a second study in Uganda in October. Both studies assess its safety, tolerability and ability to generate an immune response in healthy adults. Preclinical studies, including animal challenge experiments, have reported protective responses. However, protection against Bundibugyo virus disease in humans has not been demonstrated.

The Serum Institute of India has manufactured approximately 620,000 doses of the vaccine, with supplies allocated to clinical studies and additional doses held in stock. Despite this manufacturing progress, ChAdOx1 BDBV remains an investigational vaccine and is not available for routine vaccination.



Caption: Clinical evaluation of the ChAdOx BDBV vaccine candidate at the MRC/UVRI and LSHTM Uganda Research Unit in Masaka, Uganda.

MRNA-1469

MRNA-1469 is an mRNA-based vaccine developed by Moderna. It uses messenger RNA to instruct the body's cells to produce a selected Bundibugyo virus antigen, which stimulates an immune response.

Its Phase 1 clinical trial began in Canada in August 2026 and involved approximately 80 healthy adults. The study evaluates safety, tolerability and immunogenicity. Interim findings showed that the vaccine was generally well tolerated and produced Bundibugyo-specific binding antibody responses. Preclinical studies have also reported protective responses in animal models. However, its ability to prevent infection or disease in humans remains unknown.

Moderna is working with the Coalition for Epidemic Preparedness Innovations (CEPI) to support further development and manufacturing. CEPI has committed up to US$58.5 million to support preclinical research, clinical trials and the production of additional doses. Moderna has also committed to making at least 500,000 doses available to low- and middle-income countries at access pricing, subject to regulatory approval. This is a future supply commitment; the vaccine is not currently licensed or available for public vaccination.

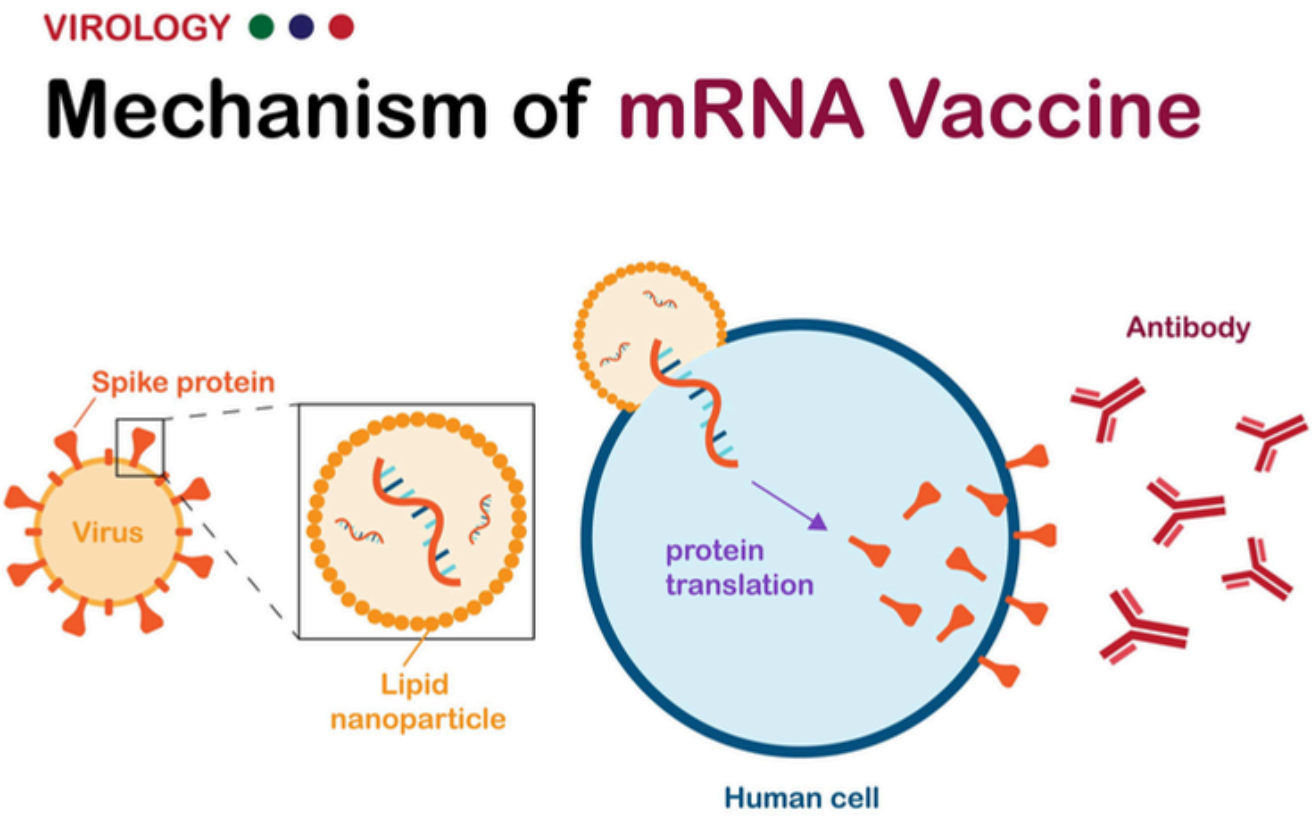


Figure 4. Mechanism of mRNA vaccine technology. The illustration shows how vaccine-delivered messenger RNA enters host cells, directs the production of a target viral antigen, and stimulates an immune response.

Other Vaccine Development Initiatives

IAVI rVSV-BDBV

The International AIDS Vaccine Initiative (IAVI), in collaboration with the University of Texas Medical Branch (UTMB), is developing an rVSV-based vaccine candidate against Bundibugyo virus. The candidate uses recombinant vesicular stomatitis virus as its delivery platform, similar to the technology used in Ervebo, but is designed to target Bundibugyo virus.

Preclinical studies have reported protective responses in animal models following vaccination. In October 2026, IAVI received an initial US$36 million award from the US Biomedical Advanced Research and Development Authority (BARDA), under a contract worth up to US$99 million. The funding will support process development, manufacturing and preparation for clinical evaluation. The candidate remains in preclinical development.

The Tumaini Clinical Trial

Tumaini is a Phase 2/3 clinical trial evaluating vaccines against Bundibugyo virus in the Democratic Republic of the Congo (DRC). The study uses a ring-vaccination approach, targeting contacts of confirmed cases and other individuals at risk of infection.

The trial initially included Ervebo, a vaccine licensed against Zaire ebolavirus, to investigate whether it offers protection against Bundibugyo virus. Its effectiveness against this virus in humans has not been established.

On 4 November 2026, WHO recommended the inclusion of ChAdOx1 BDBV and mRNA-1469 in the trial following a review of their preclinical and early clinical findings. Their inclusion is subject to national regulatory approval. The trial will assess their safety and potential protective efficacy, with initial results expected in early 2027.



Caption: Illustrative image of a healthcare professional administering a vaccine to a participant during the clinical study.

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Minapharm MVA-CR19

Minapharm Group is developing MVA-CR19, a vaccine candidate based on the Modified Vaccinia Ankara (MVA) platform. The candidate is being developed through ProBioGen, a Minapharm subsidiary, with support from the International Vaccine Institute (IVI), Bayer and the Coalition for Epidemic Preparedness Innovations (CEPI).

CEPI has committed up to US$16.5 million towards its preclinical development and preparation for early-stage clinical trials. IVI is supporting clinical development, regulatory preparation and manufacturing capacity through its ACHIEVE Africa initiative. MVA-CR19 has not yet entered human clinical trials.

Implications for Outbreak Preparedness and Response

The absence of a licensed Bundibugyo-specific vaccine remains a major challenge in managing the current outbreak. Although ChAdOx1 BDBV and mRNA-1469 have progressed to human trials, their protective efficacy has not yet been established.

The manufacturing of ChAdOx1 BDBV doses and the funding committed to the development of mRNA-1469, rVSV-BDBV and MVA-CR19 are important parts of the ongoing research effort. However, the availability of these vaccines for outbreak response will depend on clinical trial results, regulatory approval and arrangements for production and distribution.

For African countries, strengthening local vaccine research, clinical trial capacity, manufacturing and regulatory systems will be important in ensuring access to vaccines developed against emerging infectious disease threats.

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GET Global Emerging Pathogens Treatment Consortium

The Global Emerging Pathogens Treatment Consortium (GET) was established in 2014 as a direct response to the 2014-2016 Ebola virus disease outbreaks in West Africa. GET is legally registered in Nigeria, Accra, Ghana, Sierra Leone, and the United States of America. Our primary purpose is to develop African-led and Afrocentric strategies within an international context to address emerging biosecurity threats effectively.



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