

# ASEAN Biological Threats Surveillance Centre

## Situation Report of Ebola Disease Outbreak caused by the Bundibugyo virus (BDBV) in The Democratic Republic of the Congo & Uganda

July 17, 2026



With Support by:  
 Canada  
 Ebola Disease Control and Prevention Agency

### 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 May 22, WHO assessed the outbreak risk as Very High in DRC, High in Uganda, and Low globally. These risk levels remained unchanged.
- As of July 13, Africa CDC and WHO reported 2,011 confirmed cases and 754 confirmed deaths (CFR: 37.5%) in the Democratic Republic of the Congo (DRC), with cases identified across 45 health zones. In Uganda, 20 confirmed cases and two confirmed deaths (CFR: 10.0%) have been reported, with transmission remaining concentrated in Kampala. Overall, 383 patients recovered, corresponding to a recovery rate of 18.9%.

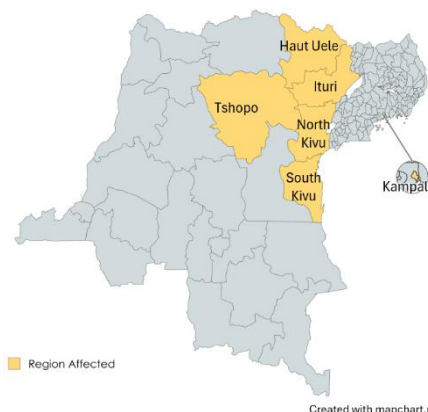


Figure 1. Regions affected by Bundibugyo virus disease in DRC and Uganda, as of July 13, 2026

Table 1. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of July 13, 2026

| Country      | Health Zone/<br>District Affected | Confirmed<br>Cases | Confirmed<br>Deaths | CFR (%)<br>Confirmed | Cured      | Recovery<br>Rate (%) |
|--------------|-----------------------------------|--------------------|---------------------|----------------------|------------|----------------------|
| DRC          | 45                                | 2,011              | 754                 | 37.5%                | 366        | 18.2%                |
| Uganda       | 2                                 | 20                 | 2                   | 10.0%                | 17         | 85.0%                |
| <b>Total</b> | <b>47</b>                         | <b>2,031</b>       | <b>756</b>          | <b>37.2%</b>         | <b>383</b> | <b>18.9%</b>         |

Source: Africa CDC, WHO

- Healthcare workers, particularly in DRC, remained affected, with 114 confirmed cases reported. In Uganda, four cases were reported with no additional infections among healthcare workers since June 1.

Table 2. Cases among Healthcare Workers (HCW)

| Country      | Confirmed cases among HCWs | Confirmed deaths among HCWs | CFR (%)      |
|--------------|----------------------------|-----------------------------|--------------|
| DRC          | 114                        | 36                          | 31.6%        |
| Uganda       | 4                          | 0                           | 0.0%         |
| <b>Total</b> | <b>116</b>                 | <b>36</b>                   | <b>30.5%</b> |

Source: Africa CDC, WHO

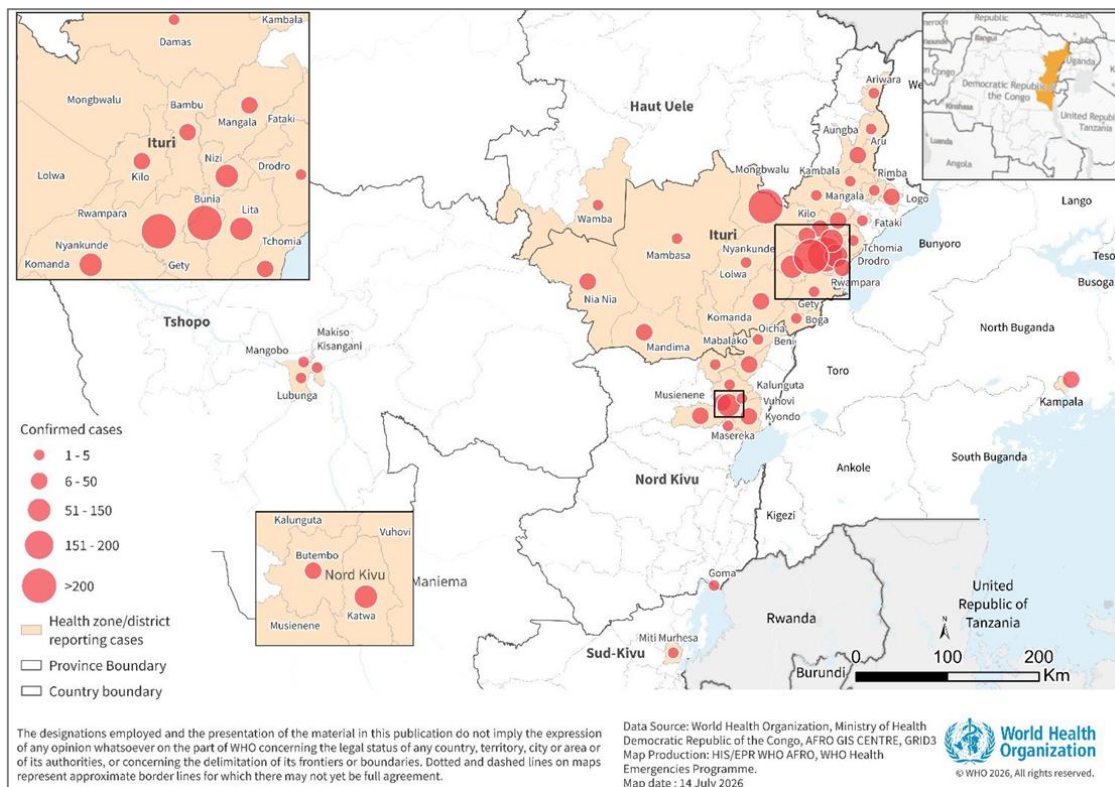


Figure 2. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in DRC and Uganda, as of July 12, 2026 (Source: WHO)

## 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%).

- **On July 9**, the DRC Ministry of Public Health officially expanded the list of affected provinces to include **Tshopo** and **Haut-Uele** following the detection of epidemiologically linked cases associated with Nia-Nia Health Zone in Ituri Province. Initial investigations indicated that the reported cases were linked to the movement of infected individuals from Ituri into the two provinces.
- **By July 13, DRC** confirmed a total of 2,011 cases and 754 deaths (CFR=37.5%). The number of recoveries was 366, representing 18.2% 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 13**, Uganda had reported 20 confirmed cases and two deaths (CFR: 10.0%). A total of 17 patients recovered, representing 85.0% of confirmed cases, with no additional cases reported after June 21.

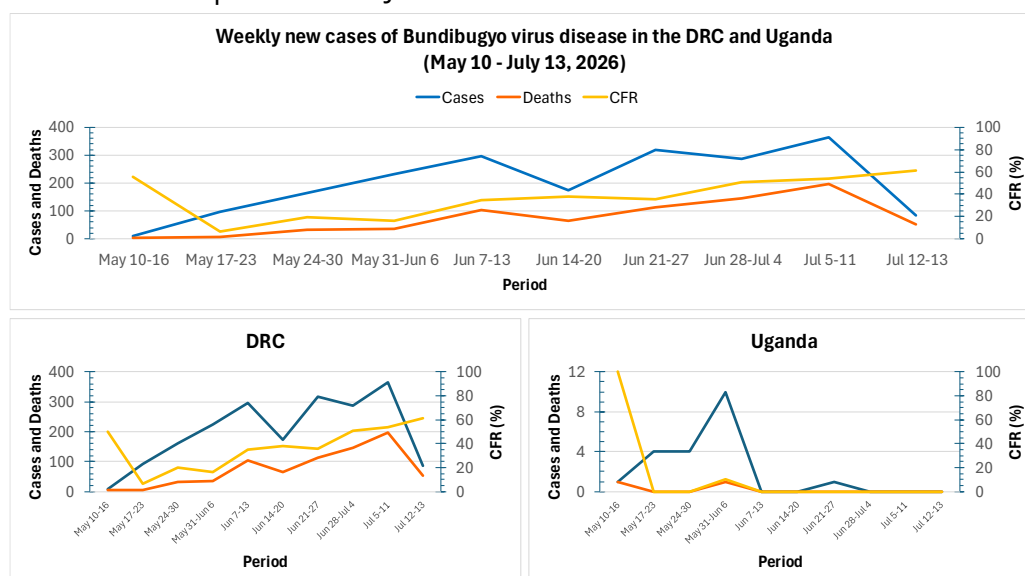


Figure 3. Weekly new cases of BVD in the DRC and Uganda (May 10 – July 13, 2026)  
(Source: Africa CDC)

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 365 during July 5–11, reflecting sustained expansion of transmission. Preliminary data from July 12 to 13 recorded an additional 85 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 196 during July 5–11, highlighting the continuing severity of the outbreak. The weekly CFR fluctuated overtime, reaching 61.2% from July 12–13.

These trends were primarily driven by the DRC with sustained increases in cases and death. 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 an imported laboratory-confirmed BDBV case in a physician returning from a humanitarian mission in Ituri Province, DRC. The patient was isolated after self-reporting symptoms upon arrival on 23 June. PCR testing confirmed infection, and five contacts identified from the flight were placed under monitoring. No secondary cases have been reported.

## Germany

- **On July 13, 2026,** an imported BVD case involving a United States humanitarian worker was medically evacuated from the DRC to Germany after testing positive for BDBV. At the time of reporting, no evidence of local transmission or secondary cases had been reported in Germany.

## Epidemiology

- Bundibugyo virus disease (BVD) is a severe Ebola disease caused by the Bundibugyo virus, an Orthoebolavirus. The current event is the 17th Ebola outbreak reported in the DRC since 1976. It is transmitted through direct contact with infected bodily fluids. The incubation period is 2–21 days, and symptoms range from fever and fatigue to severe gastrointestinal illness and haemorrhagic manifestations. Differentiating BVD from other common febrile diseases is challenging without laboratory testing.

- 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

- The Continental BVD Incident Management Support Team (IMST) continues to coordinate response operations in the DRC and Uganda while supporting preparedness activities in 11 additional high-risk countries under the One Plan, One System, One Report framework.
- In the DRC, high-level coordination was reinforced through meetings convened by the Minister of Public Health with national and provincial authorities, WHO, and partners to review the evolving outbreak situation, including the expansion of transmission into Tshopo and Haut-Uélé provinces.
- Response operations were rapidly expanded in the newly affected provinces, with multisectoral response pillars established to strengthen surveillance, case management, rapid response, and outbreak containment. Joint assessment missions by the national Incident Management Team and WHO also supported operational oversight and harmonization of epidemiological data across Ituri, Tshopo, and Haut-Uélé.
- National Incident Management Systems (IMS) in the DRC and Uganda remain operational with support from WHO, Africa CDC, UNICEF, IOM, MSF, ALIMA, IMC, Samaritan's Purse, the European Union, GOARN, Emergency Medical Teams (EMTs), the Health Cluster, and other partners through technical assistance, expert deployments, surge capacity, and field operations.

### 2. Operations support and logistics

- 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.
- Procurement and deployment of critical response supplies continued to expand, with the total emergency supply pipeline increasing to approximately US\$9.37 million. Of this amount, US\$2.59 million (28%) was delivered, US\$3.54 million (38%) was in transit, and US\$3.24 million (35%) remained under procurement.
- The value of delivered supplies increased from approximately US\$1.92 million to US\$2.59 million, with delivered cargo reaching 232 metric tons (1,333 m<sup>3</sup>), supporting response operations in Ituri and North Kivu.

- d. Essential commodities delivered included PPE, laboratory and PCR diagnostic supplies, medicines, medical equipment, hospital beds, tents, infrared thermometers, patient liners, gloves, gowns, and coveralls. Laboratory and IPC materials continued to account for the largest proportion of delivered supplies.
- e. Supply chain operations remained focused on supporting case management, laboratory testing, surveillance, IPC, and field activities. However, substantial quantities of gloves, coveralls, and other critical commodities remained in transit or under procurement, requiring close monitoring of stock levels.
- f. Procurement and logistics coordination continued through WHO's international supply network and logistics hubs in Kinshasa, Nairobi, Dubai, and Dakar, with most commodities sourced directly from manufacturers and suppliers.

### **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 12, 2026, a total of 1,156 alerts were reported across four affected provinces in the DRC, of which 1,049 (90.5%) were investigated within 24 hours.
- c. Points of entry (PoE) and points of control (PoC) surveillance continued to be strengthened in the DRC. As of 12 July 2026, all 71 planned PoE/PoC sites were operational across Ituri and North Kivu provinces. During the reporting period, 144,094 travellers passed through screening sites, of whom 95.4% were screened for BVD symptoms.
- d. In Uganda, alert management, surveillance of non-trauma deaths, and community-based surveillance continued nationwide. As of July 12, 2026, all identified contacts had completed the 21-day follow-up period.
- e. Inbound and outbound screening remained active at Ugandan points of entry, 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 12 July 2026, 14 laboratories and testing units were operational across Ituri and North Kivu, in addition to the INRB laboratories in Kinshasa and Goma.
- 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 750 treatment and isolation beds available across more than 25 Ebola Treatment Centres (ETCs) and care facilities.
- c. Recovery continued to improve. Supportive care activities continued across treatment centres, alongside the rollout of free healthcare services in priority health zones in Ituri.
- d. On July 2, 2026, the WHO-supported PARTNERS clinical trial was launched in the DRC, the first clinical trial evaluating treatments specifically for BVD.
- e. Case management activities continue to be supported by the Ministry of Health, WHO, Africa CDC, ALIMA, MSF, Samaritan's Purse, IMC, MEDAIR, Malteser International, and other research and operational partners.
- f. An integrated coordination centre for ambulance dispatch and referral services was established in Bunia to improve the transport of patients and support safe and dignified burial operations.
- g. WHO has further strengthened critical care capacity through the delivery of five Piccolo laboratory analyzers and five high-flow oxygen devices. However, the continued expansion of ETC capacity will require additional investments in critical care equipment and medical supplies.

## **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%.

## **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. Additional RCCE personnel are being deployed to support response activities in the newly affected provinces of Haut-Uélé and Tshopo, while anthropological expertise is being strengthened to better understand community perceptions and inform locally appropriate interventions.
- c. Community feedback mechanisms continued to identify concerns related to transmission risks, access to services, vaccination, and response activities. Findings are regularly shared with operational pillars to guide response actions and risk communication efforts.
- d. Findings from the first round of rapid community assessments in priority hotspots in Ituri have been endorsed and are being translated into community-led interventions. Similar assessments are being expanded to other affected areas in the DRC and to Uganda and South Sudan to strengthen cross-border community engagement and intelligence.
- e. Community engagement efforts increasingly focus on building trust in response services and addressing concerns raised by communities and frontline health workers. Particular attention is being given to high-risk and mobile populations, including mining communities, internally displaced persons, and cross-border populations affected by insecurity and population movement.

## **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. Community awareness activities reached 4,677 people, including 1,419 women, 1,001 girls, and three persons with disabilities, through engagement with community outreach workers, healthcare workers, internally displaced persons, religious groups, schools, and transport workers.
- c. A regional PRSEAH coordination meeting involving WHO Headquarters, the WHO Regional Office for Africa, Africa CDC, and the DRC National PRSEAH Coordination was convened to strengthen inter-agency collaboration and align strategic priorities for the outbreak response.



- d. Newly deployed Ministry of Health personnel received orientation on PRSEAH principles and responsibilities, while community media continued disseminating prevention messages and promoting safe reporting mechanisms.

## **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. 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**, driven by sustained transmission, increasing mortality, and continued geographic expansion from three to five affected provinces. **Uganda remained at high risk** of re-introduction because of the ongoing outbreak in DRC despite reporting no new cases. **The outbreak risk was also assessed as High at the regional level and Low at the global level.** As of July 12, these risks remained unchanged.

Table 3. WHO Risk Assessment, as of July 12, 2026

| Overall Risk          |                     |            | QIRA*        |
|-----------------------|---------------------|------------|--------------|
| National              | Uganda and Regional | Global     | ASEAN Region |
| <b>DRC: Very High</b> | <b>High</b>         | <b>Low</b> | <b>Low</b>   |

Source: WHO as of July 12, 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:
  - 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.
  - 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.
  - 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.](#)

## References

1. Africa Centres for Diseases Control and Prevention (2026). *Bundibugyo Virus Disease Outbreak Situation Report July 14, 2026*. Africa CDC. Available from: <https://khub.africacdc.org/records/resource/bundibugyo-virus-disease-outbreak-situational-report-july-13-2026>
2. European Centres for Diseases Control and Prevention (2026). *Communicable disease threats report, 19 - 26 June 2026, Week 26*. European CDC. Available from: <https://www.ecdc.europa.eu/en/publications-data/communicable-disease-threats-report-19-26-june-2026-week-26>
3. European Centres for Diseases Control and Prevention (2026). *Ebola disease outbreak in the Democratic Republic of the Congo and Uganda*. European CDC. Available from: <https://www.ecdc.europa.eu/en/ebola-outbreak-democratic-republic-congo-and-uganda>
4. The Ministry of Health Uganda (2026). *Press Statement Ebola Bundibugyo Virus Disease Outbreak 2026*. Ministry of Health Uganda. Available from: <https://health.go.ug/download/press-statement-ebola-bundibugyo-virus-disease-outbreak-2026/>
5. The Ministry of Health, Families, Autonomy, and Persons with Disabilities, France (2026). *Ebola : identification d'un 1er cas chez un médecin humanitaire de retour de mission en République démocratique du Congo (RDC)*. The Ministry of Health, Families, Autonomy, and Persons with Disabilities, France. Available from: <https://sante.gouv.fr/actualites-presse/presse/communiqués-de-presse/article/ebola-identification-d-un-1er-cas-chez-un-medecin-humanitaire-de-retour-de>
6. World Health Organization (2026). *Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda*. World Health Organization. Available from: <https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON608>
7. World Health Organization (2026). *Experts convened by WHO advise on candidate treatments and vaccines for Ebola disease caused by Bundibugyo virus*. World Health Organization. Available from: <https://www.who.int/news/item/28-05-2026-experts-convened-by-who-advise-on-candidate-treatments-and-vaccines-for-ebola-disease-caused-by-bundibugyo-virus>
8. World Health Organization (2026). *Implementation of border health and international travel-related temporary recommendations issued by the Director-General of WHO to States Parties not sharing land borders with areas with documented Bundibugyo virus detection: technical note, 26 May 2026*. World Health Organization. Available from: <https://iris.who.int/items/b07def43-df30-41b8-83e0-deb33bcfd697>
9. World Health Organization (2026). *WHO Director-General's remarks at the Virtual Ministerial Briefing on the Bundibugyo Ebola Outbreak - 25 May 2026*. World Health Organization. Available from: <https://www.who.int/news-room/speeches/item/who-director-general-s-remarks-at-the-virtual-ministerial-briefing-on-the-bundibugyo-ebola-outbreak-25-may-2026>
10. World Health Organization (2026). *EBOLA BUNDIBUGYO VIRUS DISEASE OUTBREAK Democratic Republic of the Congo | Uganda Weekly External Situation Report 09, Data as of 12 July 2026*. World Health Organization. Available from: <https://www.afro.who.int/countries/democratic-republic-of-congo/publication/ebola-bundibugyo-virus-disease-outbreak-2>



ASEAN Biological Threat Surveillance Centre (ABVC)

Health Policy Agency

Ministry of Health of Indonesia

Building 6 - Global Health Strategy and Governance Policy, 2nd floor

Jalan Percetakan Negara No. 29 Johar Baru, Jakarta Pusat, Indonesia 10560