

DRC — Ituri & Eastern Provinces

Ebola Disease Outbreak — Bundibugyo Strain, 2026

Epidemiological situation report, response analysis & risk assessment · Compiled 30 July 2026 [REVISED EDITION — supersedes the 17 May 2026 PHEIC edition · national epidemiological data through 27 July 2026 · disaggregated and operational data from INSP SitRep N°072 (25 July) · incorporates the therapeutic and vaccine trial launches and the frontline workforce crisis]

Primary sources: INSP / COUSP RDC — SitRep N°072/MVB (reporting date 25 July 2026) and the SitRep series N°055-072 · ECDC situation page and Communicable Disease Threats Reports (to 27 July 2026) · WHO Disease Outbreak News, WHO AFRO and the PARTNERS trial release (2 July 2026) · Africa CDC / ANRS MIE / ALIMA — EBO-PEP launch (14 July 2026) · University of Oxford — BD-EboV Phase I launch (13 July 2026) · Uganda Ministry of Health · RKI and BMG (Germany) · US CDC · Reuters · AP · AFP · Al Jazeera · MSF · Mercy Corps · UNHAS · European Commission DG ECHO

3 262 Confirmed cases, DRC data cut-off 26 Jul	1 437 Confirmed deaths CFR 44.1 %	48 / 140 Health zones affected 5 provinces · 25 Jul	723 Patients in isolation 27 Jul	123 Frontline workers infected, Ituri 37 deaths · CFR 30.1 % · 25 Jul
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KEY DEVELOPMENTS — SINCE THE PHEIC DECLARATION (17 MAY - 27 JULY 2026)

- ★ **The outbreak has almost equalled the entire 2018-2020 Kivu epidemic in one tenth of the time.** The DRC reported 3 262 confirmed cases and 1 437 confirmed deaths as of 27 July (data cut-off 26 July). The 2018-2020 North Kivu / Ituri epidemic — the second-largest Ebola outbreak on record — recorded 3 323 confirmed cases (3 481 including probable cases) over 694 days. The present outbreak reached 98 % of that confirmed-case total in 72 days. It passed 1 000 confirmed cases within roughly 40 days of response activation, against approximately 235 days in 2018.
- Case fatality has risen steeply and is now well above both prior BDBV outbreaks.** National CFR among confirmed cases has moved from 30.6 % on 1 July to 44.1 % on 27 July. The two previous Bundibugyo events recorded approximately 25 % (Uganda 2007-08: 37 deaths in 149 cases) and 51 % (Isiro, DRC 2012: 29 in 57). Provincial figures diverge sharply — North Kivu 64.1 % and Haut-Uélé 52.6 % against Ituri's 41.6 % — which points to later presentation and a higher post-mortem detection share outside the epicentre rather than to a difference in virulence.
- Geographic expansion to five provinces and 48 health zones.** Ituri (28 of 36 zones), North Kivu (11 of 34), Haut-Uélé (5 of 13), Tshopo (3 of 23) and South Kivu (1 of 34) — 48 of 140 zones in total, of which 47 remain in active transmission. Ituri still accounts for 89 % of cumulative confirmed cases. Tshopo places the virus on the Congo River system at Kisangani; Haut-Uélé shortens the front toward South Sudan. South Kivu had passed 60 days and Tshopo 11 days without a confirmed case as of 25 July.
- ★ **Repeated strikes by unpaid response personnel.** Protests over unpaid wages and performance bonuses began at Rwampara on 6 July; staff walked out of Rwampara General Hospital on 13 July and Bunia General Hospital on 15 July; and on 25 July the Elikya Ebola Treatment Centre in Bunia was brought to a standstill after doctors, nurses and security staff stopped work over two months of unpaid bonuses. Epidemiological surveillance teams, case investigators, drivers, gravediggers and community outreach workers have all been affected. The Elikya walkout came one day after Prime Minister Judith Suminwa toured Rwampara and Mongbwalu, where staff told her they had not been paid in two months; she stated in Bunia that the DRC had disbursed over USD 50 million in addition to partner funding.
- ★ **First Bundibugyo-specific medical countermeasures entered clinical trials.** Three studies opened within thirteen days. The WHO-sponsored PARTNERS therapeutic platform (MBP134 monoclonal antibody and remdesivir, alone and in combination) began enrolment in Ituri on 2 July; the Oxford Vaccine Group launched BD-EboV, the world's first Phase I trial of a Bundibugyo-specific vaccine (ChAdOx1 BDBV), on 13 July; and EBO-PEP began recruiting on 14 July to test obeldesivir as post-exposure prophylaxis — the first filovirus PEP trial ever conducted. None will produce an efficacy readout within the current outbreak window.
- Contact tracing remains materially below the operational threshold.** National follow-up stood at 77.8 % (12 010 of 15 440 listed contacts) on 25 July against the 95 % standard — Ituri 75.6 %, Haut-Uélé 64.8 %, North Kivu 83.7 %, Tshopo 90.9 %. The Ituri and North Kivu rates exclude ten health zones that had not reported at consolidation, so the true national figure is likely lower. Two-thirds of the confirmed deaths recorded in Ituri on 25 July were community deaths detected post-mortem.
- Treatment capacity exceeded in North Kivu; triage capacity largely absent.** 773 patients were in isolation nationally against 941 beds (82.1 % occupancy), but North Kivu stood at 121.3 % (171 patients / 141 beds) while Ituri ran at 75.3 % (602 / 800). Only 175 of 1 170 health facility triage units — 15 % — were functional.
- Nosocomial burden concentrated in the epicentre.** 123 frontline health workers and responders have been confirmed infected across eleven Ituri health zones, with 37 deaths (CFR 30.1 %), 67 recoveries and 19 still hospitalised. Bunia (35 cases), Rwampara (33) and Mongbwalu (16) account for 68 % of them. PPE and chlorine shortfalls persist. The national SitRep tabulates this indicator for Ituri only; the all-province figure is therefore higher than 123.
- Uganda: 42-day countdown under way.** Uganda recorded 20 confirmed cases and 2 deaths, all linked to travel from DRC and confined to Kampala. The last confirmed case was reported on 21 June; the final patient was discharged from the Mulago National Referral Isolation Centre on 16 July, starting the 42-day countdown, which would expire on 27 August 2026 absent new cases.
- Three cases managed outside Africa — none with secondary transmission.** Two were deliberate medical evacuations to Germany and one was a returning traveller detected in France: a US citizen admitted to the Charité special isolation unit in Berlin on 20 May (discharged 6 June; his wife and four children were evacuated as contacts); a humanitarian physician confirmed in France on 24 June and discharged in early July; and a second US citizen confirmed on 10 July, evacuated on 13 July and treated at the Frankfurt University Hospital special isolation unit. ECDC continues to assess the likelihood of infection for people living in the EU/EEA as very low.
- ★ **USD 910 m pledged, but under a quarter of the response plan financed.** The joint Africa CDC-WHO continental plan of 5 June is costed at USD 518 m for June-November 2026. Donors pledged USD 910 m at the African Union High-Level Emergency Meeting of 17 June, which also resolved to disburse the full USD 518 m within four weeks. Africa CDC reported on 18 June that under 10 % had reached affected countries; at end-June its Director-General put releases at 13 % of pledges; and on 16 July WHO stated the plan still faced a gap above USD 400 m. Around USD 160 m of the headline total is vaccine development and manufacturing-readiness money that cannot affect this outbreak. Section 6.3 sets out the instruments donor by donor, with provenance.
- Insecurity and community mistrust continue to interrupt response operations.** Armed group activity (CODECO, ADF) restricts access; a burial team was attacked in Mongbwalu health zone on 17 June and five health workers were taken hostage after being falsely accused of spreading the disease; the 25 July SitRep records an attack at the Muchanga bridge and the paralysis of activities at Nyankunde, where unrest following the death of a pregnant woman at a local facility led Mercy Corps and its partners to suspend in-person activities in mid-July. The government has reported more than 150 patient escapes from treatment facilities since late May. UNHAS operates the air bridge for teams, supplies and laboratory

samples.

Assessment — trajectory. The epidemic curve shows sustained transmission through epidemiological weeks 25–30 with no inflection. Reported growth should not be attributed primarily to improved detection: apparent laboratory positivity in Ituri was 51.3 % on 25 July and the community-death share of confirmed deaths was 66.7 % on the same day. Both indicators rise when surveillance is losing ground, and both would fall if case ascertainment alone were catching up with a stable epidemic. The combination of a striking workforce, contact follow-up roughly twenty points below threshold and 15 % triage-unit functionality is consistent with continued acceleration rather than with a plateau. This is an assessment by Pandemic Shield and not a position taken by any of the authorities cited.

1. Outbreak Overview (as of 27 July 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, declared roughly five months after the end of the Kasai (Zaire strain) outbreak of August–December 2025.
PHEIC status	Declared 17 May 2026 by the WHO Director-General under IHR Article 12; in force. Africa CDC declared a public health emergency of continental security on 18 May 2026.
Causative agent	Bundibugyo ebolavirus (BDBV) — genus <i>Orthoebolavirus</i> , family <i>Filoviridae</i> . Third BDBV outbreak in recorded history and more than twenty times larger than either predecessor.
Provinces affected	Ituri (epicentre), North Kivu, Haut-Uélé, Tshopo, South Kivu — 48 of 140 health zones, of which 47 in active transmission (25 July).
Confirmed cases (DRC)	3 262 , data cut-off 26 July, reported 27 July. 3 200 at the 25 July SitRep, of which Ituri 2 848.
Confirmed deaths (DRC)	1 437 (27 July). National CFR among confirmed cases 44.1 %; 43.9 % at the 25 July SitRep.
Recovered	571 cumulative (25 July); 482 at the 21 July reporting point.
Patients in isolation	723 (27 July). At the 25 July SitRep: 773 patients — 307 confirmed, 466 suspected — across 941 beds.
Frontline workers infected	123 confirmed infections with 37 deaths (CFR 30.1 %) across eleven Ituri health zones (25 July). The national SitRep does not tabulate this indicator for the other four provinces.
Contact tracing	77.8 % national follow-up (12 010 / 15 440) on 25 July, against a 95 % operational threshold; ten non-reporting health zones are excluded from the denominator.
Uganda	20 confirmed cases, 2 deaths. Last confirmed case 21 June; last patient discharged 16 July; 42-day countdown expires 27 August 2026 absent new cases.
Cases outside Africa	3 — two US citizens medically evacuated to Germany (Charité Berlin, May; Frankfurt University Hospital, July) and one returning humanitarian physician detected in France (June). No secondary transmission in any receiving country.
Vaccine / treatment	None licensed for BDBV. Zaire-strain products (Ervebo; Zabdeno/Mvabea; Inmazeb; Ebanga) are not indicated, and WHO advised in May 2026 against their use outside controlled research settings. Three trials now enrolling — see section 5.
Comparator — 2018–2020 Kivu	3 323 confirmed cases (3 481 including probable), 2 299 deaths, 694 days, three provinces. Ring vaccination with Ervebo reached more than 320 000 people; no equivalent tool exists for BDBV.
Global risk assessment	WHO: risk of spread beyond Central Africa low. ECDC: likelihood of infection for people living in the EU/EEA very low, with preparedness, laboratory and patient-pathway guidance issued for EU/EEA health systems.

2. Epidemiological Analysis — Provincial and Health Zone Distribution

Data note. This report uses two reporting cut-offs and labels them separately throughout. National totals (3 262 / 1 437) are from the DRC reporting point of 27 July, with data to 26 July. All province-level, zone-level and operational data are from INSP/COUSP SitRep N°072, reporting date 25 July, published 26 July — the most recent edition with full disaggregation retrieved at compilation. Later editions (N°073–074) exist but were not obtained. DRC reporting is under continuous review and harmonisation, and minor discrepancies between national totals, provincial totals and zone-level tables occur between cycles; figures are not reconciled here beyond what the sources themselves state.

Province	Confirmed cases	Deaths	CFR	Health zones affected	New cases (24 h)
Ituri	2 848	1 184	41.6 %	28 / 36 (77.8 %)	115
North Kivu	306	196	64.1 %	11 / 34 (32.4 %)	7
Haut-Uélé	38	20	52.6 %	5 / 13 (38.5 %)	3
Tshopo	5	4	80.0 %	3 / 23 (13.0 %)	0
South Kivu	3	1	33.3 %	1 / 34 (2.9 %)	0
Total	3 200	1 405	43.9 %	48 / 140	125

INSP/COUSP SitRep N°072, cumulative to 25 July 2026.

Six Ituri health zones account for 84.0 % of provincial cases and 74.7 % of the national total: **Bunia (762 cases, 215 deaths), Rwampara (550 / 238), Mongbwalu (498 / 237), Nizi (350 / 166), Lita (117 / 66) and Nyankunde (114 / 31)**. Zone-level case fatality varies from 27.2 % in Nyankunde and 28.2 % in Bunia — the two zones with the strongest treatment presence — to 47.6 % in Mongbwalu and 64.0 % in Mangala. In North Kivu the burden sits on the Butembo–Katwa–Beni axis (Katwa 138 cases, Butembo 70, Beni 43), the same corridor that sustained the 2018–2020 epidemic; Goma has recorded one case since May with no documented onward transmission.

2.1 Growth trajectory — confirmed cases and deaths, DRC



Reporting point	Confirmed cases	Confirmed deaths	CFR	Source / note
15 May 2026	8	4 (+1 Uganda)	—	Declaration day. 246 suspected cases and 65–80 suspected deaths reported in parallel
1 July 2026	1 460	447	30.6 %	INSP SitRep, cumulative to 1 July; 595 in isolation, 213 recovered
4 July 2026	1 561	506	32.4 %	DRC Ministry of Health
9 July 2026	1 759	600	34.1 %	INSP, as cited in the EBO-PEP launch statement of 14 July
15 July 2026	2 011	754	37.5 %	INSP; 2 000-case threshold passed
20 July 2026	2 344	930	39.7 %	INSP, as reported 20 July
21 July 2026	2 473	999	40.4 %	INSP SitRep; 737 in isolation, 482 recovered, 82 % of contacts followed
24 July 2026	3 075	1 354	44.0 %	Government data released 25 July
25 July 2026	3 200	1 405	43.9 %	INSP SitRep N°072; +125 cases and +51 deaths in 24 h
26 July 2026	3 262	1 437	44.1 %	Reported 27 July; 723 patients in isolation

Interpretation. Confirmed cases rose 62 % and confirmed deaths 91 % in the eleven days from 15 to 26 July. Case fatality among confirmed cases rose from 30.6 % to 44.1 % over the month, with a brief plateau around 44 % in the final week. A CFR rising in step with case counts is the signature of a response in which post-mortem community detection contributes a growing share of confirmations — people are being counted at death rather than at admission. Apparent laboratory positivity in Ituri of 51.3 % on 25 July reinforces the reading: a positivity rate above one half indicates that testing capacity, not incidence, is the binding constraint on ascertainment, and that the true case count exceeds the confirmed count by an unquantified margin. Press-reported figures typically lag the INSP series by one to two reporting cycles, which accounts for the differing totals circulating for the same calendar days in late July.

2.2 Geographic distribution of confirmed cases

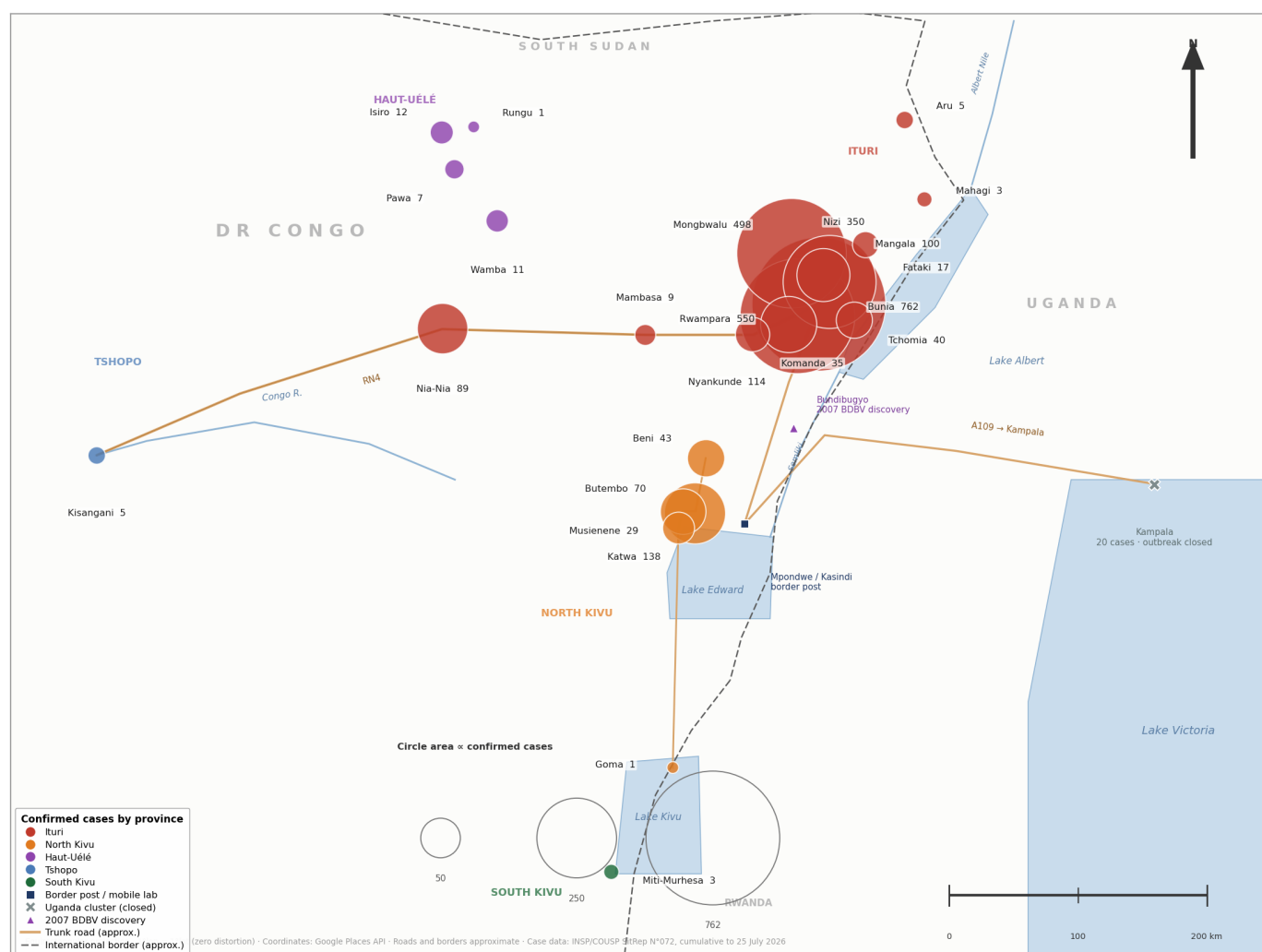


FIGURE 1 — Confirmed BDBV cases by health zone, five affected provinces, cumulative to 25 July 2026 (INSP/COUSP SitRep N°072). Circle area is proportional to confirmed cases. Uganda's Kampala cluster is shown for reference and is closed: no case since 21 June, 42-day countdown running to 27 August 2026.

Geographic verification note. Point coordinates were queried against the Google Places API and are given to four decimal places in the underlying dataset; Bunia (1.5743°N, 30.2397°E) and Mongbwalu (1.9293°N, 30.0492°E) reconcile exactly with the 17 May 2026 edition. Rwampara has no distinct settlement coordinate and is placed adjacent to the Bunia agglomeration per the geographic description used in the predecessor edition; its circle necessarily overlaps Bunia's, which reflects the real peri-urban relationship rather than a plotting artefact. Kisangani carries the combined burden of the three affected Tshopo health zones (Makiso-Kisangani, Lubunga, Mangobo). 24 mapped locations represent 26 of the 48 affected health zones and 2 892 of 3 200 confirmed cases — 90.4 % of the national total. The 22 unmapped zones are small-burden or could not be resolved to a verified coordinate; the largest omissions are Lita (117 cases) and Bambu (54). International borders and roads are schematic approximations from known route geography, not surveyed alignments, and province labels indicate position only. Projection is equirectangular with 1° longitude rendered equal to 1° latitude, so the map is undistorted but not area-true at this latitude range.

The map makes three features legible that the provincial table does not. First, the epicentre is tight. Bunia, Rwampara, Nizi, Mangala and Mongbwalu lie within about 50 km of one another in central Ituri and together account for 2 260 confirmed cases — 71 % of the national total inside a circle roughly 50 km across. Second, the North Kivu burden is not diffuse but concentrated on the Butembo-Katwa-Musienene conurbation, which sits on the north-south trunk axis some 50 km in a straight line from the Mpondwe/Kasindi crossing — the single official corridor to Uganda. Third, the western and northern extensions follow roads rather than proximity: Nia-Nia (89 cases) lies about 290 km west of Bunia on the RN4 corridor toward Kisangani, and the Haut-Uélé cluster at Isiro, Pawa, Rungu and Wamba a comparable 320 km to the north-west. Neither is contiguous with the epicentre, and both are consistent with introduction by long-distance road movement rather than radial spread. Distances are straight-line; road distances are substantially greater.

3. Surveillance, Laboratory and Points of Entry

3.1 Alert management and laboratory throughput (24 hours to 25 July 2026)

Indicator	Ituri	North Kivu	Haut-Uélé	Tshopo	South Kivu	National
Alerts carried over (J-1)	7	33	41	0	1	82
New alerts received	581	714	11	22	7	1 335
Total alerts for the day	588	747	52	22	8	1 417
Investigated within 24 h	482	707	6	4	7	1 206
Investigation rate	81.9 %	94.7 %	11.5 %	18.2 %	87.5 %	85.1 %
Validated — living suspects	168	54	2	2	7	233
Validated — community deaths	74	32	1	0	0	107
Suspected cases validated	242	86	3	2	7	340
Samples analysed	224	135	8	5	n/r	n/r
Laboratory positivity	51.3 %	5.2 %	25.0 %	0 %	n/r	n/r

The alert data expose an inversion worth noting. North Kivu generated more new alerts than Ituri (714 against 581) while carrying one tenth of the case burden, and returned 5.2 % positivity against Ituri's 51.3 %. North Kivu is therefore alerting broadly and with low specificity, which is the desired posture for a province at the edge of an epidemic; Ituri is alerting narrowly and with very high specificity, which in the epicentre means that only the most obvious cases are entering the system. Haut-Uélé's investigation rate of 11.5 %, with 41 of 52 alerts carried over from the previous day, is the weakest link in the surveillance chain and sits directly on the axis toward South Sudan.

3.2 Contact tracing (25 July 2026)

Province	Contacts under follow-up	Contacts seen	Follow-up rate
Ituri	10 901	8 245	75.6 %
North Kivu	4 307	3 606	83.7 %
Haut-Uélé	199	129	64.8 %
Tshopo	33	30	90.9 %
South Kivu	follow-up closed	—	n/a
Total	15 440	12 010	77.8 %

Ten health zones — Damas, Fataki, Kilo, Kambala, Logo, Mambasa, Nyankunde, Rimba, Masereka and Mutwanga — had no data available at consolidation and are excluded from the Ituri and North Kivu figures, so the true national rate is below 77.8 %. The deterioration is concentrated in the epicentre, where follow-up matters most, and coincides with the periods of industrial action among surveillance teams and community relays.

3.3 Points of entry and control (24 hours to 25 July 2026)

80 of 95 points of control were activated or reinforced (84.2 %) — 60 of 60 in Ituri and 16 of 16 in North Kivu, but only 4 of 19 in Tshopo (21.1 %). 155 936 travellers transited monitored points in 24 hours (Ituri 98 423, North Kivu 53 748, Tshopo 3 765), of whom 96.0 % were screened and 94.4 % performed hand hygiene. Eleven alerts were intercepted — nine in Ituri, of which six living alerts were validated and referred, and two bodies swabbed; and two bodies at the Kasitu control point in North Kivu. **The throughput figure is the operationally decisive one.** Screening 150 000 people a day can only detect the febrile, and the early prodrome of BDBV — fever, asthenia, myalgia, arthralgia, nausea, with haemorrhagic signs infrequent — is clinically indistinguishable from endemic malaria. The only detailed BDBV clinical dataset from a DRC setting (Isiro 2012; Paerisch, né Kratz, et al., PLOS ONE 2015) records a mean incubation period of 11.3 days and malaria as the leading differential diagnosis in 28.3 % of admissions. A traveller in the first three to seven days of infection is both mobile and unremarkable at a screening post.

4. Case Management, Burials and the Frontline Workforce

4.1 Treatment capacity (25 July 2026)

Indicator	Ituri	North Kivu	Haut-Uélé / Tshopo	National
Beds	800	141	not reported	941
Patients in isolation (end of day)	602	171	not reported	773
of which confirmed	287	20	—	307
of which suspected	315	151	—	466
Occupancy	75.3 %	121.3 %	—	82.1 %
Admissions (24 h)	102	49	—	151
Discharges (24 h)	76	45	—	121
of which recovered	13	2	—	15
of which died in facility	19	6	—	25
of which ruled out (non-cases)	40	37	—	77
Escapes (24 h)	2	0	—	2

North Kivu is holding 171 patients in 141 beds, of whom only 20 are confirmed and 151 suspected — a suspect-heavy caseload consistent with the province's broad, low-specificity alerting. Ituri's profile is the reverse: 287 confirmed against 315 suspected. Safe and dignified burials continue at scale — 65 death alerts, 50 burials and 40 bodies swabbed in Ituri in 24 hours, and 33 alerts with 33 bodies swabbed and 30 burials in North Kivu — but resistance to post-mortem sampling and attacks on burial teams remain the highest-ranked operational constraint in the national report. Ituri logistics comprise 38 vehicles and 12 ambulances, with Starlink kits deployed and the Rwampara treatment centre brought to 100 operational beds.

4.2 Frontline workers infected — Ituri health zones (cumulative, 25 July 2026)

Health zone	Confirmed	Recovered	In hospital	Deaths
Bunia	35	18	2	15
Rwampara	33	24	2	7
Mongbwalu	16	6	2	8
Nyankunde	14	11	1	2
Nia-Nia	10	3	7	0
Lita	4	1	2	1
Nizi	3	0	0	3
Mangala	3	1	1	1
Bambu, Kilo, Logo (combined)	5	3	2	0
Total — CFR 30.1 %	123	67	19	37

Assessment — workforce. The pay dispute is the most tractable single determinant of epidemic trajectory currently in view. Surveillance officers, case investigators and ambulance drivers together set the detection-to-isolation interval; burial teams set the post-mortem transmission risk. All four functions have withdrawn labour at least once since 6 July, and all four are named in the national report as affected. The report itself ranks non-payment of providers as the second-highest constraint of twelve and calls for a dedicated, ring-fenced financing line rather than case-by-case regularisation. A resumption was announced following the intervention of the military governor of Ituri; whether it is durable, and whether a standing financing mechanism has actually been created, is not documented in public reporting.

5. Medical Countermeasures — Three First-in-History Trials

At declaration, the defining feature of this outbreak was the absence of any licensed vaccine or therapeutic for Bundibugyo ebolavirus. The Zaire-strain toolkit that proved decisive in 2018-2020 — above all ring vaccination with Ervebo, which reached more than 320 000 people — is not available here. BDBV and Zaire ebolavirus differ by roughly 30 % at the nucleotide level, which is sufficient that immunity raised against the Zaire glycoprotein does not reliably protect against BDBV, and WHO advised in May 2026 against deploying Zaire-strain vaccines outside controlled research settings. Within ten weeks of declaration, three clinical studies had opened.

Trial	Product(s)	Opened	Design and status
PARTNERS (therapeutic)	MBP134 monoclonal antibody; remdesivir; and the combination	2 July 2026	Platform Adaptive Randomised Trial for New and Repurposed Filovirus Treatments. Sponsored by WHO with INRB (Kinshasa), the Institute of Tropical Medicine Antwerp, the University of Oxford and ALIMA. Randomised and controlled; enrolment restricted to laboratory-confirmed BVD; all arms receive optimised supportive care; minimum 28-day follow-up. Started at a single Ituri facility not publicly identified for security reasons. May require more than 1 000 patients and could run into 2027. Designed to persist across future filovirus outbreaks.
BD-Ebov (vaccine, Phase I)	ChAdOx1 BDBV — chimpanzee adenovirus vector encoding the BDBV glycoprotein	13 July 2026	World's first Phase I trial of a Bundibugyo-specific vaccine, run by the Oxford Vaccine Group and Pandemic Sciences Institute with CEPI support; investigational doses supplied by the Serum Institute of India. 50 healthy adults aged 18-55 in Oxford, United Kingdom. Oxford has stated that further studies with Ugandan partners are in preparation, subject to regulatory approval.

Trial	Product(s)	Opened	Design and status
EBO-PEP (prophylaxis)	Obeldesivir — oral antiviral (Gilead)	14 July 2026	First clinical trial to test post-exposure prophylaxis against any filovirus. Led by ANRS Emerging Infectious Diseases (France) and INRB, with ALIMA and MSF field support and Africa CDC backing; in preparation since 2024. Recruiting at PEP centres adjacent to the ALIMA treatment centres in Bunia and Rwampara. Target approximately 1 000 participants aged 12 and over, asymptomatic, with high-risk contact within the preceding five days. The platform is designed to extend to Uganda, Guinea, Liberia and Sierra Leone.

Assessment — countermeasures. Of the three, EBO-PEP is the study whose success would most directly change the operational picture: an effective oral prophylaxis for high-risk contacts would act simultaneously on health worker attrition and on household transmission, the two failure modes that classical containment is not currently closing. Its principal risk is enrolment — it depends on the same contact lists that are currently being followed at 75.6 % in Ituri. A Phase I vaccine trial in 50 volunteers in the United Kingdom cannot influence this outbreak; its value is structural, closing a market failure in which BDBV carried a priority pathogen designation for years without attracting development funding. Planning assumptions for the remainder of 2026 should continue to treat classical containment — isolation, contact tracing, safe burials, IPC and community engagement — as the only available tool set.

6. Regional and International Situation

6.1 Uganda

Uganda recorded 20 confirmed cases and 2 deaths, all epidemiologically linked to travel from DRC and confined to Kampala with no documented community spread. The last confirmed case was reported on 21 June; the final patient was discharged from the Mulago National Referral Isolation Centre on 16 July, and the Ministry of Health began the 42-day countdown, which expires on 27 August 2026 absent new cases. Uganda closed border crossings with DRC in late May and maintains screening at 22 crossings and transit routes, including pilgrimage corridors, with a mobile laboratory at Bwera Hospital serving the Mpondwe/Kasindi corridor — the single official crossing between Ituri and western Uganda, alongside at least twenty unofficial points of entry in Kasese District alone.

6.2 Cases outside Africa and the European dimension

Three cases have been managed outside Africa, none producing secondary transmission, and the distinction between them matters for preparedness planning. Two were **deliberate medical evacuations** requested by the United States and accepted by Germany: a US citizen who had treated Ebola patients in the outbreak zone was admitted to the Charité special isolation unit in Berlin on 20 May, together with his wife and four children as high-risk contacts, and was discharged on 6 June after a period in which his condition was described as life-threatening between departure from Africa and arrival in Germany; a second US citizen working for a humanitarian organisation tested positive on 10 July, was evacuated on 13 July and was treated at the Frankfurt University Hospital special isolation unit. The third was an **unrecognised importation**: a humanitarian physician returning from eastern DRC was confirmed in France on 24 June, isolated on arrival and discharged in early July after negative tests. Germany's STAKOB network of competence and treatment centres, coordinated from the Robert Koch Institute, is the operative structure for these admissions; three confirmed Ebola patients were treated in Germany during the 2014 West Africa epidemic. ECDC has issued preparedness, laboratory and patient-pathway guidance for EU/EEA health systems while maintaining that the likelihood of infection for people living in the EU/EEA is very low.

6.3 Financing — requirements, commitments and disbursement

Financing runs through three layers: a single costed continental plan, separate agency appeals, and bilateral, development-bank and product-development instruments that sit partly inside and partly outside that plan. Headline pledges exceed the plan's requirement. Disbursement does not.

Requirements

Instrument	Period	Requirement	Funding status
Joint Africa CDC-WHO Continental Strategic Preparedness and Response Plan (launched 5 June)	Jun–Nov 2026	USD 518 m	Gap of more than USD 400 m as at 16 July, per the WHO Director-General — under a quarter mobilised six weeks after launch
UNICEF revised Ebola response plan (17 July)	to Dec 2026	USD 119.3 m	UNICEF reported roughly 25 % availability in mid-July; secondary compilations put mobilisation at USD 23.5 m as at 30 June
WFP — DRC operations including Ebola logistics and food assistance in Ituri (appeal 29 July)	6 months	USD 293.6 m	Newly issued; WFP cites deepening hunger as directly undermining the response
Africa CDC escalation scenario	if transmission is not rapidly contained	up to USD 1.5 bn	Contingent projection stated at the AU High-Level Meeting of 17 June
Independent estimate — ISS African Futures Institute	2026	≥ USD 710 m additional health financing	Modelled requirement (DRC USD 540 m, Uganda USD 170 m above baseline); an estimate, not an appeal

Announced commitments and instruments

Source	Amount	Date	Channel and purpose
Pandemic Fund (hosted by the World Bank)	up to USD 220.6 m	5 Jun	Largest single package. Emergency Financing Procedures activated at an extraordinary Governing Board meeting: up to USD 175.7 m by reprogramming active projects in DRC, South Sudan, Rwanda, Burundi, Tanzania, Zambia, Angola, Kenya and Ethiopia; a further USD 44.9 m by fast-tracked approval of projects already under preparation for Uganda, the Central African Republic and the Republic of Congo. Spans twelve countries, including preparedness in states with no cases.
World Bank Group	USD 243 m	Jun	Existing and new financing combined, including USD 10 m from the Global Financing Facility, delivered largely through the HEPRR and REDISSE projects — the latter built the Bunia reference laboratory now serving as the central testing hub — with the IDA Crisis Response Window under consideration. See sourcing note below.

Source	Amount	Date	Channel and purpose
United States — Department of State	USD 270 m (total direct)	to 12 Jun	Cumulative direct Ebola response funding, not additive with the entries it contains: an initial tranche reported at USD 112 m on 28 May for PPE, screening, contact tracing and diagnostics, implemented through International Medical Corps, Medair, FHI 360 and the IFRC across some 100 health facilities; and USD 50 m committed to CEPI on 12 June for laboratory studies, clinical trials and manufacturing. Separate from USD 350 m in humanitarian assistance to DRC, South Sudan and Uganda, itself part of a USD 1.8 bn commitment to UN OCHA announced in May.
United States — CDC	USD 107 m	18 Jun	Emergency funding for the response in DRC and Uganda, announced by CDC and distinct from the State Department total above.
Gavi, the Vaccine Alliance	up to USD 50 m	29 May	First Response Fund — the largest allocation approvable by the Gavi CEO without Board approval. Up to USD 40 m to accelerate access to investigational and eventual licensed doses and to prepare manufacturing at scale; USD 10 m for outbreak response and protection of routine immunisation.
CEPI	> USD 60 m	by mid-Jun	CEPI's own commitment across four BDBV vaccine candidates (IAVI rVSV; Moderna mRNA; Oxford ChAdOx1, manufactured by the Serum Institute of India; Public Health Vaccines). Additional to, and not the same money as, the United States' USD 50 m to CEPI. Underpins the ChAdOx1 BDBV Phase I trial in section 5.
United Kingdom	up to GBP 20 m (≈ USD 26.9 m)	21 May	FCDO, announced by the Foreign Secretary; channelled through WHO, UN agencies and NGOs for surveillance, frontline worker protection and IPC. Additional to the SHER programme (over GBP 18 m since 2024) and the SAFER consortium. UKHSA has activated its Returning Workers Scheme and holds the UK Public Health Rapid Support Team on standby.
European Union	EUR 15 m	28 May	Ebola response and preparedness in DRC and Uganda, within EUR 79.5 m allocated to DRC humanitarian needs for 2026.
African Union member states (collective)	USD 80 m	17 Jun	Pledged at the High-Level Emergency Meeting convened in Bujumbura by the AU Chairperson, President Evariste Ndayishimiye of Burundi.
African Development Bank Group	USD 13 m	20 Jul	USD 10 m reallocated from the Bank's DRC portfolio and channelled through WHO; USD 3 m from the Multi-Country Emergency Assistance Project, implemented by Africa CDC. Country split: DRC USD 11 m, Uganda USD 1 m, South Sudan USD 1 m.
WHO Contingency Fund for Emergencies	USD 3.9 m	May	Released on declaration — the fastest instrument deployed, and the smallest.
DRC government	> USD 50 m	stated 24 Jul	Domestic disbursement cited by Prime Minister Judith Suminwa during her visit to Ituri. A political statement, not an audited figure.
Germany — BMZ	not quantified	Jun	500 protective suits pledged and an expert group for eastern DRC under preparation; no euro figure published. The 2026 federal budget reduced both BMZ and Health Ministry allocations, and German civil society has publicly called the contribution insufficient. Germany's principal contribution to date has been clinical: two medical evacuations managed in STAKOB special isolation units (section 6.2).
Total pledged — AU tally	USD 910 m	17 Jun	Africa CDC figure announced at the High-Level Meeting. It aggregates commitments from several entries above and is not additional to them. Its donor-by-donor composition has not been published, and its scope is broader than the USD 518 m plan — it includes vaccine R&D and preparedness in countries with no cases.

Sourcing note. The entries above are drawn from primary announcements by the funding institutions wherever possible — Pandemic Fund, Gavi, CEPI, AfDB, FCDO, US Department of State, Africa CDC. Three carry weaker provenance and are flagged accordingly. The World Bank figure of USD 243 m appears in the Bank's own Ebola factsheet as indexed in June and in a verbatim reproduction of that text, but not in the revision of that page retrievable at compilation, which predates it; it should be treated as reported rather than confirmed. The US initial tranche of USD 112 m and the UNICEF mobilisation figure of USD 23.5 m come from secondary compilations. The column is deliberately not summed: the instruments have different scopes, periods and geographies, several are ceilings ('up to') rather than commitments, and at least one — the AU tally — aggregates others in the table.

The gap is not in pledging — it is in disbursement. On 18 June Africa CDC told partners that of USD 910 m pledged, less than USD 90 m — under 10 % — had reached the affected countries; reporting at the end of June put releases at 13 % of pledges, attributed to Director-General Dr Jean Kaseya. On 16 July the WHO Director-General stated that the continental plan still faced a gap above USD 400 m, meaning under a quarter of it was financed six weeks after launch. The African Union had resolved on 17 June to mobilise and disburse the full USD 518 m **within four weeks** — a deadline that expired around 15 July and was not met. Africa CDC undertook at the same meeting to publish a weekly commitment tracker covering pledges, disbursements, supplies and deployed personnel; no published output from it was retrievable at compilation.

Assessment — financing. The failure here is one of velocity and last-mile delivery, not of donor generosity, and it has a traceable epidemiological consequence. Two structural features explain the lag. First, the largest instruments are not new cash: the Pandemic Fund package is explicitly built from reprogrammed active projects and fast-tracked pipeline approvals, and the World Bank figure combines existing and new financing across a standing portfolio. Money of that kind is quick to announce and slow to convert into per diems for a contact tracer in Bunia. Second, a substantial share of the headline total is not response money at all: Gavi's USD 50 m, CEPI's USD 60 m and the United States' USD 50 m to CEPI — some USD 160 m across the three — fund vaccine development and manufacturing readiness for products that cannot exist in time to affect this outbreak. That spending is defensible on its own terms and overdue, but it should not be counted against a six-month containment plan. The consequence appears in the same week's operational data: responders unpaid for two months, strikes at Bunia, Rwampara and the Elikya treatment centre, contact follow-up at 75.6 % in Ituri against the 90–95 % that Africa CDC and WHO identify as the containment threshold, and two-thirds of Ituri's confirmed deaths detected only post-mortem. Africa CDC's own warning that an uncontained outbreak could raise requirements from USD 518 m to USD 1.5 bn puts a price on the delay. The operative question for donors is no longer how much has been pledged but how quickly money can reach a payroll — and the DRC national report answers it plainly by asking not for more money but for a dedicated, ring-fenced financing line for provider payments.

6.4 Coordination architecture

Coordination runs on a declared 'one plan, one budget, one team' model. The DRC Public Health Emergency Operations Centre (COUSP), within INSP, holds national incident management and publishes the SitRep series this report draws on. Above it sit the joint Africa CDC–WHO continental plan of 5 June, the Africa CDC continental public health emergency declaration of 18 May, and the WHO IHR Emergency Committee convened from 19 May. The African Union added a political layer with the High-Level Emergency Meeting of 17 June. On the United Nations side a Senior Ebola Coordinator, Julien

Harneis, is in place, with WFP running logistics and UNHAS the air bridge for responders, supplies and laboratory samples. The World Bank Group coordinates with WHO, Africa CDC, Gavi and CEPI. The Bunia reference laboratory financed through REDISSE and the Kinshasa Emergency Operations Centre it rehabilitated are the two clearest instances in this outbreak of preparedness investment made years in advance paying off at the moment it was needed.

7. Principal Constraints — National Response Assessment

The constraints below are those formally recorded by the DRC Public Health Emergency Operations Centre (COUSP) in SitRep N°072. Nine of the twelve are reproduced, reordered by assessed impact on transmission dynamics; the ordering is Pandemic Shield's, the content is COUSP's.

Constraint	Impact	Required action (per COUSP)
Non-payment of response personnel — strikes in the Bunia and Rwampara health zones	Interruption of response activities including safe and dignified burials, surveillance and contact tracing	Regularise provider payments; secure dedicated, ring-fenced financing
Contact tracing performance below threshold (Ituri 75.6 %, Haut-Uélé 64.8 %)	Transmission chains not interrupted	Train, deploy and motivate community relays (RECO); reinforce supervision; investigate the decline observed in Ituri
Resistance to post-mortem sampling and insecurity targeting burial teams (Muchanga bridge attack; paralysis at Nyankunde)	Delayed confirmation, case under-ascertainment, disruption of key activities	Intensify risk communication and community engagement; involve religious and community leaders; secure teams and increase their number
Treatment capacity insufficient — 121.3 % occupancy in North Kivu, 75.3 % in Ituri	Admission delays, increased nosocomial transmission risk	Accelerate construction and expansion of treatment centres; deploy temporary structures; report bed capacity systematically
IPC consumables (PPE, chlorine) short; only 175 of 1 170 triage units (15 %) functional	High nosocomial infection risk — 123 frontline worker cases with 37 deaths	Urgent procurement; reinforce IPC training
Geographic extension to Haut-Uélé and Tshopo combined with high population mobility	Risk of urban, riverine and cross-border diffusion	Activate the 23 priority points of entry in Haut-Uélé; reinforce cross-border coordination
Decentralised diagnostics incomplete — laboratories planned at Butembo and Mambasa	Long confirmation delays, undetected transmission	Accelerate deployment of decentralised diagnostic capacity
Insecurity and restricted access (CODECO, ADF)	Restriction of operations	Reinforce security coordination and humanitarian access
Continuity of essential health services compromised	Increased indirect, non-Ebola mortality	Implement fee exemption effectively; reinforce essential service continuity

8. What Is Established and What Remains Unresolved (27 July 2026)

✓ Established	? Unresolved or contested
3 262 confirmed cases and 1 437 confirmed deaths as of 27 July across five provinces and 48 of 140 health zones — 98 % of the confirmed-case total of the entire 2018–2020 Kivu epidemic, reached in 72 days rather than 694.	Whether the epidemic has peaked cannot be determined from the available series. The national report describes sustained transmission through weeks 25–30 with fluctuations attributed to notification delay and progressive data consolidation.
Confirmed-case CFR rose from 30.6 % (1 July) to 44.1 % (27 July); North Kivu 64.1 %, Haut-Uélé 52.6 %, Ituri 41.6 %.	True infection fatality is unknown. The confirmed-case denominator is biased toward severe and post-mortem detection, so this figure overstates fatality across all infections while the unquantified undetected fraction makes the direction of the bias impossible to size.
No licensed vaccine or therapeutic exists for BDBV. Three trials — PARTNERS, BD-Ebov and EBO-PEP — opened between 2 and 14 July.	No efficacy readout is expected within the current outbreak window for any of the three. Whether EBO-PEP can reach its 1 000-participant target given insecurity, workforce disruption and incomplete contact listing is unknown.
Response personnel have struck repeatedly since 6 July over unpaid wages and bonuses; 123 responders infected in Ituri, 37 deaths.	Whether the announced resumption following the Ituri military governor's intervention is durable, and whether a ring-fenced financing line now exists, is not documented. Frontline infection figures for the four non-Ituri provinces are not published.
Uganda has recorded no confirmed case since 21 June and its 42-day countdown expires 27 August 2026.	Renewed undetected importation through the Mpondwe/Kasindi corridor or the Mahagi–West Nile route cannot be excluded. Official crossings are screened at high volume, but the corridor is dominated by unofficial points of entry and BDBV is not detectable by temperature screening during the infectious prodrome.
Three cases were managed outside Africa without secondary transmission, two of them in German special isolation units.	The risk to South Sudan, which borders northern Ituri via Aru and is now closer to the front following extension into Haut-Uélé, has still not been the subject of a published formal risk assessment by any international health authority.

9. Outlook and Planning Implications

The judgements in this section are Pandemic Shield's and are stated so that they can be tested against subsequent reporting.

- **A record about to be broken.** At the 26 July data cut-off, 61 confirmed cases separated this outbreak from the confirmed-case total of the entire 2018–2020 Kivu epidemic (3 323). At the late-July increment of roughly 125 confirmed cases per day, that threshold will have been crossed within a day or two of the cut-off — in all likelihood before this report was compiled — making the 2026 event the second-largest Ebola outbreak on record by confirmed cases. On the same increment, 4 000 confirmed cases would be reached in the first days of August.
- **What actually determines the trajectory.** The decisive variable is not the case count but the detection-to-isolation interval, which is a direct function of whether surveillance and burial teams are working. Three measurable indicators are worth tracking above all others: sustained

resolution of the pay dispute, restoration of contact follow-up above 90 % in Ituri, and bed capacity in North Kivu returning below 100 % occupancy. A fall in Ituri's laboratory positivity from 51 % toward 20–30 % would be the earliest credible signal that ascertainment is catching up with transmission.

- **Uganda's declaration should not be read as regional de-escalation.** Absent new cases Uganda will declare its outbreak over on or shortly after 27 August. The DRC epicentre is simultaneously at its highest recorded intensity, and the Mpondwe/Kasindi corridor remains the principal exportation pathway.
- **Extension risk sits north and west, not south.** Haut-Uélé and Tshopo are the provinces to watch. Tshopo places the virus on the Congo River system at Kisangani, a city of over a million with river transport to Kinshasa; Haut-Uélé, with an 11.5 % alert investigation rate, shortens the distance to South Sudan, whose health system has substantially less capacity to detect and isolate than Uganda's and for which no published formal risk assessment yet exists.
- **For European health systems.** The realistic planning case is not community transmission but the repeated medical evacuation of humanitarian and clinical personnel. Three cases in eight weeks, two of them managed in Germany, indicate a sustained rather than exceptional demand on special isolation unit capacity, high-containment laboratory throughput and STAKOB coordination for as long as the outbreak continues. Organisations deploying staff to Ituri and North Kivu should plan on the basis that medical evacuation capability, not vaccination, is their operative protective measure, and that the deploying organisation — not the host health system — will need to fund and arrange it.
- **For preparedness planning generally.** The most transferable lesson so far is that species-specific countermeasure gaps convert a manageable filovirus event into an uncontrolled one. The 2018–2020 response also contended with insecurity, community mistrust and workforce problems; the clearest difference in 2026 is the absence of ring vaccination and of licensed therapeutics, not a demonstrable degradation in operational quality. Preparedness portfolios built around Zaire-strain products should be re-examined against Sudan, Bundibugyo and Taï Forest ebolaviruses and against Marburg virus, and diagnostic platforms configured for Zaire-only detection should be treated as a structural vulnerability wherever non-Zaire species may emerge.

10. References and Sources

A. PRIMARY OFFICIAL DOCUMENTATION

- [1] INSP / COUSP RDC — Rapport de Situation de la 17ème Epidémie de la Maladie à Virus Ebola, SitRep N°072/MVB, reporting date 25 July 2026, published 26 July 2026. https://insp.cd/wp-content/uploads/2026/07/SitRep_MVE_RDC_N%C2%B0_72_25-07-2026.pdf [KEY SOURCE: provincial and zone-level cases and deaths, alert management, laboratory, contact tracing, points of entry, case management, frontline workers, constraint assessment]
- [2] INSP / COUSP RDC — SitRep series, in particular N°055 (8 July 2026) and N°068 (21 July 2026). <https://insp.cd/> — Subsequent editions (N°073–074) are referenced in secondary reporting but were not retrieved at compilation.
- [3] ECDC — Ebola disease outbreak in the Democratic Republic of the Congo and Uganda (situation page, national figures to 27 July 2026). <https://www.ecdc.europa.eu/en/ebola-outbreak-democratic-republic-congo-and-uganda>
- [4] ECDC — Threat assessment brief: Ebola disease outbreak caused by Bundibugyo virus, DRC and Uganda, 21 May 2026; Communicable disease threats reports, weeks 27–29.
- [5] WHO — Disease Outbreak News, Ebola disease caused by Bundibugyo virus, DRC and Uganda (16 and 21 May, 29 May, 8 and 19 June, 3 July 2026). <https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON613>
- [6] WHO AFRO — Ongoing outbreak in the Democratic Republic of the Congo. <https://www.afro.who.int/health-topics/ebola-disease/outbreak-drc-26>
- [7] WHO — Ebola outbreak 2018–2020, North Kivu–Ituri (final figures: 3 481 cases, of which 3 323 confirmed; 2 299 deaths). <https://www.who.int/emergencies/situations/Ebola-2019-drc->
- [8] Uganda Ministry of Health — EVD daily updates; announcement of the 42-day countdown, 16 July 2026. <https://health.go.ug/> · <https://evd-daily.health.go.ug/>
- [9] Robert Koch-Institut — Informationen zum Ebolafieber-Ausbruch (Bundibugyo-Ebolavirus) in der Demokratischen Republik Kongo. <https://www.rki.de/DE/Themen/Infektionskrankheiten/Infektionskrankheiten-A-Z/E/Ebola/Ausbruch-DRC-2026.html>
- [10] Bundesministerium für Gesundheit — Fragen und Antworten zum Ebolaausbruch in Afrika im Mai 2026, as of 20 July 2026. <https://www.bundesgesundheitsministerium.de/service/begriffe-von-a-z/ebola>
- [11] US CDC — Ebola outbreak current situation; media releases of 18 May and 10 July 2026. <https://www.cdc.gov/ebola/situation-summary/index.html>

B. CLINICAL TRIALS AND COUNTERMEASURES

- [12] WHO — Patient enrolment begins in a scientific trial to identify the first effective treatments for Bundibugyo virus disease (PARTNERS), 2 July 2026. <https://www.who.int/news/item/02-07-2026-patient-enrolment-begins-in-a-scientific-trial-to-identify-the-first-effective-treatments-for-bundibugyo-virus-disease>
- [13] University of Oxford — World's first Phase I Bundibugyo ebolavirus vaccine trial launched by Oxford Vaccine Group (BD-EboV / ChAdOx1 BDBV), 13 July 2026. <https://www.ox.ac.uk/news/2026-07-13-worlds-first-phase-i-bundibugyo-ebolavirus-vaccine-trial-launched-by>
- [14] Africa CDC — Bundibugyo Ebola Virus Outbreak: Launch of the EBO-PEP Trial to Protect High-Risk Contacts, 14 July 2026. <https://africacdc.org/news-item/bundibugyo-ebola-virus-outbreak-launch-of-the-ebop-trial-to-protect-high-risk-contacts/>
- [15] Reuters — Congo begins trial of Gilead's experimental antiviral for Ebola Bundibugyo, 14 July 2026.
- [16] EMA Emergency Task Force and African Medicines Agency — joint update on candidate vaccines and therapeutics for BDBV, June 2026.

C. FIELD REPORTING AND RESPONSE OPERATIONS

- [17] Associated Press — More health workers strike as Ebola cases in Congo near 3,000, including over 1,300 deaths, 25 July 2026.
- [18] Al Jazeera — Staff at DR Congo Ebola centre strike as virus continues spreading, 13 July 2026; DRC Ebola cases surpass 2,000 as more health workers begin strike, 15 July 2026; Ebola deaths in DRC surge past 1,300 as virus 'spreading like a wildfire', 25 July 2026.
- [19] Reuters — Congo says number of confirmed Ebola cases rises to 1,708, 8 July 2026.
- [20] Médecins Sans Frontières — Ebola disease outbreak in DR Congo: MSF response, key facts, and timeline, updated 26 July 2026. <https://www.doctorswithoutborders.org/latest/ebola-disease-outbreak-2026-how-msf-responding>
- [21] Mercy Corps — DRC Ebola cases near 2018–2020 outbreak total in just over ten weeks as insecurity disrupts response in Ituri, 28 July 2026. <https://www.mercycorps.org/press-room/releases/drc-ebola-cases-near-2018-2020-outbreak-total> [Nyakunde suspension; comparison with the 2018–2020 outbreak]
- [22] European Commission DG ECHO — Democratic Republic of the Congo country page: EUR 15 million Ebola allocation within EUR 79.5 million humanitarian aid for 2026.
- [23] UN News — Hunger hampers Ebola response as cases top 3,200 in DR Congo, 29 July 2026 (WFP requirement of USD 293.6 million; UN Senior Ebola Coordinator Julien Harneis). <https://news.un.org/en/story/2026/07/1168047>
- [24] UN News — WHO warns DR Congo Ebola outbreak is outpacing response as Uganda reaches milestone, 16 July 2026 (continental plan gap above USD 400 million; UNICEF at 25 per cent funded). <https://news.un.org/en/story/2026/07/1167959>

D. FINANCING AND COORDINATION

- [25] Africa CDC / WHO — Africa CDC and WHO launch joint continental Ebola response plan (USD 518 million, June–November 2026), 5 June 2026. <https://www.who.int/news/item/05-06-2026-africa-cdc-and-who-launch-joint-continental-ebola-response-plan>
- [26] Africa CDC — African Union High-Level Meeting mobilizes USD 910 million in pledges for Ebola Bundibugyo response in DRC and Uganda, 17–18 June 2026. <https://africacdc.org/news-item/african-union-high-level-meeting-mobilizes-usd-910-million-in-pledges-for-ebola-bundibugyo-response-in-drc-and-uganda/> [KEY SOURCE: four-week disbursement resolution; USD 80 million from AU member states; CEPI above USD 60 million; USD 1.5 billion escalation scenario; weekly commitment tracker]
- [27] The Pandemic Fund — Statement from the Voting Members of the Governing Board on the Pandemic Fund's Accelerated Support for the Ebola Emergency (USD 220.6 million), June 2026. <https://www.thepandemicfund.org/news/statement/statement-from-the-voting-members-of-the-governing-board-on-the-pandemic-funds-accelerated-support-for-the-ebola-emergency> · Africa CDC welcome statement, 5 June 2026.
- [28] World Bank Group — Response to Ebola Outbreak in Democratic Republic of Congo (DRC) and Uganda, factsheet, May–June 2026 (USD 243 million, including USD 10 million from the Global Financing Facility; HEPRR and REDISSE projects). <https://www.worldbank.org/en/news/factsheet/2026/05/27/ebola-outbreak-response-democratic-republic-of-congo-uganda>
- [29] African Development Bank Group — African Development Bank Group to provide USD 13 million to bolster Ebola response, July 2026. <https://www.afdb.org/en/news-and-events/pre-ss-releases/african-development-bank-group-provide-13-million-bolster-ebola-response-outbreak-democratic-republic-congo-south-sudan-and-uganda-95599>
- [30] U.S. Embassy in Uganda — Ebola Response Update, 12 June 2026 (USD 50 million to CEPI; implementer activity in Ituri). <https://ug.usembassy.gov/ebola-response-update-june-12-2026/> · U.S. Department of State, USD 112 million in bilateral assistance, 28 May 2026.
- [31] CIDRAP — Ebola cases near 900 as officials say less than 10% of donations have made it to affected nations, 18 June 2026 (Africa CDC press briefing; US CDC USD 107 million). <https://www.cidrap.umn.edu/ebola-ebola-cases-near-900-officials-say-less-10-donations-have-made-it-affected-nations>
- [32] The New Humanitarian — Ebola moving faster than the response, head of Africa CDC warns: interview with Dr Jean Kaseya, 9 July 2026. <https://www.thenewhumanitarian.org/interview/2026/07/09/ebola-moving-faster-response-head-africa-cdc-warns>

