

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda | France

Weekly External Situation Report 08, Data as of 05 July 2026

Key Figures at a Glance

3 Countries Affected	1 645 Confirmed Cases	523 Confirmed Deaths	31.8% CFR Confirmed	12 417 Contacts to follow
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Summary

Country	New Confirmed Cases (Last 7 days)	New Confirmed Deaths (Last 7 days)	Confirmed Cases (total)	Confirmed Deaths (total)	Probable Cases	Probable Deaths	Total Cases (Confirmed & Probable)	Total Deaths (Confirmed & Probable)	CFR (%) Confirmed & Probable
Democratic Republic of the Congo	317	144	1 624	521	-	-	1 624	521	32.1%
Uganda	0	0	20	2	1	1	21	3	14.3%
France	0	0	1	0	0	0	1	0	0.0%

Note: Only confirmed and probable cases are reported.

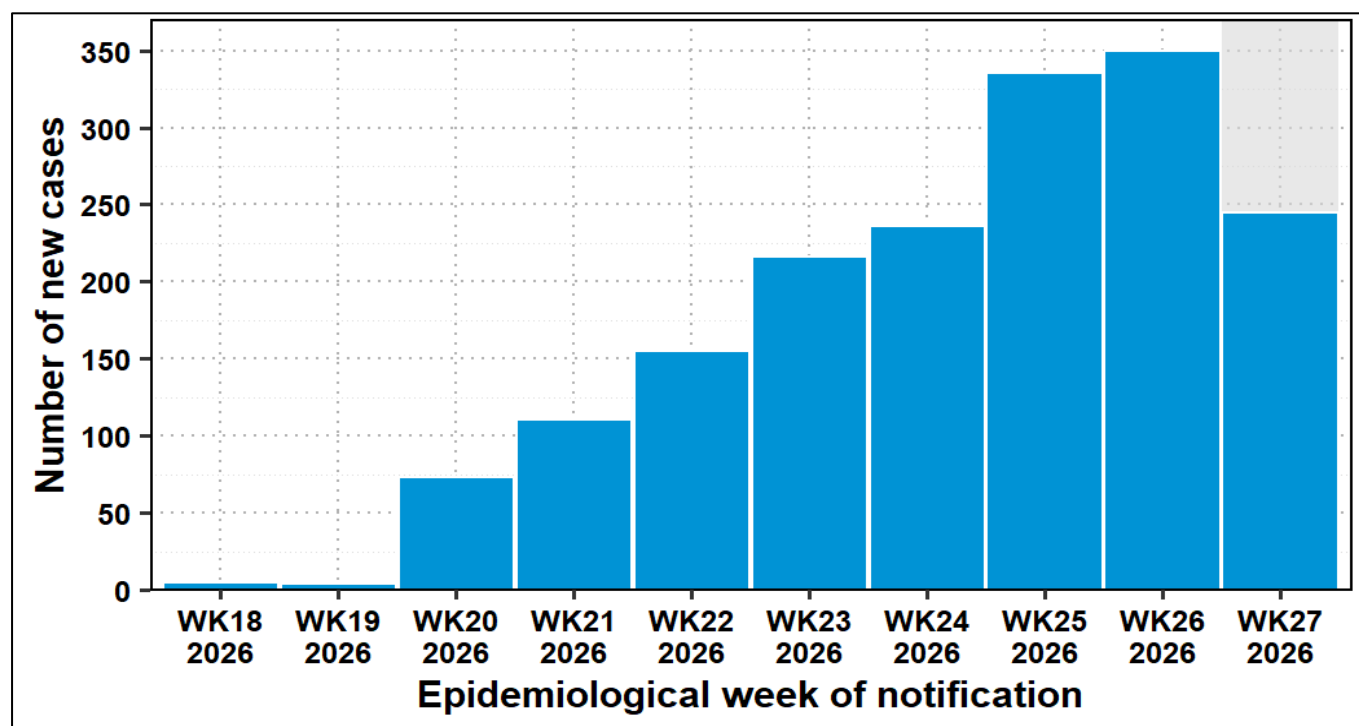
Event description

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo continues to intensify, driven by sustained transmission in hotspot health zones of Ituri and North Kivu provinces. The outbreak is marked by growing numbers of community deaths, and the continued spread of infection into previously unaffected health zones. While Uganda has not reported any new confirmed cases during the past week, and the imported case reported in France has fully recovered without evidence of secondary transmission among identified contacts, the ongoing epidemic in eastern Democratic Republic of the Congo continues to pose a significant regional and global public health threat.

Democratic Republic of the Congo

Compared with the previous update issued on 28 June 2026 ([Situation Report #7](#)), the epidemiological situation in the Democratic Republic of the Congo has deteriorated further. An additional 317 confirmed cases and 144 confirmed deaths have been reported, representing increases of 24.3% and 38.2%, in cumulative cases and deaths respectively. The crude case fatality ratio (CFR) rose from 28.8% to 32.1%. Geographic spread continues as the first confirmed case was detected in Lolwa health zone in Ituri Province, increasing the total number of affected health zones to 36.

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 18 – 27, 2026



Note: The shaded grey area for the most recent epidemiological week represents incomplete data due to reporting delays.

Mabalako and Vuhovi health zones have now completed 21 consecutive days, without reporting a confirmed case and have been added to the list of areas with no recent transmission. However, Rimba Health Zone, which had previously gone 25 days without reporting a case, has now reported a new confirmed case. This brings the total number of previously affected health zones that have surpassed the 21-day threshold to eight. These include Miti-Murhesa in South Kivu Province (46 days); Gety (45 days), Mambasa (33 days), and Aru (31 days) in Ituri Province; and Kalunguta (42 days), Goma (41 days), Vuhovi (24 days), and Mabalako (22 days) in North Kivu Province.

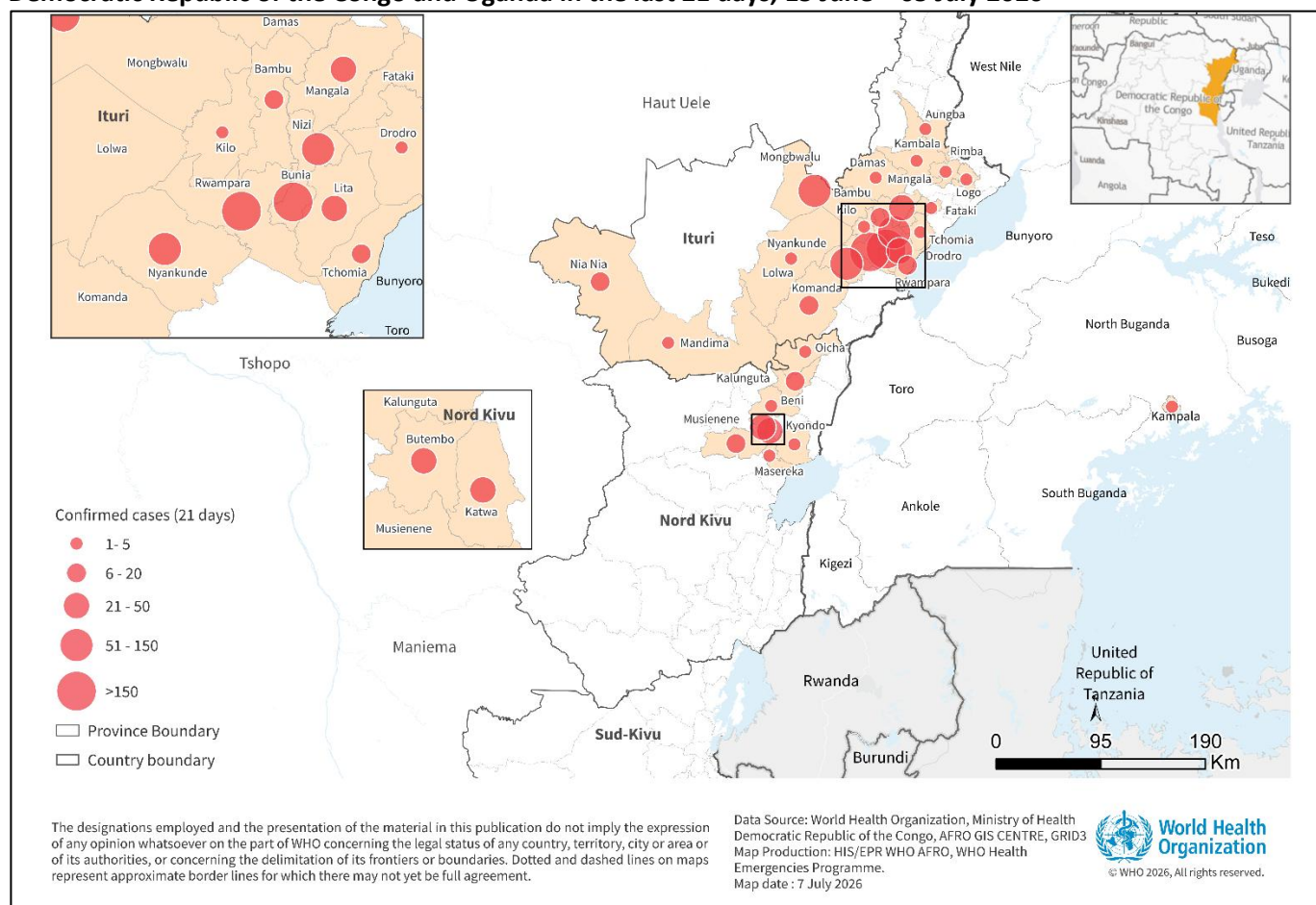
The outbreak remains active in 28 health zones across Ituri and North Kivu provinces that have reported confirmed cases within the past 21 days. During this period, 787 confirmed cases and 325 confirmed deaths were reported. Ituri Province continues to bear the overwhelming burden of the outbreak, accounting for 710 cases (90.2%) and 282 deaths (86.8%) across 21 active health zones. The remaining seven active health zones in North Kivu reported 77 cases (9.8%) and 43 deaths (13.2%).

The highest transmission was recorded in Bunia (237 cases), Rwampara (190 cases), Mongbwalu (103 cases), Nizi (62 cases), Nyankunde (51 cases), and Lita (24 cases) in Ituri Province. In North Kivu Province, Katwa (27 cases) and Butembo (21 cases) remained the main areas of transmission. Collectively, these health zones accounted for 90.9% of all confirmed cases reported during the past 21 days. A similar pattern was observed for mortality. Bunia reported the highest number of deaths (101), followed by Mongbwalu (66), Rwampara (45), Katwa (22), Nizi (18), Nyankunde (15), Lita (12), Mangala (11), and Butembo (11). Together, these health zones accounted for 92.6% of all confirmed deaths reported during the same period.

The crude CFR of the outbreak also increased over recent weeks. In Ituri Province, the CFR rose from 20.5% on 15 June to 29.7% on 05 July 2026, while North Kivu continued to record the highest provincial CFR, remaining above

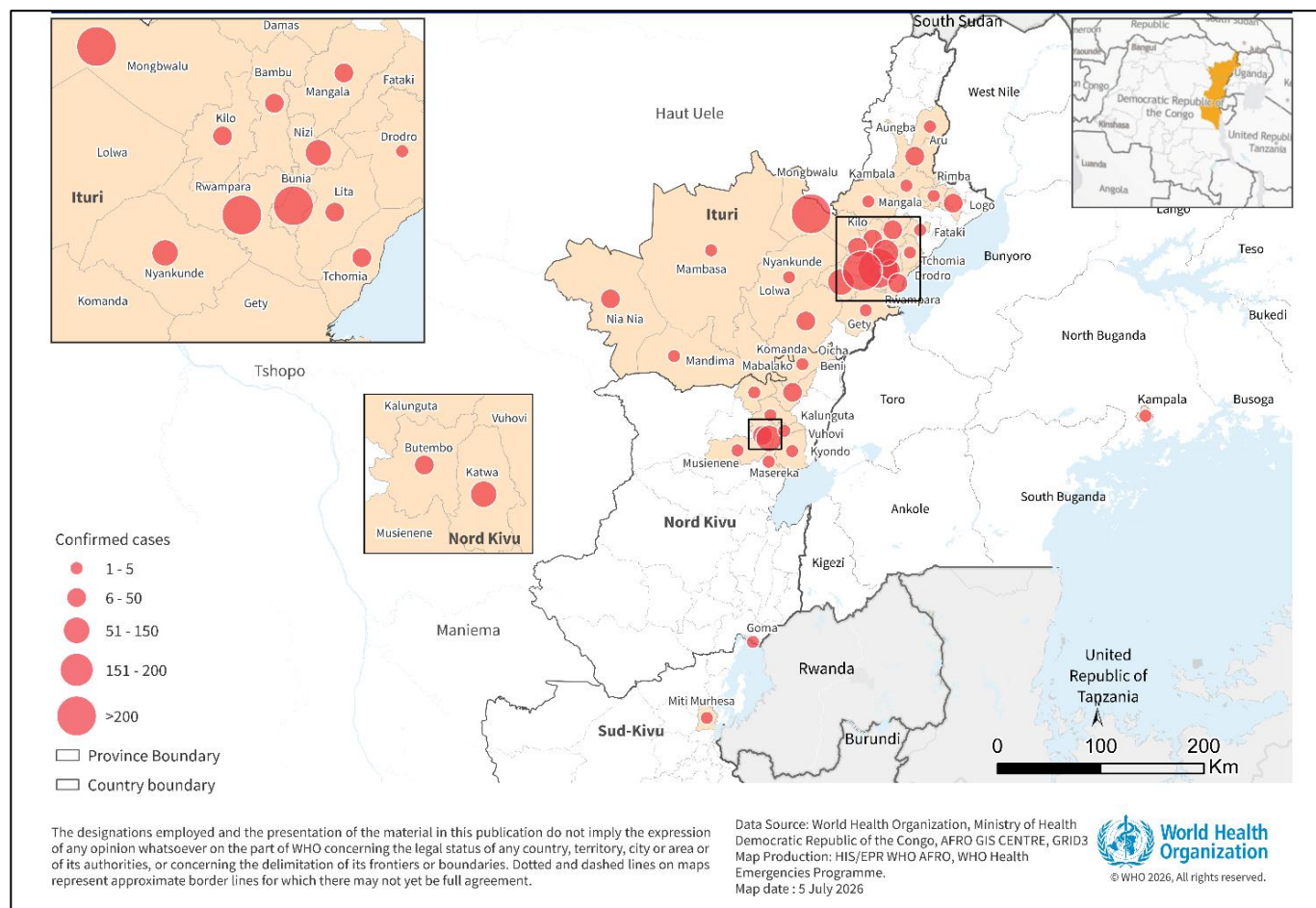
56% throughout the reporting period. The largest increase in CFR was observed in Lita Health Zone (+36.4 percentage points), followed by Komanda (+22.1 percentage points), Nizi (+18.1 percentage points), and Bunia (+17.6 percentage points). These elevated CFRs likely reflect continued delays in case detection and healthcare-seeking behaviour, compounded by the persistently high proportion of deaths occurring in the community.

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, 15 June – 05 July 2026



Since the beginning of the outbreak, the Democratic Republic of the Congo has reported 1624 confirmed cases, including 521 confirmed deaths (CFR 32.1%). Ituri Province remains the epicentre of the outbreak, accounting for 90.9% (1477) of all confirmed cases and 84.3% (439) of all reported deaths nationwide. The most affected health zones are Bunia (452 cases, 121 deaths), Rwampara (349 cases, 72 deaths), Mongbwalu (288 cases, 149 deaths), Nyankunde (96 cases, 19 deaths), Nizi (78 cases, 19 deaths), Lita (33 cases, 12 deaths), and Mangala (33 cases, 14 deaths), all located in Ituri Province, as well as Katwa (52 cases, 38 deaths), Butembo (40 cases, 18 deaths), and Beni (29 cases, 17 deaths) in North Kivu Province. Together, these health zones account for nearly 89.3% of all confirmed cases and 91.9% of confirmed deaths reported nationally.

Figure 3. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, data as of 04 July 2026

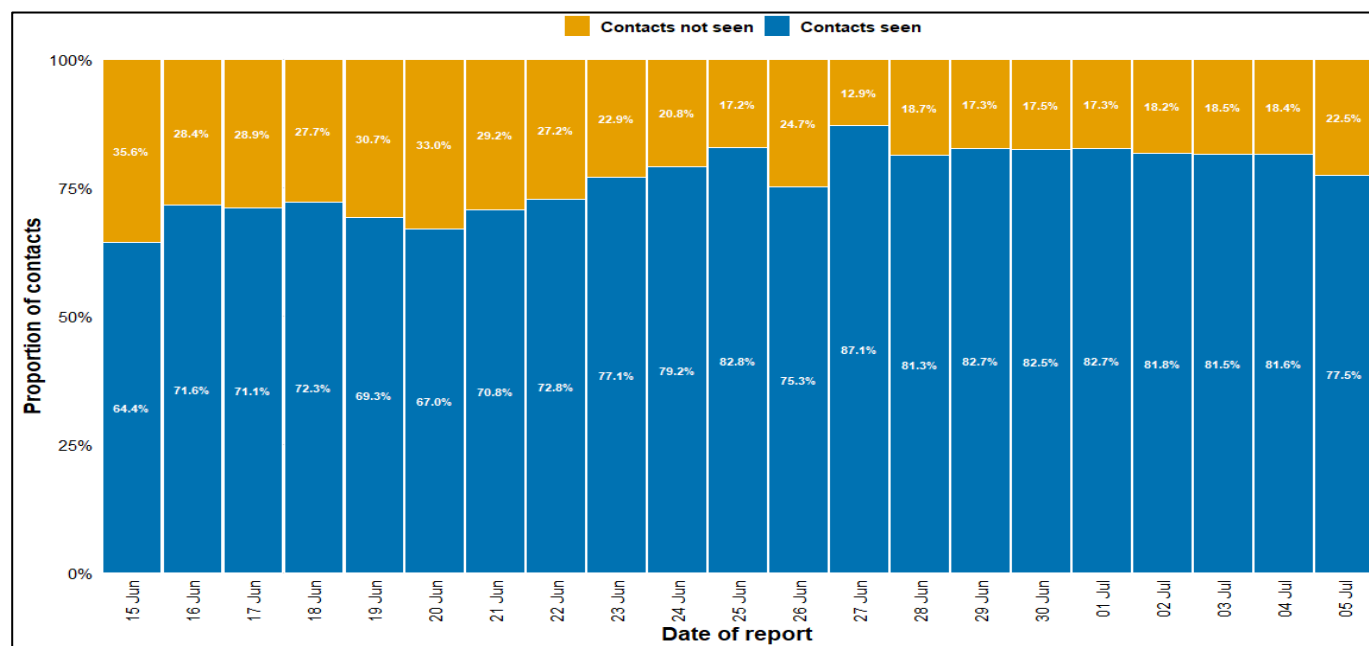


Investigation of 430 confirmed deaths as of 05 July 2026, showed that 397 (92.3%) occurred in the community or before admission to a treatment facility, highlighting persistent delays in case detection, referral, isolation, and access to clinical care. Only 33 deaths (7.7%) occurred after patients had been admitted to treatment centres or healthcare facilities.

As of 05 July 2026, a total of 12412 contacts were under follow-up of whom 9624 (77.5%) were successfully seen within the previous 24 hours. Ituri Province accounted for the majority of contacts under follow-up, with 9757 contacts, including 7574 (77.6%) seen during the reporting period. In North Kivu, 2050 out of 2655 contacts (77.2%) were followed up, while all contacts in South Kivu had completed the required 21-day monitoring period. Although contact tracing performance has improved overall, follow-up remains below optimal levels, leaving a significant proportion of contacts unreachable and increasing the likelihood of undetected infections and continued transmission.

The proportion of new confirmed cases identified among registered contacts increased steadily as the outbreak progressed, exceeding 40% by late June 2026. Overall, 32.4% of confirmed cases were detected through contact follow-up. However, a substantial number of infections continued to occur outside known contact lists, indicating ongoing gaps in surveillance. These gaps are likely driven by insecurity in affected areas, population displacement and mobility, delayed case detection, community resistance, incomplete epidemiological investigations, and the movement of suspected cases and deceased individuals across affected areas.

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, 15 June – 05 July 2026

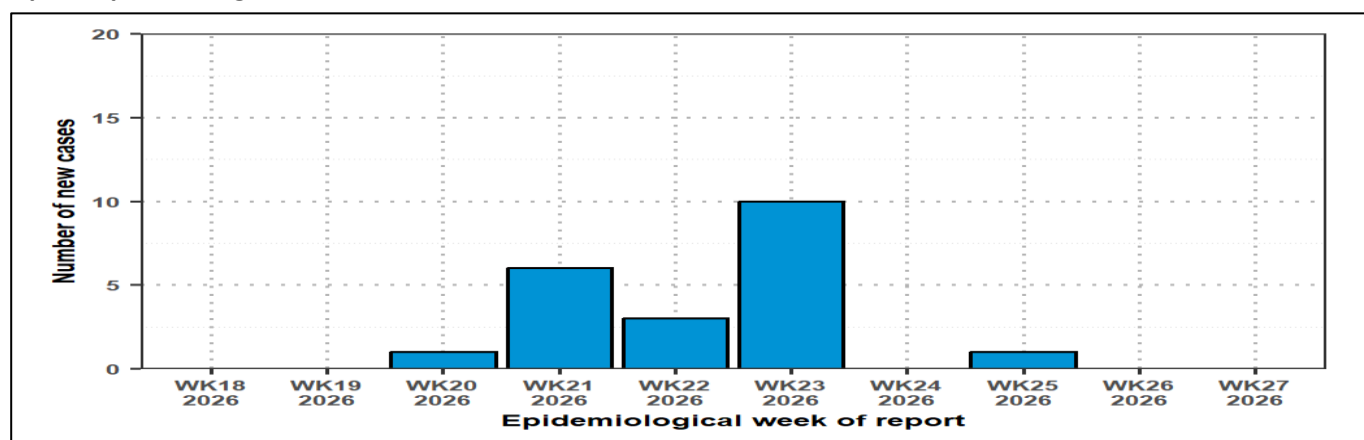


Uganda

Uganda has not reported any new cases during the past two weeks. The latest confirmed case was reported on 21 June 2026 and involved a truck driver travelling along the Democratic Republic of the Congo–Uganda international route. The case became symptomatic on 15 June 2026, crossed into Uganda on 19 June, and was admitted to the treatment unit for isolation on 20 June 2026.

As of 5 July 2026, the outbreak had resulted in a total of 21 cases (20 confirmed and one probable). Three deaths, including two confirmed and one probable, had been reported, while 16 patients had recovered and been discharged from care. Two patients remained hospitalised. Since the onset of the outbreak, health authorities had identified 831 contacts. All contacts placed under follow-up have now completed the required 21-day monitoring period without any new linked cases being detected.

Figure 5. Weekly trends of confirmed cases of Bundibugyo virus disease in Uganda by epidemiological week of report, epidemiological weeks 18 – 27, 2026



France

The imported laboratory-confirmed case of BVD, notified to WHO by the French authorities on 24 June 2026, has recovered and was discharged from hospital on 4 July after obtaining two consecutive negative laboratory test results. The patient, a middle-aged male physician, had recently returned from a five-week deployment in Ituri Province, Democratic Republic of the Congo, where he provided clinical care to patients with BVD. Upon arrival at Charles de Gaulle Airport in Paris on 23 June 2026, he voluntarily reported experiencing symptoms to airport health officials, prompting his immediate isolation and transfer to a designated high-containment treatment facility.

Contact tracing identified five passengers who had travelled on the same flight as the patient. These individuals were placed under quarantine in France and continue to be monitored. None had become symptomatic as of 5 July 2026.

Risk Assessment

The overall public health risk in the Democratic Republic of the Congo remains very high, driven by sustained and widespread transmission that continues to outpace the current response capacity. The outbreak remains concentrated in the Bunia–Rwampara–Mongbwalu corridor, although transmission persists across multiple affected health zones. The persistently elevated case fatality ratio in North Kivu suggests ongoing delays in case detection, diagnosis, and access to clinical care, while treatment capacity in Ituri Province is becoming increasingly strained. Although contact follow-up and alert investigation have improved, performance remains insufficient to rapidly interrupt transmission.

In addition, reports of threatened strike action among frontline response workers have emerged in affected areas, reportedly linked to delays in payment and other operational constraints. If not rapidly addressed by health authorities and partners, these challenges could further disrupt critical response activities and undermine ongoing outbreak control efforts.

Uganda continues to face a high risk of importation due to frequent population movement from eastern Democratic Republic of the Congo, including commercial trucking routes and possible informal cross-border crossings linked to border closures.

The imported case reported in France further demonstrates the continued risk of international spread and highlights the need to sustain enhanced surveillance, strengthen traveller awareness, and reinforce cross-border coordination and preparedness measures.

Table 1. Confirmed cases and deaths of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by geographic area, as of 05 July 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	31
		Aungba	6	2	33.3	4	1	2026-06-18	17
		Bambu	25	6	24.0	18	4	2026-07-05	0
		Bunia	452	121	26.9	237	101	2026-07-05	0
		Damas	5	0	0.0	1	0	2026-06-27	8
		Drodro	3	3	100.0	3	3	2026-06-27	8
		Fataki	2	0	0.0	2	0	2026-07-05	0
		Gety	1	0	0.0	0	0	2026-05-21	45
		Kambala	2	2	100.0	1	1	2026-06-30	5
		Kilo	9	1	11.1	5	0	2026-06-17	18

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
		Komanda	22	8	36.4	15	7	2026-07-01	4
		Lita	33	12	36.4	24	12	2026-07-02	3
		Logo	7	0	0.0	5	0	2026-06-25	10
		Mandima	4	1	25.0	4	1	2026-07-02	3
		Mambasa	2	1	50.0	0	0	2026-06-02	33
		Mangala	33	14	42.4	28	11	2026-07-05	0
		Mongbwalu	288	149	51.7	103	66	2026-07-05	0
		Nia-Nia	20	5	25.0	19	4	2026-07-05	0
		Nizi	78	19	24.4	62	18	2026-07-05	0
		Nyankunde	96	19	19.8	51	15	2026-06-30	5
		Rimba	4	0	0.0	1	0	2026-07-05	0
		Rwampara	349	72	20.6	190	45	2026-07-05	0
		Tchomia	15	2	13.3	13	2	2026-07-02	3
		Lolwa	1	1	100.0	1	1	2026-06-30	5
		Unallocated health zones	17	0	0.0	-77**	-10**	-	-
Subtotal — Ituri			1 477	439	29.8	710	282	2026-07-05	0
	North Kivu	Beni	29	17	58.6	15	7	2026-07-03	2
		Butembo	40	18	45.0	21	11	2026-07-03	2
		Goma	1	0	0.0	0	0	2026-05-25	41
		Kalunguta	2	1	50.0	0	0	2026-05-24	42
		Katwa	52	38	73.1	27	22	2026-07-02	3
		Kyondo	4	2	50.0	2	1	2026-07-02	3
		Mabalako	1	0	0.0	0	0	2026-06-13	22
		Masereka	3	0	0.0	2	0	2026-07-05	0
		Musienene	8	2	25.0	8	2	2026-07-05	0
		Oicha	3	2	66.7	1	0	2026-06-16	19
		Vuhovi	1	1	100.0	0	0	2026-06-11	24
Subtotal — North Kivu			144	81	56.3	77	43	2026-07-05	0
	South Kivu	Miti Murhesa	3	1	33.3	0	0	2026-05-20	46
Subtotal — South Kivu			3	1	33.3	0	0	2026-05-20	
Uganda	Kampala	Kampala	21	3	14.3	1	1	2026-06-21	14
Subtotal — Uganda			21	3	14.3	1	1	2026-06-21	14

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

** During the reporting period, 77 previously unallocated confirmed cases and 10 deaths were retrospectively reallocated to health zones in Ituri Province.

Public health response

Coordination

- The Continental BVD Incident Management Support Team (IMST), officially launched in Kampala, Uganda on 27 June 2026, continues to coordinate response operations in the Democratic Republic of the Congo and Uganda, while strengthening preparedness across 11 additional high-risk countries under the “One Plan, One System, One Report” framework.
- Cross-border and regional coordination remained a key operational priority, including enhanced preparedness and response interventions along high-risk border corridors and temporary arrangements to

deploy mobile laboratories and treatment units from Uganda into eastern Democratic Republic of the Congo.

- Political and regional engagement intensified during the reporting period, including an official visit by the President of South Africa to Kinshasa, Democratic Republic of the Congo to support the BVD response and reinforce bilateral cooperation between the Democratic Republic of the Congo and South Africa.
- The National Incident Management Systems (IMS) in both countries (Democratic Republic of the Congo and Uganda) continue to receive coordination support from WHO, Africa Centres for Disease Control and Prevention (Africa CDC), UNICEF, the International Organization for Migration (IOM), Médecins Sans Frontières (MSF), the Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Samaritan's Purse, the European Union, and other operational partners. Coordination in the Democratic Republic of the Congo remains under the leadership of the Ministry of Health through the Public Health Emergency Operations Centre (COUSP RDC).
- The Global Outbreak Alert and Response Network (GOARN), Standby Partners, Emergency Medical Teams (EMTs) and the Global Health Cluster continue to support response and preparedness activities across the Democratic Republic of the Congo and neighboring countries through expert deployments, surge capacity, and technical assistance. Of 101 health cluster partners across the Democratic Republic of the Congo, 68 are supporting response to the BVD outbreak.
- In the Democratic Republic of the Congo, field missions to Bunia, Beni, Katwa, Butembo, Nizi, and Nyankunde continued to strengthen operational oversight, assess treatment expansion needs, and advance hub-based coordination with rapid intervention teams.
- The broader interagency regional response requirement is estimated at USD 517 million. WHO currently faces a 72% funding gap for response operations. In late June 2026, approximately USD 900 million in cash and in-kind pledges were announced by African Union Member States and international partners; however, urgent follow-up is needed to translate these commitments into operational 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. To date, WHO has deployed 128 experts to support response operations in the Democratic Republic of the Congo, while a new "Triple I strategy" has been activated to rapidly mobilize trained professionals from partner institutions to strengthen surge response capacity.
- 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 63 000, from USD 1.86 million to USD 1.92 million, while the overall procurement and shipment pipeline expanded from USD 8.66 million to approximately USD 9.19 million as of 05 July 2026. Of the total pipeline value, USD 3.51 million (38%) remained in transit and USD 3.75 million (41%) was not yet ready for shipment.
- Delivered supplies amounted to 198.6 metric tons and 1,099.7 cubic metres, supporting response operations in the Ituri and Kivu hubs. Critical delivered items include hospital beds, infrared thermometers,

polymerase chain reaction (PCR) tests, tents, patient liners, gloves, gowns, and coveralls; however, large quantities of gloves, coveralls, gowns, and PCR tests remain in transit or not yet ready for shipment. Personal protective equipment and infection prevention and control supplies continued to account for the largest share of procured commodities, although the response operations now faces a critical shortage of PPE.

- Infection prevention and control (IPC) supplies, including personal protective equipment continued to account for the largest share of procured commodities, although critical operational constraints remain, including limited supplies of personal protective equipment.
- During the reporting period, operational support focused on enhancing field mobility, with 26 vehicles and four ambulances deployed to support response operations across affected health zones in Ituri. Logistics support also facilitated expansion of treatment capacity through continued construction and site development at the Ebola Treatment Centres (CTEs) in Elikya and Rwampara, including installation of tents, laboratory infrastructure, and electrical systems.
- Logistics constraints continue to affect response operations, particularly IPC activities, due to supply chain challenges and critical shortages of base kits, personal protective equipment, and hygiene supplies. Efforts are underway to address warehouse accessibility during weekends and holidays to ensure timely availability of supplies.
- Procurement and logistics coordination mechanisms continued to support shipment tracking, supply distribution, partner coordination, and monitoring of operational gaps in affected areas. The majority of procurement originated directly from suppliers (71%), 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.
- A high volume of alerts continued to be reported, although the timeliness and coverage of rapid alert verification and investigation varied considerably across affected provinces. On 05 July 2026, 927 alerts were reported across the three affected provinces in the Democratic Republic of the Congo, of which 824 (88.8%) were investigated within 24 hours. Most alerts originated from North Kivu (662), followed by Ituri (147) and South Kivu (15). Investigation coverage reached 100% in North Kivu and South Kivu, while Ituri reported a lower investigation rate of 58.8%. Of the total alerts, 135 suspected cases, including 23 community deaths were validated. Alerts linked to possible spread into Haut-Uélé and Tshopo provinces are also under investigation following cross-provincial movement of confirmed cases and contacts associated with Nia-Nia health zone in Ituri Province.
- Points of entry (PoE) and points of control (PoC) surveillance activities continued to be strengthened in the Democratic Republic of the Congo. As of 05 July 2026, 68 of the 69 planned PoE/PoC sites were operational nationally, including 54 of 55 in Ituri Province and 14 of 14 in North Kivu Province. During the reporting period, 135,862 travellers passed through PoE/PoC screening sites, of whom 95.8% were screened for BVD symptoms.

- In Uganda, alert management, surveillance for non-trauma deaths, and community-based surveillance continued nationwide. As of 05 July 2026, all contacts have completed 21 days of 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

- Laboratory decentralization continued to expand, reaching 60% completion, with plans to establish 15 – 20 operational laboratories to strengthen decentralized testing and reduce turnaround times. As of 05 July 2026, 12 diagnostic laboratories and testing units were operational across Ituri and North Kivu provinces, in addition to the Institut National de Recherche Biomédicale (INRB) in Kinshasa.
- In North Kivu, the laboratory backlog was fully cleared during the reporting period, with all pending samples processed.
- Laboratory testing capacity has been further strengthened through the deployment of 54 laboratory experts (approximately five per facility), as well as the distribution of 2496 polymerase chain reaction (PCR) test kits and 8000 RadiOne tests.
- Laboratory testing throughput remained high, particularly in Ituri, where positivity rates ranged from 37.9% to 63.3%, indicating sustained intense transmission, while North Kivu maintained lower positivity rates between 3% and 4.2%, alongside the clearance of residual testing backlog.
- Despite ongoing scale-up efforts, laboratory operations continued to face challenges related to delayed result reporting, weak data integration and information management systems, limited logistics capacity, and shortages of complementary diagnostic tests for clinical care.

Case Management

- Case management capacity continued to expand across the Democratic Republic of the Congo, with approximately 700 treatment and isolation beds available nationally across more than 22 Ebola treatment centres (ETCs) and care facilities. Additional treatment capacity is being established in Bunia, Nizi, Nyankunde, and other hotspot areas, including plans to establish 200 additional beds in Bunia within two weeks.
- As of 05 July 2026, 646 patients were in isolation nationally, including 477 in Ituri, 148 in North Kivu, and 21 in South Kivu, with treatment facilities operating at or near full capacity. Official isolation occupancy remained critically high at approximately 94.2% nationally, while field assessments indicated even higher effective occupancy in some facilities.
- Recovery outcomes continued to improve, with cumulative recoveries increasing from 180 on 28 June to 273 by 05 July 2026. Daily supportive care activities included the provision of hot meals across treatment facilities and the rollout of free healthcare services in four priority health zones in Ituri Province.
- The WHO-sponsored PARTNERS clinical trial was officially launched in the Democratic Republic of the Congo on 02 July 2026, becoming the first clinical trial specifically evaluating therapeutics for BVD. The trial is

assessing the monoclonal antibody MBP134 and remdesivir, individually and in combination, within participating treatment centres under the coordination of the INRB, WHO, Africa CDC, ALIMA, Médecins Sans Frontières (MSF), the Institute of Tropical Medicine Belgium, and the University of Oxford.

- Case management operations continued to receive support from multiple national and international partners, including WHO, the Ministry of Health, ALIMA, MSF, Africa CDC, and academic and research institutions supporting clinical care, treatment centre operations, and research activities.
- Despite scale-up efforts in bed capacity, ETC saturation continued to delay the timely isolation of suspect cases, while gaps in ambulance availability, intensive care support, oxygen therapy, complementary laboratory testing, staffing, and psychosocial support continued to affect the quality of care.

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

- IPC activities continued to scale up across affected provinces, including briefings for health workers and community relays, assessments in 140 health facilities in North Kivu, and the training of 34 providers from 17 priority health facilities.
- Safe and dignified burial operations and decontamination activities remained ongoing in Ituri, alongside the decontamination of households, health facilities, and transport vehicles linked to confirmed cases.
- IPC performance remained critically weak in several hotspot areas. IPC/WASH assessments in North Kivu showed an average facility score below 50%, with only two facilities achieving scores above 80%, indicating major gaps in infection prevention standards and healthcare facility readiness.
- Healthcare worker infections continued to increase, with 96 infections and 19 deaths reported among health workers, corresponding to a CFR of 19.7%. This highlights persistent occupational exposure risks and inadequate IPC implementation in health facilities.
- Key IPC challenges included incomplete Ring IPC coverage due to shortages of household kits, insufficient operational logistics, limited equipment and supplies, delayed partner response capacity, and critical gaps in hotspot areas such as Nizi, where confirmed and suspected cases were still sharing facilities without dedicated ETCs or transit centres.

Risk Communication and Community Engagement (RCCE)

- RCCE activities continued across affected provinces to support community awareness, alert reporting, contact tracing, and safe and dignified burial operations, particularly in hotspot areas of Ituri and North Kivu.
- A call and listening centre was established to strengthen the management of community alerts and improve community access to outbreak information and reporting mechanisms. Refresher training for call centre responders was also conducted.
- Community engagement efforts increasingly focused on high-risk and mobile populations, including mining communities and cross-border populations affected by insecurity, population displacement, internally displaced populations, and intense movement between eastern Democratic Republic of the Congo and neighbouring countries.

- High-level strategic communication efforts continued during the reporting period, including press briefings by national health authorities, WHO, and partners aimed at strengthening transparency, public information sharing, and partner alignment on the evolving outbreak situation. Risk communication activities also included interventions through local radio stations, social media influencers, and mass awareness campaigns.
- Key RCCE challenges persisted, including insecurity in some hotspot areas, community resistance in mining and insecure areas, misinformation risks, and difficulties maintaining timely follow-up of contacts across highly mobile populations and porous border areas.

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 BVD outbreak response.
- Joint community awareness and risk communication activities were conducted to raise awareness on the prevention of sexual exploitation and abuse and promote use of the toll-free reporting hotline.
- 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, 28 of the 47 Member States have updated their readiness assessments (60%).
- Regional deployments to support high-risk Member States are ongoing in South Sudan and the Democratic Republic of Congo. In South Sudan, case management readiness was strengthened through assessments of two treatment units and the commencement of a five-day integrated master trainer training-of-trainers programme of over 80 front line health care workers in Juba for five days.

Border Health, Travel and Mass Gatherings

- Screening has 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 border health guidance, as well as measures at points of control on high priority travel corridors.

- 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 and paid staff, 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.
- 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.
- 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 current epidemiological pattern suggests that transmission is increasingly occurring outside the reach of existing surveillance and response interventions, particularly in hotspot and insecure areas where delayed care-seeking, community deaths, and incomplete contact tracing continue to drive undetected transmission. The persistently high proportion of deaths occurring before admission, combined with the relatively low proportion of cases identified among known contacts, indicates an incomplete understanding of transmission dynamics, thereby limiting the effectiveness of isolation and transmission interruption measures. At the same time, the near-saturation of treatment facilities and gaps in IPC capacity increase the risk of onward transmission within communities and healthcare settings. These trends underscore the urgent need to intensify community-based surveillance, strengthen rapid alert investigation, improve timely referral and ambulance systems, expand safe isolation capacity in hotspot health zones, and reinforce operational access and trust-building activities among insecure and highly mobile populations. The recent expansion of laboratory networks, surge deployments, and the launch of the PARTNERS therapeutic trial represent important advances that could improve early diagnosis, patient outcomes, and overall response effectiveness if rapidly scaled up and sustained.

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