

Ebola Bundibugyo Virus Disease Outbreak in the DRC and Uganda

Virtual High Level Presidential Meeting (HLPM) of African Heads of State and Government and Partners

COMMUNIQUÉ

16 June 2026

1. The Virtual HLPM of African Heads of State and Government and Partners dedicated to the Ebola Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo (DRC) and Uganda was held on 16 June 2026 under the chairmanship of H.E. Evariste Ndayishimiye, President of the Republic of Burundi and Chair of the African Union. The HLPM brought together African Union Heads of State and Government, the African Union Commission, Africa CDC, partner countries, the United Nations, the World Health Organization (WHO), Regional Economic Communities, international financial institutions, the private sector, philanthropies, technical agencies and partners.
2. Convened in a spirit of African unity and international solidarity, the HLPM aimed to contain the outbreak at source, protect communities and frontline workers, prevent regional spread, safeguard essential health services and strengthen preparedness in countries at risk through aligned political leadership, rapid financing, coordinated technical assistance and accountable field delivery.
3. The HLPM noted with grave concern the rapidly evolving epidemiological situation. As of 15 June 2026, 827 confirmed cases and 194 confirmed deaths had been reported across the two affected countries: 808 confirmed cases and 192 confirmed deaths in the DRC, across Ituri, North Kivu and South Kivu; and 19 confirmed cases and 2 confirmed deaths in Uganda. Ituri remains the epicentre, while North Kivu has become a major concern, with daily increases in confirmed cases and the highest case fatality ratio, estimated at 64%.
4. The HLPM recognized that the outbreak has reached a critical operational tipping point, driven by continued community transmission, suboptimal contact tracing, rapid geographic expansion, high mobility linked to mining, insecurity and population displacement, community mistrust, reluctance to post-mortem testing in some areas, infection prevention and control gaps, insufficient safe and dignified burial capacity, inadequate isolation and treatment capacity, and the absence of licensed BDBV-specific vaccines or therapeutics.
5. The HLPM requested the urgent establishment of humanitarian access and response corridors, including corridors of peace where required, to enable national authorities, Africa CDC, WHO, UN OCHA and partners to safely reach affected and high-risk areas, including North Kivu and South Kivu; assess transmission and needs; deliver supplies; investigate alerts; support treatment; and maintain essential health services. It also called for an immediate seven-day operational surge to strengthen case investigation, daily data management, 21-day contact follow-up, treatment and isolation capacity, IPC, triage and PPE, safe and dignified burials, laboratory clearance, point-of-care diagnostics, and risk communication and community engagement led by trusted local leaders.
6. The HLPM commended the Governments of the DRC and Uganda for their leadership and initial financing of national response plans, including announced contributions of USD 50 million by the DRC and USD 5 million by Uganda. It paid

tribute to frontline health workers, community actors and local responders, and welcomed the activation of Africa CDC, WHO and partner support, including the Incident Management Support Team, cross-border coordination, laboratory and field deployments, logistics support, community engagement and preparation of the six-month joint response and preparedness plan.

7. The HLPM endorsed the June-December 2026 joint response and preparedness plan, with an estimated envelope of USD 518 million, and called for urgent, flexible and front-loaded financing. It welcomed pledges totaling USD 910 million, including USD 80 million from African Member States toward the USD 100 million African Member State target, and urged Member States, financial institutions, donors and partners to convert pledges into rapidly disburseable resources and priority in-kind support, including vehicles, ambulances, laboratories, data managers, community workers, treatment and isolation capacity, personal protective equipment, IPC/WASH materials, safe burial teams, logistics, security-sensitive access and health workforce surge capacity.
8. The HLPM emphasized strengthened cross-border coordination among affected and at-risk Member States under the leadership of national authorities, with Africa CDC and WHO technical support and UN OCHA humanitarian coordination. It welcomed the Uganda-DRC operational mission to finalize surveillance, laboratory and case-management arrangements, and called for similar risk-based preparedness support for high-risk neighbouring countries.
9. The HLPM reaffirmed that blanket travel or trade bans are not supported by public health evidence and may undermine response operations by discouraging reporting, diverting movement to informal crossings and delaying the movement of responders, samples, supplies and humanitarian assistance. It requested all countries to follow the Africa CDC guidance released on 9 June on entry and exit screening; share timely data with Africa CDC for centralized situational awareness; and adopt evidence-based, risk-based measures, including exit screening, rapid information-sharing, coordinated points-of-entry surveillance and safe passage for essential travel, trade and response operations.
10. The HLPM underscored that Africa must move from recurrent emergency appeals to predictable preparedness investment. It endorsed voluntary financing by African Member States and the African private sector of USD 100 million per year, to be complemented by external partners, to strengthen epidemic preparedness, sustain readiness between outbreaks and accelerate investments in local manufacturing of medical countermeasures, including vaccines, medicines, diagnostics and other essential commodities.
11. The HLPM noted that, 19 years after Bundibugyo ebolavirus was first identified, no licensed BDBV-specific vaccine or therapeutic is available. It called for accelerated, ethical and protocolized access to candidate vaccines, therapeutics and diagnostics; adaptive clinical trials; firm post-trial access commitments; benefit-sharing; technology transfer; and African manufacturing pathways. It further encouraged countries to enrol in and effectively use the African Pooled Procurement Mechanism as the continental platform for joint procurement of health commodities, and to sign and ratify, where applicable, the Treaty for the African Medicines Agency as a pillar of African health security and sovereignty.
12. The HLPM endorsed the continued leadership of Africa CDC, in close collaboration with WHO and all partners, in support of affected Member States. It welcomed the establishment of a weekly commitment tracker to monitor pledges, disbursements, deliveries and remaining gaps against the six-month plan, and resolved to maintain high-level political engagement until the outbreak is contained and regional health security risks are mitigated. The HLPM concluded with a call to all stakeholders to act with urgency, unity, solidarity and accountability: contain Ebola at source; keep borders open for science and solidarity; protect frontline workers and communities; and ensure that this emergency leaves Africa with stronger preparedness, stronger manufacturing capacity and stronger health security.