

Healix

Medical Briefing

Ebola in the Democratic Republic of Congo

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Ebola

Background

Named after the Ebola River in the Democratic Republic of Congo, where an early outbreak occurred, this disease is a very serious viral illness of Central and Western Africa which has a mortality rate of up to 90%.

There are four species of orthoebolaviruses which are known to cause disease in humans: Zaire virus, Sudan virus, Taï Forest virus, and Bundibugyo virus.

Bundibugyo virus disease (BVD) is a form of Ebola disease. It is endemic to the Democratic Republic of the Congo and Uganda, and the case fatality rate has historically ranged from 30%-50%.

Symptoms

At first a non-specific flu-like illness occurs which is difficult to distinguish from many other tropical illnesses such as malaria or influenza. This progresses over subsequent days and the virus causes a massive inflammatory response which leads to increased haemorrhage risk. Unfortunately, most people infected become critically unwell and the mortality rate can be very high.

Transmission

Fruit bats are the natural host of the Ebola virus but the virus can infect animals such as pigs, antelopes and monkeys. Humans who are involved in the slaughter of these animals or have eaten their poorly prepared meat can become infected. Human to human transmission can then occur by contact with bodily fluids of infected individuals. Close contact with someone infected with the disease is required to catch it. Specifically, the disease is transmitted by contact with the body fluids of someone infected with Ebola, or from someone who has died of the disease. Individuals are not infectious until they have symptoms themselves. As the disease becomes more severe, the risk of infection increases.

Ebola is not an airborne virus so the disease cannot be caught by breathing it in.

Ebola does not usually spread through casual or social contact. Individuals who are infectious usually feel extremely unwell so will not usually go out. For this reason transmission usually occurs to those who are looking after an Ebola victim – typically close family members or healthcare workers. Transmission also often occurs to those whose role it is to prepare a body for a funeral.

The incubation period for Ebola can vary significantly from two to 21 days.

People who are at risk of Ebola infection include:

- Close contacts of infected individuals
- Medical staff and health volunteers
- Those working in settings which facilitate close contact with large numbers of people (e.g. schools, prisons orphanages)

Diagnosis

Since Ebola presents similarly to other febrile illnesses laboratory testing is required. Diagnosis is confirmed using PCR or antigen testing. Sequencing is then used to confirm which strain of Ebola is present. Not all Ebola tests will pick up cases of Bundibugyo ebolavirus.

Treatment

As the prognosis is very poor, experimental therapies for Ebola are frequently tried when there is an Ebola outbreak.

The mainstay of treatment is organ system support in intensive care. However some specific targeted therapies have been shown to be of benefit in Ebola virus disease caused by the Zaire ebolavirus.

Although there is no specific treatment for Ebola disease caused by Bundibugyo, early detection and supportive care improves the prognosis. There is no vaccine for Bundibugyo virus. Treatment of Ebola caused by Bundibugyo virus is supportive.

Prevention

As the virus is very infectious, specialised equipment is required to protect the healthcare workers caring for patients from being infected. These may not always be available during the initial stages of an outbreak before a full public health response has been initiated. Public health measures will also usually include:

- Public education measures
- Setting up specialist Ebola treatment centres
- Provision of rapid testing to identify cases
- Tracing and monitoring of known Ebola contacts
- Vaccination of known Ebola contacts (but in the case of Bundibugyo ebolavirus there is no vaccine)

Prevention strategies for travellers include:

- Do not engage closely with anyone displaying symptoms of illness.
- Avoid travelling to areas experiencing outbreaks of the virus.
- Seek medical care immediately if you become unwell yourself.
- Practice good hand hygiene – wash hands frequently and use alcohol-based sanitisers.
- Peel fruit, cook food thoroughly, and do not eat bush-meat.
- Avoid all contact with human remains and deceased individuals (e.g. preparing for funerals).
- Adhere to all official public health control requirements (e.g. temperature screening).

Additional risk mitigation:

- Consider the operational necessity of your travel to affected regions.
- Take steps to minimise the risk of needing hospital treatment (e.g. avoid hazardous activities).
- Remember to take anti-malarial prophylaxis (the early stages of malaria can mimic Ebola – there is a risk of being sent to an Ebola treatment centre unnecessarily).
- Take meticulous precautions to avoid mosquito bites (to avoid malaria).
- Contact your assistance provider immediately if you believe that you have had contact with someone suffering from Ebola
- Pay close attention to the possibility of the imposition of new travel restrictions or the cancellation of scheduled flights.

Current Outbreak in the Democratic Republic of the Congo

A public health emergency of international concern (PHEIC) was declared by the World Health Organisation (WHO) on 16th May. On 5th May the WHO was notified of an unknown disease, and an outbreak of Bundibugyo virus disease (BVD) was subsequently confirmed on 13th May. The first known suspected case had reported onset of symptoms on 24th April.

As of 18th May 395 suspected cases and 106 fatalities have been reported. This outbreak is larger than the last BVD outbreak in the DRC in 2012, where 38 confirmed and 21 probable cases were reported alongside 34 deaths. Epidemiologists on the ground have yet to determine where this outbreak started or who the earliest case was. The large number of deaths which have already been recorded suggests the possibility of a much larger number of contacts, most of whom will not have been traced at this point.

The delayed identification of this outbreak hindered containment measures and response team effectiveness, which is likely to have severely exacerbated the event. Bundibugyo is a relatively uncommon strain of ebolavirus. As a result, it took longer than usual for this outbreak to be recognised as Ebola the initial testing was not sensitive to Bundibugyo ebolavirus. This setback is also likely a contributing factor to the high case numbers and may lead to elevated case fatality rates for this event.

The lack of a vaccine for Bundibugyo virus poses further challenges for containment as vaccinating contacts can be an effective containment strategy for other Ebola outbreaks where vaccines are available. This increases the risks for surrounding countries.

The Ituri province is prone to conflict and significantly impoverished which poses challenges in implement public health measures to managing this outbreak. Conflict presents obstacles for response teams deployed to assist with the situation. Contact tracing will prove challenging; local populations are highly mobile including migrant workers and displaced populations, increasing the risk of being unable to reach potential contacts.

Uganda

Two imported cases of BVD have been confirmed in Uganda from this outbreak. However, no community transmission has been reported in Kampala, or the rest of Uganda at this time; elevated risks remain present.

Ongoing monitoring and support

Healix continues to closely monitor this situation in coordination with our own medical analysts, relevant public health authorities and local partners. We are reviewing new information as it becomes available and assessing any potential implications for travellers and organisations.

Further updates and guidance will be issued if the situation changes. Clients are encouraged to contact Healix for individual advice or support related to travel, health, or security considerations.



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