DRC Ituri

Ebola Disease Outbreak — Bundibugyo Strain, 2026

Epidemiological situation report, geographic analysis & risk assessment · Compiled 16 May 2026 [initial edition · updated from declaration-day report with Radio Okapi corrections]

Primary sources: Africa CDC Statement (15 May 2026) · WHO AFRO Statement (15 May 2026) · WHO Press Briefing — DG Tedros (15 May 2026) · **Radio Okapi** (15–16 May 2026) · Uganda MoH / Dr. Diana Atwine (15 May 2026) · *Daily Monitor* Kampala · ChimpReports · US CDC / Jay Bhattacharya · Reuters · AFP · CBS News · CNN · Al Jazeera · Time · CIDRAP · UPI · Business Standard · Imperial College London Q&A · CEPI

KEY DEVELOPMENTS — DECLARATION DAY & IMMEDIATE AFTERMATH (15–16 May 2026)

- **Outbreak declared — 246 suspected cases, 65–80 deaths.** Africa CDC confirmed on 15 May 2026 an Ebola Disease (EBOD) outbreak in Ituri Province, DRC. Cases centre on Mongbwalu and Rwampara health zones, with suspected cases in Bunia. **Radio Okapi (15 May, 13:40 local):** 80 deaths — higher than the 65 reported by Africa CDC earlier the same day, consistent with a rapidly escalating toll. WHO AFRO reports 67 community deaths. Four deaths are laboratory-confirmed.
- **Bundibugyo ebolavirus (BDBV) confirmed — no approved vaccine or treatment exists.** DRC's INRB (Kinshasa) confirmed Ebola in 13 of 20 samples; Radio Okapi reported 8 confirmed cases. WHO DG Tedros and all major sources confirm the strain as BDBV. Only the third BDBV outbreak in recorded human history. Both WHO-prequalified Ebola vaccines (Ervebo; Zabdeno/Mvabea) target Zaire strain only. No licensed antiviral exists for BDBV.
- **Critical diagnostic delay — Zaire-only field kits failed to detect BDBV for ~10 days.** WHO was notified ~5 May. Field GeneXpert diagnostics detect Zaire ebolavirus only. Positive result obtained only after samples reached INRB reference lab in Kinshasa (~14 May). A local Mongbwalu health source told AFP deaths had been "exponential" since *mid-April* — suggesting 3–5 weeks of undetected community transmission.
- **Eyewitness accounts from Radio Okapi and AFP confirm large-scale community deaths.** Mongbwalu resident Gloire Mumbesa (AFP): "For the past few weeks, the municipality of Mongbwalu has been recording a cascade of deaths, with at least five to six people dying every day in the streets." Civil society member Salama Bamunoba (Rwampara, AFP): "We just dug graves to bury three people, but we don't actually know what these people died of." Schools in Bunia deployed barrier measures (temperature checks, mandatory handwashing) on 15 May morning.
- **Cross-border death confirmed in Kampala, Uganda (14 May).** A 59-year-old Congolese man was admitted to Kibuli Muslim Hospital (Makindye Division, Kampala) on 11 May with respiratory distress, fever, epigastric pain, nausea. He died in the ICU on 14 May with haemorrhagic symptoms. Body repatriated to DRC at 8pm that night — *before laboratory results were available*. Uganda Central Emergency Surveillance and Response Support Lab (Wandegeya, Kampala) confirmed Bundibugyo ebolavirus on 15 May. One high-risk contact (close relative of deceased) isolated; all other contacts under monitoring.
- **Uganda deploys mobile lab to Bwera Hospital (DRC border).** Uganda activated its Emergency Operations Centre, deployed screening and surveillance teams at 22 border crossings and major transit routes — including pilgrimage corridors — and established a **mobile laboratory at Bwera Hospital** near the Kasindi crossing (0.03°N, 29.77°E), the primary DRC-Uganda border point in the outbreak zone.
- **Africa CDC convenes emergency regional coordination (15 May).** DG Dr. Jean Kaseya convened urgent meeting: DRC, Uganda, South Sudan + WHO, UNICEF, FAO, US CDC, ECDC, China CDC, PHAC, MSF, IFRC, CEPI, Gavi, World Bank, Gates Foundation, Wellcome Trust, and Gilead, Merck, J&J, Regeneron, Roche, Abbott, Cepheid, BioNTech, Moderna, Evotec Biologics.
- **Potentially second-largest non-Zaire EBOD outbreak in history — with weeks of missed transmission.** Imperial College London: if suspected case numbers confirmed, this represents "the second-largest non-Zaire strain Ebola outbreak in history" with "transmission for several weeks already, with late detection." The first Bundibugyo outbreak (Uganda 2007) occurred in Bundibugyo District — directly across the border from the 2026 Ituri epicentre.

DOI: pending Zenodo registration · This report is compiled for informational and situational awareness purposes · Information current as of 16 May 2026

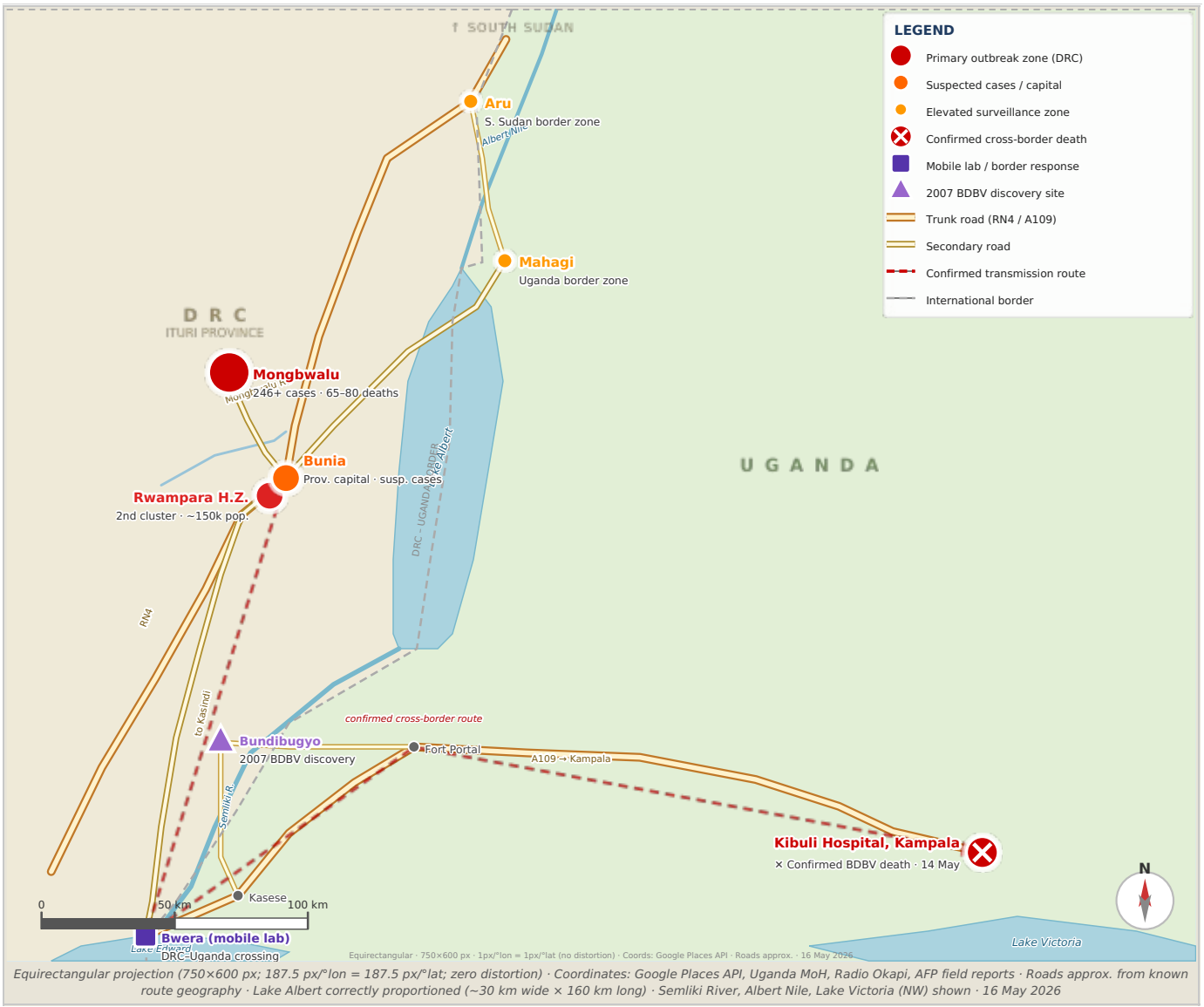
1. Outbreak Overview (as of 16 May 2026)

Outbreak declared	15 May 2026 — Africa CDC · DRC's 17th recorded Ebola outbreak since 1976
Province / Region	Ituri Province, northeastern DRC — >1,700 km from Kinshasa; borders Uganda (east) and South Sudan (north)
Primary health zones	**Mongbwalu** (~150,000 inhabitants; gold-mining epicentre; ~90 km / 2 hrs from Bunia) · **Rwampara** (~150,000 inhabitants; adjacent to Bunia)
Secondary location	**Bunia** (~300,000 inhabitants; provincial capital) — suspected cases pending confirmation; barrier measures in schools as of 15 May
Causative agent	Bundibugyo ebolavirus (BDBV) — genus *Orthoebolavirus*, family *Filoviridae*
Suspected cases	246 (Africa CDC) — likely a substantial undercount given diagnostic delay and security blind spots
Suspected deaths	65 (Africa CDC) · **80 (Radio Okapi, 15 May 13:40 local)** · 67 (WHO AFRO community deaths) — figures divergent and rapidly escalating
Lab-confirmed cases	13 positive of 20 samples (INRB) · **8 confirmed cases** (Radio Okapi, citing DRC Health Minister) · Uganda: 1 confirmed imported death
Lab-confirmed deaths	4 (DRC) + 1 (Uganda = imported)
Cross-border	1 confirmed BDBV death — Kibuli Muslim Hospital, Kampala, Uganda (admitted 11 May; died 14 May; body repatriated to DRC 14 May 8pm)
Apparent CFR (suspected)	~26–33% (consistent with historical BDBV CFR of 33–40%)
Vaccine / treatment	**None approved for BDBV.** Licensed Ebola vaccines and antivirals (mAb114, REGN-EB3) target Zaire strain only
Prior DRC outbreak	Zaire strain, Kasai Province (August–December 2025); 43 deaths; declared over ~December 2025 (~5 months prior)

2. Geographic Analysis — Documented Locations & Transmission Routes

Geographic verification note: All coordinates verified against Google Places API, Radio Okapi field reports, AFP eyewitness accounts, Uganda Ministry of Health statement (Dr. Diana Atwine, 15 May), and ChimpReports/Daily Monitor (Kampala). Rwampara health zone placed adjacent to Bunia per confirmed geographic description (Radio-Canada/AFP: "Rwampara is adjacent to the Bunia urban area"). Bwera Hospital coordinates from Google Places API — confirmed as Uganda's western DRC-border hospital and mobile lab deployment site.

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DOI: https://doi.org/10.5281/zenodo.20230585



Equirectangular projection (750×600 px; 187.5 px/°lon = 187.5 px/°lat; zero distortion) · Coordinates: Google Places API, Uganda MoH, Radio Okapi, AFP field reports · Roads approx. from known route geography · Lake Albert correctly proportioned (~30 km wide × 160 km long) · Semliki River, Albert Nile, Lake Victoria (NW) shown · 16 May 2026

3. Affected Health Zones — Verified Geographic and Epidemiological Profiles

① Mongbwalu Health Zone (1.929°N, 30.049°E) — Primary Epicentre

Mongbwalu is a gold-mining town approximately 90 km northwest of Bunia, connected by a road requiring about 2 hours under normal conditions. Its economy is dominated by artisanal and semi-industrial gold extraction, generating high-volume daily movement of workers between remote mining sites, camps, and the town's market and health facilities. Population approximately 150,000 in the health zone.

> **Radio Okapi / AFP field accounts (15 May 2026):** Local health sources confirmed "an exponential number of deaths since mid-April." Mongbwalu resident Gloire Mumbesa told AFP: "For the past few weeks, the municipality of Mongbwalu has been recording a cascade of deaths, with at least five to six people dying every day in the streets." A health worker (speaking anonymously) confirmed patients were being placed in isolation in health centres, but that staff lacked protective equipment. These accounts corroborate a significantly earlier disease onset than the official detection date of 14 May.

② Rwampara Health Zone (~1.55°N, ~30.20°E) — Second Primary Cluster

Rwampara health zone is geographically contiguous with the Bunia urban agglomeration, forming a peri-urban ring around the provincial capital. Its population of approximately 150,000 is exposed to the social and commercial networks of a city of 300,000. Cases in Rwampara that escape detection may rapidly seed Bunia proper — which the Africa CDC has already flagged as a high concern.

> **Radio Okapi / AFP field accounts (15 May 2026):** Civil society member Salama Bamunoba (Rwampara): "We just dug graves to bury three people, but we don't actually know what these people died of. We're starting to be afraid of every possible case of illness." This account suggests community deaths without formal attribution — a hallmark of pre-detection EBOD community spread.

③ Bunia (1.574°N, 30.240°E) — Provincial Capital, Suspected Cases

Bunia is the administrative, commercial, and transport hub of Ituri Province, with an estimated population of 300,000. It hosts the province's General Reference Hospital, international organisation offices, and serves as the entry point for aid and response teams. Radio Okapi reported on the morning of 15 May that schools across Bunia implemented barrier measures — temperature screening at school gates and mandatory hand-washing — following instructions issued by provincial health authorities the previous evening. Suspected cases in Bunia are pending laboratory confirmation.

④ Bwera Hospital / Kasindi Crossing (0.034°N, 29.767°E) — Uganda Mobile Lab

Bwera Hospital is Uganda's government hospital serving the Kasindi border area in Kasese District, western Uganda — the primary formal land crossing point between Ituri Province (DRC) and Uganda. Bwera/Kasindi is the most likely route used by the Kampala patient and is one of the highest-risk border points for EBOD cross-border movement. Uganda's Ministry of Health confirmed deployment of a mobile laboratory at Bwera Hospital as part of its emergency response (15 May).

⑤ Kibuli Muslim Hospital, Kampala (0.310°N, 32.595°E) — Confirmed Cross-Border Case

Kibuli Muslim Hospital is located on Kibuli Hill, Makindye Division, approximately 3 km southeast of Kampala's central business district. It is a 24-hour tertiary hospital affiliated with the Islamic University in Uganda. On 11 May, a 59-year-old Congolese national presented with respiratory distress, fever, epigastric pain, nausea, and difficulty passing urine. His condition deteriorated and he died in the ICU on 14 May with haemorrhagic symptoms. His body was repatriated to DRC

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DOI: https://doi.org/10.5281/zenodo.20230585

that evening at 8pm. Uganda's Central Emergency Surveillance and Response Support Laboratory in Wandegeya, Kampala confirmed Bundibugyo ebolavirus on 15 May. According to ChimpReports, one high-risk contact (a close relative of the deceased) has been isolated; all known contacts are under quarantine and monitoring.

> ***Epidemiological note — duration of silent transmission:*** *The patient was admitted 11 May — four days before the outbreak was officially declared — and had clearly been symptomatic for some days prior. A local Mongbwalu health source told AFP that deaths had been "exponential since mid-April." If first community cases occurred around 20 April, and mean Ebola incubation is 8–10 days, the transmission chain had approximately 2–3 generations of spread before any official diagnostic suspicion. With a basic reproduction number (R_0) of 1.5–2.5 in comparable settings and 3–4 generations elapsed, a starting cohort of 1–3 infected individuals could plausibly produce 200–400 cases — entirely consistent with 246 suspected cases at declaration. The true case count is almost certainly higher.*

4. Outbreak Summary (as of 16 May 2026)

Suspected cases	246 — Africa CDC (15 May). Likely a significant undercount; see section 3 epidemiological note.
Suspected deaths	65 (Africa CDC, 15 May morning) · **80 (Radio Okapi, 15 May 13:40 local)** · 67 community deaths (WHO AFRO). Figures diverge — Radio Okapi citing DRC Health Ministry may reflect more recent data.
Lab-confirmed cases	13 of 20 INRB samples positive · 8 confirmed cases (Radio Okapi, citing DRC Health Minister Hygiène)
Lab-confirmed deaths	4 (DRC — INRB) + 1 (Uganda — Central Lab Wandegeya) = 5 total cross-border
Cross-border	1 confirmed BDBV death (Kampala, Uganda); no locally transmitted Ugandan cases confirmed as of 16 May; 1 high-risk contact isolated
Illness onset range	Mid-April 2026 (per AFP health source) — ongoing
Virus confirmed	Bundibugyo ebolavirus (BDBV) — INRB, Kinshasa (14 May 2026); Central Lab Wandegeya, Kampala (15 May 2026)
Incubation period	2–21 days (WHO standard)
Countries affected	DRC (confirmed outbreak) · Uganda (1 confirmed imported death; 22 border crossings under screening; mobile lab at Bwera) · South Sudan (heightened surveillance)
Vaccine / treatment	No approved vaccine or specific antiviral for BDBV
WHO emergency funding	USD 500,000 released · 5 metric tons of supplies airlifted to Ituri
WHO global risk	Not formally classified; high regional risk acknowledged; global concern given cross-border confirmation

5. The Bundibugyo Ebolavirus — Pathogen Profile

Prior Outbreak Record

Outbreak	Location	Year	Suspected cases	Deaths	CFR	Note
1st (discovery)	Bundibugyo District, Uganda	2007–08	149	37	~25–40%	Novel species. Directly across border from 2026 epicentre.
2nd	Isiro, Province Orientale, DRC	2012	57	29	~51%	Geographically proximate to Ituri. Contained in ~3 months without vaccine.
3rd (current)	**Ituri Province, DRC**	**2026**	**246+ suspected**	**65–80+**	**~26–33%**	**Largest BDBV outbreak ever. Cross-border confirmed. No vaccine. Active conflict.**

Vaccine gap: Both WHO-prequalified Ebola vaccines (Ervebo, Merck; Zabdeno/Mvabea, Janssen) target the Zaire strain only. BDBV and Zaire ebolavirus are ~40% genetically divergent — sufficient to render Zaire-strain vaccines ineffective against BDBV. No licensed antiviral exists for BDBV. Ring vaccination — decisive in the 2018–2020 Zaire response — is unavailable here. Classical containment (case isolation, contact tracing, safe & dignified burials, IPC, community engagement) is the sole tool set.

Diagnostic gap: Field GeneXpert platforms in DRC were configured to detect Zaire ebolavirus only, causing the 10-day diagnostic failure between WHO notification (~5 May) and INRB laboratory confirmation (14 May). This gap is not unique to this outbreak — it is a structural vulnerability wherever BDBV, Sudan, or other non-Zaire strains emerge outside their endemic regions.

> ***Research significance — geographic proximity to 2007 BDBV discovery:*** *The 2007 outbreak occurred in Bundibugyo District, Uganda — located directly across the DRC-Uganda border from the 2026 Mongbwalu epicentre (straight-line distance ~130 km). Whether the 2026 isolate is phylogenetically related to the 2007 Uganda or 2012 DRC isolates, or represents an independent zoonotic spillover from a shared reservoir population, is a critical scientific question with direct implications for understanding BDBV spillover ecology in this region. Full genomic sequencing and Nextstrain phylogenetic analysis are urgently needed.*

6. BDBV Ituri 2026 — What We Know and What We Do Not Know (16 May 2026)

✓ Confirmed (primary sources verified)	? Unknown or unresolved
BDBV confirmed by PCR in 13 of 20 INRB samples (14 May) and in 1 Uganda patient (15 May, Wandegeya lab). Radio Okapi: 8 positive cases confirmed by DRC Health Ministry.	Full genomic sequencing and Nextstrain phylogenetic analysis not yet publicly released. Clade relationship to 2007 Uganda and 2012 DRC isolates unknown.
246 suspected cases and 65–80 suspected deaths as of 15 May. Local health source: "exponential deaths since mid-April." Eyewitness: 5–6 deaths per day in Mongbwalu streets.	True case count is substantially higher. Diagnostic delay (~10 days), security blind spots, and geographic access constraints mean a significant fraction of cases are invisible to surveillance.
Cross-border spread confirmed: 59-year-old Congolese man died at Kibuli Hospital, Kampala, 14 May. Body repatriated to DRC. 1 high-risk contact isolated in Uganda.	Unknown whether body transported back to DRC led to further transmission chains (safe and dignified burial not confirmed). Unknown if additional cross-border cases exist in Uganda or South Sudan yet undetected.
Bwera Hospital mobile lab deployed (Uganda-DRC border). 22 border points under screening. Schools in Bunia implementing barrier measures as of 15 May morning (Radio Okapi).	Whether Bunia suspected cases will be confirmed is unknown. Urban spread in Bunia (300,000 people) would constitute a major escalation.
No approved vaccine or specific antiviral for BDBV exists. Field GeneXpert Zaire-only configuration caused ~10-day diagnostic delay.	Whether any experimental broad-spectrum BDBV countermeasures (e.g., pan-ebolavirus antibodies, nucleoside antivirals) will be deployed under compassionate use or trial protocols is not yet determined.
Africa CDC emergency coordination meeting convened 15 May with 30+ global partners. WHO released USD 500,000 and is airlifting 5 metric tons of supplies.	Whether resources will reach Mongbwalu and Rwampara rapidly enough — given poor roads, security constraints, and 1,700 km distance from Kinshasa — is unknown. On-ground logistics timeline not publicly specified.
2012 BDBV outbreak (57 cases) was contained in ~3 months without a vaccine using classical measures. DRC has extensive institutional EBOD response experience (16	2026 outbreak already starts at 4× the 2012 case count at declaration, in an active conflict zone, with confirmed cross-border spread. Whether community trust in

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DOI: https://doi.org/10.5281/zenodo.20230585

prior outbreaks).	health authorities — seriously damaged in 2018–2020 — has recovered is unknown.

7. International Response (as of 16 May 2026)

WHO	DG Tedros confirmed BDBV at press briefing; USD 500,000 released; 5 metric tons supplies airlifted; additional epidemiologists/lab specialists deployed. Notified ~5 May; initial field GeneXpert results negative (Zaire-only equipment). Statement (WHO AFRO): 67 community deaths suspected. Acknowledges "insecurity, crowding, and urban context" as key risk multipliers.
Africa CDC	Declaration and emergency coordination meeting, 15 May. DG Kaseya: "Given the high population movement between affected areas and neighbouring countries, rapid regional coordination is essential." Meeting included 30+ global partners. Supporting INRB genomic sequencing.
DRC Government	INRB conducted primary laboratory confirmation (14 May). DRC Health Minister cited by Radio Okapi confirming 8 positive cases, Bundibugyo strain, 80 deaths (15 May 13:40 local). National response coordination committee activated. INRB has prior BDBV characterisation capacity from 2012 outbreak.
Uganda	MoH PS Dr. Diana Atwine confirmed imported BDBV death (died 14 May, Kibuli Hospital). Activated Emergency Operations Centre. Deployed screening/surveillance at 22 border crossings and transit routes, including pilgrimage corridors. **Mobile lab deployed at Bwera Hospital** (DRC border). Isolation facilities established. 1 high-risk contact isolated; all contacts under monitoring. Test confirmed at Central Emergency Surveillance and Response Support Lab, Wandegeya.
South Sudan	Invited to Africa CDC coordination. Shares northern Ituri border. Significantly weaker health infrastructure than Uganda. No confirmed cases; surveillance mandated.
US CDC	Acting Director Bhattacharya confirmed monitoring and technical assistance via country offices in DRC and Uganda. Press briefing 15 May. No alert level yet assigned.
CEPI	Issued readiness statement for R&D support and clinical trial facilitation. No advanced BDBV vaccine candidate in pipeline; Phase I development timeline minimum 12–18 months under emergency pathway.
MSF	Pre-existing presence in eastern DRC and Ituri; warned of catastrophic hygiene in displacement camps (early May). Engaged in Africa CDC coordination meeting. ETC deployment under security assessment.
Imperial College London	Published Q&A warning of multi-week pre-detection transmission and second-largest non-Zaire outbreak status. Emphasised challenge of non-Zaire strain containment without vaccine.

8. Risk of Cross-Border Transmission

Overview — A Structurally Porous Border Under High Epidemic Pressure

The DRC–Uganda land border stretches approximately 950 km and is widely characterised in the academic and humanitarian literature as one of the most porous borders in sub-Saharan Africa. The Ituri Province section — running east of the current outbreak zone — is the critical epidemiological interface. Unlike well-monitored checkpoints at major urban crossings, the Ituri–Uganda border is served by a single official border post at Kasindi (DRC) / Mpondwe–Bwera (Uganda), yet features at least 21 further Points of Entry in Kasese District alone — 20 of them unofficial. Community members on both sides routinely use informal river crossings, farm tracks, and forest paths specifically to avoid official crossing fees. Implementing systematic epidemiological surveillance across this border is, in the words of a 2018 Social Science in Humanitarian Action platform assessment, "not possible" given the resources available to border management agencies in this region.

Quantified Border Traffic — Mpondwe / Kasindi

IOM's Displacement Tracking Matrix (DTM), which operates flow monitoring points (FMPs) at the Uganda–DRC border, documented between 186,000 and 208,000 monthly crossings across its eight monitored FMPs in early 2020 — equivalent to 6,000–7,000 per day across all points. Mpondwe consistently registered the single highest flows among monitored crossings, accounting for 25–32% of all observed movements and recording 302,495 screenings at the Mpondwe Main official post in a single month during the 2018–2020 Zaire ebolavirus response period. Adjusted for the unofficial crossings that bypass formal screening entirely, actual total daily population movement in the Kasindi–Mpondwe corridor almost certainly exceeds several thousand individuals. The UNDP borderland policy brief (2021) confirmed that Mpondwe is Uganda's largest single informal export crossing, with informal cross-border trade valued at USD 149–172 million per year — driven predominantly by mineral, fuel, and agricultural commodity flows originating in eastern DRC, including Ituri.

> ***Critical implication:*** *The confirmed Kampala case — a 59-year-old Congolese man who crossed into Uganda through the Kasindi/Mpondwe corridor and died at Kibuli Hospital on 14 May, four days before the outbreak was declared — is direct empirical evidence that the virus was moving through this high-volume corridor during the period of undetected community transmission. Given the 11.3-day mean incubation period documented for BDBV (Paerisch (né Kratz) et al., 2015) and the volume of crossings, an unknown number of additional individuals in the incubation window almost certainly crossed before and after him.*

Gold Mining as a Structured Transmission Amplifier

Mongbwalu, the primary outbreak epicentre, is the economic centre of one of the DRC's largest artisanal and small-scale gold mining (ASGM) zones. Historical estimates place 25,000–30,000 people engaged in gold mining, transport, and processing in the Mongbwalu region alone (Wikipedia / SOKIMO concession data). A 2024 investigation by Mongabay documented that artisanal mining activity is continuing to expand along the Ituri River corridor under National Route 4, with deforestation accelerating through 2023–2024. Mining in this region operates through a layered mobility structure that systematically links the outbreak zone to international trade routes:

- **Primary mobility layer — mining camp to town:** Workers circulate daily or weekly between underground and open-pit mines in remote concessions and the Mongbwalu market town. Camp conditions — shared sleeping quarters, communal water points, no sanitation — are high-risk environments for contact transmission. An individual becoming symptomatic in a camp may return to town before symptoms progress sufficiently to restrict travel.
- **Secondary mobility layer — Mongbwalu to Bunia:** Mongbwalu is connected to Bunia by a ~90 km road requiring approximately 2 hours. Motorcycle taxis (boda-bodas), shared minibuses, and private vehicles service this route continuously. Gold and gold buyers, medical referrals, and commercial traffic all use this corridor. A person in the early prodromal phase of BDBV — presenting with non-specific fever, myalgia, and malaise indistinguishable from endemic malaria — would not be impeded from completing this journey.
- **Tertiary mobility layer — Bunia to Kasindi and across the border:** From Bunia, the road runs south ~120 km to Kasindi. Gold mined in Mongbwalu is, according to Wikipedia and the UNDP borderland brief, predominantly traded across the border to Uganda, where it enters regional commodity chains that extend to Kasese, Kampala, and ultimately to Dubai, Hong Kong, and other international markets through the Ariwara/Ituri gold trade networks. This means gold traders — a population that moves through the outbreak zone itself and crosses the border regularly — constitute a specific high-frequency transmission risk group.

Clinical Features of BDBV and Border Screening Limitations

The Paerisch (né Kratz) et al. 2015 PLOS ONE analysis of the 2012 BDBV Isiro outbreak provides the only detailed clinical dataset for BDBV in a DRC setting. Its findings are directly relevant to cross-border screening capability. Among ETC patients, 88.2% had fever or self-reported fever upon admission, but major presenting symptoms were overwhelmingly non-specific: asthenia (82.4%), myalgia (70.6%), arthralgia (76.5%), and nausea (70.6%). Critically, haemorrhagic signs — the feature most associated with clinical Ebola recognition — were infrequent. The study reported a mean incubation period of 11.3 days and a median disease duration of 18 days. The primary differential diagnoses recorded in that outbreak were malaria (28.3%), intestinal parasitosis (10.9%), and non-specific infectious syndrome (10.9%).

These findings define the border screening problem precisely: an individual in the first 3–7 days of BDBV infection presents with fever and flu-like symptoms that are clinically indistinguishable from endemic malaria — the most common febrile illness in this corridor. Temperature screening at official border posts, the standard measure deployed in previous eastern DRC Ebola responses, cannot distinguish early BDBV from malaria at the time when a traveller is still mobile enough to cross a border. The Kampala case exemplifies this: his documented symptoms (respiratory distress, fever, epigastric pain, nausea) at hospital admission were non-specific, and he was not identified as an EBOD suspect until after his death.

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DOI: https://doi.org/10.5281/zenodo.20230585

Mahagi Corridor and the West Nile / South Sudan Interface

A secondary cross-border risk corridor runs from Mahagi health zone (NE Ituri, 2.305°N, 30.976°E) northeastward toward Uganda's West Nile Region and South Sudan. Mahagi sits along a trade and movement route connecting northern Ituri to Uganda via the Goli and Paidha crossings. Unlike the Kasindi/Mpondwe corridor, this route has received no specific EBOD preparedness deployment as of 16 May. South Sudan — which borders Ituri Province via the northern Aru area — presents a distinct and severe concern: its health infrastructure was substantially degraded by years of conflict, and an EBOD case arriving in South Sudan before detection would encounter a system with far less capacity to identify, isolate, and manage it than Uganda's.

Informal Crossing Behaviour and Trust Dynamics

A 2018 cross-border dynamics assessment documented that traders at Bwera explicitly told researchers that "Ebola is politics" — denying the reality of the 2018–2020 Zaire ebolavirus outbreak and continuing cross-border movement. This finding, from the immediately preceding eastern DRC outbreak, underscores a structural challenge: border communities whose livelihoods depend on daily cross-border trade have strong economic incentives to avoid health checkpoints and may have low trust in official health communications. With Mpondwe the only official crossing in Kasese District, the majority of the population moves through informal crossings where no health authority has any surveillance presence. The incentive to use informal crossings intensifies when official crossings impose health screening delays — precisely when they are most needed.

> ***Risk synthesis (16 May 2026):*** *The combination of (i) weeks of undetected pre-declaration transmission in a gold-mining population with structured cross-border mobility, (ii) a confirmed imported death in Kampala before outbreak declaration, (iii) a border regime dominated by informal crossings that cannot be screened, (iv) BDBV clinical non-specificity during the infectious prodromal phase, and (v) community trust deficits documented from the prior eastern DRC Ebola response constitutes a high-risk cross-border transmission scenario. Uganda is the immediately threatened country and has responded faster than any prior outbreak would suggest is typical. The risk for South Sudan — with a weaker health system and a less monitored border segment — has not yet been formally addressed in any public statement from international health authorities as of 16 May 2026.*

Kasindi/Mpondwe daily official crossings	~302,000 screenings/month at official post alone (IOM DTM, 2019); Mpondwe = 25–32% of all monitored DRC-Uganda FMP flows
Unofficial crossings (Kasese District)	≥20 unofficial PoEs in Kasese District alone; preferred by community members to avoid fees; no health screening possible
Mongbwalu ASGM workforce	25,000–30,000 engaged in mining, transport, processing; gold traded primarily across border to Uganda
Key transmission route	Mongbwalu → Bunia (~90 km) → Kasindi border → Bwera/Kasese → Fort Portal → Kampala (424 km from border)
BDBV border screening detectability	Low during prodrome: non-specific fever/myalgia/nausea indistinguishable from malaria; haemorrhage infrequent (Paerisch (né Kratz) et al., 2015)
Mean BDBV incubation (2012 Isiro data)	11.3 days (Paerisch (né Kratz) et al., 2015) — individual may be infectious but asymptomatic or mildly symptomatic while crossing
Mahagi / West Nile corridor	NE Ituri → Uganda West Nile Region via Goli/Paidha crossings; no specific EBOD preparedness deployed as of 16 May
Aru / South Sudan interface	Northern Ituri → South Sudan; severely degraded South Sudan health infrastructure; no formal public risk assessment issued
Community trust	2018 fieldwork documented active denial of Ebola outbreak at Bwera crossing; trade incentives dominate screening compliance

9. References and Sources

A. PRIMARY OFFICIAL DOCUMENTATION

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[3] Uganda Ministry of Health / Dr. Diana Atwine — Ebola Bundibugyo confirmation statement (15 May 2026).

[4] US CDC / Acting Director Jay Bhattacharya — Press briefing (15 May 2026).

[5] CEPI Statement on Bundibugyo Ebola Outbreak (15 May 2026).

B. CONGOLESE AND REGIONAL SOURCES

[6] **Radio Okapi** — "Déclaration de l'épidémie d'Ebola en Ituri : 8 cas confirmés" (15 May 2026, 13:40): https://www.radiookapi.net/2026/05/15/actualite/sante/declaration-de-lepidemie-debola-en-ituri-8-cas-confirmes [KEY SOURCE: 80 deaths; 8 confirmed cases; DRC Health Minister statement]

[7] **Radio Okapi** — "Des mesures barrières renforcées dans les écoles après une alerte à Ebola à Bunia" (15 May 2026): https://www.radiookapi.net/2026/05/15/actualite/sante/des-mesures-barrieres-renforcees-dans-les-ecoles-apres-une-alerte-ebola [Barrier measures in Bunia schools]

[8] **Radio Okapi** — "L'OMS déploie des experts pour soutenir la riposte contre l'épidémie d'Ebola en Ituri" (16 May 2026): https://www.radiookapi.net/2026/05/16/actualite/sante/loms-deploie-des-experts-pour-soutenir-la-riposte-contre-lepidemie-debola

[9] ChimpReports (Uganda) — "Congolese Man Dies of Ebola in Kampala" (15 May 2026): https://chimpreports.com/congolese-man-dies-of-ebola-in-kampala/ [High-risk contact isolation; Wandegeya lab confirmation; body repatriation timeline]

[10] Daily Monitor (Uganda) — "Uganda confirms Ebola case after Congolese man dies in Kampala" (15 May 2026): https://www.monitor.co.ug/uganda/news/national/uganda-confirms-ebola-case-after-congolese-man-dies-in-kampala-5461284

[11] AFP eyewitness accounts — Gloire Mumbesa (Mongbwalu) and Salama Bamunoba (Rwampara), via AFP wire (15 May 2026); carried by AFP/Radio-Canada/Noovo.info.

C. INTERNATIONAL NEWS COVERAGE

[12] Reuters / CNBC Africa (15 May 2026): https://www.cnbcafrica.com/2026/african-public-health-agency-announces-new-ebola-outbreak-in-congo-65-suspected-deaths

[13] CBS News (15 May 2026): https://www.cbsnews.com/news/ebola-congo-dozens-dead-hundreds-more-possible-cases/

[14] CNN (15 May 2026): https://www.cnn.com/2026/05/15/health/ebola-outbreak-deaths-congo

[15] Al Jazeera (15 May 2026): https://www.aljazeera.com/news/2026/5/15/health-officials-raise-alarm-over-new-ebola-outbreak-in-dr-congo

[16] Time (15 May 2026): https://time.com/article/2026/05/15/new-ebola-outbreak-democratic-republic-of-congo/

[17] CIDRAP (15 May 2026): https://www.cidrap.umn.edu/ebola/new-ebola-outbreak-hits-democratic-republic-congo

[18] Business Standard (16 May 2026): https://www.business-standard.com/world-news/rare-ebola-virus-strain-with-no-approved-vaccine-kills-dozens-in-congo-126051600273_1.html

[19] Dr. Céline Gounder (15 May 2026): https://www.celinegounder.com/p/ebola-bundibugyo-congo-ituri-outbreak-2026 [Bwera mobile lab; Bundibugyo district geographic note]

[20] Radio-Canada / AFP (15 May 2026): https://ici.radio-canada.ca/nouvelle/2254515/ebola-rdc-nouvelle-epidemie-deces-ouganda [Rwampara geographic description; AFP field accounts]

[21] Imperial College London Q&A (15 May 2026).

[22] Euronews (15 May 2026): https://www.euronews.com/health/2026/05/15/what-we-know-about-congos-new-ebola-outbreak

D. GEOGRAPHIC VERIFICATION SOURCES

[23] Google Places API — Mongbwalu (1.9293°N, 30.0492°E); Bunia (1.5743°N, 30.2397°E); Kibuli Muslim Hospital, Kampala (0.3095°N, 32.5953°E); Bwera Hospital (0.0337°N, 29.7669°E); Bundibugyo District (0.6852°N, 30.0203°E) — all queried 16 May 2026.

[24] Wikipedia — Kibuli Hospital: "located on Kibuli Hill in Makindye Division, ~3km from Kampala CBD." https://en.wikipedia.org/wiki/Kibuli_Hospital

[25] Rwampara location per AFP/Radio-Canada: "Rwampara is adjacent to the Bunia urban agglomeration" — placed at ~1.55°N, 30.20°E on map accordingly.

E. SCIENTIFIC BACKGROUND

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[27] CDC Ebola Outbreak History: https://www.cdc.gov/ebola/outbreaks/index.html

[28] WHO Ebola Fact Sheet: https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease

[29] Paerisch (né Kratz) F, Roddy P, Wahl V, Borchert M, et al. Ebola Virus Disease Outbreak in Isiro, Democratic Republic of the Congo, 2012: Signs and Symptoms, Management and Outcomes. *PLOS ONE*. 2015;10(6):e0129333. DOI: 10.1371/journal.pone.0129333. [2012 BDBV Isiro outbreak — clinical features, incubation period 11.3 days, differential diagnosis; directly relevant to 2026 Ituri BDBV outbreak characterisation and cross-border screening assessment]

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This report is compiled for informational and situational awareness purposes. Information current as of 16 May 2026.

DOI: https://doi.org/10.5281/zenodo.20230585

F. CROSS-BORDER RISK — DATA SOURCES

[30] IOM Displacement Tracking Matrix — Flow Monitoring Dashboard: Uganda/DRC Border (2019–2020). https://dtm.iom.int/report-product-series/flow-monitoring-dashboard-ugandadrc-border [302,495 Mpondwe Main screenings/month; Mpondwe = 25–32% of all monitored DRC-Uganda FMP movements]

[31] Social Science in Humanitarian Action Platform — "Uganda–DRC Cross-Border Dynamics" (December 2018). https://www.socialscienceinaction.org/resources/uganda-drc-cross-border-dynamics/ [Mpondwe/Bwera informal crossing dynamics; community trust deficit; trader testimony: 'Ebola is politics']

[32] UNDP / Borderland Policy Briefing Series — Informal Cross-Border Trade Uganda–DRC (2021). https://www.undp.org/sites/g/files/zskgke326/files/migration/africa/policy-briefing_DRC-UGANDA_final4.pdf [Mpondwe informal exports USD 149–172M/year; gold trade networks Ituri → Uganda → Dubai/Hong Kong]

[33] Daily Monitor (Uganda) — "Why the Uganda–DRC border remains porous" (22 October 2023). https://www.monitor.co.ug/uganda/news/national/why-the-uganda-drc-border-remains-porous-4409598 [21 PoEs Kasese District; 6 illegal crossings in single sub-county; community preference for informal routes]

[34] Wikipedia — Mongbwalu. https://en.wikipedia.org/wiki/Mongbwalu [25,000–30,000 gold miners; gold traded across border to Uganda; SOKIMO / Adidi mine history]

[35] Mongabay — "Illegal gold mining drives deforestation in DRC reserve" (December 2024). https://news.mongabay.com/2024/11/illegal-gold-mining-drives-deforestation-in-drc-reserve-home-to-african-unicorn/ [ASGM expansion along Ituri River / RN4 corridor 2022–2024]

DOI: pending Zenodo registration | This report is compiled for informational and situational awareness purposes. Information current as of 16 May 2026; the outbreak was actively evolving at time of publication. Changes from the initial edition: Radio Okapi death toll corrected to 80 (from 65); Radio Okapi 8-confirmed-case figure added; WHO AFRO 67-community-death figure added; Uganda Bwera mobile lab detail added; Kibuli Hospital / Wandegeya lab confirmation details expanded; eyewitness accounts from AFP integrated; school barrier measures in Bunia added; SVG geographic map added with verified coordinates from Google Places API.

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DOI: https://doi.org/10.5281/zenodo.20230585