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Situational update on the Ebola disease outbreak caused by Bundibugyo virus, Democratic Republic of the Congo and Uganda, 4 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]. Since then, additional cases have continued to be reported. 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].

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 rates ranged from 30 to 50%. The incubation period ranges from two to 21 days. 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 illnesses[1]. 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 lifesaving[1].

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

As of 3 June 2026, 381 confirmed cases, including 64 deaths (CFR 16.8%, 64/381) and seven recoveries, were reported in the DRC. Cases have been reported across 25 health zones in 3 provinces (Ituri, North Kivu and South Kivu). Ituri accounts for the largest share of cases and deaths (359 cases, 50 deaths), followed by North Kivu (19 cases, 13 deaths) and South Kivu (3 cases, 1 death)[6]. About 4 010 contacts have been identified and are under monitoring, while 116 suspected cases are under investigation[7].

As of 2 June 2026, 15 confirmed cases have been reported in Uganda, including one death (CFR 6.7%, 1/15), two recoveries, and 12 hospitalisations[8]. Where geographical information was available, cases were reported in Kampala and Wakiso. About 668 contacts have been identified and are under monitoring[7].

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[1]. 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].

Current risk assessment and travel advice

The risk of spread is assessed as very high at the national level in the DRC, high at the regional level, and low globally[1]. WHO does not recommend any travel or trade restrictions with the affected countries due to these outbreaks[1].

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 2026[9].

As of 4 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 in South Africa and require immediate reporting to the relevant authorities and notification within 24 hours of clinical suspicion to the Notifiable Medical Condition surveillance system. For more information on notifiable medical conditions and how to notify cases, visit the NICD website[10].

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