THREAT ASSESSMENT BRIEF

Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026

21 May 2026

Summary

On 15 May 2026, Africa CDC reported an outbreak of Ebola disease in Ituri Province, DRC. Laboratory analysis at Institut National de Recherche Biomedicale of DRC identified Bundibugyo virus (BDBV). BDBV disease is a rare disease but can cause outbreaks with high case fatality rates. Considering the available information, complicated context and the uncertainties on the epidemiological information WHO declared a Public Health Emergency of International Concern on 17 May 2026. Africa CDC declared a Public Health Emergency of Continental Security on 18 May 2026.

This Threat Assessment Brief aims to assess the risk for people from the EU/EEA living in or travelling to affected areas and the overall risk of BDBV for the general population in the EU/EEA in the context of the ongoing outbreak of BDBV disease in DRC. It is intended for public health authorities in EU/EEA countries and is based on currently available evidence. It therefore carries considerable uncertainty. Recommendations are also included for how public health authorities in the EU/EEA can strengthen preparedness and response capabilities.

Epidemiological situation

Based on data reported by the World Health Organisation as at 20 May 2026, almost 600 suspected cases and 139 deaths among the suspected cases have been reported. In DRC, 51 cases were confirmed in Ituri and North Kivu Provinces. While two imported cases were confirmed in Kampala, Uganda. At least five deaths had been reported among the confirmed cases as at 18 May, four in DRC and one in Uganda. Due to the very recent declaration of the outbreak and the uncertainties related to the epidemiological information, it is probable that the outbreak is larger than what is currently being reported, not only regarding the number of affected cases but also to its geographical extent. BDBV transmission requires direct contact with blood, or other bodily fluids of living or deceased infected people, or any surfaces and materials soiled by infectious fluids. Transmission can also occur through contact with dead or live infected animals, including handling and/or consuming bushmeat, or by visiting caves or mines colonised by bats. There are currently no licensed vaccines or specific treatments available for BDBV disease.

Risk assessment

Although epidemiological information remains limited and there are important uncertainties, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is assessed as low, provided they adhere to the recommended precautionary measures. Transmission requires direct contact with blood, secretions, organs, or other bodily fluids of dead or living infected people or animals; all unlikely exposures for the general

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EU/EEA travellers or expatriates in affected areas. Staff members of humanitarian, religious and other organisations, particularly healthcare workers who are in direct contact with patients and/or local communities in the affected areas, are more likely to be exposed to the virus. Provided they adhere to the appropriate infection prevention and control measures, the likelihood of infection for this group is also low.

The most likely route by which the virus could be introduced to the EU/EEA is through people with a BDBV infection travelling from affected areas to the EU/EEA. During the Ebola disease outbreak in West Africa in 2013– 2016, which was the largest outbreak to date, where tens of thousands of cases were reported, with transmission in large urban centres, and hundreds of EU/EEA humanitarian and military personnel deployed to the affected areas, only a small number of imported cases to Europe were reported, most of them medically evacuated for treatment. Based on this experience, it is expected that imported cases would be a rare event.

The likelihood of secondary transmission of BDBV within the EU/EEA and the occurrence of sustained chains of transmission within the EU/EEA is considered very low, as cases are likely to be promptly identified and isolated and recommended control measures would be implemented. Although BDBV infection can cause severe disease in affected individuals, the population-level public health impact in the EU/EEA is expected to be very low because only very few cases would occur. Therefore, the overall current risk of BDBV for the general population in the EU/EEA is assessed to be very low.

Recommendations

EU/EEA countries should review and update the standard operating procedures on isolation and treatment for BDBV disease cases, and on contact tracing and quarantine for contacts of cases as needed.

EU/EEA public health authorities should:

1. Increase awareness among travellers to, and residents of affected areas, as well as returning travellers;
2. Increase awareness among health professionals on:
   (i) the possibility of BDBV disease in travellers returning from affected areas;
   (ii) the clinical presentation of the disease and the need to ask about the travel history and contacts of people returning from affected areas;
   (iii) the availability of protocols for testing suspected cases;
   (iv) infection prevention and control (IPC) procedures and appropriate management of suspected or confirmed cases.
3. Strengthen readiness to rapidly detect imported cases, promptly isolate them, and implement appropriate infection prevention and control measures.
4. Review testing capacity and BDBV diagnostic procedures. The EU reference laboratory for public health on Emerging, rodent-borne and zoonotic viral pathogens (EURL-PH-ERZV) offers diagnostic services to EU/EEA countries lacking capability to diagnose BDBV infection.
5. Minimise exposure in healthcare settings requires appropriate procedures, trained staff, and equipment for the safe management of BDBV cases.
6. Provide all returning travellers with clear information on symptoms, route of transmission, and what to do if symptoms develop after arrival in the EU/EEA: travellers who develop symptoms compatible with BDBV infection within 21 days after return should self-isolate, seek medical care promptly, and report their travel history and possible exposures.

Exit screening in affected countries, including symptom checks and exposure assessment, is crucial as it contributes to risk reduction by identifying symptomatic travellers before boarding and preventing travel while symptomatic. Exit screening also helps dissuade ill people from travelling and enhance public and stakeholder confidence. However, it cannot fully prevent exportation of cases, because absence of symptoms at departure does not exclude subsequent onset of disease.

ECDC actions

ECDC is monitoring the outbreak through its epidemic intelligence activities to provide epidemiological updates, situational awareness and assess the risk for the EU/EEA.

ECDC has deployed an expert through the EU Health Task Force to the Africa Centres for Disease Control and Prevention (Africa CDC) headquarters in Addis Ababa to support coordination and operational planning.

ECDC is in discussions with the European Civil Protection and Humanitarian Aid Operations (ECHO) and the Global Outbreak Alert and Response Network (GOARN) regarding the deployment of additional experts to support response activities in DRC and Uganda.

The European Union Reference Laboratory for public health on emerging, rodent-borne and zoonotic viral pathogens (EURL-PH-ERZV) offers support to the EU/EEA national reference laboratories for the diagnosis of BDBV infection, biosafety advice for handling and inactivation of samples, and also offers diagnostic services to EU/EEA countries for BDBV infection.

Epidemiological situation

On 15 May 2026, Africa CDC reported an outbreak of Ebola disease in Ituri Province, DRC [1,2]. Laboratory analysis at Institut National de Recherche Biomedicale of DRC identified BDBV [3]. Based on provisional data published by the World Health Organisation as at 20 May 2026 [4,5], approximately 600 suspected cases have been reported, including 139 deaths among suspected cases. Fifty-one confirmed cases have been reported in DRC and two imported cases in Uganda. In DRC, based on provisional data available as at 18 May 2026, most suspected cases have been reported in the Mongbwalu (302 suspected cases, 74 deaths) and Rwampara (136 suspected cases, 38 deaths), in Ituri Province. Confirmed cases from DRC have been reported from at least four health zones in Ituri Province and at least three health zones in North Kivu. In both provinces, confirmed cases have been reported in the capitals (Bunia and Goma) [4,5]. Over 500 contacts are being followed up in DRC and over 100 contacts are being followed up in Uganda. One confirmed case in a United States citizen was transferred to Germany, along with six high-risk contacts. One contact is to be transferred to Czechia [6].

Viral genomes from samples from DRC and Uganda have been published and preliminary analysis shows distinct sequences from the previous outbreaks [7].

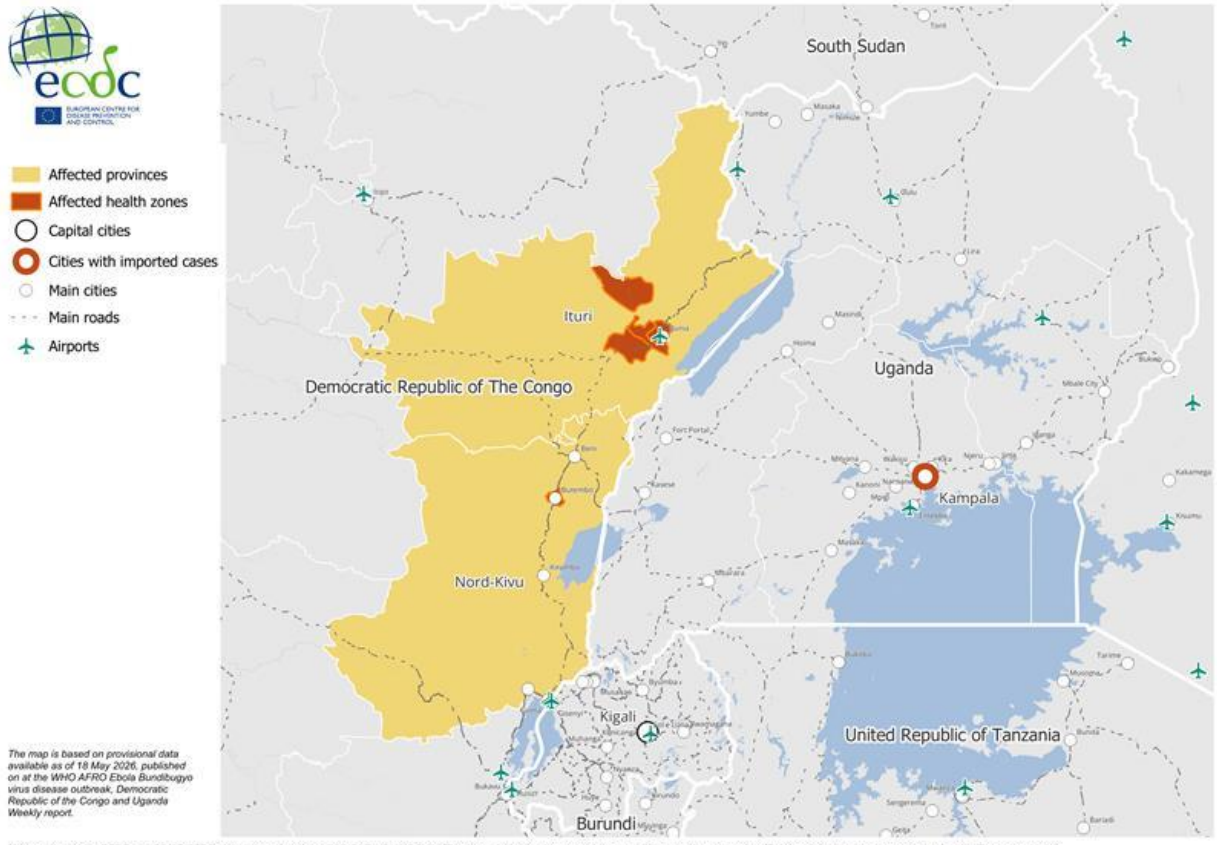
The Ministry of Health of DRC reported that the index case is a nurse (age unknown) who died in a healthcare facility in Bunia (capital of Ituri Province). The case presented with fever, bleeding, vomiting and weakness [8].

Information regarding transmission chains and affected population groups is currently limited, partly due to the complex context of ongoing insecurity and humanitarian challenges in the affected areas.

Considering the available information, complicated context and the uncertainties on the epidemiological information WHO declared a Public Health Emergency of International Concern on 17 May 2026 [9]. Africa CDC declared a Public Health Emergency of Continental Security on 18 May 2026 [10].

This is the 17th Ebola disease outbreak reported in DRC. The most recent prior outbreak in 2025 in Kasai Province was due to Ebola virus (species *Orthoebolavirus zairense)* [11]. In Ituri Province specifically, Ebola disease due to Ebola virus (*Orthoebolavirus zairense*) was last documented during the 2018-2020 outbreak. The 2018-2020 outbreak was declared on 1 August 2018 following detection of cases in North Kivu Province cases were also identified in Ituri and North Kivu with symptom onset from May 2018. The outbreak spread to South Kivu. Between 1 August 2018 and 25 June 2020, a total of 3 470 cases were reported including 3 317 confirmed and 153 probable. At the time WHO had declared the outbreak a Public Health Emergency of International Concern [12,13].

Figure 1. Areas in the Democratic Republic of the Congo and Uganda affected by the ongoing Ebola disease outbreak, using data available as at 18 May 2026



Disease background

Ebola disease is caused by viruses in the genus *Orthoebolavirus*, including Bundibugyo virus (BDBV, *Orthoebolavirus bundibugyoense*), Ebola virus (EBOV, *Orthoebolavirus zairense)*, Sudan virus *(Orthoebolavirus sudanense)*, and Taï Forest virus *(Orthoebolavirus taiense).* It is a rare disease but can cause outbreaks with high case fatality rates. To date, most outbreaks have occurred in sub-Saharan Africa. The largest outbreak occurred between 2013 and 2016 in three West African countries (Guinea, Liberia, and Sierra Leone), with over 28 000 cases and 11 000 deaths; it was caused by Ebola virus (EBOV, *Orthoebolavirus zairense*). The current outbreak is caused by Bundibugyo virus (BDBV).

Bundibugyo virus was first reported in 2007 in Bundibugyo district in Uganda during an outbreak. The second and most recent outbreak due to BDBV was in 2012 in DRC [14,15].

BDBV transmission requires direct contact with blood (e.g. through mucous membranes or broken skin) or other bodily fluids (e.g. saliva, urine or vomit) of living or deceased infected people, or with any surfaces and materials soiled by infectious fluids [16]. Transmission can also occur through contact with dead or live infected animals, including handling and/or consuming bushmeat (e.g. monkeys, apes, forest antelopes and bats), or by visiting caves or mines colonised by bats [17]. Healthcare workers can be infected through nosocomial transmission when caring for infected patients without appropriate personal protective equipment (PPE), or through occupational exposures such as needlestick injuries or splashes. Ebola disease is not an airborne disease and is generally not considered to be contagious before the onset of symptoms.

The typical incubation period ranges from two to 21 days (mean six days) [18]. The prodromal phase lasts up to 10 days during which the infected patient experiences a sudden onset of flu-like illness. This is followed by progressive weakness, anorexia, diarrhoea, nausea, and vomiting. The next stage of the disease is characterised by gastrointestinal, neurological, vascular, cutaneous, and respiratory symptoms. Haemorrhagic manifestations may also occur. In the final stage, patients may die from a combination of multi-organ failure and hypovolemic shock due to severe fluid loss.

A vaccine against Ebola disease caused by EBOV (*Orthoebolavirus zairense*) has been granted market authorisations in the EU [19]. There are no licensed vaccines against BDBV disease.

Virus persistence in immune-privileged sites (e.g. testicles, central nervous system and aqueous humour) among some survivors has been documented for EBOV (*Orthoebolavirus zairense*) [17,20,21]. As a result, transmission through sexual contact is possible.

The presence of the virus in the blood and consequently the organs and tissues of people who are asymptomatic, infected or recovered indicates that transmission of the virus via transfusion and transplantation is possible, but has not been reported, so far.

For more information, please see ECDC's Factsheet about Ebola disease.

ECDC risk assessment for the EU/EEA

What is the likelihood of infection for people from the EU/EEA living in or travelling to affected areas?

The high number of cases already reported at the time the outbreak was declared suggests that detection occurred late, after a period of undetected transmission. It is therefore likely that the outbreak is larger than currently reported, both in terms of the number of cases and its geographical extent. Although epidemiological information remains limited and there are important uncertainties, the likelihood of infection for people from the EU/EEA living in or travelling to affected areas is assessed as low, provided they adhere to the recommended precautionary measures (see further information below). Transmission requires direct contact with blood, secretions, organs, or other bodily fluids of dead or living infected people or animals; all unlikely exposures for the general EU/EEA travellers or expatriates in affected areas.

Staff members of humanitarian, religious and other organisations, particularly healthcare workers who are in direct contact with patients and/or local communities in the affected areas, are more likely to be exposed to the virus. Provided they adhere to the appropriate infection prevention and control measures, the likelihood of infection for this group is also low.

What is the overall risk of BDBV for the general population in the EU/EEA?

The most likely route by which the virus could be introduced to the EU/EEA is through people with a BDBV infection travelling from affected areas to the EU/EEA. During the Ebola disease outbreak in West Africa in 2013–2016, which was the largest outbreak to date, where tens of thousands of cases were reported, with transmission in large urban centres, and hundreds of EU/EEA humanitarian and military personnel deployed to the affected areas, only a small number of imported cases to Europe [22] were reported, most of them medically evacuated for treatment. Based on this experience, it is expected that imported cases would occur very rarely, if at all.

The likelihood of secondary transmission of BDBV within the EU/EEA and the occurrence of sustained chains of transmission within the EU/EEA is considered very low, as cases are likely to be promptly identified and isolated and recommended control measures would be implemented. Although BDBV infection can cause severe disease in affected individuals, the population-level public health impact in the EU/EEA is expected to be very low because only very few cases would occur. Therefore, the overall risk of BDBV for the general population in the EU/EEA is assessed to be very low.

The likelihood of BDBV affecting the substances of human origin donor population in the context of this outbreak is currently assessed as very low.

The assessment will be reviewed as further epidemiological and virological information becomes available.

ECDC recommendations

Strengthen preparedness and response capabilities in EU/EEA countries

To ensure, and if necessary, strengthen the preparedness and response capabilities, EU/EEA countries should consider reviewing the standard operating procedures on isolation and treatment for BDBV disease cases, and on contact tracing and quarantine for contacts of cases.

EU/EEA public health authorities should ensure preparedness through the following activities:

- Increasing awareness among travellers to and residents of affected areas, as well as returning travellers;
- Increasing awareness among health professionals on:
  (i) the possibility of BDBV disease in travellers returning from affected areas;
  (ii) the clinical presentation of the disease and the need to ask about the travel history and contacts of people returning from affected areas;
  (iii) the availability of protocols for testing suspected cases;
  (iv) infection prevention and control (IPC) procedures and appropriate management of suspected or confirmed cases [23].
- Reviewing testing capacity and BDBV diagnostic procedures. The EURL-PH-ERZV offers diagnostic services to EU/EEA countries lacking capability to diagnose BDBV infection [24].
- Readiness to rapidly detect imported cases, promptly isolate them, and implement appropriate infection prevention and control measures.

Increase awareness among people living in or travelling to affected areas

People from the EU/EEA living in or travelling to affected areas should follow the recommendations of local health authorities on the prevention and control of BDBV disease and apply the following precautionary measures:

- Avoid contact with symptomatic patients, their bodily fluids, and the bodies or bodily fluids of deceased patients;
- Avoid consumption of bushmeat and avoid contact with wild animals, whether alive or dead;
- Wash and peel fruits and vegetables before consumption;
- Wash hands regularly with soap or antiseptics hand-rubs;
- Ensure safe sexual practices.

Countries can provide information to departing as well as returning travellers through posters, pamphlets, or other means of communication, outlining the above advice as well as information on how to access healthcare in case they develop symptoms.

Screening of travellers

Exit screening in affected countries, including symptom checks and exposure assessment, is crucial as it contributes to risk reduction by identifying symptomatic travellers before boarding and preventing travel while symptomatic [25-27]. Exit screening also helps dissuade ill people from travelling and enhance public and stakeholder confidence. However, exit screening cannot fully prevent exportation of cases, because absence of symptoms at departure does not exclude subsequent onset of disease [28,29].

For now, ECDC does not recommend introducing entry screening for travellers returning to EU/EA countries from affected areas. The currently available evidence indicates that this is not an effective measure to prevent the introduction of BDBV into the EU/EEA, because travellers with infections may be in the incubation period and therefore asymptomatic at the time of screening [25,29]. If exit screening is being conducted effectively, the added value of entry screening is likely to be very small, and the resource implications considerable.

Evidence from previous Ebola disease outbreaks indicates that travel restrictions have limited public health value and can adversely affect response operations and supply chains in affected countries. During the 2013–2016 Ebola virus outbreak in West Africa, very few travel-associated cases were reported in Europe [30-32]. As a result, ECDC does not currently recommend introducing travel restrictions in Europe.

Priority should instead be given to providing travellers with clear information on symptoms, routes of transmission, and what to do if symptoms develop after arrival in the EU/EEA. Travellers, including healthcare and humanitarian workers, returning from affected areas should undergo an individual exposure assessment as soon as possible upon arrival. Depending on the level of exposure, additional measures, including self-monitoring, may be considered [33]. Travellers who develop symptoms compatible with BDBV infection within 21 days after return should self-isolate, seek medical care promptly, and report their travel history and possible exposures. If a traveller develops compatible symptoms during a commercial flight, the person should be assessed upon arrival and managed appropriately. If BDBV infection is confirmed, contact tracing of relevant co-passengers should be initiated in accordance with RAGIDA guidance [34].

Case management and treatment

There are currently no specific treatments available for BDBV disease. Monoclonal antibodies (mAbs) developed against EBOV (*Orthoebolavirus zairense*) are not expected to be protective against BDBV. Studies are ongoing on the development of mAbs combinations for broader protection against filovirus infections; however, such products are not yet available. A primate model study indicated some effectiveness of antivirals (e.g. obeldesivir) for postexposure prophylaxis and treatment of filovirus infections [35]. Therefore, the treatment of patients with BDBV disease is symptomatic and supportive therapy under careful use of infection control precautions and the application of strict barrier nursing procedures.

There are no licensed vaccines available against BDBV. No scientific evidence is available whether vaccination against EBOV would provide cross-protection against BDBV.

Infection prevention and control in healthcare facilities

Minimising exposure in healthcare settings requires ensuring the availability of procedures for the early identification, isolation, referral, safe diagnostic testing, and safe transfer of suspected, probable and confirmed cases to designated facilities, as well as the safe transfer and minimisation of moving the patient within the facility, in line with the hierarchy of control measures [36].

Patients with confirmed BDBV disease should be placed in single-bed isolation rooms with anteroom and ensuite bathroom, ideally in a high-level isolation unit (HLIU) or similar designated facility with established procedures and trained staff for the management of patients with high-consequence infectious diseases, considering availability, feasibility and safety of transfer. Although filoviruses are not considered to be transmitted through inhalation, placement in an isolation room with negative pressure is recommended, as aerosol-generating procedures are likely.

Healthcare workers providing care to suspected, probable or confirmed cases of BDBV disease, as well as staff engaged in environmental cleaning, should wear appropriate PPE, as specified by WHO [23].

Standard hospital disinfectants with activity against viruses, including sodium hypochlorite (chlorine) 0.5% are effective for routine disinfection of surfaces in patient rooms. Clinical waste from patients with BDBV disease should be handled as category A infectious waste.

The duration of transmission-based precautions for hospitalised patients with confirmed BDBV disease should be decided considering the clinical resolution or improvement of symptoms and evidence from nucleic acid amplification test (e.g. rRT-PCR in blood).

The remains of deceased patients should be sealed in a double impermeable, puncture-resistant body bag before removal from the isolation room, and the external surface of the bag should be disinfected. Staff handling the body should wear appropriate PPE.

Diagnostics and biosafety considerations

The recommended sample type for testing BDBV is whole blood or plasma for living patients, and oral swab for deceased individuals. Laboratory confirmation of *Orthoebolavirus* infections and further species identification should be done using nucleic acid amplification testing (NAAT). Ensure that the assays used can detect BDBV. Should a pan-ebolavirus PCR be used, results should be confirmed by sequencing and/or reference testing at a laboratory with a BDBV-specific assay.

If a suspected case tests negative (living patient) and the blood was drawn less than 72 hours after symptom onset, a second test should be performed with blood drawn more than 72 hours after symptom onset.

Primers and probes of in-house assays should be verified against representative sequences from the current outbreak (e.g. see Ebola Bundibugyo - Browse | Pathoplexus).

All manipulations in laboratory settings of samples originating from suspected, probable or confirmed cases should be conducted with appropriate biosafety measures according to a risk-based approach. Each laboratory should perform their own risk assessment based on materials to be handled in combination with the procedure to be performed as safe as possible and depending on the availability of control measures, including available laboratory facilities and internal procedures in place. Inactivation and open handling of specimens from suspected patients require at least Biosafety Level 3 or, after proper risk assessment, in a Class III biosafety cabinet (i.e. glove-box).

Good microbiological practice and procedure (GMPP) must be applied, including good general behaviours and aseptic techniques, in line with WHO laboratory biosafety manual [37] and national provisions.Validated virus inactivation methods must be used before testing samples that may contain orthoebolaviruses outside biocontainment areas.

The EURL-PH-ERZV supports EU/EEA countries by providing advice on BDBV diagnostics and biosafety. Further information is available in the 'ECDC actions' section of this document.

ECDC actions

Epidemiological updates

ECDC is publishing updates as new information becomes available. These updates are available at the foot of the Ebola disease webpage: https://www.ecdc.europa.eu/en/ebola-and-marburg-fevers

EpiPulse Events

An event has been opened in EpiPulse, ECDC's platform for event-based surveillance and information sharing, to support timely exchange of information and situational awareness among EU/EEA public health authorities.

EU Reference Laboratory for Public Health (EURL-PH-ERZV)

ECDC is in close contact with the European Union Reference Laboratory for public health on emerging, rodent-borne and zoonotic viral pathogens (EURL-PH-ERZV) that offers support to the EU/EEA national reference laboratories for the diagnosis of BDBV infection through provision of diagnostic protocols and reagents for in-house methods used within the EURL, biosafety advice for handling and inactivation of samples, and also offers diagnostic services to EU/EEA countries for BDBV infection.

EU Health Task Force (EUHTF)

On 19 May 2026, ECDC deployed an expert through the EU Health Task Force to the Africa Centres for Disease Control and Prevention (Africa CDC) headquarters in Addis Ababa to support coordination and operational planning. ECDC is in discussions with the European Civil Protection and Humanitarian Aid Operations (ECHO) and the Global Outbreak Alert and Response Network (GOARN) regarding the possible deployment of additional experts as the situation evolves, for example, in infection prevention, epidemiology, surveillance, and risk communication, to support response activities in DRC and Uganda.

Updates on ECDC's website

ECDC is publishing regular updates about this outbreak on its website, as well as a Questions and Answers document for the general public, which is also being regularly updated as new information becomes available.

International collaborations

ECDC is collaborating closely with the European Commission, the Africa Centres for Disease Control and Prevention (Africa CDC), the World Health Organization (WHO), and other international partners.

Limitations

Due to uncertainties in the available epidemiological information, it is difficult to assess the full extent of the outbreak, including the number of cases and its geographical spread.

Information regarding transmission chains and affected population groups is also currently limited, partly due to the complex context of ongoing insecurity and humanitarian challenges in the affected areas.

This assessment is based on experiences from previous outbreaks, most of which involved Ebola virus or Sudan virus. While the findings are likely also applicable to BDBV, data specific to BDBV are limited.

References

1. Africa Centres for Disease Control and Prevention (Africa CDC). Africa CDC Calls Urgent Regional Coordination Meeting Following Ebola Outbreak in Ituri Province, DRC. Press release, 15 May 2026. Africa CDC; 2026. Available at: https://africacdc.org/news-item/africa-cdc-calls-for-urgent-regional-coordination-meeting-following-ebola-virus-disease-outbreak-in-ituri-province-drc
2. Africa Centres for Disease Control and Prevention (Africa CDC). YouTube - EN DIRECT : Point spécial sur l'état de l'épidémie de maladie à virus Ebola || 16 mai 2026. 2026. Available at: https://www.youtube.com/watch?v=buCvpMVM-EY
3. World Health Organization Regional Office for Africa (WHO Africa). Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support. WHO Africa: 2026. Available at: https://www.afro.who.int/countries/democratic-republic-of-congo/news/democratic-republic-congo-confirms-new-ebola-outbreak-who-scales-upsupport?country=975&name=Democratic%20Republic%20of%20Congo
4. World Health Organization (WHO). EBOLA BUNDIBUGYO VIRUS DISEASE OUTBREAK - Democratic Republic of the Congo | Uganda - Weekly External Situation Report 01, Data as of 18 May 2026 WHO; 2026. Available at: https://iris.who.int/server/api/core/bitstreams/b6e1e783-91c3-43c8-ab90-16ceaa9948f0/content
5. World Health Organization (WHO). WHO Director-General's opening remarks at the media briefing on Ebola outbreak in DRC and Uganda – 20 May 2026. Geneva: WHO; 2026. Available at: https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing-on-ebola-outbreak-in-drc-and-uganda-20-may-2026
6. United States' Centres for Disease Prevention and Control (US CDC). Transcript - Updates on CDC's Response to Ebola Outbreak in DRC and Uganda and Hantavirus Linked to M/V Hondius, 5/19/2026. US CDC; 2026. Available at: https://www.cdc.gov/media/releases/2026/transcript-updates-on-cdcs-response-to-the-ebola-outbreak-in-drc-and-uganda-and-the-hantavirus.html
7. Mbala-Kingebeni P. Initial genomes from May 2026 Bundibugyo Virus Disease Outbreak in the Democratic Republic of the Congo and Uganda, reveal a new spillover event. Virological; 2026. Available at: https://virological.org/t/initial-genomes-from-may-2026-bundibugyo-virus-disease-outbreak-in-the-democratic-republic-of-the-congo-and-uganda/1032
8. Ministère de la Santé Publique Hygiène et Prévoyance Sociale. Déclaration de la 17ème épidémie de la maladie à virus Ebola dans les zones de santé de Rwampara, Mongwalu et Bunia dans la province d'Iturie. Kinshasa: Ministère de la Santé Publique, Hygiène et Prévoyance Sociale; 2026. Available at: https://administration.sante.gouv.cd/wp-content/uploads/2026/05/Declaration-de-la-17e-Epidemie-de-la-maladie-a-virus-Ebola-dans-les-zones-de-sante-de-Rwampara-Mongwalu-et-Bunia-dans-la-province-dIturi.pdf
9. World Health Organization (WHO). Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern. Geneva: WHO; 2026. Available at: https://www.who.int/news/item/17-05-2026-epidemic-of-ebola-disease-in-the-democratic-republic-of-the-congo-and-uganda-determined-a-public-health-emergency-of-international-concern
10. Africa Centres for Disease Control and Prevention (Africa CDC). Africa CDC has declared the Bundibugyo Ebola virus outbreak in the Democratic Republic of the Congo and Uganda a Public Health Emergency of Continental Security (PHECS). X; 2026. Available at: https://x.com/AfricaCDC/status/2056482517255950339
11. World Health Organization (WHO). Ebola virus disease - Democratic Republic of the Congo. Geneva: WHO; 2025. Available at: https://www.who.int/emergencies/disease-outbreak-news/item/2025-DON580
12. Mbala-Kingebeni P, Aziza A, Di Paola N, Wiley MR, Makiala-Mandanda S, Caviness K, et al. Medical countermeasures during the 2018 Ebola virus disease outbreak in the North Kivu and Ituri Provinces of the Democratic Republic of the Congo: a rapid genomic assessment. Lancet Infect Dis. 2019 Jun;19(6):648-57. Available at: https://www.ncbi.nlm.nih.gov/pubmed/31000464
13. World Health Organization (WHO). Ebola virus disease - Democratic Republic of the Congo. Geneva: WHO; 2020. Available at: https://www.who.int/emergencies/disease-outbreak-news/item/2020-DON284
14. World Health Organization (WHO). Global Alert and Response (GAR) - Ebola outbreak in Democratic Republic of Congo. Internet Archive; 2012. Available at: https://web.archive.org/web/20120819152645/http:/www.who.int/csr/don/2012_08_18/en/index.html
15. Government of Uganda. Uganda: Ebola outbreak press statement - 20 Dec 2007. reliefweb; 2007. Available at: https://reliefweb.int/report/uganda/uganda-ebola-outbreak-press-statement-20-dec-2007
16. Brainard J, Hooper L, Pond K, Edmunds K, Hunter PR. Risk factors for transmission of Ebola or Marburg virus disease: a systematic review and meta-analysis. Int J Epidemiol. 2016 Feb;45(1):102-16. Available at: https://www.ncbi.nlm.nih.gov/pubmed/26589246
17. World Health Organization (WHO). Ebola disease. Geneva: WHO; 2025. Available at: https://www.who.int/news-room/fact-sheets/detail/ebola-disease

18. Van Kerkhove MD, Bento AI, Mills HL, Ferguson NM, Donnelly CA. A review of epidemiological parameters from Ebola outbreaks to inform early public health decision-making. Sci Data. 2015;2:150019. Available at: https://www.ncbi.nlm.nih.gov/pubmed/26029377
19. European Medicines Agency (EMA). Ervebo - Ebola Zaire vaccine (rVSVΔG-ZEBOV-GP, live). Amsterdam: EMA; 2026. Available at: https://www.ema.europa.eu/en/medicines/human/EPAR/ervebo
20. Den Boon S, Marston BJ, Nyenswah TG, Jambai A, Barry M, Keita S, et al. Ebola Virus Infection Associated with Transmission from Survivors. Emerg Infect Dis. 2019 Feb;25(2):249-55. Available at: https://www.ncbi.nlm.nih.gov/pubmed/30500321
21. Diallo B, Sissoko D, Loman NJ, Bah HA, Bah H, Worrell MC, et al. Resurgence of Ebola Virus Disease in Guinea Linked to a Survivor With Virus Persistence in Seminal Fluid for More Than 500 Days. Clin Infect Dis. 2016 Nov 15;63(10):1353-6. Available at: https://www.ncbi.nlm.nih.gov/pubmed/27585800
22. European Centre for Disease Prevention and Control (ECDC). Annual Epidemiological Report for 2016 - Ebola and Marburg fevers. Stockholm: ECDC, 2016 December 2018. Available at: https://www.ecdc.europa.eu/en/publications-data/ebola-and-marburg-fevers-annual-epidemiological-report-2016
23. World Health Organization (WHO). Infection prevention and control guideline for Ebola and Marburg diseases. Geneva: WHO; 2026. Available at: https://www.who.int/publications/i/item/9789240111332
24. European Commission. EU Reference Laboratories for public health. European Commission; 2026. Available at: https://health.ec.europa.eu/health-security-and-infectious-diseases/surveillance-and-early-warning/eu-reference-laboratories-public-health_en
25. European Centre for Disease Prevention and Control (ECDC). Infection prevention and control measures for Ebola virus disease: Entry and exit screening measures. 13 October 2014. Stockholm: ECDC; 2014. Available at: https://www.ecdc.europa.eu/en/publications-data/infection-prevention-and-control-measures-ebola-virus-disease-entry-and-exit
26. World Health Organization (WHO). Exit screening at airports, ports and land crossings: Interim guidance for Ebola virus disease. 6 November 2014. Geneva: WHO, 2014. Available at: https://www.who.int/publications/i/item/WHO-EVD-Guidance-PoE-14.2
27. Mouchtouri VA, Christoforidou EP, An der Heiden M, Menel Lemos C, Fanos M, Rexroth U, et al. Exit and Entry Screening Practices for Infectious Diseases among Travelers at Points of Entry: Looking for Evidence on Public Health Impact. Int J Environ Res Public Health. 2019 Nov 21;16(23) Available at: https://www.ncbi.nlm.nih.gov/pubmed/31766548
28. Wickramage K. Airport Entry and Exit Screening during the Ebola Virus Disease Outbreak in Sierra Leone, 2014 to 2016. Biomed Res Int. 2019;2019:3832790. Available at: https://www.ncbi.nlm.nih.gov/pubmed/31915689
29. Boddington NL, Steinberger S, Pebody RG. Screening at ports of entry for Ebola Virus Disease in England-a descriptive analysis of screening assessment data, 2014-2015. J Public Health (Oxf). 2022 Jun 27;44(2):370-7. Available at: https://www.ncbi.nlm.nih.gov/pubmed/33348353
30. World Health Organization (WHO). 2014 - United Kingdom of Great Britain and Northern Ireland. Geneva: WHO; 2014. Available at: https://www.who.int/emergencies/disease-outbreak-news/item/30-december-2014-ebola-en
31. European Centre for Disease Prevention and Control (ECDC). Italy confirms case of Ebola Virus Disease (EVD) in healthcare worker. Stockholm: ECDC; 2015. Available at: https://www.ecdc.europa.eu/en/news-events/italy-confirms-case-ebola-virus-disease-evd-healthcare-worker
32. Crook P, Smith-Palmer A, Maguire H, McCarthy N, Kirkbride H, Court B, et al. Lack of Secondary Transmission of Ebola Virus from Healthcare Worker to 238 Contacts, United Kingdom, December 2014. Emerg Infect Dis. 2017 Dec;23(12):2081-4. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29148368
33. European Centre for Disease Prevention and Control (ECDC). Infection prevention and control measures for Ebola virus disease. Management of healthcare workers returning from Ebola-affected areas. 22 January 2015. Stockholm: ECDC, 2015. Available at: https://www.ecdc.europa.eu/en/publications-data/infection-prevention-and-control-measures-ebola-virus-disease-management
34. European Centre for Disease Prevention and Control (ECDC). Risk assessment guidelines for diseases transmitted on aircraft (RAGIDA). 16 June 2009. Stockholm: ECDC, 2009. Available at: https://www.ecdc.europa.eu/en/publications-data/risk-assessment-guidelines-infectious-diseases-transmitted-aircraft
35. Cross RW, Woolsey C, Chu VC, Babusis D, Bannister R, Vermillion MS, et al. Oral administration of obeldesivir protects nonhuman primates against Sudan ebolavirus. Science. 2024 Mar 15;383(6688):eadk6176. Available at: https://www.ncbi.nlm.nih.gov/pubmed/38484056
36. European Centre for Disease Prevention and Control (ECDC). Health emergency preparedness for imported cases of high-consequence infectious diseases. 22 Ocotber 2019. Stockholm: ECDC, 2019. Available at: https://www.ecdc.europa.eu/en/publications-data/health-emergency-preparedness-imported-cases-high-consequence-infectious-diseases
37. World Health Organization (WHO). Laboratory Biosafety Manual - Fourth Edition. 21 December 2020. Geneva: WHO, 2020. Available at: https://www.who.int/publications/i/item/9789240011311