GUIDANCE NOTE

Ebola Disease – Bundibugyo Virus (BVD)

Updated Guidance for Airlines and the Air Transport Industry

May 2026 | Supersedes IATA Guidance Note on Ebola, 13 November 2014

1. Introduction and Scope

This guidance note is issued by the International Air Transport Association (IATA) in response to the ongoing epidemic of Ebola disease caused by the Bundibugyo virus (BVD) in the Democratic Republic of the Congo (DRC) and Uganda, which was declared a Public Health Emergency of International Concern (PHEIC) by the WHO Director-General on 17 May 2026.

It supersedes the IATA Guidance Note on Ebola dated 13 November 2014, which was prepared in the context of the Ebola virus disease (Zaire strain) outbreak in West Africa. The current outbreak involves a distinct filovirus species — Bundibugyo virus — with epidemiological and clinical differences that are reflected in this updated guidance.

This document is intended for:

- Airlines and airline operations teams
- Cabin crew and flight deck crew
- Ground handling and airport operations staff
- Airline medical advisors and occupational health teams
- Airline regulatory and government affairs teams

2. Guiding Principles

IATA's approach to this public health emergency is governed by the following principles:

- Constant coordination with the International Civil Aviation Organization (ICAO) and the World Health Organization (WHO).
- Real-time monitoring through IATA's network of field and regional colleagues.
- Travel and health information relevant to this outbreak — including any documentation requirements mandated by individual States — will be reflected promptly in TIMATIC (www.iata.org/timatic).
- The primary responsibility for developing and implementing measures to combat public health emergencies rests with States and their public health authorities, not with airlines.
- IATA supports WHO recommendations and urges all governments to base their response measures on WHO guidance and internationally agreed IHR standards, to avoid a fragmented patchwork of national measures that creates passenger confusion and disproportionate operational burdens on airlines.

3. Epidemiological Background

The following situation summary is drawn from the WHO Technical Note dated 26 May 2026. Airlines should consult the WHO daily epidemiological updates for the latest information: https://www.who.int/emergencies/alert-and-response

Pathogen	Bundibugyo virus (BVD) – a filovirus distinct from Zaire Ebola virus
PHEIC declared	17 May 2026 by WHO Director-General under IHR (2005)
Affected areas	DRC: Ituri, North Kivu, and South Kivu provinces. Uganda: 7 cases, all with epidemiological links to DRC cases
WHO risk level	Very high (national / DRC) • High (regional) • Low (global)
Incubation period	2 to 21 days. People who do not have symptoms are not considered infectious and are not expected to spread the disease
Transmission	Direct contact with blood, secretions, organs or other body fluids of symptomatic persons or contaminated surfaces/items. Airborne transmission has NOT been documented.
Asymptomatic cases	No evidence of viral RNA detection in asymptomatic individuals. Testing of asymptomatic travellers is NOT recommended.
Vaccine / therapeutics	No licensed vaccine or specific therapeutic exists for BVD. R&D activities have been activated for candidate medical countermeasures.

4. WHO Temporary Recommendations and Key Positions

No Flight Suspensions or Denial of Entry

WHO Position (22 May 2026): Neither the suspension of flights for States Parties with documented BVD detection, nor denial of entry to travellers and conveyances arriving from those States Parties, are recommended by WHO.

IATA fully endorses this position. Suspending air services to and from affected areas would:

- Cut off the supply of urgently needed medical personnel, equipment, and humanitarian aid to the affected regions;
- Drive travel underground via informal and unmonitored routes, thereby increasing, rather than reducing, public health risk;
- Create significant economic harm to affected States at a time of crisis, with no proven epidemiological benefit (as demonstrated during the 2014 West Africa outbreak).

IATA actively encourages airlines to maintain operations to and from affected areas, consistent with their safety assessments and applicable government guidance.

Exit Screening Remains the Primary Measure

WHO's temporary recommendations maintain exit screening at international airports, seaports, and major land crossings in areas with documented BVD detection as the most effective border health measure. The key rationale is:

- Controlling the disease at source, where transmission is greatest, prevents spread before a potentially infected person boards a conveyance.

- Persons who are symptomatic are typically too unwell to travel; the window between symptom onset and incapacitation is narrow for filovirus disease.
- Entry screening can only identify individuals who develop symptoms during a flight; given the 2–21 day incubation period, this represents a small minority of cases.
- The experience with SARS entry screening (e.g., Canada screened over 1 million arrivals and detected zero cases) illustrates the limited yield of arrival-based screening in non-adjacent countries.

Any person clearly displaying symptoms consistent with BVD or who is defined by a public health authority as a case or contact under monitoring must not be permitted to travel unless the travel constitutes part of an appropriate, medically supervised evacuation.

Guidance for States NOT Sharing Land Borders with Affected Areas

The WHO Technical Note of 26 May 2026 sets out key considerations for States Parties not sharing land borders with areas of documented BVD detection: https://iris.who.int/items/b07def43-df30-41b8-83e0-deb33bcfd697

IATA's guidance and recommendations https://www.iata.org/en/programs/safety/health/diseases/ are in general in line with the above Technical Note considerations in what regards airlines.

5. In-Flight Management of a Suspected BVD Case

Risk of BVD Transmission During Air Travel

The risk of Bundibugyo virus transmission during air travel is very low.

- Like Zaire Ebola virus, there is NO evidence of transmission of BVD via the airborne route.
- Transmission requires direct contact with blood, secretions, organs, or other body fluids of a symptomatic person, or direct contact with contaminated surfaces or items.
- Evidence suggests that a person is only contagious once symptomatic, and BVD symptoms are typically severe, meaning ill persons are generally too unwell to travel.
- There is no evidence of viral RNA detection in asymptomatic individuals; asymptomatic persons do not spread the disease.
- General advice: persons who are unwell are strongly encouraged not to travel and to seek medical attention.

Suspected Case Definition for Cabin Crew

A case of BVD should be suspected when a traveller (passenger or crew member) has been in a BVD-affected country in the preceding 2 to 21 days as defined by WHO AND has a fever (temperature ≥38°C / 100°F) AND/OR one or more of the following signs or symptoms:

- Appearing unwell
- Persistent coughing
- Impaired breathing
- Persistent diarrhoea
- Persistent vomiting
- Skin rash (of infectious or uncertain cause)
- Bruising or bleeding without previous injury
- Confusion of recent onset

Note: This case definition is for airline operational purposes only, it is not intended for clinical, public health or other purposes, for which there is a WHO case definition. This temporary case definition may be updated at any time.

Step-by-Step Cabin Crew Protocol

Note: WHO or member States may, in collaboration with IATA, modify or supplement these procedures.

1. Confirm the above case definition criteria, including by asking the ill traveller about their travel history in the last 21 days and whether they have lived in the same household as, or had contact with, a person sick with a communicable disease.
2. Don appropriate available PPE.
3. Designate one cabin crew member to look after the ill traveller — preferably the crew member who has already been dealing with that traveller. Additional crew may be assigned if more care is required.
4. If medical ground support is available, contact them immediately and/or page for medical assistance on board (per company policy).
5. If no medical support is available, and if possible, relocate adjacent passengers, leaving a space of at least two metres (6 feet) between the ill passenger and others. If relocation is not possible, consider providing PPE to adjacent passengers.
6. Designate a specific lavatory for the exclusive use of the ill traveller and use appropriate signage on the door.
7. If the ill traveller is coughing: (a) provide tissues and advise their use to cover the mouth and nose when speaking, sneezing, or coughing; (b) advise proper hand hygiene — if hands are visibly soiled, washing with soap and water is required; (c) provide an airsickness bag for safe tissue disposal.
8. If a face mask is available and the traveller is coughing or sneezing, ask them to wear it. Replace when damp. Masks must not be reused and must be disposed of safely in a biohazard bag. After handling a used mask, practise hand hygiene immediately.
9. If the ill traveller cannot tolerate or refuses a mask, the designated cabin crew member (or any person within 2 metres of the ill person) should wear a mask. Airlines must ensure crew have adequate training in correct mask use to avoid inadvertently increasing risk.
10. If touching the ill passenger or their contaminated items is required, or if there is a risk of direct contact with body fluids, the designated crew member should wear the PPE contained in the Universal Precaution Kit (UPK). UPKs do not replace proper hand hygiene. PPE must be carefully doffed per training syllabus and discarded as per step 10; hands must then be washed with soap and water (alcohol-based hand rub if hands are not visibly soiled).
11. Store all soiled items (used tissues, face masks, oxygen mask and tubing, linen, pillows, blankets, seat-pocket items, etc.) in a biohazard bag. If no biohazard bag is available, use an intact plastic bag, seal it, and label it “BIOHAZARD”.
12. Ask accompanying travellers whether they have any similar symptoms.
13. Ensure the ill traveller’s hand-carried cabin baggage follows them and comply with public health authority requests.
14. As soon as possible, advise the Pilot-in-Command of the situation. The Pilot-in-Command is required under ICAO Annex 9, Chapter 8, paragraph 8.15, and WHO IHR (2005), Article 28(4), to report the suspected case(s) to air traffic control. The captain should also advise the destination station that specific cleaning and disinfection procedures may be required by local public health authorities.
15. Unless instructed otherwise by medical ground support or public health officials, ask all travellers seated in the same row, two rows in front, and two rows behind the ill traveller to complete a passenger locator form, if such forms are available on board or at the arrival station.

IATA Suspected Communicable Disease Guidelines for **Cargo and Baggage Handlers** and for **Cleaning Crews** can be found here: https://www.iata.org/en/programs/safety/health/diseases/

6. Management of Suspected Cases at Points of Entry (PoE)

In accordance with WHO guidance and PoE contingency plans and relevant national protocols, PoE health authorities should coordinate with aviation, transport, and conveyance operators to:

- Receive communication prior to arrival if a suspected BVD case has been identified on board;
- Manage suspected BVD cases in a safe and timely manner upon arrival;
- Identify contacts on board, including passengers and crew potentially exposed during travel.

If a traveller or crew member presents with symptoms compatible with BVD and has a travel history to areas where BVD has been confirmed, PoE health authorities' instructions should be followed.

PoE health authorities may decide — based on their risk assessment — to request a public health form from travellers arriving from areas with documented BVD detection.

7. Passenger Data Requirements

IATA reiterates its 2014 position that the imposition of disproportionate and technically unworkable new passenger data requirements on airlines will not meaningfully enhance public health protection.

The following are relevant technical and operational .imitations:

- Airline systems do not always have the capability to retrieve true origin and destination data, particularly for complex itineraries spanning multiple days and multiple carriers.
- Passengers frequently use different airlines to complete a multi-sector journey. The carrier operating the final leg may have no access to upline booking data and may be presented with a PNR that reflects only the last point of departure, not the true origin.
- Passengers seeking to avoid detection may book separate tickets (e.g., DRC to a European hub under one PNR, and the hub onward under a separate PNR), defeating origin-detection entirely.
- Bulk PNR requests do not meet the data quality standard required for meaningful epidemiological action; targeted, case-specific data sharing is both more effective and legally sounder.

Additionally, legal constraint need to be considered. For example, airlines operating within the European Union, or processing passenger data through EU-based systems, are subject to GDPR and are legally prohibited from transmitting PNR data to a third-country government unless a specific data transfer agreement exists. Even where national legislation permits transmission, it is typically restricted to case-specific disclosures rather than bulk requests.

IATA therefore urges States to:

- Rely on the robust exit screening systems in place at affected airports as the primary epidemiological tool;
- Use the WHO-standardised passenger locator card for targeted follow-up of individuals identified as potential contacts on a specific flight;
- Coordinate data sharing bilaterally through National IHR Focal Points, in accordance with IHR Articles 44 and 45, rather than imposing unilateral and operationally burdensome data mandates on airlines.

8. Air Transport Industry Preparedness

The air transport industry has accumulated significant experience in managing public health emergencies through prior outbreaks including the 2014–16 Ebola epidemic. The following resources and tools are in place:

- IATA guidance materials for maintenance crew, cabin crew, cleaning crew, cargo and baggage handlers, and passenger-facing agents — all endorsed by WHO and ICAO — are available at www.iata.org/en/programs/safety/health/
- The IATA Emergency Response Plan and Action Checklist for Public Health Emergencies, available at the IATA health safety pages, provides a structured framework for airline response activation.
- The IATA Suspected Communicable Disease Guidelines for Cabin Crew (updated December 2017) provide the step-by-step in-flight protocol reproduced in Section 5 of this guidance note.
- TIMATIC will be updated to reflect any vaccination, documentation, or entry requirements introduced by individual States in response to the BVD outbreak.
- The WHO Handbook for the Management of Public Health Events in Air Transport (WHO, 2016) provides the comprehensive reference framework for airline and PoE health authority coordination.

IATA remains in active coordination with the WHO, ICAO, and its travel and transport network, and will issue updated guidance as the situation evolves.

9. References and Key Resources

Regulatory and Institutional

- WHO, Director-General Temporary Recommendations under IHR (2005) – BVD PHEIC, 22 May 2026
- WHO Technical Note: Implementation of border health and international travel-related temporary recommendations for States Parties not sharing land borders with areas of documented BVD detection, 26 May 2026. https://doi.org/10.2471/B09769
- WHO International Health Regulations (2005), 3rd Edition
- ICAO Annex 9 – Facilitation, Chapter 8 (Public Health)
- ICAO Annex 9, paragraph 8.15 – Pilot-in-Command notification obligation

WHO Technical Guidance

- Considerations for border health and points of entry for filovirus disease outbreaks, Interim guidance. WHO, 2024. https://www.who.int/publications/m/item/considerations-for-border-health-and-points-of-entry-for-filovirus-disease-outbreaks
- Syndromic entry and exit screening for epidemic-prone diseases of travellers at ground crossings – Evidence review. WHO, 2024. https://www.who.int/publications/i/item/9789240090309
- Handbook for the management of public health events in air transport. WHO, 2016. https://www.who.int/publications/i/item/9789241510165
- Guide to hygiene and sanitation in aviation, 3rd edition. WHO, 2009. https://www.who.int/publications/i/item/9789241547772
- Daily Ebola/BVD situation reports: https://www.who.int/emergencies/alert-and-response

IATA Resources

- IATA Guidance Note on Ebola, 13 November 2014 [superseded by this document]
- IATA Suspected Communicable Disease Guidelines for Cabin Crew, December 2017
- IATA Emergency Response Plan and Action Checklist for Public Health Emergencies
- IATA TIMATIC: www.iata.org/timatic
- IATA Health Safety: www.iata.org/en/programs/safety/health/