AfricaCDC
Centres for Disease Control and Prevention

# EXECUTIVE BRIEFING AND REPORT

# ECG Meeting Outcome

## Summary of the ECG Meeting Deliberations and Recommendations

SEPTEMBER 16, 2026

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## Meeting Leadership and Participants

- Chair: Dr. Sultani Matendechero (stepping in for Prof. Slim Abdool Karim)
- Co-Chair: Prof. Pagwesese David Parirenyatwa

## ECG Members Present:

- Prof. Slim Abdool Karim (opened the meeting; departed early due to a family emergency)
- Prof. Pagwesese David Parirenyatwa
- Prof. Helen Rees
- Prof. Maha El Rabbat
- Dr. Sultani Matendechero
- Prof. Rose Leke Fonbang

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Africa CDC is a continental autonomous health agency of the African Union established to support public health initiatives of Member States and strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats.

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# Summary of the Deliberations

On September 16, 2026, the Emergency Consultative Group (ECG) convened to review epidemiological progress, operational challenges, and continuity of care amid the evolving outbreak dynamics, particularly across Eastern Democratic Republic of the Congo (DRC).

While the committee noted positive epidemiological indicators and progress in specific hotspots (e.g., reductions in case burdens in Ituri), the situation remains heterogeneous and complex, with new surges in select Health Zones (HZs) and persistent operational bottlenecks. Consequently, the ECG unanimously consensus-recommended maintaining the Public Health Emergency of Continental Security (PHECS) while adopting a stance of cautious optimism.

# Key Discussion Themes and Operational Findings

## 1. Epidemiological Dynamics and Surveillance

- **Dynamic Spread:** Progress is visible in core pillars (laboratory capacity, treatment, and specific hot spots in Ituri), but case increases in neighboring HZs and provinces especially North Kivu require continued cautious data interpretation.
- **Alert Framework:** Africa CDC is utilizing a composite scoring framework to monitor monthly HZ performance and dynamically track high-risk areas.
- **Surveillance Bottlenecks:** Contact listing remains suboptimal relative to overall tracing efforts that have now reaching around 87% , however the actual rate taking into considerations the expected contacts should be less than 25%. Data completeness requires urgent harmonized reporting through DHIS2 alongside WHO and key response partners.
- **Pediatric Mortality:** Unusually high child mortality rates remain a critical concern, though targeted interventions in Ituri are yielding initial reductions. Access to therapeutics (e.g., Remdesivir) needs expansion beyond central hubs like Bunia where feasible and clinically appropriate.

## 2. Continuity of Health Services and Healthcare Workforce

- **Workforce Strikes:** Clarification was provided regarding ongoing health worker strikes; impacting Ebola Treatment Centres (ETCs), though secondary impacts on other response activities including surveillance.
- **Service Continuity:** Decrease in the use of primary care services in 2026 in comparable to the sane duration in 2025, including vaccination, medical consultation and monitoring of pregnancy are of high concern.

## 3. Community Engagement, Ownership and RCCE

**Community Ownership:** Recommendations to scale up the Community Response Protocol/Village Community Response (VCR) mechanisms engaging local chiefs and Community Health Workers (CHWs) were reaffirmed as vital for localized leadership and community ownership.

## 4. Partnerships, Financing and Cross-Border Coordination

- **Resource Mobilization:** Pledges under the Financial Tracking Mechanism (FTM) have reached $1.7 billion, with approximately 60% disbursed or approved for reprogramming. DRC National Preparedness and Response plan for BVD are transitioning from the initial $240M budget to a revised $1.3B operational scale in the recentely revised one.
- **Cross-Border Preparedness:** Continued focus is required for refugee movements, border-entry SIMEX exercises, joint cross-border training, and diplomatic efforts to establish humanitarian access and, where feasible, peace corridors.

# Africa CDC ECG Recommendations for the DG:

**The ECG supports a position of cautious optimism. There are encouraging improvements in some health zones, the data could not confirmed that the peak of the outbreak has been reached and the transmission is not yet consistently controlled across all affected areas. The priority should therefore be to scale up the response intensity especially in Nord Kivu, consolidate gains, address persistent community deaths and gaps in contact identification, strengthen community ownership, and simultaneously protect and restore essential health services.**

## 1. Maintain the PHECS status for the Bundibugyo Virus Disease outbreak

- Despite encouraging decrease in number of cases and deaths in some hotspots and improvements in response capacities, the ECG considers that the conditions do not yet support lifting the PHECS designation.
- Transmission remains active in some areas, with new infections and re-emergence in health zones previously showing improvement.
- The persistently high proportion of community deaths, gaps in contact identification, and disruption of essential health services demonstrate that significant risks remain.
- The ECG therefore recommends maintaining the PHECS status and continuing the continental-level response and coordination, while monitoring progress against clearly defined criteria for eventual de-escalation.

## 2. Scale up the response intensity and consolidate gains

- Continue current efforts despite improving trends in some health zones.
- Protect gains in laboratory capacity, treatment capacity, community surveillance, contact tracing and other response capacities.
- Avoid premature relaxation of interventions while transmission remains heterogeneous.

## 3. Urgently address persistent community deaths

- Community deaths remain around 60% of reported deaths
- This indicates persistent barriers to early care-seeking, timely referral and access to treatment.
- Intensify community engagement, early detection, referral and trust-building interventions.

**4. Strengthen community ownership and accountability**

- Move from awareness activities toward genuine community ownership of the response.

- Communities should have a meaningful role in determining priorities and shaping local response interventions.
- Strengthen trust and acceptance of surveillance, treatment and vaccination.

## 5. Strengthen contact identification, tracing and surveillance in affected and re-emerging health zones

- Strengthen contact identification and listing, recognizing that high percentages of contacts traced may mask gaps in the initial identification and completeness of contact lists.
- Prioritize the quality, completeness and timeliness of data reporting
- Maintain intensified surveillance in newly affected and re-emerging health zones, with rapid reinforcement of response capacities when new infections are detected.
- Avoid interpreting short-term declines as sustained interruption of transmission and maintain vigilance until sustained interruption is demonstrated across the affected areas.

## 6. Protect and restore essential health services

- Fast track implementing the strategic shift focusing on free essential health services, to restore immunization, maternal and child health, antenatal care, nutrition and other essential PHC services affected by the outbreak.
- Address the risk of secondary increases in morbidity and mortality, including vaccine-preventable diseases.

## 7. Continue generating evidence on vaccines

- Continue the observational and other vaccine studies.
- Ensure informed consent clearly communicates that the level of protection against Bundibugyo virus remains under investigation, particularly for vaccines not specifically licensed against BDBV.
- Continue generating effectiveness and safety evidence and allow evaluation of additional vaccines according to the approved study protocols.

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