

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda | France

Weekly External Situation Report 09, Data as of 12 July 2026

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

5 Provinces 42 Health Zones Affected	4 Provinces 33 Health Zones Active Transmission	331 Cases Recovered	88.3% Bed Occupancy	12 370 Contacts to follow
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Summary

Country	New Confirmed Cases (Last 7 days)	New Confirmed Deaths (Last 7 days)	Confirmed Cases (total)	Confirmed Deaths (total)	Probable Cases	Probable Deaths	Total Cases (Confirmed & Probable)	Total Deaths (Confirmed & Probable)	CFR (%) Confirmed & Probable
Democratic Republic of the Congo	339	198	1 963	719	-	-	1 963	719	36.6%
Uganda	0	0	20	2	1	1	21	3	14.3%
France	0	0	1	0	0	0	1	0	0.0%

Note: Only confirmed and probable cases are reported.

Event description

The Bundibugyo virus disease outbreak in the Democratic Republic of the Congo intensified during the past week, with epidemiological indicators suggesting sustained and increasing transmission. The outbreak was characterized by a rising incidence of reported cases, increasing mortality and continued geographic expansion into additional provinces and health zones, indicating ongoing propagation across affected areas. Outside the Democratic Republic of the Congo, the epidemiological situation remained unchanged, with no new cases reported in Uganda or France and no evidence of secondary transmission. Nevertheless, continued geographic expansion and increasing transmission intensity within the Democratic Republic of the Congo elevate the likelihood of cross-border spread and reinforce the need for sustained regional surveillance, preparedness and response measures.

Democratic Republic of the Congo

Since the last update of 5 July 2026 ([Situation Report #8](#)), the epidemiological situation in the Democratic Republic of the Congo has further deteriorated with sustained transmission and continued geographic expansion. An additional 339 confirmed cases and 198 confirmed deaths have been reported, representing increases of 20.9% and 38.0% in cumulative confirmed cases and deaths, respectively. The crude case fatality ratio (CFR) among confirmed cases increased from 32.1% to 36.6%, likely reflecting delayed case detection, late presentation for care, and the persistently high proportion of deaths occurring in the community, rather than increased disease severity. Geographic spread also continued during the reporting period, with the outbreak expanding from three to five affected provinces following the confirmation of cases in Haut-Uélé and Tshopo provinces. The number of affected health zones increased from 36 to 42, with Wamba (Haut-Uélé Province), Ariwara and Boga (Ituri Province), and Lubunga, Makiso-Kisangani, and Mangobo (Tshopo Province) reporting their first confirmed cases.

Daily reported confirmed cases have continued to increase over the course of the outbreak, although substantial day-to-day variability is observed. A log-linear model fitted to the daily incidence data estimates an average daily growth rate of 2.3% (95% CI 2.0% - 2.5%), indicating that the outbreak continues to expand and transmission remains above the threshold required for sustained epidemic expansion.

Figure 1. Epidemic curve showing daily confirmed case incidence and estimated epidemic growth, Democratic Republic of the Congo, 11 May–12 July 2026

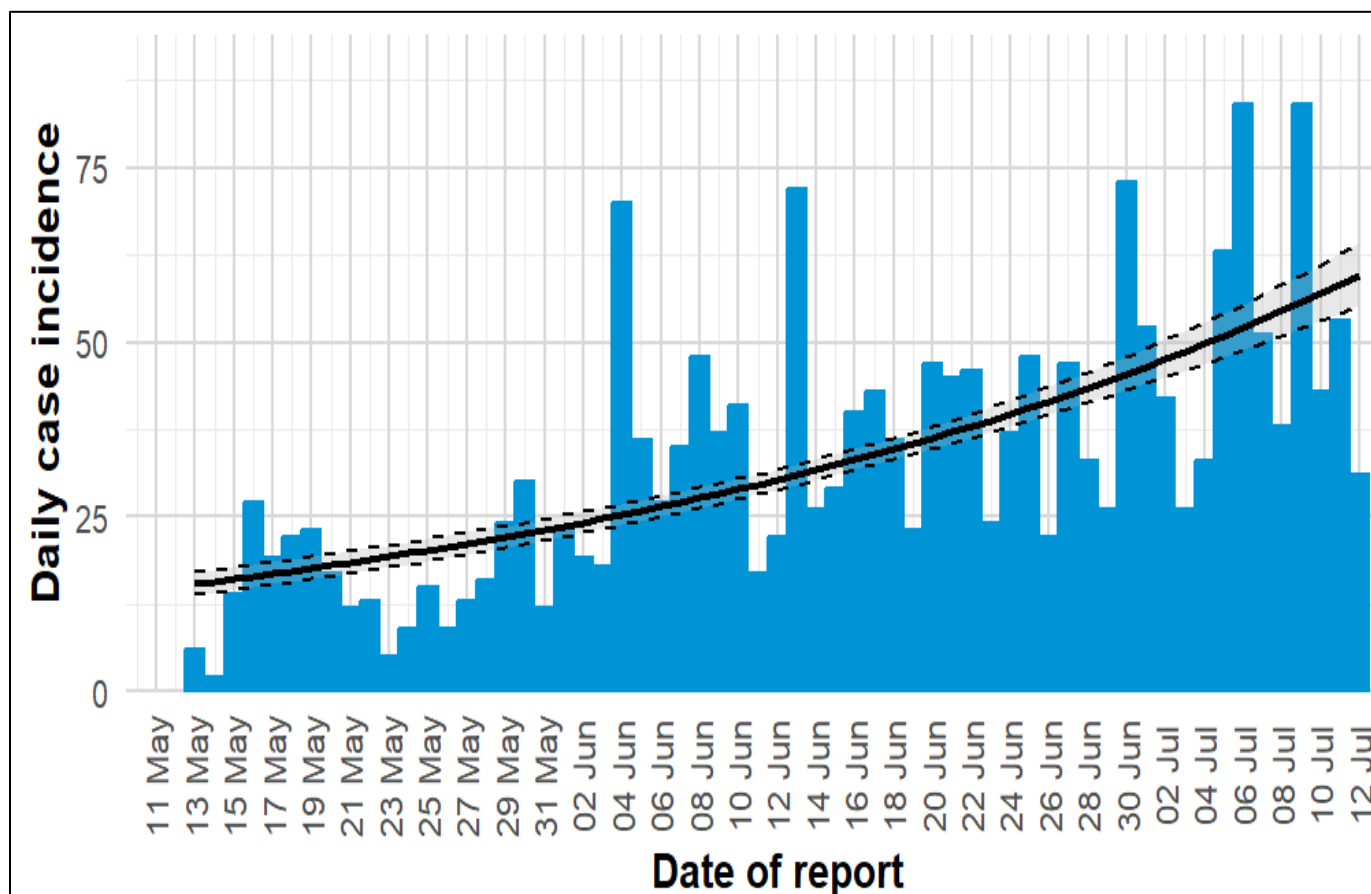
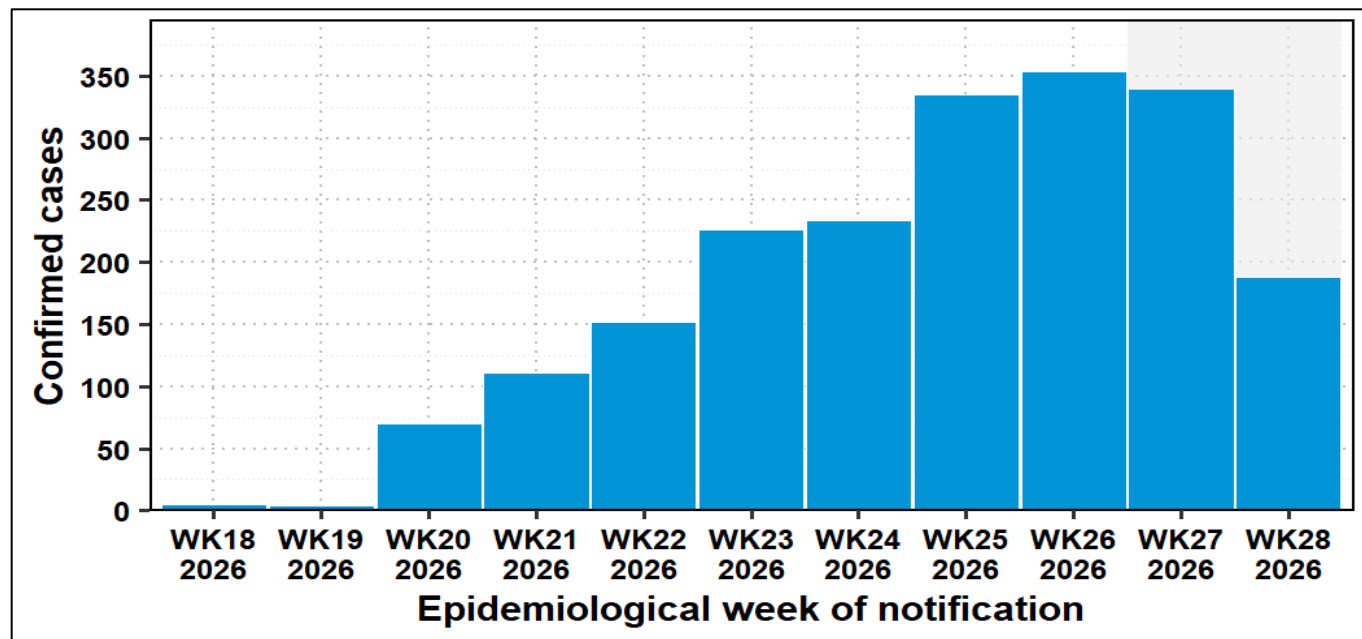


Figure 2. Weekly trends of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo by epidemiological week of report, epidemiological weeks 18 – 28, 2026



Note: The shaded grey area for the most recent epidemiological week represents incomplete data due to reporting delays.

Despite this continued geographic expansion, recent transmission remains concentrated in a subset of affected areas. Of the 42 affected health zones, 33 have reported at least one confirmed case within the past 21 days. During this period, 869 confirmed cases and 441 confirmed deaths were reported. Ituri Province continues to bear the overwhelming burden of the outbreak, accounting for 775 cases (89.2%) and 382 deaths (86.6%), while the remaining four affected provinces together reported 94 cases (10.8%) and 59 deaths (13.4%). In contrast, nine previously affected health zones have now surpassed 21 consecutive days without reporting a confirmed case, suggesting an absence of recent transmission while enhanced surveillance remains in place. These include Miti-Murhesa (53 days) in South Kivu Province; Aru (38 days), Aungba (23 days), and Gety (52 days) in Ituri Province; and Goma (48 days), Kalunguta (49 days), Mabalako (29 days), Oicha (26 days), and Vuhovi (31 days) in North Kivu Province.

The highest levels of recent transmission were recorded in Bunia (207 cases), Rwampara (159), Mongbwalu (92), and Nizi (80) in Ituri Province, reaffirming the Bunia–Rwampara–Mongbwalu transmission corridor while highlighting Nizi as an increasingly important hotspot. Transmission also intensified in Mangala (36 cases) and Nia-Nia (33), the latter serving as the epidemiological source of the newly affected provinces of Haut-Uélé and Tshopo. In North Kivu Province, Katwa (39 cases) remained the principal hotspot, followed by Butembo (16) and Beni (10). Collectively, these health zones accounted for 77.3% of all confirmed cases reported during the past 21 days.

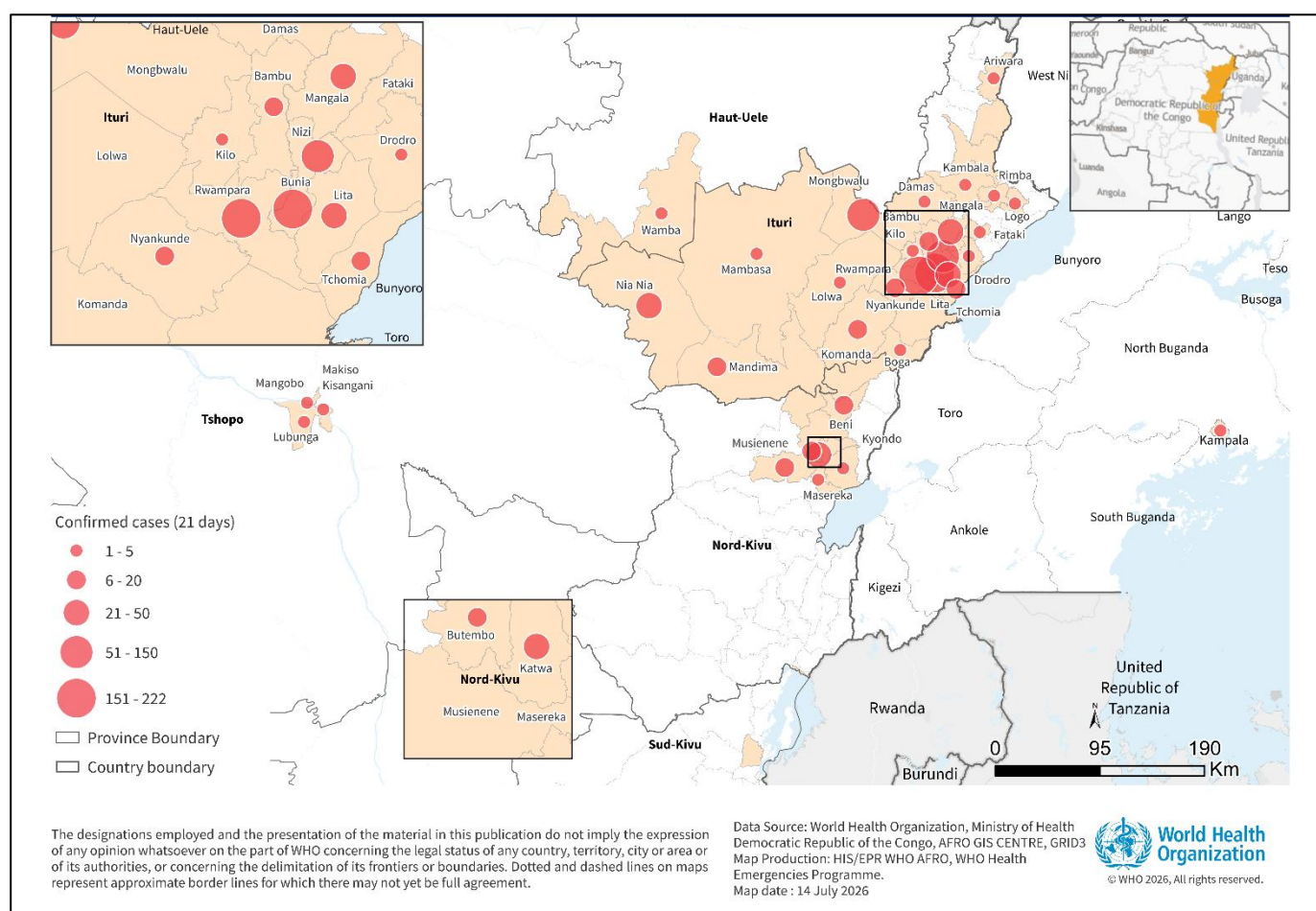
A similar pattern was observed for mortality. Bunia reported the highest number of confirmed deaths (108), followed by Mongbwalu (71), Rwampara (52), Nizi (30), Katwa (28), Mangala (23), Nyankunde (14), Lita (13), Nia-Nia (11), Beni (8), and Butembo (7). Together, these health zones accounted for 365 (82.8%) of the 441 confirmed deaths reported during the same period.

The confirmation of cases in Haut-Uélé and Tshopo provinces marks a significant geographic expansion of the outbreak beyond its original focus in Ituri and North Kivu. Although relatively few cases have been reported in these newly affected provinces, the detection of cases in three health zones in Tshopo, including Makiso-Kisangani in the provincial capital, raises concern because of its large urban population and its role as a major transport hub

connecting northeastern DRC with other parts of the country. Epidemiological investigations indicate that the cases in Tshopo and Haut-Uélé are linked to transmission originating in Nia-Nia Health Zone in Ituri, suggesting geographic extension of an existing transmission chain rather than the emergence of independent outbreak foci. The recent confirmation of the first case in Ariwara Health Zone represents a further northward expansion of the outbreak towards the borders with South Sudan and Uganda, increasing the potential for cross-border spread through frequent population movement and trade.

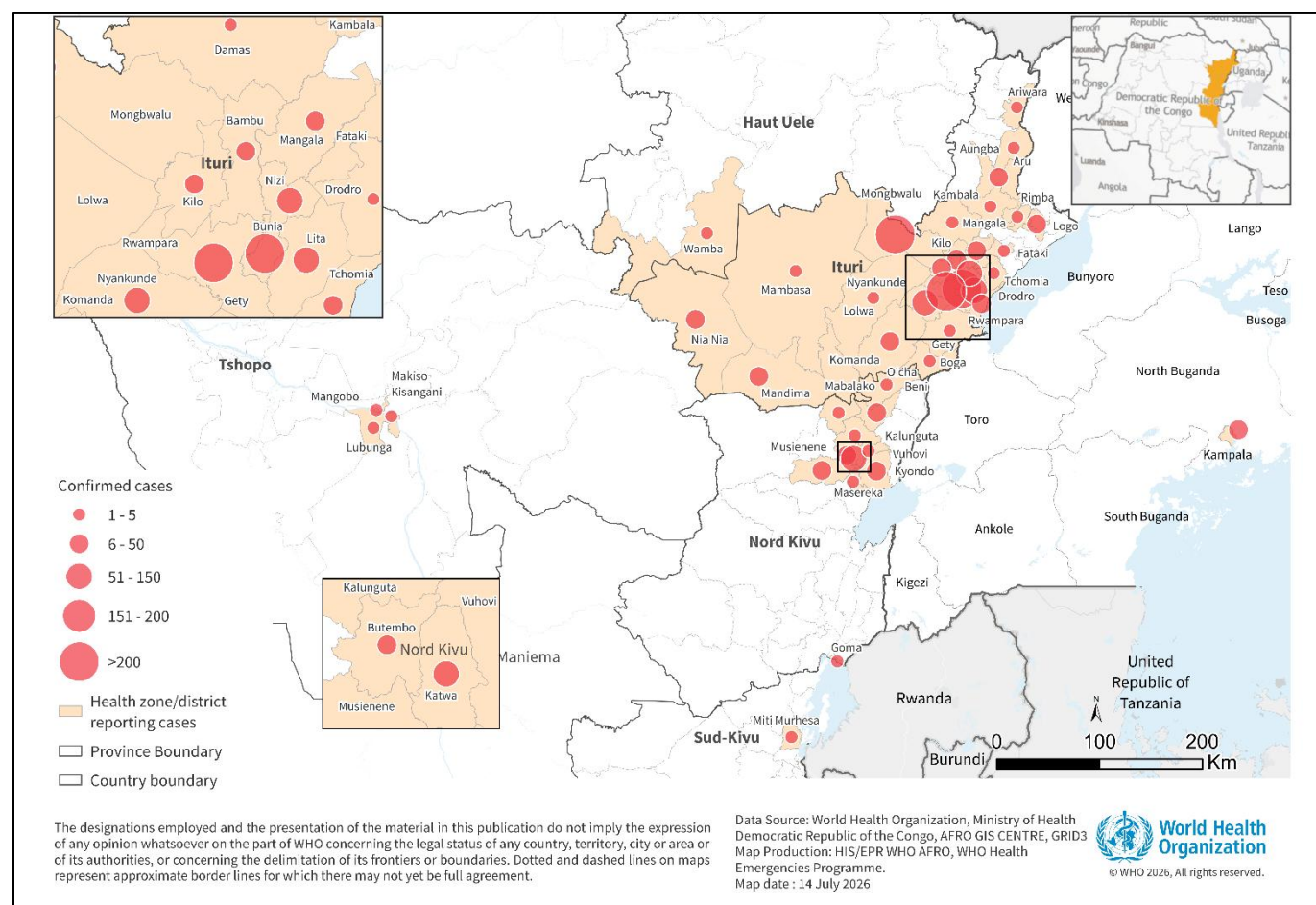
The expanding geographic footprint of the outbreak has also continued to pose risks beyond affected communities. During the reporting period, a United States humanitarian worker infected with Bundibugyo virus disease while working in the Democratic Republic of the Congo was medically evacuated to a specialized high-level isolation unit at Frankfurt University Hospital, Germany. The patient, a logistics staff member with a humanitarian organization supporting the Ebola response in Bunia, Ituri Province, was reported to be in stable condition following early diagnosis and treatment. The case highlights the continued occupational risk faced by frontline humanitarian personnel responding to the outbreak.

Figure 3. Map showing active health zones reporting confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda in the last 21 days, 22 June – 12 July 2026



Since the beginning of the outbreak, the Democratic Republic of the Congo has reported 1963 confirmed cases, including 719 confirmed deaths (CFR 36.6%). Ituri Province remains the epicentre of the outbreak, accounting for 90.3% (1,772) of all confirmed cases and 84.6% (608) of all reported deaths nationwide. The most affected health zones continue to be Bunia (503 cases, 156 deaths), Rwampara (384 cases, 89 deaths), Mongbwalu (329 cases, 171 deaths), Nizi (110 cases, 36 deaths), Nyankunde (97 cases, 23 deaths), Mangala (50 cases, 29 deaths), and Lita (45 cases, 19 deaths), all located in Ituri Province, together with Katwa (71 cases, 47 deaths), Butembo (44 cases, 20 deaths), and Beni (30 cases, 20 deaths) in North Kivu Province. Collectively, these health zones account for approximately 84.7% of all confirmed cases and 84.8% of all confirmed deaths reported nationally.

Figure 4. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, data as of 12 July 2026

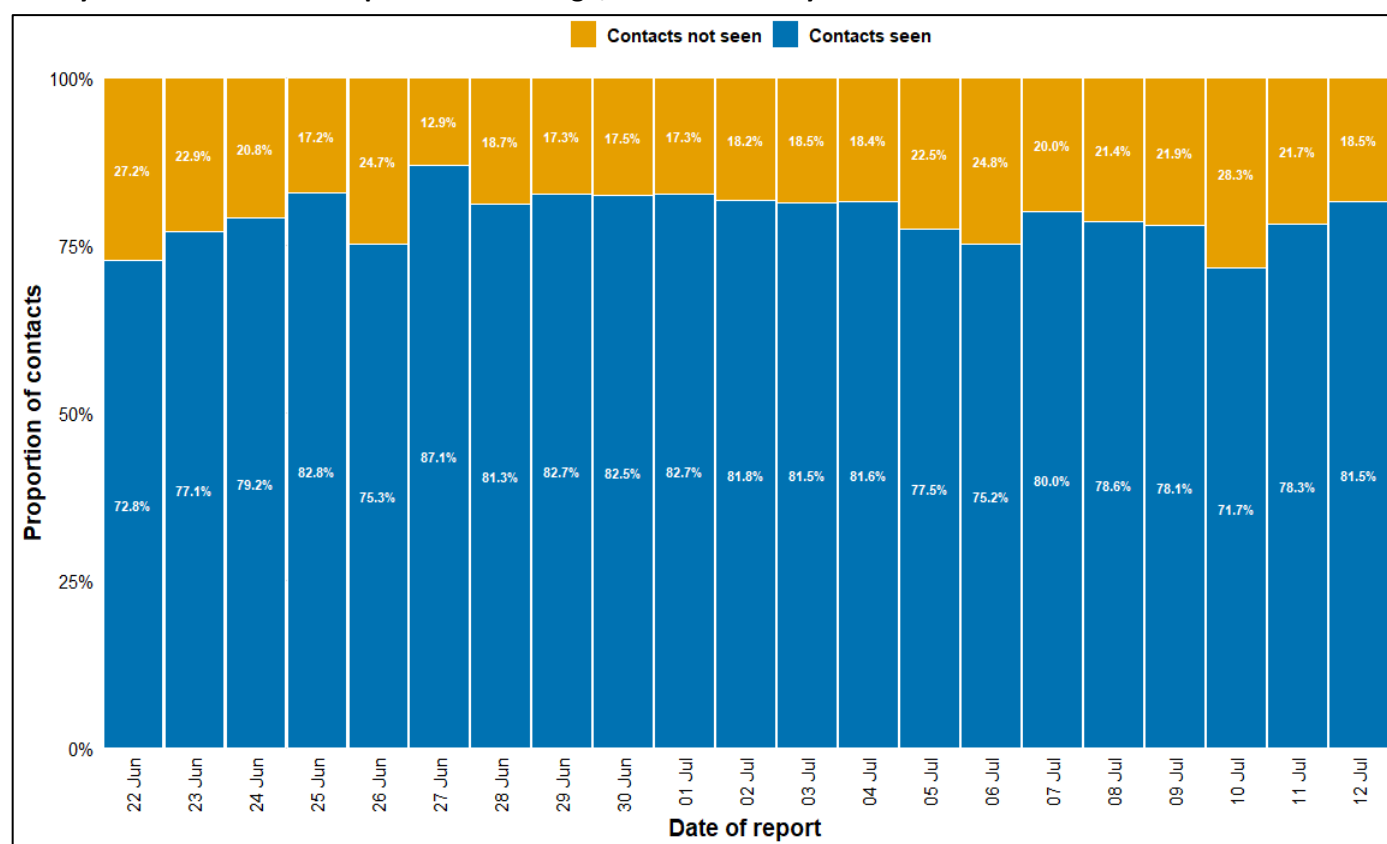


Investigation of 430 confirmed deaths as of 05 July 2026 showed that 397 (92.3%) occurred in the community or before admission to a treatment facility, highlighting persistent delays in case detection, referral, isolation, and access to clinical care. Only 33 deaths (7.7%) occurred after patients had been admitted to treatment centres or healthcare facilities. During the current reporting period, 205 additional confirmed deaths were reported, including 139 (67.8%) community deaths and 66 (32.2%) deaths among patients admitted to treatment facilities, indicating that delayed presentation for care continues to contribute substantially to mortality.

As of 12 July 2026, a total of 12,370 contacts were under follow-up, of whom 10,156 (81.5%) were successfully seen within the previous 24 hours. Ituri Province accounted for the majority of contacts under follow-up, with 9,866

contacts, including 7,830 (79.4%) successfully seen during the reporting period. In North Kivu, 2,152 of 2,377 contacts (90.5%) were successfully followed up, while all contacts in South Kivu had completed the required 21-day monitoring period. Contact follow-up data for the newly affected provinces of Haut-Uélé and Tshopo were not reported. The overall follow-up rate remains below the operational target for effective contact tracing. The marked disparity between provinces is of particular concern. While North Kivu achieved a follow-up rate exceeding 90%, Ituri, the epicentre of the outbreak and home to more than 80% of contacts under follow-up, reached only 79.4%. This leaves a substantial number of contacts in the highest transmission setting unreached each day, increasing the risk of undetected infections and sustained community transmission.

Figure 5. Proportion of identified contacts of confirmed cases of Bundibugyo virus disease reached daily in the last 21 days in the Democratic Republic of the Congo, 21 June – 12 July 2026



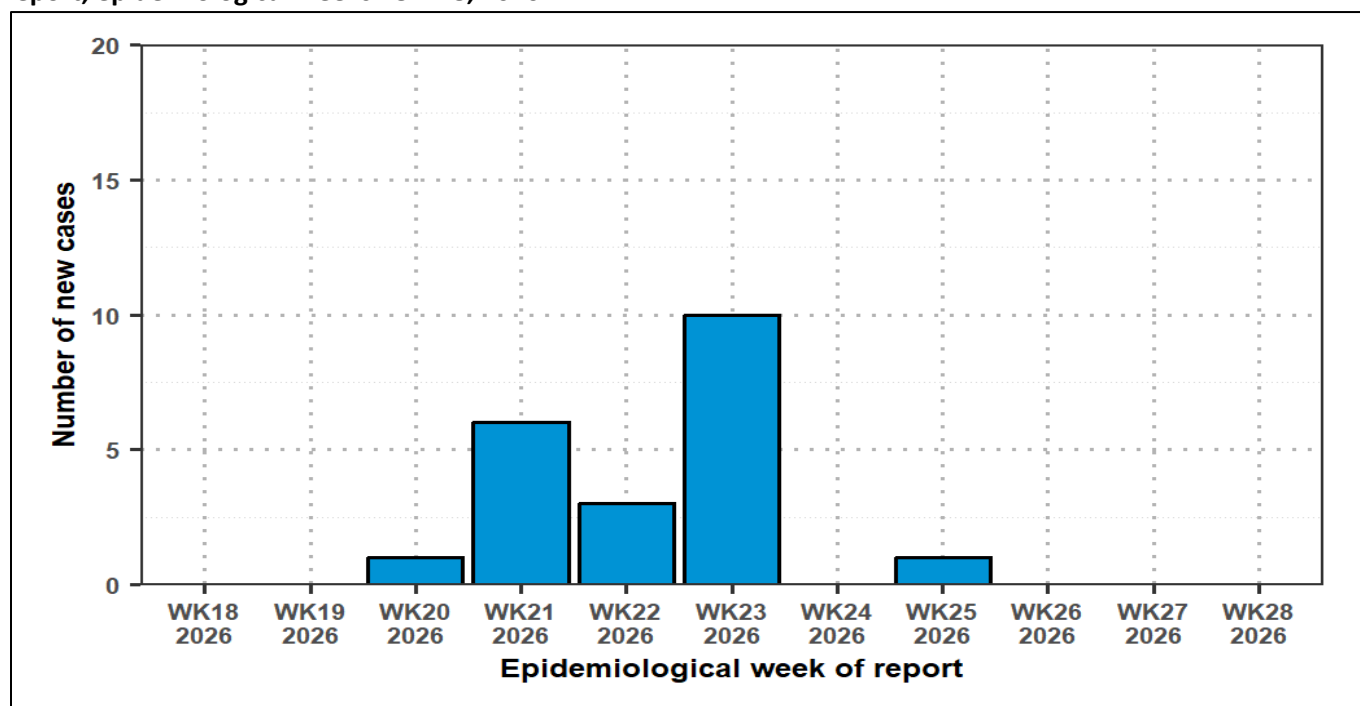
Uganda

No new confirmed case has been reported in Uganda since the previous update. The most recent confirmed case, reported on 21 June 2026, was identified in a truck driver travelling along the Democratic Republic of the Congo–Uganda international route. Since then, no additional imported or locally acquired cases have been detected and there is no evidence of ongoing transmission.

As of 12 July 2026, the outbreak remained limited to 21 cases (20 confirmed and one probable), including three deaths (two confirmed and one probable). Seventeen patients have recovered and been discharged from care, leaving one confirmed patient currently admitted to a treatment facility. Since the onset of the outbreak, 836 contacts were identified. All contacts have successfully completed the required 21-day follow-up period with 6 secondary cases detected, indicating that known transmission chains have been effectively contained.

With no new confirmed cases reported since 21 June 2026 and only one patient remaining under clinical care, Uganda is approaching the final phase of its outbreak response. In accordance with established outbreak response criteria the 42-day period required for declaration of the end of the outbreak will begin following the recovery and discharge of the final confirmed case, provided that no additional confirmed cases are detected during this period. Nevertheless, Uganda remains at high risk of re-introduction due to the ongoing outbreak in the neighbouring Democratic Republic of the Congo. The continued population movement across the shared border sustains the potential for cross-border information sharing, rapid case detection and response readiness until transmission has been interrupted in both countries.

Figure 6. Weekly trends of confirmed cases of Bundibugyo virus disease in Uganda by epidemiological week of report, epidemiological weeks 18 – 28, 2026



France

No additional Bundibugyo virus disease (BVD) cases have been reported in France since the previous update. No secondary transmission has been identified among the five flight contacts who were placed under precautionary quarantine following exposure to the imported case reported on 24 June 2026. Their formal release from follow-up had not been officially announced at the time of reporting.

Risk Assessment

The overall public health risk in the Democratic Republic of the Congo remains very high, driven by sustained transmission, increasing mortality, and continued geographic expansion from three to five affected provinces. Although transmission remains concentrated in Ituri Province, the emergence of new affected health zones in Haut-Uélé and Tshopo highlights the continued potential for spread to previously unaffected areas.

The increasing crude CFR and the high proportion of community deaths continue to indicate delays in case detection, isolation, and access to clinical care. Contact tracing remains below the operational target, particularly in Ituri Province, where follow-up performance is substantially lower than in North Kivu despite accounting for the majority of ongoing transmission.

Uganda remains at high risk of re-introduction because of the ongoing outbreak in the neighbouring Democratic Republic of the Congo despite reporting no new cases during the reporting period. The absence of secondary transmission following the imported case in France demonstrates the effectiveness of rapid public health measures but also underscores the continued risk of international spread through travel.

Table 1. Confirmed cases and deaths of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by geographic area, as of 12 July 2026

Country	Province / Region	Health zone / district	Cum. cases	Cum. deaths	CFR %	Cases (last 21 d)	Deaths (last 21 d)	Date last case	Days since last case
Democratic Republic of the Congo	Haut-Uélé	Wamba	7	7	100.0	7	7	2026-07-12	0
	Subtotal - Haut-Uélé		7	7	100.0	7	7	2026-07-12	0
	Ituri	Aru	3	1	33.3	0	0	2026-06-04	38
		Ariwara	1	1	100.0	1	1	2026-07-11	1
		Aungba	6	2	33.3	0	0	2026-06-19	23
		Bambu	31	10	32.3	17	8	2026-07-05	0
		Boga	1	1	100.0	1	1	2026-07-11	1
		Bunia	503	156	31.0	207	108	2026-07-12	0
		Damas	5	0	0.0	1	0	2026-06-27	15
		Drodro	4	3	75.0	3	2	2026-06-27	15
		Fataki	4	1	25.0	3	1	2026-07-05	7
		Gety	1	0	0.0	0	0	2026-05-21	52
		Kambala	2	2	100.0	1	1	2026-06-30	12
		Kilo	9	1	11.1	2	0	2026-06-24	18
		Komanda	25	8	32.0	15	5	2026-07-04	8
		Lita	45	19	42.2	21	13	2026-07-02	10
		Logo	7	0	0.0	2	0	2026-06-25	17
		Lolwa	1	1	100.0	1	1	2026-06-30	12
		Mandima	8	3	37.5	8	3	2026-07-02	10
		Mambasa	5	4	80.0	3	3	2026-07-09	3
		Mangala	50	29	58.0	36	23	2026-07-05	7
		Mongbwalu	329	171	52.0	92	71	2026-07-12	0
		Nia-Nia	35	13	37.1	33	11	2026-07-12	0
		Nizi	110	36	32.7	80	30	2026-07-12	0
		Nyankunde	97	23	23.7	11	14	2026-07-12	5
		Rimba	4	0	0.0	1	0	2026-07-12	0
		Rwampara	384	89	23.2	159	52	2026-07-12	0
		Tchomia	19	4	21.1	11	4	2026-07-02	10
	Unallocated health zones	17	0	0.0	-	--	-	-	
	Subtotal — Ituri			1 772	608		775	382	2026-07-12
	North Kivu	Beni	30	20	66.7	10	8	2026-07-12	0
		Butembo	44	20	45.5	16	7	2026-07-12	0
		Goma	1	0	0.0	0	0	2026-05-25	48
		Kalunguta	2	1	50.0	0	0	2026-05-24	49
		Katwa	71	47	66.2	39	28	2026-07-12	0
		Kyondo	7	3	42.9	4	2	2026-07-11	1
		Mabalako	1	0	0.0	0	0	2026-06-13	29
		Masereka	3	0	0.0	2	0	2026-07-05	7

Country	Province / Region	Health zone / district	Cum. cases	Cum. deaths	CFR %	Cases (last 21 d)	Deaths (last 21 d)	Date last case	Days since last case
		Musienene	10	2	20.0	8	1	2026-07-05	7
		Oicha	3	2	66.7	0	0	2026-06-16	26
		Vuhovi	1	1	100.0	0	0	2026-06-11	31
Subtotal — North Kivu			177	100	56.5	83	50	2026-07-12	0
	South Kivu	Miti Murhesa	3	1	33.3	0	0	2026-05-20	53
Subtotal — Tshopo			3	1	33.3	0	0	2026-05-22	53
	Tshopo	Lubunga	1	0	0.0	1	0	2026-07-11	1
		Makiso-Kisangani	2	2	100.0	2	2	2026-07-11	1
		Mangobo	1	0	0.0	1	0	2026-07-11	1
Subtotal — Tshopo			4	2				2026-07-11	1
Uganda	Kampala	Kampala	21	3	14.3	0	0	2026-06-21	21
Subtotal — Uganda			21	3	14.3	0	0	2026-06-21	21

Cells shaded green indicate health zones with no newly reported confirmed case for 21 or more days. Values are reproduced as published in the source situation report.

** During the reporting period, 77 previously unallocated confirmed cases and 10 deaths were retrospectively reallocated to health zones in Ituri Province.

Public health response

Coordination

- The Continental BVD Incident Management Support Team (IMST) continued to coordinate response operations in the Democratic Republic of the Congo and Uganda while supporting preparedness activities in 11 additional high-risk countries under the One Plan, One System, One Report framework.
- In the Democratic Republic of the Congo, high-level government leadership and coordination were reinforced during the reporting period. The Minister of Public Health convened coordination meetings with national and provincial authorities, WHO, and technical and financial partners to review the evolving epidemiological situation and response priorities, including the expansion of the outbreak into Tshopo and Haut-Uélé provinces.
- Response operations were rapidly expanded to the newly affected provinces, where multisectoral response pillars were established and strengthened to support early detection, surveillance, case management, and rapid containment of emerging transmission. Field coordination and operational oversight were reinforced through joint assessment missions by the national Incident Management Team and WHO, alongside continued harmonization of epidemiological data across Ituri, Tshopo, and Haut-Uélé to support coordinated decision-making.
- The National Incident Management Systems in the Democratic Republic of the Congo and Uganda continued to receive operational support from WHO; the Africa Centres for Disease Control and Prevention (Africa CDC); the United Nations Children's Fund (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 (EU); the Global Outbreak Alert and Response Network (GOARN); Emergency Medical Teams (EMTs); the Health Cluster; and other partners through technical assistance, expert deployments, surge capacity, and field operations.

Operations Support and Logistics (OSL)

- Procurement and deployment of critical response supplies continued to expand during the reporting period. The total emergency supply pipeline increased to approximately US\$9.37 million, compared with about US\$9.19 million previously. Of this amount, US\$2.59 million (28%) had been delivered, US\$3.54 million (38%) was in transit, and US\$3.24 million (35%) remained under procurement.
- The value of delivered supplies increased substantially from approximately US\$1.92 million to US\$2.59 million, while delivered cargo rose to about 232 metric tons and 1,333 cubic metres, strengthening support to response operations in the Ituri and North Kivu hubs.
- Essential commodities continued to reach affected areas, including personal protective equipment, laboratory diagnostics and PCR supplies, medical equipment, medicines, hospital beds, tents, infrared thermometers, patient liners, gloves, gowns, and coveralls. Laboratory and IPC commodities represented the largest share of delivered supplies.
- Supply chain activity remained high during recent epidemiological weeks, supporting case management, laboratory testing, surveillance, infection prevention and control, and field operations. However, substantial quantities of gloves, coveralls, and other critical items remained in transit or under procurement, requiring continued close monitoring of stock availability.
- Procurement and shipment coordination continued through WHO's international supply network and logistics hubs in Kinshasa, Nairobi (Kenya), Dubai (United Arab Emirates), and Dakar (Senegal). Most orders continued to originate directly from suppliers, while regional hubs supported consolidation, onward transport, shipment tracking, and distribution to affected areas.

Surveillance

- Surveillance activities continued across affected and at-risk areas, including active case finding, alert management, case investigation, contact tracing, mortality surveillance, community-based surveillance, and cross-border surveillance.
- A high volume of alerts continued to be reported, although the timeliness and coverage of rapid alert verification and investigation varied considerably across affected provinces. On 12 July 2026, 1156 alerts were reported from four affected provinces in the Democratic Republic of the Congo, of which 1049 (90.5%) were investigated within 24 hours. Most alerts originated from North Kivu (694), followed by Ituri (425), Haut-Uélé (32), and South Kivu (5). Investigation coverage was above 95% in North Kivu, South Kivu, and Haut-Uélé, while Ituri reported a lower investigation rate of 81.9%. Of the total alerts, 268 suspected cases, including 112 community deaths were validated.
- Points of entry (PoE) and points of control (PoC) surveillance activities continued to be strengthened in the Democratic Republic of the Congo. As of 12 July 2026, all 71 PoE/PoC sites were operational across Ituri and North Kivu provinces. During the reporting period, 144,094 travellers passed through PoE/PoC screening sites, of whom 95.4% were screened for BVD symptoms.
- In Uganda, alert management, surveillance for non-trauma deaths, and community-based surveillance continued nationwide. As of 12 July 2026, all contacts have completed 21 days of follow-up.

- In Uganda, inbound and outbound screening continued at points of entry, including Entebbe International Airport and high-risk border crossings. Mandatory digital Passenger Locator Forms remained in use for all inbound travellers, while holding facilities continued to be maintained for high-risk travellers. Temporary travel restrictions between Uganda and the Democratic Republic of the Congo also remained in place.

Laboratory

- Laboratory decentralization continued to expand, reaching 60% completion, with plans to establish 15 – 20 operational laboratories to strengthen decentralized testing and reduce turnaround times. As of 12 July 2026, 14 diagnostic laboratories and testing units were operational across Ituri and North Kivu provinces, in addition to the Institut National de Recherche Biomédicale (INRB) in Kinshasa and INRB-Goma laboratories.
- In North Kivu, the laboratory backlog was fully cleared during the reporting period, with all pending samples processed.
- Laboratory testing capacity has been further strengthened through the deployment of 54 laboratory experts (approximately five per facility), as well as the distribution of 2496 polymerase chain reaction (PCR) test kits and 14,000 RadiOne tests.
- Laboratory testing throughput remained high, particularly in Ituri, where positivity rates ranged from 37.9% to 63.3%, indicating sustained intense transmission, while North Kivu maintained lower positivity rates between 3% and 4.2%, alongside the clearance of residual testing backlog.
- Despite ongoing scale-up efforts, laboratory operations continued to face challenges related to delayed result reporting, weak data integration and information management systems, limited logistics capacity, and shortages of complementary diagnostic tests for clinical care.

Case Management

- Case management capacity continued to expand across the Democratic Republic of the Congo, with approximately 750 isolation and treatment beds available nationally across more 25 Ebola treatment centres (ETCs) and care facilities. Additional treatment capacity is being established Nizi, Kisangani Sota, NiaNia, and other hotspot areas, including plans to establish 100 additional beds in Bunia within five days.
- As of 12 July 2026, 736 patients were in isolation nationally, including 549 in Ituri, 170 in North Kivu, and 17 in South Kivu, with treatment facilities operating at or near full capacity in high transmission areas. Official occupancy remained critically high at 88.3% nationally.
- Recovery outcomes continued to improve, with cumulative recoveries increasing from 273 on 05 July to 331 by 12 July 2026. Daily supportive care activities included the provision of hot meals across treatment facilities and the rollout of free healthcare services in four priority health zones in Ituri Province.
- The WHO-sponsored PARTNERS clinical trial was officially launched in the Democratic Republic of the Congo on 02 July 2026, becoming the first clinical trial specifically evaluating therapeutics for BVD. The trial is assessing the monoclonal antibody MBP134 and remdesivir, individually and in combination, within participating treatment centres under the coordination of the INRB, WHO, Africa CDC, ALIMA, Médecins Sans Frontières (MSF), the Institute of Tropical Medicine Belgium, and the University of Oxford.
- Case management operations continued to receive support from multiple national and international

partners, including WHO, the Ministry of Health, ALIMA, MSF, Samaritans Purse, IMC, MEDAIR and Malteser Africa CDC, and academic and research institutions supporting clinical care, treatment centre operations, and research activities.

- An integrated outreach centre was established in Bunia to facilitate central dispatch of ambulances services for cases to transit/treatment centers and for SDB teams, tracking performance of this system is required.
- Alongside scale-up efforts in bed capacity, WHO has delivered five additional piccolo machines for clinical laboratory testing and five high flow oxygen support devices as well, with aims to augment capacity to care for the critically ill patients. The growing number of CTEs will require additional scale up of these critical medical supplies.

Infection Prevention and Control (IPC) and Water, Sanitation and Hygiene (WASH)

- IPC activities continued to scale up across affected provinces, including briefings for health workers and community relays, assessments in 140 health facilities in North Kivu, and the training of 34 providers from 17 priority health facilities.
- Safe and dignified burial operations and decontamination activities remained ongoing in Ituri, alongside the decontamination of households, health facilities, and transport vehicles linked to confirmed cases.
- IPC performance remained critically weak in several hotspot areas. IPC/WASH assessments in North Kivu showed an average facility score below 50%, with only two facilities achieving scores above 80%, indicating major gaps in infection prevention standards and healthcare facility readiness.
- Healthcare worker infections continued to increase, with 112 infections and 35 deaths reported among health workers, corresponding to a CFR of 31.3%. This highlights persistent occupational exposure risks and inadequate IPC implementation in health facilities.

Risk Communication and Community Engagement (RCCE)

- RCCE activities continued across affected provinces to strengthen community awareness, promote early alert reporting, support contact tracing, and facilitate safe and dignified burial operations, particularly in hotspot areas of Ituri and North Kivu.
- Additional RCCE personnel are being identified and deployed to expand response activities in the newly affected provinces of Haut-Uele and Tshopo. Anthropological expertise is also being strengthened to better understand community perceptions and ensure response activities are aligned with local needs, expectations and realities.
- Community feedback mechanisms continued to identify concerns related to transmission risks, access to services, vaccination and response activities. These insights are regularly analyzed and shared with operational pillars to inform response actions and messaging.
- Findings from the first round of rapid community assessments conducted in priority hotspots of Ituri Province have been endorsed by the research pillar and are being translated into community-led actions through RCCE interventions. Efforts are now underway to scale the assessments across affected areas of DRC and extend implementation to Uganda and South Sudan to strengthen cross-border community intelligence and

engagement.

- Community engagement efforts are increasingly focused on building trust in and improving access to response services, while addressing concerns raised by both communities and frontline health workers. Targeted engagement of high-risk and mobile populations, remains a priority, including mining communities internally displaced populations, and cross-border groups affected by insecurity, displacement and frequent movement between eastern Democratic Republic of the Congo and neighbouring countries.
- Key RCCE challenges persisted, including insecurity in some hotspot areas, community resistance in mining and insecure areas, misinformation risks, and difficulties maintaining timely follow-up of contacts across highly mobile populations and porous border areas.

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

- During the reporting period, a total of 352 participants, including 142 women (five persons with disabilities), received PRSEAH orientation in Ituri, North Kivu, South Kivu, and Tshopo. The sessions targeted nurses, local NGO representatives, journalists, and members of the Tshopo Emergency Medical Team, and concluded with the signing of the Code of Conduct.
- Additionally, PRSEAH community awareness activities targeting community outreach workers, healthcare workers, internally displaced persons, pregnant women, religious groups, students, teachers, parents, and motorcycle taxi riders reached 4677 people, including 1419 women (three persons with disabilities) and 1001 girls, participated.
- A regional PRSEAH coordination meeting was convened involving staff from WHO Headquarters, WHO Regional Office for Africa, Africa CDC, and the National PRSEAH Coordination of the Democratic Republic of the Congo to strengthen inter-agency collaboration, share best practices, and align strategic priorities for the outbreak response.
- During the reporting period, newly deployed Ministry of Health experts received orientation on PRSEAH principles and responsibilities to support their effective integration into the outbreak response, while community media disseminated PRSEAH messages to promote prevention and strengthen safe reporting mechanisms.

Public health preparedness

Operational Readiness

- Recent assessments showed an average readiness score of 58% among Priority 1 and 2 countries, with 90% of readiness assessments completed and submitted. To date, 28 of the 47 Member States have updated their readiness assessments (60%).
- Regional deployments to support preparedness in high-risk Member States continued during the reporting period. In Kenya, designated isolation units and other preparedness facilities were assessed, while standard operating procedures (SOPs) and operational guidelines were finalized to strengthen readiness for a potential importation event.

Border Health, Travel and Mass Gatherings

- Screening has been reinforced at airports, high-risk crossings and internal transit routes in both the Democratic Republic of the Congo and Uganda, with national authorities, IOM and partners supporting PoE surveillance and implementation of WHO border health guidance, as well as measures at points of control on high priority travel corridors.
- Priority operational actions include rapid assessments and mapping of PoEs, as well as cross-border population mobility mapping to identify key movement patterns, high-risk cross-border routes, including informal crossings, and major congregation points. Additional priorities include ensuring that field teams have adequate and paid staff, equipment, training, PPE, screening materials, disinfectants, and referral systems.
- Mass gathering risk assessment capacity is being strengthened through training and the provision of recommendations. The postponement of mass gatherings is advised in areas with documented BVD transmission until transmission is interrupted, while a risk-based approach is recommended for events held elsewhere in the region.
- Event-specific risk assessments should be conducted using the WHO all-hazards mass gathering risk assessment tool. These assessments should be complemented by implementation of measures before, during, and after events, as outlined in WHO guidance for mass gatherings attended by individuals from areas with documented Bundibugyo virus detection, including the establishment of referral pathways and RT-PCR testing capacity.
- Event organisers should distribute participant information to all attendees before and during the event, covering BVD symptoms, what to do if feeling unwell, and available health services, in line with [WHO guidance for mass gathering events attended by individuals from areas with documented BDBV detection](#).

Situation interpretation

The outbreak appears to be entering a new phase characterized by progressive geographic expansion beyond its original epicentre in Ituri. While the highest burden of disease remains concentrated in Bunia, Rwampara, Mongbwalu and surrounding health zones, the emergence of cases in Tshopo, Haut-Uélé and Ariwara demonstrates how population movement is extending transmission into new areas, including densely populated urban centres and strategic border locations. These developments increase the complexity of the response and elevate the risk of further national and cross-border spread.

At the same time, the response is being increasingly challenged by operational constraints. Community resistance, attacks on healthcare workers, patients leaving treatment centres before completion of care, and recent strike action by frontline responders have affected surveillance, contact tracing, case management, and other critical response activities. These challenges have contributed to continued community transmission and the introduction of cases into previously unaffected areas, including Tshopo and Haut-Uélé provinces.

Interrupting transmission in the established hotspots of Ituri and North Kivu remains the immediate priority, while rapidly containing newly detected transmission in Haut-Uélé and Tshopo is essential to prevent the establishment of sustained local transmission. Achieving these objectives will require an integrated community-based strategy that involves enhanced community engagement, intensified active case finding, timely isolation and treatment, comprehensive contact tracing, uninterrupted response operations, and enhanced cross-border surveillance and coordination.

Contributors

- WILLIAMS, George Sie (WHO AFRO)
- OTSHUDIEMA, John (WHO AFRO)
- CONTEH, Ishata (WHO AFRO)
- MASINA, John (WHO AFRO)
- MAMADU, Ibrahim (WHO AFRO)
- ROQUILLE, Denise (WHO AFRO)
- MUTEBA, Michel (WHO AFRO)
- BORIS, Pavlin (WHO HQ)
- HAMBLION, Esther (WHO HQ)
- KASSAMALI, Zyleen (WHO HQ)
- DIAZ, Janet Victoria (WHO HQ)
- ALLAIN IOOS, Sophie (WHO HQ)
- HAMOUDA, Mahmoud Aly Zeenelabdin (WHO HQ)
- MOLINARO, Paul (WHO HQ)
- LEGAND, Anaïs (WHO HQ)
- WAUQUIER, Nadia (WHO HQ)
- SODAGAR, Vaishali (WHO HQ)
- WANG, Ninglan (WHO HQ)
- SELENIC MINET, Dubravka (WHO HQ)
- ALEXANDROVA EZERSKA, Lidia (WHO HQ)
- MORAN, Thomas (WHO HQ)
- RUBANGAKENE, Moses (WCO Uganda)
- MGAMB, Elizabeth Adhiambo (WCO Uganda)
- FOTSING, Richard (WCO DR Congo)
- AJONG, Brian (WCO DR Congo)

Editorial Advisory Group, WHO Regional Office for Africa

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

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Correspondence on this publication may be directed to:

Health Emergency Intelligence, Surveillance and Laboratory Programme

WHO Emergency Preparedness and Response

WHO Regional Office for Africa

Email: afrooutbreak@who.int

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