

EBOLA BUNDIBUGYO VIRUS DISEASE

22 May 2026

Member State briefing

World Health Organization

Epidemiological overview - cumulative

Data as of 22 May 2026

In the **Democratic Republic of the Congo (DRC)**

745	-	82	177	07	9%	21*	04
Suspected cases	Probable cases	Confirmed cases	Suspected deaths	Confirmed deaths	Crude CFR (confirmed)	Health zones affected	HCW infections

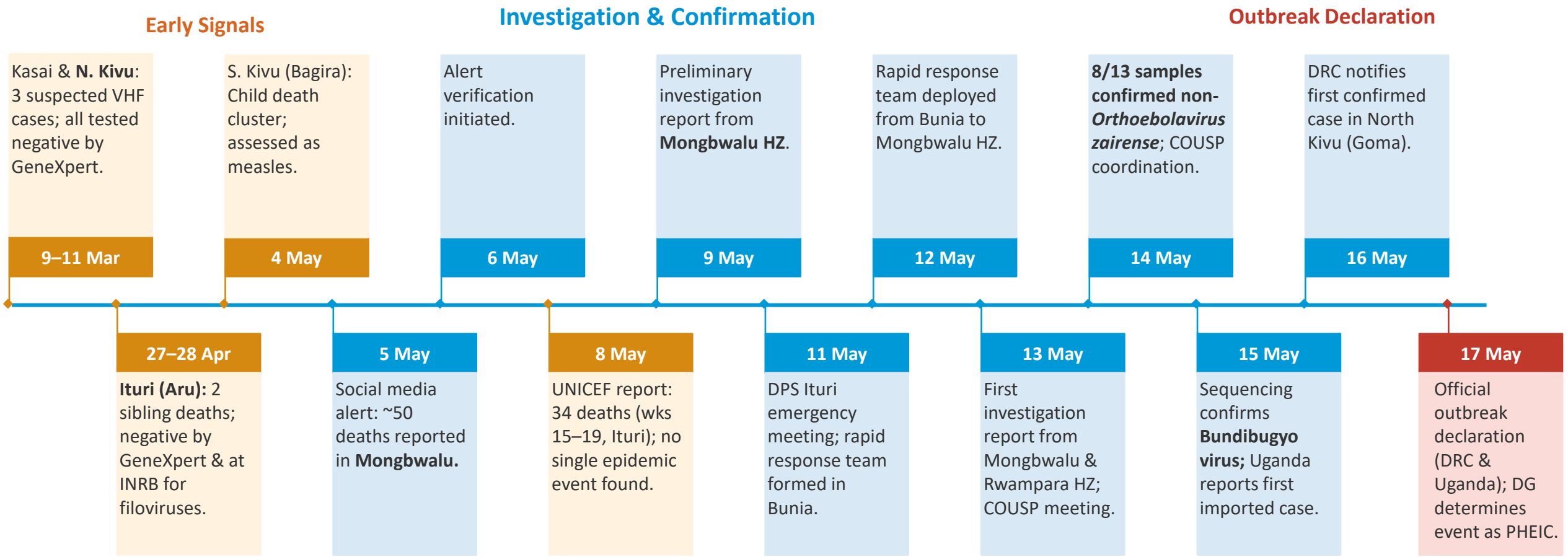
*11 health zones with confirmed cases

In **Uganda**

0	-	02	-	01	50.0%	01	0
Suspected cases	Probable cases	Confirmed cases	Suspected deaths	Confirmed deaths	Crude CFR (confirmed)	Districts affected	HCW infections

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Event timeline

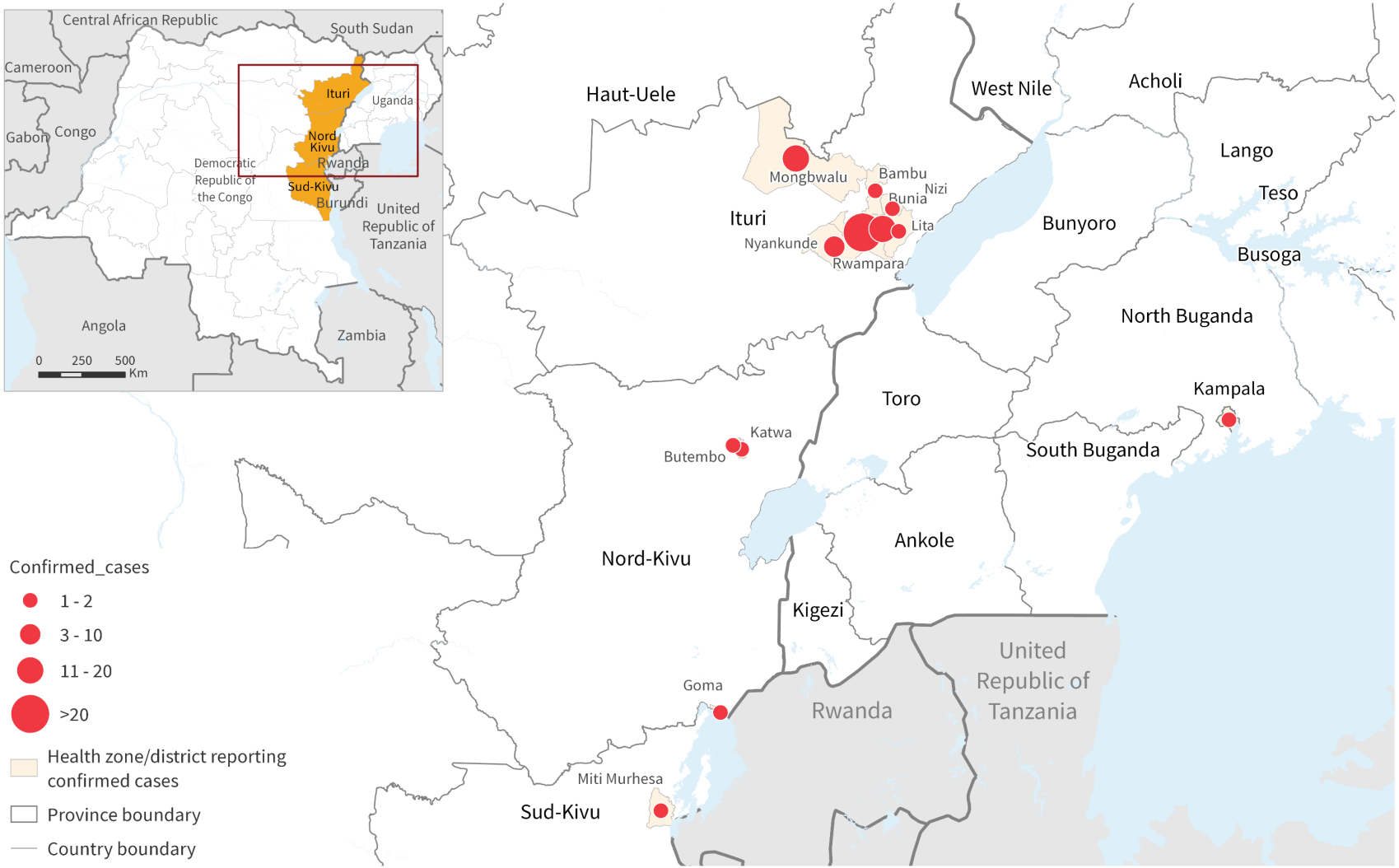


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Confirmed cases

- **11 health zones** reporting **confirmed cases** in DRC
- **7 health zones** reporting confirmed cases in **Ituri, 3** in **Nord Kivu, 1 in South Kivu**
- **2 confirmed cases** from **Kampala** in Uganda
- On 15 May 8/13 samples tested positive: **62% positivity**
- On 18 May 18/27 samples tested positive: **67% positivity**
- On 19 May 16/31 samples tested positive: **52% positivity**
- On 20 May: 12/31 samples tested positive: **39% positivity**
- On 21 May: 18/37 samples tested positive: **49% positivity**

Distribution of confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of 22 May 2026.



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Data Source: World Health Organization, Ministry of Health Democratic Republic of the Congo, GRID3
Map Production: WHO Health Emergencies Programme

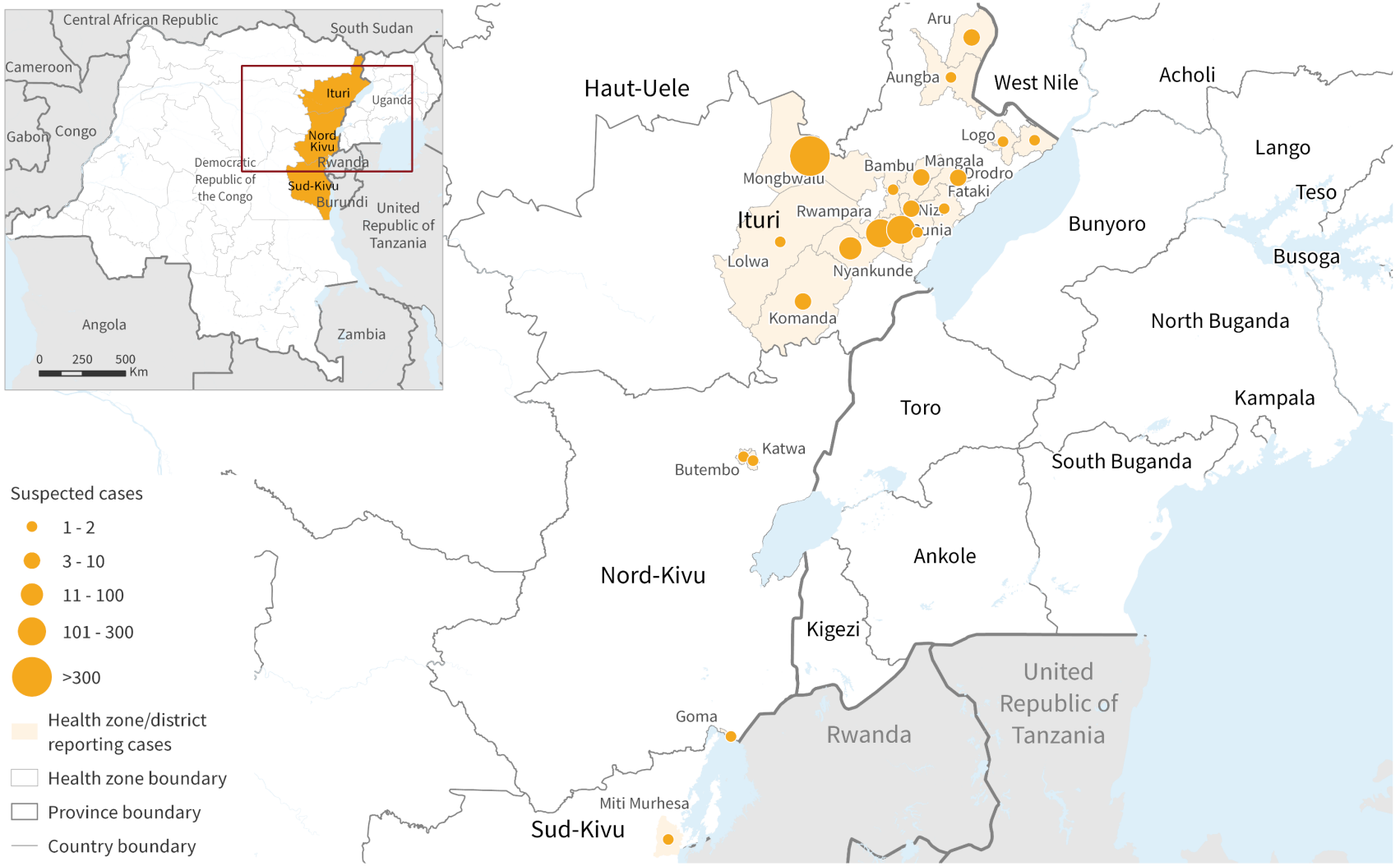
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Suspected cases

- **21 health zones** reporting **suspected or confirmed cases** as of 22 May 2026
- **17 health zones** affected in **Ituri, 3 in Nord Kivu** and **1 in South Kivu**

Distribution of suspected Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of 22 May 2026.

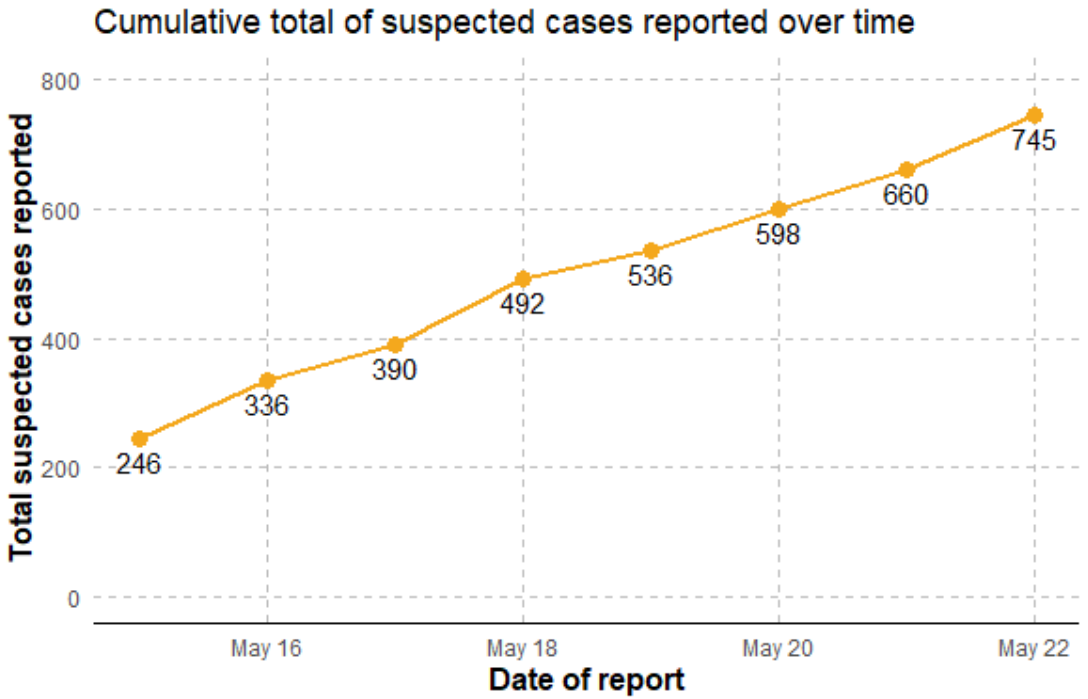


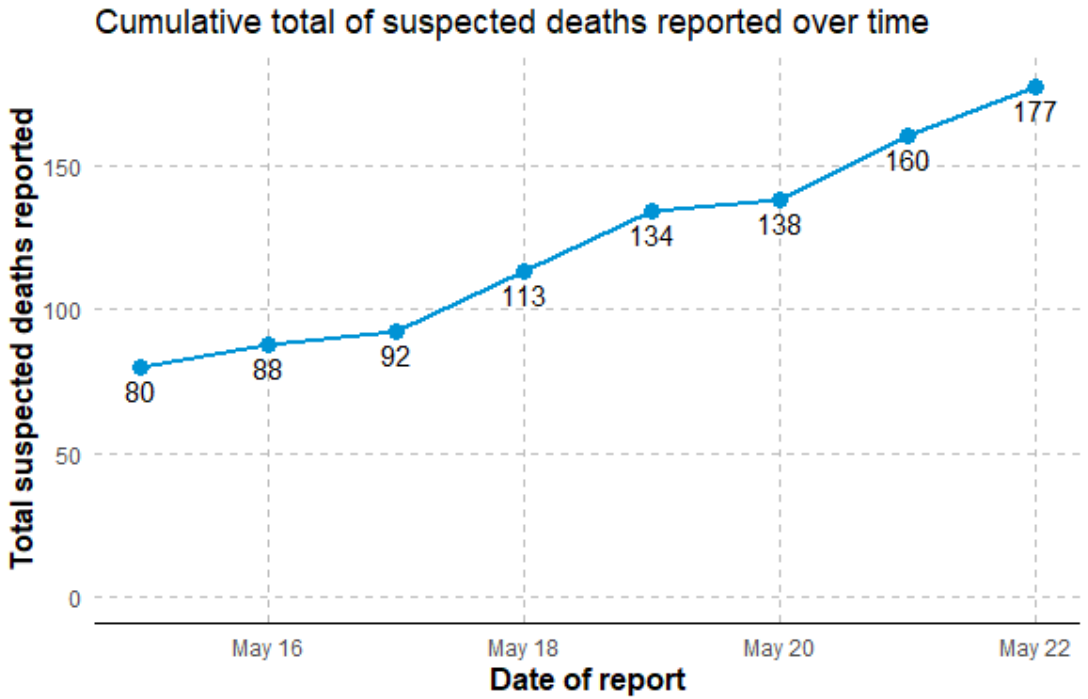
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Trends in **cumulative** suspected cases and deaths **in all health zones reporting suspected or confirmed cases**





Note: Numbers are subject to change as data are being compiled

Additional analysis: estimated outbreak size in Ituri & North Kivu provinces

Data as of 20 May 2026

Both approaches estimate outbreak size in Ituri and North Kivu as **400-900 cases** as of 20 May 2026

Approach 1: Using exported cases to Uganda and population movement data

Source population	Daily outbound travellers from source population	Source population size	Estimated number of cases: Mean (95%CI)		
			Detection window* = 10 days	Detection window* = 15 days	Detection window* = 20 days
Main scenario: Ituri	1,871	4,392,200	**470 (58 – 1,306)**	**313 (39–870)**	**235 (29–652)**
Sensitivity analysis: Ituri + Nord Kivu	4,339	13,392,200	**617 (76– 1,718)**	**412 (51– 1,145)**	**309 (38–858)**

Approach 2: Reconstructing outbreak size from reported deaths

Scenario	Doubling time (days)	Growth rate (per day)	Number of cases		
			CFR = 26%	CFR = 33%	CFR = 40%
Main scenario: Moderate growth, intermediate emergence	14	0.050	**860 (721-1,015)**	**678 (568-800)**	**559 (469-660)**
Sensitivity analysis 1: Fast growth, recent emergence	7	0.100	**1,386 (1,160-1,636)**	**1,092 (914-1,289)**	**901 (754-1,062)**
Sensitivity analysis 2: Slow growth, older emergence	21	0.034	**730 (612-862)**	**575 (482-679)**	**474 (398-560)**

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Source: Imperial College London and WHO

https://www.imperial.ac.uk/mrc-global-infectious-disease-analysis/research-themes/preparedness-and-response-to-emerging-threats/report-ebola-18-05-2026/

WHO Risk Assessment

15 May - V1

Overall risk and confidence (based on information available at time of assessment)

Overall risk		
National	Regional	Global
High	High	Low

Confidence in available information		
National	Regional	Global
Moderate	Moderate	Moderate

20 May - V2

Overall risk and confidence (based on information available at time of assessment)

Overall risk		
National	Regional	Global
Very High	High	Low

Confidence in available information		
National	Regional	Global
Moderate	Moderate	Moderate

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Rationale for Determination of a PHEIC

1. The event is **extraordinary** for the following reasons:

Current scale

- **Geographical extent** at declaration, within **Ituri and North Kivu**.
- Two cases with no apparent link to each other have been reported in **Kampala, Uganda**.
- Unusual **clusters of community deaths** with symptoms compatible with BVD across Ituri and North Kivu.
- At least four deaths among **healthcare workers.**
- There is **limited understanding of the epidemiological links** with known or suspected cases.
- **High positivity rate** in samples collected

Transmission risk

- Ongoing insecurity, population mobility, the urban or semi-urban nature of the current hotspot and the large network of informal healthcare
- There are currently **no approved Bundibugyo virus-specific therapeutics or vaccines**



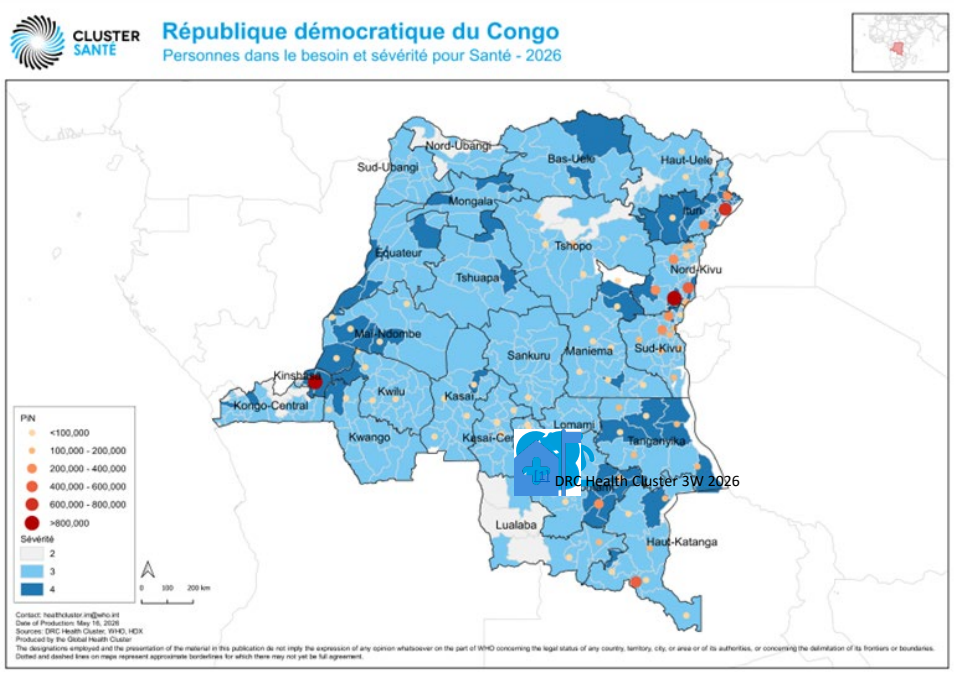
2. The event constitutes a **public health risk to other States Parties** through the international spread of disease.

3. The event requires **international coordination and cooperation.**

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The Emergency Committee's Temporary Recommendations will be published shortly.

Operating in a humanitarian context



- **Malaria remains the leading cause of illness** in the eastern provinces.
- **Food insecurity:** 9.9 million people in NK, SK, Ituri and Tanganyika will experience high levels of acute food insecurity Jan to June 2026.
- **GBV:** NK, SK, Ituri and Tanganyika accounted for 81% of 138K sexual violence cases reported in 2025.

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	Total population	People in Need of humanitarian health assistance	People targeted for health assistance	Funding received For health assistance	Total number HC partners	Total no. health facilities supported by partners
DRC	102.3M	7.5M	2.5M	30%	**101** 35 reporting to 5W	**412**
Ituri	**4.8M**	**1.2M**	**642K**	=	**17**	**113**
N. Kivu	**9.1M**	**2.5M**	**1.1M**	=	**23**	**172**

In DRC, 14.9 M people in need of humanitarian assistance in 2026, **7.5 M people** in need of health assistance. Full Plan is **only 34% funded**, health only **30% funded** as of 21 May 2026.

Ituri: No. of IDPs 926K; No. Refugees 36K; No**. Attacks on humanitarian workers** 11 since Jan 2026.

North Kivu: No. of IDPS 1.2M; no. Refugees 154K; No**. Attacks on humanitarian worker**s 44 since Jan 2026.

Non-government control areas: 1.2 million people in need of humanitarian health assistance, where **health cluster supports over 300 health facilities** through principled humanitarian response.

Immediate response priorities

1. **Immediate and urgent coordinated operational scale up**: each hub must be capacitated and resourced to safely and effectively sustain operations for the next months, with adequate supply chains, logistics and safety and security measures in place. Robust mechanism and investment in protection and prevention of sexual exploitation, abuse and harassment needed.
2. **Inclusive and consistent engagement with communities**: mechanisms established for two-way dialogue to align response interventions with community needs, capacities and expectations and to respond to community concerns while addressing concurrent ongoing emergencies in the area.
3. **Continental IMST and partner coordination**: alongside **Africa CDC** and in support of national authorities in all sites and leveraging national and international capacities as required.
4. **Comprehensive near real time mapping**: of the epidemiological situation, health infrastructure, partner presence, population mobility and access to inform response operations and operational planning.
5. **Detailed epidemiological analysis and support to field operations**: teams conducting case investigations, active case search, contact tracing, and data reporting in all sites.
6. **Functional lab system must be in place:** decentralized capacity with validated test kits, to ensure fast confirmation of suspected cases and a close link to treatment centres.
7. **Clinical management of suspected and confirmed cases:** within each hub ensure safe location for scaled up and optimized supportive care, enabling RCTs with candidate therapeutics.
8. **Ensuring IPC practices at all HCF:** including private, public and traditional facilities, and outreach in communities; rapid decontamination of impacted HCFs; availability of PPE, and ring IPC approach.
9. **Sufficient capacity for SDB**: working with partners to ensure enough teams are trained and available across all hubs.
10. **Maintaining essential health services**: ensure that response operations do not disrupt existing health services but rather enhance them wherever possible, linked with the humanitarian response.
11. **R&D for countermeasures**: There is NO vaccine, treatment nor PEP proven to be safe and effective against Bundibugyo virus. WHO is coordinating R&D efforts to accelerate development and access to medical countermeasures through clinical trials to evaluate efficacy and safety.

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Immediate, flexible funding is now critical to save lives, contain the outbreak, and prevent wider regional spread

- WHO has released **US$ 3.9 million from the Contingency Fund for Emergencies** but the balance is critically low and **replenishment is urgently needed**.
- Full budget requirements are under development and revision as plans are finalized in coordination with partners, and the true scale of the outbreak becomes clearer.

Category	Countries	Response focus
Priority 1A: Active confirmed outbreak	Democratic Republic of the Congo, Uganda	Full multi-pillar outbreak response, including containment operations in affected areas and heightened readiness in non-affected provinces and districts.
Priority 1B: High risk of cross-border spread	South Sudan, Rwanda, Burundi	Intensified preparedness, cross-border coordination, and enhanced surveillance, laboratory, and clinical readiness.
Priority 2: Enhanced readiness required	CAR, Rep. of Congo, Tanzania, Zambia, Angola, Kenya, Ethiopia	Enhanced readiness measures and risk monitoring proportionate to assessed threat.

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