

# BUNDIBUGYO VIRUS DISEASE OUTBREAK

## Democratic Republic of the Congo | Uganda | France

### Weekly External Situation Report 17, Data as of 06 September 2026

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

|                                                          |                                                                      |                                      |                                  |                                              |
|----------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------|----------------------------------|----------------------------------------------|
| <b>6</b> Provinces<br><b>61</b> Health Zones<br>Affected | <b>5</b> Provinces<br><b>52</b> Health Zones<br>Active Transmission* | <b>1 563</b><br>Cases<br>Recovered   | <b>60.0%</b><br>Bed<br>Occupancy | <b>24 479</b><br>Contacts<br>under follow up |
| <b>819</b><br>Active<br>Cases in Isolation               | <b>167</b><br>Health Worker<br>Cases                                 | <b>47</b><br>Health Worker<br>Deaths | <b>1 366</b><br>Bed<br>Capacity  | <b>25</b><br>Testing<br>Laboratories         |

*Note: Health zones with active transmission have reported at least one case in the last 21 days.*

#### 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 | Outbreak Status |
|----------------------------------|-----------------------------------|------------------------------------|-------------------------|--------------------------|----------------|-----------------|------------------------------------|-------------------------------------|------------------------------|-----------------|
| Democratic Republic of the Congo | <b>586</b>                        | <b>276</b>                         | <b>6 686</b>            | <b>3 226</b>             | -              | -               | <b>6 686</b>                       | <b>3 226</b>                        | <b>48.3%</b>                 | <b>Active</b>   |
| Uganda                           | <b>0</b>                          | <b>0</b>                           | <b>20</b>               | <b>2</b>                 | <b>1</b>       | <b>1</b>        | <b>21</b>                          | <b>3</b>                            | <b>14.3%</b>                 | <b>Ended</b>    |
| France                           | <b>0</b>                          | <b>0</b>                           | <b>1</b>                | <b>0</b>                 | <b>0</b>       | <b>0</b>        | <b>1</b>                           | <b>0</b>                            | <b>0.0%</b>                  | <b>Ended</b>    |

*Note: Only confirmed and probable cases are reported.*

#### Event description

##### *Democratic Republic of the Congo*

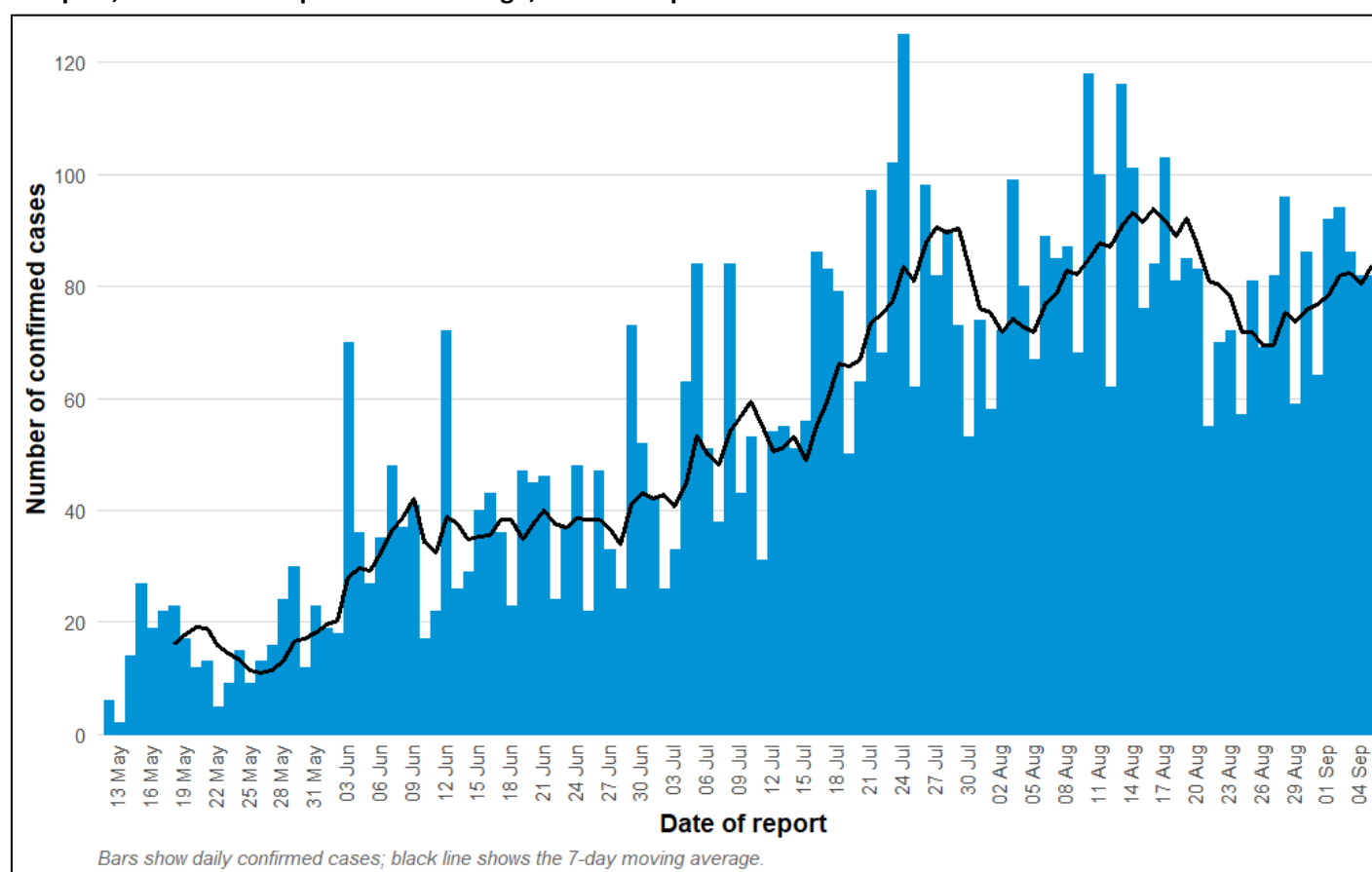
The epidemiological pattern of the Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo is becoming increasingly heterogeneous, with divergent transmission trends across affected provinces and health zones. Ituri remains the principal focus, while substantial transmission continues in Nord-Kivu and Haut-Uélé and new areas continue to be affected. Since [External Situation Report #16](#), a further 586 confirmed cases and 276 confirmed deaths have been reported, bringing the cumulative total to 6686 confirmed cases, including 3226 deaths [case fatality ratio (CFR) 48.3%], as of 6 September 2026. Ituri accounts for 80.2% of cumulative confirmed cases, down from 82.2% in the

previous update, while Nord-Kivu has now surpassed 1000 cumulative cases. The number of affected health zones increased from 60 to 61 across six provinces, with Kayna Health Zone in Nord-Kivu being the latest affected.

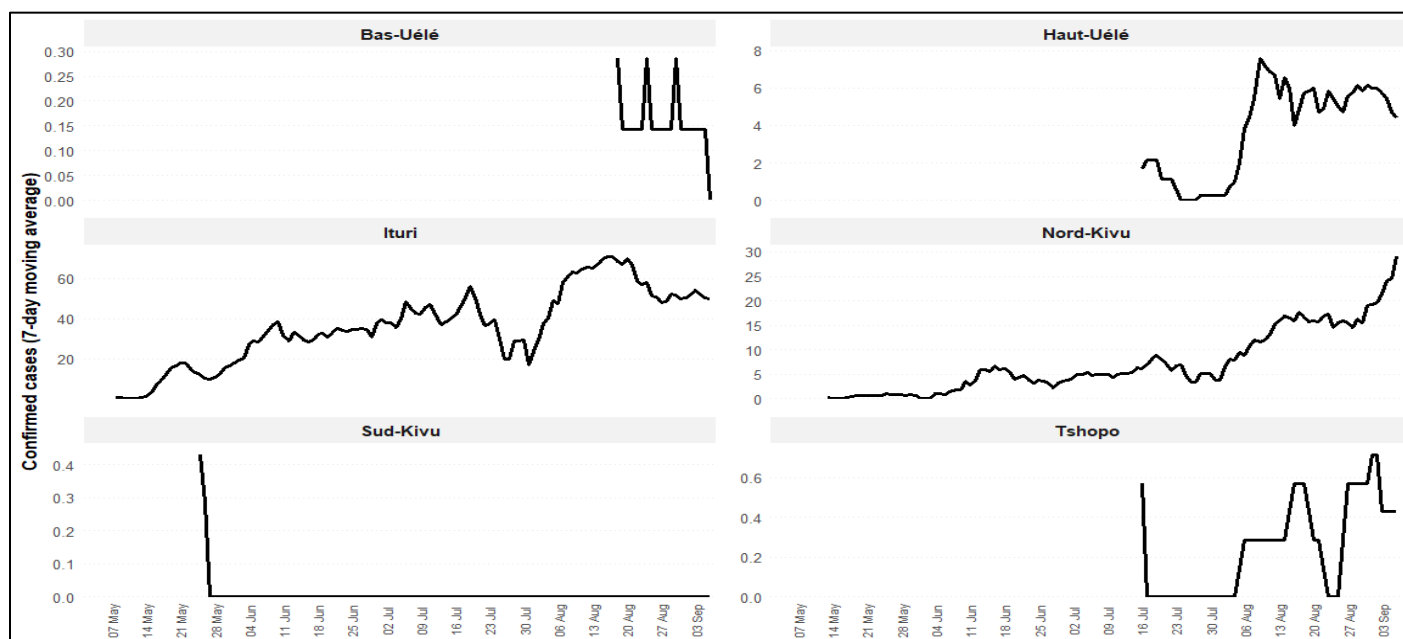
At the national level, daily incidence remains high but fluctuating, with the seven-day moving average declining from its mid-August peak before rising again in early September. This overall pattern masks increasingly divergent provincial trajectories. Ituri, while still the main driver of the outbreak, has declined substantially from its mid-August peak but remains at a high level with recent fluctuations. In contrast, Nord-Kivu is experiencing a marked and sustained increase, reaching its highest incidence since the start of the outbreak, while transmission remains sustained in Haut-Uélé. Tshopo and Bas-Uélé continue to report low but intermittent transmission, while no recent transmission is evident in Sud-Kivu. Overall, the trends reinforce an increasingly heterogeneous epidemic, with declining transmission in some areas occurring alongside intensification and continued geographic spread elsewhere.

During the most recent 21 days (17 August – 6 September 2026), 1665 confirmed cases were reported nationally. Compared with 1759 cases during the preceding 21-day period (27 July – 16 August 2026), this represents a decrease of 94 cases (–5.3%). Reported cases declined by 18.3% in Ituri, from 1356 to 1108, but increased by 47.4% in Nord-Kivu, from 293 to 432, and by 14.0% in Haut-Uélé, from 100 to 114. Consequently, Ituri's contribution to newly reported cases fell from 77.1% to 66.5%, while Nord-Kivu's contribution increased from 16.7% to 25.9% and Haut-Uélé's from 5.7% to 6.8%. The latest period also included eight cases in Tshopo and three in Bas-Uélé. Overall, the modest national decline masks a continued redistribution of transmission away from Ituri, particularly towards Nord-Kivu, where incidence continues to increase.

**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 06 September 2026**



**Figure 2. Daily provincial seven-day moving average trends in confirmed Bundibugyo virus disease cases by date of report, Democratic Republic of the Congo, as of 06 September 2026**



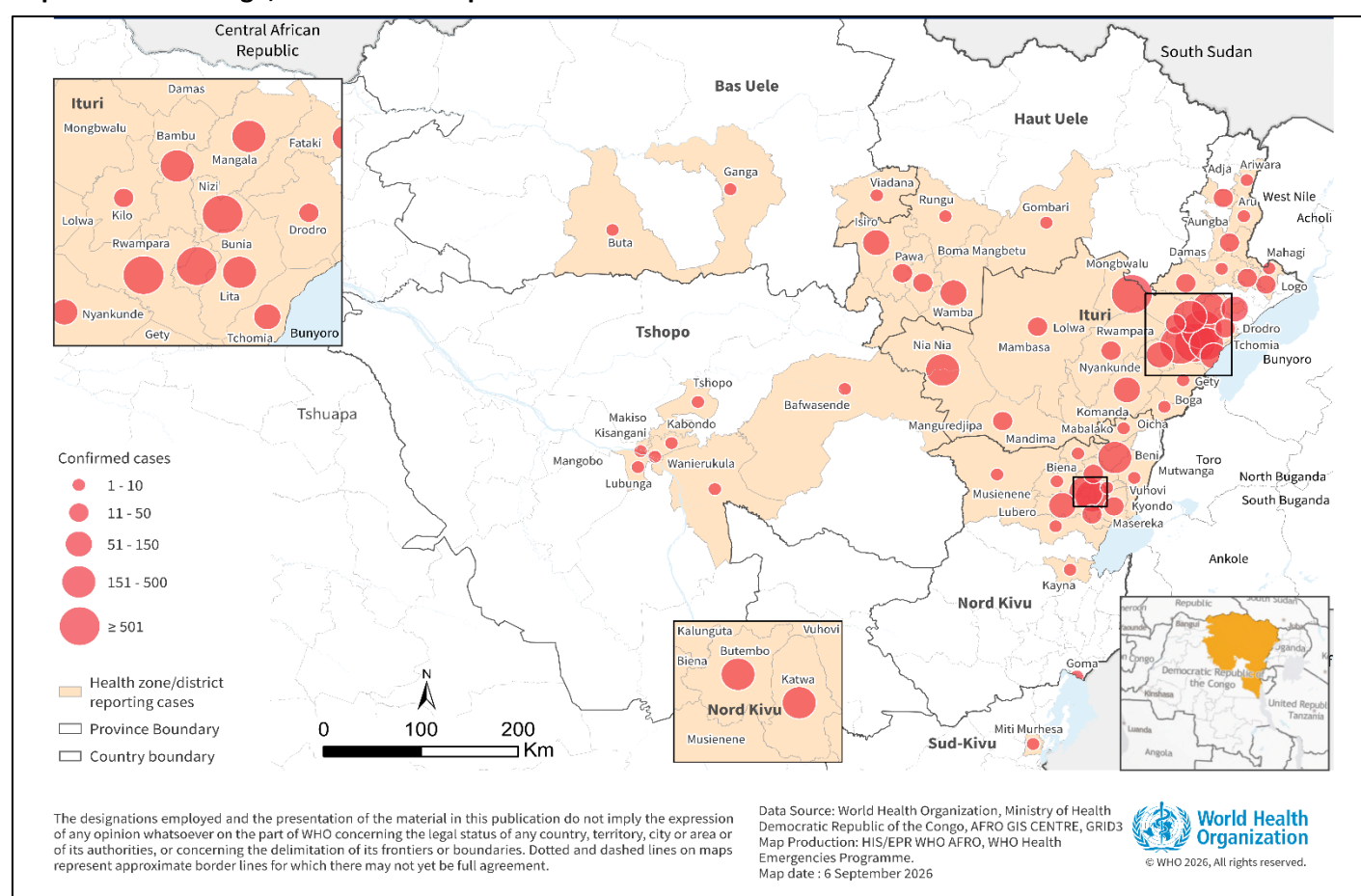
During the same period, 848 confirmed deaths were reported nationally, compared with 941 deaths during the preceding 21 days, representing a decrease of 93 deaths (–9.9%). The national decline was driven by Ituri, where reported deaths decreased from 671 to 548 (–18.3%). In contrast, deaths increased from 224 to 253 (+12.9%) in Nord-Kivu and from 42 to 43 (+2.4%) in Haut-Uélé. Consequently, Ituri’s contribution to newly reported deaths declined from 71.3% to 64.6%, while Nord-Kivu’s increased from 23.8% to 29.8% and Haut-Uélé’s from 4.5% to 5.1%. Tshopo and Bas-Uélé reported two deaths respectively during the latest period, with no net increase in cases and deaths. Overall, the modest national reduction in both cases (–5.3%) and deaths (–9.9%) masks divergent provincial trajectories and should be interpreted cautiously given reporting delays and retrospective data reconciliation. The continued increase in both cases and deaths in Nord-Kivu, alongside sustained transmission in Haut-Uélé, indicates that the outbreak is increasingly geographically heterogeneous rather than showing a uniform decline.

**Table 1. Bundibugyo virus disease cases and deaths by province across consecutive 21-day periods, 27 Jul – 16 August 2026 compared with 17 August – 06 September 2026, Democratic Republic of the Congo**

| Province        | Cases                  |                       |              | Deaths                  |                        |              |
|-----------------|------------------------|-----------------------|--------------|-------------------------|------------------------|--------------|
|                 | Cases<br>27 Jul–16 Aug | Cases<br>17 Aug–6 Sep | Change       | Deaths<br>27 Jul–16 Aug | Deaths<br>17 Aug–6 Sep | Change       |
| Ituri           | 1 356                  | 1 108                 | –18.3%       | 671                     | 548                    | –18.3%       |
| Nord-Kivu       | 293                    | 432                   | +47.4%       | 224                     | 253                    | +12.9%       |
| Haut-Uélé       | 100                    | 114                   | +14.0%       | 42                      | 43                     | +2.4%        |
| Tshopo          | 8                      | 8                     | 0.0%         | 2                       | 2                      | 0.0%         |
| Sud-Kivu        | 0                      | 0                     | –            | 0                       | 0                      | –            |
| Bas-Uélé        | 3                      | 3                     | 0.0%         | 2                       | 2                      | 0.0%         |
| <b>National</b> | <b>1 759</b>           | <b>1 665</b>          | <b>–5.3%</b> | <b>941</b>              | <b>848</b>             | <b>–9.9%</b> |

Additionally, during the most recent 21 days, 52 of the 61 affected health zones (85.2%) reported at least one new confirmed case, while nine (14.8%) reported no new cases: Adja, Kambala and Mahagi in Ituri; Goma in Nord-Kivu; Lubunga, Tshopo and Wanie-Rukula in Tshopo; Miti-Murhesa in Sud-Kivu; and Buta in Bas-Uélé. Importantly, provincial trends should not be interpreted as uniform across their constituent health zones. In Ituri, for example, the overall 18.3% decline in cases occurred alongside renewed or increasing transmission in several health zones, including Bunia, Nizi, Mangala, Bambu, Komanda, Lita and Mandima, while previously prominent hotspots such as Mongbwalu showed declining activity. Similarly, the overall increase in Nord-Kivu reflects both strong resurgence in established hotspots, particularly Katwa, Beni and Butembo, and recent or renewed activity in additional health zones. These divergent sub-provincial trajectories indicate that transmission is shifting geographically rather than declining uniformly, underscoring the need to monitor and target response interventions at the health-zone level rather than relying on provincial or national trends alone.

**Figure 3. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 06 September 2026**

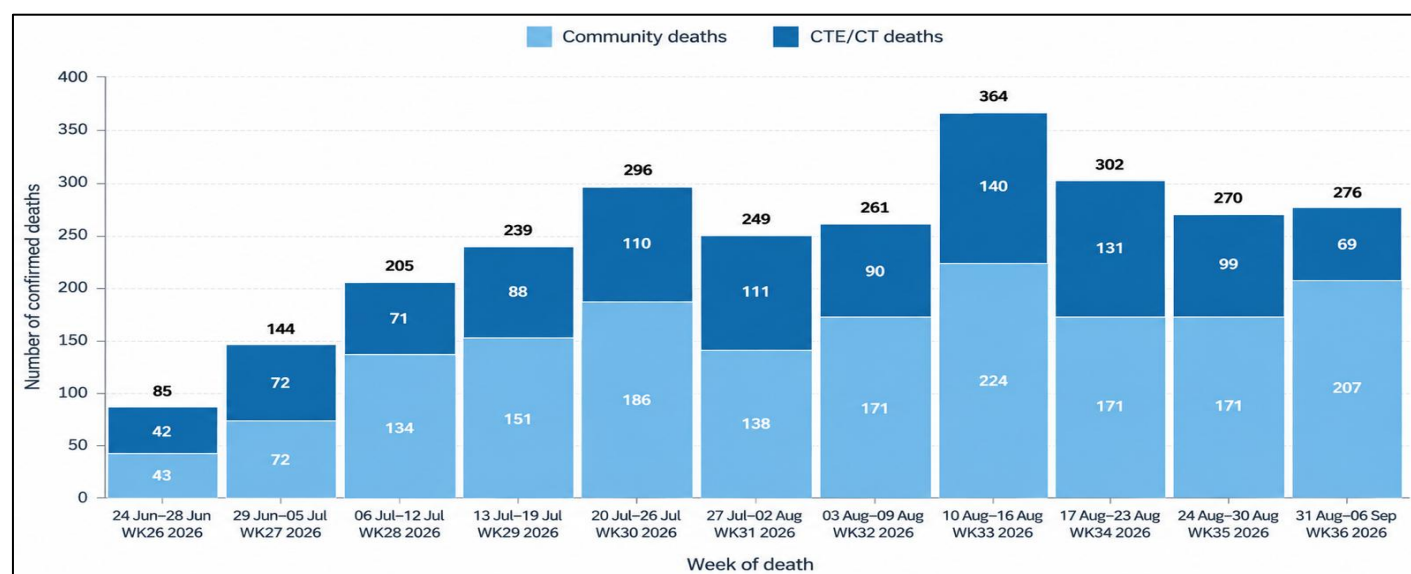


Weekly confirmed deaths peaked at 364 during 10 – 16 August, followed by declines to 302 and 270 over the subsequent two weeks. However, this downward trend did not continue in the most recent week, with deaths increasing slightly to 276 during 31 August – 6 September (+2.2%). More importantly, the latest increase was driven entirely by community deaths, which rose sharply from 171 to 207 (+21.1%), while deaths occurring in treatment facilities continued to decline from 99 to 69 (–30.3%). Consequently, the proportion of confirmed deaths occurring in the community increased from 56.6% during 17 – 23 August to 63.3% during 24 – 30 August and 75.0% during 31 August – 6 September, the highest weekly proportion observed during the reporting period. This divergence is concerning, as the increase in community

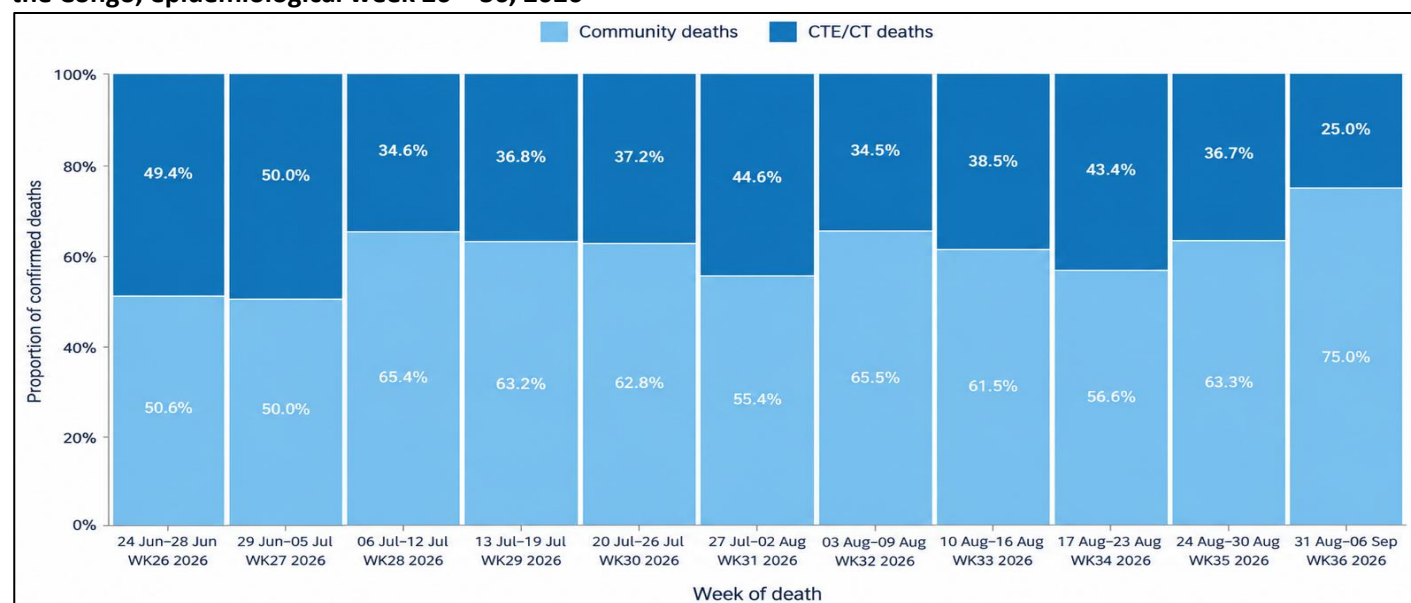
deaths alongside the continued decline in treatment facilities deaths indicates that the earlier reduction in overall mortality has not been sustained.

The persistence of high community mortality may reflect multiple barriers along the pathway to care, including delayed detection and notification, delayed referral or transfer to treatment facilities, limited recognition of illness or perceived severity, geographic and transport barriers, care-seeking outside formal health facilities, and community acceptance or trust. These factors may result in patients reaching treatment facilities late or dying before referral can be completed. The increasing proportion of community deaths, despite expanding treatment capacity, therefore suggests that increasing bed capacity alone may be insufficient and reinforces the need to strengthen early case detection, rapid referral and community-level pathways to timely care.

**Figure 4. Weekly number of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological week 26 – 36, 2026**



**Figure 5. Weekly proportion of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological week 26 – 36, 2026**



### *Risk Assessment*

The risk of further spread remains very high within the Democratic Republic of the Congo and high for neighbouring countries sharing land borders with the country. This assessment reflects sustained transmission, continued geographic expansion, high mortality, population mobility, insecurity and persistent response challenges. The risk is considered low elsewhere in Africa and globally. The second IHR Emergency Committee, convened on 18 August 2026, also reviewed the evolving situation and emphasized that the outbreak remains far from controlled, and continues to constitute a Public Health Emergency of International Concern.

## **Public health response**

### **Coordination**

- On 4 September 2026, the Government of the Democratic Republic of the Congo, with support from WHO, the United Nations system, Africa CDC and partners, launched a revised 180-day multisectoral response plan to intensify efforts to interrupt BVD transmission. The plan serves as the operational roadmap for the next six months and prioritizes strengthened surveillance and contact tracing, clinical care, community engagement and risk communication, logistics, and preparedness in at-risk provinces. Implementation is estimated to require US\$1.3 billion, with rapid resource mobilization identified as critical to achieving the planned scale-up.
- Response coordination is being further decentralized to the field, with personnel, resources and technical support being repositioned towards the highest-burden health zones and health areas, alongside stronger direct links between the national and zonal teams to improve real-time information flow and operational decision-making.
- Joint WHO–Africa CDC–partner coordination continues through the Continental IMST, with greater emphasis on integrated delivery across response pillars and follow-up of agreed actions. Coordination is being strengthened across partners and response pillars, with increased emphasis on field-level information sharing and integrated implementation and operational support..
- WHO, Africa CDC and partners continued to align technical assistance, deployments and operational resources with evolving transmission patterns and response gaps. UNICEF, International Organization for Migration (IOM), Médecins Sans Frontières (MSF), Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Samaritan's Purse, the European Union, Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams, StandBy partners and others supported field operations, laboratory activities, logistics and expert deployments in affected and at-risk areas.

### **Operations Support and Logistics (OSL)**

- The emergency supply pipeline increased to US\$12.18 million, up from US\$11.59 million in the previous update. Supplies worth US\$5.11 million (42%) have been delivered, US\$6.22 million (51%) are in transit, and approximately US\$0.85 million (7%) are not yet ready for shipment.
- Delivery of supplies continued to progress, with cumulative delivered cargo reaching 346.7 metric tonnes and 1972.7m<sup>3</sup>, compared with 346.7 metric tonnes and 1971.5m<sup>3</sup> in the previous update.



- Critical commodities continued to reach the Ituri and Kivu hubs. Cumulative deliveries include 78 274 hooded coveralls, 5.53 million examination gloves, 158 800 Level 3 gowns, 261 hospital beds, 10 076 infrared thermometers, 20 016 RadiOne PCR tests and 7200 manual PCR tests. A further 254 930 hooded coveralls, 4.19 million examination gloves, 267 800 Level 3 gowns, 500 hospital beds and 8 000 infrared thermometers are in transit.
- Personal protective equipment (PPE) and infection prevention and control (IPC) supplies remain the largest procurement category at US\$5.17 million, followed by medical equipment (US\$1.95 million), laboratory supplies (US\$1.91 million), logistics (US\$1.29 million) and medicines (US\$0.82 million).
- Pipeline readiness improved further, with 93% of supplies by value either delivered or in transit, leaving 7% not yet ready for shipment. International suppliers remain the predominant source, accounting for approximately 83% (US\$10.68 million) of procurement value, underscoring the importance of maintaining timely international shipment and onward distribution.

## Surveillance

- 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 31 August – 6 September, a total of 13 730 alerts were reported, averaging 1961 alerts per day. Of these, 12 268 (89.4%) were verified. All 2 480 validated suspected cases were investigated (100%); however, only 1319 (53.2%) were isolated and transferred to treatment centres. This indicates that, despite complete investigation of validated suspected cases, a substantial gap persists between investigation and isolation or referral, with nearly half of investigated suspected cases not transferred to treatment centres during the period.
- Contact tracing remained below the  $\geq 95\%$  target during 31 August – 6 September, with an average of 24 312 contacts requiring daily follow-up, of whom 21 120 (86.9%) were seen. Follow-up performance improved from 84.6% during the preceding period (25 – 30 August) to 86.9%, despite the continued high contact-tracing workload. As of 6 September, 24 479 contacts remained under follow-up, of whom 20 888 (85.3%) were seen on the day.
- At PoEs and PoCs, 252 682 travellers were recorded on 6 September, with 98.1% screened. Four alerts were detected. Reporting completeness across PoEs/PoCs was 76.2%, with important gaps in Bas-Uélé (34.6%) and Sud-Kivu (55.5%).

## Laboratory

- Diagnostic capacity continued to expand and decentralize, increasing from two laboratories at the onset of the outbreak to 25 active laboratories. Of these, nine primarily use open RT-PCR platforms and 16 primarily use RadiOne near-point-of-care PCR platforms, providing a combined testing capacity of more than 3180 samples per day. New laboratory capacity has been established in Lita Health Zone, with additional laboratories and diagnostic platforms planned for deployment.
- Priorities are now to consolidate and sustain the expanded network through implementation of the updated decentralization plan; reliable supplies, equipment, training and supervision; and improved turnaround-time data capture, specimen management and partner reporting. WHO is procuring approximately US\$1.5 million in

laboratory supplies and critical equipment to support new and existing laboratories.

## Case Management

- Case management capacity continues to expand, with 49 treatment centres/units providing 1366 active beds, of which 819 were occupied by confirmed cases (62.0% occupancy) as of 6 September. Capacity is expected to reach 1898 beds by mid-September, with a target of 3000 beds by end-October.
- Clinical capacity and quality of care are being strengthened, including expansion of biochemistry testing to 18 treatment units, deployment of oxygen concentrators and high-flow machines to more than 20 treatment, and additional critical-care training. Bed allocation is being adapted to epidemiological trends and patient needs, including paediatric, critical-care and maternity capacity.
- Cumulative recoveries increased to 1563 as of 6 September 2026.

## Research and Development

- Following the 17 August 2026 allocation of 70 000 doses of Ervebo® to the Democratic Republic of the Congo, operational plans have been further defined, with 20 000 doses allocated to the Phase 3 clinical trial, 20 000 to the Bundibugyo Ring-vaccination Assessment of Vaccine Outcomes (BRAVO) observational vaccine-effectiveness study among healthcare workers in Ituri, and 30 000 for off-label use among healthcare and frontline workers under separate protocols with informed consent.
- Ervebo® vaccination of healthcare and frontline workers is now underway. As of 6 September 2026, a total of 2007 people had been vaccinated across six health zones in three provinces: Tshopo, Bas-Uélé and Ituri. This included 1083 people in Makiso-Kisangani, 195 in Mangobo, 156 in Kabondo and 55 in Bafwasende (Tshopo); 498 in Buta (Bas-Uélé); and 20 in Gombe (Ituri).
- Importantly, following a review of additional evidence on 19 August 2026, the WHO Strategic Advisory Group of Experts on Immunization (SAGE) concluded that available evidence remains insufficient to support the programmatic use of Ervebo® for the prevention of BVD, and that its efficacy against BVD in humans remains unknown. WHO therefore recommends that Ervebo® be used for BVD only within the context of a research protocol.
- Alongside research evaluating Ervebo® against BVD, development of BDBV-specific vaccines is advancing. Oxford's ChAdOx1 and Moderna's mRNA candidates are in Phase 1 trials, while additional rVSV and MVA candidates are under development. Initial Oxford trial results are expected by the end of September, with further clinical studies planned in Africa.
- The WHO-sponsored PARTNERS therapeutic trial continues in the Democratic Republic of the Congo, evaluating MBP134, remdesivir and their combination for treatment of confirmed BVD, alongside standard supportive care. The six-month trial aims to enroll 700 – 1000 participants, with no interim efficacy results reported to date.
- The EBO-PEP trial continues to evaluate post-exposure prophylaxis for high-risk contacts, including oral obeldesivir in asymptomatic contacts and remdesivir in children and pregnant and breastfeeding women following high-risk exposure. The obeldesivir trial targets 998 participants, with an interim analysis planned at



50% recruitment.

- The MBOTE clinical characterization study is now recruiting across four centres, following patients from diagnosis to characterize the clinical presentation, progression and outcomes of BVD and complement evidence generated through ongoing therapeutic trials.

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

- IPC capacity continues to expand, including IPC ring interventions, decontamination, supportive supervision and supplies; however, implementation remains uneven in areas of intense or expanding transmission.
- More than 1900 health workers have been trained and mobilized, while over 3000 households and 900 health facilities have been decontaminated. In addition, 1200 screening and triage points have been established, over 1000 IPC kits distributed, and more than 1200 health-facility IPC/WASH assessments conducted, with supportive supervision and mentorship provided to over 500 facilities.
- Implementation of IPC rings, which provide targeted IPC interventions around each confirmed case, including assessment and decontamination of affected households and health facilities, remained uneven. In the latest reporting period, only 18 of 60 expected rings (30%) were activated in Ituri and 10 of 30 (33%) in Nord Kivu, compared with all three expected rings in Haut Uélé. Household decontamination reached 91% (50/55) in Ituri and 100% (16/16) in Haut Uélé, but remained substantially lower in Nord Kivu at 29% (6/21).
- Safe and dignified burial (SDB) activities continued, with 6313 burials supported cumulatively. During the latest reporting period, 71 SDBs were conducted in Ituri, 37 in Nord Kivu and five in Haut Uélé. However, community resistance prevented the swabbing of 30 bodies in Ituri and the safe and dignified burial of one reported death in Kabondo, Tshopo.
- Healthcare worker infections remain a major concern, with 167 confirmed infections and 47 deaths, underscoring persistent healthcare-associated transmission risks and the need to strengthen triage, PPE use and adherence to IPC standards.

## **Risk Communication and Community Engagement (RCCE)**

- RCCE activities continued at scale, reaching more than 6.3 million people cumulatively through approximately 1.81 million household visits. In the latest 24-hour reporting period alone, 110 767 people were reached and 23 552 households visited.
- Community engagement is increasingly targeted to transmission hotspots and populations at higher risk. RCCE teams were deployed to Niania, Mangala, Buta, Fataki and affected areas of Nord Kivu, while engagement with mining communities in Ituri brought together leaders of about 50 mining cooperatives to strengthen early referral and reduce community deaths.
- Other locally adapted approaches include engagement of traditional healers, motorcycle taxi networks,

community watch brigades, guided visits to treatment centres and survivor engagement.

- Community resistance continues to pose an important operational challenge. In Ituri, 19 refusals of isolation were reported, while resistance prevented the swabbing of 30 bodies. Serious incidents involving confirmed deaths were also reported in Beni and Katwa, Nord Kivu, and a patient in Isiro, Haut Uélé, refused to return to the treatment centre. These incidents highlight the need to intensify community engagement through trusted local actors and rapidly address community concerns to improve acceptance of isolation, referral and safe and dignified burials.

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

- PRSEAH coordination is being strengthened at global, national and operational levels, including finalization of the national and inter-agency PRSEAH response plan and mapping of technical capacity across the Democratic Republic of the Congo and high-risk areas.
- Community awareness and prevention activities are expanding, with 962 community members reached and 396 people briefed across Ituri, South Kivu and Tshopo, alongside strengthened capacity of community mobilizers.
- Survivor-centred support and safeguarding mechanisms are being reinforced, including mapping of Gender-Based Violence and victim-support services, identification of service gaps, and strengthening of community-based complaints and reporting mechanisms.
- Priority gaps remain in geographic coverage and partner alignment, with efforts focused on extending PRSEAH capacity across affected health zones, strengthening community and media outreach, and training community health workers and PRSEAH focal points, including in Aru and Mambasa.

## **Public health preparedness**

### **Operational Readiness**

- Regional preparedness continued to improve, with 31 WHO African Region Member States completing and submitting readiness assessments, increasing regional coverage to 66%.
- Ten out of 11 high-priority countries completed repeat readiness assessments, reflecting continued efforts to strengthen national preparedness capacities: Angola, Burundi, Central African Republic, South Sudan, Tanzania, Kenya, Republic of the Congo, Rwanda, Uganda and Zambia.
- Regional technical deployments continued to support preparedness and response capacity in affected and high-risk Member States, including Burundi, Central African Republic, Democratic Republic of the Congo and South Sudan.

### **Border Health, Travel and Mass Gatherings**

- Screening 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. 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 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 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, strengthening surveillance along high-risk cross-border mobility corridors, 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 and contingency plans for the safe management of suspected cases
- 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](#).

## Situation interpretation

The outbreak remains uncontrolled and increasingly heterogeneous, with improving trends in some areas occurring alongside continued transmission, geographic redistribution and the emergence of new hotspots. The widening geographic footprint is creating an increasingly complex operational environment, requiring response capacity to be sustained across widely dispersed and sometimes difficult-to-access areas. The six affected provinces collectively cover an area of approximately 630 000 km<sup>2</sup>, although transmission remains concentrated within specific health zones and health areas. This geographic dispersion increases demands on surveillance, contact tracing, referral and case management capacity, laboratory networks, logistics and field coordination, and increases the risk that emerging transmission may not be detected or contained rapidly. Further gains will therefore depend on translating the substantial expansion in response capacity into rapid, locally delivered action in active and emerging hotspots. Priorities should include early detection and referral, enhanced contact tracing, IPC interventions around cases, addressing the drivers of community deaths, and maintaining operational readiness in areas at risk of further spread.

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