World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK
Democratic Republic of the Congo | Uganda
Weekly External Situation Report 04, Data as of 07 June 2026

Summary

Country	Confirmed Cases	Confirmed Deaths	Probable Cases	Probable Deaths	Total Cases (Confirmed & Probable)	Total Deaths (Confirmed & Probable)	CFR (%) Confirmed & Probable
Democratic Republic of the Congo	550	101	-	-	550	101	18.4%
Uganda	19	2	1	1	20	3	15.0%

Note: Only confirmed and probable cases are reported.

Event description

The Bundibugyo virus disease (BVD) outbreak continues to evolve in the Democratic Republic of the Congo and Uganda since our last update (***Sitrep #3***) with data as of 31 May 2026.

Democratic Republic of the Congo

In the Democratic Republic of the Congo, intense community transmission continues, along with increasing geographic spread. Since 31 May 2026, a total of 229 new confirmed cases, including 53 new confirmed deaths, have been reported. As of 07 June 2026, a cumulative total of 550 laboratory-confirmed cases, including 101 confirmed deaths [case fatality ratio (CFR) 18.4%], have been reported across the three affected provinces of Ituri, North Kivu, and South Kivu. The reported number of health zones affected has risen to 25, including 17 of 36 health zones in Ituri Province, seven of 34 in North Kivu Province, and one of 34 in South Kivu Province. Mambasa and Rimba health zones in Ituri Province are the latest to be affected.

The outbreak remains heavily concentrated in Ituri Province, which accounts for 518 confirmed cases (94.2%), including 80 confirmed deaths (79.2%). The most affected health zones in Ituri Province are Bunia (152 cases, 15 deaths), Rwampara (111 cases, 20 deaths), Mongbwalu (98 cases, 29 deaths), and Nyankunde (26 cases, one death), which together account for 70.4% of all cases and 64.4% of all deaths reported in the Democratic Republic of the Congo. It is also worth noting that the health zone information was missing in the dataset for 94 confirmed cases, including 10 deaths reported in Ituri Province, and these cases could therefore not be attributed to specific health zones. Confirmed cases in North Kivu Province have increased to 25, including 15 deaths (CFR 60.0%), while no new cases have been reported in South Kivu province, which remains at three confirmed cases, including one death. The high CFR observed in North Kivu remains concerning.

Among 457 laboratory-confirmed cases with available demographic information as of 07 June 2026, 53.4% (244) were females and 46.6% (213) were males. Cases have been reported across all age groups, although relatively lower numbers have been observed among children and elderly. Adults aged 20 - 49 years (263 cases, 57.5%) accounted for the majority of cases, with the highest burden observed among persons aged 20 – 29 years (110 cases, 24.1%), followed by those aged 30 – 39 years (89 cases, 19.5%).

As of 07 June 2026, a total of 5418 contacts were under follow-up across the three affected provinces, of whom 3489 (64.4%) have reportedly been seen within the previous 24 hours. Follow-up coverage remains suboptimal across Ituri (60.1%) and North Kivu (79.5%) provinces, despite some improvement compared with South Kivu (99.1%) province.

Repeated security incidents continued to challenge response operations in affected areas. On 4 June 2026, a safe and dignified burial team was attacked in Katana, South Kivu Province, forcing responders to abandon a body before safe burial procedures could be completed. In Bunia, Ituri Province, four response personnel were reportedly injured during an attack linked to tensions surrounding outbreak control measures. Recurrent insecurity and armed group activity in and around Mongbwalu and newly affected areas such as Mambasa have also disrupted surveillance, patient referral, and safe burial activities, while earlier incidents resulted in confirmed cases fleeing from treatment facilities.

Uganda

In Uganda, the outbreak remains epidemiologically linked to transmission originating from the Democratic Republic of the Congo, with evidence of both imported infections and secondary transmission among contacts and healthcare workers. Since our last update, Uganda has reported an additional eight confirmed cases, including one confirmed death. As of 7 June 2026, Uganda has reported 20 cases (19 confirmed and one probable), including three deaths (two confirmed and one probable), spanning two districts (Kampala and Wakiso) within the Kampala Metropolitan Area. Of these, five are healthcare workers.

A cumulative total of 783 contacts have been identified as of 7 June. Of these, 368 have completed 21 days of monitoring, while the remaining 415 are under follow-up, with a 91% follow-up rate in the previous 24 hours as of 7 June.

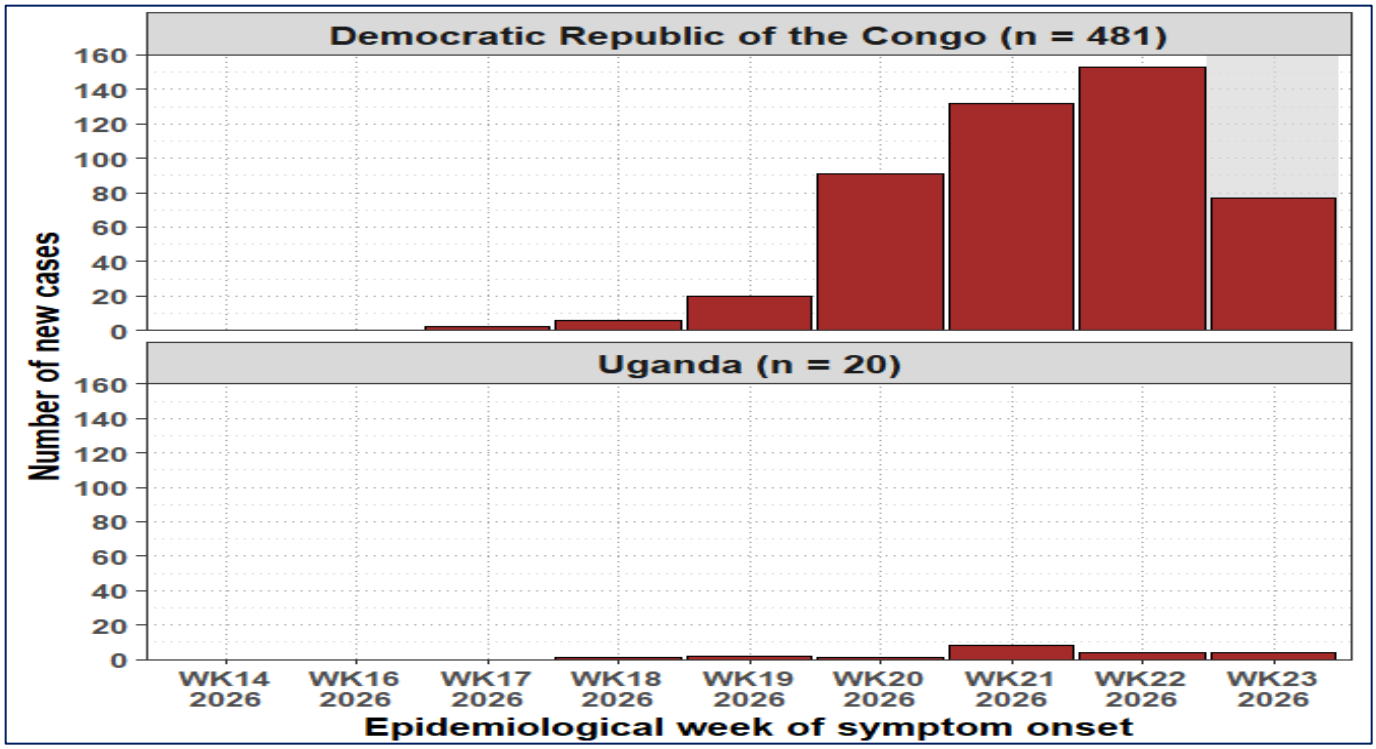
Risk Assessment

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 and high in Uganda. The risk for countries sharing land borders with the affected countries, currently the Democratic Republic of the Congo and Uganda, is considered high, while the risk for other countries in the African region is assessed as low. The risk globally remains unchanged and is assessed as low.

Recent subnational risk stratification in the Democratic Republic of the Congo identified 159 health zones as currently affected or at risk of BVD transmission. Among the 25 health zones currently reporting confirmed cases, 17 were classified as highest-risk “hotspot” health zones and eight as “active” health zones. Among health zones without confirmed cases to date, 19 were classified as “high-risk” due to their epidemiological links, population movement, or proximity to affected areas, while an additional 115 health zones were identified as at risk and requiring strengthened surveillance and readiness measures. This analysis highlights the extensive geographic scale and operational complexity of the outbreak response and is being used to guide prioritization of surveillance, preparedness, and response activities.

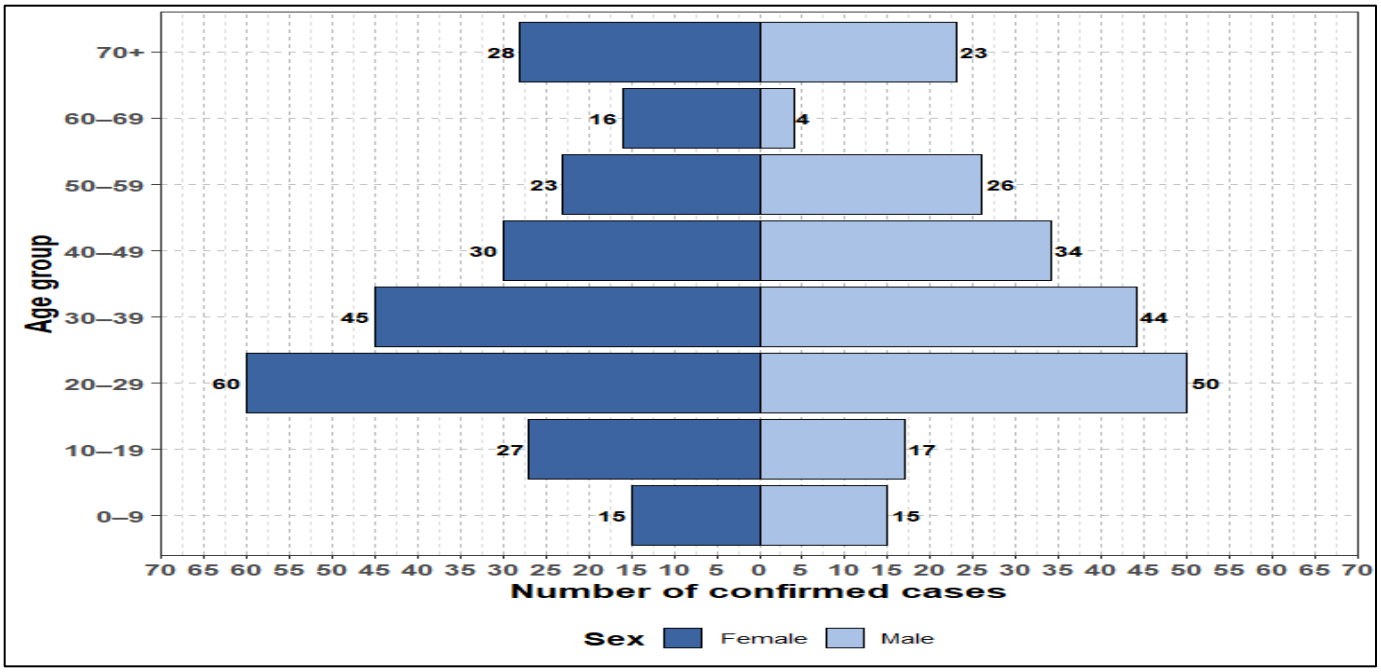
In Uganda, the risk is driven by cross-border movement from affected areas in the Democratic Republic of the Congo, exposure in urban and transit settings, and infections among health workers.

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, epidemiological weeks 14 – 23, 2026



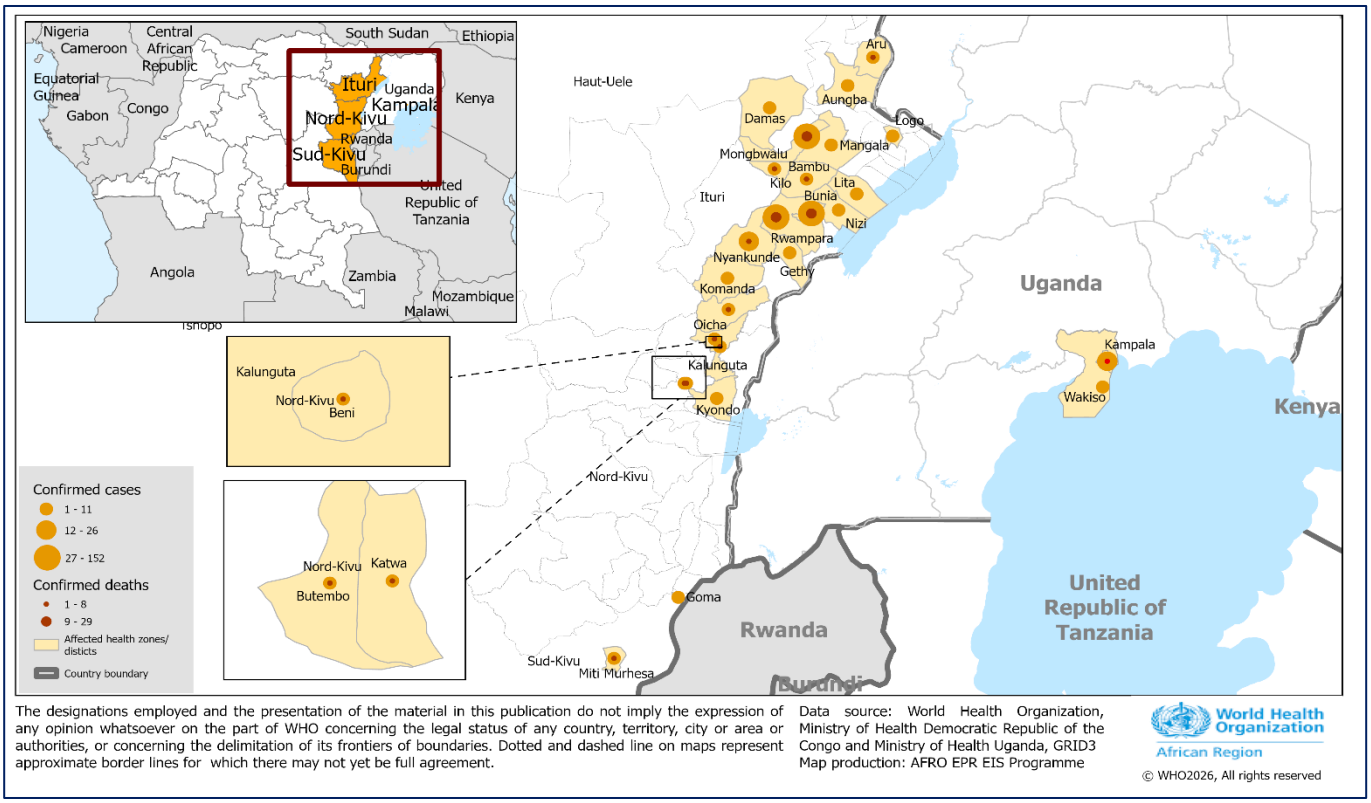
Note: Area shaded with gray background indicates incomplete data and discretion should be used in interpretation. For the Democratic Republic of the Congo, only 481 out of 550 confirmed cases with date of symptom onset are included in this graph.

Figure 2. Distribution of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo by age and sex group, data as of 07 June 2026



Only 457 out of 544 confirmed cases *were included in the age and sex analysis for the Democratic Republic of the Congo*

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 07 June 2026



Public health response

Coordination

- The continental Incident Management Support Team (IMST), co-led by WHO and the Africa Centres for Disease Control and Prevention (Africa CDC), and involving United Nations (UN) agencies, technical institutions, and operational partners, remains activated to coordinate strategic and operational support to affected and at-risk countries.

- On 5 June 2026, WHO and Africa CDC launched a joint continental preparedness and response plan covering June – November 2026, seeking US$ 518 million across multiple partners, to support affected countries and strengthen regional preparedness under a unified "One Response" approach. The plan complements national response plans in the Democratic Republic of the Congo and Uganda.

- 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 (IMC), Samaritan's Purse, the European Union (EU), other UN organizations, and operational partners.

- In the Democratic Republic of the Congo, coordination activities conducted through the national Public

Health Emergency Operations Centre (PHEOC) include joint missions to affected areas to assess health facilities and continuity of care and daily meetings to review outbreak priorities and operational gaps.

- In Uganda, coordination efforts continue to focus on cross-border management, preparedness, and response activities. The coordination established at a recent high-level ministerial meeting held in Kampala between the Democratic Republic of the Congo, Uganda, South Sudan, WHO, Africa CDC, UNICEF, and partners continues to serve as a key platform for regional solidarity, preparedness, and cross-border coordination.

- Resource mobilization efforts remain ongoing to address critical operational gaps and sustain preparedness and response activities across affected and at-risk countries.

Operations Support and Logistics (OSL)

- WHO continues to support response operations through the deployment of field personnel across the Democratic Republic of the Congo and Uganda. As of 07 June 2026, a total of 207 field personnel had been deployed. In the Democratic Republic of the Congo, 110 personnel were deployed across key outbreak hotspots, while 97 personnel (three international staff and 94 national staff and consultants) had been deployed in Uganda through nine field teams to support surveillance, case management, laboratory, logistics, and other response activities.

- Logistics and supply operations in the Democratic Republic of the Congo have expanded substantially across affected health zones, with large-scale distribution of personal protective equipment (PPE), laboratory reagents, infection prevention and control supplies, tents, cold-chain equipment, and clinical materials coordinated from Kinshasa to multiple outbreak hotspots. Laboratory equipment and reagents were also deployed to strengthen testing capacity. These operations involved inter-agency support from operational partners, including the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO).

- The reopening of Bunia Airport on 2 June significantly improved cargo throughput and field delivery timelines in the Democratic Republic of the Congo. During the reporting period, the Ebola Treatment Centre in Bunia became fully operational, including completion of patient transfers from the former isolation facility, while construction of a 24-bed extension for suspect cases remained ongoing. The development of a national Ebola logistics concept of operations has been initiated.

- In Uganda, logistics and operational readiness activities continued to strengthen across high-risk districts, including completion of a joint WHO–Ministry of Health logistics assessment in Hoima and surrounding areas to assess isolation and treatment capacity, stock availability, warehousing conditions, and operational gaps. Findings are being used to prioritize interventions and procurement needs.

- In both the Democratic Republic of the Congo and Uganda, a partner coordination platform is in place to monitor supply gaps, partner contributions, and incoming logistics pipelines.

Surveillance

- Surveillance activities continue to scale up across affected and at-risk countries, including alert reporting, case investigation, active case finding, contact tracing, mortality surveillance, retrospective reviews of cases and deaths, and cross-border surveillance.

- In the Democratic Republic of the Congo, as of 7 June 2026, a total of 5418 contacts were under follow-up across affected provinces, including 4454 in Ituri Province, 738 in North Kivu Province, and 226 in South Kivu Province. Contact follow-up rates remained suboptimal in hotspot areas, particularly in Ituri province where only 60.1% (2678) of contacts were reportedly seen within the previous 24 hours, compared with 79.5% in North Kivu Province and 99.1% in South Kivu Province. No contacts were reportedly seen during the reporting period in Mongbwalu, Kilo, and Bambu health zones, with insecurity, population movement, refusal, and loss to follow-up continuing to affect contact tracing activities.

- In Uganda, a cumulative total of 783 contacts had been identified as of 7 June 2026, of whom 368 had completed 21 days of monitoring, while 415 remained under follow-up. Contact tracing performance remained high, with a 91% follow-up rate reported within the previous 24 hours.

- As of 7 June 2026, a total of 450 alerts had been reported across the three affected provinces in the Democratic Republic of the Congo, of which 413 (91.8%) were investigated and 94 were validated as suspected cases. North Kivu Province accounted for the majority of alerts (290; 60.3%) and achieved a 100% investigation rate, while Ituri Province reported 153 alerts (38.8%) with the lowest investigation rate at 75.8%.

- In Uganda, alert management activities also remained active, with 604 alerts reported cumulatively as of 7 June 2026. Of these, 594 were verified. Mortality surveillance continued across multiple districts, with 456 non-trauma deaths reported cumulatively and 212 samples collected for testing.

- As of 7 June 2026, passenger screening was operational across 32 points of entry (PoE) and points of control in the Democratic Republic of the Congo, representing 84.6% of the planned coverage. During the reporting period, 15951 travellers passed through screening sites, of whom 15830 (99.2%) were screened for BVD symptoms. Three alerts involving dead bodies were identified and reported. The Bunia Airport was reopened by the Ministry of Transport on 2 June 2026 following a period of brief closure, with strict passenger exit and entry screening measures instituted.

- In Uganda, traveller screening and points of entry surveillance continued to be strengthened, with 7795 travellers screened within the previous 24 hours, including 4173 inbound and 3622 outbound travellers. Screening volumes declined from approximately 17700 travellers screened on 24 May to fewer than 4000 on 4 – 5 June before increasing again to nearly 8000 travellers by 6 – 7 June. Surveillance activities remained focused on high-risk border areas, informal population movement corridors, and major transit hubs, particularly Entebbe International Airport.

Laboratory

- Diagnostic testing continues across affected countries through national and subnational laboratory networks.

- In the Democratic Republic of the Congo, laboratory testing has been decentralized to Mongbwalu, Lwiro, and Bukavu health zones, in addition to existing testing capacity in Bunia, Kinshasa, and Goma. However, laboratories in Goma, Bukavu, and Lwiro health zones are currently experiencing stockouts and are awaiting the arrival of reagents to resume testing of backlogged samples. The National Institute for Biomedical Research (INRB) continues to implement a decentralized laboratory strategy aimed at expanding diagnostic

capacity to additional locations and reducing testing turnaround times.

- INRB has deployed additional polymerase chain reaction (PCR) equipment, sequencing equipment, supplies and personnel to Bunia as well as a RadiOne plateform (KH Medical, Republic of Korea) to Mongbwalu. Mobile laboratories were set up in Lwiro and Bukavu.

- 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).

- In Uganda, four laboratories are activated to test for Bundibugyo virus.

Case Management

- Case management activities continued to expand across affected provinces in the Democratic Republic of the Congo, supported by WHO and operational partners including ALIMA, MSF, IMC, MEDAIR, and Samaritan's Purse. A total of 14 operational BVD treatment and transit facilities were functional across nine health zones. However, existing treatment capacity remains insufficient to accommodate the current number of suspected and hospitalized confirmed cases. Expansion of treatment capacity is ongoing through six planned facilities expected to provide an additional 157 beds, including new facilities in Katwa and Nyankunde health zones.

- As of 7 June 2026, a total of 309 patients were in isolation across treatment and transit centres in the Democratic Republic of the Congo, including 116 confirmed and 193 suspected cases. Holistic care activities also continued, including nutritional support operations that distributed hot meals to patients. Comprehensive nutritional support will be crucial to ensuring patient compliance with isolation.

- Patient absconding from treatment and isolation facilities remains a major operational challenge. During the reporting period, six suspected and four confirmed cases reportedly absconded from care facilities, increasing the risk of ongoing community transmission and delayed clinical management.

- Other operational challenges affecting case management have included shortages of ambulances, generators, blood supplies, dignity kits, vehicles, and trained personnel, as well as limited isolation infrastructure in several health zones. Healthcare worker infections also continued to be reported, highlighting ongoing risks of transmission within healthcare settings and the need to further strengthen IPC measures.

- In Uganda, five confirmed cases remained under treatment at the Mulago Ebola Treatment Unit in Kampala. There are plans to conduct clinical care and IPC assessments of Isolation and Treatment facilities in Entebbe and Kasese for surge capacity readiness.

- Across the two affected countries, a total of 24 patients (19 in the Democratic Republic of the Congo and five in Uganda) have recovered.

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

- In the Democratic Republic of the Congo, more than 120 safe and dignified burials and decontamination interventions have been conducted. Screening, triage, and temporary isolation capacities are being established. Additionally, distribution of IPC kits and training of more than 220 frontline healthcare workers have been conducted. Assessments conducted in over 70 health facilities identified critical IPC gaps requiring targeted support.

- In Uganda, revision of Ebola IPC guidance, prepositioning of PPE and outbreak supplies, and activation of 10 IPC rapid response teams have been conducted. More than 3500 healthcare workers were reached through IPC training and mentorship activities, while over 375 high-risk health facilities and 20 isolation units were assessed to guide targeted IPC interventions, decontamination activities, and supply distribution in affected districts.

Risk Communication and Community Engagement (RCCE)

- In the Democratic Republic of the Congo, RCCE activities continued to expand across affected areas. More than 379650 people have been sensitized through community outreach activities, while over 180 community and religious leaders and 54 local chiefs were engaged through community dialogue sessions to support outbreak awareness and response efforts. Media engagement activities also continued through 36 radio stations across Ituri Province and Goma in North Kivu Province, alongside collaboration with social media influencers to strengthen public awareness and counter misinformation. In addition, sensitization sessions on barrier measures and patient admission procedures were conducted for healthcare workers and caregivers at health facilities in Bunia.

- 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.

- Community feedback, community assessments and 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 the outbreak response operations in the Democratic Republic of the Congo and Uganda through inter-agency coordination mechanisms, joint accountability frameworks, and partner engagement activities.

- To date, PRSEAH orientation and community engagement activities have reached approximately 1130 individuals, including 54 United Nations personnel, through 12 community engagement sessions conducted across three health zones.

- Sexual Exploitation Abuse and Harassment (SEAH) risk assessment data collection has been completed in the Democratic Republic of the Congo, with work ongoing to finalize the assessment report and develop a mitigation and safeguarding response plan. Reporting, referral, and accountability mechanisms continue to be strengthened in affected areas, while SEAH risk assessment activities are ongoing in Uganda.

Operational Readiness

- A regional preparedness and prioritization framework continues to guide readiness activities across the African Region, with countries categorized according to risk and preparedness needs. Priority 1A countries include the Democratic Republic of the Congo and Uganda; Priority 1B countries include South Sudan, Burundi, and Rwanda; Priority 2 countries include Angola, Central African Republic, Republic of the Congo, Ethiopia, Kenya, Tanzania, and Zambia; while all other countries remain classified as Priority 3.

- Recent assessments showed an average readiness score of 58% among Priority 1 and 2 countries, with 90% of readiness assessments completed and submitted. To date, 22 of 47 Member States, in addition to Zanzibar, have updated their readiness assessments, while seven of the ten Priority 1 and 2 countries have completed and shared contingency plans.

- Priority preparedness activities continue to focus on activation of emergency operations centres, strengthening of points of entry and border health measures, revision and testing of contingency plans, dissemination of case definitions, training of healthcare workers, deployment of supplies to high-risk areas, and deployment of regional support teams to provide technical assistance. International Health Regulations (IHR) National Focal Point profiles have also been updated to support timely notification and reporting of alerts.

Border Health, Travel and Mass Gatherings

- PoE and traveller screening operations have been reinforced at airports, 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 with documented BVD transmission in areas of BVD documented detection 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 should be conducted 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.

- Symptom-based screening combined with travel history review within the previous 21 days, 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.

- Event organisers should distribute participant information to all attendees before and during the event, covering BVD symptoms, what to do if feeling unwell, and available health services, in line with WHO guidance for mass gathering events attended by individuals from areas with documented BDBV detection.

Situation interpretation

The BVD outbreak in the Democratic Republic of the Congo continues to worsen, with sustained community transmission, increasing geographic spread, and growing operational challenges in insecure and highly mobile settings, particularly along the Ituri–North Kivu corridor. Despite improvements in laboratory capacity, logistics support, and expansion of response operations, major gaps remain in contact tracing, treatment capacity, and IPC measures, while insecurity and attacks on response teams continue to hinder surveillance and outbreak control efforts. In Uganda, ongoing imported cases and secondary transmission among contacts and healthcare workers highlight the continued risk of cross-border spread linked to population movement between the two countries. Sustained financial, operational, and security support will be critical to strengthen response activities and prevent further regional spread.

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