What you need to know about Ebola and what must be done

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Uganda's ministry of Health confirmed the country's first Ebola Bundibugyo case on May 15, 2026, a 59-year-old Congolese man who travelled from the Democratic Republic of Congo (DRC) seeking care at Kibuli Muslim Hospital in Kampala. He died in the Intensive Care Unit with bleeding symptoms a few days later.

On Monday, May 25, 2026, the ministry of Health confirmed two additional Ebola cases within Kampala city. The new cases raise serious public health concerns as transmission now appears to be occurring within the capital, prompting urgent contact tracing efforts and heightened surveillance across the city.

WHAT MAKES THIS EBOLA OUTBREAK DIFFERENT?

First identified in 2007 in western Uganda near the DRC border, the Bundibugyo ebolavirus is one of the rarest Ebola variants known to science. It causes severe haemorrhagic fever: sudden fever, fatigue, chest pain, diarrhoea, vomiting, and in later stages, unexplained bleeding and yellowing of the eyes.

Early symptoms can easily be mistaken for malaria or typhoid, and patients can take up to 21 days to develop them, meaning someone can cross a border and infect others before anyone realises they are sick. This is what precisely makes this virus so dangerous.

There is currently no licensed vaccine and no approved treatment. Its fatality rate is estimated at 30 to 40 percent, meaning that three to four die out of every 10 infected people.

UGANDA'S RECORD IN FIGHTING EBOLA

Uganda has fought and defeated Ebola multiple times. Most recently, in January 2025, a Sudan virus outbreak declared in Kampala was fully contained within 87 days. This was Uganda's eighth Ebola episode. Only 14 people were infected and four died. Transmission remained confined to close family and household contacts. More than 530 contacts were monitored, all without a vaccine or approved treatment.

Dr Chikwe Ihekweazu, the WHO acting Regional Director for Africa, noted at the April 2025 closing ceremony that Uganda has never exported a single Ebola case beyond its borders, a record that speaks for itself. On May 15, Uganda's ministry of Health activated a national response immediately upon confirming the outbreak. Screening and rapid response teams were deployed to official and informal border entry points along the western border. A mobile laboratory was activated at Bwera Hospital in Kasese. Known contacts of the index case were quarantined and the Public Health Emergency Operations Centre placed on alert.

The ministry has deployed public health response teams to enforce strict containment protocols in the city and other affected areas. Contact tracing is actively underway, with authorities compiling a comprehensive list of all individuals who may have been exposed to confirmed cases.

President Museveni postponed the 2026 Uganda Martyrs' Day celebrations, traditionally held on June 3 at Namugongo and attended by thousands of pilgrims, including some from eastern DRC - citing the risk of large cross-border gatherings.

In his letter announcing the postponement, President Museveni was unequivocal: "The protection of life must come first."

On May 18, 2026, WHO Director General Dr Tedros Adhanom Ghebreyesus commended the decision, describing it as an example of swift and responsible action to protect affected communities and bring the outbreak to an end.

WHO IS MOST AT RISK OF CONTRACTING EBOLA?

Ebola spreads through direct contact with the bodily fluids of someone who is sick or has recently died from the disease. It is not airborne. But it becomes most contagious in the disease's late stages, and the virus can remain active for days after death, which is why burial practices, and the health workers and family members caring for the dying, face the greatest danger. Women are disproportionately at risk. As primary caregivers, they are far more likely to come into close contact with sick family members. Frontline health workers, particularly those without adequate Personal Protective Equipment, face the greatest occupation danger. Border communities in Kasese, Bundibugyo, Kisoro, Ntoroko, and Kanungu face elevated risk given their daily interaction with eastern DRC. Refugee settlements, trading centres, transport corridors, and informal markets are environments where case finding and contact tracing are hardest to execute.

Stigma compounds everything. When patients fear isolation or community rejection, they delay seeking healthcare, giving the virus more time to spread.

WHAT NEEDS TO BE DONE?

Emergency funding should be deployed without delay to high-risk border districts and Kampala city to support isolation facilities, laboratory capacity, staff training, and Personal Protective Equipment (PPE).

All health workers should be equipped with adequate PPE, supported with rigorous training, and provided with psychosocial support to safeguard their wellbeing on the frontline.

Surveillance and swift contact tracing within Kampala city are critical, particularly given the high population density and the movement of people across the city's informal settlements and public spaces. Community awareness campaigns should be rolled out in local languages through radio, community leaders, and religious institutions to counter misinformation and encourage the public to report suspected cases.

Uganda has defeated Ebola every single time it has faced it. There is no doubt it will defeat this episode too, but only if it acts with the same speed, resolve, and coordination that made every previous victory possible.

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