

Cross-border transmission of Ebola virus disease caused by Bundibugyo virus into Uganda, 2026

During May 17–18, 2026, WHO and the Africa Centres for Disease Control and Prevention (Africa CDC) separately determined that the outbreak of Ebola disease caused by Bundibugyo virus (BDBV) in the Democratic Republic of the Congo and Uganda constituted a Public Health Emergency of International Concern under the International Health Regulations (2005) and a Public Health Emergency of Continental Security.^{1,2} This occurred after more than a month of undetected but suspected transmission of an unclassified viral haemorrhagic fever in Ituri province, the Democratic Republic of the Congo. On May 15, 2026, Uganda had reported a case of imported BDBV in one of its private health facilities within the city, Kampala. A second case was identified in Kampala in a separate private health facility on the next day. This outbreak arising out of two imported cases from the Democratic Republic of the Congo represents the second recognised outbreak caused by BDBV in Uganda since its initial identification in the western part of the country in 2007.^{3–5}

The two individuals were self-referrals from the epicentre in Ituri province seeking advanced care in Uganda (appendix). Case one, a male individual aged 59 years, arrived in Uganda by road via the northwestern border of Nebbi and Arua. From this point, the individual embarked on a chartered flight to Entebbe airport, seeking care in Kibuli Hospital, a private facility in the central business district of Kampala. Case two, a female individual aged 54 years, crossed from the Democratic Republic of the Congo via boat on Lake Albert, arriving on the Ugandan side at Ntoroko. Afterwards, the individual boarded a

bus to Kampala central business district, where they got admitted to Nakasero Hospital, another private health facility in Kampala. Overall, this outbreak underscores the public health risks associated with increased movement of people within the region for different socioeconomic reasons (including trade, minerals and mining, timber logging, and humanitarian crises) and medical reasons. Specifically, the two individuals in Ituri province on falling ill opted to seek advanced care in Uganda.

These movements highlight the referral pathways (whether self or institutional) for health care within the region, where individuals from eastern Democratic of the Congo and South Sudan often seek advanced or specialised care in private and public health facilities in Uganda's capital, Kampala. Consequently, Kampala serves as a recipient of spillover from the Democratic of the Congo.^{6,7} Furthermore, there might be other undiscovered movements of individuals seeking specialised medical facilities across East Africa and beyond. Reports of suspected or confirmed cases in Kinshasa, Katanga, and Goma probably represent similar movements. Moreover, other global private facilities that offer advanced care to the region of East Africa like India and Türkiye should be put on high alert. It is imperative that for other reasons of travel to and from the epicentre, including for trade, mineral business, mining, and timber logging, the existing travel advisories are followed.

Given these two cases from the Democratic of the Congo seeking care in Uganda, the declarations by WHO and Africa CDC, and the possibility for similar excursions, authorities should restrict movement of cases and/or their contacts, from the epicentre in Ituri province to Uganda and beyond. For past outbreaks, Uganda successfully controlled the export of Ebola cases by restricting movement of contacts and confirmed cases and shared the list of contacts and confirmed cases globally within the framework of

International Health Regulations. Additionally, all potential destinations for advanced or specialised care in the region and beyond should conduct a retrospective audit on all patients received within the past 21 days from the Democratic of the Congo, given that iatrogenic introduction beyond the scope of the known medical referral pathways to Europe can occur. This risk is highlighted by the proposed evacuation of an exposed American doctor from Ituri province to Germany for specialised care.⁸

In conclusion, early identification of BDBV cases provides for a window of transmission interruption through the isolation of all contacts, including health-care workers who have met any patients with confirmed BDBV, well before they themselves start exhibiting clinical disease and transmitting the virus. To interrupt further spread and transmission in the region and beyond, all regional and international destination facilities for medical referrals should be put on high alert to undertake retrospective audit of their recent admissions in order to identify any cases originating from the Democratic of the Congo.

We declare no competing interests.

Editorial note: The Lancet Group takes a neutral position with respect to territorial claims in published maps and institutional affiliations.

**Henry Kyobe Bosa, Misaki Wayengera, Atek Kagirita, Bernard Lubwama, Allan Muruta, Susan Nabadda, Andrew Nsawotebba, Charles Olaro, Diana Atwine, Jane Ruth Aceng*
hskyobe@gmail.com

Ministry of Health, Kampala, Uganda (HKB, AK, BL, AM, SN, AN, CO, DA, JRA); Interdisciplinary Consortium for Epidemics Research, Kampala, Uganda (HKB, MW); Rear Public Health Laboratory, Kampala, Uganda (HKB); Makerere University, Kampala, Uganda (MW)

- 1 World Health Organization. Ebola disease caused by Bundibugyo virus—Democratic Republic of the Congo and Uganda. Geneva: World Health Organization, 2026.
- 2 Africa CDC. Africa CDC declares the ongoing Bundibugyo Ebola outbreak a Public Health Emergency of Continental Security. 2026. <https://africacdc.org/news-item/africa-cdc-declares-the-ongoing-bundibugyo-ebola-outbreak-a-public-health-emergency-of-continental-security/> (accessed May 21, 2026).



Lancet Infect Dis 2026

Published Online

June 1, 2026

[https://doi.org/10.1016/S1473-3099\(26\)00288-4](https://doi.org/10.1016/S1473-3099(26)00288-4)

See Online for appendix

- 3 Ministry of Health. Uganda. Press statement Ebola Bundibugyo virus disease outbreak 2026. 2026. <https://health.go.ug/download/press-statement-ebola-bundibugyo-virus-disease-outbreak-2026/> (accessed May 21, 2026).
- 4 Kanyerezi S, Ayitewala A, Nsawotebba A, et al. Ebola Bundibugyo. Pathoplexus 2026, PP_006XCJJ.1. 2026. https://pathoplexus.org/ebola-bdbv/search?selectedSeq=PP_006XCJJ.1 (accessed May 21, 2026).
- 5 Nsawotebba A, Ssewanya I, Nabadda S, et al. Bundibugyo virus isolated in Uganda represents a new subclade from on-going outbreak in DRC. *Lancet* 2026; (in press)
- 6 International Organisation for Migration. Flow monitoring dashboard: Uganda/DRC border. 2020. <https://dtm.iom.int/report-product-series/flow-monitoring-dashboard-ugandadrc-border> (accessed May 21, 2026).
- 7 King P, Wanyana MW, Mayinja H, et al. Cross border population movements across three East African states: Implications for disease surveillance and response. *PLOS Glob Public Health* 2024; 4: e0002983.
- 8 Reuters. 2026. Family of US Ebola patient admitted to Berlin isolation ward. <https://www.reuters.com/business/healthcare-pharmaceuticals/family-us-ebola-patient-admitted-berlin-isolation-ward-2026-05-21/> (accessed May 21, 2026).