World Health Organization
African Region

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Kenya | Nigeria

Weekly External Situation Report 25, Data as of 7 November 2026

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

8 Provinces **67** Health Zones Affected	**5** Provinces **46** Health Zones Active Transmission*	**2 940** Cases Recovered	**49.7%** Bed Occupancy	**33 346** Contacts under follow up
1 010 Active Cases in Isolation	**357** Health Worker Cases	**55** Health Worker Deaths	**1 792** Bed Capacity	**24** 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	388	197	10 920	5 323	48.7%	Active
Kenya	0	0	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 continues at a high, sustained level of transmission, with no sign of decline: close to 390 confirmed cases were added during the reporting period and the national seven-day average has stayed between 65 and 67 cases per day. Nord-Kivu now contributes almost as many cases as Ituri and accounts for the entire increase observed over the last 21 days, while contact follow-up fell to its lowest level in weeks at the end of the period. The importation events in Kenya and Nigeria remain contained: no new case has been reported in Kenya since 19 October, six of the seven surviving patients have been discharged and the last contacts will complete monitoring on 11 November, while no secondary case has been identified in Nigeria, where contact monitoring is expected to end on 13 November. In the Democratic Republic of the Congo, insecurity in Beni health zone in North Kivu and Bafwasende in Tshopo, health-worker strikes in Bas-Uélé and Tshopo and the continued suspension of response activities in Bafwasende constrain surveillance and response operations.

Democratic Republic of the Congo

As of 7 November 2026, the BVD outbreak in the Democratic Republic of the Congo has affected 67 health zones and 247 health areas across eight provinces; no new health zone was affected during the reporting period. Since ***External Situation Report #24***, an additional 388 confirmed cases and 197 confirmed deaths have been reported, bringing the cumulative total to 10 920 confirmed cases, including 5 323 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 (69.7%), although its relative contribution is declining, while Nord-Kivu (24.7% of cumulative cases; CFR 54.8%) accounted for 46.1% of the cases reported since the previous report, almost as many as Ituri (47.2%). Transmission persists at lower levels in Haut-Uélé (4.9% of new cases), Tshopo and Nord-Ubangi.

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 65 and 67 confirmed cases per day during the reporting period (64.7 on 7 November, compared with 67.0 on 1 November and a late-October high of 76), still well below the mid-August peak of 94. Provincial trends continue to diverge. Ituri continues its slow decline from the late-July peak (seven-day average of 29 cases per day on 7 November, down from 31 on 1 November and 38 on 19 October), while Nord-Kivu has risen to 31 cases per day (up from 30 on 1 November and 26 on 19 October) and exceeded Ituri on several days of the period. Haut-Uélé remains stable at three to four cases per day, Tshopo reports sporadic cases (last case on 5 November) and Nord-Ubangi reported three further cases in Yakoma and Wapinda. 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 7 November 2026

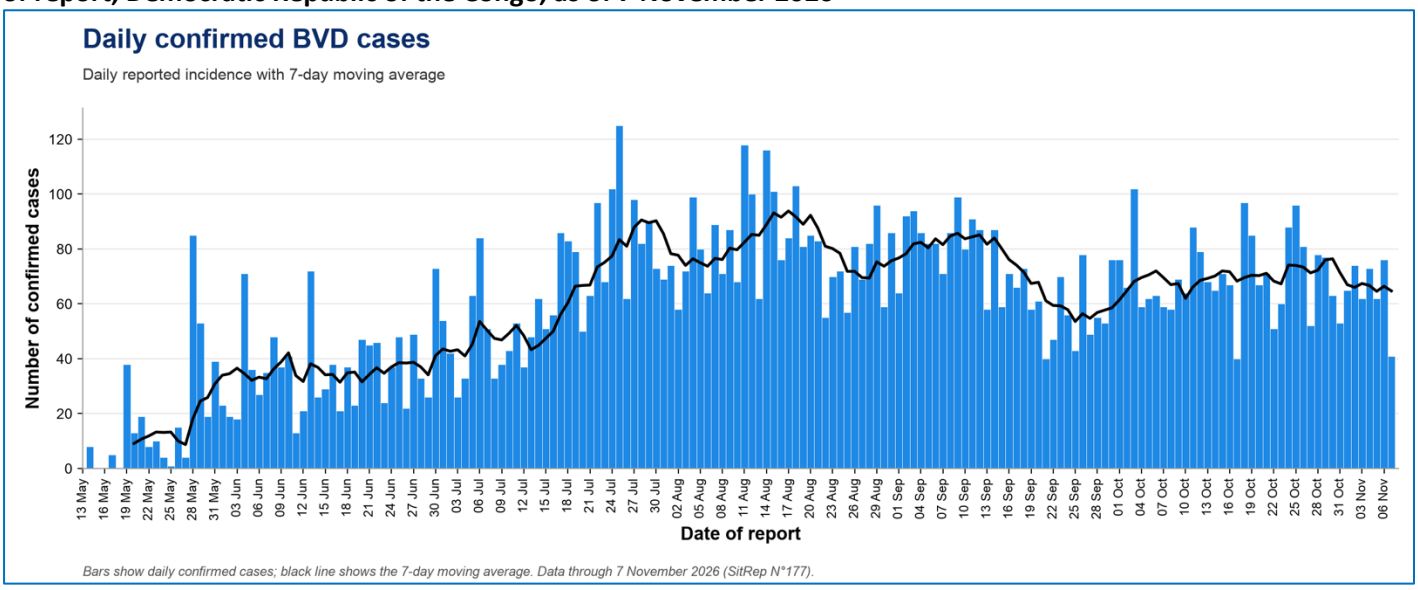
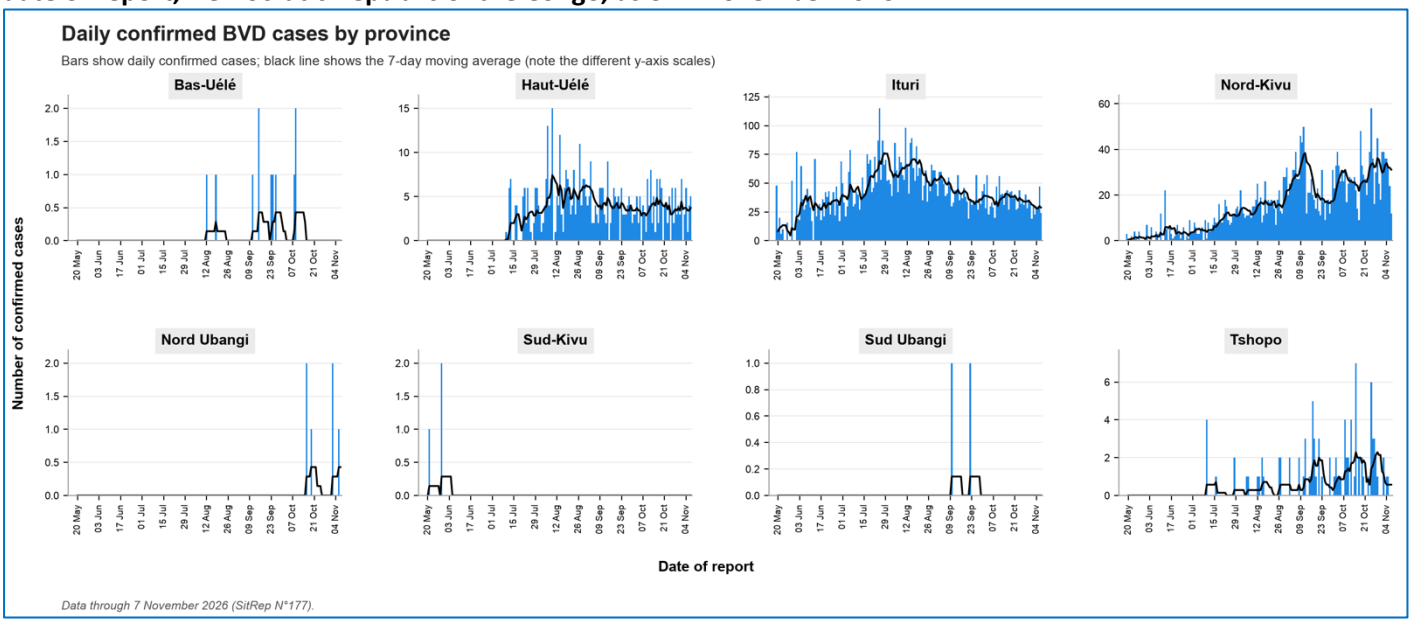


Figure 2. Daily provincial trend in confirmed Bundibugyo virus disease cases, with seven-day moving average, by date of report, Democratic Republic of the Congo, as of 7 November 2026



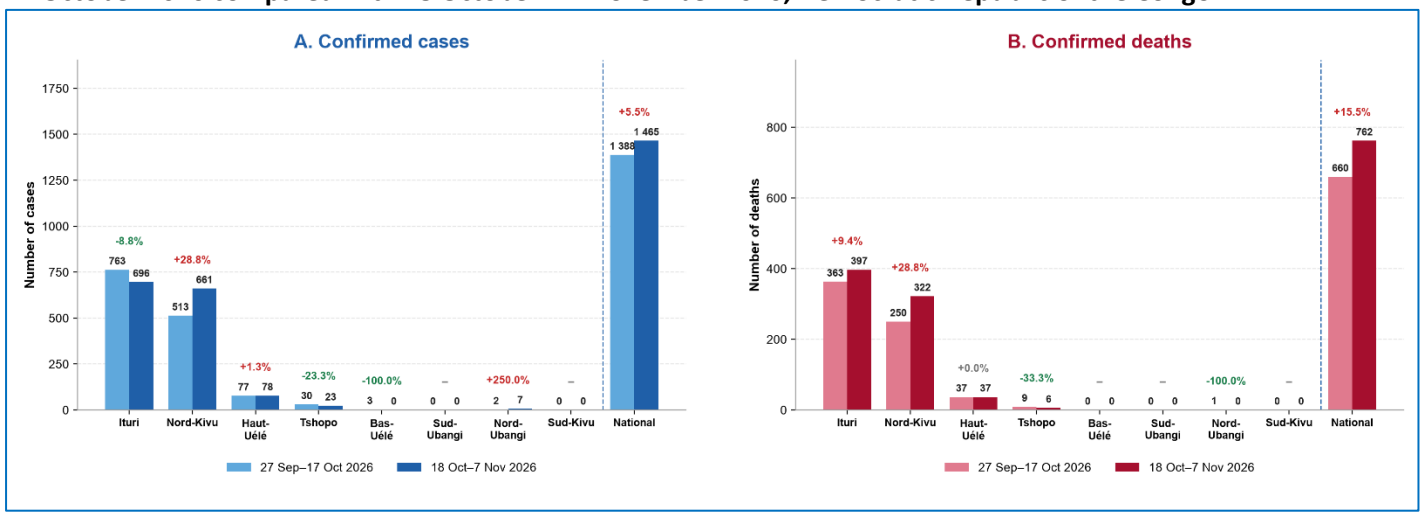
Trend Analysis (21-day comparison):

During the most recent 21-day period (18 October – 7 November 2026), a total of 1 472 confirmed cases were reported nationally, compared with 1 388 cases during the preceding 21 days (27 September – 17 October), representing an increase of 84 cases (+5.5%). Provincial trends remain heterogeneous. Cases in Ituri decreased from 763 to 696 (−8.8%), accounting for 47.5% of national cases during the latest period. In Nord-Kivu, cases increased from 513 to 671 (+31.0%), accounting for 45.1% of national cases, while in Haut-Uélé cases were stable at 77 and 78 (+1.3%), accounting for 5.3% of national cases. Tshopo reported 23 cases compared with 30 in the preceding period (−23.3%), and Nord-Ubangi

reported four cases compared with two. Bas-Uélé, which reported three cases in the preceding period, reported none; Sud-Kivu and Sud-Ubangi reported no case in either period.

During the same period, a total of 763 confirmed deaths were reported nationally, compared with 660 deaths during the preceding 21 days (27 September – 17 October), representing an increase of 102 deaths (+15.5%). Deaths increased from 363 to 397 (+9.4%) in Ituri and from 250 to 323 (+28.8%) in Nord-Kivu, were unchanged at 37 in Haut-Uélé and decreased from nine to six in Tshopo; Nord-Ubangi, which reported one death in the preceding period, reported none. As in the previous report, the rise in deaths outpaced the rise in cases and was concentrated in Nord-Kivu, where transmission is intensifying.

Figure 3. Bundibugyo virus disease cases and deaths by province across consecutive 21-day periods, 27 September – 17 October 2026 compared with 18 October – 7 November 2026, Democratic Republic of the Congo



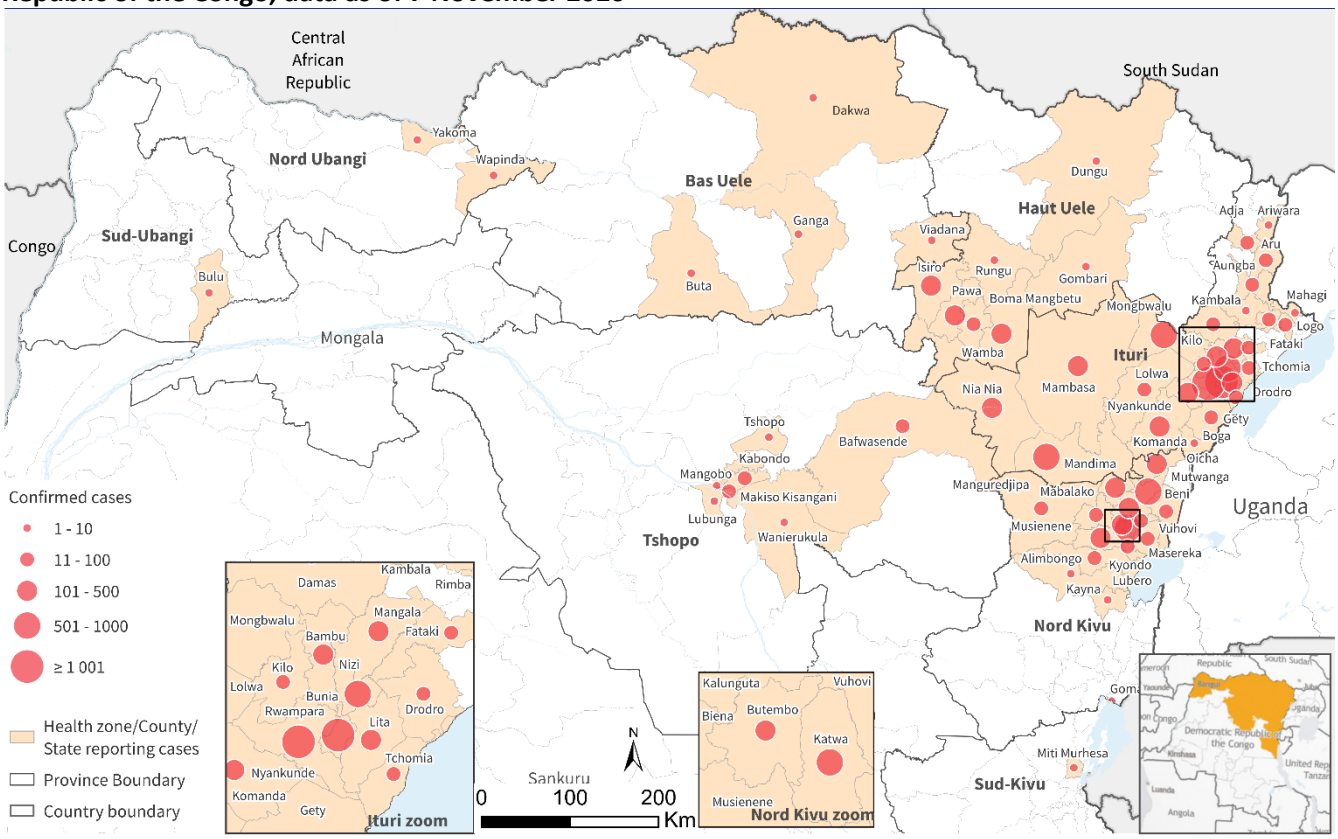
Transmission remained active in more than two-thirds of all health zones affected since the start of the outbreak. Of the 67 health zones affected to date, 51 (76.1%) in five provinces reported at least one new confirmed case during the most recent 21 days (18 October – 7 November 2026): 25 in Ituri, 15 in Nord-Kivu, five in Haut-Uélé, four in Tshopo and two in Nord-Ubangi. Case incidence increased in 23 health zones, decreased in 20 and was unchanged in one (Nyankunde) when the two periods are compared. The largest absolute increase again occurred in Beni, Nord-Kivu (177 to 309 cases; +74.6%), followed by Mutwanga, Nord-Kivu (12 to 71; +491.7%), Oicha, Nord-Kivu (26 to 54; +107.7%), Mambasa, Ituri (41 to 64; +56.1%), Aru, Ituri (3 to 14), Kabondo, Tshopo (4 to 15), Mabalako, Nord-Kivu (43 to 53; +23.3%), Isiro, Haut-Uélé (6 to 15) and Kalunguta, Nord-Kivu (25 to 34; +36.0%). Tchomia (10 cases) and Mahagi (two) in Ituri and Yakoma in Nord-Ubangi (four) reported cases after none in the preceding period (Figure 4). Conversely, the largest decreases were observed in Katwa, Nord-Kivu (84 to 45), Nia-Nia (46 to 14), Bunia (184 to 160), Rwampara (82 to 59) and Komanda (22 to 5) in Ituri, and Musienene (30 to 13) and Butembo (55 to 38) in Nord-Kivu. There were also 16 health zones without a new case in the last 21 days.

Figure 4. Health zones reporting an increase in confirmed cases between consecutive 21-day periods (27 September – 17 October compared with 18 October – 7 November 2026), Democratic Republic of the Congo, data as of 7 November 2026

Province	Health zone	27 Sep–17 Oct 2026 (cases)	18 Oct–7 Nov 2026 (cases)	% change
Ituri	Aru	3	14	+366.7%
	Damas	0	1	New
	Lita	26	29	+11.5%
	Mahagi	0	2	New
	Mambasa	41	64	+56.1%
	Mandima	212	220	+3.8%
	Mangala	33	36	+9.1%
	Mongbwalu	16	18	+12.5%
	Rimba	7	10	+42.9%
	Tchomia	0	10	New
Nord-Kivu	Beni	177	309	+74.6%
	Kalunguta	25	34	+36.0%
	Mabalako	43	53	+23.3%
	Mutwanga	12	71	+491.7%
	Oicha	26	54	+107.7%
	Vuhovi	11	18	+63.6%
Haut-Uélé	Isiro	6	15	+150.0%
	Rungu	3	4	+33.3%
Tshopo	Kabondo	4	15	+275.0%
	Tshopo	1	3	+200.0%
Nord-Ubangi	Wapinda	2	3	+50.0%
	Yakoma	0	4	New

Only health zones with an increase in confirmed cases between the two periods are shown (22 of 67 affected health zones). Periods are differences in cumulative confirmed cases between SitReps N°135 (26 Sep), N°156 (17 Oct) and N°177 (7 Nov).

Figure 5. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 7 November 2026



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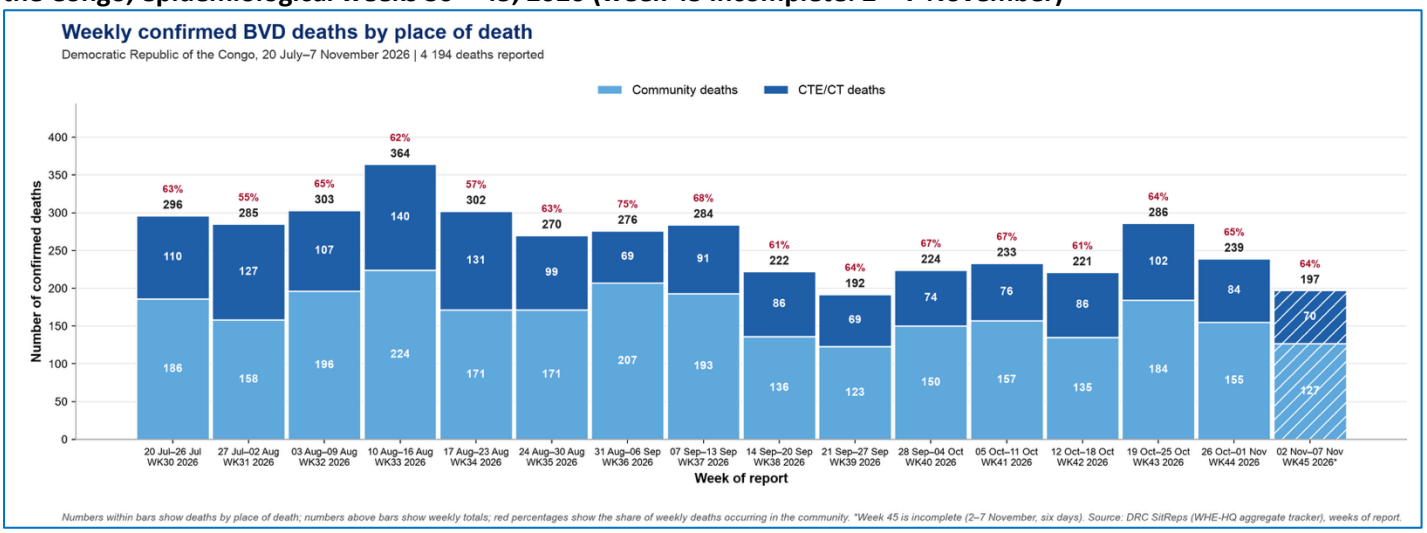
Data Source: World Health Organization, Ministry of Health Democratic Republic of the Congo, AFRO GIS CENTRE, GRID3
Map Production: HIS/EPR WHO AFRO, WHO Health Emergencies Programme.

World Health Organization

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Weekly confirmed deaths (Figure 6) fell from 286 during 19–25 October 2026, the highest weekly total since late August, to 239 during 26 October – 1 November, and 197 deaths were reported during the first six days of week 45 (2–7 November). Over the seven days of the reporting period (1–7 November), 220 confirmed deaths were reported, 16.0% fewer than the 262 of the preceding seven days (25–31 October). Community deaths decreased from 175 to 147 and deaths in treatment facilities from 87 to 73, so that the proportion of deaths occurring in the community was unchanged at 66.8%. On 7 November, 12 of the 21 confirmed deaths (57.1%) occurred in the community. 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 – 45, 2026 (week 45 incomplete: 2 – 7 November)



Kenya

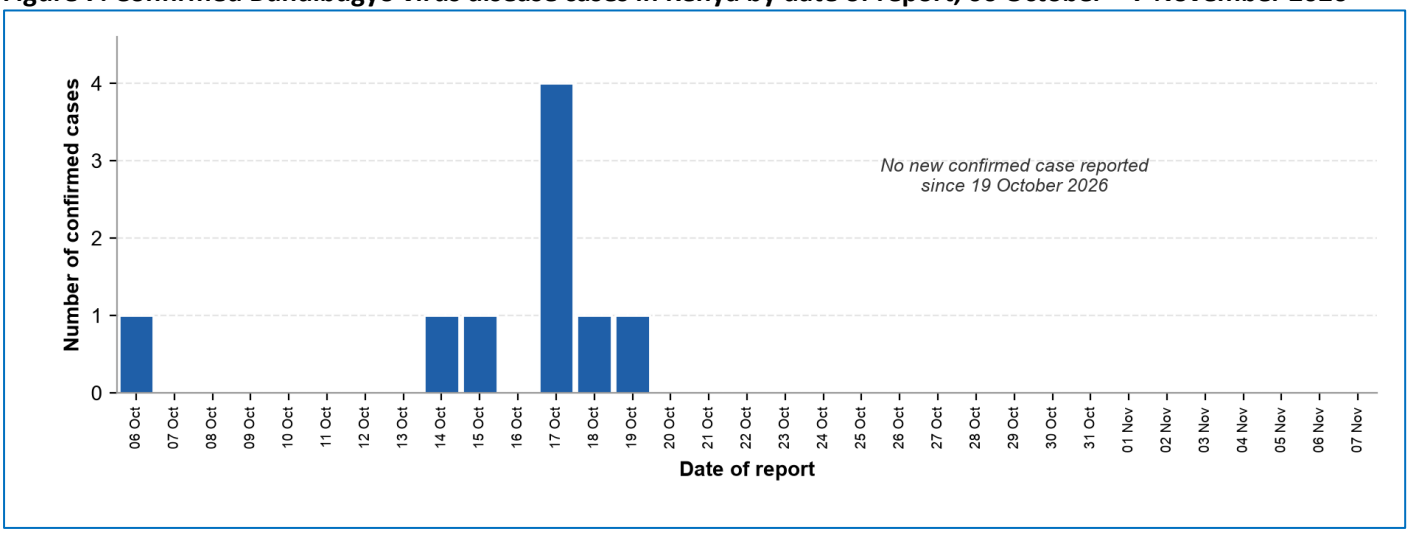
Since the previous report, Kenya has reported no new confirmed case of BVD. The cumulative total remains nine confirmed cases, including two deaths (CFR 22.2%): the imported index case, who died on 5 October, and a 65-year-old family member who died on 23 October. All eight secondary cases (four family members and four hospital staff) belong to a single known chain of transmission, were epidemiologically linked to the index case and were already under quarantine when they developed symptoms; no community spread has been detected. The last confirmed case was reported on 19 October 2026. On 6 November, day 32 since the first case was confirmed, the Ministry of Health announced that a sixth patient had recovered and was being discharged after testing negative and meeting all discharge criteria.; only one patient remains under care and continues to be closely monitored. The 42-day countdown to the end of the outbreak will start once this last patient has recovered and been discharged.

Of the nine confirmed cases, seven were male and two were female, with ages ranging from 24 to 65 years. Designated isolation facilities have 211 isolation beds (scalable to 241).

A total of 135 contacts have been listed since the index case was confirmed, 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.

Of the remaining 118 contacts, 66 had completed their 21 days of monitoring and returned home by 6 November and the remaining 52 are expected to complete quarantine by 11 November 2026.

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



Nigeria

Nigeria has 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 Nigeria Centre for Disease Control and Prevention (NCDC) was notified on 19 October and the National Reference Laboratory confirmed the infection on 20 October. The patient was clinically stable and, at the request of her country and with clearance from the Nigerian authorities, was medically evacuated to Switzerland on 26 October 2026, where she remains in isolation and under medical care in Geneva. No additional confirmed case has been reported. As of 5 November 2026, a cumulative 62 contacts linked to the index case had been identified, categorized and followed up; none had developed symptoms, no new contact had been identified, and seven contacts had completed the mandatory 21-day follow-up and left the quarantine facility, with the remaining contacts due to complete follow-up on a staggered basis between 31 October and 13 November 2026. Exposure remains confined to a single epidemiological cluster directly linked to the index case. 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 for 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.

- In Nigeria, the National Incident Management System has been activated at the highest level, with high-level coordination by the Coordinating Minister of Health and Social Welfare. The Incident Action Plan has been finalized, prioritized activities are being implemented across thematic areas, and a high-level stakeholder meeting with partner agencies was held to strengthen coordination, resource mobilization and response accountability; preparedness and readiness are being strengthened in high-risk states.

- 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 1 – 7 November 2026, a total of 25 369 alerts were reported, averaging 3 624 alerts per day, an increase of 7.4% from 23 613 (3 373 per day) during the preceding week (25 – 31 October). Alert verification remained high at 98.7%. A total of 3 336 alerts (13.1%) were validated as suspected cases and 3 602 suspected cases were investigated. On the five days of the week for which the complete alert cascade was published (1, 3, 4, 5 and 7 November), 1 216 of 2 385 investigated suspected cases (51.0%) were isolated and transferred to a treatment centre within 24 hours, compared with 53.1% in the preceding week. Close to half of the suspected investigated cases are still not isolated and transferred within 24 hours, which remains the main weakness of the alert-management cascade.

- From 1 – 7 November 2026, an average of 35 673 contacts required daily follow-up, compared with 34 426 during 25 – 31 October (+3.6%) and 32 882 during 18 – 24 October. Follow-up performance deteriorated, from 85.3% of contacts seen during the preceding week to 80.6% and fell sharply at the end of the period: 75.4% of contacts were seen on 6 November and 69.8% on 7 November, when 23 276 of the 33 346 contacts under follow-up in the five provinces that transmitted data were seen, the lowest daily performance since mid-October. Weekly follow-up was lowest in Tshopo (58.2%, down from 64.8%), where data from Bafwasende are no longer available since the suspension of activities, and in Nord-Kivu (75.8%, down from 81.3%), compared with 87.9% in Ituri (92.2% the previous week), 83.8% in Haut-Uélé and 99.6% in Bas-Uélé. On 7 November, only

62.3% of contacts were seen in Nord-Kivu and 49.3% in Tshopo. All provinces remain below the ≥95% operational target and, nationally, close to one in five contacts was not reached each day.

- At points of entry (PoEs) and points of control (PoCs), a total of 276 403 travellers were recorded on 6 November 2026, of whom 98% were screened and 97% washed their hands. Overall reporting completeness improved to 84.1% (111 of 132 PoEs/PoCs), ranging from 50% in Bas-Uélé and 56% in Sud-Kivu to 92% in Ituri, 95% in Nord-Kivu and 100% in Tshopo. Four alerts were notified on 6 November (two in Ituri and two in Nord-Kivu), all investigated within 24 hours; the three alerts among living travellers were validated and transferred to treatment centres and one body in transit from Lukaya (Ituri) was intercepted at the Kasitu PoC (Beni), validated and swabbed. Operational challenges persist, including the non-functional Avakubi PoC in Ituri owing to insecurity, continued threats against PoC staff on the Butembo axis in Nord-Kivu and the Bolebole axis (Pawa and Wamba) in Haut-Uélé, the absence of isolation facilities at PoEs in Sud-Kivu and low reporting completeness in Bas-Uélé linked to the health-worker 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 during the period.

- A total of 135 contacts has 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 6 November, 66 of the remaining 118 contacts had completed their 21 days of monitoring and returned home and 52 remained under quarantine, due to end on 11 November 2026 (Ministry of Health press release, 6 November).

- Border screening continues nationwide at points of entry in Kenya. As of 5 November 2026, a cumulative 760 415 travellers had been screened since May 2026, up from 751 225 on 2 November. No new suspected case was identified at points of entry during the period.

Nigeria

- As of 4 November 2026, 62 contacts of the index case had been identified and were under follow-up; none was symptomatic, no new contact had been identified, and seven contacts had completed the mandatory 21-day follow-up and exited the quarantine facility, one of them on 4 November. Expected completion dates range from 31 October to 13 November 2026. Additional contacts are being assessed for possible transfer to the quarantine facility.

- The national case definitions for Ebola disease were reviewed (version 3, 22 October 2026) and are being disseminated to all stakeholders, the scope and strategy of contact identification were reviewed and expanded, additional contact tracers were mapped and trained, and an Ebola disease dashboard and a contact-management dashboard are being developed in SORMAS.

- At points of entry, Port Health Services and aviation stakeholders led an in-depth investigation to support the response, surveillance has been heightened at all five international airports, sensitization and training workshops are ongoing, and partners donated personal protective equipment and IPC materials.

Laboratory

Democratic Republic of the Congo

- Diagnostic capacity remains substantially expanded and decentralized, from two reference laboratories at the onset of the outbreak to 30 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 5 000 samples per day. Decentralized testing is operational across the principal affected provinces, including the Nord-Ubangi provincial public health laboratory. During 1 – 7 November, 3 328 new samples were tested nationally, of which 439 (13.2%) were positive, compared with 2 900 samples and 500 positives (17.2%) the previous week; on 7 November, 423 samples were analysed and 41 (9.7%) were positive, with positivity ranging from 4.3% in the Beni and Butembo laboratories (Nord-Kivu) and 8.6% in Ituri to 26.3% in Isiro (Haut-Uélé). 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.

Nigeria

- Laboratory confirmation of the index case was reported by the NCDC National Reference Laboratory on 20 October 2026, and phylogenetic sequencing has been concluded by the National Reference Laboratory and the African Centre of Excellence for Genomics of Infectious Diseases (ACEGID). Standard operating procedures and job aids on sample reception, molecular detection and genomic sequencing have been validated. Testing capacity is being expanded across the laboratory network, prioritizing states with international points of entry and the Lagos laboratory, while uninterrupted testing and confirmation are maintained at the National Reference Laboratory; 500 donated test kits have been added to the stockpile and additional reagents and commodities are being positioned.

Case Management

Democratic Republic of the Congo

- Case-management demand remains high, with 1 010 patients in isolation or treatment nationally as of 7 November, compared with 961 on 1 November. The largest caseloads remain in Nord-Kivu and Ituri, which together accounted for 917 patients (90.8%) currently under care.

- Capacity and utilization remain uneven across affected provinces. As of 7 November 2026, Ituri had 363 patients in isolation (130 confirmed and 228 suspected); 79 new admissions, all suspected cases, were recorded against 71 discharges, including three recoveries and three patients who left against medical advice in Nizi and Biakato.

Only 233 of 363 patients (64.2%) received hot meals, 31 patients were evacuated and 18 of 34 planned transfers (52.9%) were completed. Nord-Kivu had 554 patients under care (191 confirmed and 363 suspected, including 71 children under five years of age and 24 critically ill patients), with 81 new admissions against 99 discharges, including one recovery. Haut-Uélé recorded 13 new admissions (three confirmed cases in Pawa, one in Wamba and nine suspected cases).

- Across the 90 treatment and isolation facilities reporting bed data on 7 November, 890 of 1 792 beds (49.7%) were occupied, ranging from 8.8% in Tshopo and 22.5% in Haut-Uélé to 41.0% in Ituri, 70.2% in Nord-Kivu and 79.4% in Bas-Uélé (27 of 34 beds).

- Operational constraints remain important. In Nord-Kivu, dedicated treatment beds are close to saturation, a substantial share of patients continues to be managed outside dedicated treatment centres, and the baseline assessment of the Musienene general referral hospital found no functional triage or emergency services, insufficient personal protective equipment and weaknesses in maternity, pediatric and nutrition services. In Ituri, one third of isolated patients did not receive hot meals on 7 November, half of planned transfers were not completed and three patients left isolation against medical advice. In Tshopo, response activities in Bafwasende remain suspended since 24 October and two confirmed patients who escaped from the Bafwasende CTE remain untraced, while in Bas-Uélé suspected cases continue to be isolated in the absence of a functional CTE, with the Buta CTE still under construction.

- Cumulative recoveries increased to 2 940 as of 7 November, from 2 834 on 1 November (+106). An additional five recoveries were reported on 7 November, including three in Ituri, one in Nord-Kivu and one 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 Bunia September has continued to build the pool of trained personnel supporting case management.
- Psychosocial support was provided to 143 confirmed cases and 344 contacts. Facility-based interventions also supported 657 patients and 1,579 caregivers, while community-based activities reached 49 EVD survivors, 353 vulnerable children, and 375 affected households. In addition, psychosocial support was provided to 69 bereaved families, including support related to 62 safe and dignified burials (SDBs).

- The post-discharge-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.

Nigeria

- Clinical care and psychosocial support for contacts in the quarantine facility are coordinated with the Federal Capital Territory case-management team and the contact-tracing pillar. Follow-up engagement has started with contacts who have exited the mandatory quarantine period, a virtual mental health and psychosocial support town hall was held for contacts who had been under quarantine and ten individualized counselling sessions were conducted for distressed contacts. Discharge criteria and follow-up procedures have been developed, a dedicated ambulance has been placed on standby for safe and rapid referral, and IPC and case-management consumables are being provided to the University of Abuja Teaching Hospital. Next steps include disseminating approved procedures for triage, isolation, supportive care and discharge, sensitizing health workers to maintain a high index of suspicion, establishing referral mechanisms from the point of detection to treatment centres, and identifying and optimizing treatment centres in states with designated points of entry.

Infection Prevention and Control (IPC)

- IPC performance in healthcare facilities remained a major concern, particularly in Nord-Kivu, Tshopo and Bas-Uélé. On 7 November 2026, IPC-WASH scorecard assessments of 11 facilities in Nord-Kivu recorded a mean score of 32.2%, substantially below the ≥80% standard, the assessment of occupational exposure found two of five staff members at high risk in Musienene, and one frontline health worker was among the 24 most recent confirmed cases in Katwa. In Haut-Uélé, only four of seven health zones (57.1%) transmitted IPC data and IPC kits remain lacking in healthcare facilities, while in Tshopo 23 providers were coached on standard precautions in two facilities. During 30 October – 5 November, 100 healthcare facilities were assessed nationally, of which only six scored above 80%, compared with 128 assessed and five above 80% the previous week.

- IPC activities continued but remained uneven across affected provinces. During 30 October – 5 November, 206 IPC rings were opened nationally (107 in Ituri and 92 in Nord-Kivu), compared with 275 the previous week, and 466 of 596 targeted households (78.2%) were decontaminated, compared with 495 of 620 (79.8%). Household decontamination reached 80.7% in Ituri (281 of 348) and 98.6% in Haut-Uélé (73 of 74) but only 62.2% in Nord-Kivu (102 of 164). On 7 November in Nord-Kivu, five of six rings were opened, only four of 17 identified households were decontaminated in Katwa, Butembo and Beni, six of 10 identified healthcare facilities were decontaminated in Kalunguta, Butembo, Beni and Masereka, and none of the decontaminated households received a household kit.

- Safe and dignified burial (SDB) performance deteriorated during the reporting period. During 30 October – 5 November, 1 155 of 1 359 requests (85.0%) were completed, compared with 1 062 of 1 140 (93.2%) during 23 – 29 October, and refusals rose from 75 to 113. Completion was lowest in Bas-Uélé (one of seven requests), Tshopo (42 of 76; 55.3%) and Nord-Kivu (460 of 566; 81.3%), compared with 87.1% in Haut-Uélé (27 of 31) and 92.0% in Ituri (625 of 679). Requests increased by 19% week on week, driven by Nord-Kivu (566 requests, up from 453) and Ituri (679, up from 575).

- Operational constraints continued to undermine IPC implementation. In Nord-Kivu, a grenade was found at the entrance of the Beni health zone office on 7 November, SDB teams required security escorts for two burials at the Bundji cemetery and for swabbing in Butuhe and the Vighole district, and IPC teams required escorts for household decontamination in Manziko (Benengule health area, Beni); ring activation and household decontamination remained inadequate, particularly in Beni and Katwa. In Tshopo, response activities remain suspended in Bafwasende since 24 October, where the house of a community health worker was burnt down and young people attempted to recover a body during the reporting period. 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, SDB and IPC supplies were delivered to Beni for the launch of community burial teams and IPC supplies (body bags, gloves, waste bags, thermometers, safety boxes, gowns, boots and hand gel) to Kalunguta, while a shipment destined for Goma remains in transit in Beni; in Haut-Uélé, SDB teams trained by FHI 360 are being activated in Isiro and IPC kits remain insufficient for healthcare facilities; in Tshopo, the post-exposure prophylaxis team was relocated to the Hôpital du Cinquantenaire and WHO conducted field assessments of triage in healthcare facilities; and in Bas-Uélé, the Buta CTE is still under construction.

Nigeria

- IPC training was conducted for 18 housekeepers at the facility where the contacts are housed, the isolation centre was inspected and assessed, the medical evacuation of the index case was supervised to ensure the

protection of health workers, and an IPC capacity needs assessment was conducted across states and health facilities. Bilateral meetings between NCDC and the management of the University of Abuja Teaching Hospital were held to secure institutional buy-in for IPC guidelines and standard and transmission-based precautions. Next steps include training of isolation staff, refresher training for environmental health officers and terminal cleaning of the index case's residence, implementation of the IPC ring strategy across concentric perimeters, and an IPC assessment of surge isolation capacity at Karu General Hospital.

Risk Communication and Community Engagement (RCCE)

Democratic Republic of the Congo

- Community engagement activities continued across affected provinces. In Nord-Kivu, household visits and educational discussions during 1 – 7 November 2026 focused on BVD prevention, the reporting of alerts, early referral of patients to health facilities, hand washing and the importance of transfer to treatment centres, and mass communication and briefings with local leaders were reinforced to counter rumours and promote acceptance of public health activities. In Ituri, household visits, educational discussions, mass sensitization sessions, community dialogues and advocacy meetings with authorities and leaders continued daily. In Tshopo, 50 members of women's associations and sports club leaders in Mangobo were briefed to counter resistance, promote vaccination and encourage early care-seeking, and community teams supported the zonal incident management system and community-based surveillance.

- RCCE continued to support surveillance, contact tracing, case management and safe and dignified burials, including the pre-listing of contacts around confirmed cases, accompaniment of household decontamination and safe burials, communication of laboratory results and transfer of suspected cases in Ituri, and sensitization of providers on post-exposure prophylaxis and contact follow-up in Tshopo. Community alerts remain an important source of detection in Ituri and Nord-Kivu.

- Community feedback management and reporting remained suboptimal. Gaps in reporting completeness, community alert detection and timely feedback resolution continue to constrain RCCE effectiveness, particularly in Nord-Kivu, where resistance and rumours persist in Beni and Katwa, and in Tshopo, where three of five refusals in Bafwasende had been lifted before the suspension of activities.

- Community engagement continued across the other affected provinces. In Haut-Uélé, household visits, educational discussions and mass activities in churches continued in Isiro, Pawa, Boma Mangbetu and Wamba, and BVD messages remain integrated into the distribution of mosquito nets. In Bas-Uélé, household visits, mass sensitization sessions and radio programmes in Buta continued, and community teams accompanied the discharge and community reintegration of survivors.

Nigeria

- Risk communication is informed by social listening and sentiment analysis of public reactions to the outbreak, and a social listening insights report was disseminated to stakeholders and partners to inform response actions. Infodemic rumour-log tools have been deployed to track and counter misleading information, social media influencers are being engaged to amplify key messages, and the RCCE pillar has responded to online narratives expressing political distrust, perceived politicization of the outbreak and conspiracy theories about government motives. A public advisory on preventive measures was issued, together with messages on the toll-free line 6232. Next steps include orientation and engagement forums for school management and religious leaders, guidance on Ebola disease for schools and mass gatherings, engagement of faith-based organizations and Media-EIS fellows, and sustained two-way communication across all platforms.

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

- PRSEAH sensitization continued across the response. On 7 November 2026, in Ituri, two members of the INRB risk-communication team were briefed on PSEAH and signed the code of conduct, 22 wood vendors (12 women, seven men and three boys) 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. In Nord-Kivu, 13 staff of the Kasindi-Lubiriha isolation centre (Mutwanga; seven women and six men) were briefed on PSEA and a community session in Mataba health area (Kalunguta) reached 15 participants, 13 of them women, mainly pregnant women. In Haut-Uélé, nine frontline workers of the Matali hospital (Wamba) were sensitized on PSEA, referral mechanisms and victims' rights, and in Bas-Uélé 23 students of the Dingila medical training institute (17 boys and six girls) were sensitized on PRSEAH.

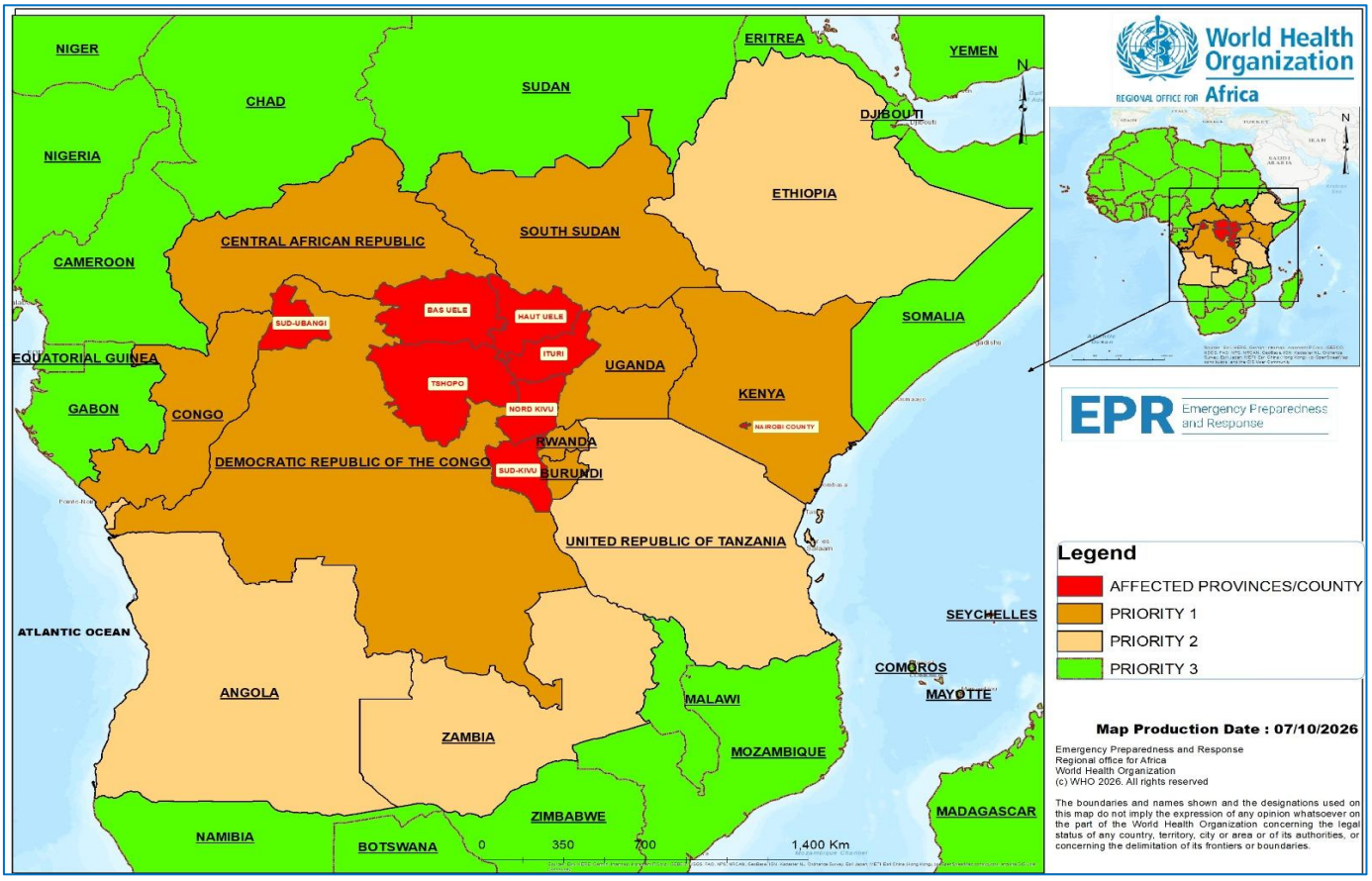
- Coverage remains limited: on 7 November only four of the eight affected provinces (Ituri, Nord-Kivu, Haut-Uélé and Bas-Uélé) reported PSEA activities, four health zones in Bas-Uélé (Viadana, Bondo, Likati and Ango) remain silent, a single partner (WHO) reports in Haut-Uélé and some partners in Ituri have not aligned with the pillar. The reporting mechanism is known in only 15 of 36 health zones (41.7%) in Ituri and six of 13 (46.2%) in Haut-Uélé. Funding for the pillar is low, posters and banners are out of stock in Bas-Uélé, and sensitization tools in French and Lingala, visibility materials and IT equipment remain insufficient; 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: close to 390 confirmed cases and 200 deaths were added in one week, the national seven-day average has held between 65 and 76 cases per day for five weeks, and the epicentre continues to shift towards Nord-Kivu, which accounted for the entire 21-day increase in cases (513 to 661) and deaths (250 to 322) and now reports as many cases as Ituri each day. Beni, Mutwanga, Oicha, Mabalako and Kalunguta are the health zones where transmission is intensifying most. At the same time, the performance of the response weakened at the end of the period: contact follow-up fell to 69.8% on 7 November, safe burial completion dropped to 85%, refusals increased, and only half of investigated suspected cases are isolated within 24 hours. Insecurity in Beni, the suspension of activities in Bafwasende and health-worker strikes in Bas-Uélé and Tshopo further increase the risk of undetected transmission. The absence of new cases in Kenya since 19 October, the discharge of six of the seven surviving patients and the imminent end of contact monitoring in Kenya (11 November) and Nigeria (13 November) indicate that the exported chains have been contained, although surveillance must be sustained 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 contact follow-up and safe burial

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