Epidemiological Alert Ebola Disease due to Bundibugyo virus in the Democratic Republic of the Congo and Uganda

21 May 2026

In light of the evolving Ebola situation in the Democratic Republic of the Congo and Uganda, the Pan-American Health Organization / World Health Organization (PAHO/WHO) is sharing updated technical guidance to support Member States in laboratory preparedness and diagnosis, infection prevention and control measures, and clinical management of cases.

Summary of the situation in Africa *(1-2)*

On 5 May 2026, the World Health Organization (WHO) was alerted of an outbreak of an unknown disease with a high mortality rate in the Mongbwalu health zone, Ituri Province, Democratic Republic of the Congo, including deaths among health care workers. On 15 May 2026, the National Institute of Biomedical Research in Kinshasa confirmed Bundibugyo virus disease in 8 tested samples. The same day, the Ministry of Health officially declared the country's 17th Ebola outbreak. On 16 May 2026, the WHO Director-General determined that the outbreak constituted a Public Health Emergency of International Concern under the International Health Regulations (2005).

As of 18 May 2026, 516 suspected cases, including 131 suspected deaths, have been reported across seven health zones in two provinces of the Democratic Republic of the Congo. Of these, 33 cases and four deaths have been confirmed: Rwampara (19 confirmed cases, 3 confirmed deaths), Bunia (6 confirmed cases, 1 confirmed death), Nyankunde (4 confirmed cases), and Mongbwalu (1 confirmed case) in Ituri province, and Butembo (1 confirmed case), Goma (1 confirmed case), and Katwa (1 confirmed case) in North Kivu province. The largest burden of suspected cases remains in the Ituri province.

Uganda reports two confirmed imported cases, including one death, in Kampala, both of which were linked to travel from the Democratic Republic of the Congo. The first case died on 15 May 2026, with subsequent investigation and follow-up of 47 identified contacts. No epidemiological links have been identified between the two cases. As of 18 May 2026, no local transmission has been identified in Uganda.

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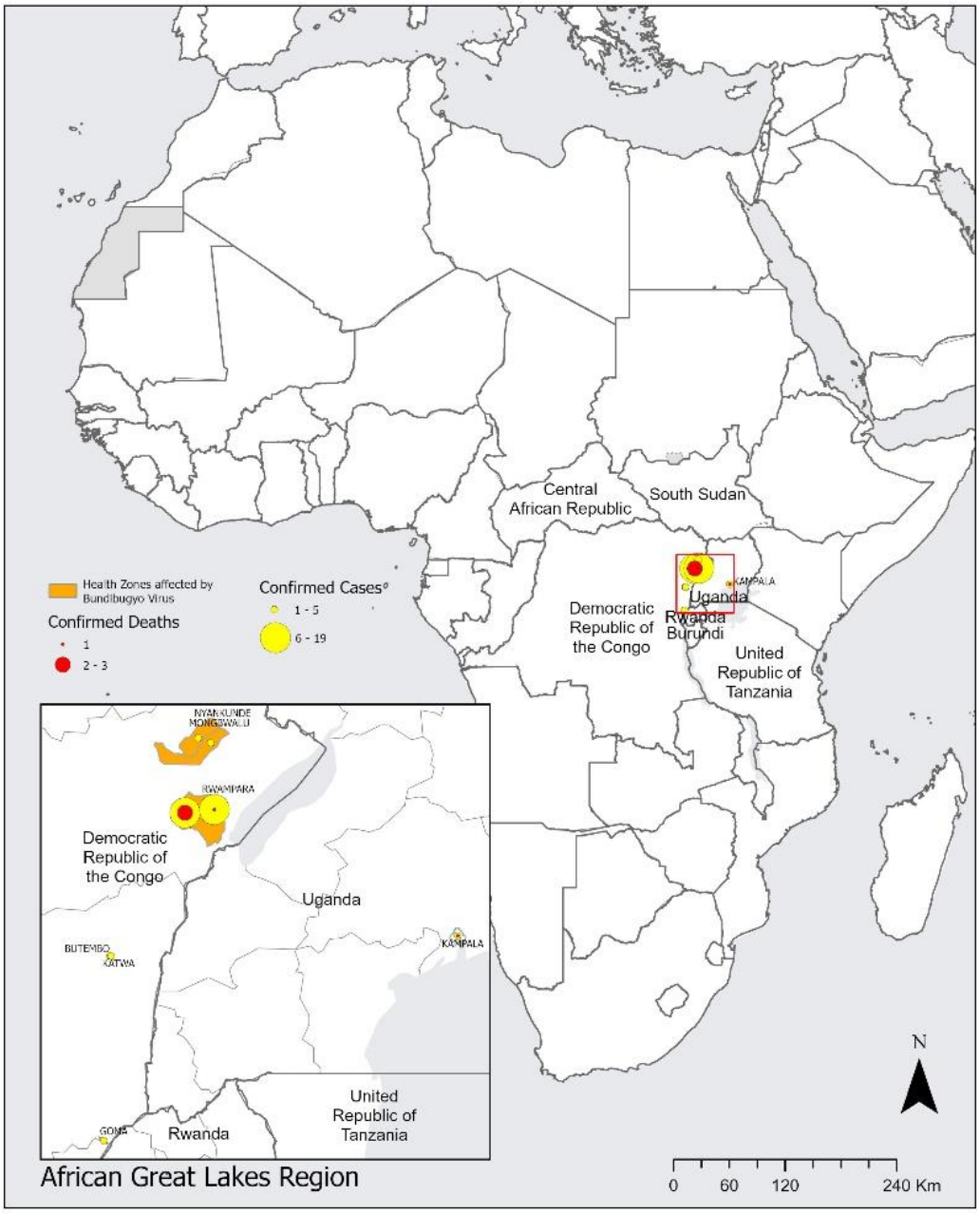
Figure 1. Confirmed cases of Ebola Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, as of 18 May 2026



PAHO

Pan American Health Organization

World Health Organization

Americas Region

Map production:
PAHO Health Emergencies Department (PHE)
Health Emergency Information and Risk Assessment Unit (HIM)

Source: Adapted from data from World Health Organization. Ebola Bundibugyo Virus Disease Outbreak, Democratic Republic of the Congo & Uganda Weekly External Situation Report 01, 18 May 2026, modified by the Pan American Health Organization. Available from: https://iris.who.int/bitstreams/bb1d4668-04e0-4563-b7c4-d1bdefbc9f05/download

Advice for Member States

The purpose of this Epidemiological Alert is to provide Member States with updated guidance on laboratory diagnosis, infection prevention and control (IPC), and clinical management in the context of the Ebola situation in the Democratic Republic of the Congo and Uganda.

Laboratory diagnosis *(3-10)*

Diagnosis of Ebola virus disease is primarily based on molecular detection (RT-PCR) in whole blood samples from symptomatic patients, as viremia is detectable from the onset of symptoms. However, a second sample may be required if the first sample is collected too early. Sample collection should be performed exclusively by trained personnel, strictly using full personal protective equipment (PPE), including double gloves, facial protection, an impermeable gown, and a mask. All required supplies should be prepared in advance, and proper labeling and complete recording of clinical and epidemiological information must be ensured.

Given that Ebola virus is a high-risk pathogen for laboratory-acquired infection, it is recommended that samples be sent to a regional reference laboratory. If molecular detection is to be conducted at the national level following a strict risk assessment, samples must first be inactivated under biosafety conditions with containment level 3 (BSL-3 or level 3 cabinet) before subsequent safe handling. These measures are essential to ensure the safety of personnel, the integrity of the sample, and the reliability of diagnostic results.

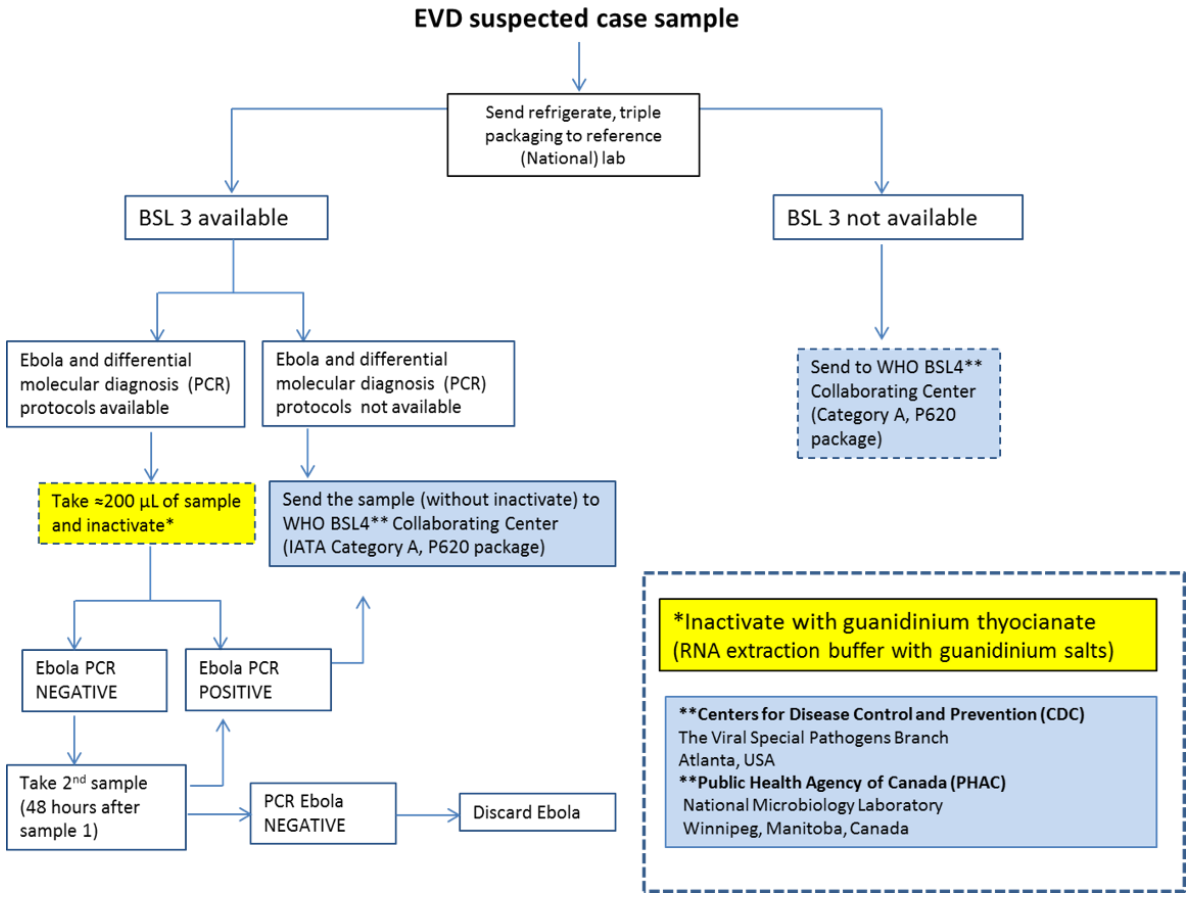
Algorithm for the management of samples suspected of Ebola virus disease (EVD) [1]

Given that the initial manifestations of EVD may be nonspecific, the only way to establish the etiology of a suspected case is through laboratory testing. However, samples obtained from patients suspected of having EVD represent a high biological risk. For this reason, in order to perform diagnostic assays (molecular detection by RT-PCR), or biochemical and hematological tests (for patient monitoring and clinical management), samples must undergo an **inactivation process** in a **laboratory with biosafety level BSL-3**. Once inactivated, samples may be safely handled in laboratories with biosafety level BSL-2. Consequently, countries that do not have BSL-3 laboratories must ensure that samples are sent to a PAHO/WHO Collaborating Center (PAHO/WHO CC), in compliance with the current regulations for the transport of Category A infectious substances, in accordance with the standards of the International Air Transport Association (IATA).

Although preliminary detection using molecular techniques may be performed in BSL-2 laboratories once the sample has been inactivated, final confirmation of the first cases identified in a country or territory must be carried out at a PAHO/WHO CC. Likewise, because Ebola virus is classified as a Risk Group 4 pathogen, any procedure involving the manipulation of viable virus, such as viral isolation, requires BSL-4 facilities.

[1] Both the algorithm and the proposed recommendations may be subject to subsequent modifications based on advances in knowledge about the disease and the etiological agent.

Figure 2. Algorithm for the management of suspected Ebola virus disease (EVD) specimens



Source: Adapted from Pan American Health Organization. Algorithm for handling of samples from suspected Ebola Virus Disease (EVD). Washington, D.C.: PAHO; 2026. Available from: https://www.paho.org/en/documents/algorithm-handling-samples-suspected-ebola-virus-disease-evd

Selection, collection, and shipment of samples

Type of sample:

- Viral detection is only possible in symptomatic patients. **Samples should not be collected from healthy contacts.**
- Once symptoms have started, viremia reaches a peak around day 6 and may be detectable until approximately day 15. However, samples collected during days 1–2 after symptom onset may test negative, even in infected individuals. For this reason, if clinical and epidemiological suspicion persists, a second sample should be collected at least 48 hours apart, taking into account the dynamics of infection.
- The recommended sample for virological diagnosis is **whole blood** (5 mL, preferably in a plastic tube with EDTA); however, serum or plasma may also be used for diagnosis.
- Oral swabs are indicated only for post-mortem cases or in situations where a blood sample cannot be obtained. They should be collected in universal viral transport

medium, only by duly trained personnel. The sensitivity of laboratory detection in this type of sample is low.

- Sample collection must be performed only by duly trained personnel, ensuring the appropriate use of all PPE. Complete recommendations are available in: Recommendations for the Safe Collection and Proper Management of Samples Potentially Infected with the Ebola Virus, available from: https://www.paho.org/en/documents/recommendations-safe-collection-and-proper-management-samples-potentially-infected-ebola *(3)*

Sample storage:

- The sample may be kept under refrigerated conditions (2–8 °C) for up to one week (**Table 1**). However, shipment to the reference laboratory within the first 48 hours after collection is recommended.
- **Do not store non-inactivated biological samples under BSL-2 conditions for longer than necessary prior to shipment**.

Table 1. Considerations regarding storage conditions

Sample type	Storage conditions
EDTA blood/plasma or serum	≤ 24 hours: room temperature (up to 25°C)
	1–7 days: 2–8°C
	> 7 days: -20°C or lower
	> 60 days from sample collection: -70°C
	Before freezing (-20°C o -70°C), EDTA plasma and serum samples should be aliquoted into cryogenic tubes. Freeze–thaw cycles should be avoided, as they may affect sample quality. Sample aliquoting should be performed only in an appropriately equipped laboratory.
Oral swabs in VTM or nuclease-free water	≤ 24 hours: room temperature
	1–7 days: 2–8°C
	> 7 days: -20°C (or -70°C if available)
	> 60 days from sample collection: -70°C
	Before freezing (-20°C o -70°C), samples suspended in VTM or nuclease-free water should be aliquoted into cryogenic tubes. Freeze–thaw cycles should be avoided, as they may affect sample quality. Sample aliquoting should be performed only in an appropriately equipped laboratory. Dry swabs that have not been resuspended in nuclease-free water should not be frozen.

Source: Adapted from World Health Organization. Diagnostic testing for Ebola and Marburg virus diseases, Interim guidance. Geneva: WHO; 2024. Available from: https://iris.who.int/server/api/core/bitstreams/e209d826-5f3d-4ca8-b278-69254569e7ac/content

Shipment of the sample to the National Reference Laboratory and to the PAHO/WHO CC:

- According to the algorithm, samples should be sent to the National Reference Laboratory, ensuring triple packaging and all relevant biosafety measures. Complete recommendations are available in: Recommendations for Proper Packaging and Shipping by Land, of Samples Potentially Infectious with Ebola Virus, available from: https://www.paho.org/en/documents/recommendations-proper-packaging-and-shipping-land-samples-potentially-infectious-ebola *(4)*
- For air shipments and shipments to PAHO/WHO CC, IATA recommendations for the transport of **Category A** biological substances must be strictly followed. Complete guidance is available in: Guidance on regulations for the transport of infectious substances, available from: https://www.who.int/publications/i/item/9789240089525 *(5)*
    - Triple packaging (P620-certified packaging)
    - Valid shipper's certificate
    - Dangerous Goods Declaration (DGD)
    - Air waybill
- The cold chain of the sample must also be maintained. If dry ice is used, a P954 thermal box (expanded polystyrene) must be used, with the corresponding labeling and marking. Complete guidance is available in: Guidance on regulations for the transport of infectious substances, available from: https://www.who.int/publications/i/item/9789240089525 *(5)*
- Before collecting and shipping the sample, the PAHO/WHO CC must be contacted through the PAHO Regional Office. PAHO/WHO CC will not receive samples without prior authorization.
- For the shipment of samples to the PAHO/WHO CC, the availability of a transport company, such as a courier or civil airline, must be ensured. *(6)*
- **Samples sent to the PAHO/WHO CC must be non-inactivated.** Only under special circumstances, where the transport of Category A infectious substances is impossible after all relevant options have been exhausted, may the shipment of an inactivated sample (Category B or exempt), be considered, following **prior** consultation with the PAHO/WHO CC and the PAHO Regional Office.

Comprehensive guidelines regarding aspects related to the inactivation of samples potentially infected with the Ebola virus are available in from: https://www.paho.org/en/documents/general-procedures-inactivation-potentially-infectious-samples-ebola-virus

Similarly, recommendations for the appropriate packaging and land transport of samples potentially infected with the Ebola virus are available from: https://www.paho.org/en/documents/recommendations-proper-packaging-and-shipping-land-samples-potentially-infectious-ebola; and recommendations for the safe collection and appropriate handling of samples potentially infected with the Ebola virus are available from: https://www.paho.org/en/documents/recommendations-safe-collection-and-proper-management-samples-potentially-infected-ebola.

Infection prevention and control (IPC) *(11-39)*

IPC is essential to mitigate transmission of Ebola virus disease and to prevent amplification through health-care-associated transmission. Strict standard and transmission base precautions (i.e. contact) should be implemented. Recommendations should be adapted to local context and implemented across all levels of the health system, including referral hospitals, laboratories, and transport systems. A comprehensive risk assessment must be conducted based on exposures and clinical history.

IPC programs should be supported by trained IPC teams at national, subnational, and facility levels, with implementation aligned to PAHO/WHO IPC core components and minimum requirements. Preparedness, readiness, response, and recovery activities should include regular IPC capacity assessments to identify operational gaps and strengthen outbreak response.

Standard Precautions

Because early symptoms of EVD may be non-specific, standard precautions should always be applied consistently with all patients, regardless of diagnosis.

Standard precautions include:

- Hand hygiene.
- Safe handling and disposal of sharps.
- Appropriate use of PPE based on risk assessment.
- Respiratory hygiene and cough etiquette.
- Safe injection practices.
- Cleaning and disinfection of reusable medical equipment.
- Environmental cleaning and disinfection of spills, surfaces, and patient-care areas.

Screening and Triage

- Screening should be implemented using:
    - Symptom assessment.
    - Epidemiological risk assessment.
    - Temperature monitoring.
    - Standardized case definitions.
- A no-touch approach and a minimum distance of one meter between the screener and the person being screened should be maintained whenever possible.
- Suspected cases should immediately be placed in a designated isolation area and managed according to established referral pathways.
- Triage and screening areas should be physically separated, adequately ventilated, and equipped with:
    - Hand hygiene stations.
    - PPE supplies (Medical mask, Eye protection (face shield or goggles), Fluid-resistant gown, One pair of gloves).
    - Infectious waste containers.

Triage areas should be physically separated, clearly marked, adequately ventilated, and equipped with dedicated hand hygiene stations, waste containers, and PPE donning and doffing areas. Any patient meeting the suspected case definition should immediately be placed in a designated isolation area and managed according to established referral pathways.

Patient Transfer

- Transfer of patients with symptoms compatible with EVD should be performed by trained personnel using dedicated patient transport vehicles.
- Only essential personnel should accompany the patient during transport.
- Personnel providing direct patient care during transport should use:
  - Gloves.
  - Impermeable gowns.
  - Medical masks.
  - Eye protection.
  - Closed shoes or boots.
- Drivers do not require PPE unless direct patient contact is anticipated.
- After transport, vehicles should be cleaned with water and detergent followed by disinfection using 0.05% chlorine solution or another approved disinfectant.

Health-Care Facilities and Isolation

Patients with symptoms compatible with EVD may be identified at different levels of the health system or at points of entry and should immediately be managed using standard precautions.

- Patients should be referred to designated health-care facilities with:
  - Contact isolation capacity.
  - Adequate PPE supplies.
  - Trained IPC personnel.
- Whenever possible, patients should be managed in single-patient rooms.
- Isolation areas should ensure unidirectional flow from clean to contaminated areas and include:
  - Dedicated sanitation facilities.
  - Hand hygiene stations.
  - Dedicated patient-care equipment.
  - Infectious waste containers.
  - Clearly designated PPE donning and doffing areas.
- Countries should identify designated facilities according to their geographic and administrative organization. Existing isolation infrastructure previously used should be considered.
- Suspected and confirmed patients should not share the same space while awaiting laboratory confirmation. Patients with different epidemiological risk profiles or possible alternative diagnoses should also remain separated.
- Restrict non-essential staff and visitors from high-risk areas. Visitor access, when permitted, should occur under controlled conditions with education on IPC measures and avoidance of direct physical contact.

Personal Protective Equipment (PPE)

- PPE use should be based on the activity performed and associated exposure risk.
- Personnel involved in direct or indirect care of suspected or confirmed EVD patients should use:
  - Medical scrubs.
  - Fluid-resistant gown or coverall with head and neck covering.
  - Apron.
  - Medical mask[2] with eye protection.
  - Two pairs of nitrile gloves.
  - Closed shoes or rubber boots.
- Respirators (N95/FFP2/FFP3) should be used during aerosol-generating procedures according to risk assessment.
- All personnel must receive practical competency-based training and supervised donning and doffing instruction.
- Single-use PPE should not be reused. Reusable PPE must undergo appropriate decontamination procedures. PPE should never be secured with adhesive tape.
- Donning and doffing procedures should always be supervised by a trained observer or buddy. Removal of PPE represents the highest risk for self-contamination and requires strict adherence to protocols, including repeated glove disinfection during removal.
- Spraying individuals with chlorine or disinfectants during PPE removal or in any clinical setting should not be performed.

Environmental Cleaning and Waste Management

- Environmental cleaning should include cleaning with soap and water followed by disinfection with 0.5% chlorine solution or another approved disinfectant.
- Dedicated cleaning equipment and waste management systems should be available in all isolation areas.
- All infectious waste, including sharp and contaminated materials, should be managed according to national biohazard waste protocols. Sharps should be disposed of in puncture-resistant containers and sealed when reaching 75% capacity. All infectious waste, including sharp and contaminated materials, should be treated as biohazardous waste and disposed of according to national protocols, including incineration where appropriate.
- Hand washing of contaminated linens should be avoided. Patient linens and clothing should be placed in designated bags prior to transport to laundry facilities through dedicated channels. Hand washing of contaminated linens should be avoided.
- If a patient develops symptoms at home prior to isolation, the household environment should undergo appropriate cleaning and disinfection. Clothing and bedding contaminated with body fluids should be safely disposed of or incinerated according to national protocols.

[2] Recommend routine use of high-efficiency respirators (N95, FFP2, or FFP3) when caring for clinically unstable patients, during invasive or aerosol-generating procedures, and in all confirmed viral hemorrhagic fever cases, given the potential need for unexpected aerosol-generating procedures with limited time to safely change PPE, particularly during prolonged periods of PPE use by healthcare workers.

- Surfaces contaminated with blood or body fluids should first be cleaned with water and detergent and subsequently disinfected using 0.05% chlorine solution or another approved disinfectant.
- Personnel performing cleaning activities should wear appropriate PPE, including gloves, gowns or aprons, and closed shoes.

Safe Management of Dead Bodies

Safe and dignified management of the deceased is essential to prevent transmission while respecting cultural and religious practices.

The body should remain intact and handling should be minimized. Embalming should not be performed.

Bodies should be disinfected using 0.5% chlorine solution, placed in leak-proof body bags, properly sealed, and transferred in closed coffins according to national procedures.

Personnel involved in body management and burial activities should be specifically designated, trained, supervised, and equipped with appropriate PPE, including:

- Gloves.
- Head covering.
- Coveralls or impermeable gowns.
- Medical mask.
- Eye protection.
- Rubber boots or closed shoes.

Heavy-duty outer gloves are recommended for burial teams and environmental services personnel.

Clinical Management

General supportive care remains the cornerstone of management and should be initiated promptly. Management of Ebola virus disease (EVD) requires strict adherence to infection prevention and control measures, including appropriate use of personal protective equipment. The mainstay of treatment is supportive care aimed at maintaining adequate organ function (e.g., cardiovascular, respiratory, and renal) while the immune system eliminates the infection. Whenever possible, patients should be managed in specialized treatment centers by trained multidisciplinary teams. Early initiation of supportive care, together with close clinical monitoring and timely management of complications, is recommended to improve survival.

Supportive care should focus on correcting fluid losses due to vomiting and diarrhea, preventing and managing hypovolemia and shock, and addressing electrolyte abnormalities. Fluid replacement should be administered orally or intravenously according to clinical severity and available resources; critically ill patients may require intravenous fluids, hemodynamic monitoring, and vasopressor support. Additional measures should include symptomatic treatment, blood products, nutritional support, and renal replacement therapy when indicated. In cases of progressive respiratory failure, invasive mechanical ventilation may be needed, while noninvasive ventilation and high-flow oxygen should generally be avoided due to the risk of aerosol generation. Empiric antimicrobial therapy should be considered in patients with clinical evidence of bacterial sepsis or co-infection.

Non-invasive ventilation and high-flow oxygen therapy should generally be avoided due to the potential risk of aerosol generation. When endotracheal intubation is clinically unavoidable, the procedure should be protocolized and performed by the most experienced provider, with the minimum number of healthcare workers present, in a room with adequate ventilation, and using at minimum a fit-tested N95, FFP2, or FFP3 respirator together with full recommended PPE for aerosol-generating procedures.

Specific therapies are available for Ebola virus (Zaire species), including monoclonal antibodies (e.g., REGN-EB3 and ansuvimab), which reduce mortality when used alongside supportive care; no approved targeted therapies exist for Sudan virus disease. Early diagnosis and timely treatment are key determinants of survival, while high viral load, severe dehydration, and advanced organ dysfunction are associated with poor outcomes.

Complete recommendations are available from:
http://www.who.int/csr/resources/publications/ebola/clinical-care/en/

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