Quarterly Newsletter of the Association of Public Health Physicians of Nigeria

APHPN NEWSLETTER

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UPDATE FROM THE PRESIDENT

Sustaining Public Health Advocacy and effectively branding APHPN

Medical Elders and Esteemed Colleagues,
It gives me great joy to write this preface for our quarterly newsletter.
In the second quarter of 2026 APHPN has been very active.

With Media outings with the New Nigerian (April 8, 2026; pp. 18,), NTA Channel 24 (April 9, 2026), Leadership NG (April 10, 2026), NAN (April 27, 2026) the President and EXCO has been very active in keeping APHPN in the front burner of the national discourse on public health and development in Nigeria.

This is borne out of the belief that APHPN must consciously remain in the conversation for economic growth and development of our nation through the agency of public health.

The APHPN presidential visit to Kogi State was simply exceptional and met all the standard for this advocacy and strategic engagement at the sub-national level. The president applauds the efforts of the Kogi State branch for a well packaged event. We look forward to other States branches emulating this.

The APHPN Estate is making sustained progress following the groundbreaking ceremony in April. Members are enjoined to key into this laudable project involving the Federal Mortgage Bank of Nigeria, individual payment options and Solap Group. It provides a win win in real estate investment opportunities for the association and it's members.
A number of our members have received elevation in their workplaces, the Association rejoices with them, and enjoins them to be worthy ambassadors for public health.

To State branches that have had a change of APHPN leadership, this quarter, the National EXCO wishes them a successful tenure whilst thanking the former branch leadership for a job well done.

The APHPN continues to advocate to the political leadership in the Federal, State and local government levels to put public health and development in the front burner.

I urge the various State branches to ramp up their outreach, advocacy and public health education activities in showing their relevance in their respective states and branding APHPN positively to the various stakeholders within their sphere of influence and jurisdiction.

Whether in the academia, hospital, in the field or in administration; we as public health physicians should be poised to make a difference even in resource limited settings.

Let us all drive innovation for common good.

Welcome to the second half of 2026.

God bless you.

Dr Terfa Kene
APHPN President

Newsletter Highlights

Editorial Board

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UPDATE FROM THE SECRETARIAT 2nd Quarter, 2026

Dr. Augustine Ajogwu

On the 7th April each year the World Health Organization commemorate the World Health Day with a theme that reflects contemporary issue of global concern in order to raise global awareness and advocacy to improve health. The year's theme was **"Together for health,** Stand with Science". The theme focuses on the power of scientific innovation, global collaboration and evidence-based solutions.

Leaning on the Innovation, Common good, Service and Research as the watch word of the current leadership of the Association Public Health Physicians of Nigeria (APHPN), on the 7th April 2026, the President, Dr Terfa Kene led, the Executives, Stakeholders and Development partners to the ground-breaking ceremony of our proposed National Secretariat, Karshi, where the proposed APHPN Estate is located. The National Secretariat will be sitting on 1,200 Sqkm donated by Solap Groups. In the spirit of collaboration, as espoused by the world health organization theme of the year, the APHPN and Solap group will be working to ensure the completion of the project. The event, which was tagged; **LEGACY PROJECT,** attracted friends and well-wishers of APHPN and was a huge success. All hands therefore, need to be on deck to ensure the success of the project.

The ground breaking was done by High Chief Mike Duru Ejiogu FCICN, Onowu Igbo Land, CEO, CITYGATE GROUP, Abuja. In his remark, Mr Ejiogu was delighted to be associated with Association Public Health Physicians of Nigeria and pledge Two Trailer load of Cement to ensure the timely completion of the secretariat. Present at the ceremony was the president of Medical Women Association Nigeria, Dr Zainab Muhammad

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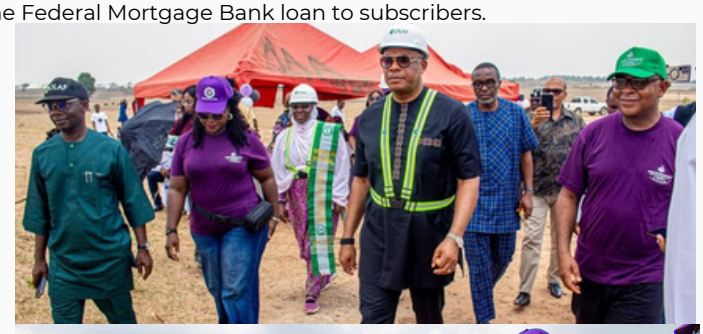
In the same vein, the APHPN estate project also commenced simultaneously with the ground breaking ceremony of the National secretariat legacy project. Individuals are then called to start subscribing by paying the first 30% of the cost of the building and spread the balance over Eight months. Also, those that could pay once, are welcome as well. Effort is being made to finalize the list for the Federal Mortgage Bank loan to subscribers.



Ground breaking Ceremony/ Foundation laying of the National Secretary by High Chief Mike Duru Ejiogu FCICN, Onowu Igbo Land, CEO, CITYGATE GROUP

The Address of the President During the Ground breaking Ceremony of the APHPN Estate and National Secretariat

By Dr Terfa Kene, President, Association of Public Health Physicians of Nigeria. To be performed by **High Chief Mike Duru Ejiogu FCICN, Onowu Igbo Land, CEO, CITYGATE GROUP**

Commemorating World Health Day with the Theme: **"Together for Health: Stand for Science"**

Distinguished guests, respected colleagues, partners in development, members of the media, ladies and gentlemen,

It is with great pleasure and a profound sense of purpose that I welcome you all to this historic occasion—the ground breaking ceremony of the APHPN Estate and National Secretariat.

Today, we gather not only to initiate a landmark project but also to commemorate World Health Day, a day that calls on all of us to reflect on our shared responsibility to advance the health and well-being of our populations. This year's theme, **"Together for Health: Stand for Science,"** resonates deeply with the mission and values of the Association of Public Health Physicians of Nigeria (APHPN).

As public health physicians, we are guided by science, driven by evidence, and committed to promoting policies and interventions that improve health outcomes for all Nigerians.

At a time when the world faces complex and evolving health challenges—from emerging infections, life style and urban housing related medical conditions like Vitamin D deficiency to climate-related health risks and the growing burden of non-communicable diseases—our collective resolve to stand for science has never been more critical.

The APHPN Estate and National Secretariat project we are unveiling today is a bold and strategic investment in the future of public health in Nigeria.

It is a partnership with **Solap Group** that have donated 1200 Sqm of land to the Association and as developers are ensuring our members own houses.

The National Secretariat will serve as:

Ø A hub for research, innovation, and policy engagement

Ø A centre for training and continuous professional development

Ø A platform for collaboration with government, academia, and development partners

Ø Legacy project for the next generation of public health physicians to leverage technology to provide telemedicine consultancy services to hard to reach populations

The APHPN Estate represents our commitment to the welfare and cohesion of our members, providing a supportive environment that fosters both professional excellence and personal well-being.

The APHPN Estate is proposed to have 70% members' ownership and 30% non-members ownership to allow families and the community access to competent healthcare personnel.

Together, these initiatives symbolize a new chapter for APHPN—one of growth, sustainability, and enduring impact.

We are particularly honoured today to have this ground breaking ceremony performed by High Chief Mike Duru Ejiogu FCICN, Onowu Igbo Land, CEO, CITYGATE GROUP, whose presence underscores the importance of partnership and leadership in advancing national development. We are grateful for your support and for identifying with our vision.

As we align with the theme "Together for Health: Stand for Science," let us reaffirm our commitment to collaboration, integrity, and evidence-based action. Let us continue to champion science as the foundation for health policy and practice in Nigeria.

As we break this ground today, we are not merely commencing construction—we are building a legacy, strengthening our association, and securing the future of public health in our country.

On behalf of the leadership and entire membership of APHPN, I invite **High Chief Mike Duru Ejiogu FCICN, Onowu Igbo Land, CEO, CITYGATE GROUP** to kindly perform the official ground breaking ceremony.

Thank you, and may we continue to **stand together—for health and for science.**

PUBLIC HEALTH SPOTLIGHT

Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda

The devastating Ebola outbreak that began in mid-2026 originated in the conflict-ridden, gold-mining hub of Mongbwalu in Ituri Province, eastern Democratic Republic of the Congo (DRC). The virus a rare Bundibugyo strain with no approved vaccine—spread undetected for weeks before spilling over into neighboring Uganda via cross-border travelers and migratory traders.

The Silent Spark in Mongbwalu

The tragedy began with a nurse in Bunia, the capital of Ituri Province, who fell severely ill in late April. Unknown to the local clinics which were critically lacking testing capabilities for rarer Ebola strains—the virus had already been quietly circulating in the remote mining regions. The nurse succumbed to the illness, and her body was repatriated to her hometown of Mongbwalu for a traditional funeral. Because communities largely mistook the disease for witchcraft or a mystical illness, mourners had widespread, unprotected contact with the body, accelerating the chain of transmission

The Human Toll and Regional Spread

By the time the DRC officially declared the 17th Ebola outbreak on May 15, hundreds of suspected cases had already materialized across health zones like Rwampara and Bunia. Deepening the crisis, armed militant groups operating in the region severely hampered humanitarian efforts.

The virus was carried across the porous border into Uganda via migratory miners, commercial drivers, and individuals seeking medical treatment in larger urban centers. By May 15, the first imported case was reported in Kampala, triggering an immediate cross-border health emergency. The outbreak has since resulted in over 1,100 confirmed cases across the DRC and dozens of imported or secondary cases in Uganda's capital and Wakiso district.

Situation at a glance

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo and Uganda continues to evolve rapidly, with increasing case numbers, geographic spread, and ongoing cross-border transmission. As of 27 May, a total of 906 suspected cases and 223 deaths among suspected cases have been reported in the Democratic Republic of the Congo. As of 29 May, a total of 134 confirmed cases, including nine in Uganda, with 18 deaths among the confirmed cases, have been reported across both countries. This is an additional 49 confirmed cases, eight confirmed deaths, 160 suspected cases and 47 suspected deaths since the last update on 21 May. In addition, there is one confirmed case, an individual from the United States of America, who had treated patients in the Democratic Republic of the Congo and is currently receiving care in Germany. In the Democratic Republic of the Congo, transmission is concentrated in Ituri, as well as North Kivu and South Kivu provinces, with challenges in contact tracing and follow-up, insecurity, inadequate isolation, care, and referral systems for patients complicating response efforts. National authorities, in collaboration with WHO and partners, are implementing response measures including deployment of rapid response teams, delivery of medical supplies, strengthened surveillance, laboratory confirmation, infection prevention and control, the set-up of safe and optimized treatment centers, and community engagement.

Dr Tedros Adhanom Ghebreyesus
Director-General of the World Health Organization (WHO)

Health zones affected by the Outbreak

The geographic heart of the crisis remains Ituri Province, which alone accounts for 1,054 of the confirmed cases. In towns like Bunia and Rwampara, as well as newly affected zones like Tchomia and Nia-Nia, emergency response teams from

Since the last update dated 21 May, an additional 42 confirmed cases including eight deaths and 160 suspected cases including 47 deaths have been reported from the Democratic Republic of the Congo. As of 27 May 2026, a total of 125 confirmed cases including 17 deaths (CFR 14%); and 906 suspected cases including 223 deaths have been reported from 13 health zones (HZ) in Ituri (7/36 HZ), North Kivu (5/35 HZ) and South Kivu Provinces (1/34 HZ) [1]. Sixteen confirmed cases have been reported among health and care workers to date. Epidemiological and laboratory investigations are ongoing to reclassify all suspected cases and deaths reported in the Democratic Republic of the Congo.

The outbreak remains concentrated in Ituri Province, which accounts for 88% (110) of confirmed cases. The highest confirmed case numbers in Ituri Province are reported from Bunia (37 cases), Rwampara (33 cases), Mongbwalu (20 cases), and Nyankunde (10 cases) HZ. Of the 17 deaths among confirmed cases in the Democratic Republic of the Congo, 10 were male (nine were over 15 years old and one under 15) and seven were female (five over 15 years old and two under 15).

A total of 774 samples have been collected as of 27 May. Of these, 648 samples (84%) have been analyzed, with 125 testing positive, representing a test positivity rate (TPR) of 19.2%. This is likely an underestimation of the actual positivity rate as over 100 samples are still awaiting testing and have been sent to Kinshasa for further analysis.

As of 27 May, 2635 contacts have been listed in Ituri and North Kivu provinces.

Security incidents against health facilities, and community resistance, have recently emerged as major operational challenges in Ituri Province, with three recent incidents reported in Mongbwalu and Rwampara HZ. These create additional risks for undetected transmission, disrupt outbreak response efforts, and reinforce the need to strengthen community protection and engagement activities

Devastating effects of the outbreak

The social fabric of the region has been devastated by the virus's specific path of transmission:

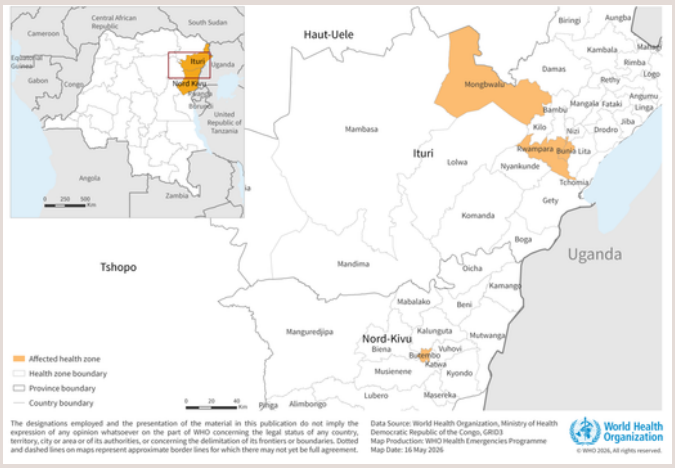
- Disproportionate Impact on Women: Women currently make up 60% of the suspected cases. Because they are traditionally the primary caretakers for sick relatives and are responsible for preparing bodies for traditional burials, they find themselves on the absolute frontlines of exposure.

- An Orphan Crisis: According to UNICEF, the outbreak has already left over 130 children entirely orphaned in Ituri Province alone, creating a secondary crisis of child protection and trauma in an area where 3 million youth are now at risk.
- Sacrifice of Health Workers: The local healthcare system has suffered devastating losses. Multiple doctors and nurses—whom the Congolese Ministry of Health honored as "courageous"—have died after treating patients in facilities lacking adequate isolation infrastructure or protective gear.

UNICEF and the World Health Organization are fighting a war on two fronts: the virus itself, and severe systemic instability.
Active militias and rebel groups in eastern DRC frequently disrupt contact tracing and block health workers from reaching remote villages. Compounding this, widespread community denial has severely delayed official tracking. Many local communities, operating under deep-seated trauma from years of war, initially labeled the terrifying physical symptoms as "witchcraft" or a "mystical illness". Rather than visiting medical centers, many infected individuals sought refuge in informal prayer centers or traditional healers, inadvertently turning these sanctuaries into hot zones for viral amplification.

Vaccine and Therapeutics

At present, there are no licensed vaccines or approved therapeutics specifically targeting Bundibugyo virus disease. WHO and partners are supporting accelerated research and development efforts to evaluate candidate vaccines and investigational therapeutics. Authorities in affected and at-risk countries are being encouraged to establish regulatory approvals and operational readiness for clinical trials and emergency use of investigational countermeasures should they become available.
Preparedness activities include strengthening cold-chain systems, identifying clinical trial sites, training healthcare workers in good clinical practice, and enhancing laboratory diagnostic capacity to support future vaccine and therapeutic studies.



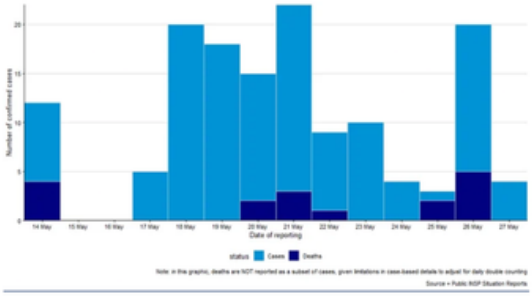
Current Containment and Response

Health authorities in the Democratic Republic of the Congo and Uganda have activated national emergency coordination mechanisms and established response operations to strengthen surveillance, laboratory testing, infection prevention and control (IPC), contact tracing and case management. WHO and international partners are supporting both countries through deployment of technical experts, provision of medical supplies and laboratory support, and reinforcement of emergency coordination systems.

Dedicated surveillance and response cells are being established in affected and at-risk health zones to improve early detection and rapid investigation of suspected cases. Enhanced disease surveillance is being prioritized, particularly for unexplained community deaths and clusters of febrile illness. Authorities are also intensifying contact tracing and monitoring activities in affected districts and border areas to limit further spread of the virus.
IPC measures are being reinforced in healthcare facilities following reports of suspected healthcare-associated transmission and deaths among healthcare workers. Efforts include systematic mapping of health facilities, triage systems, training for health workers on IPC, improved supervision, and distribution of personal protective equipment.

Cross-border collaboration is being intensified with joint preparedness measures including strengthened disease surveillance at border crossings, information sharing, rapid alert notification systems, simulation exercises and coordination of emergency response teams.

Figure 2: Number of confirmed cases (n=125) and deaths (n=17) by date of reporting in the Democratic Republic of the Congo as of 27 May 2026



Source: Ministry of Health, Democratic Republic of the Congo

NB: Newly reported confirmed cases/deaths may be part of the back log of samples waiting to be tested and therefore not necessarily newly acquired infections.

Uganda

The 2026 Uganda Ebola outbreak began as an imported crisis in mid-May 2026, driven by the rare, highly lethal Bundibugyo virus strain. Sparked by cross-border travel from mining hubs in the neighboring Democratic Republic of the Congo (DRC), the virus rapidly reached the capital city of Kampala. Aggressive containment protocols, including rapid isolation, contract tracing, and community engagement, were immediately deployed to break chains of transmission.
. Amid a deeply entrenched humanitarian and security crisis, a body carrying the Bundibugyo virus was moved from the mining corridors of the Ituri province in the DRC into a broader community, sparking a cascade of infections. Because this particular strain has no widely approved vaccines or specific antivirals, the virus moved with terrifying speed into the boarder communities of Uganda.

iWithin days, international porous borders were crossed. A symptomatic individual seeking specialized medical care traveled from the DRC into the Rwampara district of Uganda, while another traveler took public transit directly into the heart of Kampala. On May 15, 2026, clinical samples tested at the Central Emergency Surveillance and Response Support Laboratory in Wandegeya confirmed the diagnosis. The World Health Organization (WHO) swiftly declared a Public Health Emergency of International Concern.

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Epidemiology

Bundibugyo virus disease (BVD) is a severe and often fatal form of Ebola disease caused by the Bundibugyo virus, one of the Orthoebolavirus species. It is a zoonotic disease, with fruit bats suspected to be the natural reservoir. Human infection is thought to occur through close contact with the blood or secretions of infected wildlife, such as bats or non-human primates, and it subsequently spreads from person to person through direct contact with the blood, secretions, organs, or other bodily fluids of infected individuals or contaminated surfaces or items. Transmission is particularly amplified in health-care settings when infection prevention and control (IPC) measures are inadequate, and during unsafe burial practices involving direct contact with the deceased.

The incubation period for BVD ranges from 2 to 21 days, and individuals are not infectious until symptom onset. Early symptoms such as fever, fatigue, muscle pain, headache, and sore throat, are non-specific, which complicates clinical diagnosis and can delay detection. These symptoms then progress to gastrointestinal symptoms, organ dysfunction, and in some cases haemorrhagic manifestations. Case fatality rates in the past two BVD outbreaks, reported in Uganda and in the Democratic Republic of the Congo in 2007 and 2012, have ranged from approximately 30% to 50%.

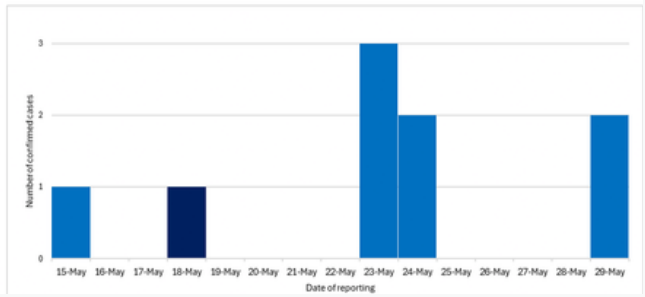
Differentiating BVD from other endemic febrile illnesses such as malaria is challenging without laboratory confirmation using PCR or antigen/antibody-based assays. Control relies on rapid case identification, isolation and care, contact tracing, safe burials, and strong community engagement, as no approved vaccines or specific treatments currently exist for BVD.

WHO risk assessment

On 22 May 2026, WHO assessed the risk of the outbreak of BVD to be very high at the national level in the Democratic Republic of the Congo, high at the regional level, and low at the global level. The risk assessment will be continuously reassessed in the coming days based on available and shared information.

For further information, please see the WHO Rapid Risk Assessment-Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo and Uganda v2.

Figure 3: Number of confirmed cases (n=9) and deaths (n=1) by date of reporting in Uganda as of 29 May 2026



WHO Advice

On 19 May 2026, the Director-General of WHO convened the first meeting of the IHR Emergency Committee, which issued the temporary recommendations on 22 May 2026 to States Parties. These recommendations underscore the importance of coordinated outbreak control, enhanced cross-border collaboration, and sustained surveillance and preparedness to prevent further regional spread and ensure an effective public health response

WHO advises against any restriction of travel to, or trade with, the Democratic Republic of the Congo or Uganda based on the currently available information. WHO continues to closely monitor and, where necessary, verify travel and trade measures in relation to this event.

For further information on the considerations for implementing border health and international travel-related temporary recommendations, please see the relevant technical note issued on 26 May 2026

Regular Information products on the outbreak of BVD in Democratic Republic of the Congo

- Daily update: Epidemiological update on BVD outbreak in Democratic Republic of the Congo and Uganda
- Published every Tuesday: Weekly External Situation Report on Ebola Bundibugyo Virus Disease Outbreak, Democratic Republic of the Congo | Uganda
- Published every Thursday:Disease Outbreak News | All Hazards Public Health Events, Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo
- Press Statements - Ministry of Health - Uganda

Nigeria's National Public Health Advisory on State Preparedness for Bundibugyo Ebola Virus Disease (EVD)

- The Nigeria Centre for Disease Control and Prevention (NCDC) drew the urgent attention to the evolving Bundibugyo Ebola Virus Disease (EVD) outbreak in the Democratic Republic of Congo and Uganda.
- The World Health Organization had declared the outbreak a Public Health Emergency of International Concern, which underscores the seriousness of the regional threat and the need for Nigeria to strengthen preparedness before any suspected case is detected within the country.
- The immediate objective of NCDCs national preparedness and readiness efforts is to ensure that every State and the FCT can reasonably detect, contain, and respond swiftly to any suspected case while protecting health workers and sustaining essential health services.
- Nigeria had no confirmed case of this outbreak at the time of this advisory. However, based on the Dynamic Risk Assessment conducted by NCDC and partners immediately after the PHEIC declaration, the overall risk of importation of the disease into Nigeria had been assessed as HIGH due to increasing on-going regional transmission, international travel, regional population movement, major airports, seaports, porous land borders, informal crossings, trade routes, and the overlap of early Ebola symptoms with common febrile illnesses such as malaria, Lassa fever, and other endemic infections.

Current Outbreak Situation

- A total of 1,077 suspected cases and 247 deaths have been reported in the DRC and Uganda. Case fatality is as high as 24.6%, and the age group mostly affected is 14–45 years. Regional and national risk remain high.
- Currently, there are no approved vaccines or specific treatments available for Bundibugyo Ebola virus disease. Control of the outbreak depends largely on rapid public health measures, including early detection, prompt isolation of suspected and confirmed cases, strict infection prevention and control (IPC) measures, contact tracing, safe burial practices, community engagement, and strong surveillance systems.
- Suspected cases have been reported in India, while Canada has announced a "temporary pause" on travel applications by residents of DRC, Uganda, and South Sudan due to the outbreak. Very recently, Uganda also announced border closure measures.

Implications for Nigeria

- The current Bundibugyo virus outbreak has no licensed vaccines or approved targeted therapeutics. Existing Ebola vaccines and monoclonal antibody treatments are primarily directed against the Zaire ebolavirus and should therefore not be relied upon as available countermeasures for this outbreak strain.
- Ebola Virus Disease is not airborne. Transmission occurs through direct contact with the blood or body fluids of a symptomatic or deceased infected person, contaminated materials, or infected animals. The incubation period ranges from 2 to 21 days; therefore, travel and exposure history within the preceding 21 days remains essential in the assessment of any suspected case.
- Early symptoms may be non-specific and include fever, fatigue, muscle pain, headache, sore throat, malaise, vomiting, diarrhea, abdominal pain, rash, hiccups, unexplained bleeding, bruising, or signs of shock. Health workers must not wait for bleeding before suspecting Ebola in any patient with compatible symptoms and relevant travel or exposure history.
- Additionally, the absence of strain-specific vaccines and approved therapeutics for Bundibugyo virus makes early, aggressive, optimized supportive care especially important. Clinical management should include rapid assessment, fluid and electrolyte management, glucose monitoring, treatment of malaria or bacterial co-infections where clinically indicated, management of shock, symptom control, and humane care in designated isolation or treatment settings.
- NCDC has activated its national Emergency Operations Centre, and it is currently in the alert mode, coordinating national preparedness with relevant federal and state institutions. State Governments, through your good selves, the Honourable Commissioners for Health are therefore requested to ensure immediate operational readiness across public and private health systems.

Accordingly, preparedness must focus on:

1. Early detection
2. Immediate isolation
3. Optimized supportive care
4. Strict infection prevention and control
5. Safe sample handling
6. Contact tracing readiness and safe referral systems
7. Risk communication and workforce protection.
8. Adequate provisions for medical countermeasures

Risk Stratification

- While all States and the FCT must maintain Ebola preparedness, the pace of readiness should reflect each State's importation and transmission risk. NCDC has therefore grouped States into three preparedness tiers:
- a. High Risk: Known Trade/travel routes with international airports/seaports, porous borders and ground crossing (Lagos, FCT, Rivers, Kano, Enugu, Borno, Akwa Ibom, Cross River, Taraba, and Adamawa.)
- b. Moderate Risk: Ogun, Nasarawa, Kaduna, Plateau, Kogi, Niger, Jigawa, Katsina, Bauchi, Ebonyi, Abia, and Bayelsa.
- c. Baseline Preparedness: All remaining States.
- This classification is intended to guide readiness prioritization while preserving the expectation that every State will act immediately on any suspected case. It is also important to note that this risk stratification may change as the situation evolves.

Required Actions for State Level Preparedness

- In the spirit of shared national preparedness, Honourable Commissioners are requested to provide leadership for coordinated Ebola readiness across their respective States and the FCT, with technical support from NCDC.
- NCDC will continue to provide national coordination, technical guidance, and escalation support, and we count on the leadership of Honourable Commissioners to translate this national posture into practical readiness across state health systems.
- Commissioners are requested to prioritize the following actions:
- 1. Activate the State public health coordination structure for Ebola preparedness.
- 2. Conduct a rapid state risk assessment, with attention to points of entry (where applicable), population movement, high-density settings, and facilities most likely to receive suspected cases.
- 3. Engage public and private health providers to ensure early suspicion, safe separation of suspected cases, and immediate notification through approved public health channels.
- 4. Identify at least one functional holding or isolation facility for suspected cases and ensure a clear referral pathway for safe transfer and further management.
- 5. Strengthen facility readiness for screening, PPE use, infection prevention and control, safe sample movement, ambulance transfer, decontamination, and waste management.
- 6. Ensure frontline workers are rapidly oriented and protected with appropriate PPE, supervision, exposure management procedures, and psychosocial support.
- 7. Intensify traveller monitoring and surveillance in States with airports, seaports, land borders, transport hubs, migrant corridors, and other high-mobility settings.
- 8. Lead calm and consistent public communication that promotes early reporting, discourages stigma and rumours, protects health workers, and directs the public to verified information.
- 9. Maintain essential health services by ensuring that screening, triage, isolation, and referral arrangements do not unnecessarily disrupt routine care.
- 10. Plan for the provision of adequate quantities of medical countermeasures, as may be necessary.
- 11. Submit a State readiness update to NCDC within 72 hours of receipt of this advisory and notify NCDC immediately of any suspected case, high-risk exposure, unusual febrile cluster, or significant readiness gap.
- To support rapid dissemination of this advisory, detailed operational tools will follow through the national and State EOC channels, including guidance on laboratory processes, PPE use, IPC, facility readiness, reporting formats, and public communication materials.
- States are requested to use this advisory to commence immediate preparedness actions while the supporting tools are distributed through the established incident coordination mechanisms.
- Nigeria's successful containment of previous Ebola importation was made possible by early recognition, decisive leadership, rapid coordination, disciplined contact tracing, strict infection prevention and control, and public trust.
- The window for preparedness is before the first suspected case is reported. I therefore urge all State Ministries of Health and Local Governments to treat this advisory as an immediate call to readiness, coordination, and disciplined public health action.

NCDC remains committed to working closely with all States and the FCT to protect Nigerians, support health workers, preserve essential services, and prevent importation or secondary transmission of Ebola Virus Disease.

Further Information

- 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
- The Ministry of Public Health, Hygiene and Social Welfare, DRC, officially declares the 17th Ebola Disease outbreak
- Message by the WHO Director-General to the people of the Democratic Republic of the Congo
- WHO Democratic Republic of Congo confirms new Ebola outbreak
- Weekly External Situation Report. EBOLA BUNDIBUGYO VIRUS DISEASE OUTBREAK Democratic Republic of the Congo | Uganda.
- Ebola Outbreak: Current Situation | Ebola | CDC
- Ebola disease fact sheet
- Disease Outbreak News. Ebola outbreak in Democratic Republic of Congo – update. WHO. 14 September 2012
- Disease Outbreak News. Ebola outbreak in Democratic Republic of Congo – update. WHO. 26 October 2012
- Disease outbreak news. Ebola disease caused by Bundibugyo virus - Democratic Republic of the Congo. 21 May 2026
- Framework and toolkit for infection prevention and control in outbreak preparedness, readiness and response at the national level
- Considerations for border health and points of entry for filovirus disease outbreaks:
- Diagnostic testing for Ebola and Marburg virus diseases: interim guidance, 20 December 2024
- Disease outbreak news. Ebola disease caused by Bundibugyo virus - Democratic Republic of the Congo and Uganda 16 May 2026
- WHO Launches Online Training to Strengthen Filovirus Outbreak Response
- Infection prevention and control guideline for Ebola and Marburg disease. WHO.17 May 2026
- Infection prevention and control and water, sanitation and hygiene in health facilities during Ebola or Marburg disease outbreaks: rapid assessment tool, user guide.
- Assessment and management of health and care workers with possible occupational exposures to Orthoebolavirus or Orthomarburgvirus: implementation guidance
- Optimized Supportive Care for Ebola Virus Disease. Clinical management standard operating procedures. WHO. 2019.
- National Public Health Advisory on State Preparedness for Bundibugyo Ebola Virus Disease (EVD). Abuja: Nigeria Centre for Disease Control and Prevention (NCDC); 2026. Available from: https://ncdc.gov.ng/news/537/national-public-health-advisory-on-state-preparedness-for-bundibugyo-ebola-virus-disease-%28evd%29

APPOINTMENTS, PROMOTIONS & CELEBRATIONS

Prof.Haroun Omeiza Isa
Reappointment as Provost,
College of Medicine -Birmingham University.
April, 2026

Dr. Dan Apagu
Appointment as Executive Secretary
FCT PHC Board.
April 2026

Dr. Nnenda Omeodu
Dean, School of Community Health and Allied Sciences, UPTH
May 2026

Prof. Chinyerem Cynthia Nwachukwu
Promotion to the rank of a Professor in Community Medicine by the Governing council of Chukwuemeka Odumegwu Ojukwu University(COOU) , Anambra State. She is also the Head of Department, Community Medicine.
June 2026
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Prof. Otaniyenuwa Eloghosa Obarisiagbon
Promotion to the rank of Professor in Public Health & Community Medicine by the Senate of the University of Benin. She is also the Head of Department, Community Medicine & Centre Leader CERHI.
June 2026

NEWS IN BRIEF

APHPN COLLABORATES WITH AFENET

The National Leadership of APHPN led by Dr Terfa Kene and accompanied by Dr Augustine Ajogwu, Dr Juliette Ango, Prof O. Wright and APHPN FCT (Dr Okoh and Dr Adegboye) had a breakfast meeting hosted by AFENET on April 17, 2026

APHPN, MHR FORGE LANDMARK PARTNERSHIP TO ADVANCE YOUTH SEXUAL AND REPRODUCTIVE

A historic Memorandum of Agreement signals renewed commitment to tackling SRHR, SGBV, and adolescent health challenges The Association of Public Health Physicians of Nigeria (APHPN), and the Media, Health and Rights Initiative of Nigeria (MHR), have signed a landmark Memorandum of Agreement (MoA), uniting two of Nigeria's foremost public health and development communications organisations in a strategic alliance to advance Sexual and Reproductive Health and Rights (SRHR) for young people across the country.

Left is the National President Association of Public Health Physicians of Nigeria Dr. Terfa Kene and Center is MHR Executive Director, Alu Azege, and right is APHPN National Secretary General Dr. Austine Ajogwu

KOGI STATE APHPN MARKS WORLD MALARIA DAY 2026

The Kogi State APHPN Chairperson, Dr. Mary Ojone Alexander-Onoja, added her voice to raise awareness on malaria prevention and control, stressing the need for _Protect. Test. Treat._

This year, the *Kogi State Malaria Elimination Team 2026*, working with SMOH, SPHCDA, LGAs, and partners, is driving the _Zero Malaria_ agenda through: ✓ Community action to eliminate mosquito breeding sites

✓ Expanded access to insecticide-treated nets

APHPN Kog State in a group photograph led by APHPN Kogi state branch Chairman, Dr. Mary Ojone Alexander-Onoja

The APHPN President delivered a goodwill message on behalf of the BOT Chairman and entire members of the APHPN family at the official **launch of the EU Support to Public Health Institutions in Nigeria (EU SPIN)** project on 11th May 2026.

APHPN President Dr. Terfa Kene anchoring the High Level Public Health Symposium organized by the Federal Ministry of Health & Social Welfare. An Insight from China and Nigeria

A NEW PARTNERSHIP

A new chapter begins as a strategic advocacy and partnership* is formed between the *Association of Public Health Physicians of Nigeria (APHPN) led by the National President; Dr Terfa Kene* and *Gift Lupus Foundation (GLF), represented by the founder; Dr Lovette Ononuga* who are committed to championing Lupus advocacy and ensuring no patient is left undiagnosed, cared for or unheard.

Left is the APHPN National Secretary General Dr. Austine Ajogwu, medium,,, Mrs Lovette Ikongo, Founder of the Gift Lupus Foundation, National President APHPN Dr. Terfa Kene and John

APHPN PLATEAU STATE , MARKS "WORLD MALARIA DAY"

Activities marking *World Malaria Day 2026* were successfully held in Plateau State through a coordinated multi-stakeholder effort involving government, development partners, and professional bodies, including the Association of Public Health Physicians of Nigeria (APHPN), Plateau State Branch.

Group photograph by APHPN Plateu State branch marking "World Malaria Day 2026"

APHPN PRESIDENT DR. TERFA KENE VISIT KOGI STATE

Dr. Terfa Kene was a Guest Speaker at the Kogi State Strategic LGA Dialogue Towards Strengthening PHCs for UHC in Lokoja, Kogi State during his 3 days official working visit to kogi State APHPN Branch and He spoke on the theme: _"The Role of Strategic Leadership in Universal Health Coverage (UHC): From Policy to Action."_

COURTESY VISIT TO THE HONOURABLE COMISSIONER FOR HEALTH, KOGI STATE.

As part of the 3 working days visit to Kogi State, Dr.Terfa Kene paid a courtesy visit to the Honourable Commissioner for Health, Kogi State, Dr. Abdulazeez Adams Adieza, where discussions focused on strengthening primary healthcare, PHC Adoption, health systems development, and improving health outcomes for the people of Kogi State.

WORLD HEALTH DAY 2026 CELEBRATION IN PLATEAU STATE*

The Plateau State Honourable Commissioner for Health, Dr. Nicholas Baamlong, led a press conference to commemorate World Health Day 2026, aligning with this year's theme, "Together for Health. Stand with Science."

He acknowledged the contributions of key partners, including the Association of Public Health Physicians of Nigeria (APHPN), (WHO), and the Plateau State Contributory Healthcare Management Agency (PLASCHEMA), among others, for their continued collaboration in advancing healthcare in Plateau State. He particularly commended APHPN for leading the coordination and celebration of this year's World Health Day activities in the state.

On 25th June 2026, The APHPN President Dr. Terfa Kene attended the inception meeting for the US Department of State–UNICEF Maternal and Child Health (MCH) Umbrella Grant in Abuja, marked the beginning of an important initiative focused on preventing malnutrition during the first 1,000 days of life in the FCT.

Group photograph with the Mandate Secretary for Health and Environment, Dr. Adedolapo Fasawe; the Executive Secretary, FCT Primary Health Care Board, Dr. Dan Gadzama; the APHPN Innovative President, Dr. Terfa Kene; APHPN FCT-Abuja Branch Chairman, Dr. Sabastine Esomonu; and as APHPN FCT-Abuja Branch Secretary, at the inception meeting for the US Department of State–UNICEF Maternal and Child Health (MCH) Umbrella Grant.

The Association of Public Health Physicians of Nigeria (APHPN) ably represented at the Inaugural Technical Consultative Meeting on the European Union Support for Public Health Initiative in Nigeria (EU SPIN)

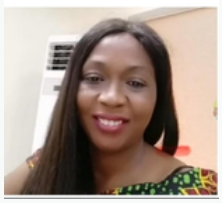
The Association of Public Health Physicians of Nigeria (APHPN) humbly represented at the Inaugural Technical Consultative Meeting on the European Union Support for Public Health Initiative in Nigeria (EU SPIN) by Dr. Esther Agmadalo M. Cegbeyi (Gen Sec FCT-Abuja Branch).

MEET THE NEW EXCOS OF GOMBE STATE APHPN

Dr John Lamingo- *Chairman*, Dr Nuhu Yusuf Babale - Secretary, Dr Ibrahim Obel Yaji - Assistant Secretary, D. Hauwa Adamu Saurayi - Treasurer, Dr Imran Alhassan Bojude - P.R.O

NECROLOGY

Dr. Hadiza Musa Abdullahi
She was the Head of Department -Community Medicine , Bayero Unversity and Aminu Kano Teaching Hospital (AKTH).
June, 2026



Dr. Obianuju Chinelo Okoye
Served as the ESecre, Anambra State Primary Health Care Development Agency (ASPHCDA)
June, 2026

AFTER 50 YEARS, APHPN PLANT PERMANENT ROOTS, BREAK GROUND ON FIRST EVER NATIONAL SECFRETARIAT (Health Physicians Unveil Secretariat, Housing Project In Abuja).

To mark the World Health day, 2026, with theme ***TOGETHER FOR HEALTH*** , the Association of Public Health Physicians of Nigeria ablely led by *Dr Terfa Kene* led Members of APHPN, Stakeholders and partners to the ground-breaking ceremony of the APHPN National Secretariat and APHPN Estate. The ground-breaking was graciously done by Chief Michael Duru Ejiogu FCICN, CEO of City gate homes Abuja. In his remark, he thanked APHPN for the collaboration and promised *Two trailer load of cement* to start the work at the secretariat.

PHOTO GALLERY FROM APHPN GROUND BREAKING EVENT

AFTER 50 YEARS, APHPN PLANT PERMANENT ROOTS, BREAK GROUND ON FIRST EVER NATIONAL SECFRETARIAT (Health Physicians Unveil Secretariat, Housing Project In Abuja).

Global Public Health Dates of Significance: July - September 2026

CULLED FROM THE WORLD HEALTH ORGANIZATION AND UNITED NATIONS WEBSITES

WORLD POPULATION DAY
JULY, 11TH 2026

JULY,28TH 2026

WORLD BREASTFEEDING WEEK
AUGUST 1ST-7TH ,2026

SEPTEMBER 10TH ,2026

WORLD SEPSIS DAY
SEPTEMBER 13TH ,2026

SEPTEMBER 29TH ,2026