World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Kenya | Nigeria

Weekly External Situation Report 24, Data as of 1 November 2026

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

8 Provinces **67** Health Zones Affected	**5** Provinces **45** Health Zones Active Transmission*	**2 834** Cases Recovered	**50.2%** Bed Occupancy	**36 126** Contacts under follow up
961 Active Cases in Isolation	**354** Health Worker Cases	**55** Health Worker Deaths	**1 828** 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	895	480	10 532	5 126	48.7%	Active
Kenya	0	1	9	2	22.2%	Active
Nigeria	0	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 in the Democratic Republic of the Congo passed 10 000 confirmed cases during the reporting period and continues at a high, sustained level of transmission, driven increasingly by Nord-Kivu while Ituri remains the largest contributor. The importation events in Kenya and Nigeria have so far remained contained: no new case has been reported in Kenya since 19 October and all secondary cases occurred among contacts already in quarantine, while no secondary case has been identified in Nigeria. However, a one new death was reported in Kenya, bring the total number of deaths to two. In the Democratic Republic of the Congo, insecurity, health-worker strikes in Bas-Uélé and Tshopo and the suspension of response activities in Bafwasende Health Zone continue to constrain surveillance and response operations.

Democratic Republic of the Congo

As of 1 November 2026, the BVD outbreak in the Democratic Republic of the Congo has affected 67 health zones across eight provinces; Yakoma Health Zone in Nord-Ubangi Province was added to the list of affected zones on 28 October. Since ***External Situation Report #23***, an additional 895 confirmed cases and 480 confirmed deaths have been reported, bringing the cumulative total to 10 532 confirmed cases, including 5 126 confirmed deaths [crude case fatality ratio (CFR) 48.7%]. Transmission remains highly heterogeneous across affected areas. Ituri continues to account for the largest proportion of cumulative confirmed cases (70.6%), although its relative contribution is declining, while Nord-Kivu (23.9% of cumulative cases; CFR 55.4%) accounted for 60.0% of the cases reported on 1 November. Transmission persists at lower levels in Haut-Uélé and Tshopo.

National daily incidence rose steadily from May to its highest levels in late July and mid-August, declined through late September and has fluctuated at a high plateau since early October. The seven-day moving average ranged between 67 and 76 confirmed cases per day during the reporting period, peaking at 76 cases per day on 29–30 October before easing to 67 on 1 November, still below the mid-August peak of 94. Provincial trends diverge. Ituri continues its gradual decline from the late-July peak (seven-day average of 31 cases per day on 1 November, down from 38 on 19 October), while Nord-Kivu is rising again (30 cases per day, up from 26) and now reports almost as many cases as Ituri each day. Haut-Uélé remains stable at four to five cases per day, Tshopo shows low-level but sustained transmission, and Nord-Ubangi reported its first cases in October. Bas-Uélé, Sud-Kivu and Sud-Ubangi have reported no case in the last 21 days (Figures 1 and 2).

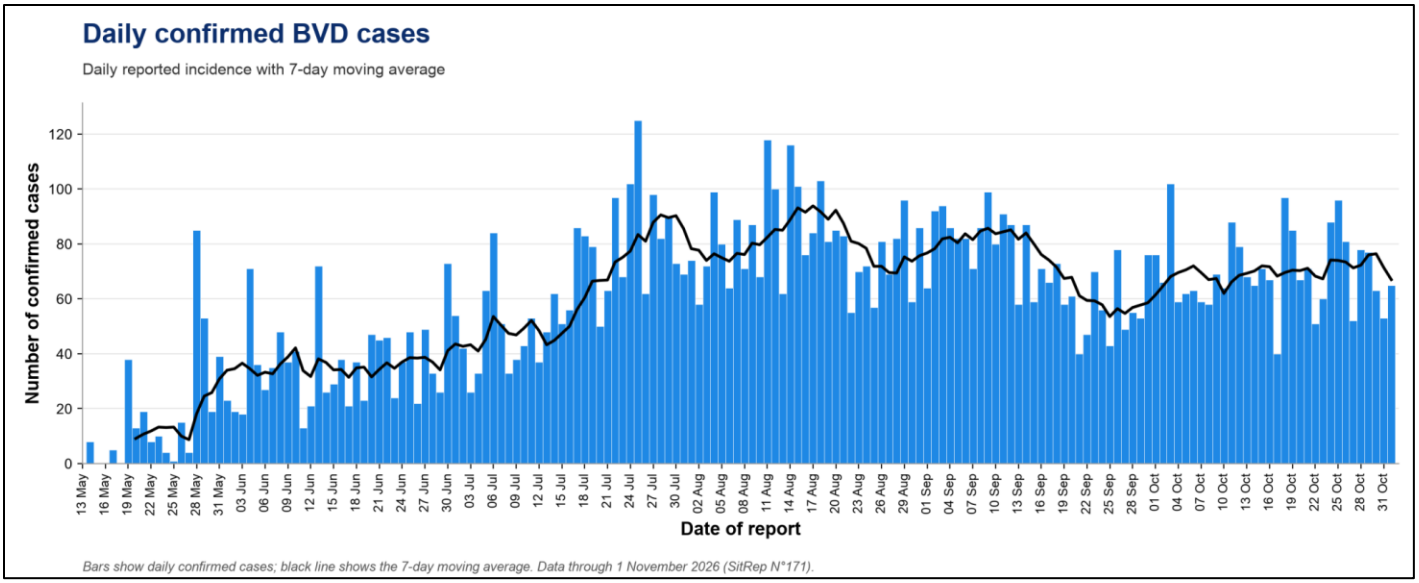


Figure 1. Daily national trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 1 November 2026

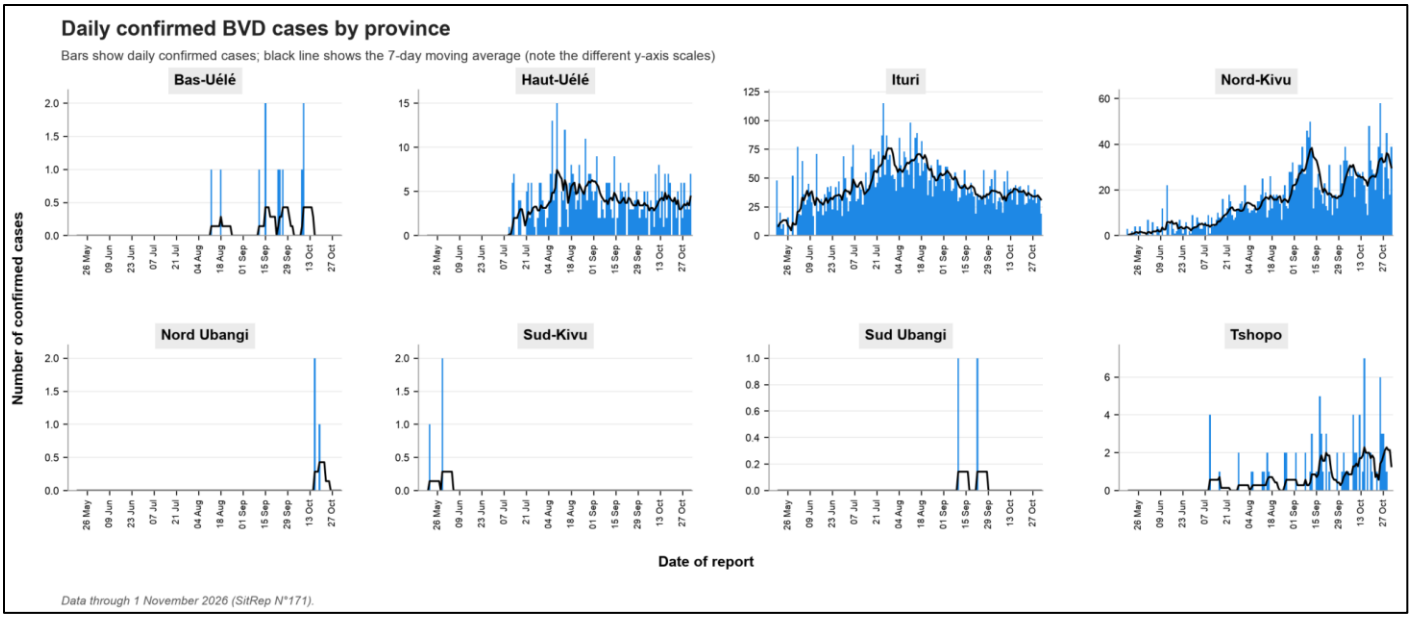


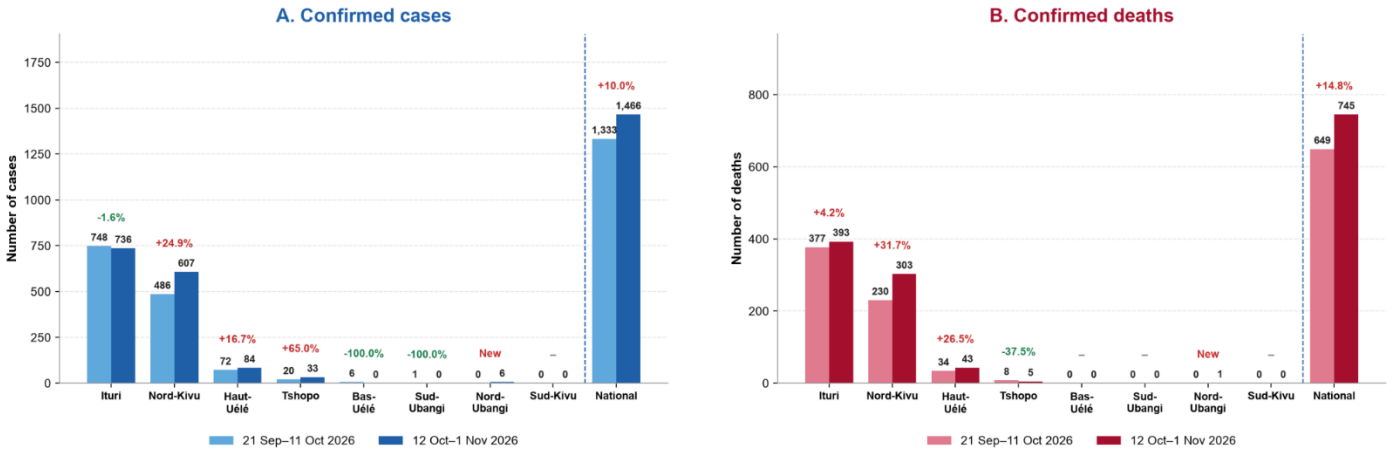
Figure 2. Daily provincial trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 1 November 2026

Trend Analysis (21-day comparison):

During the most recent 21-day period (12 October – 1 November 2026), a total of 1 466 confirmed cases were reported nationally, compared with 1 333 cases during the preceding 21 days (21 September – 11 October), representing an increase of 133 cases (+10.0%). Provincial trends remain heterogeneous. Cases in Ituri decreased slightly from 748 to 736 (−1.6%), accounting for 50.2% of national cases during the latest period. In Nord-Kivu, cases increased from 486 to 607 (+24.9%), accounting for 41.4% of national cases, while in Haut-Uélé cases increased from 72 to 84 (+16.7%), accounting for 5.7% of national cases. Tshopo reported 33 cases compared with 20 in the preceding period (+65.0%), and Nord-Ubangi reported its first six cases. Bas-Uélé and Sud-Ubangi, which reported six and one cases respectively in the preceding period, reported none.

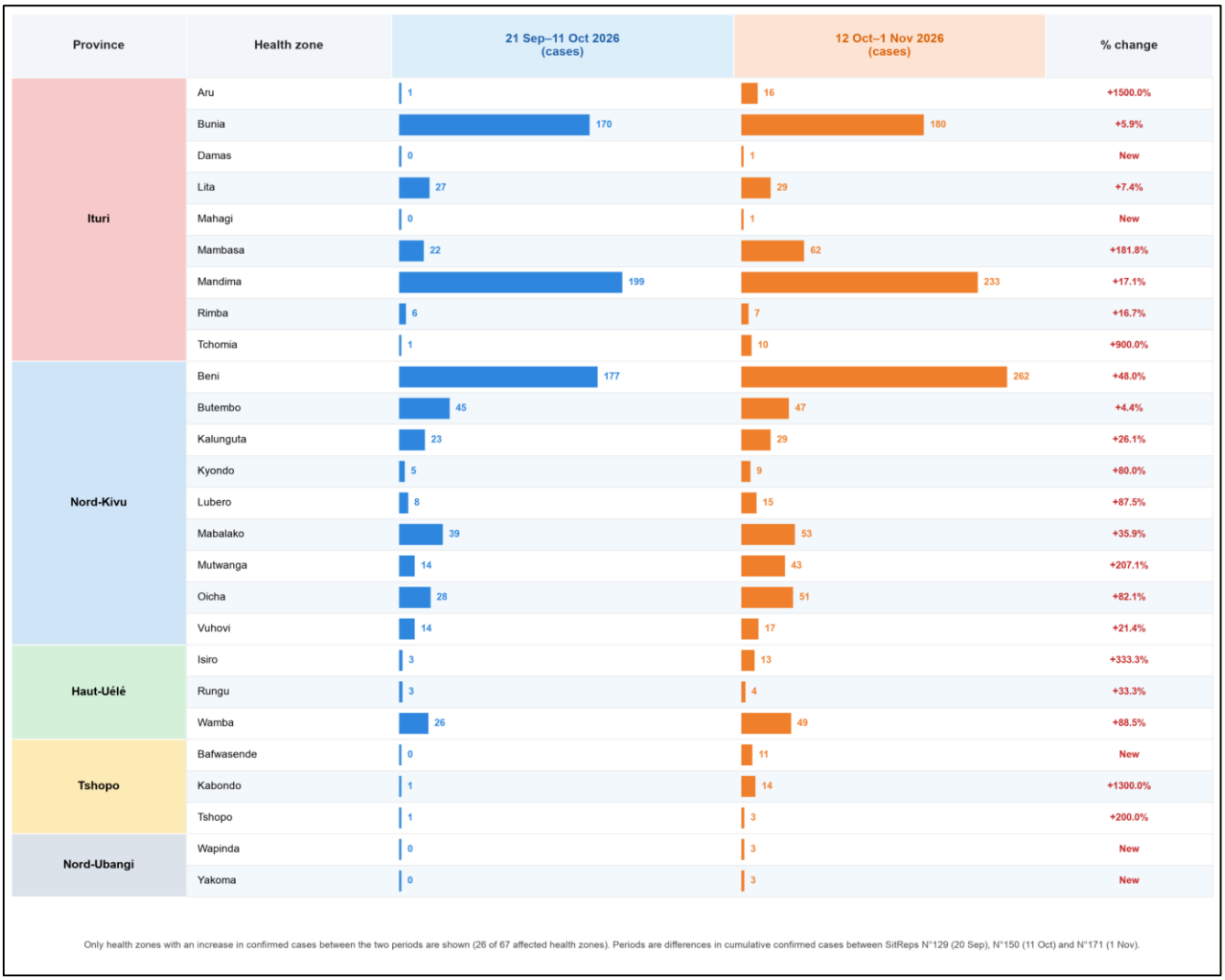
During the same period, a total of 745 confirmed deaths were reported nationally, compared with 649 deaths during the preceding 21 days (21 September – 11 October), representing an increase of 96 deaths (+14.8%). Deaths increased from 377 to 393 (+4.2%) in Ituri, from 230 to 303 (+31.7%) in Nord-Kivu and from 34 to 43 (+26.5%) in Haut-Uélé and decreased from eight to five in Tshopo; Nord-Ubangi reported its first death. The rise in deaths, concentrated in Nord-Kivu, outpaced the rise in cases, reflecting a worsening mortality burden in the province where transmission is now intensifying.

Figure 3. Bundibugyo virus disease cases and deaths by province across consecutive 21-day periods, 21 September – 11 October 2026 compared with 12 October – 1 November 2026, Democratic Republic of the Congo



Transmission remained active in two-thirds of all health zones affected since the start of the outbreak. Of the 67 health zones affected to date, 45 (67.2%) reported at least one new confirmed case during the most recent 21 days (12 October – 1 November 2026). Case incidence increased in 26 health zones, decreased in 27 and was unchanged in one when the two periods are compared. The largest absolute increase occurred in Beni, Nord-Kivu (177 to 262 cases; +48.0%), followed by Mambasa, Ituri (22 to 62; +181.8%), Mandima, Ituri (199 to 233; +17.1%), Mutwanga, Nord-Kivu (14 to 43; +207.1%), Oicha, Nord-Kivu (28 to 51; +82.1%) and Wamba, Haut-Uélé (26 to 49; +88.5%). Bafwasende in Tshopo (11 cases), Wapinda and Yakoma in Nord-Ubangi (three cases each) and Damas and Mahagi in Ituri (one case each) reported cases after none in the preceding period (Figure 4).

There were also 22 health zones without a new case in the last 21 days. These include Adja, Ariwara, Aungba, Boga, Drodro, Fataki, Gety, Kambala and Logo in Ituri; Goma and Kayna in Nord-Kivu; Dungu and Gombari in Haut-Uélé; Lubunga, Mangobo and Wanie-Rukula in Tshopo; Miti-Murhesa in Sud-Kivu; Buta, Dakwa, Ganga and Viadana in Bas-Uélé; and Bulu in Sud-Ubangi.



Province	Health zone	21 Sep–11 Oct 2026 (cases)	12 Oct–1 Nov 2026 (cases)	% change
Ituri	Aru	1	16	+1500.0%
	Bunia	170	180	+5.9%
	Damas	0	1	New
	Lita	27	29	+7.4%
	Mahagi	0	1	New
	Mambasa	22	62	+181.8%
	Mandima	199	233	+17.1%
	Rimba	6	7	+16.7%
	Tchomia	1	10	+900.0%
Nord-Kivu	Beni	177	262	+48.0%
	Butembo	45	47	+4.4%
	Kalunguta	23	29	+26.1%
	Kyondo	5	9	+80.0%
	Lubero	8	15	+87.5%
	Mabalako	39	53	+35.9%
	Mutwanga	14	43	+207.1%
	Oicha	28	51	+82.1%
	Vuhovi	14	17	+21.4%
Haut-Uélé	Isiro	3	13	+333.3%
	Rungu	3	4	+33.3%
	Wamba	26	49	+88.5%
Tshopo	Bafwasende	0	11	New
	Kabondo	1	14	+1300.0%
	Tshopo	1	3	+200.0%
Nord-Ubangi	Wapinda	0	3	New
	Yakoma	0	3	New

Only health zones with an increase in confirmed cases between the two periods are shown (26 of 67 affected health zones). Periods are differences in cumulative confirmed cases between SitReps N°129 (20 Sep), N°150 (11 Oct) and N°171 (1 Nov).

Figure 4. Health zones reporting an increase in confirmed cases between consecutive 21-day periods (21 September – 11 October compared with 12 October – 1 November 2026), Democratic Republic of the Congo, data as of 1 November 2026

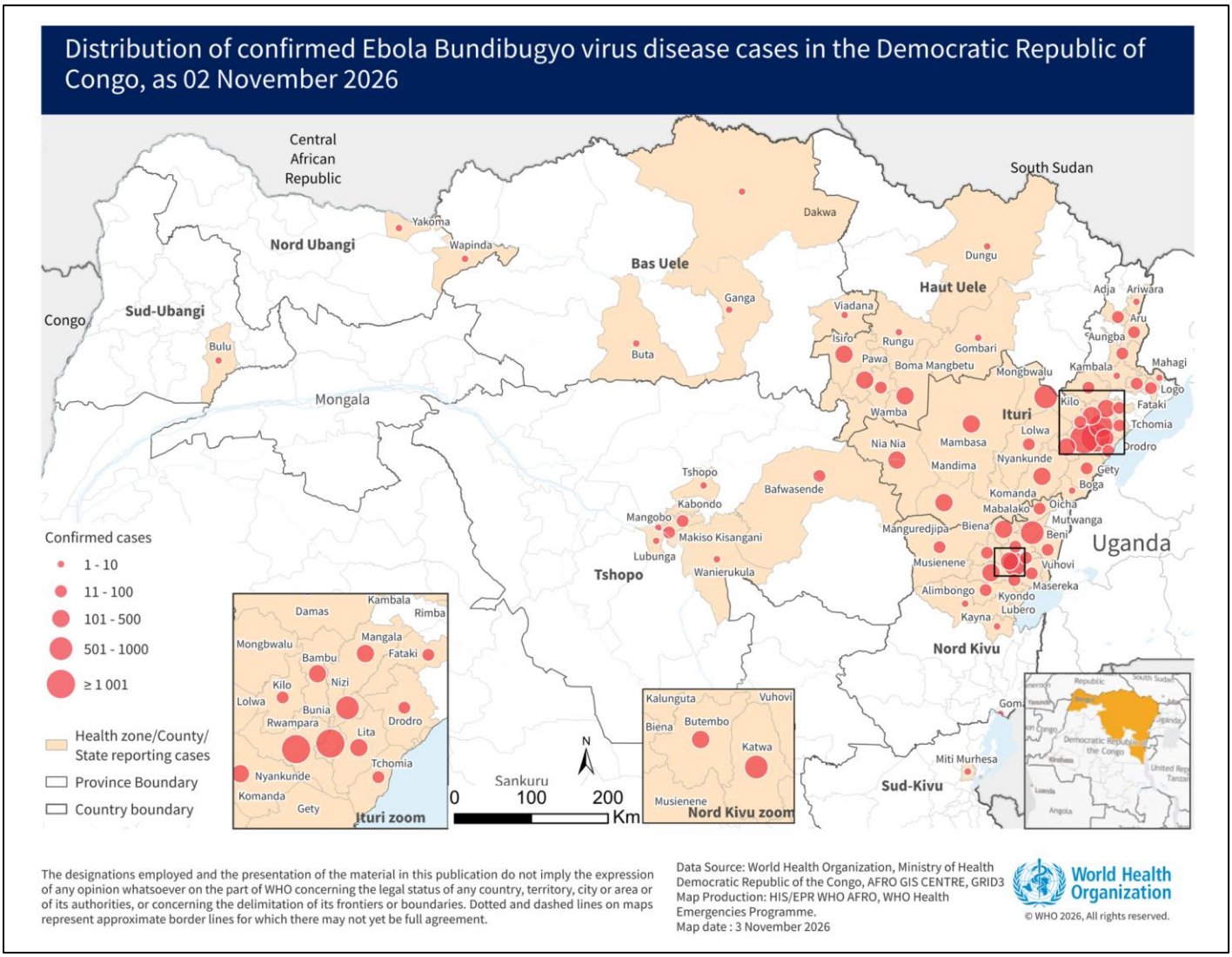


Figure 5. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 2 November 2026

Weekly confirmed deaths (Figure 6) rose to 286 during 19–25 October 2026, the highest weekly total since late August, before declining by 16.4% to 239 during 26 October – 1 November. Community deaths decreased from 184 to 155 (−15.8%) and deaths in treatment facilities from 102 to 84 (−17.6%), so that the proportion of deaths occurring in the community was essentially unchanged at 64.9% (64.3% the previous week). On 1 November alone, 20 of the 23 confirmed deaths (87.0%) occurred in the community. Close to two-thirds of confirmed deaths continue to occur outside treatment facilities, highlighting persistent challenges in early case detection, timely referral and access to treatment.

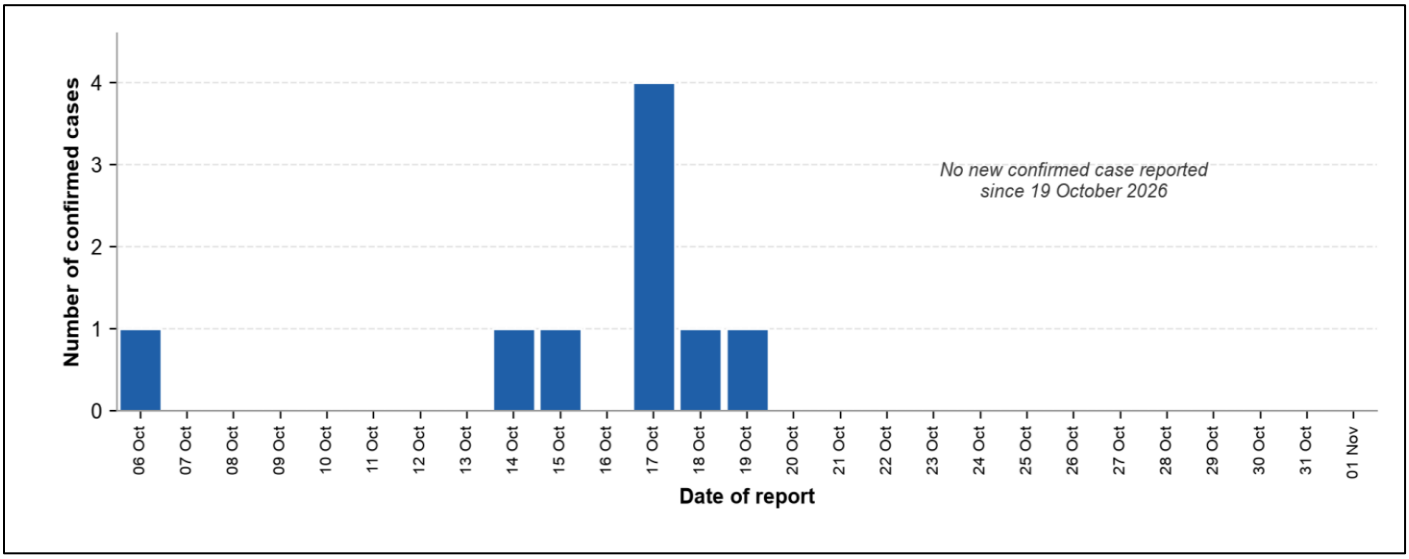


Figure 6. Weekly number of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological weeks 30 – 44, 2026

Kenya

Since the previous report, Kenya has reported no new confirmed case of BVD. The cumulative total remains nine confirmed cases, including two deaths (CFR 22.2%): the imported index case, who died on 5 October, and a 65-year-old family member who died on 23 October. All eight secondary cases (four family members and four hospital staff) were epidemiologically linked to the index case and were already under quarantine when they developed symptoms. The last confirmed case was reported on 19 October 2026; the 42-day countdown to the end of the outbreak will start once the last confirmed patient has been discharged after two negative tests.

Of the nine confirmed cases, seven were male and two were female, with ages ranging from 24 to 65 years. Seven patients remain under treatment in isolation at designated facilities, which have 211 isolation beds (scalable to 241), corresponding to a bed occupancy of 3.3%.

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 (5.9%) tested positive for BVD during quarantine (four relatives and four hospital staff), one of whom has died. As of 28 October, 98 contacts remained in quarantine in Kenya (41 hospital staff, 33 airport staff, 14 passengers and 10 family members), all of whom were followed up in the previous 24 hours (100%); 20 contacts (13 airport staff, four flight crew and three passengers) had completed follow-up and been discharged from quarantine; and nine passengers who travelled outside Kenya are being followed up through bilateral engagement with their Countries of destination.

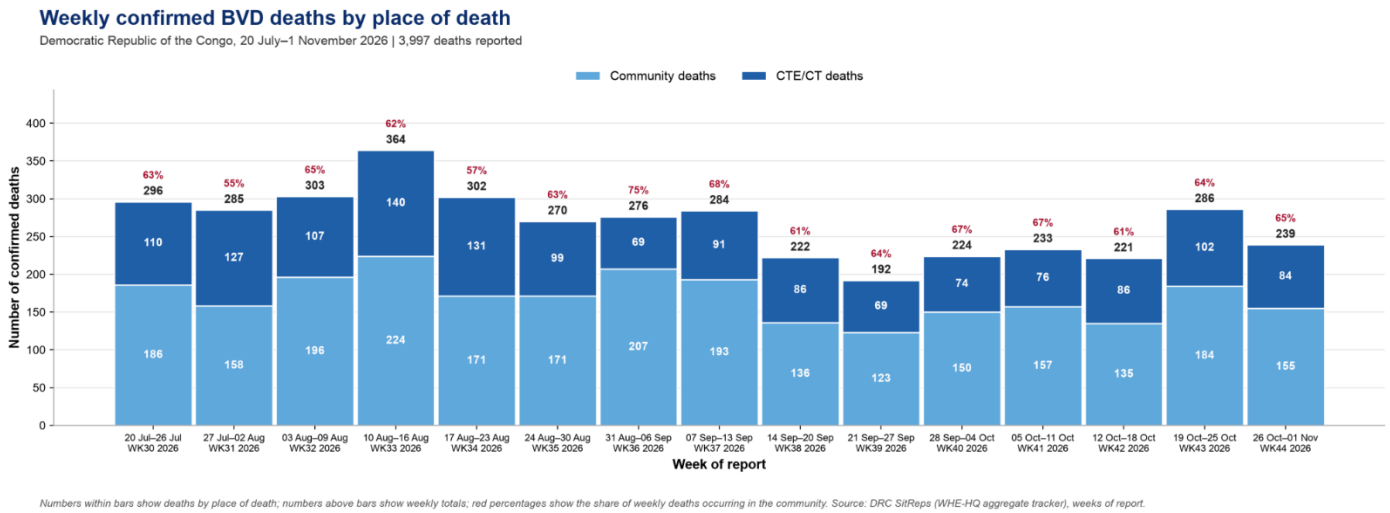


Figure 7. Confirmed Bundibugyo virus disease cases in Kenya by date of report, 06 October – 1 November 2026

Nigeria

Nigeria reported a single confirmed case of BVD, announced by the Federal Ministry of Health on 20 October 2026 in the Federal Capital Territory, Abuja. The case, a 42-year-old woman, arrived in Abuja from Uganda via Addis Ababa on 3 October, developed symptoms on 7 October and was admitted to a private health facility on 11 October. The patient was clinically stable and received supportive care before being medically evacuated to Switzerland on 26 October 2026. As of 31 October, no additional confirmed cases had been reported. As of 29 October, 62 contacts had been identified in Abuja Municipal Area Council, none of whom had developed symptoms, and 18 samples had been tested, of which one was positive. No secondary transmission has been detected; the 12-day interval between symptom onset and notification, eight days of which were spent in private-facility care, remains the main concern for undetected exposures.

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.

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 26 October – 1 November 2026, a total of 24 532 alerts were reported, averaging 3505 alerts per day, an increase of 10.1% from 22 284 (3183 per day) during the preceding week (19 – 25 October), when provincial reporting was incomplete on 25 October. Alert verification remained high at 98.7%. A total of 3550 alerts were validated as suspected cases, of which 3378 (95.2%) were investigated. Among those investigated, 1793 (53.1%) were isolated and transferred to a treatment centre within 24 hours, compared with 54.9% in the preceding week and 48.0% in mid-October. Although the timeliness of isolation has improved since mid-October, close to half of investigated suspected cases are still not isolated and transferred within 24 hours, which remains the main weakness of the alert-management cascade.

- From 26 October – 1 November 2026, the contact-tracing workload continued to grow, with an average of 36 750 contacts requiring daily follow-up, compared with 31 040 during 19 – 25 October (+18.4%) and 33 611 during 12 – 18 October. Average follow-up performance improved slightly, from 84.3% to 85.4%, but remains below the ≥95% operational target. As of 1 November, a total of 36 126 contacts were under follow-up in the six provinces that transmitted data, of whom 30 362 (84.0%) were seen. Follow-up was lowest in Tshopo (66.6%), where a health-worker strike and attacks on response teams continue to disrupt activities, and in Nord-Kivu (79.0%, with 64.7% in Beni and none of the 141 contacts in Kayna seen), compared with 90.8% in Ituri and 87.2% in Haut-Uélé. Approximately one in six contacts is still not reached each day.

- At points of entry (PoEs) and points of control (PoCs), a total of 255 806 travellers were recorded on 1 November 2026, of whom 97% were screened and 97% washed their hands. Overall reporting completeness was 79.5% (105 of 132 PoEs/PoCs), ranging from 45% in Bas-Uélé and 56% in Sud-Kivu and Tshopo to 97% in Ituri. Five alerts were notified, all in Ituri; all five were validated and investigated within 24 hours and four (80%) were transferred to treatment centres, one traveller having refused transfer. No deceased person was intercepted. Operational challenges persist, including the continued closure of the Butuhe PoC in Nord-Kivu since the security incident of 26 September, the absence of isolation facilities at the Kavimvira, Kalundu Port and Baraka PoEs in Sud-Kivu, the suspension of the Magambe PoC and non-reporting of five PoCs in Haut-Uélé owing to the health-worker strike and network outages, and low reporting completeness in Bas-Uélé linked to the strike and to connectivity and mobility constraints.

Kenya

- Kenya has maintained nationwide surveillance for suspected BVD since May 2026, with 28 counties having submitted samples for testing. As of 2 November, 611 samples had been tested, of which nine (1.5%) were positive, and no new alert had been reported by rapid response teams in the preceding 24 hours.

- 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 tested positive for BVD during quarantine (four relatives and four

hospital staff). As of 28 October, 98 contacts remained in quarantine in Kenya with 100% daily follow-up, 20 had completed follow-up and been discharged, and nine passengers who travelled outside Kenya are being followed up through bilateral engagement with the countries concerned.

- Border screening continues nationwide at 27 points of entry in Kenya. As of 2 November 2026, a cumulative 751 225 travellers had been screened since May 2026, up from 701 989 on 19 October. Twenty suspected cases had been identified cumulatively at points of entry as of 19 October, and no new suspected case at points of entry was reported during the period.

Laboratory

Democratic Republic of the Congo

- Diagnostic capacity remains substantially expanded and decentralized, from two laboratories at the onset of the outbreak to 26 laboratories reporting results during the reporting period, using open RT-PCR and 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, and the Nord-Ubangi provincial public health laboratory began reporting at the end of October. During 26 October – 1 November, 2885 new samples were tested nationally, of which 469 (16.3%) were positive; on 1 November, 464 samples were analysed and 65 (14.0%) were positive. Equipment constraints persist: one of the five RadiOne machines in Isiro (Haut-Uélé) and two modules of the Kisangani (Tshopo) platform are out of service, and the Kisangani laboratory is close to a stock-out of extraction buffer.

- 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; as of 2 November, 611 samples from 28 counties had been tested, nine of which were positive. 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 an external laboratory assessment is planned.

- 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

Democratic Republic of the Congo

- Case-management demand remains high, with 961 patients in isolation or treatment nationally as of 1 November, compared with 1029 on 19 October. The largest caseloads remain in Nord-Kivu and Ituri, which

together accounted for 896 patients (93.2%) currently under care.

- Capacity and utilization remain uneven across affected provinces. As of 1 November 2026, Ituri had 355 hospitalized patients (130 confirmed and 225 suspected), with bed occupancy of 34% (24% of beds for confirmed cases and 44% of beds for suspected cases), including 32 patients in critical condition; 47 new admissions, all suspected cases, were recorded against 69 discharges. Nord-Kivu had 541 patients under care (178 confirmed and 363 suspected, including 66 children under five years of age and six critically ill patients), of whom 179 (33.1%) were managed outside designated treatment centres; occupancy of CTE/CT beds reached 85.4% (362/424). Tshopo had 14 hospitalized patients (10 confirmed and four suspected) at the Météo CTE, corresponding to 38.9% occupancy (14/36), two of them in severe condition. Haut-Uélé transmitted no case-management data for the day. In Bas-Uélé, four new suspected cases were admitted, bringing the number of suspected cases isolated to 51 in the absence of a functional CTE, with the Buta CTE still under construction. Across the 86 treatment and isolation facilities reporting bed data on 1 November, 918 of 1828 beds (50.2%) were occupied, ranging from 16.0% in Haut-Uélé and 37.8% in Ituri to 77.0% in Nord-Kivu.

- Operational constraints remain important. In Nord-Kivu, CTE/CT beds are close to saturation (85.4%), one third of patients are managed outside dedicated treatment centres, only five of 16 ambulances were operational on 1 November and case-management reporting completeness was 79% (Butembo, Beni and Musienene missing). In Ituri, the shortage of blood products persists, 11 patients in Mandima did not receive food, admission capacity remains limited in Mambasa, Kilo, Lolwa, Mandima and Biakato, and the Kasenyi CTE did not report because of the health-worker strike. In Tshopo, two confirmed patients who escaped from the Bafwasende CTE remain untraced and a building of the CTE was burnt down, while response activities in the zone have been suspended since 24 October. Haut-Uélé continues to face shortages of nutritional inputs, and in Bas-Uélé none of the 51 isolated suspected cases receives nutritional support.

- Cumulative recoveries increased to 2834 as of 1 November, from 2574 on 19 October (+260). An additional 10 recoveries were reported on 1 November, including four in Ituri, four in Nord-Kivu 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

- Ervebo® vaccination and associated research activities continue, although implementation remains affected by intermittent vaccine availability. As of 19 October, 8 497 people had been vaccinated across 15 health zones in five provinces (Bas-Uélé, Tshopo, Kinshasa, Ituri and Sud-Ubangi) under research protocols. National reporting for 1 November indicates 2 448 people vaccinated in Ituri (1 036 women, including 26 pregnant and 72 breastfeeding women, and 1 412 men), with 35 non-serious and five serious adverse events following immunization notified since the start; 1 972 of 13 202 targeted persons (14.9%) vaccinated in Bas-Uélé, where 500 doses were received on 31 October for deployment in Bili Health Zone; and 1 191 of 7 105 targeted frontline workers (16.8%) vaccinated in Beni, Nord-Kivu, where 2 600 doses have been received. No vaccination was reported in Ituri on 1 November, pending redefinition of the frontline-worker target.

Infection Prevention and Control (IPC)

- IPC performance in healthcare facilities remained a major concern, particularly in Nord-Kivu, Tshopo and Bas-Uélé. On 1 November 2026, IPC-WASH scorecard assessments of four facilities in Beni, Musienene, Lubero and

Kalunguta (Nord-Kivu) recorded a mean score of 40.4%, substantially below the ≥80% standard; in Tshopo, the initial assessment of the CS Pekis recorded 24%, and across the province only 49 of 107 healthcare facilities (45.8%) have a functional triage circuit and 59 (55.1%) have received IPC kits. In Bas-Uélé, only 130 of 632 health workers (20.6%) are trained in IPC-WASH, 16 of 20 priority facilities lack functional triage, 17 lack water storage for 72 hours and no WASH partner supports activities around cases. During 26 October – 1 November, 125 healthcare facilities were assessed nationally, of which only six scored above 80%.

- IPC activities continued at scale but remained uneven across affected provinces. During 26 October – 1 November, 270 IPC rings were opened nationally (137 in Ituri and 127 in Nord-Kivu) and 475 of 594 targeted households (80.0%) were decontaminated, compared with 591 of 741 (79.8%) the previous week. Household decontamination reached 81.3% in Ituri (318 of 391) but only 70.9% in Nord-Kivu (100 of 141), where on 1 November 14 of 22 rings (63.6%) were opened and eight of 13 households decontaminated. Haut-Uélé and Tshopo achieved high household decontamination coverage (89.1% and 100%), while in Bas-Uélé no safe burial was performed on 1 November in the context of the health-worker strike.

- Safe and dignified burial (SDB) performance deteriorated at the end of the reporting period. National SDB requests averaged 187 per day in October, compared with 151 per day in September, while the proportion completed rose from 85.6% in September to 90.5% in October. During 26 October – 1 November, 1060 of 1216 requests (87.2%) were completed, compared with 1150 of 1274 (90.3%) the previous week, with 63 refusals. On 1 November, however, only 117 of 203 requests (57.6%) were completed and 80 were carried forward to the following day, including 61 of 116 requests in Nord-Kivu (54 completed) and 17 of 77 in Ituri (55 completed). Completion over the week was lowest in Nord-Kivu (407 of 510; 79.8%) and Bas-Uélé (two of five), compared with 92.5% in Ituri and Haut-Uélé and 96.8% in Tshopo.

- Operational constraints continued to undermine IPC implementation. In Ituri, ring activation remained incomplete (16 of 37 rings opened on 1 November) and 11 of 49 body swabs failed; in Nord-Kivu, ring activation and household decontamination remained inadequate, particularly in Beni and Katwa, and IPC teams required security escorts for decontamination in Benengule (Beni). In Tshopo, response activities have been suspended in Bafwasende since 24 October after a building of the CTE was burnt down, and gunfire by unidentified persons prevented health checks at the Iga Barrière PoC in Nizi (Ituri) on 1 November. Community resistance, delayed family consent and health-worker strikes in Bas-Uélé and Tshopo also contributed to outstanding SDB requests.

- Material and infrastructure gaps persisted across affected provinces. In Nord-Kivu, public places in Katwa and Oicha depended on 5360 litres of water supplied by the response and only two facilities in Katwa received IPC kits on 1 November; in Haut-Uélé, IPC supervisors are not yet activated in Rungu, Dungu, Boma Mangbetu and Gombari, only three of seven health zones transmitted data and IPC kits remain insufficient for healthcare facilities; in Tshopo, data-collection tools are not standardized and triage is not effective in the facilities visited; and in Bas-Uélé, the 20 priority facilities lack mattresses, 17 lack water-storage tanks and the Buta CTE is still under construction.

Risk Communication and Community Engagement (RCCE)

Democratic Republic of the Congo

- Community engagement activities remained extensive across affected provinces. In Nord-Kivu, 100 812 household visits reaching 359 746 people were reported during 26 October – 1 November 2026, together with daily educational discussions, mass communication sessions and briefings; on 1 November, a public forum was organized in Benengule health area (Beni) to address community concerns and rumours, and 68 students were sensitized in Butembo. In Ituri, 22 761 household visits reaching 93 224 people were reported on 1 November alone, together with 282 educational discussions, 46 mass sensitization sessions, two community dialogues and 11 advocacy meetings with authorities and leaders. In Tshopo, mass sensitization in markets, at the eight private river ports of Lubunga and Makiso and in 32 churches reached 126 697 people on 1 November, in addition to

3054 pupils and teachers of four schools in Kisangani, and the training of provincial and hotspot-zone RCCE actors on infodemic management was completed.

- RCCE continued to support surveillance, contact tracing, case management and safe and dignified burials. On 1 November in Ituri, community teams facilitated the pre-listing of 461 contacts around 16 confirmed cases, the decontamination of 48 of 48 households, 19 of 21 safe burials (90.5%), the communication of 16 of 16 positive laboratory results and the transfer of 59 of 73 suspected cases (80.8%). Community alerts remain an important source of detection: 367 community alerts, including 79 deaths, were notified in Ituri on 1 November, and 441 of 650 alerts (67.8%) in Nord-Kivu.

- Community feedback management and reporting remained suboptimal. On 1 November, six of nine community feedback items (66.7%) and seven of 10 incidents (70.0%) were resolved within 48 hours in Ituri, compared with 29 of 37 feedback items (78.4%) but only eight of 24 incidents (33.3%) in Nord-Kivu, where 2404 of 4750 people targeted (50.6%) were engaged in community actions. Gaps in reporting completeness, community alert detection and timely feedback resolution continue to constrain RCCE effectiveness in both provinces.

- Community engagement continued across the other affected provinces. In Haut-Uélé, 268 household visits reaching 1876 people, 33 educational discussions and eight mass activities in churches in Isiro, Pawa, Boma Mangbetu and Wamba (1584 people) were reported on 1 November, and BVD messages were integrated into the distribution of mosquito nets. In Bas-Uélé, 693 household visits reaching 3293 people, 11 mass sensitization sessions and a radio programme in Buta were reported, and community teams accompanied the discharge and community reintegration of survivors in Dakwa and Ganga; in Tshopo, two discharged survivors were accompanied and three of five refusals in Bafwasende were lifted.

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. The infodemic risk was assessed as high for 29 October – 1 November, with rising narratives around travel measures announced by Saudi Arabia and related livelihood concerns, stigma against cross-border workers and rumours about the identity of patients; claims that the outbreak is fabricated or already over, after 13 days without a new case, are being countered with messaging that closure requires 42 days without a case.

- 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 sensitization continued across the response. On 1 November 2026, 277 people were sensitized on PSEA and the reporting channels (495555/151) in Nord-Kivu, including 200 people (140 of them women) at the Letroc market in Beni with WHO support, 66 community leaders and health committee members in Mandje health area (Itebero) and 11 people in Katwa; in Ituri, 24 artisans were sensitized in Bunia, and the display of PSEAH messages and distribution of leaflets continued in Bunia, Aru, Mongbwalu, Mambasa, Fataki and Mandima health zones. Earlier in the reporting period, response staff and partner personnel were briefed and signed the code of conduct in Bunia, Rimba, Butembo and Beni, and community awareness sessions reached more than

1000 people per day in Nord-Kivu on several days.

- Coverage remains limited: on 1 November only Nord-Kivu and Ituri reported PSEA activities, a single partner (WHO) reports in Ituri, and the reporting mechanism is known in only 15 of 36 health zones (41.7%) in Ituri, eight of 34 (23.5%) in Nord-Kivu and seven of 23 (30.4%) in Tshopo. Visibility materials for mass sensitization remain insufficient and community-based complaint mechanisms are not yet effective.

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.

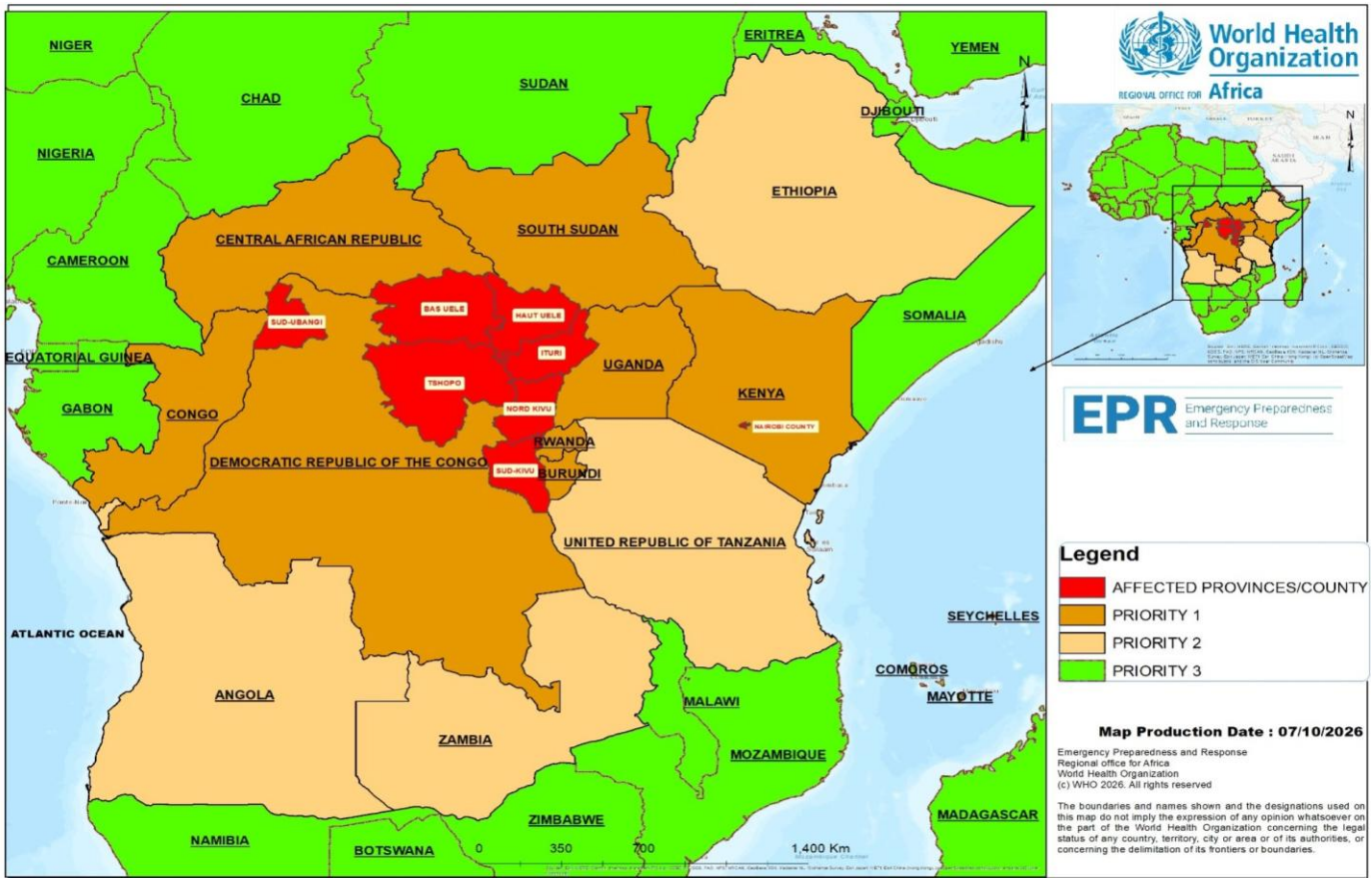


Figure 8. Regional prioritization of countries for Bundibugyo virus disease preparedness and response, as of 18 October 2026

- 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. In the Democratic Republic of the Congo, transmission is not declining: the cumulative count passed 10 000 confirmed cases, the national seven-day average has held between 67 and 76 cases per day for three weeks, and the epicentre is shifting towards Nord-Kivu, where cases rose by a quarter and deaths by a third over the last 21-day period, where one in three patients is managed outside dedicated treatment centres, and where contact follow-up and safe burial performance are the weakest. Health-worker strikes in Bas-Uélé and Tshopo, insecurity in Beni and Nizi and the suspension of activities in Bafwasende further increase the risk of undetected transmission. The absence of new cases in Kenya since 19 October and of secondary transmission in Nigeria is

encouraging and indicates that the exported chains have so far been contained, although continued surveillance is essential until the end-of-outbreak criteria are met. Priorities should focus on reinforcing response capacity in Nord-Kivu, particularly in Beni, Mutwanga, Oicha and Mabalako, restoring operational access in insecure and strike-affected areas, improving the timeliness of isolation of suspected cases and the completion of safe burials, and maintaining coordinated cross-border surveillance and information sharing to prevent further international spread.

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