Bundibugyo virus disease, Democratic Republic of the Congo (with exportation to the Republic of Uganda)

Date and version of current assessment: 22 May 2026, v2
Date(s) and version(s) of previous assessment(s): 15 May 2026, V1

Overall risk and confidence [1]

Overall risk		
National	**Regional**	**Global**
Very High	**High**	**Low**

Confidence in available information		
National	**Regional**	**Global**
Moderate	Moderate	Moderate

Risk statement

Given the evolving epidemiological situation of the current Ebola disease outbreak caused by Bundibugyo virus (BDBV) in the Democratic Republic of the Congo (DRC) with exportation to Uganda, the initial rapid risk assessment(RRA) on 15 May 2026 has been updated to incorporate newly available information, including recent epidemiological developments, cross-border implications, the declaration of the event as a Public Health Emergency of International Concern (PHEIC) by the WHO Director-General, and ongoing response activities.

On 5 May 2026, the WHO Country Office in the DRC detected social media reports of an unusual cluster of severe illness and deaths in the Mongbwalu health zone, a rural gold-mining area in Ituri Province in northeastern DRC, close to the borders with South Sudan and Uganda. The affected area is characterised by high population mobility, insecurity, and intense cross-border connectivity with neighbouring countries.

Clinical presentation among suspected cases included fever, headache, vomiting, profound weakness, and haemorrhagic manifestations, raising concern for a viral haemorrhagic fever. Retrospective investigation by a field team at the provincial level covering 15 April through 13 May 2026 identified 246 suspected cases and 65 deaths (Case Fatality Rate (CFR) 26.4%) from three health zones (Mongbwalu, Rwampara, and Bunia), including a family cluster of 15 deaths within a two-week window.

The presumed first case of the disease is a nurse of unknown age, who died at the local hospital in Bunia health zone on 24 April, where eight attending healthcare workers at the hospital also developed compatible symptoms. Twenty samples were collected, representing 12 patients who had travelled from Mongbwalu health zone to Rwampara health zone and the eight healthcare workers who developed symptoms were sent to the Institut National de Recherche Biomédicale (INRB) in Kinshasa for testing.

On 14 May 2026, WHO was notified by national authorities at the Centre d'Opération des Urgences en Santé Publique (COUSP) of 8 laboratory-confirmed cases of an Orthoebolavirus among the 20 samples tested. Further laboratory testing including genomic sequencing confirmed Bundibugyo virus.

On 15 May 2026, the Ministry of Health of Uganda reported one imported laboratory-confirmed case of a Bundibugyo virus disease (BVD) in Kampala. The patient was an elderly male from DRC who travelled to Uganda to seek care at a hospital in Kampala on 11 May and died on 14 May 2026. The body was repatriated to DRC on the same day. This event confirms the cross-border movement of a symptomatic case and exposure within an urban healthcare setting in Uganda.

Genetic sequencing results by INRB released on 15 May came back positive for Bundibugyo virus (BDBV). On the same day, both DRC and Uganda officially declared Ebola outbreaks in their respective countries.

On 19 May 2026, a suspected viral haemorrhagic fever alert was reported from Miti-Murhesa health zone in South Kivu Province following the death of a man aged between 25 to 30 years at a local hospital. Investigations were initiated to determine whether the event was linked to the ongoing BVD outbreak. The case was subsequently confirmed positive for BVD.

As of 21 May 2026 (the data used for this rapid risk assessment), the outbreak in DRC had expanded to 16 affected health zones, including 12 in Ituri Province, three in North Kivu Province, and Miti-Murhesa health zone in South Kivu Province. In total, 661 suspected cases and 160 suspected deaths (CFR 24.2%) have been reported, including 63

[1] Confidence refers to the level of confidence in the data/information or the quality of the evidence available at the time the RRA is conducted. Poor quality information may increase the overall perceived risk due to the incertitude in the assessment.

confirmed cases and four confirmed deaths associated with BVD. Uganda had cumulatively reported two confirmed cases of which one had died.

This is the 17th Ebola disease (EBOD) outbreak reported in DRC since 1976, and the second outbreak caused by BVD in the country.

Prior to this current outbreak, two BVD outbreaks had been documented: the first in Uganda during 2007–2008 and the second in DRC in 2012. Together, these outbreaks resulted in more than 200 confirmed and probable cases and approximately 66 deaths (CFR 33%).

The risk at **the national level (DRC),** which was assessed as high on 15 May 2026, is now on 22 May 2026 assessed as **very high** due to substantial changes in the epidemiological situation. Key factors informing this reassessment include:

- Outbreak caused by BVD for which no licensed vaccine or specific therapeutics are currently available for prevention and treatment. Early intensive supportive care remains the only current treatment option, along with packages of public health interventions, as done in previous outbreaks.
- On 15 May, confirmed and suspected cases were reported from both Mongbwalu and Rwampara health zones, with suspected cases also identified in Bunia and alerts from Beni and Butembo health zones in North Kivu Province, indicating early signs of geographic spread beyond the initially affected areas.
- By 21 May 2026, the outbreak had expanded rapidly from a limited number of affected health zones to 16 health zones across three provinces. Confirmed and suspected cases had been reported in 12 health zones in Ituri Province (Aungba, Bambu, Bunia, Fataki, Komanda, Logo, Lolwa, Mangala, Mongbwalu, Nizi, Nyankunde, and Rwampara), three health zones in North Kivu Province (Butembo, Goma, and Katwa) and one in South Kivu in Miti-Murhesa Health Zone. This rapid geographic expansion over a short period, combined with intense population mobility and cross-border connectivity, indicates a very high risk of further spread within DRC.
- As of 21 May, high mortality has been reported with an overall CFR of 24.2% (160/661), among suspected cases and 6.3% (4/63) among confirmed case. The current CFR is an underestimation of the actual situation as investigations are still ongoing to identify and re-classify all suspected deaths.
- The rapid increase in cases and deaths within a short period, combined with the spread across multiple health zones and cross-border transmission, is highly concerning.
- Reports of numerous community deaths and the absence of documented safe and dignified burial practices may have facilitated continued community transmission through exposure during funerals and handling of bodies.
- Healthcare worker infections and low infection prevention and control (IPC) scorecard performance in the area indicate a high risk of exposure in healthcare settings and significant gaps in IPC.
- Delays in verification of initial signal by authorities and retrospective identification of cases and deaths suggest prolonged circulation before confirmation.
- Epidemiological links and the full chain of transmission are not yet clearly established, and the source of the outbreak remains under investigation.
- The affected provinces of Ituri and North Kivu are highly insecure, with intensified fighting in recent months, causing more than 100 000 people to be newly displaced.
- The affected area is also characterized by intense population mobility linked to mining activities, trade, and movement between rural and urban centres.
- Bunia serves as a major referral, transport, and commercial hub, increasing the risk of spread to other provinces.
- Ongoing conflict in Ituri and North Kivu provinces restricts the movement of surveillance teams, limits the deployment of Rapid Response Teams, and hinders the secure transport of laboratory samples, as well as challenges in contact tracing, safe and dignified burials and control of population movement of high-risk contacts in those conflict zones.
- Significant distrust of health and external authorities among the local population.
- Limited healthcare infrastructure and inadequate isolation capacity may facilitate continued transmission in DRC.

The level of risk at the **regional level (including Uganda)** is still assessed as **High** due to:

- Confirmed cross-border spread through imported cases to Uganda.

- As of 20 May, Uganda has cumulatively reported 2 confirmed cases, both were imported cases who came to Uganda to seek medical care. One case died following admission to the local Hospital, and the second case is currently receiving care at the Ebola isolation unit at a Referral hospital.
- Frequent movement across porous borders between Ituri (DRC), Uganda, and South Sudan.
- Ongoing epidemiological links along the eastern DRC–western Uganda corridor, historically affected by Ebola outbreaks, including Bundibugyo and Sudan virus disease outbreaks.
- While not directly bordering Ituri province, Rwanda and Burundi share borders with Eastern DRC and have experienced recent cross-border disease transmission (i.e., mpox), further intensified by ongoing conflict and displacement.
- High mobility linked to mining, trade, and displacement.
- Potential for undetected chains of transmission in border communities.
- Potential for continued spillover to Kampala, Uganda – a densely populated urban hub or other cities with close transport links

The level of risk at the **global level** is assessed as **low** due to:

- As of 21 May 2026, the outbreak remained geographically limited to DRC with exportation of cases to Uganda at present.

Risk questions

Risk question		Assessment		Risk	Rationale
		Likelihood	Consequences		
Potential risk for human health?	National	Highly likely	Major	Very high	The risk to human health is considered very high due to the severe clinical presentation and high case fatality associated with BVD, combined with evidence of prolonged undetected transmission in both community and healthcare settings. A retrospective investigation between 25 April and 13 May 2026, identified 246 suspected cases and 65 deaths in Ituri Province, including family clusters and healthcare associated transmission, indicating sustained circulation prior to outbreak detection. The confirmation of two exported cases in neighboring Uganda, further demonstrates cross-border spread. The outbreak has since shown rapid epidemiological escalation, with suspected cases increasing from 246 to 661 and suspected deaths from 65 to 160 between 13 and 21 May 2026. Concurrently, 63 laboratory-confirmed cases and four confirmed deaths were reported, alongside expanding geographic distribution across multiple health zones in 3 Provinces in DRC and confirmed cases in Uganda exported from DRC. These factors indicate ongoing transmission with a high likelihood of further spread and additional severe outcomes. Infections and deaths among at least four healthcare workers indicate transmission in healthcare settings and inadequate IPC measures. The identification of Bundibugyo virus is of particular concern because no licensed vaccine or specific therapeutics are available for this virus. Delayed outbreak verification, movement of symptomatic patients between health zones, and
	Regional	Likely	Moderate	High	
	Global	Unlikely	Minor	Low	

					the absence of documented dignified and safe burial practices likely facilitated transmission within communities and healthcare settings. These factors indicate a risk that is very high nationally and high regionally, while globally, the risk for human health is low.
Risk of event spreading?	National	Highly likely	Major	Very high	The risk of further spread of this event at the national level is considered very high due to the rapid geographic expansion and increasing number of affected health zones within a short period. While retrospective investigations covering 15 April through 13 May 2026 identified 246 suspected cases and 65 deaths (CFR 26.4%) across three health zones in Ituri Province (Mongbwalu, Rwampara, and Bunia), as of 21 May 2026 suspected and confirmed cases have been reported from 16 health zones, including 12 in Ituri Province and three in North Kivu Province and one in South Kivu. Laboratory-confirmed cases are now reported from nine health zones in DRC, including six in Ituri, three in North Kivu and one in South Kivu. In addition, Uganda has reported two laboratory-confirmed cases in Kampala, further confirming cross-border transmission and increasing the risk of regional spread. Population movement between mining areas, rural communities, and urban centres is frequent, and Bunia serves as a major transport, referral, and commercial hub connected to other provinces and neighbouring countries. The affected area is located near active cross-border movement corridors linking DRC with Uganda and South Sudan. Population movement associated with trade, mining activities, and displacement increases the risk of cross-border spread, including to other countries bordering Eastern DRC, particularly if transmission remains undetected in border communities. Confirmed importation of two cases into Uganda demonstrates active cross-border transmission already occurring. Exit screening needs to be fully implemented at all PoEs. It remains unclear whether these measures are consistently applied. In addition, despite the Martyr's Day pilgrimage in Kampala, Uganda (due to be celebrated on 3 June and attracts 3 to 5 million pilgrims from all over the country and several countries in Africa) has been officially postponed by the Ugandan authorities, there remains a risk that some individuals may continue to travel to Kampala. Such large-scale population movement and congregation could facilitate further transmission of BVD and place additional pressure on healthcare and public health response capacities. Epidemiological links and the full chain of transmission are not yet clearly established, and
	Regional	Likely	Moderate	High	
	Global	Unlikely	Minimal	Low	

					the source of the outbreak remains under investigation. Therefore, the risk of regional spread is high, while the risk of global spread is low.
Risk of insufficient control capacities with available resources	National	Likely	Major	High	DRC has previous experience managing Ebola disease outbreaks and national authorities have already initiated response activities. However, the outbreak is occurring in a context of insecurity, difficult access, and limited healthcare infrastructure in parts of Ituri Province. Historical patterns from 2018-2020 North Kivu-Ituri Ebola virus disease outbreak showed significant attacks on ETCs and violence towards outbreak response teams which complicates operational presence. Healthcare worker infections indicate critical gaps in IPC implementation and healthcare capacity with risk of further healthcare worker infections. In addition, the identification of BDBV further complicates response efforts because currently available Ebola virus vaccines and therapeutics are not effective for use against other viral species. Logistical challenges related to access, surveillance, laboratory confirmation, safe and dignified burials, and contact tracing may affect the progress of response operations. The healthcare system faces several major challenges: responding to other recurrent epidemics such as malaria, cholera, mpox, a shortage of trained healthcare workers, limited laboratory capacity, security issues, and attacks by armed groups. Neighbouring countries have strengthened Ebola disease preparedness and surveillance capacities following previous outbreaks in the region. While surveillance and response gaps may persist in some remote border areas with high population mobility, the risk at the regional and global levels remains low.
	Regional	Unlikely	Minor	Low	
	Global	Unlikely	Minimal	Low	

Major actions recommended by the risk assessment team

	Action
☒	Refer the event for review by IHR Emergency Committee for consideration as a PHEIC by DG (Art 12, IHR)
☒	Immediate activation of ERF response mechanism (IMS) as urgent public health response is required
☒	Recommend setting up of grading call (funding can be accessed before grading completed)
☐	Immediate support to response, but within limit of CFE (no grading recommended at this point in time)
☒	Rapidly seek further information and repeat RRA (including field risk assessment)
☒	Support Member State to undertake preparedness measures
☒	Continue to closely monitor
☐	No further risk assessment required for this event, return to routine activities

Immediate actions

- Continue surge deployment of multidisciplinary support teams to Mongbwalu, Rwampara, Bunia and other affected health zones in Ituri, North Kivu and South Kivu
- Establish and scale-up RCCE with affected and at-risk communities, including engagement of local leaders, IDP communities and cross-border populations.

- Initiate and maintain comprehensive epidemiological investigation (including support of genomic sequencing where needed) to clarify chains of transmission, identify origin of outbreak. and guide timely interventions
- Implement robust contact identification, exhaustive contact listing and consistent follow-up in all affected areas
- Reinforce IPC standards and triage in health facilities in affected and high-risk zones, including isolation capacities, safe and dignified burials, and PPE for health workers, in addition to promotion of basic IPC practices at the community level
- Strengthen surveillance and alert management, including community-based surveillance with emphasis on border communities and screening at land borders alongside all other PoEs. This is especially important for neighboring countries not yet affected but at high risk for importation. Enhance digitization of alerts, case line listing, contact listing/tracing, laboratory to support timely data flows for decision making by response teams
- Support rapid establishment and/or scaling of Ebola treatment units and isolation facilities in priority locations, ensuring referral pathways and safe transport
- Preposition and distribute essential supplies (PPE, sample collection materials, reagents, essential medicines, WASH kits, safe-burial kits) to strategic locations and frontline facilities
- Expand access to BVD diagnostic testing by decentralizing and strengthening filovirus RT-PCR capacity, ensuring adequate and sustained supply of compatible reagents and consumables, functional sample transport, and timely reporting from national and sub-national laboratories.

Supporting information

Hazard assessment

Bundibugyo virus disease is a severe viral disease caused by several virus species within the genus *Orthoebolavirus* (family *Filoviridae*). To date, six species within the *Orthoebolavirus* genus have been identified, three of which, Ebola virus, Sudan virus, and Bundibugyo virus, have been responsible for most large Ebola outbreaks in Africa. The current outbreak has been confirmed as caused by the Bundibugyo virus, and it is the third occurrence reported globally.

The first known outbreak caused by Bundibugyo virus (BDBV) occurred in Bundibugyo District in western Uganda in 2007 and the second one was in DRC in 2012. During previous BVD outbreaks the case fatality rates were between 30%-50% BVD has a zoonotic origin, different species of bats are considered the most likely natural hosts of orthoebolaviruses. Non-human primates such as monkeys, gorillas and chimpanzees (and more rarely other wildlife) may develop severe disease and die following infection. The exact animal reservoir for BDBV has not been conclusively identified. The virus is transmitted to humans through close contact with the infected blood or body fluids of infected wildlife and then spreads through human-to-human transmission via contact with bodily fluids or contaminated items or surfaces. Traditional burial practices involving direct contact with the body of a deceased person can also spread infection. The incubation period varies from 2 to 21 days. Symptoms can appear suddenly and include fever, fatigue, muscle aches, headache, and sore throat. These are followed by vomiting, diarrhoea, a rash, symptoms of kidney and liver failure, and only in some cases, internal and external bleeding (e.g., bleeding gums, blood in the stool).
Confirmation of BVD requires specialized laboratory testing, usually performed after the onset of compatible clinical symptoms. Diagnostic approaches include primarily reverse transcription polymerase chain reaction (RT-PCR) assays to detect viral RNA.
Treatment for BVD is mainly supportive. Early access to medical care improves the chances of survival. Currently, no monoclonal antibody treatments have been specifically approved for the treatment of BVD and there is no licensed vaccine for prevention of BVD.

Effective outbreak control relies on the application of a set of interventions, namely clinical case management including rapid access to care, IPC and WASH, surveillance and contact tracing, good laboratory service, safe and dignified burials, community engagement, and social mobilization.

It also requires ensuring that suspected, probable, and confirmed cases and their contacts do not undertake travel, except as part of an authorized medical evacuation, alongside the implementation of exit screening, and preventing the cross-border movement of the human remains of deceased suspected, probable or confirmed BVD cases.

Exposure assessment

On 5 May 2026, WHO Country Office in DRC detected social media reports of an unusual cluster of severe illness and deaths in Mongbwalu Health Zone (MHZ), a rural gold-mining area in Ituri Province, in northeastern Democratic Republic of the Congo (DRC), close to the border with South Sudan and Uganda. The affected area is characterised by high population mobility, insecurity, and intense cross-border connectivity with neighbouring countries. Clinical presentation among suspected cases included fever, headache, vomiting, profound weakness, and haemorrhagic manifestations, raising concern for a viral haemorrhagic fever. Retrospective investigation by the field team at the provincial level, covering 15 April through 13 May 2026, identified 246 suspected cases and 65 deaths (CFR 26.4%) from three health zones (Mongbwalu, Rwampara, and Bunia) in Ituri province, including a family cluster of 15 deaths within a two-week window. After patients from MMHZ sought care at the local hospital in late April (exact date not specified), eight attending healthcare workers at the hospital developed compatible symptoms between 25 April and 2 May.

Twenty samples were collected from 12 patients who had travelled from MHZ to Rwampara, as well as from eight health care workers who subsequently developed symptoms. Following initial testing at the Bunia Public Health Laboratory using GeneXpert, which was negative for Ebola virus, the samples were referred to the Institut National de Recherche Biomédicale (INRB) in Kinshasa for further analysis. Additional testing for other priority pathogens, including mpox, dengue, cholera, malaria, plague, COVID-19, and rotavirus, was also negative.

On 14 May 2026, WHO was notified by national authorities through the Centre d'Opération des Urgences en Santé Publique (COUSP) that 8 of the 20 samples tested were laboratory-confirmed for an Ebola disease caused by an orthoebolavirus that was not Ebola virus.

Genetic sequencing results released on 15 May identified Bundibugyo virus (BDBV) as the causative agent. Suspected cases have been reported in Mongbwalu, Rwampara, and Bunia health zones with alerts detected in Beni and Butembo health zones in North Kivu Province. As of 20 May, 1261 contacts have been identified for follow-up. Contact tracing activities in DRC faced significant operational challenges due to insecurity and population movement restrictions in the affected areas.

On 15 May 2026, the Ministry of Health of Uganda reported one imported laboratory-confirmed case of Ebola disease caused by Bundibugyo virus in Kampala, involving an elderly male from DRC who sought care at a local hospital on 11 May and died on 14 May 2026. The body was repatriated to DRC on the same day, prior to laboratory confirmation. This event confirms cross-border movement of a symptomatic case and exposure within an urban healthcare setting in Uganda. Screening, surveillance, and response measures have been activated at points of entry (PoE) and in high-risk districts bordering DRC. This event indicates an ongoing risk of cross-border transmission and exportation of cases from Ituri Province to neighboring countries. One high- risk contact has been isolated, and an additional unspecified number of contacts were placed under quarantine.

Genetic sequencing results released on 15 May established Bundibugyo virus (BDBV) as the causative agent. On the same day, both DRC and Uganda officially declared Ebola outbreaks in their respective countries.

On 18 May 2026, the US CDC confirmed that a US physician infected with Bundibugyo virus disease while providing clinical care in Ituri Province, was evacuated to Germany for treatment. He tested positive on 17 May.

On 19 May 2026, a suspected viral haemorrhagic fever alert was reported from Miti-Murhesa health zone in South Kivu Province following the death of a man aged between 25 and 30 years old at a local hospital. The patient, with frequent travel to Ituri and Tshopo, developed progressive symptoms beginning on 20 April, including fever, headache, cough, abdominal and chest pain, followed by bloody vomiting and diarrhea.

He sought care at multiple facilities without improvement and died on 19 May. A post mortem swab sample was collected and was subsequently laboratory confirmed, and an epidemiological investigation was undertaken.

On 20 May, a US physician in DRC, reportedly exposed while in DRC, is being transferred to a specialized infectious disease hospital in Prague, Czech Republic, for precautionary monitoring and isolation. The physician is reportedly asymptomatic, and authorities stated that the transfer is being conducted under strict biosecurity procedures, including transport in an isolation unit and a planned three-week observation period.

As of 20 May 2026 in Uganda, the case count remained at two laboratory-confirmed cases, including one death (CFR 50%). Contact tracing identified 126 contacts in total, comprising 41 linked to case 1 and 83 linked to case 2, and two contacts who attended a burial in DRC. Approximately 73% of contacts are healthcare workers. The contact follow-up rate reached 90.9%. No epidemiological links or shared contacts have been identified between the two cases.

As of 21 May 2026, the outbreak in the Democratic Republic of the Congo had expanded to 16 affected health zones, including 12 in Ituri Province, three in North Kivu Province, and Miti-Murhesa Health Zone in South Kivu Province, where confirmed cases have been reported. In total, 661 suspected cases and 160 suspected deaths (CFR 24.2%) had been reported, including 63 laboratory-confirmed cases and four confirmed deaths associated with Bundibugyo virus disease (BVD). Uganda had cumulatively reported two confirmed cases, with one confirmed death in Kampala.

Geographically, confirmed and suspected transmission had been documented across 12 health zones in Ituri, including Aungba, Bambu, Bunia, Fataki, Logo, Lolwa, Komanda, Mangala, Mongbwalu, Nizi, Nyankunde, Rwampara and Butembo, Goma, Katwa in North Kivu Province and Miti-Murhesa Health Zone in South Kivu Province. This multi–health zone involvement, together with alerts on suspected cases from Beni and Butembo, indicates widespread transmission across linked surveillance and reporting areas. In Uganda, the cases were registered in Kampala at two separate health facilities where they each sought care.

Contact tracing is ongoing despite operational challenges due to insecurity, population movement, and access constraints in the affected areas. As of 20 May 2026, 1 260 contacts have been identified for follow-up.

Overall, the combination of rapid geographic expansion, sustained community and healthcare-associated transmission, high population density in affected regions, intense mobility between affected areas, and documented cross-border spread indicates a very high risk of further dissemination within the DRC and into neighbouring countries. However, the implementation of enhanced surveillance and screening measures at points of entry (PoE) between the DRC and Uganda, and other neighboring countries, points of control along major routes connecting affected areas, health zones, and provinces, together with ongoing contact tracing and response activities, may reduce the likelihood of widespread uncontrolled regional transmission. Consequently, the regional risk remains high.

At the global level, the risk is currently considered low due to the absence of evidence of sustained international transmission beyond the affected region and the availability of established international surveillance and response mechanisms.

The source of exposure, the full chain of transmission, epidemiological links between cases, and the extent of community transmission remain under investigation. The affected areas include active gold-mining zones and cave ecosystems known to harbour large bat populations, including roosts within mining concessions and abandoned mineshafts. Frequent human interaction with these environments may increase opportunities for zoonotic exposure and filovirus spillover.

Delays in outbreak detection and verification, and a high number of community deaths, may have facilitated ongoing transmission before implementation of control measures.

Context assessment

The outbreak is occurring in Ituri Province in northeastern DRC, an area historically affected by recurrent Ebola outbreaks and located within an Ebola ecological corridor extending into western Uganda. Previous circulation of Bundibugyo virus in eastern DRC, together with recurrent Sudan virus disease outbreaks in Uganda, highlights the potential for circulation of orthoebolavirus species in the region.

The initially affected health zones of Mongbwalu, Rwampara, and Bunia are situated in a highly connected cross-border area near Uganda and South Sudan, characterized by substantial population movement related to mining activities, informal trade, population displacement, and routine cross-border travel. Bunia serves as a major referral, transport, and commercial hub with connections to neighboring provinces and countries, thereby increasing the likelihood of further regional dissemination if transmission is not rapidly contained. More than 5 million internally displaced people are concentrated in North Kivu, South Kivu, and Ituri, with 96% displaced due to armed violence. Specifically, in the Ituri province, intense fighting between non-state armed groups and

government forces has escalated, leaving nearly 1 million people internally displaced. In the first quarter of 2026, more than 100 000 people were newly displaced in Ituri.

The confirmation of two imported cases in Kampala, unlinked to each other, highlights the strong connectivity between Ituri Province and major urban centres in neighbouring countries, reinforcing the risk associated with formal and informal population movement across porous borders. As Kampala is a major regional transport and transit hub, undetected transmission or delayed case identification could facilitate further national and international spread. The environmental and humanitarian context further amplifies transmission risk. The outbreak occurs in densely populated settings with inadequate water, sanitation, and hygiene infrastructure, including internally displaced persons (IDP) camps and informal settlements, where overcrowding and limited infection prevention measures complicate outbreak control.

Community deaths and traditional burial practices may increase exposure risk, particularly in settings where safe and dignified burial protocols are not consistently implemented or are met with community resistance due to mistrust, fear, stigma, or cultural sensitivities. Such resistance can delay case reporting, hinder contact tracing, and result in continued exposure of family members and community contacts to infectious bodily fluids. At the same time, weak healthcare infrastructure, limited isolation capacity, and shortages of personal protective equipment increase the risk of healthcare-associated transmission among patients and healthcare workers.

The confirmation of Bundibugyo virus presents additional operational and clinical challenges, as currently available Ebola virus vaccines and therapeutics primarily target *Orthoebolavirus zairense* and have limited applicability to this outbreak. Furthermore, Bundibugyo virus disease remains relatively poorly characterized, as this is only the third recognized outbreak globally. Limited isolation capacity, challenges in implementing safe and dignified burials, and frequent movement between rural and urban areas may further complicate response operations and facilitate ongoing transmission.

Capacities and vulnerabilities related to the chikungunya outbreak response in the affected countries

Capacities	Vulnerabilities
Leadership and coordination • Health authorities have mobilized response structures and reactivated the MVE coordination committee. **Laboratory** • DRC & Uganda have previous experience in responding to Ebola disease, though most recent outbreaks have been caused by Ebola virus or Sudan virus species. • GeneXpert exists in most districts in DRC & Uganda however this does not identify Bundibugyo ebolavirus. • In DRC decentralisation testing was conducted during Mpox, and some platforms can be diverted to Ebola response. Mapping of the effective platforms especially in the affected districts or neighbouring districts is ongoing. • Validation of the kit being used in-going but need to be fast tracked to understand kit performance and decentralization strategy. **Clinical management and IPC**	**Coordination limitations in remote or insecure areas** • Challenges of incentives of CHWs/volunteers • Inter-community conflict • Insufficient fundings allocated • Slow feedback loops and Infodemic management in remote and insecure zones • Trust remains fragile in conflict –affected areas in DRC. • Community mistrust, limited preparedness investments • Sociocultural beliefs • Lack of capacity in infodemic management-capacity building needed, including of AVOC Surge, RCCE and CHWs specialists. • Delays in sample transportation in the region **Surveillance** • Limited human resources for contact tracing • Late reporting/delayed detection & verification • Limited epidemiological information/ investigation • Need to strengthen cross border surveillance and information sharing.

- DRC & Uganda have good clinical experience on management of Ebola outbreaks with well tested clinical systems to support effective clinical response.
- The availability of training materials, treatment operational protocols and job aids support rapid expansion of capacity among HCWs. Strong presence of local clinical teams with experience from WHO Country office (WCO), Ministry of Health (MoH), clinical partners like ALIMA, MSF that can support the response.
- MSF positioned for ETC in Montgwalu health zone.
- ALIMA positioned for ETC in Rwampara.
- Samaritans Purse positioned for ETC in Bunia.

Community Protection and Resilience

- DRC & Uganda have good experience in managing Ebola responses.
- Existence of functional National RCCE and Infodemic coordination structures led by the MoHs at national and subnational levels
- Strong operational presence of partners (WHO, IFRC, UNICEF, MSF, Alima and other NGOs, etc)
- Community engagement existing platforms (CHWs, Community relays, Red Cross Volunteers, religious groups, women and youths' associations/group of pressure
- Rapid door-to-door mobilization capacity
- Strong community dialogue experience
- Experience in handling resistance during past Ebola outbreaks
- Existing community channels largely trusted (SMS campaigns, Call center, WhatsApp groups, Interpersonal communication)
- Predeveloped RCCE materials, multilingual messages and narratives in local languages
- Large infodemic management data from past outbreaks, which can inform current response.
- Social media toolkit on Ebola already available (need to be translated into local languages)
- Trained staff (AVOCSurge)
- Experience in integration of RCCE linked to CBS, Surveillance, SDB, case management, etc.

PoE, border health and mass gatherings

- Exit screening at PoEs of affected areas is being put in place and will be further scaled up.
- WHO advice has been regularly shared with travel, transport, tourism sectors to promote alignment with WHO's advice on international traffic.
- In accordance with IHR requirements, PoEs have established public health emergency contingency

Laboratory:

- Laboratory items such as testing kits/reagents, consumables, sample collection kits etc are currently limited.
- Limited Bundibugyo virus-specific lab suppliers
- Delays in issuing of laboratory results impacting timeliness of interventions (including management of suspected case and safe and dignified burials)
- Laboratory capacities in affected health zones are currently suboptimal, hampered by challenging sample transportation, inadequate level of reagents and equipment, although scale up is on-going.

Clinical management and IPC

- Lack of well-formulated screening and triage procedures in affected health zones
- Uncertain capability / capacity for management of critical illness
- Lack of dedicated facilities for patient management
- Wide geographical extent of the outbreak, which will need a rapid scale up of clinical care to support safe treatment of patients close to the community as possible.
- Threat to continuity of care secondary to HCWs infected.
- Clinical care infrastructural challenges in the area affected that will pose a huge threat to support safe and scalable care to affected population.
- Weak isolation capacity in some districts
- Risk of stigma from case transfers
- Several patients reportedly absconded from treatment centres
- Only a limited number of safe and dignified burials had been conducted.
- Multiple health workers infections reflecting limited IPC capacity.

Risk communication and community engagement

- Limited funding for community engagement
- Gaps in outreach and local language messaging
- Possibility of missing information about community perception on deaths
- Community rumours and trust misconceptions are affecting case notification and health-seeking behaviour.
- Unclear RCCE capacity and partners' possible support
- Security issues challenge engagement with the population
- Community resilience

PoE, border health and mass gatherings

- It remains unclear whether exit screening measures are consistently applied at all PoEs (land borders, air, waterways) at affected areas This

plans that can be activated during health emergencies, which is reported annually through SPAR (States Parties Self-Assessment Annual Report (SPAR)). • The government of Uganda has postponed Martyr's Day that receives pilgrims including from the DRC. This follows heightened public health concerns linked to current BVD outbreak	may create gaps to allow undetected exportation of cases and contacts. • Despite being officially postponed by Uganda authorities, the postponement of Martyr's Day mass gathering event has not been reflected on the official website. There are concerns that pilgrims may already be onsite and in transit, maintaining the potential risk of disease transmission. **Logistics** • Transport and fuel shortages for field operations • Stock-outs of essential supplies (PPE, IPC materials).

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