

EBOLA BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda

Weekly External Situation Report 01, Data as of 18 May 2026

Summary

Country	¹ Suspected Cases	¹ Suspected Deaths	CFR (%) Suspected	Confirmed Cases	Confirmed Deaths	CFR (%) Confirmed
Democratic Republic of the Congo	516	131	25.4%	33	4	12.1%
Uganda ²	-	-	-	2	1	50.0%
Total	516	131	25.4%	35	5	14.3%

¹ Data remain provisional and may be revised following ongoing epidemiological and laboratory investigations.

² All suspected cases in Uganda have been reclassified following investigations; only confirmed cases are reported.

Event description

On 5 May 2026, the World Health Organization (WHO) received an alert regarding an unknown illness with high mortality in Mongbwalu Health Zone (HZ), Ituri Province, Democratic Republic of the Congo (DRC), including reports of four health workers who died within four days. Rapid response teams deployed to Mongbwalu and Rwampara HZs conducted investigations, and on 15 May 2026, laboratory testing by the Institut National de la Recherche Biomédicale (INRB), Kinshasa confirmed Bundibugyo virus disease (BVD) caused by Bundibugyo virus. On the same day, the Ministry of Public Health, Hygiene and Social Welfare of DRC officially declared the country's 17th Ebola disease outbreak, initially affecting Rwampara, Mongbwalu and Bunia HZs. Uganda subsequently confirmed two imported cases on 15 and 16 May 2026. On 16 May 2026, the WHO Director-General determined that the outbreak constituted a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations (2005).

As of 18 May 2026, the DRC has reported 516 suspected cases, including 131 deaths from seven health zones across Ituri and North Kivu Provinces. Of these, 33 cases with four deaths have so far been confirmed from Rwampara (19), Bunia (6), Nyankunde (4), and Mongbwalu (1) HZs in Ituri Province, and Butembo (1), Goma (1), and Katwa (1) in North Kivu Province. The largest burden of suspected cases remains concentrated in Mongbwalu (302 suspected cases, including 74 deaths) and Rwampara (136 suspected cases, including 38 deaths). A total of 541 contacts have so far been listed in DRC.

In Uganda, two confirmed imported cases, including one death, have been reported in Kampala. The first confirmed case, a 59-year-old male from the DRC, initially sought care in Hoima District in western Uganda before being admitted to a health facility in Kampala on 11 May 2026. He presented with vomiting, diarrhoea, fever, nausea, and generalized weakness, and later developed respiratory distress and worsening clinical symptoms requiring intensive care. The patient died on 15 May 2026 and was subsequently confirmed as having BVD. A total of 47 contacts linked to the case have been identified and are under follow-up. The second confirmed case, a 51-year-old female from Bunia, Ituri Province, DRC,

initially developed fever, weakness, and chills and was treated for suspected malaria before her condition worsened. She later travelled to Uganda for further care and was admitted to a health facility in Kampala with reduced consciousness and signs of severe illness. Laboratory testing on 15 May 2026 confirmed BVD. The patient remains hospitalized under clinical management.

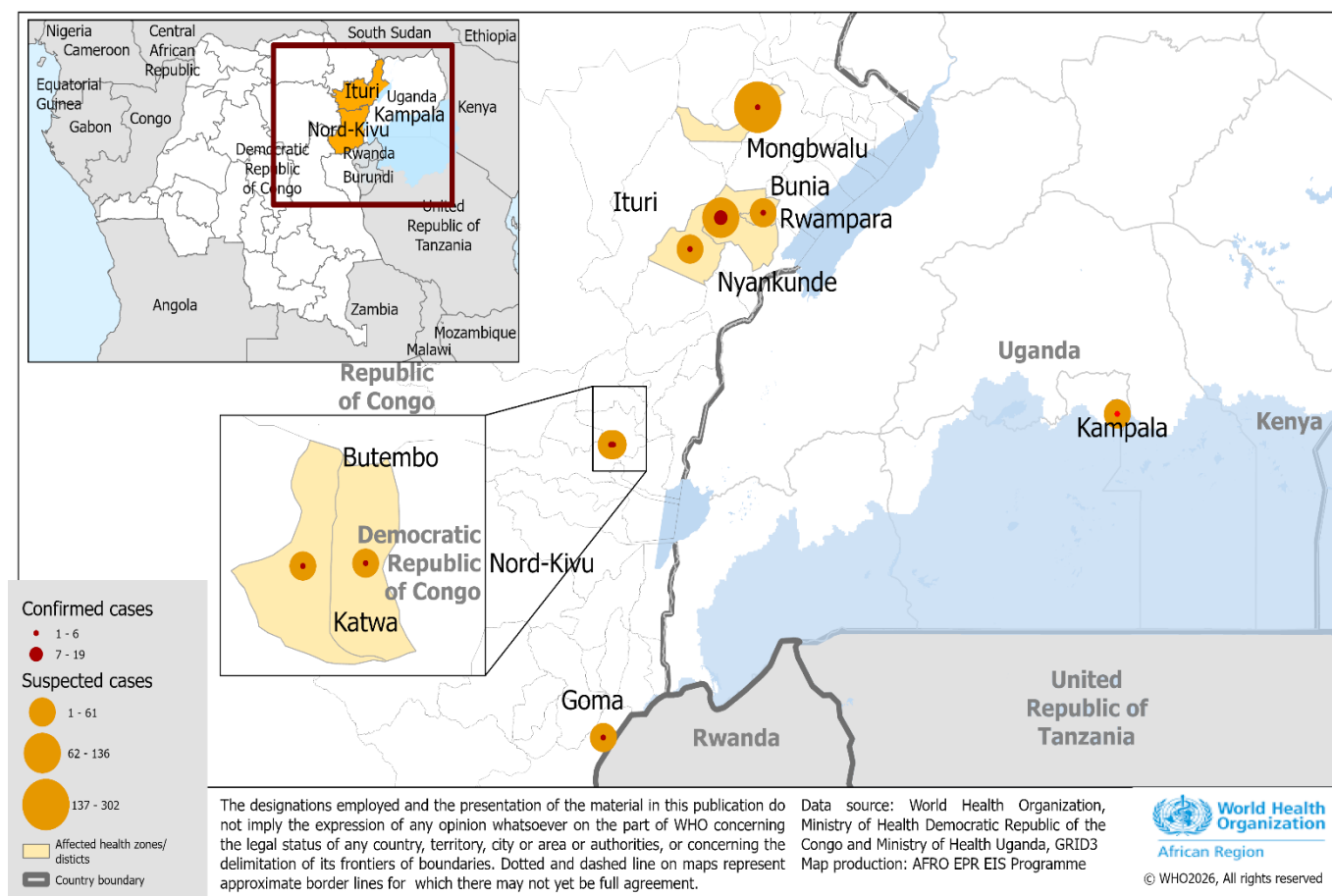
Epidemiological and laboratory investigations are ongoing to reclassify all suspected cases and deaths reported from DRC.. A total of 668 contacts have so far been identified, including 541 in DRC and 127 in Uganda, although contact tracing remains challenging in some areas of DRC due to insecurity and movement restrictions.

The outbreak presents a high risk of continued transmission and regional spread because of ongoing population movement and healthcare-seeking patterns across affected areas. Ituri Province borders Uganda and South Sudan, while Bunia functions as a commercial and transport hub, facilitating substantial population mobility and cross-border movement. Transmission risks are further amplified by mining activities, insecurity, weak contact follow-up, delayed detection, and movement of symptomatic individuals across health zones and international borders.

Table 1. Key figures by subnational areas across affected countries as of 18 May 2026

Country	Province	Health Zone	Suspected cases	Suspected deaths	Confirmed cases	Confirmed deaths
DRC	Ituri	Mongbwalu	302	74	1	0
		Nyankunde	14	1	4	0
		Rwampara	136	38	19	3
		Bunia	61	18	6	1
	North Kivu	Butembo	1	0	1	0
		Katwa	1	0	1	0
		Goma	1	0	1	0
DRC (Total)			516	131	33	4
Uganda	Kampala	Kampala	-	-	2	1
Uganda (Total)			-	-	2	1
Grand Total			516	131	35	5

Figure 1. Distribution of suspected and confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of 18 May 2026



Public health response

Coordination

- In both countries, the Incident Management System has been activated to coordinate response to the outbreak, with technical support from WHO and health partners, including Africa Centres for Disease Control and Prevention, UNICEF, Médecins Sans Frontières (MSF), International Medical Corps, and others health partners. In the DRC, subnational coordination structures are being activated at the provincial and health zones level to coordinate operational activities. Daily provincial coordination meetings involving all response pillars and operational partners are ongoing.
- In Uganda, the National Public Health Emergency Operations Centre and regional Emergency Operations Centres (EOCs) were activated in Fort Portal, Arua, Yumbe, Kampala Capital City Authority, Kabale, and Hoima, with the national response plan and rapid risk assessment finalized.
- In DRC, a total of 38 experts (20 from MoH and 18 from WHO) have been deployed from Kinshasa to Bunia to support response operations.

Operational support and logistics

- In the last days, over 17 tons of emergency supplies were shipped to DRC. Multiple supply corridors have been activated, with 6.8 metric tons shipped from WHO's Kinshasa warehouse to Bunia, 4.5 metric tons shipped from WHO's Nairobi Emergency Hub to Bunia via United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO), and 6.3 metric tons shipped from WHO's Dakar Emergency Hub warehouse, including personal protective equipment (PPE), Viral Haemorrhagic Fever supplies, tents, body bags, infection prevention and control materials, stretchers, medicines and other case management supplies. A second Nairobi air rotation carrying six metric tons is planned.
- Deployment of EpiShuttle patient isolation transport systems, vehicles, telecommunications equipment, laboratory consumables, portable point-of-care diagnostic machines, reagents, cold-chain modules, and Ebola polymerase chain reaction (PCR) testing kits to strengthen clinical transport, laboratory diagnostics, and field response operations are ongoing.
- Coordination is underway to mobilize one helicopter, three ambulances, and two armored vehicles to support cargo and personnel movement. Human resource deployment structures are being finalized and United Nations Humanitarian Air Service (UNHAS) is supporting staff movement to Bunia.
- Assessments are ongoing to identify Ebola treatment and isolation facilities, evaluate Safe and Dignified Burial capacity with the national Red Cross society, assess supply gaps at the Angola-DRC-Uganda border, and support infrastructure planning and operational requirements.
- A four-week forecast of critical PPE requirements across case management, infection, prevention and control, and burial operations has been finalized to support sustained response activities.

Surveillance

- Alert management and case investigations are being scaled up in the affected countries. In the DRC, six additional investigation teams have been deployed to Bunia and Rwampara, with scores of alerts under investigation in Ituri, North Kivu, South Kivu, and Tshopo provinces.
- In the DRC, contact tracing has been initiated with 541 contacts identified, although major operational challenges persist due to insecurity. In Uganda, 127 contacts linked to the two confirmed imported cases are under follow-up, while four active cross-border exposure clusters identified in Ntoroko District are under investigation.
- Data managers in DRC have been trained on the DHIS2 tracker, and a surveillance and digital health coordination meeting is being implemented to improve harmonization across digital platforms. In Uganda, field teams are utilizing Go.Data for contact tracing, benefiting from experience in implementing the tool during previous mpox, cholera and Sudan Virus Disease outbreaks.
- Screening is being strengthened at official and informal border crossings, major transit routes, and pilgrimage corridors. The International Organization for Migration (IOM) is supporting points-of-entry (PoEs) surveillance in DRC; however, informal crossings and weak alert management at PoEs remain significant gaps.

Case Management

- A total of 72 suspected cases are in isolation and treatment facilities across Ituri, including 12 currently admitted across key affected health zones (Mongbwalu: 3; Rwampara: 5; Bunia: 4).

- Response efforts continue to face challenges, including absence of standardized isolation and treatment facilities and weak screening and referral pathways.
- WHO, together with Alliance for International Medical Action (ALIMA), MSF, IOM, and the International Federation of the Red Cross, is supporting the establishment and operationalization of isolation and treatment facilities in affected areas.
- One case is admitted in Uganda at the Mulago Isolation Treatment Unit. Isolation facilities in high-risk districts have been activated and the Uganda National Emergency Medical Team deployed to support clinical management.

Laboratory

- Laboratory surge capacity is being rapidly expanded in DRC. INRB teams are deploying to Bunia and mobile laboratories are being deployed to Mongbwalu and Mahagi (Ituri – Uganda border) to decentralize testing capacity.
- PCR kits have been sourced, while WHO Regional Emergency Hub in Dakar is deploying reagents, Piccolo machines, and cold-chain modules to strengthen field laboratory operations.
- In both DRC and Uganda, genomic and epidemiological analyses are underway and both countries uploaded their sequences through a joint publication on virological.org. Additionally, Uganda is strengthening sequencing and sample transport systems.
- Uganda is deploying a mobile laboratory to Kasese near the DRC border, with a virtual diagnostics coordination meeting supporting cross-country laboratory operations.

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

- In DRC, operational teams are being organized for IPC, decontamination, safe and dignified burials and health facility assessments.
- Coordination mechanism for IPC response is being established under the leadership of the Division of Provincial Health (DPS) and the Public Health Emergency Operations Centre (COUSP), and IPC/WASH partner coordination is being organized through a task force, with partners requested to complete 3W mapping
- WHO delivered 5 metric tons of IPC kits and sample collection materials to Bunia, MEDAIR donated six body bags, and a four-week PPE forecast has been finalized to support sustained operations.
- Decontamination teams have been established per zone for health facilities and households and being briefed on IPC measures. Hands on IPC training was delivered to safe and dignified burials teams.
- Preliminary rapid IPC assessments conducted in affected health facilities in DRC revealed major gaps in screening, triage, and patient isolation measures, as well as limited IPC training among healthcare workers. Overall IPC assessment findings showed extremely low scores across assessed facilities, highlighting the urgent need for additional human resource surge capacity and IPC reinforcement.
- Four healthcare worker deaths have been reported to date, while inconsistent implementation of safe and dignified burial measures further underscores the significant risk of healthcare-associated transmission.

Risk Communication and Community Engagement (RCCE)

- In the DRC, Community mobilization has started in Mongbwalu, while social listening activities and deployment

of UNICEF digital platforms (U-Report and I-Hear-You) are underway to improve community feedback and information sharing.

- WHO AFRO shared a multi-country infodemic management report providing an initial analysis of community perceptions, including key questions, concerns, rumours, misinformation, and disinformation, to guide targeted risk communication and community engagement interventions. WHO, UNICEF, and IFRC are developing a shared RCCE message repository to harmonize risk communication content.
- Uganda has activated risk communication systems with community messaging and public awareness campaigns ongoing through District Health Officer networks, with health workers receiving guidance on standard precautions and public health messaging.

Operational Readiness

- Regional preparedness and prioritization framework is being activated with countries categorized by risk and readiness needs. 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.
- 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.
- 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.

Border Health, Travel and Mass Gatherings

- WHO travel and border health guidance has been disseminated across countries and transport sectors, emphasizing that cases and contacts should avoid travel unless medically evacuated, and advising against travel or trade restrictions and border closures.
- Affected and neighbouring countries are strengthening points-of-entry (PoE) preparedness, including activation of health emergency plans, enhanced screening at airports, seaports, land crossings and major internal transit routes, and improving capacities for detection, investigation, referral, and management of suspected Bundibugyo virus disease cases and contacts.
- 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.
- 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.

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