DRC
Ebola outbreak

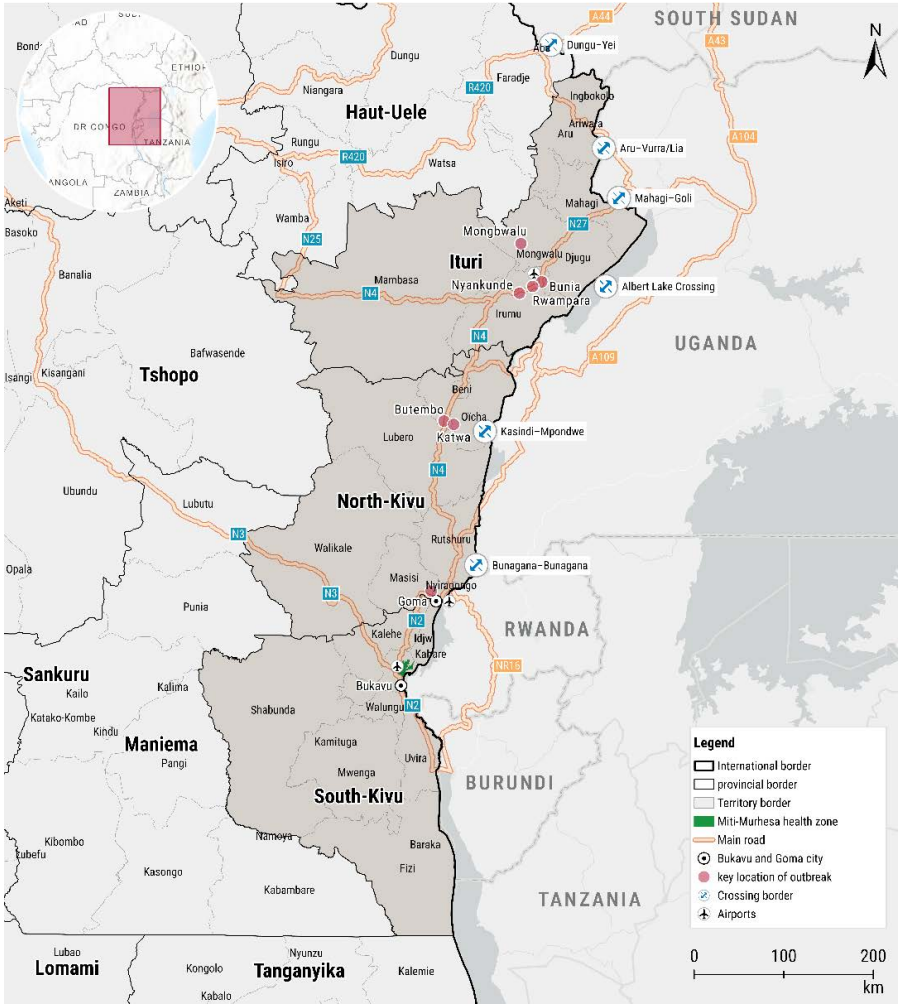
CRISIS IMPACT OVERVIEW

On 15 May 2026, authorities in the Democratic Republic of Congo (DRC) declared an Ebola outbreak after cases were confirmed in Ituri and North Kivu provinces, with further cases later confirmed in South Kivu (WHO 16/05/2026 and 18/05/2026). By 20 May, national authorities and media sources had reported 60 confirmed cases, over 670 suspected, 105 probable cases, and 160 deaths linked to the Bundibugyo strain, for which there are currently no approved vaccines or therapeutics (IMC 22/05/2026; WHO accessed 21/05/2026; AJ 20/05/2026; The Guardian 20/05/2026; BBC 21/05/2026).[1] Confirmed figures remain lower because of limited testing capacity. By 19 May, one person had also died in Kampala in neighbouring Uganda and another case had been confirmed (Reuters 19/05/2026; BBC 19/05/2026).

By 22 May, Ituri was the most affected area in eastern DRC, with cases reported in the towns of Bambu, Bunia, Fataki, Logo, Mangala, Mongwalu, Nizi, Nyankunde, and Rwampara. Bunia functions as a major commercial and transport hub linking Ituri with North Kivu, other eastern provinces, and Uganda, increasing the risk of onward transmission through mobility corridors (WHO 18/05/2026; Logistics Cluster 21/05/2026). These are densely populated mining communities with transitory populations, increasing the risk of spread. By 18 May, cases had also been confirmed in Butembo and Goma cities; and Katwa commune in North Kivu (WHO 18/05/2026; Health Cluster 18/05/2026; IMC 16/05/2026). By 21 May, one case had been confirmed in the Miti-Murhesa health zone of Kabare territory, South Kivu (Actualite 21/05/2026).

The convergence of late case identification, insufficient contact tracing capacity, population mobility, insecurity constraining case detection and response, and limited access to healthcare indicates that actual transmission levels likely exceed confirmed case counts (IMC 19/05/2026; WHO 17/05/2026; Reuters 19/05/2026). The Centre for Global Infectious Disease Analysis estimates 1,000 potential cases, but there is no certainty on case numbers because of difficulties around contract tracing, surveillance, and mistrust in health seeking (BBC 21/05/2026BBC 18/05/2026).

MAP: AREAS REPORTING EBOLA CASES BY 22 MAY



Source: ACAPS using data from BBC (21/05/2026); WHO (18/05/2026); OCHA (accessed 22/05/2026); Google (accessed 22/05/2026)

1 A suspected case is based on clinical symptoms and potential exposure, while a probable case has a more established epidemiological link to the outbreak but lacks laboratory confirmation because of practical or logistical barriers.

There have been two previous Ebola disease outbreaks caused by the Bundibugyo virus in Uganda in 2007 and DRC in 2012, with the estimated case fatality rate ranging between 25–40% (BBC 21/05/2026; MSF 18/05/2026).

The health system in eastern DRC is overstretched after years of conflict, displacement, and recurrent outbreaks, constraining response capacity in affected areas. There is a critical shortage of supplies, including personal protective equipment (PPE) and infection prevention and control (IPC) materials. Recurrent flooding, previous cholera outbreaks, armed conflict, and damaged water and sanitation infrastructure have further eroded health response capacity (IFRC 18/05/2026; IMC 16/05/2026).

DRIVERS OF THE CRISIS

Cultural practices and community mistrust

Funeral practices are a major transmission risk in Ebola outbreaks because people who die from Ebola can remain highly infectious, and burial rituals may involve direct contact with the body, bodily fluids, clothing, or contaminated belongings. The WHO notes that burial ceremonies involving direct contact with the body of a person who died from Ebola can contribute to transmission. In the current outbreak, authorities have linked rapid spread to exposure during the funeral of an early case, a nurse whose body was repatriated to Mongwalu. This makes safe and dignified burials, rapid death alerts, contact tracing, and community engagement critical to containment (WHO 24/04/2025 and 17/05/2026).

Community mistrust of health responders, persistent since 2018, is likely to affect response. During the 2018–2020 Ebola outbreak in eastern DRC, community resistance significantly undermined response efforts. Survey data indicated that 43% of respondents expressed hostility toward vaccination campaigns, 77% were unwilling to seek treatment at Ebola treatment centres (ETCs), and 50% stated they would not report suspected Ebola cases. In Bunia, 23% of respondents declined vaccination because they lacked information regarding eligibility criteria (CFR 13/06/2019; AP 28/03/2019). The response was further complicated by widespread misinformation, rumours surrounding the disease, and deep mistrust of health workers and state institutions, rooted in longstanding grievances and limited confidence in the Government. A 2018 survey also found that approximately one-quarter of respondents did not believe the Ebola virus was real, highlighting the scale of community scepticism during the outbreak (CFR 13/06/2019).

ANTICIPATED SCOPE AND SCALE

As more cases are confirmed, movement restrictions are likely to be enacted to curb the spread of the disease. By 19 May, WHO authorities had warned of the risk of the disease spreading to neighbouring countries. Uganda started restricting movement across the Ishasha–Kyeshero border crossing to limit further spillover of the virus. People attempting to cross into Rwanda from the cities of Goma and Bukavu have been stopped at the border (Reuters 19/05/2026). South Sudan issued an alert and has begun monitoring its border with DRC amid concerns of cross-border transmission (Radio Tamazuj 16/05/2026). These measures restrict freedom of movement, trade, and community livelihoods.

The confirmation of an Ebola case in the Miti-Murhesa health zone, located on the outskirts of Bukavu city in South Kivu, involving an individual who travelled from Tshopo province through Kisangani, suggests the potential presence of undetected transmission chains and unreported cases in Tshopo. The case in close proximity to Bukavu, a densely populated urban centre with an estimated population of nearly 1.5 million people, significantly increases the risk of further transmission, particularly along the major Bukavu–Goma transport corridor characterised by high population mobility and trade movements (Actualite 21/05/2026). Goma, the provincial capital of North Kivu, has also recorded a confirmed case. With a population of 750,000, including over 333,000 IDPs and 154,000 refugees and asylum seekers, overcrowded conditions and limited access to services also make the city particularly vulnerable to rapid transmission (World Population Review accessed 21/05/2026; UNHCR 14/05/2026).

During previous Ebola outbreaks in eastern DRC, particularly the 2018–2020 outbreak in North Kivu and Ituri, armed groups took advantage of the lack of government forces, movement restrictions, and disruptions to public services to strengthen territorial control and expand influence (Kraemer et al. 27/04/2020; WHO 29/11/2020). The escalation of conflict by the Allied Democratic Forces (ADF) in Ituri province since January 2026 and the M23 presence in North and South Kivu are likely to intensify as government attention and resources are increasingly redirected toward the Ebola response. This diversion of security and administrative capacity may create opportunities for armed groups to expand operations and consolidate territorial gains within the provinces, further aggravating insecurity and constraining humanitarian access (AI 05/05/2026; HumAngle 21/05/2026; CFR 18/02/2026).

A vaccine to contain the virus is estimated to take six–nine months to be ready. During this time, continued transmission increases the risk of viral mutation, potentially rendering the virus more dangerous (The Guardian 20/05/2026; BBC 21/05/2026). The absence of an effective vaccine significantly heightens risks to population health, particularly in areas with weak health systems, limited infection prevention capacity, and high population mobility. In the absence of pharmaceutical containment measures, authorities are likely to rely more heavily on non-pharmaceutical interventions, including prolonged movement restrictions, quarantine measures, and enhanced surveillance protocols to contain transmission. These measures are expected to have substantial humanitarian implications, including reduced access to healthcare and essential services, disruption of livelihoods dependent on trade and daily labour, and increased protection risks.

CRISIS IMPACTS

Health

The lack of a licensed vaccine and specific treatment means that the medical response relies primarily on supportive care aimed at improving patients' chances of survival, including fluid replacement, oxygen therapy, close monitoring of blood and cardiac parameters, and management of secondary infections. Effective outbreak response depends heavily on the availability of essential medical supplies, including intravenous fluids, oxygen equipment, laboratory materials, and PPE. DRC has reported a lack of these critical medical supplies (IRC 19/05/2026; MSF 20/05/2026; IMC 16/05/2026).

The main short-term risk is undetected community transmission. As Ebola spreads through direct contact with the blood or bodily fluids of symptomatic or deceased people, household caregivers, health workers, traditional healers, burial attendants, and people participating in funeral rites are at particularly high risk. The exposure of several people during funeral practices linked to an early case suggests that contact tracing, safe burials, and community engagement should be treated as immediate priorities. People in overcrowded settings also face higher exposure risks if isolation, hygiene, and safe caregiving measures are not possible (The Guardian 19/05/2026; BBC 21/05/2026).

Contact tracing remains critical to containing the outbreak, but limited diagnostic capacity continues to constrain response efforts. Confirmation of the Bundibugyo strain relies on Polymerase Chain Reaction (PCR) testing, which requires strain-specific diagnostic reagents and cartridges that are currently in limited supply, delaying case confirmation, isolation, and contact tracing. While PCR testing can be conducted either in reference laboratories or at the primary healthcare level through mobile GeneXpert platforms, existing GeneXpert systems appear unable to detect the current strain without specialised reagents targeting Bundibugyo viral DNA. These diagnostic limitations have likely contributed to undetected transmission for a prolonged period, increasing the risk of wider community spread before response measures were activated (MSF 20/05/2026; Science 18/05/2026).

DRC, and particularly eastern provinces, also experience illnesses such as malaria and typhoid that have the same early symptoms as Ebola, e.g. fever, which can also delay diagnosis (WHO accessed 22/05/2026).

Studies indicate that the use of healthcare services declined during previous Ebola outbreaks in West Africa (2014–2016) and DRC (2018–2020). Fear of infection, strict quarantine protocols, and community mistrust resulted in reduced healthcare utilisation, including reductions in maternal healthcare uptake (facility-based deliveries and antenatal care attendance), delays in seeking treatment, and avoidance of hospitals, which were associated with death and Ebola transmission. Some community members turned to self-medication or traditional healers, delaying seeking care because of fears of being isolated or transferred to ETCs (Kyomba et al. 19/11/2024; Ali et al. 28/06/2022).

In previous outbreaks, vaccination programmes for children were also disrupted by movement restrictions, fear of attending health facilities, and the diversion of healthcare resources toward Ebola response activities, the latter of which lead to a 30% decline in childhood vaccination coverage in Sierra Leone in 2014 (Mercy Corps 07/03/2019; Kyomba et al. 19/11/2024).

During past outbreaks in DRC, limited or insufficient community awareness and engagement measures significantly undermined containment efforts and placed people at greater risk. Mistrust of health authorities is likely to have contributed to avoidable morbidity and mortality (WHO 21/08/2025; The Guardian 19/05/2026). Reports indicate similar dynamics may be present in the current outbreak, with community

members demanding the return of a family member's body, storming and setting fire to a hospital in Rwampara. In the chaos, six patients – including three confirmed Ebola cases – escaped the facility (Africa News 21/05/2026; BBC Pidgin 21/05/2026).

Inadequate IPC measures, PPE shortages, and overstretched health facilities increase the risk of exposure for both healthcare workers and patients. During previous Ebola outbreaks, including the 2018–2020 outbreak in eastern DRC, healthcare workers were disproportionately affected as a result of gaps in training, surveillance, and safe clinical practices. The sustained exposure to high-risk environments, combined with fear of infection, heavy workloads, stigma, and witnessing high mortality rates, contributed to significant mental health and psychosocial impacts among frontline workers, including anxiety, stress, emotional exhaustion, frustration, and feelings of helplessness (Kyomba et al. 19/11/2024; Ross et al. 31/08/2024).

Water, sanitation, and hygiene

By 16 May, only 7–34% of health facilities had proper IPC and WASH coverage in DRC (IMC 16/05/2026). By 22 May, Ituri province was hosting the third largest IDP population in DRC, with more than 922,000 IDPs residing in displacement sites and host communities, including the Kigonze site, following North Kivu (1.2 million) and South Kivu (1.3 million). Limited access to clean water, handwashing facilities, and sanitation infrastructure reduces communities' ability to maintain basic infection prevention and control practices, such as regular hand hygiene and safe waste disposal, which are critical to interrupting Ebola transmission. In overcrowded displacement settings, shared latrines, unsafe water sources, and poor waste management further increase the likelihood of contact with contaminated bodily fluids and surfaces (UNHCR accessed 22/05/2026).

Protection

The outbreak is generating significant protection risks, particularly resulting from movement restrictions and quarantine measures. Households' prolonged confinement, combined with loss of income and heightened socioeconomic stress, is likely to increase the risk of gender-based violence and other forms of domestic abuse. At the same time, mistrust of health authorities and frustration over outbreak control measures have heightened security risks for response teams and healthcare facilities. On 21 May, protesters set fire to a health facility after authorities prevented a family from accessing a deceased relative's body (CNN 21/05/2026; Onyango et al. 03/01/2019).

Livelihoods

Households dependent on agriculture, trade, fishing, and daily wage labour have experienced significant income losses as a result of quarantine measures, market closures, border restrictions, and reduced mobility during previous outbreaks. Fear of infection and mistrust of affected communities also disrupted local trade networks, reduced market activity, and limited cross-border commerce with neighbouring areas (Mercy Corps 06/03/2019).

Neighbouring Uganda and South Sudan have implemented movement restrictions, including strengthened screening at official points of entry, health screening of travellers, temperature checks, surveillance of cross-border movements, and increased controls on non-essential travel and localised movement across high-risk border corridors in some cases (Reuters 19/05/2026; Radio Tamazuj 16/05/2026). While necessary for containment, these measures are disrupting local and cross-border trade, reducing market activity and access to education, and cutting off vital sources of income for border communities. The cumulative impact risks deepening long-term vulnerability to poverty across affected communities.

HUMANITARIAN RESPONSE

This information may not cover all efforts, especially community support and initiatives, given information gaps and the time constraints of the analysis.

Humanitarian constraints

The presence of armed groups directly affects the response. During the Ebola outbreak in 2018–2020, attacks on health workers and insecurity disrupted response operations. These constraints persist and are anticipated to pose similar obstacles to the current response (WHO 26/06/2020). Response operations also face logistical constraints, including damaged transport infrastructure around Bunia and Mongwalu and limited air access to affected areas. Humanitarian responders have reported bottlenecks along key supply routes, limited medical evacuation capacity, and shortages of transport and cold-chain equipment needed for surveillance and case management (Logistics Cluster 21/05/2026).

The WHO is considering experimental vaccines and therapeutics in the absence of Bundibugyo-licensed medicines. In the absence of a readily available vaccine, surveillance, early isolation, supportive care, infection prevention and control, and safe burial practices are the core containment measures (WHO 16/05/2026; The Guardian 19/05/2026).

Funding and response capacity

The response is led by the DRC Government, with regional coordination efforts involving the Ministry of Health, the WHO, Africa Centres for Disease Control and Prevention, the International Federation of Red Cross and Red Crescent Societies, and the Ugandan Government (IFRC 18/05/2026). While Norway and the UK have contributed to the funding response, the exact figures of total funding remained unavailable by 22 May (Govt. Norway 22/05/2026; Govt. UK 21/05/2026).

There is limited testing and healthcare capacity. The WHO and UN have sent medical supplies to Bunia to address limited testing and supply capacity, but gaps are likely to remain (Reuters 19/05/2026; MONUSCO 21/05/2026). By 19 May, Médecins Sans Frontières had deployed medical, logistics, and support teams, as well as 3,000 PPE sets and two full Ebola kits, including disinfectants, medicines, and medical equipment. Two 60-bed Ebola treatment centres are being established in Goma, though capacity may fall short as suspected cases continue to rise (MSF 21/05/2026).

COMPOUNDING/AGGRAVATING FACTORS

Cross-border transmission through porous corridors

The extensive network of formal and informal cross-border routes linking Ituri province with Uganda and South Sudan increases the risk of outward Ebola transmission, particularly with high population mobility, insecurity, and weak border surveillance capacity. Major official crossings such as Mahagi–Goli and Aru–Vurra/Lia facilitate continuous trade and passenger movement between eastern DRC and Uganda's West Nile region, with onward connections to South Sudan (SSHAP 02/12/2022).

Informal crossings along Lake Albert, including through Kasenyi, Mahagi port, and Tchomia, enable movement outside formal health screening and border control mechanisms, especially during periods of displacement and insecurity. Internal transport corridors linking Bunia to Haut-Uele, Kisangani, North Kivu, and Tshopo further increase the likelihood of geographic spread through commercial, humanitarian, and population flows (Bankable 02/09/2025). Similar mobility dynamics during previous Ebola outbreaks contributed to cross-border transmission risks and complicated surveillance and contact tracing efforts in the wider Great Lakes region (Ying et al. 15/02/2025).

Conflict

Conflict in Ituri and North and South Kivu provinces is protracted and volatile. In Ituri, conflict is driven by the presence of multiple armed groups, intercommunal tensions, and competition over resources. The main armed groups operating in Ituri include the Cooperative for the Development of the Congo, the ADF, and the Ituri Self-Defense Popular Front (Zaire FPAC), which have persistently conducted attacks against civilians, resulting in deaths, destruction of property, and forced

displacement (IPIS 10/08/2023; ICRC 06/11/2025). Civilians remain disproportionately affected, with recurrent attacks reported across territories such as Djugu, Irumu, and Mahagi (TNH 23/12/2024; CFR 18/02/2026; UN 20/03/2025).

In May 2026, suspected attacks carried out by the ADF killed civilians in Mambasa territory in Ituri province, including in Biakato and Makumo, while insecurity also expanded northwards towards Haut-Uele province (RFI 12/05/2026 and 15/05/2026; ACLED 11/05/2026). North and South Kivu provinces continue to be heavily affected by conflict between the M23 armed group and the Armed Forces of the Democratic Republic of the Congo. Despite several ceasefire and peace initiatives, including talks facilitated by Qatar and regional mediation efforts in early 2026, fighting and insecurity persist across parts of North and South Kivu. Although M23 announced a partial withdrawal from some areas, including Uvira and parts of Lubero territory between January–March 2026, the group continues to maintain control and influence in several strategic locations, and clashes and ceasefire violations persist (UN 05/02/2026; Kivu Today 28/05/2026; Africa News 12/05/2026; CT 15/05/2026).

Insecurity and displacement are likely to impede surveillance, contact tracing, and humanitarian access, particularly in remote and conflict-affected areas. Fear of attacks and population movements may also delay healthcare seeking and reduce community engagement with response activities. Previous Ebola responses in eastern DRC were disrupted by insecurity and attacks on healthcare workers and facilities, challenges that are likely to continue affecting current response efforts (WHO 26/06/2020).

Past disease outbreaks

Between 2018–2020, the Butembo region in North Kivu was affected by one of the deadliest Ebola outbreaks in the country. Nearly 2,300 people died, with 3,470 cases (3,317 confirmed) recorded across 29 health zones (WHO 26/06/2020). During the outbreak, there were challenges establishing trust with affected communities and reluctance to be admitted to ETCs.

DRC is also facing one of its most severe recent cholera outbreaks, with more than 20,000 reported cases and 220 deaths across 26 provinces by March 2026, including in South Kivu and Tanganyika (WFP 12/05/2026). Recurrent disease outbreaks, damaged WASH infrastructure, overcrowding, and limited access to healthcare are likely to further strain public health response capacity and complicate Ebola surveillance and containment efforts, particularly in conflict-affected and remote areas.