PANDEMIC SHIELD

more information

DRC — Ituri & Eastern Provinces

Ebola Disease Outbreak — Bundibugyo Strain, 2026

Epidemiological situation report, response analysis & risk assessment · Compiled 27 August 2026 [UPDATE EDITION — supersedes the 30 July 2026 edition] · national epidemiological data through 25 August 2026 · disaggregated and operational data from INSP/COUSP SitRep N°097 (19 August) · incorporates Uganda's outbreak closure, the Ervebo cross-protection trial launch, the sixth-province extension to Bas-Uélé, and treatment-capacity findings on nosocomial transmission]

Primary sources: INSP/COUSP RDC — SitRep N°097/MVEBDB (reporting date 19 Aug 2026, published 20 Aug) and the SitRep series N°073–097 (incl. N°082, 4 Aug) · WHO AFRO Weekly External Situation Report 13 (data to 9 Aug) · WHO Disease Outbreak News (published 14 Aug; data to 12 Aug) · WHO news items of 20 Aug (Ervebo allocation) and 26 Aug (Uganda closure) · ECDC Communicable Disease Threats Report / outbreak page (to 26 Aug) · Africa CDC statements (10 Aug) and AU High-Level Meeting follow-up reporting · Reuters · AP · AFP · Al Jazeera · Bloomberg · CNN · Washington Post · NBC News · PBS NewsHour · Tech Times · Euronews · TimesLIVE · CIDRAP · Nature Medicine (correspondence on treatment-centre capacity) · MSF/Doctors Without Borders · Mercy Corps · INRB-UMIE BDBV2026-Data (GitHub) · U.S. Department of State · European Commission DG ECHO

5 656	2 715	58 / 151	792	154
Confirmed cases, DRC data cut-off 25 Aug	Confirmed deaths CFR 48.0 %	Health zones affected 6 provinces · 25 Aug	Patients in isolation 25 Aug · 1 245 recovered	Frontline workers infected Ituri+N.Kivu · 46 deaths · 4 Aug

KEY DEVELOPMENTS — SINCE THE 30 JULY EDITION (27 JULY – 25 AUGUST 2026)

★ **The outbreak is now the second-largest Ebola epidemic ever recorded.** On 31 July confirmed cases (3 532) passed the entire 2018–2020 Kivu epidemic total (3 481 including probable; 3 323 confirmed) in 77 days of response against roughly 694 days for Kivu. Only the 2014–2016 West African epidemic (28 616 cases, 11 310 deaths across Guinea, Liberia and Sierra Leone) remains larger. Confirmed cases have since risen a further 60 % to 5 656.

• **Case fatality has kept climbing and has now roughly doubled since June.** National CFR rose from 44.1 % (26 Jul) to 48.0 % (25 Aug), passing through 45.3 % (4 Aug), 45.9 % (9 Aug), 46.8 % (12 Aug) and 47.6 % (19 Aug). MSF and other responders attribute this to collapsing contact-tracing coverage and late, disproportionately post-mortem case detection — not to a change in viral virulence.

★ **Geographic expansion to a sixth province — Bas-Uélé.** On 13 August a confirmed death was recorded in Buta, Bas-Uélé, in a person who had travelled from neighbouring Haut-Uélé — extending the known transmission chain roughly 300 km further from the epicentre and to within an estimated 35 km of the South Sudan border along high-risk travel corridors (Mercy Corps). Six provinces / 58 of 151 health zones (38.4 %) are now affected, up from five provinces / 48 zones at the last edition.

★ **Uganda's outbreak is over — after a month-long wait for WHO's formal sign-off.** Uganda's Ministry of Health declared itself Ebola-free on 28 July, citing 42 days without a new case; WHO did not confirm closure until 26 August, with Uganda's Ministry permanent secretary noting WHO "had to wait because that's the process." Final toll: 20 confirmed cases, 2 deaths. Uganda is now supporting treatment capacity at two sites inside DRC and plans two more.

• **Treatment-centre overcrowding is now documented as an active driver of transmission, not merely a symptom of it.** A Nature Medicine correspondence (data from roughly 1–4 Aug) recorded occupancy of 278 % at Nizi ETC, 200 % at the Fataki transit centre, 123 % at ISTM-Nyakunde and 104 % at CME-Bunia in Ituri, and 131.9 % in North Kivu (186 patients in 141 beds). The authors argue bed capacity should be treated as an epidemiological lever in its own right.

★ **Health-worker non-payment has now persisted for over three months with no documented resolution.** Strikes reported from early July continued at least through 6 August, when press coverage described WHO Director-General Tedros Adhanom Ghebreyesus, on a visit to the DRC that began in Kinshasa on 5 August with a Bunia leg reported to follow, personally urging the DRC government to prioritise responder pay; no confirmed disbursement has been reported in sources reviewed since.

• **First vaccine doses have reached the outbreak zone — behind a more substantial evidence base than "unproven" alone conveys.** On 18 August WHO/Africa CDC released 70 000 doses of Ervebo — licensed against Zaire ebolavirus, not Bundibugyo — from the global emergency stockpile: 50 000 for frontline/health-worker protection under informed consent, and 20 000 for a Phase 3 trial WHO's TAG-CVP concluded, at its third meeting on 31 July (publicly reported 7 August), should be run without a preceding Phase 2. That recommendation followed new non-human-primate (3 of 4 vaccinated animals survived BDBV challenge, vs 1 of 4 controls) and ferret (100 % vaccinated survival vs 0 % in controls, using a research-grade preparation) challenge data, plus human antibody and pseudovirus-neutralisation studies

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— a real, if small and preliminary, evidence base, with WHO itself cautioning the vaccine "may not provide high protection against symptomatic disease or transmission, although it could help prevent fatal outcomes" (see Section 5).

★ **The financing requirement has nearly tripled while disbursement has stalled.** Africa CDC revised its costed requirement from USD 518 m to USD 1.4 bn in late June, citing deteriorating conditions and inaccessible displacement camps in Ituri. Pledges remain near USD 910 m — unchanged since the 17 June AU High-Level Meeting — and the only public disbursement figure located for this edition, 13 % (mid-to-late June), has not been updated in later reporting reviewed.

• **Africa CDC's own officials estimate the true outbreak may be three to four times its confirmed size.** Reporting citing Africa CDC puts detection at only 30–40 % of actual infections — implying, on Pandemic Shield's extrapolation of that stated rate, an unconfirmed burden on the order of 14 000–19 000 infections beneath the 5 656 confirmed cases (see Section 9).

Assessment — trajectory. *The epidemic curve shows sustained transmission through epidemiological weeks 30–34 with no confirmed inflection. The inter-report increment slowed nominally from roughly 91 cases/day (9→19 Aug) to roughly 61/day (19→25 Aug), but a single six-day window is not sufficient to call this deceleration: national contact-tracing follow-up (82.9 %) remains below the 95 % operational threshold, the two newest provinces (Haut-Uélé 56.6 %, Bas-Uélé 59.5 %) are far below it, and laboratory positivity of 15–23 % across three provinces indicates ascertainment, not incidence, is still the binding constraint on the confirmed count. This is an assessment by Pandemic Shield and not a position taken by any of the authorities cited.*

1. Outbreak Overview (as of 25 August 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; remains in force at 100+ days. Africa CDC declared a public health emergency of continental security on 18 May 2026.
Causative agent	Bundibugyo ebolavirus (BDBV) — genus *Orthoebolavirus*, family *Filoviridae*. Third BDBV outbreak in recorded history and now more than 37 times larger than either previous outbreak (Uganda 2007–08: 149 cases; Isiro, DRC 2012: 57 cases).
Provinces affected	Ituri (epicentre), North Kivu, Haut-Uélé, Tshopo, South Kivu, **Bas-Uélé (new, 13 Aug)** — six provinces, 58 of 151 health zones (38.4 %), up from five provinces / 48 zones at the 30 July edition.
Confirmed cases (DRC)	**5 656**, national reporting point of 25 Aug (published 26 Aug). Most recent fully disaggregated INSP SitRep (N°097, 19 Aug): 5 290.
Confirmed deaths (DRC)	**2 715** (25 Aug). National CFR 48.0 %; 47.6 % at the 19 Aug SitRep.
Recovered	1 245 cumulative (25/26 Aug, ECDC); 986 at the 19 Aug SitRep; 776 at 4 Aug.
Patients in isolation	792 (25 Aug). 809 hospitalised across five provinces at the 19 Aug SitRep, against 1 308 tabulated beds (61.9 % computed occupancy nationally; North Kivu alone at 95.1–121 % across successive reports).
Frontline workers infected	154 confirmed (Ituri 140, North Kivu 14) with 46 deaths (CFR 29.9 %) — INSP SitRep N°082, 4 Aug; the national SitRep series does not tabulate this indicator for Haut-Uélé, Tshopo, Bas-Uélé or South Kivu. Press reporting of 21 Aug cites >160 infections and approximately 43 deaths nationally; this has not been reconciled against INSP figures for this edition.
Uganda	**Outbreak closed.** 20 confirmed cases, 2 deaths. Last case discharged 16 Jul; Uganda's Ministry of Health self-declared the outbreak over on 28 Jul (42 days without a new case); WHO confirmed closure on 26 Aug, roughly a month later, citing its own mandatory monitoring-period process.
Cases outside Africa	3 — unchanged since the last edition. 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, also with no secondary transmission (60+ days clear as of this edition). No new imported cases reported since 30 July.

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Vaccine / treatment	None licensed specifically for BDBV. On 18 Aug, 70 000 doses of Ervebo (Zaire-strain, Merck) were released from the global emergency stockpile — 50 000 for frontline/health-worker protection (informed consent) and 20 000 for a Phase 3 cross-protection trial WHO's TAG-CVP recommended on 31 July. Animal challenge data (small samples) and human immunogenicity studies suggest partial, and possibly death-skewed rather than infection-skewed, cross-protection — see the diligence review in Section 5 for the full evidence base and its limits. Three additional trials continue enrolling or following up (PARTNERS, BD-Ebov, EBO-PEP).
Comparator — 2018–2020 Kivu	Surpassed by confirmed-case count on 31 July 2026 (3 532 vs 3 481 including probable; 3 323 confirmed over 694 days) — reached in 77 days of response. The 2026 outbreak is now the second-largest Ebola epidemic on record after the 2014–2016 West African epidemic (28 616 cases, 11 310 deaths).
Global risk assessment	WHO: DRC risk very high; neighbouring countries — explicitly including South Sudan given the Bas-Uélé extension — assessed high for cross-border spread; Uganda's country-specific risk retired following closure. ECDC: likelihood of infection for people living in the EU/EEA remains very low; preparedness, laboratory and patient-pathway guidance for EU/EEA health systems remains in force.

2. Epidemiological Analysis — Provincial and Health Zone Distribution

Data note. *As in prior editions, this report uses two reporting cut-offs and labels them separately. The national total (5 656 / 2 715) is the DRC/ECDC-cited reporting point of 25 August, published 26 August. All province- and zone-level data are from INSP/COUSP SitRep N°097, reporting date 19 August, published 20 August — the most recent edition with full disaggregation obtained at compilation; later SitReps in the N°098–10x range were referenced in press coverage but the underlying PDFs were not obtained. DRC reporting remains under continuous review; minor discrepancies between the national total and the provincial table are a function of the six-day gap between cut-offs, not a reconciliation error.*

Province	Confirmed cases	Deaths	CFR	Health zones affected	Share of national
Ituri	4 447	1 984	44.6 %	28 / 36 (77.8 %)	84.1 %
North Kivu	663	452	68.2 %	12 / 34 (35.3 %)	12.5 %
Haut-Uélé	160	71	44.4 %	6 / 13 (46.1 %)	3.0 %
Tshopo	15	7	46.7 %	7 / 23 (30.4 %)	0.3 %
South Kivu	3	1	33.3 %	1 / 34 (2.9 %)	0.06 %
Bas-Uélé (new)	2	1	50.0 %	2 / 11 (18.2 %)	0.04 %
Total (19 Aug SitRep)	**5 290**	**2 516**	**47.6 %**	**56 / 151**	**100 %**

INSP/COUSP SitRep N°097, cumulative to 19 August 2026. "Share of national" computed by Pandemic Shield from the table's own cases column. 24-hour figures for 19 Aug (national): 81 new confirmed cases, 23 community deaths, 17 intra-CTE deaths, 37 recoveries.

Four Ituri health zones account for 74.0 % of the province's cases and 62.2 % of the national total: **Bunia** (1 244 cases, 389 deaths, CFR 31.3 %), **Rwampara** (886 / 332, CFR 37.5 %), **Mongbwalu** (593 / 282, CFR 47.6 %) and **Nizi** (567 / 244, CFR 43.0 %). Lethality varies sharply by zone — from 22.8 % in Bambu to 69.8 % in Komanda — a spread consistent with differences in treatment-seeking distance and post-mortem detection share rather than any known difference in strain. In North Kivu, four zones on the Butembo–Katwa–Beni axis (Katwa 316/210, Butembo 127/98, Beni 104/76, Musienene 66/38) account for 92.5 % of the province's cases; this is the same corridor that sustained the bulk of the 2018–2020 Kivu epidemic. Goma's single cumulative case (recorded since May, per the prior edition) had produced no documented onward transmission in any source reviewed for this edition, though no fresh zone-level figure for Goma specifically was located. The new Bas-Uélé case sits in Buta, the provincial capital, roughly 300 km northwest of the epicentre and travel-linked to Haut-Uélé rather than to an independent introduction.

2.1 Growth trajectory — confirmed cases and deaths, DRC

Date	Confirmed cases	Confirmed deaths	CFR	Source / note
15 May 2026	8	4 (+1 Uganda)	—	Declaration day.

26 Jul 2026	3 262	1 437	44.1 %	Prior edition's national data cut-off (INSP SitRep N°072 series).
31 Jul 2026	3 532	1 556	44.1 %	Surpasses the 2018–2020 Kivu epidemic's cumulative total; becomes the 2nd-largest Ebola outbreak on record (Al Jazeera, citing Africa CDC).
4 Aug 2026	3 973	1 801	45.3 %	INSP SitRep N°082.
9 Aug 2026	4 381	2 011	45.9 %	WHO AFRO Weekly External SitRep 13; confirmed deaths pass 2 000.
12 Aug 2026	4 665 (DRC)	2 184 (DRC)	46.8 %	WHO Disease Outbreak News, published 14 Aug; Bas-Uélé becomes the 6th affected province (13 Aug).
17 Aug 2026	4 945	2 325	47.0 %*	Press reporting (Tech Times, citing INSP); *CFR as computed by Pandemic Shield from the cited figures — source rounded to "46 %."
19 Aug 2026	5 290	2 516	47.6 %	INSP/COUSP SitRep N°097 — 56/151 health zones.
25 Aug 2026	5 656	2 715	48.0 %	Reported 26 Aug (ECDC/Bloomberg); 58/151 health zones. This edition's national data cut-off.

Interpretation. *Confirmed cases rose 73 % and confirmed deaths 89 % in the thirty days from 26 July to 25 August. CFR rose from 44.1 % to 48.0 % over the same window, having briefly touched 45–46 % in early-to-mid August — a pattern of near-continuous increase rather than a plateau. The inter-report daily increment fell from roughly 91 cases/day (9→19 Aug) to roughly 61/day (19→25 Aug); this is not, on its own, evidence of a slowing epidemic, both because six days is a short window against weekly reporting noise and because national contact tracing (82.9 %) and the two newest provinces' tracing rates (56.6 % and 59.5 %) remain below the operational threshold, meaning underlying transmission could exceed what is being confirmed. As in the prior edition, a CFR that rises in step with case counts is most consistent with a response counting an increasing share of cases at death rather than at admission.*

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2.2 Geographic distribution of confirmed cases

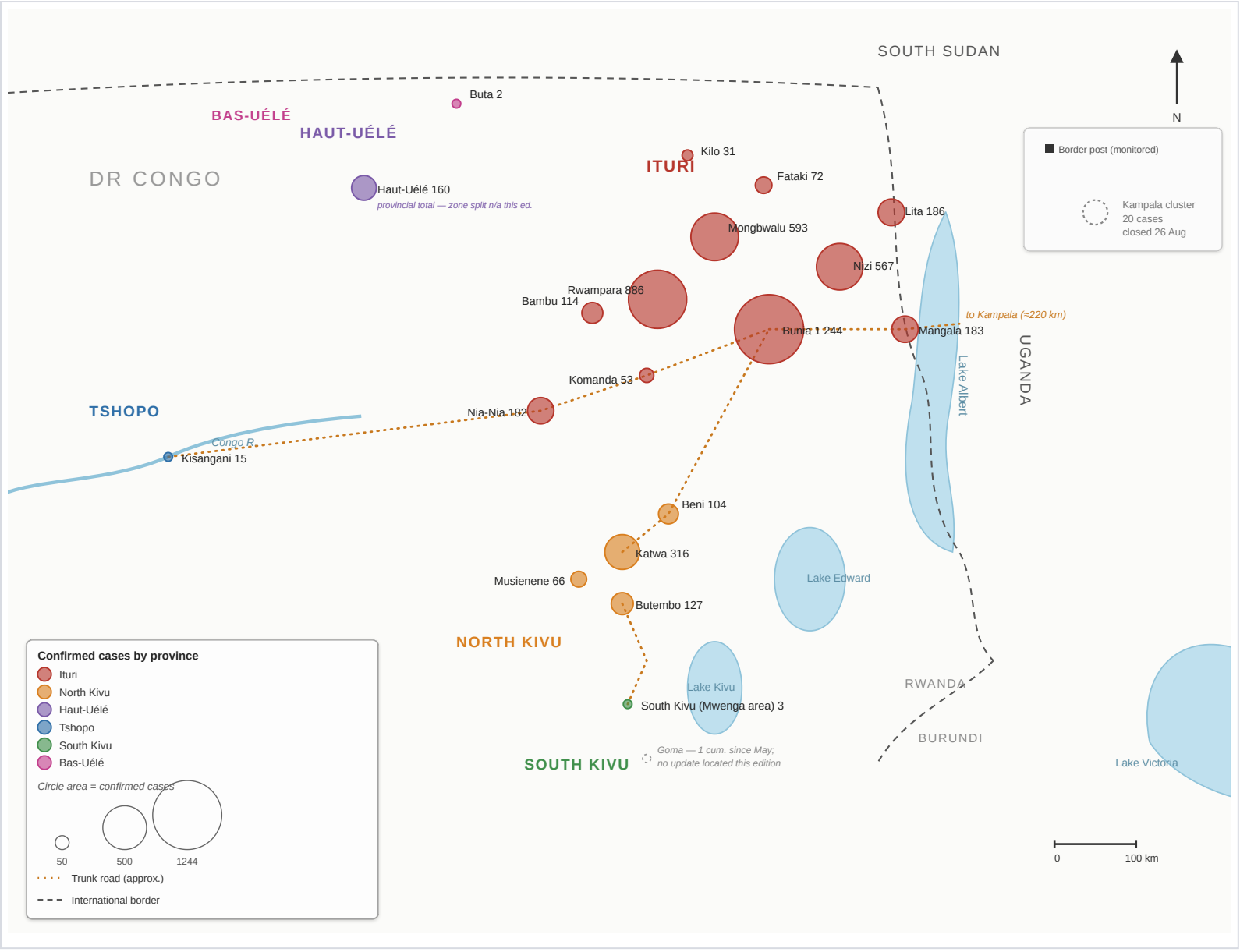

FIGURE 1 — Confirmed BDBV cases by health zone, six affected provinces, cumulative to 19 August 2026 (INSP/COUSP SitRep N°097). Circle area is proportional to confirmed cases. Uganda's Kampala cluster is shown for reference and is closed (WHO, 26 Aug). Map is schematic: positions approximate known route geography and are not surveyed coordinates; province and health-zone shapes are omitted deliberately rather than implied precisely. Zone-level detail for Haut-Uélé, Tshopo and South Kivu was not available in the sources obtained for this edition and is shown at provincial resolution only.

3. Surveillance, Laboratory and Points of Entry

3.1 Alert management and laboratory throughput (24 hours to 19 August 2026, national)

Indicator	National
Total alerts received	1 904
Alerts verified	1 752 (92.0 %)
Suspect cases validated	366 (23.8 % of verified)
Investigated within 24 h	327 (89.3 % of validated)
Referred to treatment centres	185

The provincial breakdown of alert volume was not available in the sources obtained for this edition, and SitRep N°097 tabulates this funnel differently from the 30 July edition (verified/received here, vs. investigated/received previously), so Pandemic Shield does not compare the two rates directly. Within this edition's own funnel, 89.3 % of validated suspect cases were investigated within 24 hours — a short lag between validation and field investigation that, read alongside laboratory positivity below, suggests the constraint has moved from alert triage toward diagnostic throughput.

Province	New positive results	Samples analysed	Positivity
Ituri	56	265	21.1 %
North Kivu	18	127	15.0 %
Haut-Uélé	7	30	23.3 %

Laboratory positivity of 15–23 % across the three provinces reporting this indicator is, as in the prior edition, well above the 5–10 % range associated with adequately broad testing; it indicates that testing capacity — not incidence — remains the binding constraint on how many of the true infections are being confirmed. This is the same reasoning Africa CDC has used publicly to support its estimate that only 30–40 % of actual infections are being detected (see Section 9).

3.2 Contact tracing (24 hours to 19 August 2026)

Province	Contacts under follow-up	Contacts seen	Follow-up rate
Ituri	10 509	9 204	87.6 %
North Kivu	7 540	5 830	80.5 %
Haut-Uélé	1 498	848	56.6 %
Bas-Uélé	220	131	59.5 %
Tshopo	473	473	100 %
National	**19 720**	**16 355**	**82.9 %**

National follow-up (82.9 %) has improved materially since the 30 July edition (77.8 %). Ituri drove that improvement (87.6 % vs 75.6 %, now within 8 points of the 95 % operational threshold); North Kivu instead slipped slightly (80.5 % vs 83.7 %, a 3.2-point decline that bears watching but does not yet look like a trend on one data point). The deterioration has instead relocated to the newest provinces: Haut-Uélé (56.6 %) and Bas-Uélé (59.5 %) are both well below threshold, which is the expected signature of a surveillance system still building capacity in newly affected territory rather than of a system losing ground everywhere at once, as was the case at the last edition. South Kivu's single active zone was not listed with a follow-up rate in the source reviewed.

3.3 Points of entry and control (24 hours to 19 August 2026, national)

Facilities operational	98.7 % of points of entry / control active or reinforced.
Travellers screened	313 381 persons transited monitored points; 98.3 % screening coverage; 98.7 % received hand hygiene.
Alerts at points of entry	2 notified, both in North Kivu; 0 validated as living alerts; 0 deceased bodies intercepted; 0 "problem contacts" intercepted.

Screening throughput has roughly doubled since the last edition (313 381 vs 155 936 travellers in the comparable 24-hour count) while yielding almost no confirmed interceptions — consistent with the same operational reality flagged in the prior edition: fever-based screening cannot reliably distinguish BDBV's non-specific prodrome from endemic malaria at the volumes involved, so points of entry function chiefly as a hand-hygiene and health-messaging channel rather than a case-finding one. No province-level detail on the newly relevant Bas-Uélé/South Sudan crossings was available in the sources obtained for this edition; Section 7 flags this as an unresolved operational gap given the province's new status as the outbreak's northern frontier.

4. Case Management, Burials and the Frontline Workforce

4.1 Treatment capacity (19 August 2026)

Indicator	Ituri	North Kivu	Haut-Uélé	Tshopo	Bas-Uélé	National
Beds	965	206	119	14	4	1 308
Hospitalised (end of day)	551	196	53	5	4	809
Admissions (24 h)	144	46	—	—	—	190+
Occupancy	57.1 %	**95.1 %**	44.6 %	41.7 %	**100 %**	61.9 %*

*INSP/COUSP SitRep N°097, 19 Aug. *National occupancy computed by Pandemic Shield from the beds and hospitalised columns; not stated directly in the source. Provincial occupancy percentages are transcribed as published; at least one (Tshopo) does not recompute exactly from the rounded beds/hospitalised figures shown, which Pandemic Shield attributes to the source's own underlying precision or snapshot timing rather than to an error introduced here. South Kivu not tabulated for this indicator.*

Ituri's occupancy (57.1 %) reads as adequate in aggregate but conceals severe local saturation: a Nature Medicine correspondence using data from roughly 1–4 August recorded 278 % occupancy at Nizi ETC, 200 % at the Fataki transit centre, 123 % at ISTM-Nyakunde and 104 % at CME-Bunia — i.e. the province-wide average is being pulled down by newer or smaller facilities while its highest-throughput centres are dangerously overcrowded. North Kivu (95.1 %, and previously as high as 121.3 % at the last edition) and Bas-Uélé (100 %, on only four beds) show the same pattern at provincial scale. The correspondence's central argument — that overcrowding itself, through reduced patient separation, staff shortages and delayed admission of suspect cases, is now an active transmission driver rather than a downstream symptom of caseload — is treated in this edition as an established operational finding (Section 8).

4.2 Frontline workers infected (cumulative, 4 August 2026)

Province	Confirmed	Deaths	CFR
Ituri	140	43	30.7 %
North Kivu	14	3	21.4 %
Total (INSP, 4 Aug)	**154**	**46**	**29.9 %**

INSP/COUSP SitRep N°082. Health-zone-level frontline breakdown, tabulated in the 30 July edition, was not available at province-total resolution or better for this edition's sources; INSP does not tabulate this indicator for Haut-Uélé, Tshopo, Bas-Uélé or South Kivu. Press reporting of 21 August (Al Jazeera, citing UN sources) put the figure at "over 160" infections and roughly 43 deaths nationally as of that date — a later but less granular data point that has not been reconciled against the INSP series here.

Causes. Four distinct mechanisms recur across the sources reviewed for this edition, and they compound rather than operate independently. First, personal protective equipment and infection-prevention-and-control (IPC) consumables have been reported in short supply at treatment centres since the outbreak's early weeks (NPR, 30 Jun), with some facilities described as single-entrance clinics never designed for isolation nursing and retrofitted under time pressure rather than purpose-built. Second, and directly connected to the occupancy findings in Section 4.1, the Nature Medicine correspondence's central finding — that overcrowding degrades patient separation and stretches staff and PPE thinner per patient — applies with equal force to the staff working inside those wards as to the patients inside them: a facility running at 200–278 % of rated capacity cannot maintain the nurse-to-patient ratios or PPE-change discipline that IPC protocols assume, which converts overcrowding from a bed-capacity problem into a direct driver of nosocomial health-worker infection. Third, the unresolved pay dispute documented since the last edition has a plausible biological pathway to infection risk, not only an operational one: Al Jazeera's reporting (24 Jul) describes health workers going unpaid for months, covering their own transport and food costs, and working while fatigued — conditions under which corner-cutting on donning/doffing sequences and hand hygiene becomes more likely, even among adequately trained staff. Fourth, a peer-reviewed study of IPC scorecards from DRC's 2025 Kasai outbreak (Clinical Infectious Diseases) found that PPE availability and consistent use are specifically the IPC practices that decay fastest without sustained external support — around one in five scorecard items showed significant decline within six months — while more structural organisational practices held up better; Pandemic Shield treats this as background evidence for a generalisable dynamic (IPC gains erode disproportionately on the PPE/consumables dimension over the course of a long outbreak) rather than as data specific to this outbreak, since no equivalent scorecard series for the current BDBV response was located.

Dynamics. The INSP figure of 154 covers confirmed infections among the response workforce broadly — not only hospital-based clinicians but, per the categories referenced elsewhere in this report, community health workers and case investigators, disinfection teams and ambulance crews (Section 7); burial teams are tracked separately in this report and are not included in this count. Geographically, the 140/14 Ituri/North Kivu split mirrors the general caseload's own concentration in those two provinces (Section 2), consistent with workforce exposure tracking wherever

transmission is most intense rather than any occupation-specific geographic pattern. One further observation is worth flagging as a hypothesis rather than a finding: the frontline-worker CFR of 29.9 % sits notably below the population-wide CFR range reported elsewhere in this edition (44–48 %, Section 2). Plausible explanations include occupational self-recognition of early symptoms and faster self-referral to care among trained health workers, and this cohort's generally younger, healthier baseline relative to the general case population — but Pandemic Shield has not identified a source that formally tests this, and an alternative reading (that the gap partly reflects incomplete case-ascertainment or reporting lags in one series but not the other) cannot be excluded from the data available. This should be read as a hedged observation, not an established finding.

Effects. The workforce and financing strands of this report meet directly at this indicator. Workforce attrition — whether through infection, fear-driven withdrawal, or the pay dispute — reduces exactly the surveillance, contact-tracing and IPC capacity whose shortfalls are this report's own recurring theme (Sections 3 and 7), creating a feedback loop in which reduced capacity raises transmission risk, which in turn raises health-worker exposure. Beyond the workforce itself, NPR's reporting frames a second-order effect worth naming explicitly: infections among caregiving staff and the IPC lapses that produce them compromise infection control for everyone passing through affected facilities, including non-Ebola patients seeking unrelated care, who face elevated nosocomial exposure risk at exactly the facilities they may need most. A third, harder-to-quantify effect is on community trust and care-seeking behaviour: visible health-worker infection and death, compounded by public reporting of unpaid wages, plausibly discourages both prospective recruits from joining the response and community members from presenting early at facilities perceived as unsafe — though no source reviewed for this edition provides a direct measurement of this channel, and it is noted here as a plausible mechanism consistent with the broader IPC and trust literature rather than as a quantified effect in this outbreak. Note also that NPR's report of "22 affected health zones" is a late-June snapshot and is not comparable to this edition's figure of 58/151 health zones across six provinces (Section 1); it is cited above only for its qualitative account of exposure pathways, not as a current count.

Assessment — workforce. *The pay dispute flagged as the single most tractable constraint in the 30 July edition remains unresolved three months into the response, and this edition's diligence on causes strengthens rather than changes that assessment: unpaid wages plausibly act as an infection-risk multiplier, not only a morale and retention problem, by degrading protocol adherence among fatigued staff on top of the structural PPE and overcrowding pressures already documented. WHO's own Director-General travelling to the DRC in person from 5 August — arriving in Kinshasa with a Bunia leg reported to follow — and "urging authorities to prioritise care and support for the responders" is a strong signal that the normal chain of persuasion — Africa CDC, the national SitRep, donor pressure — had not moved the DRC government by early August; no confirmed disbursement has been documented in any source obtained since that visit. Every function named as affected in the last edition — surveillance, case investigation, ambulance drivers, burial teams — remains at risk of further withdrawal of labour for as long as this is unresolved, and each additional health-worker infection or resignation feeds back into the same surveillance and IPC shortfalls tracked throughout this report.*

5. Medical Countermeasures — Four Trials, First Vaccine Doses Deployed

At the last edition, the defining feature of this outbreak was the absence of any licensed vaccine or therapeutic for Bundibugyo ebolavirus, and WHO's advice against deploying Zaire-strain products outside controlled research settings given uncertain cross-protection. That changed operationally, if not yet evidentially, on 18 August: this edition adds a fourth trial and, for the first time, doses of a real vaccine product in the outbreak zone — albeit one not licensed against this strain and deployed under an explicit research/informed-consent framing rather than as a proven countermeasure.

Trial	Product(s)	Opened	Design and status
PARTNERS (therapeutic)	MBP134 monoclonal antibody; remdesivir; and 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; enrolment restricted to laboratory-confirmed BDBV. Over 100 confirmed cases enrolled across three facilities in Ituri as of 14 Aug (WHO DON) — up from a single Bunia site at the last edition. No efficacy readout reported.
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; 50 healthy adults in Oxford, UK. No update located since the last edition; further studies with Ugandan partners remain "in preparation, subject to regulatory approval."

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EBO-PEP (prophylaxis)	Obeltedesivir — oral antiviral (Gilead)	14 July 2026	Post-exposure prophylaxis trial led by ANRS Emerging Infectious Diseases (France) and INRB, with ALIMA and MSF field support and Africa CDC backing; PEP centres adjacent to ALIMA treatment centres in Bunia and Rwampara. Target approximately 1 000 participants aged 12+, asymptomatic, within five days of high-risk contact. No enrolment update located this edition; recruitment continues to depend on the same contact lists currently followed at 82.9 % nationally (Section 3.2).
Ervebo cross-protection trial (vaccine, new)	Ervebo — rVSV-ZEBOV (Merck), licensed against Zaire ebolavirus	TAG-CVP recommendation 31 Jul; doses allocated 18 Aug	WHO's Technical Advisory Group on Candidate Vaccine Prioritisation (TAG-CVP), at its third meeting (31 July; made public 7 August), concluded that — "in the continued absence of a BDBV-specific vaccine ready for evaluation" — Ervebo should be prioritised for a Phase 3 trial without a preceding Phase 2, while stockpile doses are deployed in parallel under informed consent. 70 000 doses were released on 18 August from the International Coordinating Group's global emergency stockpile: 20 000 for the trial, 50 000 for frontline/health-worker protection. The Group was explicit that a BDBV-specific candidate "remains the preferred option" once one exists.

5.1 Diligence check — how solid is the Ervebo cross-protection evidence?

Because this claim carries real operational weight — it is the basis for injecting 70 000 doses of someone else's vaccine into this outbreak — Pandemic Shield traced it back to its primary sources rather than repeating the shorthand ("may offer some cross-protection") that circulated in press coverage of the 18 August allocation. The picture that emerges is genuinely evidence-based, but narrower and more conditional than that shorthand suggests.

The starting position was negative. WHO's own emergency guidance of 28 May concluded that cross-protection evidence was "insufficient to recommend Ervebo's use" against BDBV, citing roughly 30 % nucleotide-level divergence between the Zaire and Bundibugyo glycoproteins — the same figure this report's first edition cited as the reason immunity to one species does not reliably transfer to the other. That starting position is the correct baseline against which to read everything below: this is a position that moved under new evidence, not a claim that was strong all along.

Four evidence streams accumulated between May and the TAG-CVP's 31 July meeting. (i) *Non-human primate challenge:* three of four Ervebo-vaccinated primates survived live BDBV challenge, against one of four unvaccinated controls — directionally supportive, but a sample of four per arm is too small to estimate a protection rate with any precision. (ii) *Ferret challenge:* a research-grade Ervebo preparation produced 100 % survival in vaccinated ferrets against 0 % in controls, which all died within ten days — a strong result on its face, though it used a laboratory-grade formulation rather than the licensed clinical product, and ferrets, while an established filovirus model, are still an animal proxy for human disease. (iii) *Human immunogenicity (Lhomme et al., PREVAC cohort, 179 sera):* Ervebo recipients developed BDBV-binding antibodies, but at roughly one-sixth the titre of their response to the homologous Zaire strain for the standard single-dose regimen (a two-dose Ad26.ZEBOV/MVA-BN-Filo regimen came closer, at roughly one-half); the authors' own conclusion was that this supports "plausibility of partial heterologous immunity" while stating explicitly that "no direct assessment of vaccine efficacy against BDBV infection or disease can be made" from binding-antibody data alone. (iv) *Pseudovirus neutralisation (Hoffmann et al.):* most vaccinated sera neutralised pseudoviruses bearing the outbreak strain's glycoprotein in vitro — a step closer to functional evidence than binding antibodies, but still a laboratory correlate, not a clinical outcome.

What this does and does not establish. Taken together, the four streams are enough that WHO's own technical panel — after reviewing "published, pre-print and unpublished studies" including the animal challenge data — reversed course and judged the balance of evidence sufficient to justify field deployment under a trial and informed-consent framework. It is not enough to establish clinical effectiveness in humans, and every primary source reviewed says so explicitly rather than leaving it implied: there is no validated immunological correlate of protection for BDBV, the human antibody and neutralisation data measure laboratory proxies rather than survival, and the animal challenge samples (four per arm for primates) are too small to generalise from confidently. WHO's own framing of the likely shape of any real protection is also a meaningfully narrower claim than blanket "cross-protection": officials cautioned the vaccine "may not provide high protection against symptomatic disease or transmission, although it could help prevent fatal outcomes" — i.e. the working hypothesis is that Ervebo might reduce the chance of dying if infected, not that it necessarily prevents infection or onward spread. A fifth data point — outbreak surveillance showing no deaths documented among the small number of confirmed cases with a prior history of Ervebo vaccination — is, on Africa CDC's own characterisation of its evidence base, merely "hypothesis-generating," because vaccinated health workers differ systematically from the general case population (earlier self-referral, better facility access, generally better baseline health), a "substantial" survivor-bias risk that this observational figure cannot rule out.

Pandemic Shield's assessment of the claim as stated in press and WHO/Africa CDC communications ("early laboratory and animal data suggest Ervebo may provide some cross-protection, but effectiveness against BDBV remains unproven") is that it is **fair and consistent with the primary sources** — it does not overstate the animal and immunogenicity findings, and it correctly flags that clinical effectiveness is

unestablished. Where this report goes further than that shorthand is in specifying the asymmetry WHO itself has flagged (plausibly better protection against death than against infection or transmission) and the small sample sizes underlying the animal data, both of which matter for what planners should and should not expect from the 50 000 doses now being administered under informed consent.

Assessment — countermeasures. *The Ervebo deployment is best read as an evidence-informed hedge, not a breakthrough: real, if preliminary and small-sample, data moved WHO's own position from "insufficient evidence" to "prioritise for trial," but the same data leave open whether the practical effect is a meaningfully lower death rate among the vaccinated, a marginal effect not distinguishable from survivor bias, or something in between — and the purpose-built BD-Ebov candidate remains in a 50-person Phase I trial in Oxford with no timeline for efficacy data against this outbreak. Of the four trials tracked, EBO-PEP remains the one whose success would most directly change the operational picture — an effective oral post-exposure prophylaxis would act simultaneously on health-worker attrition and household transmission — and its principal constraint is unchanged: it depends on the same contact-tracing lists that are the report's own recurring weak point. 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 fully proven tool, with Ervebo as a plausible but clinically unconfirmed supplement rather than a substitute.*

6. Regional and International Situation

6.1 Uganda — outbreak closed

Uganda's Ministry of Health declared its own outbreak over on 28 July 2026, 42 days after its last confirmed case cleared monitoring, with the Ministry publicly stating "Uganda is officially Ebola free." The final toll was 20 confirmed cases and 2 deaths, all epidemiologically linked to travel from DRC and confined to Kampala, with no documented community transmission. WHO did not issue its own formal closure declaration until 26 August — a full month later — with Uganda's Ministry of Health permanent secretary Diana Atwine telling reporters "WHO had to wait because that's the process. That's the guideline," referring to WHO's mandatory 42-day monitoring requirement measured from its own procedural starting point rather than Uganda's. WHO's Uganda representative, Kasonde Mwinga, used the announcement to argue the cross-border collaboration model built during the response "could be expanded regionally." Practically, that model is already in motion in the other direction: Uganda is now supporting treatment capacity at two sites inside DRC and has announced plans to open two more, even as its own outbreak is closed. Uganda's 877 km border with DRC remains subject to enhanced screening; no update was located this edition on the 22 crossing points or the mobile laboratory at Bwera Hospital referenced in the last edition, and both are assumed unchanged pending confirmation.

6.2 Bas-Uélé and the South Sudan question

The extension of transmission to Bas-Uélé on 13 August — a confirmed death in Buta linked to travel from Haut-Uélé — is this edition's most consequential geographic development. Mercy Corps, operating in the region, has stated that confirmed cases now sit "just 35 kilometres from the South Sudan border, along high-risk travel corridors," and Ituri itself borders South Sudan directly in addition to Uganda. No confirmed case has been reported inside South Sudan in any source reviewed for this edition, and this report does not treat cross-border spread there as established — only as a materially elevated and, per WHO's own risk categorisation (Section 1), officially recognised risk. South Sudan's health system is widely assessed as having substantially less capacity to detect and isolate BDBV than Uganda's, and no equivalent formal preparedness assessment for South Sudan was located in sources reviewed, in contrast to the ECDC/EU-focused assessments available for European health systems (Section 6.3).

6.3 Cases outside Africa and the European dimension

The three cases managed outside Africa at the last edition remain the total: two deliberate medical evacuations to Germany (Charité Berlin and Frankfurt University Hospital special isolation units) and one unrecognised importation, a humanitarian physician confirmed in France on 24 June and discharged 4 July. All three have been discharged with no secondary transmission documented in either receiving country, and no new imported case outside Africa was reported in any source reviewed between the last edition and this one. ECDC's own risk assessment, most recently updated in the run-up to this edition's data cut-off, continues to state that "the likelihood of infection for people living in the European Union/European Economic Area is considered to be very low," and its preparedness, laboratory and patient-pathway guidance for EU/EEA health systems remains in force unchanged.

6.4 Financing — a tripled requirement, an unmoved pledge total

The single largest financing development since the last edition is that the requirement itself changed, not the money behind it. Africa CDC revised its costed continental requirement from USD 518 m to USD 1.4 bn in late June — announced in the window just after the last edition's compilation — citing deteriorating conditions in Ituri and the need to fund humanitarian access into displacement camps where transmission is believed to be running unchecked. Africa CDC Director-General Jean Kaseya put the stakes directly: "If we don't have this 1.4 billion dollars and if we don't resolve the humanitarian issue, we will not stop this outbreak." Pledges, by contrast, have not moved: they remain at approximately

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USD 910 m, the same figure mobilised at the 17 June AU High-Level Meeting referenced in the last edition. The most recent disbursement percentage located in any source reviewed for this edition is still 13 %, reported in mid-to-late June — meaning this report cannot confirm whether disbursement has improved at all in the two months since.

Instrument	Period	Requirement	Funding status
Africa CDC continental strategic plan (revised)	Jun–Dec 2026	USD 1.4 bn	Revised from USD 518 m in late June; ~USD 910 m pledged (unchanged since 17 Jun); most recent disbursement figure located is 13 % (mid-to-late June) — not updated in later reporting reviewed.
U.S. supplemental request (reported)	2026	USD 1.35 bn	USD 550 m for Ebola prevention/detection in DRC plus USD 800 m for humanitarian assistance, reported by wire coverage of the U.S. administration's supplemental spending request; a request, not confirmed appropriated or disbursed funding, and broadly consistent in scale with Africa CDC's USD 1.4 bn continental ask.
WFP — DRC operations incl. Ebola logistics and food assistance in Ituri	6 months (29 Jul appeal)	USD 293.6 m	No update located since the 30 July edition.

Figures for instruments not reissued since the last edition (WFP appeal, UNICEF plan, Pandemic Fund, World Bank, bilateral pledges by donor) are carried forward from the 30 July edition where no more recent figure was located; see the 30 July edition for the full donor-by-donor table, which is not reproduced here in full to avoid restating unconfirmed figures as current.

Assessment — financing. *The arithmetic is now sharper, and worse, than at the last edition. Against the revised USD 1.4 bn requirement, the unrevised USD 910 m pledge total already represents a USD 490 m (35 %) shortfall before any disbursement lag is counted. Applying the last-known disbursement rate of 13 % to that pledge total implies roughly USD 118 m has actually reached the response — under 9 % of the revised requirement — though Pandemic Shield stresses this is an extrapolation from a two-month-old percentage, not a confirmed current figure, precisely because no more recent disbursement tracking was located. Whether the gap has narrowed, held, or widened since is the single most consequential unresolved financing question carried into this edition (Section 8). The health-worker payment crisis documented in Section 4.2 is the most visible symptom of this gap reaching frontline operations directly, and it is difficult to reconcile with any account in which "under a quarter of pledges" — the state of play in the 30 July edition — has since substantially improved.*

6.5 Coordination architecture

Coordination continues on the "one plan, one budget, one team" model described in the last edition, run by the DRC Public Health Emergency Operations Centre (COUSP) within INSP. No change to the coordination architecture itself was identified in sources reviewed for this edition; the operative developments are the ones already described above — the widened financing gap, Uganda's exit from active-outbreak to cross-border-support status, and the extension of the affected footprint to a sixth province.

7. Principal Constraints — National Response Assessment

The table below updates the constraints table carried in the 30 July edition. Ordering by assessed impact on transmission dynamics is Pandemic Shield's own; the constraints and required actions draw on COUSP's SitRep series where cited, supplemented by the press and correspondence sources identified against each row.

Constraint	Impact	Required action / status
Health-worker non-payment, now 3+ months unresolved	Continued strikes and facility abandonment reported at least through 6 Aug; a direct WHO Director-General visit to DRC from 5 Aug (Kinshasa, with a Bunia leg reported to follow) has not produced a documented disbursement.	Regularise provider payments; secure dedicated, ring-fenced financing line — repeated from the last edition with no confirmed progress.
Treatment-centre overcrowding as an active transmission driver	278 % (Nizi), 200 % (Fataki), 123 % (ISTM-Nyakunde), 104 % (CME-Bunia) occupancy in Ituri; 95.1–131.9 % in North Kivu (Nature Medicine correspondence, SitRep). Compromises IPC, delays admission, prolongs household exposure.	Deploy modular isolation units; restore transparent, facility-level bed-availability reporting; treat bed capacity as an epidemiological lever, per the correspondence's own recommendation.

Contact tracing below threshold in the newest provinces	National follow-up improved to 82.9 % (Ituri 87.6 %, North Kivu 80.5 %), but Haut-Uélé (56.6 %) and Bas-Uélé (59.5 %) are both far below the 95 % threshold, concentrating undetected-transmission risk in the outbreak's newest and least-resourced territory.	Prioritise surveillance staffing and RECO community-relay deployment in Haut-Uélé and Bas-Uélé specifically, rather than nationally.
Geographic extension toward South Sudan	Confirmed transmission now ~35 km from the South Sudan border (Bas-Uélé/Buta, 13 Aug); no known formal South Sudan preparedness assessment identified.	Extend priority point-of-entry screening and cross-border coordination to Bas-Uélé/South Sudan crossings, mirroring the Uganda border model.
Decentralised diagnostics still incomplete	Laboratory positivity of 15–23 % across three provinces indicates confirmation lags true incidence; consistent with Africa CDC's own 30–40 % detection-rate estimate.	Accelerate deployment of decentralised diagnostic capacity, particularly in Haut-Uélé and Bas-Uélé.
Insecurity and restricted access	An EDS (surveillance/decontamination) team was assaulted in Bunji health area (Ituri) with a probable death; a vehicle was stoned at Mungamba village, Komanda zone; arson was attempted against two community-health-worker residences in Beni's Mangothe area (North Kivu) — a continuation of the pattern (Muchanga bridge attack, Nyakunde paralysis) documented at the last edition.	Reinforce security coordination and humanitarian access; the underlying armed-group and communal-mistrust dynamics are unchanged from the last edition.
True burden likely understated	Africa CDC officials cited in press reporting estimate only 30–40 % of actual infections are detected, implying a true burden of roughly 14 000–19 000 against 5 656 confirmed (Pandemic Shield extrapolation; Section 9).	No specific COUSP-tabulated action identified; flagged here as a standing analytical caveat on every count in this report.
Continuity of essential health services	No new data located this edition; carried forward as an unresolved indirect-mortality risk.	Implement fee exemption effectively; reinforce essential service continuity — unchanged from the last edition.

8. What Is Established and What Remains Unresolved (25 August 2026)

✔ Established	? Unresolved or contested
5 656 confirmed cases and 2 715 confirmed deaths as of 25 August across six provinces and 58 of 151 health zones — the outbreak passed the entire 2018–2020 Kivu epidemic's cumulative total on 31 July and is now the second-largest Ebola epidemic on record after 2014–2016 West Africa.	Africa CDC's own officials estimate only 30–40 % of actual infections are detected; on that stated rate, the true burden could run to 14 000–19 000 infections — an order of magnitude beyond the confirmed count, and not independently verified here.
Uganda's outbreak is formally closed: 20 confirmed cases, 2 deaths; WHO confirmed closure on 26 August, a month after Uganda's own 28 July declaration.	Whether cross-border transmission will reach South Sudan: confirmed cases now sit an estimated 35 km from the border, but no case has been reported inside South Sudan, and no formal South Sudan preparedness assessment was located.
National CFR has risen from 44.1 % (26 Jul) to 48.0 % (25 Aug); the rise tracks contact-tracing and detection performance, not a documented change in viral virulence.	Whether the Ervebo doses deployed from 18 August offer any real-world cross-protection against BDBV; the randomised trial is running but no efficacy readout is expected in this window.
A sixth province, Bas-Uélé, is affected as of 13 August, with one confirmed case/death (Buta) travel-linked to Haut-Uélé.	Whether the health-worker payment crisis will be resolved: unpaid since the outbreak's declaration, a direct WHO Director-General intervention on 5 Aug has not produced a documented disbursement.
Treatment-centre overcrowding (up to 278 % occupancy) is now documented in the peer-reviewed literature as an active driver of nosocomial and community transmission, not merely a symptom of caseload.	Whether the USD 490 m gap between the revised USD 1.4 bn requirement and the still-unmoved USD 910 m pledge total will close, and whether the (already two-month-old) 13 % disbursement rate has improved — no newer tracking was located for this edition.
First vaccine doses (70 000 Ervebo) have reached the response, allocated for a WHO-recommended cross-protection trial and for frontline/health-worker protection under informed consent.	Whether the most recent apparent slowing in daily case growth (~61/day, 19→25 Aug, vs ~91/day, 9→19 Aug) reflects a genuine deceleration or is an artefact of a short reporting window against still-sub-threshold contact tracing.

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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.

★ **The record has not just been approached, it has been broken.** At 5 656 confirmed cases the outbreak now exceeds the 2018–2020 Kivu epidemic's cumulative total (3 481 including probable) by 62 %, reached that milestone in 77 days of response against roughly 694 for Kivu, and sits behind only the 2014–2016 West African epidemic (28 616 cases) in the historical record. The framing question is no longer whether this becomes a record outbreak — it already is one — but how far behind West Africa's scale it ultimately lands.

- **The rising CFR remains a response signal, not a virology signal.** The climb from 44.1 % to 48.0 % over the past month continues to track a widening gap between contact-tracing coverage (82.9 % nationally, below newer-province rates as low as 56.6 %) and the true speed of transmission, corroborated this edition by MSF's own public statement that cases continue to be "detected very late" rather than at the improving pace a maturing outbreak response would normally show.
- **Treatment capacity has been reframed, correctly, as a lever on transmission rather than a downstream consequence of it.** The practical implication is that bed and modular-isolation-unit expansion now competes directly with contact tracing and vaccine-trial logistics for scarce staff and funding, not merely with each other for beds — a prioritisation question this report has not seen addressed in any COUSP or Africa CDC document reviewed.
- **Uganda's closure is real, but its lesson is bounded.** Ending a 20-case, single-city outbreak required Uganda's full national response machinery plus its own now-continuing investment in DRC treatment capacity. It is evidence that BDBV containment is achievable at small scale with adequate resourcing — it is not yet evidence that the same model is deliverable at Ituri's actual scale, where the resourcing gap (Section 6.4) runs the opposite direction.

★ **Bas-Uélé and South Sudan, not Uganda, are now the geographic frontier to watch.** A single travel-linked case 300 km from the epicentre was sufficient to open a sixth province; the same dynamic operating along the roughly 35 km remaining to the South Sudan border, into a health system with materially less assessed capacity than Uganda's, is this report's single largest unpriced regional risk.

- **The financing shortfall is now quantifiable and larger than at the last edition.** USD 1.4 bn required, ~USD 910 m pledged — a USD 490 m (35 %) gap before disbursement lag — and, on the last available disbursement rate (13 %), under 9 % of the revised requirement (~USD 118 m) has plausibly reached the response. Every operational failure catalogued in Sections 4 and 7 — unpaid responders, overcrowded treatment centres, sub-threshold tracing in new provinces — is consistent with, and at least partly explained by, this gap.
- **For countermeasure planning.** The addition of a licensed-but-unproven vaccine (Ervebo) to the toolkit changes messaging and hedges against a favourable cross-protection result, but it does not yet change the operative planning assumption from the last edition: classical containment remains the only demonstrated tool, and EBO-PEP remains the trial whose success would most directly change the operational picture if it reads out favourably.
- **For a purely illustrative sense of pace** — not a forecast — holding the most recent six-day increment (19→25 Aug, ~61 cases/day) constant would put the outbreak past 6 000 confirmed cases around 30–31 August; holding the prior ten-day increment (9→19 Aug, ~91/day) constant would put it there roughly two days sooner, around 28–29 August. The two extrapolations are close enough that the apparent slowdown between them changes the near-term picture only marginally; Pandemic Shield does not treat either as reliable beyond a few days, precisely because the underlying ascertainment rate is itself moving (Section 3).

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Editorial note. Statements of fact in this report are attributed to the sources listed above; passages headed "Assessment," "Interpretation," the diligence review in Section 5.1, and the whole of Section 9 are analytical judgements by Pandemic Shield GmbH and are not a position taken by WHO, ECDC, Africa CDC, INSP or any government cited. Two reporting cut-offs are used and labelled separately: national totals are from the DRC/ECDC reporting point of 25 August, and all disaggregated and operational data are from INSP SitRep N°097 (19 August) unless noted otherwise. Changes from the 30 July edition: national and provincial figures updated throughout; Bas-Uélé added as a sixth affected province; Uganda's outbreak recorded as closed; a fourth trial (the Ervebo cross-protection RCT) added to Section 5, with a dedicated diligence review (5.1) tracing WHO's guidance reversal to its primary evidence base; treatment-centre overcrowding elevated to an established finding based on new peer-reviewed correspondence; Section 4.2 expanded with causes, dynamics and downstream effects of frontline-worker infection; the financing section revised for Africa CDC's tripled requirement; the growth-trajectory, provincial and health-zone tables extended through 25 August; the map (Figure 1) redrawn to reflect the six-province footprint, a corrected proportional Haut-Uélé marker, and updated zone-level case counts; Sections 8 and 9 rewritten to reflect Uganda's closure and the new Bas-Uélé/South Sudan risk.

Compiled for informational and situational awareness purposes. National data as of 25 August 2026 (cut-off 25 Aug); disaggregated data as of 19 August 2026. PHEIC declared by WHO 17 May 2026.
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