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

May 18, 2026

With Support by:

Situation at a Glance

- On **May 16, 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). The outbreak is believed to have originated in the high-traffic mining region of the Mongbwalu Health Zone in Ituri Province, Democratic Republic of the Congo (DRC), and has since escalated with confirmed cross-border transmission to Bunia and neighboring Uganda.

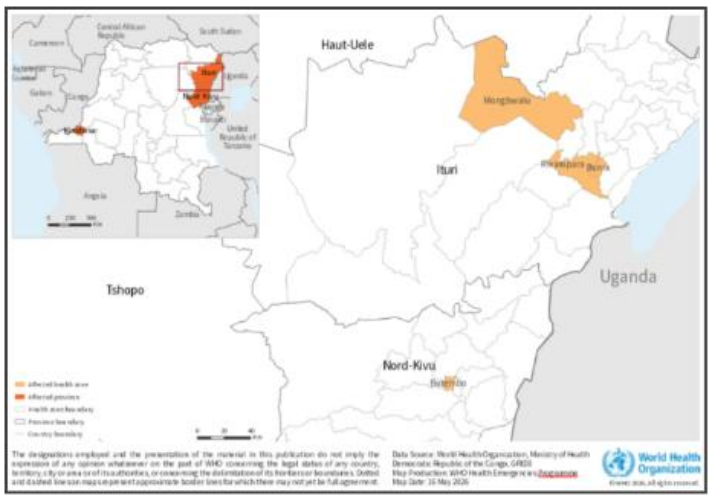

Figure 1. Health Zones affected by Bundibugyo virus disease in Democratic Republic of Congo, as of May 16, 2026

Situation Update

Democratic Republic of the Congo

- On May 5, 2026, WHO received an alert regarding an unknown illness with high mortality reported in Mongbwalu Health Zone (HZ), Ituri Province, DRC, including the deaths of four health workers within four days. The earliest currently identified suspected case, a health worker, developed symptoms including fever, haemorrhaging, vomiting, and severe malaise on April 24, 2026, and later died at a medical centre in Bunia.
- On 13 May 2026, investigations were conducted by rapid response teams in Mongbwalu and Rwampara health zones (HZ).
- On 15 May 2026, the outbreak was confirmed as Bundibugyo virus disease (BVD) caused by Bundibugyo virus (BDBV). On the same day, the Ministry of Public Health, Hygiene and Social Welfare officially declared the Democratic Republic of the Congo's 17th Ebola disease outbreak, affecting the Rwampara, Mongbwalu, and Bunia HZ.

- As of May 15, a total of 246 suspected cases and 80 deaths, including four deaths among confirmed cases, had been reported from three HZ: Rwampara, Mongbwalu, and Bunia. Twenty-four suspected cases were isolated in treatment facilities across the three HZ. Additional clusters of unexplained community deaths with symptoms compatible with BVD were under investigation in other HZ in Ituri and North Kivu. Most suspected cases were among individuals aged 20–39 years, with females accounting for more than 60% of cases, suggesting elevated risks related to household and caregiver exposure. A total of 65 contacts had been identified, including 15 classified as high-risk contacts. However, contact follow-up remained limited due to insecurity and movement restrictions, with several contacts developing symptoms and dying before isolation.
- On May 15, 2026, initial testing of 20 samples collected in Rwampara HZ using standard Ebola Xpert assays at the Provincial Public Health Laboratory in Bunia yielded negative results for Ebola virus. Subsequent analysis at the Institut National de la Recherche Biomédicale (INRB) confirmed eight samples as *Orthoebolavirus* by PCR on the same day, with genomic sequencing identifying BDBV.
- On May 16, 2026, a further suspected case was identified in an individual returning from Ituri to Kinshasa; however, confirmatory testing conducted by the Institut National de la Recherche Biomédicale (INRB) was negative for BDBV, and the individual was not classified as a confirmed case.

Uganda

- On May 15, 2026, Uganda confirmed an outbreak of BVD following identification of an imported case from DRC. The case, an elderly man admitted to a private hospital on May 11 with severe symptoms, died on May 14. A clinical sample collected on admission tested positive for BDBV on May 15 at the Central Emergency Surveillance and Response Support Laboratory in Wandegeya. The body was transferred post-mortem to DRC on the same day.
- On May 16, 2026, 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.
- Initial testing of 20 samples collected in Rwampara HZ using standard Ebola Xpert assays at the Provincial Public Health Laboratory in Bunia yielded negative results for Ebola virus. Subsequent analysis at INRB confirmed eight samples as Orthoebolavirus by PCR on 15 May, with genomic sequencing identifying BDBV.

Epidemiology

- This is the 17th Ebola disease outbreak reported in DRC since 1976, following an outbreak declared on September 4, 2025, in Bulape HZ, Kasai Province, with 64 cases and 45 deaths reported before the outbreak ended on December 1, 2025. The last reported BVD outbreak in DRC occurred in Province Orientale in 2012, with 59 cases and 34 deaths reported before the outbreak was declared over on 26 November 2012.

- BVD is a severe and often fatal form of Ebola disease caused by Bundibugyo virus, an *Orthoebolavirus* species. The disease is zoonotic, with fruit bats suspected as the natural reservoir, and spreads through contact with infected wildlife or bodily fluids of infected individuals, particularly in healthcare settings with inadequate IPC measures and during unsafe burials.
- BVD has an incubation period of 2–21 days, with infected individuals becoming infectious after symptom onset. Early symptoms are non-specific, including fever, fatigue, headache, muscle pain, and sore throat, before progressing to gastrointestinal symptoms, organ dysfunction, and occasionally haemorrhagic manifestations. Previous outbreaks in Uganda and DRC reported case fatality rates of approximately 30%–50%.
- Clinical differentiation from other endemic febrile illnesses, including malaria, is difficult without laboratory confirmation. Control measures rely on rapid case detection, isolation, contact tracing, safe burials, IPC measures, and community engagement, as no approved vaccines or specific treatments for BVD currently exist.

Public Health Response

Public Health Response in Democratic Republic of the Congo

1. **Coordination**
   - Rapid response teams have been deployed to Rwampara and Mongbwalu HZ.
   - Provincial coordination and emergency meetings have been conducted.
2. **Surveillance and Laboratory**
   - Surveillance for suspected and probable cases is ongoing, including at points of entry (POE) and border areas.
   - Operational case definitions have been developed in Ituri Province.
   - Genomic sequencing confirmed Bundibugyo virus in RT-PCR positive samples.
3. **Risk Communication and Community Engagement (RCCE)**
   - Social mobilization meetings with community leaders were conducted in the rural commune of Mongbwalu under the leadership of the Mayor.
4. **Infection Prevention and Control (IPC)**
   - IPC assessments are ongoing at key health facilities: Bunia Hospital Centre of the Evangelical Medical Centre (CME), Mongbwalu General Referral Hospital, and Abelkozo Health Centre.
   - CME Bunia continues to implement isolation protocols, and healthcare workers have been briefed on the diagnostic profile of the BDBV strain.
5. **Logistics**
   - Logistical support has been provided for outbreak investigations in Mongbwalu and Rwampara Health Zones.
   - Support has been provided for transportation of samples to INRB Kinshasa.

Public Health Response in Uganda

1. Activating national and district-level emergency measures, including enhanced surveillance, screening at borders, deployment of rapid response teams, isolation of a high-risk contact, and quarantine of all identified contacts.
2. Strengthening of preparedness activities such as mobile laboratory deployment, infection prevention, and risk communication.
3. Rapid response readiness teams have been deployed at all official and informal POE along the western border, major transit routes, and pilgrimage corridors.
4. Advising health workers to remain vigilant and adhere strictly to infection prevention measures.

WHO Support

1. **Coordination and Operations**
   - Supporting the Ministry of Health in implementation of the national Response Plan and WHO internal Response Plan, while coordinating delivery of key supplies.
   - Coordinating with the IHR NFP in DRC and Uganda to support official notification processes and communication across the IHR network.
2. **Technical and Field Support**
   - Deployment of technical expertise and rapid response teams to support outbreak response activities.
   - Supporting in-depth investigations and contact listing for suspected and probable cases.
3. **Case Management and IPC**
   - Deploying IPC, clinical management, and sample collection kits.
   - Identifying isolation facilities for case management in Bunia, Rwampara, and Mongbwalu HZ.
   - Disseminating WHO case management protocols
4. **Surveillance and Border Health**
   - Strengthening epidemiological surveillance, IPC, and RCCE activities at POE.
   - Supporting enhanced point of entry screening and cross-border coordination, including for mass gatherings.
5. **Research and Development**
   - Engaging experts on research and development priorities.

WHO Risk Assessment

- WHO assessed 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.

- The infection and deaths of healthcare workers, reports of community deaths potentially linked to unsafe burials, and challenges in contact tracing due to insecurity and movement restrictions indicate substantial gaps in infection prevention and control and outbreak response capacity.
- The location of the outbreak in Ituri Province, a major commercial and migratory hub bordering Uganda and South Sudan, increases the risk of regional spread and cross-border transmission. Uganda has already reported imported cases associated with the outbreak.
- Response efforts are further complicated by the absence of licensed vaccines or specific therapeutics for Bundibugyo virus disease, requiring reliance on public health measures including surveillance, IPC, case management, contact tracing, safe burials, and community engagement.

The WHO Advice

Following the official World Health Organization (WHO) declaration determining the outbreak of Ebola disease caused by BDBV a PHEIC, the official WHO advice is organized into specific operational categories for State Parties:

For States Parties where the event is occurring (the DRC and Uganda), WHO advised:

1. Strengthening national and subnational emergency coordination, surveillance, contact tracing, IPC, laboratory testing, case management, and partner coordination.
2. Enhancing community engagement and RCCE through local, religious, and traditional leaders.
3. Expanding surveillance and laboratory capacity, including community surveillance and decentralized testing.
4. Reinforcing IPC measures in healthcare facilities and ensuring healthcare workers receive training, PPE, and staff support.
5. Establishing safe referral systems and specialized treatment centres near outbreak epicentres.
6. Strengthening border screening, travel-related measures, cross-border coordination, and considering postponement of mass gatherings.
7. Ensuring safe and dignified burials and restricting cross-border movement of remains of suspected or confirmed cases.
8. Maintaining supply chains for essential medical and laboratory materials and supporting research on candidate therapeutics and vaccines.

For neighbouring States Parties with land borders adjoining affected countries, WHO advised:

1. Strengthening preparedness capacities, including surveillance, laboratory access, IPC, and rapid response teams.
2. Establishing coordination mechanisms for outbreak detection, investigation, isolation, diagnosis, and response.

3. Treating any suspected or confirmed case, contact, or unexplained death cluster as a health emergency requiring investigation and response within 24 hours.
4. Implementing full WHO outbreak recommendations and notifying WHO immediately if transmission is confirmed.
5. Strengthening RCCE activities, particularly at points of entry.
6. Prioritizing regulatory approvals for investigational therapeutics as part of preparedness activities.

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) (Table 1). 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.

Table 1. Air Connectivity from DRC and Uganda to ASEAN Countries

ASEAN Member States	Direct Flights from Outbreak Area?**	Key Entry Airports	Primary Transit Hubs (1-stop)
Thailand	No scheduled non-stop	Bangkok (BKK/DMK) Phuket (HKT) Chiang Mai (CNX)	Dubai (EK), Doha (QR) Addis Ababa (ET), Istanbul (TK), Nairobi (KQ)
Malaysia	No scheduled non-stop.	Kuala Lumpur (KUL) Penang (PEN) Kedah	Dubai (EK), Doha (QR) Addis Ababa (ET) Istanbul (TK)
Indonesia	No scheduled non-stop.	Bali (DPS), Jakarta (CGK) Yogyakarta (JOG) Makassar (UPG), Medan (KNO) Pekanbaru (PKU) Balikpapan (BPN)	Dubai (EK), Doha (QR) Kuala Lumpur (MH/AK) Singapore (SQ)
Cambodia	No scheduled non-stop.	Kratie Siem Reap (REP)	Bangkok (BKK) Kuala Lumpur (KUL) Addis Ababa (ET)
Vietnam	No scheduled non-stop.	Hanoi (HAN) Ho Chi Minh City (SGN) Da Nang (DAD) Nha Trang (CXR)	Dubai (EK) Doha (QR) Addis Ababa (ET) Guangzhou (CZ)
Philippines	No scheduled non-stop.	Manila (MNL)	Dubai (EK) Doha (QR) Kuala Lumpur (KUL)
Singapore	No scheduled non-stop.	Changi (SIN)	Dubai (EK), Doha (QR) Addis Ababa (ET)

ASEAN Member States	Direct Flights from Outbreak Area?**	Key Entry Airports	Primary Transit Hubs (1-stop)
			(Major global hub)
Brunei Darussalam	No scheduled non-stop.	Bandar Seri Begawan (BWN)	Kuala Lumpur (KUL) Dubai (EK)
Lao PDR	No scheduled non-stop.	Vientiane (VTE)	Bangkok (BKK) Kuala Lumpur (KUL)
Myanmar	No scheduled non-stop.	Yangon (RGN)	Bangkok (BKK) Kuala Lumpur (KUL) Dubai (EK)
Timor Leste	No scheduled non-stop.	Dili (DIL) Presidente Nicolau Lobato Intl.	Bali/Denpasar (DPS) Kuala Lumpur (KUL) Singapore (SIN — seasonal Aero Dili) Darwin (DRW — via AU)

Source: BlueDot, 2026 & FlightConnections.com

*** All ASEAN-bound movements involve at least one transit stop. No non-stop (direct) scheduled service exists from either Kinshasa (FIH) or Entebbe (EBB) to any ASEAN Member States as of 18 May 2026.*

Despite no direct flights, all ASEAN-bound travel requires 1-stop connections, primarily through major global hubs, as shown in Table 2:

Table 2. Key Transit Hubs Amplifying ASEAN Exposure

Hub airports identified based on confirmed direct service from outbreak airports and high ASEAN onward connectivity.

Hub Airport	Country	Epidemiological Significance	Key Airlines	ASEAN Routes Served
Dubai (DXB)	UAE	World's busiest international airport. Direct non-stop from Entebbe (EBB) via Emirates, flydubai and Uganda Airlines. Connects to all 10 ASEAN countries.	Emirates (EK) flydubai (FZ) Uganda Airlines (UR)	10 ASEAN Countries
Addis Ababa (ADD)	Ethiopia	Ethiopian Airlines hub with direct flights from both Kinshasa (FIH) and Entebbe (EBB). Connects to Bangkok, Singapore, Kuala Lumpur and more. Highest-frequency Africa-ASEAN connector.	Ethiopian Airlines (ET)	Bangkok, Singapore, KL, Ho Chi Minh City
Doha (DOH)	Qatar	Qatar Airways hub with seasonal service from Kinshasa and regular service from Entebbe. Excellent ASEAN connectivity including Singapore, Bangkok, Manila, Jakarta.	Qatar Airways (QR)	Singapore, Bangkok, Manila, Jakarta, KL
Istanbul (IST)	Turkey	Turkish Airlines serves both Kinshasa (FIH) and Entebbe (EBB). Strong onward connections to Southeast Asia including Bangkok, Kuala Lumpur and Singapore.	Turkish Airlines (TK)	Bangkok, KL, Singapore

Hub Airport	Country	Epidemiological Significance	Key Airlines	ASEAN Routes Served
Nairobi (NBO)	Kenya	35 weekly flights from Entebbe. Kenya Airways operates ASEAN-bound routes. Also secondary hub linking DRC to regional African connections onward to Asia.	Kenya Airways (KQ) RwandAir (WB) Uganda Airlines (UR)	Bangkok, Singapore (via KQ partnerships)
Guangzhou (CAN)	China	Direct from Entebbe via Uganda Airlines. China Southern connects to all 10 ASEAN nations. High-risk amplifier given China's extensive intra-ASEAN flight network.	Uganda Airlines (UR) China Southern (CZ)	All 10 ASEAN nations (China Southern)
Johannesburg (JNB)	South Africa	Served from both Kinshasa (FIH) and Entebbe (EBB). SAA and Ethiopian Airlines connect to regional hubs with onward ASEAN routing.	ASKY Airlines (KP) South African Airways (SA) Ethiopian Airlines (ET)	Bangkok, Singapore, KL (multi-stop)

Source: BlueDot, 2026 & FlightConnections.com

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