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 26, 2026

With Support by:

## 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). Originating in the high-mobility mining area of Mongbwalu Health Zone (Ituri Province, DRC), the outbreak has since spread to Bunia and Uganda.
- On May 19, the Director-General of WHO convened the first meeting of the IHR Emergency Committee, and temporary recommendations were issued.

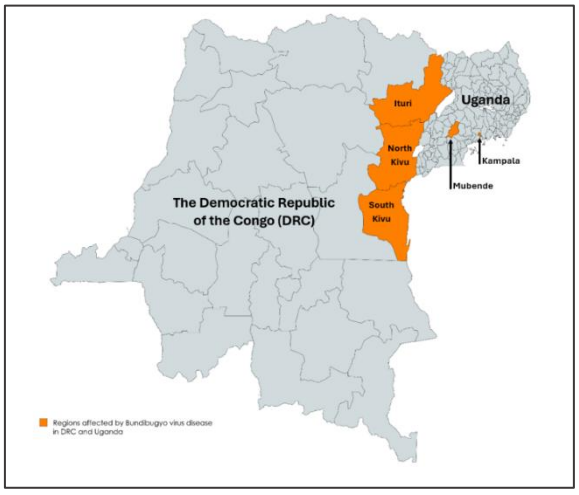


*Figure 1. Health Zones affected by Bundibugyo virus disease in the Democratic Republic of Congo and Uganda, as of May 26, 2026*

- National and international response measures are underway, including rapid team deployments, surveillance and laboratory scale-up, infection prevention and control (IPC) measures, treatment center establishment, and community engagement.

## 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, hemorrhaging, vomiting, and severe malaise on April 24, 2026, and later died at a medical centre in Bunia.
- As of May 15, a cumulative total of 246 suspected cases and 80 deaths had been reported across three health zones (Rwampara, Mongbwalu, and Bunia), including 24 cases isolated. Unexplained community death clusters in Ituri and North Kivu were placed under investigation. Demographics show a concentration in individuals aged 20–39 years, with females comprising over 60% of cases, indicating high caregiver and household exposure risks. Of the 65 initially identified contacts (15 high-risk), follow-up was severely constrained by local insecurity, leading to symptomatic deaths before isolation could occur.

Initial GeneXpert testing on 20 samples in Bunia was negative for standard Ebola strains, but subsequent PCR analysis and genomic sequencing at INRB confirmed eight positive samples for the 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 health zones.

- As of May 18, the DRC has reported 516 suspected cases, including 131 deaths from seven health zones across Ituri and North Kivu Provinces. A total of 541 contacts has so far been listed in DRC.
- As of May 21, DRC reported 746 suspected cases and 176 deaths among suspected cases.
- As of May 23, the Bunia Laboratory received 418 cumulative samples, analyzing 211, with a total of 101 yielding positive results. On May 23 alone, the laboratory processed 70 samples, consisting of 58 blood samples and 12 swabs. To control population mobility, multiple Points of Entry and Points of Control (PoE/PoC) remain operational. Authorities are actively providing traveler screening, handwashing stations, and public health awareness. Additionally, risk communication, IPC measures, and clinical management activities are being aggressively scaled up in North Kivu as well as the health zones of Bunia, Rwampara, Mongbwalu, and Nyankunde.
- On May 24, the Ministry of Communication and Media stated that the BDBV outbreak remains active across 11 health zones in three provinces: Ituri (Aru, Bunia, Kilo, Mongbwalu, Nizi, Nyankunde, Rwampara), North Kivu (Butembo, Goma, Katwa), and South Kivu (Miti-Murhesa). Cumulatively, **health authorities have recorded 101 confirmed cases and 10 confirmed deaths (CFR: 9.9%),** alongside 904 cumulative suspected cases and 119 suspected deaths (CFR: 13.2%). No patient recoveries have been reported to date.

**Uganda**

- On May 11, 2026, an elderly man from the DRC presenting with severe symptoms was admitted to a private hospital on May 11 and subsequently died on May 14, representing the first imported case. 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 repatriated post-mortem to the DRC on the same day.
- On May 15, Uganda confirmed an outbreak of BVD following identification of an imported case from DRC.
- 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 18, there were 14 cases and two deaths reported, including 12 suspected cases and one suspected death. Two confirmed cases with one confirmed death were also reported.
- As of May 23, three new infections were confirmed, bringing Uganda's cumulative total to five confirmed cases. Among these, two are Ugandan nationals (a driver who transported the first case and a health worker who provided care) identified through contact tracing and currently receiving care in Uganda. The third case was a Congolese resident who briefly sought care in Kampala before returning to the DRC. To date, two deaths have been recorded; one patient has recovered following two successive negative tests, and the remaining patients continue to receive specialized care. Beyond the immediate contacts, no wider community transmission has been identified.
- On May 25, two additional cases were confirmed, bringing **the cumulative total in the country to seven cases, including two deaths (CFR: 28.6%).** These two recent cases are healthcare workers employed at a private medical facility in Kampala. Both patients have been admitted and are currently receiving specialized care.

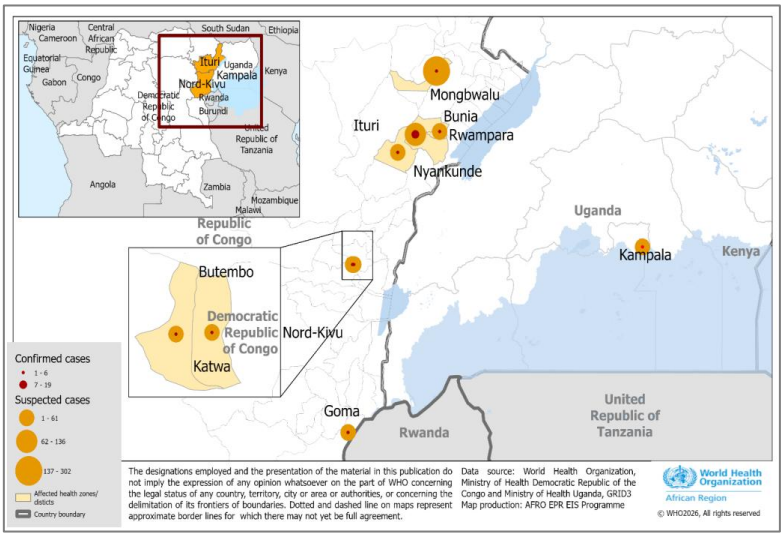


Figure 2. Distribution of suspected and confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of May 18, 2026

## 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 symptoms. Early symptoms are non-specific, including fever, fatigue, headache, muscle pain, and sore throat, before progressing to gastrointestinal symptoms, organ dysfunction, and occasionally hemorrhagic 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

1. **National & International Coordination**
    a. Mechanism Activation: The DRC and Uganda have activated national emergency coordination mechanisms across all response pillars.
    b. International Support: WHO, WFP, and international partners are actively deploying technical experts, distributing critical medical supplies, including personal protective equipment (PPE), and reinforcing laboratory and emergency logistics networks.
    c. Cross-Border Collaboration: Joint preparedness and response measures have been intensified. This includes synchronized border surveillance, real-time data and alert sharing, rapid notification systems, joint simulation exercises, and coordinated deployment of cross-border emergency response teams.
2. **Surveillance, Contact Tracing, & Laboratory**
    a. Field Scaling: Dedicated surveillance and response cells are being established in affected and high-risk health zones to accelerate early case detection and rapid investigations.
    b. Targeted Monitoring: Enhanced surveillance protocols are prioritizing unexplained community deaths and clusters of febrile illness.
    c. Contact Tracing: Ring-fencing operations and contact monitoring are systematically intensified within affected districts and critical border transit corridors to break transmission chains.
3. **Clinical Management & IPC (Infection Prevention and Control)**
    a. Treatment Infrastructure: Specialized Ebola treatment centers and isolation units are being set up directly adjacent to outbreak epicenters to provide immediate supportive and intensive clinical care. Safe, bio-secure referral pathways have been established to prevent transmission during patient transport.

b. Healthcare Worker Protection: Following suspected healthcare-associated (nosocomial) transmission and medical staff fatalities, strict IPC protocols are being reinforced. Ongoing interventions include the systematic mapping of local health facilities, mandatory triage systems, localized training on IPC, intensified supervision, and the emergency distribution of PPE.

4. **Travel advisories**

   Uganda has temporarily suspended flights to and from the DRC, non-essential cross-border travel by ferries, buses and other public transport, and border-area cultural celebrations and commemorations for at least four weeks, effective immediately on May 23, 2026.

## WHO Risk Assessment

- On May 17, 2026, 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.
- As of May 22, the WHO Secretariat assesses the **risk level as Very High for the DRC and High for Uganda**, noting that while epidemiological scales and operational contexts differ between the two nations, the threat of regional expansion remains elevated. Additionally, the WHO assessed **the risk as high at the regional level and low at the global level**.
- The outbreak's epicenter in Ituri Province, a major commercial and migratory hub bordering Uganda and South Sudan, amplifies cross-border transmission dynamics. Uganda has already confirmed multiple imported cases directly linked to this corridor.
- 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 WHO Recommendations

On May 19, 2026, the WHO Director-General convened the first IHR Emergency Committee meeting regarding the BDBV outbreak. The Committee agreed that the event constitutes a PHEIC but does not meet the criteria for a pandemic emergency. The Committee emphasized that response strategies must integrate localized contextual realities and issued Temporary Recommendations stratified by country-specific risk tiers.

***For States Parties with documented detection of Bundibugyo virus (DRC and Uganda):***

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

***For neighboring States Parties with land borders adjoining affected State Parties:***

1. Establish a national coordination mechanism articulated with subnational levels.
2. Strengthen preparedness capacities, including surveillance, laboratory access, IPC, and rapid response teams.
3. Strengthen RCCE activities, particularly at points of entry.
4. Conduct international contact tracing operations as necessary.
5. Treat any suspected or confirmed case, contact, or unexplained death cluster as a health emergency requiring investigation and response within 24 hours.
6. Implement full WHO outbreak recommendations and notify WHO immediately if transmission is confirmed.
7. Prioritize regulatory approvals for investigational therapeutics as part of preparedness activities.

***For all other State Parties:***

1. Make arrangements to detect, assess, report, and manage travelers with unexplained febrile illness arriving from areas with documented BDBV detection.
2. Provide organizations deploying personnel internationally to respond to the BVD epidemic with information on risk.
3. Prepare to facilitate the evacuation and repatriation of nationals (e.g., health workers) who have been exposed to BVD cases.
4. Provide the public with accurate and up to date information regarding the BVD epidemic and measures.

5. Strengthen cross-border biosecurity by providing up-to-date outbreak guidance to health facilities and travelers (including 21-day post-arrival symptom monitoring), coordinating with the transport sector for in transit suspected case management and international contact tracing.
6. Notify WHO immediately of any suspected, probable or confirmed BVD case.

## 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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