

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda | France

Weekly External Situation Report 11, Data as of 26 July 2026

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

5 Provinces 48 Health Zones Affected	4 Provinces 42 Health Zones Active Transmission	583 Cases Recovered	76.8% Bed Occupancy	15 498 Contacts to follow
723 Active Cases in Isolation	123 Health Worker Cases	37 Health Worker Deaths	941 Bed Capacity	18 Testing Laboratories

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	567	296	3 262	1 437	-	-	3 262	1 437	44.1%
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.

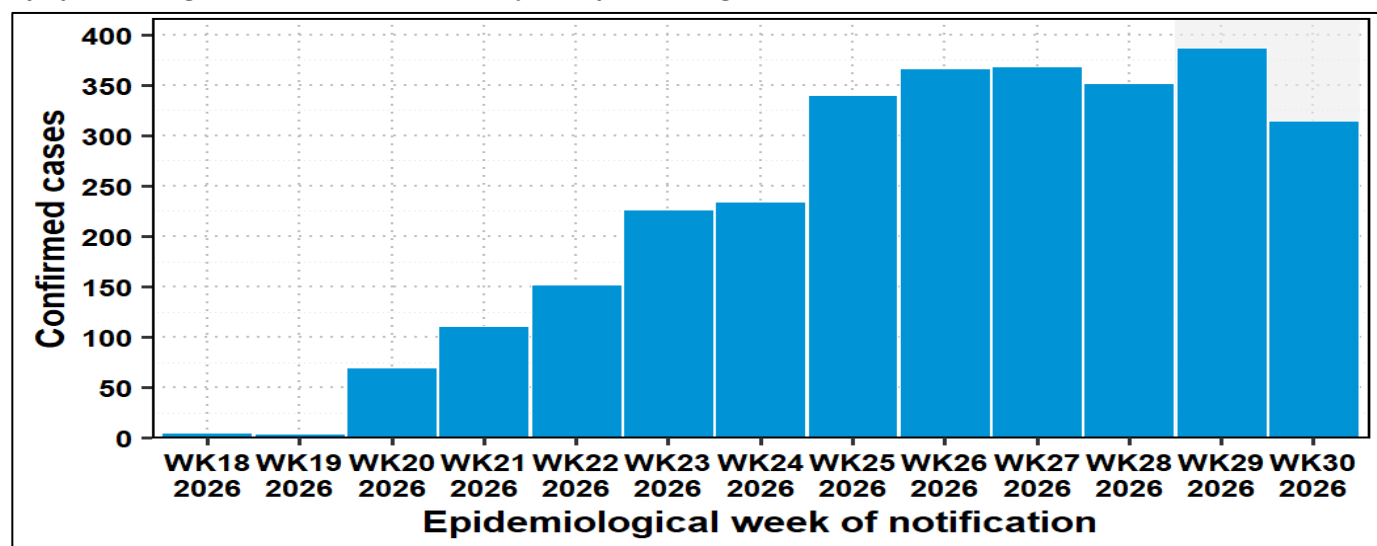
Event description

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo continued to intensify during the reporting period, with sustained transmission, increasing mortality, and ongoing geographic expansion within the country. The cumulative number of reported cases has exceeded the two previously documented Bundibugyo virus disease outbreaks, making this the largest outbreak caused by the Bundibugyo virus to date. Although no new cases have been reported outside the Democratic Republic of the Congo, persistent transmission in areas connected by major national and cross-border mobility corridors continues to sustain a high risk of regional spread. These epidemiological trends underscore the need for strengthened surveillance, cross-border collaboration, and preparedness to rapidly detect and contain any international spread.

Democratic Republic of the Congo

Since the last update of 19 July 2026 ([Situation Report #10](#)), the epidemiological situation in the Democratic Republic of the Congo has continued to deteriorate, with sustained transmission and further geographic expansion. An additional 839 confirmed cases and 470 confirmed deaths were reported, representing increases of 34.6% and 48.6%, respectively, in cumulative confirmed cases and deaths since the previous reporting period. Of these additional reports, 272 confirmed cases and 174 confirmed deaths were identified through retrospective data reconciliation (batch reporting) and therefore do not necessarily represent new infections or deaths that occurred during the current reporting period. The crude case fatality ratio (CFR) among confirmed cases increased from 39.9% to 44.1%, reflecting persistent delays in case detection, referral, and access to treatment, together with the continued predominance of community deaths. During the reporting period, Rungu Health Zone in Haut-Uélé Province became newly affected, increasing the cumulative number of affected health zones from 47 to 48. No additional provinces were affected during the reporting period.

Figure 1. Weekly trend of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo by epidemiological week of ~~notification~~report, epidemiological weeks 18 – 30, 2026



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

Despite continued geographic expansion, intense transmission remained largely concentrated. During the last 21 days, an additional 1,791 confirmed cases and 1,014 confirmed deaths were reported nationally. Ituri Province continued to account for the overwhelming majority of recent transmission, contributing 1,592 cases (88.9%) and 871 deaths (85.9%), while North Kivu, Haut-Uélé, and Tshopo together accounted for 199 cases (11.1%) and 143 deaths (14.1%). No additional cases or deaths were reported from South Kivu during the period. Of the 48 affected health zones, 42 reported confirmed cases during the preceding 21 days, whereas six health zones (Gety, Goma, Kambala, Mabalako, Miti-Murhesa, and Vuhovi) reported no new cases for more than three weeks, suggesting that transmission may have been interrupted in these areas, provided surveillance remains sufficiently sensitive to detect ongoing transmission.

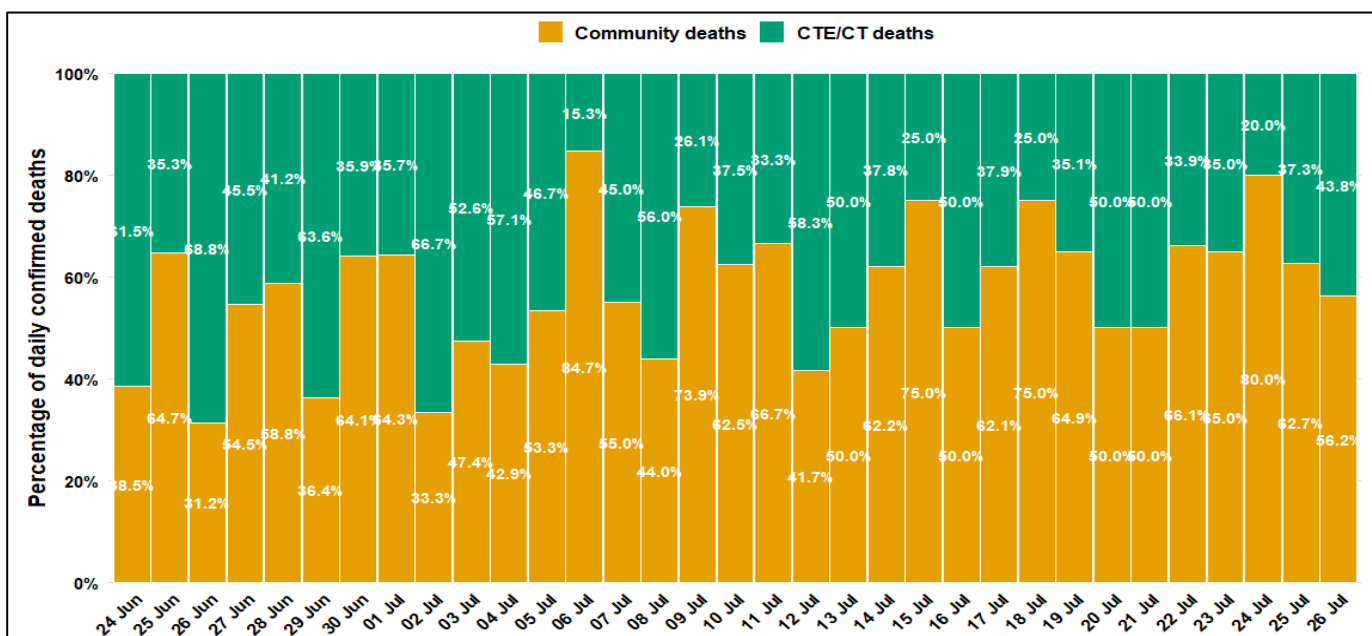
The largest increases in confirmed cases over the previous 21 days were recorded in Bunia (301 cases), Nizi (273), Rwampara (211), Mongbwalu (208), Katwa (84), Lita (77), Mangala (61), Nia-Nia (57), Butembo (32), and Bambu (29). Together, these ten health zones accounted for 85.8% of all additional confirmed cases reported nationally during the period. Bunia, Nizi, Mongbwalu and Rwampara remained the principal transmission corridor, accounting for nearly two-thirds of all newly reported cases. Continued increases in Lita, Nia-Nia, and Mahagi, together with the

emergence of transmission in Rungu Health Zone, indicate ongoing westward and northward expansion within Ituri and Haut-Uélé Provinces.

Mortality was similarly concentrated. The largest increases in confirmed deaths over the same period were reported in Rwampara (166 deaths), Nizi (147), Mongbwalu (90), Bunia (86), Lita (50), Katwa (47), Mangala (44), Nia-Nia (35), Butembo (29), and Tchomia (22). Collectively, these ten health zones accounted for approximately 83.5% of all additional confirmed deaths reported nationally during the previous 21 days, demonstrating that mortality remained concentrated within the same transmission corridor driving the epidemic.

Overall, confirmed deaths continued to occur predominantly outside designated treatment centres, indicating persistent delays in case detection, referral and access to appropriate care. During the last seven reporting days (20 – 26 July 2026), 296 confirmed deaths were reported, of which 186 (62.8%) were classified as community deaths and 110 (37.2%) occurred in designated treatment or care centres. It is important to note that, operationally, community deaths include all deaths occurring outside designated treatment facilities, even though approximately 30% of these community deaths occur in non-designated health facilities rather than in the community. The continued predominance of deaths outside designated treatment centres suggests that many patients are still being detected late in the course of illness or after death, underscoring the need to strengthen community-based surveillance, improve early recognition and referral from peripheral health facilities, and expand timely access to specialized treatment.

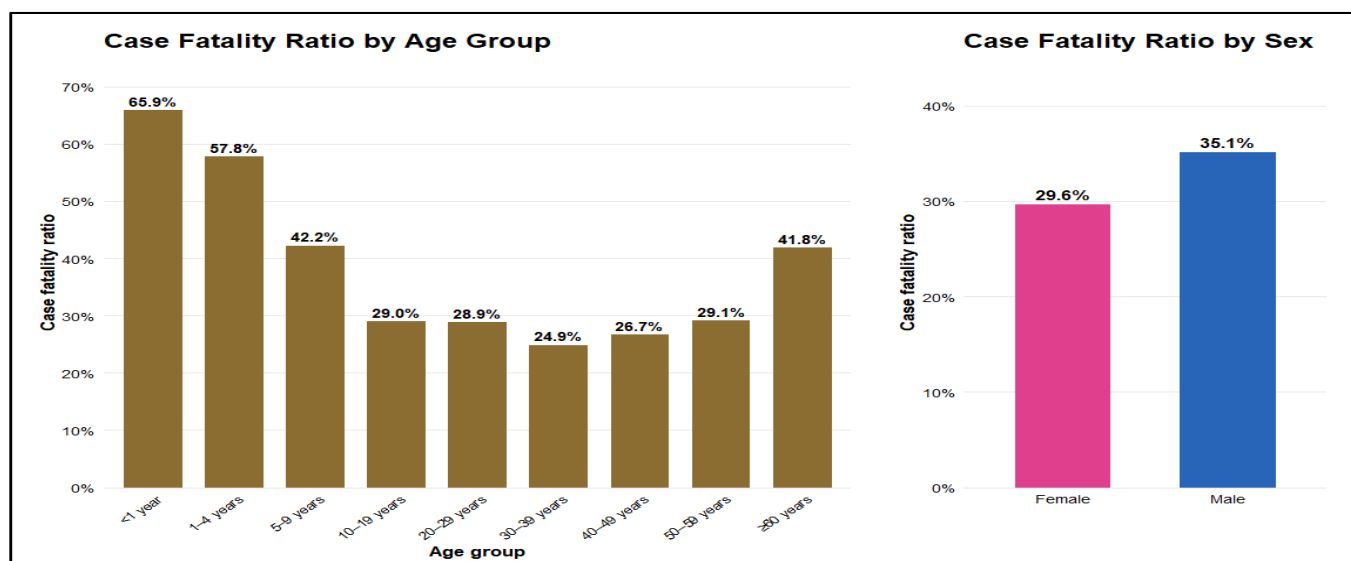
Figure 2. Reported Bundibugyo virus disease deaths in the Democratic Republic of the Congo by place of occurrence, 24 June – 26 July 2026



Of 896 confirmed deaths analysed, children aged under 5 years accounted for 17.4% (n = 156), while persons aged 5 years and older accounted for 82.6% (n = 740), reflecting the predominance of mortality among older children and adults. However, the highest case fatality ratios were observed among the youngest age groups, reaching 65.9% among infants aged under one year and 57.8% among children aged 1 – 4 years. CFR remained elevated among children aged 5 – 9 years (42.2%) and adults aged 60 years and older (41.8%), whereas it ranged from 24.9% to 29.1% among persons aged 10 – 59 years. The higher mortality observed among young children and older adults is likely multifactorial and may reflect greater biological vulnerability, less robust immune responses, and a higher prevalence of underlying conditions or malnutrition among young children in the affected areas. Overall, mortality was higher

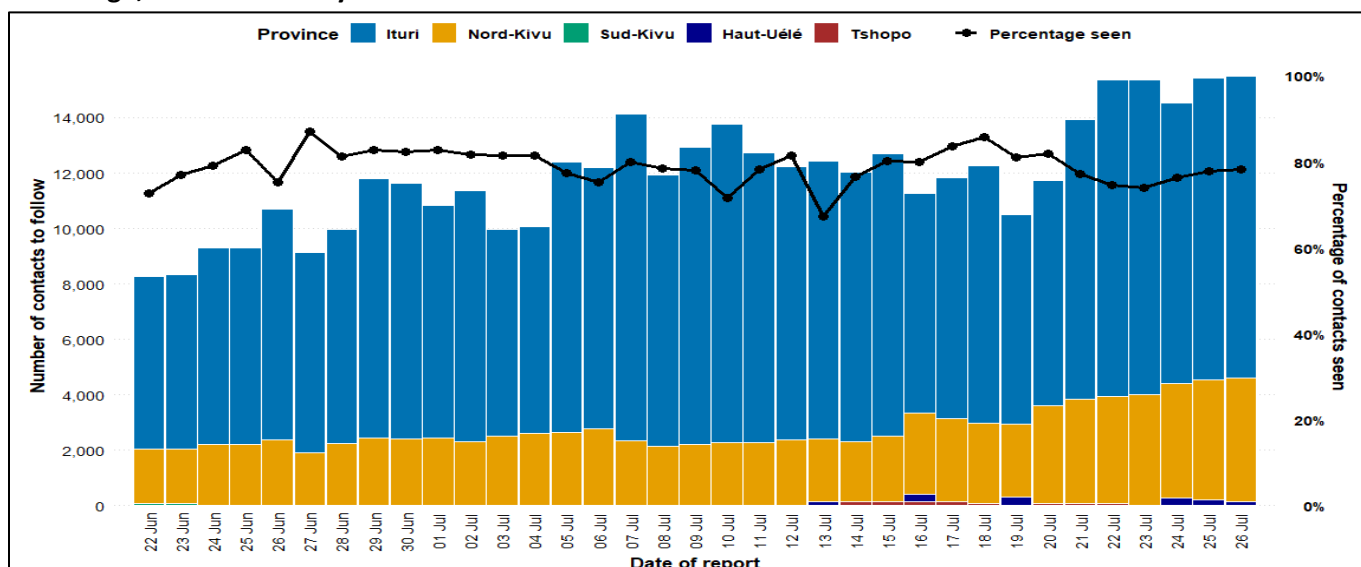
among males (CFR 35.1%) than among females (29.6%). This difference may reflect delayed healthcare seeking, occupational or behavioural factors associated with later presentation to care, differences in exposure intensity, or underlying health conditions.

Figure 3. Bundibugyo virus disease case fatality ratio by age group and sex, Democratic Republic of the Congo, data as of 25 July 2026 (n=896 deaths)



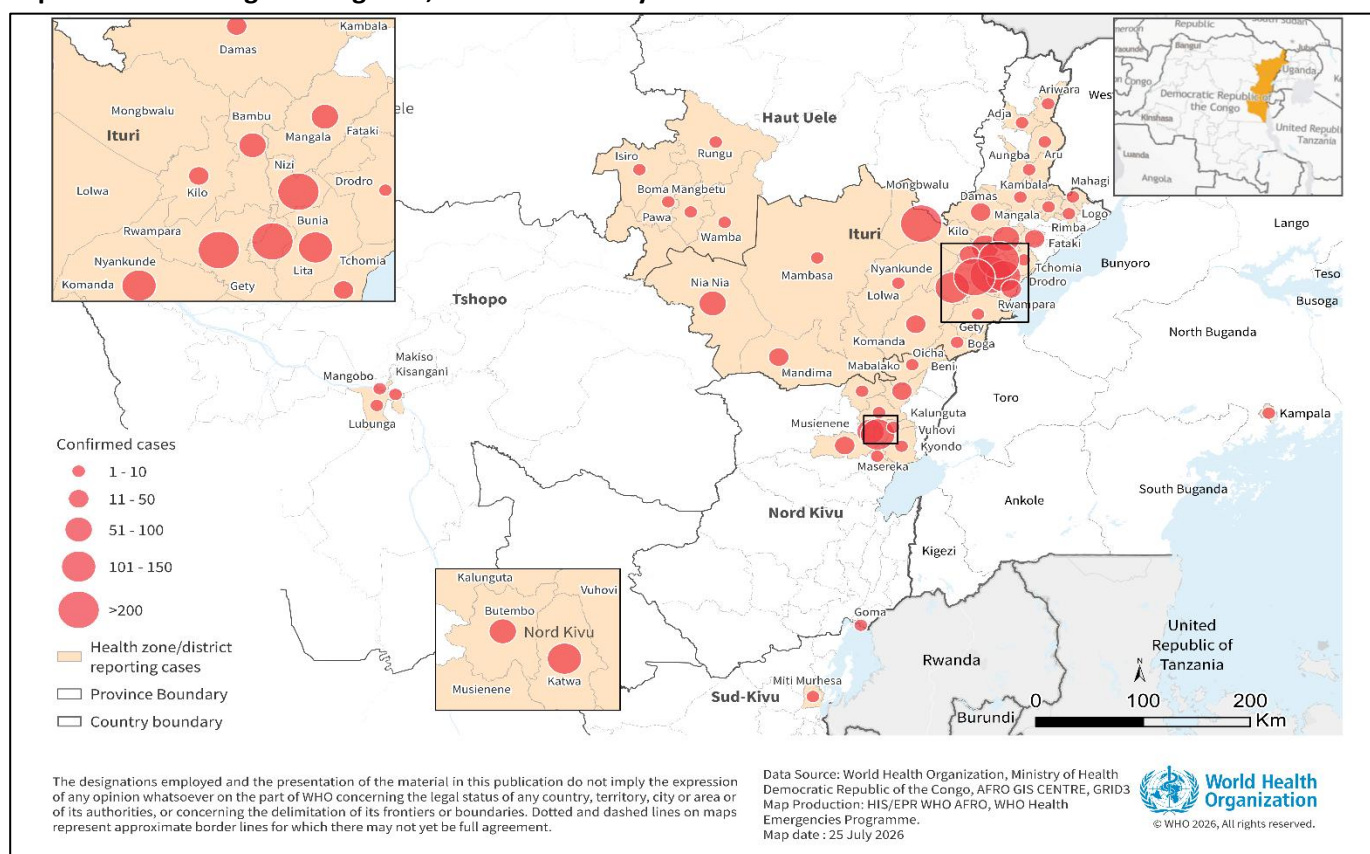
As of 26 July 2026, a total of 15,498 contacts were under follow-up in the Democratic Republic of the Congo, of whom 12,122 (78.2%) were successfully seen within the previous 24 hours. Ituri Province accounted for the majority of contacts under follow-up, although only 75.6% were successfully monitored, while Haut-Uélé achieved 60.0%, North Kivu 85.2%, and Tshopo 90.9%. Contact follow-up activities had been completed in South Kivu, reflecting the absence of recent transmission requiring monitoring. Overall follow-up performance remained substantially below the operational target of 95%, leaving 3,376 contacts not seen during the reporting period and increasing the risk of undetected infections and continued community transmission.

Figure 4. Trend in Contacts Under Follow-up and Daily Contact Follow-up Performance, Democratic Republic of the Congo, 22 June - 26 July 2026



Since the beginning of the outbreak, the Democratic Republic of the Congo has reported 3,262 confirmed cases, including 1,437 confirmed deaths, corresponding to a crude CFR of 44.1%. The outbreak now affects 48 health zones across five provinces. Ituri Province remains the epicentre, accounting for 2,901 confirmed cases (88.9%) and 1,207 confirmed deaths (84.0%) reported nationally. The most affected health zones continue to be Bunia (773 cases, 220 deaths), Rwampara (568 cases, 241 deaths), Mongbwalu (506 cases, 244 deaths), Nizi (357 cases, 171 deaths), Lita (117 cases, 66 deaths), and Nyankunde (114 cases, 31 deaths) in Ituri Province, together with Katwa (140 cases, 88 deaths) and Butembo (73 cases, 49 deaths) in North Kivu Province. Collectively, these health zones continue to account for the overwhelming majority of confirmed cases and 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 26 July 2026



Uganda and France

No new cases have been reported in Uganda and France since the previous update. In Uganda, the last confirmed patient was discharged on 16 July 2026, and the country is on Day 10 of the 42-day countdown to declare the end of the outbreak. All identified contacts have completed the required 21-day follow-up, and no contacts remain under active monitoring. In France, no secondary transmission has been detected following the imported case reported on 24 June 2026, and all five flight contacts successfully completed the 21-day follow-up period. Despite the absence of new cases, Uganda remains at high risk of reintroduction because of the ongoing outbreak in the neighbouring Democratic Republic of the Congo.

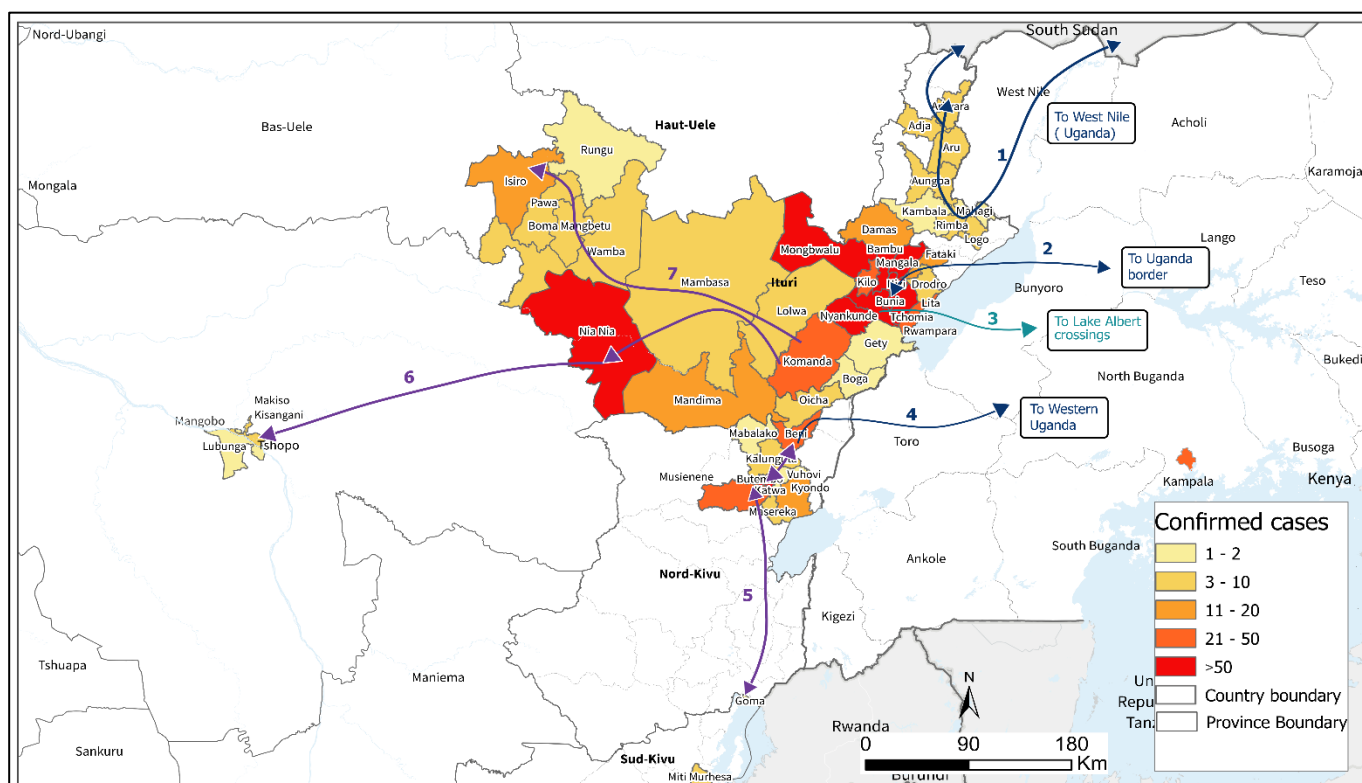
Risk Assessment

The overall public health risk in the Democratic Republic of the Congo remains very high, driven by sustained transmission, increasing mortality, continued geographic expansion across five affected provinces, and persistent transmission in the Bunia–Rwampara–Mongbwalu–Nizi corridor, the current epicentre of the outbreak. Continued spread into Haut-Uélé and newly affected health zones indicates that transmission is extending beyond its original focus.

The risk of further spread remains high because transmission is occurring along major internal and cross-border mobility corridors. Within the Democratic Republic of the Congo, the Butembo–Beni–Goma, Bunia–Komanda–Mambasa–Nia-Nia–Kisangani, and Bunia–Mongbwalu–Wamba–Isiro corridors connect the outbreak epicentre with major population centres. Internationally, the Ariwara–Aru–Mahagi corridor links the affected area with Uganda's West Nile region and onward to Eastern Equatoria State in South Sudan, while the Bunia–Nizi–Mahagi, Bunia–Tchomia (Lake Albert) and Beni–Kasindi corridors provide additional routes for cross-border spread. Frequent movement of traders, miners, displaced populations, humanitarian workers and other travellers along these routes continues to increase the risk of national and international spread.

Although Uganda has reported no new cases during the reporting period and all contacts from the previous imported case have completed follow-up, both Uganda and South Sudan remain at high risk of importation because of sustained transmission along these major mobility corridors. Continued cross-border surveillance, information sharing and preparedness remain essential to rapidly detect and contain any imported cases.

Figure 5. Bundibugyo virus disease transmission risk along major mobility corridor in the Democratic Republic of the Congo, data as of 26 July 2026



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Data Source: World Health Organization, Ministry of Health Democratic Republic of the Congo, GRID3. Map Production: HIS/EPR WHO AFRO, WHO Health Emergencies Programme. Map date: 27 July 2026

World Health Organization
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Table 1. Confirmed cases and deaths of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by geographic area, as of 26 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	Boma Mangbetu	7	4	57.1	7	4	2026-07-24	2	
		Isiro	12	7	58.3	12	7	2026-07-24	2	
		Pawa	8	6	75.0	8	6	2026-07-26	0	
		Rungu	1	0	0.0	1	0	2026-07-24	2	
		Wamba	11	4	36.4	11	4	2026-07-24	2	
Subtotal — Haut-Uélé			39	21	53.8					
Democratic Republic of the Congo	Ituri	Adja	11	1	9.1	11	1	2026-07-26	0	
		Ariwara	7	1	14.3	7	1	2026-07-20	6	
		Aru	5	5	100.0	2	4	2026-07-22	4	
		Aungba	5	4	80.0	0	2	2026-07-26	0	
		Bambu	57	11	19.3	29	2	2026-07-26	0	
		Boga	1	1	100.0	0	0	2026-07-11	15	
		Bunia	773	220	28.5	301	86	2026-07-26	0	
		Damas	16	8	50.0	11	8	2026-07-24	2	
		Drodro	10	5	50.0	7	2	2026-07-26	0	
		Fataki	18	10	55.6	15	9	2026-07-24	2	
		Gety	1	0	0.0	0	0	2026-05-21	66	
		Kambala	2	2	100.0	0	0	2026-06-30	26	
		Kilo	14	5	35.7	5	4	2026-07-24	2	
		Komanda	29	14	48.3	6	6	2026-07-24	2	
		Lita	117	66	56.4	77	50	2026-07-26	0	
		Logo	11	5	45.5	4	5	2026-07-24	2	
		Lolwa	6	2	33.3	5	1	2026-07-24	2	
		Mahagi	10	4	40.0	10	4	2026-07-26	0	
		Mambasa	17	10	58.8	13	7	2026-07-24	2	
		Mandima	16	8	50.0	11	6	2026-07-24	2	
		Mangala	82	58	70.7	43	38	2026-07-24	2	
		Mongbwalu	506	244	48.2	208	90	2026-07-26	0	
		Nia-Nia	90	47	52.2	57	35	2026-07-24	2	
		Nizi	357	171	47.9	273	147	2026-07-26	0	
		Nyankunde	114	31	27.2	18	11	2026-07-24	2	
		Rimba	7	0	0.0	3	0	2026-07-24	2	
		Rwampara	568	241	42.4	211	166	2026-07-26	0	
		Tchomia	37	17	45.9	22	15	2026-07-24	2	
		Unallocated health zones		17	0	0.0	0	0	—	—
		Subtotal — Ituri			2,901	1,207	41.6			
Democratic Republic of the Congo	North Kivu	Beni	45	32	71.1	16	13	2026-07-24	2	
		Butembo	73	49	67.1	32	29	2026-07-26	0	
		Goma	1	0	0.0	0	0	2026-05-25	62	
		Kalunguta	5	3	75.0	1	0	2026-07-26	0	

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
		Katwa	140	88	62.9	84	47	2026-07-26	0
		Kyondo	13	9	69.2	9	7	2026-07-24	2
		Mabalako	1	0	0.0	0	0	2026-06-13	43
		Masereka	4	0	0.0	1	0	2026-07-22	4
		Musienene	31	17	54.8	23	15	2026-07-26	0
		Oicha	4	3	75.0	1	1	2026-07-19	7
		Vuhovi	1	1	100.0	0	0	2026-06-11	45
Subtotal — North Kivu			314	204	65.0				
Democratic Republic of the Congo	South Kivu	Miti-Murhesa	3	1	33.3	0	0	2026-05-20	67
Subtotal — South Kivu			3	1	33.3				
Democratic Republic of the Congo	Tshopo	Lubunga	1	0	0.0	1	0	2026-07-11	15
		Makiso-Kisangani	3	3	100.0	3	3	2026-07-11	15
		Mangobo	1	1	100.0	1	1	2026-07-11	15
Subtotal — Tshopo			5	4	80.0				
Uganda	Kampala	Kampala	21	3	14.3	0	0	2026-06-21	35
Subtotal — Uganda			21	3	14.3				

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.

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. WHO, Africa Centres for Disease Control and Prevention, and partners continued to provide coordinated technical, operational, and resource mobilization support under the Incident Management System to sustain the regional response.
- National and subnational coordination structures in the Democratic Republic of the Congo continued to oversee the multisectoral response across the five affected provinces. National response leadership was strengthened with the deployment of a new National Incident Manager, while the harmonization of epidemiological data between the national and provincial levels continued to enhance situational awareness and support coordinated decision-making.
- Cross-border coordination between the Democratic Republic of the Congo and Uganda intensified through high-level bilateral engagement and sustained political commitment to strengthen cross-border collaboration and response coordination, alongside joint technical assessments and preparedness activities.
- 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; the Standby Partnership (SBP); and other partners through technical assistance, expert deployments, surge capacity, laboratory strengthening, logistics, 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 from approximately US\$9.37 million to US\$10.62 million. Of this amount, the value of delivered supplies increased from US\$2.59 million (28%) to US\$3.59 million (34%), while the value of supplies in transit decreased from US\$3.54 million (38%) to US\$2.86 million (27%). The value of commodities awaiting procurement or shipment increased to US\$4.17 million (39%), reflecting continued procurement to support the expanding response operations.
- Delivery of emergency supplies increased substantially, with the cumulative value of delivered commodities rising by nearly US\$1.0 million during the reporting period. Delivered cargo increased from approximately 232 metric tons to 265.5 metric tons and from 1,333 cubic metres to 1,583.2 cubic metres, further strengthening operational support for response activities in the Ituri and Kivu hubs.
- Essential response commodities continued to reach affected areas, including 42,974 coveralls, 1.83 million examination gloves, 156,600 Level 3 gowns, 261 hospital beds, 20,016 rapid polymerase chain reaction (PCR) tests, infrared thermometers, patient liners, medicines, and laboratory equipment. Personal protective equipment (PPE) and infection prevention and control (IPC) supplies remained the largest procurement category (US\$5.99 million), followed by medical equipment, laboratory supplies, logistics equipment, and medicines.
- Supply chain operations remained robust, supporting case management, laboratory diagnostics, surveillance, infection prevention and control, and field operations. Although the proportion of commodities in transit declined, 39% of the procurement pipeline (US\$4.17 million) remained pending shipment, requiring continued monitoring to ensure the timely availability of critical response supplies as the outbreak expanded.
- 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 procurement (81%; US\$8.12 million) continued to originate directly from international suppliers, while regional logistics 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 rapid alert investigation remained suboptimal in some affected provinces. On 26 July 2026, 1,303 alerts were reported from the affected provinces in the

Democratic Republic of the Congo, of which 1,078 (82.7%) were investigated within 24 hours. Most alerts originated from North Kivu (650) and Ituri (593), followed by Haut-Uélé (60). Investigation performance remained highest in North Kivu (91.7%), while Ituri investigated 81.3% of reported alerts within 24 hours. No alerts were investigated in Haut-Uélé during the reporting period (0.0%), highlighting a critical surveillance gap requiring immediate attention. A total of 326 suspected cases, including 216 live alerts and 110 community deaths, were validated.

- Points of entry (PoE) and points of control (PoC) surveillance continued to be strengthened in the Democratic Republic of the Congo. As of 26 July 2026, 76 of 76 (100%) planned PoE/PoC sites were operational, including 60 in Ituri, 16 in North Kivu, and all activated sites in Tshopo (60%). During the reporting period, 152,039 travellers passed through PoE/PoC screening sites, of whom 96.8% were screened for Bundibugyo virus disease (BVD) symptoms. Five alerts were generated through PoE/PoC surveillance, all of which were validated live alerts. One (20.0%) was referred to a treatment centre, and one confirmed positive case was identified among referred suspected cases during the reporting period.
- Contact tracing activities continued but remained below the operational target. As of 26 July 2026, 15,498 contacts were under follow-up, of whom 12,122 (78.2%) were successfully seen, remaining well below the operational target of 95%. Follow-up performance was highest in Tshopo (90.9%), followed by North Kivu (85.2%), Ituri (75.6%), and Haut-Uélé (60.0%), while contact follow-up had been completed in South Kivu.
- In Uganda, alert management, surveillance for non-trauma deaths, community-based surveillance, and point-of-entry screening continued nationwide. All previously identified contacts had completed the 21-day follow-up period, while enhanced surveillance and digital Passenger Locator Form requirements remained in place to support early detection of imported cases.

Laboratory

- Laboratory decentralization continued to expand with the goal to reduce turnaround times. As of 29 July 2026, 19 diagnostic laboratories and testing units were operational across Ituri, South Kivu, Tshopo, Haut-Uélé 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 across the Democratic Republic of the Congo, with operational treatment centres and care facilities providing 941 isolation and treatment beds. As of 26 July 2026, 723 patients were in isolation, corresponding to an overall bed occupancy rate of 76.8%. Bed occupancy remained particularly high in North Kivu (136.2%), indicating continued pressure on treatment capacity, while Ituri reported an occupancy rate of 66.4%. Of the 723 patients in isolation, 325 were confirmed cases and 398 were suspected cases.

- Clinical outcomes continued to improve, with cumulative recoveries increasing to 568 by 26 July 2026, reflecting the continued provision of supportive clinical care despite increasing case numbers.

Operational Research

- Clinical research and access to investigational therapeutics continued through the WHO-supported PARTNERS clinical trial, which began on 2 July 2026 in the Democratic Republic of the Congo and is evaluating MBP134 and remdesivir for the treatment of BVD. This is complemented by the partner-supported EBO-PEP trial, which commenced on 14 July 2026 and is assessing obeldesivir as post-exposure prophylaxis for high-risk contacts.
- Additionally, Phase I evaluation of candidate Bundibugyo virus vaccines is underway in the United Kingdom, with additional studies expected to begin in Africa. WHO continues to support research preparedness through the development of standardized epidemiologic protocols, a regional research tracking system, and community engagement materials to improve understanding of clinical research.

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

- In the Democratic Republic of the Congo, as of 26 July 2026, 947 health care facilities (HCFs) had been assessed for IPC readiness across the four affected provinces (Ituri, North Kivu, South Kivu, and Tshopo), covering 51 health zones. The average overall IPC score was 38.0% (median: 37.1%), indicating that IPC capacity across the response area remained critically low compared with the 80% threshold considered satisfactory for Ebola preparedness.
- Of the 947 HCFs assessed, 705 (74%) were classified as "Insufficient", 221 (23%) as "Partial", and only 21 (2%) met the "Satisfactory" threshold ($\geq 80\%$). Additionally, 248 facilities (26%) had reported at least one suspected or confirmed case, underscoring the urgency of addressing these IPC gaps.
- Across the 17 standardized IPC components assessed, the weakest areas were personal protective equipment (PPE) (11%), training (13%), isolation area set-up (17%), post-exposure management (23%), and cleaning and disinfection (25%), all of which were rated "Insufficient." Even the strongest-performing components – injection safety (75%), patient placement (72%), waste treatment (65%), sterilization (58%), and water supply (52%) – remained within the "Partial" category, indicating that no IPC component had yet reached the standard required for adequate Ebola response readiness at the national level.
- Healthcare worker infections continued to increase, with 123 infections and 37 deaths reported among healthcare workers, corresponding to a CFR of 29.8%. This underscores persistent occupational exposure risks and inadequate implementation of IPC measures in health facilities. Gaps also remain in the availability of appropriate personal protective equipment (PPE) for different categories of healthcare workers.

- In response to these findings, WHO and partners continued to scale up IPC/WASH interventions across affected areas. More than 1,000 frontline health workers, supervisors, hygienists, and members of safe and dignified burial (SDB) teams received IPC training. In addition, more than 450 IPC rings were activated, resulting in the decontamination of over 1,000 households and health facilities, the distribution of more than 130 IPC kits to health facilities, and over 450 assessments of exposed health workers. Furthermore, more than 115 screening and triage points were established, with over 500 supportive supervision and mentorship visits conducted. IPC/WASH assessments were also completed at all eight Ebola treatment centres (ETCs).
- Safe and dignified burial (SDB) operations and decontamination activities continued across affected health zones, including the decontamination of households, health facilities, and transport vehicles linked to confirmed cases.

Risk Communication and Community Engagement (RCCE)

- RCCE activities continued across affected provinces to strengthen community awareness, promote early alert reporting, support contact tracing, and SDB operations, particularly in hotspot areas of Ituri and North Kivu. Additional RCCE personnel and anthropological expertise were deployed to newly affected provinces to strengthen community engagement.
- Community feedback and rapid community assessments continued to inform the response by identifying concerns related to transmission risks, access to services, vaccination, and response activities. Findings are being translated into community-led interventions and expanded across affected areas of the Democratic Republic of the Congo, with plans to extend implementation to Uganda and South Sudan.
- Capacity-building efforts continued through the development of an RCCE Humanizing the Response training package and the training of trainers for response partners. A targeted RCCE strategy was also developed for IDP camps, incorporating findings from rapid community assessments to strengthen community engagement.
- Key RCCE challenges persisted, including delay in intervention services (like SDB), insecurity in hotspot areas, limited community trust and acceptance in mining and conflict-affected communities, misinformation, and highly mobility of populations. Community engagement efforts therefore remained focused on building trust in response services and improving access among high-risk populations.

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

- Visibility and operational materials were distributed to community awareness-raising teams in Bunia to strengthen field activities. The teams received seven megaphones, 55 T-shirts, 55 vests, one box of batteries, one package of hand sanitiser gel, 70 posters, and 1,000 information, education and communication (IEC) flyers.
- An evaluation of PRSEAH pillar activities, including field-based awareness-raising interventions, was conducted to assess progress, identify key implementation challenges, and inform the planning of upcoming awareness-raising activities. A total of 40 participants, including 30 women, took part in the evaluation.
- A PRSEAH induction briefing was conducted for 15 WHO staff members, all of whom signed the Organization's Code of Conduct. In Ituri, North Kivu, South Kivu, and Tshopo Provinces, as well as at the Rwampara Ebola Treatment Centre, 443 individuals, including 265 women, participated in PRSEAH

orientation sessions. Participants included psychologists, health care providers, community outreach workers, hygiene promoters, Red Cross volunteers, and administrative staff.

- A total of 1,556 people, including 770 women and 47 girls, participated in PRSEAH awareness sessions targeting religious leaders, pregnant women, health care workers, taxi drivers, motorcycle taxi riders, and other community members.

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, 30 of the 47 Member States (64%) have updated their readiness assessments. In addition, three high-priority countries (Angola, South Sudan, and Tanzania) have completed repeat readiness assessments, demonstrating significant improvements in their average readiness scores.
- Regional deployments to support preparedness in high-risk Member States continued during the reporting period, with ongoing deployments in Burundi, the Central African Republic, and the Democratic Republic of the Congo.

Border Health, Travel and Mass Gatherings

- Screening has been reinforced at airports, high-risk border crossings, and internal transit routes in both the Democratic Republic of the Congo and Uganda. National authorities, the International Organization for Migration (IOM), and partners continue to support the implementation of WHO border health guidance, strengthen cross-border coordination, and facilitate the timely detection 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, and South Sudan to improve the early detection of cases and reduce the risk of cross-border spread. Priority actions include strengthening coordinated cross-border disease surveillance, event-based surveillance, active case finding, joint contact tracing where required, and real-time information sharing through regular cross-border coordination meetings and harmonized reporting mechanisms.
- Priority operational actions include rapid assessments and mapping of PoEs, strengthening monitoring along high-risk cross-border mobility corridors, including informal crossings, and major congregation points, and ensuring that field teams are adequately staffed and equipped, with sustained availability of trained personnel, equipment, PPE, screening materials, disinfectants, and referral systems for the safe management of suspected cases
- Mass gathering risk assessment capacity is being strengthened through training and technical support. 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 BVD outbreak in the Democratic Republic of the Congo continues to intensify despite the ongoing scale-up of response operations. The sustained increase in transmission and mortality indicates that the outbreak remains uncontrolled. Although transmission remains concentrated within a number of interconnected health zones, its continued expansion into adjacent areas suggests that current interventions have not yet been sufficient to reduce transmission intensity or halt the geographic spread of the outbreak. The persistently high proportion of community deaths, suboptimal contact follow-up, and critically weak IPC capacity indicate that many transmission chains continue to be detected too late to prevent onward spread. Although no international spread has been reported during the current reporting period, sustained transmission along major domestic and cross-border mobility corridors continues to pose a substantial risk of regional spread. Strengthening early case detection, community engagement, IPC, and coordinated cross-border preparedness remains critical to interrupt transmission and reduce the risk of further national and international spread.

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