

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda | France

Weekly External Situation Report 12, Data as of 02 August 2026

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

5 Provinces	4 Provinces	727	72.4%	18 276
51 Health Zones Affected	42 Health Zones Active Transmission	Cases Recovered	Bed Occupancy	Contacts to follow
707 Active Cases in Isolation	140 Health Worker Cases	43 Health Worker Deaths	1 050 Bed Capacity	19 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	540	270	3 802	1 707	-	-	3 802	1 707	44.9%
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.

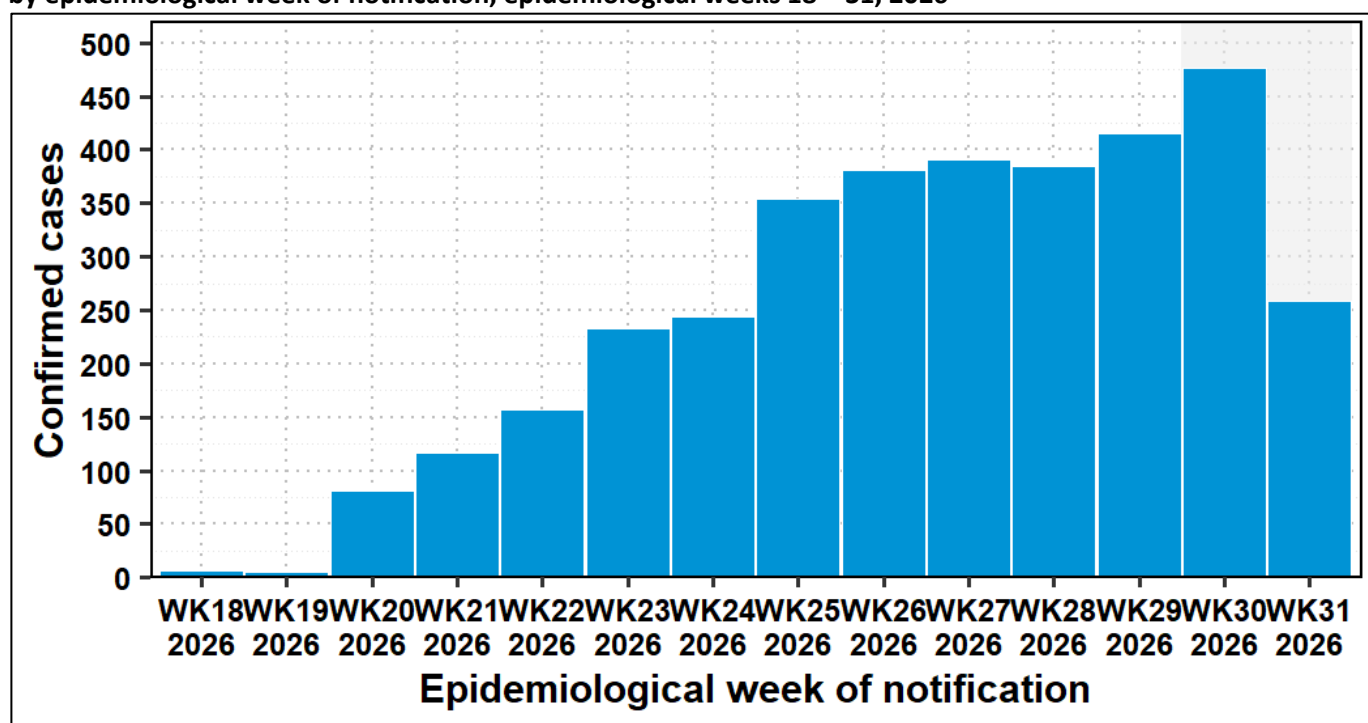
Event description

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo continues to expand rapidly, with sustained transmission, persistently high mortality, and ongoing geographic spread. It is now the largest BVD outbreak ever recorded and the second largest Ebola disease outbreak in history after the 2013 – 2016 West Africa epidemic. Since its detection only a few months ago, the epidemic has grown at an exceptional rate, highlighting its intensity and the challenges facing response efforts. Although no new international spread has been detected, continued transmission indicates that the outbreak remains in an expansion phase and continues to pose a high risk of regional and international spread.

Democratic Republic of the Congo

Since the last update of 26 July 2026 (Weekly External Situation Report #11), the Democratic Republic of the Congo has reported an additional 540 confirmed cases and 270 confirmed deaths, representing increases of 16.6% and 18.8%, respectively, in cumulative confirmed cases and deaths. Although the absolute numbers of newly reported cases and deaths remain substantial, the proportional increases are markedly lower than those reported during the previous reporting period, reflecting the absence of the large retrospective data reconciliation that contributed to last week's increase. Nevertheless, the reporting of more than 500 additional confirmed cases and more than 250 confirmed deaths within a single week indicates that transmission remains intense and that the outbreak continues to expand. The crude case fatality ratio (CFR) increased from 44.1% to 44.9%, reflecting persistently high mortality despite ongoing response efforts. During the reporting period, the cumulative number of affected health zones increased from 48 to 51, with Kabondo and Wanie-Rukula in Tshopo Province and Lubero in North Kivu Province becoming the latest affected health zones, further demonstrating the continued geographic expansion of the outbreak.

Figure 1. Weekly trend of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo by epidemiological week of notification, epidemiological weeks 18 – 31, 2026



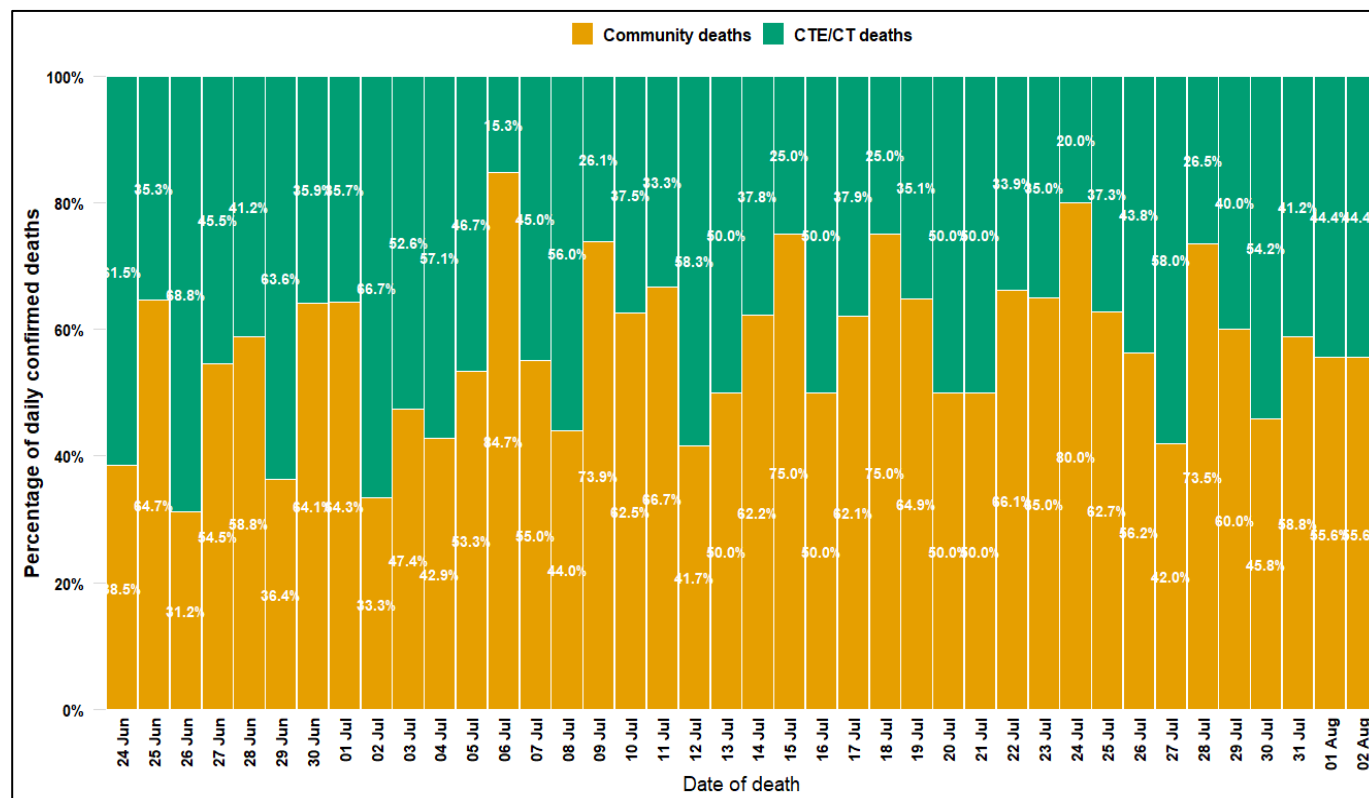
Note: The shaded grey area for the most recent epidemiological week represents incomplete data due to reporting delays.

During the last 21 days, transmission remained highly concentrated geographically, with an additional 1,867 confirmed cases and 953 confirmed deaths reported nationally. Approximately 87.9% (n=1,641) of recently reported confirmed cases and 84.8% (n=808) of deaths occurred in Ituri Province, with the Bunia–Rwampara–Mongbwalu–Nizi corridor continuing to represent the principal transmission focus. North Kivu, Haut-Uélé, and Tshopo together accounted for 223 cases (11.9%) and 144 deaths (15.1%), while South Kivu reported no new confirmed cases. However, an imported confirmed death from Tshopo Province generated new contacts requiring follow-up in South Kivu. Of the 51 affected health zones, 42 reported at least one confirmed case during the preceding 21 days, whereas nine health zones (Gety, Kambala, Lubunga, Mangobo, Mabalako, Makiso-Kisangani, Miti-Murhesa, Rungu, and Vuhovi) have not reported a confirmed case for more than three weeks, suggesting that transmission may have been interrupted in these areas, provided surveillance remains sufficiently sensitive to detect any ongoing transmission.

The largest increases in confirmed cases over the previous 21 days were recorded in Bunia (312 cases), Nizi (285), Rwampara (216), Mongbwalu (207), Katwa (104), Lita (84), Nia-Nia (66), Mangala (63), Fataki (31), and Butembo (29). Together, these ten health zones accounted for approximately 84% of all additional confirmed cases reported nationally during the period. Bunia, Nizi, Mongbwalu, and Rwampara remained the principal transmission corridor, accounting for nearly 55% of all newly reported confirmed cases. Continued increases in Lita, Nia-Nia, Mangala, and Fataki indicate sustained transmission within the Ituri epicentre, while ongoing transmission in Katwa and Butembo confirms persistent transmission in North Kivu. Continued increases in Isiro and Wamba further indicate that the outbreak is becoming increasingly established in Haut-Uélé Province.

Mortality remained concentrated within the same transmission corridor driving the epidemic. More than half (55.4%) of all confirmed deaths continue to occur outside designated treatment facilities, indicating that many patients are still being detected only late in illness or after death. Delayed case detection and delayed access to specialised treatment therefore remain major contributors to mortality. Recent analyses indicate a median interval of eight days from symptom onset to death, with almost half of deaths occurring within the first week of illness, emphasizing the narrow window available for life-saving clinical intervention.

Figure 2. Reported Bundibugyo virus disease deaths in the Democratic Republic of the Congo by place of occurrence, 24 June – 02 August 2026



Children younger than five years continue to experience disproportionately high mortality. Although they account for fewer than one in ten confirmed cases nationally, they represent approximately 17% of all confirmed deaths, experience the highest case fatality ratios of any age group, and have the shortest interval between symptom onset and death. Conversely, adults aged 20 – 59 years continue to account for most transmission, representing nearly two-thirds of confirmed cases. These findings suggest that outbreak control should continue to prioritise interrupting transmission among working-age adults while simultaneously strengthening rapid identification and referral of young children to reduce mortality.

Figure 3. Bundibugyo virus disease case fatality ratio by age group and sex, Democratic Republic of the Congo, data as of 02 August 2026 (n=1,052 deaths)

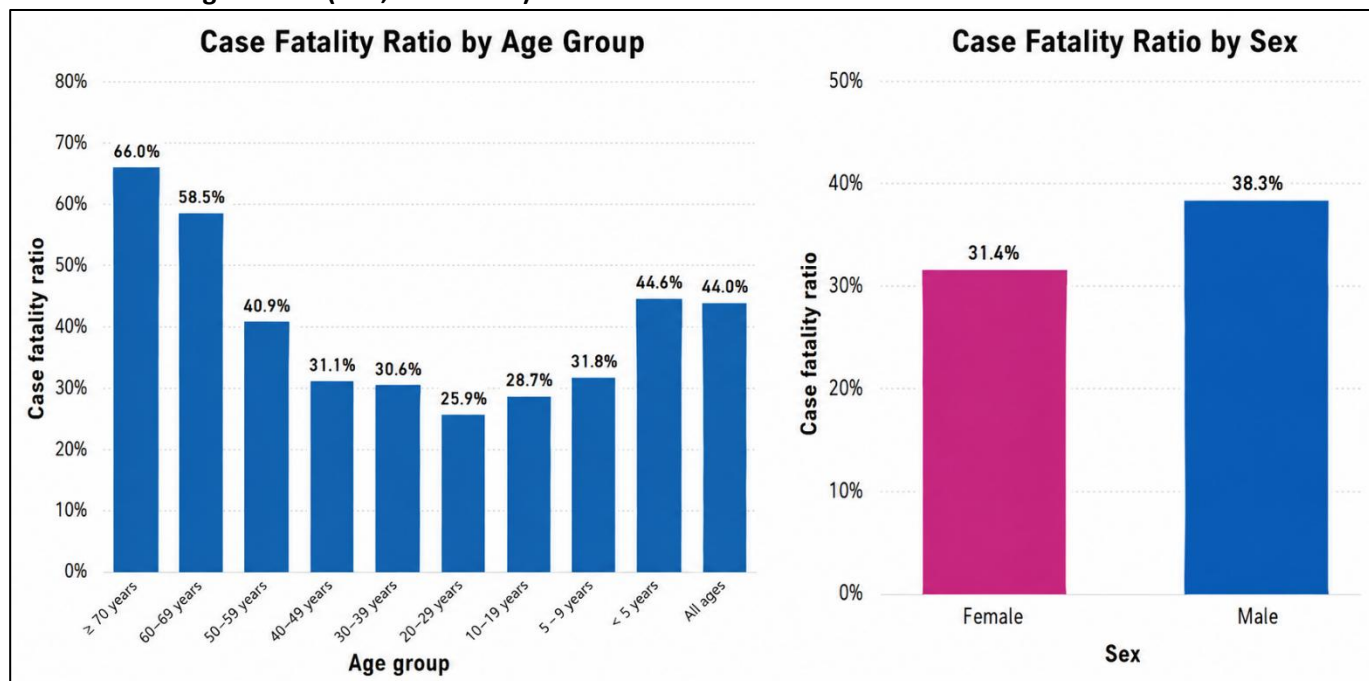
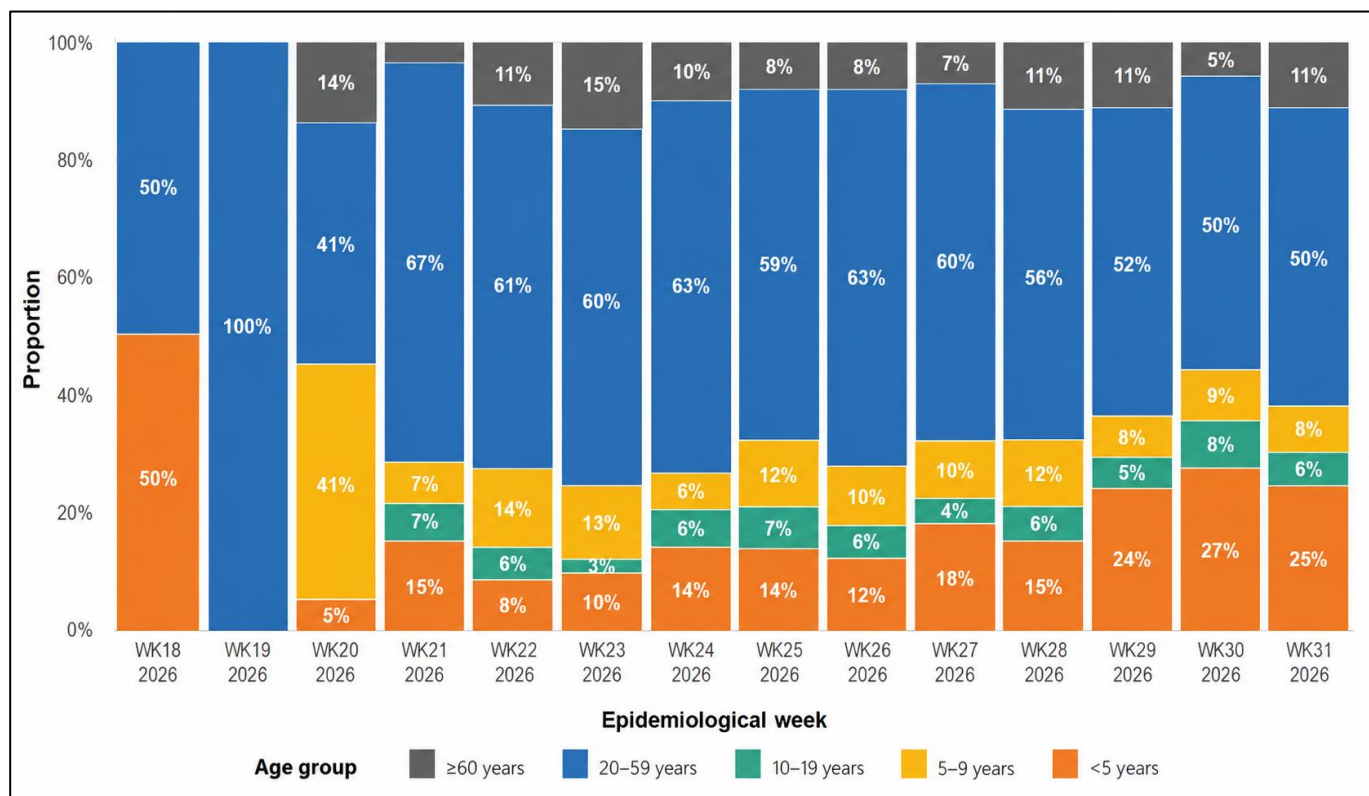
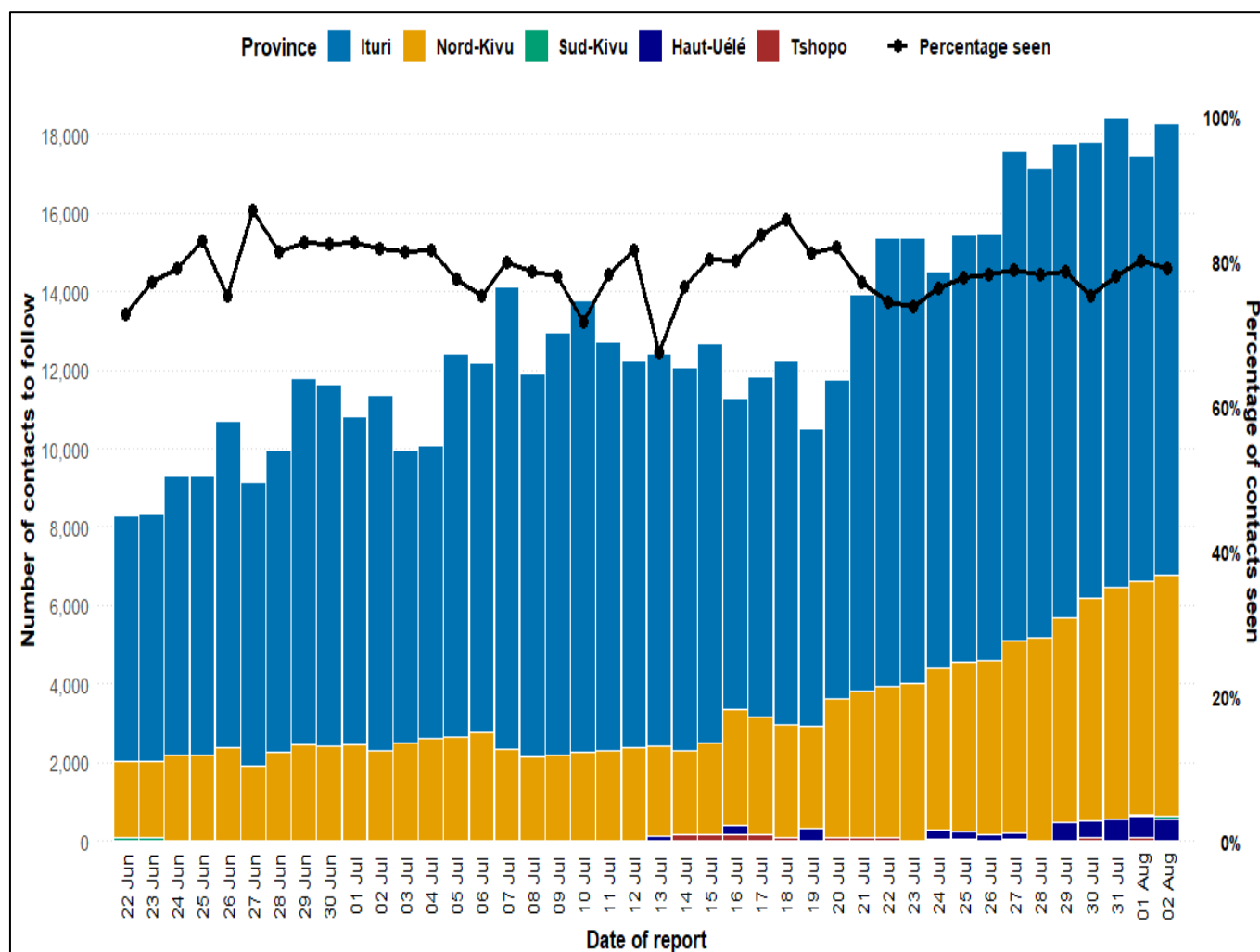


Figure 4. Weekly proportion of Bundibugyo virus disease deaths by age group, Democratic Republic of the Congo, data as of 02 August 2026 (n=1,052 deaths)



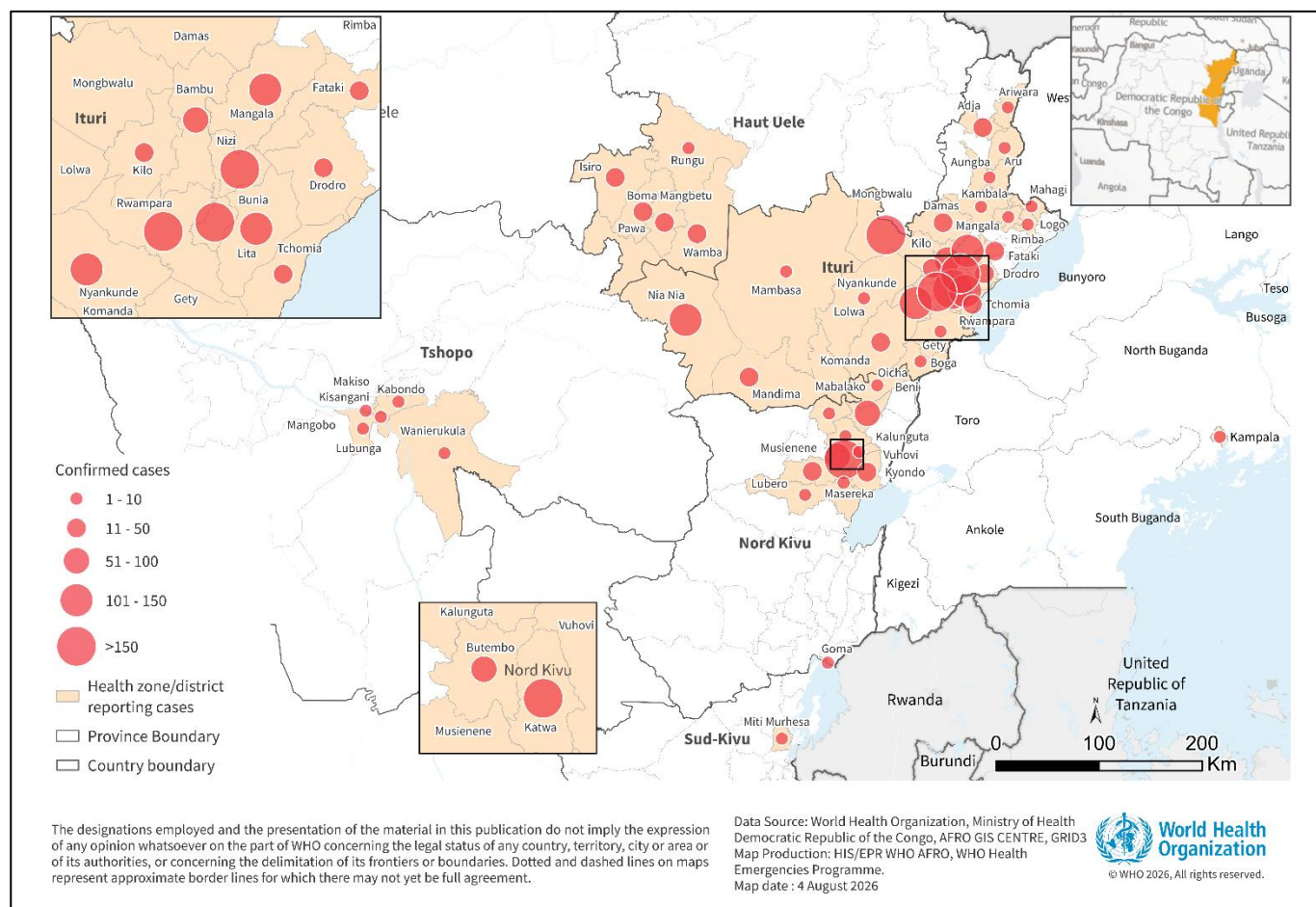
Surveillance performance remains suboptimal. As of 2 August 2026, 18,276 contacts were under follow-up nationally, of whom 14,466 (79.2%) were successfully seen during the previous 24 hours, remaining well below the operational target of 95%. Contact tracing capacity continues to lag behind the growing number of contacts to follow, particularly in Ituri and North Kivu, while persistently low follow-up rates and intermittent reporting in Haut-Uélé and Tshopo limit interpretation of recent trends.

Figure 5. Trend in Contacts Under Follow-up and Daily Contact Follow-up Performance, Democratic Republic of the Congo, 22 June - 02 August 2026



Since the beginning of the outbreak, the Democratic Republic of the Congo has reported 3,802 confirmed cases, including 1,707 confirmed deaths, corresponding to a crude CFR of 44.9%. The outbreak now affects 51 health zones across five provinces. Ituri Province remains the epicentre, accounting for 3,317 confirmed cases (87.2%) and 1,382 confirmed deaths (81.0%) nationwide. The most affected health zones remain Bunia (914 cases, 270 deaths), Rwampara (655 cases, 263 deaths), Mongbwalu (552 cases, 263 deaths), Nizi (402 cases, 194 deaths), Lita (141 cases, 84 deaths), and Nyankunde (115 cases, 34 deaths) in Ituri Province, together with Katwa (186 cases, 122 deaths) and Butembo (87 cases, 69 deaths) in North Kivu Province. Collectively, these health zones account for the overwhelming majority of confirmed cases and deaths reported nationwide.

Figure 6. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, data as of 02 August 2026



Uganda and France

No new cases have been reported in Uganda or France since the previous update. In Uganda, the last confirmed patient was discharged on 16 July 2026, and 17 days have passed without a new confirmed case. All identified contacts have completed the required 21-day follow-up, and no contacts remain under active monitoring. In France, the imported confirmed BVD case reported on 24 June 2026 recovered and was discharged on 4 July 2026 after two consecutive negative PCR test results. No secondary transmission was identified, and all five flight contacts completed their 21-day follow-up without developing symptoms. As of 2 August 2026, 29 days have passed since the patient's discharge without any additional confirmed BVD cases being reported from France. Despite the absence of new cases, Uganda remains at high risk of reintroduction because of the ongoing outbreak in the neighbouring Democratic Republic of the Congo.

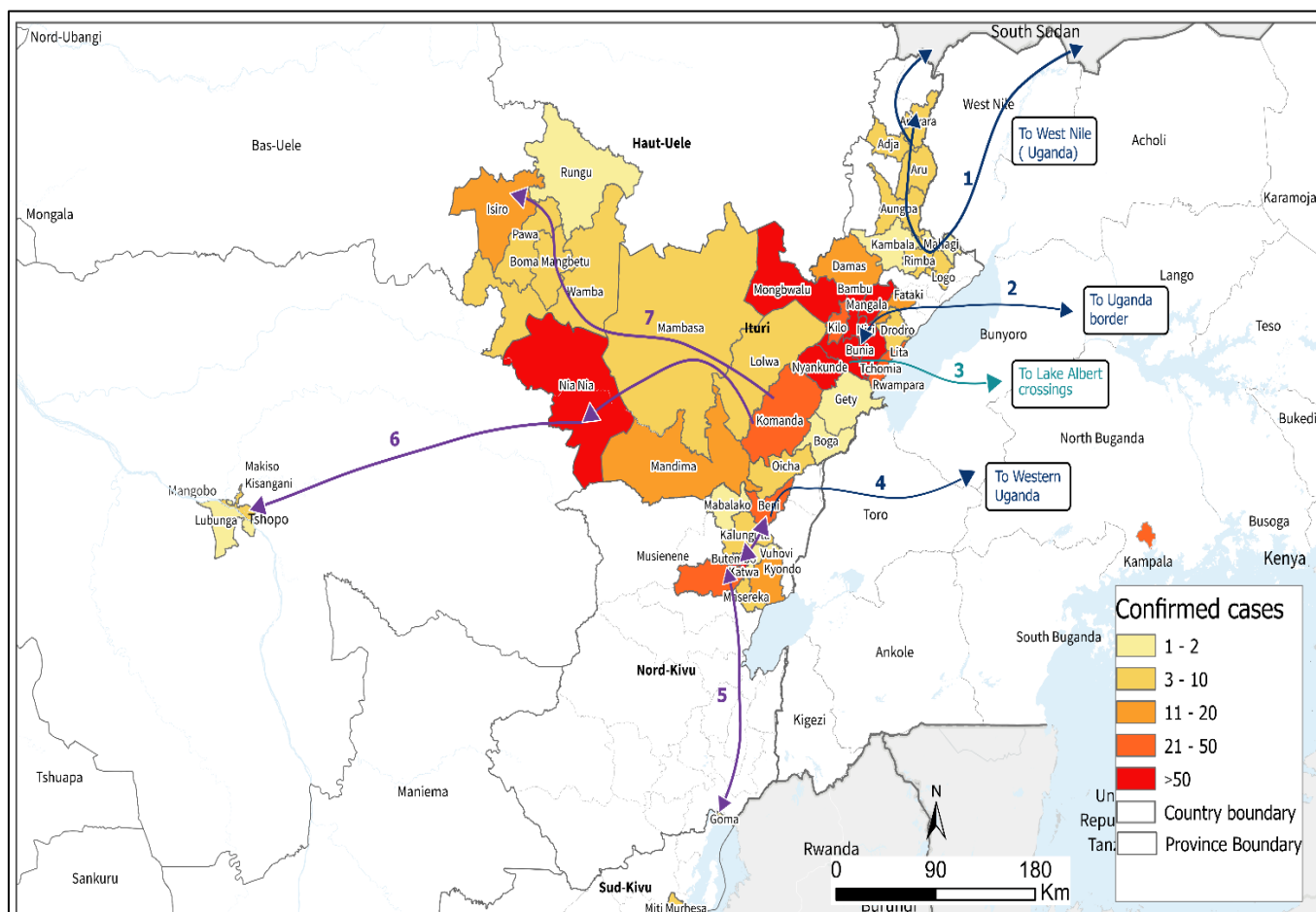
Risk Assessment

The overall public health risk in the Democratic Republic of the Congo remains very high. The outbreak continues to expand, with sustained transmission, persistently high mortality, and continued spread to newly affected health zones. Transmission remains concentrated within the Bunia–Rwampara–Mongbwalu–Nizi corridor, while ongoing spread in Haut-Uélé and Tshopo indicates progressive geographic expansion beyond the original epicentre.

The risk of further national and international spread remains high because transmission continues along major

internal and cross-border mobility corridors linking the outbreak to Uganda, South Sudan, and other neighbouring countries. Although Uganda and France have reported no additional cases since their previous imported events, sustained transmission in eastern Democratic Republic of the Congo continues to pose a significant risk of cross-border spread. Continued cross-border surveillance, rapid information sharing, and preparedness remain essential to ensure early detection and rapid containment of any imported cases.

Figure 7. Bundibugyo virus disease transmission risk along major mobility corridor in the Democratic Republic of the Congo, data as of 02 August 2026



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization, Ministry of Health Democratic Republic of the Congo, GRID3. Map Production: HIS/EPR WHO AFRO, WHO Health Emergencies Programme. Map date: 27 July 2026



Table 1. Confirmed cases and deaths of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by geographic area, as of 02 August 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	13	4	30.8	11	3	2026-07-29	4
		Isiro	19	11	57.9	18	10	2026-08-02	0
		Pawa	12	10	83.3	9	7	2026-08-01	1
		Rungu	1	0	0.0	1	0	2026-07-24	9
		Wamba	16	9	56.2	8	1	2026-08-01	1
Subtotal—Haut-Uélé			61	34	55.7	47	21		
Democratic Republic of the Congo	Ituri	Adja	11	1	9.1	11	1	2026-07-26	7
		Ariwara	7	2	28.6	6	1	2026-07-20	13
		Aru	5	5	100.0	2	4	2026-07-22	11
		Aungba	10	5	50.0	4	3	2026-08-02	0
		Bambu	64	15	23.4	33	5	2026-08-02	0
		Boga	1	1	100.0	0	0	2026-07-11	22
		Bunia	914	270	29.5	380	98	2026-08-02	0
		Damas	18	8	44.4	13	8	2026-08-01	1
		Drodro	11	6	54.5	6	3	2026-08-01	1
		Fataki	35	17	48.6	30	13	2026-07-31	2
		Gety	1	0	0.0	0	0	2026-05-21	73
		Kambala	2	0	0.0	0	0	2026-05-30	64
		Kilo	29	11	37.9	20	10	2026-07-27	6
		Komanda	37	27	73.0	10	17	2026-08-01	1
		Lita	141	84	59.6	82	61	2026-08-02	0
		Logo	9	4	44.4	2	4	2026-07-24	9
		Lolwa	7	2	28.6	5	1	2026-07-29	4
		Mahagi	4	1	25.0	4	1	2026-07-27	6
		Mambasa	10	6	60.0	5	2	2026-08-01	1
		Mandima	16	12	75.0	8	9	2026-07-27	6
		Mangala	105	66	62.9	55	37	2026-08-01	1
		Mongbwalu	552	263	47.6	216	81	2026-08-02	0
		Nia-Nia	104	57	54.8	68	50	2026-08-02	0
		Nizi	402	194	48.3	271	144	2026-08-02	0
		Nyankunde	115	34	29.6	16	8	2026-07-31	2
		Rimba	9	4	44.4	5	4	2026-07-24	9
		Rwampara	655	263	40.2	250	168	2026-08-02	0
		Tchomia	43	24	55.8	24	20	2026-08-02	0
Subtotal—Ituri			3,317	1,382	41.7	1,526	751		
Democratic Republic of the Congo	North Kivu	Beni	64	49	76.6	33	29	2026-08-02	0
		Butembo	87	69	79.3	41	47	2026-08-01	1
		Goma	1	0	0.0	0	0	2026-05-25	69
		Kalunguta	7	4	57.1	5	3	2026-08-02	0
		Katwa	186	122	65.6	110	67	2026-08-02	0
		Kyondo	13	10	76.9	6	7	2026-07-24	9
		Lubero	1	1	100.0	1	1	2026-08-02	0
		Mabalako	1	0	0.0	0	0	2026-06-13	50
		Masereka	5	1	20.0	2	1	2026-07-22	11
		Musienene	43	25	58.1	32	23	2026-08-02	0
		Oicha	4	3	75.0	1	1	2026-07-19	14
		Vuhovi	2	1	50.0	1	0	2026-08-02	0

Country	Province/ Region	Health zone/ district	Cum. cases	Cum. deaths	CFR %	Cases (last 21 d)	Deaths (last 21 d)	Date last case	Days since last case
Subtotal—North Kivu			414	285	68.8	232	179		
Democratic Republic of the Congo	South Kivu	Miti-Murhesa	3	1	33.3	0	0	2026-05-20	74
Subtotal—South Kivu			3	1	33.3	0	0		
Democratic Republic of the Congo	Tshopo	Kabondo	1	1	100.0	1	1	2026-07-27	6
		Lubunga	1	0	0.0	0	0	2026-07-11	22
		Makiso-Kisangani	3	3	100.0	0	0	2026-07-11	22
		Mangobo	1	1	100.0	0	0	2026-07-11	22
		Wanie-Rukula	1	0	0.0	1	0	2026-07-29	4
Subtotal—Tshopo			7	5	71.4	2	1		
Uganda	Kampala	Kampala	21	3	14.3	0	0	2026-06-21	42
Subtotal—Uganda			21	3	14.3	0	0		

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

- WHO continues to coordinate the international response to the BVD outbreak under the Public Health Emergency of International Concern (PHEIC) framework, working closely with the Ministries of Health of the Democratic Republic of the Congo and Uganda, neighbouring countries, and technical partners.
- WHO, the Africa Centres for Disease Control and Prevention (Africa CDC), and partners continue to implement the Joint Continental Preparedness and Response Plan. Since its launch in June, the plan has remained the primary continental coordination mechanism for supporting preparedness and response across affected and at-risk African countries.
- National coordination in the Democratic Republic of the Congo remains fully activated through the Public Health Emergency Operations Centre (PHEOC), with multisectoral response activities continuing across all five affected provinces.
- Cross-border coordination with neighbouring countries remains a priority because of sustained transmission along major population movement corridors linking the eastern Democratic Republic of the Congo with Uganda and South Sudan.
- The National Incident Management Systems in the Democratic Republic of the Congo and Uganda continued to receive operational support from WHO; 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, laboratory strengthening, logistics, and field operations.

Operations Support and Logistics (OSL)

- Procurement and deployment of critical response supplies continued during the reporting period. The total emergency supply pipeline increased from approximately US\$10.62 million to US\$11.29 million. Of this amount, the value of delivered supplies increased from US\$3.59 million (34%) to US\$4.14 million (37%), while the value of supplies in transit decreased from US\$2.86 million (27%) to US\$2.52 million (22%). The value of commodities not yet ready for shipment increased to US\$4.64 million (41%), reflecting continued procurement to support the expanding response.
- Delivery of emergency supplies continued to increase during the reporting period. The cumulative value of delivered commodities rose by approximately US\$550,000, while delivered cargo increased from 265.5 metric tons to 312.5 metric tons and from 1,583.2 cubic metres to 1,827.2 cubic metres, further strengthening operational support for response activities in the Ituri and Kivu hubs.
- Essential response commodities continued to reach affected areas, including 66,974 hooded coveralls, more than 5.53 million examination gloves, 158,800 Level 3 gowns, 261 hospital beds, 20,016 PCR tests, 10,076 infrared thermometers, patient liners, medicines, and laboratory equipment. Personal protective equipment (PPE) and infection prevention and control (IPC) supplies remained the largest procurement category (US\$5.99 million), followed by medical equipment (US\$1.82 million), laboratory supplies (US\$1.18 million), logistics equipment (US\$1.00 million), and medicines (US\$0.89 million).
- Supply chain operations continued to support case management, laboratory diagnostics, surveillance, infection prevention and control, and field operations. Although the proportion of supplies in transit declined to 22%, 41% of the procurement pipeline (US\$4.64 million) remained not yet ready for shipment, highlighting the need for continued monitoring to ensure the timely availability of critical response supplies as the outbreak continues to expand.
- Procurement and shipment coordination continued through WHO's international supply network and logistics hubs in Kinshasa (Democratic Republic of the Congo), Nairobi (Kenya), Dubai (United Arab Emirates), and Dakar (Senegal). Most procurement (81%; US\$8.85 million) continued to originate directly from international suppliers, while regional logistics hubs supported consolidation, onward transportation, 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. On 2 August 2026, 1,265 alerts were reported in the Democratic Republic of the Congo, of which 1,164 (92.0%) were investigated within 24 hours. Most alerts originated from North Kivu (731) and Ituri (531), while three alerts were reported from South Kivu. Investigation performance was highest in South Kivu (100%), followed by North Kivu (99.6%) and Ituri

(81.5%). Reporting from Haut-Uélé and Tshopo was unavailable, limiting the assessment of surveillance performance in these provinces. A total of 275 suspected cases, including 123 community deaths, were validated.

- Surveillance at points of entry (PoE) and points of control (PoC) continued to be strengthened. As of 2 August 2026, 72.7% of planned PoE/PoC sites were operational nationally, including 100% of planned sites in Ituri (60/60), North Kivu (18/18), and South Kivu (9/9), compared with 30.3% in Haut-Uélé and 21.1% in Tshopo. During the reporting period, 253,043 travellers passed through operational PoE/PoC sites, of whom 98.0% were screened for BVD symptoms. Four alerts were generated through PoE/PoC surveillance, two of which were validated as live alerts. One community death was intercepted and sampled. No confirmed cases were identified through PoE/PoC screening during the reporting period.
- Contact tracing continued but remained below the operational target. As of 2 August 2026, 18,276 contacts were under follow-up, of whom 14,466 (79.2%) were successfully seen during the previous 24 hours, remaining well below the operational target of 95%. Follow-up performance was highest in South Kivu (100%), followed by Ituri (82.1%), North Kivu (74.7%), and Haut-Uélé (66.7%). No contact tracing data were reported from Tshopo during the reporting period, limiting the assessment of contact tracing performance in that province.

Laboratory

- Laboratory decentralization continued to expand with the goal to reduce turnaround times. As of 29 July 2026, 19 diagnostic laboratories and testing units were operational across Ituri, South Kivu, Tshopo, Haut-Uélé and North Kivu provinces, in addition to the Institut National de Recherche Biomédicale (INRB) in Kinshasa and INRB-Goma laboratories.
- 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 expansion continued to expand across the Democratic Republic of the Congo, with bed capacity increasing to 1050 across 33 treatment facilities.
- As of 2 August 2026, 707 patients were in isolation, corresponding to an overall bed occupancy rate of 67.3%. However, bed occupancy is not uniformed and remained particularly high in North Kivu (131.9%).
- Clinical outcomes continued to improve, with cumulative recoveries increasing to 727 by 2 August 2026, reflecting the continued provision of supportive clinical care despite increasing case numbers.

- Capacity building on management of critically ill patients has been initiated with 3 cycles of training conducted. Over 40 healthcare workers have been trained on the use of High Flow Oxygen, with an additional 20 undergoing training for subsequent deployment in various treatment centres across affected provinces.

Operational Research

- Clinical research and access to investigational therapeutics continued through the WHO-supported PARTNERS clinical trial, which began on 2 July 2026 in the Democratic Republic of the Congo and is evaluating MBP134 and remdesivir for the treatment of BVD. This is complemented by the partner-supported EBO-PEP trial, which commenced on 14 July 2026 and is assessing obeldesivir as post-exposure prophylaxis for high-risk contacts.
- Additionally, Phase I evaluation of vaccine candidates for Bundibugyo virus are underway in the United Kingdom and Canada with additional studies expected to begin in Africa. WHO continues to support research preparedness through the development of standardized epidemiologic protocols, a regional research tracking system, and community engagement materials to improve understanding of clinical research.

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

- In the Democratic Republic of the Congo, as of 26 July 2026, 947 health care facilities (HCFs) had been assessed for IPC readiness across the four affected provinces (Ituri, North Kivu, South Kivu, and Tshopo), covering 51 health zones. The average overall IPC score was 38.0% (median: 37.1%), indicating that IPC capacity across the response area remained critically low compared with the 80% threshold considered satisfactory for Ebola preparedness.
- Of the 947 HCFs assessed, 705 (74%) were classified as "Insufficient", 221 (23%) as "Partial", and only 21 (2%) met the "Satisfactory" threshold ($\geq 80\%$). Additionally, 248 facilities (26%) had reported at least one suspected or confirmed case, underscoring the urgency of addressing these IPC gaps.
- Across the 17 standardized IPC components assessed, the weakest areas were personal protective equipment (PPE) (11%), training (13%), isolation area set-up (17%), post-exposure management (23%), and cleaning and disinfection (25%), all of which were rated "Insufficient." Even the strongest-performing components – injection safety (75%), patient placement (72%), waste treatment (65%), sterilization (58%), and water supply (52%) – remained within the "Partial" category, indicating that no IPC component had yet reached the standard required for adequate Ebola response readiness at the national level.
- Healthcare worker infections continued to increase, with 123 infections and 37 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.
- In response to these findings, WHO and partners continued to scale up IPC/WASH interventions across affected areas. More than 1,000 frontline health workers, supervisors, hygienists, and members of safe and dignified burial (SDB) teams received IPC training. In addition, more than 450 IPC rings were activated, resulting in the decontamination of over 1,000 households and health facilities, the distribution of more than 130 IPC kits to health facilities, and over 450 assessments of exposed health workers. Furthermore, more than 115 screening and triage points were established, with over 500 supportive supervision and mentorship

visits conducted. IPC/WASH assessments were also completed at all eight Ebola treatment centres (ETCs).

- Safe and dignified burial (SDB) operations and decontamination activities continued across affected health zones, including the decontamination of households, health facilities, and transport vehicles linked to confirmed cases.

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 delay in intervention services (like SDB), insecurity in hotspot areas, limited community trust and acceptance in mining and conflict-affected communities, misinformation, and highly mobility of 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)

- National and provincial coordination mechanisms continued to strengthen strategic oversight, operational alignment, information sharing, and accountability across all levels of the response.
- PRSEAH activities were expanded through induction briefings, community awareness sessions, and training for response workers, healthcare personnel, community leaders, and transport workers across the affected provinces.
- Institutional capacity for PRSEAH was further strengthened through the launch of a Health Cluster capacity assessment in Ituri and specialized training, enhancing systems for reporting, referral, and the management of complaints related to sexual exploitation and abuse.

Public health preparedness

Operational Readiness

- Regional preparedness continued to improve during the reporting period. Since the previous update, one additional Member State completed and submitted its readiness assessment, increasing coverage from 30

to 31 of the 47 Member States (64% to 66%), while the overall assessment completion rate remained high at 90%. The average readiness score among Priority 1 and 2 countries remained 58%.

- Repeat readiness assessments expanded from three to six high-priority countries. In addition to Angola, South Sudan, and Tanzania, Kenya, Rwanda, and Zambia completed repeat assessments, demonstrating continued improvements in national preparedness capacities.
- Regional deployments to strengthen preparedness continued in high-risk Member States. During the reporting period, South Sudan was added to the list of countries receiving ongoing regional support, alongside Burundi, the Central African Republic, and the Democratic Republic of the Congo.

Border Health, Travel and Mass Gatherings

- Screening and public health measures have been reinforced at airports, high-risk border crossings, and internal transit routes in both the Democratic Republic of the Congo and Uganda. National authorities, the International Organization for Migration (IOM), and partners continue to support the implementation of WHO border health guidance, strengthen cross-border coordination, and facilitate the timely detection, reporting and referral of suspected cases at PoEs and PoCs along priority travel corridors.
- Cross-border preparedness and response are being strengthened through enhanced coordination among the Democratic Republic of the Congo, Uganda, and South Sudan to improve the early detection of cases and reduce the risk of cross-border spread. Priority actions include strengthening coordinated cross-border disease surveillance, event-based surveillance, active case finding, joint investigations and contact tracing where required, and real-time information sharing through regular cross-border coordination meetings and harmonized reporting mechanisms.
- Priority operational actions include rapid assessments and mapping of PoEs, strengthening surveillance along high-risk cross-border mobility corridors, including informal crossings, and major congregation points, and ensuring readiness capacities through the provision of trained personnel, equipment, PPE, referral mechanisms, disinfectants, risk communication materials and contingency plans for the safe management of suspected cases
- Mass gathering risk assessment capacity is being strengthened through training and technical support. 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 remains in an expansion phase despite an increasingly robust response. Persistently high mortality, frequent community deaths, delayed case detection, and suboptimal contact tracing continue to sustain transmission, while weak infection prevention and control in health facilities contributes to ongoing healthcare-associated transmission. Although response capacity has expanded substantially, including laboratory services, case management, logistics, and regional preparedness, further progress will depend on rapidly improving early case detection, achieving high-quality contact tracing, strengthening infection prevention and control, reducing community deaths through earlier access to treatment, and maintaining coordinated cross-border preparedness to prevent regional and international spread.

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