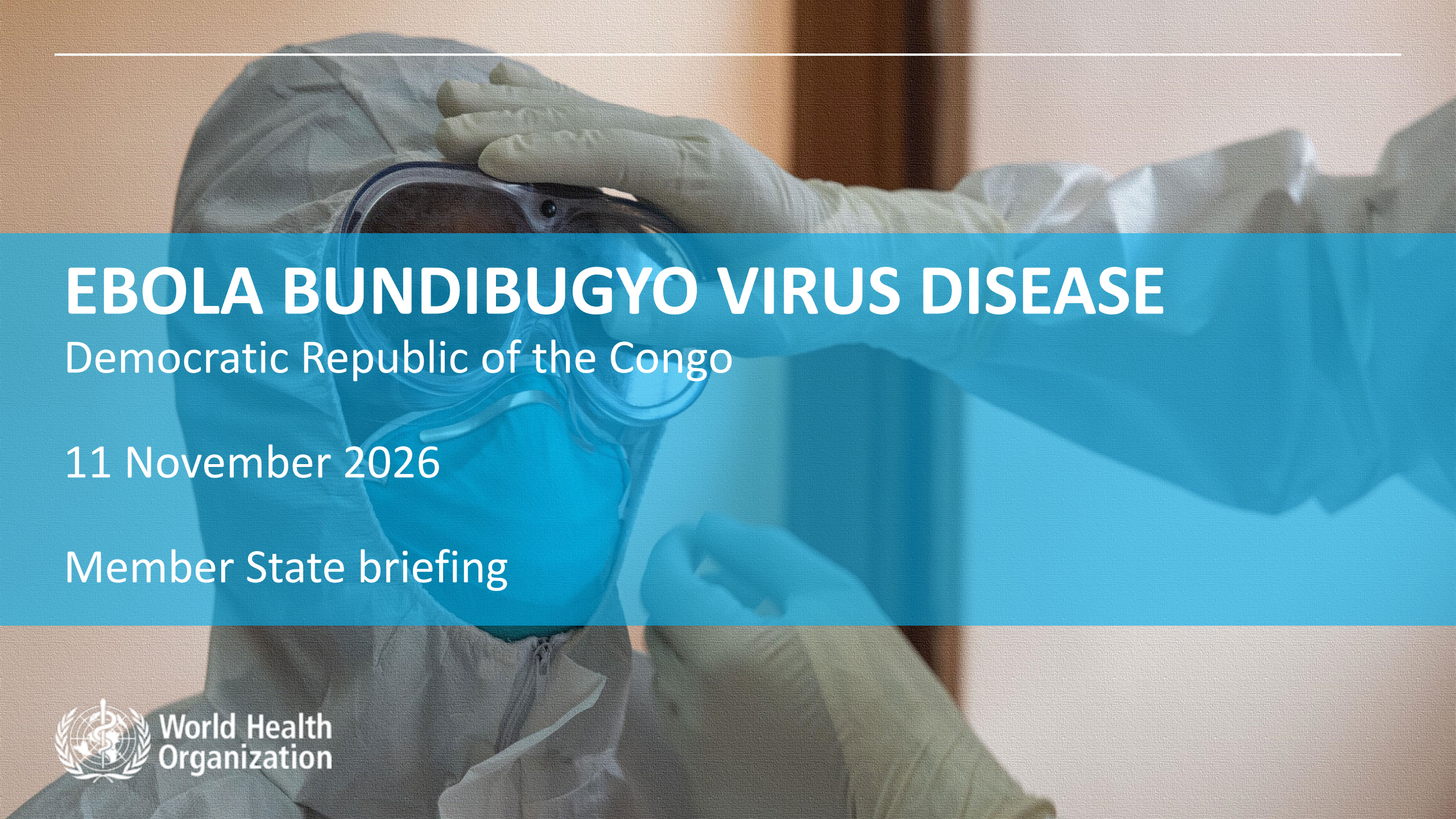


EBOLA BUNDIBUGYO VIRUS DISEASE

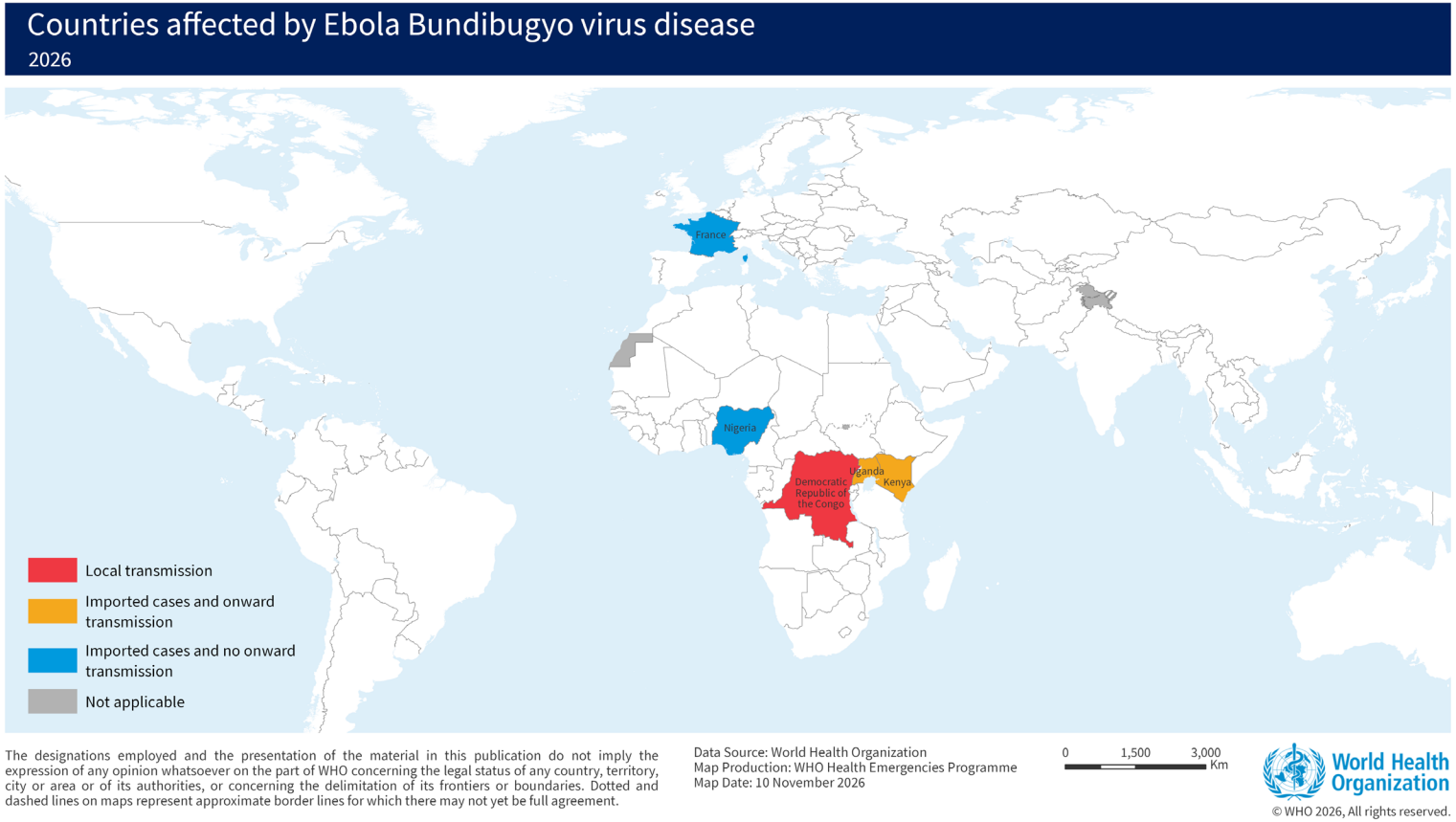
Democratic Republic of the Congo

11 November 2026

Member State briefing

World Health Organization

Global summary (as of 8 November 2026)



Country	Type of transmission	Total number of confirmed cases	42 days since last case reported
DRC	Local	~11 000	No
Uganda	Imported, onward transmission	20	Yes
Kenya	Imported, onward transmission	9	No
Nigeria	Imported, no onward transmission	1	No
France	Imported no onward transmission	1	Yes

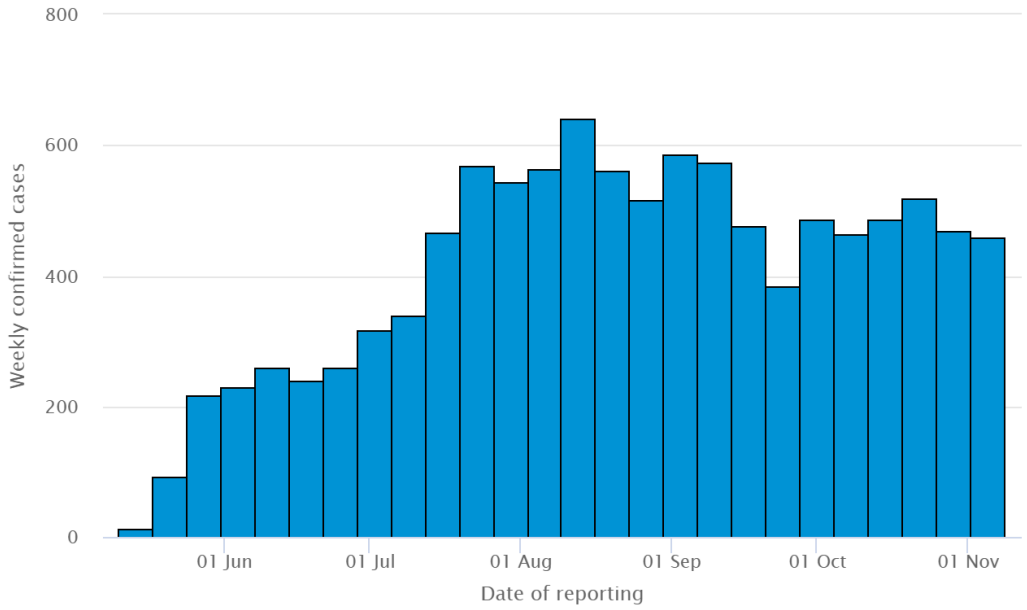
Onward transmission means additional cases reported in country following the imported case(s)

World Health Organization

Epidemiological overview DRC (Data as of 8 November)

Confirmed cases	Confirmed deaths	Recoveries	Active health zones	Health zones affected	Provinces affected
10,990 (+70)	**5,354 (+31)**	**2,951 (+11)**	**51 (-)**	**67**	**8**

Epidemic curve of confirmed cases by date of reporting



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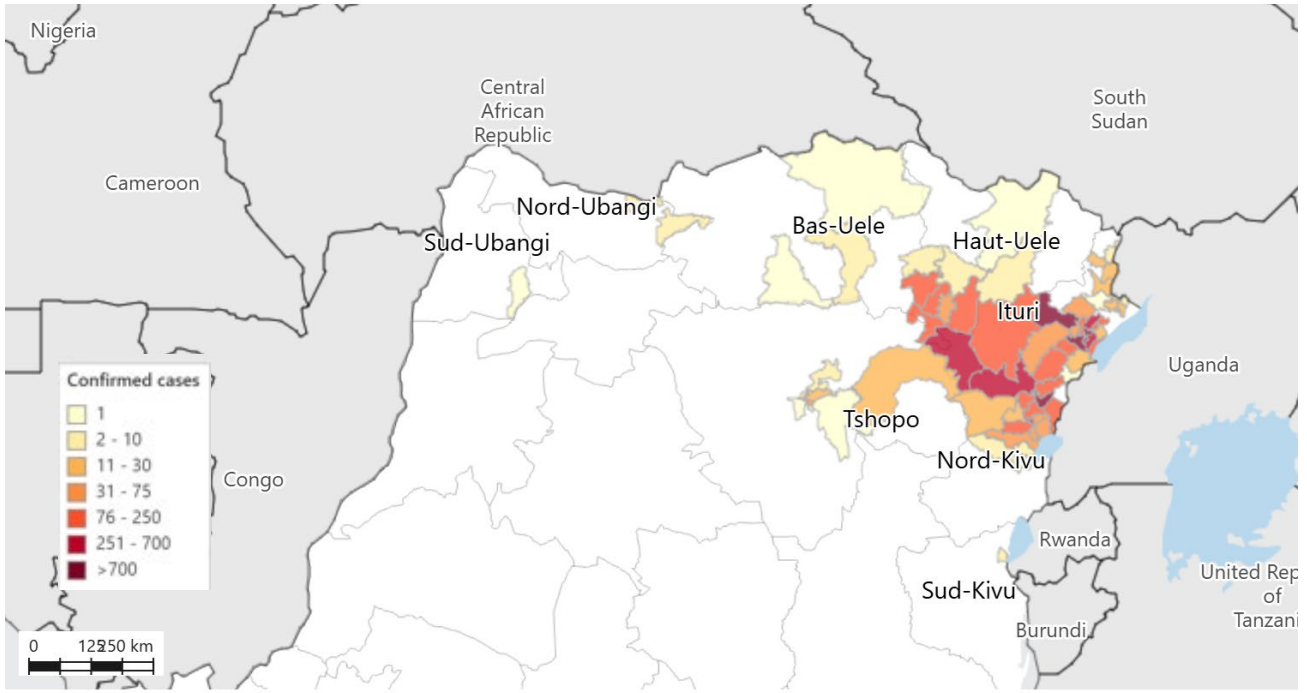
Confirmed cases by health zone



N = 10915 confirmed cases. Values may differ from cumulative counts due to retrospective adjustments.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization, Ministries of Health of the Democratic Republic of the Congo, GRID3

Map Production: WHO Health Emergencies Programme

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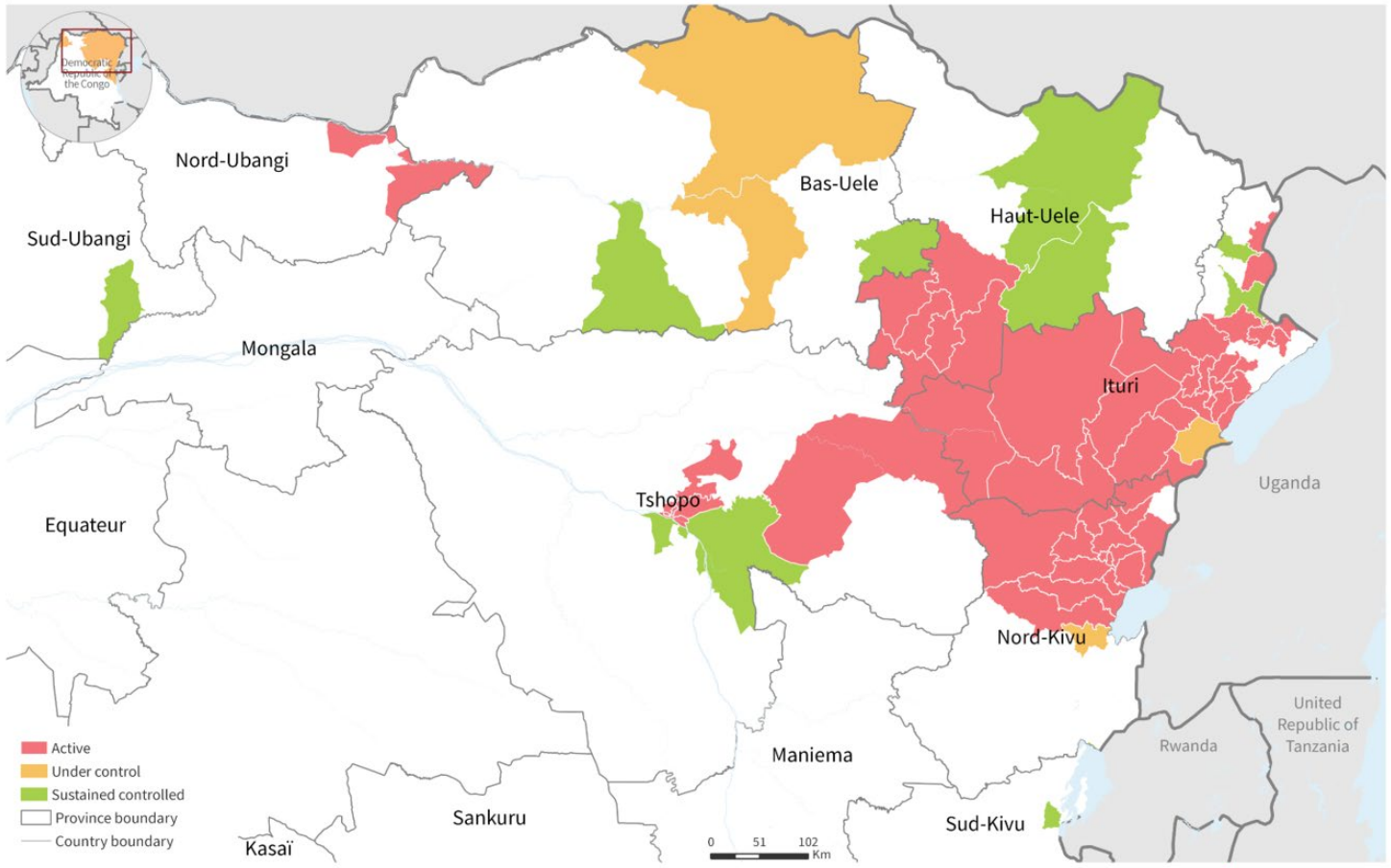
Health zone classification



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Data Source: World Health Organization, Ministry of Health of the Democratic Republic of the Congo, GRID3
Map Production: WHO Health Emergencies Programme

*Due to data availability limitations, data for Dakwa Health Zone in Bas-Uele are represented in Ango Health Zone.

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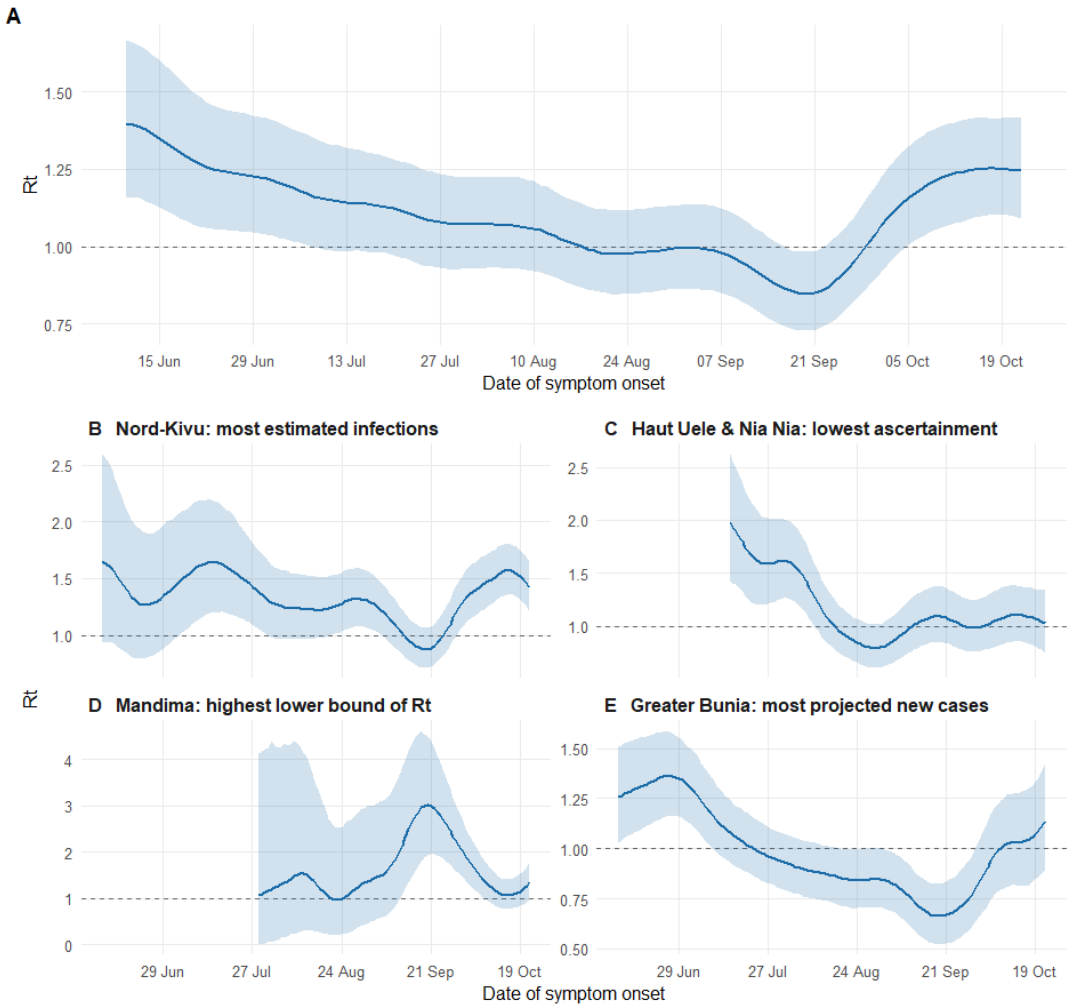
Classification	Health zones
Active zones	51
Zones under control	6
Sustained control zones	10
Total	**67**

No cases for more than 42 days:

Bas-Uele : Buta
Haut-Uele : Dungu, Gombari
Ituri : Adja, Aungba
Nord-Kivu : Goma
Sud-Kivu : Miti Murhesa
Sud-Ubangi : Bulu
Tshopo : Lubunga (Tshopo), Wanierukula

Current dynamics – R(t) and ascertainment estimates

	Now	Parameters		Future
Health zone / region	**Observed cumulative cases***	**Estimated proportion of infections detected**	**Rt**	**New cases in next 2 weeks****
National	10,100	46% (45% - 48%)	1.25 (1.09 - 1.42)	1,880 (1,480 - 2,370)
Operational regions				
Greater Bunia	4,140	55% (52% - 57%)	1.15 (0.90 - 1.43)	331 (191 - 525)
Central Ituri	816	45% (39% - 51%)	0.86 (0.44 - 1.31)	30 (9 - 82)
Haut Uele & Nia Nia	837	33% (29% - 36%)	1.06 (0.75 - 1.34)	87 (46 - 153)
Nord-Kivu	2,360	45% (43% - 47%)	1.43 (1.21 - 1.65)	1,030 (756 - 1,380)



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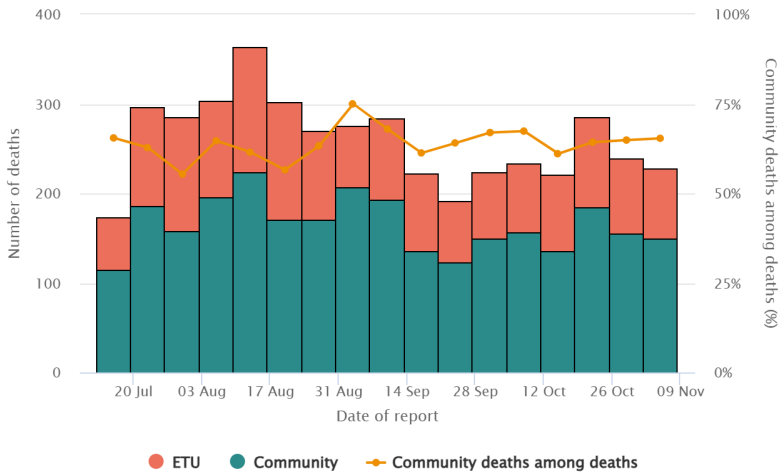
Source: WHO Collaborating Centre Imperial College London; INRB; WHO

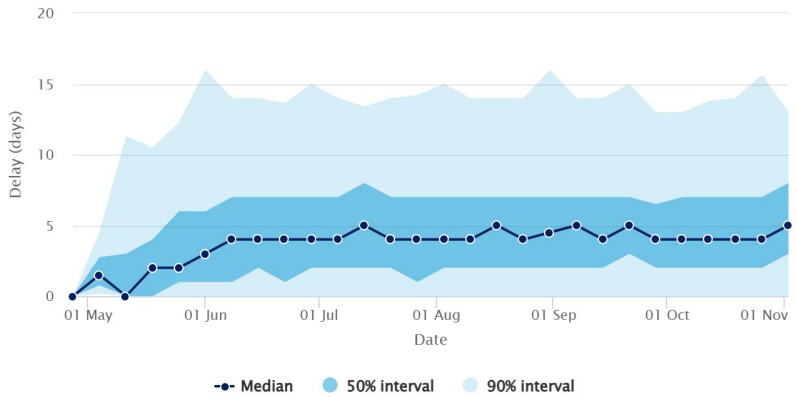
Trends in other epi metrics response: no evidence of improvement

- % of all deaths that are community deaths stable at ~70%
- % new confirmed cases classified as community deaths stable ~30%
- % new confirmed cases coming from known contacts stable at ~15%
- Average delay from symptoms onset to notification ~4 days

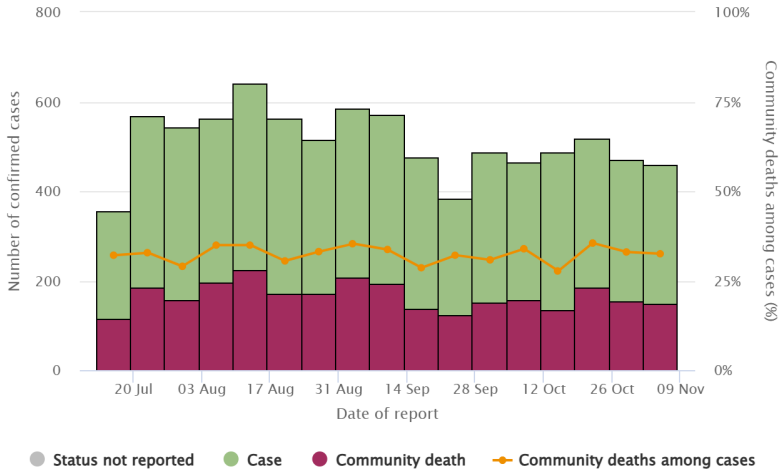
Community deaths among deaths



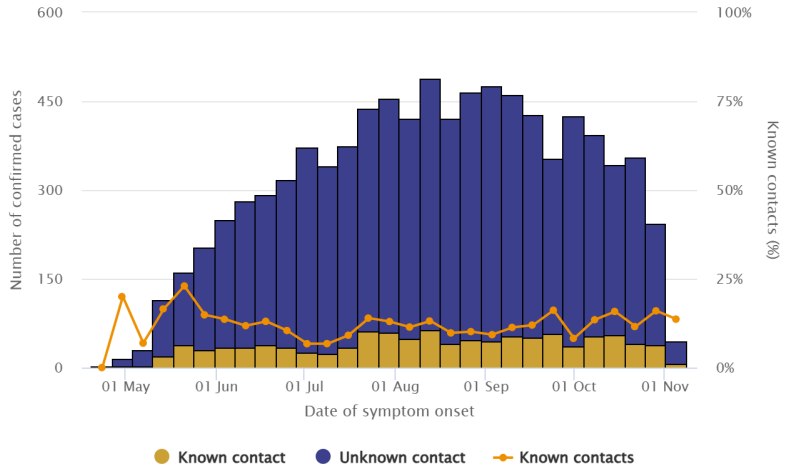
Delay from symptom onset to notification



Community deaths among all cases



Known contact among confirmed cases



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Trends in other epi metrics response: improvement or maintained

- % of validated alerts that are detected as deaths has decreased in past 6 weeks to ~20%
- >95% of deaths have safe and dignified burials
- % of alerts investigated has risen from ~80% throughout October to ~100% in past 6 weeks
- Test positivity among all new samples has decreased to ~15%

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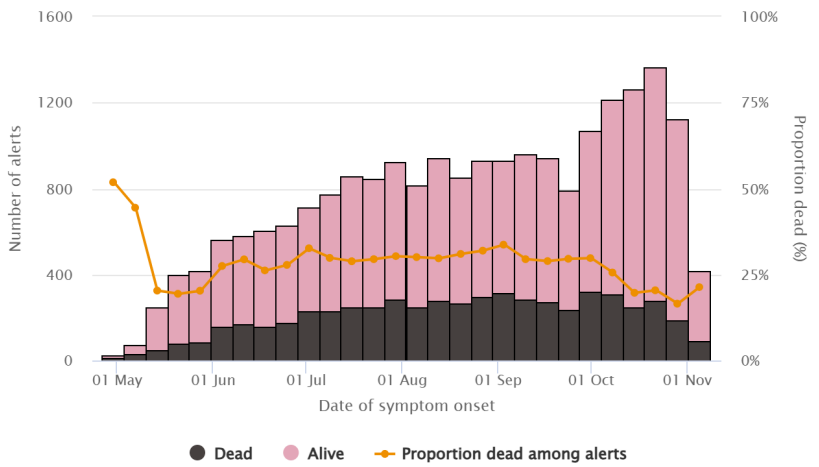
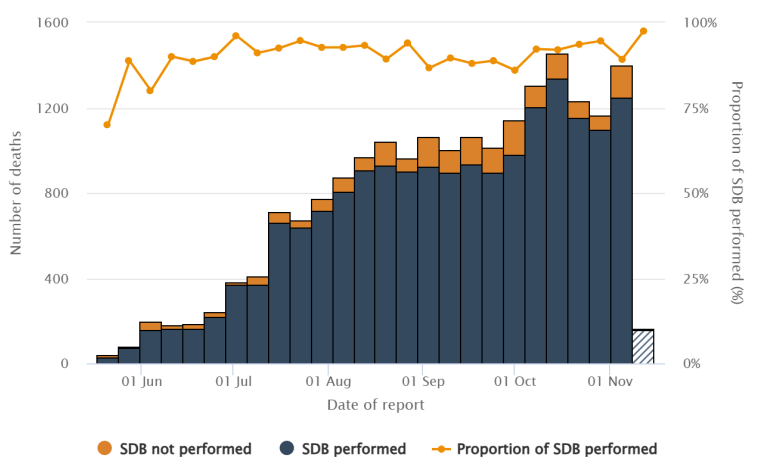
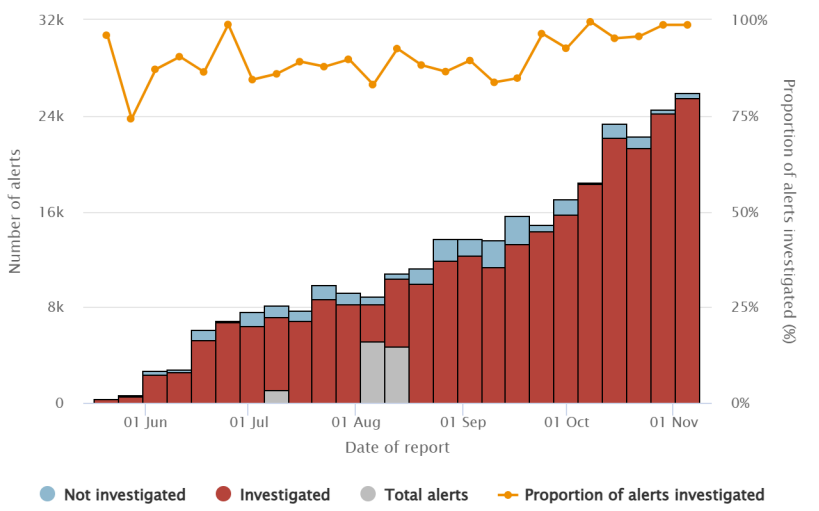
Nature of alert (validated)



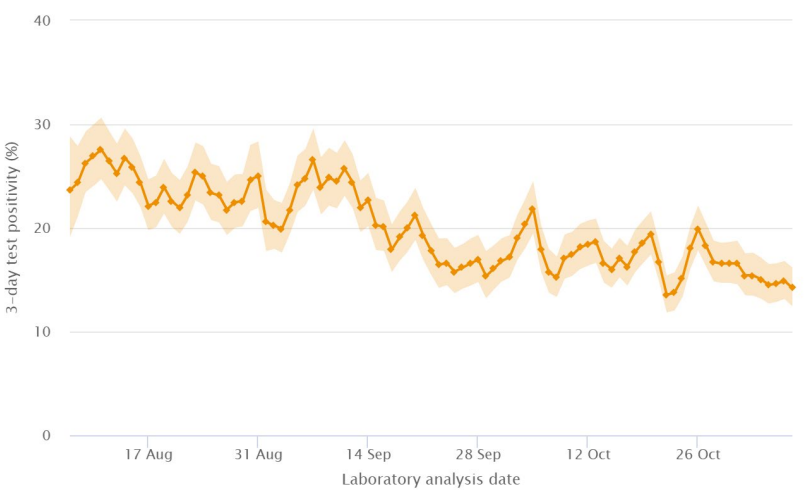
Safe and dignified burials



Proportion of alerts investigated



Test positivity among all samples



PRSEAH was built into the BVD response from the outset

Shared action, with distinct responsibilities for government, inter-agency partners and WHO

Government

National leadership

Integrates PRSEAH into response plans and strengthens local capacity.

Inter-agency

Collective accountability

Coordinates common risk mitigation, reporting and survivor referral.

WHO

Organizational accountability

Safeguards WHO personnel, partners and operations.

Response pillars, health-zone focal points and community actors

The IASC PSEA addendum and checklist provided a framework for integration from the outset with clear leadership accountability

World Health Organization

Progress: stronger capacity, community safeguards and government ownership

BVD response: reported progress in the November operational update

11 + **Government and partner focal points in each operational zone**

WHO PRSEAH specialists
Across six provinces

50,816
Community members reached

8,607
Humanitarian actors briefed / trained

18
Complaints mechanisms revitalized

Sustainable local capacity

Cascade training used to strengthen focal points and embeds PRSEAH at health-zone and village levels.

SEAH Risk Assessments & Community engagement

Systematic risk assessments & consultations inform risk mitigation and reporting. Local leaders help build community ownership.

National capacity and action

Government PRSEAH expertise and national partnerships strengthened.

ONGOING VICTIM AND SURVIVOR SUPPORT
Strengthening referral pathways and access to health, psychosocial and protection services.

World Health Organization

Sustaining PRSEAH means closing four operational gaps

1	**Coverage** Insecurity and uneven presence	**Extend technical oversight and local focal-point coverage.**
2	**Reporting** Fear and confidentiality barriers	**Embed PRSEAH mechanisms, including community-based reporting.**
3	**Survivor support** Uneven services and referrals	**Resource timely & expand victim/survivor assistance and referrals.**
4	**Accountability** Delays, funding and capacity gaps	**Strengthen predictable financing for investigation capacity, if/when needed.**

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Every allegation follows five steps, with survivor assistance throughout

Confidentiality, due process and protection from retaliation apply throughout

1 **Receive & report**

Prompt reporting through safe channels to IOS

2 **Protect & assist**

Safety assessment and interim protection

3 **Investigate**

Independent IOS assessment and investigation, as warranted

4 **Decide & act**

Authorized decisions based on findings

5 **Follow through**

Appropriate feedback and corrective action

VICTIM/SURVIVOR CENTERED APPROACHES THROUGHOUT

Assistance is based on need, independent of investigation outcomes.

World Health Organization

Key messages: PRSEAH is mainstreamed and working, but challenges persist

Four conclusions for Member States

Collaboration

All stakeholders worked collaboratively to mainstream PRSEAH in the response from the outset and to sustain it.

Risk-informed action

Systematic risk assessments and community consultations have informed mitigation and safeguarding measures in all contexts.

Systems are working

Allegations are being reported and responded to.

Challenges persist

Operational challenges continue, notably insecurity, access to communities, human and financial resources, and availability of local victim/survivor support services.

Sustained leadership and predictable financing are needed to keep PRSEAH embedded in the response

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Status of BVD Clinical Trials in DRC

	PARTNERS (INRB/Oxford/WHO)	EBO-PEP (INRB/ANRS/ITM/AfCDC)	TUMAiNi (INRB/Un Antwerp/ITM/MSF/Epicentre/WHO/CEPI)
Focus	**Treatment** *Pragmatic Factorial design* - SOC vs - Mbp134 - Remdesivir - Mbp134 + Remdesivir - (Soon Maftivimab)	**Post-exposure prophylaxis (PEP)** *Randomized control trial (RCT)* - Obeldesivir *Compassionate PEP for children < 20 kg & PW* - Remdesivir	**Vaccination** *Platform Trial* - Everbo *BDBV Specific Vaccines* - ChAdOx1 - Moderna
Population	Confirmed acute filovirus disease (ETC)	High-risk contacts (1-5 days)	Direct contacts of confirmed BVD cases withing 1-21 days
Approach	Phase III adaptive randomized platform	Obeldesivir RCT + remdesivir cohort	Phase 2/3 adaptive platform in rings
Reported progress	~ 900 participants 7 active sites	> 680 participants in RCT & >150 RDV 3 active DRC sites 1 outreach team to Nizi	>80 participants (30% <18 yo), 11 rings, 1 Site open

PARTNERS Therapeutics Trials

~ 900

participants enrolled

7 active sites
(2 new sites in Beni)

Adaptive randomized platform

Phase III, open-label trial for laboratory-confirmed acute filovirus disease, including BVD.

Primary outcome: all-cause mortality at 28 days after randomization.

Secondary outcome: time to viral clearance.

First participant: CME, 2 July 2026
Recruitment expanded across five sites; 6th site opened in Beni 27 Oct; 7th site to opened Nov 2026

PARTNERS, protocol and oversight

Protocol version 8.0

Current implementation under the approved framework.

Recruitment and treatment continue across the five active sites.

Protocol version 9.0 - Approved

Planned addition of maftivimab. Dossier submitted to the Ethics Committee and DRC national regulatory authority

Implementation to follow completion of the ongoing authorization process.

Trial oversight

Two monitoring visits completed, with findings informing implementation improvements.
The Data Monitoring Committee recommended continuation.

EBO-PEP Post Exposure Prophylaxis

>830 participants enrolled in DRC

Rwampara: first DRC enrolment 15 July
CME Bunia: active from 31 July
Nizi: active from Oct; community outreach since 25 Oct 2026

Pathway	Intervention and purpose	Enrolled
Randomized trial	Obeldesivir vs placebo Double-blind superiority trial to prevent symptomatic BVD	> 680
Compassionate use	Remdesivir prospective cohort Effectiveness, safety and feasibility in vulnerable populations	> 150

V8: High-risk contacts. Remdesivir includes pregnant / breastfeeding women and children under 12
V9: High-risk contacts. Remdesivir includes pregnant women and children > 20 kilo

.

EBO-PEP planned expansion





RTC - Sites and eligibility

Nizi established and outreach started 24 Oct.

Obeldesivir amendment: children >20 kg and lactating women, with safety monitoring.

Pregnant women remain excluded because of preclinical reproductive toxicity concerns.

Products and subprotocols

Pediatric tablet for oral suspension expected before the end of 2026.

Proposed maftivimab PEP subprotocol for high-risk contacts. Randomization, sample size and post-trial access remain under discussion.

Formal Regeneron collaboration pending.

Next steps: sustain recruitment, maintain follow-up, support case finding.

TUMAiNi Phase 2/3 vaccine platform

> 80 participants (30% < 18 yo)

Objective: assess candidate vaccine efficacy, safety and immunogenicity against BDBV

Phase 2: safety run-in for BDBV specific Vx

TAG-CVP recommended 2 specific Vx to move to Phase 2 / potentially Phase 3

Approximately 50 vaccine-arm participants plus a concurrent comparator.

Primary objective: safety.
Secondary objective: immunogenicity.
Independent DMC review before progression.

Phase 3: efficacy – Ervebo & BDBV specific
> 80 enrolled

Outcomes: Symptomatic, PCR-confirmed BVD with symptom onset during Days 10–29 after vaccination.

Phase 2 participants contribute to the efficacy endpoint.

The platform can add candidates after their safety run-in and DMC review.

Thank you

World Health Organization