

Ebola outbreak in the Congo

The Hungarian (and, generally speaking, the European) press tends to turn a blind eye to epidemics in distant parts of Africa – such as the current **Ebola outbreak in the Congo** – rarely reach the attention of the Hungarian (and, more generally, European) press, as long as they do not pose a direct threat to the continent.

According to an analysis by the European Centre for Disease Prevention and Control (ECDC), this risk to Europe is currently very low. Ebola is not airborne (unlike Covid-19 or influenza); it can only be transmitted through direct contact with a patient's bodily fluids, so the likelihood of its introduction internationally is minimal. However, global aid organisations warn that if the world turns its back on the region, a humanitarian disaster could unfold in Central Africa.

What happened in Congo?

In the **Democratic Republic of the Congo**(DRC) and neighbouring Uganda, a critical situation has arisen following the recent Ebola outbreak, prompting the **World Health Organisation** (WHO) to declare a global health emergency. International organisations have described the current situation as a **“perfect storm”** and a catastrophic crisis.



In the Ruampara and Ituri regions, angry mobs set fire to several Ebola treatment tents and clinics. Photo: BBC/Reuters

During previous major Ebola outbreaks, newly developed vaccines (such as the **Zaire Ebola**). However, the current outbreak, which originated in the north-eastern province of Ituri, is caused by the rarer **Bundibugyo virus strain** . There is currently no approved vaccine or targeted treatment for this specific variant. Control measures are therefore limited solely to the isolation of patients, contact tracing and supportive medical care. The epicentre of the outbreak is the eastern part of the DRC, which has been a battleground for armed conflicts and militias for decades.

The local population – most of whom are illiterate anyway – see that whilst they have received hardly any external aid for decades to combat armed conflicts, brutal famine and other diseases (such as malaria), they have received hardly any external aid for decades, yet with the emergence of Ebola, the region has suddenly been flooded with huge white off-road vehicles, expensive equipment and foreign aid workers. Many people are convinced that the disease was invented or is being spread by politicians and aid organisations in order to secure foreign funding, and they do not believe that Ebola is dangerous. Furthermore, relatives are not allowed to visit patients confined to isolation centres; if someone dies there, families often believe that their organs are being trafficked. According to emergency reports, several treatment centres have already come under serious attack.

The most recent events at the end of May also follow this pattern: the bodies of those who have died from Ebola are highly infectious. According to international protocol, the bodies must be buried in special bags, disinfected, and without any contact from relatives. Traditional African funeral rites are based on washing and touching the body (which inevitably spreads the virus). When doctors prohibit this, enraged family members and armed youths storm the hospitals.

In the Ruampara and Ituri regions, angry mobs set fire to several Ebola treatment tents and clinics in order to retrieve their dead or their relatives in quarantine. During such attacks, several patients confirmed to have Ebola, overcome by panic, have fled and mingled with the general population, which is accelerating the spread of the virus at a catastrophic rate; furthermore, the bodies that have been released will almost certainly spread the disease.

Ebola járvány Kongóban és Ugandában

■ Jelentett helyszínek



Source: WHO, M23 rebels, DR Congo health ministry (DSNIS)

BBC

Magyar változat: https://bolyongo.hu/doku.php?id=passport:ebolajarvany_kongoban

The Bundibugyo tribe

The rescue of relatives and the forcible removal of bodies are a veritable epidemiological time bomb. As there is no vaccine against the Bundibugyo tribe, every single patient forcibly taken home or a victim buried in the traditional manner infects dozens more people within the family and the village community. Humanitarian organisations (such as the International Rescue Committee) warn that if

the locals cannot be made to understand the gravity of the situation, this could become one of the most difficult Ebola outbreaks in history to contain.

What is more, when senior officials from the world's most influential country – such as *Robert F. Kennedy Jr.*, the Secretary of Health – openly question the safety of vaccines and rewrite childhood vaccination schedules, local African disinformation spreaders use this as a basis for their claims. Narratives circulating on Western social media that fuel mistrust of institutions are reaching Congolese and Ugandan smartphones via global platforms. Locals believe: *“If even the Americans themselves don't trust their own scientists and their vaccines, why should we accept them?”*

The MAHA (*Make America Healthy Again*) movement, spearheaded by Robert F. Kennedy Jr., and the Trump administration's domestically motivated criticism of vaccines, have unwittingly provided ammunition to Congolese rebels and anti-vaxxers. The combination of the US financial withdrawal and a global loss of trust has created a *“perfect storm”* in Central Africa, leaving international organisations powerless to prevent the uncontrolled spread of the deadly Bundibugyo Ebola strain.

Furthermore, an American missionary doctor, Dr Peter Stafford, who contracted Ebola in the Congo, is being treated in Berlin, and a major political scandal has erupted in the American press over his repatriation, as, according to an investigative report by the Washington Post, the US Centres for Disease Control and Prevention (CDC) had originally intended to transfer the doctor to a US hospital equipped with a high-level biosafety laboratory.

Citing internal government sources, the newspaper claimed that White House officials, for political reasons, did not want an Ebola patient to enter US territory, and therefore rejected the request for repatriation, leaving the task to the Germans. White House spokesperson Kush Desai, of course, *“completely false”* the Washington Post's claims.

Ebola

Ebola viruses – including the Bundibugyo strain – are so-called **zoonoses**, that is, pathogens that circulate in wild animals and are capable of crossing the species barrier through contact with an infected animal (this is known as **‘spillover’** or a spillover event). According to research, the natural reservoirs (hosts) of the virus are tropical fruit-eating bats (*family Pteropodidae*). These animals are capable of carrying the virus and shedding it via their urine, faeces or saliva without becoming ill themselves.



Red Cross staff bury an Ebola victim at Rwampara Cemetery in the town of Rwampara, Congo, on 23 May 2026. Photo: Moses Sawasawa/AP

Humans rarely become infected directly from bats. It is common for other forest animals – chimpanzees, gorillas, antelopes and porcupines – which in turn become seriously ill from the virus.

In the eastern part of the Democratic Republic of the Congo, due to extreme poverty and famine, the consumption of **‘bushmeat’** (*bush meat*) is a daily occurrence. Whilst processing, skinning or butchering the meat, people come into direct contact with the infected animal’s blood and bodily fluids (even a tiny cut on the hand or touching one’s eyes is enough).

Once this first person (the so-called **‘patient zero’**) becomes infected by the animal, the virus is immediately capable of spreading from person to person via bodily fluids without mutating, triggering the chain reaction we are currently witnessing.

There are currently six known strains (variants) of the Ebola virus, all of which belong to the *Orthoebolavirus* genus of the *Filoviridae* family .

Although they are all commonly referred to as ‘Ebola’, they differ significantly from one another in terms of their genetic makeup and level of danger. Of the six variants, four can infect humans, whilst two are dangerous only to animals.

Zaire Ebola virus (EBOV)

- **Danger:** The most dangerous strain and the one responsible for the highest number of fatalities.
- **Mortality:** A fatality rate of between 60–90 per cent.
- **Notable outbreaks:** This strain caused the largest outbreak in history, the 2014–2016 West African epidemic.
- **Vaccine:** This is the only strain for which a fully approved, highly effective vaccine (Ervebo) is

already available.

Sudan Ebola virus (SUDV)

- Risk: A high-risk strain that is particularly dangerous to humans.
- Mortality rate: Approximately 40–60 per cent.
- Most recent outbreak: This strain caused a severe outbreak in Uganda in late 2022.

Bundibugyo Ebola virus (BDBV)

- Risk: A less common but aggressive strain; this variant is also responsible for the current 2026 outbreak in the Democratic Republic of the Congo and Uganda.
- Case fatality rate: Between 30–50 per cent.

Taï Forest Ebola virus (TAFV)

- Severity: Extremely rare. It has been detected in only one person in history (in Côte d'Ivoire in 1994), who contracted the virus whilst performing an autopsy on an infected chimpanzee, but survived with appropriate treatment.

Strains not (yet) dangerous to humans:

Reston Ebola virus (RESTV)

- History: It was first identified in research monkeys from the Philippines in an American laboratory (Reston, Virginia).
- Effects: It is fatal to monkeys, and although laboratory staff have been infected with it (as indicated by the presence of antibodies in their bodies), it has not caused any symptoms or illness in any humans.

Bombali Ebola virus (BOMV)

- Discovery: This is the most recently identified strain, discovered in Sierra Leone in 2018, found exclusively in bats.
- Impact: There is currently no evidence that it is capable of infecting or causing illness in humans or other mammals.

How experience with Covid-19 helps in the fight against Ebola

International research teams are already focusing precisely on the **perfected technologies** to curb the new Ebola outbreak. In the fight against Ebola, two main technological platforms have been deployed, both of which were brought to prominence by the COVID-19 pandemic:

The mRNA platform: The major advantage of the Pfizer/BioNTech and Moderna approaches is their speed. Chinese researchers have recently presented a broad-spectrum **mRNA vaccine** which, in animal trials, provided long-term protection against even the most dangerous Ebola strains – including the Bundibugyo variant currently ravaging the Congo.

The adenovirus vector platform: Researchers at the University of Oxford (who also developed the AstraZeneca Covid vaccine) have announced that, using the same viral vector technology, they have already begun manufacturing their Bundibugyo-specific vaccine candidate.

The essence of the technology in both cases is that it is not the dangerous virus itself that needs to be produced and attenuated, but only its genetic code (a harmless **spike protein** blueprint in the case of Covid-19; for Ebola, the equivalent is the glycoprotein (GP)). These can be adapted to any new strain within days.

Normally, the development of a new vaccine or medicine takes 5–10 years. However, as there is a global health emergency, the authorities and researchers (as with COVID) are carrying out the phases in parallel to speed up the process.

The World Health Organisation (WHO) and the developers are working to the following official timetable: Thanks to the collaboration between the University of Oxford and the Serum Institute of India (SII), the first clinical safety trials in humans (Phase I) could begin as early as the summer of 2026. According to the WHO's official forecast, an experimental vaccine suitable for mass deployment in the epidemic zones of the Congo and Uganda could be available in 6–9 months at the earliest.

What led to the end of previous outbreaks?

As there was no immediately deployable, authorised mass vaccination against the subtypes in question, their containment relied purely on classic, strict public health measures. The following factors led to success:

An immediate and transparent government response

During the 2022 outbreak in Uganda, the country's leadership did not conceal the situation. They immediately placed the Mubende and Kassanda districts – identified as the epicentre – under lockdown, banned travel in and out of the country, imposed a night-time curfew, and closed entertainment venues.

Public cooperation

In contrast to the current situation, during previous successful containment efforts, local communities accepted the rules. The authorities launched awareness campaigns and made hand sanitisation and temperature checks compulsory in churches and markets. The president publicly urged people to refrain from the traditional African handshakes and hugs.

Aggressive contact tracing

For every single infected person, all individuals (family members, colleagues, fellow passengers) with whom that person had been in contact since the onset of symptoms were traced. They were placed in a mandatory 21-day quarantine by the authorities and kept under observation.

Safe funerals

It was possible to persuade the bereaved to forego the traditional washing of the body. Specially trained Red Cross and healthcare teams carried out the immediate, closed burials of infected victims.

The 42-day rule

According to the WHO protocol, an Ebola outbreak can be officially declared over if, for 42 days following the recovery or death of the last known patient (which is twice the virus's maximum incubation period), no new cases have been recorded in the country. Uganda last met this criterion in January 2023, whilst the DRC last did so in December 2025.



Local residents watch as Red Cross staff march in formation, whilst disinfecting Rwampara General Hospital, ahead of handling the body of an Ebola victim on Thursday near Bunia in the Ituri province of the Democratic Republic of the Congo. Photo: Gradel Muyisa Mumbere/Reuters

What happens if an Ebola patient boards a plane?

The Ebola virus is only infectious in the human body once the patient is already showing symptoms (high fever, vomiting, diarrhoea, bleeding). During the incubation period (which can last from 2 to 21 days), the infected person does not yet transmit the virus. Strict body temperature checks and health screenings are in place at airports in the Congo and Uganda, which have been hit by the epidemic. A patient who is already feverish and showing symptoms is unlikely to be allowed on board at all.

If someone falls ill during the flight, airlines have strict protocols for isolating the patient, sealing off the toilet and protecting the other passengers. At European airports, such aircraft are immediately placed under quarantine. Ebola is not transmitted through the air. If someone sits next to a patient on a plane or walks past them in the aisle, they will not catch the disease. It is not transmitted by sneezing, coughing or touch (provided the person's skin is dry and free of bodily fluids).

The virus is transmitted exclusively through direct contact with infected bodily fluids (blood, vomit, faeces, urine, saliva, breast milk, semen), and these must enter another person's body (for example, via the mucous membranes – eyes, mouth, nose – or through tiny breaks in the skin).

On an aeroplane, for someone to become infected, they would need to come into direct contact with the vomit or blood of a patient exhibiting severe symptoms, and then touch their own eyes or mouth with that hand.

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