Past experience positions Uganda to contain Ebola

Since Ebola was first identified in 1976, 39 outbreaks have hit the world. More than half struck just two nations: the Democratic Republic of Congo with 16 outbreaks, and Uganda with 8.

Each outbreak made Uganda stronger. Our surveillance sharpened, our health workers trained harder, and our response moved faster. Ebola was here again in 2025. Uganda acted fast: 14 cases confirmed, swift containment, no panic. Uganda is battle-tested and back on the front line. The real question now: is the system resilient enough to handle Bundibugyo Ebola outbreak?

Uganda's resilience will be tested by the virus itself. Bundibugyo Ebola virus, or BDBV, usually kills fewer people than Zaire Ebola virus, or EBOV, which caused the deadliest outbreaks. BDBV also moves slower in patients. But numbers don't tell the whole story. Case fatality rates depend on more than the virus: country response capacity, nutrition, other infections, genetics,

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how fast people seek care, and the strength of our hospitals. Some experts even argue all lethal Ebola viruses are equally deadly. The big differences in death rates may come from conditions on the ground, not the virus type.

Ebolaviruses are not airborne in the way measles or SARS-CoV-2 are. Transmission requires direct contact with the bodily fluids of a symptomatic patient or with contaminated materials.

Because these transmission routes are well understood, they are also interruptible: through rigorous contact tracing, infection prevention and control in health facilities, safe and dignified burials, and community engagement.

The index in the current outbreak was a Congolese male patient who fell sick in DRC and sought care in Uganda. Diagnosis was made posthumously after DRC authorities flagged suspected Ebola virus disease. Two additional cases linked to the index patient were confirmed. Health workers cared for a critically ill Ebola patient with full intensive care interventions, unaware they were facing one of the world's deadliest pathogens and without full Ebola-specific protection. That only two secondary cases emerged from that high-risk exposure is noteworthy. Transmission depends on care settings, protective practices, and human behaviour as much as the virus itself.

As of 10 June 2026, Uganda has recorded 19 confirmed cases, 14 imported from DRC. The cross-border dimension shows the outbreak's primary driver lies outside Uganda's borders.

Uganda's advantage is experience, not luck. It is institutional memory built from years of fighting Ebola. We have a proven playbook that works under pressure: rapid laboratory confirmation within hours, aggressive contact tracing that maps every link, community-led risk communication that earns trust, and pre-positioned response infrastructure from past outbreaks including the 2025 Sudan Ebola virus episode. In Kampala, that playbook is live.

Every contact is quarantined and monitored daily by experienced health teams. Markets and businesses run. Life moves forward because systems hold. Ebola stops in Kampala because the circle holds: detection, isolation, care, follow-up. The border is covered too.

A planned Ebola treatment unit in DRC will intercept cases before they ever reach Uganda, cutting risk at the source. This is Uganda's strength: trained teams, tested systems, and communities that know what to do. Uganda is strong enough to protect every one within its borders and Kampala city remains open. Visitors should come to Uganda with confidence.

This article was co-authored by Dr Godfrey Bwire, Assistant Commissioner Health Services and Dr Bridget Ainembabazi, Senior Epidemiologist - Division of Public Health Emergencies Preparedness and Response at the Ministry of Health.