



DRC — Ituri & Eastern Provinces

Ebola Disease Outbreak — Bundibugyo Strain, 2026

Epidemiological situation report, response analysis & risk assessment · Compiled 7 October 2026 [UPDATE EDITION — supersedes the 24 September 2026 edition] · national and provincial data through 4 October 2026 (DRC Ministry of Health daily report of 5 October, as transcribed by ECDC), updated with WHO, WHO AFRO, Africa CDC, the Kenyan and Ugandan health ministries, MSF and press reporting through 6–7 October

Primary sources: DRC MoH daily report of 5 Oct (data to 4 Oct) and of 4 Oct (data to 3 Oct) via ECDC (6 Oct) · WHO DON618 (25 Sep, data to 23 Sep) · WHO AFRO (Kenya, 6–7 Oct) · Reuters, AP, Al Jazeera (25 Sep–6 Oct) · Kenya MoH via Reuters and Kenyans.co.ke (6–7 Oct) · Uganda MoH via Watchdog Uganda (7 Oct) · Radio Okapi, Actualite.cd, Mediacongo (1–4 Oct) · MSF (1 and 5 Oct) · ECDC (1 Oct) · US Department of State (23 Sep) · INSP/COUSP SitRep N°130 (21 Sep) for zone-level detail carried forward (full list: Section 10).

8 603	4 148	64 / 167	896	~64 / day
Confirmed cases, DRC MoH report, 4 Oct	Confirmed deaths CFR 48.2 %	Health zones affected 7 provinces · 4 Oct	Patients in isolation 4 Oct · 2 235 recovered	New cases per day, 21 Sep–4 Oct (~73/day, 5–21 Sep)

KEY DEVELOPMENTS — SINCE THE 24 SEPTEMBER EDITION (22 SEPTEMBER–7 OCTOBER 2026)

- ★ **Ebola has reached Kenya.** On 6 Oct Kenya confirmed its first case: a Kenyan citizen who had lived in DRC for seven years, was ill for about a month and was seen at several facilities in DRC, travelled by road from Beni (WHO AFRO) to Kampala — although the DRC–Uganda border has been closed since May — and flew Entebbe–Nairobi on 3 Oct. He passed temperature screening at both airports and died in Nairobi Hospital late on 5 Oct. Kenya had identified 57 contacts and quarantined 10 by 7 Oct, and is tracing 23 passengers and 4 crew. Kenya is the fourth country with a confirmed case (Section 2.5).
- ★ **The decline flattened into a plateau.** Confirmed cases rose from 7 773 (21 Sep) to 8 603 (4 Oct): 830 in 13 days, ~64/day, against ~73/day in the last edition's window. The daily rate held near 52–60 through 29 Sep, then ran at ~76/day over 29 Sep–4 Oct. Deaths rose from 3 759 to 4 148 (+389); CFR 48.2 %, inside the 48.1–48.6 % band for the tenth consecutive cut. The Health Minister said on 2 Oct that the peak is behind; WHO and Africa CDC say the outbreak is not under control (Section 2.1).
- ★ **North Kivu carries a growing share, and its southern edge thickened.** North Kivu went from 1 438 to 1 729 cases (+20 %) and 16 to 17 health zones; on 4 Oct it reported 33 of the day's 59 cases. On 2 Oct Alimbongo became a new zone (4 cases) and Kayna added two — all seven zones of Lubero territory are now affected. Kayna is still the southernmost zone; Goma and South Kivu have no new case (Section 2.3).
- **Ituri is no longer falling.** Ituri added 484 cases (~37/day), level with its 16–21 Sep pace (~35/day). The last edition's call that Ituri had probably peaked holds only as a plateau, not a decline (Sections 2.1, 9).
- **Sud-Ubangi has a second confirmed case** (Radio Okapi, 1 Oct; MoH data: 2 cases, 1 death), in Bulu health zone, while doctors there are on strike. Whether it is a contact of the imported index case was not reported (Section 2.4).
- **A fourth case managed in Europe.** An MSF staff member working in the DRC response tested positive on 29 Sep and was admitted to Leiden University Medical Center (Netherlands) on 1 Oct. ECDC keeps the EU/EEA risk at very low (Section 6.5).
- **Contact follow-up fell to 79.7 %** on 4 Oct (84.5 % on 21 Sep; WHO: 83.4 % of 32 342 contacts on 23 Sep) — the lowest national figure in the cuts this series has tracked since 19 Aug (Section 3).
- ★ **Money and accountability.** The US pledged a further USD 267 million on 23 Sep (USD 886 million in total). On 2 Oct the Health Minister said only about a quarter of 97 operational partners had justified their funds, about USD 99 million of USD 227 million mobilised under the first three-month plan was unspent, and partners now need accreditation to work in the field. The Beni workers' arrears dispute has no documented resolution (Sections 4.2, 6.6).

Assessment — trajectory. The national peak of late August and early September (~85/day) has passed, but the epidemic has settled onto a plateau of roughly 55–75 confirmed cases a day rather than continuing the decline the last edition described. Three things point the same way: Ituri's daily increment stopped falling (~37/day); North Kivu's share of new cases rose (35 % of the period's cases, 56 % on 4 Oct) as transmission reached a new zone in southern Lubero; and contact follow-up dropped below 80 %. The last window (~76/day) rests on a ministerial figure for 29 Sep and on daily reports that ECDC notes are still being harmonised, so it may partly be catch-up — which is why this edition calls a plateau, not a resurgence. The Kenyan case adds a qualitatively new signal: a patient from Beni, ill for weeks and seen in several facilities, was neither detected in DRC nor stopped at a closed land border or at two airports. That is a measure of how much transmission the confirmed counts can miss. This is an assessment by Pandemic Shield and not a position taken by any of the authorities cited.

- ★ **Kigonze displacement site emptied; its Ebola transit centre burned.** After security incidents from 20 Sep — media report soldiers searching the site for weapons and suspected armed-group members — most of Kigonze's ~19 000 residents in Bunia left for host families. The site was deserted by ~29 Sep and its Ebola transit centre burned on the evening of 30 Sep (UN). Ebola deaths were confirmed there in June; its dispersed residents are now harder to follow up. Djugu clashes from 27 Sep disrupted Fataki, Drodoro and Lita (Section 4.3).



1. Outbreak Overview (as of 4 October 2026)

Outbreak declared	15 May 2026 — DRC Ministry of Public Health, Hygiene and Social Welfare; confirmed by Africa CDC. DRC's 17th recorded Ebola outbreak since 1976. About 145 days old on 7 Oct. Unchanged since the last edition.
PHEIC status	Declared 17 May 2026 under IHR Article 12; remains in force. The Second IHR Emergency Committee (met 18 Aug; report 28 Aug) found the event is not a pandemic emergency. No third meeting was located. Africa CDC public health emergency of continental security since 18 May. On 6 Oct the WHO Director-General again advised against travel restrictions on affected countries (Reuters).
Causative agent	Bundibugyo ebolavirus (BDBV), genus <i>Orthoebolavirus</i> . Third BDBV outbreak on record; now about 58 times the size of Uganda 2007–08 (149 cases) and 151 times Isiro 2012 (57 cases).
Provinces affected	Seven: Ituri, North Kivu, Haut-Uélé, Tshopo, South Kivu, Bas-Uélé, Sud-Ubangi. 64 of 167 health zones (38.3 %) on 4 Oct (63 on 21 Sep; the new zone is Alimbongo, North Kivu). WHO counted 48 of 63 zones active in the 21 days to 23 Sep; the Health Minister (2 Oct) cited 12 zones with no case for 42+ days and 8 for 22–42 days.
Confirmed cases (DRC)	8 603 (4 Oct, MoH report of 5 Oct via ECDC); 7 773 at the last edition's 21 Sep cut (+830, +10.7 %). 24-hour increment on 4 Oct: 59 (North Kivu 33, Ituri 23, Haut-Uélé 2, Tshopo 1). Crossed 8 000 between 23 and 26 Sep.
Confirmed deaths (DRC)	4 148 (4 Oct); CFR 48.2 % (48.4 % on 21 Sep). +389 deaths in 13 days (~30/day); 34 in the 24 hours to 4 Oct. Crossed 4 000 at the start of October.
Recovered	2 235 cumulative (4 Oct); 1 935 on 21 Sep.
Patients in isolation	896 (4 Oct); 839 on 21 Sep; 905 on 16 Sep. No provincial split or bed count was retrieved for this edition.
Frontline workers infected	No national INSP figure newer than SitRep N°082 (4 Aug: 154 infected, 46 deaths). AP (28 Sep) reported 50 health-worker deaths since the outbreak was announced. Katwa: 16 infected, 3 dead (15 Sep). One MSF staff member infected (positive 29 Sep). Unreconciled; carried forward.
Uganda	Outbreak closed (20 cases, 2 deaths; WHO end declaration late August). The Kenyan patient spent less than a day in Kampala before flying from Entebbe; Uganda's MoH says screening recorded a normal temperature and that Uganda remains Ebola-free.
Kenya — new	1 imported case, died 5 Oct (Nairobi). 57 contacts identified and 10 quarantined by 7 Oct; flight passengers and crew being traced. No secondary case reported at the time of writing (Section 2.5).
Cases managed outside Africa	4 — two medical evacuations to Germany (May, July), one imported case in France (June) and, new, one MSF staff member evacuated to the Netherlands (admitted 1 Oct). A UK resident was evacuated in July after an exposure, not as a case.
Vaccine / treatment	None licensed for BDBV. Ervebo (Zaire-strain) given to frontline workers since 19 Sep under research protocols; no coverage figure newer than 7 Sep (2 007 vaccinated) was located. Press reported a vaccine-stock shortage in Tshopo (28 Sep). Detail in Section 5.
Comparator	2.5 times the 2018–2020 Kivu epidemic (3 481 cases); 30 % of the 2014–2016 West African epidemic's cases and 37 % of its deaths. WHO (via AP, 28 Sep) noted the outbreak is ahead of the West African one at the same point (7 840 vs 3 781 cases by week 19).
Global risk assessment	WHO (DON618, 25 Sep): very high for DRC, high for bordering countries, low for the rest of the region and globally — Kenya, which does not border DRC, now has a case. ECDC (6 Oct): importation risk into the EU/EEA very low; multiple independent importations unlikely even in a pessimistic scenario.

2. Epidemiological Analysis — Provincial and Health Zone Distribution

Province	Confirmed cases	Deaths	CFR	Health zones affected	Change since 21 Sep
Ituri	6 450	2 968	46.0 %	28 / 36 (77.8 %)	+484 (+8.1 %)
North Kivu	1 729	1 005	58.1 %	17 / 34 (50.0 %)	+291 (+20.2 %); 16 → 17 zones
Haut-Uélé	359	152	42.3 %	7 / 13 (53.8 %)	+43 (+13.6 %)
Tshopo	50	17	34.0 %	7 / 23 (30.4 %)	+8 (+19.0 %)
Bas-Uélé	10	4	40.0 %	3 / 11 (27.3 %)	+3
South Kivu	3	1	33.3 %	1 / 34 (2.9 %)	0 — no case since 29 May (128 d at 4 Oct)
Sud-Ubangi	2	1	50.0 %	1 / 16 (6.3 %)	+1 — second case, reported 1 Oct
Total (4 Oct)	8 603	4 148	48.2 %	64 / 167 (38.3 %)	+830 (+10.7 %)

Source: DRC MoH daily report of 5 Oct (data to 4 Oct), as transcribed by ECDC (6 Oct); 21 Sep baseline INSP SitRep N°130. Provincial figures sum exactly to the national totals (cases and deaths). Ituri's share of cumulative cases fell from 76.8 % to 75.0 %; North Kivu's rose from 18.5 % to 20.1 %. Of the 830 new cases, Ituri contributed 58.3 % and North Kivu 35.1 %.



2.1 Growth trajectory — confirmed cases and deaths, DRC

Date	Confirmed cases	Confirmed deaths	CFR	New cases/day since prior row	Source / note
15 May 2026	8	4 (+1 Uganda)	—	—	Declaration day.
31 Jul 2026	3 532	1 556	44.1 %	—	Surpasses the 2018–2020 Kivu epidemic's total.
19 Aug 2026	5 290	2 516	47.6 %	—	INSP SitRep N°097.
31 Aug 2026	6 186	3 007	48.6 %	—	INSP SitRep N°109.
5 Sep 2026	6 604	3 175	48.1 %	84	INSP SitRep N°114.
11 Sep 2026	7 113	3 437	48.3 %	85	INSP SitRep N°120 (7 000 crossed 10 Sep).
16 Sep 2026	7 475	3 605	48.2 %	72	INSP SitRep N°125.
21 Sep 2026	7 773	3 759	48.4 %	60	INSP SitRep N°130 — last edition's cut.
23 Sep 2026	7 890	3 799	48.1 %	59	WHO DON618 (published 25 Sep).
26 Sep 2026	8 067	3 901	48.4 %	59	AP (28 Sep), citing official data. 8 000 crossed between 23 and 26 Sep.
29 Sep 2026	8 224	n/a	—	52	Health Minister Kamba, press conference 2 Oct (Radio Okapi).
3 Oct 2026	8 544	4 114	48.2 %	80	MoH report of 4 Oct via ECDC.
4 Oct 2026	8 603	4 148	48.2 %	59	MoH report of 5 Oct via ECDC; 59 new cases, 34 deaths in 24 h.

The 26 Sep row is dated as AP describes it; Al Jazeera dated the same 8 067 / 3 901 figure 28 Sep, which would imply 157 cases in the single day to 29 Sep and is less consistent with the series. US CDC's page (5 Oct) gave 8 442 / 4 080 "as of 2 Oct"; its underlying cut date is unclear and it is not used.

Interpretation. Over 21 Sep–4 Oct confirmed cases rose 10.7 % and deaths 10.3 %, at ~64 cases and ~30 deaths a day — slower than the ~73 and ~37 of 5–21 Sep. But the shape inside the window is flat, not falling: ~59/day (21–26 Sep), ~52/day (26–29 Sep), ~76/day (29 Sep–4 Oct). The last window includes an unusually large one-day step to 3 Oct (+80/day on average from 29 Sep) followed by a normal 59 on 4 Oct, which looks partly like reporting catch-up; it is shown hatched in Figure 1 because one of its end points is a ministerial figure. Two things stop this being read as artefact alone: North Kivu's daily contribution has drifted up (~18/day 16–21 Sep, ~22/day since, 33 on 4 Oct alone), and the outbreak seeded a new zone. CFR has now held between 48.1 and 48.6 % across ten consecutive cuts since 31 Aug; a stable, high CFR is consistent with persistent late detection rather than with improving ascertainment.

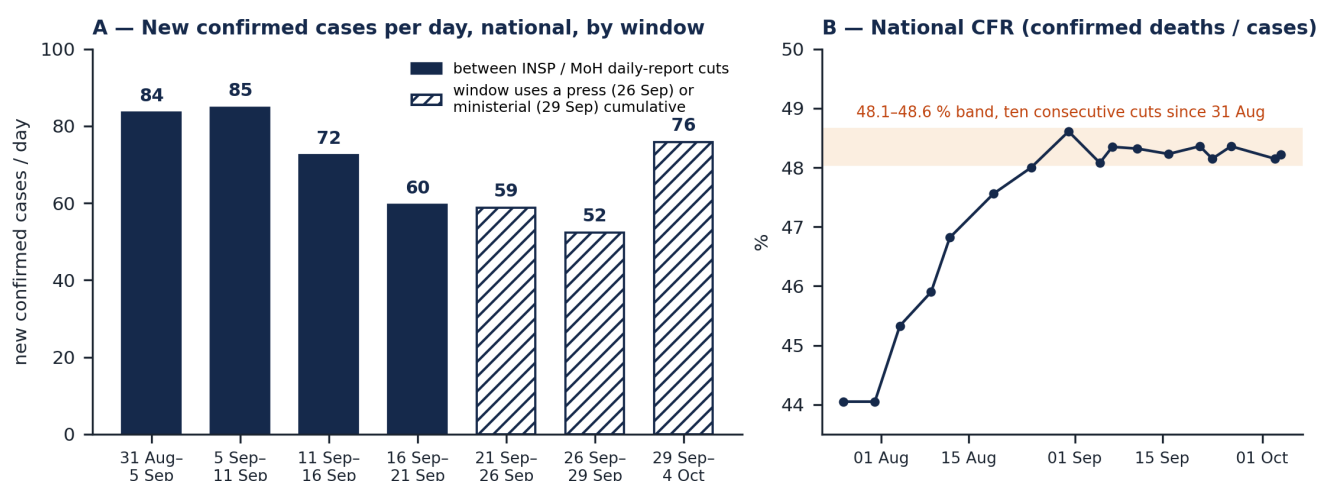
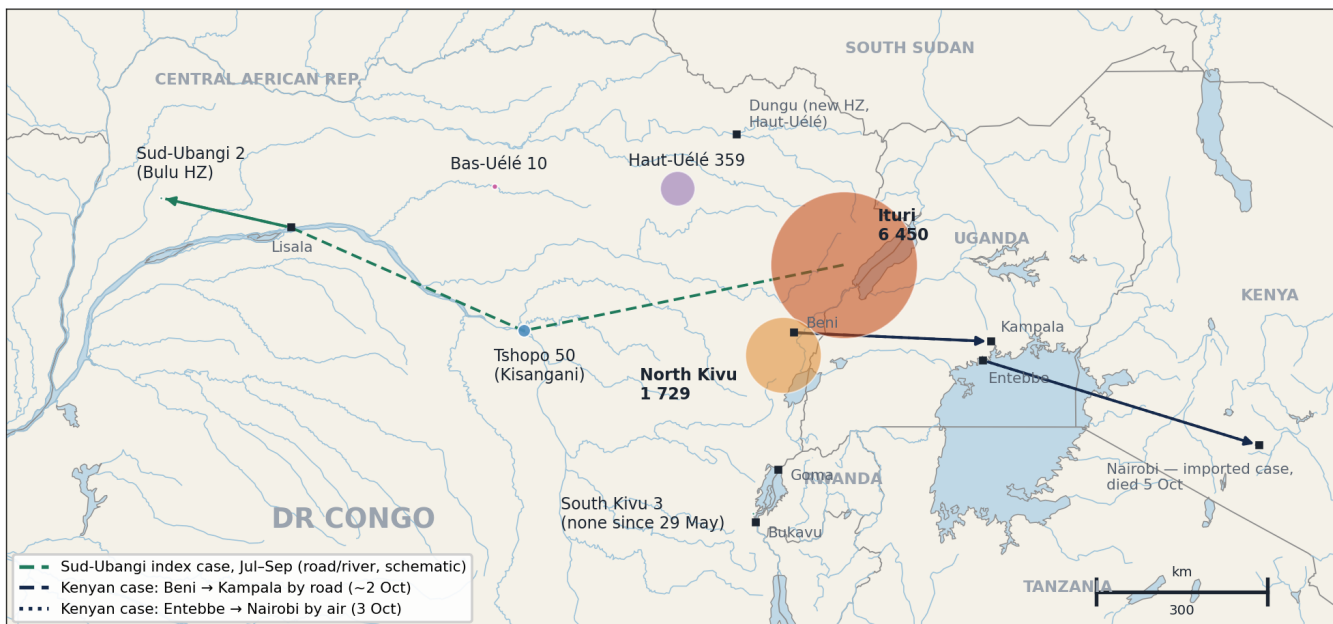


FIGURE 1 — Panel A: new confirmed cases per day between successive national cuts (31 Aug–21 Sep from INSP SitReps; 23 Sep WHO is omitted for readability; 26 Sep AP; 29 Sep Health Minister; 4 Oct MoH via ECDC). Windows are 5, 6, 5, 5, 5, 3 and 5 days. Hatched bars use a press or ministerial cumulative at one end. Panel B: national CFR at each cut in the table above, plus WHO cuts of 7 and 23 Sep.

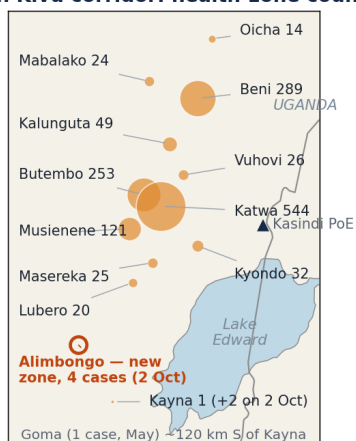


2.2 Geographic distribution of confirmed cases

A — Confirmed BDBV cases by province, 4 Oct 2026, and the two long-distance travel cases



B — North Kivu corridor: health-zone counts at 21 Sep (latest zone-level data read), zones reported since



Since the 24 Sep edition (provincial, 21 Sep → 4 Oct)

Ituri 5 966 → 6 450 (+484) · North Kivu 1 438 → 1 729 (+291)
Haut-Uélé 316 → 359 · Tshopo 42 → 50 · Bas-Uélé 7 → 10
Sud-Ubangi 1 → 2 · South Kivu 3 (unchanged)
Health zones 63 → 64 of 167 (North Kivu 16 → 17)

New zones and signals reported in the period

Dungu (Haut-Uélé, South Sudan border) — WHO, 23 Sep
Alimbongo (Lubero, North Kivu) — 4 cases, 2 Oct
Kayna — 2 new cases, 2 Oct (zone total 3)
Bulu (Sud-Ubangi) — second confirmed case, 1 Oct
Kenya — imported case from Beni, died Nairobi 5 Oct

Zone counts in panel B are INSP SitRep N°130 (21 Sep); later zone-level figures were not retrieved for this edition (Section 10).

FIGURE 2 — Panel A: provincial totals at 4 Oct (circle area proportional to cumulative confirmed cases), with the reported routes of the Sud-Ubangi index case (Jul-Sep) and the Kenyan case (Beni–Kampala by road, Entebbe–Nairobi by air, 2–3 Oct). Panel B: North Kivu health-zone counts from INSP SitRep N°130 (21 Sep) — the latest zone-level data read for this edition — with zones reported since (Alimbongo, Kayna). **Map construction:** borders, lakes and rivers from public-domain GSHHS/Natural-Earth-class data (Matplotlib Basemap); circles sit at each province's or zone's principal settlement using approximate coordinates and are **not survey-grade** (typically within 10–20 km; Alimbongo, Kyondo and Kasindi are the least certain). Routes are straight segments between reported waypoints, not surveyed paths.

2.3 NORTH KIVU — A LARGER SHARE, AND A THICKER SOUTHERN EDGE

The last edition expected North Kivu to set the tail of the epidemic and set a test: five-day increments below about 25 a day. Averaged over 13 days the province stayed under that line (~22/day), but its share of national cases rose and transmission reached a new zone at the southern end of Lubero territory.

Date	North Kivu cases	Deaths	CFR	Health zones (of 34)	New cases/day since prior row	Source
19 Aug 2026	663	452	68.2 %	12	—	INSP SitRep N°097
5 Sep 2026	1 000	659	65.9 %	16	20 (17 days)	INSP SitRep N°114
21 Sep 2026	1 438	872	60.6 %	16	27 (16 days)	INSP SitRep N°130
23 Sep 2026	1 480	n/a	59.7 %	16	21	WHO DON618 (567 cases in prior 21 days)
4 Oct 2026	1 729	1 005	58.1 %	17	23 (11 days)	MoH via ECDC



Where the growth is. MSF (5 Oct) reports that North Kivu now accounts for nearly 40 % of newly confirmed cases nationally, up from 24 % at the end of August, with a strong increase in Beni and a slight decrease in Butembo in the week before; by the MoH figures the province contributed 35 % of all cases added between 21 Sep and 4 Oct and 56 % of those reported on 4 Oct. Zone-level figures after 21 Sep (Katwa 544, Beni 289, Butembo 253 at that date) were not retrieved for this edition.

The southern edge. On 2 Oct six cases (four deaths) were confirmed in Lubero territory: four in Alimbongo, a zone affected for the first time, and two in Kayna, whose single earlier patient had recovered the week before. All seven Lubero zones (Biena, Lubero, Masereka, Musienene, Manguredjipa, Kayna, Alimbongo) are now affected; local reporting links the chains to contacts from Butembo (Mediacongo, 4 Oct). Kayna remains the southernmost affected zone; there is no new confirmed case in Goma (single case, May) or in South Kivu (none since 29 May; 128 days at 4 Oct). The trigger the last edition named for re-upgrading the southward risk — a confirmed case south of Kayna — has not been met, but the gap to it has narrowed in breadth if not in distance.

Capacity. Two treatment centres opened in Butembo on 20–21 Sep — a Uganda-built 80-bed centre at the ITAV site and CTE Matanda in Katwa (30 beds, International Medical Corps) — bringing the town to four; the provincial health chief put occupancy at 98 % in zones with centres before they opened (Actualite.cd, 22 Sep). MSF (5 Oct) nevertheless describes centres near saturation, with 34 % of confirmed cases hospitalised in non-specialised general facilities (data to 28 Sep) and more than 60 % of deaths still occurring in the community. The Kenyan case left from Beni (WHO AFRO).

Assessment — the corridor. North Kivu is where the epidemic's course is now being decided: it has the highest CFR (58 %), the fastest relative growth (+20 % in 13 days against +8 % in Ituri), most of the reported strain on beds and staff, and two of this edition's three new geographic signals originate there — southern Lubero by road from Butembo, and Kenya by road and air from Beni. Its provincial CFR has edged down from 68 % (19 Aug) to 58 %, which is consistent with earlier admission in the larger Butembo capacity, but a majority of deaths in the community (MSF) means many cases are still found after death. This is an assessment by Pandemic Shield.

2.4 SUD-UBANGI — A SECOND CASE

Sud-Ubangi now reports two confirmed cases and one death, both in Bulu health zone (MoH data via ECDC, 4 Oct; Radio Okapi, 1 Oct). The index case — a 23-year-old who left Kamanyola (South Kivu) on 10 July, transited Rwanda and Uganda and travelled through Ituri, Kisangani and Lisala before dying in Gwaka on 5 Sep — was described in the last edition. No detail on the second case (onset date, link to the index case or its 38 listed contacts) was located. Its timing is the question: the index case's 21-day contact window closed on about 26 Sep, so a second case reported on 1 Oct is either a contact who fell ill within that window and was confirmed late, or a further generation of local transmission. The response there is running during a "dry" doctors' strike over registration on the provincial health division's list (Radio Okapi, 1 Oct); contact follow-up in Sud-Ubangi was 65.5 % on 21 Sep, the lowest of any province.

The last edition framed Sud-Ubangi as a test of whether the river route was an isolated import or a template. The answer so far is in between: local transmission in Bulu is likely, but no case along the Kisangani–Lisala river corridor has been reported (Tshopo added 8 cases, all in its existing seven zones).

2.5 KENYA — THE FIRST CASE BEYOND THE BORDERING RING

Date (2026)	Reported event	Source
~early Sep	Kenyan citizen resident in DRC for seven years falls ill; seen at several facilities in DRC.	Kenya MoH via ABC News / Reuters, 6 Oct
~2 Oct	Travels by road from Beni to Kampala, despite the DRC–Uganda border being closed since May; spends one night in Uganda.	WHO AFRO 7 Oct; Africa CDC via Reuters
3 Oct	Flies Entebbe–Nairobi (Jambojet 8523), arriving 13:10; normal temperature at Entebbe exit screening (Uganda MoH); passes post-health screening at JKIA; driven by a relative to Nairobi Hospital and isolated with fever, chills and bleeding beneath the skin.	Uganda MoH; Kenya MoH
4–5 Oct	Bundibugyo virus confirmed by the National Virology Reference Laboratory and KEMRI; dies late on 5 Oct.	Kenya MoH
6 Oct	Case announced; safe burial; 28 contacts (family and health workers) identified (MoH); the Presidency reported 8 family members and 21 health workers quarantined; 23 passengers and 4 crew being traced. Africa CDC deploys a team; WHO advises against travel restrictions.	Reuters; Kenya Presidency
7 Oct	57 contacts identified, 10 in quarantine; Kenya MoH: "an imported case", not an outbreak.	Kenyans.co.ke

What the case shows. Kenya's health ministry said medication may have masked the patient's symptoms at the airport (Reuters). Temperature-based exit and entry screening is known to miss travellers on antipyretics; this case went through three checkpoints — a closed land border and two airports — without being stopped. The longer story matters more: by the health minister's account he had been ill for weeks and was seen in several DRC facilities without a diagnosis, which is consistent with MSF's report that most North Kivu deaths happen outside treatment centres. The reported month of illness is unusually long for BDBV and may include an earlier, unrelated illness; no onset date was published. Kenya's monitoring of the hospital and family contacts runs to about 27 Oct and of the flight contacts



to about 24 Oct (21 days from last exposure; Pandemic Shield calculation). Kenya hosts a US-built 50-bed Ebola quarantine facility at Laikipia Air Base, which Reuters reports has housed seven people and is currently empty.

Assessment — Kenya. *One imported case with no reported onward transmission is a contained event so far, and Kenya entered it prepared (about 5 000 health workers trained, isolation units in high-risk counties). Its significance is as evidence: WHO's risk tiers rate non-bordering African countries low, yet a resident of Beni reached a regional air hub in one day. The exposure that matters most for Nairobi is the hospital — the patient was isolated on arrival, but health workers dominate the contact list. A secondary case among them by late October would change the assessment; none by about 27 Oct would close it. This is an assessment by Pandemic Shield.*

3. Surveillance, Contact Tracing and Points of Entry

Contact tracing. WHO (DON618) reported 26 980 of 32 342 listed contacts seen in the previous 24 hours on 23 Sep (83.4 %); the MoH figure for 4 Oct is 79.7 %. The national series has run 88.0 % (31 Aug) → 85.7 % (5 Sep) → 87.5 % (11 Sep) → 87.6 % (16 Sep) → 84.5 % (21 Sep) → 83.4 % (23 Sep) → 79.7 % (4 Oct), so the dip flagged last time has continued. No provincial split was retrieved for 4 Oct. Africa CDC's Director-General argued on 25 Sep (Al Jazeera) that a caseload of this size should generate several hundred thousand contacts against roughly 30 000 listed — a statement about listing, not only follow-up.

Laboratory, alerts, beds and points of entry. INSP's SitReps N°131–143 (to 4 Oct) are published but could not be retrieved for this edition, so the laboratory positivity, alert-management, bed-occupancy and point-of-entry indicators in Sections 3–4 of the 24 Sep edition (all to 21 Sep) are not refreshed here and should be read as dated. The last values were: national positivity 10.4 % (Ituri 11.0 %, North Kivu 7.2 %); 98.6 % of alerts verified; 100 % of strategic points of entry functional; a living alert at the Kasindi crossing to Uganda on 21 Sep.

Points of entry after Kenya. The Kenyan case is the first documented traveller from the outbreak area to cross the officially closed DRC–Uganda border and continue by air. Uganda's ministry says it has stepped up screening; Kenya reports heightened surveillance at 15 entry points (Kenyans.co.ke, 7 Oct). Neither government has said where the patient crossed into Uganda.

4. Case Management, Burials and the Frontline Workforce

4.1 Treatment capacity

Nationally 896 patients were in isolation on 4 Oct (839 on 21 Sep). Ituri's province-wide occupancy was easing at the last INSP read (42.6 % on 21 Sep); North Kivu's was unreconciled, with INSP reporting no available beds in Butembo and Katwa. Since then Butembo has gained 110 beds in two centres (Section 2.3), but MSF reports a third of North Kivu's confirmed cases hospitalised in non-specialised facilities. MSF's own figures: more than 2 800 staff in the response and more than 3 500 patients treated to date (5 Oct).

4.2 Frontline workers and pay

Indicator	Value	Source
Health workers infected / died (national, official)	154 / 46	INSP SitRep N°082, 4 Aug — latest official national figure located
Health-worker deaths since declaration (press)	50	AP, 28 Sep
Katwa health zone	16 infected, 3 dead	Congo Quotidien, 15 Sep
International staff infected	1 (MSF, positive 29 Sep; evacuated to the Netherlands)	MSF, 1 Oct; ECDC
Kenya — health workers quarantined after exposure	21	Kenya Presidency via Reuters, 6 Oct

The Beni community-relay and communication staff strike over three to four months of arrears (21–23 Sep) has no documented resolution in the sources reviewed; AP (28 Sep) describes delayed payments triggering strikes more widely, and Sud-Ubangi's doctors are on strike over administrative registration. On 2 Oct the Health Minister turned the funding question toward partners: of 97 partners in the field only about a quarter had justified their funds; USD 227 million had been mobilised under the first three-month plan, of which about USD 99 million was unspent; the government's own USD 50 million was, he said, fully accounted for; and partners will need accreditation to work in the field (Actualite.cd, 2 Oct).

Assessment — workforce. *The minister's figures and the strikers' arrears can both be true: unspent partner money and unpaid government-contracted relays are different payment lines. Accreditation may improve accountability but, introduced in the middle of a plateau, it also risks slowing the partners who staff contact tracing and burials — the functions whose indicators have just weakened (contact follow-up below 80 %, a majority of North Kivu deaths in the community). The test is whether the Beni relays return and whether contact follow-up recovers in the next INSP series. This is an assessment by Pandemic Shield.*



4.3 KIGONZE (BUNIA) — A DISPLACEMENT SITE EMPTIED, A TRANSIT CENTRE BURNED

Kigonze is a site for internally displaced people in the Mudzi Pela quarter of Bunia, the Ituri capital and the outbreak's first epicentre; the UN put its population at close to 19 000 in late September (earlier counts ranged from about 15 000 to 25 000). It is not a refugee camp: its residents are Congolese displaced by the Djugu conflict. From 20 September a series of security and protection incidents emptied the site, and on the evening of 30 September the Ebola transit centre inside it was destroyed by fire. This section was added on 7 October; the incident falls inside the reporting window of this edition (UN News, 28 Sep and 1 Oct; EFE, 1 Oct).

Date (2026)	Reported event	Source
May–18 Jun	At least 30 deaths since early May with Ebola-compatible symptoms, against a usual 1–3 a month; residents refused testing of the living and the dead until 18 Jun.	Reuters, 19 Jun
16–17 Jun	About ten deaths in two days; two confirmed as Ebola. Prevention on the site described as nearly absent.	Radio Okapi, 23 Jun; 9 Jun
2 Jul	On-site health centre opens: free primary care and systematic screening of suspected cases.	Radio Okapi, 3 Jul
14 Sep	Residents advised to use the free on-site medical centre rather than the site's pharmacies, to keep suspected cases inside surveillance.	ACP, 14 Sep
From 20 Sep	Security and protection incidents. Media report soldiers entering the site to search for weapons and suspected armed-group members; gunfire reported. Many families leave for host families; humanitarian access reduced.	UN News (UN Humanitarian Coordinator D. Mama), 28 Sep
~29 Sep	Site reported fully abandoned after the mass departure.	EFE, 1 Oct
30 Sep, evening	Ebola transit centre inside the deserted site destroyed by fire. Cause, perpetrators and whether patients were present have not been reported; the UN is asking authorities to protect all health facilities.	UN Ebola response coordinator J. Harneis; UN News, 1 Oct

Sources: see Section 10, references [19]–[22]. June figures are camp officials' and partners' accounts, not INSP line-list data; no zone-level breakdown for Bunia after 21 Sep was retrieved for this edition.

What was lost

Since July the site had a working detection chain of its own: a free health centre that screened suspected cases, a transit centre to hold them until confirmation, and a push to move care out of informal pharmacies. That chain served one of the densest populations in the epicentre — large families in plastic tents less than a metre apart, with a history of community deaths and of refused testing. All three links are now gone at once. The UN Ebola coordinator stressed how hard transit and treatment capacity has been to build across the east; a transit centre is where suspected patients wait safely for a result, so losing one pushes them back into general facilities or households.

Why dispersal matters more than the fire

The fire destroyed a building in an already empty site. The larger effect is that close to 19 000 people, among whom Ebola deaths were confirmed in June, have moved without registration into host families across Bunia. The UN warned that unorganised departures and lost access would complicate surveillance, above all contact follow-up. Anyone listed as a contact in Kigonze now has to be found at a new address; anyone falling ill will seek care where they now live. Both run in the direction of the weaknesses this edition already tracks: national follow-up at 79.7 % on 4 Oct and late detection (Sections 3, 7). The timing does not show that Kigonze caused the national dip — no provincial split was retrieved and Ituri's increment held steady at ~37/day — but it is a plausible local contributor.

The wider security picture, 27 Sep–1 Oct

Kigonze is part of a broader deterioration reported by OCHA. In Djugu territory clashes resumed from 27 Sep around the Rhoe displacement site after months of relative calm: at least four killed and seven injured, more than 5 000 displaced (over 3 000 from Rhoe), houses burned in Blukwa. Partners suspended movements in the Fataki, Drodoro and Lita health zones; transfer of confirmed patients from Gina to Fataki and transport of samples from Fataki to Bunia were disrupted; risk-communication work stopped in four Drodoro health areas; and access along the RN27 is threatened. In North Kivu, two people working in the Ebola response were reportedly killed in Lubero on 27–28 Sep. The Rwampara treatment centre near Bunia was burned on 21 May; Kigonze is the second loss of response infrastructure in the Bunia area in this outbreak documented in this series.

Assessment — Kigonze. *The Kigonze incident is a security event with an epidemiological tail. Its direct cost is one transit centre; its likely cost is a gap in follow-up for a population with documented transmission, dispersed into the city that hosts the response's laboratory and coordination hub. Three things would show whether it matters: confirmed cases among former Kigonze residents in Bunia health zone before about 21 Oct (21 days after the site emptied); whether screening and transit capacity are re-established for them, at the site or in host areas; and whether Ituri's daily increment rises above its ~37/day plateau. Together with the Djugu clashes, it also weakens the case that Ituri is on a stable path down (Section 9). This is an assessment by Pandemic Shield.*



5. Medical Countermeasures

No new efficacy, cross-protection or enrolment result was located for this edition; the countermeasure picture of the 24 Sep edition is carried forward with three updates. First, no national coverage figure for the frontline Ervebo campaign launched in Bunia and Mongbwalu on 19 Sep was located (the last WHO figure is 2 007 people vaccinated by 7 Sep). Second, press reporting cited a complete shortage of vaccine stock in Tshopo (Al Jazeera, 28 Sep; product not specified). Third, the MSF staff infection is a reminder that exposure risk persists for trained, equipped staff; MSF said it cannot share whether the colleague had been vaccinated, and no source states it.

Trial / programme	Product(s)	Status at 7 Oct (latest located)
PARTNERS (therapeutic)	MBP134; remdesivir; combination	Over 300 confirmed cases enrolled in five Ituri facilities at 7 Sep (WHO DON617). No result.
BD-Ebov Phase I (vaccine)	ChAdOx1 BDBV	50 adults, Oxford; first dose 24 Jul. No update.
Moderna mRNA Phase 1	mRNA-LNP vs BDBV	Announced early Aug. No data, no DRC site.
EBO-PEP (prophylaxis)	Obeldesivir; remdesivir sub-protocol	~1 000 high-risk contacts targeted. No enrolment update.
Ervebo trial and frontline campaign	rVSV-ZEBOV (Zaire)	70 000 doses allocated; frontline vaccination since 19 Sep under research protocols; reported stock shortage in Tshopo (28 Sep).

Assessment — countermeasures. *Nothing in the period changes the evidence position: Ervebo is a Zaire-strain vaccine with unknown protection against Bundibugyo, and WHO restricts its use to research protocols. The operational message from the last edition stands and is sharpened by the MSF case: vaccinated or not, responders must be managed as unprotected, and infection prevention and control is the protection that works. This is an assessment by Pandemic Shield.*

6. Regional and International Situation

6.1 Uganda — Ebola-free, but on the route

Uganda's outbreak (20 cases, 2 deaths) remains closed. The Kenyan patient crossed from DRC by road and spent less than 24 hours in Uganda before leaving through Entebbe; Uganda's Director General of Health Services said screeners recorded a normal temperature and that no local case is linked to the transit (Watchdog Uganda, 7 Oct). How he crossed a border that has been closed since May is unexplained; a government spokesperson declined to engage (Reuters). Investigations into his movements in Uganda were continuing (Daily Monitor, 7 Oct). The last edition called the Lake Edward–Kasindi interface the most under-observed border; this case did not necessarily use it, but it shows the Beni–Uganda axis is open in practice.

6.2 Kenya and East African hubs

See Section 2.5. The case moves the export question from neighbouring countries to air hubs: Nairobi's Jomo Kenyatta airport handles about nine million passengers a year (Reuters). Africa CDC said the case underscores the need for sustained preparedness across the region.

6.3 Haut-Uélé, Bas-Uélé and South Sudan

Haut-Uélé rose from 316 to 359 cases in the same seven zones, including Dungu on the South Sudan border (named by WHO on 25 Sep among zones affected since its previous report); Bas-Uélé rose from 7 to 10 in three zones. No cross-border case into South Sudan has been reported, and no province-level point-of-entry detail for the South Sudan crossings was located. Unchanged operational gap.

6.4 South Kivu and the Great Lakes borders

Three cases, one death, none since 29 May (128 days at 4 Oct); Bukavu and Goma without new cases. Standing watch, unchanged. The upgrade trigger remains a confirmed case south of Kayna, in Goma, Bukavu or Miti-Murhesa.

6.5 Cases outside Africa and the European dimension

Four cases have now been managed in Europe: two medical evacuations to Germany (May and July), an unrecognised importation in France (June) and, since the last edition, an MSF staff member evacuated to the Netherlands and admitted to Leiden University Medical Center on 1 Oct. ECDC (1 and 6 Oct) keeps the risk to the EU/EEA general population very low and notes that its modelling covers the general population of Ituri and North Kivu, not returning health workers, whose exposure risk is substantially higher but who are under monitoring protocols. No case has been reported in the United States (CDC, 5 Oct).

6.6 Financing

Instrument	Period	Requirement	Funding status (7 Oct)
DRC national 180-day plan	4 Sep 2026 – ~Mar 2027	USD 1.3 bn*	No pledge or disbursement total located. Minister (2 Oct): USD 227 m mobilised under the first three-month plan, ~USD 99 m unspent by partners; government USD 50 m.



Instrument	Period	Requirement	Funding status (7 Oct)
United States	Since May 2026	—	Additional USD 267 m pledged 23 Sep; USD 886 m in total, incl. USD 107 m via HHS (State Dept; Nairametrics). A USD 2 bn international target is cited in press.
G20+ ministerial (New York)	23 Sep 2026	—	South Korea USD 18 m; no total located (carried forward).
Africa CDC continental plan	Jun–Dec 2026	USD 1.4 bn	~USD 910 m pledged / ~13 % disbursed (June data) — stale, not reconfirmed.

*Actualite.cd (2 Oct) refers to the 180-day plan as USD 1.2 billion; earlier sources gave USD 1.3 billion. The difference is not reconciled.

Assessment — financing. The money question has shifted from “is there funding?” to “where is it?”. The US pledge is the largest single figure in the sources, and the minister’s account of unspent partner funds is the first quantified statement of absorption. Neither tells us whether payments reach the community relays whose strike began on 21 Sep. Pandemic Shield keeps the last edition’s discipline: no aggregate funding gap is asserted without a documented total. This is an assessment by Pandemic Shield.

6.7 Coordination and framing

Framing has diverged further. The Health Minister said on 2 Oct that the peak is behind the country and that the response now deals with zonal rather than provincial epidemics (Radio Okapi). Africa CDC (28 Sep) described cases as having levelled off but the outbreak as not under control; WHO describes it as far from over and on course to approach the West African death toll (Al Jazeera, 28 Sep and 6 Oct). The data in this edition support “levelled off” and not “behind us”.

7. Principal Constraints — National Response Assessment

Ordering by assessed impact on transmission dynamics is Pandemic Shield’s own. Rows marked new or changed reflect this edition’s data; others are carried forward.

Constraint	Impact	Required action / status
North Kivu: growth meets thin capacity	1 438 → 1 729 (+20 %) in 13 days; 35 % of new national cases; new zone Alimbongo; CFR 58 %; 34 % of cases in non-specialised facilities; >60 % of deaths in the community (MSF).	Staff the new Butembo/Katwa centres; pre-position isolation in southern Lubero; publish facility-level bed data — changed, more urgent .
Late detection and missed cases	Kenyan case ill for weeks and seen in several DRC facilities undiagnosed; CFR stable at ~48 % for ten cuts; majority community deaths in North Kivu.	Lower the threshold for testing in health facilities (“every febrile patient a suspect”); decentralised testing; track community-death share — new evidence .
Contact tracing below threshold	79.7 % on 4 Oct (84.5 % on 21 Sep) against 95 %; 32 342 contacts listed (23 Sep); listing itself contested by Africa CDC.	Add relay capacity in North Kivu; audit listing per case — worsened .
Cross-border and air travel	Beni–Kampala by road across a closed border; Entebbe and JKIA screening passed; Kenya case.	Exit screening that does not rely on temperature alone (symptom history, travel declaration); cross-border case notification DRC–Uganda–Kenya — new .
Workforce pay and partner accountability	Beni strike unresolved; Sud-Ubangi doctors’ strike; minister: ~USD 99 m unspent, accreditation required.	Ring-fenced payment line for relays; accreditation without interrupting field operations — changed .
River and lake mobility	Second case in Bulu (Sud-Ubangi); Kisangani on the river route; Lake Edward shore.	Exit screening at river ports and landing sites; Sud-Ubangi contact list completion — carried forward.
Geographic extension	Seven provinces, 64 zones; northern (South Sudan) and western (river) fronts lack point-of-entry detail.	Priority screening at South Sudan crossings and on the river — carried forward.
Insecurity and access	Kigonze site (Bunia, ~19 000) emptied after search operations from 20 Sep; transit centre burned 30 Sep. Djugu clashes since 27 Sep delay Fataki–Bunia samples; 2 responders reportedly killed, Lubero (Section 4.3).	Protect health facilities; trace dispersed Kigonze residents; restore Fataki–Bunia sample and patient transport — changed .
Vaccine expectations and equity	Frontline Ervebo under research protocols; coverage not published; stock shortage reported in Tshopo; MSF staff infection.	Keep IPC discipline independent of vaccination; publish coverage and allocation — carried forward.
True burden understated	IHR EC: true infections 3–4× reported; Africa CDC: 30–40 % detected. Applied to 8 603: ~21 500–28 700 (30–40 %) or ~25 800–34 400 (3–4×) — Pandemic Shield extrapolation.	Standing analytical caveat.
Continuity of essential services	OCHA (via AP): routine primary care fell 13 % in Ituri in Apr–Jun.	Fee exemption; essential-service continuity — carried forward, now with a figure.



8. What Is Established and What Remains Unresolved (4–7 October 2026)

✓ Established	? Unresolved or contested
8 603 confirmed cases and 4 148 deaths in seven provinces and 64 zones at 4 Oct; ~64 cases/day over 21 Sep–4 Oct.	Whether the ~76/day of 29 Sep–4 Oct is reporting catch-up or renewed growth; whether the peak is "behind us" (minister) or the outbreak "not under control" (WHO, Africa CDC).
North Kivu 1 729 cases (+20 % since 21 Sep), 17 zones; new zone Alimbongo; Kayna +2 (2 Oct).	Current zone-level counts (Beni, Katwa, Butembo); whether southern Lubero seeds chains toward Goma.
Kenya: one imported, fatal case (died 5 Oct), from Beni via Kampala and Entebbe; 57 contacts, 10 quarantined (7 Oct).	Where he crossed into Uganda; whether any Kenyan or Ugandan contact develops disease before ~24–27 Oct.
Sud-Ubangi: two confirmed cases, one death, Bulu zone.	Whether the second case is a contact of the index case or a new generation; whether the river corridor carries further cases.
MSF staff member positive 29 Sep, admitted in Leiden 1 Oct; four cases managed in Europe.	Clinical outcome; how the infection occurred.
Contact follow-up 79.7 % (4 Oct).	Provincial breakdown; whether the Beni strike drives the fall.
US pledged USD 267 m more on 23 Sep (USD 886 m total); minister: ~USD 99 m of USD 227 m unspent by partners.	Total pledged and disbursed for the national plan; whether arrears to relays are paid.
CFR 48.1–48.6 % for ten consecutive cuts.	Whether this reflects late detection, a genuine plateau, or both.

9. Outlook and Planning Implications

The judgements in this section are Pandemic Shield's own and are stated so that they can be tested against subsequent reporting. The table first scores the tests set in the 24 Sep edition.

Test set on 24 Sep	Outcome by 4–7 Oct	Verdict
North Kivu five-day increments stay below ~25/day	~22/day averaged over 21 Sep–4 Oct; 33 on 4 Oct; new zone Alimbongo	Met on average, not robustly
Seven-day national average keeps falling through early October	~52–60/day to 29 Sep, ~76/day over 29 Sep–4 Oct	Not met
Sud-Ubangi quiet at ~26 Sep (isolated import)	Second case reported 1 Oct	Not met
South Kivu upgrade: case south of Kayna, in Goma, Bukavu or Miti-Murhesa	None; Kayna +2	Not triggered
Ituri has probably passed its peak	Ituri ~37/day, level with 16–21 Sep	Peak passed; decline stalled
Illustrative pace: 8 000 ~24–25 Sep, 8 500 ~1–3 Oct	8 000 crossed 23–26 Sep; 8 500 crossed 29 Sep–3 Oct	Consistent

- ★ **Plan for a plateau, not a tail.** At 55–75 cases a day the outbreak adds roughly 2 000 cases a month. Test: whether the next INSP windows return below ~60/day and stay there through mid-October.
- ★ **North Kivu sets the course.** Its share of new cases is rising toward half. Test: North Kivu daily increments relative to ~25/day, any new zone in southern Lubero, and any case in Goma.
- ★ **Export risk has moved from borders to hubs.** Kenya shows a symptomatic traveller can reach a regional air hub in a day. Test: no secondary case in Kenya by ~27 Oct; whether Uganda identifies his contacts during the transit.
- **Ituri is a plateau, not a decline** (~37/day). Test: Ituri below ~30/day in the next INSP cuts.
- **Sud-Ubangi:** a third case, or any case on the Kisangani–Lisala route, would make the river network a real front.
- **Workforce and money are now the same question.** Watch for resumption of work in Beni, the effect of partner accreditation on field operations, and recovery of contact follow-up above 85 %.
- **For a purely illustrative sense of pace** — not a forecast — at the 13-day average (~64/day) the count reaches 9 000 about 10 Oct and 10 000 about 26 Oct; at the last window's ~76/day, about 9 Oct and 22 Oct. Pandemic Shield does not treat either extrapolation as reliable beyond a few days, because reporting is still being harmonised and ascertainment is moving.
- **Kigonze and Djugu put Ituri's plateau at risk.** Close to 19 000 former Kigonze residents are dispersed across Bunia and response access in Fataki, Drodoro and Lita is reduced. Test: no confirmed case linked to former Kigonze residents before ~21 Oct; screening and transit capacity re-established for them; Ituri staying at or below ~37/day.



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B. FIELD REPORTING AND PRESS — NEW THIS EDITION

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C. CARRIED FORWARD FROM EARLIER EDITIONS (not re-verified beyond a plausibility check)

- [17] All sources of the 24 Sep 2026 edition (INSP SitReps N°097–130; WHO DON615–617 and Second IHR Emergency Committee report; UN News; Africa CDC; Actualite.cd, Congo Quotidien, Studio Hirondelle, AP, Seoul Economic Daily, Radio Okapi; trial and countermeasure sources) — full URLs as listed there.
- [18] Pandemic Shield GmbH — DRC Ituri: Ebola Disease Outbreak, Bundibugyo Strain 2026 — editions of 27 Aug, 8 Sep and 24 Sep 2026 [predecessor editions].

Editorial note. Statements of fact in this report are attributed to the sources listed above; passages headed "Assessment" or "Interpretation" are analytical judgements by Pandemic Shield GmbH and not a position taken by WHO, ECDC, Africa CDC, INSP or any government cited. **Sourcing and verification for this edition:** figures were compiled by web search and retrieval on 7 October 2026. INSP's SitReps after N°130 are listed on the INSP site but could not be retrieved, so national and provincial figures to 4 Oct are taken from ECDC's transcription of the DRC Ministry of Health daily reports, cross-checked against WHO DON618 (23 Sep), AP (26 Sep), the Health Minister (29 Sep) and US CDC; the 4 Oct provincial cases and deaths sum exactly to the national totals. Retrieval was performed through an automated page-summarisation tool rather than page-image reading; a figure with only one summarised source is not flagged as verified. **Known limits.** (a) No zone-level, laboratory, alert, bed or point-of-entry data newer than 21 Sep were read; Figure 2 Panel B and Sections 3–4 use 21 Sep values where marked. (b) The 26 Sep figure is dated differently by AP and Al Jazeera (Section 2.1). (c) The 3 Oct one-day step may reflect harmonisation. (d) The 180-day plan is given as USD 1.2 billion and USD 1.3 billion in different sources. (e) Details of the Kenyan patient's illness and route come from ministerial press conferences and may be revised. **Corrections to the 24 September edition:** none of substance; its projection that Ituri "has probably passed its peak" is qualified in Section 9. **Changes from the 24 September edition:** all national and provincial figures updated to 4 Oct; new Section 2.5 (Kenya) and a scorecard of the previous edition's tests in Section 9; Sections 2.3, 2.4, 4.2, 6 and 7 rewritten around the new data; Figure 1 extended to 4 Oct; Figure 2 redrawn as a regional map including the two long-distance travel cases. The logo, QR code and page furniture are carried over unchanged from the predecessor edition.

D. ADDED IN THIS REVISION (7 OCT 2026) — KIGONZE AND ITURI SECURITY (SECTION 4.3)

- [19] UN News — "Ebola : l'insécurité à Kigonze disperse les déplacés et complique la riposte", 28 Sep 2026. <https://news.un.org/fr/story/2026/09/1159562> · via allAfrica: <https://fr.allafrica.com/stories/202609280598.html>
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Revision note (7 Oct 2026). Section 4.3 (Kigonze displacement site, Bunia) added on a new page 7, with a corresponding key development (p. 1), an updated "Insecurity and access" row in Section 7 and an additional test in Section 9; pages renumbered to 11. National and provincial figures are unchanged. The cause of the 30 Sep fire and the whereabouts of former residents have not been reported and may be revised.