

Situation at a Glance

- On **May 17, 2026**, the World Health Organization (WHO) Director-General officially declared the **Ebola disease outbreak caused by the Bundibugyo virus (BDBV) a Public Health Emergency of International Concern (PHEIC)** under the International Health Regulations (2005).
- As of 22 May, WHO assessed the outbreak risk as Very High in DRC, High in Uganda and at the regional level, and Low globally. These risk levels remained unchanged as of June 9.
- As of June 29, Africa CDC and WHO reported 1,333 confirmed cases and 399 confirmed deaths (CFR: 29.9%) in the Democratic Republic of the Congo (DRC), with cases identified across 35 health zones. In Uganda, 20 confirmed cases and two confirmed deaths (CFR: 10.0%) have been reported, with transmission remaining concentrated in Kampala. Overall, 204 patients recovered, corresponding to a recovery rate of 15.1%.



Figure 1. Regions affected by Bundibugyo virus disease in DRC and Uganda, as of June 28, 2026

Table 1. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of June 29, 2026

Country	Health Zone/ District Affected	Confirmed Cases	Confirmed Deaths	CFR (%) Confirmed	Cured	Recovery Rate (%)
DRC	35	1,333	399	29.9%	189	14.2%
Uganda	2	20	2	10.0%	15	75.0%
Total	37	1,114	401	29.6%	204	15.1%

Source: Africa CDC, WHO

- Healthcare workers remained affected, with 96 confirmed cases reported in the DRC and four in Uganda. The cumulative number of healthcare worker cases in the DRC increased from 75 in the previous reporting period, while no additional infections among healthcare workers have been reported in Uganda since early June.

Table 2. Cases among Healthcare Workers (HCW)

Country	Confirmed cases among HCWs	Confirmed deaths among HCWs	CFR (%)
DRC	96	19	19.8%
Uganda	4	0	0.0%
Total	100	19	19.0%

Source: Africa CDC, WHO

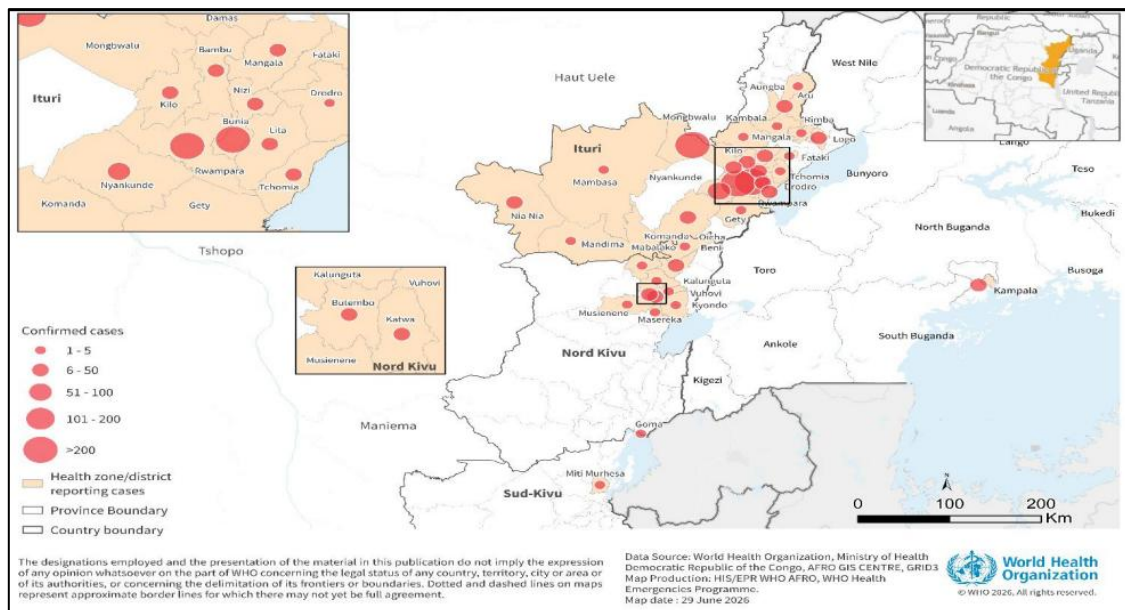


Figure 2. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in DRC and Uganda, as of June 28, 2026 (Source: WHO)

Situation Update

Democratic Republic of the Congo

- **On May 5, 2026**, WHO received an alert regarding a high-mortality outbreak in Mongbwala Health Zone, Ituri Province, including four healthcare worker deaths within four days. Retrospective investigations identified the earliest suspected case as a healthcare worker who developed fever, haemorrhaging, vomiting, and severe malaise on 24 April and later died in Bunia.
- **As of May 15**, a total of 246 suspected cases and 80 deaths had been reported across Rwampara, Mongbwala, and Bunia HZs, with 24 cases in isolation. Laboratory investigation confirmed Bundibugyo virus (BDBV) through PCR and genomic sequencing following initial negative GeneXpert results. On the same day, the Ministry of Health officially declared the country's 17th Ebola outbreak.
- **On May 24**, the outbreak was reported to be active in 11 health zones across Ituri, North Kivu, and South Kivu. A total of 105 confirmed cases and 10 deaths (CFR: 9.5%) were recorded, in addition to 906 suspected cases and 223 suspected deaths (CFR: 24.6%), with no reported recoveries.
- **As of May 29**, the Africa Centres for Diseases Control and Prevention (Africa CDC) reported 263 confirmed Bundibugyo virus disease (BVD) cases, including 42 deaths (CFR: 16.0%).
- **As of June 8**, Africa CDC reported 626 confirmed cases and 112 deaths in DRC (CFR: 17.9%). A total of 19 cases had recovered, representing 3.0% of confirmed cases.
- **By June 22**, a total of 1,094 confirmed cases and 277 deaths (CFR: 25.3%) were reported, with 112 patients recovering, representing 10.2% of confirmed cases.

- **As of June 29**, DRC has confirmed 1,333 cases with 399 deaths (CFR: 29.9%) across 35 health zones.

Uganda

- **On May 11**, 2026, the first imported case was identified in an elderly man from the DRC who was admitted to a private hospital in Kampala and died on 14 May. Laboratory testing confirmed BDBV infection on 15 May, and the body was repatriated to the DRC the same day.
- **On May 16**, a second imported case was confirmed in Kampala in an individual returning from DRC with no known epidemiological links to the first case. No local transmission had been identified in Uganda at the time of reporting.
- **As of May 23**, three new infections were confirmed, bringing Uganda's total to five confirmed cases. Two Ugandan nationals identified through contact tracing and one Congolese resident were among the cases. By this time, two deaths had been reported, one patient had recovered, and the remaining cases were receiving care. Transmission remained limited to known contacts, with no evidence of wider community spread.
- **As of May 24**, two additional cases were confirmed, bringing the cumulative total in Uganda to seven cases, including one death (CFR: 14.3%). Both cases were healthcare workers from a private medical facility in Kampala and were admitted for specialized care.
- **On June 21**, new confirmed case was reported, marking the first case since June 5.
- **By June 29**, the number of recoveries rose to 15, corresponding to 75.0% of confirmed cases; no additional cases were reported.

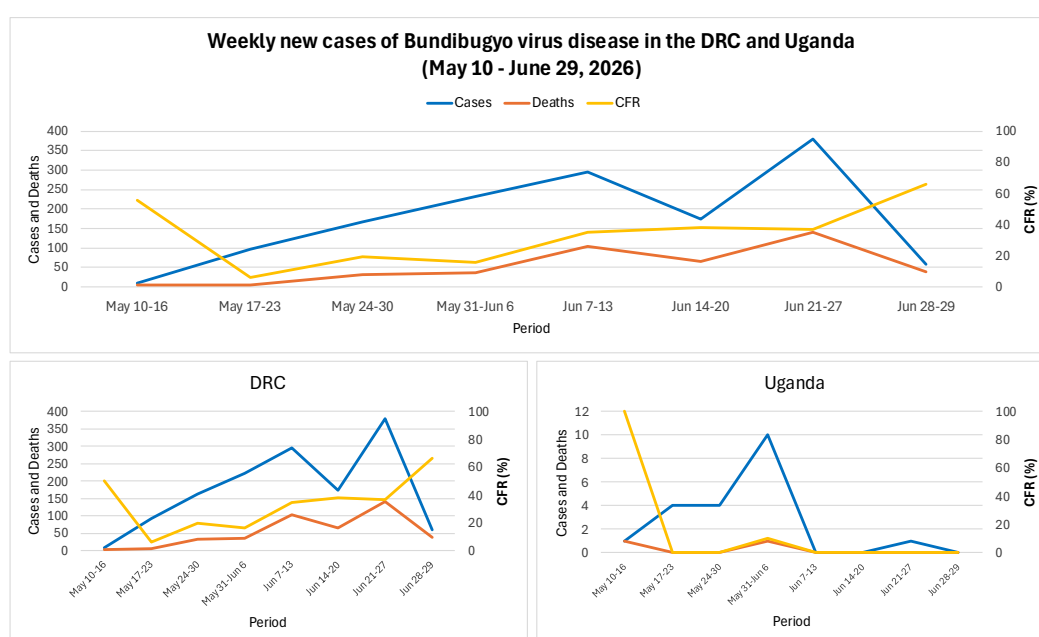


Figure 3. Weekly new cases of BVD in the DRC and Uganda (May 10 - June 29, 2026)

(Source: Africa CDC)

The outbreak showed a marked increase in weekly reported cases through mid-June, driven largely by transmission in the DRC. Weekly cases rose from 9 during May 10–16 to a peak of 296 during June 7–13, reflecting sustained expansion of transmission. Although cases declined to 174 during June 14–20, a resurgence was observed in the following week, with 380 cases reported during June 21–27, including 379 cases from the DRC and one case from Uganda. Preliminary data for 28–29 June recorded an additional 59 cases, indicating ongoing transmission.

Mortality trends followed a similar pattern, increasing from 5 deaths in mid-May to a peak of 103 during June 7–13, before declining to 66 during June 14–20. However, deaths increased again to 140 during June 21–27, largely driven by the DRC. The case fatality ratio (CFR) also increased during the most recent reporting periods, reaching 37.9% during June 14–20 and 66.1% during June 28–29, although these estimates should be interpreted cautiously due to reporting delays and incomplete weekly data.

These trends were primarily driven by the DRC, where sustained increases in cases and deaths continued throughout June. In contrast, Uganda reported limited transmission, with cases peaking at 10 from May 31 to June 6 and no additional cases reported for more than two weeks before a single new case was identified the following week.

France

- **On June 24, 2026,** France reported a laboratory-confirmed BDBV case in a physician returning from Ituri Province, DRC, where the individual had returned from a humanitarian mission. After self-reporting symptoms upon arrival on June 23, the patient was isolated and transferred to a specialized facility. The patient remained clinically stable, and PCR testing confirmed BDBV infection. Five contacts who were on the plane from Kinshasa with the case had been identified and have been placed in isolation, and no further infections have been reported.

Epidemiology

- Bundibugyo virus disease (BVD) is a severe Ebola disease caused by the Bundibugyo virus, an Orthoebolavirus. The current event is the 17th Ebola outbreak reported in the DRC since 1976.
- Bundibugyo virus disease (BVD) is a severe Ebola disease transmitted through direct contact with infected bodily fluids. The incubation period is 2–21 days, and symptoms range from fever and fatigue to severe gastrointestinal illness and haemorrhagic manifestations. Control measures include early detection, isolation, contact tracing, safe burials, IPC, and community engagement.
- Differentiating BVD clinically from other common febrile diseases (e.g., malaria) is challenging without laboratory testing.

- Effective outbreak control depends on early case identification, isolation of patients, contact tracing, safe burial procedures, adherence to IPC protocols, and strong community engagement, as there are currently no licensed vaccines or specific antiviral treatments for BVD.

Public Health Response

1. Coordination

- The continental Incident Management Support Team (IMST), co-led by WHO and Africa CDC, remains active, coordinating response efforts across affected and at-risk countries under a “One Response” approach.
- WHO and Africa CDC are implementing a joint continental preparedness and response plan (June–November 2026), requiring US\$518 million to support response and regional readiness.
- National Incident Management Systems remain operational in the DRC and Uganda, supported by WHO, UNICEF, IOM, MSF, IMC, and other partners.
- 8 June 2026 – Cross-border coordination between the DRC and Uganda was strengthened through a meeting in Aru Health Zone, focusing on surveillance, information sharing, and joint response.
- In the DRC, training and deployments have been scaled up to strengthen field coordination, including capacity-building for IMS implementation and support to hotspot health zones.
- During the reporting period, the WHO Director-General conducted a mission to the DRC and Uganda to enhance high-level engagement, assess response operations, and reinforce regional coordination.
- Through the WHO-coordinated Global Outbreak Alert and Response Network (GOARN, 14 have been deployed to support surveillance, case management, IPC, and risk communication activities in both countries.

2. Operations support and logistics

- WHO continues to support preparedness and response operations through multidisciplinary field teams deployed across the DRC and Uganda, providing support for surveillance, laboratory activities, logistics, clinical management, and cross-border preparedness.
- Operations support and logistics activities continue to scale up in the DRC. As of June 28, 2026, the value of delivered supplies increased to approximately US\$1.86 million, up from US\$1.37 million in the previous reporting period. The overall procurement and shipment pipeline expanded from US\$5.25 million to US\$8.66 million. Of the total pipeline value, US\$3.22 million (37%) remained in transit, while US\$3.59 million (41%) was awaiting shipment.

- c. Critical supplies delivered or in transit included more than 8.1 million examination gloves, 267,698 Level 3 gowns, 208,074 hooded coveralls, 20,016 PCR tests, RADIONE diagnostic materials, infrared thermometers, tents, hospital beds, and other laboratory and IPC supplies to support frontline response operations and treatment-capacity expansion.
- d. Delivered commodities reached 193.5 metric tons (1,081.8 m³) of cargo dispatched to logistics hubs in Ituri and North Kivu, an increase from 155.9 metric tons (901.4 m³) reported during the previous period.
- e. Procurement and logistics coordination mechanisms remain active, supporting shipment tracking, supply distribution, partner coordination, and monitoring of operational gaps. PPE and IPC supplies continue to account for the largest share of procurement, with most supplies sourced directly from manufacturers (68%) and supplemented through WHO logistics hubs in Kinshasa, Nairobi, Dubai, and Dakar.

3. Surveillance and Contact Tracing

- a. Surveillance activities continued across affected and at-risk areas, including active case finding, alert management, case investigation, contact tracing, mortality surveillance, community-based surveillance, and cross-border surveillance.
- b. As of June 28, 2026 – In the DRC, 9,968 contacts were under follow-up. Overall follow-up coverage improved to 81.3%, although performance remained below target in North Kivu (75.6%) and Ituri (82.9%), while South Kivu maintained 100% follow-up. A total of 903 alerts had been reported across the three affected provinces in the DRC, of which 865 (95.8%) were investigated. Investigations resulted in 166 validated suspected cases, including 60 community deaths.
- c. In Uganda, active case finding, case investigation, contact tracing, alert management, surveillance of non-trauma deaths, and community-based surveillance continued nationwide, particularly in Kampala and Wakiso districts. As of 28 June 2026, five contacts remained under active follow-up.
- d. Points of entry (PoE) and points of control (PoC) surveillance continued to be strengthened in the DRC. As of 28 June 2026, 67 of 69 planned PoE/PoC sites were operational, including 53 of 55 in Ituri and all 14 planned sites in North Kivu. During the reporting period, 129,794 travellers passed through screening sites, of whom 97.2% were screened for BVD symptoms.
- e. In Uganda, inbound and outbound screening remained active at points of entry, including Entebbe International Airport and high-risk border crossings. Mandatory digital Passenger Locator Forms continued to be used for all inbound travellers, while holding facilities remained available for high-risk travellers. Temporary travel restrictions between Uganda and the DRC also remained in place.

4. Laboratory

- a. Diagnostic testing continues across affected countries through national and subnational laboratory networks.
- b. In the DRC, diagnostic capacity has been further decentralized to Kisangani, Aru, Nyakunde, Beni, Mongbwalu, Lwiro, and Bukavu, complementing existing testing facilities in Bunia, Kinshasa, and Goma. The National Institute for Biomedical Research (INRB) continues to expand decentralized testing capacity and reduce turnaround times.
- c. INRB has deployed additional PCR and sequencing equipment, laboratory personnel, and RadiOne diagnostic platforms to Bunia, Mongbwalu, Nyakunde, Aru, and Kisangani. Mobile laboratory support has also been expanded, with testing initiated in Beni and mobile laboratories operational in Lwiro and Bukavu.
- d. WHO and partners continue to replenish laboratory reagents, test kits, and consumables to sustain diagnostic operations. To date, 8,016 RadiOne tests and 960 Altona PCR screening tests have been delivered through WHO support, while Africa CDC has pledged an additional 4,800 diagnostic tests.
- e. In Uganda, BDBV testing is conducted through four operational laboratories, including mobile laboratories in Bwera (Kasese District) and Arua City, supported by the Central Public Health Laboratories (CERSL) in Wandegaya and the Uganda Virus Research Institute (UVRI) in Entebbe.

5. Clinical Management

- a. WHO has published new clinical management guidelines for filovirus diseases, including BVD outlining key recommendations for patient care and outbreak response (<https://www.who.int/publications/i/item/B09774>)
- b. As of June 28, 2026, a total of 654 beds had been established across 35 affected health zones in the DRC, with 615 patients in isolation or hospitalization, including 229 confirmed and 386 suspected cases. Overall bed occupancy reached 96.2%, with the highest pressure reported in North Kivu (138.8%) and Ituri (91.7%).
- c. Daily bed monitoring, strengthened referral systems, and expanded ambulance capacity are being implemented to improve patient flow and referral pathways, particularly in Bunia.
- d. WHO and partners continue to strengthen quality of care through implementation of the new WHO filovirus clinical guidelines, standardized clinical training, deployment of specialist personnel, and expansion of oxygen therapy and critical care capacity.
- e. Efforts are ongoing to establish a survivor follow-up programme integrated into routine healthcare services.

- f. In Uganda, treatment capacity includes 84 beds at the Mulago isolation facility, 56 beds at the Entebbe isolation facility, and an additional 32 beds at the Mulago Field Isolation Facility. Four border facilities have also been identified for assessment and potential expansion of BVD treatment capacity.
- g. Uganda is also strengthening surge capacity through Emergency Medical Team preparedness, with 40 team members undergoing induction training in Entebbe ahead of deployment to Aru Health Province in the DRC.

6. Infection Prevention and Control (IPC) and Water, Sanitation and Hygiene (WASH)

- a. IPC activities continued across affected provinces in the DRC, including decontamination of households, health facilities, ambulances, and transport vehicles linked to confirmed and suspected cases. During the reporting period, 25 households and six health facilities were decontaminated in Ituri Province, alongside additional interventions in Katwa, Beni, and Katana health zones.
- b. IPC/WASH assessments conducted in priority health facilities identified persistent gaps in IPC preparedness and compliance. Average IPC scores remained low in several hotspot areas, including 38.8% in assessed facilities in North Kivu and 52.0% in Katana Health Zone, South Kivu.
- c. WHO and partners continued IPC capacity-building activities through training and briefings for healthcare workers, rapid response teams, community leaders, and community health workers. In Ituri Province, 283 frontline personnel and 73 community actors were trained, while IPC and household kits were distributed to priority health facilities and affected communities.

7. Risk Communication and Community Engagement (RCCE)

- a. RCCE activities continue to be scaled up in high-risk and hotspot areas of the DRC, aligned with evolving epidemiological trends.
- b. Community feedback highlights ongoing concerns regarding delays in safe and dignified burials, transport of suspected cases, and the quality of care provided at BVD treatment centres.
- c. Engagement with community leaders and local networks has helped improve access, address concerns related to resource distribution, and counter rumours and misinformation, although trust gaps remain in some areas.
- d. More than 1.7 million people have been reached through community outreach activities. Over 180 community and religious leaders and 54 local chiefs have participated in dialogue sessions to support outbreak awareness and response efforts. Risk communication has been amplified through 178 radio stations and collaboration with social media influencers, alongside sensitization activities for healthcare workers and caregivers in health facilities.

- e. In Uganda, RCCE activities focused on community and institutional engagement, including outreach to religious leaders, schools, hotels, and border communities, as well as strengthening school-based surveillance. Fifty bloggers and digital influencers were engaged to support dissemination of accurate information and counter misinformation.
- f. Community feedback mechanisms, assessments, and perception studies continue to inform response strategies and improve understanding of behaviours and practices that may influence transmission and acceptance of public health measures.

8. Preventing and Responding to Sexual Exploitation, Abuse, and Harassment (PRSEAH)

- a. PRSEAH coordination continued in collaboration with government authorities, UN agencies, NGOs, and operational partners to strengthen prevention, reporting, and response mechanisms within the Ebola outbreak response.
- b. During the reporting period, PRSEAH briefings reached 2,007 humanitarian responders, including 820 women (41%), to strengthen awareness of sexual exploitation, abuse, and harassment risks, reporting channels, and accountability standards.
- c. Community awareness and risk communication activities were conducted in Mongbwalu, Bunia, Goma, and Miti Murhesa, promoting prevention of sexual exploitation and abuse and use of the toll-free reporting hotline. A total of 1,616 women and girls were reached, representing 42% of individuals sensitized during the reporting period.
- d. Data collection for the assessment of sexual exploitation and abuse risk factors has been completed, with analysis underway to identify priority mitigation measures and strengthen prevention strategies in affected communities.
- e. PRSEAH preparedness plans and associated human resource requirements have been finalized for 12 high-risk countries to strengthen operational readiness and enhance prevention and response capacity.

9. Operational Readiness

- a. Recent assessments showed an average readiness score of 58% among Priority 1 and 2 countries. As of the reporting period, 27 of 47 Member States had updated their readiness assessments, while all 10 Priority 1 and 2 countries had completed and shared contingency plans.
- b. Regional deployments to support high-risk countries remain ongoing in South Sudan, Kenya, and the DRC.

- c. A three-day cross-border preparedness and readiness meeting was convened in Kampala, Uganda, bringing together representatives from neighbouring at-risk countries to strengthen coordination and identify priority preparedness actions. The meeting was jointly organized by WHO, Africa CDC, and the UK Health Security Agency, with participation from regional partners.
- d. Priority preparedness efforts continue to focus on activation of emergency operations centres, strengthening border health and point-of-entry measures, updating and testing contingency plans, dissemination of case definitions, healthcare worker training, prepositioning of supplies, and deployment of regional technical support teams. International Health Regulations (IHR) National Focal Point profiles have also been updated to support timely detection, notification, and reporting of public health events.

10. Border Health, Travel and Mass Gatherings

- a. Point-of-entry (PoE) screening and surveillance have been strengthened at airports, high-risk crossings, and key transit routes in the DRC and Uganda, supported by national authorities, IOM, and partners.
- b. Cross-border transmission risk remains elevated due to insecurity, high population mobility, porous borders, and ongoing transmission in urban and semi-urban hotspots, requiring enhanced surveillance and information sharing.
- c. Priority actions include mapping PoEs and population movement patterns, identifying high-risk routes and informal crossings, and ensuring adequate staffing, training, PPE, screening materials, disinfectants, and referral systems.
- d. Mass gathering preparedness is being strengthened through risk assessments, with postponement recommended in areas with active transmission and a risk-based approach applied elsewhere.
- e. Event-related measures include WHO risk assessment tools, symptom screening, travel history checks, RT-PCR testing capacity, and implementation of prevention measures before, during, and after events, including post-event surveillance for 21 days.
- f. Event organizers are advised to provide participants with clear information on BVD symptoms, reporting procedures, and available health services, in line with the [WHO guidance for mass gathering events attended by individuals from areas with documented BDBV detection](#).

WHO Risk Assessment

- On May 17, 2026, WHO declared the outbreak as a PHEIC due to ongoing transmission of BVD in DRC and imported cases reported in Uganda. The outbreak is occurring in a complex humanitarian and security context, with delayed detection, limited surveillance capacity, insecurity, population displacement, and high population mobility contributing to increased transmission risks.
- As of May 22, the WHO assessed the risk associated with the outbreak as **Very High in the DRC and High in Uganda**. While acknowledging differences in epidemiological trends and operational contexts between the two countries, WHO noted that the risk of regional spread remained elevated. **The outbreak risk was also assessed as High at the regional level and Low at the global level**. As of June 19, these risks remained unchanged.

Table 3. WHO Risk Assessment, as of June 14, 2026

Overall Risk			QIRA*
National	Uganda and Regional	Global	ASEAN Region
DRC: Very High	High	Low	Low

Source: WHO as of June 19, 2026

*) ABVC QIRA

The WHO Recommendations

- On May 19, 2026, the WHO Director-General convened an IHR Emergency Committee, which determined that the Bundibugyo virus disease (BVD) outbreak constitutes a Public Health Emergency of International Concern (PHEIC), but not a pandemic. The Committee issued tiered recommendations based on countries' risk levels:
 - Affected countries (DRC and Uganda):** Focus on strengthening outbreak response systems, including surveillance, contact tracing, clinical care, infection prevention and control (IPC), community engagement, and border measures. Efforts should also ensure safe burials, maintain supply chains, and support research on treatments and vaccines.
 - Neighboring countries:** Emphasize preparedness, including enhancing surveillance, laboratory capacity, rapid response, and cross-border coordination. Early detection and immediate response to suspected cases are critical, alongside community awareness and readiness to use investigational medical countermeasures.
 - All other countries:** Prioritize travel-related measures, including detection and management of suspected cases among travelers, public risk communication, and international coordination. Countries should also prepare for potential case importation and ensure timely reporting to WHO.

- WHO guidance emphasizes that travel restrictions are not recommended, meaning flights should not be suspended and travelers should not be denied entry solely based on origin. Instead, countries should adopt a risk-based and preparedness-focused approach to manage cross-border health risks. Key considerations include travel advice and communication, preparedness at points of entry (PoE), training and awareness, and detection and management of suspected cases, including contact tracing during travel as well as environmental and operational measures

Risk to the ASEAN Region (Based on Flight Connectivity from Ebola Outbreak Areas)

Currently, there are no direct (non-stop) flights from the outbreak source airports (Kinshasa – DRC, Entebbe – Uganda) to all ASEAN Member States (AMS). This allows for significant reduction on immediate importation risk, as passenger volume is diluted across connecting routes, and additional screening opportunities exist at transit hubs. Despite no direct flights, all ASEAN-bound travel requires 1-stop connections, primarily through major global hubs. Further details on flight connectivity can be accessed in the [Situation Report of Ebola Disease Outbreak in The Democratic Republic of the Congo and Uganda - 18 May 2026.](#)

References

1. Africa Centres for Diseases Control and Prevention (2026). *Bundibugyo Virus Disease Outbreak Situation Report June 29, 2026*. Africa CDC. Available from: <https://khub.africacdc.org/records/resource/bundibugyo-virus-disease-outbreak-situation-report-june-29-2026>
2. European Centres for Diseases Control and Prevention (2026). *Communicable disease threats report, 19 - 26 June 2026, Week 26*. European CDC. Available from: <https://www.ecdc.europa.eu/en/publications-data/communicable-disease-threats-report-19-26-june-2026-week-26>
3. The Ministry of Health Uganda (2026). *Press Statement Ebola Bundibugyo Virus Disease Outbreak 2026*. Ministry of Health Uganda. Available from: <https://health.go.ug/download/press-statement-ebola-bundibugyo-virus-disease-outbreak-2026/>
4. The The Ministry of Health, Families, Autonomy, and Persons with Disabilities, France (2026). *Ebola : identification d'un 1er cas chez un médecin humanitaire de retour de mission en République démocratique du Congo (RDC)*. The The Ministry of Health, Families, Autonomy, and Persons with Disabilities, France. Available from: <https://sante.gouv.fr/actualites-presse/presse/communiqués-de-presse/article/ebola-identification-d-un-1er-cas-chez-un-medecin-humanitaire-de-retour-de>
5. World Health Organization (2026). *Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda*. World Health Organization. Available from: <https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON608>
6. World Health Organization (2026). *Experts convened by WHO advise on candidate treatments and vaccines for Ebola disease caused by Bundibugyo virus*. World Health Organization. Available from: <https://www.who.int/news/item/28-05-2026-experts-convened-by-who-advise-on-candidate-treatments-and-vaccines-for-ebola-disease-caused-by-bundibugyo-virus>
7. World Health Organization (2026). *Implementation of border health and international travel-related temporary recommendations issued by the Director-General of WHO to States Parties not sharing land borders with areas with documented Bundibugyo virus detection: technical note, 26 May 2026*. World Health Organization. Available from: <https://iris.who.int/items/b07def43-df30-41b8-83e0-deb33bcfd697>
8. World Health Organization (2026). *WHO Director-General's remarks at the Virtual Ministerial Briefing on the Bundibugyo Ebola Outbreak - 25 May 2026*. World Health Organization. Available from: <https://www.who.int/news-room/speeches/item/who-director-general-s-remarks-at-the-virtual-ministerial-briefing-on-the-bundibugyo-ebola-outbreak-25-may-2026>
9. World Health Organization (2026). *EBOLA BUNDIBUGYO VIRUS DISEASE OUTBREAK Democratic Republic of the Congo | Uganda Weekly External Situation Report 07, Data as of 28 June 2026*. World Health Organization. Available from: <https://www.afro.who.int/countries/uganda/publication/ebola-bundibugyo-virus-disease-outbreak-democratic-republic-congo-3>



ASEAN Biological Threat Surveillance Centre (ABVC)

Health Policy Agency

Ministry of Health of Indonesia

Building 6 - Global Health Strategy and Governance Policy, 2nd floor

Jalan Percetakan Negara No. 29 Johar Baru, Jakarta Pusat, Indonesia 10560