World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda

Weekly External Situation Report 02, Data as of 24 May 2026

Summary

Country	[1]Suspected Cases	[1]Suspected Deaths	CFR (%) Suspected	Confirmed Cases	Confirmed Deaths	CFR (%) Confirmed
Democratic Republic of the Congo	906	223	24.6%	105	10	9.5%
Uganda[2]	-	-	-	7	1	14.3%
Total	906	223	24.6%	112	11	9.8%

[1]Data on suspected cases and deaths are subject to revision following ongoing epidemiological and laboratory investigations.
[2]All suspected cases in Uganda have been reclassified following investigations; only confirmed cases are reported.

Event description

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo and Uganda continues to evolve rapidly, with increasing case numbers, geographic spread, and evidence of ongoing cross-border transmission. Since our previous update (***Sitrep #1***) dated 18 May 2026, the Democratic Republic of the Congo has reported 390 additional suspected cases, including 92 deaths. Laboratory-confirmed cases also increased by 72 cases, from 33 to 105 confirmed cases, while confirmed deaths increased from four to 10 deaths. However, these numbers should be interpreted with caution, due to delayed laboratory testing and confirmation. The outbreak in the Democratic Republic of the Congo continues to expand with now 13 affected health zones across three provinces, Miti-Murhesa Health Zone in South Kivu Province being the most recent to report a confirmed case.

As of 24 May 2026, the Democratic Republic of the Congo has reported 906 suspected cases, including 223 suspected deaths. Of 295 samples tested , 105 cases, including 10 deaths, have been laboratory confirmed across 13 health zones in Ituri (seven), North Kivu (five), and South Kivu (one) provinces. The outbreak remains concentrated in Ituri Province, which accounts for 89.5% (n=94) of confirmed cases, with the highest numbers reported from Rwampara (32 cases), Bunia (24), Mongbwalu (19), Nyankunde (nine), and Nizi (two) health zones. Suspected cases are also heavily concentrated in Ituri, particularly in Mongbwalu (339 suspected cases, including 88 deaths), Bunia (249 suspected cases, including 48 deaths), and Rwampara (228 suspected cases, including 69 deaths), together accounting for 90.1% of suspected cases and 91.9% of suspected deaths.

A total of 2231 contacts have been identified in the Democratic Republic of the Congo so far. However, contact follow-up remains a major challenge, with only 19.3% of contacts reportedly seen within the previous 24 hours as of 23 May 2026. Constraints include insecurity, movement restrictions, highly mobile populations linked to mining communities, and difficulties tracing contacts across dispersed and cross-border populations, as well as limited trained contact tracers to date.

Early geospatial analyses of the outbreak in the Democratic Republic of the Congo have identified mining-linked mobility corridors in Ituri Province as likely hotspots for early spillover and silent transmission, with Mongbwalu Health Zone emerging as the highest-priority transmission node, showing strong overlap between mining activity, population

movement, settlements, and the distribution of suspected and confirmed cases. Two additional high-risk mining zones, Kibali and Muchacha, were identified as potential amplification or spillover areas. These analyses suggest that movements associated with artisanal and industrial mining may have facilitated transmission before formal outbreak detection, highlighting the need to prioritize the Mongbwalu–Bunia–Nizi–Fataki corridor for intensified surveillance and response activities.

As of 24 May, the number of confirmed cases in Uganda has increased from two to seven, while confirmed deaths remain at one, with all cases reported from Kampala. The latest cases reported include a Ugandan driver who transported the index case, a Congolese health worker serving as a liaison for Congolese nationals seeking healthcare in Uganda, a Congolese woman who travelled from the Democratic Republic of the Congo to Uganda for medical care, and two Ugandan health workers who provided care for an earlier confirmed case at a private health facility. To date, 311 contacts have been identified for follow-up.

Security incidents against health facilities and community resistance have recently emerged as major operational challenges in Ituri Province, the Democratic Republic of the Congo, with three recent incidents reported in Mongbwalu and Rwampara health zones. These incidents reflect community fear and anxiety, persistent mistrust, misinformation, and resistance to safe burial practices, creating additional risks for undetected transmission and disrupting outbreak control efforts.

The World Health Organization (WHO) has assessed the national risk associated with the outbreak as very high in the Democratic Republic of the Congo and high at the regional level including Uganda, reflecting continued community transmission, heightened risk of undetected transmission chains, increasing numbers of linked and imported cases, and expanding contact networks; with countries directly bordering affected countries being at particularly high risk. Continued spread into major transport and commercial hubs, including Bunia, Goma, and Kampala, combined with intense mining-related mobility, cross-border movement, surveillance gaps, and incomplete contact tracing, further increases the likelihood of sustained transmission and wider regional spread.

Figure 1. Temporal trends of confirmed cases in selected health zones, Democratic Republic of the Congo, 16 – 23 May 2026 (n=96)

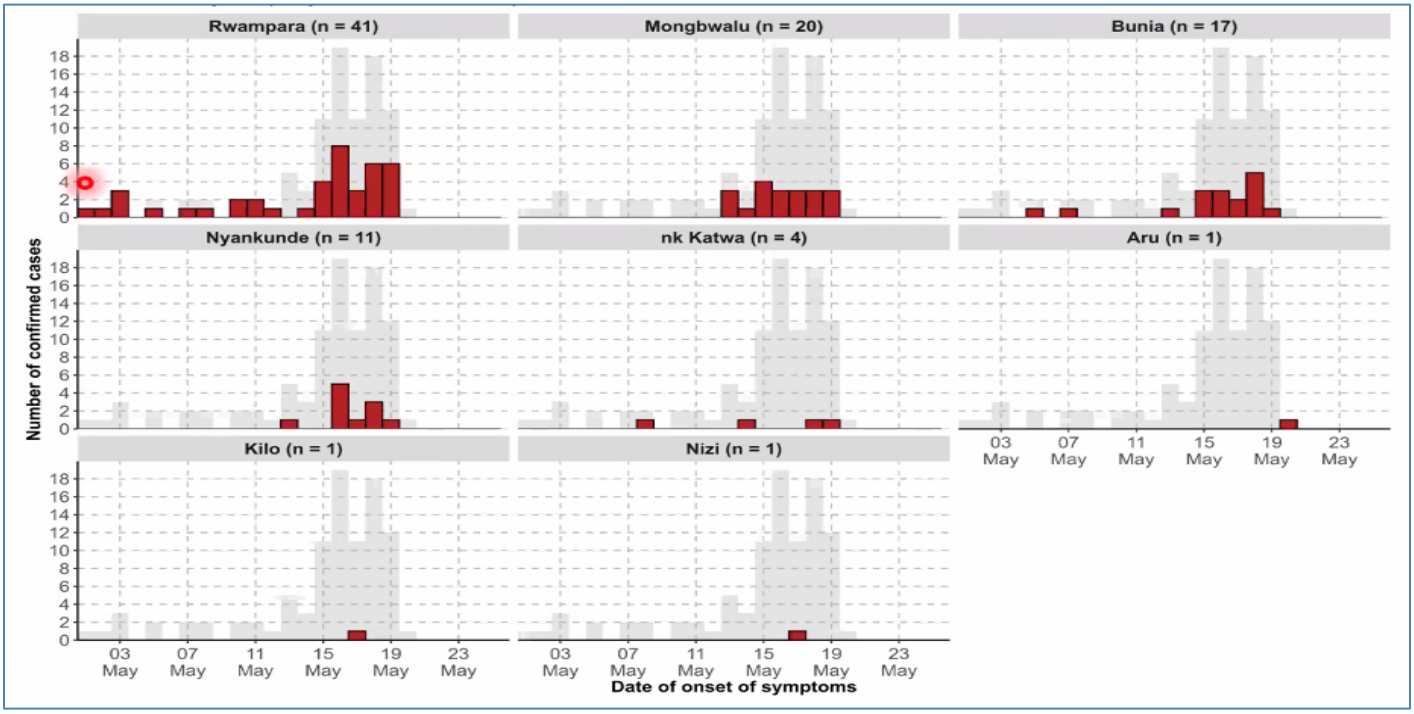
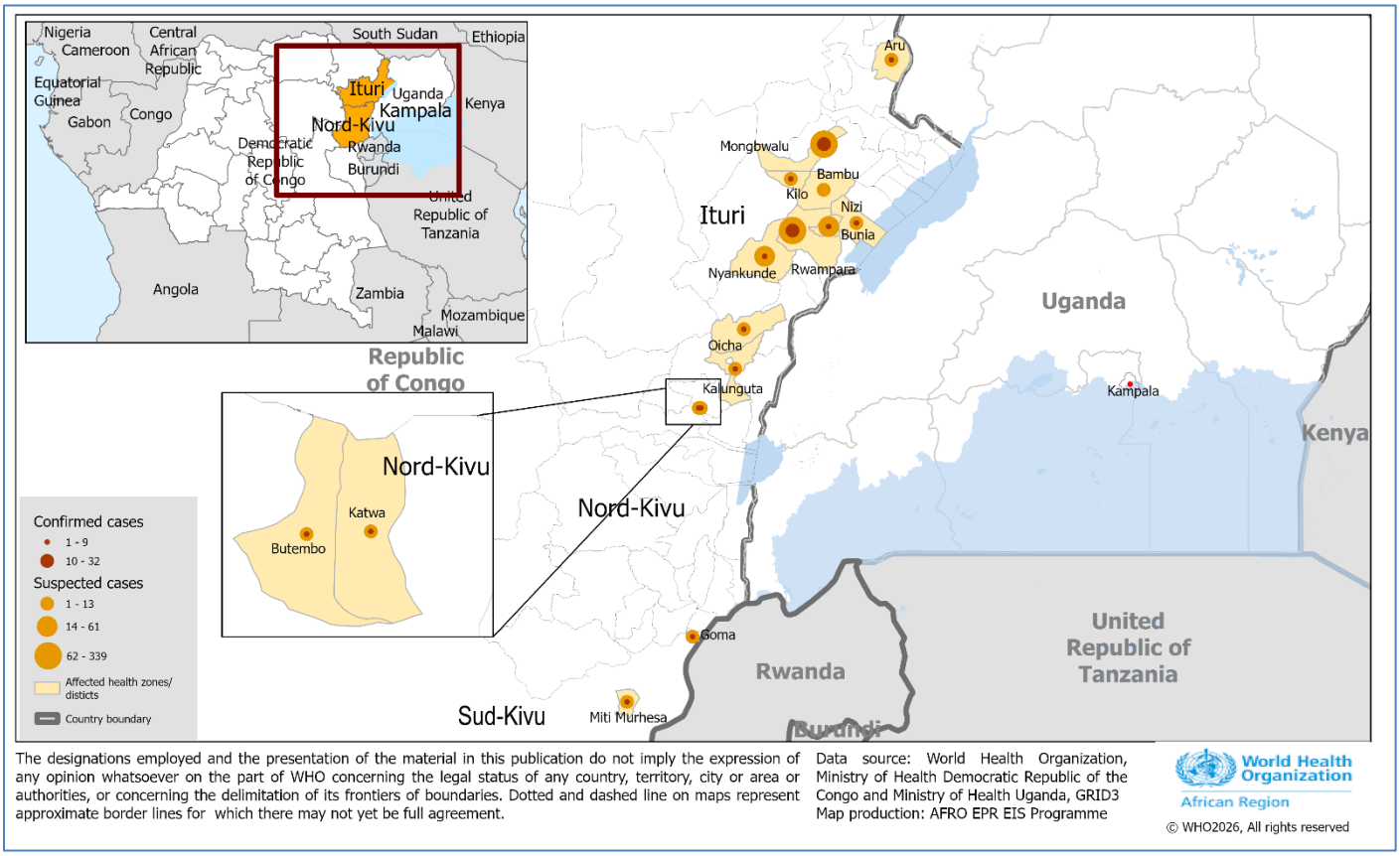


Figure 2. Distribution of suspected and confirmed Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of 24 May 2026



Public health response

Coordination

- A continental Incident Management Support Team (IMST) involving WHO, Africa Centres for Disease Control and Prevention (Africa CDC), and health partners has been launched to coordinate and provide strategic and operational support to affected and at-risk countries. Kampala, Uganda, has been designated as an expanded operational hub to facilitate regional coordination, strengthen cross-border preparedness and response activities, and support harmonized implementation across the Democratic Republic of the Congo, Uganda, and other at-risk countries. A continental response plan with a six-month operational horizon is under development.

- A high-level ministerial meeting on cross-border coordination, involving the Democratic Republic of the Congo, Uganda, and South Sudan, was convened in Kampala on 22–23 May 2026, reaffirming commitments to strengthen cross-border surveillance, joint contact tracing, information sharing, preparedness at points of entry, laboratory collaboration, and regional operational coordination. Countries also agreed to strengthen the continental IMST and harmonize preparedness and response measures across affected and at-risk areas.

- In both the Democratic Republic of the Congo and Uganda, national Incident Management Systems (IMS) remain activated, with coordination structures functioning at national and subnational levels and supported by WHO and

health partners, including Africa CDC, UNICEF, Médecins Sans Frontières, International Medical Corps, and other operational partners.

- In the Democratic Republic of the Congo, subnational coordination structures continue to operate across affected provinces and health zones, with daily provincial coordination meetings in Bunia facilitating alignment of response activities across operational pillars.

- In Uganda, the National Public Health Emergency Operations Centre and regional Emergency Operations Centres (EOCs) in Fort Portal, Arua, Yumbe, Kampala Capital City Authority, Kabale, and Hoima remain activated, while the national response plan and rapid risk assessment have been finalized to support outbreak response and preparedness activities.

Operations support and logistics

- To strengthen field response operations in the Democratic Republic of the Congo, WHO has deployed 52 surge personnel including 19 international staff and 33 national staff, as of 24 May 2026, to support coordination, logistics, surveillance, and other technical response activities across affected areas.

- Logistics corridors from Kinshasa, capital of the Democratic Republic of the Congo, Nairobi in Kenya, and Dakar in Senegal remain operational, with shipments covering personal protective equipment (PPE), viral haemorrhagic fever and case management supplies, tents, body bags, and laboratory consumables, alongside the ongoing deployment of EpiShuttle, a patient isolation transport systems, and telecommunications equipment.

- Logistics and infrastructure support for Ebola treatment capacity has continued in the Democratic Republic of the Congo, with assessments and layout finalization for a treatment facility completed. Quantification for Ebola Treatment Centre (ETC) construction and rehabilitation has been finalized, and earthworks for ETC expansion activities in Bunia have been initiated. In addition, operational assessments of warehouse readiness, stock positioning, and commodity distribution systems have been completed in Bunia to strengthen emergency supply chain visibility and delivery.

- Uganda has expanded multisectoral logistics coordination through a national operations platform involving the World Food Program, UNICEF, and approximately 10 international non-governmental organizations, with partners agreeing to share stock information through a common coordination dashboard covering health commodities, water, sanitation and hygiene, and laboratory supplies.

- Operational constraints, notably the closure of the Bunia airport, continue to affect response scale-up. Humanitarian flight coordination remains ongoing in the Democratic Republic of the Congo, including the rescheduling of cargo operations, while delays in the release of medical supplies and ongoing shortages of laboratory materials and protective equipment continue to pose challenges to response activities.

Surveillance

- Despite the complex operational and epidemiological context, surveillance activities continue to be strengthened across affected areas. In the Democratic Republic of the Congo, surveillance activities include active case finding, alert and case investigations, retrospective reviews of cases and deaths, and contact tracing. In Uganda, surveillance teams continue to support case investigations and contact monitoring using digital tools and experience from previous outbreak responses.

- Daily alerts continue to increase in the Democratic Republic of the Congo, with 71 alerts reported on 23 May, of which 53 were investigated and 47 validated, while in Uganda 42 alerts were detected and investigated, including 31 identified through points-of-entry screening.

- In the Democratic Republic of the Congo, 2231 contacts have been identified as of 24 May, though contact tracing remains a major operational challenge. Only 19.3% were seen within the previous 24 hours as of 23 May 2026. In Uganda, 311 contacts have been identified.

- Points-of-entry (PoE) screening continues to be strengthened in both countries to reduce cross-border transmission risks. With support from the International Organization for Migration, six PoE sites have been activated in the Democratic Republic of the Congo, screening 11 143 of 11 628 travellers (95.8%) on 24 May, while all 11 628 travellers received Ebola risk communication messages. No contacts were listed and no alerts were generated. In Uganda, screening activities are operational at 21 of 28 targeted PoEs, and 13 897 travellers were screened in the previous 24 hours as of 23 May 2026, generating 31 alerts, all of which were discarded.

Laboratory

- As of 24 May 2026, the Bunia Provincial Laboratory in Ituri Province, the Democratic Republic of the Congo, had cumulatively received 431 samples. Of these, 295 were analyzed, with 105 testing positive, a positivity rate of 35.6%.
- Laboratory surge operations are ongoing to address stockouts of diagnostic supplies at the Bunia Provincial Laboratory, with additional RT-PCR capacity being deployed, while WHO and Africa CDC are supporting the delivery of more than 4000 test kits.
- Both the Democratic Republic of the Congo and Uganda continue to perform confirmatory testing at their National Reference Laboratories, including genomic sequencing and data sharing, to improve understanding of transmission chains and support outbreak investigations.

Case Management

- As of 24 May 2026, the Democratic Republic of the Congo had admitted a cumulative total of 281 patients across 17 treatment and isolation facilities, with 133 patients currently in isolation centres, including eight healthcare workers. The largest numbers of admissions are in Bunia (53), Nyankunde (33), Rwampara (25), and Mongbwalu (18) health zones. In Uganda, five confirmed are being managed in isolation at the Mulago Ebola Treatment Unit (ETU) in Kampala.
- WHO and health partners are accelerating efforts to establish and operationalize standardized ETCs in hotspot areas, including infrastructure rehabilitation, provision of medical supplies and expansion of isolation capacity, although gaps remain.
- Clinical management operations have faced major disruptions due to security incidents and patient care challenges. In Mongbwalu, 18 suspected patients left the treatment centre following a security incident and the burning of one of three treatment tents, while a patient from Rwampara refused care, a confirmed case from Nyankunde was readmitted in critical condition, and a confirmed patient from Hoho Health Centre was released under community pressure despite unsuccessful counselling efforts.
- Supportive care capacity continues to improve. Nutritional management activities commenced with ALIMA to ensure that patients can receive adequate food, while additional equipment, including oxygen concentrators and multiparameter monitors, was deployed to strengthen clinical care capacity and improve quality of care.

Infection Prevention and Control (IPC) and Water, Sanitation and Hygiene (WASH)

- IPC measures continue to be progressively strengthened across affected health zones in the Democratic Republic of the Congo through supportive supervision, health facility assessments, environmental decontamination, and workforce capacity-building activities.

- Training and briefings on biomedical waste management, hand hygiene, and the appropriate use and removal of PPE were conducted for healthcare workers and support staff, including 14 healthcare providers and two supervisors in Rwampara Health Zone, as well as staff in health facilities in Bunia.

- Environmental decontamination and safe and dignified burial (SDB) activities were implemented in response to alerts and deaths. A total of 15 SDB and decontamination interventions were conducted, including five linked to seven alerts in Bunia, two community alerts in Rwampara, eight alerts in Mongbwalu, and household decontamination activities in Nyankunde and North Kivu.

- In Uganda, IPC activities focused on strengthening infection prevention measures in quarantine and treatment settings. IPC assessments were conducted in four quarantine facilities to identify gaps and strengthen IPC measures and practices.

- IPC measures are also being strengthened at the Mulago Ebola Treatment Unit (ETU) in Kampala, Uganda, an 80-bed facility with five intensive care unit beds and 10 high-dependency unit beds, to improve preparedness and reduce the risk of healthcare-associated transmission.

Risk Communication and Community Engagement (RCCE)

- RCCE activities have been scaled up in the Democratic Republic of the Congo and Uganda, with over 122 000 people reached through church outreach, mass sensitization campaigns, interactive radio programmes, and engagement of community leaders, U-Reporters, and community health workers/volunteers.

- These activities focused on understanding community perceptions and reducing transmission risks among high-risk populations.

- Anthropological investigations are ongoing to assess risky practices and understand perceptions and behaviours related to the Ebola Bundibugyo virus disease outbreak.

Prevention of Sexual Exploitation, Abuse, and Harassment (PRSEAH)

- PRSEAH activities were integrated into outbreak response operations in the Democratic Republic of the Congo and Uganda, with inter-agency coordination mechanisms and a joint action plan established to strengthen accountability and partner engagement.

- Field capacity strengthening continued, with three PRSEAH experts deployed and awareness sessions reaching more than 130 response personnel across case management, IPC, points of entry, and safe and dignified burial teams.

- Risk reduction and accountability measures are being strengthened through ongoing inter-agency risk assessments, reporting and referral systems, and mapping of partner roles to support safe and accountable response operations.

Operational Readiness

- Regional preparedness and prioritization framework is being activated with countries categorized by risk and readiness needs. The latest assessments have shown a readiness score of around 57% among priority one and two countries, highlighting the need to scale up readiness activities. Priority actions include activation of EOCs, revision of contingency plans, dissemination of case definitions, training of healthcare workers, and deployment of VHF-500 kits to high-risk areas.

- Countries have been prioritized based on epidemiological risk, cross-border exposure, and health system readiness. The Democratic Republic of the Congo and Uganda remain Tier I (Critical) due to active transmission, while South Sudan, Kenya, and Tanzania are Tier II (High Priority) and Rwanda, Burundi, and the Central African Republic are Tier III (Moderate Priority). Within the Democratic Republic of the Congo, the Ituri–North Kivu corridor, particularly Mongbwalu–Bunia and mining-linked mobility routes, remains the highest-priority transmission zone for intensified interventions.

- Preparedness efforts are focused on early detection and rapid response capacity with countries strengthening systems to ensure timely identification, investigation, isolation, and management of suspected viral haemorrhagic fever cases.

- Uganda has conducted national risk assessment, with 26 districts categorized as very high risk and 18 districts as high risk, guiding targeted preparedness and readiness measures.

Border Health, Travel and Mass Gatherings

- Points-of-entry and traveller screening operations have been reinforced at high-risk crossings and internal transit routes in both the Democratic Republic of the Congo and Uganda, with IOM and national authorities supporting PoE surveillance and implementation of WHO travel and border health guidance.

- Cross-border transmission risks remain elevated due to insecurity, humanitarian crises, high population mobility, urban/semi-urban transmission hotspots, and porous borders, requiring intensified surveillance and information sharing.

- Priority operational actions include rapid assessments and mapping of PoEs, informal crossings, and congregation points, alongside ensuring frontline teams have adequate staffing, training, PPE, screening materials, disinfectants, and referral systems. Mass gathering risk assessment capacity is being built and recommendations provided.

Situation interpretation

The outbreak is characterized by active and likely sustained transmission, currently concentrated in Ituri Province, with evidence of expansion into new provinces and cross-border spread into Uganda. Transmission appears to be driven by highly mobile mining and transport networks, delayed detection, and incomplete contact follow-up, while insecurity, incidents at health facilities with patients refusing care, and community resistance are challenging response efforts. It is important to highlight that this outbreak is occurring in an area affecting by a severe humanitarian crisis, with people facing forced displacement, acute food insecurity and gender-based violence. The low contact follow-up rate and continued transmission in commercial and cross-border hubs suggest a risk of undetected transmission chains and further geographic spread, requiring scale up of surveillance, community engagement, and hotspot-focused interventions.

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