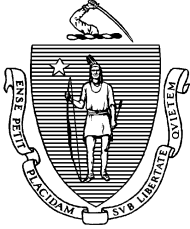


The Commonwealth of Massachusetts
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To: Massachusetts Healthcare Providers and Healthcare Facilities
From: Massachusetts DPH
Date: June 5, 2026

Clinical Advisory:

Ebola disease caused by Bundibugyo virus in DRC and Uganda

BACKGROUND

On May 15, 2026, the Democratic Republic of the Congo (DRC), and Uganda declared an outbreak of Ebola Disease following the confirmation of Bundibugyo virus disease (BVD) in both countries. On May 17, the World Health Organization (WHO) determined that the Ebola disease caused by Bundibugyo virus in DRC and Uganda constitutes a [public health emergency of international concern](#). The number of confirmed and suspect cases has been changing rapidly. Experts acknowledge that because of delays in identification of the outbreak, limitations in testing availability, and instability in the region that the outbreak is more widespread than currently described. Information on the outbreak is being kept relatively current on the U.S. Centers For Disease Control and Prevention (CDC) website.

On May 18, 2026, CDC and Department of Homeland Security (DHS) announced enhanced screening and entry restrictions for individuals traveling from affected areas. Entry to the US has been curtailed for non-US-citizens and certain US citizens. Air

passengers arriving from affected areas (currently DRC, South Sudan, and Uganda) are being re-routed to arrive at one of a limited number of airports (currently Washington-Dulles International Airport (IAD), Hartsfield-Jackson International Airport in Atlanta (ATL), John F Kennedy International Airport in New York City (JFK), and George Bush Intercontinental Airport in Houston (IAH) but subject to change). Travelers who have been in a country affected by the outbreak are being referred by federal personnel to the Massachusetts Department of Public Health (DPH) for monitoring during a 21-day period following their last day in the affected area.

Ebola virus infections are spread by direct contact with the blood or body fluids of an infected person when these fluids come into contact with broken skin or mucous membranes. Clinically, BVD presents identically to other *Orthoebolavirus* infections (Sudan virus and Ebola virus), initially 8-10 days after exposure, with fever, myalgias and fatigue (so-called “dry symptoms”) progressing to diarrhea, vomiting, and bleeding (including hemorrhagic rashes) referred to as “wet symptoms.” The incubation period is between 2 and 21 days, most commonly 8-10 days. Mortality rates in prior Bundibugyo outbreaks (in 2007-2008 and in 2012) were estimated to be between 30% and 50%. No approved vaccine or antiviral treatments are currently known to be effective in the prevention or treatment of BVD. However, rapid diagnosis and provision of supportive care, including IV fluids, can improve clinical outcomes.

GUIDANCE

Individuals who were in an affected country in the last 21 days are assessed for exposure opportunities and designated a category of risk based on the presence or absence of epidemiologic risk factors. These returned travelers are contacted by public health and engaged in symptom monitoring and asked to call their public health contact with questions or to report any symptoms.

Low Risk – individual was present in an affected country but not in an area of concern or was present in an area of concern but did not report any situations with exposure potential.

Moderate-to-High Risk – Individual:

- Was present in an area of concern and reported a situation with exposure potential including to bats or non-human primates, cared for someone with an acute febrile illness, spent time in a healthcare facility or participated in a burial.
- Had direct contact including percutaneous, mucous membrane, skin contact or other physical contacts with the body, blood or body fluids of a suspected or confirmed case of Ebola without intact personal protective equipment (PPE)

- Provided healthcare to a confirmed or suspected patient without PPE or experiencing a breach in infection control
- Lived in the same household as a confirmed or suspect case while the person was symptomatic

Any case of suspected BVD (suspect case) or individual identified as having potential exposure to a case of BVD in an area experiencing an outbreak should be immediately reported to the local board of health and DPH.

- A suspect **case** is an individual who has fever (temperature ≥ 100.4 deg F, 38 deg C) and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage AND a significant epidemiologic risk factor.

Management of suspect cases:

1. **Isolate** the case and place on the currently recommended precautions. Patients with suspected Ebola disease should be placed in a private room with the door closed; airborne infection isolation room (AIIR) is not required. CDC recommends a combination of measures to prevent transmission of VHF in healthcare settings including [personal protective equipment \(PPE\)](#). These should be used in addition to Standard Infection Prevention Control precautions.
2. Provide **supportive** care as indicated.
3. Contact DPH immediately at 617-983-6800 to report the potential case and discuss the need for testing. Inform your local infection control or other designated facility leadership.
4. Diagnostic testing for other pathogens should be performed as indicated and should not be delayed pending Bundibugyo testing. **Malaria** is the most frequent diagnosis ultimately made in suspected cases of EVD and requires urgent treatment. Lapses in early recognition and treatment of malaria result in poor outcomes and death. Routine laboratory tests needed to manage acutely ill patients such as blood cultures, complete blood counts (CBCs), and metabolic panels can be performed [safely in clinical laboratories](#) using standard and bloodborne pathogen precautions (preferably using instruments with closed-tube systems) and are not provided at the MA State Public Health Laboratory or at CDC. Testing for Ebola virus disease is available through the Massachusetts State Public Health Laboratory. Decisions about testing must be made in consultation with DPH. **Specimens for Bundibugyo virus testing should be obtained only after testing is approved by DPH**, who will provide detailed instructions

on obtaining, handling, and transport of specimens. Initial presumptive testing will be performed at the SPHL with confirmatory testing performed by CDC.

5. Maintain isolation until an alternative diagnosis is made or BVD is ruled out.

Initial evaluation and management of patients with concern for Bundibugyo should take place in the healthcare facility where they presented for care. Transfer to a higher care setting is appropriate for patients that require specialized care not available at the presenting facility, which must be coordinated with DPH. High-suspect cases or confirmed Ebola cases will require transfer to regional centers prepared to manage high consequence pathogens, which must be coordinated through DPH.

Management of potential contacts:

Those with potential exposure to Bundibugyo virus, including those at low risk, should be monitored during the 21-day incubation period in consultation with local public health and DPH.

Further information:

[Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda \(WHO, May 29, 2026\)](#)

[Ebola Information: Current Outbreak \(CDC\)](#)

[Interim Guidance for Public Health Assessment and Management of Travelers from Countries Affected by the 2026 Ebola Outbreak \(CDC\)](#)

[Instructions for Packaging and Shipping Specimens](#) (MA SPHL, ONLY AFTER CONSULTATION WITH DPH EPIDEMIOLOGY)

[Specimen Submission Form](#) (MA SPHL)

Telephone: Massachusetts DPH 24/7 Epidemiology: 617-983-6800