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

June 5, 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).
- On May 19, the Director-General of WHO convened the first meeting of the IHR Emergency Committee, and temporary recommendations were issued.

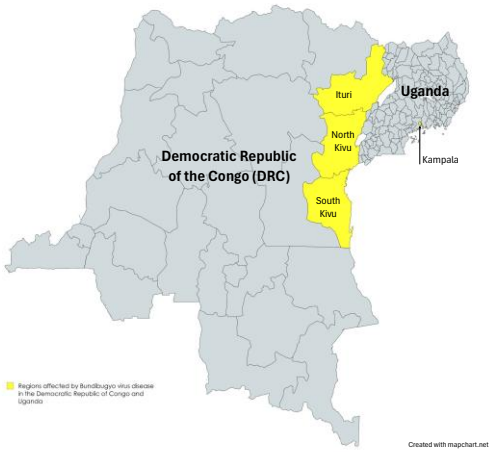

Figure 1. Regions affected by Bundibugyo virus disease in DRC and Uganda, as of June 2, 2026

- As of June 2, Africa CDC reported 344 confirmed cases and 60 confirmed deaths (CFR: 17.4%) in the Democratic Republic of the Congo (DRC), with cases identified across 24 health zones. In Uganda, 15 confirmed cases and one confirmed death (CFR: 6.7%) have been reported, with transmission remaining confined to a single district. Overall, eight patients have recovered, corresponding to a recovery rate of 2.2%.

Table 1. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of June 2, 2026

Country	Health Zone/ District Affected	Confirmed Cases	Confirmed Deaths	CFR (%) Confirmed	Cured	Recovery Rate (%)
DRC	24	344	60	17.4%	6	1.7%
Uganda	1	15	1	6.7%	2	13.3%
Total	**25**	**359**	**61**	**17.0%**	**8**	**2.2%**

Source: Africa CDC as of June 2, 2026

- Healthcare workers continue to be affected in both countries, with 29 confirmed cases reported in DRC and five in Uganda. 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.

Table 2. Cases among Healthcare Workers (HCW)

Country	Confirmed cases among HCWs	Confirmed deaths among HCWs	CFR (%)
DRC	29	5	17.2%
Uganda	5	0	0.0%
Total	**34**	**5**	**14.7%**

Source: Africa CDC as of June 2, 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, 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 DRC'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 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 105 confirmed cases and 10 confirmed deaths (CFR: 9.5%), alongside 906 cumulative suspected cases and 223 suspected deaths (CFR: 24.6%). No patient recoveries have been reported to date.

- As of May 27, the latest report from Africa CDC, a total of 1,077 suspected Ebola cases have been recorded. Of those cases, 238 were suspected deaths, 121 confirmed cases, and 17 confirmed deaths (CFR:14%).
- As of June 2, Africa CDC reported 344 confirmed cases and 60 deaths in DRC, corresponding to a CFR of 17.4%. Six cases recovered as of the reporting date, representing 1.7% of all confirmed cases.

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 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.
- As of May 24, two additional cases were confirmed, bringing the cumulative total in the country to seven cases, including one death (CFR: 14.3%). These two recent cases have been healthcare workers employed at a private medical facility in Kampala. Both patients have been admitted and are currently receiving specialized care.
- As of June 2, Africa CDC had reported 15 confirmed cases in Uganda, including one death (CFR: 6.7%) and two recoveries (13.3% of total confirmed cases).

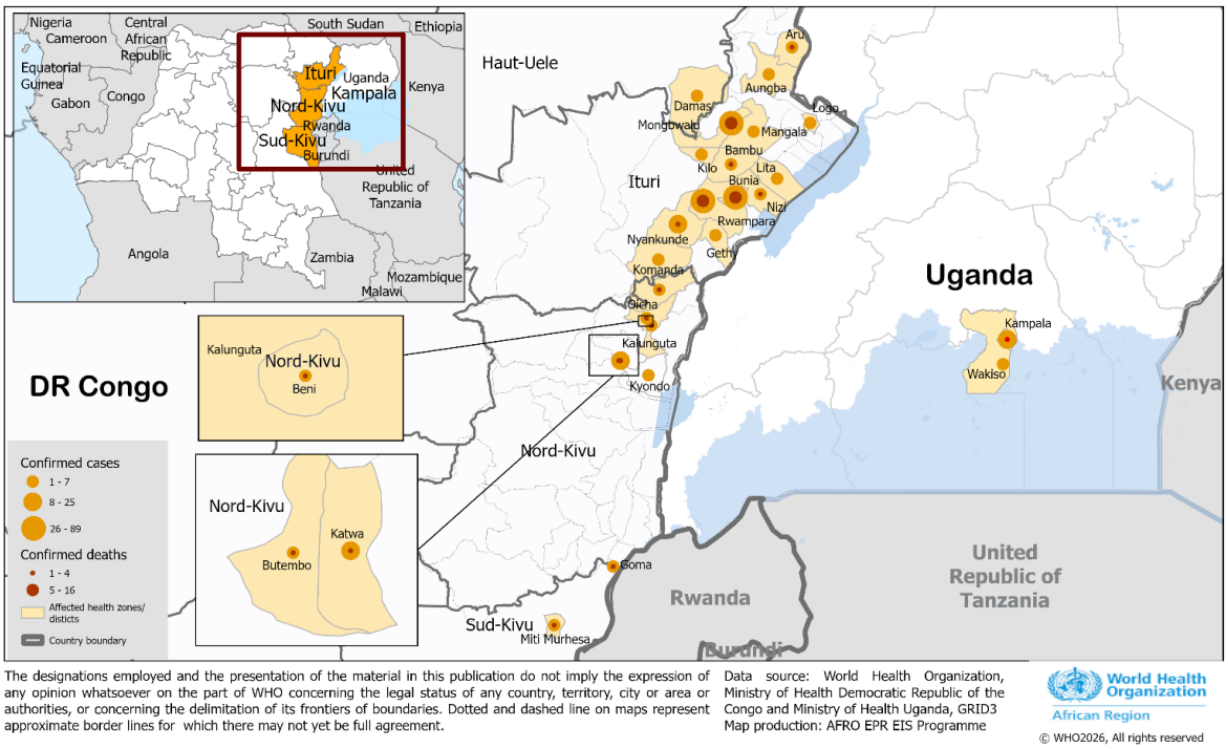

Figure 2. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in DRC and Uganda, as of May 31, 2026

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. A continental Incident Management Support Team (IMST) involving WHO, Africa Centres for Disease Control and Prevention (Africa CDC), and health partners has been launched to coordinate and provide strategic and operational support to affected and at-risk countries. Kampala, Uganda, has been designated as an expanded operational hub to facilitate regional coordination, strengthen cross-border preparedness and response activities, and support harmonized implementation across DRC, Uganda, and other at-risk countries. A continental response plan with a six-month operational horizon is under development.

b. A high-level ministerial meeting on cross-border coordination, involving DRC, Uganda, and South Sudan, was convened in Kampala on 22–23 May 2026, reaffirming commitments to strengthen cross-border surveillance, joint contact tracing, information sharing, preparedness at points of entry, laboratory collaboration, and regional operational coordination. Countries also agreed to strengthen the continental IMST and harmonize preparedness and response measures across affected and at-risk areas.

c. In both DRC and Uganda, national Incident Management Systems (IMS) remain activated, with coordination structures functioning at national and subnational levels and supported by WHO and health partners, including Africa CDC, UNICEF, Médecins Sans Frontières, International Medical Corps, and other operational partners.

d. In DRC, subnational coordination structures continue to operate across affected provinces and health zones, with daily provincial coordination meetings in Bunia facilitating alignment of response activities across operational pillars.

e. In Uganda, the National Public Health Emergency Operations Centre and regional Emergency Operations Centres (EOCs) in Fort Portal, Arua, Yumbe, Kampala Capital City Authority, Kabale, and Hoima remain activated, while the national response plan and rapid risk assessment have been finalized to support outbreak response and preparedness activities.

f. 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.

g. 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. Operations support and logistics

a. To strengthen field response operations in DRC, WHO has deployed 52 surge personnel including 19 international staff and 33 national staff, as of 24 May 2026, to support coordination, logistics, surveillance, and other technical response activities across affected areas.
b. Logistics corridors from Kinshasa, capital of DRC, Nairobi in Kenya, and Dakar in Senegal remain operational, with shipments covering personal protective equipment (PPE), viral haemorrhagic fever and case management supplies, tents, body bags, and laboratory consumables, alongside the ongoing deployment of EpiShuttle, a patient isolation transport systems, and telecommunications equipment.
c. Logistics and infrastructure support for Ebola treatment capacity has continued in DRC, with assessments and layout finalization for a treatment facility completed. Quantification for Ebola Treatment Centre (ETC) construction and rehabilitation has been finalized, and earthworks for ETC expansion activities in Bunia have been initiated. In addition, operational assessments of warehouse readiness, stock positioning, and commodity distribution systems have been completed in Bunia to strengthen emergency supply chain visibility and delivery.
d. Uganda has expanded multisectoral logistics coordination through a national operations platform involving the World Food Program, UNICEF, and approximately 10 international non-governmental organizations, with partners agreeing to share stock information through a common coordination dashboard covering health commodities, water, sanitation and hygiene, and laboratory supplies.
e. Operational constraints, notably the closure of the Bunia airport, continue to affect response scale-up. Humanitarian flight coordination remains ongoing in DRC, including the rescheduling of cargo operations, while delays in the release of medical supplies and ongoing shortages of laboratory materials and protective equipment continue to pose challenges to response activities.

3. Surveillance and Contact Tracing

a. Despite the complex operational and epidemiological context, surveillance activities continue to be strengthened across affected areas. In DRC, surveillance activities include active case finding, alert and case investigations, retrospective reviews of cases and deaths, and contact tracing. In Uganda, surveillance teams continue to support case investigations and contact monitoring using digital tools and experience from previous outbreak responses.
b. Daily alerts continue to increase in DRC, with 71 alerts reported on 23 May, of which 53 were investigated and 47 validated, while in Uganda 42 alerts were detected and investigated, including 31 identified through points-of-entry screening.

c. In DRC, 2231 contacts have been identified as of 24 May, though contact tracing remains a major operational challenge. Only 19.3% were seen within the previous 24 hours as of 23 May 2026. In Uganda, 311 contacts have been identified.

d. Points-of-entry (PoE) screening continues to be strengthened in both countries to reduce cross-border transmission risks. With support from the International Organization for Migration, six PoE sites have been activated in DRC, screening 11 143 of 11 628 travellers (95.8%) on 24 May, while all 11 628 travellers received Ebola risk communication messages. No contacts were listed and no alerts were generated. In Uganda, screening activities are operational at 21 of 28 targeted PoEs, and 13 897 travellers were screened in the previous 24 hours as of 23 May 2026, generating 31 alerts, all of which were discarded.

e. Mobile Laboratory Deployment: Mobile laboratory deployed to Mongbwalu and Mahagi (Ituri-Uganda border crossing point).

f. RadiOne Diagnostic Validated: RadiOne testing platform validated for confirmatory diagnostics.

4. Laboratory

a. As of 24 May 2026, the Bunia Provincial Laboratory in Ituri Province, DRC, had cumulatively received 431 samples. Of these, 295 were analyzed, with 105 testing positive, a positivity rate of 35.6%.

b. Laboratory surge operations are ongoing to address stockouts of diagnostic supplies at the Bunia Provincial Laboratory, with additional RT-PCR capacity being deployed, while WHO and Africa CDC are supporting the delivery of more than 4000 test kits.

c. Both DRC and Uganda continue to perform confirmatory testing at their National Reference Laboratories, including genomic sequencing and data sharing, to improve understanding of transmission chains and support outbreak investigations.

5. Clinical Management

a. As of 24 May 2026, DRC had admitted a cumulative total of 281 patients across 17 treatment and isolation facilities, with 133 patients currently in isolation centres, including eight healthcare workers. The largest numbers of admissions are in Bunia (53), Nyankunde (33), Rwampara (25), and Mongbwalu (18) health zones. In Uganda, five confirmed are being managed in isolation at the Mulago Ebola Treatment Unit (ETU) in Kampala.

b. WHO and health partners are accelerating efforts to establish and operationalize standardized ETCs in hotspot areas, including infrastructure rehabilitation, provision of medical supplies and expansion of isolation capacity, although gaps remain.

c. Clinical management operations have faced major disruptions due to security incidents and patient care challenges. In Mongbwalu, 18 suspected patients left the treatment centre following a security incident and the burning of one of three treatment tents, while a patient from Rwampara refused care, a confirmed case from Nyankunde was readmitted in critical condition, and a confirmed patient from Hoho Health Centre was released under community pressure despite unsuccessful counselling efforts.
d. Supportive care capacity continues to improve. Nutritional management activities commenced with ALIMA to ensure that patients can receive adequate food, while additional equipment, including oxygen concentrators and multiparameter monitors, was deployed to strengthen clinical care capacity and improve quality of care.
e. As of May 31, 2026, WHO has handed over a refurbished Ebola Treatment Centre (ETC) in Bunia with an initial capacity of 24 beds, extending to 60 beds. An additional annex facility is being established to provide up to 42 additional beds in the coming weeks.
f. WHO advisory groups have indicated that several candidate vaccines and therapeutics are being prioritized for evaluation in clinical trials in collaboration with DRC and Uganda.

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

a. IPC measures continue to be progressively strengthened across affected health zones in DRC through supportive supervision, health facility assessments, environmental decontamination, and workforce capacity-building activities.
b. Training and briefings on biomedical waste management, hand hygiene, and the appropriate use and removal of PPE were conducted for healthcare workers and support staff, including 14 healthcare providers and two supervisors in Rwampara Health Zone, as well as staff in health facilities in Bunia.
c. Environmental decontamination and safe and dignified burial (SDB) activities were implemented in response to alerts and deaths. A total of 15 SDB and decontamination interventions were conducted, including five linked to seven alerts in Bunia, two community alerts in Rwampara, eight alerts in Mongbwalu, and household decontamination activities in Nyankunde and North Kivu.
d. In Uganda, IPC activities focused on strengthening infection prevention measures in quarantine and treatment settings. IPC assessments were conducted in four quarantine facilities to identify gaps and strengthen IPC measures and practices.
e. IPC measures are also being strengthened at the Mulago Ebola Treatment Unit (ETU) in Kampala, Uganda, an 80-bed facility with five intensive care unit beds and 10 high-dependency unit beds, to improve preparedness and reduce the risk of healthcare-associated transmission.

7. Risk Communication and Community Engagement (RCCE)

a. RCCE activities have been scaled up in DRC and Uganda, with over 122 000 people reached through church outreach, mass sensitization campaigns, interactive radio programmes, and engagement of community leaders, U-Reporters, and community health workers/volunteers.
b. These activities focused on understanding community perceptions and reducing transmission risks among high risk populations.
c. Anthropological investigations are ongoing to assess risky practices and understand perceptions and behaviours related to the Ebola Bundibugyo virus disease outbreak.

8. Prevention of Sexual Exploitation, Abuse, and Harassment (PRSEAH)

a. PRSEAH activities were integrated into outbreak response operations in DRC and Uganda, with inter-agency coordination mechanisms and a joint action plan established to strengthen accountability and partner engagement.
b. Field capacity strengthening continued, with three PRSEAH experts deployed and awareness sessions reaching more than 130 response personnel across case management, IPC, points of entry, and safe and dignified burial teams.
c. Risk reduction and accountability measures are being strengthened through ongoing inter-agency risk assessments, reporting and referral systems, and mapping of partner roles to support safe and accountable response operations.

9. Operational Readiness

a. Regional preparedness and prioritization framework is being activated with countries categorized by risk and readiness needs. The latest assessments have shown a readiness score of around 57% among priority one and two countries, highlighting the need to scale up readiness activities. Priority actions include activation of EOCs, revision of contingency plans, dissemination of case definitions, training of healthcare workers, and deployment of VHF-500 kits to high-risk areas.
b. Countries have been prioritized based on epidemiological risk, cross-border exposure, and health system readiness. DRC and Uganda remain Tier I (Critical) due to active transmission, while South Sudan, Kenya, and Tanzania are Tier II (High Priority) and Rwanda, Burundi, and the Central African Republic are Tier III (Moderate Priority). Within DRC, the Ituri–North Kivu corridor, particularly Mongbwalu–Bunia and mining-linked mobility routes, remains the highest-priority transmission zone for intensified interventions.
c. Preparedness efforts are focused on early detection and rapid response capacity with countries strengthening systems to ensure timely identification, investigation, isolation, and management of suspected viral haemorrhagic fever cases.

d. Uganda has conducted national risk assessment, with 26 districts categorized as very high risk and 18 districts as high risk, guiding targeted preparedness and readiness measures.

10. Border Health, Travel and Mass Gatherings

a. Points-of-entry and traveller screening operations have been reinforced at high-risk crossings and internal transit routes in both DRC and Uganda, with IOM and national authorities supporting PoE surveillance and implementation of WHO travel and border health guidance.
b. Cross-border transmission risks remain elevated due to insecurity, humanitarian crises, high population mobility, urban/semi-urban transmission hotspots, and porous borders, requiring intensified surveillance and information sharing.
c. Priority operational actions include rapid assessments and mapping of PoEs, informal crossings, and congregation points, alongside ensuring frontline teams have adequate staffing, training, PPE, screening materials, disinfectants, and referral systems. Mass gathering risk assessment capacity is being built and recommendations provided.
d. 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 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 May 31, these risks remained unchanged.

Table 3. WHO Risk Assessment, as of May 31, 2026

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

Source: WHO as of May 31, 2026

- 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 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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