World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK
Democratic Republic of the Congo
Weekly External Situation Report 21, Data as of 04 October 2026

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

7 Provinces **64** Health Zones Affected	**6** Provinces **46** Health Zones Active Transmission*	**2 235** Cases Recovered	**58.2%** Bed Occupancy	**30 973** Contacts under follow up
896 Active Cases in Isolation	**245** Health Worker Cases	**47** Health Worker Deaths	**1 539** Bed Capacity	**26** Testing Laboratories

Note: Health zones with active transmission have reported at least one case in the last 21 days. Active cases in isolation include both suspected and confirmed cases.

Summary of Bundibugyo Virus Disease cases by country of reporting

Country	New Confirmed Cases (Last 7 days)	New Confirmed Deaths (Last 7 days)	Confirmed Cases (Total)	Confirmed Deaths (Total)	CFR (%) Confirmed	Status
Democratic Republic of the Congo	487	224	8 603	4 148	48.2%	Active
Kenya	1	1	1	1	100.0%	Active

Event description

The ongoing Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo has now extended to Kenya, the fourth country affected during the current outbreak, following earlier detections in Uganda and France, where the events have since been controlled. Kenya has reported its first confirmed case and associated death in a traveller arriving from the Democratic Republic of the Congo. This latest development further underscores the regional and international dimensions of the outbreak and the continuing risk of cross-border spread.

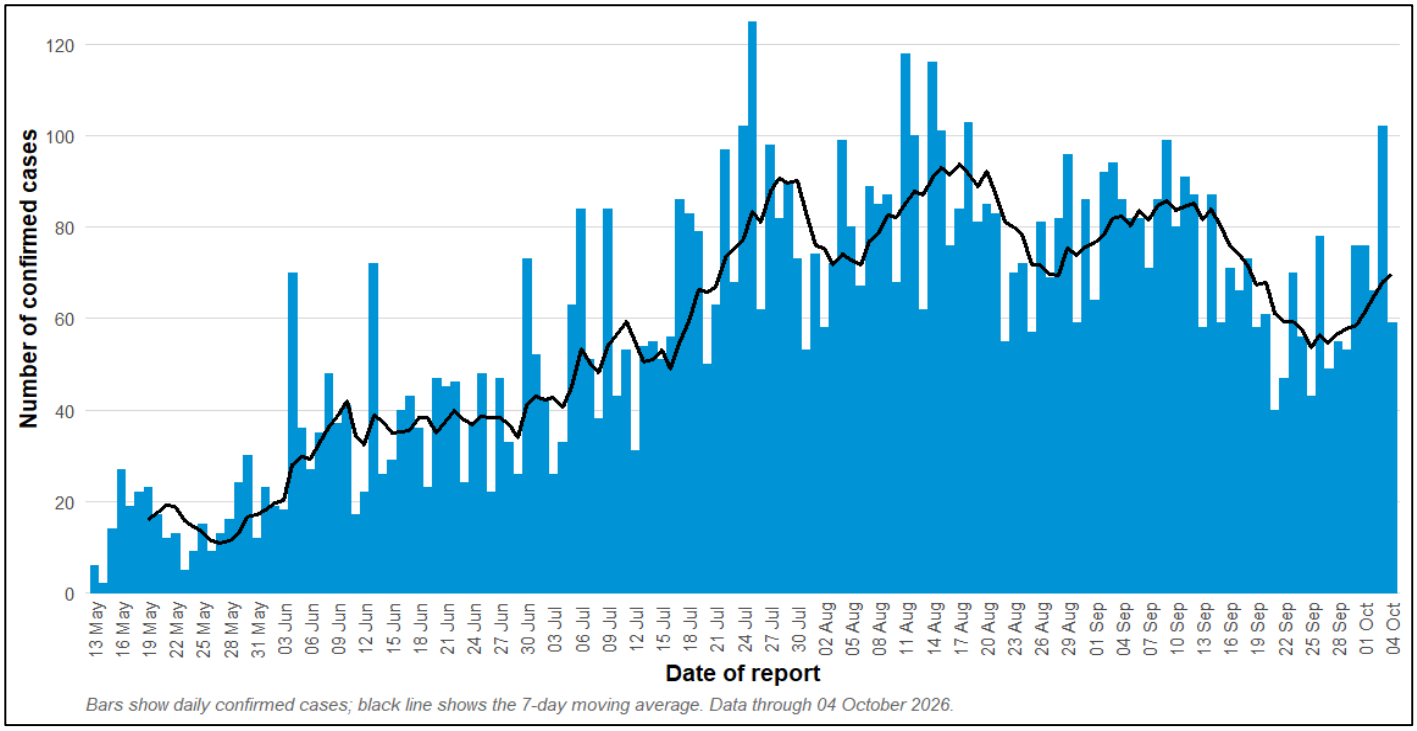
Democratic Republic of the Congo

The BVD outbreak in the Democratic Republic of the Congo continues to expand geographically, with Alimbongo Health Zone in Nord-Kivu Province becoming the latest affected health zone, bringing the total number affected since the start

of the outbreak to 64 health zones across seven provinces. Transmission remains increasingly heterogeneous across affected provinces and health zones. In the last week ending 4 October 2026, a further 487 confirmed cases and 224 confirmed deaths were reported, increasing the cumulative total to 8603 confirmed cases, including 4148 deaths [crude case fatality ratio (CFR): 48.2%]. Ituri remains the principal focus, although its relative contribution continues to decline, accounting for 75.0% of cumulative confirmed cases, while substantial transmission continues in Nord-Kivu and persists in Haut-Uélé.

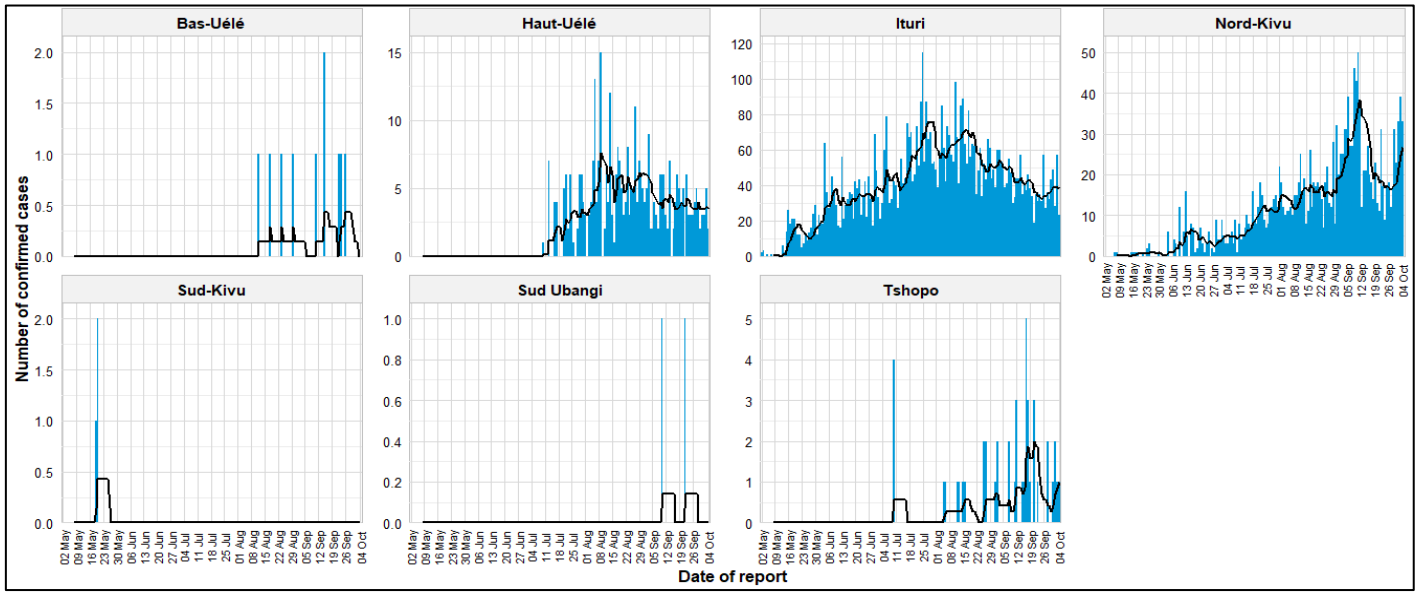
At the national level, daily incidence remains high and fluctuating, with the seven-day moving average rising again in early October following a decline through the second half of September. This pattern continues to mask divergent provincial trajectories. Ituri has declined substantially from its late-July/early-August peak but shows a recent upturn, while Nord-Kivu has rebounded sharply after a temporary decline from its mid-September peak. Transmission in Haut-Uélé remains sustained but below its August peak, while Tshopo continues to report intermittent activity from a low baseline. Bas-Uélé and Sud-Ubangi report sporadic cases, with no recent transmission evident in Sud-KivuOverall, the epidemic remains geographically heterogeneous, with the recent national rebound driven particularly by renewed transmission in parts of Ituri and Nortrd-Kivu.

Figure 1. Daily national trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 04 October 2026



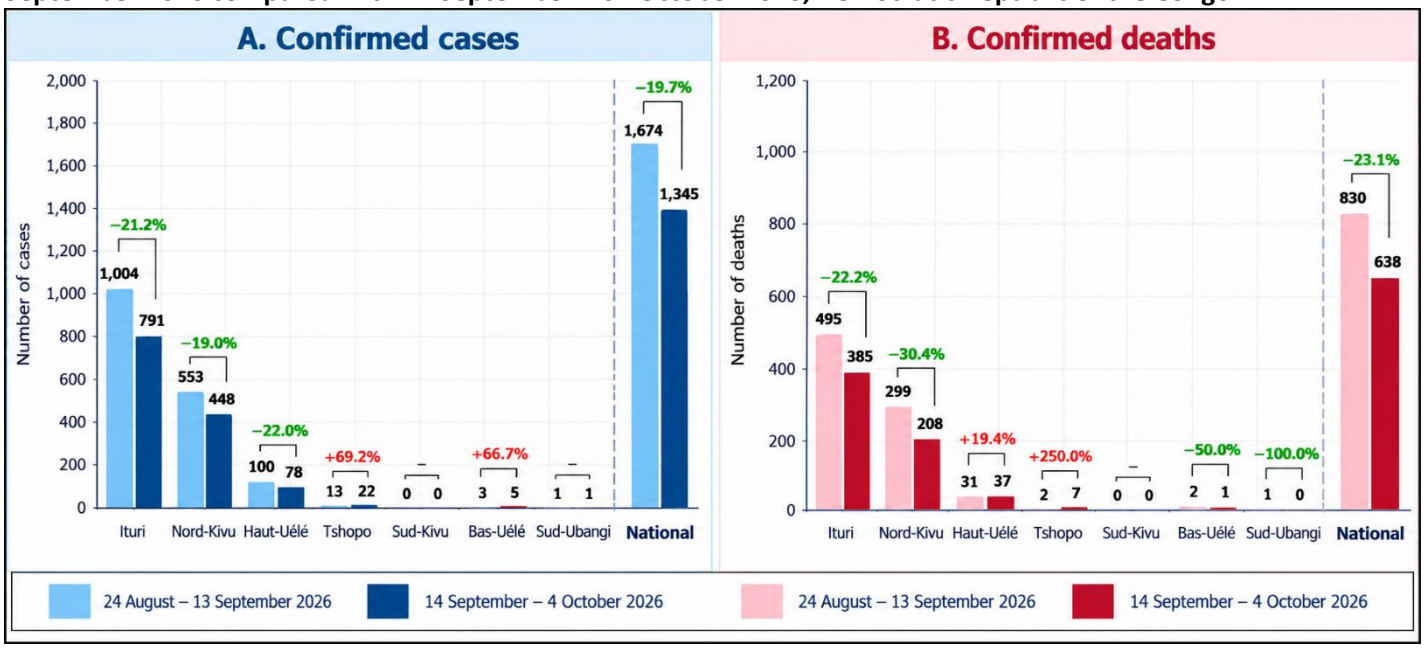
During the most recent 21 days (14 September – 4 October 2026), a total of 1345 confirmed cases were reported nationally, compared with 1674 cases during the preceding 21 days (24 August – 13 September), representing a decrease of 329 cases (−19.7%). Cases declined in the three principal transmission provinces: from 1004 to 791 (−21.2%) in Ituri, 553 to 448 (−19.0%) in Nord-Kivu, and 100 to 78 (−22.0%) in Haut-Uélé. Consequently, Ituri accounted for 58.8% of cases reported during the latest period and Nord-Kivu for 33.3%, compared with 60.0% and 33.0%, respectively, during the preceding period. However, the overall 21-day decline masks a recent reversal in trajectory, with cases increasing again during the latest week, particularly in Ituri and Nord-Kivu. The decline over the longer comparison period should therefore be interpreted cautiously and does not yet indicate sustained epidemic contraction.

Figure 2. Daily provincial trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 04 October 2026



During the same period, 638 confirmed deaths were reported nationally, compared with 830 deaths during the preceding 21 days, representing a decrease of 192 deaths (−23.1%). Deaths declined from 495 to 385 (−22.2%) in Ituri and from 299 to 208 (−30.4%) in Nord-Kivu. In contrast, deaths increased from 31 to 37 (+19.4%) in Haut-Uélé, while Tshopo reported seven deaths compared with two during the preceding period. Consequently, Ituri accounted for 60.3% of deaths during the latest period and Nord-Kivu for 32.6%, compared with 59.6% and 36.0%, respectively, during the preceding period. However, as with cases, the overall 21-day decline masks a recent reversal in trajectory, with reported deaths increasing again during the latest week.

Figure 3. Bundibugyo virus disease cases and deaths by province across consecutive 21-day periods, 24 August – 13 September 2026 compared with 14 September – 04 October 2026, Democratic Republic of the Congo

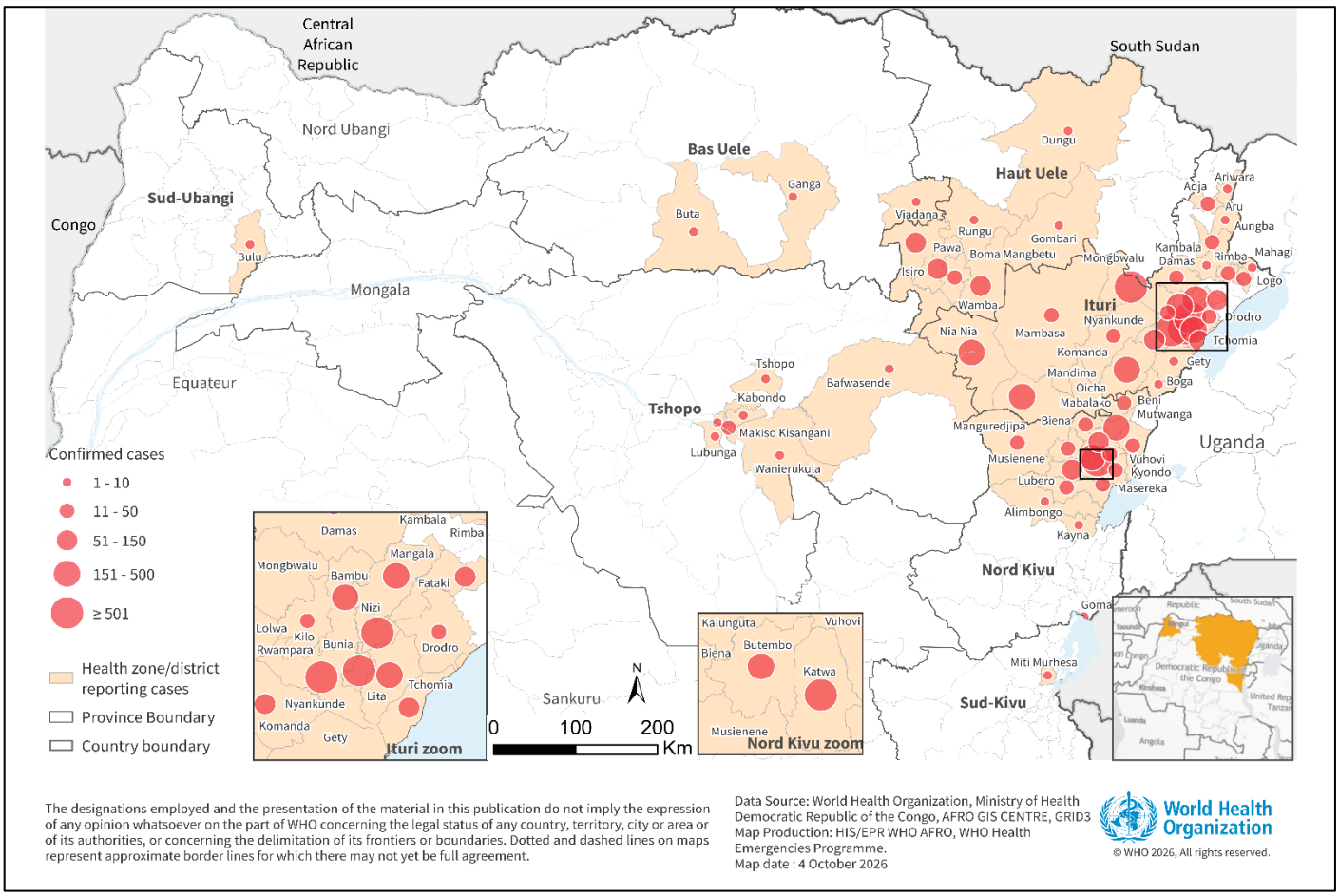


Transmission remained active in nearly three-quarters of all health zones affected since the start of the outbreak. Of the 64 health zones affected to date, 46 reported at least one new confirmed case in the last 21 days. Encouragingly, 18 health zones have not reported a new confirmed case in the last 21 days. These include Adja, Aru, Ariwara, Aungba, Boga, Drodro, Kambala, Logo and Mahagi in Ituri; Goma in Nord-Kivu; Gombari in Haut-Uélé; Bafwasende, Lubunga, Tshopo and Wanie-Rukula in Tshopo; Miti-Murhesa in Sud-Kivu; and Buta and Ganga in Bas-Uélé.

Provincial trends continue to mask important differences between health zones. In Ituri, the most pronounced increase occurred in Mandima, where cases rose from 15 to 129 (+760.0%), while Mambasa increased from 3 to 20 and Nia-Nia from 46 to 72 (+56.5%). In contrast, cases declined in several established transmission hotspots, including Bunia, from 285 to 196 (−31.2%), Nizi, from 120 to 54 (−55.0%), Mangala, from 116 to 52 (−55.2%), Lita, from 65 to 32 (−50.8%), and Komanda, from 76 to 40 (−47.4%). Rwampara remained a major focus despite a more modest decline, from 106 to 95 cases (−10.4%).

Nord-Kivu showed continued broad-based intensification, with Beni increasingly driving transmission. Cases in Beni increased from 111 during the preceding 21 days to 165 during the most recent period (+48.6%), while Butembo declined from 101 to 41 (−59.4%) and Musienene from 46 to 22 (−52.2%). Katwa also declined substantially, from 175 to 77 cases (−56.0%), although it remained an important focus of transmission. Haut-Uélé declined overall, driven largely by a sharp reduction in Isiro (−82.8%), while transmission remained relatively stable in Wamba and Pawa. However, the first case in Dungu indicates continued geographic expansion despite the provincial decline.

Figure 4. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 04 October 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.

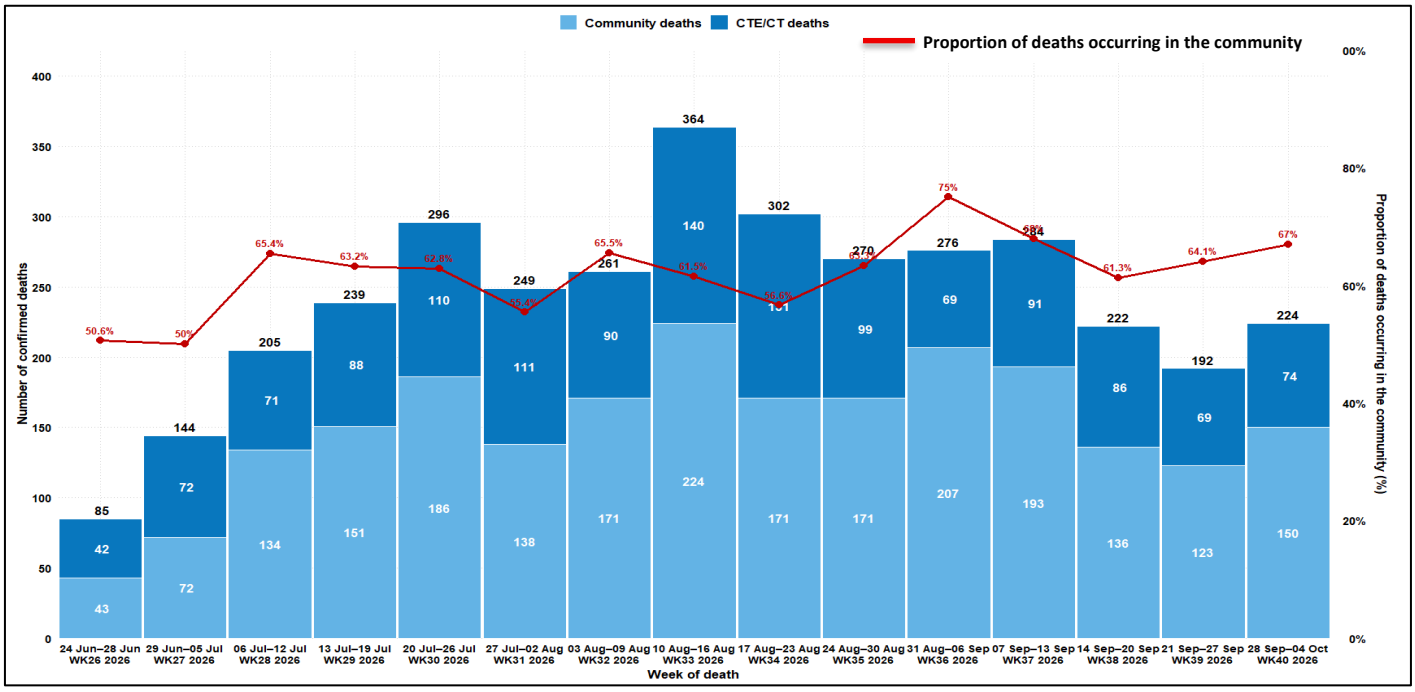
Data Source: World Health Organization, Ministry of Health Democratic Republic of the Congo, AFRO GIS CENTRE, GRID3
Map Production: HIS/EPR WHO AFRO, WHO Health Emergencies Programme.
Map date : 4 October 2026

World Health Organization

© WHO 2026, All rights reserved.

Weekly confirmed deaths generally declined after peaking at 364 in mid-August, reaching 192 during 21–27 September. However, this trend reversed in the latest week, with deaths increasing by 16.7% to 224 during 28 September–4 October. The latest increase occurred in both settings, with community deaths rising from 123 to 150 (+22.0%) and deaths in treatment facilities increasing from 69 to 74 (+7.2%). Consequently, the proportion of deaths occurring in the community increased from 64.1% to 67.0%, continuing an upward trend from 61.3% during 14 – 20 September. The latest increase in both community and facility deaths indicates a reversal of the declining mortality trend observed during the preceding weeks, with two-thirds of confirmed deaths continuing to occur in the community.

Figure 5. Weekly number of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological week 26 – 40, 2026



Kenya

A confirmed case of BVD has been reported in Kenya. The case is a 40-year-old Kenyan male and resident of the Democratic Republic of the Congo. Preliminary investigations indicate that he travelled from Buta in Bas-Uélé Province to Kisangani, Tshopo Province, arriving on 20 September 2026, where symptom onset was reportedly noted. He subsequently travelled to Beni, Nord-Kivu Province, on 1 October, stayed overnight, and continued by road to Kampala, Uganda, on 2 October. After an overnight stay in Kampala, he travelled by air from Entebbe, Uganda to Nairobi, Kenya on 3 October 2026, arriving at approximately 13:10, and proceeded directly to a healthcare facility accompanied by family members, where he was isolated. He presented with fever, chills, intense fatigue and weakness, muscle pain, painful swallowing, sore throat, and bleeding under the skin at injection sites. Samples collected on 3 October tested positive for Bundibugyo virus at the National Virology Reference Laboratory of the Kenya Medical Research Institute (KEMRI), with laboratory confirmation reported on 5 October 2026. He died later that day while undergoing care. Safe and dignified burial has been conducted.

A total of 28 contacts, including family members and healthcare workers, have so far been listed. An additional 23 passengers and crew members who travelled on the same flight as the case from Kampala, Uganda, to Nairobi, Kenya,

are being traced. Contacts already identified are being quarantined while further investigations are ongoing to establish the detailed travel itinerary of the case and identify all persons who may have been exposed in the Democratic Republic of the Congo, Uganda, and Kenya.

Risk Assessment

The risk of further spread remains very high within the Democratic Republic of the Congo, reflecting sustained transmission, continued geographic expansion, high mortality, population mobility, insecurity and persistent response challenges. The risk is considered high for neighbouring countries sharing land borders with the Democratic Republic of the Congo and low elsewhere in Africa and globally. The second IHR Emergency Committee, convened on 18 August 2026, also reviewed the evolving situation and emphasized that the outbreak remains far from controlled, and continues to constitute a Public Health Emergency of International Concern.

Public health response

Coordination

- Joint WHO–Africa CDC–partner coordination continues through the Continental Incident Management Support Team (CIMST), with increasing emphasis on translating health-zone intelligence into coordinated field action. Current priorities include strengthening the response in North Kivu while maintaining response capacity in Ituri, with attention to staffing, community linkages and other operational gaps.

- The CIMST has planned an intra-action review and revision of the continental response plan. The process is intended to assess collective response performance, identify gaps and lessons, strengthen accountability and reassess preparedness in high-risk and currently unaffected areas.

- At country level, the Government of the Democratic Republic of the Congo has adopted a revised 180-day multisectoral response plan, providing the operational framework for the next six months. The plan prioritizes surveillance and contact tracing, clinical care, community engagement and risk communication, logistics, and preparedness in at-risk areas, with implementation requirements estimated at US$1.3 billion.

- A broad network of partners continues to support implementation across affected and at-risk areas, including UNICEF, International Organization for Migration (IOM), Médecins Sans Frontières (MSF), Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Samaritan's Purse, the European Union, Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams and StandBy partners, supporting field operations, laboratories, logistics and specialist deployments.

Operations Support and Logistics (OSL)

Response workforce / deployments

WHO continues to maintain a substantial operational footprint to support the evolving outbreak response, with 341 personnel actively deployed as of 4 October 2026. An additional 33 personnel are in the deployment pipeline to reinforce and sustain response capacity. The AVoHC-SURGE roster is also supporting the response, with 37 members currently deployed in the Democratic Republic of the Congo.

Supply Chain Management

- The emergency supply pipeline stands at US$15.91 million across 93 procurement requests and 2311 procurement lines. Of the total value, US$6.17 million (39%) has been delivered, US$1.69 million (11%) is in

transit, US$5.25 million (33%) is not yet ready, while US$1.13 million (7%) is being arranged for shipment.

- Cumulative delivered cargo has increased to 450.2 metric tonnes and 2,683.2 m³, with a total delivered value of US$6.17 million. The value of delivered supplies increased by approximately US$0.38 million, from US$5.79 million to US$6.17 million.

- Critical commodities delivered to the Ituri and Kivu hubs include 95 425 hooded coveralls, 8.83 million examination gloves, 158 800 Level 3 gowns, 477 hospital beds, 10 076 infrared thermometers, 8640 manual PCR tests and 20 016 RadiOne PCR tests. The in-transit pipeline includes a further 31 119 coveralls, 901 000 examination gloves, 87 800 Level 3 gowns and 284 hospital beds.

- Personal protective equipment (PPE) and infection prevention and control supplies remain the largest procurement category, valued at US$6.86 million, followed by laboratory supplies (US$2.80 million), medical equipment (US$2.74 million), logistics (US$1.69 million), medicines (US$1.28 million) and medical consumables (US$0.53 million).

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 points of entry (PoEs) and points of control (PoCs).

- From 28 September – 4 October, a total of 17 005 alerts were reported, averaging 2429 alerts per day, an increase of 14.7% from 14 830 (2119 per day) during the preceding week. Alert verification remained high but declined from 96.4% to 92.5% (15 738 / 17 005). Of 2857 validated suspected cases, 2835 (99.2%) were investigated, improving from 97.1% in the preceding week. Among those investigated, 1485 (52.4%) were isolated and transferred, broadly unchanged from 51.2% previously. Overall, alert reporting and investigation remained strong despite the increased alert volume; however, timely isolation and referral remains the principal weakness in the alert-management cascade, with only about half of investigated suspected cases isolated and transferred.

- From 28 September – 4 October, the contact-tracing workload remained high but broadly stable, with an average of 30 906 contacts requiring daily follow-up, compared with 31 188 during 21 – 27 September, a slight decrease of 0.9%. Average follow-up performance also remained largely unchanged but low, decreasing slightly from 79.0% to 78.5%. As of 4 October, a total of 30 973 contacts were under follow-up, of whom 24 673 (79.7%) were seen. Overall, the sustained high workload alongside follow-up coverage of below 80% indicates persistent gaps in contact-tracing performance, with approximately one in five contacts not reached each day during the latest week.

- At points of entry (PoEs) and points of control (PoCs), 234,857 travellers were recorded on 4 October, of whom 96.8% were screened. Three alerts were detected, all in Ituri; one was validated as a suspected case, investigated and transferred to a treatment centre (100%), while the other two were isolated and subsequently invalidated following secondary screening. Overall reporting completeness was 94.9%, ranging from 93.3% in Ituri and 95.2% in Nord-Kivu to 100% in Tshopo. All strategic PoEs/PoCs included in the reporting system were reported as functional, although the Butuhe PoC in Nord-Kivu remained non-functional following a security incident on 26 September.

Laboratory

- Diagnostic capacity remains substantially expanded and decentralized, from two laboratories at the onset of the

outbreak to 26 active laboratories, including ten primarily using open RT-PCR platforms and 16 using RadiOne near-point-of-care PCR platforms, with a combined reported testing capacity of more than 4700 samples per day. Decentralized testing is operational across the principal affected provinces, including laboratory capacity in Bas-Uélé, where samples are now being analysed at the laboratory in Buta. Further expansion of laboratory and diagnostic-platform capacity remains planned.

- Laboratory validation of candidate BVD diagnostics under the BRIDGE-Access initiative is ongoing at the Institut National de Recherche Biomédicale (INRB) in Kinshasa, following its initiation on 14 September. The work is evaluating BDBV-specific and broader filovirus assays, including near-point-of-care diagnostics, to generate the clinical evidence required to inform future deployment, procurement and regulatory pathways.

- The priority is increasingly shifting from expansion to consolidation and sustained performance of the decentralized laboratory network. This includes implementation of the updated decentralization plan; maintaining reliable supplies and functional equipment; strengthening training, supervision and quality assurance; and improving specimen management, turnaround-time monitoring and partner reporting. WHO is supporting these efforts through the procurement of approximately US$1.5 million in laboratory supplies and critical equipment for new and existing laboratories.

Case Management

- Case-management demand remains high, with 896 patients in isolation or treatment nationally as of 4 October. The largest caseloads remain in Ituri and Nord-Kivu, which together accounted for more than three-quarters of patients currently under care.

- Capacity and utilization remain uneven across affected provinces. As of 4 October, Ituri had 372 patients in isolation, with bed occupancy of 36.7%. Nord-Kivu had 382 hospitalized patients, including 263 in standardized treatment structures, with reported bed occupancy of 63.0%; approximately 31% of hospitalized patients (119/382) were therefore being managed outside standardized structures. Haut-Uélé had 70 patients in isolation with 50.7% occupancy, while Tshopo had 20 patients with occupancy rising to 64.5%. Bas-Uélé reported 52 patients in isolation.

- Important operational gaps persist despite the overall expansion of capacity. In Ituri, limited capacity remains a concern in the treatment structures serving Mambasa, Kilo, Mangala, Mandima and Lolwa, alongside gaps in nutritional support. Bas-Uélé continues to lack a standardized treatment centre and ambulance for patient referral. In Tshopo, constraints include, insufficient beds at the Makiso-Kisangani experimental treatment centre and challenges maintaining ambulance services. These constraints are increasingly important as patient volumes continue to fluctuate across affected areas.

- Cumulative recoveries reached 2235 as of 4 October. Five additional recoveries were reported on 4 October, including four in Ituri and one in Haut-Uélé.

- Training of clinical teams continues to strengthen the quality and consistency of care in dedicated treatment centres. The multi-sectoral, multi-partner training programme initiated in September has continued to build the pool of trained personnel supporting case management.

- The survivor-care programme established in Bunia continues to provide follow-up and address the specific medical needs of people recovering from BVD, with expansion to additional sites planned to improve access to survivor services.

Research and Development

- Following the 17 August 2026 allocation of 70 000 doses of Ervebo® to the Democratic Republic of the Congo, 20 000 doses were allocated to the Phase 3 clinical trial, 2000 to the BRAVO observational vaccine-effectiveness study among healthcare workers in Ituri, and 30 000 for healthcare and frontline workers under separate research protocols with informed consent.

- Ervebo® vaccination and associated research activities have continued to expand, although implementation has been affected by intermittent vaccine availability. A total of 8497 people have been vaccinated across 15 health zones in five provinces: Bas-Uélé, Tshopo, Kinshasa, Ituri and Sud-Ubangi. In Ituri, vaccination and the study of cross-immunity between Ervebo® and BDBV were temporarily suspended pending replenishment of vaccine stocks.

- The BRAVO observational study, launched in Bunia on 20 September, continues to support assessment of Ervebo® effectiveness against BVD among healthcare and frontline workers in Ituri.

- Ervebo® use for BVD remains within a research context. Following its 19 August review, the WHO Strategic Advisory Group of Experts on Immunization (SAGE) concluded that available evidence was insufficient to support programmatic use for BVD and that efficacy against BVD in humans remains unknown. Research on Ervebo® effectiveness therefore continues alongside evaluation of BDBV-specific vaccine candidates, including Oxford's ChAdOx1 and Moderna's mRNA candidates.

- Therapeutic and post-exposure prophylaxis work continues. The most recent figures indicate that 520 participants have been enrolled in PARTNERS across five treatment centres and 307 participants enrolled in EBO-PEP across the Rwampara and CME Bunia sites, including 230 in the randomized obeldesivir/placebo trial and 77 in the compassionate-use remdesivir cohort.

- The MBOTE clinical-characterization study continues recruitment across four centres, generating evidence on the clinical presentation, disease progression and outcomes of BVD and complementing the ongoing vaccine, therapeutic and post-exposure prophylaxis studies.

Infection Prevention and Control (IPC) :

- IPC performance in healthcare facilities remains a major concern, particularly in Nord-Kivu. On 4 October, 21 IPC scorecard assessments in Nord-Kivu produced a mean score of only 33%. In Haut-Uélé, recent reporting similarly showed that only 2 of 15 assessed facilities achieved the ≥80% IPC standard. These findings indicate persistent weaknesses in adherence to core IPC standards across affected healthcare facilities.

- IPC activities continued at scale but with marked geographic variation. On 4 October, all 88 targeted households and 10 healthcare facilities in Ituri were decontaminated, compared with only 14 of 40 households (35.0%) and 19 of 25 healthcare facilities (76.0%) in Nord-Kivu. In Tshopo, cumulative timely decontamination reached 100% of affected healthcare facilities (37/37) and 87.9% of households (29/33) that had hosted a confirmed case.

- Safe and dignified burial (SDB) performance also remained uneven. In Ituri, 83 SDBs were completed from 94 alerts, including ten carried forward from previous days (88.3%), while 68 bodies were swabbed. In Nord-Kivu, 45 SDBs were conducted against 44 new alerts and 44 carried-forward alerts, with 44 bodies swabbed. Persistent gaps in SDB coverage and specimen collection continue to increase the risk of undetected community transmission.

- Operational constraints continue to limit IPC performance in the principal transmission areas. In Nord-Kivu, only 12 of 25 IPC rings (48.0%) were operational on 4 October, with particularly important gaps in Katwa, Beni and Mabalako. In Ituri, ring activation has also remained incomplete, while shortages of teams, supplies and transport, together with family and community resistance, have affected safe burials, body swabbing and decontamination activities.

- Material and infrastructure gaps persist. None of the decontaminated households reported in Ituri or Nord-Kivu on 4 October received IPC kits. Tshopo continues to report insufficient IPC supplies and trained personnel and a non-functional incinerator at Makiso-Kisangani General Referral Hospital, while facilities in Bas-Uélé continue to face deficiencies in waste-management areas, hygienic latrines, waste bins and handwashing facilities.

Risk Communication and Community Engagement (RCCE)

- Community engagement activities remained extensive across the main affected provinces, using household visits, educational discussions including with schools reopening, mass sensitization including media outreach, community dialogue and engagement with local authorities and community leaders. In Ituri alone, activities on 4 October included 23,782 household visits reaching 105 316 people, 998 educational discussions reaching 20 218 people and 112 mass-sensitization sessions reaching 6 153 people.

- RCCE activities are increasingly being integrated with operational response activities and management of community resistance. In Ituri, RCCE teams supported the pre-listing of 311 contacts around 16 confirmed cases, decontamination of all 15 targeted households and four facilities, 21 safe and dignified burials, and transfer of 35 of 36 suspected cases (97.2%). In Nord-Kivu, targeted dialogue continued with resistant groups and other influential actors, including engagement with community pressure groups in Manguredjipa and members of the armed forces.

- Important community-engagement and reporting gaps nevertheless persist. In Ituri, reporting completeness improved to 39.3% (11/28 health zones) on 4 October but remained low; 96.6% (308/319) of reported feedback was addressed and 83.3% (5/6) of community incidents were resolved within 48 hours. In Nord-Kivu, only 201 of 750 expected community alerts (26.8%) were reported, 76.5% (13/17) of feedback was resolved within 48 hours and participation in planned community-engagement activities remained low at 19.2% (910/4,750). Persistent resistance, refusals and incomplete reporting continue to constrain timely implementation and community acceptance of response interventions.

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

- A Training of Trainers (ToT) was conducted in Ituri on PRSEA, Accountability to Affected Populations (AAP), and gender, strengthening the technical, facilitation, and training capacities of 25 participants, including representatives of persons with disabilities and other marginalized and at-risk groups.

- Across Ituri, Tshopo, Haut-Uélé, North Kivu, and South Kivu, 352 participants, including 131 women, attended PSEAH briefing sessions. Participants included health-care providers, response pillar members, UN and NGO representatives, community leaders, civil society organizations, Ebola Treatment Centre staff, and Provincial Health Division personnel.

- Across the same five provinces, 2631 people, including 557 women and 642 girls, participated in PRSEAH community awareness sessions targeting students, market vendors, religious leaders, motorcycle taxi operators, Red Cross personnel, and other community groups.

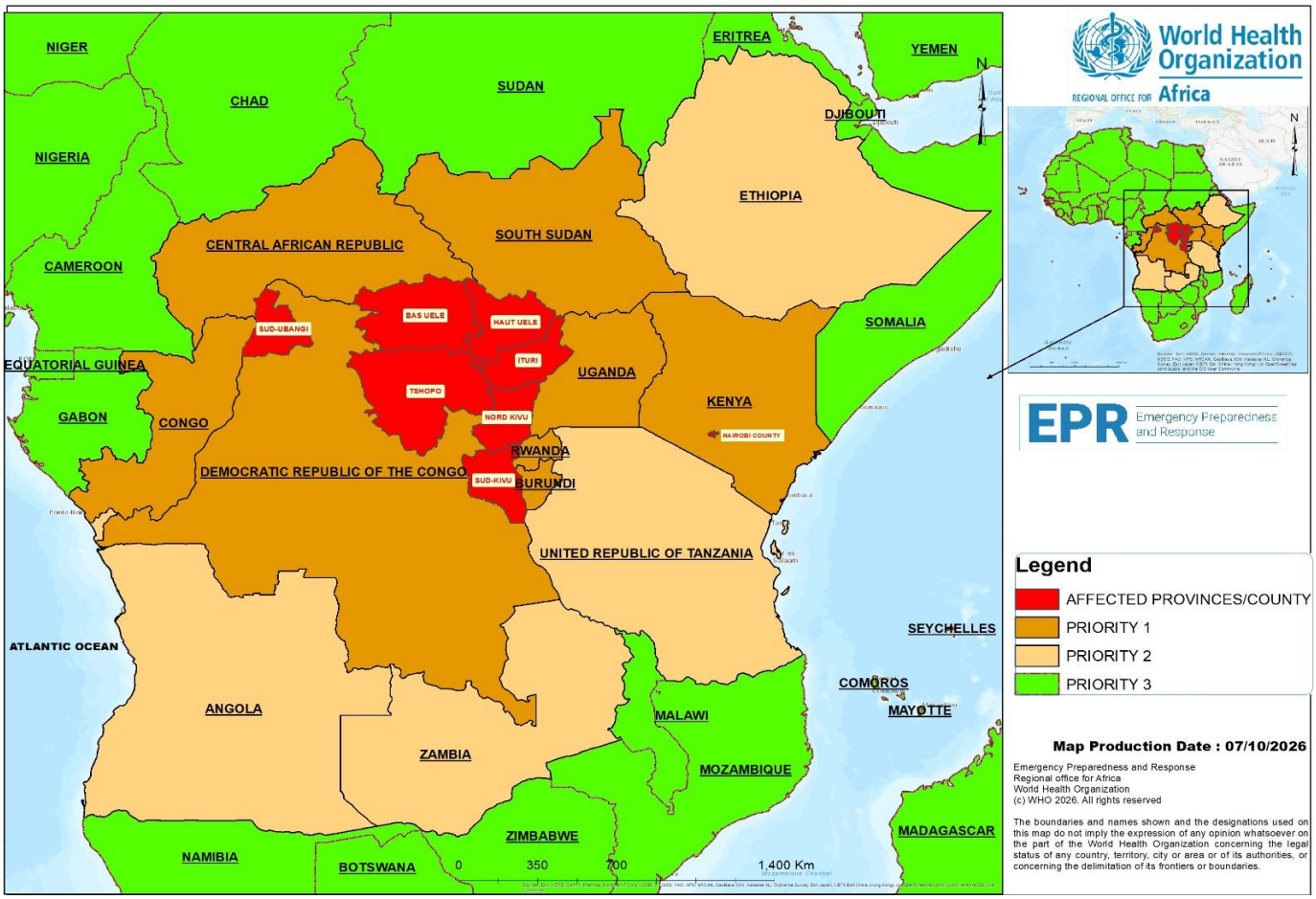
- In Tshopo, community engagement activities were conducted in BVD-affected health zones, including awareness-raising on complaints and feedback mechanisms and dissemination of referral pathways.

Public health preparedness

Operational Readiness

- Based on regional cross-border risk modelling and the evolving epidemiological situation, countries have been recategorized by priority for response and preparedness. The Democratic Republic of the Congo and Kenya are classified as the response countries (Priority 1A); Uganda, Central African Republic, South Sudan, Republic of the Congo, Burundi and Rwanda as Priority 1B countries; and Angola, Ethiopia, United Republic of Tanzania, and Zambia as Priority 2 countries.

Figure 6. Regional prioritization of countries for Bundibugyo virus disease preparedness and response, as of 04 October 2026



- Ten out of 11 high-priority countries completed repeat readiness assessments, reflecting continued efforts to strengthen national preparedness capacities: Angola, Burundi, Central African Republic, South Sudan, Tanzania, Kenya, Republic of the Congo, Rwanda, Uganda and Zambia, average scores have increased from 55% to 61%.

- Regional technical deployments continued to support preparedness and response capacity in affected and high-risk Member States, including Central African Republic, Democratic Republic of the Congo and Uganda.

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 outbreak of BVD remains uncontrolled despite expanded response capacity. Recent increases in cases and deaths, shifting transmission hotspots, persistent community deaths, suboptimal contact follow-up and delayed isolation indicate continuing gaps in breaking transmission chains. The confirmed exportation to Kenya following travel through Uganda further demonstrates the growing cross-border risk and its associated regional consequences. The immediate priorities should be to improve response performance across the different response pillars while strengthening cross-border coordination and preparedness.

Contributors

- WILLIAMS, George Sie (WHO AFRO)
- OTSHUDIEMA, John (WHO AFRO)
- CONTEH, Ishata (WHO AFRO)
- MASINA, John (WHO AFRO)
- MAMADU, Ibrahim (WHO AFRO)
- ROQUILLE, Denise (WHO AFRO)
- MUTEBA, Michel (WHO AFRO)
- DOSHI, Reena Hemendra (WCO AFRO)
- KAMBALE KAVOGA, Freddy (WHO AFRO)
- NGUNA, Joyce (WHO AFRO)
- PAVLIN, Boris (WHO HQ)
- HAMBLION, Esther (WHO HQ)
- KASSAMALI, Zyleen (WHO HQ)
- DIAZ, Janet Victoria (WHO HQ)
- ALLAIN IOOS, Sophie (WHO HQ)
- HAMOUDA, Mahmoud Aly Zeenelabdin (WHO HQ)
- MOLINARO, Paul (WHO HQ)
- LEGAND, Anaïs (WHO HQ)
- WAUQUIER, Nadia (WHO HQ)
- SODAGAR, Vaishali (WHO HQ)
- WANG, Ninglan (WHO HQ)
- SELENIC MINET, Dubravka (WHO HQ)
- ALEXANDROVA EZERSKA, Lidia (WHO HQ)
- MORAN, Thomas (WHO HQ)
- FOTSING, Richard (WCO DR Congo)
- AJONG, Brian (WCO DR Congo)

Editorial Advisory Group, WHO Regional Office for Africa

- Dr Marie Roseline Darnycka Belizaire — Regional Emergency Director, EPR/AFRO
- Dr Otim Patrick Ramadan — Programme Area Manager, EMR/EPR/AFRO & Deputy Regional Incident Manager, BVD Response
- Dr Etien Koua — Programme Area Manager, HIS/EPR/AFRO
- Dr Dick Chamla — Programme Area Manager, HEP/EPR/AFRO
- Mr Adama Thiam — Programme Area Manager, OSL/EPR/AFRO

© WHO Regional Office for Africa

This is not an official publication of the World Health Organization.

Correspondence on this publication may be directed to:

Health Emergency Intelligence, Surveillance and Laboratory Programme

WHO Emergency Preparedness and Response

WHO Regional Office for Africa

Email: afrooutbreak@who.int

Subscribe here to receive regular updates via email: **SUBSCRIBE**

Requests for permission to reproduce or translate this publication – whether for sale or for noncommercial distribution – should be sent to the same addresses.