

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda

Weekly External Situation Report 06, Data as of 21 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	1 048	267	-	-	1 048	267	25.5%
Uganda	20	2	1	1	21	3	14.3%

Note: Only confirmed and probable cases are reported.

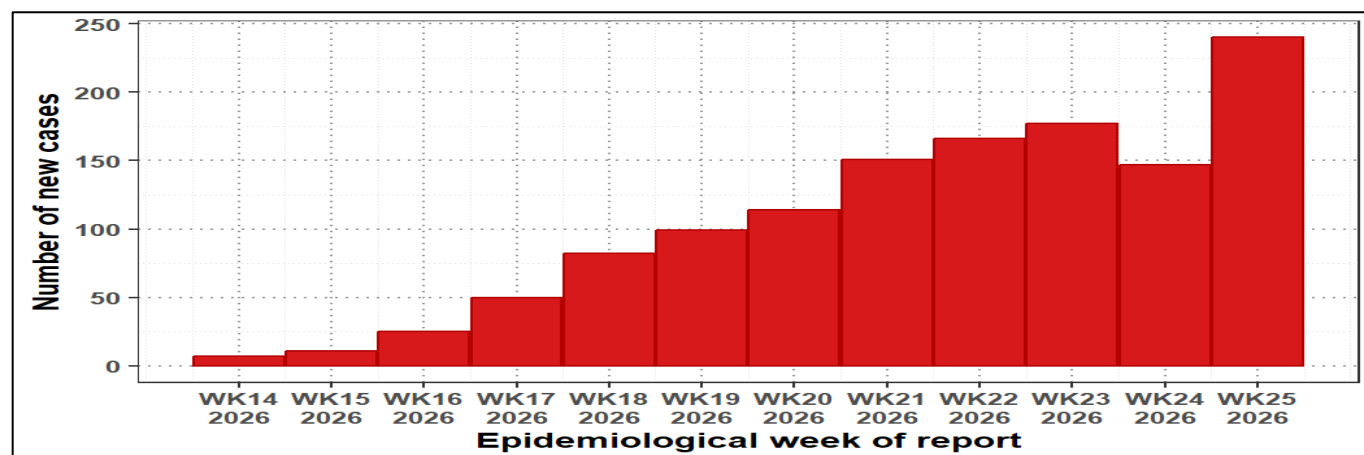
Event description

Since the last update of 14 June 2026 ([Situation Report #5](#)), the Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo has continued to evolve, with cumulative incidence surpassing the milestone of 1000 laboratory-confirmed cases and the number of affected health zones continuing to increase. Sustained community transmission continues to be observed across multiple hotspot and newly affected health zones. In Uganda, one new confirmed case was reported after nearly two weeks without a case.

Democratic Republic of the Congo

Since 14 June 2026, a total of 240 new laboratory-confirmed cases, including 75 new confirmed deaths, have been reported, representing a 29.7% increase in cumulative confirmed cases and a 39.1% increase in cumulative confirmed deaths. As of 21 June 2026, a cumulative total of 1048 laboratory-confirmed cases, including 267 confirmed deaths [case fatality ratio (CFR) 25.5%], has been reported across the three affected provinces of Ituri, North Kivu, and South Kivu.

Figure 1. Weekly trends of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo by epidemiological week of report, epidemiological weeks 14 – 25, 2026

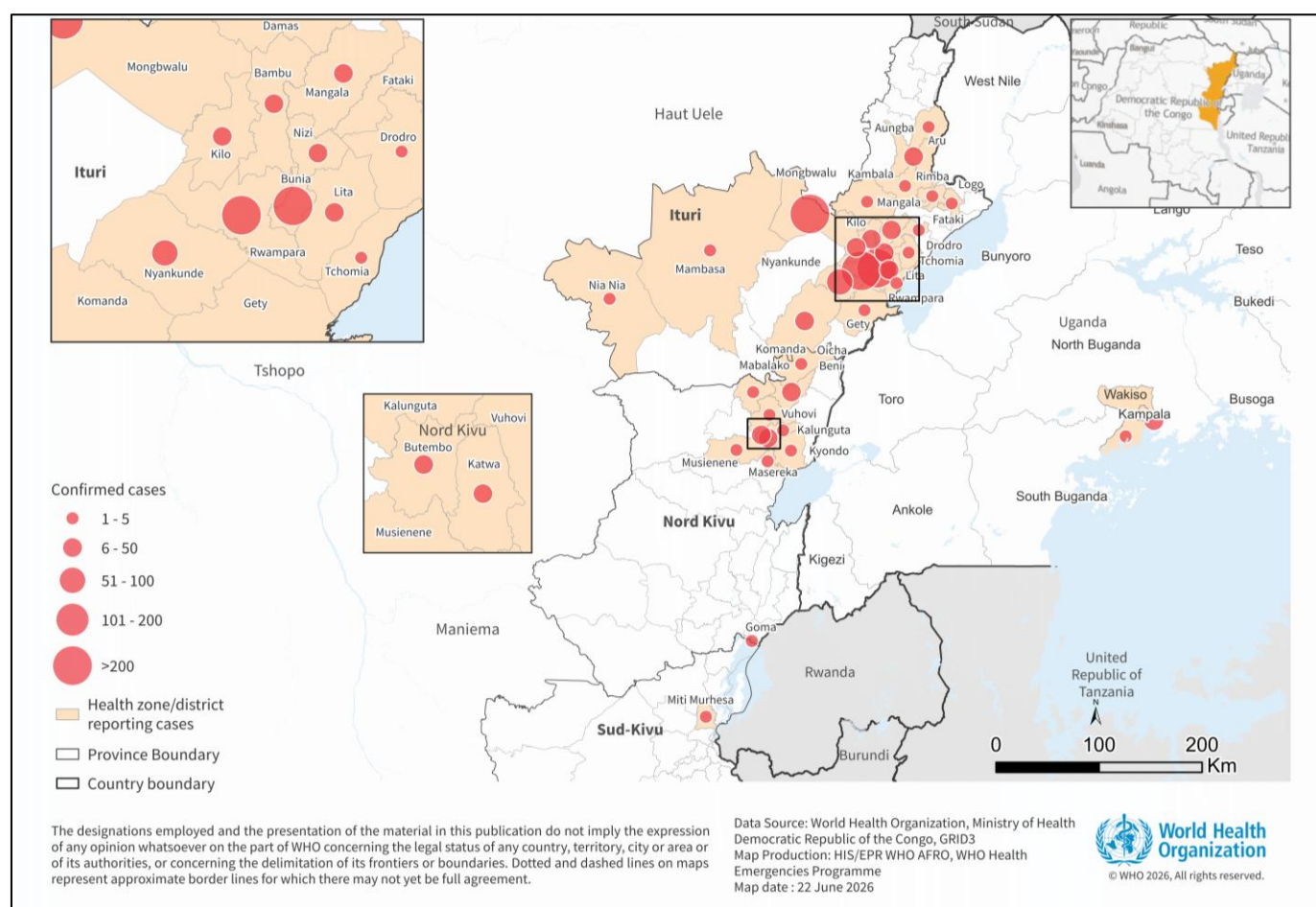


The number of affected health zones has increased from 31 to 34, representing 22 of 36 health zones in Ituri Province, 11 of 34 in North Kivu Province, and one of 34 in South Kivu Province. Newly affected health zones reported since the previous update include Drodoro and Fataki in Ituri Province and Musienene in North Kivu Province. South Kivu remains comparatively stable, with no new confirmed cases reported since 26 May 2026.

Ituri Province remains the epicentre of the outbreak, accounting for 954 confirmed cases (91.0%) and 216 confirmed deaths (80.9%) reported nationally. The highest cumulative case counts have been reported from Bunia (285 cases), Mongbwalu (229 cases), Rwampara (215 cases), and Nyankunde (86 cases) health zones, which together account for 77.8% of all confirmed cases reported in Ituri Province. Additional transmission has also been reported from Nizi (26 cases), Lita (21 cases), and Bambu (14 cases) while sporadic cases continue to emerge from several other health zones across the province.

North Kivu Province has reported 91 confirmed cases and 50 confirmed deaths to date, corresponding to the highest provincial CFR (54.9%) among affected provinces. Transmission remains concentrated in Katwa (31 cases), Butembo (29 cases), and Beni (18 cases) health zones, which are densely populated urban and commercial centres with substantial population mobility and regional connectivity.

Figure 2. Geographical distribution of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, as of 21 June 2026



Of the 34 affected health zones in the Democratic Republic of the Congo, four have not reported any new confirmed cases for more than 21 days. These include Gety in Ituri Province (31 days), Goma (27 days) and Kalunguta (28 days) in North Kivu Province, and Miti Murhesa in South Kivu Province (32 days). Despite this, transmission remains highly concentrated in a limited number of hotspot health zones. Within the past 21 days, the highest numbers of confirmed cases were reported from Bunia (198 cases), Mongbwalu (196 cases), Rwampara (136 cases), and Nyankunde (46 cases) in Ituri Province, and Butembo (28 cases) and Katwa (26 cases) in North Kivu Province. Together, these six health zones accounted for 84.7% (630) of all confirmed cases reported nationally during the same period. While the absence of recent reported cases in some health zones may suggest controlled transmission, continued surveillance and monitoring remain essential given ongoing operational challenges, including insecurity, population movement and the potential for delayed case detection and reporting.

Among the 501 confirmed cases with complete age and sex information available for analysis, 400 cases (79.8%) occurred among adults aged 20 – 49 years, with the highest numbers reported among females aged 20 – 29 years (101 confirmed cases) and males aged 30 – 39 years (70 cases), indicating sustained transmission among economically active population groups. The overall CFR was higher among males (30.7%) compared to females (20.8%). The highest age-specific CFRs were observed among children aged 0 – 9 years, reaching 75% overall, including 80% among females and 68.8% among males. Elevated CFRs were also observed among adults aged ≥70 years (35.7%), suggesting disproportionately severe outcomes among the youngest and oldest age groups.

Figure 3. Demographic distribution of confirmed cases of Bundibugyo virus disease by age group and sex in the Democratic Republic of the Congo (n=501)

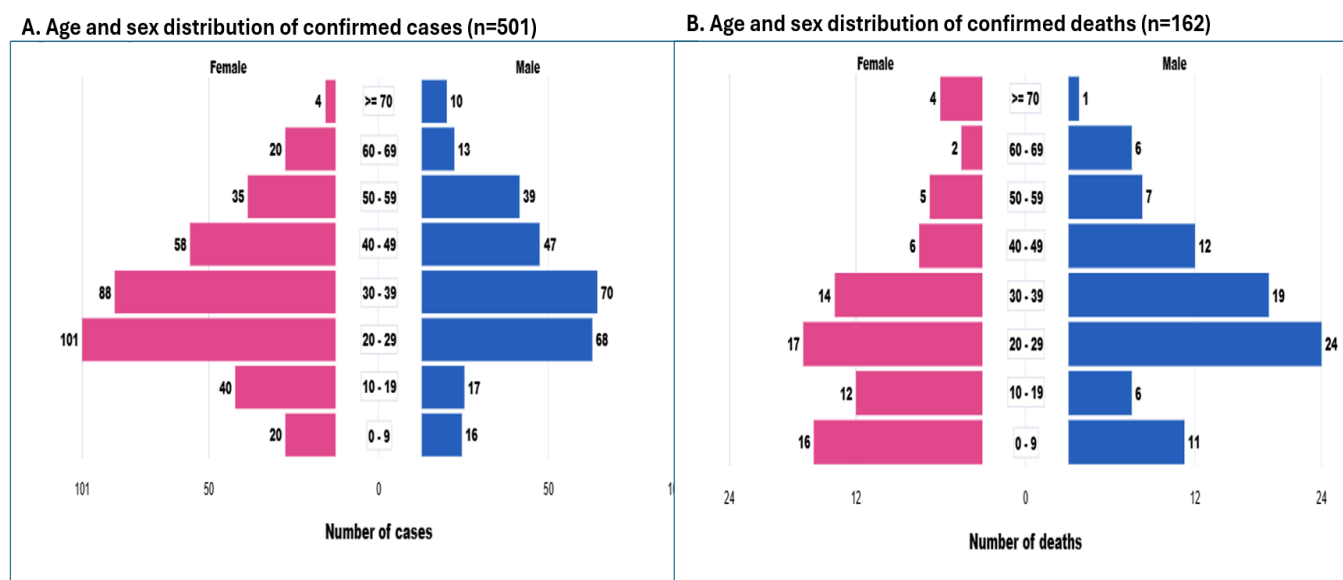
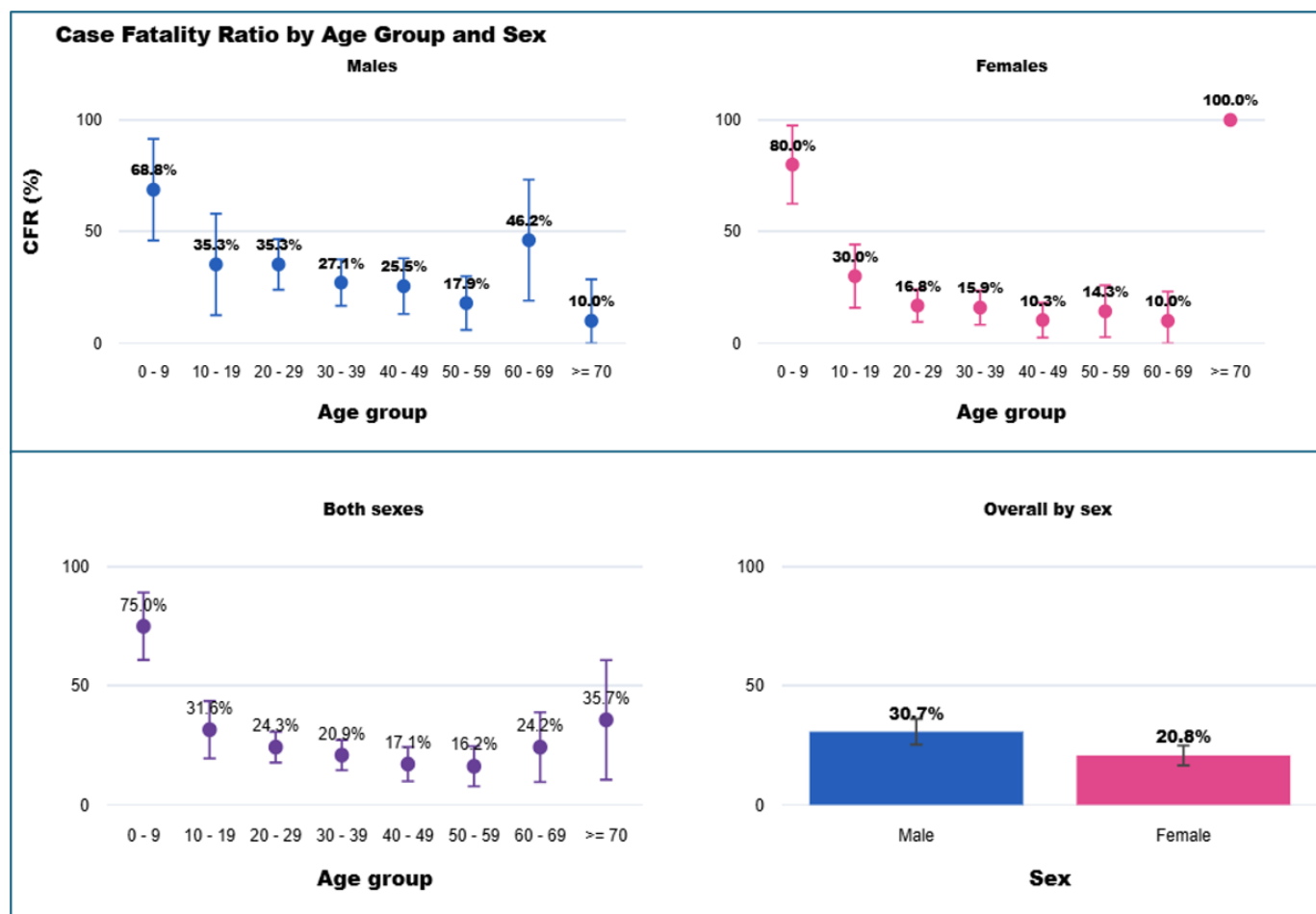


Figure 4. Case fatality ratio of Bundibugyo virus disease by age group and sex in the Democratic Republic of the Congo (n=501)



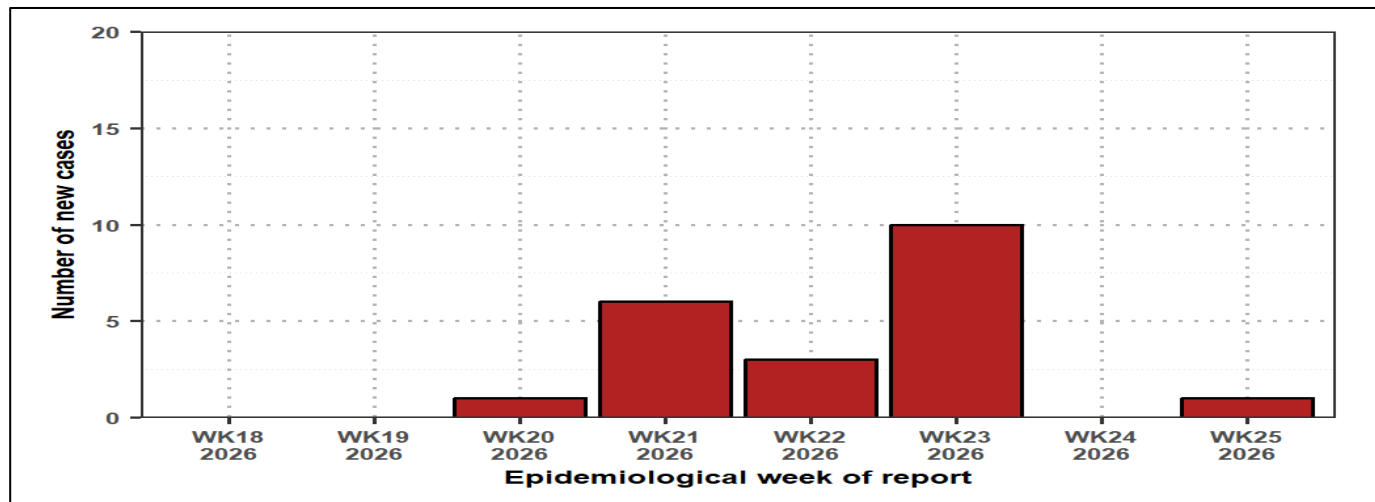
As of 21 June 2026, a total of 8424 contacts were under follow-up across the three affected provinces, of whom 5962 (70.8%) had reportedly been seen within the previous 24 hours. Contact follow-up coverage remains suboptimal, particularly in North Kivu Province (64.3%) and Ituri Province (72.7%), posing ongoing challenges to the timely identification of secondary case and rapid interruption of transmission chains.

During the reporting period, insecurity, community resistance, and operational constraints continued to impact outbreak response activities in several affected areas, particularly in Ituri and North Kivu provinces. Reports indicated ongoing hostility toward response measures, including resistance to safe and dignified burial operations, as well as continued challenges for response teams operating in insecure and hard-to-reach communities.

Uganda

One new confirmed case has been reported in Uganda since the previous external situation report, following nearly two weeks without any case. As of 20 June 2026, Uganda has reported a cumulative total of 21 cases (20 confirmed and one probable), including three deaths (two confirmed and one probable), across Kampala and Wakiso districts within the Kampala Metropolitan Area. The outbreak remains epidemiologically linked to cross-border transmission from the Democratic Republic of the Congo.

Figure 5. Weekly trends of confirmed cases of Bundibugyo virus disease in Uganda by epidemiological week of report, epidemiological weeks 18 – 25, 2026



Males accounted for 13 of the 20 confirmed cases (65%) and females for seven cases (35%). Cases have been reported across several adult age groups, with the highest numbers observed among persons aged 30 – 39 years and 50 – 59 years, each accounting for six cases (30%), followed by 20 – 29 years (four cases, 20%). Relatively few cases were reported among children and adolescents, with one case each reported among females aged 0 – 9 years and 10 – 19 years. Overall, the age and sex distribution indicates that transmission in Uganda has predominantly affected working-age adults, particularly males, likely reflecting patterns of occupational exposure, mobility, caregiving responsibilities, and cross-border movement associated with the outbreak.

Since the start of the outbreak, a total of 826 contacts have been identified. As of 20 June 2026, 56 contacts remain under active follow-up.

Table 1. Confirmed cases and deaths of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by geographic area, as of 21 June 2026

Country	Province / Region	Health zone / district	Cum. cases	Cum. deaths	CFR %	Cases (last 21 d)	Deaths (last 21 d)	Date last case	Days since last case
Democratic Republic of the Congo	Ituri	Aru	3	1	33.3	1	0	2026-06-04	17
		Aungba	6	2	33.3	3	2	2026-06-18	3
		Bambu	14	2	14.3	10	0	2026-06-20	1
		Bunia	285	45	15.8	198	17	2026-06-21	0
		Damas	4	0	0.0	3	0	2026-06-13	8
		Drodro	1	1	100.0	1	1	2026-06-12	9
		Fataki	1	0	0.0	1	0	2026-06-16	5
		Gety	1	0	0.0	0	0	2026-05-21	31
		Kambala	1	1	100.0	1	1	2026-06-10	11
		Kilo	7	1	14.3	3	1	2026-06-17	4
		Komanda	10	3	30.0	8	1	2026-06-17	4
		Lita	21	6	28.6	12	2	2026-06-21	0
		Logo	2	0	0.0	2	0	2026-06-04	17
		Mambasa	2	1	50.0	2	0	2026-06-01	20
		Mangala	11	5	45.5	11	5	2026-06-21	0
		Mongbwalu	229	96	41.9	196	87	2026-06-21	0

Country	Province / Region	Health zone / district	Cum. cases	Cum. deaths	CFR %	Cases (last 21 d)	Deaths (last 21 d)	Date last case	Days since last case
		Nia-Nia	2	2	100.0	2	2	2026-06-21	0
		Nizi	26	5	19.2	18	0	2026-06-18	3
		Nyankunde	86	9	10.5	46	6	2026-06-21	0
		Rimba	3	0	0.0	3	0	2026-06-02	19
		Rwampara	215	36	16.7	136	16	2026-06-21	0
		Tchomia	7	0	0.0	7	0	2026-06-21	0
Subtotal — Ituri			954	216	22.6	664	141	2026-06-21	0
	North Kivu	Beni	18	12	66.7	18	12	2026-06-21	0
		Butembo	28	13	46.4	28	13	2026-06-21	0
		Goma	1	0	0.0	0	0	2026-05-25	27
		Kalunguta	2	1	50.0	0	0	2026-05-24	28
		Katwa	31	19	61.3	26	15	2026-06-21	0
		Kyondo	3	1	33.3	2	0	2026-06-21	0
		Mabalako	1	0	0.0	1	0	2026-06-13	8
		Masereka	1	0	0.0	1	0	2026-06-10	11
		Musienene	2	1	50.0	2	1	2026-06-21	0
		Oicha	2	1	50.0	1	1	2026-06-16	5
		Vuhovi	1	1	100.0	1	1	2026-06-10	11
Subtotal — North Kivu			91	50	54.9	80	43	2026-06-21	0
	South Kivu	Miti Murhesa	3	1	33.3	0	0	2026-05-20	32
Subtotal — South Kivu			3	1	33.3	0	0	2026-05-20	32
Uganda	Kampala	Kampala	20	3	10	11	1	2026-06-19	2
		Wakiso	1	0	0	0	0	2026-05-25	27
Subtotal — Uganda			21	3	10	11	1	2026-06-19	2

Cells shaded green indicate health zones with no newly reported confirmed case for more than 21 days. Values are reproduced as published in the source situation report.

Public health response

Coordination

- The continental Incident Management Support Team (IMST), co-led by WHO and Africa Centres for Disease Prevention and Control (Africa CDC), remains activated to coordinate strategic and operational support to affected and at-risk countries under a unified “One Response” approach.
- In the Democratic Republic of the Congo, coordination of the response continues under the leadership of the Minister of Health through the Public Health Emergency Operations Centre (COUSP RDC) and the Ebola Incident Management System, with a progressively decentralized zonal coordination approach being implemented to strengthen operational oversight in hotspot health zones. In Uganda, national and district task forces remain activated to coordinate preparedness and response activities.
- High-level political engagement intensified during the reporting period, including deployment of three national ministers to Ituri Province and joint review sessions involving the provincial leadership, technical and financial partners, and operational response teams. Cross-border coordination between the

Democratic Republic of the Congo and Uganda also continued to be strengthened.

- National Incident Management Systems in both countries continue to receive coordination support from WHO, Africa CDC, UNICEF, the International Organization for Migration (IOM), Médecins Sans Frontières (MSF), International Medical Corps (IMC), Samaritan's Purse, the European Union, and other operational partners. Through the WHO-coordinated Global Outbreak Alert and Response Network (GOARN), expert deployments continue to support response and preparedness activities in affected and at-risk countries.
- As of 21 June 2026, there is a substantial funding shortfall, a gap of USD 81.2 million (71%) against an appeal of USD 115 million for the BVD response. The funding gap continues to constrain full implementation of response activities, particularly decentralized operations and surge capacity in hotspot and insecure areas..

Operations Support and Logistics (OSL)

- WHO continues to support response operations through the deployment of multidisciplinary field personnel across the Democratic Republic of the Congo and Uganda to support preparedness and response activities.
- Operations support and logistics activities continued to scale up across affected areas in the Democratic Republic of the Congo. As of 21 June 2026, the procurement and shipment pipeline for the response in the Democratic Republic of the Congo was valued at approximately USD 5.25 million, an increase from approximately USD 4.3 million reported during the previous reporting period. Of this amount, supplies worth approximately USD 1.37 million (26%) had been delivered.
- Critical commodities delivered or in transit included gloves, coveralls, gowns, polymerase chain reaction (PCR) diagnostic tests, infrared thermometers, tents, hospital beds, and RADIONE diagnostic materials to support frontline response operations, decentralized diagnostics, and treatment capacity expansion. Delivered commodities accounted for 155.9 metric tons and 901.4 cubic metres of cargo dispatched to logistics hubs in Ituri and North Kivu provinces.
- Logistics coordination mechanisms continued to support shipment tracking, supply distribution, partner coordination, and monitoring of operational gaps in both the Democratic Republic of the Congo and Uganda. The majority of procurement originated directly from suppliers (61%), while additional supplies were sourced through WHO logistics hubs in the Democratic Republic of the Congo, Nairobi (Kenya), and Dubai (United Arab Emirates).

Surveillance

- Surveillance activities continued across affected and at-risk areas, including active case finding, alert management, case investigation, contact tracing, mortality surveillance, community-based surveillance, and cross-border surveillance.
- In the Democratic Republic of the Congo, as of 21 June 2026, a total of 8424 contacts were under follow-up, including 6244 in Ituri Province, 2122 in North Kivu Province, and 58 in South Kivu Province. Overall contact follow-up remained suboptimal, with only 70.8% of contacts seen within the previous 24 hours. Follow-up rates remained low in North Kivu (64.3%) and Ituri (72.7%) provinces, while South Kivu maintained 100.0% follow-up.

- As of 21 June 2026, 831 alerts had been reported across the three affected provinces in the Democratic Republic of the Congo, all of which were investigated. A total of 202 suspected cases, including 60 community deaths were validated.
- Points of entry (PoE) and points of control (PoC) surveillance activities continued to be strengthened in the Democratic Republic of the Congo. As of 20 June 2026, 60 of the 72 planned PoE/PoC sites were operational nationally, including 44 of 55 in Ituri Province and 12 of 13 in North Kivu Province. During the reporting period, 133 554 travellers passed through PoE/PoC screening sites, of whom 96.0% were screened for BVD symptoms.
- In Uganda, active case finding, case investigation, contact tracing, alert management, surveillance for non-trauma deaths, and community-based surveillance continued nationwide, particularly in Kampala and Wakiso districts. As of 21 June 2026, nine contacts remained under active follow-up.
- In Uganda, inbound and outbound screening continued at points of entry, including Entebbe International Airport and high-risk border crossings. Mandatory digital Passenger Locator Forms remained in use for all inbound travellers, while holding facilities continued to be maintained for high-risk travellers. Temporary travel restrictions between Uganda and the Democratic Republic of the Congo also remained in place.

Laboratory

- Diagnostic testing continues across the affected countries through national and subnational laboratory networks.
- In the Democratic Republic of the Congo, laboratory testing has been decentralized to Aru, Nyakunde, Beni, Mongbwalu, Lwiro, and Bukavu health zones, in addition to existing testing capacity in Bunia, Kinshasa, and Goma. Reagents were delivered and backlogged samples tested. 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 RadiOne platforms (KH Medical, Republic of Korea) to Bunia, Mongbwalu, Nyakunde and Aru. With support from the Regional Mobile Laboratory in Goma, testing was initiated in Beni and mobile laboratories were set up in Lwiro (moving to Kayina) and Bukavu health zones.
- WHO and partners continue replenishing laboratory reagents, test kits, and consumables to sustain diagnostic operations. A total of 8016 RadiOne (KH Medical, Republic of Korea) and 960 Altona screening PCR (Altona Diagnostics GmbH, Germany) tests were delivered to the Democratic Republic of the Congo through WHO support, while additional testing supplies have been pledged by Africa CDC (4800 tests).
- In Uganda, Bundibugyo virus testing is being conducted through four operational laboratories, including mobile laboratories in Bwera (Kasese District) and Arua City, with additional support from the Central Public Health Laboratories (CERSL) in Wandegaya and the Uganda Virus Research Institute (UVRI) in Entebbe..

Case Management

- In the Democratic Republic of the Congo, case management activities continued across affected provinces, with treatment and isolation centres in Ituri, North Kivu, and South Kivu managing both confirmed and

suspected cases. As of 21 June 2026, a total of 371 patients were in isolation or hospitalization, including 196 confirmed cases and 175 suspected cases, with a national bed occupancy rate of 82.8%. Occupancy remained highest in Ituri Province (89.3%), reflecting sustained pressure on treatment capacity.

- During the reporting period, 67 new admissions were recorded across treatment and isolation facilities, while 75 patients were discharged, including 21 deaths, 40 non-cases, and eight recoveries. Six patient abscondments were also reported in Ituri Province, highlighting persistent challenges related to patient retention, psychosocial support, and community trust in treatment centres.
- Twelve patients were declared recovered on 21 June 2026 after obtaining two negative control tests, including nine in Ituri and three in North Kivu, bringing the cumulative number of recoveries to 112 nationally. Nutritional support activities also continued in treatment centres.
- Clinical severity remained particularly concerning in North Kivu, where the CFR reached 57.1%, significantly above the national average, suggesting continued delays in care-seeking, referral and access to timely treatment.
- Mental health and psychosocial support services continued to support confirmed and suspected patients, caregivers, separated children, and affected households, although coverage remained uneven, particularly in Ituri and North Kivu provinces.
- In Uganda, treatment capacity included 84 beds, including 10 critical care beds, at the Mulago isolation facility in Kampala; 56 beds, including four critical care beds, at the Entebbe isolation facility; and an additional 32 beds at the Mulago Field Isolation Facility. A total of 14 cases had recovered while four were still in admission.

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

- In the Democratic Republic of the Congo, IPC performance remained critically weak despite ongoing scale-up efforts. As of 21 June 2026, 236 health facilities had been assessed across 28 health zones, including 70 facilities reporting cases. Overall IPC performance averaged only 44%, with 66% of facilities classified as insufficient (<50%), highlighting major preparedness and infection prevention gaps.
- The most critical IPC weaknesses identified included safe and dignified burial preparedness (22%), isolation capacity (23%), and post-exposure management (27%). Better-performing components included injection safety (79%), healthcare waste management (75%), sterilization (69%), patient placement (66%), and water supply systems (64%).
- WHO and partners continued to support the Ministry of Health of the Democratic Republic of the Congo to strengthen IPC implementation through rapid training and deployment of frontline healthcare workers, supportive supervisors, decontamination teams, and Safe and Dignified Burial (SDB) teams, particularly in newly affected and high-risk health zones. International surge staff and additional national IPC focal points from previous outbreaks were also deployed to hotspot areas.
- In Uganda, IPC preparedness and capacity-building activities continued nationwide. A three-day IPC Training of Trainers in Bundibugyo District prepared 55 trainers to cascade IPC knowledge to healthcare facilities. During the reporting period, 23 baseline IPC assessments were completed and 34 healthcare workers

received on-site mentorship. Cumulatively, 1,147 IPC assessments had been conducted, 3,832 healthcare workers oriented, and 547 healthcare workers trained, with an overall IPC performance score of 66.6%. However, 311 facilities remained below the minimum IPC threshold and required targeted support.

Risk Communication and Community Engagement (RCCE)

- In the Democratic Republic of the Congo, RCCE activities continue to expand in high-risk zones, prioritizing hotspot areas aligned with epidemiological trends.
- Community feedback indicates persistent concerns regarding delays in safe and dignified burial procedures, transport of suspected cases and quality of care at BVD treatment centres.
- Engagement with local leaders and community networks has contributed to improved access and have helped address community concerns about resource distribution and rumours linked to self-medication, though trust gaps remain.
- In affected areas more than 1.7 million people have been directly reached through community outreach activities. Over 180 community and religious leaders along with 54 local chiefs have been engaged through community dialogue sessions to support outbreak awareness and response efforts. Media engagement has continued via 178 radio stations across Ituri Province and Goma in North Kivu Province, complemented by collaboration with social media influencers to strengthen public awareness and counter misinformation. Additionally, 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 coordination activities continued in collaboration with government authorities, the inter-agency PRSEAH network, international non-governmental organizations, United Nations agencies, and operational partners to strengthen prevention and response measures within the Ebola outbreak response.
- Joint PRSEAH briefings were conducted for 2007 humanitarian actors engaged in the BVD response, including 820 women (41%), to strengthen awareness of sexual exploitation, abuse, and harassment risks, reporting mechanisms, and accountability standards among frontline responders.
- Joint community awareness and risk communication activities were conducted in Mongbwalu and Bunia health zones in Ituri Province, Goma in North Kivu Province, and Miti Murhesa in South Kivu Province to raise awareness on the prevention of sexual exploitation and abuse and promote use of the toll-free reporting hotline. A total of 1616 girls and women were reached, representing 42% of all individuals sensitized during

the reporting period.

- Data collection for the assessment of sexual exploitation and abuse risk factors has been completed, and analysis is ongoing to identify priority mitigation measures and strengthen prevention strategies in affected communities.
- The PRSEAH preparedness plan and associated human resource requirements have been finalized for 12 high-risk countries to strengthen operational readiness and enhance prevention and response capacity for sexual exploitation abuse and harassment risks in priority settings.

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, 26 of 47 Member States, in addition to Zanzibar, have updated their readiness assessments, while nine of the ten Priority 1 and 2 countries have completed and shared contingency plans (80%). Regional deployments to support high risk member states have is ongoing in South Sudan, Kenya, and the Democratic Republic of the Congo.
- 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, as well as cross-border population mobility mapping to identify key movement patterns, high-risk cross-border routes, including informal crossings, and major congregation points. Additional priorities include ensuring that field teams have adequate staffing, equipment, training, PPE, screening materials, disinfectants, and referral systems.
- Mass gathering risk assessment capacity is being strengthened through training and the provision of

recommendations. The postponement of mass gatherings is advised in areas with documented BVD transmission until transmission is interrupted, while a risk-based approach is recommended for events held elsewhere in the region and outside affected areas. A Mass Gathering Readiness Checklist for host countries sharing land borders with affected countries and expecting attendees from areas with documented BVD transmission is being finalized.

- Event-specific risk assessments should be conducted using the WHO all-hazards mass gathering risk assessment tool. These assessments should be complemented by implementation of measures before, during, and after events, as outlined in WHO guidance for mass gatherings attended by individuals from areas with documented Bundibugyo virus detection, including the establishment of referral pathways and RT-PCR testing capacity. Capacities for symptom-based screening combined with travel history and exposure assessment within the previous 21 days should also be in place, alongside promotion of hand hygiene and BVD risk communication. These measures should be further complemented by event-based surveillance, coordination with public health authorities for cross-border contact tracing, and post-event surveillance for at least 21 days following the event.
- 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 remains a complex and evolving public health emergency, characterized by sustained community transmission, increasing numbers of cases and deaths, and continued geographic expansion across Ituri and North Kivu provinces. Transmission remains concentrated in major hotspot health zones, particularly Bunia, Mongbwalu, and Rwampara, while spread into newly affected health zones highlights continued expansion beyond the initial epicentres. Although surveillance, laboratory, logistics, and treatment operations continue to scale up, response efforts remain constrained by low contact follow-up rates, increasing pressure on treatment capacity, shortages of key supplies, insecurity, population mobility, and community resistance in affected areas. In Uganda, one new confirmed case was reported during the reporting period, after nearly two weeks without any newly confirmed cases. While the epidemiological situation remains relatively stable, the continued link to transmission in the Democratic Republic of the Congo underscores the ongoing risk of cross-border spread and secondary transmission. Sustained operational, financial, and security support will remain critical to addressing ongoing response challenges, strengthening outbreak control measures, interrupt transmission and prevent further spread.

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