DRC Ituri

Ebola Disease Outbreak — Bundibugyo Strain, 2026

Epidemiological situation report, geographic analysis & risk assessment · Compiled 20 May 2026 [UPDATED EDITION — revised from the 17 May edition · incorporates the case surge past 500 suspected, expansion to ten Ituri health zones, the first international case (a US physician evacuated to Berlin), US Title 42 entry restrictions and Level 4 advisories, and the shift on countermeasures after the WHO vaccine advisory group met on 19 May].

Primary sources new since 17 May: WHO (PHEIC statement; DON-602; R&D Blueprint / vaccine advisory group, 19 May) · WHO DRC representative briefing (Dr. Anne Ancia, 19 May) · US CDC (HAN-00530; Current Situation; Newsroom) · US Dept. of State (19 May) · ECDC (19 May) · Africa CDC (DG Kaseya; Dr. Mosoka Fallah, 19 May) · Reuters · AFP / AP · STAT · Nature / Scientific American · Bloomberg · CNBC Africa · The Conversation · NBC News · UN News.

About this edition. This is a full updated edition of the Pandemic Shield report first issued 17 May 2026 (DOI 10.5281/zenodo.20230585, CC BY 4.0). It carries forward the still-current core analysis from that edition — the Bundibugyo pathogen profile, the Goma surveillance-gap analysis (§2a of the 17 May edition) and the cross-border transmission analysis — in condensed form, and revises all figures, the response picture and the countermeasures outlook to reflect developments through 20 May 2026, including the outcome of the WHO vaccine advisory group meeting of 19 May. Counts are provisional and differ between reporting bodies on any given day. To protect the privacy of affected individuals, this edition does not name the medically evacuated patient or their family.

New Since 17 May Edition — Key Developments (18–20 May 2026)

★ **Case count roughly doubles in three days.** As of 19 May, WHO/ECDC reported **over 500 suspected cases, ~130–134 deaths and 30 laboratory-confirmed cases** — up from 336 / 88 / 8 in the 17 May edition. DRC Health Minister Kamba cited **513 suspected cases and 131 deaths**; live trackers recorded up to **543 suspected cases**; AP reported up to 134 suspected deaths. The jump in lab-confirmed cases from 8 to 30 largely reflects INRB clearing a sample backlog rather than a discrete new wave.

★ **Outbreak now spans ten health zones in Ituri, and confirmed cases extend into North Kivu.** WHO's DRC representative said on 19 May the outbreak affects **ten Ituri health zones** (US CDC cited nine on 18 May), with **confirmed cases now in Goma and Butembo** (North Kivu) in addition to the Ituri epicentre. Demographically, most DRC cases are aged **20–39** and roughly **two-thirds are female**, a pattern consistent with household, caregiving and burial transmission.

★ **First international case — a US physician evacuated to Berlin's Charité.** A US medical missionary physician contracted Bundibugyo virus while treating patients at **Nyankunde Hospital near Bunia**. They developed symptoms over the weekend, tested positive late on 17 May, and were airlifted under high-biosecurity conditions to the **special isolation ward at Charité University Hospital, Berlin**. ECDC states the patient plus **six high-risk contacts** are being evacuated; family members and a second exposed physician are being relocated for monitoring and care. None are scheduled to return to the US. *(Individuals are not named in this report.)*

★ **The vaccine question shifts from "none" to "which, and how" — WHO advisory group meets (19 May).** There is still **no vaccine licensed for Bundibugyo**, but a WHO technical advisory group (R&D Blueprint) convened on 19 May to advise WHO and the affected States on which candidate vaccine to prioritise for this response. Merck's **Ervebo** — licensed only for the Zaire strain — is the front-runner for possible off-label / trial use, on the strength of limited, primate-only cross-protection data (one developer calls its BDBV efficacy "a coin flip"). WHO's DRC representative cautioned that the prequalified Zaire-strain vaccines **"cannot be used in the current response"** as things stand pending further study, that any Ervebo deployment would take **~2 months** to materialise, and that any decision rests with the DRC and Uganda governments. The DRC was separately reported to be expecting shipments of an **Oxford-developed experimental Ebola vaccine** from the US and UK.

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- **A therapeutics trial is in preparation.** A WHO-sponsored clinical trial of two experimental BDBV treatments is reported (via *Nature*) to be in the works, pending DRC/Uganda approval; up to **four candidates** are under RCT consideration — monoclonal antibodies and Gilead's **remdesivir** (IV and oral), with lab data hinting BDBV may be more remdesivir-susceptible than the Zaire strain. No trial had enrolled a participant as of 20 May.

- **US imposes Title 42 entry restrictions and Level 4 advisories.** On 18 May, CDC and DHS implemented a **Title 42 order restricting entry of foreign nationals present in the DRC, Uganda or South Sudan in the prior 21 days**, plus enhanced screening; the State Department issued **Level 4 ("Do Not Travel")** advisories for all three countries and is coordinating with FIFA ahead of the 2026 World Cup.

- **Large US financial and operational commitment.** An initial **USD 23 million** in bilateral aid and funding for **up to 50 Ebola treatment/response clinics** (largely via UN CERF/OCHA); a **DART** deploying to the DRC; an Ebola Response Task Force led by veterans of the 2014 and 2018 responses.

- **Africa CDC opposes the travel restrictions.** DG Dr. Jean Kaseya argued border measures may raise rather than lower risk, urging support for outbreak control at source: **"global health security cannot be achieved through borders alone."**

- **WHO: "deeply concerned about the scale and speed."** DG Tedros voiced alarm on 19 May. EURL-PH-ERZV (EU) issued BDBV diagnostic/biosafety guidance and the World Bank is mobilising financing. The separate IHR Emergency Committee on temporary trade/travel recommendations had not yet convened.

- **Response-capacity caveat.** WHO's DRC representative noted on 19 May that neither US CDC nor Africa CDC were yet operationally on the ground (MSF and the Red Cross were); commentators linked recent US CDC cuts and the US WHO withdrawal to constraints on the response.

1. Outbreak Overview (as of 20 May 2026)

Changes from the 17 May edition shown in colour. Figures provisional; ranges reflect differing official tallies on 18–19 May.

Outbreak declared	15 May 2026 (Africa CDC / DRC MoH) · DRC's 17th recorded Ebola outbreak since 1976 · PHEIC declared by WHO 17 May 2026
Province / region	Ituri Province, north-eastern DRC; confirmed cases now also in Goma and Butembo (North Kivu); imported cases in Uganda
Affected health zones	**Ten Ituri health zones** (WHO, 19 May; nine per US CDC, 18 May) — up from 3 at declaration. Spread reported up to ~200 km from the epicentre.
Suspected cases	**~500–543** (WHO / DRC MoH / trackers, 18–19 May) — up from 336 on 17 May; still a likely undercount.
Suspected deaths	**~130–134** (DRC Health Minister / ECDC / AP, 19 May) — up from 88 on 17 May.
Laboratory-confirmed cases	**30** (WHO/ECDC, 19 May) — up from 8. Plus Uganda: 2 imported confirmed; North Kivu (Goma, Butembo): confirmed.
Demographics	**NEW** — majority of DRC cases aged 20–39; ~two-thirds female (US CDC, 18 May)
First international case	**NEW** — a US physician infected at Nyankunde Hospital, Bunia; evacuated to Charité Berlin isolation ward (17–19 May), with six high-risk contacts. (Not named in this report.)
Cross-border / imported	Uganda: 2 confirmed (Kampala; 1 death, 1 in treatment) · North Kivu (DRC): confirmed cases in Goma and Butembo · Kinshasa suspected: **NEGATIVE** on confirmatory testing

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Apparent CFR (suspected)	~24–26% on current suspected tallies; historical BDBV CFR 25–51%; DRC Health Minister continues to cite a strain CFR that "can reach 50%."
Vaccine / treatment	**No vaccine or antiviral licensed for BDBV**, but the posture shifted on 19 May: a WHO vaccine advisory group met to prioritise candidates, with Ervebo (Zaire-licensed) under evaluation for possible off-label/trial use (~2 months to availability if requested); a therapeutics trial is in preparation. See §3.
WHO global risk	PHEIC in force. Tedros "deeply concerned about the scale and speed." IHR Emergency Committee (temporary recommendations) not yet convened.

2. Geographic & Epidemiological Picture — Update

The defining epidemiological feature of the 18–20 May window is confirmation that the outbreak has broken well beyond its three declaration-day health zones: WHO's DRC representative now describes **ten affected health zones in Ituri** (US CDC cited nine on 18 May), with the virus reported up to ~200 km from the epicentre and **confirmed cases in Goma and Butembo in North Kivu**. The reported demographic profile — cases concentrated in working-age adults (20–39) and skewed roughly two-thirds female — is compatible with both healthcare-associated transmission and household/burial transmission, the two amplification routes most characteristic of Ebola in this region.

The structural geographic risks set out at length in the 17 May edition are unchanged and remain the backbone of the assessment: the gold-mining mobility structure radiating from Mongbwalu through Bunia to the Kasindi/Mpondwe border; the ~950 km, largely informal DRC–Uganda border with at least 20 unofficial crossings in Kasese District alone; the Mahagi–West Nile and Aru–South Sudan secondary corridors; and BDBV's clinical non-specificity during the infectious prodrome, which defeats temperature-based border screening (mean incubation ~11.3 days; haemorrhage infrequent).

GOMA SURVEILLANCE GAP — STATUS UNCHANGED, AND NOW MORE CONSEQUENTIAL

The laboratory-confirmed Goma (North Kivu) case — now joined by confirmed cases in Butembo — remains **uncountable and unmanaged through the official IHR system** because Goma is under AFC/M23 administration and the DRC Ministry of Public Health has no operational jurisdiction there (full analysis in §2a of the 17 May edition). An AFC/M23 official has since stated the administration set up entry/exit points in Goma and would take responsibility for funerals if the virus spreads — underscoring that any Goma response now runs through non-government structures with no IHR reporting obligation. As the Ituri caseload climbs and movement along the Bunia–Goma (RN2) axis continues, the inability to contact-trace, isolate, or conduct safe burials in a city of ~1.5 million at the confluence of DRC–Rwanda– Uganda–Burundi trade routes is the most serious single operational blind spot in the response.

2a. First International Case — Medical Evacuation to Berlin

The most significant qualitative development since the 17 May edition is the first confirmed case moved out of the African region. A US medical missionary physician contracted Bundibugyo virus while caring for patients at Nyankunde Hospital near Bunia, in the Ituri epicentre. They tested positive late on 17 May and were transferred under strict biosecurity to the high-consequence-infectious-disease isolation ward at Charité University Hospital, Berlin, after the US government requested German assistance — chosen partly for shorter flight time and Germany's prior experience caring for Ebola patients. To protect privacy, this report does not name the patient, their family, or the second exposed physician.

Per ECDC's 19 May assessment, the case together with six high-risk contacts are being evacuated; family members and a second exposed physician are being relocated for continued risk monitoring and specialised care, with none scheduled to return to the United States. US authorities have begun contact tracing among people potentially exposed before and during the evacuation.

WHY THIS MATTERS

A confirmed healthcare-worker case requiring intercontinental medevac reinforces two themes from the 17 May edition: (i) healthcare-worker exposure has been central to this outbreak from its 24 April index case (a health

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worker) onward, with health-facility transmission a recurring pattern; and (ii) with no licensed BDBV vaccine or therapeutic, even patients moved to one of the world's best-equipped isolation units receive *supportive care* as the mainstay — though early, aggressive supportive care (fluids, blood-pressure and oxygen management) is itself life-saving. The case also catalysed a markedly more aggressive Western governmental posture than the outbreak's African epidemiology alone had previously elicited.

3. Countermeasures — The Vaccine Question Reopens

The 17 May edition's central scientific finding — that no vaccine or therapeutic is *licensed* for BDBV, leaving classical containment as the only deployable tool set — still holds. What changed this week is that the question moved from "there are no countermeasures" to active, formal prioritisation of candidates, after a WHO advisory group met on 19 May.

Vaccines — outcome of the 19 May WHO advisory group

A WHO technical advisory group (the R&D Blueprint group, acting lead Vasee Moorthy) convened on Tuesday 19 May to advise WHO and the affected States on which candidate vaccine to prioritise for this outbreak. The clear front-runner for possible off-label or trial use is Merck's **Ervebo** (rVSV-ZEBOV-GP), even though it is licensed only against the Zaire strain. The scientific basis is genuine but thin: a small primate study (Geisbert and colleagues) found that animals given an Ervebo precursor were more likely to survive a lethal BDBV challenge, but a later, differently-designed primate study raised questions about that result, and the model is imperfect because BDBV is not uniformly lethal in monkeys. Geisbert's own characterisation of Ervebo's likely human efficacy against BDBV is "a coin flip"; Merck (MSD) notes that independent non-Zaire data is "limited, not from humans and not from evaluation of Ervebo." Crucially, WHO's DRC representative said that for now international experts judge the prequalified Zaire-strain vaccines **cannot be used in the current response** without further study; that even if Ervebo were requested, it would take roughly **two months** to become available; and that any decision rests with the DRC and Uganda governments. The DRC was separately reported to be expecting shipments of an **Oxford-developed experimental Ebola vaccine** from the US and UK. Earlier-stage candidates — from Moderna and a Chinese tri-strain mRNA vaccine covering Bundibugyo (PNAS, tested only in mice) — remain pre-clinical and years from field use, with cost and cold-chain hurdles.

Therapeutics

A WHO-sponsored clinical trial of two experimental BDBV treatments is reported (via *Nature*) to be in preparation, pending DRC/Uganda government approval; researchers describe the trial infrastructure as well positioned to launch quickly. Officials are weighing up to four candidates under randomised-controlled-trial protocols: monoclonal antibodies and Gilead's antiviral remdesivir in intravenous and oral formulations, with laboratory work suggesting BDBV may be more remdesivir-susceptible than the Zaire strain. The two WHO-recommended Zaire-strain monoclonals (mAb114/Ebanga and REGN-EB3/Inmazeb) target EBOV glycoprotein epitopes not conserved in BDBV, so their BDBV efficacy is unvalidated; US CDC says it is exploring development of a BDBV-directed monoclonal antibody. No trial had enrolled a participant as of 20 May.

BOTTOM LINE ON COUNTERMEASURES

As of 20 May there is still **no vaccine or specific antiviral licensed for BDBV**, and no trial has yet enrolled a participant — but the posture shifted this week from "no countermeasures" to active prioritisation. A WHO vaccine advisory group met on 19 May with Ervebo as the leading (and uncertain, ~"coin-flip") option whose Zaire-strain prequalified vaccines "cannot be used in the current response" as things stand; a WHO-sponsored therapeutics trial is in preparation; and the DRC expects experimental-vaccine shipments. Real-world value still depends on government sign-off, regulatory clearance, a ~2-month Ervebo lead time, cold-chain logistics in a conflict zone, and — for any trial — the epidemic lasting long enough to generate evidence. The operational mainstay therefore remains unchanged: isolation, contact tracing, safe and dignified burial, IPC, community engagement, and early supportive care.

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4. International Response — Update (18–20 May 2026)

WHO	PHEIC in force; DG Tedros (19 May) "deeply concerned about the scale and speed." R&D Blueprint vaccine advisory group met 19 May to prioritise candidate vaccines; sponsoring a planned BDBV therapeutics trial (pending DRC/Uganda approval). IHR Emergency Committee (temporary recommendations) not yet convened. USD 500,000 released; supplies airlifted.
US CDC	Issued HAN-00530. Reports 9 Ituri health zones (18 May). Country offices ~30 staff (DRC), ~100 (Uganda); experts deploying (largely remote/arriving as of 19 May). Supporting disease tracking, contact tracing, sample collection and sequencing; exploring a BDBV monoclonal antibody. Coordinating with FIFA on 2026 World Cup traveller safety.
US State Dept.	NEW Title 42 entry restriction (21-day; DRC/Uganda/South Sudan) and enhanced screening from 18 May; Level 4 advisories for all three. USD 23M initial bilateral aid; funding for up to 50 treatment clinics (via CERF/OCHA); DART deploying; Ebola Response Task Force activated.
Africa CDC	DG Kaseya (19 May) publicly opposed the US travel restrictions as counter-productive. Science lead Dr. Mosoka Fallah signalled Africa CDC would advise on the best countermeasure approach given the lack of licensed tools. Not yet operationally on the ground (19 May).
EU / ECDC	NEW EURL-PH-ERZV issued BDBV diagnostic/biosafety guidance and testing support to EU/EEA states; ECDC liaising with Africa CDC, the European Commission and WHO via the EU Health Task Force.
Germany	NEW Federal Ministry of Health confirmed admission of the US patient to Charité Berlin's special isolation ward, citing a national expert network for high-consequence infectious-disease care.
UK / Oxford	NEW DRC reported to be expecting shipments of an Oxford-developed experimental Ebola vaccine from the US and UK.
World Bank / CEPI	World Bank mobilising financing and technical support. CEPI (DG Richard Hatchett: concern "pretty high") maintaining readiness for accelerated BDBV countermeasure development.
On the ground	MSF and the Red Cross/ICRC operationally present in Ituri; UNICEF distributing initial relief supplies across treatment centres in Ituri. Uganda maintains 22-crossing screening and the Bwera mobile lab. Rwanda's DRC border closure continues.

5. Analysis — The Travel-Restriction Controversy

A genuinely new *political* fault line opened this week between the US containment posture and the Africa CDC's source-control doctrine. The US case for Title 42 restrictions and Level 4 advisories is protection of the homeland and buying time while domestic and field capacity ramps up. The Africa CDC's objection, voiced by DG Kaseya, is the established public-health consensus: blanket travel and entry restrictions rarely stop a contact-transmitted pathogen, can drive movement onto unmonitored informal routes (precisely the dynamic this outbreak's porous-border analysis describes), and can disincentivise the transparency that made early international notification possible.

The friction is sharpened by two structural facts. First, the US formally withdrew from the WHO this year and has reduced CDC staffing — so a US-led, bilaterally-channelled response (DART, 50 clinics via CERF/OCHA, Title 42) is operating partly outside the multilateral IHR architecture the PHEIC is meant to coordinate, and as of 19 May neither US CDC nor Africa CDC were yet on the ground. Second, the IHR Emergency Committee, whose job is to advise on proportionate, evidence-based temporary recommendations on trade and travel, had not yet convened — so unilateral national measures (the US

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restrictions, Rwanda's border closure) are filling the vacuum, with no harmonised international standard against which to judge them.

6. Updated Risk Assessment — What Has Changed and What Remains Unresolved

✓ Newly established (18–20 May)	? Unknown or unresolved
• Outbreak confirmed across **10 Ituri health zones**, with confirmed cases in Goma and Butembo (North Kivu); ~500–543 suspected, ~130–134 deaths, 30 lab-confirmed. • Case profile: mostly 20–39, ~two-thirds female. • First case evacuated off-continent (a US physician → Charité Berlin) plus six high-risk contacts. • Countermeasure posture shifted: WHO vaccine advisory group met 19 May; Ervebo the leading (uncertain) option; therapeutics trial in preparation; Oxford vaccine shipments expected. • US imposed Title 42 + Level 4; committed USD 23M and up to 50 clinics; EU/ECDC and World Bank engaged.	• True case burden — still likely undercounted; the Goma/North Kivu blind spot is uncountable through the official system. • Whether DRC/Uganda will request Ervebo and whether the ~2-month lead time and "coin-flip" efficacy justify deployment. • Whether DRC/Uganda approve the WHO therapeutics trial, and whether any candidate works before the epidemic peaks or wanes. • Timing and content of the IHR Emergency Committee's temporary recommendations. • Whether announced resources reach ten affected zones fast enough given conflict, terrain and ~1,700 km from Kinshasa. • Net effect of US CDC cuts and the US WHO withdrawal on response capacity and coordination.

RISK SYNTHESIS — 20 MAY 2026

The three-day trajectory — suspected cases roughly doubling, spread to ten Ituri health zones plus confirmed North Kivu cases, and the first off-continent case — meets or exceeds the escalation the 17 May edition anticipated. Every structural vulnerability identified earlier remains in force: still no *licensed* BDBV countermeasure (though a WHO vaccine advisory group began formally prioritising candidates on 19 May), a porous and largely informal DRC–Uganda border, an unmanageable cluster of confirmed cases in AFC/M23-administered North Kivu, and clinical non-specificity that defeats temperature screening during the infectious prodrome. Two developments cut in opposite directions: a countermeasure pathway is opening for the first time (a potential medium-term positive, albeit ~2 months out at best for any vaccine), while a US–Africa CDC split over travel restrictions — combined with the not-yet-convened IHR Emergency Committee and a US response operating partly outside the multilateral system — introduces a new coordination risk at exactly the moment harmonised action matters most.

7. References — New Since 17 May Edition

OFFICIAL / MULTILATERAL

[A1] WHO — PHEIC determination statement (17 May 2026): who.int/news/item/17-05-2026…
[A2] WHO — Disease Outbreak News, DON-602: who.int/…/2026-DON602
[A3] WHO — Ebola virus disease: Vaccines (Q&A; SAGE/Ervebo background): who.int/…/ebola-vaccines
[A4] US CDC — Ebola Disease: Current Situation (18 May 2026): cdc.gov/ebola/situation-summary
[A5] US CDC — Health Advisory HAN-00530: cdc.gov/han/php/notices/han00530.html
[A6] US Dept. of State — Ebola Response Update, 19 May 2026: state.gov/…/ebola-response-update-may-19-2026
[A7] ECDC — Ebola virus disease outbreak in the DRC, 19 May 2026: ecdc.europa.eu/…/19-may-2026
[A8] UN News / UN Media (UNifeed) — WHO DRC representative Dr. Anne Ancia briefing, Geneva (19 May 2026): news.un.org/en/story/2026/05/1167542

VACCINES & THERAPEUTICS (19 MAY ADVISORY GROUP)

[V1] STAT — "WHO Ebola experts weigh trying old vaccine in new outbreak" (Ervebo; R&D Blueprint; Moorthy; Falzarano) (18 May 2026): statnews.com/…
[V2] Reuters / CNBC Africa — "International health experts meet in search for Ebola Bundibugyo vaccine options" (19 May 2026): cnbcafrica.com/…
[V3] Al Jazeera — "WHO to hold emergency committee meeting as Ebola death toll rises to 131" (Fallah; agenda) (19 May 2026): aljazeera.com/…
[V4] AP (via KPBS) — "WHO chief concerned over 'scale and speed'" (Ervebo ~2 months; Oxford vaccine shipments; Goma/M23) (19 May 2026): kpbs.org/…

DOI: https://doi.org/10.5281/zenodo.20230585

[V5] Scientific American (repr. of *Nature* news) — therapeutics trial in preparation; Geisbert "coin flip" (18 May 2026): scientificamerican.com/…
[V6] Bangkok Post / AFP — MSD statement; Chinese mRNA PNAS candidate (19 May 2026): bangkokpost.com/…

NEWS & REPORTING

[B1] Reuters (via Detroit News) — US physician evacuated to Germany (19 May 2026): detroitnews.com/…
[B2] AFP (via Channels TV) — "Germany to treat US Ebola patient from DR Congo" (19 May 2026): channelstv.com/…
[B3] NBC News — outbreak overview as first American tests positive (19 May 2026): nbcnews.com/…
Carried forward (full citation list in the 17 May edition): Africa CDC 15 May; WHO AFRO 15 May; Radio Okapi 15–16 May; Uganda MoH/Dr. Atwine; ChimpReports; Daily Monitor; Mire et al. 2013; Towner et al. 2008; Bornholdt et al. 2019; Paerisch (né Kratz) et al. 2015; IOM DTM; UNDP; SSHAP; Mongabay.

Changes from the 17 May edition: all case figures updated (336→~500–543 suspected; 88→~130–134 deaths; 8→30 lab-confirmed); affected health zones updated (3→10 in Ituri) with confirmed North Kivu cases (Goma, Butembo) added; first international case and Charité Berlin evacuation added with individuals de-identified (§2a); countermeasures section revised around the 19 May WHO vaccine advisory group, Ervebo's "coin-flip"/~2-month status, the Oxford experimental-vaccine shipments and the WHO-sponsored therapeutics trial (§3); International Response table updated (§4); travel-restriction analysis added (§5); risk synthesis revised (§6); pathogen profile, Goma surveillance-gap analysis and cross-border transmission analysis carried forward in condensed form from the 17 May edition.

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