World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK
Democratic Republic of the Congo | Uganda
Weekly External Situation Report 03, Data as of 31 May 2026

Summary

Country	Confirmed Cases	Confirmed Deaths	Probable Cases	Probable Deaths	Total Cases (Confirmed & Probable)	Total Deaths (Confirmed & Probable)	CFR (%) Confirmed & Probable
[1]Democratic Republic of the Congo	321	48	-	-	321	48	15.0%
[2]Uganda	11	1	1	1	12	2	16.7%

[1]Reported case counts should be interpreted with caution, as ongoing epidemiological and laboratory investigations continue to reclassify suspected cases on a daily basis. While those testing positive are reclassified as confirmed cases and those testing negative are discarded and removed from the case count, 116 suspected cases remain pending reclassification and are not yet reflected in the current totals.
[2]All suspected cases in Uganda have been reclassified following investigations; only confirmed and probable cases are reported.

Event description

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo continues to intensify, with sustained transmission, expansion into new health zones, and increasing risks of national and regional spread. In Uganda, additional cases have also been reported, all linked to previous cases or to travel from the Democratic Republic of the Congo. Since our previous update (***Sitrep #2***) with data as of 24 May 2026, the Democratic Republic of the Congo has reported an additional 216 laboratory-confirmed cases, including an additional 38 confirmed deaths. The outbreak has expanded from 13 to 23 affected health zones, across Ituri (15), North Kivu (seven), and South Kivu (one) provinces. In Ituri province, 15 of the 36 health zones are now affected, with Aungba, Damas, Gety, Komanda, Lita, Logo, and Mangala being the newly affected health zones. In North Kivu province, the detection of confirmed cases in Beni and Kyondo health zones has increased the number of affected health zones to seven out of 35.

Democratic Republic of the Congo

As of 31 May 2026, a total of 321 laboratory-confirmed cases, including 48 confirmed deaths, have been reported across the three affected provinces of Ituri, North Kivu and South Kivu in the Democratic Republic of the Congo. Of the 1077 previous suspected cases, including 246 suspected deaths reported to date, those testing positive have been reclassified as confirmed cases, while those with negative laboratory results have been discarded and removed from the case count. A total of 116 suspected cases remain under investigation and are not yet reflected in the reported totals. The outbreak remains heavily concentrated in Ituri province, which accounts for 299 confirmed cases (93.1%), followed by North Kivu (19 confirmed cases), and South Kivu (three confirmed cases). Within Ituri Province, the most affected health zones are Bunia, Rwampara, Mongbwalu, and Nyankunde.

A total of 3200 contacts had been identified for follow-up across the three affected provinces as of 29 May, of whom 967 (30.2%) were reportedly seen within the previous 24 hours. Contact tracing performance remained particularly

weak in Ituri Province, where major transmission hotspots such as Bunia, Mongbwalu, and Rwampara reported no contacts followed up during the reporting period, while substantially higher follow-up coverage was achieved in North Kivu Province (90.7%). The low follow-up rate highlights persistent challenges in the outbreak epicentre, where insecurity, population mobility, and operational constraints continue to hamper effective contact tracing.

Among 168 laboratory-confirmed cases with available demographic information, 54.8% (92) are males and 45.2% (76) are females. Adults aged 18 – 49 years accounted for the majority of cases, with the highest burden observed among persons aged 30 – 49 years, followed by those aged 18 – 29 years. Children aged 0–4 years and adults aged 50 years and above accounted for a smaller proportion of cases, although these groups may remain at increased risk of severe outcomes and mortality. The predominance of cases among economically active adults, particularly males, is consistent with the outbreak's association with mining activities and population mobility corridors in affected areas.

Uganda

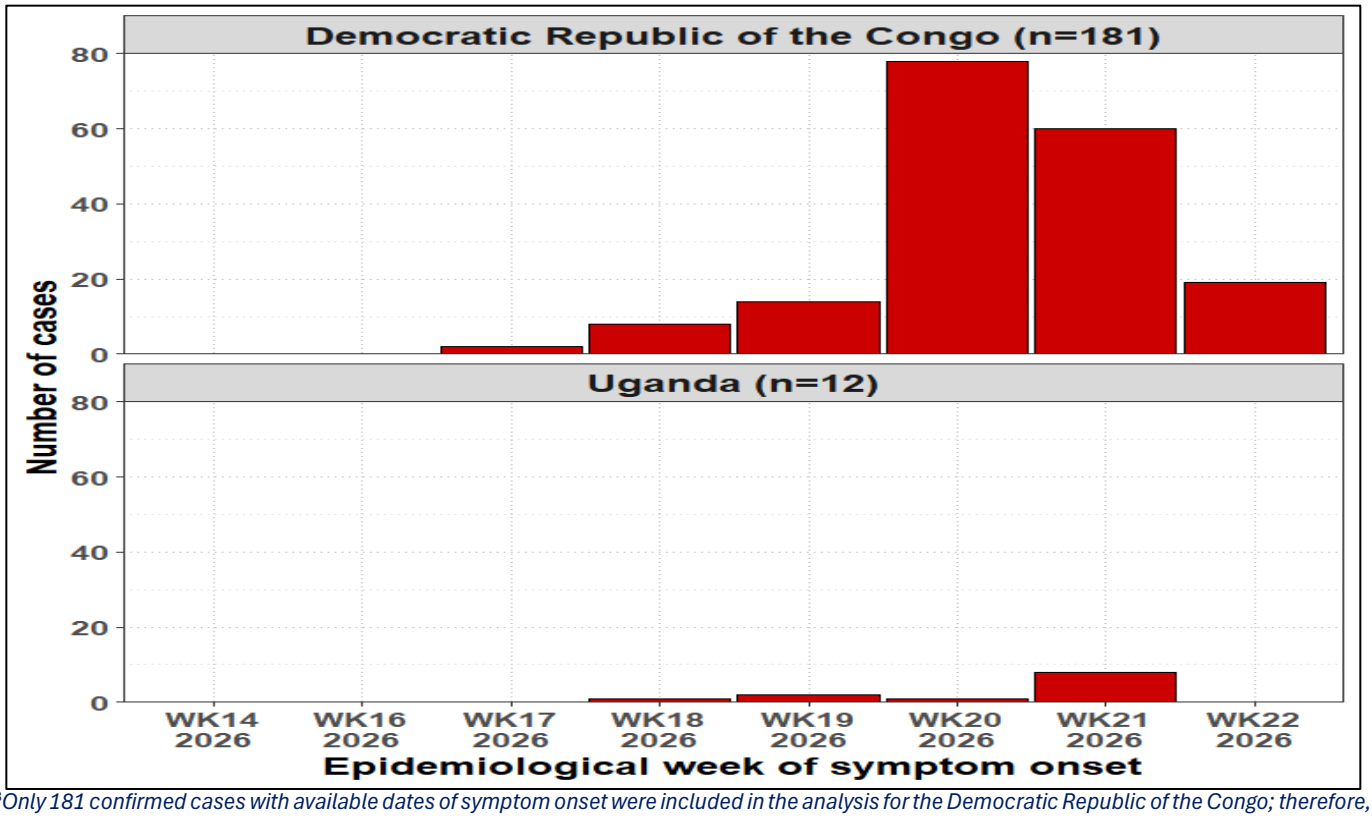
In Uganda, the outbreak remains epidemiologically linked to transmission originating in the Democratic Republic of the Congo, with evidence of both imported infections and secondary transmission among contacts and healthcare workers. Since the previous update, Uganda has reported five additional cases, including four confirmed cases and one probable case who died.
As of 30 May 2026, Uganda has reported 12 cases (11 confirmed and one probable), including two deaths (one confirmed and one probable), spanning two districts (Kampala and Wakiso) within the Kampala Metropolitan Area. Of these, five are healthcare workers. A total of 642 contacts have been identified and are under follow-up. Among the cases reported, 66.7% (eight) are males and 33.3% (four) are females.

Adults aged 31 – 50 years account for the majority of cases (58.3%; 7). Three cases were reported among persons aged 51 – 59 years and two among those aged 21 – 30 years. No cases have been reported among children or adolescents. The age distribution indicates that transmission has primarily affected working-age adults, consistent with the cross-border travel patterns and occupational exposures reported among confirmed cases.

Risk Assessment

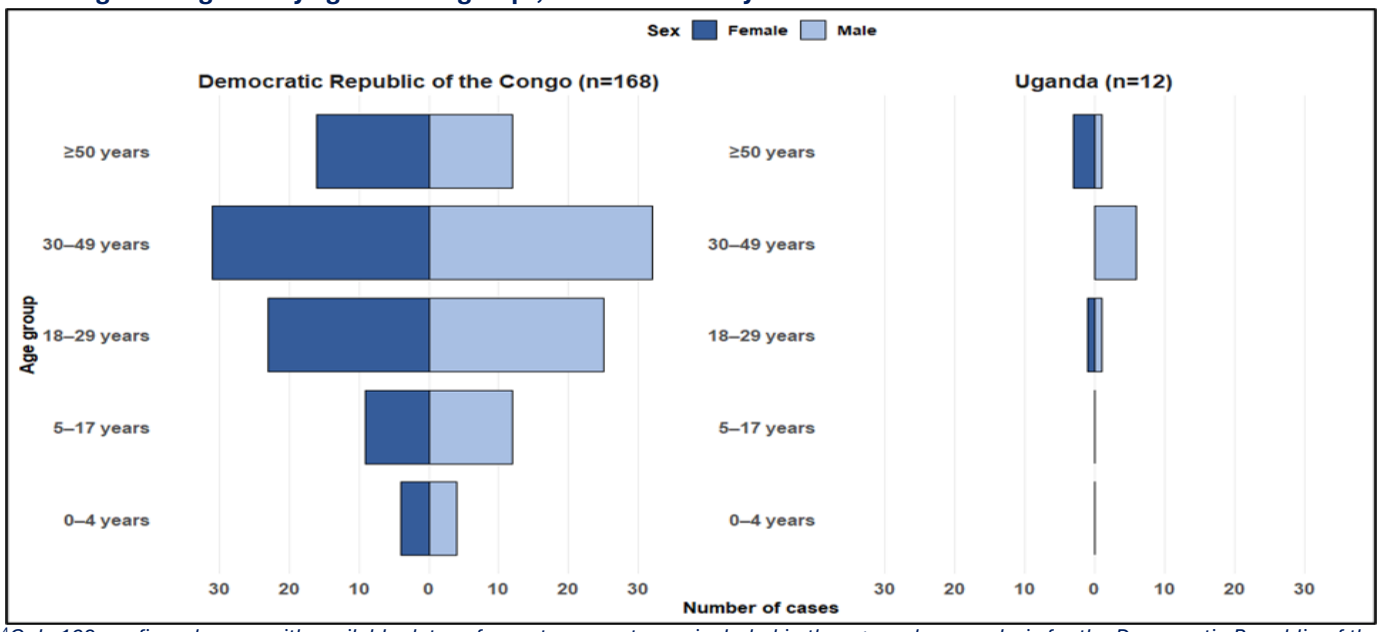
The World Health Organization (WHO) continues to assess the national risk associated with the outbreak as very high in the Democratic Republic of the Congo, high at the regional level including in Uganda, and low at the global level. The outbreak in the Democratic Republic of the Congo is occurring in a complex humanitarian context with chronic insecurity, large-scale population displacement, limited access to health services, and underfunded humanitarian operations. The affected provinces host millions of internally displaced persons, face recurrent attacks on humanitarian workers, and experience high levels of food insecurity and vulnerability, complicating surveillance and response activities.

Figure 1. Weekly trends of confirmed and probable cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by epidemiological week of symptom onset[3], epidemiological weeks 14 – 22, 2026



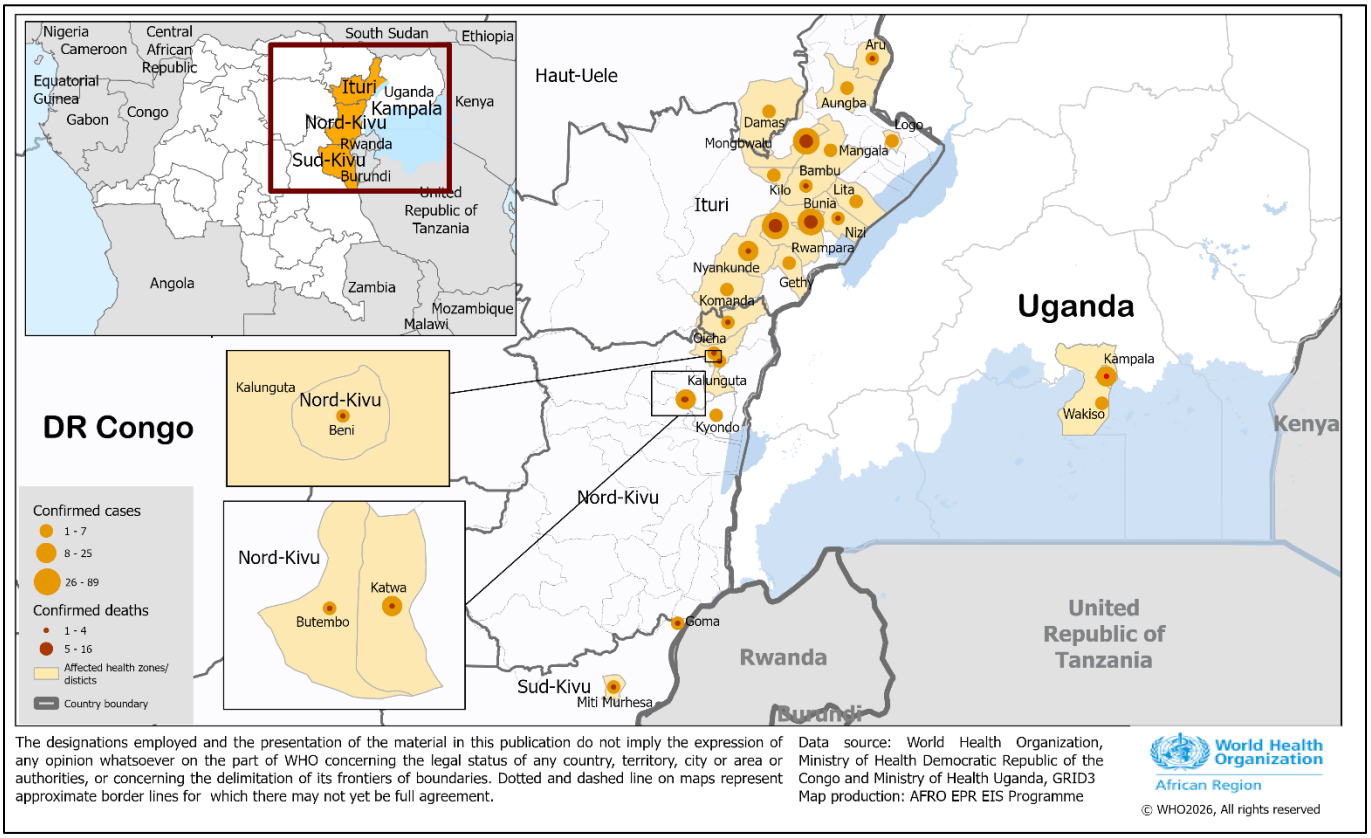
[3]*Only 181 confirmed cases with available dates of symptom onset were included in the analysis for the Democratic Republic of the Congo; therefore, the epi curve does not represent all 321 confirmed cases reported to date.*

Figure 2. Distribution of confirmed and probable cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by age and sex group[4], data as of 31 May 2026



[4]*Only 168 confirmed cases with available dates of symptom onset were included in the age and sex analysis for the Democratic Republic of the Congo; therefore, the graph does not represent all 321 confirmed cases reported to date.*

Figure 3. Geographical distribution of confirmed and probable cases of Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of 31 May 2026



Public health response

Coordination

- The continental Incident Management Support Team (IMST), led by WHO and the Africa Centres for Disease Control and Prevention (Africa CDC), and involving United Nations agencies, technical institutions, and health partners, remains activated to coordinate strategic and operational support to affected and at-risk countries. A continental response plan and resource mobilization framework are being operationalized to strengthen preparedness and response capacities. Coordination meetings and emergency briefings continue to be held routinely.

- 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, supported by WHO, Africa CDC, the United Nations Children's Fund (UNICEF), the International Organization for Migration (IOM), Médecins Sans Frontières (MSF), International Medical Corps, Samaritan's Purse, other organizations within the United Nations system, and other operational partners.

- WHO Director-General Dr Tedros Adhanom Ghebreyesus, accompanied by senior WHO leadership, including the WHO Regional Director for Africa and the Executive Director of the WHO Health Emergencies Programme, conducted a high-level mission to the Democratic Republic of the Congo from 29 to 30 May 2026, including visits to Kinshasa and to Bunia, Ituri Province. Together with national authorities, including

the Minister of Health, the mission reinforced political commitment and operational support for the response, emphasizing strengthened coordination, community engagement, early detection, and the delivery of quality clinical care in affected areas.

- WHO, national authorities, and partners continue to engage donors and mobilize additional resources to address critical funding gaps and sustain response operations across affected and at-risk areas.

Operations support and logistics

- WHO has deployed 155 field personnel across the Democratic Republic of the Congo and Uganda to support response operations. In the Democratic Republic of the Congo, 58 personnel (19 international and 39 national staff) are deployed across key outbreak hotspots, while 97 personnel (three international staff and 94 national staff and consultants) have been deployed in Uganda through nine field teams to support surveillance, case management, laboratory, logistics, and other response activities.
- Logistics corridors from Kinshasa in the Democratic Republic of the Congo, Nairobi in Kenya, Dakar in Senegal, and other regional hubs remain operational, facilitating the movement of emergency supplies and equipment to affected areas. To date, 38 metric tonnes of medical equipment, laboratory consumables, personal protective equipment (PPE), and other emergency supplies have been transported to support response operations across Ituri, North Kivu, and South Kivu provinces. WHO has also received an additional five metric tonnes of emergency supplies through support from the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO).
- Commodities valued at approximately US$ 1.88 million have been mobilized for the response. Of these, supplies worth US$ 373 542 (20%) have been delivered, US$ 802 528 (42%) are in transit, and US$ 706 817 (38%) remain under procurement or preparation.
- Rehabilitation of the Centre Médical Évangélique (CME) Ebola Treatment Centre in Bunia has been completed, providing capacity for 100 beds to support the isolation and clinical management of suspected and confirmed cases.
- Cargo flights and logistics support continue to facilitate the delivery of critical response commodities despite persistent access challenges in some affected areas. Operational assessments of warehousing, stock positioning, and supply chain management continue to support commodity visibility and distribution across affected provinces.
- In Uganda, logistics support for outbreak response continues to be strengthened through support to treatment centres, isolation facilities, and points of entry (PoE). Multisectoral logistics coordination involving WHO, UNICEF, the World Food Programme, government authorities, and operational partners remains active to ensure the timely deployment of supplies and equipment.

Surveillance

- Surveillance operations continue to scale up across affected and at-risk countries, including for alert reporting, case investigation, active case finding, contact tracing, retrospective reviews of cases and deaths, and cross-border surveillance.
- To strengthen surveillance capacity in the Democratic Republic of the Congo, 15 epidemiologists have been deployed across affected health zones in Ituri, North Kivu, and South Kivu provinces to support alert investigation, case investigation, and contact tracing activities. In addition, 100 healthcare workers have been briefed on BVD surveillance, including case definitions and alert management, while 20 000 surveillance forms have been distributed to affected health zones to standardize data collection, alert reporting, and

contact listing.

- As of 29 May 2026, a total of 3200 contacts had been identified across affected provinces in the Democratic Republic of the Congo, of whom 967 (30.2%) were seen within the previous 24 hours. Contact tracing performance remains low, particularly in Ituri Province, where insecurity, population mobility, and operational constraints continue to hamper follow-up activities. In Uganda, 634 contacts have been identified and remain under follow-up with a 93% follow up rate as of 29 May 2026.
- In the Democratic Republic of the Congo, community-based surveillance is being strengthened, including in sites for internally displaced persons. The number of reported alerts continues to increase, with 149 alerts reported on 29 May 2026, of which 84 (56.4%) were investigated and 73 (86.9%) validated.
- Cross-border surveillance and surveillance at PoEs is a major area of focus to reduce the risk of regional spread. In the Democratic Republic of the Congo, 13 960 travellers passed through monitored PoE sites on 30 May 2026, of whom 13 187 (94.4%) were screened, while all travellers received BVD risk communication messages. No contacts were identified and no alerts were generated.
- In Uganda, PoE screening continues to be strengthened to reduce the risk of cross-border transmission. As of 30 May 2026, 31 of 37 targeted PoEs had been activated. During the previous 24 hours, 5485 travellers were screened, generating eight initial alerts, all of which were investigated and discarded. At Entebbe International Airport, 3814 travellers were screened, with no alerts detected. Following the announcement on 27 May 2026 of the temporary closure of official border crossings with the Democratic Republic of the Congo and the suspension of selected cross-border transport activities, surveillance and screening activities in Uganda have been intensified at unofficial entry points and along high-risk population movement corridors to mitigate the risk of undetected cross-border transmission.

Laboratory

- Diagnostic testing continues across affected countries through national and subnational laboratory networks. As of 31 May 2026, laboratory testing in the Democratic Republic of the Congo continued at the Bunia Provincial Laboratory and the National Institute for Biomedical Research (INRB) in Kinshasa.
- INRB has deployed additional polymerase chain reaction (PCR) equipment, supplies and personnel to Bunia. WHO and partners continue replenishing laboratory reagents, test kits, and consumables to sustain diagnostic operations. A total of 2016 RadiOne (KH Medical, Republic of Korea) and 14 Altona screening PCR (Altona Diagnostics GmbH, Germany) test kits were delivered to Bunia Provincial Laboratory through WHO support, while additional testing supplies have been pledged by Africa CDC (4800 tests) and the United States Centers for Disease Control and Prevention (more than 2000 tests). Recent laboratory stockouts have been resolved, significantly improving diagnostic capacity and turnaround times across the three affected provinces. The backlog of samples to be tested has been fully cleared.
- In both the Democratic Republic of the Congo and Uganda, confirmatory testing continues through national reference laboratory networks, with partners supporting quality assurance, surge testing capacity, and regional laboratory preparedness.

Case Management

- Treatment capacity continues to expand in affected areas. ALIMA has operationalized treatment centres in

Bunia, Rwampara, and Goma, while rehabilitation of the Centre Médical Évangélique Ebola Treatment Centre (ETC) in Bunia has been completed, providing capacity for up to 100 beds for the isolation and management of suspected and confirmed cases. However, this remains insufficient to cater to the current number of suspected and hospitalized confirmed cases.

- Médecins Sans Frontières (MSF) is also supporting case management operations across affected provinces through the construction and operationalization of ETCs, including a 65-bed ETC in Ituri, an 80-bed ETC in Goma, and additional ETCs in Bukavu and Lwiro, alongside isolation units in multiple health facilities.
- As of 31 May, 342 persons were being managed in isolation and treatment facilities across affected provinces in the Democratic Republic of the Congo, including 104 suspected cases and 238 confirmed cases.
- Patient absconding from treatment and isolation facilities remains a major operational challenge. During the reporting period, 15 patients left treatment centres, including 11 from HGR Bambu, undermining continuity of care and increasing the risk of community transmission.
- In Uganda, five confirmed cases remain under treatment at the Mulago Ebola Treatment Unit in Kampala.
- Across the two affected countries, ten patients (six in the Democratic Republic of the Congo and four in Uganda) have recovered and been discharged from care, representing the first documented recoveries during the current outbreak.

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

Democratic Republic of the Congo

- IPC/WASH/Safe and Dignified Burial (SDB) coordination mechanisms have been established and operationalized at national and provincial levels, with WHO and partners supporting the Ministry of Health in validating IPC guidance documents and assessment tools.
- A total of 42 district supervisors, 50 MONUSCO personnel, and 220 frontline healthcare workers have received IPC training and technical briefings, while 11 screening and triage points were established and IPC kits, including PPE, were distributed to 60 high-risk health facilities.
- IPC assessments conducted in 54 health facilities identified major gaps in screening, triage, isolation capacity, PPE availability, and health worker protection. These findings are guiding targeted IPC strengthening activities in affected areas. A total of 102 SDB and associated decontamination activities were conducted to reduce transmission risks in affected communities.

Uganda

- An IPC ring approach is being implemented around high-risk health facilities and affected households, with decontamination conducted in all identified high-risk healthcare facilities and households linked to confirmed cases.
- IPC assessments have been conducted in 88 health facilities across 10 regions to identify and address gaps in healthcare worker protection, PPE availability, training, screening, triage, and isolation capacity. WHO-supported IPC and healthcare worker risk assessment tools have been validated and digitalized to strengthen real-time monitoring and targeted response interventions.

Risk Communication and Community Engagement (RCCE)

- In the Democratic Republic of the Congo, more than 6500 people have been reached with health promotion messaging through schools, churches, community volunteers, youth groups, and community dialogues

conducted in Bunia, Mongbwalu, Butembo, Katwa, Nyankunde, Bambu, Aru, and Rwampara health zones.

- In Uganda, RCCE activities focused on institutional and community sensitization, engagement with religious leaders, schools, hotels, and border communities, and strengthening school-based surveillance. Fifty bloggers and digital influencers were also oriented to amplify accurate messaging and counter misinformation through social media platforms.

- Anthropological assessments and community perception studies continue in affected areas to better understand perceptions, behaviours, and practices influencing outbreak transmission and response acceptance.

Preventing and Responding to Sexual Exploitation, Abuse, and Harassment (PRSEAH)

- PRSEAH activities continue to be integrated into outbreak response operations in the Democratic Republic of the Congo and Uganda through inter-agency coordination mechanisms, joint accountability frameworks, and partner engagement activities.

- A total of 595 response personnel, including 319 men and 276 women, have been trained and sensitized on the prevention of and response to sexual exploitation, abuse, and harassment across all response pillars to strengthen safeguarding and accountability during outbreak operations.

- Risk assessments have been initiated in Bunia and Rwampara to identify and mitigate safeguarding risks associated with outbreak response activities, while reporting, referral, and accountability mechanisms continue to be strengthened in affected areas.

Operational Readiness

- A regional preparedness and prioritization framework is being activated, with countries categorized by risk and readiness needs. The latest assessments have shown an average readiness score of 58% among priority one and two countries (with 90% of their readiness assessments completed and received) while 22 of 47 Member States have so far updated their readiness assessment, highlighting the need to scale up readiness activities. Priority actions include activation of emergency operations centres, revision of contingency plans, dissemination of case definitions, training of healthcare workers, and deployment of supplies 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 (Highest Priority) 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 zones 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

- PoE 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 national authorities, IOM and partners supporting PoE surveillance and implementation of WHO travel and border health guidance, as well as measures at points of control on high priority travel corridors.
- 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 field teams have adequate staffing, equipment, training, PPE, screening materials, disinfectants, and referral systems. Mass gathering risk assessment capacity is being built and recommendations provided.
- Postponement of mass gatherings is advised in areas of documented detection of the virus until transmission is interrupted, while a risk-based approach applies for events in the rest of the region/outside affected areas.
- Event-specific risk assessment is recommended to be done using the WHO all-hazards mass gathering risk assessment tool. This should be complemented by the establishment of referral pathways and RT-PCR capacity before events, ensuring that suspected cases can be isolated pending laboratory confirmation.
- Primary symptom screening, hand hygiene and BVD risk messaging should be maintained at events, alongside event-based surveillance, cross-border contact tracing, and post-event surveillance for at least 21 days.

Situation interpretation

The BVD outbreak in the Democratic Republic of the Congo continues to expand geographically, with sustained transmission concentrated in the Ituri–North Kivu corridor and increasing risks of further spread to neighbouring provinces and countries. Intense cross-border mobility, mining-related population movement, healthcare-associated exposure, and persistent operational challenges linked to insecurity, displacement, and limited access to health services continue to pose significant challenges for the response. While access to diagnostic testing kits have improved, there are still significant turnaround times in certain health zones in North Kivu and efforts are underway to further decentralize lab capacity. Although response capacities are improving, major gaps remain in contact tracing, IPC readiness, community acceptance, clinical care, and patient retention, while ongoing funding constraints and the complex humanitarian context continue to challenge response operations.

In Uganda, the occurrence of imported cases, secondary transmission among healthcare workers and contacts, and international travels involving confirmed cases highlights the continued risk of cross-border and international spread.

WHO advises all countries, particularly high-risk neighbouring countries, to strengthen preparedness and readiness activities, including surveillance, laboratory capacity, IPC, and rapid response measures. Sustained financial and operational support from donors and partners remains critical to contain the outbreak and reduce the risk of further regional and international spread.

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