DRC — Ituri & Eastern Provinces

Ebola Disease Outbreak — Bundibugyo Strain, 2026

Epidemiological situation report, response analysis & risk assessment · Compiled 8 September 2026 [UPDATE EDITION — supersedes the 27 August 2026 edition] · national epidemiological data through 5 September 2026 · disaggregated data from INSP/COUSP SitRep N°097 (19 Aug) updated with press/dashboard reporting through 7 Sep 2026 · this edition's focus: the southward corridor from North Kivu toward South Kivu, and Bukavu's precautionary response

Primary sources: INSP/COUSP RDC — SitRep N°097/MVEBDB (19 Aug, published 20 Aug) · WHO Disease Outbreak News DON615 (14 Aug, data 12 Aug) and DON616 (26 Aug) · Africa CDC — 180-day response plan announcement (6 Sep) and funding statements · ECDC Ebola outbreak page · Congo Synthèse daily Ebola dashboard (congosynthese.com, 3 Sep) · Actualite.cd, Congo Quotidien, 7sur7.cd, Radio Okapi, RT en français, Kivu-Avenir, Reporter.cd, Agence Ecofin (2–8 Sep press reporting) · Wikipedia (2026 Central Africa Ebola epidemic, cross-check only) · WHO AFRO, MSF, Africa CDC, Nature Medicine, CDC MMWR (carried forward from the 27 Aug edition where unchanged)

6 604	3 175	61 / 151	851	~160 / ~45
Confirmed cases, DRC data cut-off 5 Sep	Confirmed deaths CFR 48.1 %	Health zones affected 6 provinces · 5 Sep	Patients in isolation 5 Sep · 1 548 recovered	Frontline workers infected / died · Aug–Sep, unreconciled

KEY DEVELOPMENTS — SINCE THE 27 AUGUST EDITION (26 AUGUST – 8 SEPTEMBER 2026)

★ **The southward corridor is now the defining epidemiological story of this edition.** North Kivu's confirmed count climbed from 663 (19 Aug) to 836 (30 Aug) to 969 (4 Sep) — up 46 % in 16 days — with 16 of the province's 34 health zones now affected, against 12/34 in the last edition. Katwa health zone (Butembo area) has been named the new provincial epicentre, with 393 cases and 284 deaths — roughly 40 % of North Kivu's cumulative total in a single zone. Katwa and Butembo sit on the direct road corridor toward Goma and Bukavu (Section 2.3).

★ **South Kivu's confirmed transmission remains flat; its risk posture does not.** Miti-Murhesa, the province's only affected zone since May (3 cases, 1 death), had gone 79–92 days without a new confirmed case across the sources reviewed for this edition. Separately, Bukavu — South Kivu's capital, a much larger and entirely unaffected health zone — suspended large public gatherings as a precaution, and the city's Ibanda health zone issued its own vigilance call despite zero confirmed cases locally (Kivu-Avenir). This is a precautionary and geographic story, not yet a confirmed-case one; Section 2.3 sets out why Pandemic Shield treats it as this edition's most consequential development regardless.

• **The national curve has re-accelerated, not plateaued.** Cases rose from 5 656 (25 Aug) to 6 604 (5 Sep) — 948 new confirmed cases in 11 days, ~86/day — faster than the ~61/day pace recorded between the 19 and 25 August cuts in the last edition. Deaths rose from 2 715 to 3 175 over the same window; CFR held at 48.1 %.

★ **DRC launched a revised, national 180-day response plan costed at USD 1.3 billion** on 4 September in Kinshasa, with WHO AFRO and Africa CDC support. No source reviewed clarifies how this national plan relates to Africa CDC's own USD 1.4 billion continental strategic-plan ask from late June — whether additive, overlapping, or in the process of being reconciled is an open question carried into Section 6.4.

• **Vaccine doses have moved from delivery to administration.** More than 16 000 of the 70 000 Ervebo doses released from the global stockpile on 18 August had physically arrived in DRC by 22 August, with administration to frontline workers and trial participants under way per WHO and press reporting — a concrete step beyond the prior edition's "doses reached the outbreak zone" milestone.

• **National contact-tracing follow-up kept improving even as the case count re-accelerated** — up to ~88.5 % (3 Sep) from 82.9 % (19 Aug) nationally, though no fresher province-level split was located to confirm whether Haut-Uélé and Bas-Uélé have closed their gap to the 95 % operational threshold.

★ **The health-worker payment dispute remains unresolved, and is now drawing open political criticism.** On 8 September, opposition figure and former human-rights minister Marie-Ange Mushobekwa accused the government of prioritising constitutional-revision debates over the outbreak response, calling the response "calamitous" — the first domestic political attack of this kind identified in the sources reviewed.

• Uganda's closure holds; no change since the WHO-confirmed 26 August closure. A first small private-sector financing signal appeared: Chinese mining companies operating in DRC reportedly contributed USD 1 million to the response in early September (Actualite.cd).

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> ***Assessment — trajectory.*** *The epidemic's growth has not slowed since the last edition — it has re-accelerated (~86 cases/day over 25 Aug–5 Sep vs ~61/day over 19–25 Aug), and the geographic story has shifted from the pure northward/eastward spread tracked in the last two editions (Bas-Uélé, the South Sudan border) to a southward one: North Kivu's growth is now concentrated on the Beni–Butembo–Katwa axis, the same road corridor that continues south to Goma and Bukavu. South Kivu's own confirmed count has not moved since late May, so this is, on the evidence available, a proximity and preparedness story rather than a confirmed-transmission one — but it is the correct thing to be watching. This is an assessment by Pandemic Shield and not a position taken by any of the authorities cited.*

1. Outbreak Overview (as of 5 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. Unchanged since the last edition.
PHEIC status	Declared 17 May 2026 by the WHO Director-General under IHR Article 12; remains in force past 110 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 over 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 — six provinces, 61 of 151 health zones (40.4 %), up from 58/151 at the last edition. North Kivu's affected-zone count rose fastest (12→16 of 34) in the sixteen days since its 19 August cut-off (Section 2.3).
Confirmed cases (DRC)	**6 604**, national reporting point of 5 September (published 8 Sep, Actualite.cd citing COUSP). Most recent fully disaggregated INSP SitRep obtained for this edition remains N°097 (19 Aug): 5 290.
Confirmed deaths (DRC)	**3 175** (5 Sep). National CFR 48.1 %; 47.6 % at the 19 Aug SitRep.
Recovered	1 548 cumulative (5 Sep, per Actualite.cd); 1 495 at 3 Sep (Congo Synthèse); 1 245 at the 25/26 Aug cut-off of the last edition.
Patients in isolation	851 (5 Sep); 738 (3 Sep); 792 at the last edition's 25 Aug cut-off. Bed-occupancy detail in Section 4.1 was not refreshed for this edition (no newer treatment-capacity table was located).
Frontline workers infected	154 confirmed (Ituri 140, North Kivu 14) with 46 deaths per INSP SitRep N°082 (4 Aug) remains the most recent officially disaggregated figure located. Press reporting from 19–21 August cites "quelque 160" infections (La Libre, 21 Aug) and at least 45 deaths (RT/Reporter.cd); no fresher or reconciled INSP figure was located for this edition — unchanged data gap from the last edition.
Uganda	**Outbreak closed.** 20 confirmed cases, 2 deaths. Ministry of Health self-declared over on 28 July (42 days without a new case); WHO confirmed closure 26 August. No change since the last edition.
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. No new imported case reported since 30 July.
Vaccine / treatment	None licensed specifically for BDBV. Of the 70 000 Ervebo (Zaire-strain, Merck) doses released from the global emergency stockpile on 18 August, **more than 16 000 had physically arrived in DRC by 22 August** (Al Jazeera, La Libre) with administration to frontline workers and the Phase 3 cross-protection trial under way per subsequent press reporting — the concrete-deployment update this edition adds to Section 5.
Comparator — 2018–2020 Kivu	Surpassed on 31 July 2026 (confirmed-case count 3 532 vs 3 481 including probable; 3 323 confirmed over 694 days of response). At 6 604 confirmed cases, the 2026 outbreak is roughly 90 % larger than the 2018–2020 Kivu epidemic's final confirmed count and remains second only to the 2014–2016 West African epidemic (28 616 cases, 11 310 deaths) in the historical record.

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Global risk assessment	WHO: DRC risk very high; neighbouring countries — including South Sudan given the Bas-Uélé extension — assessed high for cross-border spread. South Kivu's international exposure is broader than any other affected province: it borders Rwanda, Burundi, and (across Lake Tanganyika) is within short transit of Tanzania, which is part of why Africa CDC's regional alert in May named ten at-risk African countries once South Kivu was first confirmed (Section 6.2). ECDC: likelihood of infection for people in the EU/EEA remains very low; guidance in force.

2. Epidemiological Analysis — Provincial and Health Zone Distribution

Province	Confirmed cases	Deaths	CFR	Health zones affected	As of
Ituri	**~5 323**	n/a	n/a	28 / 36 (77.8 %)	3 Sep (share) / 19 Aug (zones)
North Kivu	**969**	n/a	~66–70 %	16 / 34 (47.1 %)	4 Sep
Haut-Uélé	160	71	44.4 %	6 / 13 (46.1 %)	19 Aug
Tshopo	16	7	43.8 %	7 / 23 (30.4 %)	3 Sep (cases) / 19 Aug (zones)
South Kivu	3	1	33.3 %	1 / 34 (2.9 %)	Unchanged since 24 May; 79–92 d. no new case
Bas-Uélé	2	1	50.0 %	2 / 11 (18.2 %)	19 Aug
Total (5 Sep, national)	**6 604**	**3 175**	**48.1 %**	**61 / 151**	

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.
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. Last edition's national data cut-off.
31 Aug 2026	**6 100**	**2 950**	**48.4 %**	7sur7.cd; 60/151 health zones nationally for the first time.
3 Sep 2026	**6 436**	**3 095**	**48.1 %**	Congo Synthèse dashboard; national contact follow-up 88.5 %.
5 Sep 2026	**6 604**	**3 175**	**48.1 %**	Actualite.cd (8 Sep), citing COUSP; 61/151 health zones; +82 new cases on the day.

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> ***Interpretation.*** *Confirmed cases rose 17 % and confirmed deaths rose 17 % in the eleven days from 25 Aug to 5 Sep, at an average of ~86 new cases/day — faster than the ~61/day pace over the prior edition's final six-day window (19→25 Aug), and closer to the ~91/day pace recorded over 9→19 Aug. Read together with national contact-tracing follow-up that kept improving over the same period (82.9 %→88.5 %), the acceleration is more consistent with genuinely faster transmission than with a surveillance artefact — a surveillance system finding more cases without also improving its follow-up rate would be the more likely signature of a detection-driven rather than transmission-driven rise. CFR has now held in the 48.0–48.4 % band for three consecutive cuts (31 Aug, 3 Sep, 5 Sep) after climbing steadily since June; whether this is a genuine plateau or another short window of reporting noise is not yet resolvable from an eleven-day series, exactly as flagged for the equivalent six-day window in the last edition.*

2.2 Geographic distribution of confirmed cases

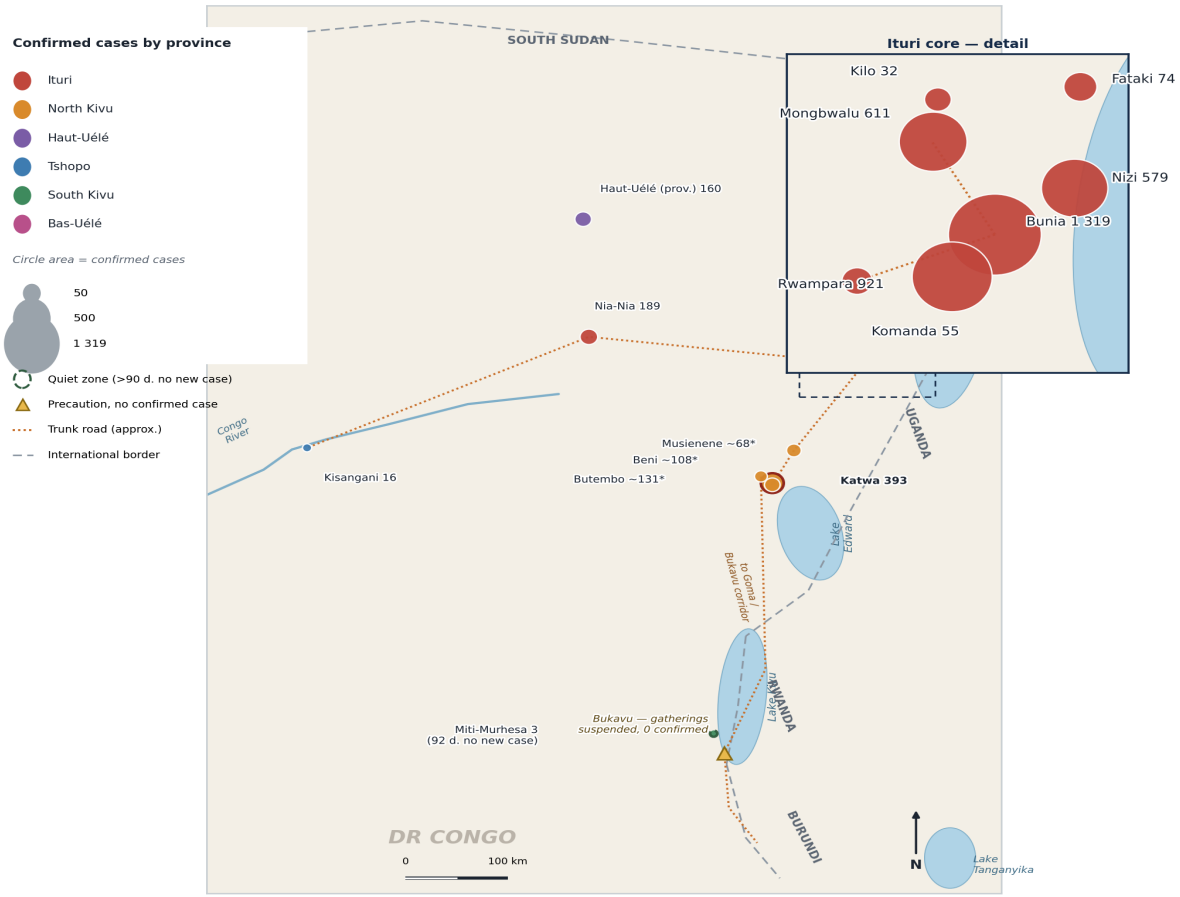

FIGURE 1 — Confirmed BDBV cases by health zone, six affected provinces. Ituri and Tshopo figures are the most recent zone-level cut obtained (INSP/COUSP SitRep N°097, 19 Aug, cross-checked against later provincial totals where available); North Kivu's Katwa figure and provincial total are updated to 1–4 September; South Kivu shows the unchanged Miti-Murhesa count and Bukavu's precautionary posture. Circle area is proportional to confirmed cases; the Ituri core (Bunia–Rwampara–Mongbwalu–Nizi–Komanda–Fataki–Kilo) is close together in reality and is shown enlarged in the inset. ***Coordinates for provincial capitals and major towns (Bunia, Beni, Butembo, Goma, Bukavu, Uvira, Kisangani, Buta, Isiro) and the lake chain and international borders were cross-checked against live OpenStreetMap map views during compilation;*** *smaller health-zone localities are positioned as accurately as those checks allow but are not independently surveyed. This session's network policy blocked direct OSM tile and geocoder retrieval, so the map is redrawn from verified coordinates rather than built from literal OSM tile imagery — an improvement in geographic accuracy over the fully schematic map in the 27 August edition, short of a literal embedded OSM basemap.*

2.3 THE SOUTHWARD CORRIDOR — NORTH KIVU'S ADVANCE TOWARD SOUTH KIVU

This subsection is new in this edition, added because the most consequential change in the six-day-to-two-week epidemiological picture since 25 August is not a new province (as Bas-Uélé was in the last edition) but an acceleration inside an existing one, on a road that leads directly toward the province this report has been asked to watch most closely.

Date	North Kivu cases	Deaths	CFR	Health zones (of 34)	Source
19 Aug 2026	663	452	68.2 %	12	INSP SitRep N°097

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Date	North Kivu cases	Deaths	CFR	Health zones (of 34)	Source
30 Aug 2026	836	n/a	n/a	n/a	RT en français (7 Sep, retrospective)
1 Sep 2026	875	609	70.0 %	15	Radio Okapi
4 Sep 2026	**969**	n/a	**66.0 %**	**16**	RT en français (7 Sep)

Katwa, not Beni or Butembo, is now the province's epicentre. Of North Kivu's 969 cumulative cases (4 Sep), Katwa health zone alone accounted for 393 cases and 284 deaths as of the most recent zone-level figure located (early September, ~1 Sep data), with Butembo and Beni continuing to add cases (six and four, respectively, on 1 September alone) and smaller additions reported in Maseraka, Lubero, Mabalako and Manguredjipa. Katwa sits immediately north of Butembo, on the same road corridor this report's Figure 1 traces south through Beni, Butembo, Katwa, Musienene and onward to Goma and Bukavu — the corridor is not a Pandemic Shield construction, it is the actual road network connecting North Kivu's outbreak zone to South Kivu's capital.

South Kivu itself: confirmed transmission flat, risk posture rising. Miti-Murhesa — a rural health zone in Kabare territory, northwest of Bukavu — remains South Kivu's only zone with a confirmed case, at 3 cases and 1 death since two cases were confirmed on 24 May. Sources reviewed for this edition put the zone at 79 days without a new confirmed case (Congo Synthèse, 3 Sep) and separately at 91–92 days (Radio Okapi press review, 3 Sep; Congo Quotidien, 6 Aug retrospective) — the discrepancy is not reconciled in the sources and is likely a function of which exact day each outlet counted from. Bukavu itself — the provincial capital, a separate and far larger health zone that has never recorded a confirmed case — pre-emptively suspended large public gatherings as an Ebola-preventive measure, and Bukavu's Ibanda health zone separately issued its own call for vigilance "despite the absence of reported cases" in the city (Kivu-Avenir; both items could not be fully retrieved due to this session's access restrictions on that outlet and are cited from their published headlines).

Why this matters more than South Kivu's raw case count suggests. South Kivu is the only affected province bordering more than one other country — Rwanda and Burundi directly, and Tanzania within a short crossing of Lake Tanganyika — which is why Africa CDC's regional risk alert in May, triggered by South Kivu's first case, named ten African countries at elevated risk rather than the two or three bordering Ituri or Bas-Uélé (Section 6.2). A province with this international exposure profile going from "quiet" to "actively transmitting," even from a low base, would carry disproportionate downstream consequences relative to an equivalent rise in, say, Tshopo.

> ***Assessment — the corridor.*** *Pandemic Shield draws a clear line between what is confirmed and what is anticipatory here, and thinks that line matters more than the headline framing of "Ebola reaching South Kivu." What is confirmed: North Kivu's outbreak is accelerating on a corridor that geographically continues to Bukavu, and the province's own capital has judged the risk high enough to pre-emptively restrict gatherings before any case has been confirmed there. What is not confirmed: any growth in South Kivu's own case count, any specific chain of transmission linking Katwa to Bukavu, or any World Health Organization risk-level change specific to South Kivu since May. On the evidence available, the responsible framing is that South Kivu is this outbreak's most consequential province to watch over the next reporting cycle — not that it is currently experiencing a surge. Whether Pandemic Shield's read holds is directly testable against the next INSP SitRep and against whether Miti-Murhesa's confirmed count moves off 3.*

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

Province	New positive results	Samples analysed	Positivity
Ituri	56	265	21.1 %
North Kivu	18	127	15.0 %

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Province	New positive results	Samples analysed	Positivity
Haut-Uélé	7	30	23.3 %

Laboratory positivity of 15–23 % across the three provinces still reporting this indicator is, as in the last two editions, well above the 5–10 % range associated with adequately broad testing — the same reasoning Africa CDC uses publicly to support its estimate that only 30–40 % of actual infections are being confirmed (Section 9).

3.2 Contact tracing (national)

Province	Contacts under follow-up	Contacts seen	Follow-up rate	As of
Ituri	10 509	9 204	87.6 %	19 Aug
North Kivu	7 540	5 830	80.5 %	19 Aug
Haut-Uélé	1 498	848	56.6 %	19 Aug
Bas-Uélé	220	131	59.5 %	19 Aug
Tshopo	473	473	100 %	19 Aug
National (19 Aug)	**19 720**	**16 355**	**82.9 %**	
National (3 Sep)	**n/a — not disaggregated**	**n/a**	**88.5 %**	Congo Synthèse

National follow-up improved a further 5.6 points to 88.5 % by 3 September, continuing the improvement already noted in the last edition (77.8 %→82.9 % over 30 Jul–19 Aug). No province-level breakdown at the 88.5 % national figure was located for this edition, so whether Haut-Uélé and Bas-Uélé specifically have closed on the 95 % operational threshold — both were still 10+ points below it at the last edition — cannot be confirmed here and is carried forward as an open item in Section 7.

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

Facilities operational	98.7 % of points of entry / control active or reinforced. No fresher figure located.
Travellers screened	313 381 persons transited monitored points (19 Aug indicator); 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.
Bas-Uélé / South Sudan crossings	No province-level detail located in any source reviewed for this edition. Given Bas-Uélé's confirmed case sits an estimated 35 km from the South Sudan border along high-risk travel corridors (unchanged from the last edition), this remains an unresolved operational gap (Section 7).

4. Case Management, Burials and the Frontline Workforce

4.1 Treatment capacity (last figures located: 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 %*

Ituri's province-wide occupancy of 57.1 % still conceals severe local saturation: a Nature Medicine correspondence (data ~1–4 Aug) recorded 278 % occupancy at Nizi ETC, 200 % at the Fataki transit centre, 123 % at ISTM-Nyakunde and 104 % at CME-Bunia. North Kivu's 95.1 % province-wide figure — with Katwa now the province's confirmed epicentre (Section 2.3) — is the indicator most likely to have deteriorated further since 19 August; no fresher figure was located to confirm this one way or the other.

4.2 Frontline workers infected

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

No fresher province-level breakdown was located for this edition. Press reporting from 19–21 August — "quelque 160 cas d'Ebola parmi le personnel soignant" (La Libre, 21 Aug) and "au moins 45 professionnels de santé" dead (RT en français, Reporter.cd, Beninwebtv, similar dates) — puts the toll modestly higher than the 4 August INSP figure, consistent with continued attrition, but these press figures have still not been reconciled against an INSP series in any source obtained for this edition, an unchanged gap from the last edition.

> ***Assessment — workforce.*** *The pay dispute flagged as the single most tractable constraint in the 30 July edition remains unresolved four months into the response, and this edition's evidence — the plausible attrition implied by the higher press figures, the fresh political criticism logged in Section 7, and North Kivu's occupancy already sitting at 95 % before its case count re-accelerated — points the same direction as last time: unpaid wages, overcrowding and case growth are reinforcing each other rather than resolving. No confirmed disbursement against the pay dispute has been documented in any source obtained since the outbreak's declaration.*

5. Medical Countermeasures — Four Trials, Vaccine Doses Now Being Administered

The last edition's defining development was the arrival of the first real vaccine doses in the outbreak zone, deployed under a research/informed-consent framing rather than as a proven countermeasure. This edition's update is operational rather than evidentiary: doses have moved from delivery to administration, but no new efficacy or cross-protection data was located, so Pandemic Shield's diligence conclusions from the last edition (Section 5.1) are carried forward unchanged.

Trial	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 100 confirmed cases enrolled across three facilities in Ituri as of 14 Aug (WHO DON) — no fresher enrolment figure located for this edition.
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.
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; centres adjacent to ALIMA treatment centres in Bunia and Rwampara. No enrolment update located this edition; current contact lists reportedly followed at 82.9 %→88.5 % 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 concluded the Phase 3 trial should run without a preceding Phase 2. 70 000 doses released 18 August: 20 000 for the trial, 50 000 for frontline/health-worker protection. **Over 16 000 doses had physically arrived in DRC by 22 August** (Al Jazeera, La Libre, UN News) with administration under way per subsequent press reporting; no source located specifies how the arrived doses split between the trial arm and frontline protection.

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Assessment — countermeasures. *Unchanged from the last edition: the Ervebo deployment is best read as an evidence-informed hedge, not a breakthrough. What has changed operationally is that the hedge is now reaching arms rather than sitting in warehouses — over 16 000 of 70 000 doses delivered inside four days of the stockpile release is a genuinely fast logistics turnaround for the outbreak zone described elsewhere in this report as facing PPE shortages and unpaid staff. Classical containment — isolation, contact tracing, safe burials and community engagement — remains the only fully proven tool, and North Kivu's re-acceleration in a context of 95 % bed occupancy (Section 4.1) is the sharpest current test of whether that containment machinery is keeping pace.*

6. Regional and International Situation

6.1 Uganda — outbreak closed

Unchanged since the last edition. Uganda's Ministry of Health declared its own outbreak over on 28 July, 42 days after its last confirmed case; WHO confirmed closure a month later, on 26 August. Final toll: 20 confirmed cases, 2 deaths, all epidemiologically linked to travel from DRC. Uganda continues to support treatment capacity at two sites inside DRC. No update was located this edition on the 22 border crossing points or the mobile laboratory at Bwera Hospital referenced in earlier editions.

6.2 Bas-Uélé and the South Sudan question

Unchanged since the last edition: the single confirmed case in Buta (13 Aug) remains DRC's most consequential northward geographic development, sitting an estimated 35 km from the South Sudan border along high-risk travel corridors (Mercy Corps). No confirmed cross-border case has been reported inside South Sudan in any source reviewed for this edition, and no province-level detail on Bas-Uélé/South Sudan crossings was located (Section 3.3).

6.2b South Kivu's regional exposure — three borders, not one

South Kivu is the only affected province that borders more than one country: Rwanda and Burundi directly, with Tanzania a short crossing of Lake Tanganyika away from Uvira. This is the structural reason Africa CDC's regional risk statement in May, issued when South Kivu's first case was confirmed, named ten African countries at elevated risk — a far wider net than the two-to-three-country alerts triggered by Ituri's Uganda/South-Sudan exposure or Bas-Uélé's South Sudan exposure alone. No update to that ten-country regional risk categorisation was located for this edition; it is referenced here as the standing analytical basis for why Section 2.3's corridor development deserves more weight than South Kivu's own case count would otherwise suggest.

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 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 discharged with no secondary transmission documented in either receiving country, and no new imported case outside Africa was reported in any source reviewed for this edition. ECDC's risk assessment continues to state that "the likelihood of infection for people living in the European Union/European Economic Area is considered to be very low."

6.4 Financing — three separate uncertainties, not one funding gap

The single largest financing development since the last edition is not a change to the continental requirement Africa CDC has been citing since late June, but the announcement of a distinct, national instrument: DRC and its partners (with WHO AFRO and Africa CDC support) launched a revised **180-day multisectoral response plan costed at USD 1.3 billion** on 4 September in Kinshasa, covering surveillance, case management, risk communication and logistics across the six affected provinces. Pandemic Shield treats the resulting funding picture as uncertain on three separate counts, and is deliberately not collapsing them into a single headline figure. **First**, no source obtained states whether this 180-day national plan sits inside, alongside, or supersedes Africa CDC's own USD 1.4 billion continental strategic-plan requirement from late June — the two totals are close enough (within 8 %) that they could plausibly be re-statements of largely the same ask, but no source makes that reconciliation explicit. **Second**, the pledge and disbursement figures this report has carried for the continental plan — ~USD 910 million pledged, ~13 % disbursed — are frozen at a mid-to-late-June data point; no source reviewed in the roughly eleven weeks since has reconfirmed or updated either number, so the true current position could be better or worse than what this report is still citing. **Third**, no pledge or disbursement figure of any kind has yet been located for the new national plan itself, so calling it underfunded would be an assumption, not a documented fact — the honest description is that its funding status is simply unknown.

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Instrument	Period	Requirement	Funding status
Africa CDC continental strategic plan (revised)	Jun–Dec 2026	USD 1.4 bn	~USD 910 m pledged (17 Jun AU High-Level Meeting) and ~13 % disbursed (mid-to-late June) remain the most recent figures located; neither has been reconfirmed by any source in the ~11 weeks since, so both are stale reference points, not a confirmed current status.
DRC national 180-day response plan (new)	4 Sep 2026 – ~Mar 2027	USD 1.3 bn	Launched 4 Sep in Kinshasa; no pledge or disbursement figure of any kind located yet in the sources reviewed for this edition. Relationship to the Africa CDC continental ask above is not clarified in any source obtained.
Private-sector contribution (new)	Early Sep 2026	USD 1 m (reported)	Chinese mining companies operating in DRC reportedly contributed toward the response (Actualite.cd, 8 Sep) — the first domestic private-sector financing signal identified in the sources reviewed for either edition.

> ***Assessment — financing.*** *Conflating this edition's three funding uncertainties into a single number would overstate how much is actually known. A naive sum of the two plans — USD 2.7 billion — is only a meaningful planning figure under the additive reading, and no source has confirmed that reading over the alternative, that the national plan restates rather than adds to the continental ask; the two readings imply very different real financing needs. Separately, the ~USD 910 million pledged / ~13 % disbursed figures this report has carried since June are themselves now roughly eleven weeks stale and unconfirmed by later reporting — treating them as still accurate is an assumption in its own right, not a fact carried forward. And separately again, the new national plan's funding status is not "underfunded" but simply undocumented: no source obtained states what, if anything, it has attracted. Pandemic Shield's assessment is that the responsible planning position is not one figure but three open questions to track into the next edition: whether the two plans reconcile, whether the continental plan's financing has moved since June, and whether the national plan has attracted any funding at all.*

6.5 Coordination architecture

Unchanged since the last edition. Coordination continues on the "one plan, one budget, one team" model, run by the DRC Public Health Emergency Operations Centre (COUSP) within INSP. The operative developments are the ones already described above: the new national financing plan, North Kivu's acceleration and South Kivu's precautionary posture, and continued attrition in the frontline workforce.

7. Principal Constraints — National Response Assessment

The table below 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 COUSP's SitRep series where cited, supplemented by the press and correspondence sources identified against each row.

Constraint	Impact	Required action / status
North Kivu's southward acceleration, closing on South Kivu	Cases up 46 % in 16 days (663→969, 19 Aug→4 Sep); Katwa now the province's epicentre on the same corridor that continues to Goma and Bukavu. South Kivu's own case count is flat, but the province has no second confirmed zone to draw on for surge capacity if that changes.	Pre-position surge capacity and ring-fenced surveillance staffing in South Kivu now, before a confirmed case rather than after one — new recommendation this edition, extending the last edition's Haut-Uélé/Bas-Uélé staffing recommendation south.
Health-worker non-payment, now 4+ months unresolved	Strikes and facility abandonment reported since early July; fresh political criticism (8 Sep) alleges the government is distracted by unrelated constitutional-revision debate. No documented disbursement since the outbreak's declaration.	Regularise provider payments; secure a dedicated, ring-fenced financing line — repeated from both prior editions with no confirmed progress.
Treatment-centre overcrowding as an active transmission driver	278 % (Nizi), 200 % (Fataki), 123 % (ISTM-Nyakunde) and 104 % (CME-Bunia) occupancy in Ituri; 95.1 % province-wide in North Kivu even before its case count re-accelerated (Nature Medicine correspondence; INSP SitRep).	Deploy modular isolation units; restore transparent, facility-level bed-availability reporting — unchanged recommendation, now more urgent given North Kivu's growth.

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Constraint	Impact	Required action / status
Contact tracing still below threshold in the newest provinces	National follow-up improved to 88.5 % (3 Sep, from 82.9 % at 19 Aug), but no province-level split was located to confirm whether Haut-Uélé (56.6 %) and Bas-Uélé (59.5 %) — both far below the 95 % threshold at the last edition — have closed the gap.	Prioritise surveillance staffing and RECO community-relay deployment in Haut-Uélé and Bas-Uélé specifically, pending confirmation of current rates.
Geographic extension outpacing preparedness — now a two-front problem	Confirmed transmission ~35 km from the South Sudan border (Bas-Uélé/Buta) and a rapidly worsening North Kivu corridor bearing down on South Kivu's international borders with Rwanda, Burundi and (via Lake Tanganyika) Tanzania.	Extend priority point-of-entry screening and cross-border coordination to both the Bas-Uélé/South Sudan and the North-Kivu/South-Kivu axes — broadened this edition from the single-axis recommendation in the last one.
Decentralised diagnostics still incomplete	Laboratory positivity of 15–23 % across the three provinces still reporting this indicator (unchanged since the last edition) indicates confirmation lag, not incidence.	Accelerate deployment of decentralised diagnostic capacity, particularly in Haut-Uélé and Bas-Uélé — unchanged.
Insecurity, restricted access, and a converging displacement crisis	Unchanged pattern of attacks on response teams carried from prior editions, now compounded by a separate but geographically overlapping crisis: families displaced from AFC/M23 conflict in Masisi are moving toward Walikale, inside North Kivu's outbreak footprint (Congo Quotidien, 6 Sep). No direct causal link between the two crises is established in sources reviewed, but the overlap raises population-movement risk in exactly the province now accelerating fastest.	Reinforce security coordination for response teams; response planning should explicitly account for displacement-driven population movement inside the North Kivu outbreak zone — new this edition.
True burden likely understated	Africa CDC officials cite press reporting estimating only 30–40 % of actual infections are detected, implying a true burden of roughly 16 500–22 000 against 6 604 confirmed (Pandemic Shield extrapolation; unchanged methodology from the last edition, updated to the new confirmed total).	No specific COUSP-tabulated action identified; flagged as a standing analytical caveat on every count in this report.
Political prioritisation of the response	New this edition: on 8 September, opposition figure Marie-Ange Mushobekwa publicly accused the government of prioritising constitutional-revision debate over the epidemic response, calling it "calamitous" — the first domestic political criticism of this kind identified in the sources reviewed for either edition.	Flagged as an emerging governance risk to watch, not (yet) as an established operational fact; no COUSP or WHO response to the criticism was located.
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.

8. What Is Established and What Remains Unresolved (5 September 2026)

✔ Established	? Unresolved or contested
6 604 confirmed cases and 3 175 confirmed deaths as of 5 September across six provinces and at least 61 of 151 health zones; the outbreak has grown 17 % in cases since the last edition's 25 August cut-off.	Whether the 25 Aug→5 Sep acceleration (~86 cases/day) is a genuine and durable re-acceleration or a short eleven-day window against still-improving (not yet complete) surveillance — not independently resolvable from the series available.
North Kivu's confirmed count rose 46 % in the sixteen days to 4 September (663→969), with Katwa health zone now the province's confirmed epicentre (393 cases, 284 deaths) on the road corridor toward Goma and Bukavu.	Whether North Kivu's acceleration will translate into new confirmed transmission in South Kivu: Miti-Murhesa's count has not moved off 3 since May, and no source establishes a transmission chain linking Katwa to South Kivu.
Bukavu (South Kivu's capital) and its Ibanda health zone have adopted precautionary measures — suspending large gatherings and issuing a vigilance call — despite zero confirmed cases in the city.	How much of Bukavu's precautionary posture reflects a specific, non-public risk signal versus general regional prudence given North Kivu's trajectory; the underlying justification was not located in the sources obtained.

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✔ Established	? Unresolved or contested
DRC and partners launched a costed, national 180-day response plan (USD 1.3 bn) on 4 September, alongside continued administration of the first Ervebo doses (16 000+ delivered by 22 August).	Whether the new USD 1.3 bn national plan is additive to, or a restatement of, Africa CDC's USD 1.4 bn continental ask — and what has actually been pledged or disbursed against either, beyond the stale ~13 % disbursement figure carried since June.
National contact-tracing follow-up improved to 88.5 % by 3 September, continuing the improvement trend noted in the last edition.	Whether Haut-Uélé and Bas-Uélé specifically — both well below threshold at the last edition — have closed the gap; no province-level breakdown at the newer national figure was located.
National CFR has held in a narrow 48.0–48.4 % band across three consecutive data cuts (31 Aug, 3 Sep, 5 Sep), after climbing steadily every prior edition since June.	Whether this represents a genuine plateau in lethality/detection dynamics or another short window of noise, as an equivalent-looking plateau at the last edition partly was.

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.

★ **Watch South Kivu, not because its numbers demand it, but because its geography does.** A province with three international borders sitting one road corridor away from an accelerating outbreak zone is this report's highest-value indicator to track over the next reporting cycle — more so than any single province's raw case count, including South Kivu's own.

• **The record keeps breaking, and the pace has picked back up.** At 6 604 confirmed cases the outbreak is roughly 90 % larger than the 2018–2020 Kivu epidemic's final confirmed count, and the 25 Aug–5 Sep growth rate (~86 cases/day) is faster than the ~61/day pace that briefly suggested deceleration in the last edition. That apparent deceleration did not hold.

★ **North Kivu's Katwa-centred acceleration is this edition's most important confirmed development** — not the more attention-grabbing South Kivu framing. Planning should treat the Beni–Butembo–Katwa–Goma–Bukavu corridor as a single epidemiological unit rather than as separate provincial problems.

• **Rising CFR has plausibly stabilised, but the underlying signal it was tracking has not disappeared.** A CFR holding near 48 % is still consistent with a response detecting a large share of its cases only at or after death, exactly as MSF described in the last edition; a stable-but-high CFR is not evidence of an improving response on its own.

★ **The financing picture carries three separate uncertainties, not one funding gap** (Section 6.4): whether the USD 1.3 bn national plan and USD 1.4 bn continental plan are additive or the same ask restated; whether the continental plan's ~13 % disbursement figure, unconfirmed since June, still holds eleven weeks on; and whether the national plan has attracted any funding at all. Planning assumptions should treat all three as open rather than resolving any of them by default.

• **Vaccine deployment has crossed from pledge to practice**, which changes what is operationally testable next edition: whether administration reaches meaningful coverage among frontline workers, and whether any early signal on infection or severity among vaccinated responders emerges, distinct from the survivor-bias caveat flagged in the last edition.

• **For a purely illustrative sense of pace** — not a forecast — holding the most recent eleven-day increment (25 Aug→5 Sep, ~86 cases/day) constant would put the outbreak past 7 000 confirmed cases around 16–17 September. Holding the shorter 3→5 Sep increment (~84/day, from 6 436 to 6 604) constant points to almost the same date. Pandemic Shield does not treat either extrapolation as reliable beyond a few days, precisely because the underlying 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 via web search and retrieval on 8 September 2026 against primary official sources (INSP, WHO, ECDC, Africa CDC) and DRC/regional press (Actualite.cd, Congo Quotidien, Radio Okapi, RT en français, 7sur7.cd, Agence Ecofin, Reporter.cd, La Libre, Al Jazeera) plus one aggregation dashboard (Congo Synthèse). Two Kivu-Avenir articles on Bukavu's precautionary measures ([17],[18]) could not be fully retrieved due to access restrictions on that domain and are cited from their headlines and surrounding search context only — flagged explicitly rather than treated as fully verified. All other numbered sources in Sections A–C were independently fetched and read in full. Every figure in the report body was cross-checked against surrounding figures for internal consistency (e.g., the health-zone-count/province-share arithmetic flagged in Section 2's footnote); where two sources disagreed and neither could be shown to supersede the other, both are shown rather than silently reconciled (North Kivu's CFR in Section 2; Miti-Murhesa's days-since-last-case in Section 2.3). Section D sources carry forward from the 27 August predecessor edition without independent re-verification beyond a plausibility check against newer reporting; readers relying on this report for time-sensitive decisions should weight Section D citations accordingly. Changes from the 27 August edition: national and provincial figures updated throughout to 5 September; a new Section 2.3 traces the North Kivu–South Kivu corridor and is this edition's central analytical addition; Section 6 gains a new South-Kivu regional-exposure discussion (6.2b) and an updated, more cautious financing section (6.4) reflecting the new 180-day national plan; Section 7 gains two new constraint rows (the corridor itself, and political prioritisation); Figure 1 is redrawn with real-world coordinates cross-checked against OpenStreetMap, replacing the fully schematic layout used before.*

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