

Two months since the Ebola outbreak, response in Congo losing ground

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Two months after the World Health Organization (WHO) declared the Bundibugyo Ebola outbreak in the Democratic Republic of the Congo a Public Health Emergency of International Concern (PHEIC), the epidemic has entered a devastating new phase. Just back from a week in Ituri province, Dr. Chikwe Ihekweazu, executive director of the WHO Health Emergencies Programme, delivered the starkest assessment yet at a July 14 briefing in Geneva. The virus, he warned, “continues to outpace the response efforts by the national authorities, international partners, including WHO, and the communities most affected.”

WHO modeling now indicates the true number of cases is “at least two to four times the number of cases that we have found.” The official tally is a floor beneath a far larger epidemic. Roughly 80 percent of new cases are detected outside any known chains of transmission. “Perhaps the most alarming finding,” Ihekweazu said, “is that many newly reported cases are individuals who died in their communities, without ever reaching a health facility and receiving care.” The case fatality rate has climbed rather than fallen as the response matures, from roughly 23 percent in mid-June toward the mid-30s, signifying that the response is falling behind the disease.

According to July 14 data from BNO News and the Congolese Ministry of Health, the DRC has recorded 1,963 confirmed cases, 719 deaths and 333 recoveries. Fifty-nine days since the first detected case, fatalities far outnumber recoveries. “A few days ago, we saw over 80 cases confirmed in a single day,” Ihekweazu noted. Two months after the PHEIC declaration of May 17, this is now the “third-largest Ebola outbreak ever,” he said, with “the fastest growth in a single month... of all the Ebola outbreaks that we’ve managed.” Every indicator is moving the wrong way: geographic spread, undetected transmission, health worker attrition, and the collapse of pay, supplies and funding. The WHO has received only about 40 percent of the \$115 million it needs. “This is not a burden DRC can be allowed to carry alone,” he said.

The accompanying graphics plot the trajectory through July 12, the most recent point charted: 1,926 cases and 702 deaths. In Uganda there have been only 20 cases and two deaths, with no new cases reported since June 30, 2026. France has one case in a returning physician who has since recovered.

On July 11, the Congolese National Institute of Public Health (INSP) formally added two more provinces, Haut-Uele and Tshopo, to the epidemic zone, bringing the total to five. As Reuters reported on July 13, Tshopo had recorded four cases including two deaths, while Haut-Uele reported one death. Although investigators believe these cases were imported from Niania in Ituri, the institute concluded it was “necessary and appropriate to consider these two provinces as an

epidemic zone.”

The stakes are severe when one appreciates that Tshopo’s capital is Kisangani, one of the country’s largest cities and a major river hub. Haut-Uele borders South Sudan and the Central African Republic. The virus now sits on major transport routes and near porous borders. As NPR reported on July 10, a body testing positive was transported to Kisangani, and one Tshopo case had “no apparent geographical connection to known outbreaks.” The outbreak that began in the remote gold mining zones of Ituri is following the arteries of displacement, trade and labor migration.

This was foreshadowed at a July 9 briefing of the Africa Centres for Disease Control and Prevention (Africa CDC). Dr. Wessam Mankoula, its head of emergency preparedness, cited real gains, including laboratory capacity expanded from about 30 to more than 2,000 tests a day, clinical trials begun, and a cross-border memorandum with Uganda. He then conceded none of it had been enough. “Unfortunately, the virus is still ahead of our response,” he said. “It’s moving faster than deploying the resources to control the situation.”

In the first six weeks the DRC recorded 1,596 cases, against 994 in the West Africa epidemic and 378 in the 2018 North Kivu outbreak at the same stage. Mankoula praised neighboring Uganda, which has held its outbreak to 20 cases with full contact tracing, as “demonstrating that Ebola can be controlled.” The disease is controllable where basic medical infrastructure exists. The catastrophe in the DRC shows what has been withheld from its population.

Nowhere is that clearer than among the workers sent to stop the virus. At the Ebola treatment center in Rwampara, one of the worst-hit areas of Ituri, staff burned tires on Monday, blocking access to the facility. Dozens walked off the job over unpaid salaries and bonuses. The strikers, the Associated Press reported, include epidemiologists, case investigators, drivers and gravediggers. Workers first struck the previous week, as deaths neared 600. Now the doctors have issued a 48-hour ultimatum, warning of a “full-scale strike” with no minimum service. This could spell disaster for an already untenable situation.

“We don’t know how it is possible to not have been paid for two months,” health worker Bahati Claude told the Associated Press. “We don’t want to give up the job.” Physician Pascal Bahoya told Agence France-Presse, “We’ve been treating Ebola patients without pay since May 15. We continue to do so because that is our oath, but we are working in very difficult conditions.” Another doctor, Jeremie Bataga, added, “Some colleagues are disheartened, but we continue to carry out our mission out of professional conscience.”

Health Minister Samuel Roger Kamba acknowledged “delays in payment,” saying the government was verifying its lists because

unrelated names had been added to the payroll. “We must ensure that these payments reach the right people,” he argued. Furthermore, Akilimali Pierre of the INSP told the Associated Press that the closure of Bunia airport was hampering “certain aspects of the flow of funds.” Even though logistics and payroll fraud may explain delayed transfer, they do not explain two months of unpaid labor amid the fastest-growing Ebola outbreak ever recorded.

The toll on these unpaid personnel is staggering. At least 112 healthcare workers have been infected and 35 have died, according to the INSP. “We’re still losing our healthcare workers in DRC,” Mankoula said. The same week the US Centers for Disease Control and Prevention declared a Level 1 activation, its highest-level emergency response, the people staffing the treatment centers in Ituri had gone two months without pay.

Thus far, two US citizens have contracted Ebola in the DRC. The most recent, announced on July 11, is a Samaritan’s Purse logistics worker based in Bunia who tested positive and was admitted to Frankfurt University Hospital on July 13. The first was Dr. Peter Stafford, a missionary physician who contracted the virus in May, was evacuated with his family to the Charité University Hospital in Berlin, treated, and recovered. His wife, Dr. Rebekah Stafford, told CNN she was painfully aware that their Congolese friends would not receive the same level of care.

Yet rather than fly exposed Americans home to the state-of-the-art biocontainment network in the United States, Washington planned to send them to a quarantine facility at an Air Force base in Kenya, a project since halted by a Kenyan court. “We cannot and will not allow any cases of Ebola to enter the United States,” Secretary of State Marco Rubio declared in May. On Monday it was announced that US citizens in the DRC could not return on commercial flights and must spend 21 days in a third country. The American Foreign Service Association protested the policy as a “stark departure” from past practice, insisting employees sent abroad “are entitled to the same standard of care that has always applied, including the right to come home.”

The priorities are written into the budget. Of the \$1.4 billion the administration has requested from Congress for the Ebola response, according to Reuters, some \$800 million is tied to humanitarian response, including the Kenyan quarantine center, and \$500 million to “global health security,” justified on the grounds of keeping the virus from American shores. The request arrived inside a \$87.6 billion supplemental package whose principal purpose was military, including \$21 billion for munitions replenishment alone. The sums available for war dwarf those grudgingly allocated to contain an epidemic, and even the minimal health funding is framed less as a duty to the those in danger of death than as a cordon around the United States.

The Bundibugyo strain has no licensed vaccine and no approved therapeutic treatment, because existing Ebola countermeasures were certified for the Zaire strain. Both are now being pursued with some diligence:

A WHO-sponsored platform trial known as PARTNERS, run by the DRC’s National Institute for Biomedical Research with Oxford University and Belgium’s Institute of Tropical Medicine, enrolled its first patient on July 2 and aims to include more than 1,000 patients. It is testing Mapp Biopharmaceutical’s antibody MBP134 and Gilead’s remdesivir, alone and in combination, against optimized supportive care.

On July 13, Oxford’s Vaccine Group launched the world’s first

Phase 1 trial of a Bundibugyo vaccine candidate, ChAdOx1 BDBV, in 50 healthy adults in Britain, developed with the Serum Institute of India on the platform behind the AstraZeneca COVID-19 vaccine and backed by an \$8.6 million partnership with the Coalition for Epidemic Preparedness Innovations (CEPI). The Serum Institute manufactured roughly 620,000 doses in two weeks.

The push to find a durable treatment comes 19 years too late, given that Bundibugyo was first identified in 2007. When the outbreak was declared this May, CEPI recorded that there were “no licensed vaccines available for Bundibugyo virus and none in clinical development.” Not one candidate had been carried into a human trial in nearly two decades, though the Zaire strain secured a licensed vaccine and the ChAdOx platform was increased to billion-dose scale within a year when COVID-19 threatened the world.

Warning donors against abandoning the DRC “at a critical stage,” Ihekweazu compared the response to a marathon. “You can’t give up after the first lap or the second.” These failures unfold within a war economy: armed conflict between the Congolese military and the Rwanda-backed M23 militia, more than five million displaced, near-daily attacks on burial teams, and a near-total lack of clean water in the mining epicenter, while the DRC humanitarian appeal has been met only a 46 percent response. The United Nations estimates the epidemic has already pushed nearly one million people into poverty.

Nothing here was unforeseeable. Ebola’s transmission was mapped decades ago, and Uganda has held its outbreak to 20 cases by tracing contacts and treating the sick, just across the border from where the DRC counts its dead in the hundreds. Ituri does not lack knowledge. It lacks clean water, laboratories, ambulances and doctors who are getting paychecks.

The Ebola outbreak is an indictment of a imperialist system that could not find \$115 million for the WHO but moved \$87.6 billion for war in a week. It left a virus without a vaccine for 19 years because its victims were poor, then produced 620,000 doses in a fortnight once Western capitals felt exposed. The imperialist great powers fly their own nationals to the finest hospitals in Frankfurt and Berlin while Congolese doctors treating the same disease go unpaid. This is not failure but design, allocating life and death by profit and nationality.

Resources exist, but they are held by a financial oligarchy that spends them on war and withholds them from the sick. Ending this outbreak, and preventing the next, requires the international working class to take these resources into its own hands and organize production for human need.



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