

ASEAN Biological Threats Surveillance Centre

Situation Report of Ebola Disease Outbreak caused by the Bundibugyo virus (BDBV) in The Democratic Republic of the Congo & Uganda

June 12, 2026



With Support by:
 Canada
 Africa CDC
 Ebola Disease Control and Prevention Agency

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 6 June.
- As of June 8, Africa CDC reported 626 confirmed cases and 112 confirmed deaths (CFR: 17.9%) in the Democratic Republic of the Congo (DRC), with cases identified across 26 health zones. In Uganda, 19 confirmed cases and two confirmed deaths (CFR: 10.5%) have been reported, with transmission remaining concentrated in Kampala. Overall, 23 patients have recovered, corresponding to a recovery rate of 3.6%.

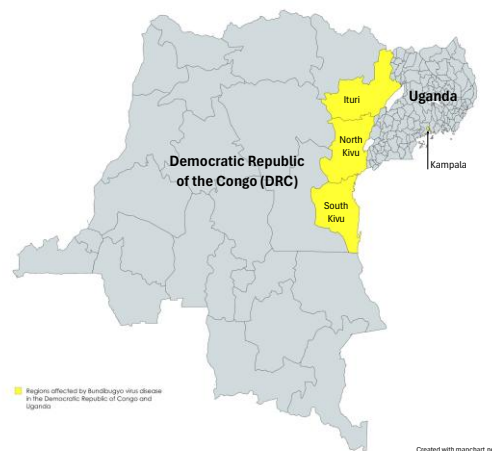


Figure 1. Regions affected by Bundibugyo virus disease in DRC and Uganda, as of June 8, 2026

Table 1. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of June 8, 2026

Country	Health Zone/ District Affected	Confirmed Cases	Confirmed Deaths	CFR (%) Confirmed	Cured	Recovery Rate (%)
DRC	26	626	112	17.9%	19	3.0%
Uganda	2	19	2	10.5%	4	21.1%
Total	28	645	114	17.7%	23	3.6%

Source: Africa CDC as of June 8, 2026

- Healthcare workers continue to be affected, with 29 confirmed cases reported in DRC and five in Uganda. The infection and deaths of healthcare workers potentially linked to unsafe burials and difficulties in contact tracing, highlighting challenges in infection prevention and control (IPC) and response capacity. No additional healthcare worker cases or deaths have been reported since June 2.

Table 2. Cases among Healthcare Workers (HCW)

Country	Confirmed cases among HCWs	Confirmed deaths among HCWs	CFR (%)
DRC	29	5	17.2%
Uganda	5	0	0.0%
Total	34	5	14.7%

Source: Africa CDC as of June 8, 2026

Situation Update

Democratic Republic of the Congo

- On May 5, 2026, WHO received an alert regarding an unknown illness with high mortality reported in Mongbwalu Health Zone (HZ), Ituri Province, DRC, including the deaths of four health workers within four days. The earliest currently identified suspected case, a health worker, developed symptoms including fever, hemorrhaging, vomiting, and severe malaise on April 24, 2026, and later died at a medical centre in Bunia.
- As of May 15, a total of 246 suspected cases and 80 deaths had been reported across Rwampara, Mongbwalu, and Bunia HZs, with 24 cases in isolation. Clusters of unexplained community deaths in Ituri and North Kivu were under investigation. Among 65 identified contacts, follow-up was hindered by insecurity, resulting in some symptomatic contacts dying before isolation. While initial GeneXpert testing was negative for standard Ebola strains, PCR and genomic sequencing confirmed eight samples as Bundibugyo virus (BDBV). On the same day, the Ministry of Health officially declared DRC's 17th Ebola disease outbreak.
- On May 24, the Ministry of Communication and Media stated that the BDBV outbreak remains active across 11 health zones in three provinces: Ituri (Aru, Bunia, Kilo, Mongbwalu, Nizi, Nyankunde, Rwampara), North Kivu (Butembo, Goma, Katwa), and South Kivu (Miti-Murhesa). Cumulatively, health authorities have recorded 105 confirmed cases and 10 confirmed deaths (CFR: 9.5%), alongside 906 cumulative suspected cases and 223 suspected deaths (CFR: 24.6%). No patient recoveries have been reported to date.
- 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%). In addition, 1,199 suspected cases and 259 suspected deaths (CFR: 21.6%) were reported. In its May 31 update, Africa CDC reclassified suspected cases and deaths, reducing the number of suspected cases to 321 as testing capacity expanded, while the number of suspected deaths remained unchanged. Since June 8, Africa CDC has no longer reported suspected case and death counts.
- 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.

Uganda

- On May 11, 2026, an elderly man from the DRC presenting with severe symptoms was admitted to a private hospital on May 11 and subsequently died on May 14, representing the first imported case. A clinical sample collected on admission tested positive for BDBV on May 15 at the Central Emergency Surveillance and Response Support Laboratory in Wandegaya; the body was repatriated post-mortem to the DRC on 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 cumulative total to five confirmed cases. Among these, two are Ugandan nationals (a driver who transported the first case and a health worker who provided care) identified through contact tracing and currently receiving care in Uganda. The third case was a Congolese resident who briefly sought care in Kampala before returning to the DRC. To date, two deaths have been recorded; one patient has recovered following two successive negative tests, and the remaining patients continue to receive specialized care. Beyond the immediate contacts, no wider community transmission has been identified.
- As of May 24, two additional cases were confirmed, bringing the cumulative total in the country to seven cases, including one death (CFR: 14.3%). These two recent cases have been healthcare workers employed at a private medical facility in Kampala. Both patients have been admitted and are currently receiving specialized care.
- As of June 8, Uganda reported 19 confirmed cases and 2 deaths (CFR: 10.5%). A total of 4 cases had recovered, representing 21.1% of confirmed cases.

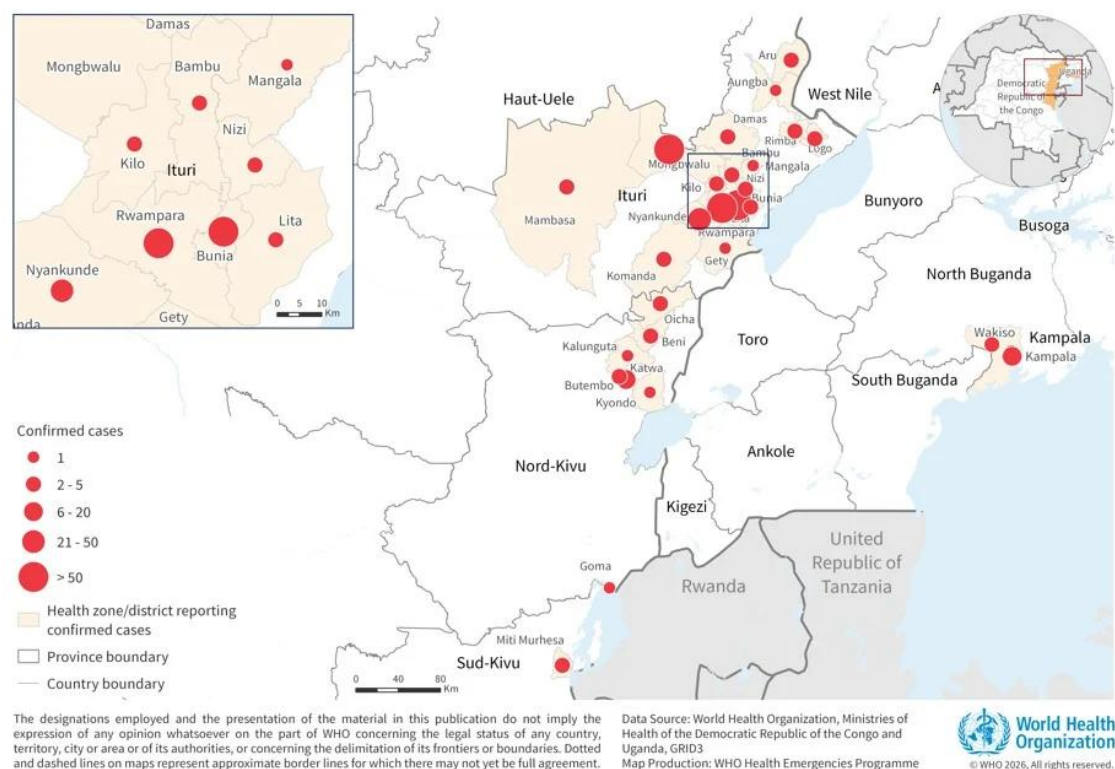


Figure 2. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in DRC and Uganda, as of June 6, 2026

The outbreak experienced a sharp increase in weekly new cases, rising from around 10 cases in mid-May to a peak of approximately 240 cases in early June (Figure 3). The recent decline should be interpreted with caution, as the latest reporting period (June 7–8) does not cover a full week and likely underestimates the actual number of weekly new cases.

Deaths increased more steadily and leveled off at about 30–40 per week since May 24. The case fatality rate (CFR) was initially very high (around 60%) but fell rapidly as more cases were identified and has since stabilized at roughly 20–25%.

These trends are largely driven by the DRC, where both cases and deaths increased significantly and remain elevated. In contrast, Uganda reported limited and short-term increases in cases, with very few deaths. Overall, the outbreak remains concentrated and ongoing in the DRC.

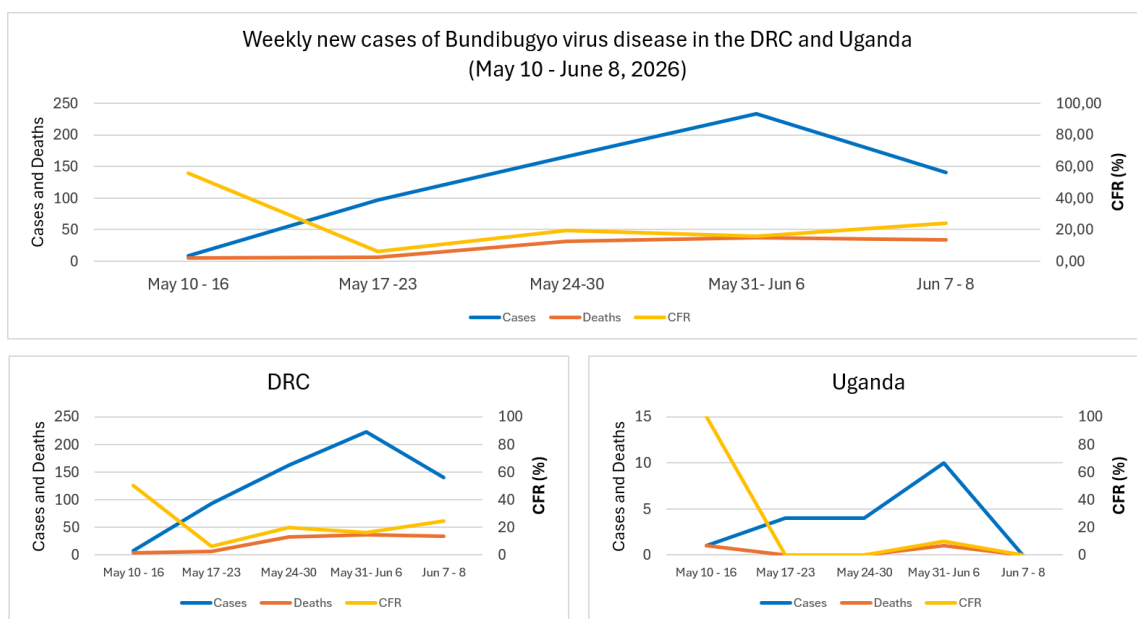


Figure 3. Weekly new cases of Bundibugyo virus disease (BVD) in the DRC and Uganda (May 10 – June 8, 2026), 2026 (Source: Africa CDC as of June 8, 2026)

Epidemiology

- Earlier, a BVD outbreak occurred in Province Orientale, DRC, in 2012, with 59 cases and 34 deaths, ending on November 26, 2012. More recently, an outbreak was declared on September 4, 2025, in Bulape Health Zone, Kasai Province; 64 cases and 45 deaths were recorded before it was officially declared over on December 1, 2025. This current outbreak represents the 17th Ebola outbreak documented in the DRC since 1976.
- BVD is a severe and often fatal form of Ebola disease caused by Bundibugyo virus, an *Orthoebolavirus* species. It is a zoonotic infection, with fruit bats considered the primary natural reservoir. Transmission occurs through direct contact with infected animals or through bodily fluids of infected individuals, particularly in healthcare environments with insufficient infection prevention and control (IPC) measures and during unsafe burial practices.

- BVD has an incubation period of 2–21 days, and individuals become infectious only after symptoms develop. Initial symptoms are non-specific, such as fever, fatigue, headache, muscle aches, and sore throat, and may later progress to gastrointestinal symptoms, organ failure, and sometimes hemorrhagic manifestations. Previous outbreaks in Uganda and the DRC have shown a case fatality rate of approximately 30%–50%.
- 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. National & International Coordination

- a. A continental Incident Management Support Team (IMST) involving WHO, Africa Centres for Disease Control and Prevention (Africa CDC), and health partners, has been launched to coordinate and provide strategic and operational support to affected and at-risk countries. Kampala, Uganda, has been designated as an expanded operational hub to facilitate regional coordination, strengthen cross-border preparedness and response activities, and support harmonized implementation across DRC, Uganda, and other at-risk countries. A continental response plan with a six-month operational horizon is under development.
- b. A high-level ministerial meeting on cross-border coordination, involving DRC, Uganda, and South Sudan, was convened in Kampala on 22–23 May 2026, reaffirming commitments to strengthen cross-border surveillance, joint contact tracing, information sharing, preparedness at points of entry, laboratory collaboration, and regional operational coordination. Countries also agreed to strengthen the continental IMST and harmonize preparedness and response measures across affected and at-risk areas.
- c. In both DRC and Uganda, national Incident Management Systems (IMS) remain activated, with coordination structures functioning at national and subnational levels and supported by WHO and health partners, including Africa CDC, UNICEF, Médecins Sans Frontières, International Medical Corps, and other operational partners.
- d. In DRC, subnational coordination structures continue to operate across affected provinces and health zones, with daily provincial coordination meetings in Bunia facilitating alignment of response activities across operational pillars.

- e. In Uganda, the National Public Health Emergency Operations Centre and regional Emergency Operations Centres (EOCs) in Fort Portal, Arua, Yumbe, Kampala Capital City Authority, Kabale, and Hoima remain activated, while the national response plan and rapid risk assessment have been finalized to support outbreak response and preparedness activities.
- f. International Support: WHO, WFP, and international partners are actively deploying technical experts, distributing critical medical supplies, including personal protective equipment (PPE), and reinforcing laboratory and emergency logistics networks.
- g. Cross-Border Collaboration: Joint preparedness and response measures have been intensified. This includes synchronized border surveillance, real-time data and alert sharing, rapid notification systems, joint simulation exercises, and coordinated deployment of cross-border emergency response teams.

2. Operations support and logistics

- a. To strengthen field response operations in DRC, WHO has deployed 52 surge personnel including 19 international staff and 33 national staff, as of 24 May 2026, to support coordination, logistics, surveillance, and other technical response activities across affected areas.
- b. Logistics corridors from Kinshasa, capital of DRC, Nairobi in Kenya, and Dakar in Senegal remain operational, with shipments covering personal protective equipment (PPE), viral haemorrhagic fever and case management supplies, tents, body bags, and laboratory consumables, alongside the ongoing deployment of EpiShuttle, a patient isolation transport systems, and telecommunications equipment.
- c. Logistics and infrastructure support for Ebola treatment capacity has continued in DRC, with assessments and layout finalization for a treatment facility completed. Quantification for Ebola Treatment Centre (ETC) construction and rehabilitation has been finalized, and earthworks for ETC expansion activities in Bunia have been initiated. In addition, operational assessments of warehouse readiness, stock positioning, and commodity distribution systems have been completed in Bunia to strengthen emergency supply chain visibility and delivery.
- d. Uganda has expanded multisectoral logistics coordination through a national operations platform involving the World Food Program, UNICEF, and approximately 10 international non-governmental organizations, with partners agreeing to share stock information through a common coordination dashboard covering health commodities, water, sanitation and hygiene, and laboratory supplies.

- e. Operational constraints, notably the closure of the Bunia airport, continue to affect response scale-up. Humanitarian flight coordination remains ongoing in DRC, including the rescheduling of cargo operations, while delays in the release of medical supplies and ongoing shortages of laboratory materials and protective equipment continue to pose challenges to response activities.

3. Surveillance and Contact Tracing

- a. Despite the complex operational and epidemiological context, surveillance activities continue to be strengthened across affected areas. In DRC, surveillance activities include active case finding, alert and case investigations, retrospective reviews of cases and deaths, and contact tracing. In Uganda, surveillance teams continue to support case investigations and contact monitoring using digital tools and experience from previous outbreak responses.
- b. Daily alerts continue to increase in DRC, with 71 alerts reported on 23 May, of which 53 were investigated and 47 validated, while in Uganda 42 alerts were detected and investigated, including 31 identified through points-of-entry screening.
- c. In DRC, 2231 contacts have been identified as of 24 May, though contact tracing remains a major operational challenge. Only 19.3% were seen within the previous 24 hours as of 23 May 2026. In Uganda, 311 contacts have been identified.
- d. Points-of-entry (PoE) screening continues to be strengthened in both countries to reduce cross-border transmission risks. With support from the International Organization for Migration, six PoE sites have been activated in DRC, screening 11 143 of 11 628 travellers (95.8%) on 24 May, while all 11 628 travellers received Ebola risk communication messages. No contacts were listed and no alerts were generated. In Uganda, screening activities are operational at 21 of 28 targeted PoEs, and 13 897 travellers were screened in the previous 24 hours as of 23 May 2026, generating 31 alerts, all of which were discarded.
- e. Mobile Laboratory Deployment: Mobile laboratory deployed to Mongbwalu and Mahagi (Ituri-Uganda border crossing point).
- f. RadiOne Diagnostic Validated: RadiOne testing platform validated for confirmatory diagnostics.

4. Laboratory

- a. As of 24 May 2026, the Bunia Provincial Laboratory in Ituri Province, DRC, had cumulatively received 431 samples. Of these, 295 were analyzed, with 105 testing positive, a positivity rate of 35.6%.

- b. Laboratory surge operations are ongoing to address stockouts of diagnostic supplies at the Bunia Provincial Laboratory, with additional RT-PCR capacity being deployed, while WHO and Africa CDC are supporting the delivery of more than 4000 test kits.
- c. Both DRC and Uganda continue to perform confirmatory testing at their National Reference Laboratories, including genomic sequencing and data sharing, to improve understanding of transmission chains and support outbreak investigations.

5. Clinical Management

- a. As of 24 May 2026, DRC had admitted a cumulative total of 281 patients across 17 treatment and isolation facilities, with 133 patients currently in isolation centres, including eight healthcare workers. The largest numbers of admissions are in Bunia (53), Nyankunde (33), Rwampara (25), and Mongbwalu (18) health zones. In Uganda, five confirmed are being managed in isolation at the Mulago Ebola Treatment Unit (ETU) in Kampala.
- b. WHO and health partners are accelerating efforts to establish and operationalize standardized ETCs in hotspot areas, including infrastructure rehabilitation, provision of medical supplies and expansion of isolation capacity, although gaps remain.
- c. Clinical management operations have faced major disruptions due to security incidents and patient care challenges. In Mongbwalu, 18 suspected patients left the treatment centre following a security incident and the burning of one of three treatment tents, while a patient from Rwampara refused care, a confirmed case from Nyankunde was readmitted in critical condition, and a confirmed patient from Hoho Health Centre was released under community pressure despite unsuccessful counselling efforts.
- d. Supportive care capacity continues to improve. Nutritional management activities commenced with ALIMA to ensure that patients can receive adequate food, while additional equipment, including oxygen concentrators and multiparameter monitors, was deployed to strengthen clinical care capacity and improve quality of care.
- e. As of May 31, 2026, WHO has handed over a refurbished Ebola Treatment Centre (ETC) in Bunia with an initial capacity of 24 beds, extending to 60 beds. An additional annex facility is being established to provide up to 42 additional beds in the coming weeks.
- f. WHO advisory groups have indicated that several candidate vaccines and therapeutics are being prioritized for evaluation in clinical trials in collaboration with DRC and Uganda.

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

- a. IPC measures continue to be progressively strengthened across affected health zones in DRC through supportive supervision, health facility assessments, environmental decontamination, and workforce capacity-building activities.
- b. Training and briefings on biomedical waste management, hand hygiene, and the appropriate use and removal of PPE were conducted for healthcare workers and support staff, including 14 healthcare providers and two supervisors in Rwampara Health Zone, as well as staff in health facilities in Bunia.
- c. Environmental decontamination and safe and dignified burial (SDB) activities were implemented in response to alerts and deaths. A total of 15 SDB and decontamination interventions were conducted, including five linked to seven alerts in Bunia, two community alerts in Rwampara, eight alerts in Mongbwalu, and household decontamination activities in Nyankunde and North Kivu.
- d. In Uganda, IPC activities focused on strengthening infection prevention measures in quarantine and treatment settings. IPC assessments were conducted in four quarantine facilities to identify gaps and strengthen IPC measures and practices.
- e. IPC measures are also being strengthened at the Mulago Ebola Treatment Unit (ETU) in Kampala, Uganda, an 80-bed facility with five intensive care unit beds and 10 high-dependency unit beds, to improve preparedness and reduce the risk of healthcare-associated transmission.

7. Risk Communication and Community Engagement (RCCE)

- a. RCCE activities have been scaled up in DRC and Uganda, with over 122 000 people reached through church outreach, mass sensitization campaigns, interactive radio programmes, and engagement of community leaders, U-Reporters, and community health workers/volunteers.
- b. These activities focused on understanding community perceptions and reducing transmission risks among high risk populations.
- c. Anthropological investigations are ongoing to assess risky practices and understand perceptions and behaviours related to the Ebola Bundibugyo virus disease outbreak.

8. Prevention of Sexual Exploitation, Abuse, and Harassment (PRSEAH)

- a. PRSEAH activities were integrated into outbreak response operations in DRC and Uganda, with inter-agency coordination mechanisms and a joint action plan established to strengthen accountability and partner engagement.

- b. Field capacity strengthening continued, with three PRSEAH experts deployed and awareness sessions reaching more than 130 response personnel across case management, IPC, points of entry, and safe and dignified burial teams.
- c. Risk reduction and accountability measures are being strengthened through ongoing inter-agency risk assessments, reporting and referral systems, and mapping of partner roles to support safe and accountable response operations.

9. Operational Readiness

- a. Regional preparedness and prioritization framework is being activated with countries categorized by risk and readiness needs. The latest assessments have shown a readiness score of around 57% among priority one and two countries, highlighting the need to scale up readiness activities. Priority actions include activation of EOCs, revision of contingency plans, dissemination of case definitions, training of healthcare workers, and deployment of VHF-500 kits to high-risk areas.
- b. Countries have been prioritized based on epidemiological risk, cross-border exposure, and health system readiness. DRC and Uganda remain Tier I (Critical) due to active transmission, while South Sudan, Kenya, and Tanzania are Tier II (High Priority) and Rwanda, Burundi, and the Central African Republic are Tier III (Moderate Priority). Within DRC, the Ituri–North Kivu corridor, particularly Mongbwalu–Bunia and mining-linked mobility routes, remains the highest-priority transmission zone for intensified interventions.
- c. Preparedness efforts are focused on early detection and rapid response capacity with countries strengthening systems to ensure timely identification, investigation, isolation, and management of suspected viral haemorrhagic fever cases.
- d. Uganda has conducted national risk assessment, with 26 districts categorized as very high risk and 18 districts as high risk, guiding targeted preparedness and readiness measures.

10. Border Health, Travel and Mass Gatherings

- a. Points-of-entry and traveller screening operations have been reinforced at high-risk crossings and internal transit routes in both DRC and Uganda, with IOM and national authorities supporting PoE surveillance and implementation of WHO travel and border health guidance.
- b. Cross-border transmission risks remain elevated due to insecurity, humanitarian crises, high population mobility, urban/semi-urban transmission hotspots, and porous borders, requiring intensified surveillance and information sharing.

- c. Priority operational actions include rapid assessments and mapping of PoEs, informal crossings, and congregation points, alongside ensuring frontline teams have adequate staffing, training, PPE, screening materials, disinfectants, and referral systems. Mass gathering risk assessment capacity is being built and recommendations provided.
- d. Uganda has temporarily suspended flights to and from the DRC, non-essential cross-border travel by ferries, buses and other public transport, and border-area cultural celebrations and commemorations for at least four weeks, effective immediately on May 23, 2026.

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 6, these risks remained unchanged.

Table 3. WHO Risk Assessment, as of June 6, 2026

Overall Risk		
National	Uganda and Regional	Global
DRC: Very High	High	Low

Source: WHO as of June 6, 2026

- The outbreak’s epicenter in Ituri Province, a major commercial and migratory hub bordering Uganda and South Sudan, amplifies cross-border transmission dynamics. Uganda has already confirmed multiple imported cases directly linked to this corridor.

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:

1. **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.
 2. **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.
 3. **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:
 1. **Travel advice and communication:** Provide clear, up-to-date information to travelers and health professionals, including guidance for monitoring symptoms for 21 days after arrival from affected areas.
 2. **Preparedness at points of entry (PoE):** Countries should establish standard procedures to detect and manage suspected cases, ensure availability of trained staff, PPE, and isolation space, and coordinate with transport operators and laboratories.
 3. **Training and awareness:** Personnel at PoEs and first responders should be trained to recognize symptoms, apply infection prevention and control (IPC) measures, and respond appropriately to suspected cases.
 4. **Detection and management of suspected cases:** Systems should allow rapid identification, safe handling, notification, and referral of suspected cases, while minimizing exposure and enabling safe continuation of travel for unaffected passengers.
 5. **Contact tracing during travel:** Authorities should identify and follow up contacts of suspected cases across borders, ensuring coordination between countries through established IHR mechanisms.
 6. **Environmental and operational measures:** Adequate procedures should be in place for cleaning, disinfection, waste management, and safe handling of potentially contaminated environments and conveyances.

- WHO convened expert groups to evaluate potential BVD treatments and vaccines. As no approved BVD-specific countermeasures currently exist, all candidates should be assessed through clinical trials. Promising therapeutics include the monoclonal antibodies MBP134 and Maftivimab®, and the antiviral remdesivir. For post-exposure prevention, obeldesivir is being considered but depends on effective contact tracing. Among vaccine candidates, rVSV Bundibugyo is the most advanced, while ChAdOx1 Bundibugyo may be available sooner for clinical testing pending additional data. WHO is supporting clinical research in affected countries to generate evidence for future outbreak response.

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](#).

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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