

BUNDIBUGYO VIRUS DISEASE OUTBREAK

Democratic Republic of the Congo | Uganda

Weekly External Situation Report 05, Data as of 14 June 2026

Summary

Country	Confirmed Cases	Confirmed Deaths	Probable Cases	Probable Deaths	Total Cases (Confirmed & Probable)	Total Deaths (Confirmed & Probable)	CFR (%) Confirmed & Probable
Democratic Republic of the Congo	808	192	-	-	808	192	23.8%
Uganda	19	2	1	1	20	3	15.0%

Note: Only confirmed and probable cases are reported.

Event description

Since our last update of 07 June 2026 ([Situation Report #4](#)), the Bundibugyo virus disease (BVD) outbreak situation in the Democratic Republic of the Congo has continued to evolve, with sustained transmission and increasing geographic spread being reported. In Uganda, the outbreak situation remains stable, with no new confirmed cases reported during the past week.

Democratic Republic of the Congo

In the Democratic Republic of the Congo, intense community transmission and geographic expansion continue to characterize the outbreak. Since 07 June 2026, a total of 258 new confirmed cases, including 91 new confirmed deaths, have been reported, representing a 60.0% increase in confirmed cases and a 90.1% increase in confirmed deaths reported. As of 14 June 2026, a cumulative total of 808 laboratory-confirmed cases, including 192 confirmed deaths [case fatality ratio (CFR) 23.8%], have been reported across the three affected provinces of Ituri, North Kivu, and South Kivu.

The number of affected health zones has increased from 25 to 31, including 20 of 36 health zones in Ituri Province, 10 of 34 in North Kivu Province, and one of 34 in South Kivu Province. Newly reporting health zones include Tchomia, Kambala and Nia-Nia in Ituri Province and Mabalako, Masereka, and Vuhovi in North Kivu Province. However, the identification of cases in some of these newly reporting health zones may reflect previously undetected transmission rather than recent introduction of the virus. Epidemiological investigations indicate that transmission had likely been occurring in some of these areas for several weeks before the first cases were confirmed and reported. In contrast, health zones such as Nia-Nia have reported cases with symptom onset only within the past week, suggesting more recent spread of the outbreak into new areas.

Ituri remains the most affected province to date, accounting for 738 confirmed cases (91.3%) and 153 confirmed deaths (79.7%) of all cumulative cases and deaths reported in the Democratic Republic of the Congo. Within the province, the highest cumulative burden continues to be observed in Bunia (215 cases), Mongbwalu (175 cases), Rwampara (152 cases), and Nyankunde (42 cases) health zones, which together account for 72.3% of all confirmed cases reported in the Democratic Republic of the Congo. While these health zones remain the main hotspots of transmission, additional cases have also been reported from several other health zones within and beyond Ituri

Province, indicating an increasingly wide geographic distribution of affected areas.

North Kivu has reported 62 confirmed cases to date (7.9% of all confirmed cases), including 58 cases reported within the last 21 days, indicating increasing transmission activity in the province. The highest cumulative numbers of cases have been reported from Katwa (25 cases), Butembo (19 cases), and Beni (14 cases) health zones, which are densely populated and highly connected commercial and urbanized areas. The continued rise in cases across these health zones suggests increasingly established transmission chains within North Kivu. Additional sporadic cases have also been reported from Goma, Kalunguta, Kyondo, Mabalako, Masereka, Oicha, and Vuhovi health zones, indicating a widening geographic distribution of affected areas within the province.

North Kivu has also reported the highest case fatality ratio (56.7%), compared with 20.7% in Ituri and 33.3% in South Kivu. These differences should be interpreted cautiously and may reflect variations in healthcare access, timeliness of case detection and care-seeking, insecurity-related barriers affecting response operations, and differences in surveillance sensitivity and case ascertainment between affected provinces. Anecdotal reports further suggest that some patients may have travelled from Ituri to North Kivu while already severely ill, arriving during the later stages of disease progression. In contrast, South Kivu remains comparatively stable, with three confirmed cases, including one death, and no new confirmed cases reported since 26 May 2026.

As of 14 June 2026, a total of 6120 contacts were under follow-up across the three affected provinces, of whom 3862 (63.1%) had reportedly been seen within the previous 24 hours. Follow-up coverage remains particularly suboptimal in Ituri Province (64.2%) and North Kivu Province (56.4%), posing continued challenges to interruption of transmission chains.

Transmission continues to be amplified by insecurity, high population mobility, and operational challenges in affected areas. The outbreak hotspots remain affected by armed group activity, artisanal mining-related population movement, and porous cross-border mobility. Insecurity and community resistance continue to affect surveillance, safe and dignified burials, contact tracing, and healthcare delivery in several affected areas.

Uganda

No new confirmed cases have been reported in Uganda since the previous external situation report. As of 14 June 2026, Uganda has reported a cumulative total of 20 cases (19 confirmed and one probable), including three deaths (two confirmed and one probable), across Kampala and Wakiso districts within the Kampala Metropolitan Area. The outbreak remains epidemiologically linked to cross-border transmission from the Democratic Republic of the Congo. The last confirmed case was reportedly identified on 05 June 2026, suggesting a possible stabilization of transmission. Following case reclassification, the number of affected healthcare workers was revised from five to four.

Males have accounted for 13 cases (65.0%) and females for seven cases (35.0%). Cases have been reported across several adult age groups, with the highest burden observed among persons aged 30 – 39 years (six cases, 30.0%) and those aged 50 – 59 years (six cases, 30.0%), followed by 20 – 29 years (four cases, 20.0%). Relatively few cases were reported among children and adolescents, with one case each reported among females aged 0 – 9 years and 10 – 19 years. Overall, the age and sex distribution suggests that transmission in Uganda has primarily affected working-age adults, particularly males, likely reflecting patterns of occupational exposure, mobility, caregiving responsibilities, and cross-border movement associated with the outbreak.

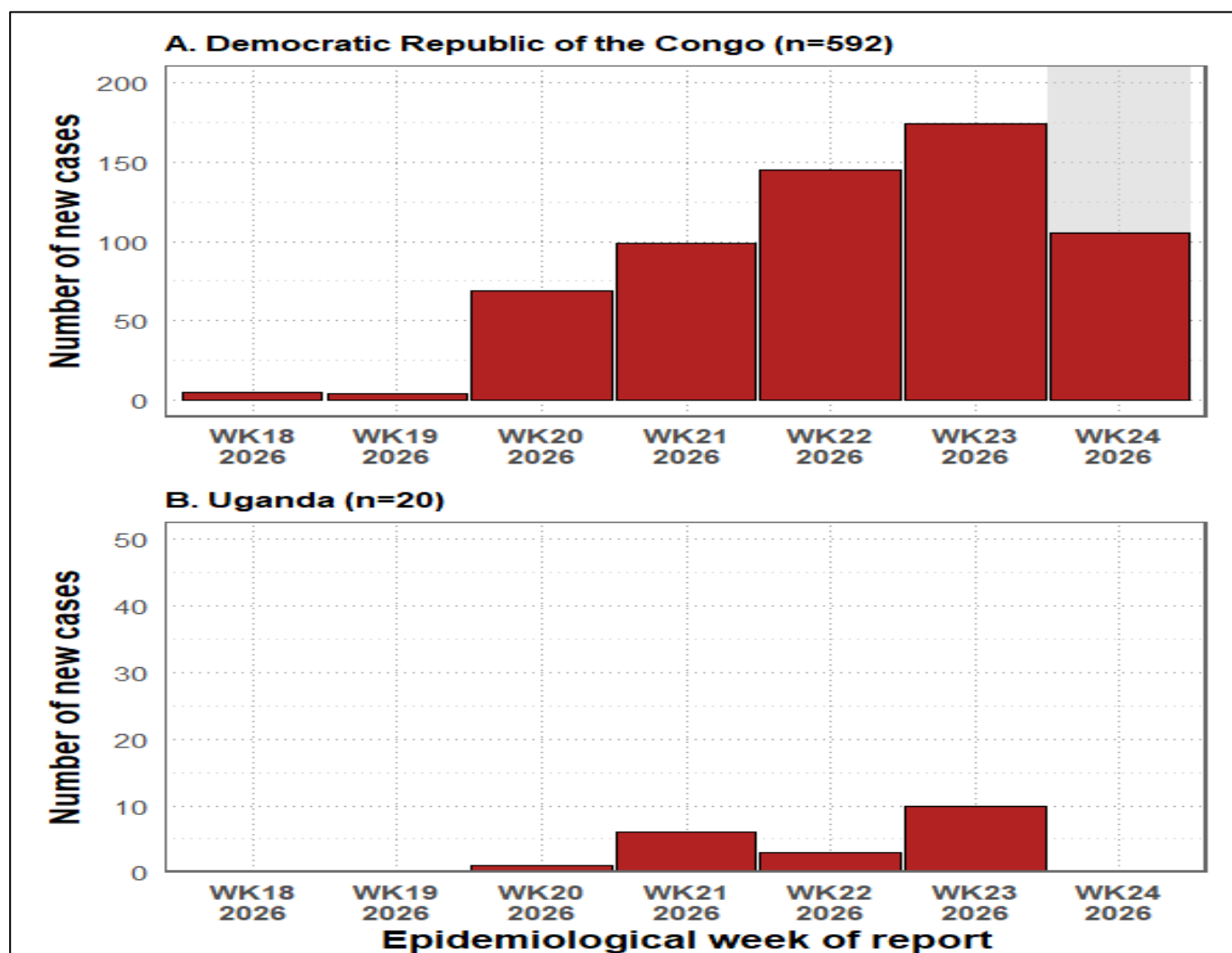
A total of 826 contacts have been identified since the start of the outbreak. Of these, 350 remain under active follow-up as of 14 June 2026.

Risk Assessment

The World Health Organization (WHO) continues to assess the national risk associated with the outbreak as very high in the Democratic Republic of the Congo and high in Uganda. The risk for countries sharing land borders with the affected countries remains high due to intense cross-border population movement, porous borders, insecurity, and the expanding geographic spread of the outbreak in eastern Democratic Republic of the Congo. The regional and global risk remains low.

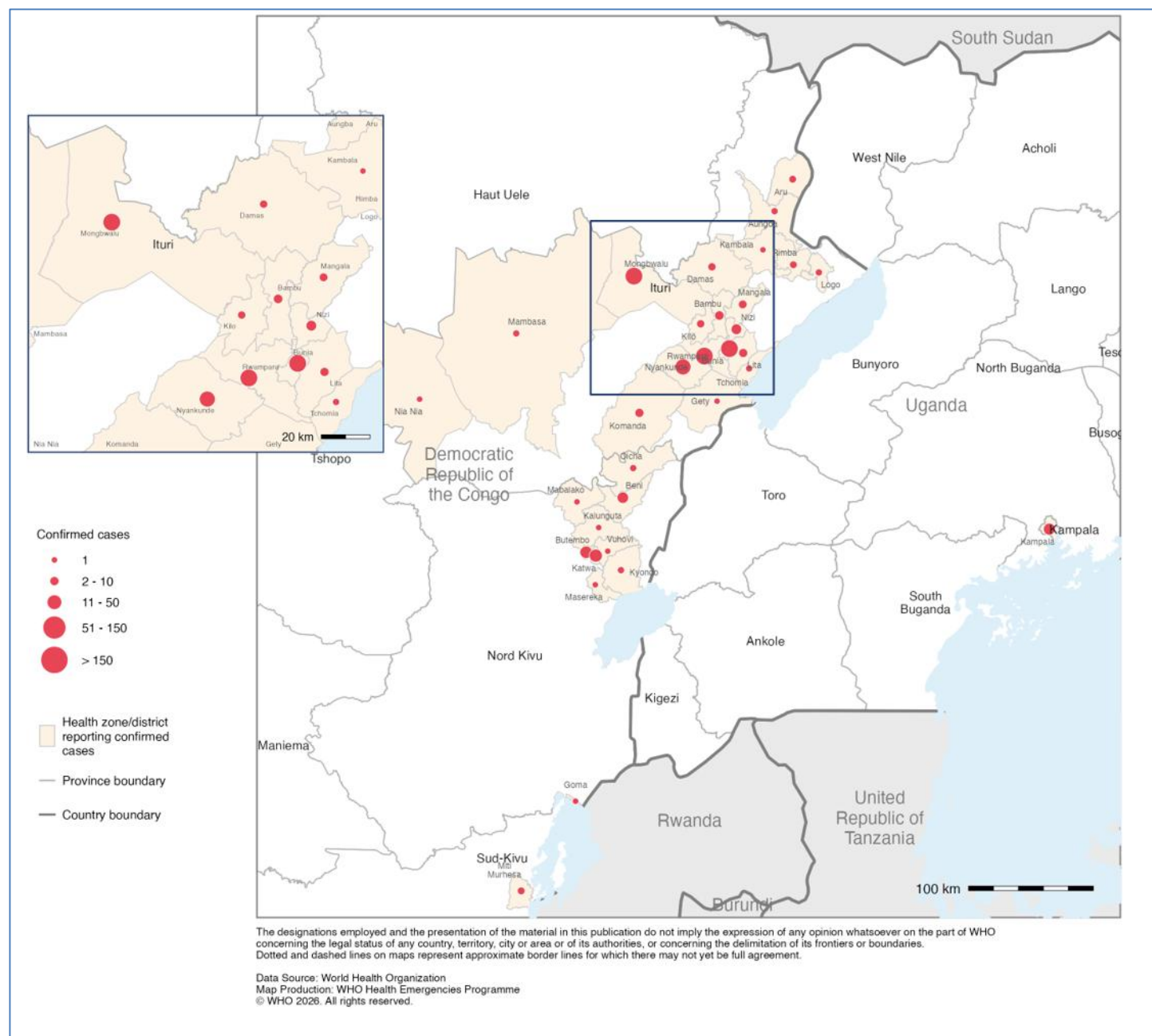
The widening geographic distribution of affected health zones, persistent transmission in urban and mining-linked settings, suboptimal contact follow-up rates in some provinces, and ongoing insecurity in affected areas continue to complicate response operations and increase the risk of further spread within the Democratic Republic of the Congo and to neighbouring countries.

Figure 1. Weekly trends of confirmed and probable cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda by epidemiological week of report, epidemiological weeks 14 – 24, 2026



Note: Area shaded with gray background indicates incomplete data and discretion should be used in interpretation. For the Democratic Republic of the Congo, only 592 out of 808 confirmed cases with date of report are included in this graph.

Figure 2. Geographical distribution of confirmed cases of Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda, as of 14 June 2026



Public health response

Coordination

- The continental Incident Management Support Team, co-led by WHO and the Africa Centres for Disease Control and Prevention (Africa CDC), in collaboration with United Nations agencies, technical institutions, and operational partners, remains activated to coordinate strategic and operational support to affected

and at-risk countries under a unified “One Response” approach.

- WHO and Africa CDC continue to advance the joint continental preparedness and response plan for June – November 2026, launched on 5 June 2026, which seeks US\$ 518 million to support affected countries and strengthen regional preparedness under a unified “One Response” approach.
- National Incident Management Systems remain active in both the Democratic Republic of the Congo and Uganda, with coordination support from WHO, Africa CDC, the United Nations Children’s Fund, the International Organization for Migration (IOM), Médecins Sans Frontières (MSF), International Medical Corps (IMC), Samaritan’s Purse, the European Union, and other operational partners.
- On 8 June 2026, WHO and partners supported the launch of a cross-border coordination meeting between the Democratic Republic of the Congo and Uganda in Aru Health Zone to strengthen surveillance, information-sharing, and response coordination along the international border.
- In the Democratic Republic of the Congo, training activities continued for Health Zone Chief Medical Officers, community mobilizers, and 60 national and provincial pillar leads on Incident Management System implementation, decentralization, and zonal response scale-up. Multidisciplinary teams were also deployed to Beni and Butembo health zones to strengthen field coordination and operational oversight.
- During the reporting period, the Director-General of WHO conducted a mission to Uganda and the Democratic Republic of the Congo to assess outbreak response operations, strengthen high-level political engagement, and support regional coordination efforts. Discussions focused on cross-border collaboration, sustaining surveillance and response operations, strengthening treatment and isolation capacity, and mobilizing international support for the response.
- Through the WHO-coordinated Global Outbreak Alert and Response Network (GOARN), eight experts have been deployed to support outbreak response operations in the Democratic Republic of the Congo and Uganda, covering areas of surveillance, case management, infection prevention and control, and risk communication activities.

Operations Support and Logistics (OSL)

- WHO continues to support response operations through the deployment of field personnel across the Democratic Republic of the Congo and Uganda. In the Democratic Republic of the Congo, WHO multidisciplinary teams continued to support surveillance, laboratory operations, case management, logistics, and coordination activities in priority hotspots, including Bunia, Mongbwalu, Rwampara, Beni, Butembo, and Katwa, while field teams in Uganda continued to support surveillance, border health, case management, and operational readiness activities.
- Operations support and logistics activities continued to scale up across affected areas in the Democratic Republic of the Congo. WHO and partners supported the expansion of treatment and isolation capacity in Bunia, Rwampara, and Nyankunde in response to increasing bed occupancy, which reached 83.8% during the reporting period. The Ebola Treatment Centre in Bunia remained operational, while additional treatment and isolation capacity continued to be expanded in priority areas.
- Through the WHO Technical Science for Health Network (Techne), remote technical support continued to be provided for the design of screening facilities, transit centres, and treatment centres across affected

areas in the Democratic Republic of the Congo and Uganda. This support covered the layout and infrastructure of patient flow, triage, and care zones to strengthen infection prevention and control and ensure adherence to minimum design standards for Ebola response.

- As of 14 June 2026, procurement and shipment operations had mobilized approximately US\$ 4.3 million worth of critical response supplies, including personal protective equipment (PPE), laboratory supplies, medical equipment, medicines, and medical consumables. Of these, supplies worth approximately US\$ 1.2 million had already been delivered to affected areas, while shipments valued at more than US\$ 2 million remained in transit.
- A total of 110.1 metric tons of supplies and 622.7 cubic metres of cargo had been delivered to logistics hubs in Ituri and North Kivu provinces. Delivered and pre-positioned supplies included coveralls, examination gloves, gowns, respirators, patient liners, polymerase chain reaction testing supplies, and RADIONE diagnostic materials to support accelerated laboratory testing, decentralized diagnostics, and frontline response operations.
- In both the Democratic Republic of the Congo and Uganda, logistics coordination mechanisms continued to support shipment tracking, supply distribution, partner coordination, and the monitoring of operational gaps. However, significant challenges remain, including insufficient infection prevention and control supplies in North Kivu, increasing pressure on treatment capacity, insecurity affecting field access, and funding shortages affecting the continuity of response operations.

Surveillance

- 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.
- In the Democratic Republic of the Congo, as of 14 June 2026, a total of 6120 contacts were under follow-up, including 4828 in Ituri Province, 1212 in North Kivu Province, and 80 in South Kivu Province. Overall contact follow-up remained suboptimal, with only 63.1% of contacts seen within the previous 24 hours. Follow-up rates were particularly low in North Kivu Province (56.4%) and remained below the target in Ituri Province (64.2%), while South Kivu Province achieved 100.0% follow-up.
- As of 14 June 2026, 588 alerts had been reported across the three affected provinces in the Democratic Republic of the Congo, of which 505 (85.9%) were investigated. A total of 165 suspected cases, including 54 community deaths, were validated. North Kivu Province reported the highest number of alerts (329) and achieved a 100.0% investigation rate, while Ituri Province reported 241 alerts, with the lowest investigation rate at 65.6%.
- In Uganda, active case finding, case investigation, contact tracing, alert management, surveillance for non-trauma deaths, and community-based surveillance continued nationwide, particularly in Kampala and Wakiso districts. All high-risk contacts remained under mandatory 21-day follow-up, while screening of public transport passengers from high-risk districts and cities also continued.
- Points of entry (PoE) and cross-border surveillance continued to be strengthened in both countries. In the Democratic Republic of the Congo, two additional points of control (PoC) were activated along the Bunia–

Mahagi–Anzida corridor. As of 14 June 2026, 40 of the 55 planned PoC in Ituri Province were operational. During the reporting period, 47525 travellers passed through screening sites, of whom 90.0% were screened for BVD symptoms.

- In Uganda, inbound and outbound screening continued at points of entry (PoE), including Entebbe International Airport and high-risk border crossings. Mandatory digital Passenger Locator Forms remained in use for all inbound travellers, while holding facilities were maintained for high-risk travellers. Temporary travel restrictions between Uganda and the Democratic Republic of the Congo also remained in place.
- Surveillance training continued in the Democratic Republic of the Congo for Health Zone Chief Medical Officers, surveillance personnel, community health workers, and frontline responders on BVD surveillance, including community-based surveillance, contact tracing, and alert management in affected and high-risk health zones, particularly in Ituri Province.

Laboratory

- Diagnostic testing continues across the affected countries through national and subnational laboratory networks.
- In the Democratic Republic of the Congo, laboratory testing has been decentralized to Nyakunde, Beni, Mongbwalu, Lwiro, and Bukavu health zones, in addition to existing testing capacity in Bunia, Kinshasa, and Goma. Reagents were delivered and backlogged samples tested. The National Institute for Biomedical Research (INRB) continues to implement a decentralized laboratory strategy aimed at expanding diagnostic capacity to additional locations and reducing testing turnaround times.
- INRB has deployed additional polymerase chain reaction (PCR) equipment, sequencing equipment, supplies and personnel to Bunia as well as RadiOne platforms (KH Medical, Republic of Korea) to Mongbwalu and Nyakunde. With support from the Regional Mobile Laboratory in Goma, testing was initiated in Beni and mobile laboratories were set up in Lwiro and Bukavu health zones.
- WHO and partners continue replenishing laboratory reagents, test kits, and consumables to sustain diagnostic operations. A total of 8016 RadiOne (KH Medical, Republic of Korea) and 960 Altona screening PCR (Altona Diagnostics GmbH, Germany) testss were delivered to the Democratic Republic of the Congo through WHO support, while additional testing supplies have been pledged by Africa CDC (4800 tests).
- In Uganda, Bundibugyo virus testing is being conducted through four operational laboratories, including mobile laboratories in Bwera (Kasese District) and Arua City, with additional support from the Central Public Health Laboratories (CERSL) in Wandegaya and the Uganda Virus Research Institute (UVRI) in Entebbe.

Case Management

- Case management activities continued to expand across affected provinces in the Democratic Republic of the Congo, supported by WHO and operational partners, including ALIMA, Médecins Sans Frontières (MSF), International Medical Corps (IMC), MEDAIR, and Samaritan’s Purse. As of 14 June 2026, a total of 363 patients were in isolation and treatment centres, including 155 confirmed and 208 suspected cases. A total of 48 patients had recovered as of 14 June 2026.

- Overall bed occupancy reached 83.8%, including 94.8% in Ituri Province, indicating increasing pressure on treatment and isolation capacity, particularly in the main transmission hotspots.
- Construction and expansion of treatment and transit facilities continued in Bunia, Nyankunde, Rwampara, and other priority areas. Eight additional tents installed at the Bunia BVD Treatment Centre are expected to become operational on 15 June 2026 to support surge capacity.
- Nutritional support activities continued across treatment centres for confirmed and suspected cases, contacts, and caregivers during the reporting period. Mental health and psychosocial support interventions also continued for patients, caregivers, children, and affected households.
- Active planning is underway to establish dedicated human resources to support the Bundibugyo virus disease (BVD) survivor programme, ensuring sustained follow-up and survivor care activities.
- Recognizing the need to maintain continuity of essential health services alongside outbreak-related care, WHO continues to monitor service delivery in areas of operational presence and feed findings into the wider response to support informed decision-making and resource allocation.
- Key operational challenges affecting case management included high bed occupancy, insufficient treatment capacity in hotspot areas, shortages of infection prevention and control supplies and essential medicines, and continued risks associated with community transmission and insecurity.
- In Uganda, treatment capacity included 84 beds, including 10 critical care beds, at the Mulago isolation facility in Kampala; 56 beds, including four critical care beds, at the Entebbe isolation facility; and an additional 32 beds at the Mulago Field Isolation Facility. A total of five cases had recovered while 12 were still in admission.
- Uganda also maintained 15 ambulances for the evacuation of high-risk contacts, suspected cases, and confirmed cases, including seven ambulances in the Kampala metropolitan area and eight positioned along the Uganda–Democratic Republic of the Congo border and at PoE.

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

- In the Democratic Republic of the Congo, more than 120 safe and dignified burials and decontamination interventions have been conducted. Screening, triage, and temporary isolation capacities are being established. Additionally, distribution of IPC kits and training of more than 220 frontline healthcare workers have been conducted. Assessments conducted in over 70 health facilities identified critical IPC gaps requiring targeted support.
- In Uganda, revision of Ebola IPC guidance, prepositioning of PPE and outbreak supplies, and activation of 10 IPC rapid response teams have been conducted. More than 3500 healthcare workers were reached through IPC training and mentorship activities, while over 375 high-risk health facilities and 20 isolation units were assessed to guide targeted IPC interventions, decontamination activities, and supply distribution in affected districts.

Risk Communication and Community Engagement (RCCE)

- In the Democratic Republic of the Congo, RCCE activities continue to expand in high-risk zones, prioritizing hotspot areas aligned with epidemiological trends.
- Community feedback indicates persistent concerns regarding delays in safe and dignified burial procedures, transport of suspected cases and quality of care at BVD treatment centres.
- Engagement with local leaders and community networks has contributed to improved access and have helped address community concerns about resource distribution and rumours linked to self-medication, though trust gaps remain.
- In affected areas more than 379650 people have been directly reached through community outreach activities. Over 180 community and religious leaders along with 54 local chiefs have been engaged through community dialogue sessions to support outbreak awareness and response efforts. Media engagement has continued via 36 radio stations across Ituri Province and Goma in North Kivu Province, complemented by collaboration with social media influencers to strengthen public awareness and counter misinformation. Additionally, sensitization sessions on barrier measures and patient admission procedures were conducted for healthcare workers and caregivers at health facilities in Bunia.
- In Uganda, RCCE activities focused on institutional and community sensitization, engagement with religious leaders, schools, hotels, and border communities, and strengthening school-based surveillance. Fifty bloggers and digital influencers were also oriented to amplify accurate messaging and counter misinformation through social media platforms.
- Community feedback, community assessments and perception studies continue in affected areas to better understand perceptions, behaviours, and practices influencing outbreak transmission and response acceptance.

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

- WHO and UNICEF conducted joint community awareness and PRSEAH sessions through U-Reporters and health zones, reaching approximately 1000 students and additional community members in affected areas in the Democratic Republic of the Congo.
- PRSEAH orientation and community engagement activities reached approximately 3856 individuals during the reporting period across Ituri, North Kivu, and South Kivu provinces through 25 community sessions, including women and girls, community leaders, healthcare workers, teachers, transporters, nutrition partners, and health experts.
- In Uganda, PRSEAH briefings were conducted for 208 participants, including healthcare providers, community relays, teachers, health committee leaders, nurses, and community leaders, while additional briefings were provided to 33 health educators in Kampala and 65 emergency medical team members deploying to Arua and Kisenyi.
- Sexual exploitation abuse and harassment risk assessments and preparedness activities continued in Uganda and South Sudan, including participation of PRSEAH focal points in simulation exercises and development of

inter-agency guidance integrating PRSEAH into Ebola preparedness and response operations.

Operational Readiness

- A regional preparedness and prioritization framework continues to guide readiness activities across the African Region, with countries categorized according to risk and preparedness needs. Priority 1A countries include the Democratic Republic of the Congo and Uganda; Priority 1B countries include South Sudan, Burundi, and Rwanda; Priority 2 countries include Angola, Central African Republic, Republic of the Congo, Ethiopia, Kenya, Tanzania, and Zambia; while all other countries remain classified as Priority 3.
- Recent assessments showed an average readiness score of 58% among Priority 1 and 2 countries, with 90% of readiness assessments completed and submitted. To date, 22 of 47 Member States, in addition to Zanzibar, have updated their readiness assessments, while eight (8) of the ten Priority 1 and 2 countries have completed and shared contingency plans (80%). Regional deployments to support high risk member states have commenced with South Sudan.
- A Tabletop Exercise was conducted in South Sudan on 13 June 2026 to assess operational readiness for a BVD outbreak, with emphasis on capacities across PoE, surveillance, laboratory services, case management, IPC, RCCE, and safe and dignified burial practices. In parallel, support continues for other Member States to design and adapt similar tabletop exercises to strengthen preparedness and response capacities.
- Priority preparedness activities continue to focus on activation of emergency operations centres, strengthening of points of entry and border health measures, revision and testing of contingency plans, dissemination of case definitions, training of healthcare workers, deployment of supplies to high-risk areas, and deployment of regional support teams to provide technical assistance. International Health Regulations (IHR) National Focal Point profiles have also been updated to support timely notification and reporting of alerts.

Border Health, Travel and Mass Gatherings

- PoE and traveller screening operations have been reinforced at airports, high-risk crossings and internal transit routes in both the Democratic Republic of the Congo and Uganda, with national authorities, IOM and partners supporting PoE surveillance and implementation of WHO travel and border health guidance, as well as measures at points of control on high priority travel corridors.
- 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.
- Priority operational actions include rapid assessments and mapping of PoEs, as well as cross-border population mobility mapping to identify key movement patterns, high-risk cross-border routes, including informal crossings, and major congregation points. Additional priorities include ensuring that field teams have adequate staffing, equipment, training, PPE, screening materials, disinfectants, and referral systems.
- Mass gathering risk assessment capacity is being strengthened through training and the provision of recommendations. The postponement of mass gatherings is advised in areas with documented BVD transmission until transmission is interrupted, while a risk-based approach is recommended for events held elsewhere in the region and outside affected areas. A Mass Gathering Readiness Checklist for host countries

sharing land borders with affected countries and expecting attendees from areas with documented BVD transmission is currently under development.

- Event-specific risk assessments should be conducted using the WHO all-hazards mass gathering risk assessment tool. These assessments should be complemented by implementation of measures before, during, and after events, as outlined in WHO guidance for mass gatherings attended by individuals from areas with documented Bundibugyo virus detection, including the establishment of referral pathways and RT-PCR testing capacity. Capacities for symptom-based screening combined with travel history and exposure assessment within the previous 21 days should also be in place, alongside promotion of hand hygiene and BVD risk communication. These measures should be further complemented by event-based surveillance, coordination with public health authorities for cross-border contact tracing, and post-event surveillance for at least 21 days following the event.
- Event organisers should distribute participant information to all attendees before and during the event, covering BVD symptoms, what to do if feeling unwell, and available health services, in line with [WHO guidance for mass gathering events attended by individuals from areas with documented BDBV detection](#).

Situation interpretation

The BVD outbreak in the Democratic Republic of the Congo continues to deteriorate, with sustained community transmission, increasing numbers of cases and deaths, and ongoing geographic expansion across Ituri and North Kivu provinces. Transmission remains concentrated in major hotspot health zones, particularly Bunia, Mongbwalu, and Rwampara, while spread into newly affected health zones highlights continued expansion beyond the initial epicentres. Although surveillance, laboratory, logistics, and treatment operations continue to scale up, response efforts remain constrained by low contact follow-up rates, increasing pressure on treatment capacity, shortages of key supplies, insecurity, population mobility, and community resistance in affected areas. In Uganda, no new confirmed cases were reported during the reporting period, suggesting relative stabilization; however, the continued epidemiological link to transmission in the Democratic Republic of the Congo underscores the ongoing risk of cross-border spread and secondary transmission. Sustained operational, financial, and security support will remain critical to interrupt transmission and prevent further spread.

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