Ebola deaths pass 400 in the DRC as US guts surveillance systems to stop it

Benjamin Mateus
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On June 30, exactly 46 days into the epidemic, BNO News reported 1,354 confirmed Ebola cases, reflecting a daily increase of 26 infections. The death toll climbed by 22 to reach 401, alongside just 204 recoveries. The low recovery-to-death ratio and a crude case fatality rate of roughly 30 percent among cases reported to date underscore the severity of the crisis. The Democratic Republic of the Congo (DRC) carries almost the entire burden with 1,333 confirmed cases and 399 deaths. Uganda has recorded 20 cases and two deaths linked mostly to cross-border transmission, and France has reported one confirmed case, a physician who had returned from a humanitarian mission in the DRC.

This is the 17th Ebola outbreak in the DRC since 1976, but the first large-scale epidemic driven by the Bundibugyo strain. The World Health Organization (WHO) declared the Ebola outbreak a Public Health Emergency of International Concern (PHEIC) on May 17. The country's persistent social crisis has made each outbreak of Ebola and other deadly pathogens more dangerous, not only to the DRC but to the wider region and beyond. That danger is compounded in a world engulfed in escalating imperialist violence and incapable of any cogent response to the suffering of millions of Congolese, or to populations elsewhere facing earthquakes and the severe effects of climate change.

For the current Bundibugyo strain, as Oxfam and the Coalition for Epidemic Preparedness Innovations (CEPI) note, there is no licensed vaccine or approved therapeutic, and candidate vaccines and antivirals are only now entering clinical trials.

A recent analysis by the Centers for Disease Control and Prevention (CDC), published in the Morbidity and Mortality Weekly Report, found a 65 percent likelihood that the outbreak will exceed 20,000 cases within three months absent aggressive case isolation. Worse, the outbreak has now spread to a fourth province, Haut-Uele, according to Agence France-Presse. The entire northeast of the DRC, home to roughly 15 million people, is now affected. The virus is crossing the Uganda border precisely as global financing and public health capacity are being ruthlessly slashed by capitalist governments.

More than 90 percent of the 1,354 confirmed Ebola cases are concentrated in Ituri province, spreading across North Kivu and the M23 militia-controlled regions of South Kivu, according to the Africa Center for Strategic Studies. Across these three provinces, more than 5 million people are displaced, one of the highest totals in the world. At a 15,000-person camp in Bunia, at least 30 suspected deaths have occurred since early May, with confirmed positive cases at two other camps. Because deaths occur in communities before identification, Oxfam warned in mid-June that official figures must be read as underestimates of the true scale of the crisis.

This toll is driven by the population's near-total lack of basic necessities. In the Mongbwalo mining epicenter, just 20 percent of residents have clean water and 25 percent have functional sanitation. Clean water costs $2 per 20 liters, forcing families to consume surface water fouled by mining runoff. Those 20 liters constitute the WHO daily survival minimum for one person. A family requires several times that volume for outbreak prevention, meaning survival water is sold at a price the population cannot pay. Nationally, only 43 percent of the DRC population uses basic water services and 15 percent have basic sanitation, according to a Dec. 8, 2025, UNICEF report.

This scarcity is also driving a deepening cholera catastrophe. In 2025, the DRC recorded 64,427 cholera cases and 1,888 deaths nationally, concentrated in the same eastern provinces. Children accounted for 14,818 cases and 340 deaths. UNICEF called the cholera outbreak "wholly preventable." The high-profile Ebola epidemic commands global attention while the quiet cholera catastrophe kills far more.

Without water for decontamination, health centers become transmission nodes. Oxfam field coordinator Manel Rebordosa stressed that water is the absolute first line of defense. Yet medical capacity has collapsed. The World Bank recorded 0.2 physicians per 1,000 people. The International Committee of the Red Cross (ICRC) reported 85 percent of Kivu facilities lack medication and 40 percent suffered staff exoduses. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) notes DRC humanitarian appeal was cut 46 percent, from $2.58 billion in 2024 to $1.4 billion in 2026, with local responders receiving less than 6 percent. War, displacement, contaminated water, hunger, and destroyed infrastructure are the accelerants of this outbreak, exposing the underlying political economy that produces such disasters.

A recent report by Jon Cohen in the journal Science provides a key explanation for this capitalist policy turn. Cohen found that the Trump administration has struck what some see as the "final blow" to the President's Emergency Plan for AIDS Relief (PEPFAR), a program credited with saving 26 million lives over 23 years. The State Department has declared that support from the CDC will end in most countries as of Sept. 30, 2026.

Historically, approximately half of PEPFAR funding flowed through the CDC, which assisted 46 recipient countries. Under new May 5 guidance, it is largely each country's choice whether to outsource work to the agency. As Cohen explains, funds are now paid directly to countries, mostly through bilateral financial deals. In some cases, the administration demands something in return, such as access to mineral resources. These five-year memorandums of understanding (MOUs) reach far beyond HIV, extending into malaria, tuberculosis, nutrition, and maternal and child health.

This establishes a fee-for-service mechanism. Rather than deploying its own staff, the CDC now sells assistance to countries item by item, from a priced menu of services. Longtime global health analyst Emily Bass, who obtained and published the fee schedule, describes it as replacing a system that once transferred roughly $2 billion a year to the agency. Countries receiving more than $125 million in annual aid under the America First Global Health Strategy are required to buy at least a minimum package. Only 31 of these agreements have been signed, with several large recipients locked in disputes.

The scale of the cut is clearest in a single country. For Uganda, now battling Ebola's cross-border spread, the new arrangement represents a 14-fold reduction from what the CDC spent there in fiscal year 2023. Separately, NPR and Devex report that of the roughly $6 billion Congress appropriated for HIV work in 2026, only about $640 million of the $1.3 billion meant for the CDC has actually been released.

The deterioration is already visible. According to the April 2026 PEPFAR fiscal year 2025 fourth-quarter data release, analyzed by The New York Times, amfAR, KFF, and the Center for Global Development, PEPFAR-supported HIV testing plummeted from 21.9 million to 17.2 million in a single quarter year-over-year. Diagnoses correspondingly fell from 385,000 to 307,000. HIV and Bundibugyo Ebola are now treated as risks managed only insofar as they touch United States interests.

Laboratory capacity, health-worker training, and logistics systems built with PEPFAR funding underpinned Ebola surveillance during previous DRC outbreaks, according to Science, analyst Emily Bass, and the Africa Center for Strategic Studies. Bass notes that PEPFAR-built laboratories diagnose Ebola, Marburg, and hantavirus; defunding the HIV platform weakens all of it. Michele Montandon told Science that CDC expertise previously aided Marburg and mpox responses, but under the new framework, the United States is "not on the ground to respond to threats as they arise."

Oxfam reports contact tracing fell to 43 percent as of June 8, compared to 79 percent one month into the 2018 to 2020 outbreak. Africa CDC Director-General Jean Kaseya warns that 95 percent of national health-system beds are occupied. HIV clinics double as nodes for outbreak detection, and analyst Jirair Ratevosian noted in the fiscal year 2025 data that upstream testing and case-finding are being scaled back, echoing past Ebola responses. Rebranding these capitalist cuts as efficiency mirrors the domestic assault on public health that has seen the reemergence of measles and anti-vaccine policies that threaten the lives of children.

The epidemiological curve in the figure above records the regression precisely. The 2026 trajectory climbs steeper than any prior outbreak at the same stage, and it does so against the smallest response of any of them. The 2014 to 2016 West Africa epidemic, 28,600 cases and 11,325 deaths, built the surveillance and vaccine architecture now in use. The 2018 to 2020 Kivu outbreak drew more than 1,500 WHO personnel, 16,000 local workers, and 300,000 vaccinations with a licensed Zaire-strain vaccine.

This outbreak has none of it. There is no licensed vaccine for the Bundibugyo strain. Humanitarian financing has been slashed, and the little that remains barely reaches local responders. The CDC, the institution that helped end 16 outbreaks since 1976 and holds the technical memory of how it was done, has been cut out of the response by deliberate policy. The knowledge to stop this epidemic exists, but the infrastructure to apply it is being dismantled while the cases climb. That is not a failure of capacity. It is a decision, and its result will be counted in preventable deaths.