

The Bundibugyo Ebola virus highlights the need for a resilient future for global and continental health security

On 17 May, the World Health Organization (WHO) declared the current Ebola outbreak caused by the Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda as a public health emergency of international concern (PHEIC),^[1] in keeping with the criteria in the 2005 International Health Regulations (IHR). It was stressed that the outbreak did not meet the criteria for a pandemic emergency, as defined in the IHR. However, the public health risk to other states or parties through the international spread of disease is a reality, and already at that stage, international spread had been documented, with two confirmed cases reported in Kampala, Uganda on 15 and 16 May following travel from the DRC. International co-ordination and co-operation were called for to assess the full extent of the outbreak, align surveillance, prevention and response efforts, and scale up and strengthen operations to ensure effective implementation of control measures.^[1]

Ebola, a zoonotic disease first identified in 1976, with fruit bats of the *Pteropodidae* family believed to be the natural reservoir, refers to a group of severe viral haemorrhagic fevers caused by orthoebolaviruses, members of the *Filoviridae* family. Non-human primates may also become infected. In untreated cases, Ebola has a fatality rate of ~50 - 70%. With timely supportive care and, where available, approved treatments, survival improves considerably. According to the WHO, case fatality rates in past outbreaks have ranged widely, from 25% to 90%. Since its discovery, Ebola has caused sporadic outbreaks across several African countries. The largest occurred in West Africa between 2014 and 2016, when nearly 30 000 cases were reported. Four species of orthoebolavirus are known to infect humans. The current outbreak in the DRC is caused by a distinct strain of the Bundibugyo virus (*Orthoebolavirus bundibugyoense*), previously linked to only two outbreaks. It is centred in eastern DRC, near the borders of Uganda, Rwanda and Burundi. Human infection can occur through contact with the blood, organs, or other bodily fluids of infected animals. Once introduced into the human population, the virus spreads through direct contact with the blood or bodily fluids of infected individuals, as well as through contaminated surfaces or materials. Ebola is not airborne, and does not spread through the air. Importantly, transmission occurs only after symptoms develop; individuals are not infectious during the incubation period.^[2]

The repeated emergence of Ebola outbreaks in Africa continues to highlight persistent weaknesses in surveillance systems, healthcare infrastructure, laboratory capacity, infection prevention and control (IPC) and emergency co-ordination. Recent responses to mpox, Marburg virus disease, cholera and other epidemic-prone illnesses have underscored the urgent need for integrated, multi-pathogen preparedness systems capable of rapidly detecting and containing emerging threats. Lessons from past Ebola outbreaks in the DRC, Uganda, Republic of Guinea, Liberia and Sierra Leone have shown that delayed detection, limited community engagement, inadequate IPC and fragmented co-ordination can quickly accelerate transmission and overwhelm health systems. More recent responses have further emphasised the importance of strengthened genomic surveillance, decentralised laboratory networks, community-centred

risk communication, survivor follow-up, cross-border collaboration and resilient health systems.^[3]

To address the latest public health emergency, the Africa Centres for Disease Control and Prevention (Africa CDC), in collaboration with the WHO, has issued a continental preparedness and response plan, which offers a strategic framework for co-ordinating an effective and unified response to the outbreak. The plan emphasises that combating Ebola is not solely the responsibility of the directly affected countries, but a collective obligation of all African Union (AU) member states. It goes on to state that in an increasingly interconnected world, the health security of each nation is closely tied to that of its neighbours. As such, effective prevention, preparedness and response must be grounded in African solidarity, strengthened regional co-operation and a shared commitment to building a healthier, more resilient continent.^[3] South Africa (SA)'s President Cyril Ramaphosa, the AU Champion for Pandemic Prevention, Preparedness and Response, underscored that the current Ebola outbreak is unfolding in regions characterised by high population mobility, insecurity, porous borders, humanitarian pressures and active trade routes. These conditions complicate rapid containment, and increase the urgency of a co-ordinated regional response. He paid tribute to frontline health workers who have faced successive epidemics and outbreaks, yet continue to demonstrate remarkable resilience, dedication and endurance in confronting a highly dangerous public health threat. Ramaphosa emphasised that protecting these workers is critical. This includes ensuring adequate supplies of high-quality personal protective equipment, deploying sufficient staff to allow for rest and recovery, and equipping healthcare personnel with the necessary resources to deliver safe and effective care. He also pledged that, in the spirit of African solidarity and homegrown solutions to continental challenges, the government and people of SA would make an initial contribution of USD5 million to the Africa CDC to support the ongoing Ebola response across the continent.^[3]

Regarding travel, the WHO advised against closing borders or imposing restrictions on travel and trade, noting that such actions are often driven by fear rather than scientific evidence. These measures can divert the movement of people and goods to unregulated border crossings, increasing the risk of disease spread. Critically, they may also disrupt local economies and hinder response operations, particularly by creating challenges for security and logistics.^[1] Despite WHO guidance, several countries have imposed travel restrictions on individuals from the DRC. On 27 May, Uganda temporarily closed its border with the DRC. In the USA, the Centers for Disease Control and Prevention restricted entry for individuals who had been in the DRC, Uganda, or South Sudan within the previous 21 days, regardless of nationality. Media reports also indicated that the US government planned to send American citizens exposed to Ebola to Kenya for observation and treatment, rather than repatriating them. Additionally, Canada, the Bahamas, Jordan and Bahrain barred entry to travellers from the DRC, Uganda and South Sudan, while countries such as India, Thailand and Kenya implemented enhanced screening at their borders.^[2]

From a global perspective, the situation highlights not only the world's persistent lack of preparedness for another major health crisis, but also a concerning decline in the international funding and co-operation needed to respond effectively. The consequences of recent global aid cuts extend well beyond the current Ebola outbreak. Gavi, the global vaccine alliance, has supported the immunisation of >1.2 billion children worldwide, yet its funding has recently declined sharply following the termination of a USD2.6 billion grant by the USA. Although there are indications that the USA may seek to re-engage, vaccination programmes, the most effective tool for protecting children and preventing outbreaks, have already been weakened in the interim. At the same time, there has been a shift away from multilateral co-operation towards bilateral agreements. This risks further undermining global health preparedness, and the approach, which some critics characterise as using healthcare funding as leverage to secure more transactional or 'extractive' aid arrangements, threatens to erode collective progress. What is needed instead is a renewed commitment to multilateralism, underpinned by strengthened regional leadership and capacity. Navigating this shifting geopolitical landscape is a critical challenge for global health security^[4] and global solidarity.

This PHEIC should serve as a compelling signal for action towards strengthening investment in pandemic preparedness across the continent and the globe. Expediting the development of national public health institutes, emergency operations centres,

robust surveillance systems, genomic capabilities and community health workforces is essential. Equally important is building and sustaining African capacity for research, innovation and local manufacturing. These efforts are critical to ensuring a more resilient and self-reliant future for global and continental health security.

AI contribution. Artificial intelligence (AI) was used to refine language in this editorial.

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1. World Health Organization. Epidemic of Ebola disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern. Geneva: WHO, 2026. <https://www.who.int/news/item/17-05-2026-epidemic-of-ebola-disease-in-the-democratic-republic-of-the-congo-and-uganda-determined-a-public-health-emergency-of-international-concern> (accessed 23 June 2026).
2. Lang K. Ebola: What you need to know and what you need to do about suspected cases. *BMJ* 2026;393:e166095. <https://doi.org/10.1136/bmj-2026-166095>
3. Africa Centres for Disease Control, World Health Organization. Bundibugyo Ebola virus. Continental preparedness and response plan June - November 2026. Africa CDC, WHO, 2026. https://www.afro.who.int/sites/default/files/2026-06/Bundibugyo%20Virus%20Disease%20Continental%20Preparedness%20and%20Response%20Plan_Final.pdf (accessed 23 June 2026).
4. Dobson J. The heat is on to contain the Ebola outbreak. *BMJ* 2026;393:e336108. <http://doi.org/10.1136/bmj-2026-336108>