

Bundibugyo Virus Disease in the Democratic Republic of the Congo and Uganda: A Neglected Public Health Threat

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Keywords

Bundibugyo virus • Bundibugyo virus disease • BDBV • Democratic Republic of the Congo
Uganda • viral hemorrhagic fever • emerging infectious diseases

Dear Editor,

Bundibugyo virus disease (BVD) is a rare haemorrhagic fever caused by the Bundibugyo virus, a genetically distinct species within the ebolavirus group [1]. BVD was first identified in Uganda in 2007. Since then, it has been reported only three times. The most recent outbreak began in April-May 2026 in Ituri Province, eastern Democratic Republic of the Congo (DRC). The outbreak later crossed the border into Uganda [1]. On 17 May 2026, the World Health Organization (WHO) designated this outbreak, the DRC's 17th Ebola-related outbreak since 1976, as a Public Health Emergency of International Concern (PHEIC) [2]. By 25 July 2026, the DRC had recorded 3,200 confirmed cases and 1,405 deaths, with 773 patients being isolated and 571 having recovered; Ituri Province alone accounted for 2,848 cases and 1,184 deaths [3]. These totals already exceed the two previous BVD outbreaks combined (131/42 in Uganda, 2007-08; 38/13 in DRC, 2012) [4].

This outbreak is important for reasons beyond the number of cases. It is the first BVD outbreak to be declared a PHEIC. This decision was linked to the documented spread of the virus across the border into Uganda. There were also cases that were transported for medical care to Germany, France, and the United States [1, 3, 5]. Nosocomial transmission has also been an important feature of the outbreak. It was first recognised after the death of a nurse in Mongbwalu, highlighting ongoing gaps in infection prevention and control [6]. Unlike Zaire ebolavirus, Bundibugyo virus has no licensed vaccine or approved therapeutic, leaving responders dependent on non-pharmaceutical measures [7].

Several factors may explain the resurgence of BVD. Ongoing armed conflict, population displacement, and artisanal mining have created highly mobile communities. This movement makes it more difficult to trace contacts and control the spread of infection [8]. Genomic evidence also suggests that the current outbreak may have resulted from a new spillover from an animal reservoir. In addition, limited investment in filovirus diagnostic capacity has created further challenges. GeneXpert, which is mainly optimised for detecting Zaire ebolavirus, did not detect Bundibugyo

virus effectively. This contributed to delays in confirming cases and isolating infected individuals [9].

Current prevention relies mainly on early case detection, isolation, contact tracing, safe burials and community engagement. However, these measures remain difficult to implement effectively in a conflict-affected setting. The outbreak has also exposed major gaps in diagnostic capacity, although WHO added the first molecular test specifically for Bundibugyo virus to its Emergency Use Listing in July 2026 [7, 10, 11].

Recent studies have highlighted important gaps in preparedness for non-Zaire filoviruses. These include limited diagnostic capacity and the need to develop effective medical countermeasures more quickly. In response, investigational treatments, including remdesivir and monoclonal antibodies such as MBP-134, are being evaluated. Vaccine candidates are also being developed and tested [7, 12].

We recommend: (1) improving filovirus diagnostics to enable pan-ebolavirus detection; (2) sustained and protected funding for contact tracing and infection control in conflict zones; (3) faster development of Bundibugyo-specific vaccines and therapeutics, alongside evaluation of cross-protection; (4) stronger cross-border coordination between DRC, Uganda and neighbouring states; and (5) conflict-sensitive risk communication adapted to the context of eastern DRC. The 2026 outbreak highlights that non-Zaire ebolaviruses remain a neglected but significant threat requiring sustained investment.

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Consent for Publication

Not applicable.

Data Availability

All data referenced in this Letter to the Editor are publicly available from the cited sources.

Conflicts of interest statement

The author declares no conflict of interest.

Authors' contributions

ZK: Conceptualization, Methodology, Literature review, Investigation, Writing-Original Draft, Writing-Review & Editing, and Final approval of the manuscript.

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