

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 22, Africa CDC and WHO reported 1,094 confirmed cases and 277 confirmed deaths (CFR: 25.3%) in the Democratic Republic of the Congo (DRC), with cases identified across 34 health zones. In Uganda, 20 confirmed cases and two confirmed deaths (CFR: 10.0%) have been reported, with transmission remaining concentrated in Kampala. Overall, 126 patients have recovered, corresponding to a recovery rate of 11.3%.

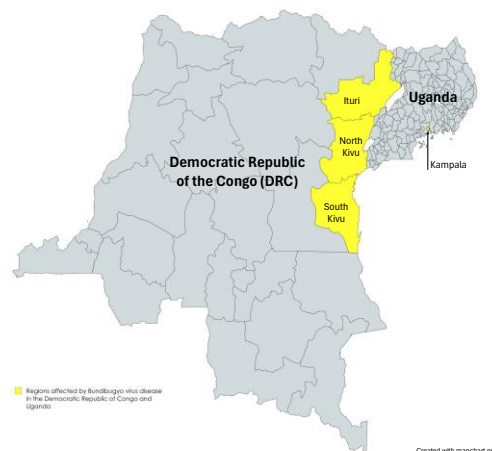


Figure 1. Regions affected by Bundibugyo virus disease in DRC and Uganda, as of June 16, 2026

Table 1. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in the Democratic Republic of the Congo and Uganda, as of June 22, 2026

Country	Health Zone/ District Affected	Confirmed Cases	Confirmed Deaths	CFR (%) Confirmed	Cured	Recovery Rate (%)
DRC	34	1094	277	25.3%	112	10.2%
Uganda	2	20	2	10.0%	14	70.0%
Total	36	1,114	279	25.0%	126	11.3%

Source: Africa CDC, WHO

- Healthcare workers have been affected, with 75 confirmed cases in the DRC and four in Uganda. These infections, including associated deaths, have been linked to unsafe burials and limitations in contact tracing, underscoring challenges in IPC and response capacity.

Table 2. Cases among Healthcare Workers (HCW)

Country	Confirmed cases among HCWs	Confirmed deaths among HCWs	CFR (%)
DRC	75	17	22.7%
Uganda	4*	0	0.0%
Total	79	17	21.5%

*confirmed HCW in Uganda was revised following reclassification

Source: Africa CDC, WHO

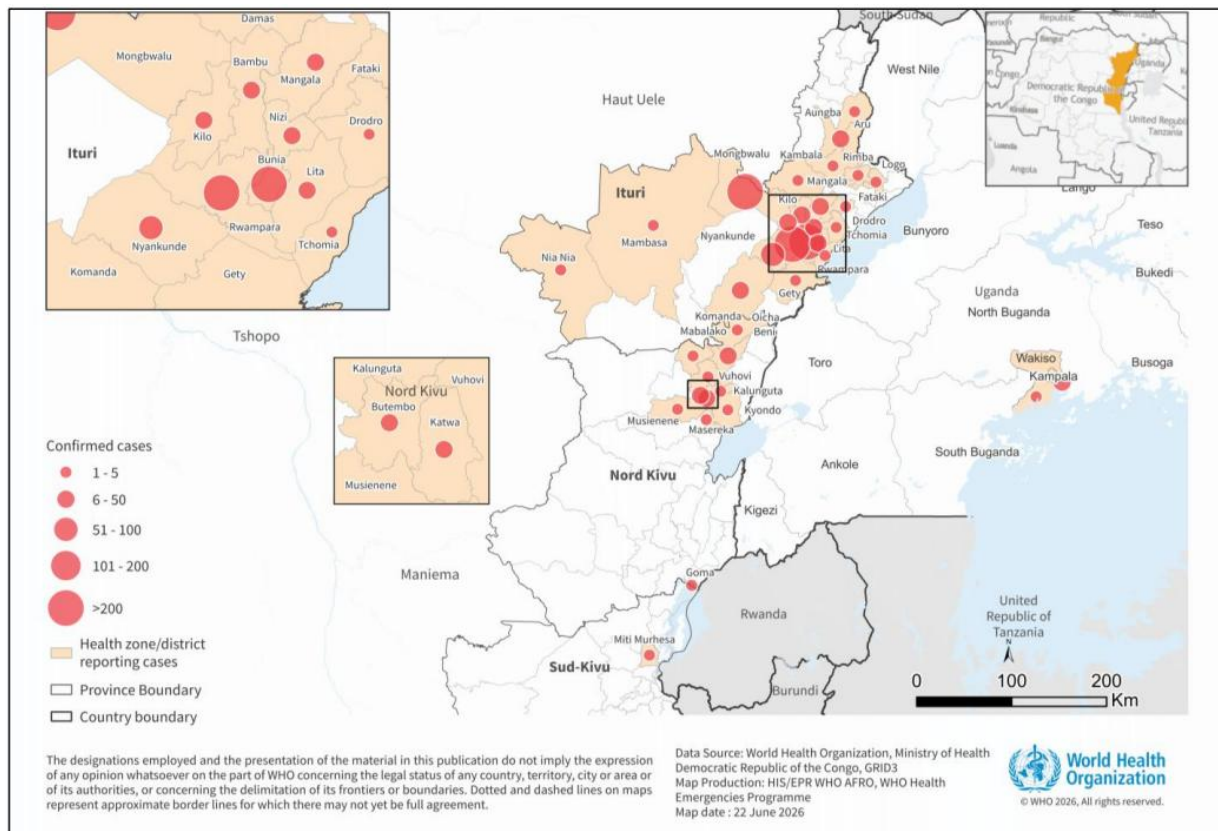


Figure 2. Distribution of Suspected and Confirmed Ebola Bundibugyo virus disease cases in DRC and Uganda, as of June 19, 2026 (Source: WHO)

Situation Update

Democratic Republic of the Congo

- **On May 5, 2026**, WHO received an alert regarding a high-mortality outbreak in Mongbwalu 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, Mongbwalu, 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%). 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. As of 8 June, suspected case and death figures are no longer reported.
- **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.

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 22, the number of recoveries rose to 14, corresponding to 70.0% of confirmed cases.

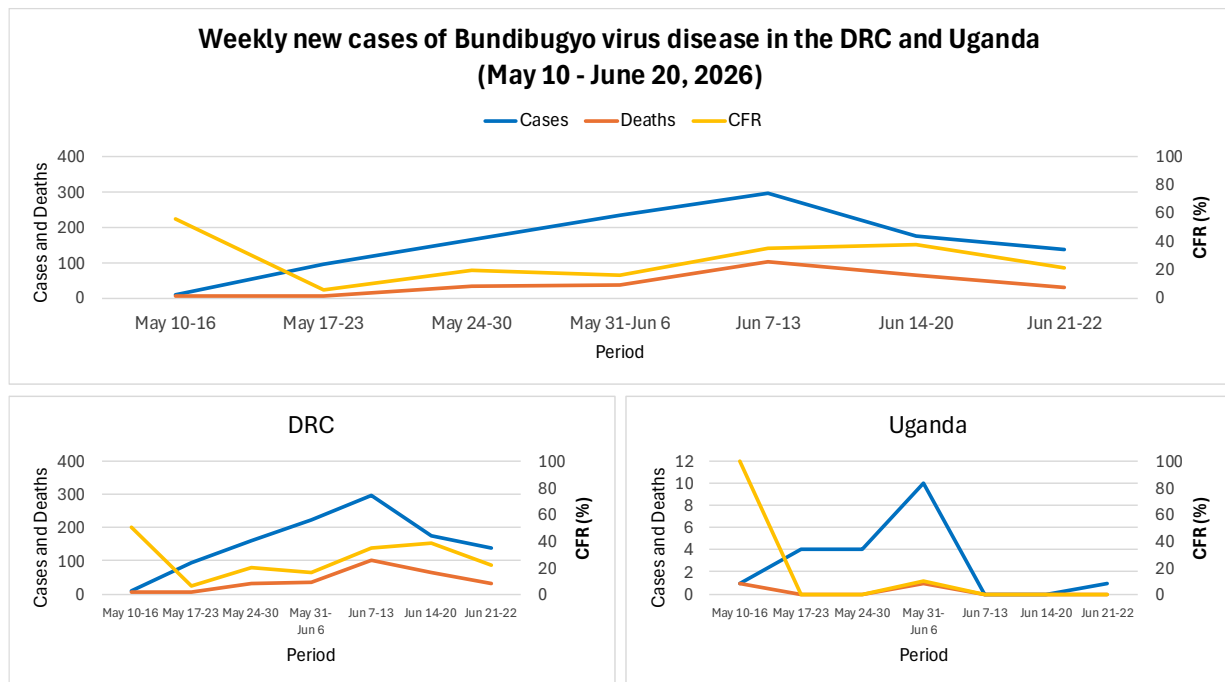


Figure 3. Weekly new cases of BVD in the DRC and Uganda (May 10 - June 22, 2026)

(Source: Africa CDC)

The outbreak demonstrated a marked increase in weekly reported cases as of June 13, particularly driven by transmission in the DRC. Weekly cases rose rapidly from 9 during May 10–16 to a peak of 296 during June 7–13, reflecting intensified transmission, particularly in the DRC. A decline to 174 cases was observed in the week ending 20 June; however, early data from 21–22 June indicate continued high transmission, with 138 new cases and 30 deaths reported in the DRC within two days. In Uganda, one additional case was reported following the last previously confirmed case on 5 June.

Mortality trends followed a similar pattern, increasing steadily from 5 deaths in mid-May to 103 deaths during June 7–13, before gradually declining to 66 in June 14–20.

These trends were primarily driven by the DRC, where sustained increases in cases and deaths were observed. In contrast, Uganda reported low and largely contained transmission, with cases peaking at 10 during May 31 to June 6 and no additional cases or deaths reported as of June 20, suggesting interruption of transmission. However, one new case reported on June 21 indicates continued vigilance is required.

Overall, the outbreak remains active and expanding in the DRC, while transmission in Uganda appears limited and relatively stable.

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. Coordination

- a. 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.
- b. 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.
- c. National Incident Management Systems remain operational in the DRC and Uganda, supported by WHO, UNICEF, IOM, MSF, IMC, and other partners.
- d. 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.
- e. 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.
- f. 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.

- g. Through GOARN, WHO has deployed eight experts to support surveillance, case management, IPC, and risk communication activities in both countries.

2. Operations support and logistics

- a. WHO continues to support response operations through deployed field teams in the DRC and Uganda, focusing on surveillance, laboratory, case management, logistics, and coordination in priority hotspots.
- b. In the DRC, treatment and isolation capacity has been expanded in Bunia, Rwampara, and Nyankunde in response to increased bed occupancy (83.8%), with the Bunia ETC remaining operational.
- c. Through WHO's Techne network, remote technical support is ongoing for the design and layout of screening sites, transit centres, and treatment facilities to strengthen patient flow and IPC standards.
- d. As of 14 June 2026 – Procurement and shipment operations mobilized approximately US\$4.3 million in critical supplies, with about US\$1.2 million delivered and over US\$2 million in transit.
- e. A total of 110.1 metric tons (622.7 m³) of supplies have been delivered to logistics hubs in Ituri and North Kivu, including PPE, laboratory materials, and diagnostic supplies.
- f. Logistics coordination mechanisms remain active in both countries, supporting supply tracking and distribution; however, challenges persist, including IPC supply gaps, pressure on treatment capacity, insecurity, and funding constraints.

3. Surveillance and Contact Tracing

- a. Surveillance activities continued across affected and at-risk areas, including active case finding, case investigation, contact tracing, mortality surveillance, community-based surveillance, and cross-border surveillance.
- b. As of 14 June 2026 – In the DRC, 6,120 contacts were under follow-up, with overall follow-up coverage at 63.1%. Performance remained below target in Ituri (64.2%) and North Kivu (56.4%), while South Kivu achieved 100%.
- c. A total of 588 alerts were reported, of which 505 (85.9%) were investigated, resulting in 165 validated suspected cases, including 54 community deaths. Alert investigation rates varied by province, with North Kivu achieving full coverage and Ituri reporting lower performance (65.6%).
- d. In Uganda, surveillance activities continued nationwide, particularly in Kampala and Wakiso, with all high-risk contacts under 21-day follow-up and enhanced screening of public transport passengers from high-risk areas.
- e. Points of entry (PoE) and cross-border surveillance were further strengthened. In the DRC, 40 of 55 planned points of control were operational, with 47,525 travellers passing through screening, of whom 90.0% were screened.

- f. In Uganda, PoE screening remained active, including at Entebbe International Airport and high-risk border crossings, supported by digital Passenger Locator Forms and holding facilities for high-risk travellers. Temporary cross-border travel restrictions also remained in place.
- g. Surveillance training continued in the DRC to strengthen capacity in case investigation, contact tracing, community-based surveillance, and alert management, particularly in high-risk health zones in Ituri Province.

4. Laboratory

- a. Diagnostic testing continues across affected countries through national and subnational laboratory networks.
- b. In the DRC, testing has been decentralized to Nyakunde, Beni, Mongbwalu, Lwiro, and Bukavu, alongside existing capacity in Bunia, Kinshasa, and Goma, reducing turnaround times and addressing sample backlogs.
- c. The National Institute for Biomedical Research (INRB) has deployed additional PCR and sequencing equipment, personnel, and RadiOne platforms, with mobile laboratory support extending testing capacity to Beni, Lwiro, and Bukavu.
- d. WHO and partners continue to replenish laboratory supplies. A total of 8,016 RadiOne tests and 960 PCR test kits have been delivered, with an additional 4,800 tests pledged by Africa CDC.
- e. In Uganda, BDBV testing is conducted through four laboratories, including mobile units in Bwera and Arua, supported by the Central Public Health Laboratories (CERSL) in Wandegaya and the Uganda Virus Research Institute (UVRI) in Entebbe.

5. Clinical Management

- a. Case management activities continue to expand across affected provinces in the DRC, supported by WHO and partners.
- b. As of 14 June 2026 – A total of 363 patients were in treatment and isolation centres (155 confirmed, 208 suspected), with 48 reported recoveries.
- c. Bed occupancy reached 83.8%, including 94.8% in Ituri Province, indicating increasing pressure on treatment capacity in key hotspots.
- d. Expansion of treatment and transit facilities is ongoing in Bunia, Nyankunde, and Rwampara, with additional surge capacity being installed in Bunia.
- e. Nutritional support and mental health and psychosocial services continued for patients, contacts, caregivers, and affected communities.
- f. Planning is underway to establish a dedicated survivor programme to support long-term follow-up and care.
- g. WHO continues to monitor essential health service delivery to ensure continuity alongside outbreak response operations.
- h. Key challenges include high bed occupancy, limited treatment capacity, shortages of IPC supplies and essential medicines, and insecurity affecting response activities.

- i. In Uganda, treatment capacity includes isolation facilities in Kampala and Entebbe, with dedicated critical care beds, while case management remains centralized.
- j. Ambulance networks remain operational, supporting the safe transport of high-risk contacts and cases, with coverage in Kampala and along border areas.

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

- a. In the DRC, over 120 safe and dignified burials and decontamination activities have been conducted, alongside the establishment of screening, triage, and temporary isolation capacities. IPC kits have been distributed, and more than 220 healthcare workers trained, while assessments in over 70 health facilities identified critical IPC gaps.
- b. In Uganda, IPC measures have been strengthened through updated Ebola IPC guidance, prepositioning of PPE and supplies, and activation of 10 rapid response teams. More than 3,500 healthcare workers have been trained, and over 375 high-risk facilities and 20 isolation units assessed to guide targeted IPC interventions and supply distribution.

7. Risk Communication and Community Engagement (RCCE)

- a. In the DRC, RCCE activities continue to scale up in high-risk and hotspot areas in line with epidemiological trends.
- b. Community feedback highlights concerns related to delays in safe and dignified burials, case transport, and perceived quality of care at treatment centres.
- c. Engagement with community leaders and networks has improved access and helped address misinformation, although trust gaps persist.
- d. Over 379,650 people have been reached through community outreach, with engagement of more than 180 religious leaders and 54 local chiefs. Media outreach includes 36 radio stations and collaboration with social media influencers, alongside sensitization activities for healthcare workers and caregivers.
- e. In Uganda, RCCE efforts focused on community and institutional engagement, including religious leaders, schools, hotels, and border communities, as well as strengthening school-based surveillance. Digital engagement was enhanced through orientation of 50 bloggers and influencers.
- f. Community feedback, assessments, and perception studies continue to inform response strategies and improve community acceptance.

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

- a. In the DRC, WHO and UNICEF conducted joint community awareness and PRSEAH sessions, reaching approximately 1,000 students and community members through U-Reporters and health zone activities.

- b. During the reporting period, around 3,856 individuals were reached across Ituri, North Kivu, and South Kivu through 25 community sessions involving women, community leaders, healthcare workers, and other stakeholders.
- c. In Uganda, PRSEAH briefings reached over 200 participants, with additional sessions conducted for health educators and emergency medical teams deployed to high-risk areas.
- d. PRSEAH risk assessments and preparedness activities continued in Uganda and South Sudan, including participation in simulation exercises and development of inter-agency guidance integrating PRSEAH into Ebola response operations.

9. Operational Readiness

- a. A regional preparedness framework continues to guide readiness across the African Region, with countries prioritized by risk: DRC and Uganda (Priority 1A); South Sudan, Burundi, and Rwanda (Priority 1B); and other neighboring countries classified under Priority 2 and 3.
- b. Recent assessments indicate an average readiness score of 58% among Priority 1 and 2 countries, with most assessments completed and contingency planning underway. Regional support deployments have commenced, including to South Sudan.
- c. 13 June 2026 – A tabletop exercise was conducted in South Sudan to assess outbreak readiness across key pillars, including surveillance, laboratory, case management, IPC, RCCE, and border health.
- d. Preparedness efforts focus on strengthening emergency operations centres, points of entry, contingency planning, healthcare worker training, and prepositioning of supplies in high-risk areas.
- e. International Health Regulations (IHR) National Focal Point profiles have been updated to support timely detection, notification, and reporting of outbreaks.

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 14, 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.

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 has convened expert groups to assess potential BVD treatments and vaccines. With no approved countermeasures currently available, all candidates are being evaluated through clinical trials. Promising therapeutics include MBP134, Maftivimab®, and remdesivir, while obeldesivir is under consideration for post-exposure prevention, contingent on effective contact tracing. Among vaccine candidates, rVSV Bundibugyo is the most advanced, with ChAdOx1 Bundibugyo expected to enter clinical testing pending further data. WHO is supporting clinical research in affected countries to inform 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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