World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK
Democratic Republic of the Congo | Uganda | France
Weekly External Situation Report 14, Data as of 16 August 2026

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

6 Provinces **55** Health Zones Affected	**5** Provinces **47** Health Zones Active Transmission*	**1 061** Cases Recovered	**63.4%** Bed Occupancy	**19 630** Contacts under follow up
751 Active Cases in Isolation	**155** Health Worker Cases	**45** Health Worker Deaths	**1 184** Bed Capacity	**22** Testing Laboratories

Note: Health zones with active transmission have reported at least one case in the last 21 days.

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	640	367	5 021	2 378	-	-	5 021	2 378	47.4%
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.

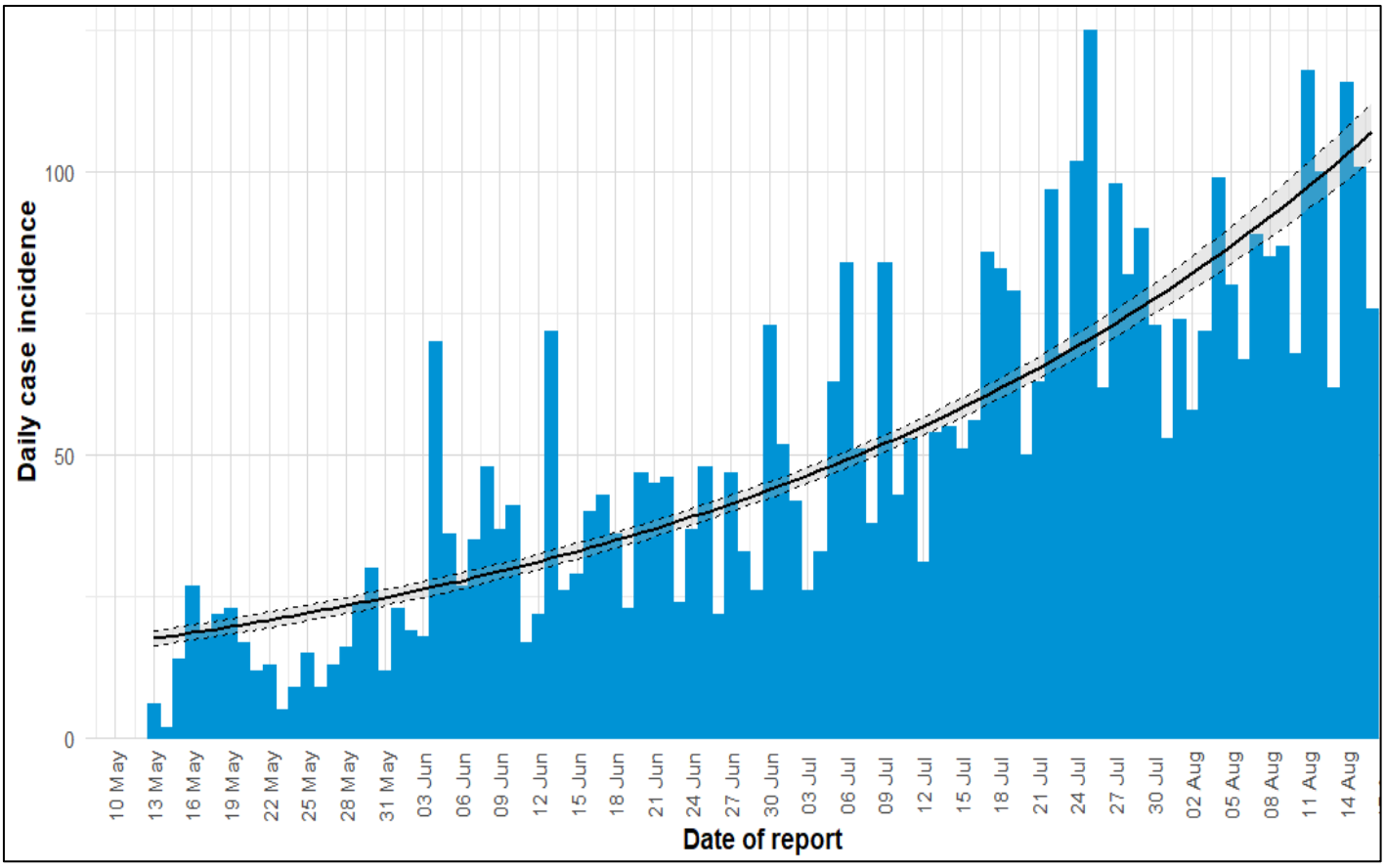
Event description

Democratic Republic of the Congo

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo has expanded to a sixth province, with the detection of a confirmed case in Bas-Uélé province in the north-east, indicating further geographic spread beyond the main transmission areas in the eastern part of the country. Since *External Situation Report #13*, an additional 640 confirmed cases and 367 confirmed deaths have been reported, reflecting continued sustained transmission and high mortality. The crude case fatality ratio (CFR) has increased from 45.9% to 47.4%, continuing the upward trend observed over several weeks.

As of 16 August 2026, a total of 5021 confirmed cases, including 2378 confirmed deaths have been reported across 55 health zones in six provinces. Buta health zone in Bas-Uélé province and Tshopo health zone in Tshopo province are the latest affected health zones. Ituri remains the epicentre, accounting for 84.8% of cumulative confirmed cases and 79.0% of cumulative confirmed deaths.

Figure 1. Daily growth trend in confirmed Bundibugyo virus disease cases in the Democratic Republic of the Congo, by date of report, as of 16 August 2026



During the most recent 21 days (27 July – 16 August 2026), a total of 1 759 confirmed cases and 941 confirmed deaths were reported nationally. Transmission remained concentrated in Ituri, which accounted for 1 356 cases (77.1%) and 671 deaths (71.3%), followed by Nord-Kivu with 293 cases (16.7%) and 224 deaths (23.8%), and Haut-Uélé with 101 cases (5.7%) and 42 deaths (4.5%).

Compared with the preceding 21-day period (6 – 26 July 2026), the number of newly reported cases increased by 121 (+7.4%), and deaths by 25 (+2.7%). However, trends varied substantially between provinces. In Ituri, newly reported cases and deaths declined by 68 (−4.8%) and 97 (−12.6%) respectively. In contrast Nord-Kivu reported an increase of 123 newly reported cases (+72.4%) and 101 deaths (+82.1%). Haut-Uélé recorded the largest relative increase, with 61 additional newly reported cases (+156.4%) and 21 additional newly reported deaths (+100.0%). Tshopo remained a smaller transmission focus, while the detection of a case and death in Bas-Uélé indicates further geographic expansion.

At the health-zone level, transmission remained geographically widespread. Of the 55 health zones affected since the start of the outbreak, 47 (85.5%) reported at least one confirmed case during the most recent 21 days. Eight health zones reported no new confirmed cases during this period: Adja, Ariwara, Boga and Kambala in Ituri; Goma in Nord-Kivu; Rungu in Haut-Uélé; Lubunga in Tshopo; and Miti-Murhesa in Sud-Kivu. Seven health zones reported confirmed

cases for the first time since the beginning of the outbreak: Gombari in Haut-Uélé, Lubero in Nord-Kivu, Bafwasende, Kabondo, Tshopo and Wanie-Rukula in Tshopo, and Buta in Bas-Uélé. This indicates continued geographic expansion, including into previously unaffected health zones.

Despite this expansion, transmission remains highly concentrated in a limited number of health zones. Bunia, Rwampara, Nizi, Katwa, Mongbwalu and Nia-Nia together reported 1186 cases during the most recent 21 days, , accounting for 67.4% of all cases reported nationally during this period.

The distribution of transmission is also changing. Cases increased substantially in Bunia (+80; +24.9%), Rwampara (+69; +31.5%) and Katwa (+63; +71.6%), while substantial relative increases were observed in Wamba (+31; +281.8%), Beni (+34; +226.7%), Fataki (+37; +246.7%) and Isiro (+18; +150.0%). Conversely, cases declined in established transmission foci such as Mongbwalu (−134; −61.5%) and Nizi (−97; −34.8%). Overall, the data indicate a redistribution of transmission, with declining activity in some established hotspots occurring alongside intensification in others and continued geographic expansion into new health zones.

Table 1. Bundibugyo virus disease confirmed cases and deaths by province across consecutive 21-day periods, 6 – 26 July 2026 compared with 27 July – 16 August 2026, Democratic Republic of the Congo

Province	Cases					Deaths				
	Cumulative cases	6 - 26 Jul	27 Jul - 16 Aug	Net change	Relative change	Cumulative deaths	6 - 26 Jul	27 Jul - 16 Aug	Net change	Relative change
Ituri	4 257	1 424	1 356	**-68**	**↓ -4.8%**	1 878	768	671	**-97**	**↓ -12.6%**
Nord-Kivu	607	170	293	**+123**	**↑ +72.4%**	428	123	224	**+101**	**↑ +82.1%**
Haut-Uélé	139	39	100	**+61**	**↑ +156.4%**	63	21	42	**+21**	**↑ +100.0%**
Tshopo	14	5	9	**+4**	**↑ +80.0%**	7	4	3	**-1**	**↓ -25.0%**
Sud-Kivu	3	0	0	**0**	**→ Stable**	1	0	0	**0**	**→ Stable**
Bas-Uélé	1	0	1	**+1**	**New**	1	0	1	**+1**	**New**
Democratic Republic of the Congo	**5 021**	**1 638**	**1 759**	**+121**	**↑ +7.4%**	**2 378**	**916**	**941**	**+25**	**↑ +2.7%**

Notes: Cumulative totals are as of 16 August 2026. Net change is the absolute difference between 27 July – 16 August and 6 – 26 July. Relative change is the net change expressed as a percentage of the preceding 21-day period. "New" indicates that no cases or deaths were reported during the preceding period, so a percentage change cannot be calculated.

Mortality remains high and varies substantial across affected areas. Ituri continues to account for the largest absolute burden, with 1878 cumulative confirmed deaths, representing 79.0% of all deaths nationally. However, the CFR is considerably higher in Nord-Kivu (70.5%), than in Ituri (44.1%) and Haut-Uélé (45.3%). This disparity was also evident

during the most recent 21 days, when Nord-Kivu accounted for only 16.7% of reported cases but 24.0% of reported deaths nationally.

At health-zone level, the largest numbers of deaths were reported from major transmission foci in Ituri, particularly Bunia, Rwampara and Mongbwalu. However, CFRs were substantially higher in several health zones in Nord-Kivu, including, Butembo (85.6%), Beni (75.8%) and Katwa (68.1%), compared with Bunia (29.8%), Rwampara (38.9%), and Mongbwalu (49.9%). These marked geographic variation indicate that mortality is not explained by transmission intensity alone and warrants further assessment of differences in case detection, timeliness of presentation and referral, community deaths, access to care and clinical management.

Mortality remains high both in the community and among patients in treatment facilities. During the past six weeks, an average of approximately 162 community deaths and 98 treatment facility deaths were reported each week. Community deaths accounted for approximately 60% of all confirmed deaths during this period. The high proportion of community deaths highlights persistent challenges in early case detection, referral and access to designated treatment facilities. Mortality among patients reaching treatment facilities may reflect late presentation and severe disease at admission, while further assessment is needed to determine the contribution of clinical management capacity, quality of care and patient vulnerabilities, including age, malnutrition and comorbidities. For the purposes of this report, community death refers to death occurring outside a designated Ebola treatment facility, including at home, in the community, or in another (non-Ebola) health facility.

Figure 3. Weekly proportion of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological week 26 – 33, 2026

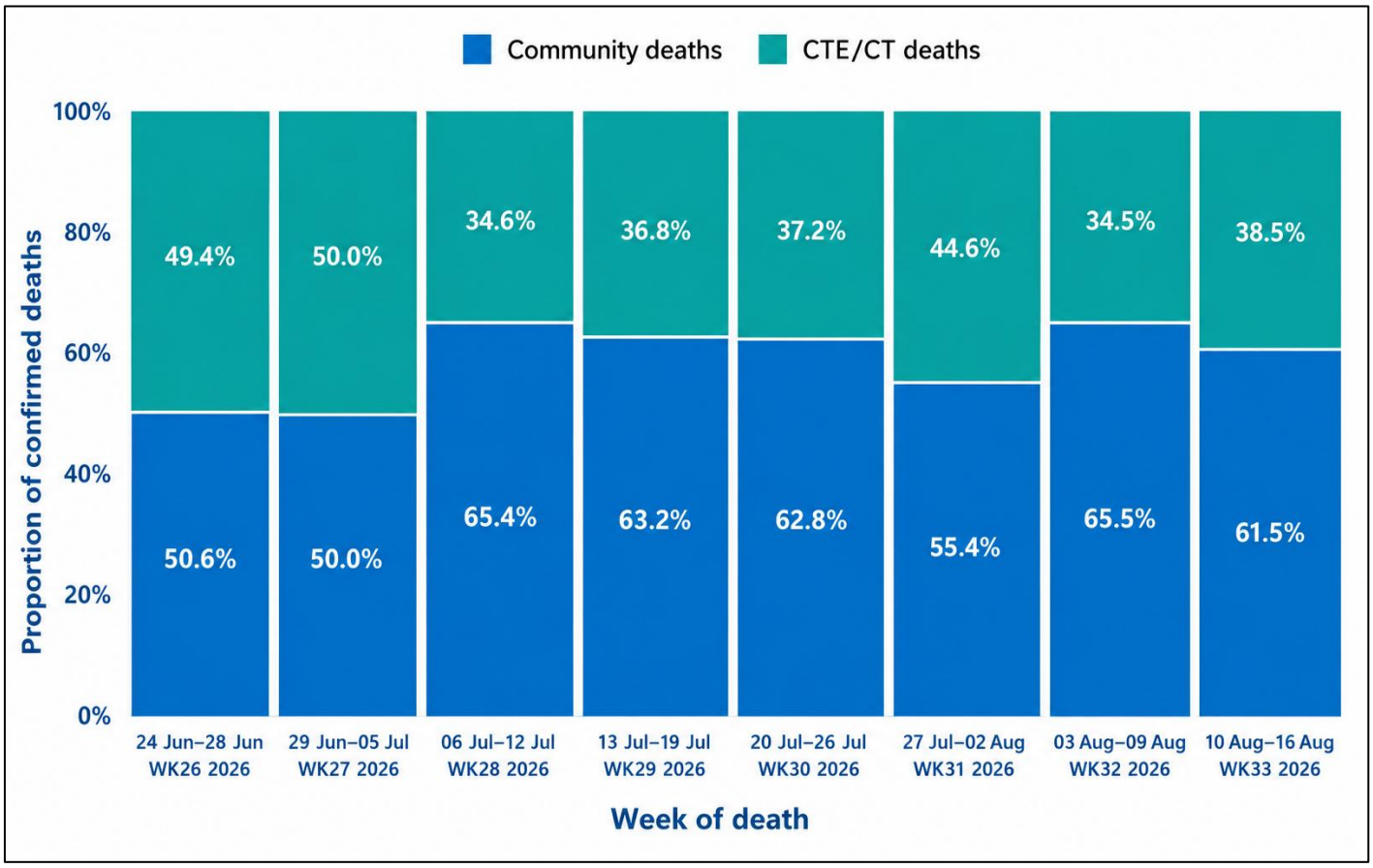
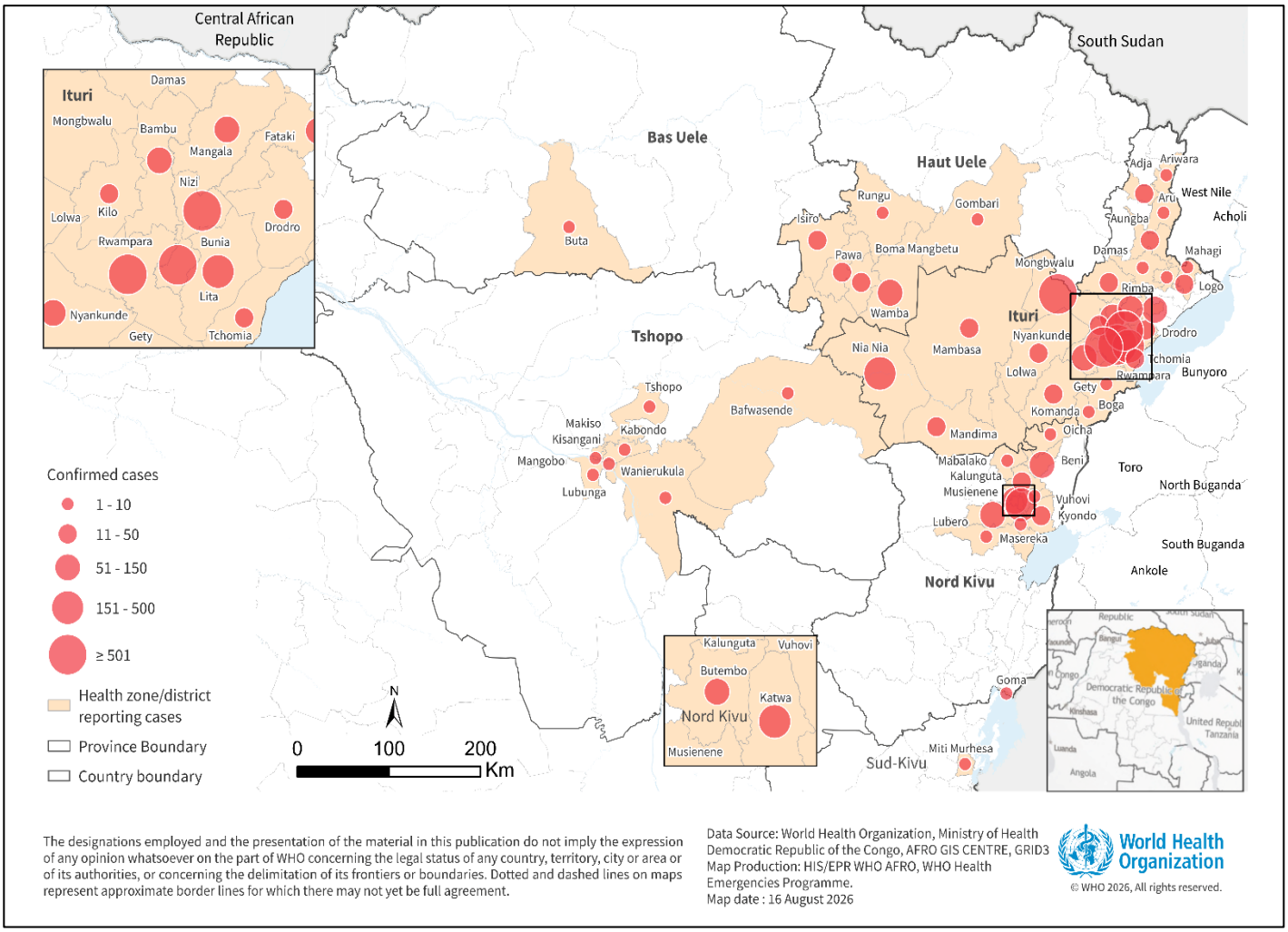
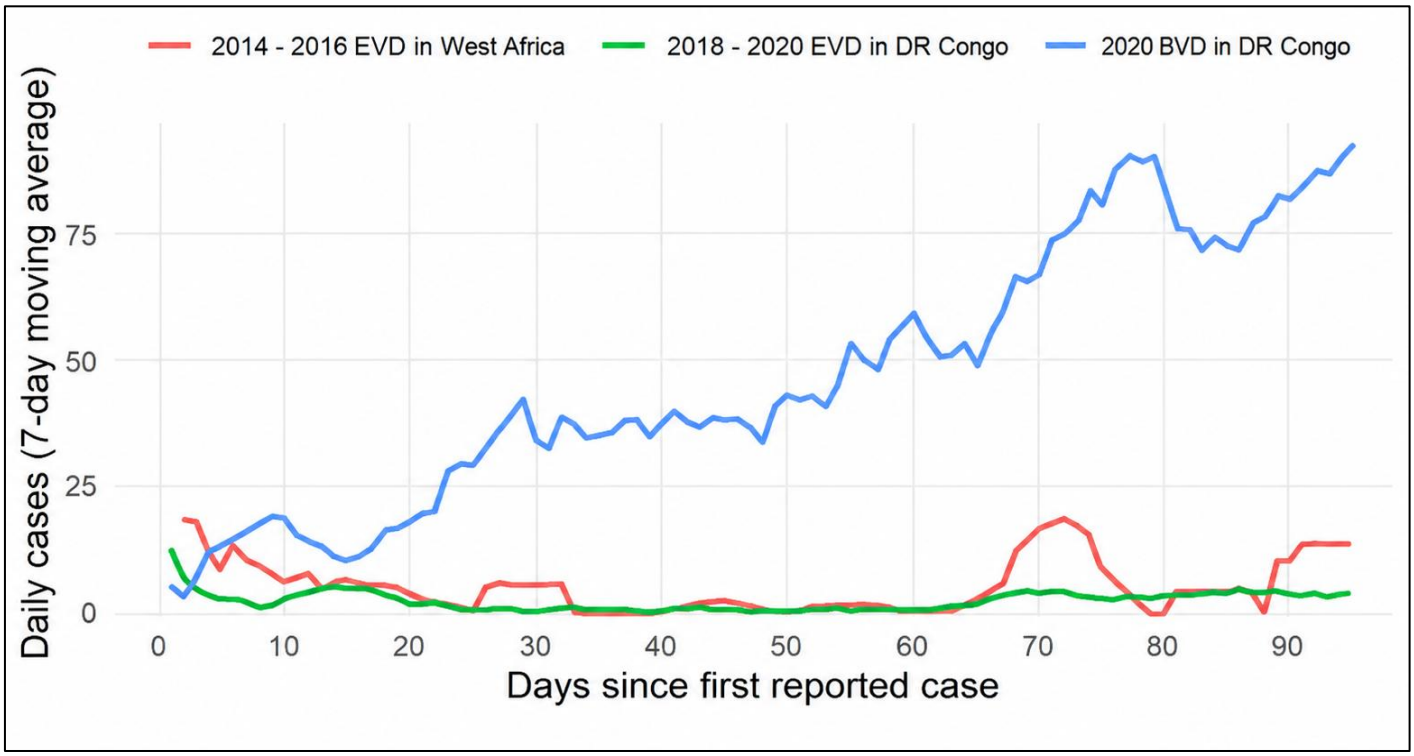


Figure 4. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 16 August 2026



The current BVD outbreak continues to follow a markedly different trajectory from previous major Ebola disease outbreaks. During the first 95 days of reporting, the 7-day moving average increased progressively, reaching more than 90 confirmed cases per day, substantially higher than the levels observed during comparable period of the 2014 – 2016 West Africa and 2018 – 2020 Democratic Republic of the Congo outbreaks. With 5 021 confirmed cases reported as of 16 August 2026, this has become the largest BVD outbreak ever recorded and the second-largest Ebola disease outbreak on record. The sustained high incidence and continued geographic expansion indicates that transmission remains intense and that the outbreak has not yet entered a clear declining phase.

Figure 5. Comparison of three major Ebola disease outbreak trajectories during the first 95 days of reporting using seven-day moving averages of the daily number of confirmed cases reported.



Uganda and France

Uganda has now recorded 31 consecutive days without a new confirmed BVD case since the last patient was discharged on 16 July 2026. All identified contacts have completed follow-up, with no further cases detected. The continued high level of transmission in neighbouring eastern Democratic Republic of the Congo, however, means that the risk of cross-border reintroduction remains.

France has reported no new confirmed BVD cases for 43 consecutive days since the imported case was discharged on 4 July 2026. This period is more than twice the maximum 21-day incubation period for BVD. No secondary transmission has been detected, and all five identified flight contacts completed follow-up without developing symptoms.

Risk Assessment

The risk of further geographic spread within the Democratic Republic of the Congo remains very high, while the risk of cross-border spread remains elevated. The detection of a case in Buta, Bas-Uélé and additional affected health zones in Tshopo, together with sustained transmission in highly mobile areas of Ituri, Nord-Kivu and Haut-Uélé, increases the potential for onward spread along major transport corridors. Tshopo, particularly the Kisangani transport hub, is of particular concern because of its connectivity with other parts of the country and the potential for longer-distance dissemination towards Kinshasa. Continued transmission in eastern and north-eastern Democratic Republic of the Congo also increases the likelihood of cross-border movements of infected persons. Uganda, South Sudan and the Central African Republic remain at particularly high risk of importation, given their geographic proximity to affected areas of the Democratic Republic of the Congo, established cross-border population movements and connectivity along major mobility corridors. Enhanced surveillance, information sharing, preparedness and cross-border coordination should therefore be maintained along priority mobility corridors and at points of entry.

Public health response

Coordination

- The WHO – Africa Centres for Disease Control and Prevention (Africa CDC) Continental Incident Management Support Team (IMST) in Kampala continued to support implementation of the Joint Continental Preparedness and Response Plan under the "One Response" approach, coordinating operational planning, information sharing, partner engagement and preparedness support to affected and high-risk countries. The joint plan covers June – November 2026 and provides the overarching framework for coordinated continental action.

- In the Democratic Republic of the Congo, coordination increasingly focused on decentralizing and adapting response operations to the expanding geographic footprint of the outbreak, with national and provincial coordination missions supporting priority areas in Nord-Kivu and Haut-Uélé and strengthening coordination along key transmission and population mobility corridors.

- Cross-border coordination was strengthened, including support for surveillance activities in the Grand Virunga area and the launch of a systematic assessment of points-of-entry (PoEs) and points-of-control (PoCs) operations across Ituri, Nord-Kivu, Haut-Uélé, Bas-Uélé and Tshopo, reflecting increased attention to risks associated with internal and cross-border population movement.

- WHO, Africa CDC and operational partners continued to support national and subnational response coordination, with increasing emphasis on aligning partner presence, technical support and resources with the evolving geographic distribution of transmission and emerging operational gaps. The United Nations Children's Fund (UNICEF), International Organization for Migration (IOM), Médecins Sans Frontières (MSF), Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Samaritan's Purse, European Union , Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams (EMTs), Health Cluster, and other partners continued to provide technical assistance, expert deployments, laboratory support, logistics, and field operations in affected and at-risk areas.

Operations Support and Logistics (OSL)

- The total emergency supply pipeline increased from US$11.35 million to US$12.69 million. The value of supplies delivered increased from US$4.26 million to US$4.42 million, although their share of the expanded pipeline declined from 38% to 35%. Supplies in transit decreased slightly from US$2.64 million to US$2.45 million, while commodities not yet ready for shipment increased substantially from US$4.45 million to US$5.83 million, representing 46% of the total pipeline.

- Approximately US$ 160 000 in additional supplies were delivered during the reporting period. Cumulative delivered cargo increased from 316.7 to 322.6 metric tonnes, while the delivered volume increased from 1787 to 1 844 cubic metres.

- Delivery of critical commodities to the Ituri and Kivu hubs continued. Cumulative deliveries included 66 974 hooded coveralls, more than 5.53 million examination gloves, 158 800 Level 3 gowns and 261 hospital beds, while diagnostic supplies included 20 016 RadiOne PCR tests and 4320 manual PCR tests. Approximately 2.19 million examination gloves and 25 100 hooded coveralls remained in transit.

- Personal protective equipment and infection prevention and control supplies remained the largest procurement

category, increasing from US$6.03 million to US$6.66 million. Laboratory supplies increased substantially from US$1.18 million to US$1.74 million, while medical equipment reached US$1.84 million, logistics supplies US$1.22 million and medicines US$0.89 million.

- Despite continued deliveries, overall pipeline readiness deteriorated as procurement requirements expanded. The value of commodities either in transit or not yet ready for shipment increased from US$7.09 million to US$8.28 million, representing 65% of the total pipeline, compared with 62% previously. International suppliers continue to account for the majority of procurement value, emphasizing the need to accelerate procurement, shipment and onward delivery as the response expands geographically.

Surveillance

- Surveillance activities continued across affected and at-risk areas, including active case finding, alert management and investigation, contact tracing, mortality surveillance, community-based surveillance, and surveillance at PoEs and PoCs.

- Alert volume decreased from 1426 on 9 August 2026 to 1067 on 16 August 2026 (-25.2%). However, investigation performance remained very high, with 99.3% (270/272) of validated suspected cases investigated on 16 August 2026. Of those investigated, 134 (49.6%) were transferred to treatment centres. Sud-Kivu province did not report alert data.

- The contact-tracing workload increased substantially, with the number of contacts under follow-up rising from 16 183 on 9 August 2026 to 19 630 on 16 August (+21.3%). Despite this increase, 82.2% (16 130/19 630) of contacts were seen, remaining below the 95% operational target. Follow-up performance was highest in Tshopo (100%), but remained lower in Haut-Uélé (83.8%), Ituri (82.4%), and Nord-Kivu (80.5%), and Bas-Uélé (18.9%).

- PoE and PoC screening volume nearly doubled, from 106 546 travellers on 9 August 2026 to 208 687 on 16 August (+95.9%), while screening coverage declined slightly from 98.0% to 96.4%. Seven alerts were detected. Overall, 87.9% (94/107) of designated PoEs/PoCs were operational, although functionality remained particularly low in Tshopo (35%).

Laboratory

- Diagnostic capacity continued to expand and become increasingly decentralized, with the laboratory network supporting testing across the expanding geographic footprint of the outbreak. Deployment and operationalization of additional testing capacity continued in priority transmission areas, including Ituri and Haut-Uélé.

- Laboratory workload remained high, with continued detection across multiple affected provinces. On 16 August 2026, 404 samples were analyzed across Ituri, Nord-Kivu, Haut-Uélé and Tshopo, of which 76 were positive (18.8%). Ituri accounted for 63 (82.9%) of all positive results, with a positivity rate of 25.4%, compared with 7.6% in Nord-Kivu, 12.5% in Haut-Uélé and 25.0% in Tshopo

- Genomic surveillance continued, building on more than 400 Bundibugyo virus genomic sequences generated and shared through open-access databases to support the monitoring of viral evolution and transmission dynamics.

- Despite the expansion of diagnostic capacity, operational gaps persisted, particularly in specimen transport,

timely return of results, laboratory reporting and data integration, underscoring the need to ensure that decentralized testing capacity keeps pace with the geographic expansion of transmission. In parallel, continued attention is needed to maintain adequate diagnostic stock levels, as procurement and replenishment timelines are affected by upstream manufacturing and supply-chain constraints.

Case Management

- Demand for clinical care remained high as transmission continued and expanded geographically. As of 16 August 2026, 751 patients were in isolation or receiving care nationally. The latest consolidated capacity assessment, conducted on 12 August 2026, identified 33 operational treatment and transit facilities with 1184 active beds, indicating substantial overall capacity.

- Localized capacity constraints persisted despite the overall availability of beds. Several facilities in Ituri remained saturated, while beds designated for suspected cases in Nord-Kivu reached 100% occupancy. Major geographic gaps also remained, particularly in Haut-Uélé, where no standardized Ebola treatment centre was operational across the six affected health zones, and in Tshopo, where treatment capacity remained limited.

- Referral and patient transport remained important constraints, with insufficient ambulance capacity reported across several affected provinces. These limitations are increasingly important as transmission expands into areas with less-developed treatment infrastructure.

- Cumulative recoveries increased from 869 on 9 August 2026 to 1061 on 16 August 2026, representing an additional 192 recoveries during the reporting period despite continued pressure on case management services.

Research and Development

- Clinical research on therapeutics continued to expand in the Democratic Republic of the Congo. The WHO-sponsored PARTNERS platform trial is evaluating MBP134, remdesivir and their combination for the treatment of confirmed BVD, with enrolment continuing across five study sites. The trial is coordinated by the National Institute for Biomedical Research (INRB), the Institute of Tropical Medicine Antwerp and the University of Oxford, with WHO sponsorship and support from Africa CDC and other partners.

- WHO's therapeutics advisory group has prioritized obeldesivir for clinical evaluation as post-exposure prophylaxis. The EBO-PEP study continued to evaluate oral obeldesivir as post-exposure prophylaxis for high-risk contacts and the administration of remdesivir in children, as well as in pregnant and breastfeeding women who have had high-risk exposure, with efforts underway to expand enrolment through more flexible delivery approaches.

- The MBOTE natural history study has commenced, expanding evidence generation on the clinical presentation, progression and outcomes of BVD and complementing ongoing interventional therapeutic studies.

- BVD vaccine development progressed from trial initiation to vaccination of trial participants. The University of Oxford's Phase I BD-Ebov trial of the ChAdOx1 BDBV vaccine is evaluating safety and immune responses in 50 healthy adults aged 18 – 55 years. The first participant was vaccinated on 24 July 2026, and recruitment and vaccination are continuing. Approximately 620 000 doses have been manufactured and stockpiled by the Serum Institute of India, including 4000 investigational doses supplied for clinical evaluation. Preparations for additional studies in Uganda are continuing, subject to regulatory approval. Phase 1 trials for Moderna's

candidate BVBD vaccine, mRNA-1469, began in Canada on 4 August 2026. WHO guidance continues to state that the licensed ERVEBO vaccine should not be used programmatically for BVD, as available evidence is insufficient to establish meaningful cross-protection against Bundibugyo virus. Evaluation of potential cross-protection therefore remains a research question rather than an established response intervention.

- WHO has published a target product profile for BVD vaccines, alongside technical guidance to support candidate prioritization, clinical evaluation and potential future emergency use.

- Operational research continued in affected areas, including studies on laboratory result turnaround times, decision-making processes, and social and behavioural factors, with increasing emphasis on translating findings into response operations.

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

- IPC capacity continued to be strengthened across affected areas, including expansion of IPC ring interventions, decontamination capacity, supportive supervision, and provision of IPC supplies. However, implementation remained uneven, particularly in areas experiencing intense or expanding transmission.

- Capacity for safe and dignified burials (SDBs) continued to expand in response to the high number of deaths, with burial teams operating across affected provinces and additional personnel being trained and deployed. However, the ability to translate this increased capacity into timely SDB coverage remained constrained by community resistance, insecurity, operational limitations and difficulties accessing some affected communities.

- Healthcare worker infections remain a major concern, with the latest consolidated data indicating 155 confirmed infections, including 45 deaths, among healthcare workers. While some of these infections have occurred in the community, the continued burden of occupational infections highlights persistent risks of healthcare-associated transmission and the need to strengthen triage, appropriate use of PPE, adherence to IPC standards, and investigation and management of occupational exposures.

- Important IPC gaps persist, including insufficient teams and supplies in some locations, variable adherence to IPC standards, and low IPC performance in some health facilities. These gaps are increasingly important as the outbreak expands into areas with more limited IPC capacity and response infrastructure.

Risk Communication and Community Engagement (RCCE)

- RCCE activities continued to expand across affected provinces, supporting early case detection, contact tracing, timely care-seeking, safe and dignified burials, and acceptance of response measures.

- Engagement of high-risk and mobile populations increased, including outreach to motorcycle-taxi associations in Nord-Kivu and targeted household and community activities in affected areas.

- RCCE expanded into newly affected areas, including Tshopo, through household engagement, local team training, radio programmes and community sensitization.

- Community feedback and trusted local networks continued to guide response activities, helping to address misinformation and improve acceptance of surveillance, referral and burial interventions.

- Mistrust and resistance remain important challenges, including refusals of safe burials, post-mortem sampling and decontamination, underscoring the need for sustained trust-building and locally adapted engagement.

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

- PRSEAH safeguarding remained integrated across the BVD response, with an emphasis on government-led coordination, workforce protection, safe reporting mechanisms, survivor-centred referrals, and sexual exploitation, abuse and harassment (SEAH) risk mitigation as response operations expand geographically.

- Government leadership and coordination were strengthened through a three-day workshop that brought together key institutions and technical partners to update the national PRSEAH response plan, harmonize approaches, and strengthen implementation and follow-up arrangements.

- Safeguarding was further embedded within frontline response structures through continued capacity-building for community outreach workers, volunteers, and PRSEAH focal points within rapid response teams.

- Community-level prevention and reporting capacity was reinforced through engagement with community leaders and the provision of practical communication materials, including megaphones and French- and Swahili-language materials, to increase awareness of SEAH risks and facilitate access to safe reporting channels.

Public health preparedness

Operational Readiness

- From 14 – 15 August 2026, WHO, Africa CDC, and the Economic and Monetary Community of Central Africa (CEMAC) convened a meeting in Bangui, Central African Republic to advance a regional coordination mechanism for strengthening cross-border preparedness, involving the Central African Republic, Democratic Republic of the Congo, Republic of the Congo, South Sudan and Uganda. Countries identified priority risk corridors and developed a draft multi-country collaboration framework and operational plan
- Regional preparedness continued to improve during the reporting period. A total of 31 WHO African Region Member States have completed and submitted their readiness assessment, increasing coverage to 66%.
- A total of eight high-priority countries have completed repeat readiness assessments, demonstrating continued improvements in national preparedness capacities. These include Angola, Central African Republic, South Sudan, Tanzania, Kenya, Republic of Congo, Rwanda, and Zambia.
- Regional deployments to strengthen preparedness continued in affected and high-risk Member States. These include Burundi, Central African Republic, Democratic Republic of the Congo, and South Sudan.

Border Health, Travel and Mass Gatherings

- Screening and public health measures have been reinforced at airports, high-risk border crossings, major ports and internal transit routes in the Democratic Republic of the Congo and Uganda. National authorities, 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, the Central African Republic 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

- The postponement of mass gatherings is advised in areas with documented BVD transmission until transmission is interrupted. 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 is evolving into a more geographically dispersed emergency, with persistent transmission in established hotspots occurring alongside intensification in other areas and continued seeding of new locations. The combination of very high mortality, substantial deaths outside designated treatment facilities, increasing surveillance workload and uneven response capacity suggests that current interventions are not yet achieving sufficient speed, coverage or intensity to interrupt transmission. The response should therefore be increasingly risk-informed and geographically differentiated, with the intensity and combination of interventions adapted to local transmission patterns and operational gaps, while simultaneously establishing sufficient response capacity ahead of transmission in newly affected and high-risk areas. Given increasing connectivity between affected areas and major population-movement corridors, stronger interprovincial and cross-border surveillance and preparedness are also critical to prevent further geographic spread.

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