

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda | France

Weekly External Situation Report 15, Data as of 23 August 2026

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

6 Provinces 57 Health Zones Affected	5 Provinces 47 Health Zones Active Transmission*	1 215 Cases Recovered	64.7% Bed Occupancy	22 015 Contacts under follow up
846 Active Cases in Isolation	155 Health Worker Cases	45 Health Worker Deaths	1 308 Bed Capacity	22 Testing 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	563	302	5 584	2 680	-	-	5 584	2 680	48.0%	Active
Uganda	0	0	20	2	1	1	21	3	14.3%	Controlled
France	0	0	1	0	0	0	1	0	0.0%	Controlled

Note: Only confirmed and probable cases are reported.

Event description

Democratic Republic of the Congo

More than three months into the response, the Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo remains characterized by sustained transmission, high mortality and continued geographic expansion. The epidemiological picture is increasingly heterogeneous, with persistent transmission in established hotspots in Ituri, intensifying transmission in parts of Nord-Kivu and Haut-Uélé, and continued geographic expansion through the emergence of cases in previously unaffected health zones. Since [External Situation Report #14](#), a total of 563 new confirmed cases and 302 confirmed deaths have been reported, bringing the cumulative total to 5 584 confirmed cases,

including 2 680 deaths. The number of affected health zones has increased from 55 to 57 across six provinces, with Viadana in Bas-Uélé and Mutwanga in Nord-Kivu being the most recently affected health zones.

Figure 1. Daily growth trend in confirmed Bundibugyo virus disease cases in the Democratic Republic of the Congo, by date of report, data as of 23 August 2026

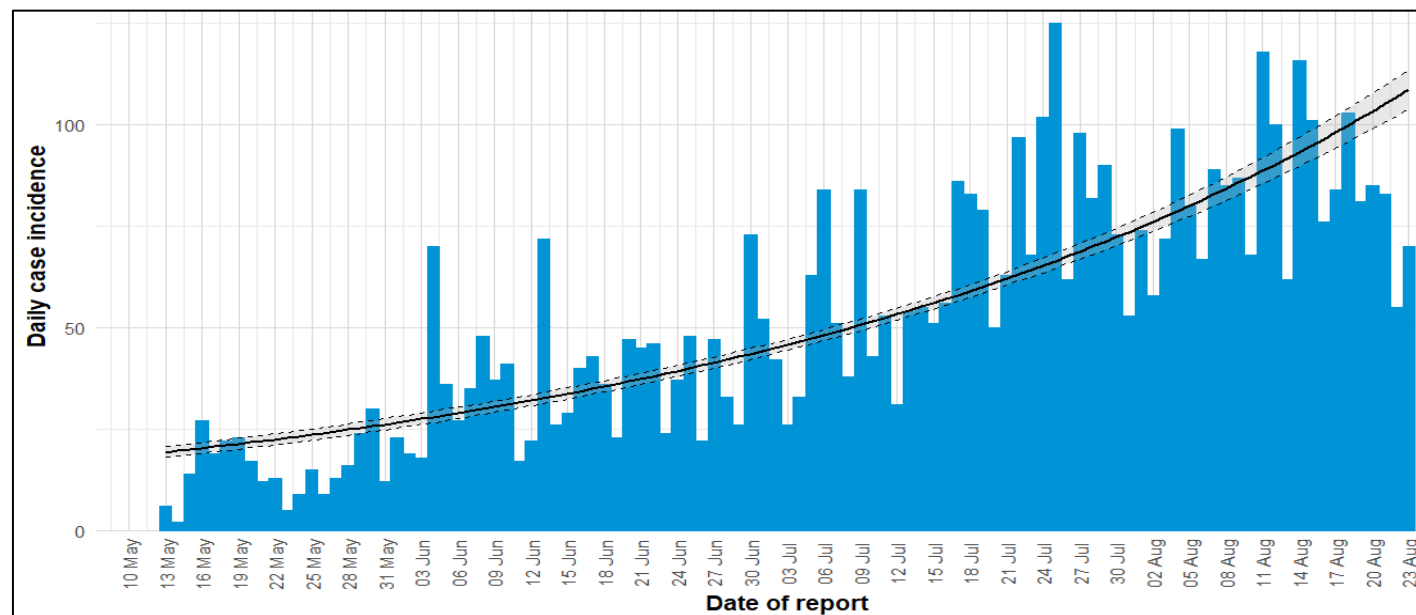
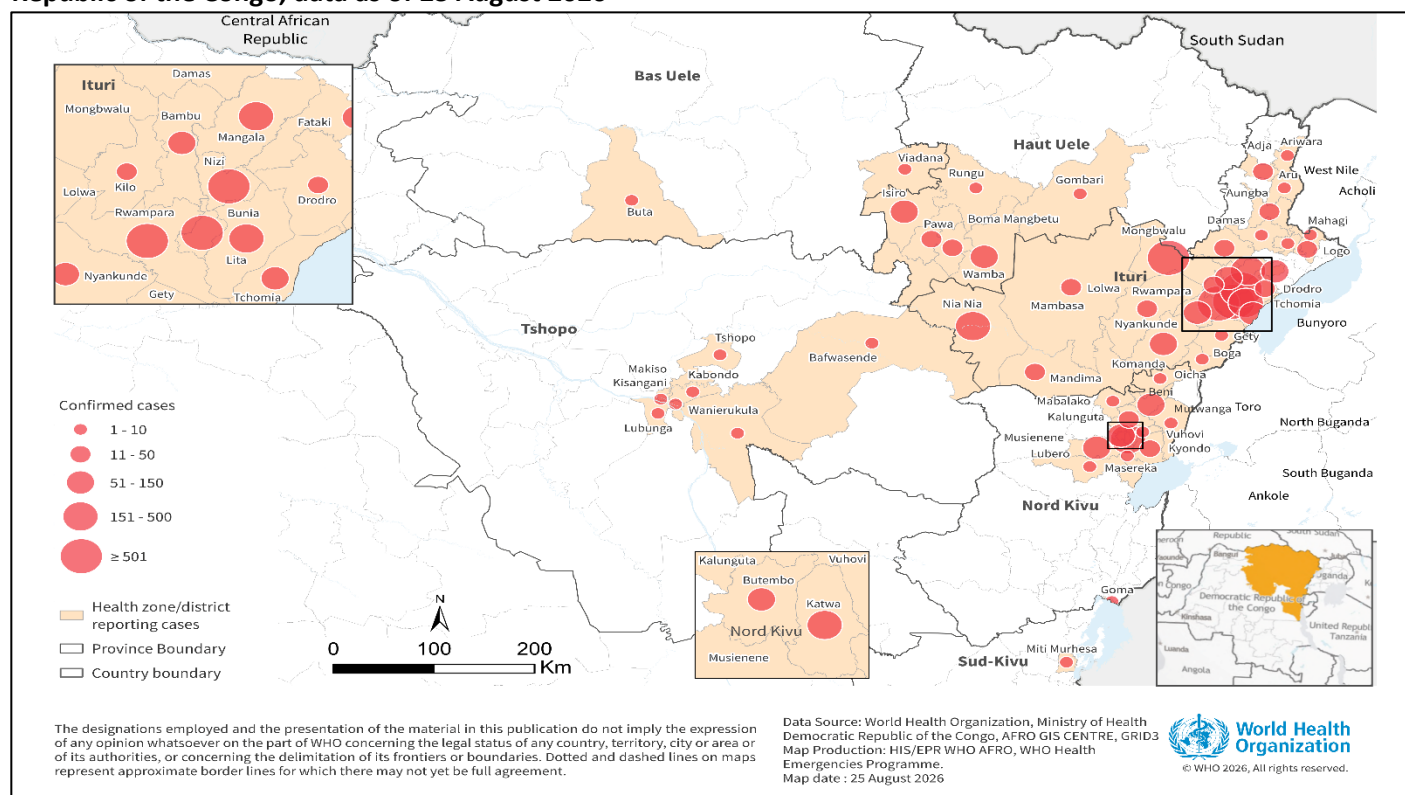


Figure 2. Geographical distribution of cumulative confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo, data as of 23 August 2026



During the most recent 21 days (3 – 23 August 2026), 1 782 confirmed cases were reported nationally. Compared with the preceding 21-day period (13 July – 2 August 2026), reported cases declined slightly by 57 (–3.1%). Given the small magnitude of this decline and the potential influence of reporting delays and retrospective data reconciliation, this should be interpreted cautiously because it does not yet provide clear evidence of declining transmission. The national trend also masks a continued redistribution of reported incidence, with cases declining by 13.4% in Ituri but increasing by 32.5% in Nord-Kivu and 122.2% in Haut-Uélé. Consequently, Ituri's contribution to newly reported cases declined from 84.0% to 75.1%, while the contribution of Nord-Kivu increased from 12.9% to 17.6% and that of Haut-Uélé more than doubled from 2.9% to 6.7%.

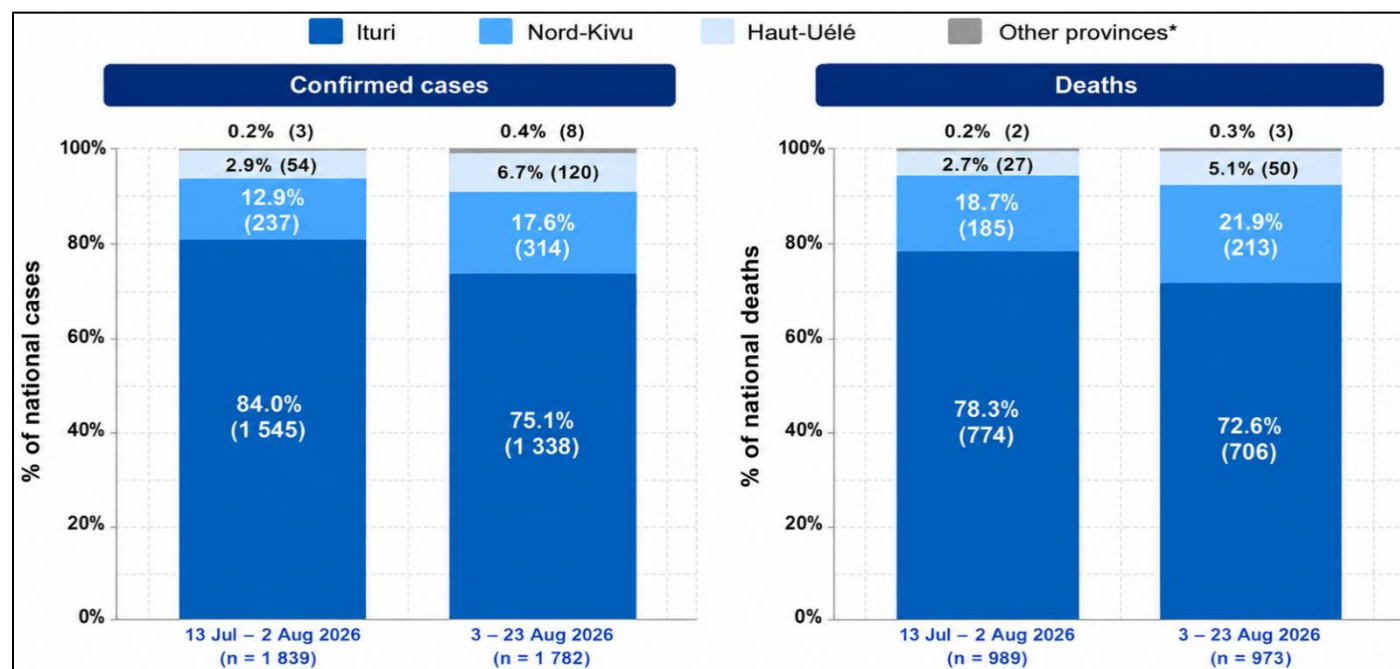
During the same period, 973 confirmed deaths were reported nationally, a slight decrease of 16 deaths (–1.6%) compared with the preceding 21 days. A marked geographic redistribution of mortality was nevertheless observed. While deaths declined by 8.8% in Ituri, they increased by 15.1% in Nord-Kivu and 85.2% in Haut-Uélé. Consequently, Ituri's contribution to newly reported deaths declined from approximately 78.3% to 72.6%, while Nord-Kivu's contribution increased from 18.7% to 21.9% and Haut-Uélé's nearly doubled from 2.7% to 5.1%. Transmission therefore remains dominated by Ituri but is increasingly distributed across other active foci, indicating that the outbreak is becoming progressively less concentrated in its original epicentre.

Table 1. Bundibugyo virus disease confirmed cases and deaths by province across consecutive 21-day periods, 13 Jul – 02 August 2026 compared with 03 – 23 August 2026, Democratic Republic of the Congo

Province	Cases					Deaths				
	Cumulative cases	13 Jul - 2 Aug	3 - 23 Aug	Net change	Relative change	Cumulative deaths	13 Jul - 2 Aug	3 - 23 Aug	Net change	Relative change
Ituri	4 655	1 545	1 338	-207	↓ -13.4%	2 771	774	706	-68	↓ -8.8%
Nord-Kivu	728	237	314	+77	↑ +32.5%	319	185	213	+28	↑ +15.1%
Haut-Uélé	181	54	120	+66	↑ +122.2%	77	27	50	+23	↑ +85.2%
Tshopo	23	3	8	+5	↑ +166.7%	11	2	3	+1	↑ +50.0%
Sud-Kivu	5	0	0	0	→ Stable	1	0	0	0	→ Stable
Bas-Uélé	2	0	2	+2	New	1	0	1	+1	New
Democratic Republic of the Congo	5 584	1 839	1 782	-57	↓ -3.1%	2 680	989	973	-16	↓ -1.6%

Notes: Data are as of 23 August 2026. Net change is the absolute difference between 03 – 23 August and 13 July – 02 August. Relative change is the net change expressed as a percentage of the preceding 21-day period. "New" indicates that no cases or deaths were reported during the preceding period, so a percentage change cannot be calculated.

Figure 3. Proportion of Bundibugyo virus disease confirmed cases and deaths by province across two consecutive 21-day periods, 13 Jul – 02 August 2026 compared with 03 – 23 August 2026, Democratic Republic of the Congo



At health-zone level, the changing geographic pattern is more pronounced, with substantial variation in reported incidence across established and emerging transmission foci. In Ituri, reported cases declined markedly in Mongbwalu from 223 to 50 (–173; –77.6%), Lita from 96 to 56 (–40; –41.7%), and Nizi from 292 to 210 (–82; –28.1%), while Bunia declined slightly from 411 to 384 (–27; –6.6%) and Rwampara from 271 to 258 (–13; –4.8%). In contrast, cases increased in Bambu from 33 to 63 (+30; +90.9%), Mangala from 55 to 92 (+37; +67.3%), and Nia-Nia from 69 to 89 (+20; +29.0%). Outside Ituri, reported cases increased substantially in Katwa from 115 to 162 (+47; +40.9%) and Beni from 34 to 53 (+19; +55.9%) in Nord-Kivu, and in Isiro from 19 to 49 (+30; +157.9%) and Wamba from 9 to 47 (+38; +422.2%) in Haut-Uélé. These patterns indicate that the declining contribution of Ituri is being driven primarily by substantial reductions in several established hotspots, particularly Mongbwalu and Nizi, rather than by a uniform decline across the province. At the same time, increasing incidence in selected health zones within Ituri and the continued growth of foci in Nord-Kivu and Haut-Uélé indicate an increasingly heterogeneous and geographically dispersed transmission pattern.

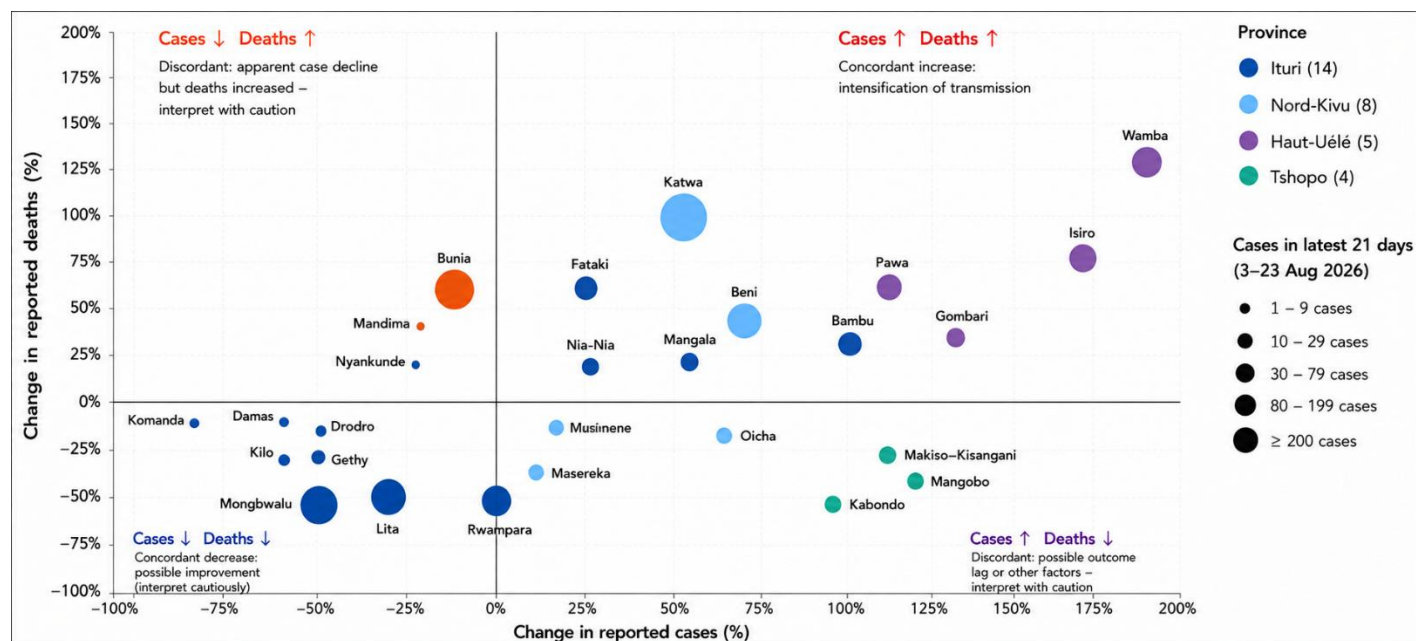
Reported deaths at health-zone level show a broadly similar geographic redistribution but also highlight important discordance with trends in reported cases. In Nord-Kivu, deaths in Katwa increased from 71 to 112 (+41; +57.7%), alongside the increase in reported cases, while deaths in Beni increased from 29 to 35 (+6; +20.7%). In Haut-Uélé, deaths increased in Isiro from 11 to 18 (+7; +63.6%) and Wamba from two to 17 (+15; +750.0%), consistent with increasing reported incidence in both health zones. In Ituri, deaths declined substantially alongside cases in several established hotspots, including Mongbwalu from 82 to 20 (–62; –75.6%), Nizi from 146 to 58 (–88; –60.3%), Lita from 62 to 25 (–37; –59.7%), and Rwampara from 173 to 72 (–101; –58.4%).

However, the pattern was not consistent across all health zones. Most notably, Bunia recorded a 29.8% increase in deaths, from 104 to 135 (+31), despite a 6.6% decline in reported cases. Deaths also increased in Bambu from 5 to 13 (+8; +160.0%), alongside the increase in cases, while Mangala showed little change in deaths, from 37 to 40 (+3; +8.1%), despite a 67.3% increase in reported cases. These discordant trends warrant cautious interpretation of apparent declines in reported incidence. Where fatal infections are more consistently ascertained than non-fatal cases, a reduction in reported cases without a corresponding reduction in deaths may reflect differences in case ascertainment,

reporting delays, or the lag between case detection and death rather than a true decline in transmission. Interpretation of recent health-zone mortality patterns in Ituri is further limited by 250 cumulative deaths that had not yet been assigned to a health zone as of 23 August 2026.

Ten previously affected health zones reported no confirmed cases during the most recent 21 days (3 – 23 August 2026): Adja, Boga, Kambala and Mahagi in Ituri; Goma and Lubero in Nord-Kivu; Rungu in Haut-Uélé; Lubunga and Wanierukula in Tshopo; and Miti-Murhesa in Sud-Kivu. During the same period, six health zones were reported as affected for the first time: Mutwanga in Nord-Kivu; Gombari in Haut-Uélé; Bafwasende and Tshopo in Tshopo; and Buta and Viadana in Bas-Uélé.

Figure 4. Change in reported Bundibugyo virus disease confirmed cases and deaths by health zone across two consecutive 21-day periods, 13 Jul – 02 August 2026 vs. 03 – 23 August 2026, Democratic Republic of the Congo



Note: newly affected health zones and those without a case in the last 21 days are not included in Figure 4.

Mortality remains high, with 302 confirmed deaths reported during the last seven days, including 171 (56.6%) in the community and 131 (43.4%) in BVD treatment facilities. The persistently high proportion of community deaths (defined as both deaths at home and at non-BVD health facilities) highlights continued challenges with early detection, referral and timely access to treatment, while mortality in BVD treatment facilities may reflect late presentation, quality of care and patient vulnerabilities, including age, malnutrition and comorbidities; further analysis to understand the risk factors is underway.

Among 4807 confirmed cases and 1820 deaths with available age and sex information, adults aged 20 – 59 years continue to account for the majority of confirmed cases, representing about two-thirds of cases overall and 58% in the most recent epidemiological week. However, mortality remains disproportionately concentrated among young children. In week 34, children aged <5 years accounted for 17% of reported cases but 29% of deaths, continuing the increased contribution of this age group to mortality observed in recent weeks. Overall, the sex distribution of cases is relatively balanced, although females account for slightly more cases, while deaths are broadly similar between males and females. These findings continue to indicate a high burden of transmission among working-age adults alongside disproportionate mortality among young children.

Figure 5. Weekly proportion of confirmed Bundibugyo virus disease deaths by place of death, Democratic Republic of the Congo, epidemiological week 26 – 34, 2026

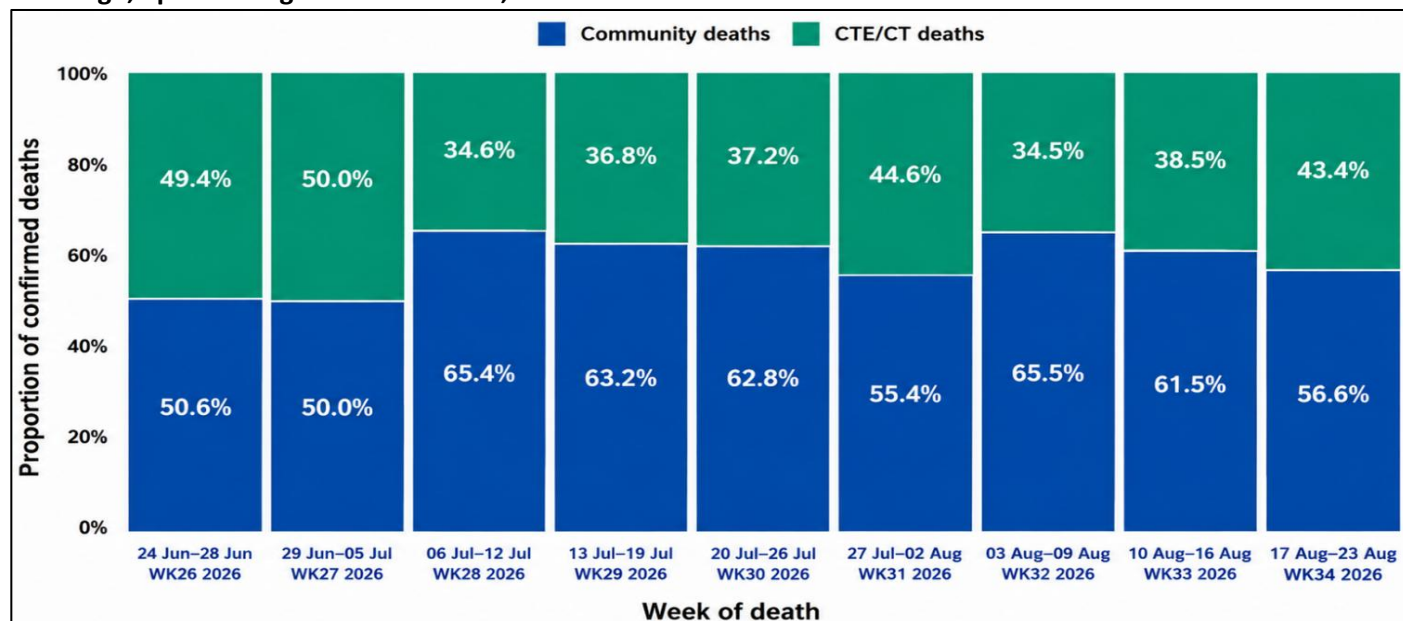
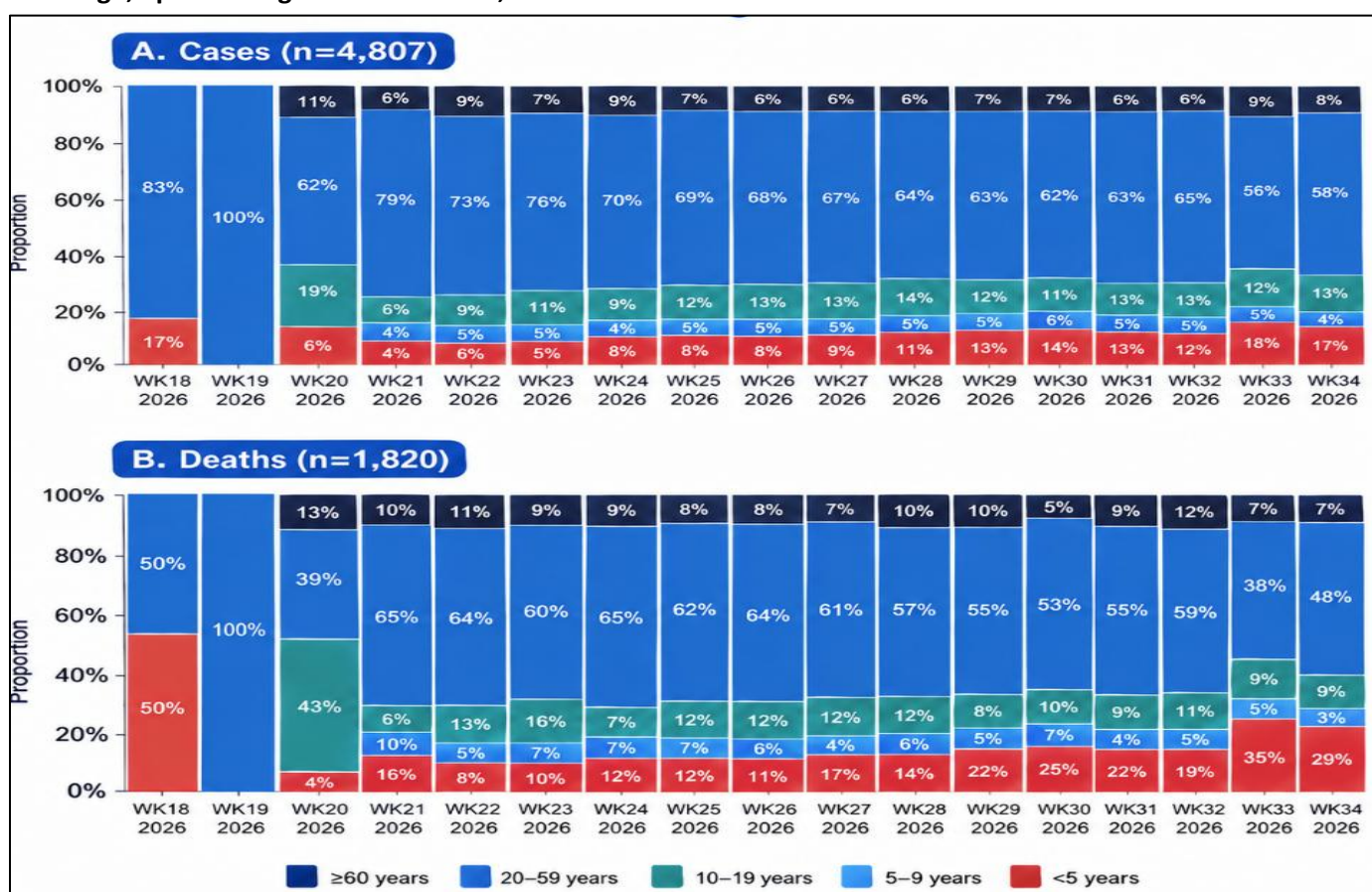
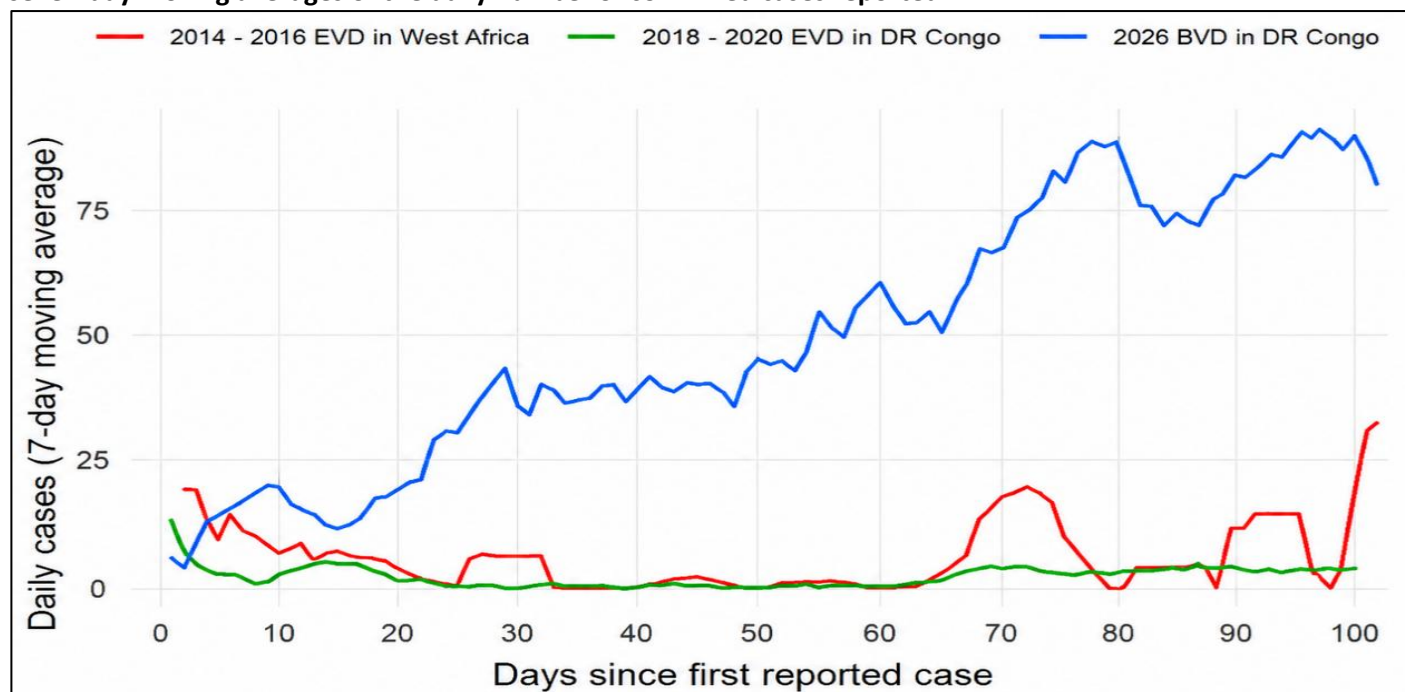


Figure 6. Proportion of confirmed Bundibugyo virus disease cases and deaths by age group, Democratic Republic of the Congo, epidemiological week 26 – 34, 2026



The current BVD outbreak continues to follow a markedly different trajectory from previous major Ebola disease outbreaks. During the first 102 days of reporting, the 7-day moving average of daily cases remained substantially higher than levels observed during comparable periods of the 2014 – 2016 West Africa and 2018 – 2020 Democratic Republic of the Congo outbreaks, reaching more than 90 confirmed cases per day at its recent peak. With 5514 confirmed cases, including 2642 deaths, reported as of 22 August 2026, this is the largest BVD outbreak ever recorded and the second-largest Ebola disease outbreak on record. Notably, the number of deaths has already surpassed the 2287 deaths reported during the entire 2018–2020 outbreak in eastern Democratic Republic of the Congo.

Figure 7. Comparison of three major Ebola disease outbreak trajectories during the first 102 days of reporting using seven-day moving averages of the daily number of confirmed cases reported.



The security situation in eastern Democratic Republic of the Congo remains volatile and continues to present operational challenges for the outbreak response. Recent insecurity has included armed clashes, attacks affecting civilians and health services, population displacement and constraints on humanitarian access in parts of the affected area. In addition, the AFC/M23 group recently announced restrictions on movement to and from Ebola-affected government-controlled areas as a measure to reduce the risk of disease importation into areas under their control. While the operational implications of these measures are still being assessed, continued insecurity, displacement and restrictions on population movement underscore the complexity of maintaining coordinated outbreak response activities across areas with different security and administrative contexts.

Uganda and France

Uganda has now recorded 38 consecutive days without a new confirmed BVD case since the last patient was discharged on 16 July 2026. All identified contacts completed follow-up, with no further cases detected. The continued high level of transmission in neighbouring eastern Democratic Republic of the Congo, however, means that the risk of cross-border reintroduction remains. France has reported no new confirmed BVD cases for 50 consecutive days since the imported case was discharged on 4 July 2026. The outbreak is thus considered over by WHO's norm of 42 days without any cases.

Risk Assessment

According to WHO's latest Rapid Risk Assessment as of 20 August 2026, 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. The 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

- The WHO – Africa Centres for Disease Control and Prevention (Africa CDC) Continental Incident Management Support Team (IMST) in Kampala continued to support implementation of the Joint Continental Preparedness and Response Plan under the “One Response” approach, coordinating operational planning, information sharing, partner engagement and preparedness support to affected and high-risk countries. The joint plan covers June – November 2026 and provides the overarching framework for coordinated continental action.
- In the Democratic Republic of the Congo, coordination increasingly focused on decentralizing and adapting response operations to the expanding geographic footprint of the outbreak, with national and provincial coordination missions supporting priority areas in Nord-Kivu and Haut-Uélé and strengthening coordination along key transmission and population mobility corridors.
- WHO, Africa CDC and operational partners continued to support national and subnational response coordination, with increasing emphasis on aligning partner presence, technical support and resources with the evolving geographic distribution of transmission and emerging operational gaps. The United Nations Children's Fund (UNICEF), International Organization for Migration (IOM), Médecins Sans Frontières (MSF), Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Samaritan's Purse, European Union, Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams (EMTs), StandBy partners, and others continued to provide technical assistance, expert deployments, laboratory support, logistics, and field operations in affected and at-risk areas.

Operations Support and Logistics (OSL)

- The emergency supply pipeline increased slightly from US\$11.35 million to US\$11.38 million during the past week. Supplies worth US\$4.80 million (42%) have been delivered, while US\$5.40 million (47%) are in transit and US\$1.18 million (10%) are not yet ready for shipment.
- Delivery of supplies continued to progress. Cumulative delivered cargo reached 332.3 metric tonnes and 1 904.4 m³, compared with 331.0 metric tonnes and 1892.1 m³ in the previous week.
- Critical commodities continue to reach the Ituri and Kivu hubs. Cumulative deliveries include 78 274 hooded coveralls, more than 5.53 million examination gloves, 158 800 Level 3 gowns, 261 hospital beds, 10 076 infrared thermometers, 20 016 RadiOne tests and 4 320 manual polymerase chain reaction (PCR) tests. A further 174 200 hooded coveralls and 4.19 million examination gloves are in transit.

- Personal protective equipment (PPE) and infection prevention and control (IPC) supplies remain the largest procurement category at US\$5.05 million, followed by medical equipment (US\$1.96 million), laboratory supplies (US\$1.55 million), logistics (US\$1.35 million) and medicines (US\$0.89 million).
- Pipeline readiness remains high, with 89% of supplies by value either delivered or in transit. Only 10% (US\$1.18 million) is not yet ready for shipment. International suppliers account for approximately 80% (US\$8.53 million) of procurement value, reinforcing the need to maintain timely shipment and onward distribution as response operations continue.

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).
- Alert volume varied considerably throughout the past week, from a low of 1 067 alerts on 16 August to a high of 1 904 alerts on 19 August. Investigation performance during that time ranged from 75% on 17 August to 92% on 19 August. Alert investigation performance varied by province, reaching 98-100% in Nord Kivu, Tshopo and Haut-Uélé, compared to 67% in Ituri.
- The contact-tracing workload continued to increase, with a maximum of 24 332 contacts under follow up on 17 August. Despite this increase, 82-86% of contacts were seen during the week, remaining below the 95% operational target. Follow-up performance was highest in Tshopo (95% average over the week), but remained lower in Haut-Uélé (64% average), Ituri (88% average), and Nord-Kivu (81% average), and Bas-Uélé (46%; noting a large increase from 19% on 18 August to 53% on 22 August). There were no data for Sud-Kivu contact follow-up.
- PoE and PoC screening volume continued to increase, with a low of 247 670 travelers screened on 17 August and a high of 318 703 travelers screened on 21 August, and screening coverage remained high at 97.5-98.6%. A total of 28 alerts were detected from 17 to 22 August.

Laboratory

- Diagnostic capacity continued to expand and decentralize, increasing from 2 laboratories at outbreak onset to 22 active laboratories, supported by 42 RadiOne POC PCR and 9 RT-PCR platforms, with capacity exceeding 3,036 samples per day. New laboratory capacity has been established in Buta, Butembo and Durba, with further platforms in the pipeline.
- Testing demand remains substantial but well within available capacity. During 15 – 21 August 2026, 3 435 specimens were tested and 727 were positive (21.2%), equivalent to approximately 400 – 500 specimens tested daily. Cumulatively, 28 094 specimens had been tested by 21 August 2026.
- Laboratory workforce and regional preparedness are being strengthened, including training of approximately 60 personnel/trainers from the Democratic Republic of the Congo and Uganda in field biosecurity and specimen management, with cascade training planned for other countries in the region.

- 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

- Demand for clinical care remained high as transmission continued and expanded geographically. As of 23 August 2026, 846 patients were in isolation or receiving care nationally. The operational treatment and transit facilities consolidated capacity has increased from 33 to 49. Bed capacity also increased from 1 184 to 1 308 active beds, indicating substantial overall capacity.
- Localized capacity constraints persisted despite the overall availability of beds. Several facilities in Ituri remained saturated, while beds designated for suspected cases in Nord-Kivu reached 100% occupancy. Major geographic gaps also remained, particularly in Haut-Uélé, where no standardized Ebola treatment centre was operational across the six affected health zones, and in Tshopo, where treatment capacity remained limited.
- Referral and patient transport remained important constraints, with insufficient ambulance capacity reported across several affected provinces. These limitations are increasingly important as transmission expands into areas with less-developed treatment infrastructure.
- Cumulative recoveries increased from 1 061 on 16 August 2026 to 1 215 on 23 August 2026, representing an additional 154 recoveries during the reporting period despite continued pressure on case management services.

Research and Development

- On 17 August 2026, the International Coordination Group on Vaccine Provision allocated 70 000 of ERVEBO, at the request of the government of DRC. ERVEBO is licensed for the prevention of Ebola virus disease caused by *Zaire ebolavirus*. The allocation includes 20 000 doses for a Phase 3 clinical trial to evaluate the vaccine's effectiveness against Bundibugyo virus disease and 50 000 doses for frontline and health workers, in line with the current recommendations of the WHO Strategic Advisory Group of Experts on Immunization (SAGE).
- Clinical research on therapeutics continued to expand in the Democratic Republic of the Congo. The WHO-sponsored PARTNERS platform trial is evaluating MBP134, remdesivir and their combination for the treatment of confirmed BVD, with enrolment continuing across five study sites. The trial is coordinated by the National Institute for Biomedical Research (INRB), the Institute of Tropical Medicine Antwerp and the University of Oxford, with WHO sponsorship and support from Africa CDC and other partners.
- WHO's therapeutics advisory group has prioritized obeldesivir for clinical evaluation as post-exposure prophylaxis. The EBO-PEP study continued to evaluate oral obeldesivir as post-exposure prophylaxis for high-risk contacts and the administration of remdesivir in children, as well as in pregnant and breastfeeding women who have had high-risk exposure, with efforts underway to expand enrolment through more flexible delivery approaches.
- The MBOTE natural history study has commenced, expanding evidence generation on the clinical presentation, progression and outcomes of BVD and complementing ongoing interventional therapeutic studies.

- BDBV vaccine development progressed from trial initiation to vaccination of trial participants. The University of Oxford's Phase I BD-Ebov trial of the ChAdOx1 BDBV vaccine is evaluating safety and immune responses in 50 healthy adults aged 18 – 55 years. The first participant was vaccinated on 24 July 2026, and recruitment and vaccination are continuing. Approximately 620 000 doses have been manufactured and stockpiled by the Serum Institute of India, including 4000 investigational doses supplied for clinical evaluation. Preparations for additional studies in Uganda are continuing, subject to regulatory approval. Phase 1 trials for Moderna's candidate BDBV vaccine, mRNA-1469, began in Canada on 4 August 2026.

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.
- Safe and dignified burial capacity is increasing through additional teams, training and deployment, but community resistance, insecurity and access constraints continue to limit timely SDB coverage.
- Healthcare worker infections remain a major concern, with 155 confirmed infections and 45 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 to expand across affected provinces, supporting early case detection, contact tracing, timely care-seeking, safe and dignified burials, and acceptance of response measures.
- Engagement of high-risk and mobile populations increased, including outreach to motorcycle-taxi associations in Nord-Kivu and targeted household and community activities in affected areas.
- RCCE expanded into newly affected areas, including Tshopo, through household engagement, local team training, radio programmes and community sensitization. Increasing number of community health workers are being mobilised and integrated into the response.
- Community feedback and trusted local networks continued to guide response activities, helping to address misinformation and improve acceptance of surveillance, referral and burial interventions. Feedback is reported on daily basis and prioritised for interventions. The second round of community rapid assessment is finalised and analysis is being shared.
- Mistrust and resistance remain important challenges, including refusals of safe burials, post-mortem sampling and decontamination, underscoring the need for sustained trust-building and locally adapted engagement.

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 cross-border coordination continued to advance, supported by a high-level meeting co-convened by WHO, Africa CDC, the Economic and Monetary Community of Central Africa (CEMAC) and the Central African Republic in Bangui from 14–15 August 2026. Ministers and delegations from the Democratic Republic of the Congo, Central African Republic, Republic of the Congo, South Sudan and Uganda mapped high-risk cross-border corridors and conducted field visits to the PK24 treatment centre, Mongoumba border port, laboratory and community health centre. Engagement with the President of the Central African Republic on 17 August reinforced the need to shift from reactive response to sustained preparedness. Countries agreed to finalize a multi-country Memorandum of Understanding, develop harmonized workplans and address funding gaps.
- Regional preparedness continued to improve, with 31 WHO African Region Member States completing and submitting readiness assessments, increasing regional coverage to 66%.
- Nine high-priority countries completed repeat readiness assessments, reflecting continued efforts to strengthen national preparedness capacities: Angola, 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 BVD outbreak continues to evolve into a more complex and geographically dispersed phase, in which modest reductions in some established hotspots are being offset by intensification and emergence of transmission elsewhere. The simultaneous persistence of high mortality, community deaths, health-worker infections, uneven contact follow-up, localized treatment constraints and community resistance indicates that expansion of response capacity alone is not yet translating consistently into transmission control. The priority must remain faster, locally differentiated and community-centred operations, concentrating resources on active and emerging transmission foci, closing critical surveillance, IPC and treatment gaps, and ensuring rapid access to affected communities. At the same time, sustained regional preparedness and cross-border coordination are essential to contain further geographic spread.

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)
- DOSHI, Reena Hemendra (WCO AFRO)
- KAMBALE, Freddy (WHO AFRO)
- NGUNA, Joyce (WHO AFRO)
- PAVLIN, Boris (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)
- FOTSING, Richard (WCO DR Congo)
- AJONG, Brian (WCO DR Congo)

© WHO Regional Office for Africa

This is not an official publication of the World Health Organization.

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

Subscribe here to receive regular updates via email: [SUBSCRIBE](#)

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

Requests for permission to reproduce or translate this publication – whether for sale or for noncommercial distribution – should be sent to the same addresses.