

WHO emergency guidance on the use of licensed Ebola vaccine during Bundibugyo virus disease outbreaks

Interim guidance
31 August 2026



This guidance updates the WHO emergency guidance published on 28 May 2026.

Abbreviations and acronyms

BDBV	Bundibugyo virus, species <i>Orthoebolavirus bundibugyoense</i>
EBOV	Ebola virus, species <i>Orthoebolavirus zairense</i>
FLW	Frontline worker
HCW	Health care worker
RCT	Randomized clinical trial
rVSV	Recombinant vesicular stomatitis virus
SAGE	Strategic Advisory Group of Experts on Immunization
SUDV	Sudan virus, species <i>Orthoebolavirus sudanense</i>
VE	Vaccine effectiveness
WHO	World Health Organization

Context

Ervebo® is currently the only licensed Ebola vaccine available. Ervebo® (rVSV-EBOV-GP) is a live, recombinant vesicular stomatitis virus (rVSV)-based vaccine licensed that was prequalified by the World Health Organization (WHO) in 2019 for the prevention of Ebola virus disease caused by Ebola virus (EBOV, species *Orthoebolavirus zairense*, previously known as Zaire ebolavirus) in individuals aged one year or older. It is not licensed for use against Bundibugyo virus (BDBV) and therefore the use of Ervebo® against BDBV constitutes off-label use¹.

¹ Use of a vaccine for an unapproved indication (not described in the approved labelling) or in an unapproved age group, dosage, or route of administration.

BDBV and EBOV cause Ebola disease that is clinically similar but are genetically and antigenically distinct virus species. Their glycoproteins share approximately only 60–65% amino acid sequence identity, a distinction that is particularly relevant for vaccination because currently available Ebola vaccines, including Ervebo®, target the viral glycoprotein. Consequently, although Ervebo® is highly effective against EBOV, the extent to which Ervebo®-induced immunity provides clinically meaningful protection against BDBV remains unknown. (1)

On 19 August 2026 (2), the Strategic Advisory Group of Experts on Immunization (SAGE) reviewed and deliberated on the additional evidence that had become available following the publication of the *WHO emergency guidance on the use of licensed Ebola virus vaccine during Bundibugyo virus disease outbreaks, 28 May 2026*. (3)

The BDBV outbreak in the Democratic Republic of the Congo has spread substantially, with continued transmission and high mortality, creating an urgent need to strengthen outbreak response and reduce preventable deaths. (4) The severity of the disease and evolving epidemiological situation increases the imperative to consider all potentially beneficial interventions, while at the same time carefully weighing the unknown efficacy of Ervebo® against BDBV, and resultant risks.

A ring vaccination randomized controlled trial (henceforth referred to as ring RCT) of Ervebo® and BDBV-specific vaccine candidates is planned to be conducted in the Democratic Republic of the Congo as a matter of urgency. (5) If well designed and rigorously implemented, the trial would provide the critical evidence currently lacking on the efficacy of Ervebo® against BDBV.

Assessment of additional evidence on Ervebo® performance against BDBV since May 2026

Findings from an increased, albeit still limited, number of studies conducted to date in non-human primates and ferrets suggest some protection by Ervebo® against BDBV-related mortality, while showing little or no protection against viraemia and clinical disease (see Table 1).

In the absence of an established correlate or surrogate of protection against BDBV, the extent to which findings from animal challenge models (disease and laboratory-based immunological studies) can predict protection in humans remains unknown.

Available human immunogenicity data regarding potential cross-protection conferred by Ervebo® against BDBV showed that Ervebo® induces cross-reactive BDBV glycoprotein-binding antibodies which are at levels approximately 5-fold lower than against EBOV, and that cross-neutralization of BDBV pseudoviruses with neutralizing titres are approximately 3.5–4-fold lower than against EBOV (see Table 2).

No Ervebo® vaccine efficacy data against BDBV in humans have been generated yet.

There are a small number of anecdotal reports of previously vaccinated health care workers who subsequently developed BDBV disease and survived. However, no conclusions regarding vaccine efficacy or effectiveness can be drawn from these observations because of the very small sample size, the absence of an appropriate comparator group, the potential for substantial bias, non-systematic data collection, and the resulting considerable statistical uncertainty.

Overall, the limited data and anecdotal reports are suggestive of some protection against BDBV-related mortality and are consistent in trending towards some as yet unquantified benefit.

In conclusion, the available data remain insufficient to determine whether Ervebo® provides any clinically meaningful protection against BDBV in humans or to reliably estimate the magnitude of such protection, including protection against infection, disease, severe disease or death.

Benefit–risk considerations regarding off-label use of Ervebo® in the context of unknown efficacy against BDBV

There is currently clinical equipoise regarding the efficacy of Ervebo® against BDBV. Vaccine efficacy in humans remains to be established and could range from high efficacy, with substantial clinical and public health benefit, through moderate or partial efficacy, to limited or negligible efficacy, with little or no meaningful protection. The lower limit of the range of potential effects may even include harm. The potential ratio of benefits and risks of broader use therefore differ considerably depending on where within this range the true efficacy ultimately lies.

If efficacy is high or clinically meaningful, broader use while the ring RCT is underway could potentially reduce severe disease and deaths and, if the vaccine also protects against infection and transmission, contribute to outbreak control. In a context where other medical countermeasures remain limited, earlier access could provide populations at high risk with a vaccine that has a well-characterized safety profile, while BDBV-specific vaccines remain under evaluation and are not yet available for use. Use within appropriately designed research frameworks could also generate complementary real-world effectiveness data. In addition, vaccinated individuals would be expected to benefit from protection against Ebola virus disease should they subsequently be exposed during a future EBOV outbreak.

Conversely, if efficacy is low, negligible or absent, the balance of benefits and risks would be substantially less favourable. Considerable financial, logistic and human resources would be diverted to an intervention providing little or no clinical or public health benefit. These resources could otherwise support outbreak-control measures of established effectiveness, including surveillance, contact tracing, timely testing and case detection, isolation, infection prevention and control, and safe and dignified burials. These resources could also have been better invested in the development of BDBV-specific vaccines.

A scenario in which Ervebo® provides meaningful protection against severe disease or death, but limited or no protection against infection, viraemia or onward transmission, would require careful consideration. Protection against severe disease or death would constitute an important individual and public health benefit, even in the absence of substantial effects on infection or transmission. However, vaccination could then reduce morbidity and mortality without necessarily interrupting transmission. If this efficacy profile is not clearly understood and communicated, vaccination could lead to false reassurance among vaccinated individuals, communities and responders, potentially reducing adherence to established outbreak-control measures. Such behavioural changes could offset some of the benefits of vaccination and, if infection and onward transmission are not sufficiently reduced, could contribute to continued transmission and potentially prolong or exacerbate the outbreak.

If efficacy proves limited or negligible, substantial numbers of breakthrough cases or deaths could also undermine public trust in the outbreak response and confidence in Ebola vaccines, vaccination programmes generally, and the health sector more broadly. Once broader vaccination has commenced, a subsequent decision to restrict or discontinue Ervebo® use, if

the evidence shows limited efficacy, could itself create important communication and trust challenges.

There are also important evidence-generation trade-offs. The use of Ervebo® outside rigorous research protocols could interfere with the feasibility, recruitment, implementation and scientific integrity of studies, particularly the ring RCT, designed to establish vaccine efficacy for Ervebo® and BDBV-specific vaccine candidates (which are expected to have the potential for better performance against BDBV). This could delay the generation of the robust evidence needed to guide policy. Observational Ervebo® effectiveness studies could provide useful complementary information but are inherently more susceptible to bias and confounding than RCTs and may therefore be more difficult to interpret or insufficiently robust to resolve the central question of efficacy. Vaccine effectiveness (VE) studies of vaccines with modest efficacy are particularly prone to these limitations. Hence the value of any observational study depends partly on the extent to which its design can ensure that uptake of the intervention is as close to random as possible and that outcome data are collected systematically from all participants allowing comparable analysis, thereby reducing selection and information biases. Conversely, if the ring RCT demonstrates clinically meaningful efficacy of Ervebo® and/or BDBV-specific vaccine candidates, such a trial would provide a strong basis for rapidly updating policy and expanding vaccine(s) use to benefit the wider population.

Extensive reliance on Ervebo® could potentially affect community willingness to participate in future studies or receive BDBV-specific vaccines, which become especially important if the efficacy of Ervebo® against BDBV is insufficient.

Finally, widespread deployment would have implications for global vaccine security. Large-scale use of available Ervebo® doses against BDBV could temporarily deplete the International Coordinating Group on Vaccine Provision stockpile and potentially compromise timely access to vaccine for response to a future outbreak caused by EBOV, against which Ervebo® has demonstrated efficacy and is licensed.

Taken together, the uncertainties described above reinforce the importance of obtaining robust efficacy data as rapidly as possible while carefully weighing the potential benefit of any broader use against its potential negative consequences.

WHO recommendations

1. The evidence available to date remains insufficient to support the programmatic use² of Ervebo® for the prevention of BDBV. Therefore, at this time, Ervebo® should only be used for BDBV within the context of a research protocol.
2. WHO considers a well-designed and well-executed ring RCT to be the most robust and reliable approach to determine the efficacy of Ervebo® against BDBV. Every feasible measure should be taken to enable and safeguard its timely implementation, scientific integrity and successful completion. If clinically meaningful efficacy against BDBV is demonstrated, the recommendation for use of Ervebo® could be rapidly expanded to benefit a broader population and help to control the outbreak. Conversely, if clinically meaningful efficacy is not demonstrated, substantial financial, logistic and human resources committed to premature wider use of Ervebo® could represent a significant opportunity cost, as these resources could instead have been directed towards strengthening established and proven outbreak-control measures.
3. WHO recognizes that, given the current context of a rapidly expanding BDBV outbreak and its associated high mortality in the Democratic Republic of the Congo, any country experiencing a major BDBV outbreak, may wish to consider broader use of Ervebo® beyond a ring RCT. If broader use is pursued before results from the ring RCT become available, WHO recommends that it be implemented only within the context of a research protocol and accompanied by a comprehensive risk-mitigation plan. The plan should be developed, implemented and monitored to address each identified potential risk, drawing on the strategies outlined below:
 - 3.1. **Explicit communication** about the unknown efficacy of Ervebo® to protect against BDBV infection, transmission and severe disease. Vaccination must not be presented as known protection or as a substitute for established core outbreak-control measures. Any use of Ervebo® against BDBV should be accompanied by a carefully designed, culturally appropriate, risk communication and community engagement strategy, supported by social listening and adapted to the local social and cultural context and evolving epidemiologic and social context.

² Programmatic use refers to use outside the context of a research protocol (including a ring RCT).

3.2. Sequential approach to expanding Ervebo® vaccination, within a carefully designed research protocol with predefined criteria for pausing, continuing or further expanding vaccination to additional groups in BDBV-affected geographical areas. Recognizing the inherent weaknesses of observational research, the protocol must be designed to maximize the likelihood of policy relevant evidence. Initial implementation should focus on health care workers (HCWs)³ and frontline workers (FLWs)⁴ in BDBV-affected areas, who are at increased risk of occupational exposure and expected to be better positioned to understand the rationale for use within a research context, including the uncertainties regarding vaccine efficacy against BDBV. Contacts of cases and contacts of contacts should be prioritized for inclusion in a ring RCT unless their inclusion is not feasible. (6) Further expansion of use of Ervebo® to communities with high BDBV transmission should be considered only when supportive clinical evidence emerges that provides greater confidence that Ervebo® confers clinically meaningful protection against BDBV, which would offset the known risks relative to currently unknown benefits.

3.3. Protect and accelerate the ring RCT: Prioritize the conduct and resourcing of a high-quality ring RCT once design is agreed, including regulatory and ethics approval process for swift initiation of recruitment, rapid enrolment, high-quality data collection, trial monitoring, and analysis. Geographical, temporal and/or operational separation between Ervebo® use outside the ring RCT and areas in which the ring RCT is being conducted should be established and maintained to protect the feasibility and scientific integrity of the trial.

³ Health care workers are all people engaged in work actions whose primary intent is to improve health. This includes health service providers, such as doctors, nurses, midwives, public health professionals, laboratory, health and medical and non-medical technicians, personal care workers, community health workers, healers and some practitioners of traditional medicine. It also includes health management and support workers, such as cleaners, drivers, hospital administrators, district health managers and social workers and other occupational groups in health-related activities. Health workers include not only those who work in acute care facilities but also those employed in long-term care, public health, community-based care, social care and home care and other occupations in the health and social work sectors as defined by the International Standard Industrial Classification of All Economic Activities (ISIC), revision 4, section Q: Human health and social work activities

⁴ Frontline workers are clinical health workers tending to Ebola disease patients and non-clinical staff performing heavy duty services such as transporting symptomatic patients, care-setting cleaning, environment decontamination and who are part of safe and dignified burial teams. Health care worker is a more generalized term for those personnel who also will use personal protective equipment but are not necessarily in direct patient contact or performing high risk activities.

3.4. Sustain and strengthen outbreak control activities irrespective of vaccination use or individual vaccination status: surveillance, rapid diagnosis, appropriate isolation and clinical management of cases, infection prevention and control, comprehensive contact tracing, safe and dignified burials, and effective risk communication and community engagement.

4. Consistent with WHO recommendations issued in 2024 (7), WHO continues to recommend the preventive use of Ervebo® among HCWs³ and FLWs⁴ in EBOV-priority areas of countries with a history of Ebola virus disease outbreaks. In those areas that overlap with those affected by the current BDBV outbreak, Ervebo® should not be used as part of the BDBV outbreak response, unless it is implemented within the context of a research protocol designed to generate evidence on its efficacy and safety, such as a ring RCT, or a well-designed observational VE study. Exceptionally, where implementation of an appropriately designed ring RCT or VE study is not feasible, off-label use of Ervebo® may be undertaken outside a research protocol (6), provided that robust and systematic vaccination record systems are in place to ensure reliable identification of vaccine recipients and linkage to subsequent BDBV exposures and health outcomes.
 - HCWs and FLWs should be explicitly informed that, although Ervebo® provides a high degree of protection against EBOV, evidence for the protection against BDBV is unknown. Ervebo® vaccination must therefore not lead to reduced adherence to established BDBV infection prevention and control measures, use of appropriate personal protective equipment, or other proven outbreak-response measures.
5. WHO emphasizes the need to accelerate the development and rigorous evaluation of BDBV-specific vaccines and post-exposure prophylaxis products. Use of Ervebo® prior to the availability of efficacy data should take into account its potential impact on the demand for and acceptability of future BDBV-specific vaccines, as well as the feasibility of conducting the research needed to evaluate these vaccine candidates.
6. WHO strongly encourages clear coordination between relevant partners to provide timely and sufficient support to the Democratic Republic of the Congo and any other country considering the use of Ervebo® within a research protocol in the current BDBV outbreak. Ideally, master protocol(s) for the ring RCT and high-quality observational studies should

be developed and shared so that any country experiencing an ongoing or substantial new BDBV outbreak could access and implement. Competing research activities should be carefully coordinated, and prioritization of promising interventions should occur through established mechanisms, including the WHO Research and Development Blueprint and its relevant independent expert advisory processes.

Methodology

Evidence was identified through a scoping review conducted by the Coalition for Epidemic Preparedness Innovations, supplemented by an additional review of the scientific literature. In parallel, the University of New South Wales and Monash University, Australia, established a living evidence map to consolidate and synthesize available data supporting the demonstration of effectiveness of developmental vaccines BDBV. (8) The assessment considered evidence such as animal challenge studies, human immunological studies of cross-reactivity, and emerging observational data in humans.

The evidence was reviewed by the SAGE Ebola Working Group on 13 August and by SAGE on 19 August 2026. Recommendations⁵ were formulated considering the balance of benefits and risks, public health needs, feasibility, acceptability, equity, resource implications, and the implications of remaining uncertainty.

⁵ The recommendations contained in this publication are based on the advice of independent experts who have considered the best available evidence, a risk–benefit analysis and other factors, as appropriate. This publication may include recommendations on the use of medicinal products for an indication, in a dosage form, dose regimen, population or other use parameters that are not included in the approved labelling. Relevant stakeholders should familiarize themselves with applicable national legal and ethical requirements. WHO does not accept any liability for the procurement, distribution and/or administration of any product for any use.

Summary of evidence on Ervebo® performance against BDBV

Table 1. Summary of animal data on Ervebo® performance against BDBV

Study	Vaccine / construct	Methods	Key findings	Key limitations
Falzarano et al., 2011 (9)	Research-grade rVSV-ZEBOV-GP, not licensed Ervebo®	Cynomolgus macaques. rVSV-ZEBOV-GP (n=4), rVSV-Côte d'Ivoire Ebola GP (n=4), mock (n=4). Challenge: 10 000 TCID ₅₀ BDBV. Survival, viremia, clinical disease, IgG.	3/4 survived after rVSV-ZEBOV vs 1/4 controls. Reduced viremia and milder disease among survivors. No sterilizing immunity. Cross-reactive BDBV IgG detected, but did not correlate with survival.	Small groups. Non-human primate BDBV model has incomplete lethality. Experimental construct rather than licensed Ervebo®
Mire et al., 2013 (10)	Research-grade rVSV constructs, not licensed Ervebo®	Cynomolgus macaques, n=3/group: PBS; homologous rVSV-BDBV-GP; blended rVSV-SUDV + rVSV-ZEBOV; heterologous prime-boost rVSV-SUDV → rVSV-ZEBOV. Challenge: 1000 PFU BDBV.	Homologous BDBV: 3/3 survived. Heterologous prime-boost: 3/3 survived. Blended heterologous: 1/3; controls: 1/3. Higher cross-reactive BDBV IgG associated with survival.	Small groups; different regimens do not directly test single-dose ERVEBO; incomplete control lethality. Research-grade constructs.
Lehrer et al., 2026 (11)	Licensed Ervebo® obtained from Merck, full human dose	Cynomolgus macaques. Ervebo® alone D0 (n=4); Ervebo® + UHM-21 D0/D14 (n=8); concurrent controls (n=2) + 5 historical controls. Challenge 10 000 TCID ₅₀ BDBV at 12 weeks. Survival, viremia, clinical disease, IgG.	Ervebo® alone: 3/4 survived with reduced viremia/milder disease and BDBV-binding antibodies. Controls: 2/7 survived overall; both concurrent controls died. Combination: only 2/8 survived, despite highest BDBV antibody titres. Antibody titre did not correlate with protection.	Small groups, particularly Ervebo® (n=4) and concurrent control (n=2); reliance partly on historical controls; BDBV NHP model incompletely lethal. Unpublished.
Wight et al., 2026 (12)	Research-grade rVSV-ZEBOV, not licensed Ervebo®	Ferrets. One dose (n=6); two doses D0/D14 (n=6); saline controls (n=2); staggered unvaccinated controls (n=2). Challenge: 1000 TCID ₅₀ BDBV, mostly D28. Survival, viremia, shedding, IgG.	12/12 vaccinated survived vs 0/4 controls. Reduced viremia and viral shedding; cross-reactive BDBV IgG. Ten historical controls also reportedly all died within 9 days.	Small # of controls. Limited experience/validation of BDBV ferret model. Unpublished challenge study.

Table 2. Summary of human data on Ervebo® performance against BDBV

Study	Vaccine / exposure	Methods	Key findings	Key limitations
Ehrhardt et al., 2019 (13)	Ervebo® / rVSV-ZEBOV vaccine recipients	Samples from seven Phase I recipients. EBOV GP-specific memory B cells isolated; monoclonal antibodies generated and assessed for binding, neutralization, epitope specificity and cross-reactivity to BDBV GP.	Approximately 30–76% of isolated antibodies showed some cross-reactivity across ebolavirus species. Serum heterologous responses to BDBV were substantially weaker than homologous EBOV responses.	Only seven participants. No assessment of BDBV cross-neutralization. Clinical relevance of cross-reacting antibodies has not been established.
Lhomme et al., 2026 – PREVAC (14)	Licensed Ebola vaccine regimens, including rVSVΔG-ZEBOV-GP	Participants in West Africa: one-dose rVSV; two-dose rVSV D0/D56; Ad26.ZEBOV/MVA-BN-Filo. Multiplex Luminex GP binding assay; D28 n=55, M3 n=124; adults and children.	Cross-reactive BDBV-binding antibodies after vaccination. Levels lower than against EBOV/Kikwit but higher than Marburg virus. No additional BDBV response from D56 rVSV booster.	Binding antibodies only; no BDBV neutralization or Fc-mediated functional assays; clinical relevance unknown.
Halbrook et al., 2026 (15)	rVSVΔG-ZEBOV-GP vaccination in the Democratic Republic of the Congo	1081 participants from North Kivu and Equateur. Multiplex pan-filovirus assay measuring antibodies against EBOV, BDBV, Sudan virus (SUDV) and Marburg virus; longitudinal follow-up.	Sustained EBOV GP response over ~5 years and evidence of sustained BDBV cross-reactivity. Patterns differed between regions.	Preprint. Binding assay; no cross-neutralization or Fc-function assessment. Regional differences suggest possible effects of background exposure/other factors. Does not establish protection.
Hoffmann et al., 2026 (16)	Ervebo® recipients	Serum from 10 Phase I participants, D28 and D180. rVSV pseudovirus neutralization assay using EBOV Makona, SUDV and three BDBV strains (2007/08, 2012, 2026).	Robust EBOV neutralization; no SUDV neutralization. Some neutralization of all three BDBV pseudoviruses, consistently lower than against EBOV.	Only 10 participants. Pseudovirus rather than native BDBV; measures viral entry only; relationship to clinical protection unknown.
Democratic Republic of the Congo outbreak surveillance / Mongbwalu observations, 2026 (17)	Prior Ervebo® vaccination	Descriptive surveillance observations.	Nine confirmed BDBV cases with recorded prior Ervebo® reportedly survived; none of 242 deaths with available vaccination status was recorded as vaccinated. Probable HCW cluster: 3/3 vaccinated survived vs 0/5 unvaccinated.	Vaccination histories and denominators incomplete; survivor and ascertainment bias; major confounding; HCW cluster not laboratory confirmed. Cannot estimate vaccine effectiveness or establish protection.
LaRochelle et al., 2026 – Bunia hospital cohort (18)	Prior Ervebo® vaccination	Descriptive surveillance observations.	37 hospital staff admitted with infectious symptoms; 11 BDBV-	Very small cohort; incomplete testing/vaccination documentation;

			positive. Three of the 11 confirmed cases had previously been vaccinated. Two confirmed cases died: one unvaccinated, one vaccination status unknown. Presence of breakthrough BDBV among vaccinees confirms Ervebo® does not provide complete protection. Findings compatible with possible partial protection but cannot quantify it.	exposure, care and selection differences; no valid denominator/comparator for vaccine effectiveness.
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Research priorities

- Development of BDBV-specific vaccines: Accelerate the development and clinical evaluation of BDBV-specific vaccines, including the generation of safety, immunogenicity and efficacy data needed to inform future regulatory and policy decisions.
- Ervebo® cross-protection and homologous boosting: Determine whether Ervebo® has any protection against BDBV and, if so, measure the magnitude and duration of that protection, and assess whether, and at what interval, an additional dose of Ervebo® may enhance or prolong cross-protection.
- BDBV-specific vaccination following Ervebo®: Assess whether prior vaccination with Ervebo® enhances, modifies or impairs immune responses to subsequent vaccination with a BDBV-specific vaccine, including the potential influence of the interval between vaccinations.
- Heterologous prime–boost strategies. Evaluate sequential vaccination strategies combining Ervebo® and BDBV-specific vaccines, and potentially vaccines targeting other orthoebolaviruses, to determine whether such approaches can provide broader, stronger or more durable protection.
- Existing Ervebo®-vaccinated populations. Where feasible, leverage existing cohorts, vaccination records and surveillance data from previous Ervebo® vaccination campaigns to assess BDBV infection, disease severity and mortality according to prior Ervebo® vaccination status and time since vaccination.
- Correlates of cross-protection. Characterize immune responses associated with protection against BDBV following Ervebo® vaccination, including binding and neutralizing antibodies, antibody-mediated functional responses and cellular immunity. Where feasible, these investigations should be nested within clinical efficacy and vaccine effectiveness studies to support identification of immune correlates of cross-protection.
- Modelling of vaccination strategies and public health impact. Model the potential population-level impact of alternative vaccination strategies, including revaccination and heterologous boosting strategies under different assumptions regarding cross-protection, duration of protection and epidemiological conditions. Modelling should also assess implications for vaccine demand, supply, allocation and the Ervebo® stockpiles.

Plans for updating

WHO continues to monitor the situation closely for any changes that may affect this emergency guidance. Should any factors change, WHO will issue an update. This guidance will no longer be considered valid six months after publication if an update is not published.

Acknowledgements

WHO gratefully acknowledges the many individuals who contributed to the development of this emergency guidance.

This emergency guidance was prepared by Alba Vilajeliu, Pierre Gsell, and Melanie Marti of the SAGE Secretariat, Department of Immunization, Vaccines and Biologicals, WHO headquarters, under the supervision of Annelies Wilder-Smith, Senior Team Lead, SAGE Secretariat; Gitte Giersing, Unit Head, Research, Development and Policy; and Kate O'Brien, Director, Department of Immunization, Vaccines and Biologicals, and the technical guidance from the SAGE Working Group on Ebola Vaccines and SAGE.

SAGE Working Group on Ebola Vaccines: Helen Rees, Wits Reproductive Health and HIV Institute, South Africa (Chair); Yemane Berhane, Addis Continental Institute of Public Health, Ethiopia (Co-Chair); Ezzeddine Mohsni, Eastern Mediterranean Public Health Network, Tunisia; Nick Andrews, UK Health Security Agency, United Kingdom of Great Britain and Northern Ireland [United Kingdom]; Ndack Diop, Université Cheikh Anta Diop, Senegal; David Durrheim, University of Newcastle, Australia; Mosoka Fallah, Africa Centres for Disease Control and Prevention, Ethiopia; Jean-Paul Jemmy, Médecins Sans Frontières, Belgium; Ann Kelly, University of Oxford, United Kingdom; Keymanthri Moodley, Stellenbosch University, South Africa; Robert Pless, Public Health Agency of Canada, Canada; Marie-Angélique Sène, Institut Pasteur de Dakar, Senegal; Oyewale Tomori, Redeemer's University, Nigeria; and Fred Were, University of Nairobi, Kenya.

SAGE members: Anthony Scott, KEMRI-Wellcome Trust Research Programme, Kenya (Chair of SAGE); Ruth Karron, Johns Hopkins University, United States of America; Ghassan Dbaibo, American University of Beirut, Lebanon; Cristiana Toscano, Universidade de Federal de Goiás, Brazil; Punnee Pitisuttithum, Mahidol University, Thailand; Sonali Kochhar, University of Washington, United States of America; Saad Omer, Peter O'Donnell Jr. School of Public Health, UT Southwestern Medical Center, United States of America; Carla Vizzotti, National University of San Martín, Argentina; Ziad Memish, Saudi Ministry of Health, Saudi Arabia; Gabriel Leung, University of Hong Kong, Hong Kong Special Administrative Region, China; Rebecca Grais, Pasteur Network, France; Marc Jit, New York University, United States of America; Glenda E. Gray, Wits University, South Africa; and Fiona Russell, University of Melbourne, Australia.

Declaration of interests

The membership and declaration of interests of SAGE Working Group on Ebola vaccines and SAGE can be found on the WHO website:

- The membership and declaration of interests of the SAGE Working Group on Ebola vaccines: www.who.int/groups/strategic-advisory-group-of-experts-on-immunization/working-groups/ebola
- The membership and declaration of interests of SAGE: [https://www.who.int/news-room/events/detail/2026/08/19/default-calendar/extraordinary-meeting-of-the-strategic-advisory-group-of-experts-\(sage\)-on-immunization-19-august-2026](https://www.who.int/news-room/events/detail/2026/08/19/default-calendar/extraordinary-meeting-of-the-strategic-advisory-group-of-experts-(sage)-on-immunization-19-august-2026)

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Suggested citation. WHO emergency guidance on the use of licensed Ebola vaccine during Bundibugyo virus disease outbreaks, 31 August 2026. Geneva: World Health Organization; 2026. <https://doi.org/10.2471/B09884>