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DRC has strengthened its response to Ebola - but conflict and funding cuts are testing its capacity

Healthcare workers are at high risk of contracting the disease and must be protected, say **Aula Abbara** and **Michael Adeyemi Lawal**

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The outbreak of Bundibugyo ebolavirus, ongoing in the Democratic Republic of the Congo (DRC), shows no signs of slowing down. Ebolavirus was confirmed in samples on 15 May although the disease is likely to have been circulating since at least early April. As of 6 June, 515 cases and 91 deaths have been recorded in the DRC and 19 cases and two deaths in Uganda, according to the World Health Organization.[1] This delay highlights the fragile health system in the area and challenges to testing capacity, particularly to this strain of the virus. As ever, those individuals on the frontline of the response are at highest risk of contracting the disease.

Ebola has emerged in a context of severe, protracted humanitarian crisis, insecurity, and global funding cuts. The current outbreak represents the 17th in the DRC since its discovery in 1976. Médecins Sans Frontières/Doctors Without Borders (MSF) has been present in the DRC for nearly 40 years. We support healthcare across the country, including in Ituri, the epicentre of the current outbreak, and neighbouring North Kivu where cases have also been detected and in South Kivu. We have responded to previous Ebola outbreaks in the area, including the previous Bundibugyo outbreak in 2012 (57 cases, 29 deaths) and the 2018-20 outbreak (3481 cases, 2999 deaths), which was caused by the Zaire ebolavirus strain. The 2018-20 event was the second largest ebolavirus outbreak on record and occurred in a setting of insecurity, high community mistrust, and logistical complexity; however, it allowed for the trial of therapeutics and vaccines, furthering the tools available in subsequent outbreaks.

The DRC has seen the largest number of Ebola outbreaks globally; it has built testing capacity, strengthened surveillance systems, and improved response capacity in collaboration with international partners. It has also been at the forefront of international research collaborations and trials including for vaccination and novel treatments such as monoclonal antibodies. However, Bundibugyo virus disease presents particular challenges. The Zaire strain has been responsible for most of the largest and most severe outbreaks; therefore, there are no licenced vaccines or approved therapeutics for the Bundibugyo strain, although researchers are beginning to develop them.[2]

Another challenge in the current outbreak is the ability to rapidly confirm cases. The available molecular diagnostics such as polymerase chain reaction tests depend on strain specific testing capacity. However, the limited availability of diagnostic cartridges for the Bundibugyo strain has constrained timely confirmation of suspected cases. Operational research to tackle this gap may take weeks to establish but is urgently needed now. As a result, MSF's experience in rapidly deploying staff skilled in surveillance, community engagement, infection control, and case management is paramount in supporting the response. We have already established Ebola treatment centres, supported surveillance activities, and are continuing to provide support for non-Ebola related activities; the latter is essential given ongoing outbreaks of measles and cholera as well high rates of malaria in the affected areas.

MSF staff are skilled in responding to viral haemorrhagic fever outbreaks and the early recognition and isolation of suspected cases. However, healthcare workers remain among the most vulnerable; the first known suspected case involved a health worker who first showed symptoms on 26 April and later died in Bunia medical centre. At least four deaths among healthcare workers in ministry of health facilities have been reported, suggesting gaps in infection prevention and control in healthcare settings.

The protection of staff is essential, not only for the healthcare workers themselves but also for the detrimental impacts that their illness or death can have on local health systems which are already under strain. Workforce losses weaken clinical capacity, disrupt service continuity, reduce supervision, and erode institutional experience in outbreak management. Beyond this, fear and stigma among healthcare workers and the community can interrupt an effective response; as such, MSF's strong links with the community in the areas where we work remain key.

This outbreak occurs at a crucial time in the humanitarian sector where funding cuts have led to grave harms. We are witnessing the erosion of critical surveillance and the weakening of response systems on the frontline. For the affected communities in the DRC, this is not only a funding deficit but also a critical failure that could lead to an escalating catastrophe. We must therefore ensure humanitarian access, close working with communities, and transparent responses.

MSF calls for a return to the fundamental principles of humanitarian action - prioritising effective responses to affected communities based on urgent needs and not political agendas. Healthcare workers, patients, and health facilities must be safeguarded

to ensure safe care and access. We must increase access to Ebola care, including diagnostics for Bundibugyo disease while maintaining access to essential healthcare. Without this, the required response will stall, leading to further loss of life, not only from Ebola but also from other diseases owing to the wider interruptions to the health system.

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1 World Health Organization Disease Outbreak News. Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda. 8 June 2026. https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON606

2 Baraniuk C. Ebola: Three vaccines rushed into development for Bundibugyo outbreak. *BMJ* 2026;393:e557985. pmid: 42229937. doi: 10.1136/bmj-2026-557985