

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda | France

Weekly External Situation Report 07, Data as of 28 June 2026

Key Figures at a Glance

3 Countries Affected	1 328 Confirmed Cases	379 Confirmed Deaths	28.5% CFR Confirmed	9 968 Contacts DR Congo
3 Provinces 35 Health Zones Affected in DR Congo	2 Provinces 28 Health Zones Active in DR Congo	195 Cases Recovered	96.2% Bed Occupancy DR Congo	81.3% Contact follow-up rate DR Congo

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	1 307	377	-	-	1 307	377	28.8%
Uganda	20	2	1	1	21	3	14.3%
France	1	0	0	0	1	0	0.0%

Note: Only confirmed and probable cases are reported.

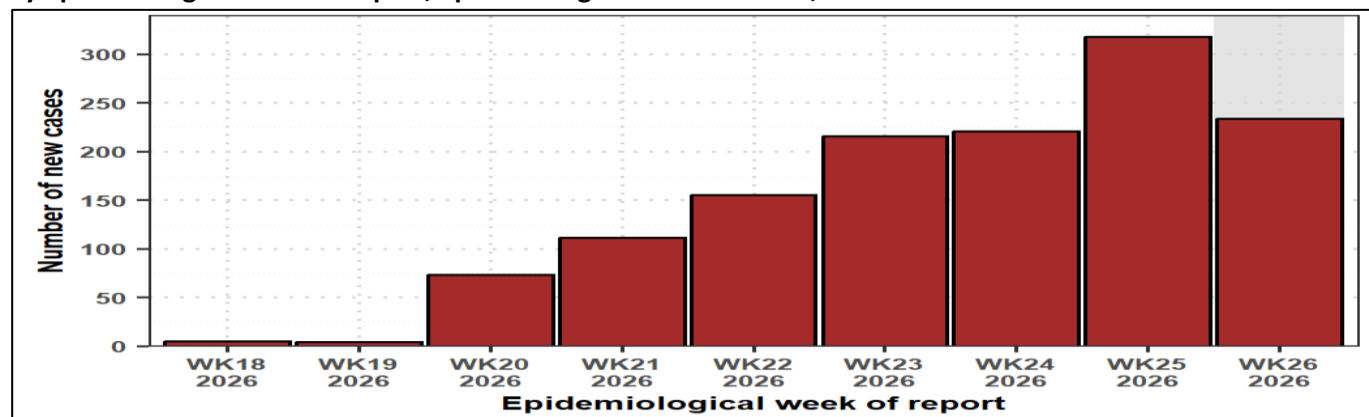
Event description

The Bundibugyo virus disease (BVD) outbreak remains active, with ongoing transmission in the Democratic Republic of the Congo and one imported case reported in France in a physician returning from the affected country. In the Democratic Republic of the Congo, the number of confirmed cases continue to rise , and an additional health zone reported cases during the current reporting week. No new confirmed cases were reported in Uganda over the past week.

Democratic Republic of the Congo

Since the last update of 21 June 2026 ([Situation Report #6](#)), cumulative case incidence in the Democratic Republic of the Congo has increased by 24.7%, with 259 new confirmed cases reported. Cumulative deaths also increased by 41.2%, with 110 new confirmed deaths recorded during the reporting period. An additional health zone, Mandima in Ituri Province, reported its first confirmed case, bringing the total number of affected health zones since the start of the outbreak to 35.

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 – 26, 2026



Of the 35 affected health zones, the outbreak remains active in 28 health zones that have reported cases in the past 21 days. The remaining seven health zones have not reported any new cases during this period. These include Gety (38 days), Mambasa (26 days), Rimba (25 days), and Aru (24 days) in Ituri Province; Kalunguta (35 days) and Goma (34 days) in North Kivu Province; and Miti-Murhesa (39 days) in South Kivu Province.

Among the 28 health zones that have reported 709 confirmed cases, including 262 confirmed deaths in the past 21 days, transmission remains heavily concentrated in Ituri Province, which accounts for 89.4% of reported cases (634 cases) and 86.3% of deaths (226 deaths) during this period. Most cases reported during this period were from Bunia (181), Rwampara (173), Mongbwalu (144), Nyankunde (62), and Nizi (34) in Ituri Province, as well as Butembo (27) and Katwa (26) in North Kivu Province. Together, these health zones account for 91.3% of all confirmed cases reported nationally over the past 21 days. No new confirmed case has been reported from South Kivu since 26 May 2026.

Deaths reported during the same period were also concentrated in a limited number of health zones, particularly Mongbwalu (81), Bunia (59), Rwampara (36), Katwa (15), Nyankunde (12), Mangala (12), and Butembo (10). Together, these health zones account for 85.9% of all deaths reported nationally in the past 21 days.

Cumulatively, a total of 1307 confirmed cases, including 377 confirmed deaths [case fatality ratio (CFR) 28.8%], have been reported in the Democratic Republic of the Congo since the start of the outbreak. Ituri Province remains the most affected, accounting for 91.6% (1197) of all confirmed cases and 84.4% (318) of all reported deaths nationwide. The most affected health zones are Bunia (344 cases, 74 deaths), Rwampara (295 cases, 56 deaths), Mongbwalu (258 cases, 121 deaths), Nyankunde (94 cases, 13 deaths), and Nizi (39 cases, 9 deaths), all located in Ituri Province, as well as Katwa (38 cases, 23 deaths) and Butembo (33 cases, 14 deaths) in North Kivu Province. Together, these seven health zones account for 84.2% of cumulative confirmed cases and 82.2% of confirmed deaths reported nationally.

The CFR remains highest in North Kivu Province at 54.2% (58 deaths/107 cases), followed by South Kivu at 33.3% (1/3), and Ituri at 26.6% (318/1197), indicating persistently higher mortality among reported cases in North Kivu.

The geographic distribution of recent transmission largely mirrors the cumulative outbreak pattern, with sustained concentration in Ituri Province and continued high mortality reported from a limited number of health zones.

Figure 2. Map showing active health zones reporting confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda in the last 21 days, 08 – 28 June 2026

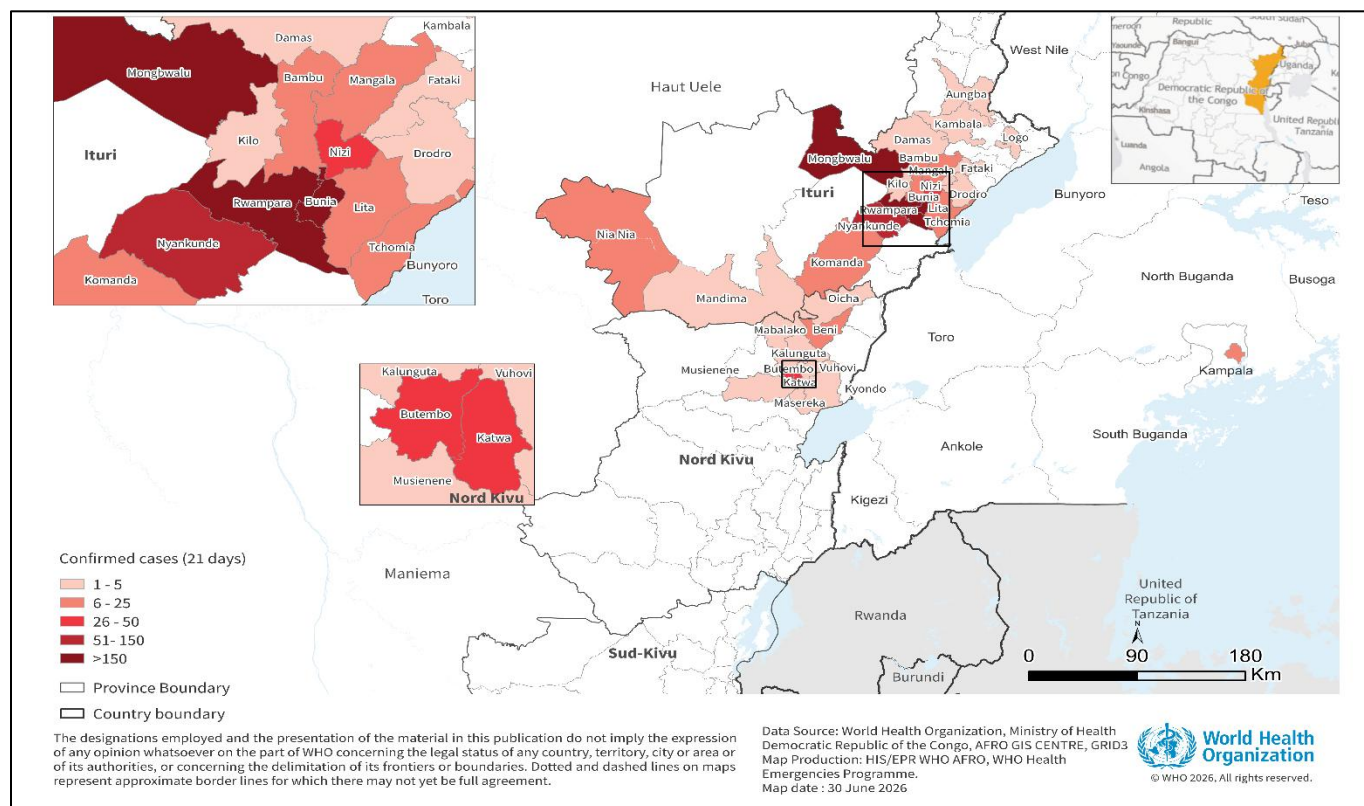
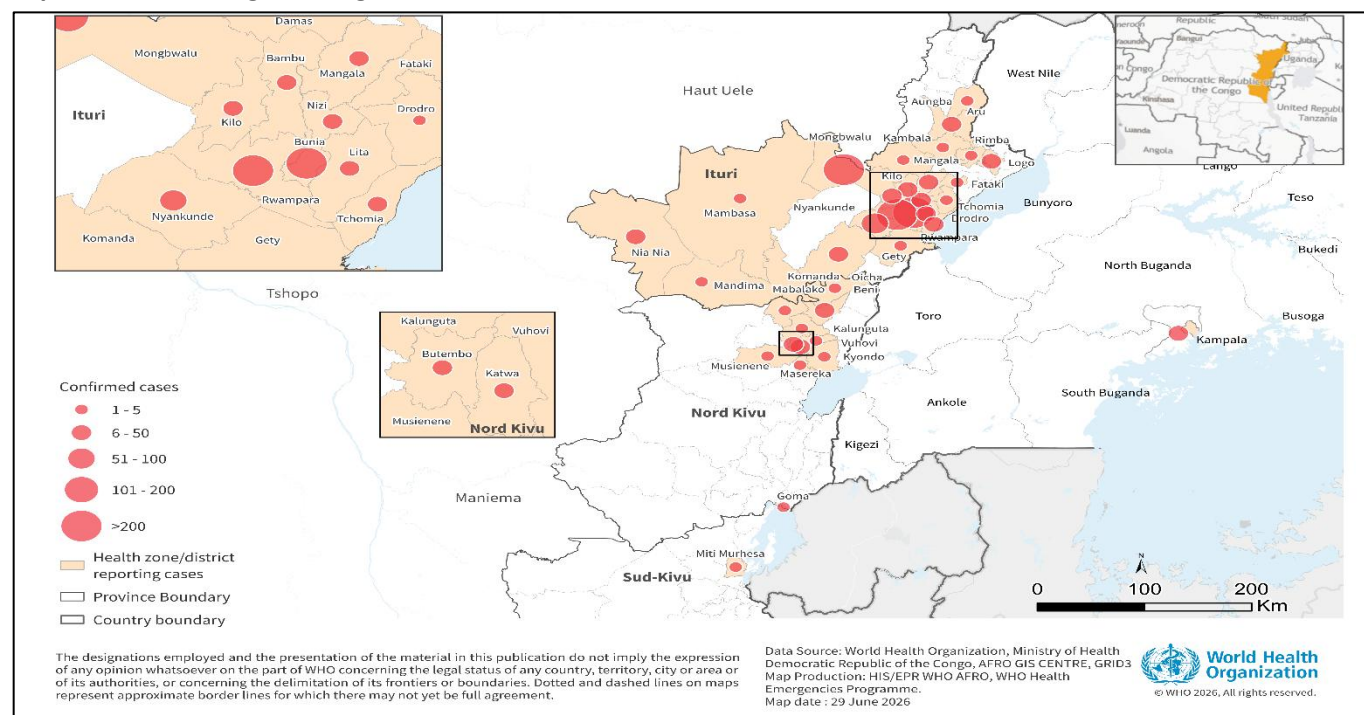
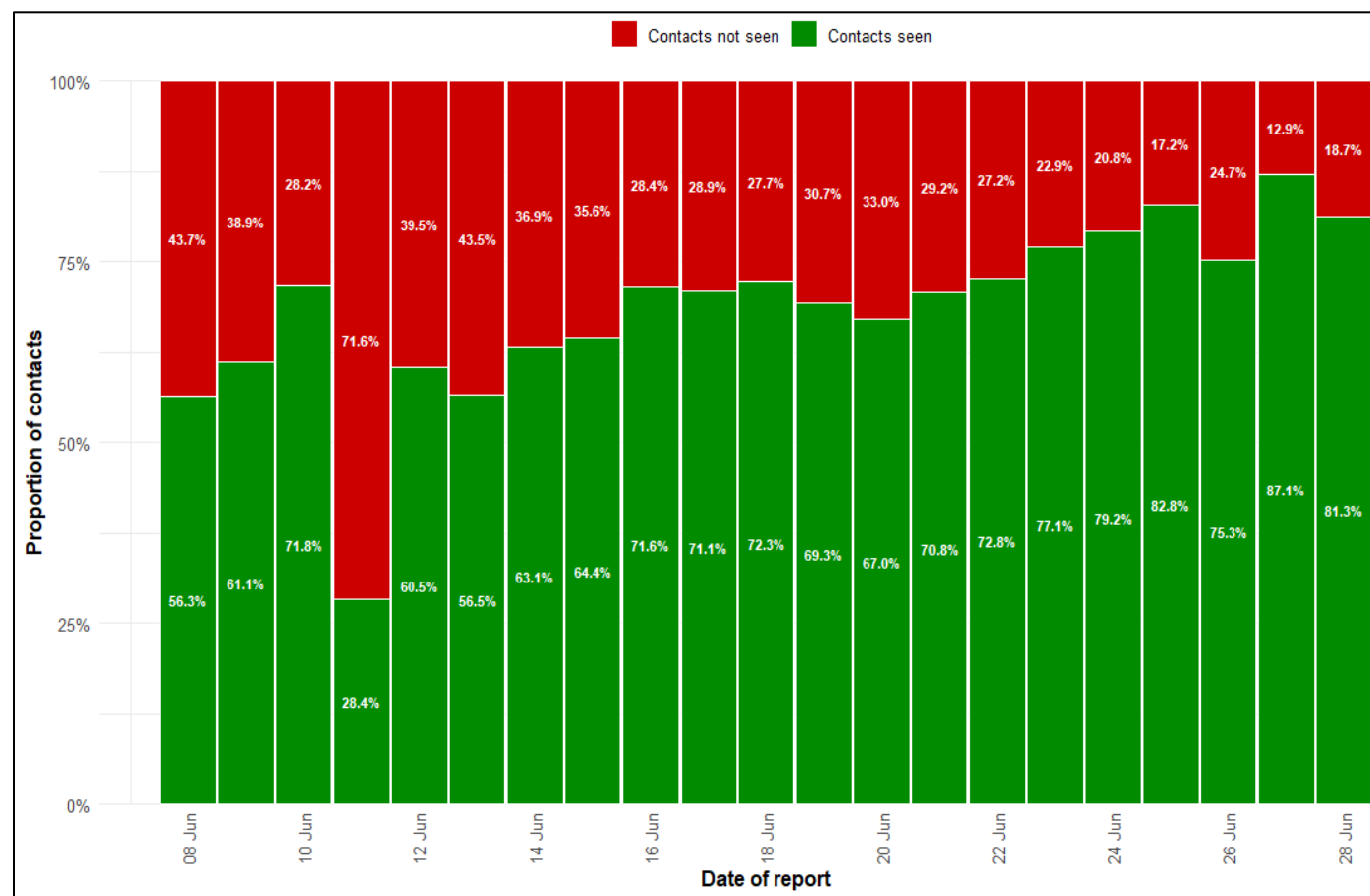


Figure 3. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, data as of 28 June 2026



As of 28 June 2026, a total of 9968 contacts were under follow-up across affected provinces in the Democratic Republic of the Congo, of whom 8105 (81.3%) were successfully seen in the past 24 hours. Ituri accounted for the largest number of contacts under follow-up, with 7706 contacts, of whom 6319 (82.9%) were reached. In North Kivu, 2244 of 1696 contacts (75.6%) were seen, while all 18 identified contacts in South Kivu were followed up, corresponding to a 100% follow-up rate. Despite recent improvements, contact follow-up coverage remains suboptimal overall, leaving a significant proportion of contacts not reached and increasing the risk of missed infections and ongoing transmission.

Figure 4. Proportion of identified contacts of confirmed cases of Bundibugyo virus disease reached daily in the last 21 days in the Democratic Republic of the Congo, 8 – 28 June 2026

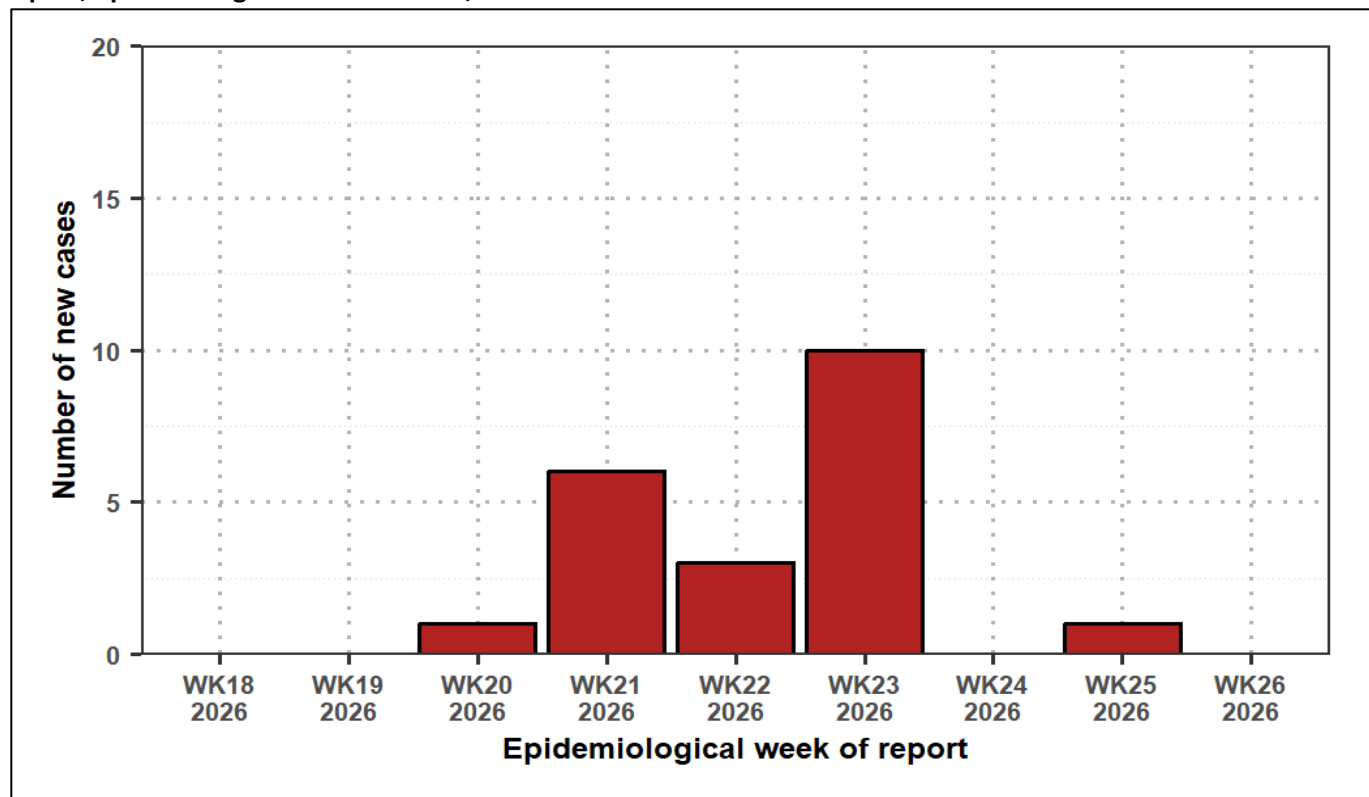


Uganda

No new case has been reported from Uganda since the last update. The most recent case, reported on 21 June 2026, involved a truck driver operating along the Democratic Republic of the Congo–Uganda international route. The case developed symptoms on 15 June 2026, entered Uganda on 19 June 2026, and was isolated on 20 June 2026 at the Mulago Ebola Treatment Unit.

As of 28 June 2026, a cumulative total of 21 cases (20 confirmed and one probable), including three deaths (two confirmed and one probable), had been reported in the Kampala.. A total of 15 patients have recovered and been discharged, while three remain admitted for care. Of the 831 contacts identified since the start of the outbreak, five remained under follow-up as of 28 June 2026.

Figure 5. Weekly trends of confirmed cases of Bundibugyo virus disease in Uganda by epidemiological week of report, epidemiological weeks 18 – 26, 2026



France

On 24 June 2026, French authorities notified WHO of a laboratory-confirmed case of Ebola disease caused by Bundibugyo virus in a middle-aged male physician returning from the Democratic Republic of the Congo. The patient had been deployed for five weeks in Ituri Province, where he was involved in the care of patients with BVD. Upon arrival at Charles de Gaulle Airport on 23 June 2026, the patient self-reported symptoms to airport health authorities, prompting immediate isolation and referral to a designated high-containment healthcare facility.

At the time of reporting, the patient was clinically stable and afebrile, with no reported vomiting, diarrhoea, or haemorrhagic manifestations during travel. PCR testing detected Bundibugyo virus. Comprehensive contact tracing has been initiated.

Risk Assessment

The overall risk remains very high in the Democratic Republic of the Congo, with transmission continuing at a scale that exceeds current response capacity, particularly in the Bunia–Rwampara–Mongbwalu corridor and across other affected health zones. North Kivu’s markedly higher CFR points to possible delays in diagnosis and access to care, while clinical capacity in Ituri is approaching saturation. Although contact follow-up and alert investigation have improved, performance remains insufficient to rapidly interrupt transmission. Uganda remains exposed through sustained population movement from eastern Democratic Republic of the Congo, including trucking routes and possible informal cross-border movement linked to border closures. The imported case reported in France further confirms that international exportation risk persists, requiring strengthened surveillance, traveller awareness, and cross-border coordination.

Table 1. Confirmed cases and deaths of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by geographic area, as of 28 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	0	0	2026-06-04	24
		Aungba	6	2	33.3	4	1	2026-06-18	10
		Bambu	16	4	25.0	11	2	2026-06-27	1
		Bunia	344	74	21.5	181	59	2026-06-28	0
		Damas	5	0	0.0	2	0	2026-06-27	1
		Drodro	3	3	100.0	3	3	2026-06-27	1
		Fataki	1	0	0.0	1	0	2026-06-16	12
		Gety	1	0	0.0	0	0	2026-05-21	38
		Kambala	1	1	100.0	1	1	2026-06-11	17
		Kilo	9	1	11.1	5	0	2026-06-17	11
		Komanda	16	5	31.3	13	5	2026-06-27	1
		Lita	28	8	28.6	24	8	2026-06-28	0
		Logo	7	0	0.0	5	0	2026-06-25	3
		Mambasa	2	1	50.0	0	0	2026-06-02	26
		Mangala	24	12	50.0	23	12	2026-06-28	0
		Mongbwalu	258	121	46.9	144	81	2026-06-27	1
		Nia-Nia	11	5	45.5	11	5	2026-06-28	0
		Nizi	39	9	23.1	34	9	2026-06-28	0
		Nyankunde	94	13	13.8	62	12	2026-06-27	1
		Rimba	3	0	0.0	0	0	2026-06-03	25
		Rwampara	295	56	19.0	173	36	2026-06-28	0
		Tchomia	13	2	15.4	13	2	2026-06-28	0
		Mandima	1	0	0.0	1	0	2026-06-27	1
Subtotal — Ituri			1 165*	301	22.6	711**	236**	2026-06-28	0
	North Kivu	Beni	22	13	59.1	13	6	2026-06-25	3
		Butembo	33	14	42.4	27	10	2026-06-25	3
		Goma	1	0	0.0	0	0	2026-05-25	34
		Kalunguta	2	1	50.0	1	0	2026-05-24	35
		Katwa	38	23	60.5	26	15	2026-06-28	0
		Kyondo	3	2	66.7	2	2	2026-06-21	7
		Mabalako	1	0	0.0	1	0	2026-06-13	15
		Masereka	1	0	0.0	1	0	2026-06-11	17
		Musienene	2	2	100.0	2	2	2026-06-21	7
		Oicha	3	2	66.7	1	0	2026-06-16	12
		Vuhovi	1	1	100.0	1	1	2026-06-11	17
		Subtotal — North Kivu			91	50	54.9	75	36
	South Kivu	Miti Murhesa	3	1	33.3	0	0	2026-05-20	38
Subtotal — South Kivu			3	1	33.3	0	0	2026-05-20	32
Uganda	Kampala	Kampala	21	3	14.3	11	1	2026-06-21	7
Subtotal — Uganda			21	3	14.3	11	1	2026-06-21	7

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.

*17 confirmed cases reported from Ituri province have not yet been attributed to any health zone. ** During the reporting period, 77 previously unallocated confirmed cases and 10 deaths were retrospectively reassigned.

Public health response

Coordination

- The continental Incident Management Support Team (IMST), co-led by WHO and 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 continues under the leadership of the Ministry of Health through the Public Health Emergency Operations Centre (COUSP RDC) and the Ebola Incident Management System, with efforts ongoing to strengthen decentralized coordination and operational oversight in hotspot health zones. In Uganda, national and district task forces remain activated to coordinate preparedness and response activities.
- Joint rapid assessment missions involving the Ministry of Health, WHO, MEDAIR, and European Civil Protection and Humanitarian Aid Operations (ECHO) were conducted in Sota health areas in Nyankunde Health Zone to identify urgent operational gaps and priorities for integrated rapid response interventions, including transit and treatment capacity.
- 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.
- Cross-border coordination between the Democratic Republic of the Congo and Uganda is being enhanced through the launch of a joint 90-day preparedness and response plan focused on surveillance, laboratory capacity, contact tracing, clinical preparedness, and coordination along high-risk border corridors.
- Through the WHO-coordinated Global Outbreak Alert and Response Network (GOARN), 14 expert deployments have been mobilized to support response and preparedness activities in affected and at-risk countries. These deployments span the fields of case management, risk communication and community engagement, infection prevention and control, epidemiology and surveillance, and mathematical modelling.
- A recent high-level meeting of Heads of State and partners held in late June 2026 reinforced political commitment and continental solidarity for the outbreak response, resulting in approximately USD 900 million in pledges from African Union Member States and international partners. However, urgent follow-up is required to translate these commitments into timely and operationally usable resources.

Operations Support and Logistics (OSL)

- WHO continues to support preparedness and response operations through the deployment of multidisciplinary field personnel across the Democratic Republic of the Congo and Uganda, including support for surveillance, laboratory operations, logistics coordination, clinical care, and cross-border preparedness activities.
- Operations support and logistics activities continued to scale up across affected areas in the Democratic Republic of the Congo. Since the previous reporting period, the value of delivered supplies increased by approximately USD 490 000, from USD 1.37 million to USD 1.86 million. During the same period, the overall

procurement and shipment pipeline expanded from USD 5.25 million to approximately USD 8.66 million as of 28 June 2026. Of the total pipeline value, USD 3.22 million (37%) remained in transit and USD 3.59 million (41%) was not yet ready for shipment.

- Critical commodities delivered or in transit included more than 8.1 million examination gloves, 267 698 Level 3 gowns, 208074 hooded coveralls, 20016 PCR diagnostic tests, RADIONE diagnostic materials, infrared thermometers, tents, hospital beds, and other laboratory and infection prevention and control supplies to support frontline response operations, decentralized diagnostics, and expansion of treatment capacity. Delivered commodities accounted for 193.5 metric tons and 1081.8 cubic metres of cargo dispatched to logistics hubs in Ituri and North Kivu provinces, compared with 155.9 metric tons and 901.4 cubic metres reported during the previous reporting period.
- Procurement and logistics coordination mechanisms continued to support shipment tracking, supply distribution, partner coordination, and monitoring of operational gaps in affected areas. Personal protective equipment and infection prevention and control supplies remained the largest procurement category by value. The majority of procurement originated directly from suppliers (68%), while additional supplies were sourced through WHO logistics hubs in Kinshasa, Nairobi (Kenya), Dubai (United Arab Emirates), and Dakar (Senegal).

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 28 June 2026, a total of 9968 contacts were under follow-up, including 7706 in Ituri Province, 2244 in North Kivu Province, and 18 in South Kivu Province. Overall contact follow-up remained suboptimal, with 81.3% of contacts seen within the previous 24 hours. Follow-up rates remained low in North Kivu (75.6%) and Ituri (82.9%) provinces, while South Kivu maintained 100.0% follow-up.
- On 28 June 2026, 903 alerts had been reported across the three affected provinces in the Democratic Republic of the Congo, of which 865 (95.8%) were investigated. A total of 166 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 28 June 2026, 67 of the 69 planned PoE/PoC sites were operational nationally, including 53 of 55 in Ituri Province and 14 of 14 in North Kivu Province. During the reporting period, 129,794 travellers passed through PoE/PoC screening sites, of whom 97.2% 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 28 June 2026, five 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 Kisangani, 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, Aru, and Kisangani. 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

- WHO has published new clinical management guidelines for filovirus diseases, including BVD outlining key recommendations for patient care and outbreak response.
<https://www.who.int/publications/i/item/B09774>
- Clinical treatment capacity continues to expand in line with the evolving outbreak, with 654 beds established across 35 affected health zones in the Democratic Republic of the Congo. As of 28 June 2026, a total of 615 patients remained in isolation or hospitalization across treatment facilities, including 229 confirmed and 386 suspected cases, with an overall bed occupancy rate of 96.2%. Occupancy remained particularly high in North Kivu (138.8%) and Ituri (91.7%), reflecting continued pressure on clinical care capacity.
- Daily bed monitoring, strengthened referral systems, and expansion of ambulance capacity are being implemented to improve patient flow and referral pathways, particularly in Bunia.
- The cumulative number of recoveries has increased to 180, including 170 in Ituri, eight in North Kivu, and two in South Kivu.
- WHO and partners continue to strengthen quality of care through implementation of the new WHO GRADE-based filovirus clinical guidelines, standardized clinical training, deployment of specialists, enhancement of

oxygen and critical care capacity, and use of facility-based quality indicators.

- Efforts are ongoing to establish a survivor follow-up programme integrated within routine healthcare services.
- In Uganda, treatment capacity includes 84 beds at the Mulago isolation facility in Kampala, 56 beds at the Entebbe isolation facility, and an additional 32 beds at the Mulago Field Isolation Facility. Four border facilities have also been identified for assessment and expansion of BVD treatment capacity. Forty Emergency Medical Team members are currently undergoing induction training in Entebbe in preparation for deployment to Aru Health Province in the Democratic Republic of the Congo.

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

- Infection prevention and control (IPC) activities continued across affected provinces, including decontamination of households, health facilities, ambulances, and transport vehicles around confirmed and suspected cases in Ituri, North Kivu, and South Kivu. A total of 25 households and six health facilities were decontaminated in Ituri during the reporting period, while additional decontamination activities were conducted in Katwa, Beni, and Katana health zones.
- IPC/WASH assessments and scorecard evaluations conducted in priority health facilities revealed persistent gaps in IPC readiness and compliance. Average IPC scores remained suboptimal in several hotspot health zones, including 38.8% in assessed facilities in North Kivu and 52% in Katana Health Zone in South Kivu, highlighting continued vulnerabilities in healthcare settings.
- WHO and partners continued capacity-building activities through training and briefing of healthcare workers, rapid response teams, community leaders, and community health workers on IPC measures in the context of the Ebola outbreak. In Ituri alone, 283 frontline personnel and 73 community actors were trained, while IPC kits and household kits were distributed to priority facilities and affected communities.

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.

Public health preparedness

Operational Readiness

- 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, 27 of the 47 Member States have updated their readiness assessments, while all ten Priority 1 and 2 countries have completed and shared contingency plans (100%).
- Regional deployments to support high-risk Member States are ongoing in South Sudan, Kenya, and the Democratic Republic of the Congo.
- A three-day cross-border readiness and preparedness meeting was held in Kampala, Uganda, bringing together officials from neighbouring at-risk countries to strengthen coordination and identify priority

readiness actions requiring immediate support. The meeting was jointly organized with Africa CDC and the United Kingdom Health Security Agency, with participation from key regional preparedness partners.

- Priority preparedness activities continue to focus on activation of emergency operations centres, strengthening 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.
- 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 continues to expand at a pace that exceeds current response capacity, with sustained high-intensity transmission ongoing in several hotspot areas. Although important operational gains have been achieved, including improved contact follow-up, expanded decentralized laboratory capacity, increased treatment capacity, and strengthened cross-border coordination, overall response performance remains below the level required to rapidly interrupt transmission. The continued increase in cases and deaths, near-saturation of treatment facilities, and suboptimal IPC readiness in health facilities underscore the need for a stronger operational surge focused on hotspot containment, rapid case detection and isolation, expansion of decentralized clinical and laboratory services, enhanced community engagement, and strengthened cross-border surveillance. The imported case reported in France further highlights the continuing risk of international spread and reinforces the need for sustained regional and international mobilization, including rapid operationalization of pledged resources and intensified support to frontline response activities.

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