

FIP Ebola reference guide

Guidance on Ebola virus disease for pharmacists and the pharmaceutical workforce
2026



FIP Development Goals

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Contents

Acknowledgements	2
Purpose	3
1. Why pharmacists are fundamental to Ebola preparedness and response	3
2. The role of pharmacists	3
3. Understanding Ebola virus disease	4
3.1. What is EBOD?	4
3.2. Species of the virus	4
3.3. Transmission	5
3.4. Common misconceptions about transmission	6
4. Clinical information	6
4.1. Onset and incubation period	6
4.2. Signs and symptoms	6
4.3. Treatment and supportive care	7
4.4. Post-recovery and survivor follow-up	7
4.5. Prevention measures	8
5. Pharmacist-led infection prevention and control activities	8
5.1. Hand hygiene	8
5.2. Personal protective equipment (PPE)	9
5.3. Environmental cleaning and disinfection	9
5.4. Waste management and safe handling of potentially contaminated materials	9
6. Key actions for pharmacists during an Ebola outbreak	9
6.1. Screening	9
6.2. Referral	10
6.3. Vaccination	10
6.4. Patient and public education	11
7. Pharmacy preparedness for EBOD outbreaks	11
7.1. Surveillance and early detection	11
7.2. Maintaining essential pharmacy services	12
7.3. Staff protection, training, and preparedness	12
8. Conclusions	12
Appendix 1. Example national adaptation: DRC	13
Purpose	13
A1. Epidemiological context	13
A2. Responsibilities of pharmacists in the DRC	13
A3. Operational checklist for pharmacy settings	13
A4. Minimum preparedness indicators	15
References	16

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Purpose

This document provides updated information and guidance on Ebola disease (EBOD) to support the pharmaceutical workforce in preparing for and responding to outbreaks and public health emergencies. It reflects recent developments in EBOD preparedness, prevention and response, and complements the World Health Organization (WHO) guidance on filovirus diseases.

It is intended for pharmacists working across community, hospital, primary care, and public health emergency settings. It supports them in recognising potential cases, providing accurate public health information, reinforcing infection prevention and control (IPC) measures, and referring suspected patients safely and appropriately according to national and local protocols.

Compared with the previous FIP guidance published following the 2014-2016 West African EBOD outbreak, this document includes updated information on:

- EBOD species
- clinical management
- vaccination options and strategies
- infection prevention and control
- surveillance and outbreak preparedness
- community engagement and public health response.

As one of the most accessible healthcare professionals, pharmacists may be approached by patients and caregivers for advice during EBOD outbreaks or periods of heightened public concern. This document aims to support the pharmaceutical workforce in responding with accurate information, reinforce public health guidance, protect staff and patients, and strengthen coordinated outbreak preparedness and response.

1. Why pharmacists are fundamental to Ebola preparedness and response

EBOD can be prevented, detected early, and controlled through coordinated action by governments, healthcare professionals, public health authorities, communities, and the media. Pharmacists are an essential part of this response because of their accessibility, their role in public health literacy, and their contribution to medicine supply, infection prevention, referral, and continuity of care.

Since the notable 2014 EBOD outbreak, global understanding of outbreak preparedness and response has significantly evolved. The recent WHO guidance emphasises the importance of surveillance, contact tracing, clinical preparedness, IPC, and cross-border preparedness in responding to EBOD outbreaks.¹

Pharmacists can contribute effectively to EBOD preparedness and response through practical, evidence-based public health, clinical, and educational activities that can be adapted to national and local context. Pharmacists should not be seen only as medicine suppliers during outbreaks. They are trusted public healthcare professionals who are equipped to support disease prevention, outbreak preparedness, early identification of risk, safe referral, community engagement and education, vaccination-related services where authorised, and the maintenance of essential health services during public health emergencies.

2. The role of pharmacists

Pharmacists support EBOD preparedness and response through public health, clinical, operational, and educational activities. As one of the most accessible healthcare professionals, they contribute to disease

¹ World Health Organization. Clinical management and infection prevention and control for filovirus diseases: interim guidance, May 2026. Geneva: World Health Organization; 2026. Available from: <https://www.who.int/publications/i/item/9789240127253>

prevention, health promotion, early recognition of suspected cases, appropriate referral, IPC, medicine and vaccine management, public health communication and continuity of care.

The responsibilities of pharmacists vary according to their practice setting, national legislation, and the local outbreak context. Community pharmacists are unlikely to be directly involved in the clinical management of confirmed EBOD cases but play a critical role in prevention, public education, early recognition, appropriate referral, and reinforcing public health measures. Hospital pharmacists, particularly those working in healthcare systems with EBOD treatment centres, may contribute directly to multidisciplinary patient care, including procurement of investigational medication and vaccines, medicines management and supportive care for patients with EBOD.

Depending on the practice setting and outbreak context, pharmacists may contribute to:

- prevention and health promotion
- early recognition and referral
- infection prevention and control
- medicines and vaccine management
- public education and health literacy
- surveillance and public health collaboration
- preparedness and workforce development.

Pharmacists should remain informed about national guidance, local outbreak situations, and referral pathways to ensure meaningful contributions to broader public health response efforts.

3. Understanding Ebola virus disease

3.1. What is EBOD?

EBOD is a severe, highly infectious, and often haemorrhagic fatal disease caused by viruses within the genus *Orthoebolavirus*, family *Filoviridae*. Although outbreaks primarily occur in Africa, EBOD remains a global public health concern because of its potential for cross-border spread and its disruptive impact on healthcare systems.

EBOD outbreaks occur primarily in Central and East Africa and are often associated with zoonotic spillover events followed by human-to-human transmission. While outbreaks are relatively infrequent, they can have a significant impact on affected communities and healthcare systems, particularly where resources are limited. Recent outbreaks continue to demonstrate the importance of preparedness, surveillance, and rapid response capacity.

Advances in outbreak response, supportive care, vaccination, and therapeutics have significantly improved over the past decade. However, prevention, early detection, isolation, IPC, community engagement, and coordinated public health action remain essential components of outbreak preparedness and response.

3.2. Species of the virus

Three ebolaviruses are known to cause disease in humans. They belong to three species within the genus *Orthoebolavirus* (family *Filoviridae*):

- Ebola virus (EBOV); species *Orthoebolavirus zairense*
- Sudan virus (SUDV); species *Orthoebolavirus sudanense*
- Bundibugyo virus (BDBV); species *Orthoebolavirus bundibugyoense*

Historically, *Orthoebolavirus zairense* has been responsible for the majority of large outbreaks including the 2014-2016 West African epidemic. It is also currently the only species for which licensed vaccines and WHO-recommended monoclonal antibody therapies are available.

However, recent outbreaks have highlighted the continuing public health significance of non-*Orthoebolavirus zairense*. On 17 May 2026, WHO declared the cross-border outbreak of BDBV involving the Democratic Republic of the Congo (DRC) and Uganda, a Public Health Emergency of International Concern (PHEIC), highlighting the continued need for global vigilance, preparedness, and coordinated outbreak response.

Unlike a decade ago, identification of the causative virus is an important component of outbreak response. Determining the species involved helps guide public health strategies, informs the availability and use of vaccines and therapeutics, and supports the pharmaceutical workforce in providing appropriate prevention and treatment information during outbreaks.

At present, outbreaks caused by *Orthoebolavirus sudanense* and *Orthoebolavirus bundibugyoense* continue to rely primarily on high-quality supportive care, strict IPC measures, surveillance, laboratory confirmation, contact management, community engagement, and coordinated public health action. No licensed vaccines or approved virus-specific treatments are currently available. In the DRC, promising countermeasures may be evaluated only through authorised research protocols led by competent national authorities and ethics bodies. This highlights the reality that not all EBOD outbreaks can be managed using the same vaccines and treatment approaches.

3.3. Transmission

EBOD is transmitted through direct contact with the blood or other body fluids, secretions or organs of an infected person. Transmission may also occur through contact with surfaces, equipment, or materials contaminated with infectious body fluids.

The virus may be transmitted through:

- direct contact between mucous membranes (e.g., eyes, nose or mouth) or broken skin (e.g., cuts, wounds or abrasions) and blood, tissues or body fluids (such as saliva, mucus, vomitus, urine, stool, semen, vaginal discharge, sweat, tears, breast milk, bile and phlegm) of an individual with suspected or confirmed EBOD;
- direct contact with environments or contaminated clothing, bedding, medical equipment, or other materials;
- exposure to blood or body fluids of an infected person in healthcare settings where appropriate IPC measures are not implemented;
- exposure to infected animals, including handling or consumption of infected wildlife;
- participation in funeral or burial processes involving direct contact with the body or body fluids of a deceased person who had EBOD;
- sexual contact with survivors who continue to carry the virus in certain body fluids, particularly semen;
- transmission from a pregnant person to their foetus during pregnancy, to the newborn during childbirth, or through contact with infectious maternal body fluids after birth.

The risk of transmission increases as the illness progresses and viral levels rise. Individuals are not generally considered infectious before the onset of symptoms. Prompt identification and isolation of suspected cases, appropriate IPC measures, safe patient management, and community engagement are critical to preventing further transmission during outbreaks.

3.4. Common misconceptions about transmission

EBOD neither spreads or is transmitted in the same way as respiratory viruses such as influenza and COVID-19. Based on current evidence, EBOD is not transmitted through casual social contact with asymptomatic individuals.

EBOD is not known to be transmitted through:

- particulate matter from air over long distances in the manner of airborne respiratory diseases such as measles;
- mosquitoes or other insect vectors;
- food, water, or commercially imported goods that have not been contaminated with infectious body fluids;
- casual contact (such as shaking hands, hugging, contact with intact skin, or sitting next to someone) with healthy individuals who have not been exposed to the virus;
- vaginal fluids from a person who has recovered from EBOD.

The risk of infection is associated with direct exposure to infected body fluids or contaminated materials rather than routine social interaction. Clear communication of these facts is essential to reduce unnecessary anxiety, combat stigma, and support adherence to public health recommendations.

4. Clinical information

4.1. Onset and incubation period

The incubation period for EBOD ranges from 2 to 21 days, with symptoms most commonly appearing 7-11 days after exposure. Individuals are not generally considered infectious before symptoms develop. Once symptoms appear, the risk of transmission increases as the illness progresses and viral levels increase. Early recognition of symptoms and prompt referral are essential to reducing transmission and improving patient outcomes.

4.2. Signs and symptoms

The early symptoms of EBOD are often non-specific and may resemble those of other infectious diseases. Common early symptoms include:

- fever
- fatigue and weakness
- headache
- muscle and joint aches
- sore throat.

As the disease progresses, additional symptoms may include:

- vomiting
- diarrhoea
- abdominal pain
- rash
- dehydration
- impaired liver or kidney function.

Severe illness may progress to shock, organ dysfunction, or bleeding manifestations, although bleeding is not present in all patients.

Because early symptoms of EBOD overlap with many other common infectious diseases, including influenza, symptom assessment should always be considered alongside epidemiological risk factors such as travel history, occupational exposure, or contact with a suspected or confirmed case. Pharmacists should not attempt to diagnose or clinically manage suspected EBOD cases but should refer individuals promptly according to national or local protocols.

Laboratory testing is recommended for individuals with suspected EBOD and should be performed as soon as possible after symptom onset. Nucleic acid amplification testing (NAAT), including reverse transcription polymerase chain reaction (RT-PCR), is the preferred diagnostic method. Identifying the causative *Orthoebolavirus* species is important because it informs the selection of appropriate diagnostics, vaccines, and therapeutics where available. Testing asymptomatic individuals, including contacts, is not routinely recommended unless they develop symptoms consistent with suspected EBOD.

4.3. Treatment and supportive care

Advances in the management of EBOD have significantly improved patient outcomes over the last decade. For diseases caused by *Orthoebolavirus zairense*, WHO recommends the monoclonal antibody therapies Ansuvimab (mAb114) and Inmazeb (REGN-EB3), where available and appropriate. These therapies are recommended for laboratory-confirmed patients, including pregnant and breastfeeding women, children, and neonates born to confirmed EBOD mothers as early as possible, within seven days. These therapies have been shown to improve survival when administered early in the course of illness.

At present, equivalent approved therapies are not available for all Ebola virus species. Outbreaks caused by *Orthoebolavirus sudanense* and *Orthoebolavirus bundibugyoense* therefore continue to rely primarily on supportive care, IPC measures, surveillance, and public health interventions.

Despite these advances, supportive care remains the foundation of EBOD management and is essential for all EBOD species. Supportive care may include:

- early recognition and referral
- appropriate isolation while maintaining IPC precautions
- monitoring of clinical status
- fluid and electrolyte replacement to manage dehydration
- treatment of co-infections and complications
- management of shock and organ dysfunction
- nutrition and psychosocial support.

Paracetamol (acetaminophen) is recommended for fever and mild pain where appropriate. Opioids may be used for moderate to severe pain. Aspirin, diclofenac, ibuprofen, and other non-steroidal anti-inflammatory drugs (NSAIDs), and medicines with anticoagulant effects should generally be avoided because of the increased risk of bleeding.

Although community pharmacists are unlikely to provide direct clinical management for suspected or confirmed EBOD cases, they play a key role in providing accurate information, facilitating timely referral, supporting access to essential medicines and IPC products, and, where authorised, contributing to vaccination programmes.

Hospital pharmacists may contribute directly to multidisciplinary patient care, including medicines management, pharmaceutical care, antimicrobial stewardship, pharmacovigilance, and support for investigational therapies and vaccination programmes.

4.4. Post-recovery and survivor follow-up

Recovery from EBOD does not necessarily mark the end of a patient's healthcare needs. Survivors may experience continued physical, psychological, and social changes following infection, including fatigue,

musculoskeletal pain, visual disturbances, mental health challenges, and difficulties associated with stigma and social reintegration.

WHO recommends that individuals who recover from EBOD receive structured follow-up care after discharge. Follow-up care should be person-centred and may include ongoing clinical assessment, psychosocial support, counselling, rehabilitation services, and management of persistent or emerging health concerns.

Because the virus may persist in certain body fluids after clinical recovery, particularly semen, survivors should receive counselling on sexual health and transmission prevention. Current WHO recommendations support follow-up programmes, including semen testing where available, and adherence to updated public health guidance on safer sex practices, until transmission risks have been adequately addressed.

Pharmacists can support survivors by reinforcing public health recommendations, promoting medicine adherence where appropriate, providing ongoing education, and referring individuals to additional healthcare and psychosocial services. They also have an important role in helping to reduce stigma and supporting community understanding of recovery and long-term follow-up.

4.5. Prevention measures

Preventing EBOD requires coordinated action by individuals, communities, and healthcare systems. Early detection, rapid response, IPC measures, community engagement, and effective public health communication are central to preventing transmission and controlling outbreaks.

Key prevention measures:

- Avoid direct contact with blood and body fluids of individuals with suspected or confirmed EBOD.
- Practise effective hand hygiene using alcohol-based hand rubs (ABHR) or soap and water.
- Avoid contact with contaminated materials and environments.
- Ensure the safe management of deceased individuals through trained personnel and appropriate public health procedures.
- Avoid exposure to infected wildlife and unsafe handling of bushmeat.
- Seek medical attention promptly if symptoms develop following potential exposure.

Pharmacists contribute to prevention efforts by reinforcing public health messages, promoting health literacy and community engagement, encouraging adherence to IPC measures, and ensuring the availability of essential IPC products, including hand hygiene supplies and disinfectants.

5. Pharmacist-led infection prevention and control activities

Pharmacists contribute to IPC by implementing measures that protect patients, the pharmaceutical workforce, and the wider community during EBOD outbreaks. Effective IPC reduces the risk of transmission, supports continuity of healthcare services, and strengthens broader outbreak response efforts. Pharmacies should implement context-specific IPC measures based on their level of risk and national public health guidance. This includes ensuring that the pharmaceutical workforce is appropriately trained, essential IPC supplies are available, clear procedures are in place, and recommended IPC precautions are consistently followed.

5.1. Hand hygiene

Hand hygiene remains one of the most effective measures for reducing the transmission of infectious diseases. The pharmaceutical workforce should perform hand hygiene:

- before and after contact with patients

- after contact with potentially contaminated surfaces or materials
- after removing gloves or other PPE
- before and after handling medicines, medical devices, or health products.

Alcohol-based hand rubs (ABHR) should be used when hands are not visibly soiled. Soap and water should be used when hands are visibly dirty or contaminated. WHO recommends that ABHR formulations should have an alcohol content of 80% (ethanol) or 75% (isopropyl alcohol). In the updated guidelines, WHO explicitly recommends against using bleach/chlorine for hand hygiene where ABHR and soap and water are available, only allowing it as an interim emergency measure.

Pharmacies play a role by stocking or preparing ABHR, raising awareness about appropriate hand hygiene, and promoting good hand hygiene practices within their workplaces and communities.

5.2. Personal protective equipment (PPE)

The use of PPE should be guided by risk assessment and local protocols. Depending on the level of patient contact and outbreak situation, PPE may include gloves, surgical masks, eye protection, and gowns. PPE should complement, rather than replace other IPC measures such as hand hygiene and environmental cleaning. The pharmaceutical workforce should be trained in the correct selection, use, removal, and disposal of PPE to minimise the risk of contamination. Rigorous stock management and ongoing staff education should also be implemented.

5.3. Environmental cleaning and disinfection

Regular cleaning and disinfection of the pharmacy environment can help to reduce the risk of disease transmission. Attention should be paid to high-touch surfaces including counters, payment terminals, door handles, chairs, consultation areas, and equipment used by staff and patients (e.g., pens, scissors, and computer keyboards). Pharmacists should ensure that cleaning protocols are documented, consistently implemented, and understood by all staff.

5.4. Waste management and safe handling of potentially contaminated materials

Materials potentially contaminated with body fluids should be handled and disposed of using context-specific protocols. Appropriate procedures should address PPE, cleaning materials, reusable equipment, and other potentially contaminated waste. Staff should receive training to minimise occupational risk and maintain a safe working environment.

6. Key actions for pharmacists during an Ebola outbreak

6.1. Screening

Most patients presenting to a pharmacy with fever or influenza-like symptoms are unlikely to have EBOD. In the DRC, malaria, typhoid-like syndromes, cholera and other diarrhoeal diseases, measles, mpox, and other endemic infections may overlap clinically with early EBOD. Pharmacists should not attempt to diagnose or exclude EBOD. They should assess symptoms alongside epidemiological risk factors, recent travel history, known contact with suspected or confirmed cases, occupational risk, exposure to infected wildlife or contaminated environments where relevant, and current national and local outbreak alerts. Individuals with suspected EBOD should be referred promptly according to national or local protocols.

Pharmacists should remain informed about current outbreak situations and ensure pharmacy staff are also regularly trained. Familiarity with national and local screening protocols can support timely identification of

individuals who may require further assessment and referral. Pharmacists should also develop written standard operating procedures for managing a person with suspected EBOD who presents at the pharmacy.

6.2. Referral

Individuals suspected of having EBOD should be referred promptly according to regional or country-specific protocols. The WHO does not advise families or communities to care for individuals with symptoms of EBOD at home. Unnecessary physical contact should be avoided, and exposure of the suspected individual to the pharmaceutical workforce and members of the public should be minimised.

Pharmacists should be familiar with:

- contextual referral pathways
- public health reporting requirements
- local emergency contact procedures and contact details
- infection prevention measures to implement while awaiting referral.

Timely referral is an essential contribution that pharmacists can make. Familiarity with referral pathways before an outbreak occurs can facilitate rapid and coordinated responses when needed.

Where feasible and consistent with national and local public health protocols, pharmacies should identify a designated area where an individual with suspected EBOD can wait briefly for transfer by the appropriate response team. Measures should be taken to minimise exposure to pharmacy staff, other patients, and the public. Procedures for isolation, transfer, and environmental decontamination should follow national and local public health guidance.

6.3. Vaccination

Vaccination has become an important component of EBOD response for disease caused by *Orthoebolavirus zairense*. The recombinant vesicular stomatitis virus-Zaire Ebola virus (rVSV-ZEBOV) vaccine is the primary licensed vaccine used in outbreak response. It is administered as a single dose and has been used extensively in ring vaccination strategies to help interrupt transmission among contacts of confirmed cases and their contacts.

Pharmacists can offer vaccination services in countries where they are appropriately trained and authorised to vaccinate within their scope of practice. They also contribute to vaccination programmes by:

- public education on vaccine eligibility
- promotion of vaccine confidence
- addressing vaccine hesitancy and misinformation
- leading vaccination drives where authorised
- supporting vaccination ring activities where implemented
- ensuring appropriate vaccine storage and cold-chain management
- documenting and maintaining vaccination records
- post vaccination education and counselling
- supporting pharmacovigilance by reporting adverse events.

Pharmacists should remain aware that vaccination recommendations vary according to the *Orthoebolavirus* species involved, vaccine availability, and the specific outbreak situation. At present, licensed vaccines are available only to protect against *Orthoebolavirus zairense*. While there are a number of candidate *Orthoebolavirus bundibugyoense* vaccines in the pipeline, no licensed vaccines are currently available to protect against *Orthoebolavirus sudanense* and *Orthoebolavirus bundibugyoense*. Understanding the vaccines available, their indications, and their limitations enables pharmacists to provide accurate public education, address vaccine-related questions, and support vaccination programmes where authorised.

6.4. Patient and public education

During EBOD outbreaks, pharmacies are often among the most accessible healthcare settings and serve as trusted sources of information for patients, caregivers, and communities. Pharmacists should provide information that is:

- evidence-based
- consistent with public health guidance
- clear and understandable
- culturally appropriate
- responsive to community concerns
- corrective of misinformation.

Pharmacists should actively answer questions from patients and communities, discourage the spread of misinformation, and direct individuals to reliable sources of information, including WHO, FIP, and national public health authorities. In areas at risk of or affected by outbreaks, pharmacists can also display educational materials, use point-of-care communication materials, organise community question-and-answer sessions where appropriate, and implement simple risk assessments to help identify individuals who may require referral.

Community engagement complements patient education by working with individuals, communities, and trusted local stakeholders to promote understanding of EBOD, encourage proactive behaviours, and support adherence to public health measures. Pharmacists can reinforce public health messages, collaborate with community partners, and promote accurate, culturally appropriate information to strengthen public confidence during outbreaks.

Misinformation, fear, and stigma can undermine outbreak response efforts by reducing trust in healthcare systems, delaying care-seeking behaviour, discouraging participation in contact tracing, and contributing to discrimination against affected individuals, survivors, family members, and healthcare professionals. Pharmacists play an important role in addressing misinformation by communicating respectfully, acknowledging concerns, providing clear, evidence-based information, and maintaining open dialogue. They can also help reduce stigma by treating individuals with dignity and respect while supporting community understanding of recovery and survivor health needs.

Pharmacists may also be asked about travel-related risks during EBOD outbreaks. Providing accurate information about disease transmission, preventive measures, and travel-related risk can help reduce unnecessary anxiety while encouraging appropriate precautionary behaviours. Travellers should be advised to remain informed about public health recommendations for affected areas and seek medical attention promptly if symptoms develop following travel to an outbreak area or after a potential exposure.

7. Pharmacy preparedness for EBOD outbreaks

7.1. Surveillance and early detection

Early detection of EBOD is essential for limiting transmission and improving outbreak response. Surveillance systems support the identification of suspected cases, monitoring of disease trends, contact tracing activities and implementation of appropriate public health interventions.

Effective surveillance relies on timely reporting, laboratory confirmation, and coordinated communication among healthcare professionals and public health authorities. Laboratory testing remains essential for confirming cases, identifying the causative virus species, and informing outbreak response strategies, including the selection of appropriate vaccines and therapeutics where available.

Pharmacists are often among the most accessible healthcare professionals and may encounter individuals seeking advice before they access other health services. Their awareness of outbreak situations, travel-related risks, and referral pathways can help contribute to early detection and public health response efforts.

7.2. Maintaining essential pharmacy services

Public health emergencies can disrupt healthcare delivery, medicine supply chains, and access to essential health services. Maintaining continuity of care remains an important component of health system resilience during EBOD outbreaks.

Pharmacy services often continue to support patients requiring treatment for chronic diseases, acute illnesses, and preventive healthcare needs while implementing appropriate infection prevention and control measures.

Preparedness planning includes:

- maintaining workforce knowledge and preparedness through regular training
- stock management of essential medicines and health products
- emergency communication procedures
- coordination with public health authorities and colleagues.

Pharmacists play a critical role in maintaining access to medicines and healthcare services during public health emergencies. Maintaining access can reduce indirect morbidity and mortality associated with disruptions to routine care. Preparedness planning can help the pharmaceutical workforce continue delivering safe and effective services while protecting staff, patients and communities. This helps ensure continuity of patient care while supporting broader public health response efforts.

7.3. Staff protection, training, and preparedness

The updated WHO guidance on filovirus disease highlights that effective outbreak response depends not only on clinical management but also on preparedness, workforce readiness, IPC, surveillance, and coordinated public health action. Recent EBOD outbreaks have demonstrated the importance of ensuring that healthcare professionals are trained to recognise suspected cases, implement appropriate IPC measures, and respond according to established referral and reporting pathways.

Preparedness should include continuous education and training, access to appropriate IPC supplies, clear communication procedures, simulation exercises where appropriate, and monitoring of critical supplies. The pharmaceutical workforce should receive regular training relevant to their practice setting. Employers should support the physical and psychological well-being of their workforce during public health emergencies.

8. Conclusions

The response to the 2026 EBOD outbreak in the DRC has reinforced the importance of preparedness measures beyond direct patient care. It highlights the need for all healthcare professionals to maintain readiness, strengthen collaboration, and support coordinated public health action.

As trusted and accessible healthcare professionals, pharmacists make important contributions to EBOD preparedness and response. By promoting prevention, recognising suspected cases, facilitating timely referral, supporting infection prevention and control, maintaining access to medicines, and providing accurate public health information, pharmacists help strengthen health system resilience and protect patients and communities before, during, and after Ebola outbreaks.

Appendix 1. Example national adaptation: DRC

Purpose

This appendix illustrates how the recommendations in this guidance may be adapted to the national context during an active EBOD outbreak. It is based on recommendations provided by the National Council of the Order of Pharmacists of the Democratic Republic of Congo (CNOP-DRC: Conseil National de l'Ordre des Pharmaciens de la République Démocratique du Congo) during the external review of this guidance. It should be read together with the latest instructions issued by the Ministry of Public Health, Hygiene and Social Welfare, and the National Public Health Institute (INSP), provincial health authorities, and the relevant health-zone. This appendix provides updated information and guidance on Ebola disease (EBOD) to support the pharmaceutical workforce during outbreaks and public health emergencies. It reflects recent developments in EBOD preparedness, prevention and response, and complements the World Health Organization (WHO) guidance on filovirus diseases.

A1. Epidemiological context

The Democratic Republic of the Congo (DRC) is responding to its seventeenth EBOD outbreak caused by *Orthoebolavirus bundibugyoense*, initially declared in Ituri province in May 2026. The outbreak has primarily affected Ituri province, with additional cases reported in North Kivu, Haut-Uele, Tshopo, and South Kivu.

The response has been complicated by insecurity, population displacement, cross-border population movement, challenging access to some health zones, and pressure on routine health services. The pharmaceutical workforce should therefore remain informed of the latest epidemiological situation and follow national and local public health instructions as the outbreak evolves.

A2. Responsibilities of pharmacists in the DRC

In addition to the recommendations presented throughout this guidance, pharmacists and the pharmaceutical workforce in the DRC should:

- follow alerts, case definitions, reporting instructions and referral pathways issued by relevant authoritative bodies
- immediately notify the designated health zone or emergency response focal point when a suspected case is identified
- coordinate with CNOP-DRC regarding professional communication and training
- maintain traceability and responsible management of medicines, oral rehydration products, disinfectants, PPE, and other critical health products while helping prevent shortages, stockpiling, speculation, and counterfeit products
- maintain continuity of treatment for malaria, HIV, tuberculosis, diabetes, hypertension, maternal and child health services, and other priority conditions
- communicate using French and locally appropriate languages while working with trusted community leaders.

A3. Operational checklist for pharmacy settings

The following actions provide an example of how this guidance may be operationalised in community and hospital pharmacies, medicine depots, and other pharmaceutical settings in the DRC. They complement, but do not replace national response protocols.

Immediate management of a suspected case

- Maintain a safe distance and minimise unnecessary physical contact.
- Ask only essential screening questions.
- Do not perform procedures that may expose staff to blood or body fluids.
- Immediately notify the designated health zone response team.
- Record the incident confidentially.
- Restrict access to potentially contaminated areas until appropriate decontamination has been completed.

Referral and reporting

Pharmacists should maintain readily accessible contact details for:

- the health zone focal person
- referral facilities for EBOD treatment centres
- ambulance or emergency response teams
- provincial pharmacy authorities
- CNOP-DRC.

Reporting should always follow the official public health notification chain.

Medicines and supply management

Preparedness should include:

- maintaining emergency stock levels of essential medicines, oral rehydration salts, approved disinfectants, and IPC supplies
- monitoring stock consumption and shortages
- reporting medicine shortages and abnormal price increases through authorised channels
- avoiding promotion or supply of unapproved EBOD treatments.

Infection prevention and environmental readiness

Pharmacists should:

- establish written IPC procedures
- designate an IPC focal person
- ensure staff receive regular IPC training
- maintain hand hygiene facilities, cleaning supplies, and appropriate PPE
- use chlorine products only for approved environmental disinfection and not for routine hand hygiene when ABHR or soap and water are available
- maintain staff exposure records and report occupational exposures promptly.

Communication and community engagement

Communication activities should:

- use validated public health messages from authorised national and international sources
- actively address stigma affecting survivors, healthcare professionals, and affected communities
- engage trusted community leaders and local organisations where appropriate
- communicate in locally appropriate languages
- always cite the date and source when referring to outbreak data.

A4. Minimum preparedness indicators

Each pharmacy should aim to have:

- current patient information available in French and locally appropriate languages
- incident exposure and stock registers
- an emergency continuity list for patients receiving chronic treatment
- hand hygiene supplies, cleaning materials, and basic PPE available
- staff trained within the previous three months
- up-to-date referral and reporting contacts
- a designated Ebola or IPC focal person and an identified alternate.

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