



DRC — Ituri & Eastern Provinces

Ebola Disease Outbreak — Bundibugyo Strain, 2026

Epidemiological situation report, response analysis & risk assessment · Compiled 24 September 2026 [UPDATE EDITION — supersedes the 8 September 2026 edition] · national and provincial epidemiological data through 21 September 2026 (INSP/COUSP SitRep N°130), updated with WHO, ECDC, UN, Africa CDC and press reporting through 23–24 September

Primary sources: INSP/COUSP RDC — SitReps N°109 (31 Aug), N°114 (5 Sep), N°120 (11 Sep), N°125 (16 Sep) and N°130 (21 Sep; published 22 Sep) · WHO DON617 (10 Sep, data to 7 Sep), DON615/616 and Second IHR Emergency Committee report (18 Aug) · WHO Director-General (16 Sep) · ECDC (23 Sep) · UN News (21, 23 Sep) · Africa CDC (20 Sep) · Actualite.cd, Congo Quotidien, Studio Hirondelle, Radio Okapi, AP/ABC News (10–24 Sep press) · earlier editions' sources carried forward where unchanged (full list: Section 10).

7 773	3 759	63 / 167	839	~73 / day
Confirmed cases, DRC INSP SitRep N°130, 21 Sep	Confirmed deaths CFR 48.4 %	Health zones affected 7 provinces · 21 Sep	Patients in isolation 21 Sep · 1 935 recovered	New cases per day, 5–21 Sep (~86/day, 25 Aug–5 Sep)

KEY DEVELOPMENTS — SINCE THE 8 SEPTEMBER EDITION (6–24 SEPTEMBER 2026)

- ★ **The national curve has bent downward from a high plateau — slowly and unevenly.** Confirmed cases rose from 6 604 (5 Sep) to 7 773 (21 Sep): 1 169 new cases in 16 days, ~73/day, against ~86/day in the last edition's window. The slowdown is concentrated late: ~85/day (5–11 Sep), ~72/day (11–16 Sep), ~60/day (16–21 Sep); the 24-hour count on 21 Sep was 40. Deaths rose from 3 175 to 3 759 (+584), CFR 48.4 %. The 8 Sep edition's "re-accelerated" reading held only until about 11 Sep (Section 2.1).
- ★ **North Kivu is the rising front, and its treatment system is the weak point.** Confirmed cases went from 1 000 (5 Sep) to 1 438 (21 Sep), +44 % (663 on 19 Aug: more than doubled). WHO's 21-day comparison shows +73 % in North Kivu against –26 % in Ituri and –15 % in Haut-Uélé (UN News, 23 Sep). Katwa (544 cases, 344 deaths) is the epicentre; Beni (163 → 289, +77 %) is the fastest-growing zone; provincial CFR is 60.6 %; INSP reports no available beds in Butembo and Katwa. Daily increments have eased since the 5–11 Sep peak (~39 → ~24 → ~18/day), which this edition treats as unconfirmed (Section 2.3).
- ★ **A seventh province — Sud-Ubangi — through one imported case, about 1 200 km west of Bunia.** On 10 Sep the provincial governor declared Ebola after INRB confirmed a 23-year-old man who died on 5 Sep in Bulu health zone (Gwaka). Per the Health Minister he left Kamanyola (South Kivu) on 10 July, transited Rwanda and Uganda, re-entered DRC through Ituri and travelled by Kisangani and Lisala. No second case through 21 Sep; contact follow-up there is 65.5 %, the lowest of any province (Section 2.4).
- **South Kivu has now been quiet for 115 days; the southward-corridor risk has not materialised.** Three cases and one death, all in Miti-Murhesa; WHO dates the last case to 29 May (the last edition carried 24 May). Bukavu has no confirmed case. On the Beni–Goma road the southern frontier is Kayna (one case); Goma's single case dates from May. The "watch South Kivu" call is downgraded to a standing watch (Sections 2.3, 6.2b).
- **Vaccination has reached frontline workers.** DRC began vaccinating health and frontline workers with Ervebo in Bunia and Mongbwalu on 19 Sep (AP); WHO had reported 2 007 people vaccinated across six health zones in three provinces by 7 Sep. Of 70 000 doses allocated, 50 000 are for frontline and health workers and 20 000 for the trial (AP). Efficacy against Bundibugyo is unknown and WHO restricts use to research protocols (Section 5).
- ★ **The response-worker pay dispute has turned into a strike.** On 21–23 Sep community-engagement, communication and psychosocial staff and community relays in Beni stopped work over three to four months of arrears and barricaded health-zone offices; the Health Minister denies a funding shortage and cites "Ebola business" abuses. In Katwa, 16 health workers have been infected, three fatally (Sections 4.2, 7).
- **Contact tracing slipped after a strong run.** National follow-up was 84.5 % on 21 Sep (88.0 % on 31 Aug, 87.6 % on 16 Sep) with 31 612 contacts under follow-up. Haut-Uélé (81.4 %) and Bas-Uélé (89.6 %) improved sharply from 56.6 % and 59.5 % on 19 Aug, but no province reaches the 95 % threshold (Section 3.2).
- **Financing: first multilateral pledge since the 180-day plan.** At a US-convened G20+ ministerial (New York, 23 Sep) South Korea pledged USD 18 million; Africa CDC (20 Sep) asked for faster, transparent disbursement. No pledged or disbursed totals for the USD 1.3 billion national or USD 1.4 billion continental plan were located (Section 6.4).
- **A lake-shore front toward Uganda.** Kyavinyonge (Lake Edward, Kyondo zone) recorded its first confirmed death on 17 Sep, a man from Butembo; the Kasindi border post raised an alert on 21 Sep. Uganda's own outbreak remains closed (Section 6.1).



Assessment — trajectory. The epidemic is no longer accelerating. The national average fell from ~85/day to ~60/day across the three INSP windows since 5 September; laboratory positivity has roughly halved in Ituri (21.1 % → 11.0 %) and North Kivu (14.2 % → 7.2 %) between 19 Aug and 21 Sep, with national sample volume broadly unchanged (422 → 384; Ituri's own fell by about a third); and CFR has stayed inside 48.1–48.6 % for six consecutive cuts. Together these are more consistent with a genuine, slow decline in Ituri than with a surveillance dip. Three things keep it from being called a peak: WHO's reading on 23 Sep is that the outbreak "is still not under control"; North Kivu is rising on WHO's 21-day comparison with beds and staff saturated; and about half of the confirmed deaths recorded on 21 Sep (14 of 27) were community deaths. The geographic story of this edition is lateral rather than southward — a lake-shore case toward Uganda and a river-borne import 1 200 km to the west. This is an assessment by Pandemic Shield and not a position taken by any of the authorities cited.

1. Outbreak Overview (as of 21 September 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. Now about 130 days old. Unchanged since the last edition.
PHEIC status	Declared 17 May 2026 by the WHO Director-General under IHR Article 12; remains in force. The Second IHR Emergency Committee (met 18 Aug; report published 28 Aug) concluded that the epidemic continues to constitute a PHEIC but does not meet the criteria for a "pandemic emergency" (11 of 12 members); it estimated true infections at three to four times the reported count. No date for the next meeting was located. 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 now 52 times the size of the Uganda 2007–08 outbreak (149 cases) and 136 times Isiro, DRC 2012 (57 cases). 810 sequences from four countries were available on public platforms on 21 Sep (GenomicEpi).
Provinces affected	Seven: Ituri (epicentre), North Kivu, Haut-Uélé, Tshopo, South Kivu, Bas-Uélé and — new since 10 Sep — Sud-Ubangi. INSP now reports 63 of 167 health zones (37.7 %) ; 167 is the sum of the health zones in the seven affected provinces (the 151 used in earlier editions covered the first six). On the old basis the count is 62/151 (41.1 %), up from 61/151 on 5 Sep. Eight zones have had no new case for 42+ days; 55 are active.
Confirmed cases (DRC)	7 773 (21 Sep, INSP SitRep N°130, published 22 Sep); 6 604 at the last edition's 5 Sep cut-off (+1 169, +17.7 %). WHO DON617: 6 757 at 7 Sep. 24-hour increment on 21 Sep: 40 (Ituri 19, North Kivu 13, Haut-Uélé 5, Tshopo 3).
Confirmed deaths (DRC)	3 759 (21 Sep). National CFR 48.4 % (48.1 % on 5 Sep; 47.6 % on 19 Aug). 27 deaths in the 24 hours to 21 Sep: 14 community, 13 in facilities.
Recovered	1 935 cumulative (21 Sep, INSP); 1 798 on 16 Sep; 1 548 on 5 Sep. 33 discharged in the 24 hours to 21 Sep.
Patients in isolation	839 (21 Sep) — Ituri 432, North Kivu 338, Haut-Uélé 50, Tshopo 11, Bas-Uélé 8. 905 on 16 Sep (highest of the cuts reviewed); 851 on 5 Sep. Capacity detail in Section 4.1.
Frontline workers infected	No national figure newer than INSP SitRep N°082 (4 Aug): 154 confirmed (Ituri 140, North Kivu 14), 46 deaths. Press in 19–21 Aug cited ~160 infections and at least 45 deaths. New local datum: 16 health workers infected and 3 dead in Katwa health zone (Congo Quotidien, 15 Sep). WHO DON617 gave no health-worker count. Unreconciled data gap, carried forward.
Uganda	Outbreak closed. 20 cases, 2 deaths. Ministry of Health declared the outbreak over on 28 July; WHO-recognised closure followed in late August (WHO 26 Aug; ECDC dates it 25 Aug, Africa CDC 27 Aug). No reopening. Uganda's Lake Edward shore now faces the new Kyavinyonge case (Section 6.1).
Cases outside Africa	3 — unchanged. Two medical evacuations to Germany (Charité Berlin; Frankfurt University Hospital), both discharged with no secondary transmission; one humanitarian physician confirmed in France on 24 June, discharged 4 July. ECDC (23 Sep) confirms three recoveries and no new import.



Vaccine / treatment	None licensed specifically for BDBV. Ervebo (Zaire-strain, Merck): 2 007 people vaccinated by 7 Sep in six health zones of three provinces (WHO DON617); frontline and health-worker vaccination launched in Bunia and Mongbwalu on 19 Sep. PARTNERS therapeutic trial: over 300 confirmed cases enrolled across five facilities in Ituri (DON617). Detail in Section 5.
Comparator — 2018–2020 Kivu	Surpassed on 31 July 2026. At 7 773 confirmed cases the 2026 outbreak is 2.2 times the 2018–2020 Kivu epidemic's final total (3 481 including probable) and remains second only to the 2014–2016 West African epidemic (28 616 cases, 11 310 deaths) — 27 % of its case count.
Global risk assessment	WHO (DON617, 10 Sep): risk very high for DRC, high for bordering countries, low for the rest of the African Region and low globally. ECDC (23 Sep): likelihood of infection for people in the EU/EEA remains very low; the risk of importation is very low and modelling shows a minimal probability of multiple independent importations even in pessimistic scenarios.

2. Epidemiological Analysis — Provincial and Health Zone Distribution

Province	Confirmed cases	Deaths	CFR	Health zones affected	Change since 5 Sep
Ituri	5 966	2 737	45.9 %	28 / 36 (77.8 %)	+640 (+12.0 %)
North Kivu	1 438	872	60.6 %	16 / 34 (47.1 %)	+438 (+43.8 %)
Haut-Uélé	316	129	40.8 %	7 / 13 (53.8 %)	+67 (+26.9 %); 6 → 7 zones
Tshopo	42	15	35.7 %	7 / 23 (30.4 %)	+20 (+90.9 %)
Bas-Uélé	7	4	57.1 %	3 / 11 (27.3 %)	+3 (+75.0 %)
South Kivu	3	1	33.3 %	1 / 34 (2.9 %)	0 — no case since 29 May (115 d)
Sud-Ubangi (new)	1	1	100 %	1 / 16 (6.3 %)	+1 — imported, 10 Sep
Total (21 Sep)	7 773	3 759	48.4 %	63 / 167 (37.7 %)	+1 169 (+17.7 %)

Source: INSP/COUSP SitRep N°130 (21 Sep) and N°114 (5 Sep). Provincial figures sum exactly to the national totals in both reports (cases and deaths). Ituri's share of national cases fell from 80.6 % to 76.8 % over the period; North Kivu's rose from 15.1 % to 18.5 % and accounted for 37.5 % of the 1 169 new cases.

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.
26 Jul 2026	3 262	1 437	44.1 %	—	INSP SitRep N°072 series.
31 Jul 2026	3 532	1 556	44.1 %	54	Surpasses the 2018–2020 Kivu epidemic's total.
4 Aug 2026	3 973	1 801	45.3 %	110	INSP SitRep N°082.
9 Aug 2026	4 381	2 011	45.9 %	82	WHO AFRO Weekly External SitRep 13; confirmed deaths pass 2 000.
12 Aug 2026	4 665	2 184	46.8 %	95	WHO DON615 (published 14 Aug); Bas-Uélé becomes 6th province (13 Aug).
19 Aug 2026	5 290	2 516	47.6 %	89	INSP SitRep N°097 — 56/151 health zones.
25 Aug 2026	5 656	2 715	48.0 %	61	Reported 26 Aug (ECDC/Bloomberg); the 27 Aug edition's national cut-off.
31 Aug 2026	6 186	3 007	48.6 %	88	INSP SitRep N°109 (replaces the rounded press figure 6 100 / 2 950 used on 8 Sep).
5 Sep 2026	6 604	3 175	48.1 %	84	INSP SitRep N°114 — last edition's cut-off.
7 Sep 2026	6 757	3 267	48.3 %	77	WHO DON617 (published 10 Sep); 71 new cases in the 24 hours to 7 Sep.



Date	Confirmed cases	Confirmed deaths	CFR	New cases/day since prior row	Source / note
11 Sep 2026	7 113	3 437	48.3 %	89	INSP SitRep N°120. 7 000 crossed on 10 Sep (7 022 / 3 398).
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 (published 22 Sep); 40 new cases in the last 24 hours.

Interpretation. Over 5–21 September confirmed cases rose 17.7 % and confirmed deaths 18.4 %, at ~73 cases/day and ~37 deaths/day — slower than the ~86 cases/day and ~42 deaths/day of 25 Aug–5 Sep. The deceleration sits in the second half of the window (~85 → ~72 → ~60/day; deaths ~44 → ~34 → ~31/day), so the last edition's "re-accelerated, not plateaued" description was right for its window but did not persist beyond about 11 September. Two indicators favour a real decline: laboratory positivity fell by about half in Ituri and North Kivu with national testing volume broadly steady, and CFR did not rise — a collapse in the detection of living cases while deaths continued to be swabbed would push CFR up. Two cut the other way: national contact follow-up drifted down (85.7 % on 5 Sep → 84.5 %), and saturated North Kivu beds and unpaid workers could themselves suppress reporting. The fall is modest (~30 % from the early-September rate), rests on three windows, and WHO cautions it is too early to call a peak. CFR has now held between 48.1 and 48.6 % across six consecutive cuts (31 Aug 48.6, 5 Sep 48.1, 7 Sep 48.3 [WHO], 11 Sep 48.3, 16 Sep 48.2, 21 Sep 48.4 %), after climbing steadily from 44 % in July.

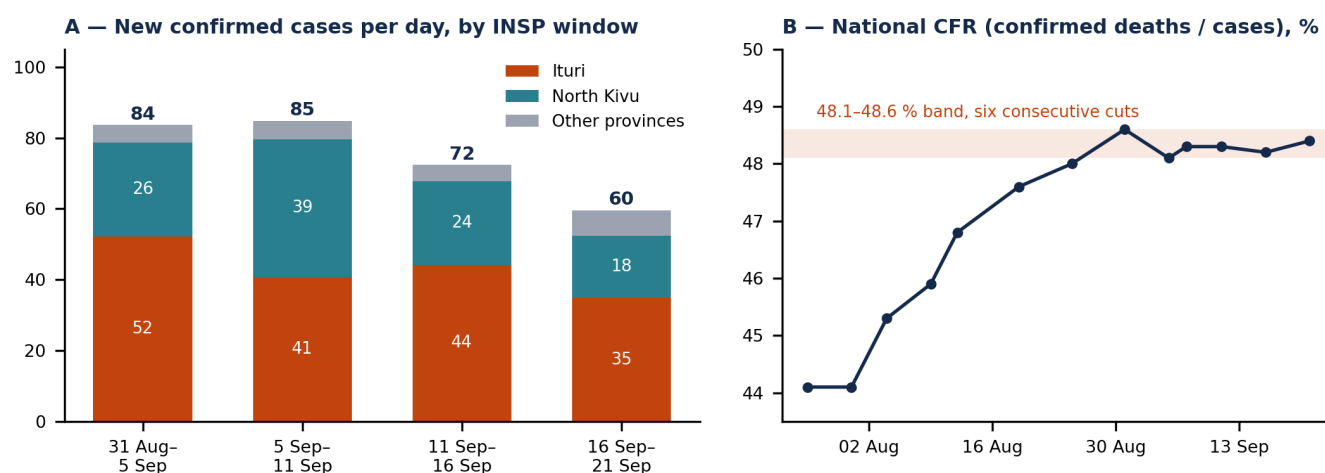


FIGURE 1 — Panel A: new confirmed cases per day between successive INSP SitReps, split into Ituri, North Kivu and all other provinces (computed from the cumulative provincial counts in SitReps N°109, 114, 120, 125 and 130; the windows are 5, 6, 5 and 5 days). North Kivu's rate falls from 39 to 18 per day after its 5–11 Sep peak; Ituri's is not monotone (41, 44, 35). Panel B: national CFR at each cut listed in the table above; the 7 Sep point is WHO DON617.



2.2 Geographic distribution of confirmed cases

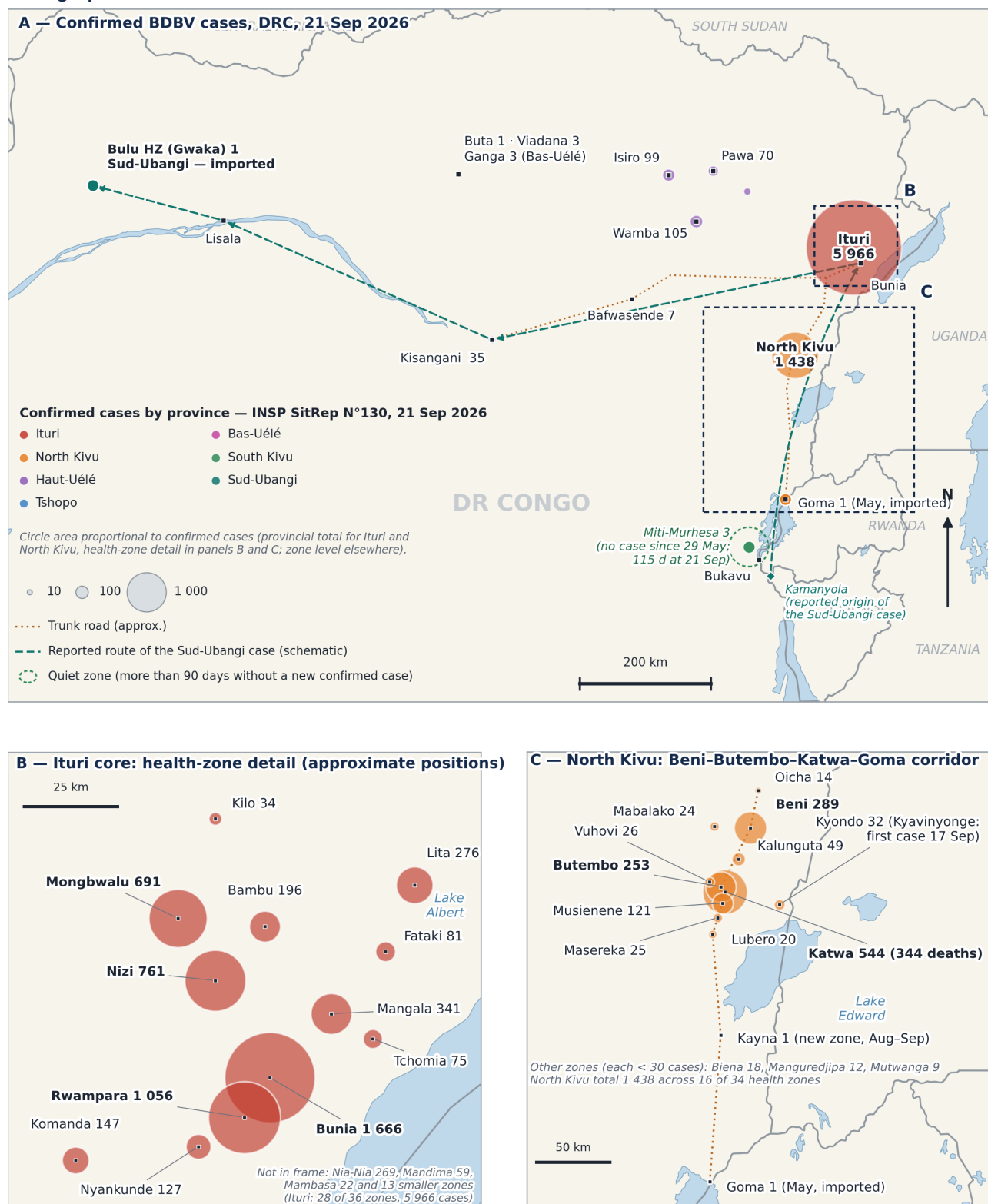


FIGURE 2 — Confirmed BDBV cases by province and health zone, DRC, 21 September 2026 (INSP/COUSP SitRep N°130). Panel A: national view — Ituri and North Kivu shown as province totals, other provinces by health zone; Panel B: Ituri core; Panel C: the Beni–Butembo–Katwa–Goma corridor and Lake Edward shore. Circle area is proportional to cumulative confirmed cases within each panel (scales differ between panels). Case counts are the SitRep’s health-zone figures, which sum exactly to the provincial totals. **Map construction:** country borders, lakes and coastlines are drawn from public-domain GSHHS/Natural-Earth-class vector data (Matplotlib Basemap); health-zone symbols are placed at each zone’s principal settlement using approximate coordinates and are **not survey-grade** (typically within 10–20 km, less certain for Mangala, Lita, Bambu and the Ituri detail, which is a schematic enlargement). The route of the Sud-Ubangi case is drawn as straight segments between reported waypoints, not as a surveyed path; roads are indicative. This edition’s map was not cross-checked against OpenStreetMap views, unlike the 8 September edition’s Figure 1 (map).



2.3 NORTH KIVU — THE LAGGING FRONT AND ITS SOUTHERN FRONTIER

The last edition's central addition was the corridor from Beni through Butembo and Katwa toward Goma and Bukavu. This edition tests it against 16 more days of INSP data: North Kivu did keep growing, faster in relative terms than Ituri or Haut-Uélé, but the frontier of confirmed cases has not moved south of Kayna, and the new geographic extensions have been lateral.

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
31 Aug 2026	868	589	67.9 %	15	17 (12 days)	INSP SitRep N°109
5 Sep 2026	1 000	659	65.9 %	16	26	INSP SitRep N°114
11 Sep 2026	1 232	774	62.8 %	16	39	INSP SitRep N°120
16 Sep 2026	1 350	828	61.3 %	16	24	INSP SitRep N°125
21 Sep 2026	1 438	872	60.6 %	16	18	INSP SitRep N°130

Health zone	5 Sep	21 Sep	Change	Deaths, 21 Sep	CFR
Katwa	445	544	+99 (+22 %)	344	63.2 %
Beni	163	289	+126 (+77 %)	204	70.6 %
Butembo	204	253	+49 (+24 %)	162	64.0 %
Musienene · Kalunguta · Kyondo	n/a	121 · 49 · 32	—	65 · 16 · 20	—
Vuhovi · Masereka · Mabalako · Lubero	n/a	26 · 25 · 24 · 20	—	7 · 9 · 11 · 10	—
Biena · Oicha · Manguredjipa · Mutwanga	n/a	18 · 14 · 12 · 9	—	7 · 11 · 4 · 2	—
Goma · Kayna	n/a	1 · 1	—	0 · 0	—

Source: INSP SitReps N°114 (5 Sep; zone counts for Katwa, Beni, Butembo) and N°130 (21 Sep). North Kivu's zone-level cases and deaths sum exactly to the provincial totals (1 438 / 872).

Katwa is still the epicentre, but Beni is now the fastest-growing zone. Katwa added 99 cases in 16 days (+22 %), Butembo 49 (+24 %) and Beni 126 (+77 %, from 163 to 289). Zone-level CFRs of 63–71 % in the three main zones — against 40–46 % in Ituri and Haut-Uélé — are more consistent with late presentation into saturated facilities than with a more lethal virus (an inference; no clinical series was located). The last edition's Katwa figure (393 cases, 284 deaths, from early September press) has become 544 and 344.

The southern frontier has stalled at Kayna. Kayna (WHO DON617's "newest" zone) and Goma each report a single case; Goma's single case is understood to be the May importation linked to a death in Bunia (Africanews, 18 May); INSP lists no new Goma case. Lubero has 20 cases, Vuhovi 26, Masereka 25. There are no confirmed cases in Bukavu. South Kivu's own count is unchanged at three cases and one death in Miti-Murhesa; WHO dates the last case to 29 May, so the zone has now gone 115 days without a new confirmed case (the last edition carried 24 May and counted 79–92 days — the difference is the start date, not new information).

What moved instead is lateral. On 17 Sep a man over 40 from Butembo died at Kyavinyonge, a fishing settlement on Lake Edward in Kyondo health zone, the first case in that community; Kyondo now has 32 cases and 20 deaths and Oicha 14 and 11. Kyavinyonge is a crossing point toward Uganda (Actualite.cd, 18 Sep), and INSP logged a living alert at Kasindi point of entry on 21 Sep. The other extension — Sud-Ubangi — arrived by river from the east (Section 2.4). Neither is a southward step, and neither implies transmission chains toward South Kivu. The previously flagged displacement of families from the AFC/M23 conflict toward Walikale inside North Kivu is carried forward without a refresh.

Assessment — the corridor. The 8 Sep edition treated the Beni–Butembo–Katwa–Goma–Bukavu road as one epidemiological unit and named South Kivu as the province to watch. Sixteen days later the evidence supports the first half and not the second: the corridor's northern and middle segments grew strongly (North Kivu +44 %, Beni +77 %), but no confirmed case has appeared in South Kivu, Bukavu or Goma since May, and the frontier sits at Kayna. South Kivu's geography — Rwanda, Burundi and Lake Tanganyika — is unchanged, which is why it remains a standing watch item; but with 115 quiet days the responsible framing is now a low-probability, high-consequence risk rather than the edition's most consequential story. What would upgrade it: a new confirmed case in Miti-Murhesa, Bukavu, Goma or any zone south of Kayna. What has become more consequential is North Kivu's capacity: the province is carrying 18.5 % of the outbreak's cases with the weakest response infrastructure. This is an assessment by Pandemic Shield.



2.4 SUD-UBANGI — THE SEVENTH PROVINCE AND THE RIVER CORRIDOR

On 10 September the interim governor of Sud-Ubangi, Jean-René Galekwa Vundake, declared Ebola in the province after INRB confirmed Bundibugyo virus in a sample from Bulu health zone (locality Gwaka, Budjala territory, north-western DRC near the Central African Republic border). The province had never before reported a case in this outbreak; it appears in INSP reporting from 10 Sep (Actualite.cd) and in SitReps N°120, N°125 and N°130 with one case and one death.

Date (2026)	Reported movement of the index patient (23-year-old man)	Source
10 Jul	Leaves Kamanyola, South Kivu.	Health Minister Kamba via Actualite.cd, 14 Sep
Mid-Jul	Transits Rwanda, then Uganda.	same
Late Jul–early Aug	Re-enters DRC through Ituri; passes through Bunia, then Kisangani (Tshopo) and Lisala (Mongala).	same; Studio Hironnelle, 10–11 Sep
Before 3 Sep	Symptoms begin on a boat from Lisala; arrives in South Ubangi on 3 Sep; admitted to a health centre.	same
5 Sep	Dies at the Miluna health centre, Gwaka; INRB (Kinshasa) confirms Ebola Bundibugyo.	Actualite.cd, 11 Sep
10 Sep	Governor declares the outbreak in Sud-Ubangi; 38 contacts identified per Studio Hironnelle.	Studio Hironnelle

The Health Minister's own framing is "an imported case — it is not a case of South Ubangi". By 21 Sep, 11 days after the announcement, INSP listed no second case; contact follow-up in Sud-Ubangi was 65.5 % (36 of 55), the lowest of any province. The 21-day observation window for contacts exposed up to the patient's death on 5 September closes on about 26 September (Pandemic Shield calculation). Kisangani launched a "Fleuve Congo sans Ebola" traveller-awareness project on 16 Sep (Radio Okapi).

What the itinerary does and does not say. The route begins in South Kivu, which might suggest a link to that province's outbreak; but Miti-Murhesa's last case was on 29 May, six weeks before the patient left Kamanyola, and he then spent weeks in Uganda and Ituri. On the reported dates, exposure in Ituri or on the Bunia–Kisangani road is the more plausible source (Pandemic Shield inference; no sequencing or exposure history has been published). What the case does show is that an infected traveller can complete a journey of well over 1 000 km by road and river through Ituri, Tshopo, Mongala and Sud-Ubangi before being recognised — symptoms began only on the final boat leg — so screening at points of departure, not only at destination, matters, and the river network from Kisangani to the Ubangi is a real exposure pathway for the west of the country.

3. Surveillance, Laboratory and Points of Entry

3.1 Alert management and laboratory throughput (24 hours to 21 September 2026, national)

Indicator	National, 21 Sep (INSP N°130)	National, 19 Aug (previous edition)
Total alerts received	1 898	1 904
Alerts verified	1 872 (98.6 %)	1 752 (92.0 %)
Suspect cases validated	359 (19.2 % of verified)	366 (20.9 % of verified)*
Investigated within 24 h	355 (98.9 % of validated)	327 (89.3 % of validated)
Referred to treatment centres	212	185

Province	New positive results	Samples analysed	Positivity, 21 Sep	Positivity, 19 Aug
Ituri	19	172	11.0 %	21.1 % (56 / 265)
North Kivu	13	180	7.2 %	14.2 % (18 / 127)*
Haut-Uélé	5	27	18.5 %	23.3 % (7 / 30)
Tshopo · Bas-Uélé	3 · 0	4 · 1	small numbers	—
National	40	384	10.4 %	19.2 % (81 / 422)

*The 8 Sep edition printed 15.0 % for North Kivu on 19 Aug (18 positives in 127 samples is 14.2 %) and 23.8 % for validated suspects as a share of verified alerts (366 of 1 752 is 20.9 %); the recomputed figures are used here. 19 Aug figures are from INSP SitRep N°097; only three provinces reported laboratory data that day.



Positivity has roughly halved since the last edition's cut (national 19.2 % → 10.4 %; Ituri 21.1 % → 11.0 %; North Kivu 14.2 % → 7.2 %) while total samples analysed stayed close (422 → 384). North Kivu's 7.2 % is now inside the 5–10 % range associated with adequately broad testing; Haut-Uélé's 18.5 % (on 27 samples) and Ituri's 11.0 % are not yet, so the last edition's caveat about confirmation lag has narrowed rather than disappeared. Ituri's daily sample count fell by about a third (265 → 172) — consistent with fewer suspects presenting, but also a reminder that positivity is a ratio and that a partial testing pull-back would flatter it. Another lens is timing of detection: community deaths were 14 of 27 confirmed deaths on 21 Sep (52 %), down from 64 % (16 Sep), 82 % (11 Sep) and 75 % (31 Aug); WHO's Regional Emergency Director said on 23 Sep that one in three new infections is still identified only after death in the community.

3.2 Contact tracing (national)

Province	Contacts under follow-up	Contacts seen	Follow-up rate, 21 Sep	Rate, 19 Aug
Ituri	17 438	14 915	85.5 %	87.6 %
North Kivu	13 119	10 915	83.2 %	80.5 %
Haut-Uélé	457	372	81.4 %	56.6 %
Tshopo	332	280	84.3 %	100 %
Bas-Uélé	211	189	89.6 %	59.5 %
Sud-Ubangi	55	36	65.5 %	—
National	31 612	26 707	84.5 %	82.9 %

The last edition's open item — whether Haut-Uélé and Bas-Uélé had closed their gap to the 95 % operational threshold — has a partial answer: Haut-Uélé rose 24.8 points and Bas-Uélé 30.1 points, but neither, nor any other province, is at 95 %. The national rate has moved 88.0 % (31 Aug) → 85.7 % (5 Sep) → 87.5 % (11 Sep) → 87.6 % (16 Sep) → 84.5 % (21 Sep) while the contact caseload grew by 60 % since 19 Aug (19 720 → 31 612), so the recent dip is at least partly a workload effect. Sud-Ubangi's 65.5 % (36 of 55) is the weakest figure nationally and sits in the province with the only recent new introduction. South Kivu does not appear in INSP's contact table.

3.3 Points of entry and control (24 hours to 21 September 2026, national)

Facilities operational	100 % of strategic points of entry / control functional in all reporting provinces (98.7 % on 19 Aug). Report completeness 88.6 % (93 of 105 reports).
Travellers screened	269 518 persons (21 Sep indicator; 313 381 on 19 Aug); 97.8 % hand-hygiene compliance (98.7 % on 19 Aug); community sensitisation 99.0 %.
Alerts at points of entry	3 living alerts notified in 24 h: Ituri 1 (Foner, Mambasa point of control — transfer refused); North Kivu 2 (Kasindi point of entry and Maboya point of control — both transferred). Kasindi is a Uganda border crossing.
Bas-Uélé / South Sudan crossings	Bas-Uélé now has 7 confirmed cases (Buta 1, Viadana 3, Ganga 3; 3 of 11 zones) with 89.6 % contact follow-up, but no province-level point-of-entry detail was located for the South Sudan crossings and no cross-border case has been reported. Unchanged operational gap.

4. Case Management, Burials and the Frontline Workforce

4.1 Treatment capacity (INSP SitRep N°130, 21 September 2026)

Indicator	Ituri	North Kivu	Haut-Uélé	Tshopo	Bas-Uélé	National
Beds	1 015	308*	138	31	—	1 492 (sum)
Hospitalised (isolation)	432	338	50	11	8	839
Admissions (24 h)	92	92	11	3	2 (suspects)	200 (incl. 2 suspects)
Occupancy, 21 Sep	42.6 %	unreconciled*	36.2 %	35.5 %	n/a (non-standard site)	n/a
Occupancy, 19 Aug (previous)	57.1 %	95.1 %	44.6 %	41.7 %	100 %	61.9 %



*North Kivu: INSP reports 338 hospitalised, of whom 274 in standard structures (308 beds) and 64 (18.9 %) in non-standard facilities, and prints an occupancy of 66.2 %; that figure does not reconcile with 274/308 (89 %) or 338/308 (110 %), and the same report also cites 34.2 % of patients outside standard structures. It is therefore not used here. The bed total sums the provinces reporting beds; UN News (23 Sep) cites 49 Ebola treatment centres with about 1 400 beds and 25 laboratories able to run 2 500 tests a day.

Ituri's province-wide occupancy has eased steadily (55.1 % on 31 Aug, 52.1 % on 5 Sep, 43.5 % on 16 Sep, 42.6 % on 21 Sep), consistent with its falling incidence. North Kivu tells the opposite story: 128.6 % (31 Aug), 115.0 % (5 Sep), 141.4 % (10 Sep), 139.0 % (11 Sep) and 96.9 % (16 Sep, on a larger reported bed count), with INSP's 21 Sep text still stating "no beds available in Butembo and Katwa". New treatment centres have opened (CTE Matanda in Katwa; CTE ITAV in Butembo handed over), but WHO's Regional Emergency Director cited a shortage of staff and partners to run expanded facilities, particularly in remote villages. Local saturation reported in early August in Ituri (Nizi ETC 278 %, Fataki 200 %, ISTM-Nyakunde 123 %, CME-Bunia 104 %; Nature Medicine correspondence) has not been refreshed.

4.2 Frontline workers infected

Province / zone	Confirmed	Deaths	CFR	Source
Ituri	140	43	30.7 %	INSP SitRep N°082, 4 Aug
North Kivu	14	3	21.4 %	INSP SitRep N°082, 4 Aug
Total (INSP, 4 Aug)	154	46	29.9 %	Most recent official national figure located
Katwa health zone (local)	16	3	18.8 %	Congo Quotidien, 15 Sep; Katwa chief medical officer

No newer national health-worker figure was located; the 19–21 August press estimate (~160 infected, at least 45 dead) remains unreconciled against any INSP series, and WHO DON617 gave none. The Katwa report adds that health workers are typically infected before a diagnosis is made — "consider every patient a suspect during an epidemic", in the chief medical officer's words — and that the zone's only neurosurgeon died on 10 August; four of its infected workers had recovered by 9 September. Alongside infections, the workforce is now striking: response-community staff in Beni have stopped work over three to four months of arrears (21–23 Sep, Actualite.cd).

Assessment — workforce. The pay dispute the last two editions flagged as the most tractable constraint has moved from threat to action, and it has moved in the province with the least spare capacity. The Health Minister's public position (23 Sep) is that funding is not short and that abuses of "Ebola business" allowances are the problem, with pay harmonisation to follow in a supplementary budget; strikers in Beni describe unpaid allowances of up to four months. Both can be true, and neither is verifiable from the sources located: no disbursement against the dispute has been documented. Pandemic Shield's reading is that unpaid community relays and communication staff matter for exactly the indicators that have just improved — contact follow-up, community-death share, safe burials — so a sustained strike in North Kivu would be expected to show first in those figures, not in the case count. This is an assessment by Pandemic Shield.

5. Medical Countermeasures — Frontline Vaccination Has Begun

The defining change since the last edition is operational rather than evidentiary: Ervebo has moved from arrival in DRC to administration to frontline and health workers, and it did so on 19 September under a research framing rather than as a proven countermeasure. No new efficacy or cross-protection result was located, so the diligence conclusions of the earlier editions (Section D references) are carried forward unchanged.

Trial / programme	Product(s)	Opened	Design and status
PARTNERS (therapeutic)	MBP134 monoclonal antibody; remdesivir; the combination	2 July 2026	Platform adaptive randomised trial sponsored by WHO with INRB (Kinshasa), the Institute of Tropical Medicine Antwerp, the University of Oxford and ALIMA. Over 300 confirmed cases enrolled across five facilities in Ituri as of 7 Sep (WHO DON617), up from over 100 across three facilities at 14 Aug. No efficacy result located.
BD-Ebov (vaccine, Phase I)	ChAdOx1 BDBV — chimpanzee adenovirus vector encoding the BDBV glycoprotein	13 July 2026 (first dose 24 July)	World's first Phase I trial of a Bundibugyo-specific vaccine, run by the Oxford Vaccine Group and Pandemic Sciences Institute with CEPI support; 50 healthy adults in Oxford. No update located since the last edition.



Trial / programme	Product(s)	Opened	Design and status
Moderna mRNA (vaccine, Phase 1) — <i>new row</i>	mRNA-LNP candidate against BDBV	Early Aug 2026	First-in-human Phase 1 announced with CEPI backing in the first week of August (press 4–5 Aug); listed here for completeness — no data and no DRC site were located. Other candidates (IAVI and Public Health Vaccines rVSV constructs) were in manufacturing/preparation at the last tracker update (IPPS, 31 Jul).
EBO-PEP (prophylaxis)	Obeldesivir — oral antiviral (Gilead)	14 July 2026	Post-exposure prophylaxis trial led by ANRS Emerging Infectious Diseases and INRB with ALIMA and MSF field support and Africa CDC backing; ~1 000 high-risk contacts targeted, with a remdesivir sub-protocol for children and pregnant or breastfeeding women. No enrolment update located; national contact follow-up is 84.5 % (Section 3.2).
Ervebo cross-protection trial and frontline campaign	Ervebo — rVSV-ZEBOV (Merck), licensed against Zaire ebolavirus	TAG-CVP recommendation 31 Jul; 70 000 doses allocated 18 Aug; frontline vaccination launched 19 Sep	70 000 doses: 20 000 for the Phase 3 cross-protection trial and 50 000 for frontline and health-worker protection (AP, 20 Sep). More than 16 000 doses had arrived by 22 Aug. WHO DON617: 2 007 people vaccinated in six health zones of three provinces (Tshopo, Bas-Uélé, Ituri) by 7 Sep. WHO's emergency guidance (1 Sep) supports use only within research protocols, not programmatic use. Launch at Bunia and Mongbwalu on 19 Sep (AP). Sources differ on how the doses and the campaign are split between trial and non-trial use; WHO's Director-General said on 16 Sep that vaccine trials "should begin in the coming weeks".

Assessment — countermeasures. Two points change since the last edition. First, the hedge is now reaching arms: vaccination of the people most exposed — and most often infected — has begun in Ituri, which is where the outbreak is easing, while North Kivu, where incidence is rising and 16 health workers have been infected in Katwa alone, is only named as a later expansion site in one press account and not confirmed by any source read here. Second, the evidence position is unchanged: Ervebo protects against Zaire ebolavirus, cross-reactive antibody data for Bundibugyo are partial, and WHO advises research-only use. The practical risk to guard against is behavioural — a vaccinated responder treated as protected — so infection prevention and control discipline (PPE, triage, screening) should not be relaxed on the strength of a campaign whose effect on infection is not yet measurable. The demographic that carries the worst outcomes is not obviously covered: UN News (21 Sep) reports that a quarter of confirmed cases are children, they account for about a third of deaths, and case fatality exceeds 60 % in under-fives; the only paediatric-specific element located is the EBO-PEP remdesivir sub-protocol. Classical containment — isolation, contact tracing, safe burials and community engagement — remains the only proven tool. This is an assessment by Pandemic Shield.

6. Regional and International Situation

6.1 Uganda — outbreak closed; a new lake-shore interface

Uganda's status is unchanged: 20 confirmed cases, 2 deaths, all epidemiologically linked to travel from DRC; the Ministry of Health declared its outbreak over on 28 July and closure was recognised in late August (dates vary by source: WHO 26 Aug, ECDC 25 Aug, Africa CDC 27 Aug), with no reopening. What is new is on the DRC side of the border: the Kyavinyonge death on Lake Edward (17 Sep), the Kyondo and Oicha case counts (32 and 14) and a living-alert at the Kasindi point of entry on 21 Sep put North Kivu's outbreak on the DRC–Uganda lake and road interface. No Uganda alert or suspected case was located in the sources reviewed. Uganda's support to treatment capacity at two sites inside DRC, the 22 border crossing points and the mobile laboratory at Bwera Hospital referenced in earlier editions were not updated.

6.2 Bas-Uélé and the South Sudan question

Bas-Uélé now has 7 confirmed cases and 4 deaths in three health zones (Buta 1, Viadana 3, Ganga 3), up from 4 cases on 5 Sep; contact follow-up is 89.6 %. The Buta case of 13 August remains DRC's most consequential northern development, an estimated 35 km from the South Sudan border along high-risk travel corridors (Mercy Corps). No cross-border case has been reported and no province-level point-of-entry detail for the South Sudan crossings was located (Section 3.3). WHO rates the risk for bordering countries as high.



6.2b South Kivu and the Great Lakes borders — quiet, but geography unchanged

South Kivu remains the only affected province bordering more than one country: Rwanda and Burundi directly, with Tanzania a short crossing of Lake Tanganyika from Uvira. Its case count has not moved since May (3 cases, 1 death; 115 days without a new case at 21 Sep) and Bukavu has none. The ten-country regional alert that Africa CDC issued in May when South Kivu's first case was confirmed was not updated in any source located. The one South Kivu link in this edition is historical: the Sud-Ubangi index patient departed Kamanyola on 10 July (Section 2.4), which on the reported dates points to exposure elsewhere. The last edition gave this geography more weight than the province's own count suggests; with sixteen further days without a case, that weighting is reduced.

6.2c Sud-Ubangi and the north-west

Sud-Ubangi lies in north-western DRC and borders the Central African Republic. No cross-border information, and no suspected case there or in neighbouring provinces along the Kisangani–Lisala route, was located; Tshopo, through which the patient passed, has 42 confirmed cases in seven zones (35 in Kisangani's six urban zones, 7 in Bafwasende). WHO's Director-General named Kisangani (1.5 million inhabitants) among the major cities at risk on 16 Sep.

6.3 Cases outside Africa and the European dimension

Unchanged since the last edition. The three cases managed outside Africa remain the total: two deliberate medical evacuations to Germany (Charité Berlin; Frankfurt University Hospital) and one unrecognised importation, a humanitarian physician confirmed in France on 24 June and discharged 4 July. All three have recovered with no secondary transmission, and no new imported case outside Africa was reported in any source reviewed. ECDC (23 Sep): "The risk of importation into the EU/EEA from the outbreak area remains very low"; its modelling indicates that even in pessimistic scenarios the probability of multiple independent importations is minimal.

6.4 Financing — three uncertainties still open, one new signal

The 4 September launch of the USD 1.3 billion, 180-day national plan is now followed by the first multilateral pledging moment the sources show: a G20+ foreign-ministers' meeting on Ebola in New York on 23 September, convened by the United States, at which South Korea pledged USD 18 million (Seoul Economic Daily, 24 Sep). Africa CDC (20 Sep) welcomed the meeting and pressed for "faster, transparent and accountable delivery", a village-centred response and tracking of disbursements through its Financial Tracking Mechanism; WHO's Director-General told donors on 16 Sep that "to slow this epidemic, and to stop it, we need resources" and urged full funding of the government response and humanitarian plans. No aggregate of pledges from the New York meeting was located, and the three uncertainties of the last edition are unchanged in kind: whether the national plan is additive to or a restatement of Africa CDC's USD 1.4 billion continental requirement; whether the ~USD 910 million pledged and ~13 % disbursed at the continental level (June data) has moved; and whether the national plan has attracted any funding at all.

Instrument	Period	Requirement	Funding status (24 Sep)
Africa CDC continental strategic plan (revised)	Jun–Dec 2026	USD 1.4 bn	~USD 910 m pledged (17 Jun) and ~13 % disbursed (~USD 118 m, 25 Jun) remain the latest figures located; they are now 13–14 weeks old and neither reconfirmed nor updated in any source — stale reference points, not current status. Requirement had risen from USD 518 m in early June (CIDRAP, 25 Jun).
DRC national 180-day response plan	4 Sep 2026 – ~Mar 2027	USD 1.3 bn	Launched 4 Sep with WHO AFRO and Africa CDC support. No pledge or disbursement figure located. Health Minister Kamba denied a funding shortage on 23 Sep while response workers in Beni report 3–4 months of arrears.
G20+ ministerial on Ebola, New York — <i>new</i>	23 Sep 2026	—	South Korea: USD 18 m (about KRW 25 bn). No other pledge and no total located. Follows a G7 leaders' declaration in June (Seoul Economic Daily).
Private-sector contribution	Early Sep 2026	USD 1 m (reported)	Chinese mining companies operating in DRC reportedly contributed USD 1 million (Actualite.cd, 8 Sep) — carried forward.

Assessment — financing. *The financing picture is better described as less opaque than better funded. There is now a named forum, a named pledge and a named tracking mechanism, but not one aggregate number for either plan, and the ministerial's own message from Africa CDC is a call for transparency — which is itself informative. Pandemic Shield keeps the last edition's discipline: adding the two plans (USD 2.7 billion) is meaningful only if they are additive; the June pledge and disbursement figures cannot be treated as current; and "underfunded" cannot be asserted for the national plan without a documented funding figure. The workforce dispute (Section 4.2) is the point where the funding question becomes operational: whether payment lines exist on paper and reach workers is testable in the next INSP series. This is an assessment by Pandemic Shield.*



6.5 Coordination architecture

Coordination continues on the "one plan, one budget, one team" model run by the DRC Public Health Emergency Operations Centre (COUSP) within INSP. Framing of the epidemic has diverged: on 11 September the response team and INRB's Prof. Placide Mbala Kingebeni described the epidemic as under control and past its peak (Radio Okapi; Studio Hironde); on 15 September WHO's Olivier le Polain said it was too early to be certain the peak has passed and the UN's Julien Harneis that the situation is "mixed — early signs of decline in some zones, exponential increase in others"; and on 23 September WHO's Dr Marie Roseline Belizaire said the outbreak "is still not under control". The data in this edition sit closest to the middle view.

7. Principal Constraints — National Response Assessment

The table updates the constraints table carried in the last two editions. Ordering by assessed impact on transmission dynamics is Pandemic Shield's own; the constraints and required actions draw on INSP's SitRep series where cited, supplemented by the press and agency sources identified against each row.

Constraint	Impact	Required action / status
North Kivu's surge meeting saturated care	Cases +44 % in 16 days (1 000 → 1 438); +73 % on WHO's 21-day comparison; Katwa 544 and Beni 289 (+77 %); provincial CFR 60.6 %; INSP: no beds in Butembo and Katwa; 64 patients in non-standard facilities; bed-occupancy reporting unreconciled.	Staff and equip the new Katwa (Matanda) and Butembo (ITAV) centres; pre-position isolation capacity around Beni; publish reconciled facility-level bed availability — carried forward and made more urgent.
Health-worker and response-worker non-payment, now a strike	Beni strike 21–23 Sep over 3–4 months of arrears, with barricades at health-zone offices; 16 health workers infected in Katwa (3 dead); Health Minister denies a funding shortage; no documented disbursement since the declaration.	Regularise payments through a dedicated, ring-fenced line and publish the schedule; verify against the next INSP series (contact follow-up, community-death share, safe burials).
Late detection and community deaths	14 of 27 confirmed deaths on 21 Sep were community deaths (52 %; 64 % on 16 Sep, 82 % on 11 Sep); WHO: one in three new infections identified only after death; new infections without known epidemiological links.	Community engagement, safe and dignified burials, and decentralised testing so that suspects are found alive; track the community-death share as a headline indicator — new this edition.
Contact tracing below threshold	84.5 % nationally against a 95 % threshold; North Kivu 83.2 %, Haut-Uélé 81.4 %, Sud-Ubangi 65.5 %; contact caseload up 60 % since 19 Aug (31 612).	Add community-relay (RECO) capacity in North Kivu and Haut-Uélé; complete Sud-Ubangi's contact list before ~26 Sep.
River and lake mobility	Sud-Ubangi index case travelled well over 1 000 km by road and river; Kyavinyonge (Lake Edward) is a crossing toward Uganda; Kasindi alert on 21 Sep; Kisangani (1.5 million) sits on the river route.	Exit screening at river ports and lake landing sites ("Fleuve Congo sans Ebola" started at Kisangani on 16 Sep); cross-border coordination on the Lake Edward and Kasindi axis — new this edition.
Geographic extension outpacing preparedness	Seven provinces, 63 zones; the northern front (Bas-Uélé, 7 cases, ~35 km from South Sudan) and the western river front both lack point-of-entry detail.	Extend priority screening and cross-border coordination to the South Sudan crossings and the river system; carried forward, now three-front.
Decentralised diagnostics still incomplete	Positivity 18.5 % in Haut-Uélé and 11.0 % in Ituri (7.2 % in North Kivu) indicates residual confirmation lag; Tshopo and Bas-Uélé test very few samples (4 and 1 on 21 Sep).	Accelerate decentralised diagnostic capacity, particularly in Haut-Uélé and the western provinces — unchanged.
Insecurity, restricted access and displacement	Pattern of attacks and access problems carried forward; WHO's Director-General (16 Sep) cites impassable roads, aircraft access difficulties, security threats to aid workers and attacks on health facilities. The AFC/M23-linked displacement toward Walikale was not refreshed.	Reinforce security coordination; plan explicitly for displacement-driven movement inside the North Kivu outbreak zone — unchanged.
Vaccine expectations and equity — new	Frontline vaccination began 19 Sep under a research framing; efficacy unknown; sources differ on trial versus non-trial split; children (25 % of cases, ~33 % of deaths) not clearly covered.	Communicate clearly that vaccinated staff remain at risk and keep infection prevention discipline; publish the allocation split and coverage.



Constraint	Impact	Required action / status
True burden likely understated	The IHR Emergency Committee estimated true infections at three to four times reported; Africa CDC officials cite only 30–40 % of infections detected. Applied to 7 773 confirmed cases: roughly 19 400–25 900 (30–40 % detection) or 23 300–31 100 (3–4 times) — Pandemic Shield extrapolation.	No specific action tabulated; a standing analytical caveat on every count in this report.
Political prioritisation of the response	Carried forward from 8 Sep: opposition figure Marie-Angé Mushobekwa accused the government of prioritising constitutional revision over the response. No new domestic political criticism was located; the Health Minister's 23 Sep statements on "Ebola business" allowances are a separate governance signal.	Flagged as an emerging governance risk to watch; no COUSP or WHO response to the criticism located.
Continuity of essential health services	No new data located; carried forward as an unresolved indirect-mortality risk.	Implement fee exemption effectively; reinforce essential-service continuity — unchanged.

8. What Is Established and What Remains Unresolved (21 September 2026)

✓ Established	? Unresolved or contested
7 773 confirmed cases and 3 759 confirmed deaths across seven provinces and 63 health zones at 21 Sep; national average fell from ~85/day to ~72 and ~60/day across the last three INSP windows.	Whether this is a durable peak-and-decline or a dip driven by saturation, strikes or testing patterns — WHO ("too early"; "not under control") and the response team ("under control") disagree.
North Kivu 1 000 → 1 438 (+44 %) since 5 Sep, +73 % on WHO's 21-day comparison; Katwa 544 and Beni 289 (+77 %); no beds in Butembo and Katwa.	Whether North Kivu's easing daily increments since 11 Sep (~39 → ~24 → ~18/day) are real; what North Kivu's true bed occupancy is.
South Kivu: 3 cases, none since 29 May (115 days at 21 Sep); no confirmed case in Bukavu; the southern frontier of the Beni–Goma corridor is Kayna (1 case).	Whether the Bukavu/Ibanda precautionary posture reflects a specific signal; whether Kayna seeds chains toward Goma.
Sud-Ubangi: one imported case (died 5 Sep, Bulu), no second case at 21 Sep; contact follow-up 65.5 %.	Whether any of the 38 identified contacts and boat travellers develop disease before the ~26 Sep window closes; where the patient was infected (no sequencing or exposure history published).
Frontline vaccination with Ervebo began 19 Sep in Bunia and Mongwalu; 2 007 people had been vaccinated by 7 Sep; 70 000 doses allocated.	Efficacy against Bundibugyo; how doses are split between trial and non-trial use (sources differ); whether infections in vaccinated responders will be reported.
Lake Edward: Kyavinyonge case on 17 Sep; Kasindi point-of-entry alert on 21 Sep; Uganda's outbreak closed.	Whether the lake front generates cross-border cases.
A G20+ ministerial on Ebola met in New York on 23 Sep; South Korea pledged USD 18 million; the USD 1.3 billion national plan launched 4 Sep.	Totals pledged or disbursed for either the national or the continental plan; whether the two are additive.
National CFR has held at 48.1–48.6 % across six consecutive cuts; community deaths fell from 82 % (11 Sep) to 52 % (21 Sep) of daily confirmed deaths.	Whether a stable-high CFR reflects late detection or is a genuine plateau; whether the falling community-death share persists through the Beni strike.
Response workers in Beni struck from 21 Sep over 3–4 months of arrears; 16 health workers infected in Katwa.	Whether the strike spreads beyond Beni; whether payments resume; the current national health-worker infection count.

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.

- ★ **Ituri has probably passed its peak; North Kivu will set the tail.** Ituri's increments fell from ~52/day (31 Aug–5 Sep) to ~35/day (16–21 Sep), its bed occupancy is 42.6 % and its positivity 11 %. North Kivu carries 18.5 % of cases with 60.6 % CFR and unreconciled capacity. Test: whether North Kivu's five-day increments stay below ~25/day in the next INSP cuts.
- ★ **The decline is real enough to plan on, not to relax on.** WHO's own language remains "not under control", about half of confirmed deaths are still community deaths, and the national rate (~60/day) is still above the ~54/day of late July (26–31 Jul). Test: whether the seven-day average keeps falling through early October.
- **Sud-Ubangi is a test of whether the river route is an isolated import or a template.** A quiet ~26 September would support the former; a second case in Bulu, or any case along Kisangani–Lisala, would turn the river network into a fourth front.



- **South Kivu moves from headline item to standing watch.** Its geography argues for vigilance, its 115 quiet days against the last edition's alarm. What would upgrade it again: a confirmed case in Miti-Murhesa, Bukavu, Goma or south of Kayna.
- ★ **The lake-shore and Uganda interface is the most under-observed border.** Kyondo, Oicha, Kyavinyonge and Kasindi form a cluster of signals in one week, against a Uganda that has declared itself outbreak-free.
- **Vaccination will not show up in the numbers soon.** The first operational read-out to look for is coverage and delivery in Ituri, then whether North Kivu is added as a site; effect on infection among vaccinated responders will lag by weeks. Infection-control discipline should not be traded for it.
- **Financing is now trackable.** The G20+ meeting and Africa CDC's tracking mechanism make it possible, for the first time, to test whether pledges reach payment lines — watch for a pledged total and for the Beni strike's resolution.
- **For a purely illustrative sense of pace** — not a forecast — holding the most recent five-day pace (~60/day) constant gives 8 000 confirmed cases about 25 Sep and 8 500 about 3 Oct; the 16-day average (~73/day) gives 8 000 about 24 Sep and 8 500 about 1 Oct. **Correction:** the 8 Sep edition's equivalent illustration (7 000 "around 16–17 September") was an arithmetic slip — 396 further cases at ~84–86/day take 4–5 days from 5 Sep, i.e. about 9–10 Sep, and the count in fact passed 7 000 on 10 Sep (7 022). Pandemic Shield does not treat either extrapolation as reliable beyond a few days, precisely because the ascertainment rate is itself moving (Section 3.1).



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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 24 September 2026. The INSP SitReps N°109, 114, 120, 125 and 130 were retrieved and read for this edition; in each of the five, provincial cases and deaths sum exactly to the national totals, and the health-zone case counts in N°130 sum exactly to the provincial totals in all seven provinces. Web retrieval of INSP, WHO, ECDC and UN documents was performed through an automated page-summarisation tool rather than page-image reading, so figures were cross-checked across independent sources (INSP against ECDC, WHO, UN News, the epiforecasts transcription and press) wherever more than one existed; a figure with only one summarised source is not flagged as verified. **Known limits.** (a) In N°130 the Ituri health-zone death column sums to 2 244 against a provincial total of 2 737 and is not used; only zone-level cases are. (b) North Kivu's bed-occupancy figure in N°130 does not reconcile internally and is shown as unreconciled. (c) Access to Kivu-Avenir was again limited and its Bukavu measures are cited from headlines only. (d) Sources disagree on the Uganda closure date (25/26/27 Aug) and on the split of the 70 000 Ervebo doses; both accounts are shown. **Corrections to the 8 September edition:** its 31 Aug national point (6 100 / 2 950, a rounded press figure) is replaced by INSP N°109 (6 186 / 3 007); the last case in South Kivu is dated 29 May (WHO), not 24 May; the illustrative 7 000-case date was mis-computed (Section 9); North Kivu positivity of 18/127 on 19 Aug is 14.2 %, not 15.0 %; validated suspects on 19 Aug were 20.9 % of verified alerts (366/1 752), not 23.8 %; the drug name is obeldesivir, not "obeltedesivir"; the health-zone denominator of 151 covered six provinces and is 167 with Sud-Ubangi; and the reinforced Bukavu gathering restrictions follow measures first announced in May (Actualite.cd, 24 May), so they were not new on 8 Sep. **Changes from the 8 September edition:** all national, provincial and health-zone figures updated to 21 September; new Sections 2.4 (Sud-Ubangi) and 6.2c; Section 2.3 re-cast around North Kivu's lagging front; Section 3 gains trend comparisons and community-death share; Section 5 leads with frontline vaccination; Section 6.4 adds the G20+ meeting; Section 7 gains three new rows (community deaths, river and lake mobility, vaccine expectations); the fifth headline indicator on page 1 now shows the average daily case count in place of the unreconciled health-worker figure (which remains in Sections 1 and 4.2). A new **Figure 1** charts daily cases by window and the CFR plateau; the map, now **Figure 2**, is redrawn as a three-panel map on real border, lake and coastline data (Matplotlib Basemap / GSHHS) with approximate health-zone positions; it has not been cross-checked against OpenStreetMap and is not survey-grade. The logo, QR code and page furniture are carried over unchanged from the predecessor edition.