

## ESCMID Emerging Infections Subcommittee Situation update

### ESCMID Emerging Infections Subcommittee on the Ebola Bundibugyo outbreak in the Democratic Republic of the Congo and Uganda

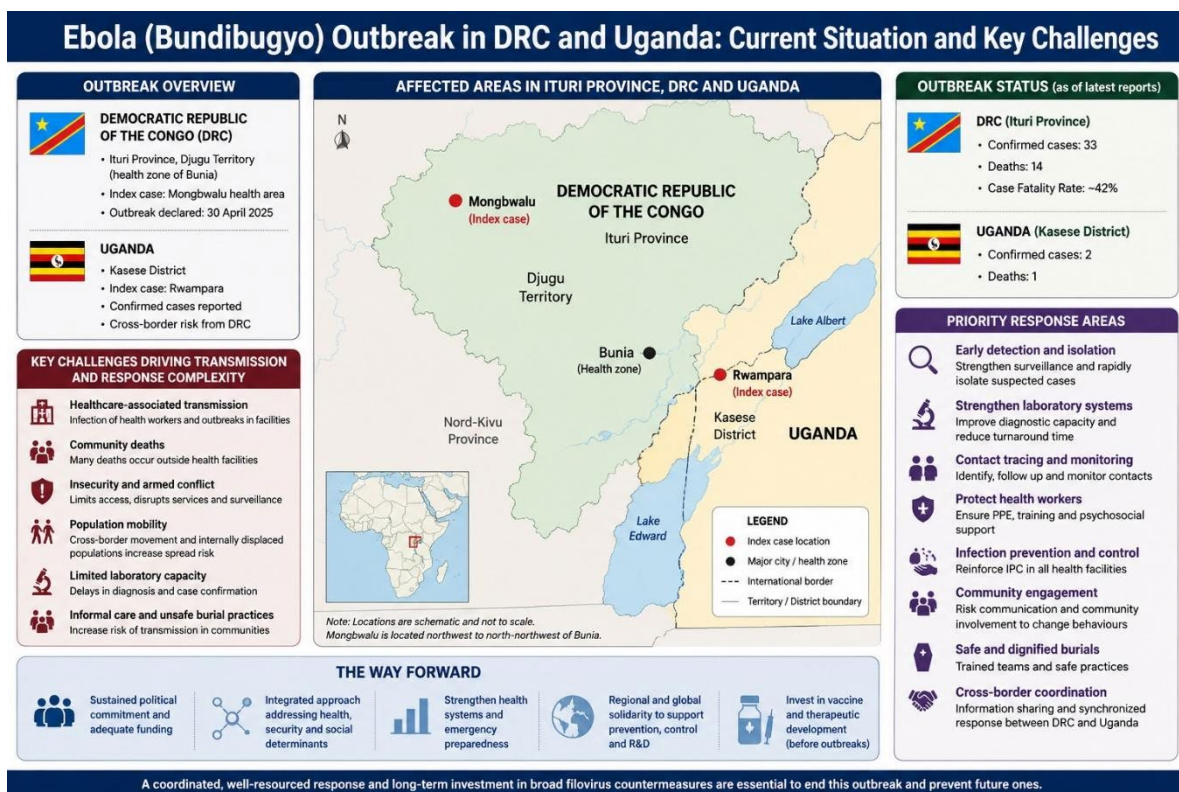
*Date: 19 May 2026*

#### Highlights

- WHO declared the Ebola disease outbreak caused by *Bundibugyo ebolavirus* in the Democratic Republic of the Congo (DRC) and Uganda a **Public Health Emergency of International Concern on 17 May 2026**.
- The outbreak was **first detected in Ituri Province, DRC**, with affected health zones including Rwampara, Mongbwalu and Bunia, and major urban centers and transportation hubs.
- The **first reported suspected case was a healthcare worker** with symptom onset on **24 April 2026**, who later died in Bunia. Considering rapid progression of the number of cases there had been an initial problem of detection and diagnosis.
- Despite the early phase, **case numbers have increased rapidly**. As of 19 May 2026, over 500 suspected cases and 130 deaths had been reported, including imported cases in Uganda.
- **Key concerns** include high community deaths, infections and deaths among healthcare workers (HCW), possible healthcare-associated transmission, delayed case recognition due to initial testing focused on Zaire ebolavirus, insecurity and population movement, and limitations in contact tracing and health system capacity.
- There is a **high probability of a prolonged outbreak**, driven by insecurity, delayed detection, and patterns similar to the 2018–2020 outbreak in the same region. Additional challenges include community mistrust and the absence of licensed vaccines or specific therapeutics for Bundibugyo ebolavirus, meaning that management relies largely on early supportive care.
- ECDC has assessed the likelihood of infection for people living in the EU/EEA as “very low”. At the same time, the risk for EU/EEA travellers or residents in Ituri Province is considered “low”.
- ESCMID members should remain alert to possible viral haemorrhagic fever in febrile travellers or healthcare workers with relevant exposure history within the preceding 21 days. Update on areas involved in the outbreak is strongly recommended.
- Globally, healthcare facilities should review pathways for early recognition, isolation, notification, safe specimen handling, referral, infection prevention and control, and occupational health management.

- The response should prioritise surveillance, laboratory capacity, contact tracing, healthcare worker protection, community engagement, safe burials, supportive care and cross-border coordination and communication.
- WHO advises against unnecessary travel or trade restrictions, recommending instead risk-based preparedness, traveller information and rapid identification of suspected cases.
- The response will require **strong international solidarity**, particularly to ensure adequate care capacity and medical evacuation options for infected healthcare workers

**Figure 1: Current situation and key challenges in the Ebola Bundibugyo outbreak in the Democratic Republic of the Congo and Uganda.**



*This figure is a schematic, AI-assisted visual summary intended for communication purposes only. It is not drawn to scale, and the geographic markers are approximate rather than precise GIS coordinates. The figure does not include case numbers because reported counts are evolving rapidly and should be interpreted using the latest official situation reports from WHO, ECDC, CDC and national public health authorities. AI-assisted image generation was used to create the visual layout; all scientific content, terminology and public health messages were reviewed and edited by the authors.*



## Sections in this update

[Background](#)

[Current epidemiological situation](#)

[Clinical and virological context](#)

[Challenges complicating outbreak control](#)

[Regional and international implications](#)

[European risk assessment](#)

[Public health response priorities](#)

[Implications for ESCMID members](#)

[Research and development priorities](#)

[Conclusions](#)

[References](#)

## Background

The ESCMID Emerging Infections Subcommittee is closely monitoring the ongoing outbreak of Ebola virus disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda. On 17 May 2026, the World Health Organization declared the outbreak a Public Health Emergency of International Concern, while clarifying that the event does not currently meet the criteria for a pandemic [1].

The outbreak was initially detected in Ituri Province in eastern DRC, involving the health zones of Rwampara, Mongbwalu and Bunia. WHO was first alerted on 5 May 2026 following reports of a high-mortality cluster of unexplained illness, including infections and deaths among healthcare workers. The first known suspected case was reportedly a healthcare worker with symptom onset on 24 April 2026, who later died in Bunia. Laboratory confirmation of *Bundibugyo* virus infection was obtained on 15 May 2026 by the Institut National de Recherche Biomédicale in Kinshasa, and on the same day, the DRC Ministry of Public Health officially declared the country's seventeenth Ebola outbreak [2].

## Historical context

The current outbreak should also be viewed in the context of previous filovirus outbreaks in the region. Bundibugyo virus disease has caused two recognised outbreaks before this event, in Uganda in 2007 and in the Democratic Republic of the Congo in 2012, both associated with substantial mortality and limited disease-specific countermeasures [2,3]. The affected area also overlaps with the setting of the 2018–2020 North Kivu–Ituri Zaire ebolavirus outbreak, which became the second-largest Ebola outbreak ever recorded, with 3,481 cases and 2,299 deaths, and took almost two years to contain [2]. The 2018-2020 response was severely complicated by armed conflict, community mistrust, attacks on health facilities and deaths among healthcare workers and response personnel. This history underscores that outbreak control in eastern DRC is not only a biomedical challenge but also a security, community engagement, health systems, and humanitarian challenge.

## Current epidemiological situation

As of the WHO statement dated 17 May 2026, the outbreak included eight laboratory-confirmed cases, 246 suspected cases and 80 suspected deaths in Ituri Province, DRC, with two confirmed imported cases in Kampala, Uganda, including one death [1]. CDC's update of 18 May 2026 reported 11 confirmed cases, 336 suspected cases, and 88 deaths in the DRC, and 2 confirmed cases in Uganda, including 1 death, with no further spread reported in Uganda at that time (Figure 1) [4].

The true scale of transmission remains uncertain. WHO, ECDC, and CDC have highlighted several factors that may contribute to under-detection, including limited surveillance and diagnostic capacity, insecurity and armed conflict in affected regions, community deaths, population displacement, high cross-border mobility, informal healthcare systems, delayed healthcare-seeking, and possible healthcare-associated transmission [1,2,4,5].

Particular concern has arisen from reports of infections and deaths among healthcare workers and clusters of unexplained community deaths. These events suggest that undetected transmission may have occurred before laboratory confirmation and that healthcare-associated amplification may be contributing to the spread.

## **Clinical and virological context**

Ebola virus disease remains one of the most severe viral haemorrhagic fevers. Clinical manifestations typically include abrupt onset of fever, malaise, headache, myalgia, gastrointestinal symptoms and, in severe cases, multiorgan dysfunction and haemorrhage. Transmission occurs through direct contact with infected bodily fluids or contaminated materials, including exposure during caregiving, healthcare procedures or funeral practices.

The current outbreak is caused by *Bundibugyo* virus, a relatively uncommon ebolavirus species first identified in Uganda in 2007 [3]. Historically, *Bundibugyo* virus disease has been associated with case fatality rates of approximately 25% to 50% [6]. Although this may be lower than that reported in some *Zaire* ebolavirus outbreaks, *Bundibugyo* virus disease remains a severe infection with substantial mortality.

Unlike outbreaks caused by *Zaire* ebolavirus, there are currently no licensed vaccines or approved virus-specific therapeutics for *Bundibugyo* virus disease [7]. Existing licensed *Zaire* ebolavirus vaccines are indicated for the Ebola virus, and reliable protection against *Bundibugyo* virus disease should not be assumed. Preclinical studies suggest that *Bundibugyo*-specific rVSV vaccine constructs may provide protection in non-human primate models, underscoring the need for species-specific, broadly protective filovirus vaccine development [8]. This reinforces the need for sustained work on broader filovirus vaccines and therapeutics, including approaches that could protect against multiple ebolavirus species. Such work is scientifically feasible but technically challenging, and it requires sustained funding, international collaboration, and trial readiness before outbreaks occur.

## **Challenges complicating outbreak control**

Several factors are complicating the response. The affected regions in eastern DRC continue to experience insecurity, armed conflict, population displacement and fragile healthcare infrastructure. These conditions hamper surveillance, laboratory confirmation, patient isolation, contact tracing and safe referral pathways.

Delayed recognition may also have contributed to wider spread. Viral haemorrhagic fevers can be difficult to distinguish clinically from other endemic febrile illnesses, particularly malaria, arboviral infections and severe bacterial infections. If diagnostic systems are narrowly focused on a single viral species or assay target, uncommon ebolavirus species may be missed or recognised late.

This outbreak also highlights a broader diagnostic preparedness gap. Rapid systems can be extremely valuable in outbreaks, especially when deployed close to affected communities, but they cannot substitute for robust laboratory infrastructure. Durable preparedness requires trained laboratory personnel, biosafety capacity, quality-assured molecular testing, sequencing capability, genomic data analysis tools, supply chains,

data systems and links to reference laboratories. Broadly reactive filovirus PCR assays and sequencing-based approaches have been described, but they require functioning laboratories and technical capacity. A short-term “testing established” success is not enough if systems cannot be maintained between outbreaks.

Healthcare-associated transmission remains a central concern [5]. Healthcare worker infections suggest gaps in infection prevention and control, delayed recognition of suspected viral haemorrhagic fever, inadequate access to appropriate personal protective equipment or insufficiently rehearsed isolation and referral pathways. Unsafe funeral practices, direct handling of deceased individuals and informal care networks continue to represent major amplification risks.

## **Regional and international implications**

The outbreak has already demonstrated cross-border spread into Uganda through imported cases identified in Kampala. Neighbouring countries remain at elevated risk due to porous borders, population mobility, mining activity, trade routes, and regional travel connections.

The outbreak has also affected international healthcare personnel. Reports indicate that an American healthcare worker exposed while caring for patients in DRC tested positive and was transferred to Germany for treatment and monitoring [4]. Such events underline the need for clear pathways for healthcare worker protection, exposure assessment, evacuation, monitoring and management.

International preparedness measures have been intensified. While targeted traveller information, symptom screening, monitoring of exposed persons and healthcare preparedness may be appropriate, public health measures should remain evidence-based and linked to exposure risk. Restrictions should be based on individual epidemiological risk and be aligned with the biology of transmission. The Ebola virus does not recognise citizenship. Risk assessment should be based on exposure, symptoms, contact history, healthcare or funeral exposure, laboratory exposure and travel to affected areas, rather than immigration category alone.

## **European risk assessment**

ECDC has assessed the overall risk for the general population in the EU/EEA as “very low”, because the probability of importation and sustained secondary transmission in Europe remains limited [5]. However, sporadic imported cases remain possible among travellers returning from affected regions, healthcare workers, humanitarian personnel and laboratory contacts.

For people from the EU/EEA living in or travelling to Ituri Province, the risk is higher than for the general European population, but remains dependent on individual exposure. Healthcare work, contact with suspected or confirmed cases, participation in funeral practices, contact with sick persons or work in settings with inadequate infection prevention and control would substantially increase risk.

ECDC continues to monitor the outbreak through epidemic intelligence activities and remains in contact with key partners, including Africa CDC, the European Commission

and WHO. Discussions regarding a potential role for the EU Health Task Force should be interpreted in the context of preparedness and support for affected regions, rather than as evidence of increased risk to the general European population.

### **Public health response priorities**

The response should prioritise early case detection, isolation, intensive supportive clinical care, contact tracing and monitoring, infection prevention and control, safe and dignified burials, community engagement, risk communication and cross-border coordination and communication.

Healthcare worker protection must be central to the response. This includes adequate PPE, training in donning and doffing, supervised IPC implementation, safe waste management, environmental cleaning, clear triage pathways, reliable payment and support for frontline staff, and occupational health systems for exposure management.

Laboratory strengthening is important. Outbreak response requires not only rapid tests, but also durable laboratory systems capable of safe specimen handling, molecular confirmation, sequencing, quality assurance and integration with surveillance. Investment in laboratory infrastructure should be sustained between outbreaks, rather than rebuilt during each emergency.

WHO continues to advise against generalised travel or trade restrictions, emphasising instead risk-based preparedness, targeted screening where appropriate, rapid isolation of suspected cases and support to affected countries [1].

### **Implications for ESCMID members**

For infectious diseases physicians, microbiologists, infection prevention specialists, emergency physicians, intensivists, travel medicine practitioners and clinical microbiology laboratories across Europe, the outbreak highlights several priorities.

Clinicians should maintain awareness of viral haemorrhagic fever syndromes in patients presenting with compatible febrile illness and relevant epidemiological exposure, particularly travel to affected regions of DRC or Uganda within the preceding 21 days, healthcare exposure, funeral attendance, laboratory exposure or contact with suspected or confirmed cases.

Healthcare facilities should review local pathways for rapid triage, immediate isolation, notification, referral and escalation. Infection prevention teams should ensure that staff are familiar with PPE requirements, isolation procedures, waste management, environmental cleaning and occupational health pathways for exposed healthcare workers.

Clinical microbiology laboratories should review specimen handling, packaging, transport and referral pathways for suspected viral haemorrhagic fever samples. Hospitals should also maintain coordination with national public health authorities and reference laboratory networks.

Preparedness for imported cases should include clear clinical pathways, access to specialist advice, ICU planning, high-level isolation where available and communication plans that avoid unnecessary alarm or stigma.

## Research and development priorities

The current outbreak underlines the imbalance in countermeasure development across ebolavirus species. Most vaccine and therapeutic progress has focused on the *Zaire* ebolavirus. *Bundibugyo* virus disease requires a broader research agenda, including candidate vaccines, monoclonal antibodies, antivirals, improved diagnostics and pan-filovirus approaches.

Current Ebola vaccines show largely species-specific protection, and reliable cross-protection of Zaire ebolavirus vaccines against Bundibugyo virus disease should not be assumed [9,10]. This reflects substantial antigenic diversity among ebolaviruses; although cross-reactive IgG responses may occur, they do not necessarily imply protective neutralisation [11]. These limitations support the development of broadly reactive monoclonal antibodies, multivalent vaccines, and Bundibugyo-specific rVSV vaccine constructs [12–14]. Sustained investment in broad filovirus countermeasures is needed before outbreaks occur, rather than only after transmission is established.

Diagnostics also require a broader vision. Highly specific cartridge assays are useful, but preparedness for uncommon filoviruses requires broadly reactive molecular assays, sequencing, quality-assured reference laboratories and trained personnel. Investment in real laboratory infrastructure is essential for sustainable outbreak readiness.

Broadly protective monoclonal antibody approaches are also being explored. A two-antibody cocktail, MBP134/MBP134AF, showed pan-ebolavirus neutralisation and protection in animal models, but remains a candidate therapeutic requiring further evaluation before it can inform outbreak treatment [15].

## Conclusions

The 2026 *Bundibugyo* Ebola outbreak represents a major regional public health emergency with important international implications. The absence of licensed vaccines or virus-specific therapeutics, together with insecurity, delayed outbreak recognition, probable under-detection, healthcare-associated transmission and ongoing population mobility, substantially complicates outbreak control efforts.

At present, the overall risk to the general EU/EEA population remains “very low” according to ECDC assessments. Nevertheless, European healthcare systems should maintain vigilance, preparedness and close coordination with public health authorities.

This outbreak is a reminder that preparedness for emerging infections must extend beyond pathogens for which vaccines and therapeutics are already available. *Bundibugyo* virus disease highlights the need for sustained investment in surveillance, healthcare worker protection, laboratory systems, infection prevention, community-centred responses, cross-border coordination, and equitable research into diagnostics, vaccines, and therapeutics for non-Zaire ebolaviruses.

The ESCMID Emerging Infections Subcommittee will continue to monitor developments closely and provide updates relevant to clinical practice, laboratory preparedness, infection prevention and public health response.

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