World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Kenya | Nigeria

Weekly External Situation Report 23, Data as of 19 October 2026

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

8 Provinces **66** Health Zones Affected	**6** Provinces **50** Health Zones Active Transmission*	**2 574** Cases Recovered	**66.9%** Bed Occupancy	**31 725** Contacts under follow up
1 029 Active Cases in Isolation	**301** Health Worker Cases	**48** 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 (Since last update)	New Confirmed Deaths (Since last update)	Confirmed Cases (Total)	Confirmed Deaths (Total)	CFR (%) Confirmed	Status
Democratic Republic of the Congo	572	265	9 637	4 646	48.2%	Active
Kenya	8	0	9	1	11.1%	Active
Nigeria	1	0	1	0	0.0%	Active
Uganda	0	0	20	2	10.0%	Ended
France	0	0	1	0	0.0%	Ended

Event description

The Bundibugyo virus disease (BVD) outbreak is becoming increasingly challenging, marked by an expanding cluster of cases linked to the imported index case in Kenya, further geographic expansion into a new province of the Democratic Republic of the Congo, and the confirmation of a case in Nigeria. These developments highlight the widening international dimension and the growing complexity of the outbreak, particularly in the Democratic Republic of the Congo, where escalating insecurity, population displacement and restricted humanitarian access threaten to further undermine surveillance and response operations.

Democratic Republic of the Congo

As of 19 October 2026, the BVD outbreak in the Democratic Republic of the Congo has affected 66 health zones across eight provinces, following the recent expansion into Wapinda Health Zone in Nord-Ubangi Province. Since ***External Situation Report #22***, an additional 572 confirmed cases and 265 confirmed deaths have been reported, bringing the cumulative total to 9637 confirmed cases, including 4646 confirmed deaths [crude case fatality ratio (CFR) 48.2%]. Transmission remains highly heterogeneous across affected areas. Ituri continues to account for the largest proportion of cumulative confirmed cases (72.7%), although its relative contribution is declining, while substantial transmission persists in Nord-Kivu and Haut-Uélé.

National daily incidence increased steadily from May, reaching its highest levels in late July and mid-August, before fluctuating at persistently high levels through September. Following a decline in late September, incidence rebounded in early October. The most recent seven-day moving average indicates a modest upward trend, suggesting renewed intensification of transmission. Provincial trends remain heterogeneous. Ituri shows a slight recent rebound despite an overall decline from its August peak, while Nord-Kivu continues to experience elevated but fluctuating transmission. Haut-Uélé remains relatively stable with a slight increase, and Tshopo shows renewed upward activity. Transmission remains sporadic in Bas-Uélé, with newly reported cases in Nord-Ubangi, while Sud-Kivu and Sud-Ubangi report no recent transmission in the last 21 days (Figures 1 and 2).

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 19 October 2026

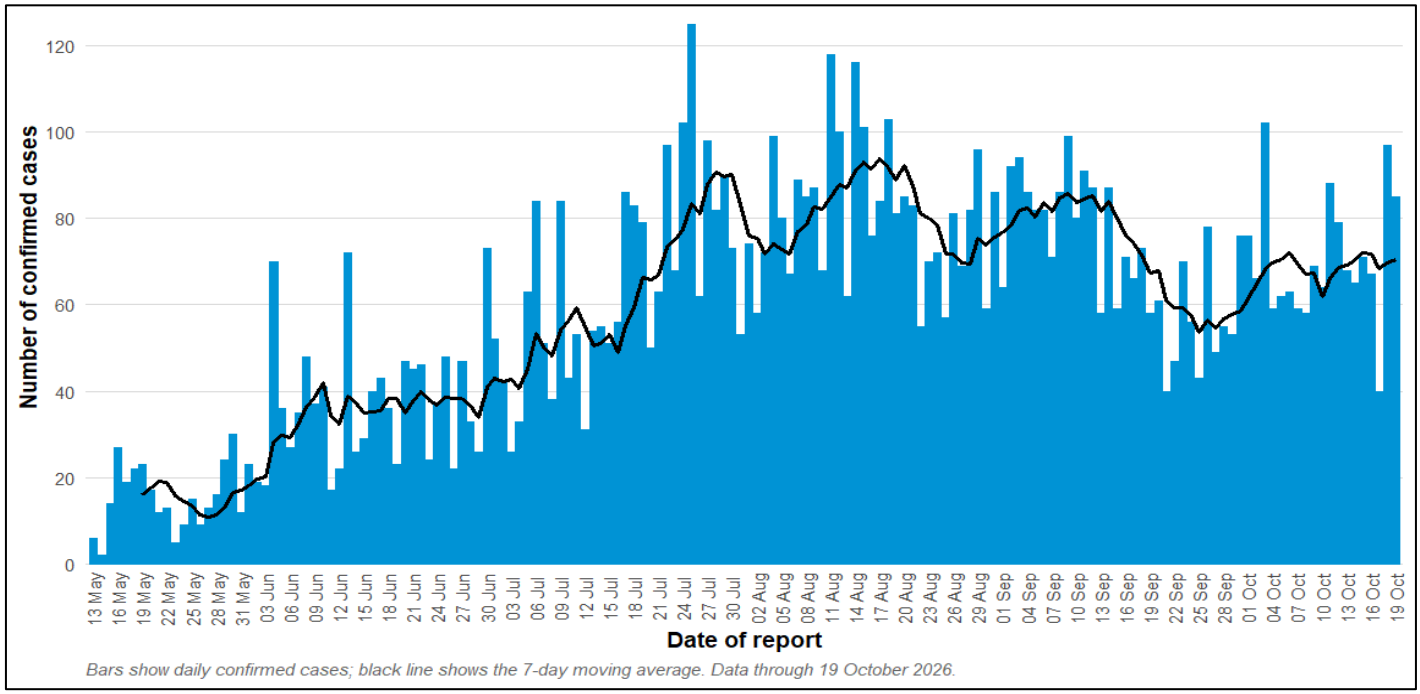
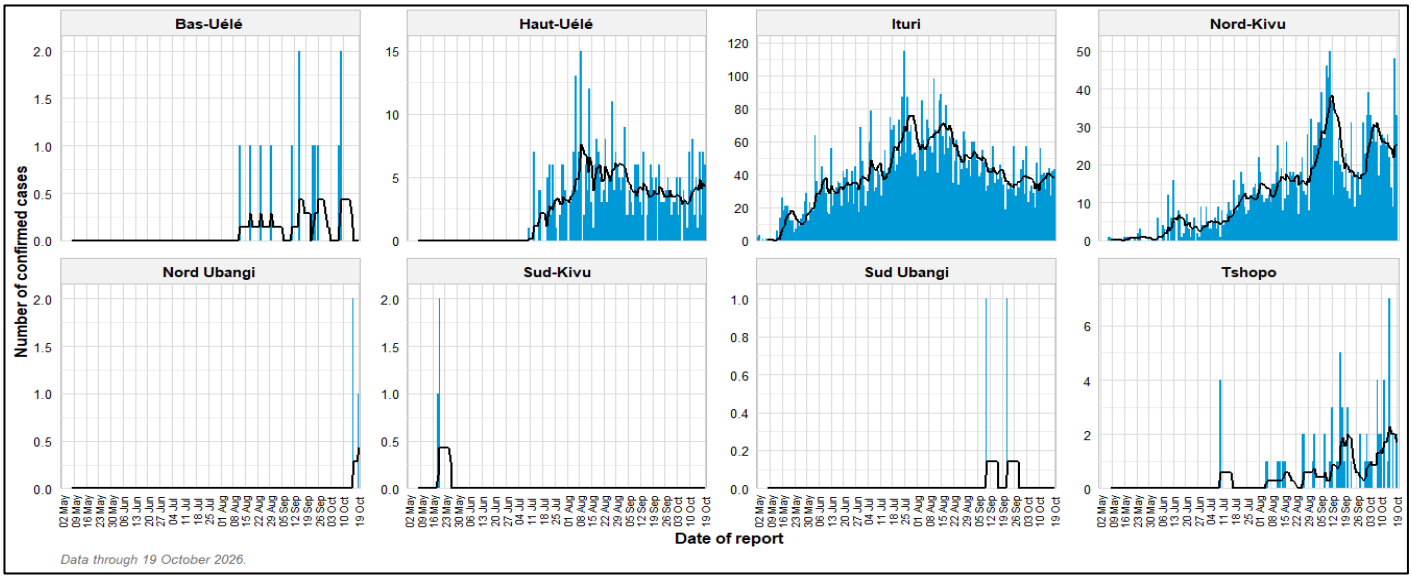


Figure 2. Daily provincial trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 19 October 2026

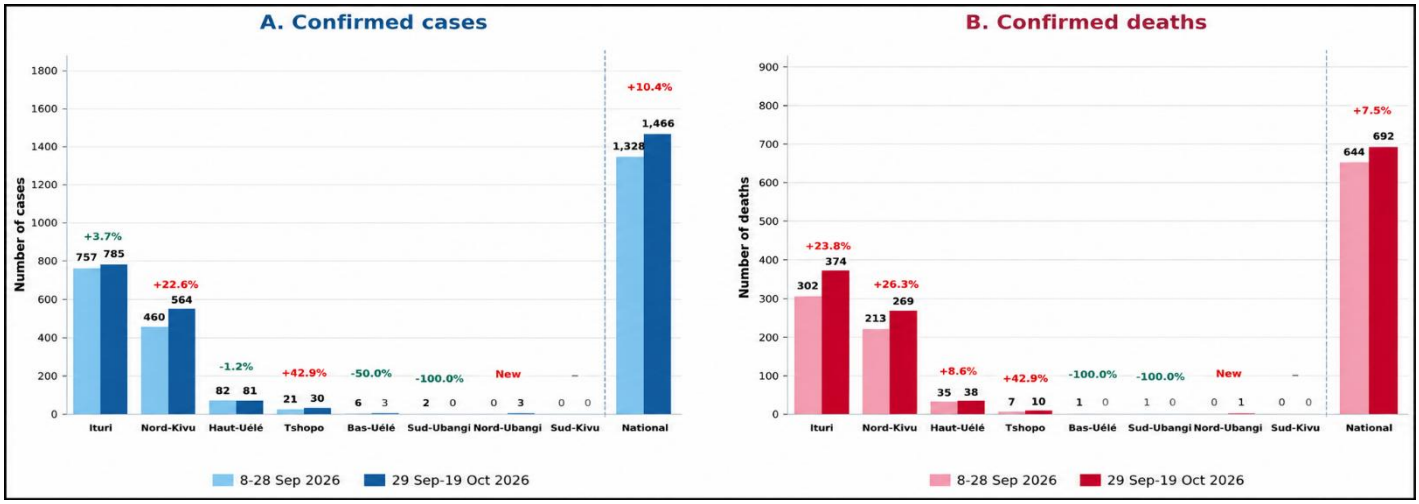


Trend Analysis (21-day comparison):

During the most recent 21-day period (29 September – 19 October 2026), a total of 1466 confirmed cases were reported nationally, compared with 1328 cases during the preceding 21 days (8 – 28 September), representing an increase of 138 cases (+10.4%). Provincial trends remain heterogeneous. Cases increased in Ituri from 757 to 785 (+3.7%), accounting for 53.5% of national cases during the latest period. In Nord-Kivu, cases increased from 460 to 564 (+22.6%), accounting for 38.5% of national cases while in Haut-Uélé cases decreased slightly from 82 to 81 (−1.2%), accounting for 5.5% of national cases.

During the same period, a total of 692 confirmed deaths were reported nationally, compared with 644 deaths during the preceding 21 days (8 – 28 September), representing an increase of 48 deaths (+7.5%). Deaths increased from 302 to 374 (+23.8%) in Ituri, from 213 to 269 (+26.3%) in Nord-Kivu, from 35 to 38 (+8.6%) in Haut-Uélé, and from seven to ten (+42.9%) in Tshopo. The increase in confirmed deaths, particularly in Ituri and Nord-Kivu, reflects a worsening mortality burden alongside rising national case incidence.

Figure 3. Bundibugyo virus disease cases and deaths by province across consecutive 21-day periods, 08 – 28 September 2026 compared with 29 September – 19 October 2026, Democratic Republic of the Congo



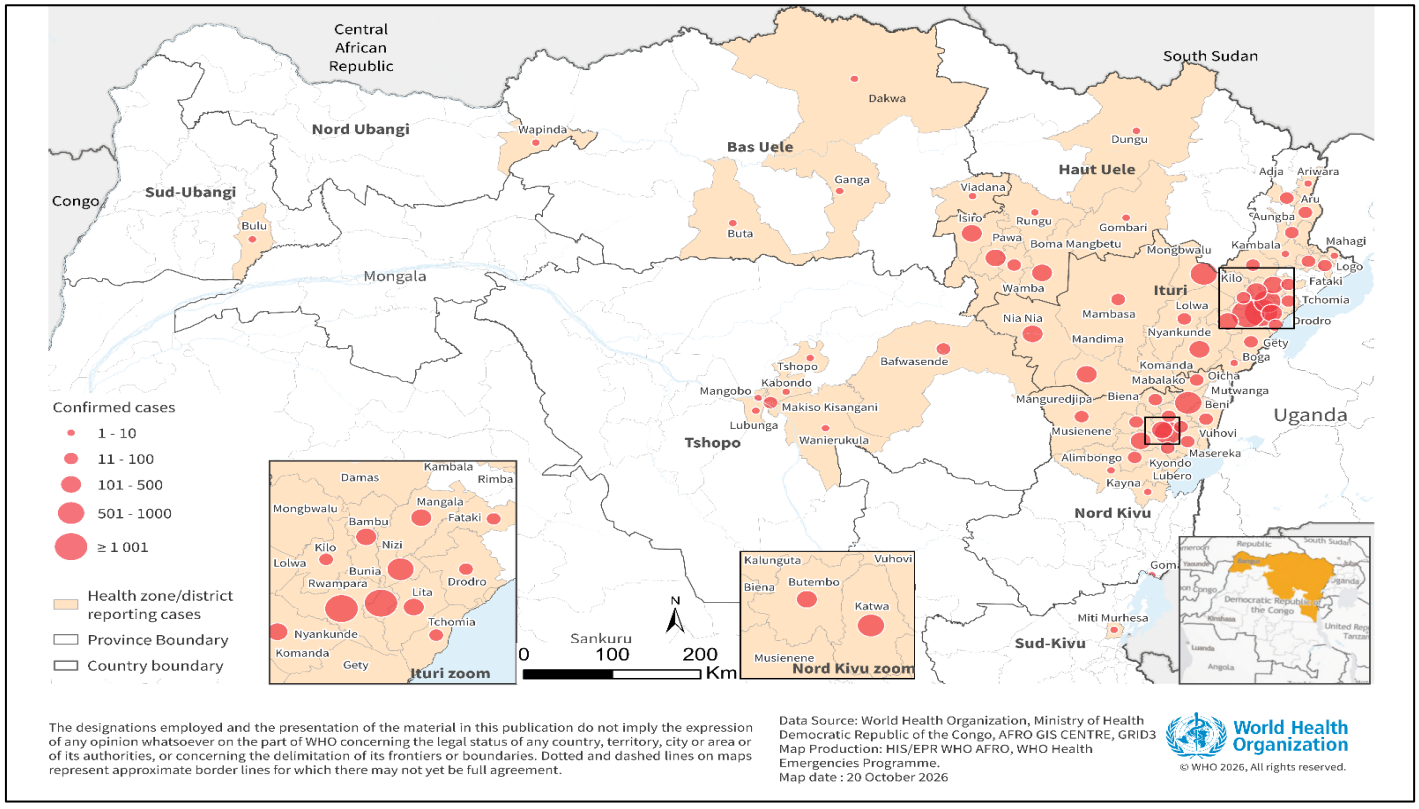
Transmission remained active in more than three-quarters of all health zones affected since the start of the outbreak. Of the 66 health zones affected to date, 50 (75.8%) reported at least one new confirmed case during the most recent 21 days (29 September – 19 October 2026). Case incidence increased in 31 health zones while 21 health zones reported a decreased in cases comparing the two periods. The largest absolute increase occurred in Mandima, Ituri (87 to 216 cases; +148.3%), while substantial increases were also observed in Mambasa (12 to 45; +275.0%) and several health zones in Nord-Kivu, particularly Mabalako (22 to 47; +113.6%), Oicha (17 to 28; +64.7%) and Beni (158 to 194; +22.8%) (Figure 4).

There were also 16 health zones without a new case in the last 21 days. These include Adja, Ariwara, Aungba, Boga, Drodro, Kambala and Mahagi in Ituri; Goma in Nord-Kivu; Dungu and Gombari in Haut-Uélé; Lubunga and Wanie-Rukula in Tshopo; Miti-Murhesa in Sud-Kivu; Buta and Viadana in Bas-Uélé; and Bulu in Sud-Ubangi.

Figure 4. Health zones reporting increase in cases in the last 21 days, data as of 19 October 2026

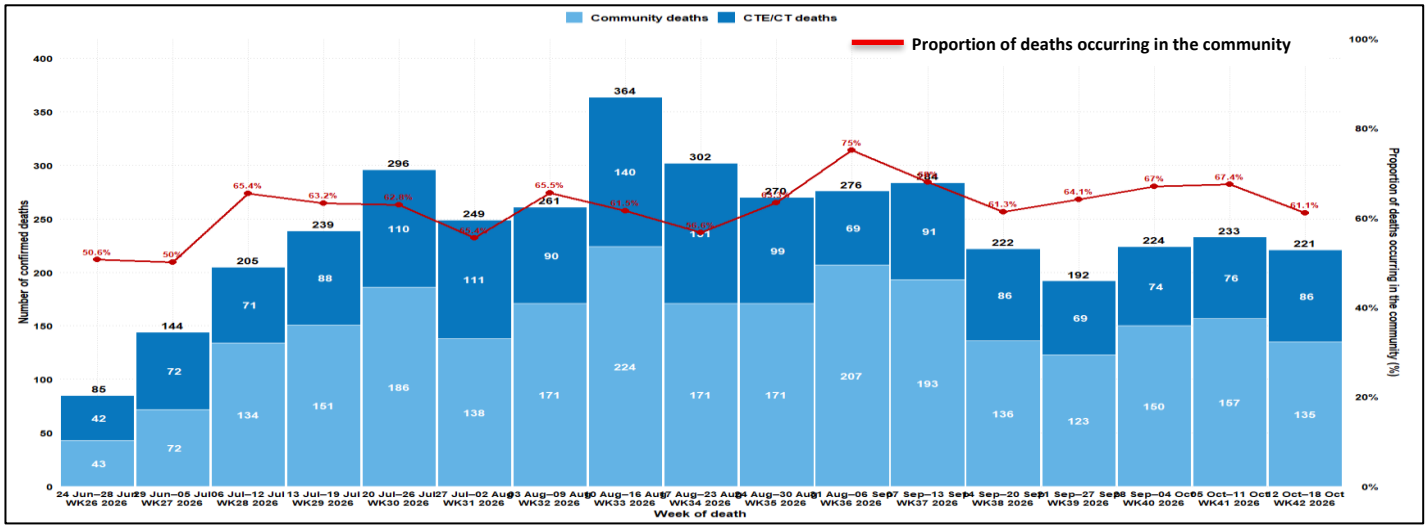
Province	Health zone	8-28 Sep 2026 (cases)	29 Sep-19 Oct 2026 (cases)	% change
Ituri	Aru	0	5	New
	Gethy	0	4	New
	Kilo	2	3	+50.0%
	Logo	0	1	New
	Mambasa	12	45	+275.0%
	Mandima	87	216	+148.3%
	Nizi	52	57	+9.6%
	Nyankunde	3	6	+100.0%
	Rimba	1	7	+600.0%
	Rwampara	83	89	+7.2%
Nord-Kivu	Beni	158	194	+22.8%
	Butembo	41	57	+39.0%
	Katwa	82	88	+7.3%
	Kayna	0	2	New
	Kyondo	8	11	+37.5%
	Lubero	14	15	+7.1%
	Mabalako	22	47	+113.6%
	Alimbongo	0	5	New
	Musienene	22	31	+40.9%
	Mutwanga	10	17	+70.0%
	Oicha	17	28	+64.7%
	Vuhovi	21	24	+14.3%
Haut-Uélé	Rungu	0	4	New
	Wamba	24	42	+75.0%
Tshopo	Bafwasende	3	10	+233.3%
	Kabondo	1	5	+400.0%
	Mangobo	3	4	+33.3%
	Tshopo	0	2	New
Bas-Uélé	Dakwa	0	1	New
	Ganga	1	2	+100.0%
Nord-Ubangi	Wapinda	0	3	New

Figure 5. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 19 October 2026



Weekly confirmed deaths (Figure 6) declined by 5.2%, from 233 during 5–11 October to 221 during 12–18 October 2026, reversing the upward trend observed over the preceding two weeks. Community deaths decreased from 157 to 135 (−14.0%), while deaths in treatment facilities increased from 76 to 86 (+13.2%). Consequently, the proportion of deaths occurring in the community declined from 67.4% to 61.1%. Despite the overall reduction, more than six in ten confirmed deaths continued to occur in the community, highlighting persistent challenges in early case detection, timely referral and access to treatment.

Figure 6. Weekly number of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological week 26 – 42, 2026



Kenya

Since the previous report, Kenya has confirmed eight additional cases of BVD, bringing the cumulative total to nine cases, including one death (CFR: 11.1%). All eight new cases were epidemiologically linked to the imported index case and were already under quarantine when they developed symptoms. The secondary cases included four family members and four hospital staff.

Of the nine confirmed cases, seven were male and two were female, with ages ranging from 24 to 65 years. Eight patients are currently in isolation and receiving treatment at two designated facilities. All are reportedly in stable condition.

A total of 135 contacts have been listed, comprising 46 airport staff, 45 hospital staff, 26 passengers, 14 relatives and four flight crew members. Of these, eight have tested positive for BVD (four relatives and four hospital staff). Eight passengers travelled outside Kenya, and the authorities in their destination countries were notified. Among the 119 contacts remaining under follow-up in Kenya, 118 (99.2%) are in quarantine, while one passenger remains outside quarantine.

Figure 7. Confirmed Bundibugyo virus disease cases in Kenya by date of report, 06 – 19 October 2026

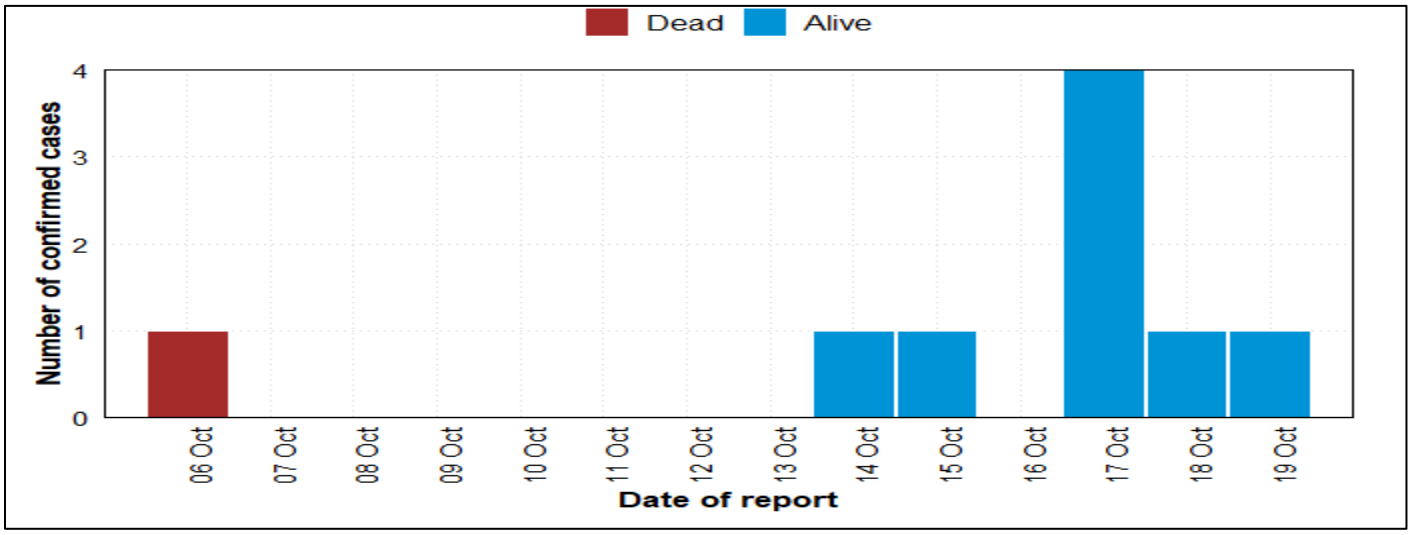


Table 1. Contact listing and quarantine status by contact category, Kenya, as of 19 October 2026

Contact category	Contacts Listed	Positive Contacts	Travelled out of Kenya	Under follow-up	In quarantine n (%)	Not in quarantine
Passengers	26	0	8	18	17 (94.4%)	1
Flight crew	4	0	0	4	4 (100%)	0
Jomo Kenyatta International Airport staff	46	0	0	46	46 (100.0%)	0
Relatives	14	**4**	0	10	10 (100.0%)	0
Hospital Staff	45	**4**	0	41	41 (100.0%)	**0**
Total	**135**	**8**	**8**	**119**	**118 (99.2%)**	**1**

Nigeria

On 20 October 2026, the Federal Ministry of Health of Nigeria announced a confirmed case of BVD in the Federal Capital Territory, Abuja. The case involved a woman who reportedly travel from Uganda to Nigeria on 3 October 2026. She developed symptoms on 7 October 2026 and sought care at a private health facility on 11 October 2026. Following clinical deterioration, laboratory testing confirmed BVD on 20 October 2026. The patient is currently in isolation and receiving treatment. A total of 44 close contacts have so far been identified, including healthcare workers, patients, caregivers and travel contacts. Additional investigation is underway to establish her travel itinerary, including all those who may have been potentially exposed while the case was symptomatic.

Public health response

Coordination

- Joint WHO–Africa CDC–partner coordination continues through the Continental Incident Management Support Team (CIMST), with increasing emphasis on translating epidemiological intelligence into coordinated operational action across affected countries.

- The CIMST has initiated an assessment of the collective response performance to identify operational gaps and lessons learned, strengthen accountability, and reassess preparedness and response priorities in affected and at-risk countries, particularly in light of the recent international spread.

- In the Democratic Republic of the Congo, the Government continues to implement a recently adopted 180-day multisectoral response plan which provides an operational framework a six-month period. The plan prioritizes surveillance and contact tracing, clinical care, community engagement and risk communication, logistics, and preparedness in at-risk areas, with estimated implementation requirements of US$1.3 billion. A national incident management team led by the government with support from WHO and partners continue to coordinate response activities.

- In Kenya, a national task force has been activated to provide strategic oversight and coordinate the national outbreak response. An Incident Management Team is in place to coordinate technical and operational activities, while the Public Health Emergency Operations Centre remains activated to support response coordination, information management and operational monitoring.

- A broad network of partners continues to support response operations across affected and at-risk countries, including UNICEF, the International Organization for Migration (IOM), Médecins Sans Frontières (MSF), the Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Samaritan's Purse, the European Union, the Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams and StandBy partners. Support includes surveillance, clinical care, laboratory services, logistics, technical assistance and specialist deployments.

Operations Support and Logistics (OSL)

Democratic Republic of the Congo

- The emergency supply pipeline is valued at US$15.90 million, a decrease of US$0.23 million from the previously reported US$16.13 million. Of the total, US$7.57 million (48%) has been delivered, US$2.28 million (14%) is in transit, and US$1.25 million (8%) is being arranged for shipment.

- Cumulative inbound deliveries have increased to 524.4 metric tonnes and 3,236.3 m³, compared with 473.6 metric tonnes and 2,799.8 m³ previously reported. The delivered value increased by US$0.59 million (+8.4%), from US$6.98 million to US$7.57 million.

- Critical commodities delivered include 9.73 million examination gloves, 130 295 hooded coveralls, 348 700 Level 3 gowns, 20 016 RadiOne PCR tests, 18 076 infrared thermometers, 8640 manual PCR tests and 477 hospital beds. A further 130 534 hooded coveralls, 15 400 Level 3 gowns and 284 hospital beds are in transit, while 498 000 examination gloves, 19 975 hooded coveralls and 35 200 Level 3 gowns are not yet ready for shipment.

- Personal protective equipment and infection prevention and control (PPE/IPC) supplies remain the largest procurement category at US$5.11 million, followed by laboratory supplies (US$4.86 million), medical supplies (US$3.29 million), logistics (US$2.09 million) and kits (US$0.55 million).

- Overall, the proportion of the supply pipeline delivered has increased from 43% to 48%, reflecting continued progress in procurement and inbound deliveries. However, approximately 52% of the pipeline remains undelivered, including 31% awaiting procurement, shipment arrangements or readiness.

Kenya

- A total of 21 partners have been mapped, with approximately US$41.1 million in financial commitments for the outbreak response, primarily from the Government of Kenya (US$20.3 million) and the United States Government (US$14.52 million), alongside contributions from other humanitarian and development partners.

- In-kind contributions valued at approximately US$650,000 have been mobilized, including US$116,000 from WHO for viral haemorrhagic fever (VHF) kits, PPE and surge support, and US$534,000 from the Government of India. India's donation comprised approximately 11 metric tonnes of medical supplies and equipment, including 30 000 N95 masks, more than 7000 protective gowns, approximately 10 000 nitrile gloves, 60 powered air-purifying respirators, six biosafety cabinets and four cold-chain refrigerators.

- WHO has delivered five PCR machines and 20 diagnostic kits, sufficient for approximately 2000 tests, to the Ministry of Health to expand diagnostic capacity.

- Additional partner support includes infection prevention and control supplies, laboratory and biosafety equipment, clinical management materials, and commodities for point-of-entry screening, alongside technical assistance for surveillance, contact tracing and case management.

Surveillance

Democratic Republic of the Congo

- 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 12 – 18 October 2026, a total of 23 290 alerts were reported, averaging 3327 alerts per day, an increase of 26.1% from 18 472 (2639 per day) during the preceding week (5 – 11 October). Alert verification remained high at 99.1%. A total of 3654 alerts were validated as suspected cases, of which 3574 were investigated. Among those investigated, 1715 (48.0%) were isolated and transferred within 24 hours, compared with 48.9% in the preceding week. Overall, the substantial increase in alert volume was accompanied by consistently high verification performance; however, timely isolation and referral remain a critical weakness in the alert-management cascade, with fewer than half of investigated suspected cases isolated and transferred within 24

hours.

- From 12 – 18 October 2026, the contact-tracing workload increased, with an average of 33 611 contacts requiring daily follow-up, compared with 28 466 during 5 – 11 October, representing an 18.1% increase. Average follow-up performance declined from 81.4% to 79.0%, remaining well below the ≥95% operational target. As of 19 October, a total of 31 725 contacts were under follow-up, of whom 24 679 (77.8%) were seen. Overall, the increased workload was accompanied by a deterioration in follow-up performance, with approximately one in five contacts not reached each day, highlighting persistent gaps in contact-tracing capacity.

- At points of entry (PoEs) and points of control (PoCs), a total of 283,933 travellers were recorded on 19 October 2026, of whom 97.5% were screened. Overall reporting completeness declined to 88.3%, ranging from 55.6% in Sud-Kivu and Tshopo to 100% in Haut-Uélé. Eight alerts were reported across PoEs/PoCs, including three each in Ituri and Tshopo, and one each in Sud-Kivu and Haut-Uélé. Three live alerts were validated as suspected cases, all investigated within four hours, but only two (66.7%) were transferred to treatment centres. Two deceased persons were intercepted, one each in Ituri and Sud-Kivu, of whom only one was sampled. Operational challenges persist, including the continued closure of the Butuhe PoC in Nord-Kivu and the Avakubi PoC in Ituri due to insecurity, inadequate isolation facilities at selected PoEs in Sud-Kivu, and shortages of PPE, IPC supplies and dedicated ambulances.

Kenya

- Since May 2026, more than 350 alerts have been reported and investigated across 17 counties in Kenya, reflecting nationwide surveillance and investigation activities for suspected BVD cases.

- A total of 135 contacts have been listed, including 46 airport staff, 45 hospital staff, 26 passengers, 14 relatives and four flight crew members. Eight contacts have tested positive for BVD (four relatives and four hospital staff), while eight passengers travelled outside Kenya and their destination countries were notified. Of the 119 contacts remaining under follow-up in Kenya, 118 (99.2%) are in quarantine, with one passenger not in quarantine.

- Border screening continues nationwide in Kenya. On 19 October 2026, a total of 2990 travellers were screened at points of entry, including 2,849 arriving from Uganda and 141 from the Democratic Republic of the Congo, bringing the cumulative number screened to 701 989 since May 2026. A total of 588 conveyances were screened during the reporting period, bringing the cumulative total to 145 090. No new suspected cases were detected in the past 24 hours, while 20 suspected cases have been identified cumulatively at points of entry.

Laboratory

Democratic Republic of the Congo

- Diagnostic capacity remains substantially expanded and decentralized, from two laboratories at the onset of the outbreak to 26 active laboratories, including eleven primarily using open RT-PCR platforms and 19 using RadiOne near-point-of-care PCR platforms, with a combined reported testing capacity of over 5000 samples per day. Decentralized testing is operational across the principal affected provinces. The most recent laboratory was established in Biakato, within Mandima Health Zone, Ituri Province. 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 over US$1.5 million in laboratory supplies and critical equipment for new and existing laboratories. WHO shared forecasts of laboratory needs for the next six months with partners to inform coordinated planning and resource mobilization.

Kenya

- Five laboratories have been designated for BVD diagnosis, comprising the National Virology Reference Laboratory (NVRL), Kenya Medical Research Institute (KEMRI) laboratories in Nairobi and Kisumu, and two mobile laboratories at the Busia and Lwakhakha border points. Confirmed cases have been diagnosed through testing at the NVRL and KEMRI laboratories. Sample referral is operational across all counties, with a reported turnaround time of 6 – 12 hours, including confirmatory testing. On 15 October 2026, WHO delivered five PCR machines and 20 diagnostic kits, sufficient for approximately 2000 tests, to the Ministry of Health. Training is being organized by the Regional Office, and the external laboratory assessment to take place next week

- Genomic sequencing conducted in Kenya confirmed that the Bundibugyo ebolavirus detected in the country is closely related to the virus currently circulating in the Democratic Republic of the Congo.

Case Management

- Case-management demand remains high, with 1029 patients in isolation or treatment nationally as of 19 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. As of 19 October 2026, Ituri had 431 hospitalized patients (193 confirmed and 238 suspected), with bed occupancy of 42.5%, including 57 patients in critical condition. Nord-Kivu had 509 hospitalized patients, including 332 in treatment facilities, where bed occupancy reached 81.0%; 177 patients (34.8%) were being managed outside designated treatment facilities, while occupancy of beds for suspected cases reached 86.5% (166/192). Haut-Uélé had 29 hospitalized patients, including six in critical condition, with bed occupancy of 17.2%, while Tshopo had 13 hospitalized patients, corresponding to 36.1% occupancy. In Bas-Uélé, 20 new patients were admitted, bringing the total in isolation to 47, with all three beds designated for confirmed cases occupied (100%).

- 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 2,574 as of 19 October. An additional 24 recoveries were reported on 19 October, including 10 in Nord-Kivu, seven in Haut-Uélé, five in Ituri, and two in Tshopo.

- 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 remained a major concern, particularly in Nord-Kivu and Haut-Uélé. Between 12 and 19 October 2026, repeated IPC assessments in Nord-Kivu recorded mean scores ranging from 36.3% to 49.4%, substantially below the ≥80% standard. In Haut-Uélé, facility assessments identified scores as low as 13.0%, while in Tshopo, the CS Mbilinga recorded an IPC score of 43.5%. In Bas-Uélé, 16 of 20 priority healthcare facilities lacked functional triage, all 20 lacked adequate mattresses, and 17 lacked sufficient water storage for 72 hours.

- IPC activities continued at scale but remained uneven across affected provinces. In Ituri, 160 of 306 targeted IPC rings (52.3%) were opened between 12 and 19 October, while 250 of 317 targeted households (78.9%) were decontaminated. In Nord-Kivu, daily ring activation ranged from 37.5% to 78.9% on days with available data, while household decontamination remained particularly low, reaching only 18.5% on 18 October. Haut-Uélé generally achieved high household and healthcare facility decontamination coverage, although ring activation remained inconsistent. In Tshopo, healthcare facility monitoring, staff briefings and targeted decontamination continued across affected health zones.

- Safe and dignified burial (SDB) activities increased, with improvements in overall performance. National SDB requests averaged approximately 180 per day in October, compared with 140 in September, while the proportion completed increased from approximately 81% in early October to 95% by 19 October (three-day moving average). Nevertheless, provincial reports documented persistent gaps, particularly in Ituri and Nord-Kivu, where unsuccessful burials, delayed interventions and incomplete body swabbing continued. On 19 October alone, Ituri completed 85 of 115 SDB requests (73.9%), while Nord-Kivu completed 48 burials, with 44 requests carried forward to the following day.

- Operational constraints continued to undermine IPC implementation. In Ituri, insufficient ring activation, incomplete household decontamination and resistance to SDB activities persisted throughout the reporting period. In Nord-Kivu, ring activation and household decontamination remained inadequate, particularly in Beni, Katwa and surrounding health zones. Decontamination teams were reportedly assaulted in Butsili and Butanuka in Beni Health Zone on 18 October. Community resistance, delayed family consent and insufficient burial supplies also contributed to outstanding SDB requests.

- Material and infrastructure gaps persisted across affected provinces. In Nord-Kivu, decontaminated households repeatedly received no IPC kits, while shortages of equipment and supplies constrained field operations. Tshopo continued to report insufficient IPC materials, trained personnel and reliable water supplies in healthcare facilities. In Bas-Uélé, inadequate triage facilities, water storage, waste management infrastructure and essential IPC equipment remained major concerns. Haut-Uélé continued to report shortages of IPC kits, limited mobility and incomplete reporting from affected health zones.

Risk Communication and Community Engagement (RCCE)

Democratic Republic of the Congo

- Community engagement activities remained extensive across affected provinces during 12–19 October 2026. In Ituri, a total of 160 116 household visits were reported, reaching 560 516 people over the eight-day period. Activities also included educational discussions, mass sensitization, community dialogues, advocacy with religious and traditional leaders, and radio broadcasts. In Nord-Kivu, household visits, educational discussions and mass communication continued, including the “STOP EBOLA” campaign in Beni, broadcast through more than 72 media outlets, and sensitization of 217 motorcycle taxi drivers in Musienene.

- RCCE continued to support surveillance, contact tracing, case management and safe and dignified burials. In Ituri, community teams facilitated the identification and pre-listing of contacts, household decontamination, communication of positive laboratory results, referral of suspected cases and engagement with families regarding safe burials.

- Community feedback management and reporting remained suboptimal, particularly in Ituri and Nord-Kivu, where gaps in reporting completeness, community alert detection and timely feedback resolution continued to constrain RCCE effectiveness.

- Community engagement continued across other affected provinces, including Bas-Uélé, Haut-Uélé and Nord-Ubangi, through household visits, school sensitization, community dialogues and engagement with religious and traditional leaders, supporting alert detection, safe burials and community participation in response activities.

Kenya

- RCCE coordination and public communication have been intensified, with daily partner coordination, activation of the RCCE technical working group, finalization of the RCCE strategic and infodemic management plans, and

engagement of 127 editors and journalists.

- Government communication has expanded through official press briefings, television interviews, digital and social media, public health advisories, and 20 educational posters in English and Kiswahili. The national toll-free hotline (719) and complementary digital communication channels are operational to provide public information and facilitate reporting of suspected cases.

- Community engagement and infodemic management have been strengthened through daily social listening, weekly analysis of community concerns and targeted engagement with community and religious leaders. Emerging concerns include misinformation, declining public trust, fears of movement restrictions, stigma and questions about response preparedness.

- Priorities include strengthening real-time rumour management, mobilizing community health promoters across 27 priority counties, and expanding community outreach.

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.

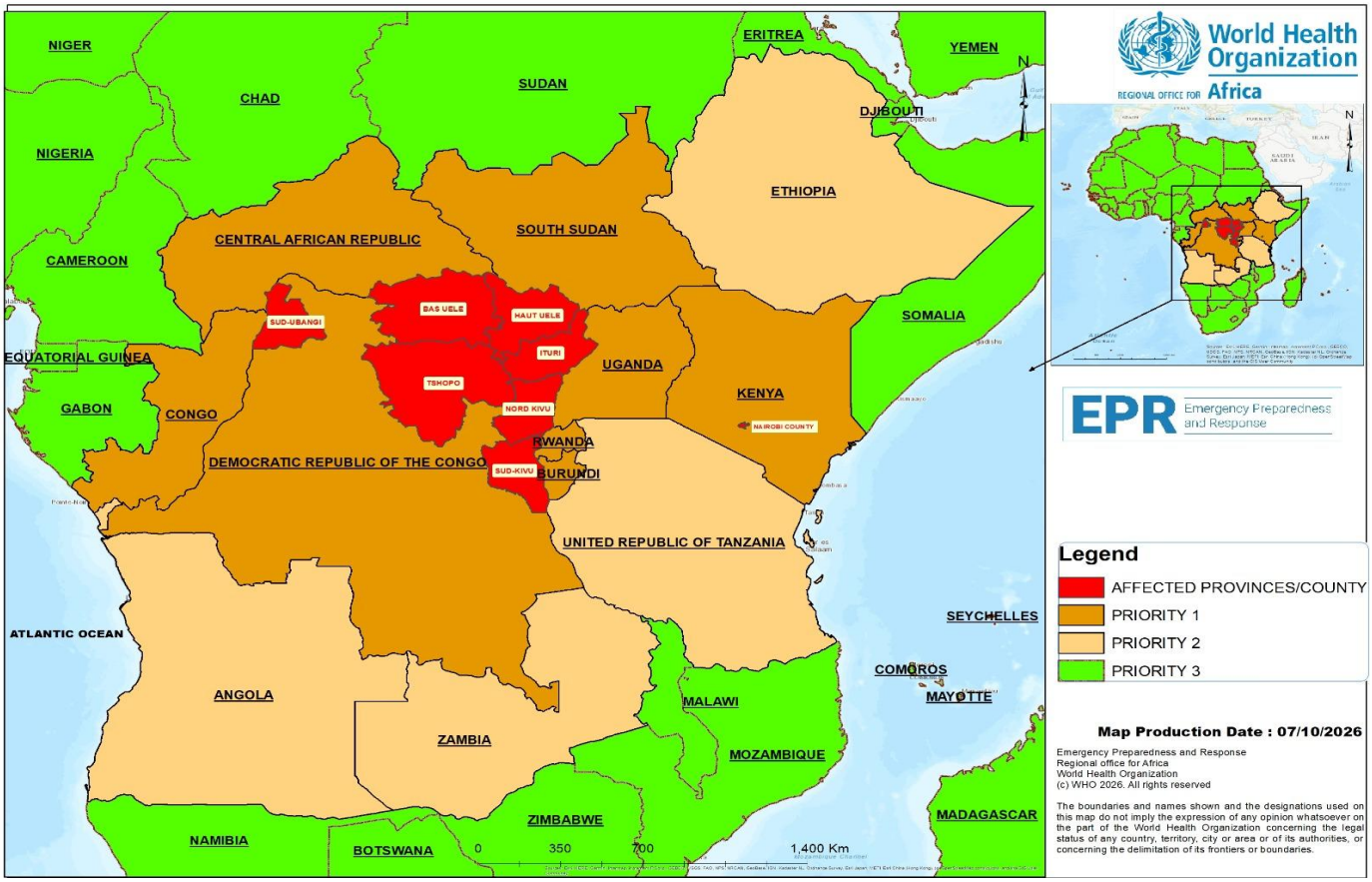
Public health preparedness

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 8. Regional prioritization of countries for Bundibugyo virus disease preparedness and response, as of 18 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

- Surveillance 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, Kenya, Nigeria 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, South Sudan and other neighbouring countries 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, particular attention continues to be given to high- volume mobility corridors, including river, road and air transport networks connecting affected and at-risk areas, 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, contingency plans and simulation exercises to support surveillance, safe management of suspected cases, infection prevention and control, environment hygiene and sanitation, sensitization of travellers, and engagement of border communities.

- 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. With several major mass gathering events upcoming, including the Youth Olympic Games in Senegal, the evolving BVD situation underscores the importance of maintaining enhanced vigilance and proportionate, risk-based preparedness and response measures, consistent with WHO guidance.

Situation interpretation

The BVD outbreak remains at a critical juncture, with sustained transmission in the Democratic Republic of the Congo and international spread highlighting persistent gaps in outbreak containment. In the Democratic Republic of the Congo, escalating insecurity, displacement and restricted humanitarian access are further challenging response operations and increasing the risk of undetected transmission. In Kenya, the identification of all secondary cases among known, quarantined contacts is encouraging, suggesting that transmission chains remain traceable, although continued surveillance is essential to detect any unrecognized spread. In Nigeria, the prolonged period between symptom onset and confirmation raises concern about potentially undetected exposures and secondary transmission, requiring urgent retrospective investigation and intensified surveillance. Priorities should focus on targeted interventions in transmission hotspots, restoring operational access in insecure areas, strengthening early detection and rapid containment, and intensifying coordinated cross-border surveillance and information sharing to prevent further international spread.

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