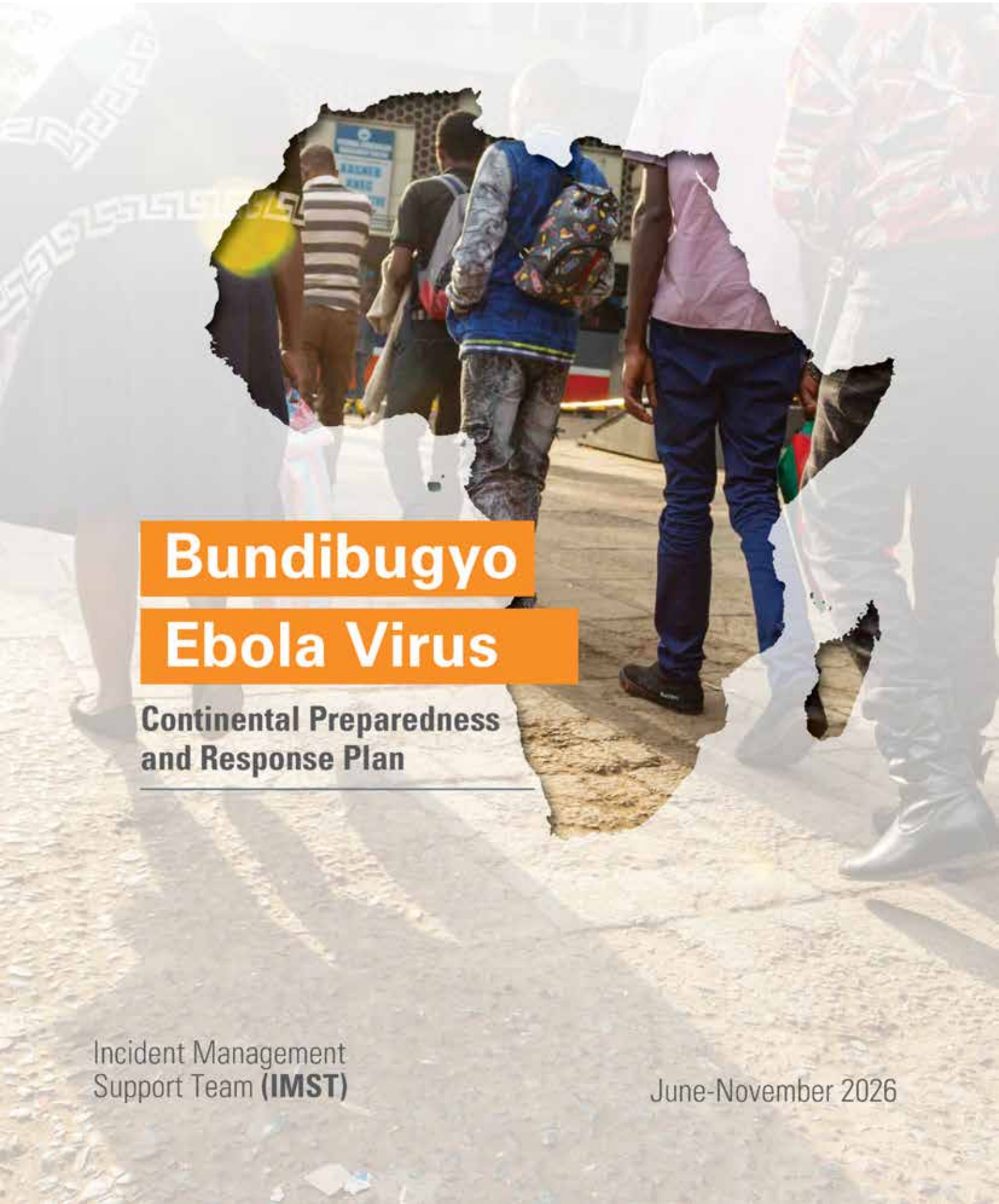
AfricaCDC
Centres for Disease Control and Prevention

World Health Organization



Bundibugyo Ebola Virus

Continental Preparedness and Response Plan

Incident Management Support Team **(IMST)**

June-November 2026

One Africa, One Team, One Plan, One Budget, and One M&E Framework

H.E. Evariste Ndayishimiye

President, Republic of Burundi
Chairperson of the African Union

Africa has repeatedly demonstrated its ability to confront public health emergencies with courage, solidarity, and determination. Today, as our continent faces a new outbreak of Ebola Virus Disease caused by the Bundibugyo ebolavirus in the Democratic Republic of the Congo and Uganda, we are once again called upon to act collectively to protect our populations and safeguard the progress we have made toward development, security, and prosperity.

The fight against Ebola is not solely the responsibility of the countries directly affected. It is a shared responsibility of all Member States of the African Union. In an interconnected world, the health security of each nation depends on the health security of its neighbors. Prevention, preparedness, and response must therefore be guided by African solidarity, regional cooperation, and a common vision for a healthier and more resilient continent.

This Continental Ebola Preparedness and Response Plan reflects our collective commitment to act as One Africa, with One Team, One Plan, One Budget, and One Monitoring and Evaluation Framework. It provides a roadmap not only for supporting the countries currently affected but also for strengthening preparedness across high-risk countries, protecting vulnerable populations, preserving economic stability, and enhancing the resilience of our health systems.

We must ensure that our actions are guided by science, evidence, and risk assessment. While vigilance remains essential, unnecessary travel and trade restrictions can cause significant economic and social harm without improving public health outcomes. Instead, Member States should strengthen screening and surveillance at Points of Entry, reinforce cross-border collaboration, and invest in preparedness measures that enable early detection and rapid response.

I call upon all Member States, regional institutions, development partners, the private sector, researchers, civil society, and communities to support the implementation of this plan. Together, we can contain this outbreak, protect our people, and build stronger, more resilient health systems capable of responding to future epidemics and pandemics.

History has shown that crises can become opportunities for transformation. Let this response to Ebola stand as a testament to African leadership, African solidarity, and African solutions for African challenges.

Together, we will protect our people. Together, we will strengthen our continent. Together, we will prevail.

An urgent call to action to contain the Bundibugyo Ebola Outbreak

H.E. Cyril Ramaphosa,

South Africa's President and African Union Champion on Pandemic Prevention, Preparedness and Response

I thank Africa CDC for convening this important High-Level Ministerial Meeting at a critical moment for our continent.

Africa is once again being tested by a dangerous Ebola outbreak affecting the Democratic Republic of the Congo and Uganda, with a serious risk of wider regional spread.

The outbreak is unfolding in areas marked by intense population movement, insecurity, porous borders, humanitarian pressures and active trade corridors. These realities make rapid containment more difficult and increase the urgency of our collective response.

I pay tribute to the frontline health workers who have shouldered a succession of epidemics and outbreaks.

Yet, they continue to demonstrate unwavering commitment and stamina in the face of a highly dangerous and demanding public health threat.

It is of utmost importance that we ensure their lives and livelihoods are protected: by securing ample supplies of high quality personal protective equipment, ensuring there are enough health workers deployed to allow for rest and recouperation and equipping them with all the tools of trade they require to deliver high quality health and care.

I commend Africa CDC, under the leadership of Dr. Jean Kaseya, for acting swiftly and decisively in accordance with the mandate entrusted to the institution by African Heads of State and Government.

Africa CDC has led a unified strategy for the continent by immediately mobilising affected countries, coordinating regional preparedness, convening a ministerial platform and galvanising the joint incident management team in collaboration with the World Health Organization.

I commend the Governments of the Democratic Republic of Congo, Uganda and South Sudan for the courage and solidarity they demonstrated during the Kampala High-Level Ministerial Meeting.

At a moment of uncertainty, these countries chose cooperation over isolation and unity over fragmentation. This is the Africa we must continue to build.

The latest situation remains deeply concerning. We are witnessing continued transmission in the DRC, confirmed cases in Uganda and heightened risk for several neighbouring countries.

We have already lost more than 200 people. Africa CDC has said that this is the second largest Ebola outbreak after the one in West Africa in 2014.

Although, at the onset of this outbreak, there are no therapeutics and vaccines for the Bundibugyo strain, we have reason to be hopeful. Working together with Africa CDC and the World Health Organization through the interim medical countermeasures network, organisations such as GAVI, CEPI and UNITAID are working at speed on promising vaccine and therapeutic candidates towards clinical trials.

We strongly support these efforts, as Africa cannot continue to face deadly epidemics without equitable access to diagnostics, vaccines and treatments. We call on all relevant partners and manufacturers to accelerate research and development, strengthen genomic surveillance, expand laboratory systems, and fast-track the equitable delivery of safe and effective vaccines and therapeutics.

The Kampala meeting aligned behind a continental preparedness and response plan of approximately $319 million for the period June to November 2026. This plan

will support outbreak control in affected countries while strengthening preparedness in at least ten high-risk Member States.

Importantly, African countries themselves have already committed initial domestic contributions representing approximately 10 percent of the required financing. This demonstrates ownership and responsibility. Africa is no longer waiting passively for others to act.

In this spirit of African solidarity and African solutions to African challenges, the Government and people of South Africa are pleased to announce an initial contribution of U$5 million to Africa CDC in support of the ongoing continental Ebola response.

This contribution is a demonstration of our confidence in Africa CDC as the Public Health Agency of Africa and in the importance of collective continental action.

We encourage other Member States, African financial institutions, philanthropy and the African private sector to join this effort urgently.

I particularly welcome the mobilization of African business leaders, including Mr Aliko Dangote, Professor Benedict Oramah, Dr George Elombi, and Mr Simon Tiemtoré, who are stepping forward to support this response. Their engagement reflects a growing understanding that health security is also economic security, development security and continental security.

At the same time, we call on the international community to stand with Africa in a spirit of partnership, solidarity and respect. The world is safer when Africa is safer. Delayed support today will result in much higher human, social and economic costs tomorrow.

This outbreak reminds us that preparedness cannot begin when a crisis is already expanding.

We must continue investing in resilient health systems, strong national public health institutes, emergency operations centres, local manufacturing of medical countermeasures, community health workers, genomic surveillance and sustainable domestic financing.

Africa has the institutions, expertise and leadership to respond effectively.

What is required now is speed, unity, solidarity and trust in our collective capacity.

The people of the Democratic Republic of the Congo, Uganda and all countries at risk must know that they are not alone. Africa stands with them.

I thank you.

Call for African Health Sovereignty as Ebola Escalates

H.E. Mahmoud Ali Youssouf,
Chairperson,
African Union Commission

Your Excellency, the Head of State and Government, the Honourable Minister, the Director General of Africa CDC, distinguished partners, ladies and gentlemen.

I would first like to thank Africa CDC for promptly convening this important ministerial meeting on the Ebola outbreak, which is currently affecting the Democratic Republic of the Congo and Uganda with a high risk of regional spread.

I would also like to acknowledge the remarkable leadership of the Director General of Africa CDC, and the commitment of the governments of the Democratic Republic of the Congo, Uganda and South Sudan, who demonstrated at the Kampala meeting that Africa is capable of speaking with one voice to health threats by finalising a US$319 million response plan.

This epidemic reminds us of a fundamental truth: health security is now a matter of sovereignty, economic stability, peace and continental security. Africa can no longer remain vulnerable to repeated health crises.

It is unacceptable that nine years after the identification of the Bundibugyo Ebola virus, the world still has neither approved vaccines nor specific treatment against this strain. This reality must challenge us collectively. Our populations must no longer depend exclusively on the priorities, funding, supply chains and production capacities of other regions of the world to protect their health and lives.

This is why this crisis must accelerate our agenda for health sovereignty.

Excellencies, ladies and gentlemen, the African Union fully supports the declaration by Africa CDC of this epidemic as a Public Health Emergency of Continental Security, as well as its continental leadership role in coordinating the African response. We also welcome the coordination approach put in place around the principle of one team, one plan, one budget and one monitoring framework.

Africa must act in a coordinated, united and strategic manner. I salute African solidarity that is already beginning to materialise. I warmly congratulate His Excellency President Cyril Ramaphosa and the South African Government for their voluntary contribution of US$5 million to Africa CDC to support this continental response.

This gesture is significant. It is a concrete expression of the principle that African problems require African leadership and African responsibility. I also commend the mobilisation of the African private sector and other economic leaders on the continent who are standing with Africa in these difficult times.

This epidemic must also be a wake-up call to strengthen our investments in pandemic preparedness. We must accelerate the development of national public health institutes, emergency operations centres, surveillance systems, genomics, community health workers and, most importantly, African capacities for research, innovation and local manufacturing.

The African Union also continues to advance institutional reforms aimed at building a stronger, more effective and more responsive Union capable of delivering on the aspirations of our peoples.

This year's African Union Theme of the Year, 'Assuring Sustainable Water Availability and Safe Sanitation Systems to Achieve the Goals of Agenda 2063', highlights the importance of water security, climate resilience, public health and sustainable development as essential foundations for Africa's future.

The African Union will remain fully mobilised alongside Africa CDC, Member States and all committed partners to end this epidemic and build a more resilient, stronger and more sovereign Africa.

Thank you.

About Africa CDC

The Africa Centres for Disease Control and Prevention (Africa CDC) is a continental autonomous public health agency of the African Union that supports member states in efforts to strengthen health systems and improve surveillance, emergency response, and prevention and control of diseases.

Learn more at: **http://www.africacdc.org**

About World Health Organization

The World Health Organization contributes to a better future for people everywhere. Good health lays the foundation for vibrant and productive communities, stronger economies, safer nations and a better world. As the lead health authority within the United Nations system, our work touches people's lives around the world every day. In Africa, WHO serves 47 Member States and works with development partners to improve the health and well-being of all people living here. The WHO Regional Office for Africa is located in Brazzaville, Congo.

Learn more at **www.afro.who.int**

Incident Management Support Team (IMST)

AfricaCDC Centres for Disease Control and Prevention | An entity of the African Union | World Health Organization

Contents

Acronyms/Abbreviations

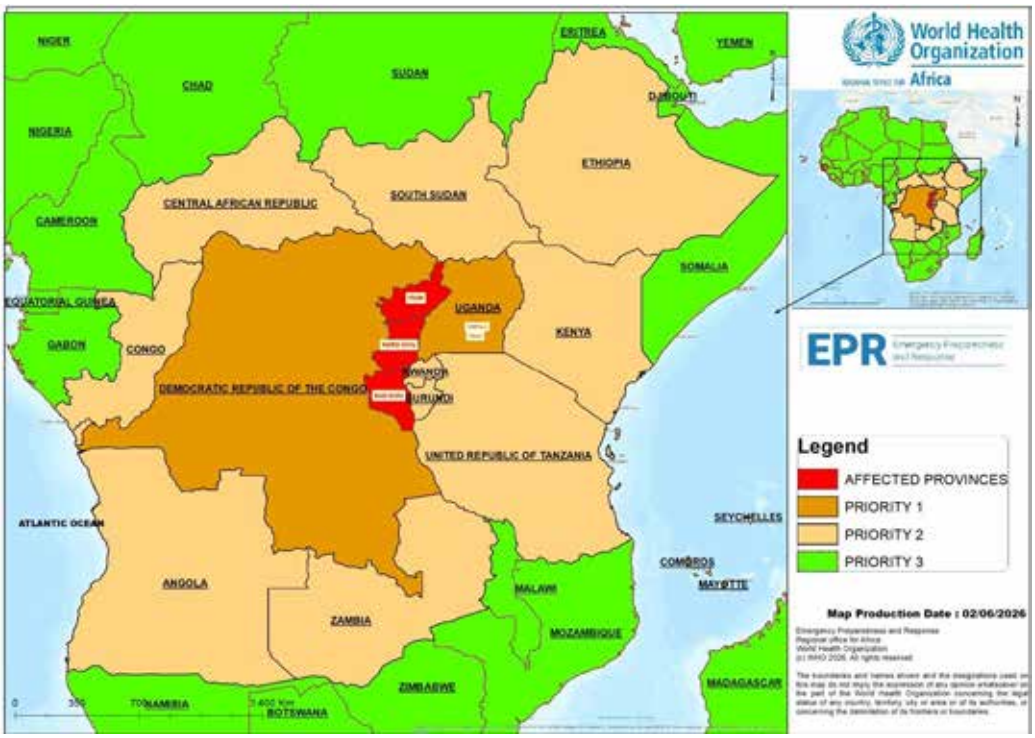
Africa CDC	Africa Centres for Disease Control and Prevention
ASLM	African Society for Laboratory Medicine
AU	African Union
CDC	Centres for Disease Control and Prevention
CFR	Case Fatality Ratio
CHWs	Community Health Workers
DRC	Democratic Republic of the Congo
ECG	Emergency Consultative Group
EPR	Emergency Preparedness and Response
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IHR	International Health Regulations
IFRC	International Federation of Red Cross and Red Crescent
i-MCM-net	Interim Medical Countermeasures Network
IMS	Incident Management System
IOM	International Organization for Migration
IPC	Infection Prevention and Control
MSF	Médecins Sans Frontières
M&E	Monitoring and Evaluation
MHPSS	Mental health and psychological support services
NPHI	National Public Health Institute
PPE	Personal Protective Equipment
PPPR	Pandemic Prevention and Preparedness Response
PHECS	Public Health Emergency of Continental Security
PHEIC	Public Health Emergency of International Concern
PSEAH	Prevention from sexual Exploitation, Abuse and Harassment
PRSEAH	Prevention and response to sexual exploitation, abuse, and Harassment
RCCE	Risk Communication and Community Engagement
SEAH	Sexual Exploitation, Abuse and Harassment
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organization

Foreword

The African continent continues to face an increasingly complex landscape of public health threats driven by emerging and re-emerging infectious diseases, climate and environmental change, rapid urbanization, population mobility, humanitarian crises, limited access to essential services and persistent health system vulnerabilities. Among these threats, Ebola disease remains one of the most severe epidemic-prone diseases with the potential to cause devastating human, social, economic, and security consequences if not rapidly detected and effectively contained.

The ongoing outbreak of Bundibugyo virus disease (BVD) in the Democratic Republic of the Congo (DRC) and Uganda, with associated regional risks for neighbouring countries, serves as a stark reminder that epidemic preparedness and response must remain a continental priority. The epidemiological situation is particularly concerning because the outbreak is unfolding amid intense population movement, porous borders, insecurity, humanitarian challenges, weak health infrastructure, and extensive regional trade and mobility networks. These conditions increase the likelihood of cross-border transmission and threaten to reverse hard-won gains in health security across the continent. These epidemiological and contextual situations led the WHO and the Africa CDC to declare the outbreak of Bundibugyo virus disease a Public Health Emergency of International Concern (PHEIC) and a Public Health Emergency of Continental Security (PHECS), reflecting the seriousness of the situation and the urgent need for coordinated continental action. Importantly, the current outbreak also presents unique operational challenges, as there are currently no licensed vaccines or therapeutics specifically approved for Bundibugyo virus disease. This underscores the critical importance of strengthening preparedness systems, accelerating research and innovation, and ensuring rapid operational readiness across all Member States.

Over the past decade, Africa has accumulated invaluable experience in responding to Ebola virus disease and other major public health emergencies, including mpox, Marburg virus disease, cholera, and COVID-19. These experiences have demonstrated that effective outbreak control requires more than emergency response alone. It demands resilient health systems, strong surveillance and laboratory networks, empowered communities, trusted leadership, sustained financing, and regional solidarity, aligned with Africa's Health Security and Sovereignty (AHSS) agenda. They have also reinforced the importance of



local scientific leadership, integrated multi-pathogen preparedness systems, cross-border collaboration, and equitable access to medical countermeasures.

This Bundibugyo Virus Disease Continental Preparedness and Response Plan represent a collective commitment by African Union Member States, the Africa CDC, the WHO and other UN agencies such as UNICEF, UNHCR, OCHA and IOM, Regional Economic Communities, technical partners, research institutions, civil society, and communities to strengthen Africa's preparedness and response capacities against Ebola disease outbreaks and other emerging health threats. The plan provides a strategic framework for coordinated action across the continent, emphasizing rapid detection, timely response, community-centred interventions, continuity of essential health services, protection of frontline health workers, and prevention of regional and international spread.

At the heart of this plan is the recognition that preparedness is a continuous investment, not a temporary intervention. Sustainable preparedness requires countries to build resilient systems before crises occur, maintain operational readiness between outbreaks, and foster strong partnerships grounded in solidarity, accountability, and shared responsibility.

It also requires ensuring that vulnerable populations, including communities affected by conflict, are systematically prioritized, including refugees, internally displaced persons (IDPs), asylum-seekers, returnees, and host communities living in fragile health system settings, so that they are systematically included and not left behind.

The successful implementation of this plan will depend on sustained political commitment, coordinated leadership, adequate and predictable financing mechanisms, including emergency funding triggers and resilient supply chain systems to ensure availability of personal protective equipment (PPE), diagnostics and medical countermeasures, the solidarity of the global health community, and active engagement of communities and frontline responders across the continent. By working together and applying lessons from previous epidemics, Africa can strengthen its collective capacity to prevent, detect, and respond to Bundibugyo virus disease, advancing a safer, healthier, and more resilient future for all.

Together, we reaffirm our shared commitment to protecting lives, strengthening health systems, and safeguarding the continent against current and future public health threats.

H.E. Dr. Jean Kaseya
Director General
Africa Centres for Disease Control and Prevention

Prof. Mohamed Yakub Janabi
Regional Director
WHO Regional Office for Africa

Dr. Tedros Adhanom
Director General
World Health Organization

Executive Summary

An outbreak of Bundibugyo Virus Disease (BVD) caused by Bundibugyo virus (BVD), a species of the Orthoebolavirus genus, has been reported in Ituri Province in the eastern Democratic Republic of the Congo (DRC), with epidemiological investigations indicating that the outbreak likely originated in the mining-intensive Mongbwalu Health Zone and subsequently expanded across Ituri, North Kivu and South Kivu, with cross-border transmission confirmed to Uganda.

The epidemiological context is highly concerning because the affected areas are characterized by intense population mobility, informal artisanal mining, overcrowded settlements, weak health infrastructure, insecurity linked to armed group activity, and extensive cross-border interactions with Uganda and South Sudan. Bunia additionally serves as a major regional commercial and transport hub linking eastern DRC to neighboring countries, significantly increasing the risk of regional dissemination.

As of 27 May 2026, a total of 129 confirmed cases, 1,077 suspected cases, and 246 suspected deaths from the Bundibugyo Virus Disease (BVD) outbreak have been reported from the Democratic Republic of the Congo (DRC) and Uganda. These cases were reported from 15 health zones: DRC (14 HZs) and Uganda. The outbreak has expanded well beyond the initial Ituri epicentre: as of 27 May 2026, 15 health zones across Ituri (Bambu, Bunia, Mongbwalu, Nizi, Lita, Nyankunde, Rwampara, Aru and others), North Kivu (Butembo, Katwa, Goma) and South Kivu (Miti-Murhesa) are affected. Four frontline healthcare workers have died and at least eight additional infections among health workers have been reported, Uganda has reported 7 laboratory-confirmed cases in Kampala, with one confirmed death, linked to cross-border population movement from Bunia. Uganda activated its National Task Force on 16 May 2026 and is included as a Priority 1A response country alongside DRC. Evidence suggests several weeks of undetected viral circulation between epidemiological weeks 15 and 19 (early April through mid-May 2026). However, the true scale of the outbreak is likely substantially underestimated because of delayed detection, underreporting, insecurity, weak community-based surveillance, limited diagnostic capacity, and constrained access to affected communities.

The outbreak has been determined as both a Public Health Emergency of International Concern (PHEIC) by the WHO under the International Health Regulations (IHR) and a Public Health Emergency of Continental Security (PHECS) by the Africa CDC, reflecting the serious regional and global implications of the event. The outbreak is considered extraordinary because

of increasing reports of unexplained community deaths, infections among healthcare workers, unclear epidemiological links, evidence of undetected transmission chains, and spread into urban and semi-urban settings. The operational complexity is further exacerbated by insecurity, humanitarian challenges, displacement, weak infection-prevention systems, and high population mobility. Moreover, unlike Ebola virus disease outbreaks, there are currently no approved vaccines or therapeutics specifically targeting Bundibugyo virus, creating major preparedness and response challenges.

The recurrence of Ebola disease outbreaks in Africa continues to expose vulnerabilities in surveillance systems, healthcare infrastructure, laboratory capacity, infection prevention and control (IPC), and emergency coordination mechanisms. Recent experiences responding to mpox, Marburg virus disease, cholera, and other epidemic-prone diseases have reinforced the urgent need for integrated multi-pathogen preparedness systems capable of rapidly detecting and containing emerging public health threats. Lessons from previous Ebola disease outbreaks in DRC, Uganda, Guinea, Liberia, and Sierra Leone demonstrated that delayed detection, weak community engagement, inadequate IPC, and fragmented coordination can rapidly amplify transmission and overwhelm health systems. More recent responses also highlighted the critical importance of genomic surveillance, decentralized laboratory networks, community-centered risk communication, survivor monitoring, cross-border collaboration, and resilient health systems.

The BVD Continental Preparedness and Response Plan (June – November 2026) provides a strategic framework to guide coordinated preparedness, readiness, and response efforts across African Union Member States. The plan adopts a multisectoral, risk-based, and community-centered approach aligned with the IHR, the Africa Health Security and Sovereignty agenda, and the One Health framework. The overall goal of the plan is to support African Union Member States in preventing, detecting, containing, and mitigating BVD outbreaks while minimizing morbidity, mortality, socioeconomic disruption, and regional spread.

The response strategy emphasizes a differentiated approach tailored to the epidemiological risk profiles and preparedness capacities of Member States.

Central to the strategy is the establishment of unified coordination structures under the principle of "one response team, one preparedness and response plan, one budget, and one monitoring and evaluation framework." The plan calls for strengthening continental and national incident management systems, emergency operations centers, multisectoral coordination mechanisms, and emergency governance structures to ensure rapid and accountable response operations.

This plan highlights 14 preparedness and response pillars: coordination, surveillance, laboratory, risk communication and community engagement (RCCE), infection prevention and control (IPC), case management, development of vaccination and therapeutics, research and knowledge management, logistics and supplies, One Health, AI and risk assessment, humanitarian response, and continuity of essential services that are inclusive to mobile and displaced populations within the context of an ongoing and protracted humanitarian crisis. This plan recognizes that population mobility, including cross-border movement, forced displacement, labor migration, and transit through transport and trade corridors, is a central driver of increased transmission dynamics and must be systematically addressed through mobility-sensitive, cross-border, and points-of-entry interventions integrated across all response pillars.

The implementation of this plan requires an estimated budget of **US$517,678,605.01** over the six months, based on the updated costing. The successful implementation of this Continental Preparedness and Response Plan will require sustained political commitment, strong continental leadership, coordinated partnerships, adequate financing, and active community and frontline responder engagement. By leveraging lessons learned from previous Ebola disease epidemics and recent mpox responses, the plan provides a strategic pathway toward stronger, more resilient, and integrated epidemic preparedness systems capable of protecting Africa from BVD and future emerging public health threats.

Background and Epidemiology

An outbreak of Bundibugyo virus disease (BVD) has been reported in Ituri Province in the eastern DRC, with epidemiological investigations indicating that the outbreak likely originated in the mining-intensive Mongbwalu Health Zone. The area is characterized by intense population mobility, informal artisanal mining, overcrowded living conditions, weak health infrastructure, insecurity linked to armed group activity, and extensive cross-border interactions, all of which create favorable conditions for rapid disease amplification and regional spread. Transmission subsequently spread into Rwampara Health Zone and Bunia Health Zone as symptomatic individuals sought medical care, increasing the risk of urban transmission and healthcare-associated spread. Ituri Province shares porous borders with Uganda and South Sudan, while Bunia lies along a major regional trade and transport corridor linking eastern DRC to neighboring countries. These geographic, economic, and sociopolitical dynamics significantly heighten the risk of cross-border transmission and regional dissemination of the virus.

As of 27 May 2026, a total of 129 confirmed cases, 1,077 suspected cases, and 246 suspected deaths from the Bundibugyo Virus Disease (BVD) outbreak have been reported from the Democratic Republic of the Congo (DRC) and Uganda. These cases were reported from 15 health zones: DRC (14 HZs) and Uganda. The outbreak has expanded well beyond the initial epicentre, with 15 health zones across Ituri (Bambu, Bunia, Mongbwalu, Nizi, Lita, Nyankunde, Rwampara, Aru and others), North Kivu (Butembo, Katwa, Goma) and South Kivu (Miti-Murhesa) now affected. Four frontline healthcare workers have died and at least eight additional healthcare worker infections have been documented, while Uganda has reported 7 laboratory-confirmed cases in Kampala (Kibuli Hospital), with one confirmed death, epidemiologically linked to cross-border population movement from Bunia, Ituri Province, along the Mpondwe

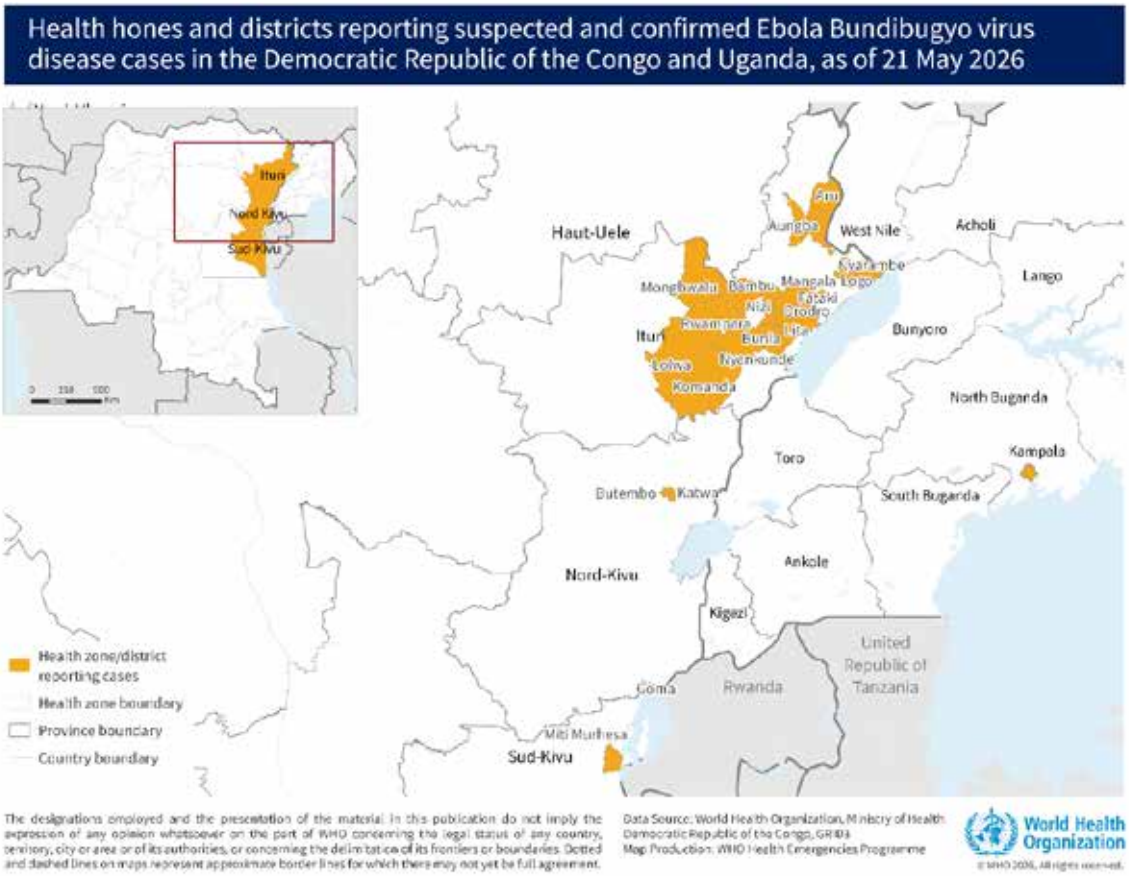


Figure 1: Health districts reporting Ebola Bundibugyo virus cases in DRC and Uganda, as of May 27, 2026

and Lhubiriha border corridors.[1] However, these figures likely underestimate the true scale of transmission due to delayed reporting, limited laboratory confirmation capacity, insecurity, and gaps in community-based surveillance. Epidemiological investigations suggest widespread community transmission across multiple health zones in Ituri Province, with concentration in mining and transport corridors characterized by intense population movement and frequent cross-border mobility. Population mobility patterns, including movement of miners, traders, transport workers, displaced populations, and cross-border communities, as well as congregation points such as transport hubs, markets, mining sites, and informal settlements, play a critical role in shaping transmission pathways and complicating surveillance, contact tracing, and continuity of care across geographic areas.

Bundibugyo virus is one of the six known species within the genus *Orthoebolavirus* and was first identified during an outbreak in Uganda in 2007, centered in Bundibugyo District, from which the virus derives its name. That outbreak resulted in more than 130 confirmed and probable cases, demonstrating the virus's capacity for sustained human-to-human transmission and healthcare-associated amplification. A second major BVD outbreak of more than 50 cases occurred in the DRC in 2012 in Equateur Province, further highlighting the recurrent risk posed by zoonotic spillover events in ecologically vulnerable forested regions of Central Africa.[2] Unlike the Ebola virus species responsible for the devastating West African epidemic of 2014–2016 and subsequent outbreaks in eastern DRC, there are currently no licensed vaccines or therapeutics specifically approved for BVD. This significantly complicates outbreak response operations, as containment efforts

1 https://www.afro.who.int/countries/democratic-republic-of-congo/publication/ebola-bundibugyo-virus-disease-outbreak-democratic-republic-congo-uganda-weekly-external-situation
2 https://pmc.ncbi.nlm.nih.gov/articles/PMC4642951/

rely heavily on early detection, comprehensive contact tracing, infection prevention and control (IPC), safe and dignified burials, supportive clinical care, and strong community engagement.

Preliminary investigations indicate healthcare-associated transmission, highlighted by the infection and deaths of at least four healthcare workers within a four-day period at HGR Mongbwalu, with at least eight additional infections among health workers documented as of 21 May 2026. This underscores critical weaknesses in IPC, including inadequate triage systems, delayed identification and isolation of suspected cases of viral hemorrhagic fever, shortages of personal protective equipment (PPE), overcrowded healthcare facilities, and limited IPC training among frontline personnel. Initial joint MoH/WHO IPC and WASH rapid assessments at key facilities returned scores of 7% at Abelkozo Health Post and 34% at Mongbwalu HGR, both far below acceptable thresholds. A particularly concerning feature of the outbreak is the delayed detection gap between symptom onset in the probable index case and official outbreak confirmation. During this interval, sustained undetected transmission likely occurred within households, healthcare facilities, and communities, facilitating amplification of the outbreak. Early recognition was further complicated by concurrent circulation of malaria, arboviral infections, typhoid fever, and influenza-like illnesses, all of which share overlapping clinical features with early BVD and reduced healthcare providers' initial index of suspicion. Initial laboratory testing in Bunia targeted Zaire ebolavirus only on the GeneXpert platform and returned negative, further delaying detection; Bundibugyo virus was identified only after samples were shipped to INRB Kinshasa where eight samples tested positive on a pan-filovirus assay, with whole-genome sequencing confirming the species on 14 May 2026.

Second, insecurity and armed conflict in parts of Ituri continue to restrict humanitarian access, complicate contact tracing, disrupt surveillance activities, and undermine continuity of health services. Third, community mistrust, misinformation, stigma, and fear associated with Ebola disease outbreaks may discourage early healthcare seeking, reduce adherence to public health measures, and increase resistance to response teams, as previously observed during the 2018–2020 Ebola virus disease outbreak in eastern DRC. These dynamics also generate social, protection and psychosocial impacts that can affect response uptake, including distress, stigma, grief, family separation, disruption of social support systems, frontline worker stress and reduced trust in services. Fourth, the mining economy and extensive population movement across informal transport and trade networks create persistent risks for silent transmission across provinces and international borders. Weak laboratory networks, inadequate surge workforce capacity, fragile supply chains, and limited treatment infrastructure further constrain response effectiveness. Supply chains remain vulnerable to transport disruptions, border and administrative delays, and risks of stockouts of critical supplies such as PPE and laboratory reagents, while last-mile delivery to remote or insecure areas remains a major operational bottleneck. Limited pre-positioning of supplies and weak logistics coordination further increase the risk of disruptions and require prioritizing scarce resources for the highest-risk areas. Consequently, containment efforts depend heavily on rapid case detection, comprehensive contact tracing, strict implementation of IPC, safe and dignified burials, strong risk communication and community engagement, and coordinated cross-border preparedness and response. Collectively, these factors place the outbreak at high risk for sustained national transmission and further regional spread, with potentially significant implications for regional health security if not rapidly contained, necessitating an urgent, coordinated, multisectoral, and cross-border response.

Risk Assessment

Overall Risk	National	Regional	Global
	Very High	High	Low

The ongoing BVD outbreak in the DRC, with confirmed cross-border transmission to Uganda, presents a **very high national risk**, **high regional risk**, and **low global risk**. The outbreak is rapidly evolving, with confirmed and suspected cases expanding across multiple provinces in eastern DRC and imported cases reported in Kampala, Uganda.

Key factors driving the elevated regional risk include:

- Rapid geographic expansion across 16 affected health zones in Ituri, North Kivu, and South Kivu provinces.
- Confirmed cross-border transmission to Uganda and risk of further spread to neighbouring countries through porous borders and high population mobility corridors.

- Intense movement linked to mining activities, trade, forced displacement, and urban-rural connectivity, particularly through Bunia and Kampala transport hubs.
- Ongoing insecurity and armed conflict in eastern DRC, limiting surveillance, contact tracing, laboratory transport, effective healthcare services and safe burial operations.
- Delayed outbreak detection and evidence of prolonged undetected community transmission.
- High number of community deaths and healthcare worker infections associated with weak IPC implementation.
- Lack of licensed vaccines and specific therapeutics for Bundibugyo virus disease, increasing reliance on supportive care and public health interventions.
- Weak healthcare infrastructure, limited isolation capacity, shortages of PPE and trained personnel in affected areas.
- Risk of amplification in densely populated urban centres, poorly equipped refugee and internally displaced hosting sites, and during population movements and gatherings.
- Potential for undetected transmission chains in border communities and along regional transport corridors.

The outbreak context is further complicated by concurrent humanitarian crises, recurrent epidemics, population displacement, fragile community trust, and operational access constraints. These factors collectively increase the likelihood of sustained transmission and regional spread if preparedness and response capacities are not rapidly strengthened across affected and at-risk countries.

Overall Risk Rating

Affected countries, with community transmission: VERY HIGH RISK (Category 1)

The combination of delayed outbreak detection, ongoing community transmission, healthcare-associated infections, insecurity, weak surveillance systems, high population mobility, and the absence of licensed Bundibugyo virus-specific vaccines or therapeutics places the DRC's national risk at a very high level (category 1). The peri-urban and mining-associated nature of the outbreak further increases the likelihood of sustained transmission and geographic expansion.

Eastern and Central African countries bordering affected countries: HIGH RISK (Category 2)

The documented cross-border spread to Uganda, porous borders with neighboring countries, active trade and migration networks, and limited preparedness capacities in some bordering areas significantly elevate the regional risk. Continued population movement through mining corridors, transport routes, and humanitarian displacement pathways may facilitate further international spread if containment measures are not rapidly intensified.

Countries with a previous history, limited health system capacity: MODERATE (Category 3)

Although the outbreak currently remains geographically concentrated in Ituri Province, the potential for seeding into major regional urban centers and transit corridors presents a substantial continental concern. The current epidemiological situation provides a critical but narrowing window for thorough containment efforts at local, national, and regional levels before broader continental dissemination occurs.

Countries with strong health systems and no recent history of similar outbreaks: LOW (Category 4)

Some countries in Africa and beyond, with no recent history of similar outbreaks and no direct or indirect border crossings with affected or proximal countries, have minimal risk of a Bundibugyo virus disease outbreak.

Indicative mapping to the response operational categorization

For operationalizing the response efforts, we prioritize countries as indicated in Table 1.

Table 1: Operational prioritization of affected and at-risk countries*

Operational prioritization	Countries	Response
Priority 1A	DRC and Uganda (active outbreak)	Full multi-pillar response
Priority 1B	South Sudan, Rwanda, and Burundi (immediate neighbours with high cross-border risk)	Operational readiness, recommended readiness actions, intensified risk monitoring and cross-border coordination
Priority 2	Central African Republic, Republic of Congo, Tanzania, Zambia, Angola, Kenya, Somalia, Ethiopia (direct land borders or high traffic with Priority 1A countries)	Minimum operational requirements, recommended readiness actions and continuous risk monitoring
Priority 3	All other Member States	Risk monitoring and alert dissemination through IHR National Focal Points

**The risk assessment is a continuous process, and the country prioritization will continue to be reviewed and updated accordingly.*

Escalating or Downgrading the Risk

The escalation or downgrading of Ebola outbreak risk should be guided by epidemiological trends, transmission dynamics, geographic spread, and the effectiveness of response measures. Risk escalation may be warranted when there is evidence of sustained community transmission, increasing incidence, expansion into new geographic areas, infection among healthcare workers, failure to identify transmission chains, or cross-border spread that threatens regional or international health security. Conversely, risk may be downgraded when transmission is demonstrably interrupted, and response capacities are sufficient to rapidly detect and contain any residual cases.

The principal benchmark for downgrading risk is achieving 42 consecutive days with no confirmed or probable Ebola cases, equivalent to twice the maximum incubation period of 21 days.[3] This countdown begins the day after the last confirmed case records two consecutive negative PCR test results collected at least 48 hours apart, or the day after the safe and dignified burial of the last deceased case. Reaching the 42-day threshold indicates interruption of active transmission and may support reclassification of the outbreak risk from high to moderate or low, depending on the broader context. However, declaration of the end of an outbreak requires continued vigilance, including intensive active and passive surveillance, rapid investigation of alerts, and monitoring of survivors for potential viral persistence. Enhanced surveillance should continue for at least six months after the 42-day milestone to detect and rapidly respond to any flare-ups associated with undetected transmission chains or persistence of the virus in immune-privileged sites, thereby providing confidence that the outbreak has been fully controlled and the risk further reduced.[4]

3 https://www.who.int/docs/default-source/inaugural-who-partners-forum/who-recommended-criteria-for-declaring-the-end-of-the-ebola-virus-disease-outbreak.pdf

4 https://www.who.int/docs/default-source/inaugural-who-partners-forum/who-recommended-criteria-for-declaring-the-end-of-the-ebola-virus-disease-outbreak.pdf

Declaration of Bundibugyo virus disease outbreak as a PHECS and PHEIC

The Director-General of the World Health Organization has declared the ongoing Ebola outbreak caused by the Bundibugyo virus in the Democratic Republic of the Congo and Uganda a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations (2005), following consultations with the affected countries and consideration of scientific evidence, public health risks, and the potential for international spread.

Similarly, the Africa CDC Director-General declared the outbreak a Public Health Emergency of Continental Security (PHECS). The declaration, made under Article 3, Paragraph F of the Africa CDC Statute, empowers Africa CDC to coordinate and support Member States during major public health emergencies. Prior to the declaration, Africa CDC conducted extensive consultations with H.E. Mahmoud Ali Youssouf, Chairperson of the African Union Commission; H.E. Cyril Ramaphosa, President of the Republic of South Africa and Pandemic Prevention, Preparedness and Response Champion of the African Union; and affected and at-risk Member States. Moreover, the declaration followed extensive deliberations by the Africa CDC Emergency Consultative Group (ECG), an independent body of scientific experts that reviewed epidemiological trends, preparedness capacities, operational constraints, and regional transmission risks before unanimously recommending the declaration. In its assessment, the ECG considered disease severity, transmission dynamics, health system impacts, availability of medical countermeasures, socioeconomic consequences, public concern, and governance implications. The ECG concluded that the outbreak met the threshold for a PHECS owing to its severity, potential for cross-border transmission, operational complexity, and significant implications for regional and global health security.

WHO and Africa CDC consider the outbreak extraordinary because of several concerning factors, including unexplained community deaths, infections among healthcare workers, unclear epidemiological links, and evidence suggesting the outbreak may be substantially larger than currently detected. The high positivity rate among initial samples, increasing reports of suspected cases, and spread into urban and semi-urban areas heighten concerns about wider regional transmission. Ongoing insecurity, humanitarian challenges, intense population movement, and weak infection prevention systems further increase the risk of spread, similar to conditions observed during the 2018–2019 Ebola epidemic in eastern DRC. Unlike Ebola Zaire strains, however, there are currently no approved vaccines or therapeutics specifically targeting Bundibugyo virus disease. WHO and Africa CDC also emphasized the need for unified efforts to strengthen surveillance, response operations, and cross-border preparedness.

Guiding Principles

These principles are drawn from lessons learned during the 2007 and 2012 BVD outbreaks and previous Ebola virus disease outbreaks in DRC, Uganda, Guinea, Liberia, and Sierra Leone, and align with the 2023 Lusaka Agenda, which emphasizes strengthening joint approaches to achieving equity in health outcomes, operational coherence, and coordinated product development and research.

Country-Driven Approach: The continental plan focuses primarily on Ebola disease preparedness and response interventions based on the priorities identified by affected countries. This ensures the response is tailored to each country's specific needs. The plan covers response activities in affected areas, as well as preparedness and readiness activities in high-risk areas for introduction.

- **Science-Driven Strategies:** All strategic approaches and key interventions are grounded in the best available scientific evidence, ensuring that the response is effective and adaptive to the evolving understanding of the virus and its transmission in a social and ecological context.
- **Equity and Solidarity:** Prioritization of issues and resource allocation should be sensitive to the needs of the most affected regions/provinces, vulnerable groups, and countries most in need. This principle is supported by global solidarity, ensuring that medical countermeasures and PPE are made available to African Member States in an equitable manner.
- **Unified approach:** align all partners around a single cohesive plan. This alignment ensures that all stakeholders work toward common objectives, minimizing duplication and maximizing impact.
- **Continuity of Essential Health Services:** Prioritize uninterrupted delivery of life-saving health services, including maternal, child health, and management of communicable and non-communicable diseases, even during response
- **Sustainability:** Focus on developing sustainable, long-term solutions that can be scaled and maintained over time, ensuring that countries are better prepared for future outbreaks and that the response efforts have a lasting impact.
- **Mobility-Sensitive and Cross-Border Approach:** Preparedness and response interventions will systematically integrate population mobility dynamics, including cross-border movement, forced displacement and presence of individuals with international protection needs, and internal mobility, ensuring targeted and protection-sensitive actions at points of entry, along mobility corridors, and at high-risk congregation points.
- **Humanitarian–Development–Peace Nexus (HDPN):** The response is delivered in one of Africa's most complex humanitarian environments and must simultaneously protect vulnerable populations facing humanitarian crises, as well as the outbreak, including populations living in conflict-affected, hard-to-reach areas, IDPs, refugees, asylum seekers, mining and mobile populations, women and children, and frontline workers.
- **Safeguarding, PSEAH, GBV risk mitigation and Do No Harm:** Given the elevated SEAH risk in eastern DRC (IASC risk index 6.9/9.9) and high prevalence of gender-based violence, all response operations must integrate prevention of sexual exploitation, abuse and harassment (PSEAH), GBV risk mitigation measures and survivor-centered GBV services from the outset, including accessible community-level reporting channels, mandatory training of all responders, and partner compliance with UN PSEAH standards.
- **Community-centered and psychosocially informed response:** Preparedness and response interventions should be designed and implemented with affected communities, recognizing that fear, stigma, grief, misinformation, mistrust, family separation and frontline worker stress can affect care-seeking, contact tracing, safe isolation, safe and dignified burials, survivor reintegration and continuity of essential services.

Goal and Response Strategy

Goal

Stop the Ebola outbreak and protect communities.

Overall preparedness and response strategy

One plan, one budget, one team: To address the ongoing BVD outbreak, a comprehensive strategy is crucial for effective management and mitigation. This plan emphasizes a community-centered, well-coordinated, multisectoral, and differentiated approach adapted to the epidemiology and risk category of Member States that bolsters surveillance and laboratory testing, engages communities, provides clinical care and prevents further infections, ensures availability of critical countermeasures and builds resilient and equitable health systems. Each pillar is expected to develop sub-activities based on priorities and sequences to implement its respective strategic objective and key actions, demonstrating phased implementation from active containment to sustained response.

Preparedness and Response Pillars and Strategic Objectives

Pillar 1: Coordination, Leadership and Governance

Strategic Objective

Establish and sustain a unified, functional coordination architecture with one response team, one strategic preparedness and response plan, one budget, and one monitoring and evaluation framework at continental, national, and subnational levels to ensure timely, coordinated, and accountable preparedness and response for Bundibugyo virus disease.

Actions

Strengthening strategic leadership, multisectoral coordination, emergency governance, and resource mobilization mechanisms to support an effective Bundibugyo virus disease response.

A. Continental Level

- Establish a continental Bundibugyo virus disease outbreak response coordination mechanism co-led by Africa CDC and WHO to harmonize strategic guidance, operational support, resource mobilization, and partner engagement.
- Activate a continental Incident Management System (IMS) to coordinate technical assistance and surge support to affected and at-risk Member States.
- Convene regular consultations with the Africa CDC Emergency Consultative Group (ECG), African Union governance structures, WHO regional offices, and technical partners to align response priorities and policy guidance.
- Leverage the interim medical countermeasures network (iMCMNet) as a key global partner coordination mechanism to align technical and financial support, reduce duplication across implementing agencies, and facilitate coordinated decision-making on medical countermeasures (MCMs) development, access and allocation, including diagnostics, vaccines, and therapeutics and other relevant health products.
- Ensure that iMCMNet supports both partner coordination and, as relevant, coordination of access and allocation to quality-assured medical countermeasures, such as the Ebola International Coordination Group (ICG) for emergency vaccine provision.
- Prevent, detect, and respond to sexual exploitation, abuse, and harassment (SEAH) across all preparedness and response operations, ensuring safe, accountable, and survivorcentred programming that upholds the principles of Do No Harm, human rights, and dignity in all affected communities.
- Establish a continental emergency operations dashboard integrating epidemiological, laboratory, logistics, community and operational data for real-time situational awareness.
- Coordinate regional cross-border preparedness and response mechanisms involving neighboring countries and regional economic communities.
- Support political advocacy and high-level diplomatic engagement to maintain sustained attention to the outbreak and mobilize domestic and international resources.
- Develop a continental accountability framework with regular operational reviews and performance monitoring.
- Strengthen One Health coordination involving human health, animal health, wildlife, environmental, and security sectors.
- Establish a partner coordination forum to align technical and financial support and reduce duplication across implementing agencies.
- Develop and maintain a continental partner mapping and resource tracking platform (Who, What, Where, When, and Funding) to support coordination and gap identification.
- Conduct routine donor and partner briefings to communicate evolving priorities and mobilize resources.

B. Member State Level

- Support Ministries of Health to establish national Bundibugyo virus disease outbreak response coordination mechanisms chaired at a high political level and involving all relevant government sectors and partners.
- Strengthen Public Health Emergency Operations Centers (PHEOCs) and national IMS structures for coordinated response management.
- Support decentralized coordination structures at provincial, district, and community levels.
- Develop and regularly update national preparedness and response plans with clear operational priorities, readiness actions and financing frameworks.
- Facilitate partner mapping, development of 4W matrices, and accountability mechanisms.
- Conduct regular simulation exercises, early and after-action reviews, and preparedness/readiness assessments, including in districts/provinces at high risk of introduction.
- Strengthen civil-military coordination where insecurity and humanitarian crises affect outbreak response operations, including logistics, security of supply chains, and support to procurement and distribution of medical countermeasures.
- Establish emergency financing mechanisms and rapid disbursement procedures to accelerate response implementation.
- Support the establishment of formal mechanisms that allow for rapid decisions while respecting human rights and national frameworks

Pillar 2: Risk Communication and Community Engagement

Strategic Objective

Empower and partner with communities to co-lead the response by ensuring timely access to accurate, transparent and actionable information; building and sustaining trust in authorities and response actors; and fostering community ownership of prevention and control measures. RCCE efforts will actively reduce fear, stigma, and misinformation, while promoting early care-seeking, safe practices and adherence to public health and social measures to interrupt transmission and mitigate secondary social and economic impacts.

RCCE interventions will be community-centered, evidence-based, culturally appropriate, and continuously adapted through real-time feedback and social listening. They will be fully integrated across all response pillars and phases – preparedness, response and recovery - to strengthen accountability, reinforce trust, and enable sustained behaviour to change at scale.

Actions

- Establish and operationalize local RCCE coordination mechanisms, e.g., RCCE Technical Working Groups or bolster existing humanitarian community engagement working groups, to ensure alignment, clear roles, and integration across all response pillars and phases.
- Strengthen appropriate RCCE coordination mechanisms at continental and global levels such as the RCCE Continental Pillar and Collective Service.
- Integrate RCCE across preparedness, response and recovery, ensuring consistency with surveillance, case management, IPC, and vaccination efforts.
- Conduct rapid community assessments and anthropological profiles, generate behavioural insights to identify, knowledge gaps, access and trust in information, perceptions, experiences, practices and practical, locally grounded solutions with tailored approaches for Bundibugyo virus disease prevention and control, This includes understanding community knowledge, social supports, information environments, care-seeking

practices, trust and engagement in the response, and barriers to the uptake of public health advice and measures.

- Continuously adapt RCCE strategies through real-time social listening and operational research, including through context- specific dynamics (e.g. mobility, urban density, beliefs, displacement).
- Ensure social listening and community feedback findings are regularly analysed and shared with relevant response pillars to inform operational adaptations where fear, stigma, rumours, mistrust or community concerns affect uptake of response measures.
- Establish and support community-led preparedness and response structures to foster ownership, trust and local accountability.
- Engage trusted community actors (traditional, religious, youth, women, survivors, community leaders, and social networks) in co-design and delivery of RCCE interventions.
- Especially involve traditional healers and faith leaders responsible for prayer rooms as active partners in the response through awareness-raising and briefings on control measures and the reasoning, basic IPC, alert reporting, and contact tracing; provide basic PPE (gloves, masks) and structured channels for notifying suspected cases, encouraging safe and dignified burials and early care seeking. Engaging them as champions against misinformation.
- Develop and disseminate culturally appropriate, evidence-based communication materials in local languages on symptoms, prevention, transmission, care seeking and survivor support.
- Strengthen cross-border and mobility-sensitive RCCE coordination, including targeted risk communication for mobile populations at points of entry, transport hubs, markets, mining sites, and other congregation points, using harmonized messaging adapted to languages, mobility patterns and risk profiles in border and mobility corridors.
- Train and activate local networks, including community health workers and Red Cross volunteers, humanitarian actors working with communities, and other trusted community actors, who play a critical role in bridging communities and health services.
- Promote community-based surveillance and community participation in contact identification and referral, including in mobile and border populations.
- Establish and scale up infodemic management systems, including rumor tracking, social listening, and digital platforms (e.g., Infodemic insights, U-report, I hear you, Chat Bots).
- Strengthen accountability to affected populations (AAP) by expanding community feedback mechanisms and ensuring rapid analysis and response integrated into decision-making.
- Support media engagement and responsible reporting, including training journalists on accurate and ethical outbreak communication.
- Integrate RCCE into Points of Entry (PoE) preparedness and screening activities, including traveller awareness and community sensitization.
- Integrate RCCE with social community protection and economic support programmes including food assistance, transport, mental health and psychosocial support and livelihood support where feasible.
- Address stigma and discrimination associated with BVD Ebola disease survivors, affected families, healthcare workers, and frontline responders. Integrate mental health and psychosocial support-informed approaches into RCCE interventions.
- Develop accountability and monitoring and evaluation frameworks and indicators to monitor the effectiveness and impact of RCCE interventions during the response
- Document and disseminate lessons learned, best practices, community insights, and RCCE innovations during and after the outbreak response to strengthen future preparedness and response efforts
- Use Africa CDC continental exchange platforms, including the HPCE-SBC Community of Practice for Africa, and regional WCA and ESA RCCE platforms to disseminate accurate information and strengthen Member States' and partners preparedness.
- Address accessibility barriers in RCCE strategies and communication materials.
- Sensitize frontline workers and communities on disability-inclusive engagement approaches.
- Engage organizations of persons with disabilities and disability-focused community structures.

Pillar 3: Surveillance and Epidemiology

Strategic Objective

Strengthen integrated event-based, indicator-based, community-based, and cross-border surveillance systems for early detection, rapid investigation, risk assessment, contact tracing, and interruption of Bundibugyo virus disease transmission.

Actions

- Integrate Bundibugyo virus disease surveillance into existing Integrated Disease Surveillance and Response (IDSR) systems.
- Ensure Bundibugyo virus disease is immediately reported and notifiable in all Member States.
- Strengthen case detection, alert management, contact tracing, and active case finding.
- Train all contact tracers, rapid response teams and case investigators in basic psychosocial support skills, including Psychological First Aid, respectful and stigma-sensitive communication, active listening, recognising acute distress and bereavement, and onward referral, with particular attention to case investigation, traceback and contact follow-up.
- Pair contact tracers with trusted community actors (CHWs, Red Cross volunteers, religious leaders, survivors) in areas with low community acceptance
- Conduct traceback investigations to attempt to identify the source(s) of the outbreak and to identify missed chains of transmission, as practical.
- Deploy rapid response teams to investigate suspected cases of BVD and cases of unexplained deaths.
- Establish real-time digital surveillance, data management, and reporting platforms.
- Strengthen community-based surveillance through community health workers and local volunteers.
- Enhance mortality surveillance and safe investigation of unexplained deaths.
- Enhance mortality surveillance and safe investigation of unexplained deaths, conducted with structured death notification, family communication protocols, and basic psychosocial support skills by trained team members, coordinated with Pillar 6 (SDB) so families experience one integrated team.
- Provide a bereavement package (psychosocial support at the time of investigation, information

on what comes next, MHPSS referral) to every household where a confirmed or probable BVD death is identified.

- Investigate risks of additional zoonotic spillover, including through animal health surveillance, using a One Health approach.
- Scale up event-based surveillance at all levels in high-risk countries, provinces/health zones. Conduct epidemiological analyses and modelling to better understand transmission dynamics, risk factors, growth rates and other epidemiological parameters and other relevant health information (e.g., facility locations, terrain, transportation networks) within a collaborative surveillance framework, to support evidence-based response actions.
- Integrate population mobility mapping and flow monitoring tools to identify high-risk mobility corridors, cross-border routes, and congregation points to inform targeted surveillance, screening and response.
- Integrate genomic epidemiology and sequencing data into surveillance systems and epidemiological analyses.
- Support regular production of epidemiological situation reports and operational dashboards.
- Strengthen surveillance in humanitarian contexts, displacement camps, mining communities, and conflict-affected areas,
- Ensure surveillance systems are fully operational in refugee camps, settlements, and displacement sites, including community-based surveillance through trained refugee community health workers.
- Conduct enhanced surveillance for healthcare-associated infections.

PoE & PoC priority actions

- Implement exit screening at all points of entry at affected area, consisting of, at a minimum, a questionnaire encompassing history of potential exposure to BVD, a temperature measurement and, in case of fever, an in-depth assessment of the risk of BVD, by personnel trained and equipped with PPE. Any traveller determined to present with an illness consistent with BVD should not be allowed to travel unless the travel is part of an appropriate medical evacuation.
- Prioritizing exit and entry screening at high-risk domestic airport and ports, such as those located in or near affected areas
- Conduct Population Mobility Mapping (PMM) for assessing population mobility dynamics and patterns to enable more accurate prioritization of vulnerable locations around cross border transport routes and public health intervention, support high-risk countries to develop/update and implement a Bundibugyo virus disease Points of Entry contingency plan, including provision of training and conducting exercises where necessary for its implementation, -- Conduct a Risk/Readiness assessment every two weeks, both in affected and at high-risk provinces/health zones and countries, to inform timely, evidence-based decision-making and adaptive response measures
- Strengthen surveillance at Points of Entry, and integrate screening data into national surveillance systems and establishing real-time cross-border information-sharing mechanisms
- Develop Points of Entry guidance for screening, isolation management, and appropriate referral and transport mechanisms and conduct tailored capacity building-- Strengthen IPC at POE and POC through the procurement and last mile distribution of PPE supplies and equipment to frontline workers, staff training, and safe management of suspected cases.
- Support construction or rehabilitation of POE infrastructure to ensure it is fit-for-purpose for isolation, management and screening including traveller flow procedures.
- Enhance risk communication and community engagement efforts targeting border communities, travellers, and transport operators to improve adherence to public health measures., This also includes developing messaging for voluntary screening at POE and POC.
- Conduct trainings for health and non-health frontline workers at POE and other screening points including points of control to ensure adherence to national guidelines and protocols.
- Coordinate with conveyance operators (e.g. airlines, bus companies/ unions) to facilitate timely communication, prior to arrival and to relevant authorities, of any suspected BVD cases on board conveyances, and to identify contacts associated with conveyances on an international voyage. The identification of such contacts entails, where applicable, the communication of personal details to the countries known as the final destination of those contacts.

- Conduct ongoing supervision of POE and POC frontline workers to maintain quality and consistency of implementation.

Cross-border coordination

- Organize cross-border meetings among affected and high-risk member states. including border communities across border committees for joint response. This includes establishing coordination mechanisms to detect and assess travelers with unexplained febrile illness, and to share information about contacts who have, or may have, crossed the border, thus enabling continuity of follow-up.
- Operationalize joint cross-border platforms with weekly to bi-weekly coordination meetings between DRC and Uganda, and monthly meetings with Priority 1B countries (South Sudan, Rwanda, Burundi), in line with IHR; refrain from health measures that unnecessarily interfere with travel and trade
- Reinforce contact identification, listing within 24 hours of case detection, and daily follow-up, with standardized investigation forms (notification, investigation, alert, contact follow-up) harmonized across DRC, Uganda, and Priority 1B countries, including strengthening electronic information sharing platforms.

Mass Gatherings

- Strengthen surveillance, mapping and risk-mitigation arrangements for scheduled mass-gathering events, in particular the Uganda Martyrs' Day pilgrimage of 3 June 2026, which involves substantial cross-border population movement between Uganda and DRC; coordinate with event organizers and national PHEOCs even where official events are cancelled, as informal pilgrim movement may persist.

Pillar 4: Laboratory Systems and Genomic Sequencing

Strategic Objective

Strengthen laboratory diagnostic and genomic surveillance capacity to ensure timely confirmation of suspected Bundibugyo virus disease cases, improve outbreak detection, and monitor viral evolution and transmission dynamics.

Actions

- Strengthen national and regional reference laboratories for Ebola disease diagnostics.
- Support the decentralization of molecular testing capacity to strategic subnational laboratories.
- Ensure availability of validated PCR assays and specimen collection kits for all known ebolavirus species (Bundibugyo, Zaire, Sudan, Taï Forest, Reston), including pan-filovirus assays where available, to avoid the species-specific detection gaps that delayed confirmation of the current outbreak by several days.
- Provide technical and operational support to strengthen and optimize safe and efficient sample transportation systems.
- Strengthen biosafety and biosecurity measures in laboratories handling high-risk pathogens.
- Train laboratory personnel on Ebola disease diagnostics, specimen handling, packaging, transport, and waste management.
- Integrate genomic sequencing into routine outbreak investigations and surveillance.
- Establish regional genomic surveillance networks and data-sharing mechanisms.
- Strengthen quality assurance systems and external quality assessment programs.
- Improve laboratory data management and integration into national surveillance systems.
- Support operational research on diagnostic performance and rapid diagnostic tests.
- Establish contingency stockpiles of laboratory reagents and consumables.
- Strengthen laboratory surge capacity and rapid deployment mechanisms during outbreaks.

Pillar 5: Case Management and Clinical Care

Strategic Objective

Reduce morbidity and mortality by promptly identifying, isolating, referring, and providing high-quality clinical, nutritional, psychosocial, and supportive care for patients with Bundibugyo virus disease.

Actions

- Develop and disseminate standardized Bundibugyo virus disease clinical management guidelines.
- Establish and operationalize dedicated BDV Treatment Units (ETUs), transit centers, and screening/isolation facilities with a reliable referral system, family liaison, basic psychosocial support capacity, child-friendly arrangements, and referral to MHPSS, CP, GBV/PSEAH, social protection services, or specialized services as needed.
- Train healthcare workers in BDVD clinical management, triage, supportive care, and management of complications, and basic psychosocial support skills (including Psychological First Aid during EBV, respectful communication with patients and families, and structured death notification).
- Ensure adequate supplies of essential medicines, fluids, blood products, oxygen, and critical care equipment. Including clinical laboratory testing and point-of-care clinical assessment.
- Strengthen referral systems and medical evacuation pathways, including establishment of 24/7 MEDEVAC protocols covering WHO, Africa CDC, UN personnel, implementing partners and international humanitarian personnel, with predefined escalation pathways and receiving facility agreements: train ground ambulance MedEvac teams on safe patient transfer, IPC measures, and use of personal isolation units (e.g., EpiShuttle).
- Provide integrated nutritional support and psychosocial services to patients and caregivers in all BVD treatment units, transit centres and isolation facilities, in line with the IASC MHPSS Minimum Service Package (Activity 4.1 — MHPSS in clinical management of infectious diseases), with structured family communication, age-appropriate care and dignified, private conditions
- Implement protocols for management of pregnant women, children, healthcare workers, and vulnerable populations.

- Establish survivor monitoring systems to assess long-term complications and potential viral persistence, rehabilitation, stigma, community reintegration, and linkages to protection, education and social protection support where needed.
- Support safe discharge protocols and survivor reintegration programs.
- Ensure strict biosecurity, infection prevention measures within treatment facilities.
- Establish a dedicated unit to ensure clinical care for survivors and address motor, pain, vision and cognitive impairments through rehabilitation and psychosocial support.
- Establish mechanisms for clinical mentoring and telemedicine support.
- Promote standardized clinical data collection to inform research and improve patient outcomes.
- Use key performance indicators to monitor performance.
- Enable delivery of investigational therapeutics ethically approved clinical trial protocols.
- Ensure access to case management, referral pathways, and treatment services for refugees and displaced populations, including those in remote or camp-based settings. Prepare staff and health structure for the implementation of clinical trials of candidate therapeutics.
- Ensure specialized and community-based continuum of care and protection for children, women, caregivers and affected families, including prevention of family separation, support to appropriate and safe alternative care arrangements, access to child protection and GBV prevention and response services

Pillar 6: Infection Prevention and Control (IPC), WASH and Safe and Dignified Burials

Strategic Objective

Strengthen infection prevention and control (IPC), Water, Sanitation, and Hygiene (WASH), and Safe and Dignified Burial (SDB) systems across healthcare facilities, points of entry, and communities to reduce healthcare-associated and community transmission of Bundibugyo Ebola Virus Disease through coordinated response measures.

Actions

Healthcare worker protection and IPC and WASH in healthcare facilities

- Strengthen coordination with implementing partners supporting IPC and WASH activities to ensure harmonized implementation of the IPC ring approach in health facilities, standardized interventions, and consistent delivery of accurate IPC messages and guidance to healthcare workers.
- Ensure IPC guidelines, SOPs, and operational tools are available and implemented across all health facilities, with regular IPC/WASH assessments and monitoring to support compliance and continuous improvement, prioritizing interventions using the IPC ring strategy approach.
- Coordinate with partners to map available IPC human resources and deploy surge IPC personnel to support outbreak response activities in affected healthcare facilities and treatment centers in high-risk areas.
- Strengthen screening, triage, isolation, and referral systems for suspected cases at all levels of the health system, including establishment of dedicated isolation areas with appropriate IPC infrastructure.
- Conduct comprehensive IPC assessments in affected and high-risk health facilities based on prioritization in DRC, Uganda, and other priority countries to identify gaps and guide targeted agreed interventions.
- Train and mentor healthcare workers on IPC measures, screening, triage, safe patient handling, and waste management in collaboration with other pillars to control and reduce transmission risks.

- Strengthen supportive supervision, IPC mentorship, and regular IPC audits in health facilities to reinforce adherence to recommended practices.
- Ensure adequate availability and pre-positioning of all required PPE and IPC supplies for healthcare workers, rapid response teams (RRTs), and safe and dignified burial (SDB) teams,
- Investigate healthcare-associated infections and exposure incidents promptly to identify transmission risks and implement corrective actions.
- Provide guidance on IPC measures for vaccination of healthcare workers, frontline responders and priority contacts as soon as investigational vaccines become available and approved for use.
- Assess and strengthen WASH services in health facilities, including access to adequate and safe water, sanitation, environmental cleaning, healthcare waste management, and hand hygiene infrastructure.
- Conduct decontamination of affected healthcare facilities in high-risk areas according to recommended IPC protocols.

IPC and Water, Sanitation and Hygiene (WASH) in community settings

- Conduct household and other community settings decontamination activities and distribute hygienic kits to affected households and high-risk communities with clear family communication, privacy and dignity safeguards, stigma prevention.
- Support implementation of community-based WASH interventions using the IPC ring approach around confirmed cases, including targeted awareness activities in affected communities and public places linked to cases such as markets, schools, transportation hubs and other congregate settings.
- Carry out rapid community-level WASH assessments to identify critical gaps and support targeted improvements in water supply, sanitation, hygiene, and waste management services.
- Support the training of community health workers and volunteers on IPC and WASH measures to strengthen contact tracing, community surveillance, referral of suspected cases, risk communication and community engagement (RCCE), and community decontamination activities.

- Facilitate mapping and engagement of community-based organizations, civil society groups, NGOs, pharmacies, traditional healers, women-led organizations, youth, private healthcare providers, and local community structures to strengthen risk communication, community engagement, early detection, and response efforts.
- Strengthen coordination and integration of the community health workforce into outbreak response planning, assessments, and implementation, with clearly defined roles and responsibilities.
- Ensure IPC measures and WASH services are implemented in specific settings, such as camps and shelters, and accessible for women, children, the elderly, IPDs, and other vulnerable population groups.

Safe dignified burials

- Provide technical support for the development and implementation of a comprehensive strategy for the safe and dignified management of deceased individuals in communities, health facilities, and treatment centers.
- Ensure burial practices are culturally sensitive, respectful, and aligned with local customs while maintaining compliance with IPC and public health measures.
- Engage community leaders, religious leaders, and key stakeholders to strengthen community acceptance and trust in safe and dignified burial (SDB) practices in collaboration with the RCCE teams. Co-design safe alternative mourning and farewell options with religious and traditional leaders in each affected community recognising that SDB acceptance and disclosure of deaths depend on families being able to grieve in a way that is meaningful to them. Pay particular attention to deaths of children, pregnant women, and healthcare workers, where ritual expectations and grief require additional adaptation
- Train and support burial teams on technical IPC procedures (safe handling of bodies, use of PPE, decontamination, waste management), oral swabbing of all suspected corpses, and basic psychosocial support, grief-sensitive engagement, stigma prevention, and safe referrals to MHPSS services as needed.
- Monitor implementation of SDB activities and community acceptance to identify concerns, distress, stigma or resistance, address barriers to safe and dignified burial, improve compliance, and ensure findings are shared with RCCR and MHPSS actors to adapt approaches and support affected families.

IPC, WASH and SDB PREPAREDNESS AND READINESS activities in priority countries:

- Identify and designate Ebola treatment and isolation centres with adequate IPC and WASH infrastructure and operational capacity.
- Ensure IPC/WASH guidelines, SOPs, and operational tools are available, disseminated, and implemented across all health facilities.
- Strengthen screening, triage, isolation, and referral systems for suspected cases at all levels of the health system, including establishment of dedicated holding and isolation areas.
- Conduct IPC awareness sessions and capacity-building activities for all healthcare workers, including simulation-based training for teams managing isolation and treatment units.
- Strengthen IPC and WASH measures at points of entry, including screening, hand hygiene facilities, risk communication, and referral mechanisms for suspected cases.
- Ensure adequate pre-positioning and availability of PPE and essential IPC supplies for healthcare workers and response teams.
- Integrate community-level public health and social measures (PHSM) into the overall outbreak preparedness and response strategy.
- Engage community leaders, religious leaders, and key stakeholders, in collaboration with RCCE teams, to strengthen community trust, promote adherence to public health measures, and support safe and dignified burial (SDB) practices.

Pillar 7: Research and Knowledge Management and Access to Medical Countermeasures

Strategic Objective

Coordinate and strengthen research to promote innovation, development, evaluation and accelerate equitable access to vaccines, therapeutics, and diagnostics; and establish robust knowledge management systems to generate, synthesize, disseminate, and translate evidence into policy and operational action to improve preparedness and response to Bundibugyo Ebola virus disease outbreaks

Actions

- Strengthen regional coordination and collaboration for operational, epidemiological, laboratory, and social science research related to Bundibugyo virus disease, including development of research priorities, evidence generation agendas, and multi-country research networks using a One Health approach.
- Establish and strengthen platforms for operational research, evidence generation, information sharing, and dissemination of best practices across Member States and partners to support preparedness and outbreak response.
- Support operational and epidemiological research to improve understanding of transmission dynamics, healthcare associated transmission, healthcare worker exposure, survivor needs, and outbreak response strategies, and to strengthen implementation and effectiveness of response interventions.
- Conduct social science and operational research to understand community perceptions, stigma, misinformation, fear, grief, trust, barriers to care seeking and adherence to public health measures, and the mental health, psychosocial, and protection related impacts of outbreaks on affected populations, including women, children, survivors, bereaved families, and frontline workers, and translate findings into operational adaptations across relevant pillars.
- Promote innovation, interoperable data

systems, artificial intelligence, geospatial analytics, predictive modelling, implementation research, and operational learning to strengthen surveillance, outbreak forecasting, preparedness planning, and outbreak response decision making.

- Strengthen research governance, ethical review, and regulatory coordination mechanisms, including multi country review processes and emergency research governance approaches, to support timely implementation of operational and social science research during outbreaks.
- Integrate research findings and operational lessons into preparedness planning, operational guidance, policy formulation, and outbreak response decision-making at regional, national, and subnational levels.
- Establish and maintain repositories and knowledge management platforms for guidance documents, protocols, datasets, operational tools, publications, and lessons learned, and strengthen systems for documentation and dissemination of best practices, case studies, after-action reviews, and intra-action reviews.
- Produce evidence syntheses, policy briefs, operational guidance notes, technical updates, and scientific summaries for policymakers, responders, and partners, and facilitate scientific exchange, peer learning, technical collaboration, webinars, and communities of practice among Member States and partners.
- Strengthen scientific communication, publication capacity, translation, dissemination of African-led evidence and outbreak experiences, and preservation of institutional knowledge and continuity of expertise between outbreaks through lessons learned platforms, responder debriefings, and existing regional and global coordination mechanisms.
- Activate and strengthen the WHO R&D Blueprint and partner coordination mechanisms, including collaboration with Africa CDC, Filovirus CORC, and other partners, to support prioritization, evaluation, and coordinated clinical assessment of candidate vaccines and therapeutics for Bundibugyo virus disease.
- Maintain an up-to-date landscape of candidate vaccines and therapeutics and support prioritization of products for clinical evaluation based on emerging epidemiological, clinical, laboratory, and operational evidence, feasibility, product availability, and outbreak needs.
- Accelerate development and evaluation of vaccines and therapeutic sand other medical countermeasures for Bundibugyo virus disease through implementation of outbreak-ready clinical trial protocols, adaptive and sequenced trial designs, and coordinated clinical research activities, recognizing that currently licensed Ebola medical countermeasures are validated primarily for the Ebola virus.
- Support implementation of coordinated clinical evaluation activities in affected and at-risk countries, including evaluation of candidate therapeutics and vaccines, supportive care interventions, and post-exposure prophylaxis approaches where appropriate.
- Strengthen preparedness for clinical research and investigational medical countermeasure deployment, including regulatory, ethical, safety monitoring, data management, allocation, manufacturing coordination, and operational readiness systems, in collaboration with national regulatory authorities, AVAREF, and regional and global partners.
- Support rapid activation of clinical trial readiness activities, including implementation of core protocols, Good Clinical Practice training, coordination of product availability and allocation, and strengthening of systems for evidence sharing and operational decision-making during outbreaks.
- Strengthen equitable access, community confidence, procurement, logistics, cold chain, stock management, and deployment systems for medical countermeasures through existing coordination mechanisms (iMCM-net).
- Promote community engagement, risk communication, and approaches to maintain confidence in vaccines, clinical research activities, and outbreak response interventions, including addressing misinformation, stigma, informed consent, expectations management, and community trust.
- Promote sustainable financing, strategic partnerships, technology transfer, regional manufacturing initiatives, and coordinated access approaches for vaccines and therapeutics and other critical medical supplies in Africa.

Pillar 8: Operations Support, Logistics and Workforce Deployment

Strategic Objective

Ensure timely operational support, workforce deployment, supply chain management, and logistics systems to sustain effective preparedness and response operations, including under conditions of constrained access and disrupted supply chains. As well ensure close coordination with other response pillars, and other logistics partners, to align supply delivery with operational needs.

Actions

- Develop standardized lists and technical specifications for outbreak response commodities.
- Conduct coordinated forecasting and procurement planning between response partners.
- Establish emergency stockpiles of PPE/WASH, laboratory supplies, medicines, and field equipment.

- Strengthen warehousing, transportation, and cold chain systems.
- Support customs facilitation and expedited clearance for emergency supplies, while mitigating risks of delays due to administrative or border restrictions, including through targeted advocacy to ensure timely logistical access.
- Enhance logistics coordination mechanisms across partners, including shared logistics platforms and information systems to improve real-time visibility, avoid duplication, and optimize allocation of resources.
- Deploy multidisciplinary surge teams, including epidemiologists, clinicians, laboratorians, logisticians, anthropologists, WASH/IPC and RCCE specialists.
- Maintain a rapid alert roster of pre-qualified responders for immediate activation.
- Ensure pre-deployment training and just-in-time orientation for all surge personnel.
- Strengthen Surge teams' safety and security management systems, including medical evacuation protocols.
- Establish an organisational duty of care for the mental health and wellbeing of all national and international responders, including paid staff, incentive workers, CHWs and volunteers — covering pre-deployment orientation, on-mission supervision and peer support, access to confidential individual MHPSS, structured post-mission debriefing, and bereavement support when colleagues die.
- Pay particular attention to frontline national staff, healthcare workers and CHWs, who carry the heaviest psychological load, including exposure to deaths in their own networks and stigma in their own communities and require community-based peer support and structured debrief as well as individual services
- Establish clear reporting channels for security incidents and team well-being concerns.

- Establish operational hubs and field coordination offices in hotspot areas with contingency plans for temporary relocation or remote coordination when access is disrupted.
- Establish appropriate team transport means, with necessary fleet or transportation management systems in place
- Strengthen emergency telecommunications, internet connectivity, and power supply, in field operations, including radios, satellite communications, telephony systems, and reliable energy solutions (including solar) in operational sites and health facilities.
- Coordinate cross-border logistics flows and regional pre-positioning through WHO AFRO logistics hubs in Dakar and Nairobi, or other temporary staging areas, with pre-positioning of Ebola standard list items in priority operational areas, while addressing regulatory and operational constraints affecting cross-border movement of goods and personnel.
- Establish coordination mechanisms with partners to ensure shared logistics infrastructure and assets are deployed to appropriate locations in a timely manner. Establish data sharing platforms at country level, and at regional/global level to track needs, pipelines and flag potential gaps
- Provide appropriate logistics support to clinical trials for vaccine and therapeutics through international shipping, import, reception, onward deployment with appropriate management and monitoring. Mobilize surge expertise through the Global Health Emergency Corps (GHEC), the Africa Health Emergency Workforce (AFEW), AVoHC-SURGE, EMT network, GOARN and Stand-by Partners across different expertise for the response.

Operational Support

- Support Ministries of Health and partners in operational planning, coordination, and implementation of response activities.
- Establish and maintain operational support platforms, including emergency operations centres (EOCs), field coordination hubs, office facilities, and accommodation for deployed personnel.
- Facilitate mobility of response teams through road and air transport solutions, including access to hard-to-reach and insecure areas.
- Provide operational communications support, including internet connectivity, radios, satellite communications, and telephony systems.
- Develop and operationalize a context-adapted Concept of Operations (ConOps) for high-risk and insecure environments.
- Strengthen partner coordination mechanisms to optimize resource utilization, avoid duplication, and reinforce interoperability across response actors.
- Establish fleet and asset management systems, including maintenance planning, fuel management, and tracking mechanisms.
- Conduct operational risk assessments and security-informed logistics planning in collaboration with UNDSS and operational partners.

Health Logistics

- Support identification, rehabilitation, setup, and operationalization of isolation units, transit centres, Ebola Treatment Centres (ETCs), and laboratory facilities.
- Support implementation of IPC and WASH measures, including management and distribution of IPC kits, healthcare waste management, water supply systems, sanitation infrastructure, and decontamination activities.
- Facilitate transport of laboratory samples, vaccines, biomedical equipment, and temperature-sensitive products in coordination with surveillance and laboratory pillars.
- Support operations at Points of Entry (PoEs) and Points of Control (PoCs) through provision of screening infrastructure, tents, handwashing facilities, power supply, and communications equipment.
- Ensure sustainable access to water and reliable energy solutions, including solar systems, in operational sites and health facilities.
- Strengthen local logistics capacities through training, mentoring, and operational support to national authorities and implementing partners.

Pillar 9: Continuity of Essential Health and Social Services and Community Health Systems

Strategic Objective

To strengthen health facilities and community health systems and ensure the continuity, accessibility, quality, and resilience of essential health and social services during Bundibugyo virus disease outbreaks including through coordinated deployment and operationalization of CHWs and community structures, while minimizing indirect morbidity, mortality, service disruption, and broader socioeconomic impact

Actions

- Activate pillar coordination structures at national and sub-national levels.
- Conduct rapid needs assessments and mapping.
- Designate national and sub-national focal persons.
- Develop harmonized operational guidelines, SOPs and reporting tools.
- Conduct partner mapping (4W Matrix) and gap analysis.

Continuity of Essential Services (CEHS)

- Support the development and operationalization of sub-national continuity plans for essential health and social services during Ebola outbreaks and other public health emergencies.
- Support and integrate plans to protect the disruption of humanitarian response and service delivery where they exist.
- Support re-orientation of healthcare and social workers on CEHS during outbreaks
- Support mapping of the functional capacity of public and private health facilities
- Monitor health service utilization, excess mortality, and disruptions to essential services through routine health information systems and rapid assessments.
- Develop contingency staffing plans and surge workforce strategies to sustain critical healthcare services during outbreaks.
- Ensure uninterrupted supply chains for essential medicines, vaccines, diagnostics, blood products, oxygen, and other lifesaving commodities.
- Strengthen community-based service delivery and decentralized healthcare approaches, including mobile clinics and community health worker platforms.
- Strengthen screening, triage and referral systems to ensure safe continuation of routine healthcare while minimizing healthcare-associated transmission of BVD.
- Support uninterrupted delivery of priority health services, including maternal, newborn, child and adolescent health, routine immunization, malaria, SRH including clinical management of rape for GBV survivors, MHPSS, NCDs, HIV, tuberculosis, and nutrition.
- Ensure continuity of essential health services for people affected by humanitarian crises including refugees, returnees, IDPs, those living in conflict affected, insecure, hard to reach or non-government-controlled areas, and socially marginalised groups for example due to ethnicity, language, political affiliation, age, gender, people with disabilities, mobile populations such as nomadic populations and migrants.
- Support continuity of emergency, surgical, trauma, blood transfusion, and intensive care services during outbreaks.
- Support mental health and psychosocial support services (MHPSS) for patients, survivors of BVD, healthcare workers, caregivers, and communities in the outbreak affected areas, including continuity of mental health care and medication for people with pre-existing mental health conditions, and community-based psychosocial support delivered through CHWs, trained lay providers and trusted community actors.
- In collaboration with the RCCE pillar, ensure continuity of education and school health services through coordinated multisectoral planning, IPC adaptation in schools, continuity of learning, time limited and targeted closure only when required by public health risk assessment, and safe reopening measure that support the return of orphans, survivors and other BVD-affected children.
- Ensure continuity of child protection and GBV prevention and response services for children, women, caregivers at risk or victims of violence and social services for older people, and people with disabilities. Identify, register and case-manage children directly affected by BVD —

including child patients, child survivors, orphans, separated and unaccompanied children, and children of confirmed cases and frontline workers — and prioritise family- and community-based care over institutional care, with Family Tracing and Reunification capacity pre-positioned.

- Link the outbreak response to national social protection and humanitarian assistance systems to support affected households, contacts in isolation, children without appropriate care, separated or unaccompanied children, children who have lost a parent or caregiver, and other vulnerable families, including through food, hygiene items, communication support, cash or voucher assistance and other basic needs support where appropriate.
- Support rehabilitation and assistive technology services for survivors of BVD and continuity of care for people with pre-existing impairments and disabilities through referrals to specialized services and community-based rehabilitation programmes.
- Advocate for non-discriminatory approaches and for the continuous inclusion of refugees in national health and social systems, while increasing international support to national systems to cope with additional demands.

Community Health Systems

- Ensure integration of community health activities across operational pillars.
- Support the planning, implementation and evaluation of CHW training and deployment process
- Review and update Ebola disease CHW training materials- and digitalize these materials where possible for efficient training of CHWs.
- Develop job aids, SOPs, and reporting tools.
- Map CHWs and community structures in affected and high-risk areas to identify gaps both on skills and coverage and deploy additional CHWs as needed.
- Include refugee community health workers and volunteers in training, deployment, and supervision frameworks.
- Support training (Ebola signs and symptoms, Alert generation and reporting, Safe referral, IPC measures, RCCE, Rumour tracking, MHPSS basics, protection and self-care) and deployment of CHWs to priority districts and hotspots.
- Establish supportive supervision and reporting mechanisms.
- Coordinate provision of PPE and operational tools, including digital tools for learning and reporting mechanisms.
- Equip CHWs with essential commodities, including malaria and other essential medicines.

Pillar 10: AI analytics and threat assessment

Strategic objective

Strengthen AI-driven analytics, surveillance, and threat assessment capacities to support early detection, risk analysis, forecasting, and evidence-based preparedness and response to public health threats

Actions

- Risk assessment and country categorization
- Chain-of-Transmission Mapping
- Cross-border risk mapping
- Spatial and Predictive Transmission Modeling and Bulletin and output development

Pillar 11: Preparedness and Readiness

Strategic Objective

Strengthen national and regional preparedness and readiness capacities to prevent, detect, and rapidly respond through coordinated planning, risk assessment, capacity building, and operational readiness.

Actions

- Support to high-risk countries to develop/update and implement a BVD contingency plan, providing training where necessary for its implementation
- Continuously conduct a Risk/Readiness assessment every two weeks, both in affected and at high-risk countries, to inform evidence-based decision making.
- Organize high-level Ministerial meeting among affected and high-risk Member States to enhance cross-border collaboration and coordination
- Develop Points of Entry guidance for screening, isolation, management, and appropriate referral and transport SOPs
- Conduct Points of Entry capacity building for screening, isolation management, and appropriate referral and transport mechanisms
- Organize cross-border meetings among affected and high-risk member states. including border communities in cross-border committees for joint response
- Support high-risk countries to test key capabilities to implement the BVD contingency plan through simulation exercises and close the identified gaps.

Pillar 12: One Health

Strategic Objective

Strengthen multisectoral One Health coordination and collaboration among human, animal, and environmental health sectors to prevent, detect, and respond effectively

Actions

- Activate multisectoral One Health coordination mechanisms at continental, regional and national levels.
- Conduct joint risk assessments involving human, animal, and environmental health sectors.
- Strengthen integrated surveillance and information sharing across sectors.
- Monitor and investigate zoonotic and environmental risks linked to Ebola transmission.
- Support coordinated field investigations and outbreak response activities.
- Enhance laboratory collaboration and specimen sharing between sectors.
- Promote community awareness on zoonotic disease prevention and safe practices.
- Strengthen cross-border collaboration and regional information exchange.
- Support operational research and data analysis to inform response strategies.
- Facilitate joint planning, resource mobilization, and partner coordination across sectors

Pillar 13: Humanitarian Response and Service Delivery

Strategic Objective

Strengthen coordinated humanitarian response and essential service delivery to reduce morbidity, mortality, and the socio-economic impact of public health emergencies through timely, equitable, and people-centered interventions. Essential health, nutrition and humanitarian services must be inclusive and sustained to address immediate needs, for the outbreak and pre-existing crises and to contribute to longer-term stability and resilience.

Actions

- Coordinate humanitarian response activities among government, UN agencies, NGOs, and partners.
- Provide protection, support and continuity of essential services for vulnerable and high-risk populations.
- Monitor humanitarian needs, service gaps, and response effectiveness to guide decision-making.

Health care workers protection

- Assess occupational risk, exposure
- Facilitate the provision of Mental Health and Psychosocial Support (MHPSS) to health care workers

Pillar 14: Prevention and response of Sexual Exploitation, Abuse and Harassment (PSEAH) and Safeguarding

Strategic Objective

Outbreak responses in fragile and high-mobility settings such as eastern DRC and cross-border areas carry elevated risks of sexual exploitation, abuse, and harassment (SEAH) due to power imbalances, weakened systems, and heightened vulnerability among women, children, displaced, and marginalised populations.

To address these risks, the Bundibugyo virus disease response embeds Prevention of SEAH (PSEAH) as a core operational requirement across all preparedness and response activities, rather than a standalone function.

PSEAH is integrated across all response pillars (coordination, community engagement, case management, IPC/WASH, operations, and essential services), which requires dedicated indicators, budgets, and activities, as well as clear accountability. Key components include strengthening feedback and response mechanisms, referral systems, ensuring partner capacity and compliance and due diligence, empowering and raising awareness in communities, and maintaining robust investigation and accountability mechanisms. In contexts where IASC clusters are not activated, UNHCR will support government leadership on PSEAH in the context of refugee sites.

Priority actions focus on:

- Governance and coordination: Establishing or reinforcing PSEAH structures (PSEA Networks), focal points, and oversight mechanisms at all levels.
- Prevention and risk mitigation: Conducting risk assessments and integrating safeguards and risk mitigation measures into all operations, in consultation with communities.
- Workforce safeguarding: Mandatory training, supervision, and occupational health measures for all responders, including volunteers.
- Community engagement: Raising awareness on expected standards of conduct and how to report concerns, reducing stigma, and ensuring accessible, safe and confidential feedback and response channels.
- Survivor-centered response: Providing timely access to clinical, psychosocial, legal, and protection services.
- Monitoring and accountability: Implementing real-time reporting, compliance tracking, and continuous performance review.

Progress is measured by indicators including the integration of PSEAH across pillars, workforce training coverage, the availability of reporting mechanisms, the functionality of referral systems, incident resolution rates, and partner compliance.

Overall, the strategy ensures that outbreak response efforts are safe, accountable, and protective of the rights and dignity of affected populations.

Response Implementation Framework

Overall coordination and leadership

The continental response to the BVD outbreak will be co-coordinated and co-led by Africa CDC and WHO, supported by workstreams led by key partners, leveraging their comparative advantages (Table 2). As the IASC Cluster Lead Agency for Health, WHO will also remain in its leadership of humanitarian health response, continuing its work with IASC on wider multisectoral humanitarian response efforts.

In line with the Lusaka Agenda and consistent with the one team, one plan, one budget, one M&E framework established by the BVD Continental IMST on 22 May 2026, the continental Bundibugyo virus disease outbreak response will be implemented through one Incident Management Team, including members from key partners (Figure 2).

WHO and Africa CDC will work with all relevant stakeholders, including the UN and non-governmental Organizations and Civil Society Organizations, who will be represented in the 14 response pillars. At the Member State level, the BVD outbreak response will be coordinated and led by the Ministry of Health at both strategic and technical levels. At the subnational level, coordination will be led by the local authority or the head of health, in accordance with the laws of the specific country.

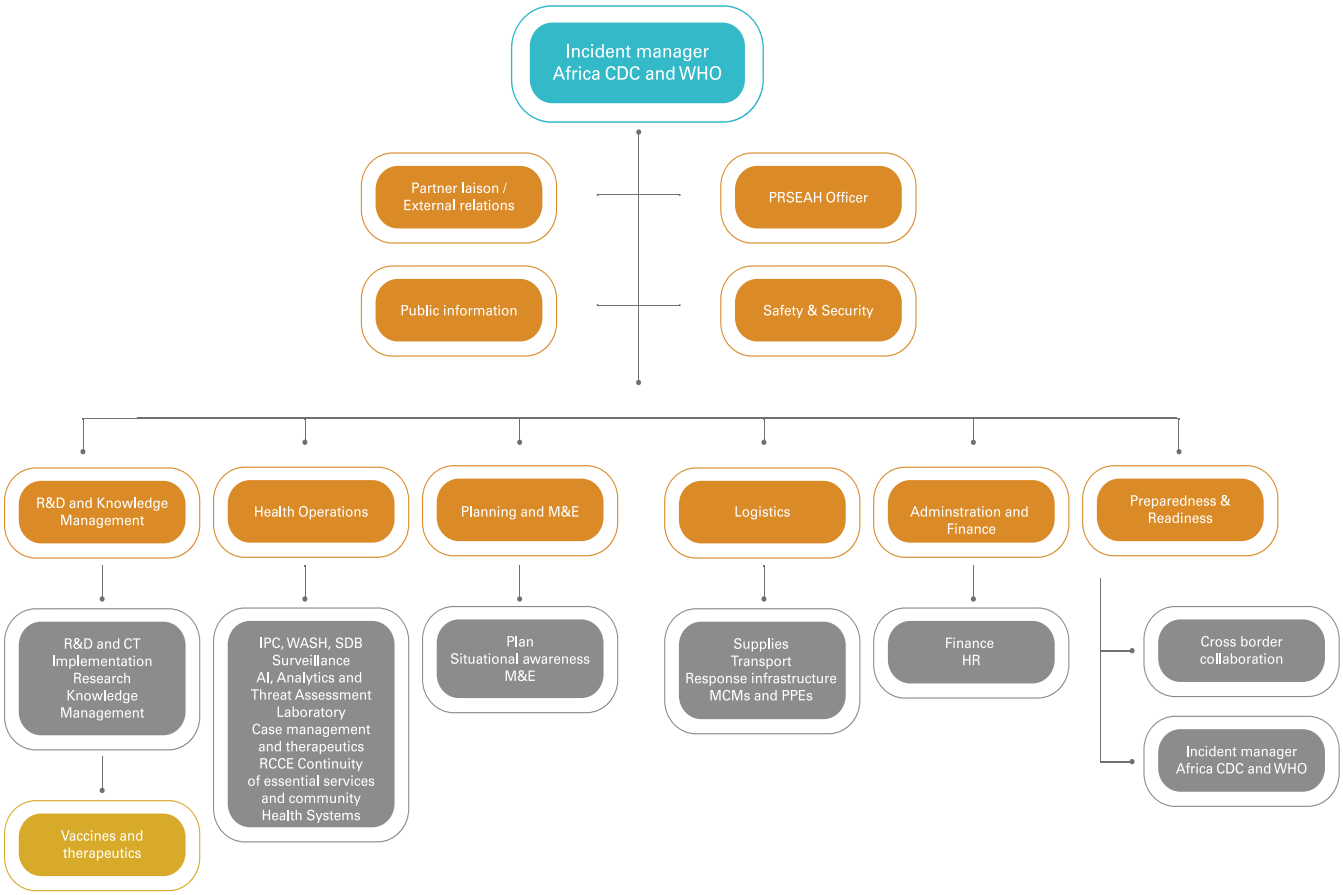


Figure 2: Continental response structure to respond to Bundibugyo virus disease outbreak
NB: The structure is dynamic and may be extended with more staff as needed

Table 2: Main functions of partners by pillars of response

Pillars	Africa CDC co-lead	WHO co-lead	Other co-leads	Sub-pillar	Support partners*
Pillar 1: Coordination, Leadership and Governance	Tolbert G. Nyenswah /Yap Boum	Marie Roseline Belizaire/ Patrick Otim		Partner Liaison	Africa CDC, WHO
				Public Information	Africa CDC, WHO
				PRSEAH	WHO
				Safety & Security	Africa CDC, WHO
Pillar 2: Risk Communication and Community Engagement (RCCE)	Paidamoyo Magaya	Julienne ANOKO	UNICEF	Community feedback mechanisms and infodemics	IFRC, UNICEF, WHO, UNHCR
				Community engagement	GAVI, IFRC, UNAIDS, UNICEF, WHO, NHCR
				Risk Communication	Africa CDC, UNICEF, WHO, UNHCR
				Behavioral insights	UNICEF, WHO, UNHCR

Pillars	Africa CDC co-lead	WHO co-lead	Other co-leads	Sub-pillar	Support partners*
Pillar 3: Surveillance and Epidemiology	Merawi Aragaw	Etien Koua	USCDC	Alert and Investigation	Africa CDC, WHO
				Contact tracing	Africa CDC, WHO
				Active case finding	Africa CDC, IFRC, RCRC, WHO
				Health information management	Africa CDC, JHU, PATH,Yale University, USCDC
Pillar 4: Laboratory Systems and Genomic Sequencing	Yenew Kebede/ Yao	Nicksy Gumede	USCDC	Diagnostics	Africa CDC, FIND, USCDC, WHO
				Quality control and assurance	Africa CDC, ASLM, WHO
				Genomics sequencing and bioinformatics	Africa CDC, WHO
				Biosafety and biosecurity	Africa CDC, WHO
Pillar 5: Case Management and Clinical Care	Rajabu/Carole/Judith	John Masina		Clinical	Africa CDC, IFRC, MSF, UNAIDS, WHO
				Psychosocial	UNICEF, WHO, UNHCR
				Nutrition	ACF, UNICEF, WFP
Pillar 6: Infection Prevention and Control (IPC), WASH and Safe and Dignified Burials	Denis Bunyoga	Landry CIHAMBANYA	UNICEF	Health facilities	MSF, WHO, UNHCR
				Community	IFRC, OXFAM, UNICEF
				WASH	OXFAM, UNICEF, WaterAid, UNHCR
Pillar 7: Research, Knowledge Management and Access to Medical Countermeasures	Mosoka Fallah, Folake Olayinka, Nebiyu Dereje	Reena Doshi		Clinical trials/R&D	Africa CDC, AMA, AUDA-NEPAD, AVAREF, CEPI, EDCTP, JHU, NIH, WHO
				Implementation/ Operational research	Africa CDC, EDCTP, GAVI, Wellcome Trust
				Ethics and regulatory	Africa CDC, GAVI, UNICEF, WFP, WHO
				Knowledge Management	Africa CDC, UNICEF, UNHCR, GAVI, WHO
Pillar 8: Operations Support, Logistics and Workforce Deployment	Shanelle Hall/ Tesfaye Hailemichael	Adama Thiam		Procurement	Africa CDC, GAVI, Pandemic Funds, UNICEF, UNHCR, World Bank, WFP, WHO
				Supply	Africa CDC, IFRC, WHO, UNHCR, UNICEF, WFP
				Health Logistics and Operations	Africa CDC, MSF, UNICEF, WFP, WHO
				Administration and Finances	Africa CDC, WHO

Pillars	Africa CDC co-lead	WHO co-lead	Other co-leads	Sub-pillar	Support partners*
Pillar 9: Continuity of Essential Health and Social Services and Community Health Systems	Landry Tsague	Elongo Lokombe		Health care services	Africa CDC, MSF, UNHCR, UNICEF, USG, WHO
Pillar 10: AI, Analytics & Threat Assessment	Kyeng Mercy	Etien Koua			
Pillar 11: Preparedness and Readiness	Mathew Tut	Dick Chamla		Cross-border collaboration	Africa CDC, IOM, WHO, UNHCR
				PoEs	Africa CDC, IOM, WHO
Pillar 12: One Health	Yewande Alimi	Tieble Traore		One Health	Africa CDC, WHO, FAO, WOAH
Pillar 13: Humanitarian Response and Service Delivery		Solomon Woldetsadik	OCHA	Protection services for women and children	Africa CDC, APORA, OCHA, UNFPA, WHO, UNHCR
				Education	
Pillar 14: PSEAH and Safeguarding					

*Support partners are arranged in alphabetical order

High-Level Roles and Responsibilities of IMST as a Coordinating Mechanism

The Incident Management Support Team (IMST), jointly led by Africa CDC and WHO, serves as the central coordination and leadership structure for the continental response to the Bundibugyo virus disease outbreak. This unified mechanism is designed to ensure strategic coherence, operational efficiency, and evidence-based decision-making across all levels of intervention. At the core of the IMST is a shared leadership model, with technical leads embedded within key response pillars, including surveillance, RCCE, laboratory, IPC, Case Management, and research and innovation and knowledge management, among others. This structure enables seamless integration of expertise and ensures that each pillar is guided by specialized leadership aligned with continental priorities.

The IMST will adapt and implement joint standardized guidelines, strategies, and tools, including a comprehensive Continental Bundibugyo Ebola Incident Action Plan. These resources will provide a consistent framework for response activities, ensuring that interventions are harmonized across regions and adaptable to local contexts. Maintaining close interaction with Member States is a cornerstone of the IMST's approach. Through continuous feedback loops, information sharing, and technical guidance, the IMST will support national response teams in real time, fostering agility and responsiveness in outbreak management.

Capacity building is another key function of the IMST. Tailored training programs, technical assistance, and mentorship will be provided to strengthen national Ebola disease response teams, ensuring that countries are equipped with the skills and tools needed to manage outbreaks effectively. To promote transparency and learning, the IMST will facilitate regular communication, documentation, and the sharing of experiences among Member States. This includes convening technical exchanges, publishing best practices, and maintaining a centralized knowledge hub.

A harmonized Monitoring & Evaluation (M&E) framework will be jointly developed to track progress, measure impact, and guide adaptive strategies. This framework will ensure accountability and enable

data-driven decision-making across all response activities. In support of innovation and continuous improvement, the IMST will also jointly develop unified research protocols and encourage collaborative publications that reflect the strength of the partnership and contribute to the global Ebola knowledge base. The complementarity of mandates between Africa CDC and WHO is a key strength of this joint IMST. Africa CDC brings deep contextual knowledge, strong relationships with AU Member States, and a proven track record in public health capacity building. WHO contributes normative leadership, global standards, and international coordination. Together, they form a powerful alliance capable of delivering a unified, impactful, and sustainable response to the BVD outbreak across Africa.

Africa CDC and WHO will work closely together to co-lead the Bundibugyo virus disease outbreak Continental Preparedness and Response Plan for Africa, leveraging their respective mandates, expertise, and comparative advantages to ensure a coordinated, efficient, and effective response across the continent. This partnership will leverage Africa CDC's regional expertise and coordination role within the African Union with WHO's global health leadership, technical expertise, and access to the international network. Together, they will ensure a robust, equitable, and sustainable response to the Bundibugyo Ebola virus outbreak, enhancing health security for all African nations and contributing to global health resilience. This collaboration is built on a foundation of mutual support and partnership, recognizing the unique strengths each organization brings to the table.

Africa CDC, as a public health agency of Africa, is mandated to strengthen the capacity and capability of Africa's public health institutions and systems to detect and respond quickly and effectively to public health threats and outbreaks. Africa CDC serves as the central point for coordinating health-related responses across Africa, ensuring a unified, continent-wide approach to public health emergencies.

Some of its key comparative advantages for this Continental Preparedness and Response Plan are:

- Africa CDC has a unique deep contextual understanding, experience, expertise and knowledge in addressing public health challenges in Africa
- Africa CDC is uniquely positioned to coordinate the efforts of the 55 AU member states. It can mobilize political support, facilitate resource-sharing, and harmonize public health measures across countries to ensure a unified continental response.
- Africa CDC has a strong track record in continental capacity building, particularly in developing and supporting national public health institutes, training health workers, and improving surveillance systems and laboratory networks. This capability will be crucial for strengthening the response to the Bundibugyo Ebola virus outbreak at the national and community levels.

WHO, as the leading international public health agency, is mandated to promote global health security, coordinate international health responses, and provide technical expertise and guidance to its member states. WHO's global role involves developing and disseminating evidence-based health policies, strategies, and best practices, and supporting countries in strengthening their health systems.

Some of its key comparative advantages for this Continental Preparedness and Response Plan are:

- WHO has the authority and experience to set international standards and guidelines for disease control, including those for surveillance, vaccination, treatment, and public health preparedness. WHO's endorsement provides credibility and legitimacy to the preparedness and response efforts for the Bundibugyo virus disease outbreak.
- WHO's global reach and established partnerships with other international organizations, partners, and research institutions provide access to vital resources, including knowledge, vaccines, treatments, and diagnostics.
- WHO's extensive country presence through its country offices enables direct operational support, sustained engagement with national authorities, and timely implementation of preparedness and response activities in affected and at-risk countries.
- WHO convenes and manages global expert networks and coordination mechanisms, including those supporting the prioritization, allocation, and equitable access to licensed and investigational medical countermeasures, ensuring timely, evidence-based decision-making and fair distribution during health emergencies.

- WHO possesses vast technical expertise in various health domains, including epidemiology, virology, immunology, and health systems strengthening. This expertise will be critical to developing evidence-based strategies and interventions to effectively manage the Bundibugyo Ebola virus outbreak.

- WHO is the IASC Cluster Lead Agency for Health Cluster and humanitarian health response, and its role is able to ensure integration, and complementarity of humanitarian response to bolster a multisectoral response to Bundibugyo Ebola virus outbreak, even in the most remote, hard to reach and conflict affected areas, as well as mitigate disruption to humanitarian response and service delivery.

Africa CDC and WHO will collaborate in the following critical key areas, supported by other partners who are involved in this plan:

a. **Joint Strategy Development and Implementation**: Both organizations will work together to develop a unified continental strategy for BVD outbreak preparedness and response that will be informed by evidence and best practices, ensuring alignment with global health standards while being tailored to the African context. Africa CDC and WHO will coordinate the implementation of the plan across AU member states, leveraging their respective networks and resources to ensure comprehensive coverage.

b. **Integrated Surveillance and Data Sharing**: Africa CDC and WHO will collaborate and jointly coordinate with IOM on enhancing and integrating BVD surveillance systems across Africa to improve early detection, reporting, and monitoring of cases considering the cross-border challenges. This will involve standardizing data collection protocols, facilitating real-time data sharing between countries, and utilizing digital health technologies for rapid information exchange. WHO's global surveillance network will complement Africa CDC's regional surveillance efforts and IOM's Health Border and Mobility Management (HBMM) framework, ensuring that accurate data informs public health interventions.

c. **Coordinated Vaccine Deployment and Medical Countermeasures**: through the interim medical countermeasures network (i-MCM-Net), Africa CDC and WHO will jointly coordinate with UNICEF, Gavi, and other partners the procurement, distribution, and deployment of PPEs, vaccines, and other medical countermeasures, as soon as they are available. i-MCM-net will leverage its relationships with global manufacturers and donors to secure timely and sufficient supplies and facilitate equitable allocation across affected and at-risk countries based on epidemiological data and risk assessments. Partner organizations will work to ensure that countries with the highest need receive priority access and support capacity-building efforts to manage vaccine storage and administration effectively.

d. **Risk Communication and Community Engagement**: Africa CDC and WHO will work together with UNICEF to lead the RCCE efforts to ensure clear, consistent, and culturally appropriate messaging about BVD prevention, symptoms, and response measures. This collaboration will involve developing and disseminating public health information tailored to different communities, addressing misinformation, and engaging local leaders, civil society organizations, and healthcare workers in public education campaigns.

e. **Research and Development and Knowledge Management**: Africa CDC and WHO will work together to identify current gaps in knowledge and medical countermeasures to launch appropriate research and development and operational research to address these gaps. Together with other partners, they will collaborate to develop guidance materials, document and disseminate scientific outputs and publications, and conduct joint communities-of-practice and knowledge-exchange events.

f. **Capacity Building and Health Systems Strengthening**: Both organisations will work together in collaboration with other partners to strengthen national health systems to better prepare for and respond to Bundibugyo Ebola virus outbreaks. Africa CDC will lead efforts to build regional and national capacities, including training healthcare workers, enhancing laboratory

and diagnostic capabilities, and developing public health emergency management systems. WHO will provide technical support, guidance, and training materials, drawing on its global experience and expertise.

g. **Resource Mobilization and Advocacy**: Africa CDC and WHO will collaborate to mobilize resources, both financial and technical, needed to implement the Bundibugyo Ebola virus outbreak preparedness and response plan effectively. This will involve joint fundraising efforts with international donors, governments, and private sector partners, as well as advocating for global solidarity and equitable access to medical countermeasures for Africa.

h. **Monitoring, Evaluation, and Adaptive Response**: Both organizations will jointly establish monitoring and evaluation mechanisms to assess the effectiveness of the Bundibugyo Ebola virus outbreak response and preparedness measures. This will include setting up feedback loops to continuously improve strategies based on real-time data and lessons learned, ensuring that the response remains adaptive to the evolving situation.

Roles and Responsibilities of Member States

All Member States should also adhere to the standing recommendations, comply with IHR, and follow the relevant guidance published by WHO and Africa CDC after the declaration.

- The Member States have the primary responsibility of responding to the Bundibugyo Ebola virus outbreak in their geographical jurisdiction.
- Members States are responsible for ensuring plans and strategies ensure equitable access for all persons within the national territory. This includes refugees, returnees, internally displaced populations, migrants whether in regular or irregular situations, those live in hard to reach, or conflict affected areas, mobile populations such as nomadic populations, socially marginalised groups for example due to ethnicity, language, political affiliation, age, gender, people with disabilities, people living with conditions potentially associated with stigma such as mental health conditions, HIV, survivors of gender based violence (GBV), people in detention and institutional settings.
- The activities of the member states will be supported by technical assistance from partners. Thus, member states need to build favorable working relationships and environments with all partners and monitor the technical assistance they provide.
- Member states are also required to share the epidemiological data required for the response with the Africa CDC and WHO.
- Follow temporary recommendations after PHEIC/ PHECS: Member States should also follow the relevant guidance found within the Temporary Recommendations issued by WHO after the PHEIC declaration and Africa CDC after the PHECS. These recommendations are designed to enhance specific national and regional responses in light of the evolving situation.
- Compliance with IHR: Every Member State must adhere to the International Health Regulations (IHR), which provide the necessary framework to prevent and respond to public health risks with the potential to cross borders. This adherence is essential for coordinated international efforts to manage the risk of the spread of the Bundibugyo Ebola virus.
- Considering the security threats associated with responding to Ebola, Member States are required to ensure the outbreak responders and infrastructure are protected.

Suggested priority actions based on country categorization

For this plan, the African Union Member States are classified into four categories based on their status of Bundibugyo virus disease outbreak (Table 3). This risk level is purely for planning and resource optimization to respond to the active and sustained transmission epicentres. The suggested priority actions below are neither prescriptive nor exhaustive, but an indication of the differentiated and adaptable strategy of this plan.

Table 3: Categorization of AU Member States as per the current levels of Ebola risk

Category → / Pillar ↓	**Category 1:** sustained human-to-human transmission	**Category 2:** sporadic human cases and / or, endemic zoonotic reservoirs	**Category 3:** Countries at risk based on the proximity to Category 1 countries by land, air or sea	Others
Coordination, Leadership and Governance	Establish/enhance a multisectoral strategic and operational coordination mechanism led by the MoH with support of Africa CDC and WHO, at national and sub-national levels; Implement the full package of the response plan	Establish/enhance a multisectoral strategic and operational coordination mechanism led by the MoH with support of Africa CDC and WHO, at national and sub-national levels; Develop and implement national response plans for sporadic transmission control and enhance multisectoral coordination	Build capacity for Ebola preparedness and response; conduct readiness assessments; develop national contingency plans; activate/ elevate PHEOCs to alert mode/lowest level of activation	Develop and implement national contingency plan; maintain routine unified coordination structures at all levels to ensure preparedness and alertness for Ebola outbreaks.
RCCE	Implement tailored RCCE strategies to address human-to-human transmission, driving vaccine acceptability (when available) and reducing stigma	Implement tailored RCCE strategies to address human-to-human transmission, driving vaccine acceptability (when available) and reducing stigma	Develop strategies, plans, and culturally and linguistically adapted messages; disseminate messages focused on awareness through appropriate channels	Develop strategies, plans, culturally and linguistically adapted messages and disseminate through appropriate channels
Surveillance, Epidemiology	Implement active surveillance (health facilities and community), contact tracing, and cross-border data sharing to promptly identify cases and interrupt Ebola transmission through targeted interventions; integrate Ebola into IDSR	Enhance surveillance with active and community-based efforts, contact tracing in areas reporting sporadic cases Ensure detailed case investigation and reporting to understand transmission dynamics; integrate Ebola into IDSR	Implement sensitive surveillance and laboratory capacity-building to enable prompt Ebola diagnosis, enhancing capacity, data sharing, and surveillance training at entry points in at-risk countries. Integrate Ebola into IDSR; Develop Points of Entry guidance for screening, isolation management, and appropriate referral and transport mechanisms and conduct tailored capacity building.	Enhance routine surveillance with digital tools and continuous training for health workers to increase alertness and reporting of suspected Ebola cases. Integrate Ebola into IDSR

Category → / Pillar ↓	**Category 1:** sustained human-to-human transmission	**Category 2:** sporadic human cases and / or, endemic zoonotic reservoirs	**Category 3:** Countries at risk based on the proximity to Category 1 countries by land, air or sea	Others
Laboratory and genomic sequencing	Testing of 100% of Ebola suspected cases, including suspected community deaths through strengthening of testing at national and sub national levels; implement upgraded lab infrastructure, decentralized qPCR testing, and genomic sequencing to effectively control active Ebola transmission.	Diagnostic capacity at the national reference laboratory to achieve 100% of suspected cases to be tested; boost national lab capacity to test all suspected cases, deploy rapid tests, enhance data reporting, and use genomic sequencing to identify unclear transmission and control Ebola.	Diagnostic capacity at national reference laboratory to achieve 100% of suspected cases to be tested; build national lab capacity to confirm all suspected cases; prepare at-risk districts by building lab capacity, implementing sample transport systems, and validating new diagnostic tools.	Diagnostic preparedness through the supply of test kits; build national lab capacity to confirm all suspected cases. Prepare at-risk countries with lab capacity building, sample transport systems, and validation of new diagnostic tools
Case Management and clinical care	Implement comprehensive case management (clinical, psychosocial, nutritional) protocols, supply provision, and capacity building for Ebola to reduce the case fatality rate (CFR); Establish Ebola treatment centres Establish continuity of care, including a survivor care programme	Implement comprehensive case management protocols. Establish Ebola treatment centres as needed	Develop adaptable protocols and train healthcare workers to prepare countries at increased risk of Ebola transmission.	Develop adaptable protocols, train healthcare workers to prepare countries at increased risk for potential Ebola transmission
IPC, WASH and safe burial	Implement comprehensive IPC measures and interventions through the IPC ring approach with tailored guidelines/ SOPs, supplies, assessments, screening, isolation measures and training in health facilities, and community settings to control active Ebola transmission; develop and implement dignified and safe burial strategies	Rapid implementation of IPC & WASH interventions through: develop IPC guidelines / SOPs and supply necessary IPC supplies e.g., PPE, strengthening screening, triage and isolation measures to quickly control sporadic Ebola transmission; enhance IPC measures at PoE; develop and implement dignified and safe burial strategies	Strengthen the IPC measures & WASH services readiness capacities through, establish / activation of coordination mechanism. Taskforce, including partners, develop and revise IPC guidelines/SOPs, surge capacity plans, training HCWs to prepare at-risk health districts for potential Ebola outbreaks	Strengthen preparedness and readiness IPC & WASH capabilities at both national and healthcare facility levels through the IPC coordination mechanism. Develop and revise IPC guidelines/ SOPs; strengthen IPC assessment, readiness plans, HAI surveillance, HCWs training, strengthen implementation of standard and transmission-based precautions in healthcare facilities, and maintain alertness for Ebola transmissions.

Category → / Pillar ↓	**Category 1:** sustained human-to-human transmission	**Category 2:** sporadic human cases and / or, endemic zoonotic reservoirs	**Category 3:** Countries at risk based on the proximity to Category 1 countries by land, air or sea	Others
Vaccination, as soon as the vaccine becomes available	Ensure timely readiness and operational capacity for evaluation and potential deployment of candidate vaccines and therapeutics during outbreaks. Implement a targeted vaccination strategy to stop acute outbreaks, including emergency use authorization for vaccines under investigation, ensuring vaccine allocation to high-risk groups and areas, and integrating with other public health measures. This depends on the vaccine availability.	Ensure timely readiness and operational capacity for evaluation and potential deployment of candidate vaccines and therapeutics during outbreaks. Develop national vaccination plans to quickly address human-to-human transmission, ensuring access and safety monitoring; obtain regulatory approvals for emergency use of vaccines	Develop a vaccine readiness introduction plan; obtain regulatory approvals for emergency use of vaccines	Enhance routine vaccine uptake through RCCE approaches and advocacy for local manufacturing; obtain regulatory approvals for emergency use of vaccines
Research and Innovation and Knowledge Management	Launch rapid research initiatives on diagnostics, vaccines, therapeutics and transmission dynamics to address critical knowledge gaps and support response efforts; conduct rapid evidence synthesis, develop and disseminate guidance documents to inform response, document and disseminate experiences, facilitate knowledge exchange among response personnel, and publish outputs for wider reach.	Launch rapid research initiatives on diagnostics, vaccines, therapeutics and transmission dynamics to address critical knowledge gaps and support response efforts; conduct rapid evidence synthesis, develop and disseminate guidance documents to inform response, document and disseminate experiences, facilitate knowledge exchange among response personnel, and publish outputs for wider reach.	Prepare at-risk countries by developing research protocols and obtaining relevant approvals	Prepare countries by developing research protocols and obtaining relevant approvals
Operational Support and logistics	Ensure timely, equitable, and prioritized delivery of equitable and efficient supply of medical countermeasures and PPE to control active Ebola transmission; ensure the provision of supplies to areas with an active outbreak	Ensure supplies are provided to areas with active outbreaks and pre-positioned in at-risk districts, supported by contingency stock levels, alternative supply routes, and monitoring systems to prevent stockouts and pipeline disruptions; strengthen last-mile distribution capacity to peripheral and remote facilities.	Prepare at-risk countries by developing strategic stockpiles, coordinating demand forecasting, and enhancing cold chain capacities; pre-position of supplies at national and/or in at-risk districts including logistics data systems for visibility and coordination.	Maintain routine supply chain monitoring and cooperative networks to ensure readiness and alertness for Ebola outbreaks; pre-position of supplies at the national level, strengthen national logistics systems and integration with regional supply networks, including targeted pre-positioning and capacity to rapidly scale operations if risk levels increase.

Category → / Pillar ↓	**Category 1:** sustained human-to-human transmission	**Category 2:** sporadic human cases and / or, endemic zoonotic reservoirs	**Category 3:** Countries at risk based on the proximity to Category 1 countries by land, air or sea	Others
Continuity of essential services and community health systems	Ensure close monitoring of continuity and utilization of essential health, education, and social services; maintain continuity of essential health services	Maintain continuity and utilization of essential health, education, and social services; monitor utilization of essential services	Advocate for service continuity and addressing potential challenges to maintain essential health gains and establish monitoring systems	Advocate for service continuity and addressing potential challenges to maintain essential health gains and establish monitoring systems
Preparedness and Readiness	Implement response activities at PoEs, including screening and cross-border coordination and collaboration-related activities	Implement tailored intervention to put in place PoEs activities and cross-border support. In addition, support member states in ensuring preparedness, readiness, including planning, validation and testing	Support member states to prepare and ensure readiness by doing simulation exercises and PoEs intervention	Support member states to prepare and ensure readiness by doing simulation exercises and PoEs intervention
AI, Analytics & Threat Assessment	Perform in-depth analysis and synthesis to enable evidence-based response	Risk analysis	Risk analysis, Forecasting	Risk analysis, Forecasting
One Health	Activate multisectoral One Health coordination mechanisms at continental, regional and national levels	Activate multisectoral One Health coordination mechanisms at continental, regional and national levels	Create/operationalize One Health coordination mechanism	Create/operationalize One Health coordination mechanism
Humanitarian response and Service delivery	Coordinate humanitarian response activities among government, UN agencies, NGOs, and partners.	Coordinate humanitarian response activities among government, UN agencies, NGOs, and partners.		
Prevention and response of Sexual Exploitation, Abuse and Harassment (PSEAH) and Safeguarding	Establish PSEAH coordination mechanisms	Establish PSEAH coordination mechanisms		

Budget and Resource Mobilization

Planning Assumptions for Bundibugyo Ebola Virus Outbreak Preparedness and Response in Africa

Estimated number of cases expected

As of 27 May 2026, a total of 129 confirmed cases, 1,077 suspected cases, and 246 suspected deaths from the Bundibugyo Virus Disease (BVD) outbreak have been reported from the Democratic Republic of the Congo (DRC) and Uganda. These cases were reported from 15 health zones: DRC (14 HZs) and Uganda. Given the region's limited detection capacity, this number may be underestimated. With intensified surveillance and laboratory testing, including community-based surveillance, we expect to detect an average of 20 confirmed cases per day over the next 6 months. The total number of cases estimated over the six months will be 3,600.

Estimated number of treatment centres needed

Estimating the number of Ebola treatment centers (ETCs) required is both an epidemiological and operational exercise that must continuously adapt to evolving transmission dynamics, contextual risks, and health system constraints. As the response builds a more complete picture of the outbreak's scale, certain assumptions must be made to support operational scale-up.

The estimation process is driven by epidemiological projections, anticipated healthcare demand, geographic spread, and operational feasibility. The primary objective is to ensure sufficient capacity for rapid isolation, safe clinical management, infection prevention and control (IPC), and surge response while minimizing healthcare-associated transmission and delays in treatment. Because Ebola outbreaks can evolve rapidly, treatment infrastructure planning must remain dynamic and adaptable to changing transmission patterns and outbreak intensity.[1] [2]

Estimating the treatment center involves projecting the expected number of active BVD cases at the peak of the outbreak, based on epidemiological indicators such as the daily incident case count, reproduction rate (R_0 or Rt), doubling time, transmission trends, and the effectiveness of contact tracing and isolation measures.[3] A commonly used operational approach estimates the number of required treatment beds by multiplying the projected daily number of new cases by the average duration of hospitalization or isolation. For Ebola virus disease, patients often require admission for approximately 14 days.[4] Assuming an average daily detection of 20 new confirmed or suspected cases and an average treatment duration of 14 days, the outbreak would require approximately 280 operational treatment and isolation beds at peak occupancy. Applying a contingency surge buffer of 30% to account for under-detection, reporting delays, super-spreading events, and sudden escalation in transmission increases the estimated requirement to approximately 364 beds over a 14-day period.

For operational planning over a six-month response period, these assumptions suggest the need for a decentralized network of Ebola treatment and isolation facilities capable of managing both sustained transmission and localized surges. Standard Ebola Treatment Units (ETUs) commonly operate with a capacity of 20–30 beds, depending on staffing and IPC capability. Using an average operational capacity of 25 beds per ETU, approximately 15 functional ETUs would be required to safely manage projected caseloads over the six-month period. However, because outbreak transmission is unlikely to be evenly distributed geographically, these facilities should be complemented by smaller community isolation units and transit centers positioned near outbreak hotspots, border crossings, and high-risk mobility corridors. In the current Bundibugyo Ebola outbreak in Ituri Province, treatment infrastructure would likely need to be distributed across Mongbwalu Health Zone, Bunia Health Zone, and Rwampara Health Zone, with additional transit and isolation facilities positioned near key border areas with Uganda to strengthen cross-border preparedness.

A practical six-month operational configuration could therefore include approximately 5–7 larger ETUs

1 World Health Organization (WHO). Ebola Response Roadmap. Geneva: WHO; 2014.
2 Lamunu M, Lutwama JJ, Kamugisha J, et al. Containing a haemorrhagic fever epidemic: the Ebola experience in Uganda (October 2000–January 2001). Int J Infect Dis. 2004;8(1):27–37.
3 World Health Organization (WHO). Manual for the Care and Management of Patients in Ebola Care Units/Community Care Centres. Geneva: WHO; 2015.
4 Evans DK, Goldstein M, Popova A. Health-care worker mortality and the legacy of the Ebola epidemic. Lancet Glob Health. 2015;3(8):e439–e440.

strategically located in major referral hubs, 8 - 10 medium-sized decentralized treatment or isolation centers in hotspot districts, and several smaller transit or holding units integrated into district hospitals and points of entry. This layered approach would support rapid triage, reduce delays in isolation, and minimize the need for long-distance patient transport, particularly in insecure or hard-to-reach settings. The requirement for decentralized infrastructure is especially important in eastern DRC, where insecurity, poor road networks, mining-related mobility, and population displacement may rapidly generate new transmission clusters. In such settings, flexible and mobile isolation capacity may be as important as fixed ETC infrastructure.

Importantly, ETC estimation should not rely solely on physical bed counts. Functional capacity depends heavily on workforce availability, IPC readiness, laboratory support, supply chains, referral systems, and operational safety. Ebola treatment facilities require highly trained multidisciplinary teams, including clinicians, nurses, laboratorians, hygienists, psychosocial workers, logisticians, burial teams, and surveillance personnel. In many outbreaks, staffing shortages and weak IPC systems become the primary limiting factors rather than infrastructure itself. A facility with 50 physical beds may safely operate only 20–30 beds if adequate personnel, PPE, oxygen supplies, and waste management systems are unavailable. Consequently, treatment center planning must integrate infrastructure, surge capacity for the workforce, laboratory networks, logistics systems, and community engagement into a unified operational framework.

Additional considerations for the current Bundibugyo virus disease outbreak further increase the requirements for treatment infrastructure. Unlike outbreaks caused by Ebola virus, there are currently no licensed vaccines or therapeutics specifically approved for Bundibugyo virus disease, increasing dependence on supportive clinical care and thorough containment measures. The ongoing outbreak is also occurring in a context characterized by insecurity, humanitarian pressures, weak health systems, high population mobility, and delayed outbreak detection, all of which heighten the risk of sustained transmission and healthcare-associated amplification. These factors support the need for larger contingency surge capacity, stronger IPC-ready facilities, decentralized treatment networks, and integrated cross-border preparedness systems.

Estimated number of antivirals, therapeutics, and other supplies needed

IV fluids and ORS, antivirals, antibiotics and other supportive medications are required for the treatment of 3600 estimated cases. Moreover, PPEs and supportive nutritional medications are required

Estimated budget

The effective implementation of the Plan requires adequate and sustained resources to support the priority activities outlined in the strategy. This section outlines the key resource requirements, costing assumptions and funding strategies for the initial six-month period (June 2026 to November 2026), which are critical for containing ongoing outbreaks, reducing morbidity and mortality, and preventing further spread across the continent. A total of **US$517,678,605.01** is estimated to be required to respond to the Bundibugyo virus disease over the six-month period, based on updated costing (Tables 4-7). Out of the estimated total budget, **US$264,973,389.00** will be used to support the affected member states (DRC and Uganda) and **US$79,100,000.00** will be used to support preparedness activities in the high-risk countries.

Summary of Estimated Total Budget

Table 4: Summary of the total estimated budget for the continental Bundibugyo virus disease response plan.

Pillars	Budget (USD)
Coordination, Leadership and Governance	$18,058,133.59
Risk Communication and Community Engagement	$46,603,241.51
Surveillance, Cross-Border Preparedness and One Health	$66,279,990.82
Laboratory Systems and Genomic Sequencing	$41,183,296.43
Case Management and Clinical Care	$66,486,336.41
IPC, WASH and Safe and Dignified Burials	$49,118,723.40
Research, Knowledge Management and Access to MCMs	$67,695,618.30
Operations Support, Logistics, Nutrition and Workforce Deployment	$129,896,342.17
Continuity of essential health services and Community Health Systems	$32,356,922.38
Total	**$517,678,605.01**

Table 5: Member States' Response Budget (as per submitted response plans) USD**

Country	Coordination	RCCE	Surveillance	Laboratory	Case Mgt	WASH- IPC	Operations support	CES	Research	Total
DRC	$90,672,920.00	$9,480,650.00	$18,793,150.00	$2,825,500.00	$9,799,520.00	$9,705,940.00	$85,120,250.00	$11,711,000.00	$2,157,000.00	$240,265,930.00
Uganda	$2,475,956.00	$3,658,844.00	$4,620,577.00	$1,559,341.00	$7,170,166.00	$603,363.00	$4,327,267.00	$162,575.00	$129,370.00	$24,707,459.00
TOTAL	$93,148,876.00	$13,139,494.00	$23,413,727.00	$4,384,841.00	$16,969,686.00	$10,309,303.00	$89,447,517.00	$11,873,575.00	$2,286,370.00	$264,973,389.00

Table 6: Member States in preparedness phase

Country	Budget (USD)
South Sudan	$7,400,000.00
Rwanda	$5,000,000.00
Kenya	$5,000,000.00
Zambia	$5,000,000.00
Central African Republic	$16,700,000.00
Tanzania	$5,000,000.00
Ethiopia	$5,000,000.00
Somalia	$5,000,000.00
Angola	$5,000,000.00
Republic of Congo	$5,000,000.00
Burundi	$15,000,000.00
TOTAL	**$79,100,000.00**

***This budget, estimated by the member states, is included in the overall budget estimated for the response

Table 7: Partners Funding:

Partners	$173,605,216.01

A detailed review of partner budgets is underway to harmonize planned activities, remove overlapping costs, and ensure efficient use of available funding. The revised budget breakdown will be shared upon completion of the consolidation process. The budget could be changed as more partners join the response efforts.

Resource Mobilization

The ongoing Ebola outbreak presents a critical public health challenge requiring an urgent, coordinated, and well-resourced response across affected and at-risk countries. In response to the evolving epidemiological situation, WHO AFRO and Africa CDC have jointly developed a continental Preparedness and Response Plan with an estimated budget requirement of **US$413,678,605.01** to support preparedness, response operations, cross-border coordination, and protection of vulnerable populations. Given the scale and complexity of the response, a robust resource mobilization strategy will be essential to secure timely, flexible financing, sustain operational capacities, strengthen coordination among partners, and ensure continued political and donor engagement. Africa CDC and WHO will leverage their respective comparative advantages and strategic partnerships to mobilize the required resources and ensure coordinated support to Member States. Africa CDC will utilize its continental political convening power, engagement with African Union Member States and regional institutions, and partnerships with regional financing mechanisms to advocate for domestic resource mobilization, political commitment, and regional solidarity. WHO will leverage its global mandate, donor coordination platforms, technical leadership, and relationships with international financing institutions, UN agencies, philanthropic organizations, and development partners to support global advocacy and resource mobilization efforts. The strategy will combine high-level advocacy, targeted donor outreach, strategic communications, private-sector engagement, and strengthened accountability mechanisms to support rapid resource mobilization and reinforce regional efforts to contain the outbreak and save lives.

I. Advocacy for Domestic Resource Mobilization: Epidemic Fund, APHEF

Advocacy efforts will focus on strengthening domestic and regional financing mechanisms for emergency preparedness and response, with particular emphasis on the WHO AFRO Africa Public Health Emergency Fund (APHEF) and the Africa CDC's Africa Epidemic Fund (AfEF). WHO AFRO and Africa CDC will engage closely with Member States, Ministries of Finance, regional economic communities, and political leadership to promote increased allocation of domestic resources toward the financing mechanisms for preparedness, rapid response capacities, and ultimately resilient health systems. This approach will also aim to position health security as a core regional development and economic priority, requiring sustained and predictable investment beyond emergency response cycles.

II. Continental Emergency Appeal

A joint continental Emergency Appeal will be launched by the WHO AFRO and the Africa CDC to articulate the epidemiological situation, operational priorities, resource requirements, and funding gaps under the plan. The appeal will serve as the primary advocacy and resource mobilization instrument to galvanize coordinated donor support for response operations, preparedness activities, and cross-border interventions across affected and at-risk countries. The appeal will also emphasize the urgent need for flexible and rapidly deployable funding to support evolving operational priorities.

III. Weekly donor briefings to include acknowledgment of donors already supporting the response through a panel session

WHO AFRO and Africa CDC will convene weekly donor briefings to provide real-time epidemiological updates, operational progress, funding requirements, and priority gaps requiring urgent support. These briefings will serve as a key platform for transparency, coordination, and sustained partner engagement throughout the response period. The sessions will also include dedicated segments acknowledging donors already supporting the response through panel discussions and partner spotlight sessions to strengthen visibility, accountability, and continued solidarity.

IV. Investment cases for under-resourced pillars

Targeted investment cases will be developed for under-resourced response pillars to clearly articulate operational needs, anticipated impact, and return on investment for partners. These investment cases will provide evidence-based justification for resource allocation and support tailored engagement with donors interested in specific technical areas such as surveillance, laboratory systems, logistics, infection prevention and control, and risk communication. This will be informed by the continuous tracking of funding per pillar.

V. Private sector engagement & High net worth individuals

Dedicated engagement efforts will be undertaken to mobilize support from the private sector, philanthropic foundations, and high-net-worth individuals to diversify the response's funding base. Engagements will focus on sectors with strategic relevance to outbreak response, including logistics, telecommunications, digital health, artificial intelligence, mining, aviation,

and financial services. Advocacy efforts will emphasize the economic and social impact of Ebola outbreaks and the importance of public-private partnerships in strengthening preparedness, innovation, and operational surge capacities across the continent.

VI. **Targeted bilateral engagements**

Targeted bilateral engagements will be undertaken with key donor governments, development agencies, embassies, and financing institutions to present priority funding needs and strengthen coordinated support for the response. These engagements will focus on aligning donor contributions with identified operational gaps and ensuring timely mobilization of financial and technical assistance.

VII. **High-Level Side Events & Conferences**

High-level side events and strategic engagements will be organized during major global and regional conferences, ministerial meetings, and health security platforms to sustain political attention and mobilize additional resources for the Ebola response. These events will provide opportunities to showcase operational updates, elevate the voices of affected countries and frontline responders, strengthen advocacy, and foster new partnerships to support preparedness and response efforts.

VIII. **Donor Transparency and Accountability**

Acknowledgment of donor support on social media

Donor transparency and accountability will be a central component of the resource mobilization process to ensure confidence, trust, and sustained partner engagement throughout the outbreak response. Africa CDC and WHO will establish strong accountability mechanisms to provide regular reporting on resource mobilization, allocation, utilization, and operational impact across all response pillars. Periodic financial and programmatic updates will be shared with partners to support coordinated planning, demonstrate the effective use of resources, and ensure visibility of ongoing response achievements and remaining gaps

Financial tracking mechanism

A Financial Tracking Mechanism (FTM) similar to the one utilized during the Mpox response will be utilized to strengthen transparency, coordination, and accountability of resource mobilization efforts and funding flows across the response. The FTM will support real-time monitoring of donor contributions, funding allocations, implementation status, and resource gaps, enabling evidence-based decision-making and improved donor reporting throughout the outbreak response.

Regional and National Accountability Mechanisms

A dedicated BVD Continental IMST finance-tracking mechanism, consistent with the one budget principle, will be established to uphold financial integrity, operational transparency, and social responsibility throughout the implementation of response activities.

Ensuring robust accountability is central to the success and sustainability of the continental response to the Bundibugyo Ebola virus outbreak. At both regional and national levels, the finance-tracking mechanism used during the mpox and cholera outbreak responses will be extended to the Bundibugyo Ebola virus outbreak to uphold financial integrity, operational transparency, and social responsibility throughout the implementation of response activities.

Financial accountability will be maintained through standardized budgeting processes, transparent finance management dashboards, and regular audits. Transparent reporting systems will be established to track resource allocation and utilization, ensuring that funds are directed toward high-impact interventions and that donor confidence is sustained.

Operational accountability will be reinforced through performance monitoring frameworks aligned with the "One Monitoring & Evaluation" approach. These frameworks will include clear indicators, timelines, and deliverables for each response pillar. Regular progress reviews, field assessments, and partner reporting will help identify gaps, measure impact, and inform adaptive strategies.

Social accountability will be promoted by engaging communities, civil society organizations (CSOs), and local leaders in the planning, implementation, and evaluation of the Bundibugyo Ebola virus outbreak response. Feedback mechanisms, such as community scorecards, hotlines, and public forums, will be used to ensure that interventions are responsive to local needs and that affected populations have a voice in shaping the response.

Monitoring, Evaluation, and Impact Assessment (M&E)

This subsection aims to estimate the intervention's expected impact and assess its effectiveness. It outlines the objectives of the M&E component and describes the methodology for monitoring progress toward the defined goals. This includes a clear statement of purpose and the methodology to apply.

Results-based monitoring

Monitoring the response plan will be guided by a results-based monitoring approach. This approach recognizes that achieving the overarching goal of the response plan and its objectives. It involves a complex interplay of processes and interventions that collectively contribute to achieving the desired outcomes and long-term impact, transitioning from inputs to impacts. At each results chain, a set of SMART indicators developed and validated by leadership will be used to track progress on results in the response.

- **Monitoring:** Input and output will be monitored through a set of reporting tools developed by the IMST, which will be adhered to by all stakeholders. Process monitoring will be conducted using specific tools such as the IPC assessment checklist; EPR readiness checklist; and Risk communication checklist among others.
- Periodic and ad-hoc joint support supervision visits will be undertaken; and to ensure the correctness, completeness, and timeliness of monitoring data, a series of internal review mechanisms will be used, including weekly and monthly reviews at national, regional and continental levels.
- **Evaluation:** The Continental IMST will conduct periodic evaluations of the plan, including intra- and after-action reviews and accountability forums, among others.
- **Report Chains and Data Submission:** Data collected during the implementation of this plan will be shared with the Continental IMT, which has the primary mandate for its monitoring.

Key performance indicators (KPIs)

The IMST will define and validate the response's key performance indicators into a performance indicator reference sheet. This will include a set of indicators to measure results at each level of the results chain, including process indicators and efficiency indicators to assess how the process of delivering activities is science-driven and responsive to local context.

The following KPIs are designed to ensure effective monitoring of the Plan (Table 7).

Table 7: Key Performance Indicators of the Response Plan

Objective	KPI	Target	Means of verification	Frequency
Establish a unified and functional coordination mechanism and guided by the principles of one team, one plan, one budget, and one monitoring and evaluation framework across continental, regional, national, and subnational levels.	Functional coordination structure established at continental, national, and subnational levels	One at each level	TORs, Reports, meeting and minutes	Monthly
Support and engage communities, including the most vulnerable groups, to promote the adoption of key public health measures and ensure access to essential services aimed at reducing Bundibugyo Ebola virus outbreak transmission, morbidity, mortality, and associated secondary impacts	Percentage increase in public knowledge about Bundibugyo virus transmission and prevention measures.	Number of populations reached 90% reach as measured by surveys.	Survey Report	Quarterly
	Percentage of individuals who report practicing recommended measures to protect themselves from Bundibugyo Ebola virus outbreak (broken down by behaviour)	90%	Survey	Monthly
To rapidly detect, confirm, characterize, and monitor the evolution of an outbreak to inform and guide immediate, effective, and targeted control interventions aimed at interrupting transmission and minimizing morbidity and mortality.	Percentage of alerts investigated and tested within 24 hours of reporting.	90% of alerts investigated within 24 hours	SitRep and weekly epidemic intelligence report	Monthly
	Percentage of Member States established cross border surveillance system	100% of Member States	Surveillance report	Monthly
To ensure timely and accurate laboratory confirmation of Bundibugyo Ebola virus cases during outbreaks to guide public health response and resource allocation.	Number of laboratories with functional capacity to conduct Bundibugyo Ebola virus testing	One laboratory per province high-risk countries and at least one national reference laboratory in at risk and other Member States	Laboratory Report	Monthly
To provide high-quality and comprehensive treatment and holistic care for patients with Bundibugyo Ebola virus through early establishment of treatment centers, capacity building, and providing guidance	Number of engagements, and events to improve Bundibugyo virus case management	Case fatality ratio below 20%	Report on CFR	Quarterly
	Number of facilities with staff trained on Bundibugyo Ebola virus case management			

Objective	KPI	Target	Means of verification	Frequency
To enhance IPC measures in Bundibugyo Ebola virus treatment centers and households	Percentage of health facilities supported with IPC improvement plans	80% of health facilities with strengthened IPC	IPC & WASH assessment tool / report	Quarterly
	% of facilities implementing health and care workers risk assessment after potential BVD exposure	100 %	WHO HCWs risk of exposure assessment tool	Monthly
	% of Households and healthcare facilities decontaminated within 24 hours from identifying confirmed case	100%	Direct observation and implementation	24 hours
	% of healthcare facilities with functional screening, triage and isolation areas	≥ 80%	IPC rapid assessment tool	Monthly
	times)	80%	Assessment report	Quarterly
Ensure timely, equitable, and high-coverage vaccine deployment in response to outbreaks (when available)				
	To be developed			
Ensure procurement, delivery, management, and coordination of essential supplies and equipment to sustain preparedness and response activities	Percentage of member states that receive at least 80% of the Bundibugyo virus-related supplies ordered.	80%	Report	Monthly
Leverage research and innovation to generate and translate evidence to strengthen data-driven outbreak response, improve risk communication, and optimize logistics during emergencies	Research coordination mechanism established	A functional continental research coordination mechanism in-place	Report / Publications	Quarterly
	Knowledge products developed and disseminated		Report / Publications	Quarterly
Ensure uninterrupted delivery of critical health services while responding to Bundibugyo virus	Percentage of health facilities in each Health Zone that are operational and providing health services in hot spots health districts.	80%	Assessment report/DHIS 2 report	Monthly

Incident Management Support Team

The Incident Management Support Team (IMST) is Africa's continental effort co-led by Africa CDC and WHO, that collaborates with ministries of Health, regional partners, and global stakeholders to expand vaccination efforts, enhance diagnostic access, and strengthen health system resilience.

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