World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK
Democratic Republic of the Congo
Weekly External Situation Report 22, Data as of 11 October 2026

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

7 Provinces **65** Health Zones Affected	**6** Provinces **50** Health Zones Active Transmission*	**2 389** Cases Recovered	**58.2%** Bed Occupancy	**27 043** Contacts under follow up
895 Active Cases in Isolation	**269** 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	463	233	9 066	4 381	48.3%	Active
Kenya	0	0	1	1	100.0%	Active
Uganda	0	0	20	2	10.0%	Ended
France	0	0	1	0	0.0%	Ended

Event description

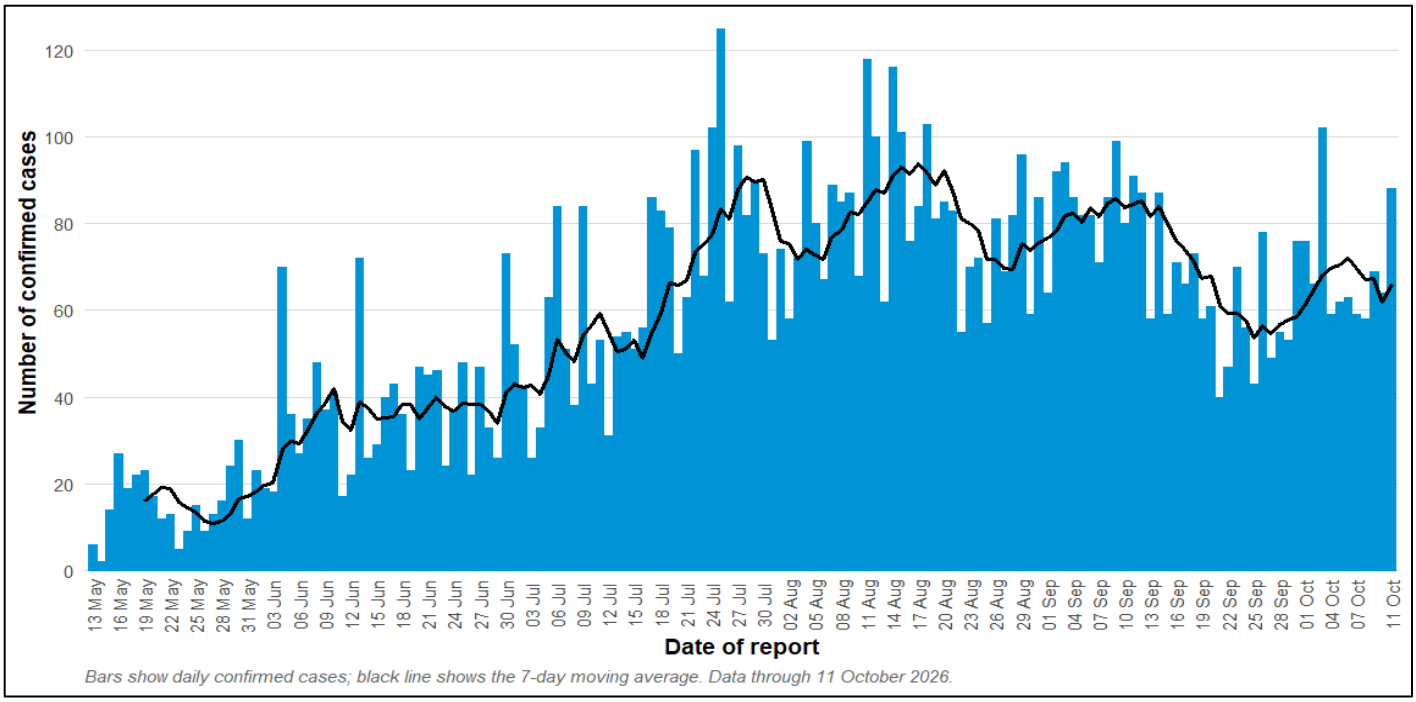
Democratic Republic of the Congo

The BVD outbreak in the Democratic Republic of the Congo continues to evolve, expanding both geographically and in terms of the numbers of cases and deaths. The Dakwa Health Zone in Bas-Uélé Province has become the latest affected

health zone, bringing the total number of impacted health zones to 65 across seven provinces since the start of the outbreak. Transmission remains highly heterogeneous across these regions. Since External Situation Report #21, a total of 463 additional confirmed cases and 233 confirmed deaths have been reported. This increases the cumulative total to 9066 confirmed cases, including 4381 confirmed deaths [crude case fatality ratio (CFR) 48.3%] as of 11 October 2026. Ituri remains the principal focus of the outbreak, though its relative contribution is declining; it is currently for 73.8% of cumulative confirmed cases. Substantial transmission persist in Nord-Kivu and Haut-Uélé.

National incidence remains high and fluctuating, with no sustained downward trajectory evident. Following rapid expansion through July and August, the epidemic has entered a more heterogeneous phase characterized by repeated declines and rebounds. This pattern reflects asynchronous transmission across provinces and health zones; declining activity in established Ituri hotspots is being offset by persistent or renewed activity elsewhere, particularly in Nord-Kivu, while sporadic detections continue to extend the geographic footprint. The overall trend suggest a shifting and geographically fragmented epidemic than sustained contraction.(Figure 1)

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 11 October 2026

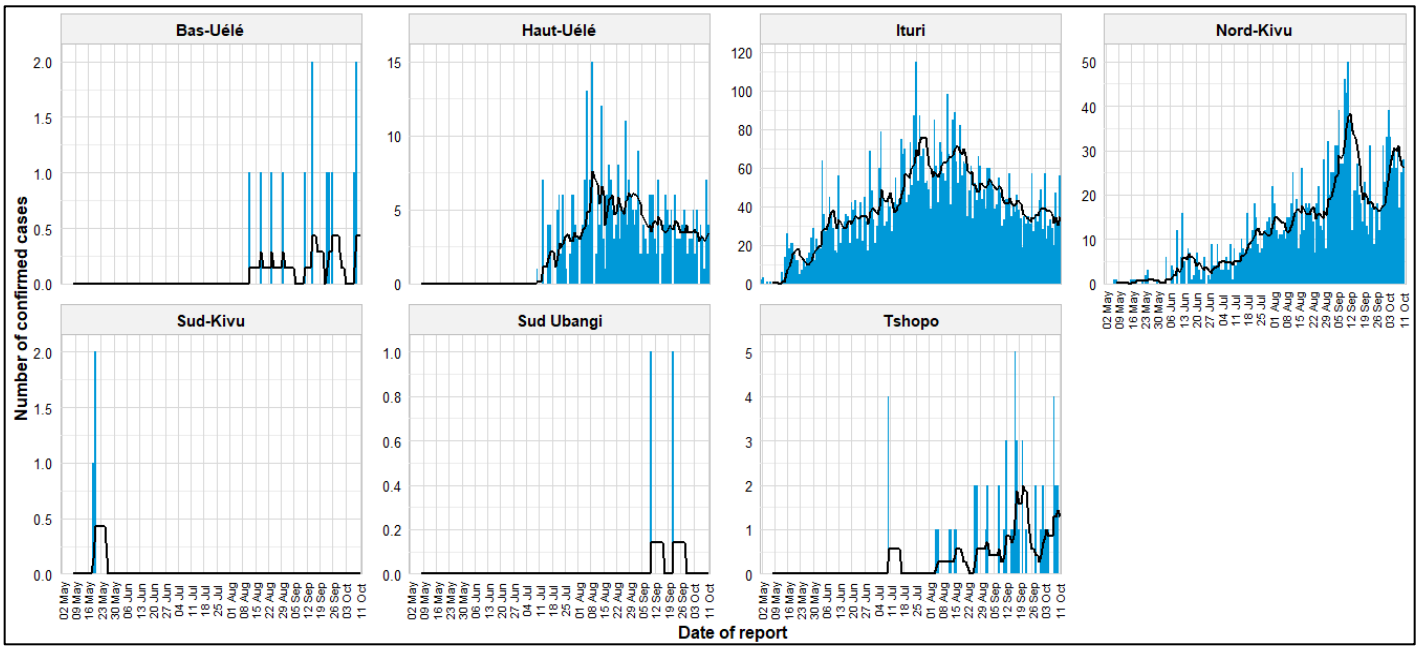


Trend Analysis (21-day comparison): During the most recent 21- days period (21 September – 11 October 2026), a total of 1333 confirmed cases were reported nationally, compared with 1633 cases during the preceding 21 days (31 August–20 September). This represents a decrease of 300 cases (−18.4%). Cases declined across the three principal transmission provinces: Ituri: Decreased from 931 to 748 (−19.7%) accounting for 56.1% of national cases in the latest period.

- Nord-Kivu: Decreased from 589 to 486 (−17.5%)accounting for 36.5% of national cases
- Haut-Uélé: Decreased from 89 to 72 (−19.1%)

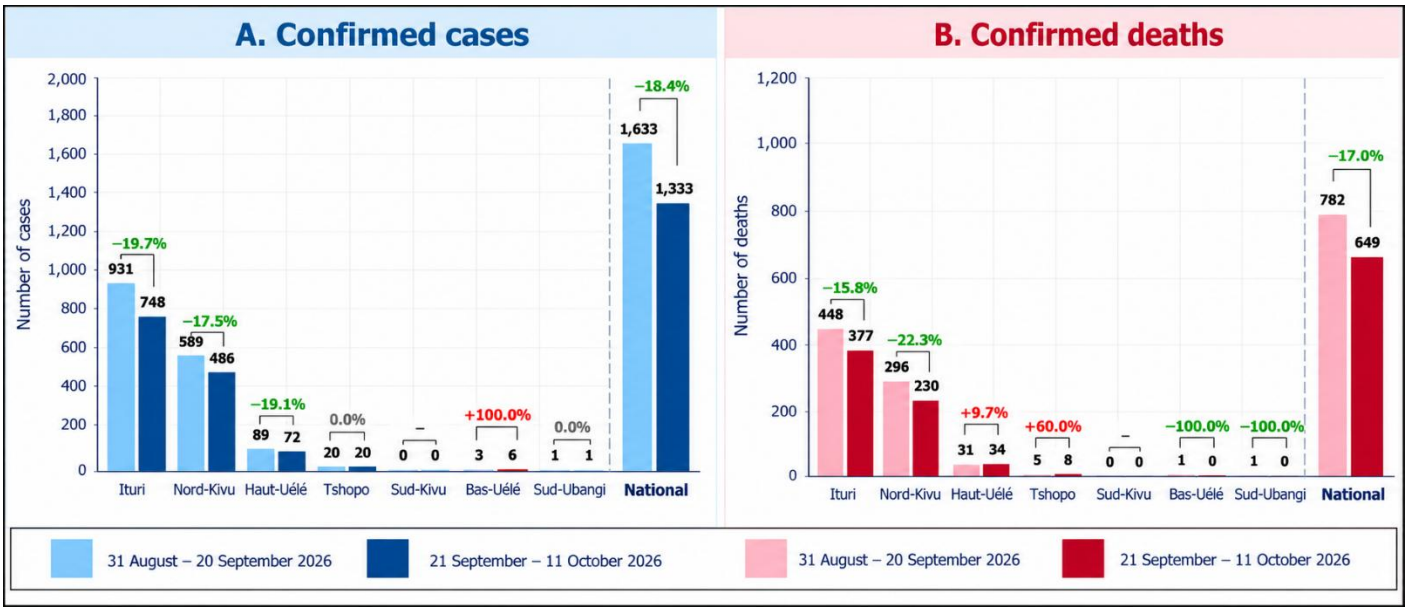
Despite the overall 21-day decline, daily incidence continues to fluctuate, with repeated rebounds, particularly in Ituri and Nord-Kivu. Consequently, these reductions should be interpreted cautiously and do not yet indicate a sustained contraction of the epidemic (Figure 2).

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 11 October 2026



During the same period, 649 confirmed deaths were reported nationally, compared with 782 deaths during the preceding 21 days, representing a decrease of 133 deaths (−17%). Deaths declined from 448 to 377 (−15.8%) in Ituri and from 296 to 230 (−22.3%) in Nord-Kivu. In contrast, deaths increased from 31 to 34 (+9.7%) in Haut-Uélé and from five to eight (+60.0%) in Tshopo. Consequently, Ituri accounted for 58.1% of deaths during the latest period and Nord-Kivu for 35.4%, compared with 57.3% and 37.9%, respectively, during the preceding period. However, as with cases, the overall 21-day decline masks continued fluctuations in mortality and should be interpreted cautiously, as it does not yet indicate a sustained downward trajectory (Figure 3).

Figure 3. Bundibugyo virus disease cases and deaths by province across consecutive 21-day periods, 31 August – 20 September 2026 compared with 21 September – 11 October 2026, Democratic Republic of the Congo



Transmission remained active in more than three-quarters of all health zones affected since the start of the outbreak. Of the 65 health zones affected to date, 50 reported at least one new confirmed case in the last 21 days. Case incidence increased in 23 health zones (Figure 4), decreased in 26 and remained unchanged in one, highlighting substantial heterogeneity in local transmission. The most pronounced increase occurred in Mandima, Ituri (23 to 199 cases; +765.2%), while substantial increases were also observed in Mambasa and several health zones in Nord-Kivu, particularly Beni, Mabalako and Oicha.

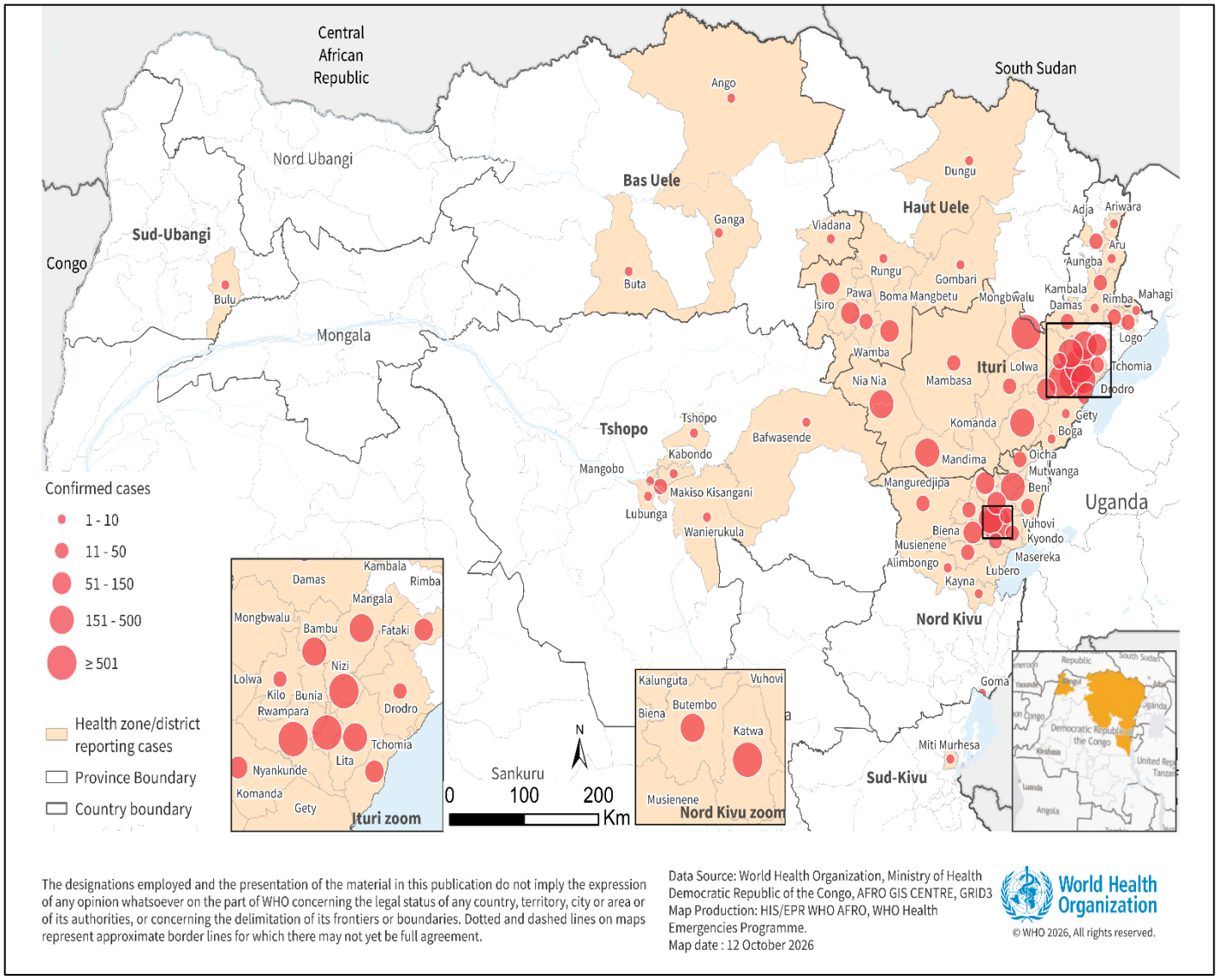
Figure 4. Health zones reporting increase in cases in the last 21 days, data as of 11 October 2026

Province	Health zone	31 Aug – 20 Sep (cases)	21 Sep – 11 Oct (cases)	% change	Recent 7-day MA trend (21 Sep – 11 Oct)	Trend
Ituri	Adja	0	1	N/A		Increase
	Aru	0	1	N/A		Increase
	Gethy	1	4	+300.0%		Increase
	Kilo	2	4	+100.0%		Increase
	Mambasa	4	22	+450.0%		Increase
	Mandima	23	199	+765.2%		Increase
	Nia-Nia	54	58	+7.4%		Increase
	Nyankunde	3	6	+100.0%		Increase
	Rimba	2	6	+200.0%		Increase
Nord-Kivu	Alimbongo	0	5	N/A		Increase
	Beni	143	177	+23.8%		Increase
	Kayna	1	2	+100.0%		Increase
	Mabalako	19	39	+105.3%		Increase
	Mutwanga	8	14	+75.0%		Increase
	Oicha	7	28	+300.0%		Increase
Haut-Uélé	Rungu	1	3	+200.0%		Increase
	Wamba	25	26	+4.0%		Increase
Tshopo	Makiso-Kisangani	11	12	+9.1%		Increase
	Mangobo	2	6	+200.0%		Increase
	Tshopo	0	1	N/A		Increase
Bas-Uélé	Viadana	2	3	+50.0%		Increase
	Dakwa	0	1	N/A		Increase
	Ganga	1	2	+100.0%		Increase

Declines were widespread across Ituri and Nord-Kivu, including several major transmission hotspots such as Bunia, Katwa, Mangala, Mongbwalu and Komanda, while particularly marked reductions were observed in Tchomia (−94.4%) and Isiro (−83.3%).

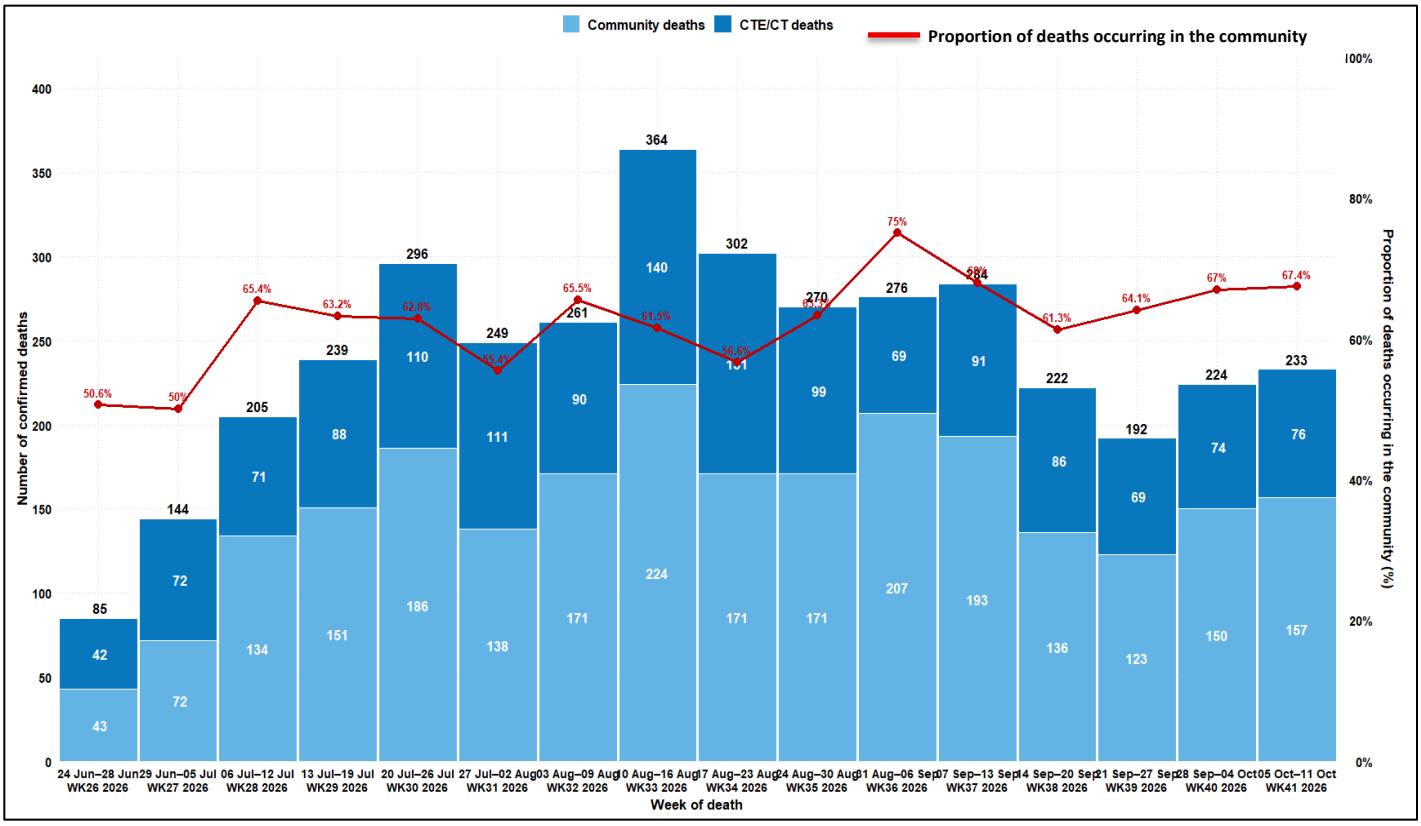
The number of health zones with no reported confirmed cases during the latest 21-day period decreased from 18 to 15. These include Ariwara, Aungba, Boga, Damas, Drodro, Kambala and Mahagi in Ituri; Goma in Nord-Kivu; Dungu and Gombari in Haut-Uélé; Bafwasende, Lubunga and Wanie-Rukula in Tshopo; Miti-Murhesa in Sud-Kivu; and Buta in Bas-Uélé.

Figure 5. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 11 October 2026



Weekly confirmed deaths (Figure 5) increased for the second consecutive week, from 192 during 21 – 27 September to 224 during 28 September – 4 October and 233 during 5 – 11 October. In the latest week, deaths increased by 4.0%, with community deaths rising from 150 to 157 (+4.7%) and deaths in treatment facilities from 74 to 76 (+2.7%). Community deaths continued to account for approximately two-thirds of all confirmed deaths, increasing slightly from 67.0% to 67.4%. The sustained increase in deaths over the past two weeks, particularly the persistently high proportion occurring in the community, remains a key concern.

Figure 5. Weekly number of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological week 26 – 41, 2026



Kenya

As of 12 October 2026, no new confirmed BVD cases or deaths have been reported in Kenya since the detection of the imported case, and the cumulative total remains one confirmed case with one death (CFR 100%).

The imported case was a 40-year-old Kenyan male who travelled from the Democratic Republic of the Congo through Uganda before arriving in Nairobi on 3 October 2026. He presented for care and was isolated on the day of arrival, with laboratory testing confirming Bundibugyo virus infection. He died on 5 October and received a safe and dignified burial on 6 October 2026.

Contact tracing and monitoring remain ongoing, with 128 contacts currently listed, comprising 26 passengers, four flight crew, 43 Jomo Kenyatta International Airport staff, 10 relatives and 45 healthcare workers. Of these, 108 (84.4%) are in quarantine and were successfully followed up, while 20 remain outside quarantine. The latter group includes seven passengers who have not yet been located, seven newly identified healthcare workers and one immigration officer who remains unreachable. The remaining five contacts are passengers who had onward travels their respective destination countries have been notified.

A total of 289 alerts have so far been investigated, generating 293 laboratory tests, with all 292 results other than the index case testing negative.

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)

- 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.
- The emergency supply pipeline has increased to US$16.13 million. Of the total value, US$6.98 million (43%) has been delivered, US$2.83 million (18%) is in transit, and US$1.08 million (7%) is being arranged for shipment.

- Cumulative delivered cargo has increased to 473.6 metric tonnes and 2799.8m³, with a delivered value of US$6.98 million, an increase of approximately US$0.81 million from the previously reported US$6.17 million.

- Critical commodities delivered to the Ituri and Kivu hubs include 8.83 million examination gloves, 118 865 hooded coveralls, 158 800 Level 3 gowns, 20 016 RadiOne PCR tests, 10 076 infrared thermometers, 8640 manual PCR tests and 477 hospital beds. The pipeline includes a further 901 000 examination gloves, 140 339 hooded coveralls, 268 200 Level 3 gowns, 8000 infrared thermometers and 284 hospital beds in transit.

- Personal protective equipment and infection prevention and control supplies remain the largest procurement category at US$6.83 million, followed by laboratory supplies (US$3.90 million), medical equipment (US$2.26 million), logistics (US$2.08 million), medicines (US$0.88 million), kits (US$0.55 million) and medical consumables (US$0.28 million).
- Overall, the increase in delivered value to 43% of the pipeline indicates continued progress in supply deployment, although the outstanding 39% represents an important outstanding portion of the pipeline.

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 5 – 11 October, a total of 18 472 alerts were reported, averaging 2639 alerts per day, an increase of 8.6% from 17 005 (2429 per day) during the preceding week. Alert verification improved substantially from 92.5% to 99.2% (18 329 / 18 472). A total of 2861 alerts were validated as suspected cases. Among those investigated, 1410 (48.9%) were isolated and transferred within 24 hours, decreasing from 52.4% in the preceding week. Overall, alert reporting and verification remained strong despite the increased alert volume; however, isolation and referral remain the principal weakness in the alert-management cascade, with fewer than half of investigated suspected cases isolated and transferred within 24 hours during the latest week.

- From 5 – 11 October, the contact-tracing workload decreased, with an average of 28 466 contacts requiring daily follow-up, compared with 30 906 during 28 September – 4 October, representing a 7.9% decrease. Average follow-up performance improved from 78.5% to 81.4%, although it remained below the ≥95% target. As of 11 October, 27 043 contacts were under follow-up, of whom 21 512 (79.5%) were seen. Overall, despite the reduced workload and improvement in average weekly follow-up coverage, contact-tracing performance remains suboptimal, with approximately one in five contacts still not reached each day.

- At points of entry (PoEs) and points of control (PoCs), a total of 241 651 travellers were recorded on 11 October, of whom 97.9% were screened. Reporting completeness improved to 98.0%, ranging from 95.2% in Nord-Kivu to 98.3% in Ituri and 100% in Tshopo. Ten alerts were reported across PoEs/PoCs, including six in Ituri, three in Bas-Uélé and one in Haut-Uélé. In Ituri, five alerts were validated as suspected cases; one (20.0%) was transferred to the Komanda treatment centre and subsequently confirmed positive, while four refused transfer. A deceased alert was intercepted and sampled in Bas-Uélé, while an alert in Haut-Uélé was subsequently invalidated. Although all strategic PoEs/PoCs included in the reporting system were reported as functional, the Butuhe PoC in Nord-Kivu remained non-functional following the security incident of 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 895 patients in isolation or treatment nationally as of 11 October. The largest caseloads remain in Ituri and Nord-Kivu, which together accounted for 774 patients (86.5%) currently under care.
- Capacity and utilization remain uneven across affected provinces. Ituri had 337 hospitalized patients, with reported bed occupancy of 33.2%, including 41 patients in critical condition. Nord-Kivu had 437 hospitalized patients, including 330 in treatment facilities, where bed occupancy reached 88.2%; 107 patients (24.5%) were being managed outside treatment facilities, while occupancy of beds for suspected cases had reached 95.2% (157/165). Haut-Uélé had 45 patients, with occupancy of 32.6%, while Tshopo had 15 hospitalized patients, corresponding to 41.7% occupancy. In Bas-Uélé, 12 new suspected cases were admitted to transit centres.
- Operational constraints remain important, particularly in Nord-Kivu, where near-saturation of beds for suspected cases and limited ambulance capacity continue to affect case management. In Ituri, limited capacity in several CT/CTEs and the management of 41 critically ill patients remain concerns, while Haut-Uélé, Tshopo and Bas-Uélé continue to face infrastructure, staffing, supply and referral constraints.
- Cumulative recoveries increased to 2,389 as of 11 October. An additional 19 recoveries were reported on 11 October, including 17 in Ituri and two 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 and Tshopo. In Nord-Kivu, four IPC scorecard assessments conducted in healthcare facilities produced a mean score of only 30.8%, with none achieving the ≥80% standard. In Tshopo, only two of 104 assessed healthcare facilities (1.9%) had an IPC score above 80%. These findings continue to indicate substantial weaknesses in adherence to core IPC standards in affected healthcare facilities.

- IPC activities continued at scale but remained uneven across provinces. In Ituri, 21 of 25 targeted households (84.0%) and all three targeted healthcare facilities were decontaminated, although only eight of 22 IPC rings (36.4%) were opened. In Nord-Kivu, 23 of 32 rings (71.9%) were opened, while 26 of 32 healthcare facilities (81.3%) and only 14 of 30 households (46.7%) were decontaminated. Haut-Uélé achieved decontamination of both targeted households in Isiro (2/2), while in Tshopo all 41 identified rings had been opened, and cumulative household decontamination reached 35 of 44 (79.5%).

- Safe and dignified burial (SDB) performance also remained uneven. In Ituri, 55 SDBs were completed from 68 alerts, including 15 carried forward from the previous day (80.9%), and 56 bodies were swabbed. In Nord-Kivu, 57 SDBs were conducted from 54 new death alerts and 48 carried forward, with 54 bodies swabbed and 45 alerts carried forward to the following day. In Haut-Uélé, eight of nine SDB alerts (88.9%) were completed and five bodies swabbed, with one refusal reported in Isiro. In Tshopo, one body was swabbed from two SDB alerts.
- Operational constraints continue to limit IPC performance in the principal transmission areas. In Ituri, low ring activation (36.4%), insufficient teams in Komanda, Mangala and Mandima, inadequate mobility and shortages of SDB supplies and transport persist, alongside eight instances of resistance to SDB activities in Mandima. In Nord-Kivu, gaps in ring activation remain in Katwa and Mabalako, household decontamination remains low in Katwa, Butembo and Musienene, and four of five assessed healthcare workers had high-risk exposures.

- Material and infrastructure gaps persist. None of the decontaminated households in Ituri or Nord-Kivu received IPC kits. Haut-Uélé continues to report shortages of IPC kits for healthcare facilities and households, together with incomplete reporting. In Tshopo, shortages of IPC supplies persist and the incinerator at Makiso-Kisangani General Referral Hospital remains non-functional. These operational and material gaps continue to constrain effective implementation of IPC measures across affected areas.

Risk Communication and Community Engagement (RCCE)

- Community engagement activities remained extensive across the main affected provinces. In Ituri, 24 812 household visits reached 83 512 people, 1002 educational discussions reached 15 563 people, eight mass-

sensitization activities reached 2090 people, and four community dialogues reached 158 people. In addition, 38 spots were broadcast through 36 radio stations and nine radio programmes were conducted.

- RCCE continued to support surveillance and other operational response activities. In Ituri, 460 community alerts, including 129 deaths, were reported, while RCCE teams supported the pre-listing of 859 contacts around 19 confirmed cases and the community reintegration of a BVD survivor. In Nord-Kivu, RCCE supported the listing of 55 contacts in Lubero and Manguredjipa, alongside household visits, educational discussions, mass communication and engagement through religious gatherings.

- Community engagement also intensified in other affected provinces. In Tshopo, 26 mass-sensitization sessions reached 31 861 people, including 4219 children, and all 20 community alerts reported were addressed; both feedback items received were resolved. In Haut-Uélé, activities reached 5092 people, all three feedback items were resolved, and 31 family members of a suspected death were engaged on contact follow-up, decontamination and safe burial. In Bas-Uélé, mass sensitization reached 839 people in Dakwa, survivor-led engagement reached 53 people in Viadana, and all five community alerts reported were addressed.

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

- PRSEAH capacity strengthening continued across the response. In Ituri, Tshopo, Haut-Uélé, North Kivu and South Kivu, 507 people, including 224 women, participated in PSEAH briefings and training sessions. Participants included national-level actors involved in the Ebola response, internally displaced persons and media professionals.

- PRSEAH risk-mitigation measures were reinforced among response personnel. A total of 51 humanitarian personnel, including staff and drivers from WHO, Africa CDC, Oxfam, FHI 360 and AFENET, completed refresher training on PSEAH. Further training of community-based workers is planned to strengthen risk-mitigation measures across service providers involved in the response.

- WHO strengthened national and inter-agency PRSEAH coordination through a five-day training-of-trainers session for national DPS staff, aimed at strengthening national capacity and promoting harmonized implementation of PSEAH standards and approaches across the Ebola response.

- Community awareness of PRSEAH was further expanded, reaching 4,057 people, including 1,392 women, across Ituri, Tshopo, Haut-Uélé, North Kivu and South Kivu. Those reached included healthcare providers, taxi drivers, vendors and caregivers accompanying patients.

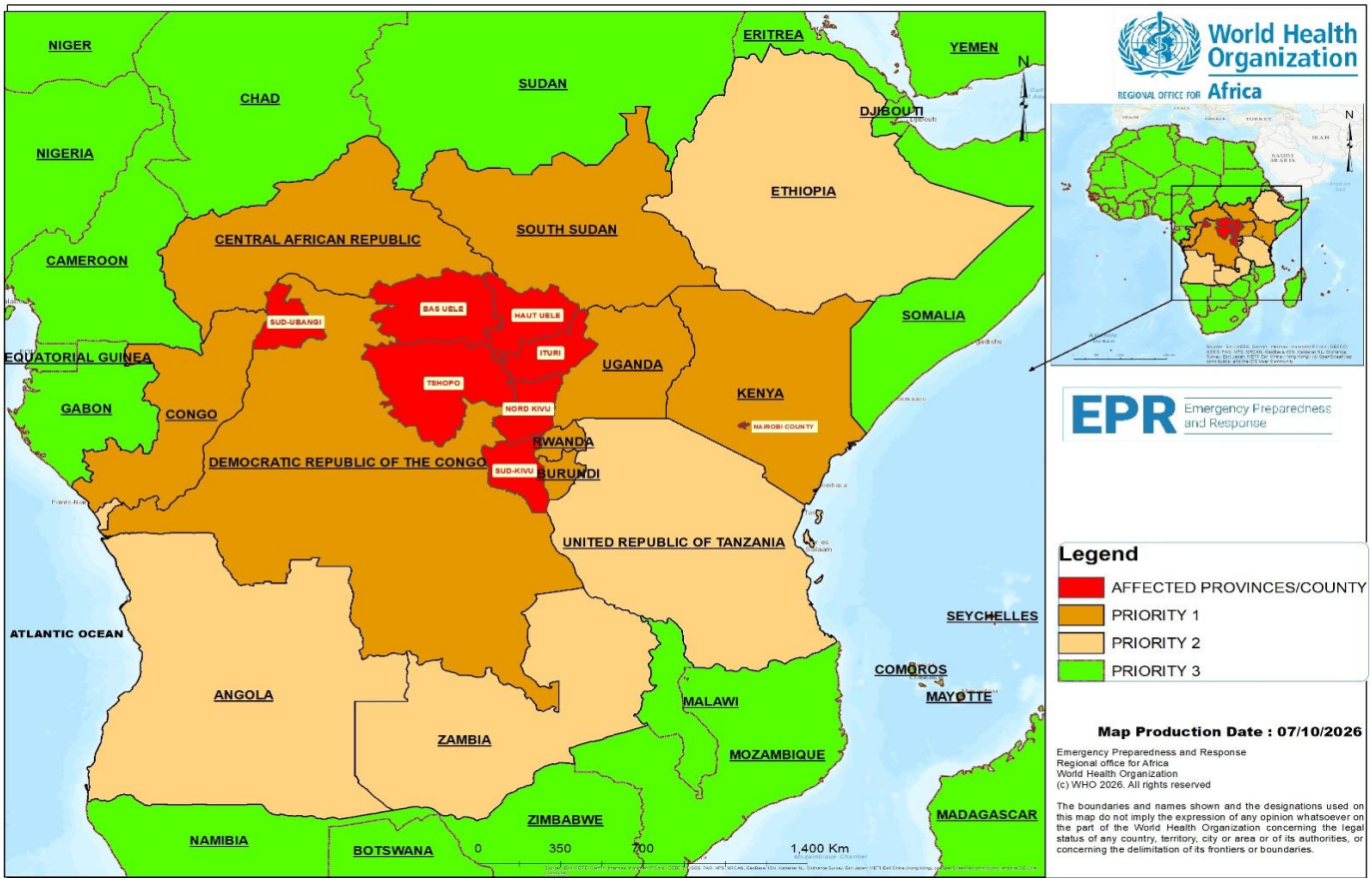
- A PRSEAH Task Force was established in Mongbwalu, bringing together 11 organizations under the joint coordination of WHO and the Provincial Health Division (DPS) to strengthen coordination and implementation of PSEAH measures at operational level.

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 11 October 2026



- High-priority countries completed repeat readiness assessments, reflecting continued efforts to strengthen national preparedness capacities as well as readiness assessments in high risk subnational units. Activities from their contingency plans are being implemented to support critical readiness pillars.
- 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, Kenya, South Sudan and Uganda including support visits to cross border areas where recent exportation occurred to strengthen capacities. IHR coordination and cross border meetings are being supported to strengthen inter-country

information sharing.

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 fluctuating national trajectory reflects uneven interruption of transmission across a complex, geographically dispersed and increasingly cross-border outbreak. Although response capacity has expanded substantially, persistent gaps in early detection, contact follow-up, timely isolation and referral, together with population mobility, insecurity and variable access to affected communities, continue to allow transmission chains to persist or re-emerge. The imported case detected in Kenya, following travel from the DRC through Uganda, underscores the risk of further international spread, although no secondary transmission has been detected in Kenya to date. Bringing the outbreak under control will require rapid interruption of remaining transmission chains through earlier case detection and isolation, ≥95% contact follow-up, investigation of community deaths, strengthened IPC and safe burials, intensified surveillance in emerging hotspots, and rapid management of unlinked cases, alongside strengthened cross-border surveillance, information sharing and coordinated contact tracing. Without consistent implementation of these measures across all affected and at-risk areas, localized gains are likely to continue being offset by renewed transmission and further geographic spread.

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