Public health risk assessment related to Ebola disease due to Bundibugyo virus: implications for the Americas Region

18 June 2026

Risk assessment based on data available as of 7 June 2026 (Uganda) and 6 June 2026 (Democratic Republic of the Congo)

Overall risk
Regional
Low

Confidence in available information
Regional
High

General risk statement

This public health risk assessment aims to assess the current public health risk for the Americas associated with the ongoing outbreak of Ebola disease caused by Bundibugyo virus (BDBV) in the Democratic Republic of the Congo and Uganda.

This risk assessment was conducted considering, among others, the following criteria: (i) the potential risk to human health following an imported case in the Americas, including the clinical, virological and epidemiological behavior of the disease, the risk of exposure, and measures of magnitude and severity based on the increasing trend in confirmed cases in the countries with documented Bundibugyo virus disease (BVD) transmission; (ii) the risk of importation and the potential spread in the Americas, particularly in the context of the FIFA World Cup 2026™ (11 June–19 July) and (iii) the risk to public health in the light of early detection, prevention, and control capacities in the Americas Region.

On 5 May 2026, WHO detected reports of an unusual cluster of severe illness and deaths in Mongbwalu Health Zone (HZ), a rural gold-mining area in Ituri Province, northeastern Democratic Republic of the Congo, bordering with South Sudan and Uganda. Retrospective investigation identified 246 suspected cases and 80 deaths (case fatality rate [CFR] 32.5%) from three health zones (Mongbwalu, Rwampara, and Bunia). On 14–15 May 2026, 13 laboratory-confirmed cases of non-Zaire Ebola disease were reported; genetic sequencing confirmed Bundibugyo virus (BDBV) as the causative agent *(1)*. On 17 May 2026, the event was determined to constitute a public health emergency of international concern (PHEIC) by the WHO Director-General *(2, 3)*. On 22 May 2026, WHO Director-General issued temporary recommendations accordingly *(4)*, and guidance on the implementation of the temporary recommendations have been published *(5, 6)*.

As of 6 June 2026, the outbreak in the Democratic Republic of the Congo had expanded further, with 515 confirmed cases including 91 confirmed deaths (CFR 17.7%) across 25 health zones in three provinces: Ituri remains the most affected, with 487 confirmed cases, followed by North Kivu, with 25 confirmed cases, and South Kivu, with three confirmed cases *(7)*. As of 7 June 2026, Uganda reported a cumulative total of 19 confirmed cases and one probable case, including two confirmed deaths and one probable death (CFR 10.5% among confirmed cases; 15.0% combined), with cases linked to travel from the Democratic Republic of the Congo *(8).*

Since the start of the current outbreak, no cases of BVD have been reported in any country in the Region of the Americas. Although there are no direct commercial air routes linking affected countries to the Americas, importation remains possible; however, any introduction would require indirect, multi-leg travel, which likely reduces its probability. Cases of Ebola disease caused by Ebola virus have previously been detected and managed in the Americas following an importation via commercial air travel from Africa (United States of America in 2014) *(9, 10)*. Notably, these cases were detected and contained without a licensed vaccine or specific therapeutic available at the time — the same constraint that applies to Bundibugyo virus today — underscoring both the feasibility of intercontinental introduction and the central role of preparedness, early detection, and infection prevention and control.

The overall risk posed by this event to the Americas Region is classified as "Low" with a "High" confidence level based on the available information.

The risk assessment will be reviewed if more epidemiological, clinical, or virological information becomes available.

Criteria		Assessment		Risk	Rationale
		Likelihood	Consequences		
Potential risk to human health	**Regional**	Unlikely	Minor	Low	• BVD is associated with severe illness and high case fatality. The case fatality rates in the past two BVD outbreaks were 30% and 50% respectively *(1, 11)*. • There is no licensed vaccine, no monoclonal antibody treatment or specific therapeutic for BVD. Only intensive supportive care is available *(1, 11)*. • As of 6 June 2026, a total of 515 confirmed cases including 91 confirmed deaths (CFR 17.7%) had been reported in the Democratic Republic of the Congo across 25 health zones in three provinces. As of 7 June 2026, Uganda reported a cumulative total of 19 confirmed cases and one probable case, including two confirmed deaths and one probable death (CFR 10.5% among confirmed cases; 15.0% combined), with at least three of the confirmed cases linked to travel from the Democratic Republic of the Congo *(7, 8)*. • Healthcare worker infections indicate transmission in healthcare settings and inadequate implementation of infection prevention and control (IPC) measures. • No cases of BVD have ever been detected in the Americas Region. The geographic distance and absence of direct sustained travel links between the affected areas in the Democratic Republic of the Congo (Ituri, North Kivu, South Kivu) and Uganda (Kampala, Wakiso) and cities in the Americas substantially reduce the probability of importation. However, Kampala is a major regional aviation hub with substantially greater international connectivity than Ituri and should be monitored as the operational center of gravity of the outbreak evolves. • Historical precedent from the 2014 Ebola virus importation to the United States resulted in nosocomial transmission. • The Americas Region has experience with Ebola disease preparedness, clinical care and IPC protocols, and isolation capacity in secondary and tertiary referral centers — including capacity built and lessons learned following the 2014 Ebola virus importations to the United States — which would mitigate human health consequences if an imported case were identified.

Criteria		Assessment		Risk	Rationale
		Likelihood	Consequences		
Risk of dissemination	**Regional**	Unlikely	Minor	Low	• As of 7 June 2026, the outbreak remains geographically restricted to the Democratic Republic of the Congo and Uganda. While the likelihood of BVD case importation into the Americas Region is considered low, the possibility cannot be entirely excluded. • With respect to international travel, there are currently no direct commercial air routes linking countries with documented BVD transmission to the Americas Region. Entebbe International Airport serves as Uganda's principal international hub, with onward connections to major African hubs (Addis Ababa), European hubs (Istanbul, London, Paris), and Gulf transit hubs (Doha, Dubai). Addis Ababa functions as the primary gateway for onward travel to the Americas. Consequently, any potential introduction of BVD into the Region would most likely occur via indirect, multi-leg itineraries, which may increase opportunities for case detection en route and thereby reduce the overall risk of importation. Within the Region of the Americas, the United States of America, Brazil, and Canada are assessed as having the highest relative exposure, owing to their international connectivity and passenger volumes, followed by Mexico, Colombia, Panama, Chile, Peru, and Argentina. • The FIFA World Cup 2026™, commencing on 11 June 2026, convenes millions of individuals across multiple host cities in Canada, Mexico, and the United States, representing one of the largest mass gathering events globally. In such contexts, public health risks may be amplified by increased international travel, close interpersonal contact among attendees, and heightened demand on health services. • On 28 May 2026, Canada, Mexico, and the United States, as host countries of the FIFA World Cup 2026™, issued a joint

					statement announcing harmonized public health travel measures for persons arriving from the African countries with documented transmission (Uganda and the Democratic Republic of the Congo) or areas assessed to be at highest risk of BVD transmission (South Sudan). The stated objective of these measures is to safeguard residents and visitors during the tournament, while maintaining essential cross-border travel, trade, and commerce. Canada applied measures for 90 days, Mexico applied measures for 60 days for non-Mexican nationals or residents who had been in those countries and the United States of America applied measures for 30 days for non-U.S. persons who had been in those countries within the preceding 21 days *(12-15)*. Other International Health Regulations (IHR) States Parties that have adopted international border measures include Antigua and Barbuda and Saint Kitts and Nevis for a list of African countries *(16-17)*. • Other public health measures to mitigate the risk of BVD importation are implemented in the region as follows *(18-35)*: 1) enhanced surveillance and preparedness activities at points of entry: the Bahamas, Barbados, Belize, Chile, the Dominican Republic, Ecuador, Jamaica, Paraguay, Peru, Saint Vincent and the Grenadines, and Uruguay. 2) travel advisory issuance: the Bahamas, Belize, Brazil, Costa Rica, Jamaica, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, and Venezuela have issued travel health advisories. 3) risk based quarantine: the Bahamas, Barbados, Canada, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, and the United States. • The incubation period for BVD is 2–21 days and the requirement for close contact with bodily fluids of a symptomatic case for transmission make widespread dissemination from a single imported case unlikely, especially with early detection and effective IPC measures *(11)*.

Criteria		Assessment		Risk	Rationale
		Likelihood	Consequences		
Risk of insufficient prevention and control capacity with available resources	**Regional**	Unlikely	Minor	Low	• Currently available Ebola virus-specific vaccines and therapeutics are not effective against other ebolaviruses. • Several countries in the Americas have demonstrated capacity to detect (under the required biosafety measures) and manage Viral Hemorrhagic Fevers (VHF) endemic to the region — including arenavirus diseases (e.g., Argentine, Bolivian, Venezuelan and Brazilian Hemorrhagic Fevers), hantavirus cardiopulmonary syndrome, and yellow fever. However, less-resourced countries in the Americas may face greater challenges if an imported case were detected, particularly regarding specialized laboratory diagnostics (RT-PCR for BVD), isolation facilities, and clinical management teams with VHF experience. • All countries in the Americas are updating plans to manage suspected traveler cases and sample transportation to regional labs.

Background information

Hazard assessment

Ebola Bundibugyo virus disease
Ebola Bundibugyo virus disease (BVD) is a severe viral haemorrhagic disease caused by Bundibugyo virus (BDBV), a member of the genus *Orthoebolavirus* (family Filoviridae). To date, six species within the *Orthoebolavirus* genus have been identified; three of which — Ebola virus, Sudan virus, and Bundibugyo virus — have been responsible for most large Ebola disease outbreaks in Africa *(11)*. The current outbreak is the third recognized BVD outbreak globally: the first occurred in Bundibugyo District, Uganda (2007–2008), and the second in the Democratic Republic of the Congo (2012). Together, previous BVD outbreaks resulted in more than 200 confirmed and probable cases and approximately 66 deaths (CFR 33%) *(1)*. BDBV has a zoonotic origin; different species of bats are considered the most likely natural hosts of ebolaviruses, though the exact animal reservoir for BDBV has not been conclusively identified. The virus is

transmitted to humans through close contact with the blood or body fluids of infected wildlife and then spreads through human-to-human transmission via direct contact with bodily fluids. Traditional burial practices involving direct contact with the body of a deceased person can also spread infection *(11)*.

The incubation period varies from 2 to 21 days. Symptoms appear suddenly and include fever, fatigue, muscle aches, headache, and sore throat, followed by vomiting, diarrhea, rash, and signs of kidney and liver failure; hemorrhagic manifestations occur in some cases *(11)*. Confirmation requires specialized laboratory testing, primarily RT-PCR assays to detect viral RNA. The GeneXpert Ebola assay (Zaire ebolavirus–specific), widely available in the Democratic Republic of the Congo and the Americas, do not detect BDBV *(36, 37)*.

Treatment for BVD is supportive; early access to medical care improves survival. No monoclonal antibody treatments are specifically approved for BVD and there is no licensed vaccine. Currently approved vaccines and monoclonal antibodies are specific to EBOV (*Orthoebolavirus zairense)* and are not expected to be effective against BDBV *(11)*.

BVD has never been detected in the Americas *(38)*. The natural reservoir hosts (fruit bats of the family *Pteropodidae* and other bat species) associated with BDBV are not known to be established in the Americas *(11)*. There is no evidence of sylvatic reservoir for any *Orthoebolavirus* species in the Americas.

Exposure assessment

On 5 May 2026, WHO detected an unusual cluster of severe illness and deaths in Mongbwalu Health Zone (HZ), Ituri Province, northeastern Democratic Republic of the Congo. Retrospective investigation (15 April–13 May 2026) identified 246 suspected cases and 80 deaths (CFR 32.5%) from three health zones. Eight healthcare workers at Rwampara developed compatible symptoms after attending patients from Mongbwalu HZ. Of 20 samples tested at the National Institute of Biomedical Research (INRB, Institut National de Recherche Biomédicale) in Kinshasa, 13 were laboratory-confirmed; genetic sequencing on 15 May 2026 identified BDBV as the causative agent *(1).*

As of 6 June 2026, the outbreak in the Democratic Republic of the Congo had expanded further, with 515 confirmed cases including 91 confirmed deaths (CFR 17.7%) reported across 25 health zones in three provinces: Ituri remains the most affected with 487 confirmed cases, followed by North Kivu with 25 cases, and South Kivu with three cases *(7).* The cumulative suspect-case count is undergoing harmonization by national authorities and is not currently published; 223 suspected deaths last reported on 27 May remain under investigation *(7).* As of 7 June 2026, Uganda reported 19 confirmed cases and one probable case, with two confirmed deaths and one probable death (CFR 10.5% among confirmed cases; 15.0% combined), with cases linked to travel from the Democratic Republic of the Congo *(8).*

Contact tracing has expanded substantially. As of 6 June 2026, a cumulative total of 5,040 contacts had been listed across the three affected provinces in the Democratic Republic of the Congo, of whom 2,535 (50.3%) remained under active follow-up; activities continue to face significant operational challenges due to insecurity, population movement, and access constraints in the affected areas. In Uganda, as of 7 June 2026, 454 contacts were under active follow-up and 371 had completed their 21-day follow-up period *(8).*

No exposure has been documented in the Americas. The two evacuated physicians (U.S. nationals) who were being cared for outside the Americas have both been discharged following the 21-day quarantine *(39)*.

Context assessment

The outbreak is occurring mainly in Ituri Province in northeastern Democratic Republic of the Congo, an area historically affected by recurrent Ebola outbreaks and located within an Ebola ecological corridor extending into western Uganda. The affected health zones are situated in a highly connected cross-border area characterized by substantial population movement related to mining, informal trade, displacement, and routine cross-border travel. In Ituri alone, 1.2 million people need health assistance. There are 4 million people in need of urgent humanitarian assistance and over 2 million people who have been forcibly displaced in both Ituri and North Kivu provinces alone. Bunia serves as a major referral, transport, and commercial hub, and confirmation of unlinked imported cases in Kampala underscores the strong connectivity between Ituri Province and major urban centers.

The Region of the Americas has no direct travel routes that would facilitate rapid case importation without transit through European or Middle Eastern hubs. The 2014 West Africa Ebola virus disease epidemic (Ebola virus) demonstrated that the health system could manage and contain imported cases, though nosocomial transmission occurred in Texas before full containment. The PHEIC declaration heightened risk perception, prompting Member States to take proactive preparedness measures. Some have already arranged to detect, assess, report, and manage travelers with unexplained febrile illness from areas with documented BVD cases.

A defining contextual factor for this assessment is the FIFA World Cup 2026™, hosted by Canada, Mexico, and the United States starting 11 June 2026, drawing millions of international travelers and substantially increasing cross-border population movement into and among the three host countries during the event period — conditions that can elevate the likelihood of case importation and the demand for health services. This contextual risk is partially

mitigated by established preparedness capacity: since 2023, the Pan American Health Organization (PAHO) has convened a Health Security Working Group with the three host countries, including delegates from the health sector, other national authorities, and FIFA, to strengthen mass-gathering preparedness and to share information for health planning of high-visibility events.

Through eight meetings held between July 2023 and May 2026, alongside technical webinars on lessons learned from previous mega-events, security coordination, event-based surveillance, and mass-gathering preparedness, the Working Group has developed an enhanced surveillance strategy that includes a daily report covering the period before, during, and after the tournament to support early detection and coordinated response across the host countries. On 28 May 2026, in the context of the WHO declaration of a public health emergency of international concern (PHEIC) related to the Ebola disease epidemic caused by the Bundibugyo virus in the Democratic Republic of the Congo and Uganda, PAHO convened an extraordinary meeting of the Working Group, underscoring the importance of sustained surveillance, preparedness, and cross-border coordination ahead of the tournament *(40)*.

Table 1. Strengths and vulnerabilities of countries and territories in the Americas Region with regard to Ebola disease due to Bundibugyo virus, June 2026.

Strengths	Vulnerabilities
Surveillance and Alert • PAHO has activated epidemiological alert mechanisms across Member States, publishing two epidemiological alerts including recommendations for Member States *(41)*. • IHR National Focal Points are operational in all 35 PAHO/WHO Member States. • Several countries in the region have surveillance capabilities that have enabled them to respond immediately and effectively should an imported case be identified and quickly implement control measures like isolation of cases and contact tracing.	**Surveillance and Alert** • Smaller and less-resourced countries in the Americas may face greater challenges if an imported case were detected, particularly regarding specialized laboratory diagnostics (RT-PCR for BDBV), specialized isolation facilities, and clinical management teams with VHF experience.
Laboratory • There are two PAHO/WHO Collaborating Centers (PAHO/WHO CC) for viral hemorrhagic fevers in the Americas, and at least three additional reference labs with capacity to receive and process samples. • Based on a risk assessment and biosafety protocols, RT-PCR for BDBV might be rapidly implemented in selected countries. • As part of the laboratory support and technical expertise provided by PAHO, technical guidance has recently been developed and disseminated on selection, collection, preservation, and transport of clinical samples suspected of Ebola virus disease *(42)*.	**Laboratory** • Near-point-of-care molecular tests and rapid antigen tests either do not detect or are not validated for BDBV. • To date, confirmatory RT-PCR for BDBV is available only in select reference laboratories. • Limited number of couriers and transport companies for Category A samples.
Clinical Management and IPC • Availability of trained referral hospitals and specialized teams. Several countries in the Americas have biocontainment units for managing VHF. • Clinical care guidance and IPC protocols for VHF are established and practiced in major referral hospitals, informed by the 2014 Ebola response. New WHO filovirus guideline due imminently. • Improved IPC programs after the COVID-19 pandemic.	**Clinical Management and IPC** • No approved vaccine or specific therapeutic exists for BDBV. Ebola virus-specific countermeasures would not be effective. • Limited experience in Latin America and the Caribbean (LAC) managing Ebola patients. Most countries in the Americas have conducted simulations and tabletop exercises rather than managing confirmed cases. • Potential personal protective equipment (PPE) stock shortages within the region threaten the operational readiness of designated Ebola disease treatment centers. • Limited availability of biocontainment units outside United States or Canada. Most LAC countries would need to repurpose intensive care unit (ICU) or referral hospital capacity to manage Ebola cases, potentially affecting routine critical care and other ongoing health emergencies

Strengths	Vulnerabilities
Risk Communication and Community Engagement • PAHO and national health authorities have established risk communication and community engagement (RCCE) mechanisms; media briefings and public advisories have been issued. • PAHO published in 2014 a risk communication plan describing the possible risk communication activities supporting the public announcement of a possible first case of Ebola diagnosed in the Region *(43)*.	**Risk Communication and Community Engagement** • Risk of public misinformation and stigmatization of travelers from Africa, as observed during the 2014 Ebola epidemic and COVID-19 pandemic. • Large African diaspora communities in the Americas may face heightened stigma or anxiety during outbreak response.
Points of Entry (PoE) and Border Health • Entry airports in the United States: Washington-Dulles International Airport (IAD), Hartsfield-Jackson Atlanta International Airport (ATL), George Bush Intercontinental Airport (IAH), John F. Kennedy International Airport (JFK) among others Sao Paulo-GRU, have activated Ebola preparedness protocols and updated contingency plans • On 28 May 2026, a joint statement was released indicating the United States, Canada and Mexico will apply aligned public-health travel measures for people coming from African regions at highest Ebola/BVD risk, aiming to protect residents and FIFA World Cup 2026™ visitors while keeping cross-border travel and commerce functioning *(12)*. • Ahead of the preparation of the FIFA World Cup 2026™, Mexico, Canada and the USA performed mass gathering risk assessment, including the BVD potential risk. • The WHO/PAHO FIFA World Cup 2026™ travel health advisory has been revised to include BVD, and a daily situation report is published on the WHO Event Information Site for IHR National Focal Points (EIS) secured platform.	**Points of Entry (PoE) and Border Health** • The FIFA World Cup 2026™ (11 June–19 July) will significantly increase passenger volumes at PoEs in the three host countries.

References

1. World Health Organization. Disease Outbreak News: Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda, 16 May 2026. Geneva: WHO; 2026. Available from: https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON602.

2. World Health Organization. Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern. WHO: Geneva; 2026. Available from: https://www.who.int/news/item/17-05-2026-epidemic-of-ebola-disease-in-the-democratic-republic-of-the-congo-and-uganda-determined-a-public-health-emergency-of-international-concern.

3. World Health Organization. Disease Outbreak News: Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda, 29 May 2026. Geneva: WHO; 2026. Available from: https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON605.

4. World Health Organization. First meeting of the IHR Emergency Committee regarding the epidemic of Ebola Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda 2026 - Temporary recommendations, 22 May 2026. Geneva: WHO; 2026. Available from: https://www.who.int/news/item/22-05-2026-first-meeting-of-the-ihr-emergency-committee-regarding-the-epidemic-of-ebola-bundibugyo-virus-disease-in-the-democratic-republic-of-the-congo-and-uganda-2026-temporary-recommendations.

5. World Health Organization. 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. Geneva: WHO; 2026. Available from: https://iris.who.int/items/b07def43-df30-41b8-83e0-deb33bcfd697.

6. World Health Organization. WHO guidance for mass gathering events attended by individuals from areas with documented Bundibugyo virus detection, May 2026. Geneva: WHO; 2026. Available from: https://www.who.int/publications/i/item/B09770.

7. Democratic Republic of the Congo, Institut National de Santé Publique. Rapport de Situation de la 17ème épidémie de la maladie a virus EBOLA/ RDC, SitRep N°023/MVB du 06/06/2026. Kinshasa: INSP; 2026. Available from: https://insp.cd/sitrep-n23-mvb_06-06-2026/.

8. The Republic of Uganda Ministry of Health. Ebola Updates. Kampala: MOH; 2026 [cited 7 June 2026]. Available from: https://evd-daily.health.go.ug/.

9. World Health Organization. Disease Outbreak News: Ebola virus disease — United States of America, 1 October 2014. Geneva: WHO; 2014. Available from: https://www.who.int/emergencies/disease-outbreak-news/item/01-october-2014-ebola-en .

10. Chevalier MS, Chung W, Smith J, Weil LM, Hughes SM, Joyner SN, et al. Ebola virus disease cluster in the United States — Dallas County, Texas, 2014. MMWR Morb Mortal Wkly Rep. 2014;63(46):1087–8. Available from: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm63e1114a5.htm.

11. World Health Organization. Ebola disease, Key facts. Geneva: WHO; 2025 [cited 2 June 2026]. Available from: https://www.who.int/news-room/fact-sheets/detail/ebola-disease.

12. United States Department of State, Office of the Spokesperson. Joint statement on public health travel measures ahead of FIFA World Cup 2026, 28 May 2026. Washington, D.C.: U.S. Department of State; 2026. Available from: https://www.state.gov/releases/office-of-the-spokesperson/2026/05/joint-statement-on-public-health-travel-measures-ahead-of-fifa-world-cup-2026/.

13. United States Centers for Disease Control and Prevention. Information for travelers returning from Ebola-affected areas. Atlanta: U.S. CDC; 2026 [cited 10 June 2026]. Available from: https://www.cdc.gov/ebola/situation-summary/returning-travelers.html.

14. Public Health Agency of Canada. Ebola disease: border measures for travellers entering Canada. Ottawa: PHAC; 2026 [cited 10 June 2026]. Available from: https://www.canada.ca/en/public-health/services/diseases/ebola/border-measures.html.

15. Secretaría de Gobernación de México, Instituto Nacional de Migración. Oficio No. INM/DGCVM/1414/2026: Instrucción de restricción de ingreso ante riesgos sanitarios. Ciudad de México: Secretaría de Gobernación; 2026.

16. Government of Antigua and Barbuda. Report from the Cabinet of Antigua and Barbuda meeting of Wednesday 27 May 2026. St. John's: Government of Antigua and Barbuda; 2026. Available from: https://embassy.ag/dario-item-antigua-barbuda-report-from-the-cabinet-of-antigua-and-barbuda-meeting-of-wednesday-27th-may-2026/.

17. Saint Kitts and Nevis Information Service. Travel advisory, 27 May 2026. Basseterre: SKNIS; 2026. Available from: https://www.sknis.gov.kn/2026/05/27/st-kitts-nevis-travel-advisory/

18. The Government of the Bahamas Ministry of Foreign Affairs. Ebola Bundibugyo virus disease in the Democratic Republic of the Congo and surrounding countries, 26th May 2026 Ebola Bundibugyo Virus Disease in the Democratic Republic of the Congo & Surrounding Countries. Nassau: MOFA; 26 May 2026. Available from: https://mofa.gov.bs/ebola-bundibugyo-virus-disease-in-the-democratic-republic-of-the-congo-surrounding-countries/.

19. Barbados Government Information Service. Update on Ebola risk assessment and Barbados' preparedness. Bridgetown: GIS; 2026. Available from: https://gisbarbados.gov.bb/blog/update-on-ebola-risk-assessment-barbados-preparedness/.

20. Government of Belize Press Office. Ministry of Health and Wellness Advisory on Ebola. Belmopan: Government of Belize Press Office; 2026. Available from: https://www.pressoffice.gov.bz/ministry-of-health-and-wellness-advisory-on-ebola/.

21. Presidencia de la República Dominicana. República Dominicana fortalece vigilancia epidemiológica y protocolos preventivos ante alerta internacional por ébola. Santo Domingo: Presidencia de la República Dominicana; 2026. Available from: https://presidencia.gob.do/noticias/republica-dominicana-fortalece-vigilancia-epidemiologica-y-protocolos-preventivos-ante.

22. Ministerio de Salud Pública de Ecuador. Ecuador fortalece la comunicación para enfrentar al ébola y chikungunya. Quito: MSP; 2026. Available from: https://www.salud.gob.ec/ecuador-fortalece-la-comunicacion-para-enfrentar-al-ebola-y-chikungunya/.

23. Ministerio de Salud Pública de Ecuador. Ministerio de Salud ha capacitado a 674 personas como parte del plan de preparación frente al ébola. Quito: MSP; 2026. Available from: https://www.salud.gob.ec/ministerio-de-salud-ha-capacitado-a-674-personas-como-parte-del-plan-de-preparacion-frente-al-ebola/.

24. Jamaica Ministry of Health and Wellness, Jamaica Information Service. Health alert: travel caution to Ebola-affected countries. Kingston: MOHW; 28 May 2026. Available from: https://jis.gov.jm/health-alert-travel-caution-to-ebola-affected-countries/.

25. Ministerio de Salud Pública y Bienestar Social de Paraguay. Salud refuerza la vigilancia sanitaria en puntos de entrada al país y emite recomendaciones. Asunción: MSPBS; 2026. Available from: https://dgvs.mspbs.gov.py/salud-refuerza-la-vigilancia-sanitaria-en-puntos-de-entrada-al-pais-y-emite-recomendaciones/.

26. Ministerio de Salud de Perú. Recomendaciones para viajeros internacionales; 2026. Lima: MINSA; 2026. Available from: https://www.dge.gob.pe/portalnuevo/recomendaciones-para-viajeros-internacionales/.

27. Saint Vincent and the Grenadines Ministry of Health, Wellness, Environmental Health and Energy. Public communication on Ebola preparedness. Kingstown: SVG Health; 2026. Available from: https://www.facebook.com/SVGHEALTH/posts/pfbid0dx3p5XguvdaTsYC23vJ1ZNEpPesPnt3a5sXPR59etr2BDA1rebE6rrPWfP5iQjwwl.

28. Ministerio de Salud Pública de Uruguay. MSP monitoriza la evolución del brote de Ébola, declarado Emergencia de Salud Pública por parte de la OMS. Montevideo: MSP; 2026. Available from: https://www.gub.uy/ministerio-salud-publica/comunicacion/noticias/msp-monitoriza-evolucion-del-brote-ebola-declarado-emergencia-salud-publica.

29. Agência Nacional de Vigilância Sanitária do Brasil. Nota técnica nº 26/2026: Febres Hemorrágicas Virais (FHV). Brasilia: ANVISA; 2026. Available from: https://www.gov.br/anvisa/pt-br/assuntos/paf/vigilancia-epidemiologica/alertas-epidemiologicos/vigentes/nota-tecnica-no-26-2026-febres-hemorragicas-virais.

30. Agência Nacional de Vigilância Sanitária do Brasil. Anvisa atualiza norma para medidas de saúde em portos e aeroportos. Brasilia: ANVISA; 2026. Available from: https://www.gov.br/anvisa/pt-br/assuntos/noticias-anvisa/2026/anvisa-atualiza-norma-para-medidas-de-saude-em-portos-e-aeroportos.

31. Ministério da Saúde do Brasil. Dois casos suspeitos de ebola são descartados no Brasil. Brasilia: MS; 2026. Available from: https://www.gov.br/saude/pt-br/canais-de-atendimento/sala-de-imprensa/notas-a-imprensa/2026/dois-casos-suspeitos-de-ebola-sao-descartados-no-brasil.

32. Ministerio de Salud de Costa Rica. Costa Rica sin casos de Ébola; Salud pide mantener prevención. San José: MS; 2026. Available from: https://www.ministeriodesalud.go.cr/index.php/prensa/67-noticias-2026/2439-costa-rica-sin-casos-de-ebola-salud-pide-mantener-prevencion.

33. Government of Saint Lucia. Saint Lucia issues travel advisory for Ebola virus disease. Castries: Government of Saint Lucia; 2026. Available from: https://www.govt.lc/news/saint-lucia-issues-travel-advisory-for-the-ebola-virus-disease.

34. Ministerio del Poder Popular para la Salud de la República Bolivariana de Venezuela. Ébola virus. Caracas: MPPS; 2026. Available from: https://mpps.gob.ve/wp-content/uploads/2026/05/Ebolavirus.pdf.

35. Mexico government, Federal Ministry of Health. Travel Health Notice Ebola Virus Disease (EVD). Ciudad de México: Gobierno de México; 2026. Available from: https://www.gob.mx/cms/uploads/attachment/file/1081323/APV-EVE-28MAY2026_Actualizacion.pdf.

36. Pan American Health Organization/World Health Organization. Epidemiological Alert: Ebola Disease due to Bundibugyo virus in the Democratic Republic of the Congo and Uganda, 21 May 2026. Washington, D.C.: PAHO/WHO; 2026. Available from: https://www.paho.org/en/documents/epidemiological-alert-ebola-disease-due-bundibugyo-virus-democratic-republic-congo-and.

37. World Health Organization. Disease Outbreak News: Ebola disease caused by Bundibugyo virus - Democratic Republic of the Congo, 21 May 2026. Geneva: WHO; 2026. Available from: https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON603.

38. Pan American Health Organization/World Health Organization. Public Health Emergency of International Concern (PHEIC) related to Bundibugyo virus disease in the Democratic Republic of the Congo and Uganda. Implications for the Americas Region, 17 May 2026. Washington, D.C.: PAHO/WHO; 2026. Available from: https://www.paho.org/en/documents/public-health-emergency-international-concern-pheic-related-bundibugyo-virus-disease.

39. United States Centers for Disease Control and Prevention. Ebola Outbreak: Current Situation. Atlanta: US CDC; 2026 [cited 10 June 2026]. Available from: https://www.cdc.gov/ebola/situation-summary/index.html.

40. Pan American Health Organization. PAHO supports regional coordination for health security ahead of FIFA World Cup 2026. Washington, DC: PAHO; 2026. Available from: https://www.paho.org/en/news/29-5-2026-paho-supports-regional-coordination-health-security-ahead-fifa-world-cup-2026.

41. Pan American Health Organization/World Health Organization. Epidemiological updates and alerts. Washington, D.C.: PAHO/WHO; 2026 [cited 7 June 2026]. Available from: https://www.paho.org/en/epidemiological-alerts-and-updates.

42. Pan American Health Organization. Ebola virus disease documents. Washington, D.C.: PAHO; 2026. Available from: https://www.paho.org/en/documents/topics/ebola-virus-disease.

43. Pan American Health Organization. Risk Communication Plan for the first case of Ebola. Washington, D.C.: PAHO; 2014. Available from: https://www.paho.org/en/documents/risk-communication-plan-first-case-ebola.