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Overview of the Ebola disease (Bundibugyo virus) outbreak

Clinical and Risk Communication & Community Engagement Webinar

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Update to 28 May 2026 RCCE BVD readiness briefing

Theme: Protecting families and communities, preventing fear through preparedness

RCCE Webinar
16 July 2026

10h05–10h15

From 28 May to 16 July: why this update matters

Outbreak expansion has increased the importance of calm, practical, evidence-based RCCE preparedness.

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28 MAY BRIEFING BASELINE

Initial operating picture

DRC: 121 confirmed cases and 17 confirmed deaths.
Uganda: 7 confirmed cases and 1 death.
Outbreak affecting three DRC provinces and 13 health zones.

South Africa readiness shift

22 May baseline: 40%
19 June current: 74.6%
Target: ≥80% adequate and tested readiness

JULY UPDATE

DRC CONFIRMED
1,926
702 deaths | CFR 36.4%

AFFECTED AREAS
42 HZ
5 DRC provinces

REGIONAL SIGNAL
3 countries
DRC, Uganda, France

What changed operationally

- Sustained community transmission in DRC hotspot health zones.
- Uganda outbreak remains epidemiologically linked to DRC, with no new cases since 21 June in the latest WHO update.
- One confirmed imported case in France illustrates onward travel risk.
- South Africa has improved readiness, but must prove the importation pathway operationally.

Main message for RCCE

The aim is not to alarm communities. It is to prepare trusted voices, clear messages and listening systems before an imported alert occurs.

Sources: 27 May internal WHO brief; DRC SitRep No. 058, report date 11 July 2026; WHO Weekly External SitRep 08, data as of 05 July 2026; South Africa readiness scores, 19 June 2026.

Current outbreak situation at a glance

Latest DRC national data are later than the latest WHO weekly regional snapshot; figures are subject to retrospective revision.

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DR CONGO
1,926 confirmed
702 confirmed deaths | 36.4% CFR
5 affected provinces | 42 health zones
53 new confirmed cases in last 24h

UGANDA
20 confirmed + 1 probable
3 deaths total; no new confirmed cases reported since 21 June; no documented community transmission in latest WHO DON.

FRANCE
1 imported case
Response-linked clinician returned from DRC; recovered in the latest weekly update with no evidence of secondary transmission among identified contacts.

WHAT PEOPLE NEED TO UNDERSTAND

Transmission facts for clear RCCE

Bundibugyo virus disease is an Ebola disease. Transmission occurs through direct contact with blood, secretions, organs or other body fluids of infected people, and with contaminated surfaces or materials. Unsafe care and unsafe burial practices can amplify transmission.

Care-seeking and follow-up facts

Incubation is 2–21 days and people are not infectious until symptom onset. Anyone with compatible symptoms after exposure to affected areas or known cases should seek care early, call ahead where possible, and avoid direct contact with others.

Operational interpretation

DRC remains the epidemic epicentre. Uganda remains a linked cross-border event. The France case validates the need for travel-health information, early self-reporting, isolation and rapid contact management without stigmatizing travellers or responders.

Sources: DRC SitRep No. 058, 11 July 2026; WHO Disease Outbreak News, 3 July 2026; WHO Weekly External SitRep 08, data as of 05 July 2026.

DRC epidemic trajectory: sustained and high transmission

The DRC epidemic curve shows continued growth through recent epidemiological weeks; Week 28 remains incomplete.

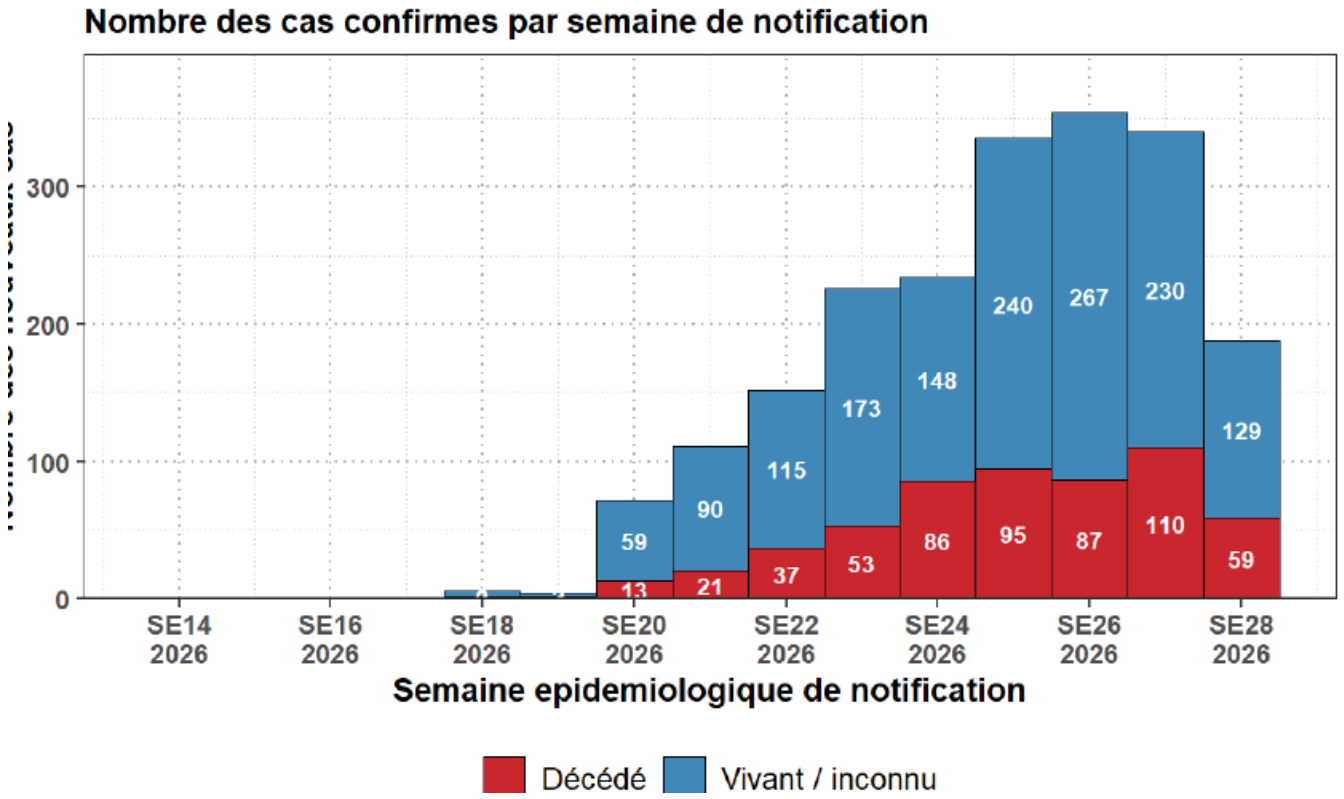

Figure: DRC SitRep No. 058, report date 11 July 2026.

Key epidemiological signals

- Weekly confirmed case counts exceeded 300 during recent reporting weeks.
- On 11 July, DRC reported 53 new confirmed cases and 30 deaths in 24 hours; two-thirds of deaths were community deaths.
- Contact follow-up was 78.3% across the two active provinces in the DRC SitRep.

Why this matters for readiness

Delayed detection, community deaths, weak follow-up and unsafe care or burial practices increase the chance that chains of transmission are missed. RCCE should support early reporting, rapid referral, safe care-seeking and reduced fear.

Implication for South Africa

Preparedness should assume a possible alert could present through an airport, private facility, EMS transfer, medevac route or traveller self-report within 21 days after exposure.

Where transmission is occurring and why it is difficult to interrupt

Transmission remains concentrated in eastern DRC, especially Ituri and North Kivu, with cross-border relevance to Uganda.

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Geographic concentration

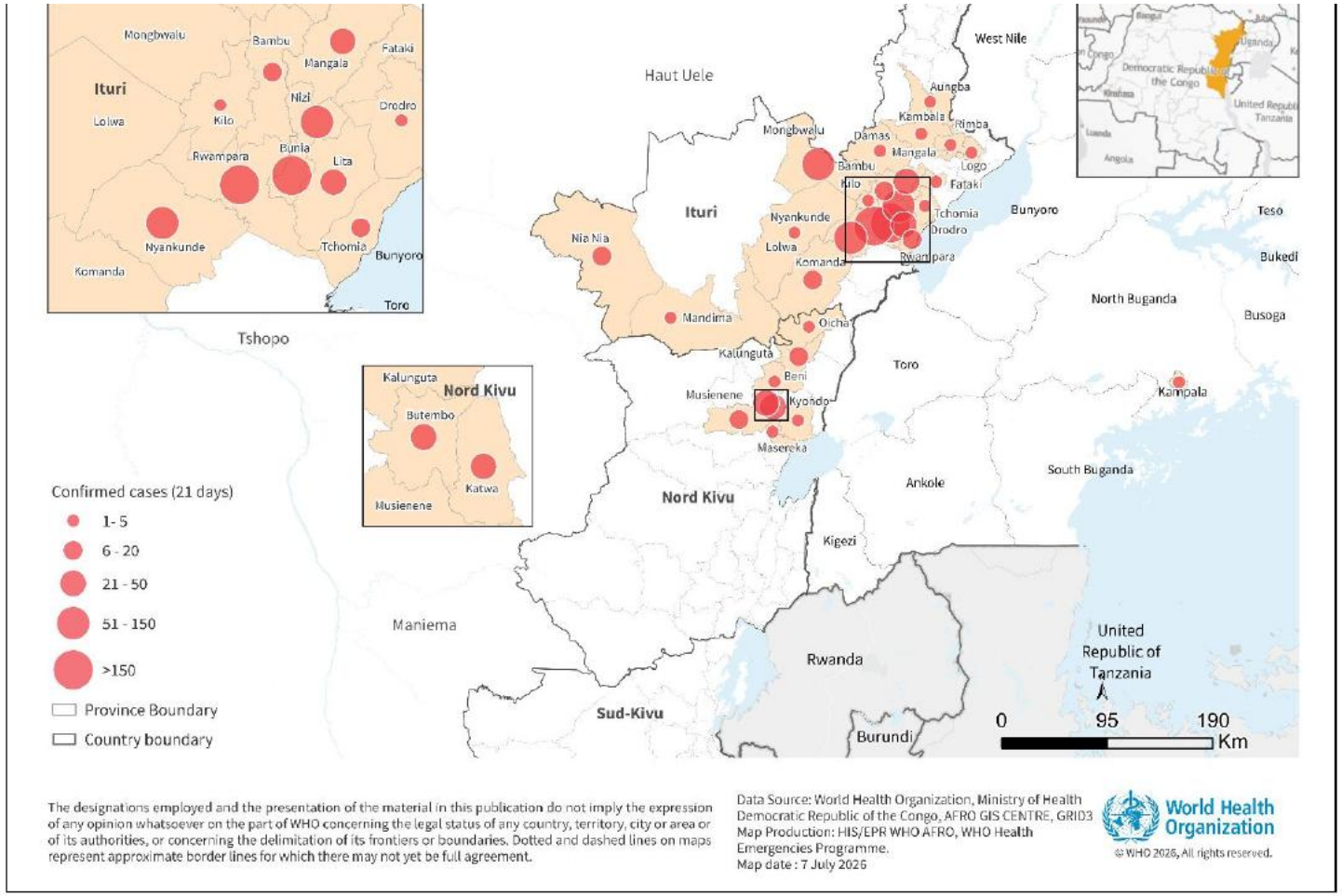
- Ituri is the epicentre: 1,745 confirmed cases and 601 confirmed deaths in the 11 July DRC SitRep.
- Highest-burden Ituri health zones include Bunia, Rwampara, Mongbwalu, Nizi and Nyankunde.
- North Kivu has fewer cases but a high CFR, with Katwa, Butembo and Beni among key zones.

Transmission and operational drivers

- High population mobility, mining and trade corridors.
- Insecurity and displaced populations.
- Delayed case detection and late referral.
- Community deaths and safe burial challenges.
- Healthcare exposure and IPC gaps.
- Contact follow-up below optimal levels.

RCCE interpretation

Local leaders, trusted health workers, traveller-facing information and community feedback loops are not add-ons; they are control measures.



Map: WHO Weekly External Situation Report 08, data as of 05 July 2026, map date 7 July 2026; DRC SitRep No. 058 for 11 July DRC headline figures.

Risk assessment and South Africa readiness focus

South Africa has no confirmed BVD/EVD case in the project sources; readiness priority is imported alert detection and safe management.

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WHO RISK ASSESSMENT

Current WHO risk framing

DRC: very high risk due to ongoing transmission and expansion.
Uganda: high risk due to imported cases and epidemiological links.
Land-border countries adjoining DRC/Uganda: high risk.
Rest of Africa and global level: low risk.

WHO travel advice

WHO advises against restrictions on travel to, or trade with, DRC or Uganda based on currently available information. The priority is risk-based detection, referral, IPC and contact monitoring.

SOUTH AFRICA READINESS SNAPSHOT

Current readiness	RCCE/public awareness	Travel / PoE
74.6% moderate	87.5% adequate	80% adequate

Preparedness category and focus

The 28 May preparedness categorization placed South Africa in Priority 3 – risk monitoring. Current readiness has improved from 40% to 74.6%, but is still below the ≥80% adequate threshold and requires operational validation.

Gaps that could affect an imported alert

- Logistics / operational support: 30% limited.
- SDB, RRT and contact tracing remain moderate and need testing.
- VHF referral facilities, EMS transfer, sample routing, IPC, PoE and RCCE must be tested as one pathway.

Operational target

Move from documented readiness to tested readiness: detect → isolate → notify → safely refer/test → list contacts → communicate clearly.

Sources: WHO Disease Outbreak News, 3 July 2026; 27 May internal WHO brief; South Africa EVD/BVD readiness scores, 19 June 2026.

RCCE implications for today's workshop

Protecting families and communities, preventing fear: RCCE must enable early action without stigma.

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1. Build and maintain trust

Use one aligned source of truth. Communicate early, transparently and without exaggeration. Prepare spokesperson lines for "no case in South Africa", "what to do after travel/exposure", and "where to seek help".

2. Listen and use data

Track hotlines, social media, health worker questions, traveller concerns and community rumours. Feed insights into daily message updates and operational decisions.

3. Help people act

Messages should make the action easy: report compatible symptoms after affected-area exposure, call ahead, avoid direct contact with body fluids, and cooperate with 21-day follow-up if listed as a contact.

4. Prevent fear and stigma

Protect responders, travellers and affected families from stigma. Avoid language that blames people or nationalities. Reinforce that early reporting protects family, health workers and communities.

RCCE should be integrated into the alert pathway

Alert verification | PoE and traveller information | Health facility scripts | Community feedback | Media lines | Misinformation management | Contact follow-up support | Safe and dignified burial communication

Core behavioural objective

People at risk know the signs, know what to do, trust the response, and can act quickly without panic.

Practical handover to RCCE session

The RCCE pillar should leave today with agreed priority audiences, message hierarchy, spokesperson lines, listening channels, rumour escalation, MEL indicators and a first-72-hour RCCE activation checklist.

Sources: WHO RCCE readiness and response toolkit for Ebola disease; WHO COMBI toolkit; WHO Outbreak Communication Planning Guide.

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Key takeaways and handover

1
The DRC outbreak has intensified and remains the epidemic driver, with Ituri and North Kivu the main operational focus.

2
Uganda remains linked but has no recent confirmed cases in the latest WHO update; France confirms travel-related exportation is plausible.

3
South Africa should focus on the imported-alert pathway: PoE/facility detection, isolation, notification, lab, EMS, contacts and RCCE.

4
RCCE success means communities and travellers know what to do, seek care early, avoid stigma and trust the response.

Immediate handover ask

Use the rest of the webinar to align clinical, IPC, PoE and RCCE messages into one tested national communication package for the first 72 hours after an imported alert.

Protect families and communities. Prevent fear. Prepare calmly.

Core sources: DRC SitRep No. 058 (11 July 2026); WHO Weekly External SitRep 08 (data as of 05 July 2026); WHO Disease Outbreak News (3 July 2026); South Africa readiness scores (19 June 2026); Draft webinar programme (16 July 2026).