WHO declares Ebola public health emergency as Trump cuts cripple global disease surveillance

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17 May 2026

On May 16, 2026, the World Health Organization (WHO) declared the epidemic of Ebola caused by the Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda a public health emergency of international concern (PHEIC). This is the third PHEIC ever declared over Ebola, following the 2014 West Africa epidemic and the 2018-2020 Kivu epidemic in the DRC, and the first involving the rare Bundibugyo strain, for which there are no approved vaccines or treatments.

The declaration was extraordinary in another respect. WHO Director-General Tedros Adhanom Ghebreyesus issued it without convening the WHO Emergency Committee, the first time in the history of the International Health Regulations (IHR) that a PHEIC has been determined without a formal recommendation from that body. The committee will be convened retrospectively. The bypassing of customary procedure underscores both the urgency of the threat and the scale of the institutional crisis engulfing WHO since the Trump administration completed the United States' withdrawal in January.

Official case counts as of May 16 stood at eight laboratory-confirmed cases, 246 suspected cases, and 80 suspected deaths, including at least four healthcare workers. Local and regional reporting suggests a considerably larger burden, with sources in Ituri Province citing at least 336 suspected and confirmed cases and 87 deaths. WHO itself acknowledged "significant uncertainties to the true number of infected persons and geographic spread." The presence of the disease in Kinshasa and Kampala raises serious concerns about transmission across international borders.

A delayed detection and misdiagnosis

Epidemiologists trace the suspected onset of the crisis to late April 2026, when a nurse in the Rwampara health zone presented with fever, vomiting and severe bleeding. She died before a diagnosis could be established. Africa CDC Director-General Jean Kaseya has acknowledged that the true index case remains unknown, meaning the virus circulated undetected for several weeks. The outbreak is now thought to have originated in Mongbwalu, a high-traffic gold mining hub in Ituri, with cases subsequently migrating to Rwampara and Bunia as patients sought medical care. The crisis escalated when the virus crossed into Uganda, resulting in a confirmed death in Kampala.

WHO received its first notification of suspected cases on May 5 and deployed an investigative team. Initial field samples tested negative because the regional laboratory equipment in Bunia was calibrated only to detect the Zaire species of Ebola, the strain responsible for every previous DRC outbreak. Samples were transported approximately 1,500 kilometers to the National Institute of Biomedical Research in Kinshasa, where on May 14 and 15 eight of 13 samples tested positive for Bundibugyo. Africa CDC formally confirmed the outbreak on May 15, and WHO elevated it to a PHEIC the following day.

In its formal advice to states not directly affected, WHO instructed that "no country should close its borders or place any restrictions on travel and trade," characterizing such measures as "usually implemented out of fear" with "no basis in science." In the same document, WHO acknowledged that the outbreak points "towards a potentially much larger outbreak than what is currently being detected and reported." The agency conceded that it does not know the true extent of the outbreak while telling the world to keep its airports open as normal. It mandated rigorous exit screening at departure points in DRC and Uganda, while stating that "entry screening at airports or other ports of entry outside the affected region are not considered needed."

The epidemiological logic is impossible to reconcile. A feverish traveler cannot board a flight in Kinshasa, yet the same traveler's destination is under no obligation to check who has just arrived. The WHO document makes the commercial logic explicit, warning that travel restrictions "can also compromise local economies and negatively affect response operations from a security and logistics perspective." The IHR framework, under Article 43, discourages receiving states from imposing additional measures beyond WHO recommendations, immunizing global commerce from the burden of outbreak response while concentrating it entirely on the affected, impoverished states.

The responsibility of the Trump administration

The Trump administration bears immediate and direct responsibility for the conditions that allowed this outbreak to spread undetected for three weeks. The dismantling of global disease surveillance has unfolded in deliberate stages over the past 16 months.

In late January 2025, USAID transmitted a single email terminating the $100 million STOP Spillover program, a five-year project designed to detect zoonotic spillovers of Ebola, Marburg, Lassa and other hemorrhagic fevers in Uganda, the DRC border region, Liberia and four other countries. Field teams monitoring bat reservoirs were dispersed within days. Researchers in Liberia were left with freezers of unprocessed blood samples drawn from people who had agreed to be tested for Ebola exposure. The Uganda-DRC cross-border surveillance infrastructure went dark.

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USAID itself was dismantled the same month. Its functions were absorbed into the State Department, the vast majority of its staff were laid off, and thousands of grants and contracts were terminated, including PEPFAR programs that formed the operational backbone of disease surveillance across sub-Saharan Africa. By mid-2025, 71 percent of PEPFAR implementing partners reported the cancellation of at least one category of activities. Laboratory networks, supply chains, contact-tracing systems and trained personnel were gutted.

The US formally withdrew from WHO on January 22, 2026. It had been the agency's single largest funder, contributing approximately $700 million annually in peak years. No state has stepped up to replace these funds. WHO is now shedding approximately 2,371 staff—roughly a quarter of its workforce—by mid-2026, with the African Regional Office particularly affected. This institutional crisis has directly degraded WHO's emergency response capacity and contributed to the delayed response to both the Ituri outbreak and the concurrent Andes hantavirus outbreak aboard the MV Hondius cruise ship.

On January 26, 2025, the administration also issued a gag order prohibiting all CDC communication with WHO. Modified but never rescinded, the gag order was effectively made permanent by the WHO withdrawal itself. As Jennifer Nuzzo of Brown University's Pandemic Center observed when a suspected DRC Ebola outbreak was reported in early 2025, "When there was the suspected outbreak of Ebola in the DRC a few weeks ago, CDC couldn't call them and ask what's going on." That condition has persisted for 16 months. It was operative throughout the period of misdiagnosis in Ituri.

Ituri: conflict, mining and an abandoned public health system

The epicenter of the outbreak is Ituri Province in the conflict-affected northeastern DRC, separated by vast distances and poor infrastructure from Kinshasa, with porous borders and intense population movement driven by cross-border trade, armed conflict and small-scale mining. The spread of the Bundibugyo virus is being accelerated by the ongoing war in the region, involving the Allied Democratic Forces and the CODECO militia. Four days after the suspected index nurse fell ill, CODECO carried out a retaliatory massacre on April 28, killing at least 69 civilians. Continuous violence obstructs every basic epidemiological measure: health workers cannot safely conduct contact tracing, surveillance teams are blocked from rural communities and safe burial practices become impossible. Civilians fleeing the violence are forced into crowded displacement camps where the virus can amplify.

Intertwined with this violence is the brutal exploitation of the region for its mineral wealth. The town of Mongbwalu sits at the center of Concession 40, a 2,000-square-kilometer gold-bearing zone whose industrial exploration was carried out by AngloGold Ashanti through its subsidiary AngloGold Ashanti Kilo. The South African mining giant suspended the project in 2013 amid falling gold prices and later sold its interest. The abandoned concession is now worked by an estimated 100,000 small-scale miners, many of them ex-combatants from Ituri's ethnic wars, under conditions of extreme insecurity.

To the north in Haut-Uélé Province, the Kibali Gold Mine—owned by Barrick Mining Corporation and AngloGold Ashanti at 45 percent each, with the DRC parastatal SOKIMO holding 10 percent—extracts approximately 700,000 ounces of gold annually, making it one of the largest gold operations on the African continent.

Communities surrounding the mines suffer from degraded water and sanitation infrastructure, chronic exposure to toxic dumping and heightened vulnerability to infectious disease. Health facilities are far from the mining sites, and small-scale miners earning a few dollars a day cannot afford to reach them. The constant movement of transient laborers across porous borders carries pathogens with it.

The healthcare workers now dying in Ituri are members of a working class with a documented record of struggle against these conditions. During the 2020 Ebola outbreak in Equateur Province, Congolese health workers struck over unpaid salaries and inadequate protective equipment, blocking the Ebola testing laboratory in Mbandaka. The four healthcare worker infections in the current outbreak are the foreseeable consequence of a health system stripped to service debt obligations and corporate profit extraction.

The broader health system in eastern DRC has been hollowed out by decades of deliberate fiscal constraint. The IMF's 2021-2024 Extended Credit Facility for the DRC conditioned loan disbursements on fiscal targets that repeatedly squeezed social spending; the IMF's own reviews show the program's social-spending floors were missed in multiple years, with expenditure reprioritized toward security and debt service. A successor arrangement approved in January 2025 continues the same framework. Advanced laboratory capacity remains centralized in Kinshasa, turning diagnostic procedures that should take hours into delays of days or weeks.

The immense dangers posed by the Bundibugyo Ebola outbreak

Bundibugyo is a filovirus closely related to the Zaire and Sudan strains. After an incubation of two to 21 days, the disease progresses from a nonspecific febrile phase to severe gastrointestinal symptoms with massive fluid loss, and ultimately to a hemorrhagic phase leading to multiple organ failure. Transmission requires direct contact with infected bodily fluids, and the virus is shed only after symptoms appear. Patients carry the highest viral loads in late illness and at death, which is why understaffed medical centers and traditional burial ceremonies become amplification hubs.

The Bundibugyo strain carries a historical case fatality rate of roughly 25 to 40 percent—lower than Zaire (up to 90 percent untreated) or Sudan (around 50 percent), yet still catastrophic without vaccines or specific treatments. Existing Ebola medical countermeasures were developed exclusively for the Zaire strain following the 2014 West Africa epidemic. With only two prior documented Bundibugyo outbreaks, pharmaceutical corporations calculated that developing a targeted vaccine would not generate adequate returns. Clinicians are left with basic supportive care, guaranteeing elevated mortality and leaving affected populations defenseless.

The dismantling of public health and pandemic preparedness did not begin with Trump's second term. In May 2018, National Security Adviser John Bolton dissolved the White House's NSC Directorate for Global Health Security and Biodefense, the body created after the 2014 Ebola outbreak to coordinate a whole-of-government pandemic response. Its senior director was pushed out and not replaced. Beth Cameron, the directorate's founding director, later wrote that disbanding it "left an unclear structure and strategy for coordinating pandemic preparedness and response." COVID-19 confirmed her warning. Capitalist governments responded to the pandemic by normalizing mass infection and accelerating the defunding of institutions designed to stop future outbreaks.

The WHO withdrawal was the centerpiece of a broader America First Global Health Strategy released in September 2025, which cut annual US global health spending by nearly 70 percent and replaced multilateral commitments with bilateral agreements that reframe African disease surveillance as a commercial asset and geopolitical lever against China.

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Under this framework, viral specimens and genomic sequences from outbreaks like the one in Ituri are to flow first to American pharmaceutical companies, with affected African states given no enforceable claim on vaccines or treatments developed from them.

The MV Hondius hantavirus outbreak illustrates the same institutional collapse. In a closed environment with a known passenger manifest and the resources of wealthy Western nations behind the response, 30 passengers were allowed to disembark at Saint Helena and disperse globally without testing or quarantine instructions. The same gag order, defunding and rupture with WHO underlie both failures. If the world's wealthiest health systems cannot manage a localized cluster on a single vessel, they are vastly less capable of managing a hemorrhagic fever epidemic moving through the population centers of eastern DRC.

The DRC possesses vast reserves of gold, cobalt and copper, extracted at enormous profit by corporations headquartered in Toronto, Johannesburg and London, with concessions at the epicenter of the outbreak, while its population suffers under chronic public-health underfunding and brutal poverty. Rampant deforestation, relentless mining and the systemic neglect of medical infrastructure produce the precise conditions that drive zoonotic spillover.

A rational, science-based response requires massive global investment in public health infrastructure, an immediate end to the extractive practices and imperialist wars that produce the ecological conditions for viral spillover, and the governance of vaccine development by human need rather than the profit calculations of pharmaceutical monopolies or Wall Street speculators.

The current emergency is a harbinger. The defense of human life requires the independent political mobilization of the international working class to reorganize global resources and medical research under democratic, socialist control.

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