100 Days into the Bundibugyo response:

Rapid progress made towards equitably accessible countermeasures, but more needs to be done

25 August 2026

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August 25th marks 100 days since the Bundibugyo outbreak was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO); the following day, the Africa Centres for Disease Control and Prevention (Africa CDC) declared a Public Health Emergency of Continental Security (PHECS).

The outbreak is far from over. Cases continue to rise and so does the death toll. The 100 days milestone offers an opportunity to examine what the world can learn from this outbreak about how to achieve the 100 Days Mission: the aim to develop safe, effective and accessible medical countermeasures within 100 days of a pandemic threat.

This brief focusses on the vaccines R&D and manufacturing response.

Where we are, at Day 100

- **Two BDBV vaccine candidates in Phase 1 trials**: ChAdOx1-BDBV (Oxford/Serum Institute of India (SII)) and mRNA-1469 (Moderna) – *with funding from CEPI.*
- **At-risk manufacturing of clinical doses:** SII and Moderna investigational doses available for trial use; Hilleman Laboratories will take forward the manufacturing process and production of the IAVI rVSV candidate – *all with funding from CEPI.*
- **Studies being initiated to inform how to make best use of existing vaccines:** Evaluation of cross-reactive antibodies induced by vaccines either already or previously licensed against Ebola Zaire in humans – *with funding from CEPI.*
- **Ph2/3 trial being prepared:** Trial protocol in development, consortium being established, ethical and regulatory submissions planned – *multiple partners including CEPI.*
- **Push-pull financing coordination:** Early coordination between *CEPI, Gavi and UNICEF* on financing approaches allowed rapid funding signals to be activated[1]; Gavi has made up to $40M available to enable accelerated access to investigational doses, and incentivise eventual procurement of approved vaccines via UNICEF.
- **Biosecurity and outbreak resilience support:** Technical assistance on safe and secure sample acquisition, transfer and storage as well as biowaste management, and ongoing threat monitoring across a conflict-affected operating environment.
- **Ervebo vaccines allocated to the Democratic Republic of the Congo (DRC),** including 20,000 doses for a Phase 3 clinical trial that will assess impact of the vaccine against BDBV, and an additional 50,000 doses for frontline and health workers, *under the auspices of the DRC, the Institut National de Recherche Biomédicale and Africa CDC, and with $7M Gavi funding for the doses.*

Equitable access is at the forefront of the Bundibugyo R&D response, with equitable access provisions in all CEPI-funded vaccine candidate agreements; plans underway for Phase 1 trials of BDBV vaccine candidates in East Africa and for inclusion of children and pregnant women in trials at the earliest appropriate stage; and with discussions started on the need for African manufacturing. In parallel, work is underway to prepare for post-trial vaccine access via the continental Incident Management Support Team co-chaired by Africa CDC and WHO AFRO; and coordination between CEPI and downstream partners will facilitate smooth handoffs.

We are moving fast – but we need to be faster

This outbreak illustrates both the progress the world has made with the 100 Days Mission and the distance it still needs to go.

Outbreaks differ and faster timelines reflect many factors. However, it is clear that the speed and equity of the response depends on what is already in place on Day 1.

This response has achieved genuine world firsts, hitting some milestones faster than seen during the COVID-19 pandemic. Comparing to the 2014-2016 Ebola outbreak (a closer match, albeit not identical, for outbreak size, epidemiology and affected region) is even starker. For example, from the first case reported to WHO: **more than 100 days faster to declare the Public Health Emergency of International Concern**; for adenovirus vaccines, **half the time to start Phase 1 trials** ***(Figures 1 & 2).***

Scientific knowledge, vaccine libraries, platforms, clinical trial networks, manufacturing processes, regulatory pathways, infrastructure and relationships are still being built. These need to be ready to activate when the outbreak hits. Speed in one part of the pathway is not enough; it must be across the end-to-end system. For this Bundibugyo outbreak, only some of these capabilities are already in place, and not all of them were sufficiently ready.

Figure 1: Days from first case reported to WHO[1], to declaration of PHEIC

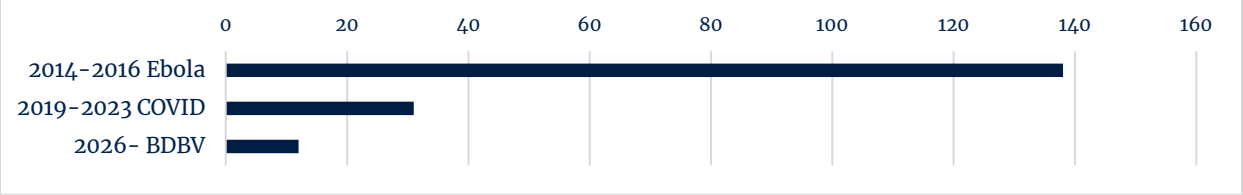
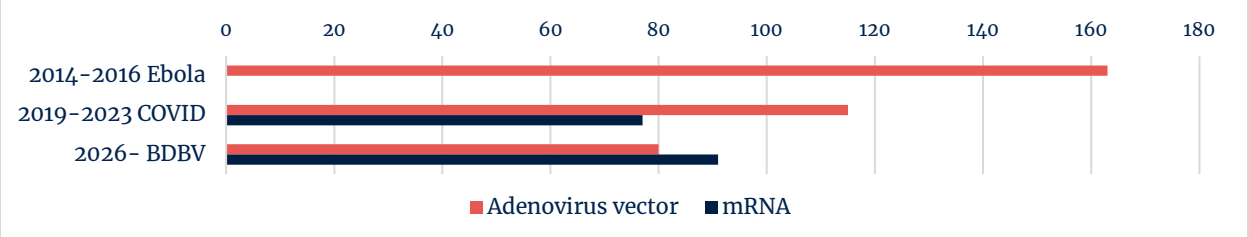


Figure 2: Days from first case reported to WHO, to first dose received in Ph 1 vaccine trial



[1] Based on retrospective estimate of first case, the delay to report to WHO is also decreasing: three months for Ebola 2014-2016; one month for COVID-19; and less than two weeks for Bundibugyo in 2026.

Progress to accelerate vaccine development timelines

A viral family approach

Bundibugyo is a rare ebolavirus. At the start of the outbreak, there were no approved vaccines, and Bundibugyo-specific candidates only had limited preclinical data. However, there were existing knowledge and scientific assets developed through work on other members of the filovirus family – including antigen designs, survivor samples, characterisation work, and some early vaccine constructs. Existing scientific institutions and relationships could also be mobilised. This is the practical argument for a viral family approach over a pathogen-by-pathogen one: we don't know which virus will cause the next outbreak, so we need to build a response capability that can work for any of them.

This outbreak also shows the approach is not yet complete. Filoviruses benefit from a deep base of prior investment, CEPI-funded and otherwise, built up over more than a decade of work on Ebola Zaire, Ebola Sudan, and Marburg. Even so, gaps remained in the readiness for this outbreak at Day 1. For example, there was no substantial pre-existing data on BDBV using existing rapid response platforms, and we remain unable to rapidly measure an immune response. Equally, while there was limited preclinical and clinical evidence regarding the presence of cross-reactive antibodies[2] against BDBV induced by existing licensed or investigational vaccines against other ebolaviruses, additional serological data now needs to be generated rapidly during the response.

We need to invest both to take known threats off the table, and to reduce risk from unknown and rare threats. Instead of investing in a single pathogen, we need to build broader readiness, with insights from one pathogen strengthening our understanding and preparedness for others. Learnings from Bundibugyo are already helping to inform what needs to be in place before an outbreak, to make us better prepared and ready to respond within a viral family.

'Warm-ready' vaccine platforms

A 'warm-ready' platform may allow vaccine candidates to move quickly from sequence selection through clinical evaluation to full-scale production, by having partnerships, pre-clinical and clinical data, manufacturing processes, quality systems, supply chains, and regulatory preparedness in place – alongside ready-to-pivot manufacturing facilities.

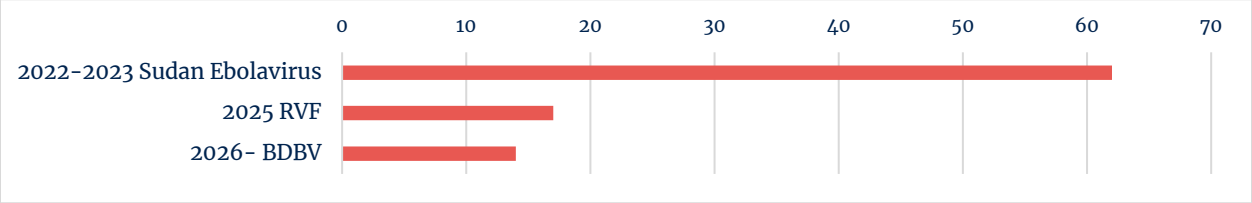
The lead Bundibugyo vaccine candidates all use vaccine platforms; of these, CEPI is supporting candidates using Oxford/SII's ChAdOx1, Moderna's mRNA, IAVI's rVSV and Public Health Vaccine's rVSV. Platforms have the potential to significantly reduce timelines, for example:

- Faster vaccine design (e.g., Moderna COVID vaccine was designed in 36 hours)
- Faster manufacturing (e.g., after receiving the essential materials, SII produced Bundibugyo doses for clinical trial use in two weeks. This follows a prior record of just 16 days to produce doses for the 2025 Rift Valley Fever outbreak[ii], ***Figure 3***.)

[2] Clinical trials will also be required to determine if non-BDBV Ebola vaccines provide cross-protection. WHO Technical Advisory Group guidance is that a monovalent BDBV-specific vaccine is likely to be most effective; it therefore remains imperative to continue to advance matched candidates.

- Contributing to faster trial starts (e.g., first dose in Phase 1 trials for Bundibugyo within 12 weeks for ChAdOx1; 13 weeks for Moderna mRNA)
- For successful candidates, the platform data may be able to be leveraged to facilitate authorisation (e.g., Moderna COVID-19 omicron strain change to approval in 9 weeks)

Figure 3: Days for manufacturing lead time of vaccine drug substance of ChAdOx at SII



This outbreak has demonstrated what two 'warm-ready' platforms can achieve - but readiness of this kind does not exist for all platforms, and cannot be assumed for the next threat. We need to invest in readiness of platforms with diverse characteristics, paired with proportionate biosafety and biosecurity risk oversight, in advance of the next outbreak, to increase resilience and give the next response more options from Day 1.

Networks and ready-to-activate capabilities

Platforms and viral family knowledge only translate into speed if they can be operationalised through existing technical and operational capabilities. Outbreak-ready networks are CEPI's way of making sure the world never again loses precious weeks to confusion and fragmentation. When operational, they create a system where the essential pieces of response - detection, data, trials and manufacturing - are already in place and ready to switch on, and regulatory authorities have the available tools to accelerate their reviews.

Within **three days** of the PHEIC declaration, CEPI activated six pre-positioned networks, spanning capability areas of immunology labs, preclinical models, epidemiology, manufacturing, clinical research and regulatory. These networks and their current capabilities have significantly supported the response, including through assay development, coordination of scarce preclinical models for vaccine testing, adaptation of clinical trial protocols, regulatory engagement on evidence requirements, and at-risk manufacturing.

The experience of the Uganda Virus Research Institute (UVRI), detailed in the call-out box below, makes this tangible. Prior preparedness investment meant that, rather than building capabilities from scratch, existing assets were ready to be adapted to support the response.

There is clear progress in rapidly activated networks for BDBV; at the same time, more work is needed for these to be fully operationally ready in the future. Operational readiness depends on whether the specific capacity, materials and operating arrangements needed to respond are available at outbreak speed. For example, within the Preclinical Model Network, access to specific capacity was initially limited, and required new partners; within the Centralised Laboratory Network, although assays, reagents and survivor samples were available, constraints in moving samples, securing the necessary cross border agreements and coordinating logistics caused delays in making use of these assets. These constraints are as much governance as logistics. Pre-negotiated material transfer agreements, secure sample

transport arrangements, and clarity over the safe stewardship of materials needs to be in place before an outbreak, not assembled during one. Building these arrangements in advance would allow existing assets to be used at outbreak speed while maintaining responsible oversight of dangerous pathogen samples.

We also need to engage partners across surveillance, labs, clinical trials, manufacturing and regulation to practice working together through real-world responses and simulation exercises. By rehearsing critical parts of the vaccine development and manufacturing process, gaps can be identified and fixed before an emergency to ultimately deliver the 100 Days Mission.

Long-term preparedness strengthened UVRI's response to regional disease threats

UVRI was one of the Centralised Laboratory Network partners activated rapidly in this response. Long-standing preparedness investments, with CEPI support, had pre-positioned scientific assets, quality systems and partnerships, reducing the amount of work needed before research could begin, supporting credible locally-led evidence generation, and giving UVRI a stronger foundation from which to contribute to outbreak response.

> *Without these capabilities the team would have been "just observing, with no survivor access, no assays, and no reagents."* - Researcher, UVRI

What was in place	How it was used	Why it mattered
Assays, reagents and survivor samples	Adapted for Bundibugyo response work	Leveraged existing lab methods, reduced the number of steps needed before research could begin
Quality-assured laboratory and biorisk management systems	Used to generate and manage outbreak evidence under established biosecurity and biosafety controls	Made data reliable, traceable and usable across partners, and ensured dangerous samples were handled under trusted local stewardship
Scientific & regional partnerships	Mobilised for technical support, training and collaboration	Expanded access to expertise and supported regional cooperation, leveraged existing trust amongst partners

This demonstrates the importance of preparedness investments that build ready-to-activate capabilities before outbreaks happen; address operational barriers before the emergency; treat partnerships and trust-building as preparedness infrastructure; and empower local leadership. It also shows that trusted, locally-led stewardship of dangerous pathogen samples is itself a preparedness asset, strengthening rather than competing with the case for regionally anchored, locally-led response. The full case study will be published shortly.

What the world still needs to do

For this outbreak

Fill the funding gap. The Africa CDC and the WHO together launched a joint Continental Preparedness and Response Plan[iii], which aims to raise $518M to support African countries, together with partners to respond to the outbreak. To date, only $333.2M[iv] has been disbursed. For vaccines R&D, CEPI's goal is to bring at least two Bundibugyo virus vaccine candidates to

Emergency Use Authorisation. This could help curtail the outbreak and save lives, while strengthening the global pipeline of countermeasures to tackle future Bundibugyo outbreaks and making an early contribution to CEPI 3.0's goal of improving preparedness and protection against the world's most dangerous viral threats. CEPI is making an urgent appeal for additional contributions to the emergency response[v]. Without immediate additional funding, we risk delays to Phase 2/3 trials, to vaccine access, and ultimately fewer lives saved.

Ensure post-trial equitable access. Equitable access is not guaranteed and must be considered from the outset. Vaccine partners have identified draft, non-exhaustive access priorities, to be refined and published in a vaccine access roadmap, in support of the Continental Incident Management Support Team. These include the need to: ensure access is embedded in clinical trial design such as integration of RCCE and social and behavioural science into trials and beyond; understand country-level acceptability for vaccine candidates; resolve indemnification and liability gaps; integrate special access approaches for displaced and refugee populations; and ensure country readiness receive, authorise and deploy vaccines. There is further an urgent need to understand community perspectives and implications around use of Ervebo on access to BDBV vaccines and ensure transparency of evidence to foster trust in affected communities.

For the future: make the 100 Days Mission into an operational reality

Use 100 days as the organising logic. The world is aligning around a shared goal: to accelerate research, development and manufacturing, with the aim of safe, quality, effective, equitable, affordable and accessible medical countermeasures within the first 100 days of a pandemic threat. The "100 days" target is recognised in the submitted Political Declaration for this year's UN High Level Meeting on Pandemic Prevention, Preparedness and Response.

Improve ecosystem monitoring. The ecosystem requires robust independent monitoring that measures progress towards the UN-agreed target of 100 days, including through evaluation of end-to-end operational capability readiness, and through better capture of cross-sectoral financing commitments, that go beyond a health-only lens. The 100 Days Mission must hold regardless of how an outbreak begins, and readiness assessments should reflect that.

Strengthen regional and cross-sectoral partnerships: Rapid and equitable 100 Days Mission response depends not only on having technologies ready, but on having institutions, capabilities and relationships ready to activate, geographically anchored in regions, and working across sectors – including health, security, defence, finance, and different medical countermeasure types, with relationships, trust, and shared ways of working established between emergencies rather than improvised during them.

Secure the future. Pandemic preparedness is at risk of being deprioritised – even with the COVID-19 pandemic – and its toll of 15 million excess deaths and US$13.8 trillion in lost output - still fresh in memory, and what may become the largest ever ebolavirus outbreak unfolding. We cannot allow this to happen. The world must invest in the institutions and capabilities that make us all safer, advancing preparedness and readiness to enable rapid surge in an outbreak response. Earlier this year, CEPI launched its 3.0 Strategy[vi], outlining an ambitious program of investments in viral families, platforms and ready-to-activate networks. An investment in CEPI[vii] is an investment in the capabilities required to drive measurable progress to turn the 100 Days Mission into operational reality.

[i] Gavi. News Release [29 May 2026] https://www.gavi.org/news/media-room/gavi-commits-us-50-million-bundibugyo-ebolavirus-vaccines-and-outbreak-response
[ii] CEPI. News Release [13 January 2026] https://cepi.net/cepi-oxford-serum-create-largest-ever-reserve-investigational-rift-valley-fever-vaccine
[iii] WHO AFRO. Bundibugyo Ebola Virus | Continental preparedness and response plan: June-November 2026 [June 2026] https://www.afro.who.int/publications/bundibugyo-ebola-virus-continental-preparedness-and-response-plan-june-november-2026
[iv] WHO. BVD Coordinated Financial Tracking Mechanism. [Accessed 24 August 2026] https://who-emergencies.shinyapps.io/bvd-ftm/
[v] CEPI. Funding is needed NOW to deliver the R&D response [August 2026] https://cepi.net/Bundibugyo-RD-funding-appeal
[vi] CEPI. 3.0 Strategy Report [February 2026] https://static.cepi.net/downloads/2026-02/CEPI%203.0%20Strategy%20Report%20DIG%20ENG%20FINAL.pdf
[vii] CEPI. 3.0 Investment Case [February 2026] https://static.cepi.net/downloads/2026-02/FINAL_DIGITAL_CEPI%203.0-Investment%20Case%20Report_ENG_small-file_V1.1_0.pdf