Ebola outbreak threatens to expand into densely populated Ugandan capital Kampala

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On September 20, 2022, Uganda's health authorities declared an outbreak of Ebola after confirmation of the disease in a young 24-year-old man from Mubende village. He developed symptoms on September 11 consisting of high fevers, convulsions, bloody vomit and diarrhea, loss of appetite, stomach pains, and bloody eyes, according to a situation report published by the World Health Organization (WHO) on September 26.

The incubation period for Ebola ranges from two to 21 days before leading to significant multiorgan failure. The virus spreads through contact with an infected person's blood or bodily fluids. Case fatality rates are incredibly high, and treatment remains supportive when the disease manifests. The primary zoonotic reservoir or intermediate host is not known. The consumption of bush meat or bite from an animal harboring the virus has been speculated to cause sporadic outbreaks.

After seeking assistance at two different privately run clinics, the man from Mubende village was referred to a regional hospital on September 15, where he was placed in isolation for suspected viral hemorrhagic fever. A blood sample was collected two days later and sent to Uganda's Virus Research Institute. On September 19, the blood sample confirmed an Ebola infection with the Sudan virus genus of *Ebolavirus*. The young man passed on the same day.

As of September 30, the number of Ebola infections has risen quickly to 54, with 35 cases confirmed and 19 listed as probable. The death toll has reached 25, with seven confirmed with Ebola infection and 18 probable infections. Additionally, the latest situation update from the WHO African region identified at least 427 contacts and 16 that were being treated for their infection. Two patients have made recoveries.

After behind-the-scenes high-level meetings with the WHO, Uganda's health minister Dr. Jane Ruth Aceng confirmed during a press briefing Saturday that six medical workers were diagnosed with the Sudan Ebola virus, and two more were in dire condition.

It is not clear if one of these in critical condition was Tanzanian physician Dr. Mohammed Ali, who tested positive on September 26 and died on Saturday, October 1, at a regional referral hospital in Fort Portal, about 190 miles west of the capital, Kampala. His was the second death of a health care worker after a midwife from St. Florence Clinic died of probable Ebola infection.

Thus far, no cases have been detected in the densely populated capital of 1.68 million people in the city proper, with another five million in the neighboring districts situated on the north shore of Lake Victoria, Africa's largest lake and an economic and food security lifeline for 30 million people. Kampala is one of Africa's fastest-growing cities, with an annual growth rate of over 4 percent. The country's poverty rate, the percent of the population living on less than US $5.50 per day, stands at 89 percent.

Uganda's economy is sustained by agriculture. However, lacking the necessary technology and infrastructure and hampered by corruption, its economic growth has slowed since 2016 while debt continues to grow. It relies heavily on external investments, which lead to higher debt servicing. Poverty has been climbing in Uganda for over a decade.

The present Ebola outbreak is situated in the communities of Mubende (epicenter in Madudu) sub-county, Kyegwegwa, Kassanda, and Kagadi district, spanning a radius of 75 miles along a busy highway that runs between Kampala and the Democratic Republic of Congo (DRC, formerly Zaire) to the west. Health officials fear the virus may have been spreading undetected since early August, threatening to circulate through the capital more broadly to other African countries and the rest of the world.

In their risk assessment last week, the WHO noted, "The outbreak was detected among individuals living around an active gold mine. Mobility among traders of this commodity is likely to be high, and the declaration of the outbreak may cause some miners already incubating the disease to flee. The currently affected Mubende district has no international borders. Nevertheless, the risk of international spread cannot be ruled out due to the active cross-border population movement."

Former senior military officer and current president of Uganda since 1986, 78-year-old Yoweri Museveni, made a televised statement on September 29 saying that there would be no restrictions on moving and gatherings. He said, "I want to reassure all Ugandans and all residents that the government will quickly gain control of this outbreak as we have done before.

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Therefore, there is no need for anxiety, panic, restriction of movement, or unnecessary closure of public places like schools, markets, and places of worship as of now."

However, these assurances appear entirely unwarranted, as indicated by a commentary published in *Fortune* by Aceng, titled, "Uganda urgently needs help to stop the Ebola outbreak in its tracks."

Aceng wrote, "Shockingly, Uganda is still isolated in the struggle to address this new threat despite the world having just endured the challenges of the COVID-19 pandemic as a single global health security problem. There has been an increased focus on the need for pandemic preparedness, resilient health systems, and a well-protected workforce to respond successfully to threats. However, the global response is not to the level of the threat we know Ebola to be to Uganda and the rest of the world."

She added, "We urgently need more well-trained, well-equipped, and well-protected health workers who can safely help respond to stop this outbreak in its track." Besides the threat posed by COVID-19 and Ebola, she noted recent upsurges in malaria in the North and East of Uganda, tuberculosis, HIV, non-communicable diseases, and traumas impacting the population's well-being.

The present Ebola outbreak in Uganda is caused by the Sudan virus, one of four species in the *Ebolavirus* genus known to cause human disease. The clinical illness it causes is indistinguishable from the Zaire Ebola genus, but is genetically distant enough that the current vaccine available for the Zaire genus, Ervebo (manufactured by Merck), is ineffective against the Sudan virus. Nancy Sullivan, head of biodefense research at the National Institute of Allergy and Infectious diseases (NIAID), said of the two Ebola viruses, "[They] are not variants, and they're not strains—they're different viruses."

Both viruses were first discovered in their respective geographic locations in 1976. However, the more familiar Zaire Ebola virus has garnered the lion's share of attention, especially during the Ebola epidemic in West Africa between 2014 to 2016 that killed 11,325 people (38 percent of cases were fatal) and then in the Democratic Republic of Congo in 2018, in which 2,280 people died from Ebola infections. The name for the virus was given from the Ebola River in DRC, where it was first described.

Uganda has experienced several outbreaks of Ebola viruses. The first was from October 2000 to January 2001 with the Sudan virus, in which 224 of 425 cases resulted in fatalities, a byproduct of people attending funerals of cases and lack of adequate personal protective equipment by attendants. Eight years later, a smaller outbreak occurred with the Bundibugyo Ebola virus, the first time it was ever identified, killing 37 of 149 cases. In 2012, two outbreaks occurred with the Sudan virus. One in June infected 11 people, while another in November infected six. Most recently, in 2019, five people died from Ebola infections in Uganda.

As the WHO scrambles to build Ebola Treatment Units in the affected regions, it calls for international donors to contribute $18 million to contain the outbreak for the next three months.

Dr. Yonas Tegegn Woldermariam, Uganda's WHO representative, said even this amount might not cover all the necessary costs. He told reporters, "If we go into the preparedness, we are talking, even for the three months, three times or four times that amount. Plus, there are things that we take for granted, assuming the system will provide them. Those are additional costs like transportation, like fuel, like human resources, which we have to consider also to fund as we go ahead."

Meanwhile, international health agencies working with pharmaceuticals have potentially identified two candidate vaccines—one from GlaxoSmithKline, which donated the license to the Sabin Vaccine Institute in 2019 (40,000 doses available), and the other being developed by scientists at the University of Oxford's Jenner Institute (71 doses available, with Serum Institute of India working to produce 20,000 doses)—enough in development to begin emergency clinical trials to address the evolving crisis.

Ana Maria Henao-Restrepo, a WHO vaccine specialist involved in coordinating and organizing discussions between the Ugandan government, pharmaceuticals, and international stakeholders, said, "We are moving really fast this time, and people are really willing to work to get these vaccines on the ground. We are doing everything that you are supposed to do when you want to get a trial started in a week or two, [at] maximum."

After nearly three years of the COVID-19 pandemic, and under conditions in which nearly every world government is imposing a "forever COVID" policy of unending waves of mass infection, death and debilitation, world capitalism is entirely unprepared for a massive outbreak of Ebola. The danger exists that the current outbreak in Uganda could spread internationally, as was allowed with monkeypox.

To prevent this from happening and to put an end to the scourge of myriad infectious diseases, the international working class must take control of the economy and rebuild society on socialist foundations, which would entail a vast expansion of public health resources and universal health care in every country.

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