World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK
Democratic Republic of the Congo | Uganda | France
Weekly External Situation Report 10, Data as of 19 July 2026

Key Figures at a Glance (Democratic Republic of the Congo)

5 Provinces **47** Health Zones Affected	**4** Provinces **40** Health Zones Active Transmission	**469** Cases Recovered	**87.3%** Bed Occupancy	**10 519** Contacts to follow
734 Active Cases	**121** Health Worker Cases	**36** Health Worker Cases	**841** Bed Capacity	**18** Testing Laboratories

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	460	248	2 423	967	-	-	2 423	967	39.9%
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.

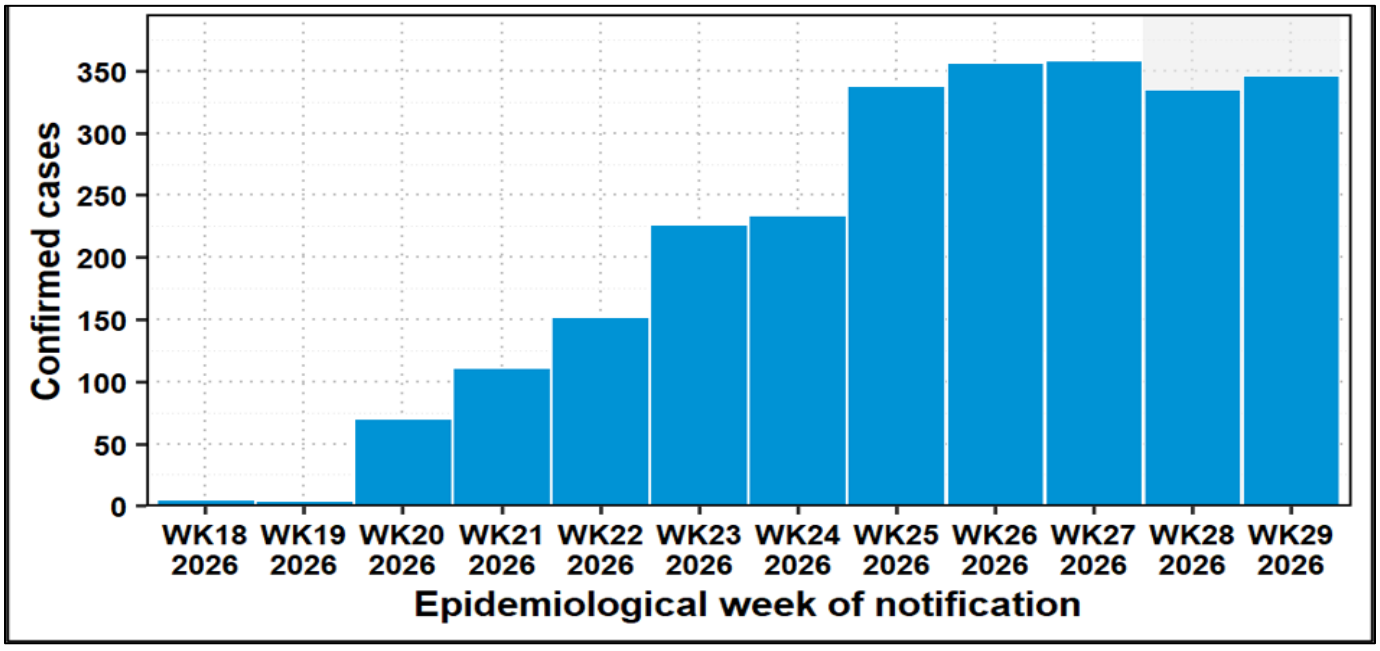
Event description

Transmission of Bundibugyo virus disease (BVD) remained intense in the Democratic Republic of the Congo during the reporting week, with continued detection of new confirmed cases and deaths across multiple affected areas, alongside further expansion of the outbreak's geographic footprint. The epidemiological situation outside the Democratic Republic of the Congo remained stable, with no new cases or evidence of secondary transmission reported in Uganda or France. However, the persistence and geographic expansion of transmission within the Democratic Republic of the Congo continue to increase the risk of cross-border spread, highlighting the need for sustained regional surveillance, preparedness, and response efforts.

Democratic Republic of the Congo

Since the last update of 12 July 2026 (***Situation Report #9***), the epidemiological situation in the Democratic Republic of the Congo has continued to deteriorate, with sustained transmission and ongoing geographic expansion. An additional 460 confirmed cases and 248 confirmed deaths have been reported, representing increases of 23.4% and 34.5% in cumulative confirmed cases and confirmed deaths, respectively. The crude case fatality ratio (CFR) among confirmed cases increased from 36.6% to 39.9%, likely reflecting delayed case detection, late presentation for care, and the persistently high proportion of deaths occurring outside designated treatment facilities, rather than increased disease severity. During the reporting period, the outbreak expanded to five additional health zones across Haut-Uélé and Ituri provinces, increasing the total number of affected health zones from 42 to 47. The newly affected health zones were Pawa, Boma Mangbetu, and Isiro in Haut-Uélé Province, and Mahagi and Adja in Ituri Province.

Figure 1. Weekly trend of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo by epidemiological week of report, epidemiological weeks 18 – 29, 2026



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

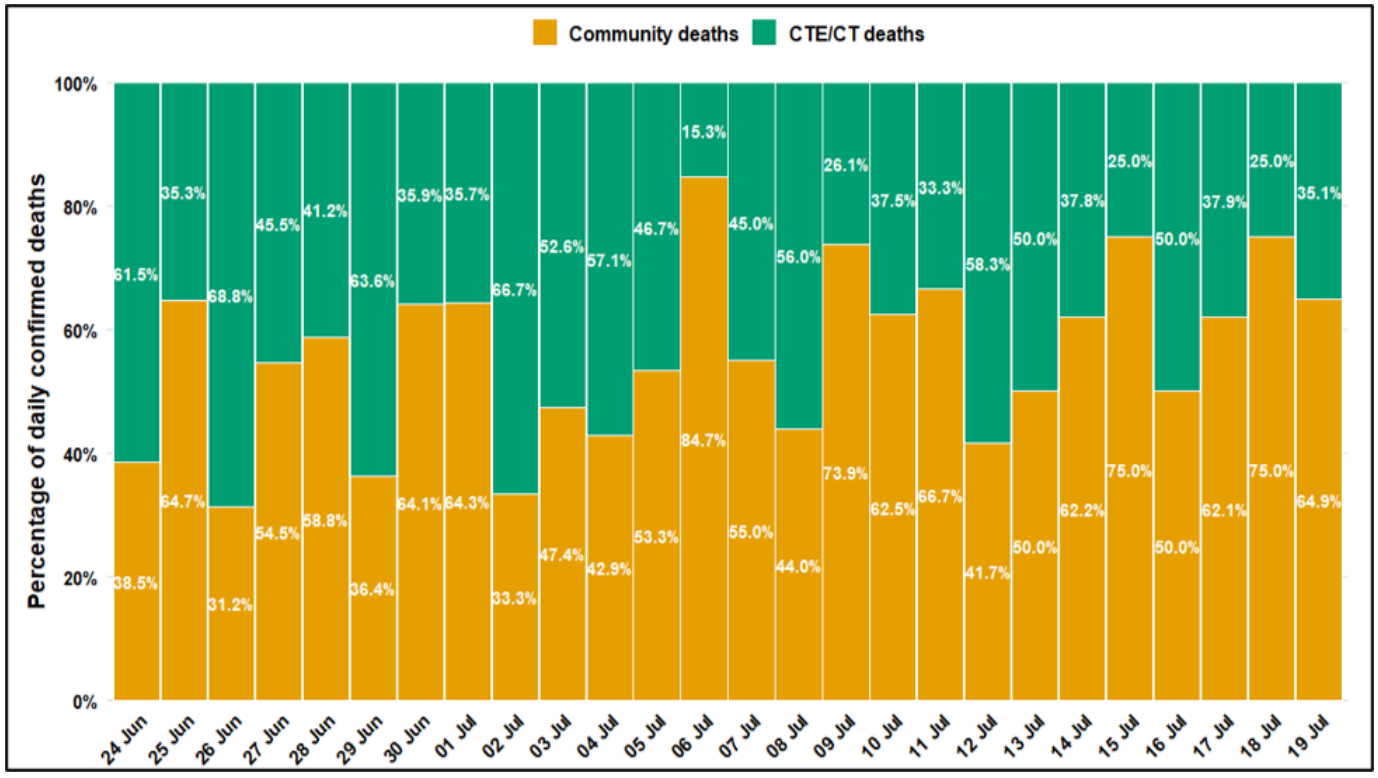
Despite this continued geographic expansion, recent transmission remains concentrated in a subset of affected areas. Of the 47 affected health zones, 40 have reported at least one confirmed case during the past 21 days. During this period, 1,090 confirmed cases and 568 confirmed deaths were reported. Ituri Province continues to bear the overwhelming burden of the outbreak, accounting for 946 cases (86.8%) and 476 deaths (83.8%), while the remaining four affected provinces together accounted for 144 cases (13.2%) and 92 deaths (16.2%). In contrast, seven affected health zones have now gone more than 21 consecutive days without reporting a confirmed case, suggesting an absence of recent transmission, provided that surveillance remains sufficiently sensitive to detect ongoing transmission. These health zones include Miti-Murhesa (60 days) in South Kivu Province; Aungba (30 days) and Gety (59 days) in Ituri Province; and Goma (55 days), Kalunguta (56 days), Mabalako (36 days), and Vuhovi (38 days) in North Kivu Province.

Recent transmission remained highly concentrated in a limited number of health zones. The largest increases over the 21-day period were recorded in Bunia (281 cases), Nizi (173), Rwampara (155), Mongbwalu (105), Katwa (59), Lita (49), Nia-Nia (40), Mangala (37), and Bambu and Butembo (24 each). Together, these ten health zones accounted

for approximately 86.9% of all additional confirmed cases reported during the period. Bunia, Rwampara, Mongbwalu, and Nizi remained the principal transmission corridor. The rapid increase in cases in Nizi, a health zone hosting several internally displaced persons (IDP) camps, together with the emergence of cases in Adja Health Zone, indicates continued westward and northward expansion of transmission within Ituri Province.

Mortality was similarly concentrated. The largest increases in confirmed deaths over the same 21-day period were reported in Bunia (129 deaths), Nizi (84), Mongbwalu (80), Rwampara (73), Katwa (45), Mangala (26), Lita (18), Butembo (16), Nyankunde (13), and Beni (11). Collectively, these ten health zones accounted for approximately 87.0% of all additional confirmed deaths reported during the period.

Figure 2. Reported Bundibugyo virus disease deaths in the Democratic Republic of the Congo by place of occurrence, 24 June – 19 July 2026

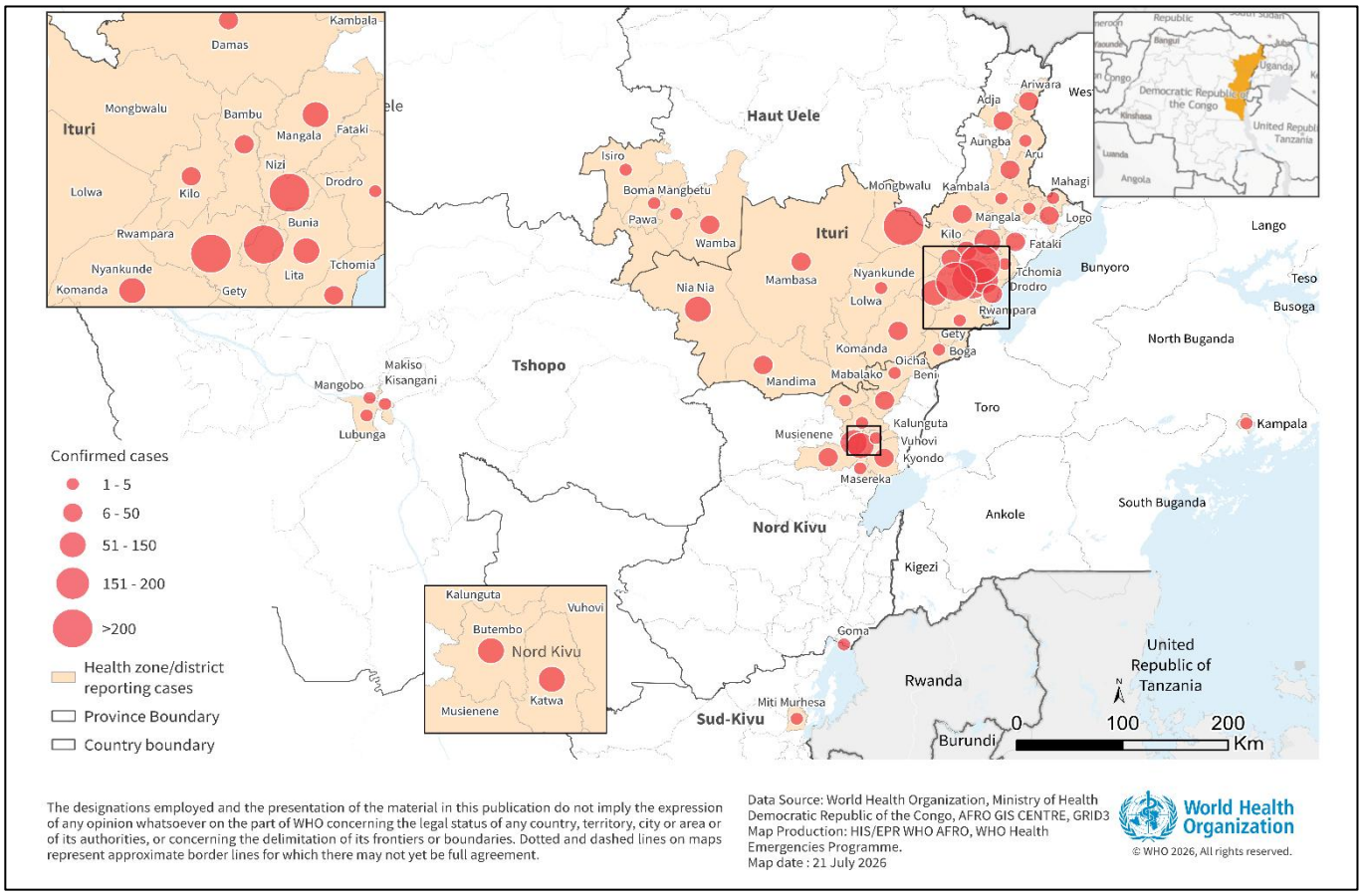


Overall, the distribution of confirmed deaths remained heavily skewed towards deaths occurring outside designated treatment centres, highlighting persistent delays in case detection, referral, and access to treatment. Between 24 June and 19 July 2026, 673 confirmed deaths were reported, of which 400 (59.4%) occurred outside designated treatment centres and 273 (40.6%) occurred within designated treatment centres. During the most recent reporting week (13 – 19 July 2026), mortality remained high, with community deaths (defined as deaths occurring outside designated treatment centres) accounting for 65.4% of all reported deaths, compared with 34.6% occurring within designated treatment centres. This persistent predominance of community deaths suggests that delays in case detection, referral, and timely access to treatment continue to contribute substantially to mortality and underscore the need to strengthen community surveillance, rapid referral, and early access to care.

Since the beginning of the outbreak, the Democratic Republic of the Congo has reported 2,423 confirmed cases, including 967 confirmed deaths, corresponding to a crude case fatality ratio (CFR) of 39.9%. Ituri Province remains the epicentre, accounting for 2,160 confirmed cases (89.1%) and 811 confirmed deaths (83.9%) reported nationally.

The most affected health zones continue to be Bunia (639 cases, 211 deaths), Rwampara (450 cases, 133 deaths), Mongbwalu (363 cases, 203 deaths), Nizi (214 cases, 93 deaths), Nyankunde (99 cases, 28 deaths), Lita (78 cases, 27 deaths), and Mangala (61 cases, 38 deaths) in Ituri Province, together with Katwa (104 cases, 72 deaths), Butembo (58 cases, 30 deaths), and Beni (37 cases, 25 deaths) in North Kivu Province. Collectively, these ten health zones account for approximately 86.8% of all confirmed cases (2,103 of 2,423) and 88.9% of all confirmed deaths (860 of 967) reported nationally, demonstrating that, despite continued geographic expansion, the burden of the outbreak remains highly concentrated.

Figure 3. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, data as of 19 July 2026

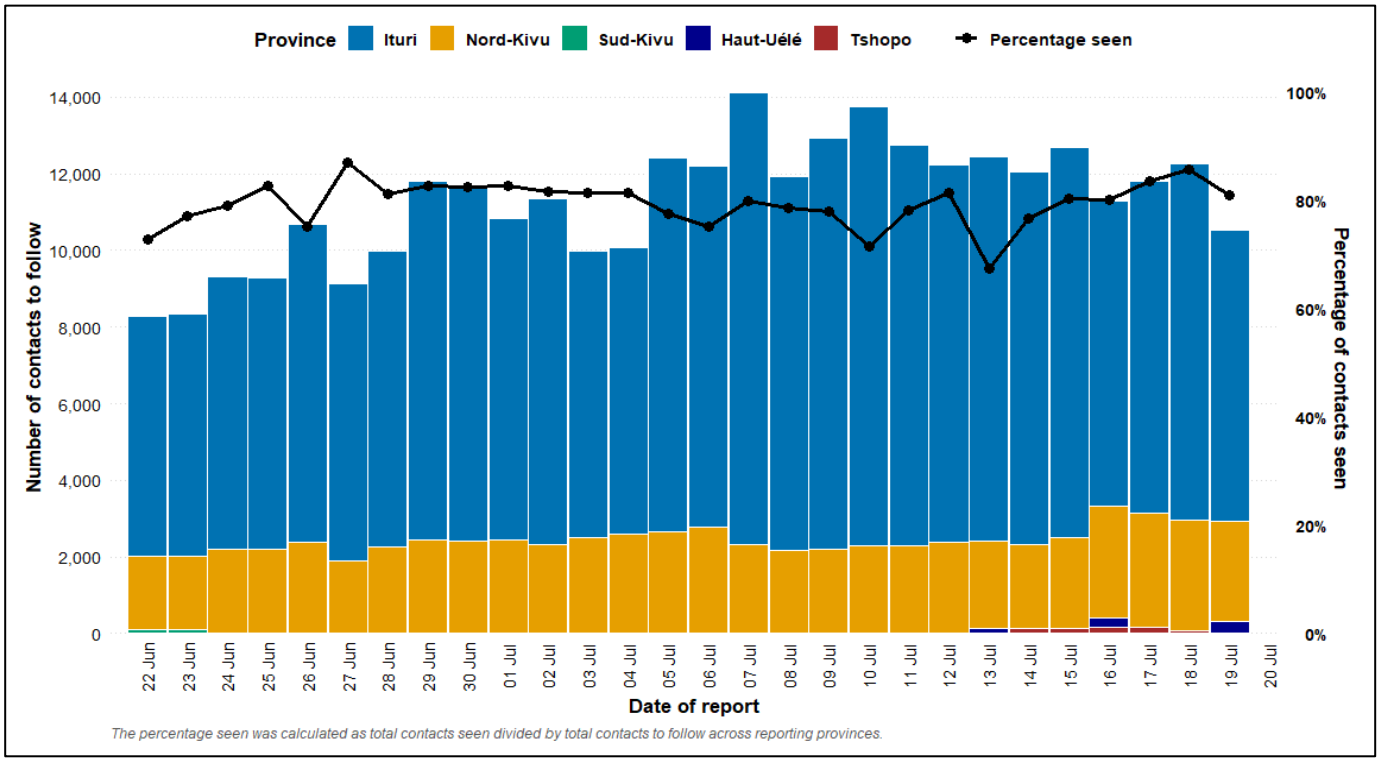


As of 19 July 2026, a total of 10,519 contacts were under follow-up in the Democratic Republic of the Congo, of whom 8,531 (81.1%) were successfully seen within the previous 24 hours. Ituri Province accounted for the majority of contacts under follow-up, with 7,537 contacts, including 6,123 (81.3%) successfully seen during the reporting period. In North Kivu Province, 1,801 of 2,149 contacts (83.8%) were successfully followed up, while Haut-Uélé Province, one of the newly affected provinces, reported 607 contacts, of whom only 317 (52.3%) were seen within the previous 24 hours. South Kivu Province had no contacts under active follow-up, reflecting the absence of recent transmission requiring contact monitoring, whereas contact follow-up data for Tshopo Province were not reported.

The overall contact follow-up rate remains below the operational target for effective contact tracing. Although follow-up performance in Ituri Province improved slightly compared with previous weeks, more than 1,400 contacts were not reached during the reporting period. The markedly low follow-up rate in Haut-Uélé Province is of particular

concern given the recent geographic expansion of the outbreak. These gaps increase the risk of undetected infections, missed chains of transmission, and sustained community transmission in both established and newly affected areas.

Figure 4. Trend in Contacts Under Follow-up and Daily Contact Follow-up Performance, Democratic Republic of the Congo, 22 June–19 July 2026



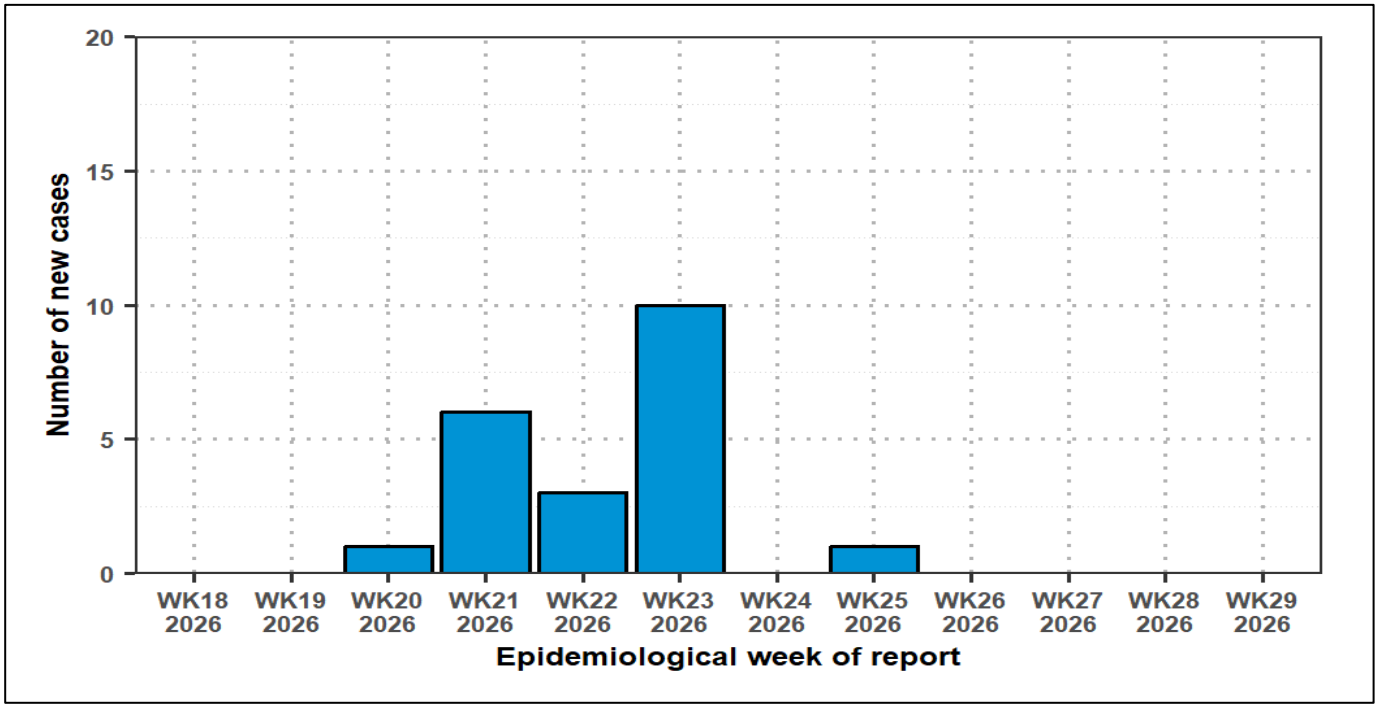
Uganda

No new confirmed cases have been reported in Uganda since the previous update. The most recent confirmed case, reported on 21 June 2026, was identified in a truck driver travelling along the Democratic Republic of the Congo–Uganda international route. Since then, no additional imported or locally acquired cases have been detected, and there is no evidence of ongoing transmission.

As of 19 July 2026, the outbreak remains limited to 21 cases (20 confirmed and one probable), including three deaths (two confirmed and one probable). All 18 recovered patients have now been discharged from care, with the last confirmed patient discharged on 16 July 2026. Since the beginning of the outbreak, 836 contacts have been identified, all of whom successfully completed the required 21-day follow-up period, during which six secondary cases were detected. No contacts are currently under follow-up, reflecting the absence of active transmission chains.

Following the discharge of the last confirmed patient on 16 July 2026, Uganda entered the 42-day countdown required to declare the end of the outbreak. As of 19 July 2026, the country was on Day 5 of the countdown. Nevertheless, Uganda remains at high risk of reintroduction due to the ongoing outbreak in the neighbouring Democratic Republic of the Congo. Continued population movement across the shared border underscores the importance of maintaining cross-border coordination, surveillance, rapid case detection, and response readiness until transmission has been interrupted in both countries.

Figure 5. Weekly trends of confirmed cases of Bundibugyo virus disease in Uganda by epidemiological week of report, epidemiological weeks 18 – 29, 2026



France

No additional Bundibugyo virus disease (BVD) cases have been reported in France since the previous update. No secondary transmission has been identified among the five flight contacts who were placed under precautionary quarantine following exposure to the imported case reported on 24 June 2026. All five flight contacts successfully completed the 21-day monitoring period.

Risk Assessment

The overall public health risk in the Democratic Republic of the Congo remains very high, driven by sustained transmission, increasing mortality, and continued geographic expansion from three to five affected provinces. Although transmission remains concentrated in Ituri Province, the emergence of newly affected health zones in Haut-Uélé and Tshopo provinces highlights the continued potential for spread into previously unaffected areas.

The rising CFR and the high proportion of community deaths continue to indicate delays in case detection, isolation, referral, and access to clinical care. Contact tracing performance remains below the operational target, particularly in Ituri Province, where follow-up coverage is substantially lower than in North Kivu despite Ituri accounting for the majority of ongoing transmission.

Uganda remains at high risk of reintroduction because of the ongoing outbreak in neighbouring Democratic Republic of the Congo, despite reporting no new cases during the reporting period. The absence of secondary transmission following the imported case in France demonstrates the effectiveness of rapid public health measures, but also underscores the continued risk of international spread through travel.

Table 1. Confirmed cases and deaths of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by geographic area, as of 19 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	Haut-Uélé	Boma Mangbetu	4	2	50.0	4	2	2026-07-12	6
		Isiro	3	2	66.7	3	2	2026-07-13	6
		Pawa	3	3	100.0	3	3	2026-07-13	6
		Wamba	6	3	50.0	6	3	2026-07-17	2
	Subtotal - Haut-Uélé		16	10	62.5	16	10	2026-07-17	2
	Ituri	Adja	10	1	10.0	10	1	2026-07-19	0
		Ariwara	7	1	14.3	7	1	2026-07-19	0
		Aru	4	1	25.0	1	0	2026-07-17	2
		Aungba	6	2	33.3	0	0	2026-06-19	30
		Bambu	40	14	35.0	247	10	2026-07-19	0
		Boga	1	1	100.0	1	1	2026-07-11	8
		Bunia	639	211	33.3	281	129	2026-07-19	0
		Damas	7	0	0.0	2	0	2026-07-15	4
		Drodro	5	3	60.0	2	0	2026-07-13	6
		Fataki	11	7	63.6	10	7	2026-07-18	1
		Gety	1	0	0.0	0	0	2026-05-21	59
		Kambala	2	2	100.0	1	1	2026-06-30	19
		Kilo	11	3	27.3	2	2	2026-07-17	2
		Komanda	27	10	37.0	11	5	2026-07-04	15
		Lita	78	27	34.6	49	18	2026-07-19	0
		Logo	8	1	12.5	1	1	2026-07-19	0
		Lolwa	2	1	50.0	2	1	2026-07-13	6
		Mahigi	1	0	0.0	1	0	2026-07-15	4
		Mambasa	8	6	75.0	6	5	2026-07-17	2
		Mandima	9	4	44.4	8	4	2026-07-14	5
		Mangala	61	38	62.3	37	26	2026-07-19	0
		Mongbwalu	363	203	55.9	105	80	2026-07-19	0
		Nia-Nia	51	15	29.4	40	10	2026-07-19	0
		Nizi	214	93	43.5	173	84	2026-07-19	0
		Nyankunde	99	28	28.3	5	13	2026-07-12	7
		Rimba	5	0	0.0	2	0	2026-07-12	7
		Rwampara	450	133	29.6	155	73	2026-07-19	0
		Tchomia	23	6	26.1	10	4	2026-07-19	0
		Unallocated health zones	17	0	0	-	--	-	-
Subtotal — Ituri			**2 160**	**811**	**37.5**	**946**	**476**	**2026-07-19**	**0**
	North Kivu	Beni	37	25	67.6	15	11	2026-07-18	1
		Butembo	58	30	51.7	24	16	2026-07-19	0
		Goma	1	0	0.0	0	0	2026-05-25	55
		Kalunguta	2	1	50.0	0	0	2026-05-24	56
		Katwa	104	72	69.2	59	45	2026-07-19	0
		Kyondo	9	4	44.4	6	2	2026-07-18	1
		Mabalako	1	0	0.0	0	0	2026-06-13	36
		Masereka	3	0	0.0	2	0	2026-07-05	14

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
		Musienene	19	5	26.3	16	3	2026-07-19	0
		Oicha	4	3	75.0	1	1	2026-07-19	0
		Vuhovi	1	1	100.0	0	0	2026-06-11	38
Subtotal — North Kivu			239	141	59.0	123	78	**2026-07-19**	**0**
	South Kivu	Miti Murhesa	3	1	33.3	0	0	2026-05-20	60
Subtotal — South Kivu			3	1	33.3	0	0	2026-05-22	60
	Tshopo	Lubunga	1	0	0.0	1	0	2026-07-11	8
		Makiso-Kisangani	3	3	100.0	3	3	2026-07-11	8
		Mangobo	1	1	100.0	1	1	2026-07-11	8
Subtotal — Tshopo			5	4	80.0	5	4	**2026-07-11**	8
Uganda	Kampala	Kampala	21	3	14.3	0	0	2026-06-21	28
Subtotal — Uganda			**21**	**3**	**14.3**	**0**	**0**	**2026-06-21**	**28**

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.

Public health response

Coordination

- The Continental BVD Incident Management Support Team (IMST) continued to coordinate response operations in the Democratic Republic of the Congo and Uganda while supporting preparedness activities in 11 additional high-risk countries under the One Plan, One System, One Report framework.

- National and subnational coordination structures in the Democratic Republic of the Congo continued to oversee the multisectoral response across the five affected provinces, with operational support deployed to newly affected areas and incident management strengthened in areas where transmission expanded.

- Cross-border coordination between the Democratic Republic of the Congo and Uganda was reinforced through joint technical assessments aimed at strengthening preparedness and response capacities in border areas.

- High-level government engagement continued to support response operations, including oversight visits to affected health zones to assess treatment centre readiness and recognize the efforts of frontline responders.

- National rapid response teams were deployed to strengthen incident management and coordination in newly affected provinces, while preparedness activities continued in areas at risk of further spread.

- The National Incident Management Systems in the Democratic Republic of the Congo and Uganda continued to receive operational support from WHO; the Africa Centres for Disease Control and Prevention (Africa CDC); the United Nations Children's Fund (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 (EU); the Global Outbreak Alert and Response

Network (GOARN); Emergency Medical Teams (EMTs); the Health Cluster, the Standby Partnership (SBP); and other partners through technical assistance, expert deployments, surge capacity, and field operations.

Operations Support and Logistics (OSL)

- Procurement and deployment of critical response supplies continued to expand during the reporting period. The total emergency supply pipeline increased to approximately US$9.37 million, compared with about US$9.19 million previously. Of this amount, US$2.59 million (28%) had been delivered, US$3.54 million (38%) was in transit, and US$3.24 million (35%) remained under procurement.

- The value of delivered supplies increased substantially from approximately US$1.92 million to US$2.59 million, while delivered cargo rose to about 232 metric tons and 1,333 cubic metres, strengthening support to response operations in the Ituri and North Kivu hubs.

- Essential commodities continued to reach affected areas, including personal protective equipment, laboratory diagnostics and PCR supplies, medical equipment, medicines, hospital beds, tents, infrared thermometers, patient liners, gloves, gowns, and coveralls. Laboratory and IPC commodities represented the largest share of delivered supplies.

- Supply chain activity remained high during recent epidemiological weeks, supporting case management, laboratory testing, surveillance, infection prevention and control, and field operations. However, substantial quantities of gloves, coveralls, and other critical items remained in transit or under procurement, requiring continued close monitoring of stock availability.

- Procurement and shipment coordination continued through WHO's international supply network and logistics hubs in Kinshasa, Nairobi (Kenya), Dubai (United Arab Emirates), and Dakar (Senegal). Most orders continued to originate directly from suppliers, while regional hubs supported consolidation, onward transport, shipment tracking, and distribution to affected areas.

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 across affected provinces. On 19 July 2026, 1,209 alerts were reported from the five affected provinces in the Democratic Republic of the Congo, of which 1,108 (91.6%) were investigated within 24 hours. Most alerts originated from Ituri (1,002), followed by North Kivu (155), Haut-Uélé (48), Tshopo (3), and South Kivu (1). Investigation coverage remained above 95% in North Kivu, South Kivu, Haut-Uélé, and Tshopo, while Ituri continued to report lower investigation performance. Of the total alerts, 252 suspected cases, including 137 community deaths, were validated.

- Points of entry (PoE) and points of control (PoC) surveillance continued to be strengthened in the Democratic Republic of the Congo. As of 19 July 2026, 75 PoE/PoC sites were operational across Ituri and North Kivu provinces. During the reporting period, 167,229 travellers passed through PoE/PoC screening sites, of whom 99.8% were screened for Bundibugyo virus disease (BVD) symptoms. A total of 11 alerts generated through

PoE/PoC screening were validated and investigated.

- In Uganda, alert management, surveillance for non-trauma deaths, and community-based surveillance continued nationwide. As of 12 July 2026, all identified contacts had completed the 21-day follow-up period.
- 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 with the goal to reduce turnaround times. As of 19 July 2026, 16 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 and INRB-Goma laboratories.
- 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 14,000 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 22 operational Ebola treatment and care facilities providing approximately 841 isolation and treatment beds. Despite this expansion, 734 patients were in isolation as of 19 July 2026, corresponding to an estimated national bed occupancy of 87.3%, while treatment capacity in North Kivu remained overstretched.
- Clinical outcomes continued to improve, with cumulative recoveries increasing to 469 by 19 July 2026, reflecting the sustained provision of supportive clinical care. At the same time, treatment capacity and referral systems continued to be strengthened in high-transmission areas.
- Clinical research and access to investigational therapeutics continued through the WHO-supported PARTNERS clinical trial, which is evaluating MBP134 and remdesivir for the treatment of Bundibugyo virus disease, alongside the EBO-PEP trial, which is assessing obeldesivir as post-exposure prophylaxis for high-risk contacts.
- National and international partners continued to strengthen clinical care capacity through the deployment of laboratory and clinical equipment, expansion of diagnostic services, and support for treatment centre

operations. Additional workforce and logistical support remained a priority in response to the increasing patient load.

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

- IPC activities continued to scale up across the affected provinces, including briefings for healthcare workers and community relays, as well as IPC assessments in health facilities. In Ituri Province, screening points were established in 175 health facilities, IPC kits were distributed to 45 health facilities, and 100 traditional healers in Bunia and Rwampara were sensitized on public health and infection prevention measures.

- Safe and dignified burial (SDB) operations and decontamination activities continued in affected health zones, including 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 Ituri Province found that only 12 health facilities achieved scores above 80%, highlighting substantial gaps in infection prevention standards and health facility preparedness.

  Healthcare worker infections continued to increase, with 121 infections and 36 deaths reported among healthcare workers, corresponding to a CFR of 29.8%. This underscores persistent occupational exposure risks and inadequate implementation of IPC measures in health facilities. Gaps also remain in the availability of appropriate personal protective equipment (PPE) for different categories of healthcare workers.

Risk Communication and Community Engagement (RCCE)

- RCCE activities continued across affected provinces to strengthen community awareness, promote early alert reporting, support contact tracing, and SDB operations, particularly in hotspot areas of Ituri and North Kivu. Additional RCCE personnel and anthropological expertise were deployed to newly affected provinces to strengthen community engagement.

- Community feedback and rapid community assessments continued to inform the response by identifying concerns related to transmission risks, access to services, vaccination, and response activities. Findings are being translated into community-led interventions and expanded across affected areas of the Democratic Republic of the Congo, with plans to extend implementation to Uganda and South Sudan.

- Capacity-building efforts continued through the development of an RCCE Humanizing the Response training package and the training of trainers for response partners. A targeted RCCE strategy was also developed for IDP camps, incorporating findings from rapid community assessments to strengthen community engagement.

- Key RCCE challenges persisted, including insecurity in hotspot areas, community resistance in mining and conflict-affected communities, misinformation, and difficulties in maintaining timely follow-up of highly mobile and cross-border populations. Community engagement efforts therefore remained focused on building trust in response services and improving access among high-risk populations.

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

- PRSEAH activities continued across affected provinces, including coordination with the Government and response partners to strengthen the capacity of PRSEAH focal points across 18 health zones in Ituri Province. A preparedness plan for the Democratic Republic of the Congo and South Sudan, as well as for 10 high-priority countries, continued to be implemented.

- PRSEAH coordination capacity was strengthened through the deployment of a national coordinator, technical specialists, and regional support personnel across Ituri, North Kivu, South Kivu, Haut-Uélé, and Tshopo to support the implementation and oversight of PRSEAH activities.

- Community awareness-raising on PRSEAH reached 19,231 people, including 6,912 women and 1,346 girls, through targeted engagement with religious leaders, internally displaced persons, healthcare workers, pregnant and breastfeeding women, transport workers, teachers, students, and other community groups.

- Capacity-building activities continued for frontline responders, with 826 personnel, including 352 women, receiving PRSEAH briefings in Ituri, North Kivu, South Kivu, and Tshopo. Participants included psychosocial workers, psychologists, healthcare workers, and staff from partner organizations to strengthen the prevention of, reporting of, and response to sexual exploitation, abuse, and harassement.

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, 30 of the 47 Member States (64%) have updated their readiness assessments. In addition, three high-priority countries (Angola, South Sudan, and Tanzania) have completed repeat readiness assessments, demonstrating significant improvements in their average readiness scores.

- Regional deployments to support preparedness in high-risk Member States continued during the reporting period, with ongoing deployments in Burundi, the Central African Republic, and the Democratic Republic of the Congo.

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 BVD outbreak in the Democratic Republic of the Congo continues to intensify despite the ongoing scale-up of response operations. Although transmission remains highly concentrated in a limited number of health zones in Ituri Province, continued geographic expansion into Haut-Uélé and Tshopo provinces indicates that new transmission foci continue to emerge. Persistently high mortality, driven by the large proportion of deaths occurring outside designated treatment centres, together with a rising CFR, indicates that many patients are still being detected and referred too late to benefit from optimal clinical care. While surveillance, laboratory, case management, and operational capacities continue to expand, important gaps remain in contact tracing, infection prevention and control, and community engagement, particularly in newly affected areas. Strengthening early case detection, improving contact follow-up, expanding timely access to clinical care, reinforcing infection prevention and control measures in healthcare settings, and sustaining community trust and cross-border preparedness will be critical to interrupt transmission and reduce mortality

.

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