Vates Special Report: Ebola Beyond the Congo – The Uganda Corridor and East Africa's Exposure

Health Security/Regional Risk Analysis
October 2026

Executive Summary

The Ebola Bundibugyo virus disease (BVD) outbreak in the eastern Democratic Republic of the Congo (DRC), declared on May 15, is now the second-largest Ebola outbreak on record, with 9,552 confirmed cases and 4,602 deaths across eight provinces as of Oct 19.[1] In October it moved beyond the DRC through Uganda's transit corridor. A Kenyan resident of the DRC travelled by bus via Beni to Kampala, flew from Entebbe to Nairobi on Oct 03 and died on Oct 05, seeding a cluster that has reached nine confirmed cases. A Somali national who shared his hotel and a taxi to Entebbe Airport flew home via Addis Ababa the same day and was quarantined in Mogadishu on Oct 11. On Oct 20, Nigeria confirmed an imported case in a woman who had transited Uganda in early October.

Both confirmed exports passed through Entebbe undetected and were only identified after reaching better-resourced health systems. Uganda, declared Ebola-free on Jul 28, reports no active cases, but the corridor it sits on links the epicentre by road and air to Nairobi, Addis Ababa, Mogadishu and Juba. There is no approved vaccine or treatment for BVD.[2]

This report assesses the exposure of Kenya, Somalia, South Sudan and Ethiopia and the implications for organisations with staff and operations in the region. Vates assesses further exported cases from the corridor over the next 90 days are likely, and that Kenya's cluster will likely remain within its existing contact lists. For most clients the principal impact will come from travel restrictions, screening delays and duty-of-care decisions rather than community transmission, although a case outside known contact chains in any of the four countries would change that picture quickly.

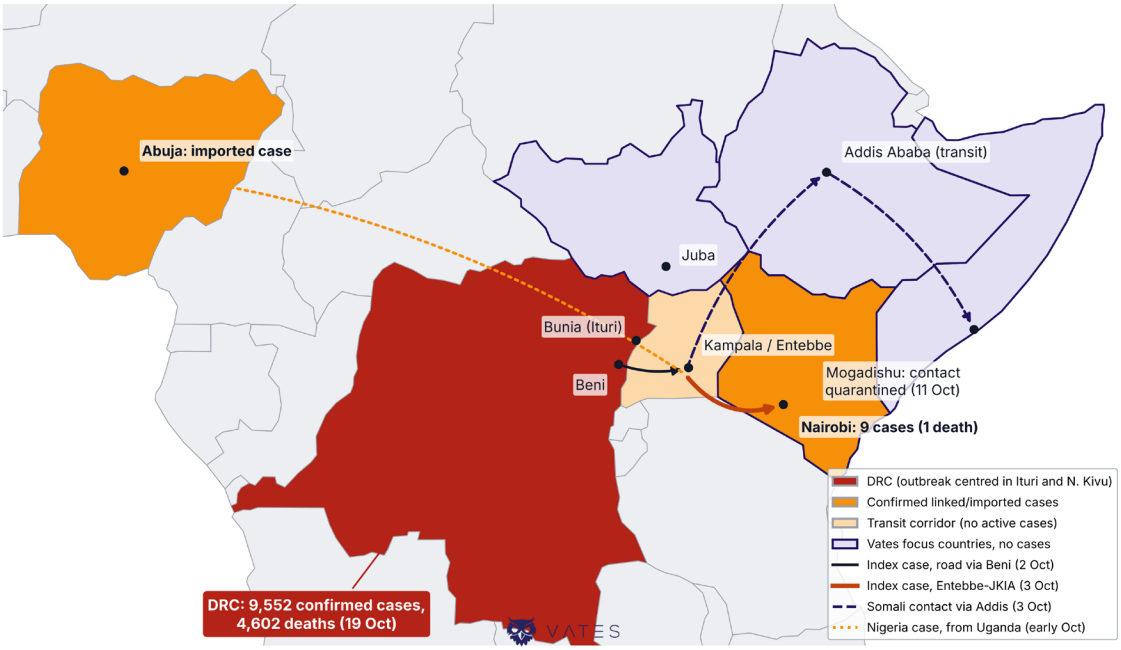


Figure 1 Ebola Bundibugyo virus disease (BVD) exports from eastern DRC through the Uganda corridor, Oct 2026. Source: Vates; WHO, ECDC and national Ministry of Health reporting.

[1] ECDC, Ebola disease outbreak in the Democratic Republic of the Congo and Uganda, updated Oct 20 2026 (DRC data as of Oct 19). The DRC Ministry of Health notes its data remain under continuous review. https://www.ecdc.europa.eu/en/ebola-outbreak-democratic-republic-congo-and-uganda

[2] WHO advised on May 28 against using the Zaire-strain vaccine (Ervebo) for Bundibugyo, citing weak evidence of cross-protection. CEPI funded three candidate vaccines (IAVI, Moderna, Oxford) on Jun 1; none is licensed.

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The Epicentre

The DRC outbreak is concentrated in Ituri (6,960 cases, 3,217 deaths) and North Kivu (2,084 cases, 1,176 deaths), with 415 cases in Haut-Uélé and smaller numbers in Tshopo, Bas-Uélé, Sud-Kivu, Sud-Ubangi and Nord-Ubangi; 66 of 178 health zones are affected. Around 100 new confirmed cases are being reported per update, and only 76.9% of identified contacts are under follow-up. The response has been hampered since May by attacks on treatment centres and burial teams, patients leaving isolation, and Allied Democratic Forces (ADF) violence around Beni. Ituri borders both Uganda and South Sudan, and Haut-Uélé borders South Sudan and the Central African Republic.

The Uganda Corridor

Uganda contained its own outbreak of 20 cases between May and July and has kept its border with the DRC closed.[3] The October exports show the closure does not stop movement. The Kenyan index patient had been ill since mid-September and treated at several DRC facilities before travelling by bus via Beni to Kampala on Oct 02. He flew Jambojet 8523 from Entebbe to Jomo Kenyatta International Airport (JKIA) at 1310hrs on Oct 03, passing screening at both airports; Kenyan officials have suggested medication may have masked his symptoms. He died at Nairobi Hospital at approx. 2330hrs on Oct 05.

Ugandan authorities later established that a Somali citizen had stayed at the same hotel and shared a vehicle with him to Entebbe. The Somali flew to Mogadishu via Addis Ababa, arriving on Oct 03, and was not traced until Uganda notified Somalia on Oct 10.[4] The Nigerian case, described by Uganda's Ministry of Health as a businesswoman returning from eastern DRC, transited Uganda without symptoms and arrived in Nigeria around Oct 03. Her symptoms began on Oct 07, she sought care at a private facility in Abuja on Oct 11, and Bundibugyo virus was only confirmed on Oct 20; 44 contacts are under monitoring. Uganda maintains it has no active cases, stresses that transit does not establish where infection occurred, and has requested travel and clinical records from Nigeria.[5]

Two exports through the same airport within a fortnight, each detected only on arrival elsewhere, indicate that screening based on temperature checks and health declarations is not detecting infected travellers. Early BVD symptoms are non-specific and easily mistaken for malaria; the incubation period runs to 21 days; and a person is only infectious once symptomatic. Each detected export is therefore consistent with a larger pool of infected or recently exposed people moving out of eastern DRC without being identified.

Country Exposure

Kenya: The Ministry of Health (MoH) has confirmed nine cases in a single cluster: the index patient, close relatives, health workers and hospital staff exposed before contact listing began on Oct 06. The ninth, a 24-year-old relative, tested positive on Oct 19 after developing symptoms in quarantine; the eight surviving patients are reported stable. 134 of 135 identified contacts have been traced, and the first group is due to leave quarantine from Oct 25 if symptom-free.[6] Suspected cases in Wajir and Laikipia tested negative. Kenya gazetted Ebola as a formidable epidemic disease on Oct 12 and has routed arrivals from ten countries through a designated screening gate at JKIA since Oct 07.[7] On Oct 19 the U.S. Department of State raised Kenya to Level 3 (Reconsider Travel) on health grounds; the UK has not changed its advice. MSC Cruises has suspended boarding of Kenyan nationals, including crew, until Oct 31.

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[3] Uganda declared its outbreak over on Jul 28 after a 42-day monitoring period: 20 confirmed cases and two deaths, both DRC nationals. Uganda closed its border with the DRC on May 27. https://www.aljazeera.com/news/2026/7/28/uganda-declares-end-to-ebola-outbreak

[4] Somali Ministry of Health and Human Services statement, Oct 12, as reported by Dawan Africa and Eastleigh Voice. Uganda's IHR focal point notified Somalia on Oct 10. https://www.dawan.africa/news/somalia-quarantines-citizen-who-travelled-with-person-who-died-of-ebola

[5] Federal Ministry of Health, Nigeria and WHO, Oct 20; Uganda Ministry of Health statement, Oct 20, as reported by allAfrica, Oct 21. https://allafrica.com/stories/202610210118.html

[6] Kenya Ministry of Health statement signed by Director-General for Health Dr Patrick Amoth, Oct 20. https://allafrica.com/stories/202610210086.html

[7] The ten countries routed through JKIA Gate 16 since Oct 07 are the DRC, Uganda, Tanzania, Ethiopia, Angola, Zambia, Rwanda, Burundi, South Sudan and the Central African Republic. https://www.kenyans.co.ke/news/127667-travellers-drc-uganda-ethiopia-among-10-countries-face-enhanced-ebola-screening-jkia

Somalia: The Cabinet set up a six-ministry Ebola committee chaired by the Deputy Prime Minister on Oct 08. The Somali contact of the Kenyan index case was traced in a joint MoH, Immigration and CID operation and moved to the Ebola Quarantine and Treatment Centre at Forlanini Hospital in Mogadishu on Oct 11. The MoH described this as precautionary and has not published a test result. If he remains symptom-free, his 21-day monitoring period from last exposure ends around Oct 24. Somalia's wider exposure comes from its links to the corridor: Uganda is AUSSOM's largest troop contributor, with personnel rotations and logistics moving between Entebbe and Mogadishu,[8] and much regional travel to Mogadishu connects through Addis Ababa, Nairobi or Entebbe. Isolation capacity outside Mogadishu is minimal, so a case in Somalia would likely be detected late and contained with difficulty.

South Sudan: South Sudan has reported no suspected cases, but it borders both Uganda and the affected provinces of north-eastern DRC. The MoH raised its alert on Oct 07 after the Kenya case, with screening at points of entry, Juba International Airport and 15 high-risk border counties, and eight isolation units.[9] Its exposure is primarily a travel and operational one: the U.S. suspends entry for most non-U.S. nationals who have been in South Sudan, Uganda or the DRC in the previous 21 days, a measure first imposed in May whose current order runs to Nov 10.[10] Canada also suspended visas for residents of all three countries in May. For organisations rotating international staff through Juba, the 21-day rule already constrains onward travel to the U.S.

Ethiopia: Ethiopia has reported no cases and on Oct 18 announced screening at air and land entry points, isolation facilities, laboratory testing and rapid response teams.[11] Its exposure is as a hub. The Somali contact transited Addis Ababa on Oct 03, Ethiopian Airlines connects Entebbe and Kinshasa with the Horn and beyond, and Kenya already includes Ethiopia among the ten countries whose arrivals are routed through enhanced screening. Ethiopia also borders South Sudan and Kenya. The main risks are an infected traveller passing through Bole International Airport or other border points undetected, and other countries applying screening or restrictions to travellers from Ethiopia because of its connections.

Travel and Trade Measures

The World Health Organization (WHO) continues to advise against travel or trade restrictions on affected countries. Formal government measures remain limited to the U.S. entry suspension covering the DRC, Uganda and South Sudan, the U.S. Level 3 advisory for Kenya, and enhanced entry screening across the region. Private-sector measures such as the MSC suspension, and requests from partners abroad for health declarations, are likely to spread faster than government restrictions. Each new export increases the likelihood that peer governments follow the U.S. lead on Kenya, and that the U.S. adds countries to its entry suspension.

Assessment

Near Term (to mid-Nov): Further cases within Kenya's existing contact lists are likely before monitoring ends, as exposure continued until at least Oct 05 and each new case creates new contacts; the watch period will very likely extend into November. A case outside those lists, or outside Nairobi, would be the key indicator of undetected spread. Further exported cases from the corridor to the region or beyond are likely within the next 90 days, given two in October and no change in the conditions that enabled them. The U.S. entry suspension will very likely be renewed on Nov 10.

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[8] Uganda was the largest AUSSOM troop contributor in 2025, with 4,500 troops allocated to Sector 1 (Mogadishu/Lower Shabelle). See Vates Special Report, Not So AUSSOM – Somalia's Security Mission in Crisis, May 2025.

[9] South Sudan Ministry of Health, Oct 07, as reported by Xinhua, Oct 08. WHO assessed national preparedness at 65%, up from 29% in May and 45% in June. https://english.news.cn/africa/20261008/b3b183ec91fe44b8829c66ef6854b829/c.html

[10] CDC order suspending entry of certain non-U.S. persons present in the DRC, Uganda or South Sudan in the prior 21 days, extended from Oct 11 to Nov 10 unless modified. https://www.cdc.gov/port-health/legal-authorities/evdorder.html

[11] Ethiopia Ministry of Health statement, Oct 18, as reported by Xinhua, Oct 19. https://english.news.cn/africa/20261019/375928d8c9194d3f95af13946ccee3b1/c.html

Medium Term (to Jan 2027): The DRC outbreak will very likely continue into 2027, sustaining pressure on the corridor. An introduction into South Sudan is a realistic possibility given its border with the affected provinces and weak surveillance; detection there would likely be late. Somalia and Ethiopia are less likely to see cases, but each is linked to the corridor by daily flights, cross border trade and, in Somalia's case, by AUSSOM troop movements.

Long Term: Without a licensed vaccine, containment depends on detection, contact tracing and isolation, which are weakest where movement is highest. Unless DRC case numbers fall sharply, the region should plan for intermittent imported cases, periodic tightening of travel measures and continuing duty-of-care pressures well into 2027.

Implications for Clients and Travellers

The risk to individuals remains concentrated among people who have recently been in affected areas of the DRC, their close contacts and health workers. Nairobi's cluster arose in a hospital emergency department, so staff with fever after regional travel should telephone ahead rather than walk into a clinic. Organisations should confirm medical evacuation cover for suspected infectious disease, as providers may decline such cases; check staff itineraries for transits through Entebbe given the U.S. 21-day rule; expect delays for arrivals at JKIA from the ten listed countries; and advise anyone returning from an outbreak area to monitor their health for 21 days. Contingency triggers should include a case without a known link in Kenya, any confirmed case in Mogadishu, Juba or Addis Ababa, a locally acquired case in Uganda, and any extension of U.S. restrictions to Kenya or Ethiopia.

Key Upcoming Dates

Approx. Oct 24: End of 21-day monitoring for the Somali contact quarantined in Mogadishu (estimated from last exposure)
Oct 25: First Kenyan contacts complete 21-day quarantine if symptom-free
Oct 31: Scheduled end of MSC Cruises' suspension of Kenyan passengers and crew
Nov 10: Expiry of the U.S. CDC entry suspension for the DRC, Uganda and South Sudan unless extended
Early Dec at the earliest: Kenya's cluster can only be declared over 42 days after its last case

Conclusion

The Bundibugyo outbreak is no longer a DRC problem with regional preparedness implications; it is moving through Uganda's airports and roads into the capitals where Vates' clients are based. Kenya's response has so far contained its cluster within known contacts, but the front-end failure that allowed the index case through two airports has not been fixed, and the same pathways link the epicentre to Mogadishu, Juba and Addis Ababa.

Vates continues to track the outbreak daily alongside its security reporting on Somalia, Kenya, Ethiopia, South Sudan and other regional countries. Organisations reviewing their posture should plan for further importations and tighter travel measures, and should not assume that the absence of reported cases means the absence of risk. **End**