

Bundibugyo virus disease outbreak in DR Congo: current trajectory and potential risk for a Pandemic Emergency

On May 15, 2026, DR Congo declared the 17th orthoebolavirus disease outbreak—the third in the country in two decades caused by the Bundibugyo virus variant (*Orthoebolavirus bundibugyoense*)—in the conflict affected north-eastern province of Ituri.¹ The next day, the WHO Director-General determined this event a Public Health Emergency of International Concern (PHEIC) and on May 18, the Africa Centres for Disease Control and Prevention (CDC) declared a Public Health Emergency of Continental Security.² 10 days earlier, WHO received an alert about a cluster of unexplained deaths, including deaths among health workers, in the Mongbwalu Health Zone. Initial laboratory results were negative for orthoebolavirus and reagents from Ituri were reasonably provisioned for Ebola virus.¹

The index case, timelines, and transmission chains are being reconstructed. Current assumptions place the onset of community transmission in early April, 2026, or earlier. By May 22, more than 745 suspected cases had been identified across three DR Congo provinces, with around 100 additional suspected cases reported per day against in-country PCR capacity of approximately 40 tests per day.¹ By that date, around 40% of identified contacts have been traced. Five cases have been confirmed in Uganda, with onward transmission chains established and contacts evacuated to Europe for isolation and further examination based on standard protocol.² Risk is rated by WHO as high in DR Congo, moderate continentally,

and low globally, but increasing air travel makes transmission of orthoebolavirus beyond Africa a substantial risk warranting real-time multiregion surveillance.

This trajectory is uncomfortable because it is familiar. The 2014–16 Ebola epidemic in west Africa was preceded by a long undetected timeperiod; by the time the pathogen was identified, Ebola had established itself across Guinea, Liberia, and Sierra Leone, and response capacity was permanently catching up.³ The situation in eastern DR Congo now is similar to the circumstances in Guinea in March, 2014. The amplifying factors, such as cross border population movement, armed conflict, and mistrust are also familiar.

The context is not identical as some elements are better in DR Congo, including domestic genomic sequencing at the Institut National de Recherche Biomédicale in Kinshasa, optimised supportive care protocols, and Africa CDC and WHO architectures that were emerging or non-existent in 2014. The reforms since then have led to clear governance, stronger institutions, and equity commitments to enable faster actions.

Yet in three respects, the situation is worse. First, there is no licensed vaccine or therapeutic for the Bundibugyo virus. There was no vaccine for Ebola virus during the epidemic in west Africa, but there are now countermeasures that transformed responses to subsequent Ebola virus outbreaks.⁴ Vaccine candidates against orthoebolaviruses exist, including a ChAdOx-vectored vaccine and monoclonal antibody cocktails, but the regulatory and trial scaffolding to deploy these at outbreak speed is not in place. The ring vaccination strategy is currently not an option. Second, community trust is degraded as the epicentre lies within armed conflict involving multiple national militaries and non-state groups. Transactional resource diplomacy has fuelled rumours that

public health measures are pretexts and attacks on health facilities continue. Without countermeasures, the entire transmission reduction burden falls on contact tracing, isolation, and safe and dignified burials, which require community involvement. Third, the international framework for a collective response is weaker than during previous large filovirus outbreaks. The dismantling of USAID in 2025 disrupted community health workers and medical stockpiles in the affected provinces (Ituri and North Kivu) and the US withdrawal from WHO and prohibitions on bilateral coordination have removed technical capacity and convening power. International support has been mobilised, but coherence is harder than before. WHO African region projections suggest a protracted outbreak and substantial socioeconomic toll.

These conditions justify calling a PHEIC and raise a harder question of where the pandemic emergency threshold is now? In the 2024 amendments to the International Health Regulations (Article 1), a pandemic emergency requires a PHEIC for a communicable disease that has or is at high risk of wide geographical spread, exceeding national response capacity, and substantial social or economic disruption; and the response needs to be rapid, equitable, coordinated, and whole-of-government and whole-of-society.⁵ The repeated “is at high risk of” formulation creates eight combined pathways to determination. Pre-emption, not post-hoc confirmation, is the design and pandemic emergency determination has never been made before.

At present, two of the three substantive risk-of-harm criteria have been plausibly met (figure). Geographical spread is established as cross border transmission to Uganda was confirmed on the day the outbreak was declared and three DR Congo provinces are affected.



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Met or high risk Elevated risk Not applicable Initial geographical risk grading: high in DR Congo, moderate continentally, and low globally		
Criterion	Status (May 25, 2026)	Forward risk
PHEIC declared for a communicable disease	Met: May 16, 2026	NA
Wide geographical spread or at high risk of spread	Met: 3 DR Congo provinces and Uganda; evacuations to Europe	High
Exceeding or at high risk of exceeding national response capacity	Met: ~40 tests per day vs ~100 new suspected cases per day; ~40% of identified contacts traced	High
Substantial social or economic disruption (or both), including international air traffic	Emerging: flight cancellations and >7 countries with entry restrictions; WHO African region projections: protracted outbreak	High
Requires rapid, equitable, coordinated whole-of-government, and whole-of-society action	Partly in place: PHEIC declared, commitments mobilised; US–WHO coordination reduced	Determinative

Figure: Pandemic Emergency criteria (2024 amendments) under International Health Regulations for the Bundibugyo virus disease outbreak in DR Congo and Uganda as of May, 2026

Two of the three substantive risk-of-harm criteria have been plausibly met (ie, geographical spread and exceeding national response capacity), and the third is approaching the threshold (ie, social and economic disruption).⁵ PHEIC=Public Health Emergency of International Concern.

National response capacity is being exceeded as testing throughput is roughly a quarter of the suspect cases, contact tracing reaches less than half of contacts, and a surge workforce is constrained by funding contraction. International traffic is affected by flight cancellations to and from Ituri, reroutings, and entry restrictions in at least seven countries.

Judgement about future risk remains, particularly with mass gathering events, such as the 2026 Youth Olympic Games in Senegal, FIFA World Cup qualification fixtures (including the DR Congo national team), and upcoming large political and religious gatherings, and air travel that has previously facilitated transmission of filovirus from Africa to other continents within days, the probability of further spread is high. The criteria for a WHO Pandemic Emergency are currently unmet, but are within reach in the near future. A Pandemic Emergency would unlock equitable access to provisions, accelerate cross border countermeasures, and provide

financing that WHO local actors cannot gather. Waiting for unambiguity would mean repeating the errors made during the 2014–16 Ebola epidemic.

The operational priorities are identifiable. Bundibugyo targeted vaccines and therapeutics need to move under the WHO R&D Blueprint for Epidemics from contingency planning to active deployment. Decentralised molecular diagnostics in border health zones must shorten detection-to-confirmation intervals. Real-time multicountry surveillance, including in countries with upcoming mass gatherings, needs to be matched with analytics that can act on the data. Community engagement needs to be led by trusted local actors, including women's caregiving networks (as women face much of the burden of household exposure to Ebola virus disease and other communicable diseases), rather than externally imposed protocols. None of these priorities are new, and none can be deferred.

The world is not in 2014, which is precisely why the margin for excuses

is smaller. A decade of reforms has produced clearer targets, stronger institutions, better tools, and an explicit commitment to equity, but reforms matter only if they change the speed of action before the trajectory of an outbreak becomes obvious. At this point, preparedness becomes crucial. Orthoebolavirus is already ahead of the response. As the WHO Director-General, Dr Tedros Adhanom Ghebreyesus has long maintained during the COVID-19 pandemic, "no one is safe until everyone is safe". The task now is to ensure that governance, financing, diagnostics, community partnership, and international solidarity move faster than the outbreak.

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