

Situation at a Glance

- On **May 17, 2026**, the World Health Organization (WHO) Director-General officially declared the **Ebola disease outbreak caused by the Bundibugyo virus (BDBV) a Public Health Emergency of International Concern (PHEIC)** under the International Health Regulations (2005).
- As of 22 May, WHO assessed the outbreak risk as Very High in DRC, High in Uganda, and Low globally. These risk levels remained unchanged.
- As of July 7, Africa CDC and WHO reported 1,759 confirmed cases and 600 confirmed deaths (CFR: 34.1%) in the Democratic Republic of the Congo (DRC), with cases identified across 37 health zones. In Uganda, 20 confirmed cases and two confirmed deaths (CFR: 10.0%) have been reported, with transmission remaining concentrated in Kampala. Overall, 301 patients recovered, corresponding to a recovery rate of 16.9%.



Figure 1. Regions affected by Bundibugyo virus disease in DRC and Uganda, as of July 10, 2026

Table 1. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of July 7, 2026

Country	Health Zone/ District Affected	Confirmed Cases	Confirmed Deaths	CFR (%) Confirmed	Cured	Recovery Rate (%)
DRC	37	1,759	600	34.1%	285	16.2%
Uganda	2	20	2	10.0%	16	85.0%
Total	39	1,779	602	33.8%	301	16.9%

Source: Africa CDC, WHO

- Healthcare workers, particularly in DRC, remained affected, with 112 confirmed cases reported. In Uganda, four cases were reported with no additional infections among healthcare workers in Uganda since June 1.

Table 2. Cases among Healthcare Workers (HCW)

Country	Confirmed cases among HCWs	Confirmed deaths among HCWs	CFR (%)
DRC	112	35	31.3%
Uganda	4	0	0.0%
Total	116	35	30.2%

Source: Africa CDC, WHO

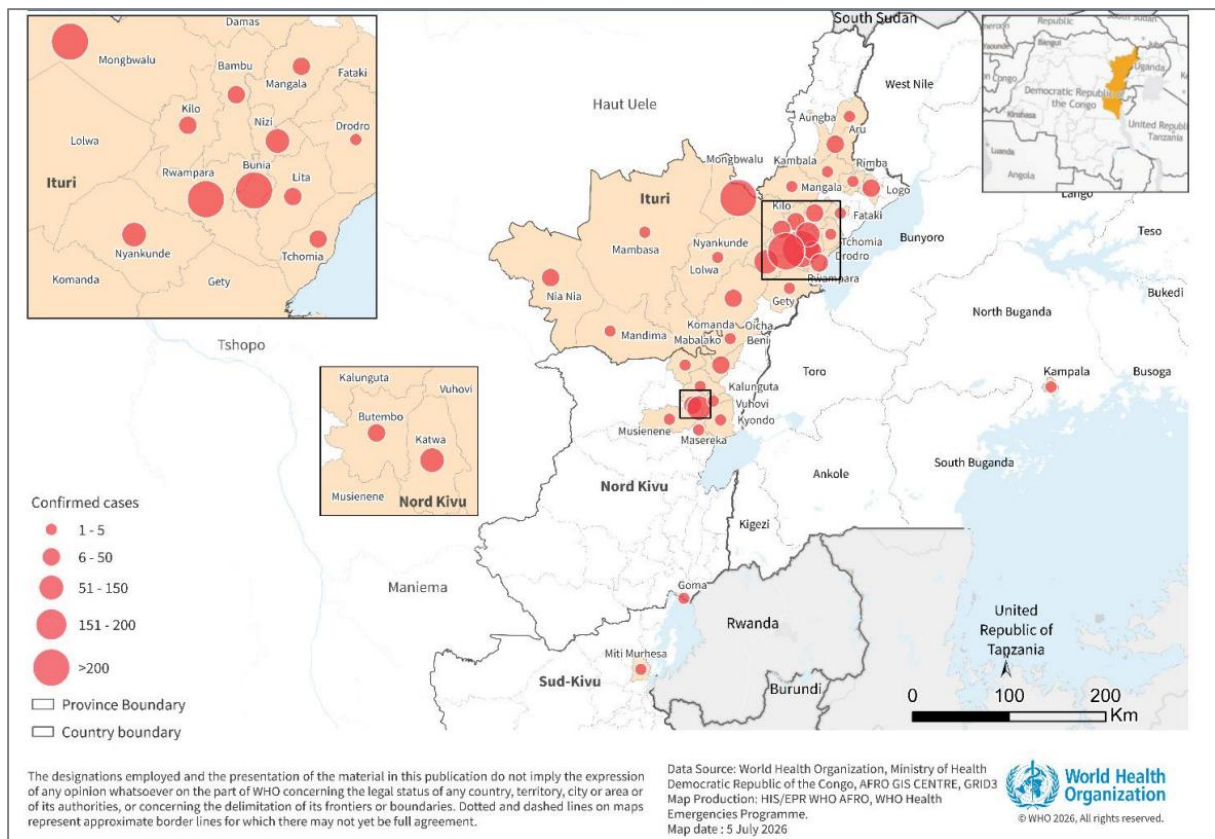


Figure 2. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in DRC and Uganda, as of July 5, 2026 (Source: WHO)

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, haemorrhaging, 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 had 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.
- **By June 8**, Africa CDC reported 626 confirmed cases and 112 deaths in DRC (CFR: 17.9%). A total of 19 cases had recovered, representing 3.0% of confirmed cases.
- **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.

- **From June 21 to 27**, transmission intensified further, with 318 new cases and 113 deaths (CFR=35.5%), the highest weekly case count reported to date.
- In the week ending **July 4**, a further 287 cases and 146 deaths were reported (weekly CFR: 50.9%). By 4 July, cumulative totals had reached 1,561 confirmed cases and 506 deaths (CFR: 32.4%) across 36 affected health zones.
- **From July 5 to 7**, an additional 198 cases and 94 deaths were reported, increasing cumulative totals to 1,759 confirmed cases and 600 deaths. The number of recoveries were 285, representing 16.2% of confirmed cases.

Uganda

- **On May 11**, 2026, the first imported case was identified in an elderly man from the DRC who was admitted to a private hospital in Kampala and died on May 14. Laboratory testing confirmed BDBV infection on 15 May, and the body was repatriated to the DRC the same day.
- **On May 16**, a second imported case was confirmed in Kampala in an individual returning from DRC with no known epidemiological links to the first case. No local transmission had been identified in Uganda at the time of reporting.
- **As of May 24**, the cumulative case count reached seven confirmed cases, including one death (CFR: 14.3%). Cases identified through contact tracing included healthcare workers and other close contacts, with transmission remaining largely confined to known exposure chains.
- **On June 21**, one additional confirmed case was reported, marking the first new case since 5 June.
- **By July 7**, Uganda had reported 20 confirmed cases and two deaths (CFR: 10.0%). A total of 16 patients recovered, representing 80.0% of confirmed cases, with no additional cases reported after 21 June.

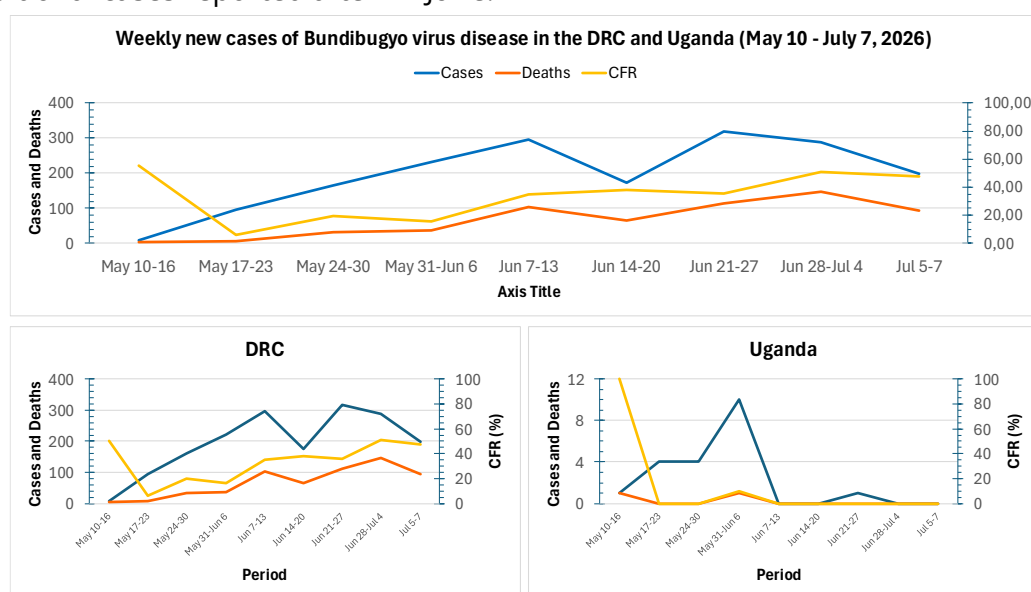


Figure 3. Weekly new cases of BVD in the DRC and Uganda (May 10 – July 7, 2026)
(Source: Africa CDC)

The outbreak showed a marked increase in weekly reported cases through late June, driven largely by transmission in the DRC. Weekly cases rose from 9 during May 10–16 to a peak of 319 during June 21–27, reflecting sustained expansion of transmission. Transmission decreased to 287 cases from June 28 to July 4. Preliminary data from July 5 to 7 recorded an additional 198 cases, indicating continued intense transmission.

Mortality trends followed a similar pattern, increasing from 5 deaths in mid-May to 103 during June 7–13, before declining to 66 from June 14 to 20. Deaths subsequently rose to 113 during June 21–27 and further to 146 during June 28 to July 4, highlighting the continuing severity of the outbreak. The weekly CFR fluctuated overtime, reaching 50.9% from June 28 to July 4.

These trends were primarily driven by the DRC, where sustained increases in cases and deaths continued throughout June and early July. In contrast, Uganda reported limited transmission, with cases peaking at 10 during May 31 to June 6 and no additional cases reported for more than two weeks before a single new case was identified during June 21–27, with no further cases reported.

Overall, the outbreak remains active and expanding in the DRC, while transmission in Uganda remains limited, with no evidence of sustained community spread.

France

- **On June 24, 2026,** France reported a laboratory-confirmed BDBV case in a physician returning from Ituri Province, DRC, where the individual had returned from a humanitarian mission. After self-reporting symptoms upon arrival on June 23, the patient was isolated and transferred to a specialized facility. The patient remained clinically stable, and PCR testing confirmed BDBV infection. Five contacts who were on the plane from Kinshasa with the case had been identified and were placed in isolation, and no further infections have been reported.

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.
- Effective outbreak control depends on early case identification, isolation of patients, contact tracing, safe burial procedures, adherence to IPC protocols, and strong community engagement, as there are currently no licensed vaccines or specific antiviral treatments for BVD.

Public Health Response

1. Coordination

- a. On June 27, 2026, the Continental BVD Incident Management Support Team (IMST) was launched in Kampala. It continues to coordinate response activities in the DRC and Uganda while supporting preparedness efforts in 11 additional high-risk countries under the “One Plan, One System, One Report” framework.
- b. Cross-border coordination remains a priority, including strengthened preparedness and response activities along high-risk border and arrangements for deployment of mobile laboratories and treatment units.
- c. Regional political engagement intensified during the reporting period, including a visit by the President of South Africa to the DRC to support the outbreak response and strengthen bilateral cooperation.
- d. National Incident Management Systems (IMS) in the DRC and Uganda remain active, with support from WHO, Africa CDC, and other partners. In the DRC, overall coordination continues under the Ministry of Health through the Public Health Emergency Operations Centre (COUSP RDC).
- e. GOARN, Emergency Medical Teams (EMTs), Standby Partners, and the Global Health Cluster continue to provide surge capacity, technical expertise, and operational support across affected and at-risk countries. In the DRC, 68 of 101 health cluster partners are supporting the BVD response.
- f. Field missions to Bunia, Beni, Katwa, Butembo, Nizi, and Nyankunde continued to strengthen operational oversight, assess treatment expansion needs, and support coordination with rapid response teams.
- g. The broader regional response requires an estimated US\$517 million. Despite approximately US\$900 million in cash and in-kind pledges announced by African Union Member States and international partners, WHO continues to face a substantial funding gap, highlighting the need to rapidly translate commitments into operational resources.

2. Operations support and logistics

- a. WHO continues to support preparedness and response operations through multidisciplinary field teams deployed across the DRC and Uganda, providing support for surveillance, laboratory activities, logistics, clinical management, and cross-border preparedness.
- b. Operations support and logistics activities continue to scale up in the DRC. As of July 5, 2026, the value of delivered supplies increased to approximately US\$1.92 million, while the overall procurement and shipment pipeline expanded to US\$9.19 million.

- c. Delivered commodities reached 198.6 metric tons (1,099.7 m³), supporting response operations in Ituri and the Kivu provinces. Critical supplies included hospital beds, tents, infrared thermometers, PCR diagnostic tests, patient liners, gloves, gowns, and coveralls.
- d. Personal protective equipment (PPE) and IPC supplies continue to account for the largest share of procured commodities; however, critical shortages of PPE remain a major operational challenge.
- e. During the reporting period, logistics support enhanced field mobility through the deployment of 26 vehicles and four ambulances in Ituri. Continued infrastructure development also supported expansion of treatment capacity at the Elikya and Rwampara Ebola Treatment Centres.
- f. Logistics constraints continue to affect response operations, particularly IPC activities, due to supply chain challenges and shortages of PPE, hygiene supplies, and essential base kits. Efforts are ongoing to improve warehouse accessibility and supply availability.
- g. Procurement and logistics coordination mechanisms remain active, supporting shipment tracking, distribution, partner coordination, and monitoring of operational gaps. Most commodities were sourced directly from suppliers (71%), with additional support provided through WHO logistics hubs in Kinshasa, Nairobi, Dubai, and Dakar.

3. Surveillance and Contact Tracing

- a. Surveillance activities continued across affected and at-risk areas, including active case finding, alert management, case investigation, contact tracing, mortality surveillance, community-based surveillance, and cross-border surveillance.
- b. As of July 5, 2026, a total of 927 alerts were reported across the three affected provinces in the DRC, of which 88.8% were investigated within 24 hours.
- c. Alerts associated with possible spread to Haut-Uélé and Tshopo provinces are under investigation following the movement of confirmed cases and contacts linked to Nia-Nia Health Zone in Ituri Province.
- d. Points of entry (PoE) and points of control (PoC) surveillance continued to be strengthened in the DRC.
- e. In Uganda, alert management, surveillance of non-trauma deaths, and community-based surveillance continued nationwide. As of 5 July 2026, all identified contacts had completed their 21-day follow-up period.
- f. Inbound and outbound screening remained active at points of entry in Uganda, including Entebbe International Airport and high-risk border crossings. Digital Passenger Locator Forms continued to be used for inbound travellers, while holding facilities for high-risk travellers and temporary travel restrictions between Uganda and the DRC remained in place.

4. Laboratory

- a. Diagnostic testing continues across affected countries through national and subnational laboratory networks.
- b. Laboratory decentralization continued to expand, reaching approximately 60% completion. As of 5 July 2026, 12 laboratories and testing units were operational across Ituri and North Kivu, in addition to the National Institute for Biomedical Research (INRB) in Kinshasa.
- c. In North Kivu, all pending samples were processed during the reporting period, eliminating the laboratory testing backlog.
- d. Laboratory capacity was further strengthened through the deployment of 54 laboratory experts and the distribution of 2,496 PCR test kits and 8,000 RadiOne tests.
- e. Testing throughput remained high, particularly in Ituri, where positivity rates ranged from 37.9% to 63.3%, indicating sustained transmission. In contrast, North Kivu reported lower positivity rates (3.0%–4.2%) following clearance of the testing backlog.
- f. Despite ongoing scale-up efforts, challenges persist, including delays in result reporting, weak data integration and information management systems, limited logistics capacity, and shortages of complementary diagnostic tests for clinical care.

5. Clinical Management

- a. WHO has published new clinical management guidelines for filovirus diseases, including BVD outlining key recommendations for patient care and outbreak response (<https://www.who.int/publications/i/item/B09774>)
- b. Case management capacity continued to expand in the DRC, with approximately 700 treatment and isolation beds available across more than 22 Ebola Treatment Centres (ETCs) and care facilities.
- c. As of July 5, 2026, a total of 646 patients were in isolation. National bed occupancy remained high at 94.2%, with some facilities operating beyond planned capacity.
- d. Recovery continued to improve. Supportive care activities continued across treatment centres, alongside the rollout of free healthcare services in priority health zones in Ituri.
- e. On July 2, 2026, the WHO-supported PARTNERS clinical trial was launched in the DRC, the first clinical trial evaluating treatments specifically for BVD.
- f. Case management activities continue to be supported by WHO, the Ministry of Health, Africa CDC, ALIMA, MSF, and other partners involved in clinical care, treatment centre operations, and research activities.
- g. Despite ongoing expansion efforts, treatment facilities remain under significant pressure. Key challenges include ETC saturation, delayed isolation of suspected cases, limited ambulance availability, gaps in critical care and oxygen therapy, staffing shortages, and limited psychosocial support services.

- h. In Uganda, treatment capacity includes 84 beds at the Mulago isolation facility, 56 beds at the Entebbe isolation facility, and an additional 32 beds at the Mulago Field Isolation Facility. Four border facilities have also been identified for assessment and potential expansion of BVD treatment capacity.
- i. Uganda is also strengthening surge capacity through Emergency Medical Team preparedness, with 40 team members undergoing induction training in Entebbe ahead of deployment to Aru Health Province in the DRC.

6. Infection Prevention and Control (IPC) and Water, Sanitation and Hygiene (WASH)

- a. IPC activities continued across affected provinces in the DRC, including healthcare worker and community relay briefings, assessments in 140 health facilities in North Kivu, and training of 34 healthcare providers from 17 priority facilities.
- b. Safe and dignified burial operations and decontamination activities continued in Ituri, including the disinfection of households, health facilities, and vehicles linked to confirmed cases.
- c. IPC/WASH assessments identified persistent gaps in infection prevention readiness. In North Kivu, the average facility IPC score remained below 50%, with only two facilities achieving scores above 80%.
- d. Healthcare worker infections continued to increase, with 96 confirmed infections and 19 deaths reported (CFR: 19.7%), underscoring ongoing occupational exposure risks and IPC challenges in healthcare settings.

7. Risk Communication and Community Engagement (RCCE)

- a. RCCE activities continued across affected provinces to support community awareness, alert reporting, contact tracing, and safe and dignified burial operations, particularly in hotspot areas of Ituri and North Kivu.
- b. A call-and-listening centre was established to strengthen community alert management and improve access to outbreak information and reporting mechanisms. Refresher training was also conducted for call centre personnel.
- c. Community engagement efforts increasingly targeted high-risk and mobile populations, including mining communities, border populations, internally displaced people, and communities affected by insecurity and cross-border movement.
- d. Strategic risk communication activities continued through press briefings led by national authorities, WHO, and partners, alongside outreach through local radio stations, social media influencers, and mass awareness campaigns.

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

- a. PRSEAH coordination activities continued in collaboration with government authorities, the inter-agency PRSEAH network, international non-governmental organizations, United Nations agencies, and operational partners to strengthen prevention and response measures within the BVD outbreak response.
- b. Joint community awareness and risk communication activities were conducted to raise awareness on the prevention of sexual exploitation and abuse and promote use of the toll-free reporting hotline.
- c. Data collection for the assessment of sexual exploitation and abuse risk factors has been completed, and analysis is ongoing to identify priority mitigation measures and strengthen prevention strategies in affected communities.
- d. The PRSEAH preparedness plan and associated human resource requirements have been finalized for 12 high-risk countries to strengthen operational readiness and enhance prevention and response capacity for sexual exploitation abuse and harassment risks in priority settings.

9. Operational Readiness

- a. Recent assessments showed an average readiness score of 58% among Priority 1 and 2 countries. As of the reporting period, 28 of 47 Member States (60%) had updated their readiness assessments.
- b. Regional deployments to support high-risk countries remain ongoing in South Sudan and the DRC.
- c. In South Sudan, preparedness efforts focused on strengthening case management readiness through assessments of two treatment units and implementation of a five-day training-of-trainers programme for more than 80 frontline healthcare workers in Juba.
- d. Priority readiness activities continue to focus on strengthening emergency operations, surveillance, laboratory capacity, case management, IPC, border health measures, contingency planning, healthcare worker training, and prepositioning of response supplies in high-risk areas.

10. Border Health, Travel and Mass Gatherings

- a. Screening and surveillance have been reinforced at airports, high-risk border crossings, and major transit routes in the DRC and Uganda, supported by national authorities, IOM, and partners.
- b. Priority activities include mapping points of entry (PoE), population mobility patterns, informal crossings, and high-risk congregation points, while ensuring frontline teams have adequate staffing, training, PPE, screening materials, disinfectants, and referral capacity.

- c. Mass gathering preparedness continues to be strengthened through risk assessment and planning. Postponement of mass gatherings remains recommended in areas with documented BVD transmission, while a risk-based approach is advised for events in unaffected areas.
- d. Event organizers are advised to provide participants with clear information on BVD symptoms, reporting procedures, and available health services, in line with the [WHO guidance for mass gathering events attended by individuals from areas with documented BDBV detection](#).

WHO Risk Assessment

- On May 17, 2026, WHO declared the outbreak as a PHEIC due to ongoing transmission of BVD in DRC and imported cases reported in Uganda. The outbreak is occurring in a complex humanitarian and security context, with delayed detection, limited surveillance capacity, insecurity, population displacement, and high population mobility contributing to increased transmission risks.
- As of May 22, the WHO assessed the risk associated with the outbreak as **Very High in the DRC and High in Uganda**. While acknowledging differences in epidemiological trends and operational contexts between the two countries, WHO noted that the risk of regional spread remained elevated. **The outbreak risk was also assessed as High at the regional level and Low at the global level**. As of July 3, these risks remained unchanged.

Table 3. WHO Risk Assessment, as of June 14, 2026

Overall Risk			QIRA*
National	Uganda and Regional	Global	ASEAN Region
DRC: Very High	High	Low	Low

Source: WHO as of July 3, 2026

*) ABVC QIRA

The WHO Recommendations

- On May 19, 2026, the WHO Director-General convened an IHR Emergency Committee, which determined that the Bundibugyo virus disease (BVD) outbreak constitutes a Public Health Emergency of International Concern (PHEIC), but not a pandemic. The Committee issued tiered recommendations based on countries' risk levels:
 1. **Affected countries (DRC and Uganda):** Focus on strengthening outbreak response systems, including surveillance, contact tracing, clinical care, infection prevention and control (IPC), community engagement, and border measures. Efforts should also ensure safe burials, maintain supply chains, and support research on treatments and vaccines.

2. **Neighboring countries:** Emphasize preparedness, including enhancing surveillance, laboratory capacity, rapid response, and cross-border coordination. Early detection and immediate response to suspected cases are critical, alongside community awareness and readiness to use investigational medical countermeasures.
 3. **All other countries:** Prioritize travel-related measures, including detection and management of suspected cases among travelers, public risk communication, and international coordination. Countries should also prepare for potential case importation and ensure timely reporting to WHO.
- WHO guidance emphasizes that travel restrictions are not recommended, meaning flights should not be suspended and travelers should not be denied entry solely based on origin. Instead, countries should adopt a risk-based and preparedness-focused approach to manage cross-border health risks. Key considerations include travel advice and communication, preparedness at points of entry (PoE), training and awareness, and detection and management of suspected cases, including contact tracing during travel as well as environmental and operational measures

Risk to the ASEAN Region (Based on Flight Connectivity from Ebola Outbreak Areas)

Currently, there are no direct (non-stop) flights from the outbreak source airports (Kinshasa – DRC, Entebbe – Uganda) 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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