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Policy Media Department | Brief

2026 Ebola Virus outbreak in Central Africa

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Abstract — Dating from May 2026, the Ebola virus resurfaces throughout the Democratic Republic of Congo and Uganda, sparking a Public Health Emergency of International Concern. From the origins of Ebola towards the recent 2026 outbreak, this brief will examine policy impact, political stances, and potential options moving forward.

Keywords — Ebola, Virus, Outbreak, Africa, Bundibugyo, Democratic Republic of Congo, Uganda

EXECUTIVE SUMMARY

A global health emergency has emerged out of the 2026 Ebola outbreak in Central Africa. Rooted in the Democratic Republic of Congo and spreading into Uganda, the Bundibugyo strain of Ebola has no approved vaccine. This brief situates this strain as a center of international concern. Containment efforts have been complicated, as inadequate healthcare measures and ongoing cross-border travel allowed the disease to rapidly spread between neighboring countries. In response, global intervention from the World Health Organization and the African CDC have coordinated large-scale humanitarian and containment efforts. This outbreak highlights the necessity of international cooperation in addressing emerging infectious diseases.

I. OVERVIEW

Causing multiple outbreaks across Africa since first identified in 1976, Ebola is a highly contagious, often deadly disease that spreads through direct contact with bodily fluids. The 2014-2016 West African epidemic—with a 40% mortality—is the largest outbreak to date, demonstrating the necessity of early detection and containment. In May 2026, an outbreak involving the Bundibugyo strain emerged out of Central Africa, heightening global concern and drawing international intervention for early containment strategies.

A. Pointed Summary

- The 2026 Ebola outbreak in Central Africa involves the Bundibudgyo strain, which currently has no fully approved vaccine or specialized treatment.
- Weak healthcare infrastructure and extensive cross-border movement have complicated containment efforts.
- International organizations including the World Health Organization and Africa

CDC have intervened, coordinating large scale surveillance and emergency response operations.

- This outbreak reveals a vulnerability of global health systems to emerging infectious disease, emphasizing the importance of epidemic preparedness.

B. Relevance

Outbreaks of the Ebola virus disease have historically resulted in high mortality rates and severe humanitarian crises, making the recent 2026 outbreak a cause for global concern. The 2014 - 2016 outbreak of Ebola in West Africa led to over 28,000 reported cases and more than 11,000 deaths across Guinea, Liberia, and Sierra Leone, marking the deadliest outbreak in recorded history.[1] Since first detected in 1976, Ebola has killed over 15,000 individuals across Africa, with certain strains exhibiting mortality rates ranging from 50% to 90%. [2] The 2026 outbreak involving the Bundibuygyo strain, drew immense concern due to its rarity. Although this strain has historically demonstrated lower fatality rates of 25% to 40%, there is still a substantial threat to all affected communities. [3] Unlike the more prevalent Zaire strain of the Ebola disease, there is no fully approved vaccine that specifically targets the Bundibuygo variant.[4] Consequently, this recent outbreak marks a vulnerability of global health systems to emerging and largely infectious disease, underscoring the need for international cooperation and a sustained epidemic preparation.

II. History

Ebola virus disease is a severe and often fatal infection caused by viruses in the genus Orthoebolavirus, belonging to the Filoviridae family. It causes extreme fever, rash, and profuse hemorrhaging, with an average fatality rate of roughly 50 percent – though past outbreaks have ranged from 25-90 percent mortality.[5] Ebola is fundamentally a disease born from ecological disruption. The virus is zoonotic in origin, with fruit bats serving as its most probable natural host and transmission occurring through direct contact with infected wildlife before spreading person to person.[6] Research has consistently linked Ebola outbreaks to recent deforestation: as forests are cleared, humans and reservoirs are forced into closer contact, making spillover events not random, but predictable.[7] The virus was first identified in 1976 during near-simultaneous outbreaks in Zaire, now the DRC, and what is now South Sudan, carrying an 88 percent fatality rate among 318 reported cases.[8] The most devastating outbreak, the 2014-2016 West Africa outbreak, ultimately claimed more than 11,000 lives across 28,000 cases.[9] The 2018-2020

[1] Barbiero, Victor K. "Ebola: A Hyperinflated Emergency." *Global Health: Science and Practice* 8, no. 2 (May 19, 2020): 178–82. https://doi.org/10.9745/GHSP-D-19-00422

[2] CDC. "Ebola Outbreak History." CDC, May 6, 2024. https://www.cdc.gov/ebola/outbreaks/index.html

[3] Izudi, Jonathan, and Francis Bajunirwe. "Case Fatality Rate for Ebola Disease, 1976–2022: A Meta-Analysis of Global Data." *Journal of Infection and Public Health* 17, no. 1 (January 1, 2024): 25–34. https://doi.org/10.1016/j.jiph.2023.10.020.

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[8] Lesley Kennedy, "The Origins of the Ebola Virus | HISTORY," HISTORY, May 21, 2026, https://www.history.com/articles/ebola-virus-origins.

[9] Krutika Kuppalli, "Ebola: Ten Years Later—Lessons Learned and Future Pandemic Preparedness," ed. Julia

outbreak in eastern DRC, the second largest in history, claimed 2,299 lives entirely within an active conflict zone.[10] That same region is now the epicenter of the current 2026 Bundibugyo outbreak. [11]

A. Current Stances

The 2026 Bundibugyo outbreak has drawn sharply divergent responses along political lines. The Trump Administration has framed its response around American safety, with the State Department and CDC jointly mounting what they describe as a rapid and comprehensive response, prioritizing travel restrictions and consular support for Americans abroad. [12] Congressional Democrats, however, argue the administration's own prior decisions created the crisis. Ranking Member Delauro stated the outbreak "shines a light on the need for CDC to have the resources it needs," arguing that global health is "not transactional" and that ongoing coordination—not what she called "profit-driven trade agreements"—is essential to containing deadly outbreaks.[13] Public health experts have echoed this concern: Georgetown University's Matthew Kavanagh argued that U.S. aid cuts and WHO withdrawal have directly hampered the Ebola response, calling it "not just an outbreak of a virus" but "a politically driven epidemic."[14]

B. Tried Policy

Global outbreak response has evolved significantly with each successive crisis. During the 2014–2016 West Africa Ebola outbreak, CDC established a response framework centered on early detection and isolation, infection control, and safe burials—explicitly rejecting involuntary quarantine after a forced lockdown in Monrovia resulted in community violence.[15] These lessons directly shaped COVID-19 policy: contact tracing infrastructure and incident management coordination developed during the DRC Ebola outbreaks were identified as critical tools and leveraged for the pandemic response.[16] WHO's Health Emergencies Programme and the Coalition for Epidemic Preparedness Innovations were both created in the aftermath of 2014 to accelerate surveillance and fast-track countermeasures in future outbreaks.[17]

Robinson, *PLOS Global Public Health* 4, no. 9 (September 26, 2024): e0003662, https://doi.org/10.1371/journal.pgph.0003662.

[10] World Health Organization, "Ebola Outbreak 2018-2020- North Kivu/Ituri, DRC," www.who.int, 2020, https://www.who.int/emergencies/situations/Ebola-2019-drc-.

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[13] "Ranking Member DeLauro Statement on the Latest Ebola Outbreak," House Committee on Appropriations, May 18, 2026, https://democrats-appropriations.house.gov/news/press-releases/ranking-member-delauro-statement-latest-ebola-outbreak.

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[16] Linda Meta Mobula et al., "Recommendations for the COVID-19 Response at the National Level Based on Lessons Learned from the Ebola Virus Disease Outbreak in the Democratic Republic of the Congo," *The American Journal of Tropical Medicine and Hygiene* 103, no. 1 (July 8, 2020): 12–17, https://doi.org/10.4269/ajtmh.20-0256.

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III. Policy Problem

A. *Stakeholders*

Affected populations of the new Ebola outbreak include residents in the DRC, with several cases being reported across regions such as the Ituri province, Uganda, and North Kivu.[18] As a result, the WHO, European Health Security Committee, and the Africa Centre for Disease Control have distributed 6.3 tonnes of critical medical supplies, cofinanced by the EU and WHO.[19] Along with this, the European Commission has agreed to a €7.4 million contribution contract with the WHO, a measure aimed at supporting efforts to develop vaccines and treatments in response to the epidemic.[15] On the individual scale, healthcare workers and patients in the DRC are experiencing consequences most directly, with U.S. funding reductions to global health initiatives acting as an amplifier to the problem.[20] Health care workers in the DRC have reported that disease surveillance, body bags, laboratory access, and infection countermeasure supplies remain inadequate, severely dampening Ebola response efforts.[16] As a result, workers are not only having difficulty caring for patients safely, but also risk being compromised themselves.[16]

B. *Risks of Indifference*

If healthcare systems are unable to meet containment and treatment needs of the Bundibugyo outbreak, the risk of infection, fatality, and suffering for vulnerable populations becomes substantial.[21] Absent a commitment to invest in ongoing health networks and practices and to develop outbreak countermeasures, health system deficiencies worsen, increasing vulnerability. [17]

C. *Nonpartisan Reasoning*

The U.S. Department of State Office of the Spokesperson issued a response on May 19th. The response begins with emphasizing the protection of the American homeland as well as its citizens from the outbreak. Additionally, the Office also stated that the U.S. will provide a broad commitment of funding up to 50 treatment clinics with the goal of demonstrating a position of U.S. humanitarian support. [22] In the most recent response update on May 23 by the Office of the Spokesperson, this position of commitment to humanitarian assistance and international cooperation remains the same. [23]

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[18] World Health Organization. 2026. "WHO Director-General's Opening Remarks at the Media Briefing on Ebola Outbreak in DRC and Uganda – 20 May 2026." Who.int. 2026. https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing-on-ebola-outbreak-in-drc-and-uganda-20-may-2026.

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IV. Policy Options

Policymakers at the national and international level are currently weighing several distinct approaches. One option already underway is enhanced border controls and travel restrictions. The United States has already invoked Title 42, implementing entry restrictions on non-U.S. passport holders who have been in Uganda, DRC, or South Sudan within the previous 21 days, and enhancing port health protection, contact tracing, and hospital readiness nationwide.[24] While proponents argue this reduces importation risk, the Infectious Diseases Society of America warned that public health policies that single out non-U.S. citizens won't prevent viruses from crossing borders, because "diseases don't recognize passports." [25] Prior Ebola outbreaks have shown that travel bans can hamper the movement of responders and delivery of supplies, and could paradoxically increase spread via covert and circuitous travel routes. [26]

Additionally, policymakers are pursuing the emergency deployment of medical countermeasures and treatment infrastructure. The United States announced an initial $23 million in bilateral foreign assistance to bolster each country's response, supporting surveillance, laboratory capacity, risk communication, safe burials, entry and exit screening, and clinical case management, alongside a commitment to fund up to 50 treatment clinics in Ebola-affected regions of the DRC and Uganda.[27] The EU pursued a parallel strategy: The European Commission provided a €7.4 million contribution with WHO for a research and development blueprint aimed at fast-tracking clinical trials, and delivered 6.3 tonnes of critical supplies to DRC, including specialized personal protective equipment, medication, and sample collection kits. [28] However, the outbreak is occurring in Ituri, an area affected by insecurity, population displacement, mining-related population movement, and frequent cross-border travel, all of which complicate containment and increase the risk of further transmission. [29]

Another option under debate is emergency vaccine research and experimental countermeasure access. There are currently no approved vaccines for the Bundibugyo strain. Two potential vaccine candidates exist, but neither is ready to move to human testing—the more promising could take six to nine months before enough doses are ready for trials, while the other may be available in two to three months but has not yet shown supporting results in animal studies. [30] WHO experts are debating whether

[24] CDC, "CDC Statement on the Use of Public Health Travel Restrictions to Prevent the Introduction of Ebola Disease into the United States," Ebola, May 19, 2026, https://www.cdc.gov/ebola/situation-summary/title-42-order.html.

[25] IDSA, "Statement on Ebola Travel Ban," Idsociety.org, 2026, https://www.idsociety.org/news--publications-new/articles/2026/statement-on-ebola-travel-ban/.

[26] Nicole J. Cohen et al., "Travel and Border Health Measures to Prevent the International Spread of Ebola," *MMWR Supplements* 65, no. 3 (July 8, 2016): 57–67, https://doi.org/10.15585/mmwr.su6503a9.

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[29] CDC, "Ebola Disease Outbreak in the Democratic Republic of the Congo and Uganda," Health Alert Network (HAN), May 19, 2026, https://www.cdc.gov/han/php/notices/han00530.html.

[30] Berkeley Lovelace Jr, "Ebola Vaccine for Bundibugyo Strain Could Take Months before Human Trials," NBC News, May 20, 2026, https://www.nbcnews.com/health/health-news/ebola-vacci

Merck's Ervebo—licensed for the Zaire strain—could offer cross-protection, though the FDA-approved vaccine for Ebola disease is not considered effective for the current 2026 outbreak caused by Bundibugyo virus. [31] Precedent from a prior outbreak offers a potential path forward: during the 2018-2020 DRC outbreak, WHO and DRC authorities agreed on protocols for using experimental treatments on a compassionate basis, and for the first time in an Ebola outbreak response, every patient was offered voluntary and equitable access to groundbreaking treatments, demonstrating that ethically sound research is possible during an active outbreak. [32]

Furthermore, a longer-term structural option involves restoring and expanding global health surveillance funding. A Senate Foreign Relations Committee roundtable in April 2025 highlighted the increased risks to Americans from diseases including Ebola as a direct result of cuts to U.S. global health programs, noting that emergency response systems that had cut outbreak response times to less than 48 hours were eliminated.[33] The U.S. withdrawal from WHO and the shutdown of USAID have disrupted global health governance, threatening disease surveillance and reversing progress in combating infectious diseases.[34] At the same time, at the World Health Assembly in May 2025, China pledged to increase its voluntary contribution agreement with WHO to $500 million over the next five years, meaning China will replace the U.S. as WHO's largest national contributor and could steer priorities in global health programs toward its own interests. [35]

V. Conclusions

Along with current holistic approaches by the WHO, the African CDC, and other health organizations, a distinct solution to follow is ultimately community engagement and a new approach to cultural adaptation. Successful community collaboration has yet to be achieved, but it is important to discuss the cruciality of navigating outbreaks as a community—while international help is already a major step, effectively managing large-scale issues is truly up to individuals working together as a group and having a common ground against the social complication. As like in the previous 2014 outbreak and currently now, mistrust, stigma, denial, and prospected black propaganda surrounding bacterial outbreaks have posed a strong obstacle towards health officials and workers. As civic unrest, extreme fear, and denial grow in current DC and Ugandan communities—followed by the violent attacks, protests, and riots on medical staff and centers—the increased likelihood of the prolonged issues. To reach both safe collaboration and efficiency, health organizations must take the time and effort to develop empowered

ne-bundibugyo-strain-take-months-human-trials-rcna345926.

[31] CDC, "Ebola Disease Frequently Asked Questions," Ebola, May 21, 2026, https://www.cdc.gov/ebola/faq/index.html.

[32] World Health Organization, "Ebola Then and Now: Eight Lessons from West Africa Being Applied in the Democratic Republic of the Congo," Who.int (World Health Organization: WHO, April 10, 2020), https://www.who.int/news-room/feature-stories/detail/ebola-then-and-now.

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[35] Mitchell Hammond, "How the U.S. Withdrawal from WHO Could Affect Global Health Powers and Disease Threats," ed. Patricia Nicholson, January 20, 2026, https://doi.org/10.64628/aam.xu4fkphva.

collaboration among local communities where anti-ebola practices are implemented. While this will take time and may be a highly projected goal moving forward towards the future, the promotion of education and active partnership and participation within these communities as a whole can create a great difference in health. As of now, the future of the Bundibugyo outbreak relies on travel restrictions, surveillance, and active vaccine research. While recent outbreaks like Ebola and Hantavirus may spark fears and the remembrance back towards the global pandemic, we bring back the importance of awareness, trust, and joint effort not as individuals, but as a group against major issues.

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