***Figure:*** **Efficacy of a single dose of modified and non-modified Andes virus mRNA vaccines against infection in hamsters**
(A) Hamsters were intramuscularly vaccinated with modified or non-modified Gn/Gc mRNA vaccines at 25 μg, 5 μg, and 1 μg (five hamsters per dose per vaccine). One group was mock-vaccinated with PBS. Hamsters were challenged with 350 PFU of Andes virus by the intramuscular route at day 28. Panel A was created with BioRender.com. (B) All hamsters were monitored for survival, bodyweight change, and clinical scores (1–4 scale, where 1=healthy and 4=humane endpoint; highest daily score for each hamster is shown) for 28 days after the challenge. (C) Liver virus titres from hamsters that died, reached euthanasia criteria, or surviving hamsters at the day 56 study endpoint (PFU per gram of tissue). (D) Gn/Gc-specific IgG serum titres were determined by ELISA before infection. Error bars represent mean ± SE. Dashed line indicates limit of detection. Repeated-measures two-way ANOVA with Tukey's multiple comparisons test was used to compare temporal changes within each vaccine dose group. The Kruskal–Wallis test with Dunn's post-hoc correction was used to compare dose levels for each vaccine at each timepoint. Mann–Whitney *U* tests with Bonferroni correction was used for comparison between vaccines at each dose level and timepoint. LNP=lipid nanoparticle. PBS=phosphate buffered saline. PFU=plaque-forming units. *p<0·005.

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# WHO and Africa CDC declare the 2026 Ebola disease outbreak a public health emergency

The 2026 outbreak of Ebola virus disease in DR Congo and Uganda, caused by Bundibugyo virus (*Orthoebolavirus bundibugyoense*), represents one of the most consequential epidemic emergencies in Africa. The current outbreak is particularly concerning because of its epidemiological and operational complexity. As of May 27, 2026, 129 confirmed cases, 1077 suspected cases, and 246 suspected deaths from the outbreak have been reported in DR Congo and Uganda.[1] Transmission has occurred in highly mobile mining and commercial corridors and conflict-affected zones, with increasing risk of regional dissemination. Delayed detection further amplified transmission. No medical countermeasures currently exist against the Bundibugyo virus.[2] Africa is therefore once again confronting a severe epidemic threat with inadequate validated diagnostics, therapeutics, and vaccines, reflecting a broader structural imbalance in global health security in which research and development priorities continue to be driven more by market incentives than by epidemiological realities in vulnerable regions.[3] Cognisant of these realities, WHO and the Africa Centres for Disease Control and Prevention (Africa CDC) declared the outbreak a Public Health Emergency of International Concern and a Public Health Emergency of Continental Security (PHECS), respectively, to galvanise a coordinated response.

The declaration reflects the growing institutionalisation of African health sovereignty and continental governance mechanisms. Engagement of relevant political leadership and scientific experts before the declaration reflects the growing recognition that epidemic threats increasingly constitute continental security concerns that require coordinated African political leadership and operational solidarity.[4] After extensive review of epidemiological trends, transmission risks, health system impacts, operational complexities, and socioeconomic implications, the Africa CDC Emergency Consultative Group concluded that the outbreak met the threshold for a PHECS due to its severity, cross-border risks, and implications for regional and global health security.[5] The Emergency Consultative Group also recommended that the response be coordinated by

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the Incident Management Support Team—which operates in the One Team, One Plan, One Budget, and One Monitoring and Evaluation Framework—to unify governments, technical agencies, donors, non-governmental organisations, research institutions, and humanitarian actors under a coordinated operational architecture to reduce fragmentation and accelerate decision making.[6]

The response requires rapid implementation of the Incident Management Support Team structure and strengthened cross-border collaboration between affected and neighbouring countries. Early detection with immediate isolation through strengthened surveillance and decentralised diagnostics must be urgently expanded. Infection prevention and control measures also require immediate reinforcement. Safe and dignified burials, regular handwashing, and avoidance of direct contact with symptomatic individuals and sick or dead animals must be prioritised to reduce community transmission and reduce exposure during caregiving and funeral practices. Community engagement and culturally sensitive risk communication are essential to counter fear, stigma, misinformation, and resistance to public health measures. Accelerated research and development are urgently needed to evaluate candidate vaccines, therapeutics, and diagnostics for Bundibugyo virus disease.

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## Urgent call for an Ebola truce in DR Congo

The current outbreak of Ebola virus disease caused by Bundibugyo virus in DR Congo and Uganda is not only a biomedical emergency, but a test of whether global health diplomacy can be made operational in a conflict zone. WHO has declared the event a Public HEALTH Emergency of International Concern, citing insecurity, population mobility, health-care worker infections, and uncertainty about the extent of transmission.[1]

The affected area sits within one of the world's most complex humanitarian crises, with armed violence, contested authority, displacement, and disrupted access to health care affecting large parts of eastern DR Congo.[2] An Ebola response in this setting must cross front lines, checkpoints, areas controlled or influenced by different armed actors, and communities that have experienced years of violence and mistrust. The response should also reach displaced populations: recent data from the International Organization for Migration estimate that more than 2·1 million people have been internally displaced in North Kivu and Ituri alone.[3] Overcrowding, poor water and sanitation, and fragile health services in such settings can turn delayed detection, unsafe care, or disrupted burial practices into amplified transmission.

In this context, we call for an urgent, time-limited humanitarian pause centred on outbreak control—an Ebola truce. This truce should not be framed as a political settlement or recognition of any groups party to the conflict. Rather, it should be a narrowly defined operational agreement, or at least a set of parallel guarantees, involving all actors able to facilitate or obstruct the response. These actors include national and provincial authorities within DR Congo; the Congolese armed forces; allied local armed groups, including Wazalendo; armed groups active in Ituri, North Kivu, and South Kivu, including the Allied Democratic Forces and Cooperative for the Development of Congo, the Alliance Fleuve Congo, and Mouvement du 23 Mars, where these groups control territory, roads, or checkpoints; MONUSCO (the UN peacekeeping mission) where relevant; community and religious leaders; national and international non-governmental organisations; Africa Centres for Disease Control and Prevention; WHO; and trusted local mediators.

The purpose of this truce would be practical: safe passage for all patients, health workers, ambulances, burial teams, laboratory samples, supplies,