

Situational update on the Ebola disease outbreak caused by Bundibugyo virus, Democratic Republic of the Congo and Uganda, 11 June 2026.

Overview

On 15 May 2026, health authorities in the Democratic Republic of the Congo (DRC) and Uganda declared outbreaks of Ebola disease caused by the Bundibugyo virus, following reports of laboratory-confirmed cases in their respective countries^{1,2,3}. On 16 May 2026, the World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern (PHEIC) in accordance with the provisions of the International Health Regulations (IHR)⁴. On 18 May 2026, the Africa Centres for Disease Control and Prevention (Africa CDC) declared the outbreak a Public Health Emergency of Continental Security (PHECS)⁵. Since then, additional cases have continued to be reported.

Bundibugyo virus disease (BVD) is a severe and fatal viral zoonotic disease caused by Bundibugyo virus, one of the four *Orthoebolavirus* species known to cause disease in humans. In previous BVD outbreaks in 2007 (Uganda) and 2012 (DRC), the case fatality rate (CFR) ranged from 30 to 50%. The incubation period ranges from two to 21 days. Infected persons are considered non-infectious during the asymptomatic phase (during the incubation period); however, they become infectious from the time of symptom onset. Initially, symptoms may be non-specific, with common early symptoms including fever, headache, muscle pain, sore throat, and fatigue. The disease may progress to organ dysfunction, gastrointestinal symptoms, and haemorrhage in some cases. Differential diagnoses may include malaria and other endemic febrile illnesses¹. Since there are currently no approved or licensed vaccines or specific treatment for BVD, control measures rely on rapid case identification, isolation and care, prompt contact tracing, safe and dignified burials, and effective community engagement. However, early symptomatic treatment and supportive care are lifesaving¹.

Situation in the Democratic Republic of the Congo (DRC) and Uganda

As of 09 June 2026, 635 confirmed cases, including 127 deaths (CFR: 20%) and 119 suspected cases, were reported in the DRC. In addition, 260 patients are in hospital isolation, with 30 cumulative recoveries and 61.1% of contact follow-up rates reported. Cases have been reported in 26 out of 104 health zones in three provinces (Ituri, North Kivu, and South Kivu). Ituri accounts for the largest number of cases and deaths (600 cases, 104 deaths, CFR: 17.3%) amongst confirmed cases, followed

by North Kivu (32 cases, 22 deaths, CFR: 68.8%) and South Kivu (3 cases, 1 death, CFR: 33.3%)⁶. Though contact-tracing challenges persist, 5814 contacts have been identified, and 2847 are under follow-up and monitoring⁷.

In Uganda, as of 08 June 2026, 19 confirmed cases, including two deaths (CFR: 10.5%), have been reported from Kampala and Wakiso districts. Of the confirmed cases, 14 were imported cases, and five were secondary infections linked to the imported cases. All the cases are epidemiologically linked to the DRC outbreak. One probable case and one probable death were reported. Approximately 792 contacts were identified, of which 388 completed follow-up and symptom monitoring, and 404 remained active and are being monitored^{7,8,9,10}.

Public health response, risk assessment, and travel advice

With support from partners and the WHO, both countries have instituted various public health response measures to contain and prevent further spread. The public health response activities include, but are not limited to, the deployment of rapid response teams, strengthening of surveillance and laboratory confirmation, contact tracing, isolation and treatment of cases, and cross-border coordination between the high-risk countries. Response efforts in the eastern DRC are largely affected by insecurity, population movement, weak contact follow-up, and challenges associated with extensive mining in the areas^{1,9,10}.

The risk of spread has been assessed as very high at the national level in the DRC and as high in Uganda. The risk in the neighbouring countries that share a land border with DRC and Uganda is considered high due to high cross-border population movements, trade, and mining activities. However, the risk is low at the Africa region level, and globally¹⁰. Based on existing information, WHO does not recommend any travel or trade restrictions with the countries currently reporting BVD outbreaks⁹.

Situation in South Africa

The National Institute for Communicable Disease (NICD), in collaboration with the National Department of Health (NDOH), has issued preparedness guidance for BVD following outbreaks declared by health authorities in DRC and Uganda on 15 May 2026¹¹.

As of 11 June 2026, there have been no laboratory-confirmed cases of BVD in South Africa linked to the current outbreaks in the DRC and Uganda. However, healthcare workers should remain vigilant and maintain a high index of suspicion for individuals presenting with febrile illness and a recent travel history to affected areas in the DRC and Uganda. Additionally, malaria should be considered in the differential diagnosis of febrile illness in returning travellers.

If a suspected BVD case is identified (as per the case definition), testing should be requested via the NICD Hotline at 0800 212 552 (a 24-hour service for healthcare professionals only), with a detailed clinical, travel, and exposure history. Testing for viral haemorrhagic fevers (VHFs) in South Africa is available only at the NICD.

VHFs, including BVD, are Category 1 Notifiable Medical Conditions (NMCs) in South Africa and require immediate reporting to the relevant authorities and notification within 24 hours of clinical suspicion to the NMC surveillance system. For more information on NMCs and how to notify cases, visit the NICD website¹².

References

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