

# Marburg virus disease confirmed in Ethiopia amid regional instability

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The first documented outbreak of Marburg virus disease (MVD) in Ethiopia was confirmed this month in Jinka, a market town in the South Ethiopia Regional State that functions as a commercial hub with active cross-border movement from South Sudan and Kenya. A suspected case of viral hemorrhagic fever was initially reported to Africa Centres for Disease Control and Prevention (CDC) on November 12, 2025. Ethiopia's Ministry of Health confirmed MVD on November 14 following molecular testing at the Ethiopia Public Health Institute (EPHI). Sequencing indicated that the virus is genetically similar to previously identified East African strains.

As of November 14, 2025, 9 cases had been identified among residents of Jinka. Local reports indicate that the index case died roughly two weeks before the outbreak was formally recognized, facilitating secondary transmission through close contact and traditional burial practices.

Health officials reported 6 deaths—including a police officer, three religious leaders, and a banker—all linked to the initial case through contact tracing. Despite praise from the World Health Organization for the swift confirmation of the outbreak, the full extent remains uncertain. Ethiopian media reported that regional health officials were instructed not to disclose information, and woredas (district-level administrative units) and zones were advised against releasing updates. As a result, the true case count, death toll, and clinical outcomes remain only partially documented.

The Marburg virus is a highly pathogenic RNA virus in the same family as Ebola virus. Its natural reservoir is the Egyptian fruit bat (*Rousettus aegyptiacus*). Human infection occurs through exposure to infected animals and subsequently through direct contact with bodily fluids, contaminated materials, or unsafe burial

practices. Reported case fatality rates range from 24 to 90 percent, with an average of about 50 percent.

The disease clinically presents after an incubation period of two to 21 days, most commonly between five and 10 days. Early symptoms are non-specific and resemble influenza: sudden high fever, malaise, severe headache, myalgia, and fatigue. Around the third day, patients often develop severe watery diarrhea, vomiting, abdominal cramping, and nausea. Hemorrhagic manifestations—including bleeding from the gums, nose, and vagina and fresh blood in vomit and stool—typically appear about one week after symptom onset. In severe cases, multi-organ dysfunction, shock, and death follow eight to nine days after symptoms begin, often due to profound blood loss.

MVD is a zoonotic disease. Primary infections typically arise from prolonged exposure to bat-inhabited caves or mines where the virus is present in bat saliva, urine, and feces. Human-to-human transmission then drives outbreaks, especially in healthcare settings where fomite transmission is common. Sexual transmission has been documented, with viral antigens detected in semen. Current evidence does not support airborne spread.

Jinka, the administrative center of the Ari Zone and gateway to the Lower Omo Valley, sits at the crossroads of a region grappling with severe political instability. Recurrent armed conflict and civil unrest in Amhara, Oromia, and Gambella have disrupted humanitarian access, strained basic health services, and eroded the state's capacity to detect and contain emerging infections. These pressures converge with widespread economic distress, mass displacement, and simultaneous outbreaks of malaria, cholera, and measles. An estimated 21.4 million people require

humanitarian assistance. Jinka's proximity to South Sudan further heightens the risk of cross-border spread, given South Sudan's profound state fragility and near-total health system collapse.

The wider African region has seen a marked increase in both the frequency and geographic spread of MVD outbreaks. This acceleration has coincided with expanded international trade, intensified commercial activity, and widespread political turmoil. These forces contribute to human encroachment into ecologically sensitive habitats, population displacement, environmental disruption, and weakened surveillance systems—conditions ripe for zoonotic spillover and rapid viral spread.

Historically, the Marburg virus emerged sporadically. The first known outbreak in 1967 in Germany and the former Yugoslavia produced 31 cases and 7 deaths, traced to imported African green monkeys from Uganda. Cases occurred in 1975 in South Africa (linked to exposure in Zimbabwe) and in two outbreaks in Kenya during the 1980s associated with bat-inhabited caves. A major resurgence in the mining town of Durba in the Democratic Republic of the Congo from 1998 to 2000 resulted in 154 cases and 128 deaths, with an average interval of about eight years between outbreaks from 1967 to 2000.

A profound shift began in the twenty-first century. The 2004–2005 Angola outbreak remains the largest on record, with 252 cases and 227 deaths. Uganda experienced three outbreaks between 2012 and 2017. From 2020 to 2025, seven outbreaks occurred—including first-ever events in Guinea (2021), Ghana (2022), Equatorial Guinea (2023), Tanzania (2023 and 2025), Rwanda (2024), and Ethiopia (2025). The interval between outbreaks has collapsed to less than one year, placing the 2020s on track to surpass all previous decades combined. This surge reflects fundamental shifts in ecology, surveillance, and the socioeconomic crises reshaping the African continent.

The Egyptian fruit bat's range spans the Lake Victoria basin and much of East and Central Africa. Economic deprivation, displacement, and conflict push communities into closer contact with bat habitats. High-risk livelihoods—particularly artisanal mining in bat-inhabited caves such as the Goroumbwa Mine in the Democratic Republic of the Congo and the Kitaka Mine in Uganda—have been repeatedly linked to

outbreak origins. Economic marginalization also drives reliance on wildlife hunting and consumption (“bushmeat”), frequently implicated in filovirus emergence.

Armed conflict further amplifies spillover risk by destroying healthcare systems, driving population displacement into marginal environments, disrupting water and sanitation infrastructure, and eroding trust in public authorities. The relationship is reciprocal: conflict fosters disease emergence, while outbreaks destabilize already fragile regions.

Epidemiological studies show conflict settings carry nearly a two-fold increased risk of reported filovirus cases, including Ebola in the Democratic Republic of the Congo and Guinea. The current outbreak in Ethiopia exemplifies this convergence of ecological, economic, and political vulnerabilities. Meanwhile, intranational and cross-border travel along trade corridors linking Uganda, Tanzania's Kagera region, Burundi, and Rwanda facilitates rapid spread following any spillover event.

Although no licensed Marburg vaccine exists, the Sabin Vaccine Institute, in collaboration with the US National Institutes of Health Vaccine Research Center, has developed a promising candidate that uses a chimpanzee adenovirus vector. Phase two trials are underway in Uganda, Kenya, and multiple US sites, with additional emergency deployment in Rwanda's 2024 MVD outbreak, where more than 1,700 doses were administered within days, largely to healthcare workers.

While the development of effective countermeasures marks an important advance, vaccines alone cannot overcome the political violence, economic pressures, environmental disruption, and global inequities that continue to drive Marburg's emergence.



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