The Ebola epidemic in the Congo: Nearly 1 month since the declaration of the Public Health Emergency of International Concern

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Nearly one month has passed since the World Health Organization (WHO) declared the Bundibugyo Ebola outbreak in central Africa a Public Health Emergency of International Concern (PHEIC) on May 17. While official tallies of suspected cases have recently declined in certain health zones, this apparent improvement is illusory. The rate of confirmed cases continues to climb, and the drop in suspected cases reflects the catastrophic collapse of disease surveillance and testing rather than genuine containment of the virus.

According to an interview published in *STAT*, the epidemic has now reached at least 708 confirmed cases and 141 deaths across the two affected countries. In Uganda, public health measures have largely kept the virus in check, limiting the toll to 19 confirmed infections and two deaths. The Democratic Republic of the Congo (DRC) bears the overwhelming burden, accounting for 689 confirmed cases and 139 deaths.

Returning from his second visit to the epicenter of the outbreak in northeastern DRC, WHO Director-General Tedros Adhanom Ghebreyesus issued a grim assessment. He warned that the virus is moving much faster than the response. Critical interventions are failing, with contact tracing rates recently plunging as low as 28 percent, far below the level required to isolate the sick and halt transmission chains.

Tedros acknowledged the profound and justified alienation of the local population, noting that communities see Ebola as only one of many deadly threats. For the working class and impoverished masses of the region, the virus is routinely described as a lesser evil compared to the daily horrors of imperialist-backed armed conflict, unchecked malaria and widespread starvation. He explained:

It doesn’t exist because people are afraid for their lives. Anything can happen to them. They could die because of other things. Ebola is the least killer. That’s what they think. … They see the other health problems they have. Many are dying every single day. And they also see those who are dying because of conflict. So, the numbers they see of people dying [from other causes] dwarfs what they see because of Ebola.

After more than a century of capitalist resource extraction and the systematic dismantling of local public health infrastructure through global austerity, these communities are deeply suspicious of the international response. Residents pointedly told the WHO chief that foreign powers are intervening only to prevent the virus from reaching Western borders, rather than out of any genuine desire to save African lives. They correctly recognize that the major capitalist powers are mobilizing a meager, militarized response to protect their own national interests, while remaining indifferent to the broader social catastrophe they have deliberately manufactured in central Africa.

The infiltration of the Bundibugyo virus into the sprawling internal displacement camps of the eastern DRC marks a dangerous new phase of the epidemic. Reporting by Gradel Muyisa and Benoit Nyemba for Reuters highlights fatal confirmed cases in the Kpangba displacement camp, which alone traps approximately 30,000 people who have fled decades of imperialist-backed proxy wars. Residents endure severe overcrowding and inadequate sanitation, with hundreds forced to share a single toilet while open defecation remains common. Caitlin Brady, the country director for the Danish Refugee Council, warned that the virus will spread extremely quickly under these conditions, sparking panic and mass flight.

The United Nations is now raising urgent alarms over the threat to the youngest and most vulnerable. In a report for *UN News*, Daniel Johnson noted that agencies are bracing for a spike in child infections. Dr. Douglas Noble, a UNICEF global incident manager, warned that as the outbreak shifts toward household transmission, children will increasingly bear the brunt of the disease. These children face extraordinary vulnerabilities engineered by global inequality. UNICEF data reveals that more than half of children under age five in Ituri Province suffer from chronic malnutrition, and more than one in five are “zero dose” children, who have never received a single routine vaccination against preventable illnesses like diphtheria, tetanus or measles.

High population density and reliance on shared facilities make contact tracing and isolation practically impossible, while chronic malnutrition and coinfections weaken immune systems, radically increasing the risk of death. As Dr. Noble observed, past outbreaks demonstrate that children in these conditions face the highest case fatality rates. The virus is no longer confined to isolated rural areas or transient mining clusters; it is now deeply entrenched in densely populated, highly vulnerable communities that harbor historically justified suspicions of both state authorities and international aid agencies.

To understand the explosive potential of the outbreak, consider the deadly mathematics of Ebola transmission. A 2017 study in *PLOS Neglected Tropical Diseases* by Amanda Tiffany and colleagues found that traditional burial practices, which frequently involve washing and touching the deceased, were associated with high numbers of secondary infections. A single unsafe burial, the study found, could see an average of 2.58 new cases, rapidly multiplying the outbreak and sustaining chains of transmission.

Current efforts to implement safe and dignified burials in the DRC are directly informed by these findings, but the protocols are running into deep, sometimes violent suspicion. From the perspective of local families, anonymous burial teams arrive to remove their loved ones, prevent customary funeral rites, and sometimes refuse access to the bodies of the deceased. This clash recently erupted in the town of Rwampara, where angry residents set fire to an Ebola treatment center after authorities stopped them from retrieving the body of a local preacher for a traditional

funeral.

To grasp the scale of the danger, consider recent epidemiological projections. The Centers for Disease Control and Prevention (CDC) published a branching process model of the Bundibugyo outbreak in its *Morbidity and Mortality Weekly Report*. The model simulates many possible outbreak trajectories based on assumptions regarding how many people each patient infects and how rapidly interventions are implemented. The researchers calibrated their central scenarios against three assumed cumulative death counts as of May 24, 2026, anchoring their models at 50, 100 and 200 deaths, and inferred that the initial zoonotic spillover most likely occurred between late January and mid-February.

The scientists projected future transmission under four intervention scenarios corresponding to the percentage of symptomatic patients successfully isolated, defined as poor at 20 percent, moderate at 50 percent, high at 70 percent and extremely high at 95 percent. The main conclusion is devastating. Under the poor isolation scenario, there is a 65 percent likelihood that the outbreak will exceed 20,000 cases within just three months. Even if workers achieve a high 70 percent isolation rate, tens of thousands of cases and thousands of deaths remain plausible depending on the number of early undetected fatalities. The CDC stressed that this is already the largest Bundibugyo outbreak ever recorded, and under low isolation scenarios it has the potential to become one of the largest Ebola epidemics in human history.

These projections carry grim implications for the displacement camps and conflict zones of the eastern DRC. The more pessimistic scenarios are not remote mathematical possibilities but highly realistic outcomes. Achieving high isolation and contact tracing coverage is extremely difficult, if not impossible, in regions where the health infrastructure has been deliberately starved of resources by international funding cuts.

In a recent interview on the NewsNation network, Acting CDC Director Jay Bhattacharya claimed he had seen no evidence that the Trump administration's foreign aid cuts had impacted the ability of health agencies to address the current outbreaks. Bhattacharya, a prominent opponent of basic infection-control measures, is providing political cover for a brutal austerity regime. By denying the catastrophic impact of defunding, officials attempt to obscure a fundamental truth: The Bundibugyo outbreak is the direct product of long-term policy decisions and imperialist plunder.

The reality of these decisions is documented in a June 2026 interim staff analysis by the House Committee on Oversight and Government Reform, titled "People Are Already Dying, and More Will Die." The report outlines the consequences of dismantling the US Agency for International Development (USAID), finding that the elimination of the agency and its global health security portfolio has led to hundreds of thousands of preventable deaths and drastically increased global vulnerability to epidemics. It cites a study in *The Lancet* by Daniella Medeiros Cavalcanti and colleagues and notes that models estimate more than 600,000 people, mostly children, have died from preventable causes in just over a year due to the agency's shutdown.

Critical programs for Ebola prevention, disease surveillance and laboratory testing were among those gutted. This directly weakened surveillance networks, early detection and medical surge capacity in countries like the DRC and Uganda. Deprived of diagnostic tests and essential resources, local health systems were left unable to track, isolate and treat patients, and the virus spread undetected for weeks in a volatile, war-torn region.

According to a report in *Stars and Stripes* by John Vandiver, the United States Africa Command has placed boots on the ground at the Laikipia Air Base in central Kenya. Hundreds of military personnel, including engineers and security forces, were dispatched to construct a 50-bed temporary isolation unit. While US officials insist the project is necessary to protect Americans potentially exposed to the virus, the facility is explicitly oriented toward serving US personnel.

The Kenyan government, led by President William Ruto, is making eager accommodations with the imperialist powers. Despite massive protests by Kenyan youth and a High Court order temporarily suspending the facility, construction has proceeded. The Ebola crisis is being actively weaponized for US hegemony. Under the pretext of a health emergency, the Laikipia facility functions essentially as a forward medical and quarantine installation for American troops and government officials deployed across East Africa. It offers no serious contribution to outbreak control in the DRC. Instead, building high-containment infrastructure inside a friendly military base strengthens the logistical backbone of US military operations in a region rich in strategically important resources.

This is not a sudden or opportunistic intervention but the extension of an established military posture. In January 2026, Washington broke ground on a $70 million State Department-funded expansion of the runway at Manda Bay and Camp Simba, key air bases used for operations against al-Shabaab. That investment itself built on a five-year defense cooperation agreement signed in September 2023 by then-Secretary of Defense Lloyd J. Austin III and Kenyan Defense Minister Aden Bare Duale. The Laikipia facility is the latest layer of this years-long militarized alliance, not a one-off humanitarian gesture.

The eastern provinces of the DRC possess immense wealth in gold, cobalt, coltan and other critical minerals essential to global supply chains. The outbreak is being used as a humanitarian justification to deepen the US military footprint in East Africa. This militarization belongs to the rivalry between the great powers. Over the past two decades, China has vastly expanded its economic footprint across Africa, concentrating its investments in energy, mining and infrastructure. US strategists view this integration as a major challenge to American dominance, and Washington is recalibrating its engagement through military partnerships and the expansion of bases. For the United States, public health crises have become opportunistic avenues to project military power against geopolitical rivals.

The class character of this response is starkly revealed by contrasting the resources devoted to military infrastructure with the chronic underfunding of regional health systems. While the State Department coordinates a $220 million whole-of-government response that includes deploying troops and establishing US-centric Ebola facilities in Kenya, public health systems in the DRC, Uganda and surrounding countries are systematically starved of funds. The resources used to build and staff the Kenyan installation could have financed primary care centers, diagnostic laboratories, safe water infrastructure and community health workers directly in the outbreak zone.

This is not a question of technical capacity but of political priorities. Within the framework of global capitalism, the lives of Congolese workers and peasants are treated as expendable compared to the safety of a small number of US troops and defense contractors. The American response to the Bundibugyo outbreak exposes an imperialist system that places the militarization of the African continent and the pursuit of corporate profit above the survival of the international working class.