Trump weaponizes public health as Ebola epidemic expands

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As the Bundibugyo Ebola epidemic accelerates across central Africa, the United States government has responded not with a mobilization of medical resources but with the invocation of Title 42, a public health statute it has already proven willing to deploy as a tool of immigration enforcement and now of foreign policy.

In a stark departure from every prior Ebola response, Washington is refusing to repatriate exposed American citizens for advanced biocontainment care at home. Instead, it is arranging to keep them out of the country entirely, diverting potentially infected Americans to a quarantine and treatment facility in Kenya and, when necessary, to high-level biocontainment units in Europe.

Title 42 is a provision of the 1944 Public Health Service Act that grants the federal government authority to halt the introduction of persons from foreign countries when a quarantinable disease abroad is deemed a serious danger to public health. In March 2020, the Trump administration invoked Title 42 under the pretext of controlling COVID-19, in a scheme devised by White House aide Stephen Miller, and used it to expel 400,000 immigrants. The Biden administration maintained and expanded this regime for years, expelling 2.3 million more before the policy formally expired in May 2023.

Public health experts and human rights advocates explicitly condemned the policy throughout its COVID-19 application. In a 2022 study published in the *American Journal of Public Health,* researchers noted that the policy lacked any genuine infection control rationale and was instead a political weapon used to justify anti-immigrant, xenophobic border measures in violation of international law.

The Trump administration has now resurrected that same instrument. A May 18, 2026, order issued by the Centers for Disease Control and Prevention (CDC) invoked Title 42 to bar the entry of noncitizens who had been in the Democratic Republic of the Congo (DRC), Uganda, or South Sudan within the previous 21 days. Within days, the Department of Health and Human Services issued an interim final rule extending those same restrictions to lawful permanent residents. Green card holders who had been in any of the three countries within the prior three weeks were now barred from returning to the United States.

This maneuver reproduces the brutal logic of the COVID-19 pandemic. Rather than individualized risk assessments, scientific testing, and supported quarantine protocols, the administration treats people from heavily affected African nations as disease vectors to be excluded en masse. The use of broad geographic triggers instead of targeted medical interventions reveals the political reality: the same tool once used to deny asylum to Latin American migrants is now being turned against African travelers and US residents under the banner of Ebola.

Having barred foreigners from entry, the administration then applied the same underlying logic to its own citizens. The pivot was swift and its implications are damning. In a departure with no precedent in the history of American Ebola responses, the Trump administration announced plans to send US citizens who may have been exposed to the Bundibugyo virus to a quarantine and treatment facility in Kenya, rather than bring them home for care.

The policy did not emerge without warning. Earlier in May, the administration flew an American doctor who had developed symptoms to Germany and transferred six other exposed Americans to Germany and the Czech Republic for monitoring. Those transfers were improvised; the Kenya facility represents the institutionalization of the policy.

According to reporting by the *New York Times,* the facility is being established as a joint effort by the State and Defense departments and the Department of Health and Human Services, with dozens of Public Health Service officers already being trained for deployment to Kenya. The initial plan was to monitor exposed Americans there and transfer anyone who developed symptoms to Europe; the plan has since expanded to include treatment in Kenya itself, including for government scientists and physicians.

One detail has received almost no attention in the coverage: the Kenya facility still requires formal approval

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from the Kenyan government. The United States is preparing an offshore Ebola camp in a country that has not yet officially consented to host it. This is not a footnote. It illustrates how imperialist powers run roughshod over the sovereignty of a supposedly independent nation already bearing the brunt of the regional crisis.

The wealthiest countries on earth continuously outsource hazardous industrial and medical activities to the Global South while slashing the funding that sustains health systems there and then use border controls to ensure the resulting catastrophe stays on the other side of the line.

The United States possesses multiple state-of-the-art biocontainment facilities, including the Nebraska Biocontainment Unit at the University of Nebraska Medical Center, which successfully treated Ebola patients during the 2014 West Africa outbreak. The decision not to use them is not a logistical one. It is a political one, rooted in the same nationalist calculation that produced Title 42: the perceived political and biological risk of providing Ebola care on American soil is, to this administration, unacceptable. The border must hold, even against the US citizens, setting an ominous precedent for the future.

As of May 26, 2026, the DRC Ministry of Health reported 121 confirmed cases, including 17 deaths, and 1,077 suspected cases, including 238 suspected deaths. Uganda has reported seven confirmed cases and one death. The combined toll stands at more than 1,200 suspected and confirmed infections across three provinces: Ituri, North Kivu and South Kivu. This is the third-largest Ebola outbreak on record.

When the WHO declared a public health emergency of international concern (PHEIC) on May 17, the third time an Ebola outbreak has met that threshold, the official tally stood at eight confirmed cases, 246 suspected cases, and 80 suspected deaths in Ituri Province. The pace at which those figures have multiplied since is itself an indictment. The virus circulated undetected for weeks in April while local health infrastructure remained stripped of critical resources and testing capabilities, a direct consequence of the chronic underfunding that USAID program terminations have accelerated.

On May 23, WHO upgraded its national risk assessment for the DRC from high to very high. Two days later, WHO secretary-general Tedros addressed a virtual ministerial briefing of international health leaders and delivered a candid admission: “We are urgently scaling up operations, but at the moment, the epidemic is outpacing us.” He cited the intense insecurity of Ituri and North Kivu provinces, where more than 100,000 people have been newly displaced by fighting in recent months; the deep distrust of outside health authorities among affected communities; and the complete absence of approved vaccines or specific therapeutics for the Bundibugyo strain.

That admission deserves careful reading. WHO named the failure without naming its causes. The Trump administration has cut 83 percent of global programs run by the U.S. Agency for International Development (USAID). The eastern DRC is devastated by militia offensives that have displaced millions into overcrowded camps. An estimated 25.6 million people nationwide face crisis or emergency levels of food insecurity, producing the severe malnutrition that weakens immune systems and accelerates mortality from infectious disease. These are not background conditions. They are the determinants of outbreak severity, and they are the direct product of imperialist policy.

Suspected cases under investigation have already appeared in Italy and India, tracking the international airline routes that make geographic containment a fiction. The Bundibugyo strain carries an incubation period of up to 21 days, meaning infected, asymptomatic travelers can transit through dense global networks long before any border screening could detect them. No Title 42 order and no offshore quarantine camp can change that biological reality.

In the corporate media and in official statements, international health authorities describe a global response being outpaced by a fast-moving virus. But the epidemic is not outpacing a genuine global mobilization. It is outpacing a response that the dominant capitalist power has ensured will remain inadequate. This is a deliberate choice: the instruments of public health have been converted into instruments of nationalism, and the real discussion—about resources, about war, about the structural conditions that make central Africa a recurring site of epidemic catastrophe—is not taking place at all.

The working class and impoverished masses of the DRC are left to absorb the immediate and lethal consequences of that imperialist policy.

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