Ebola deaths pass 1,000 in the DRC, faster than any previous outbreak

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As of July 21, 67 days after the Bundibugyo Ebola outbreak was declared in the Democratic Republic of the Congo (DRC) on May 15, 2026, confirmed deaths have surpassed 1,000. Ministry of Health figures record 2,536 confirmed cases, 1,033 confirmed deaths and 506 recovered patients, a case fatality among confirmed cases of 40.7 percent. That day brought 63 new cases and 34 new deaths, with 306 suspected cases and 738 patients in isolation.

The virus is active in Ituri, North Kivu, South Kivu, Haut-Uele and Tshopo. With Uganda's 20 cases and two deaths and one case in France, the total stands at 2,557 confirmed cases and 1,035 deaths. Ituri accounts for nearly 90 percent of confirmed cases and more than 80 percent of the deaths. Uganda has recorded no new case since June 21.

It took 67 days for this outbreak to cross the grim 1,000-death milestone. The West Africa epidemic, declared on March 23, 2014, took 142 days to reach the same toll, more than twice as long.

If current growth rates hold, the outbreak would reach West Africa's 28,616 cases about five months after declaration and its 11,310 deaths in four. West Africa took 27 months. Such projections carry uncertainty; epidemic curves bend. What is certain is that no licensed vaccine or treatment exists, and that the surveillance which would narrow the uncertainty has been cut.

Contact tracing in Ituri, North Kivu and Tshopo now reaches 82 percent of identified contacts, against a WHO target of 90 to 95 percent. WHO Director-General Tedros Adhanom Ghebreyesus admitted on July 22 that teams cannot reach every community, diagnose every sick person or deploy where needed. Africa CDC puts it far more starkly: fewer than 9 percent of the contacts that ought to be traced are monitored at all. One measures performance against a list of known contacts. The other statistic presents the reality of the epidemic in a war torn country.

That gap is the reason the confirmed tally is a floor. As the *World Socialist Web Site* reported on July 16, roughly 80 percent of new cases are detected outside any known chain of transmission, a finding Jon Cohen has since confirmed in *Science*. The system traces the shrinking fraction of chains it can still see, while most transmission happens off the books.

The WHO has noted, as reported in STAT, that two-thirds of confirmed deaths never sought care and were tested only after death. WHO modeling indicates the true number of cases is at least 2-4 times the confirmed count. The case fatality figure therefore measures what the response can see, and how little reaches those who do arrive at a treatment facility.

Placide Mbala-Kingebeni, head of epidemiology at the National Institute of Biomedical Research, said the outbreak was brewing for months before detection and that many health zones remain unreachable because of insecurity. Ituri is a gold-mining region where nearly a million people have been displaced by years of armed conflict. In late June an Ebola treatment centre in the province was attacked and set on fire. Two people were killed and patients fled into the surrounding communities.

Almost nothing is known about this virus, because almost nothing was spent on finding out.

As of early July 2026 the Pathoplexus database held 3,388 Zaire ebolavirus genomes, 166 Sudan and 49 Bundibugyo. Fifteen of the 49 come from the current outbreak. Across 19 years and two prior outbreaks, the world had assembled only 34 sequences of the virus now killing people in Ituri.

Alisen Ayitewala, Adrienne Amuri-Aziza and colleagues report in *The Lancet* that the virus is a distinct new clade rather than a re-emergence, carrying 219 single nucleotide polymorphisms against the reference genome, including substitutions across the glycoprotein. Countermeasures in early development, they note, may need tailoring to it.

In "Cross-Reactive Bundibugyo Antibody Responses after Receipt of Licensed Ebola Vaccines," published in the *New England Journal of Medicine* on July 22, Edouard Lhomme and colleagues analyzed 179 serum samples from the earlier PREVAC trial. They found cross-reactive Bundibugyo binding antibodies after every vaccine formulation, though at levels far below the response against Zaire. Calling the comparisons exploratory and the protective value unknown, they nonetheless conclude the stockpiled vaccine should be evaluated now.

That has renewed pressure to test Ervebo, Merck's licensed Zaire vaccine, in the outbreak itself. More than 300,000 people in this region were vaccinated with it during the 2018-2020 epidemic, and the international stockpile holds 500,000 doses. IAVI, which is developing a Sudan vaccine on the same platform, is in discussions with Africa CDC about supplying doses. No trial has been approved.

On May 28 the WHO issued emergency guidance recommending that Ervebo not be used against Bundibugyo outside controlled research settings, judging the evidence on cross-protection too limited to estimate effectiveness. The guidance does not bar research. Two months later the doses are still in storage.

Clinicians have said openly that this is untenable. Isaac Bogoch of the University of Toronto argues that trials of the licensed vaccines should proceed in parallel precisely because they are immediately available. Jean Kaseya, director-general of Africa CDC, was blunter at a summit in Ghana on July 22. People are dying, he said, because there are no vaccines, no medicine and no funding.

The University of Oxford launched the world's first Phase I Bundibugyo vaccine trial on July 13, roughly eight weeks into the outbreak. It will test the safety of a candidate built on the Oxford COVID-19 vaccine's viral vector in 50 healthy adults. Modeling by Bogoch and colleagues found ring vaccination may underperform anyway, since it depends on contact tracing and most cases surface only after death.

One trial has reached patients. On July 2 the WHO opened enrollment in PARTNERS, the first randomized trial ever conducted for Bundibugyo virus disease, at a treatment centre in Ituri. It is testing remdesivir, donated by Gilead, and MBP134, an investigational monoclonal antibody from Mapp Biopharmaceutical, and aims to enroll more than 1,000 patients. Neither drug was made for this virus. Nineteen years after Bundibugyo was identified, the response is assembled from what was built for other pathogens and what companies agreed to give away.

The lessons of previous outbreaks were set down in writing. In a 2020 paper in the *Journal of Infection and Public Health*, Ramat Toyin Kamorudeen and colleagues examined a catastrophe that infected more than 28,600 people and killed 11,310. Their recommendations read now as an indictment of things left undone. They called for vaccines in the affected regions, hemorrhagic fever research written into national budgets, treatment facilities at every quarantine center, trained health workers and surveillance of the animal reservoir. Of these, one was carried out. Governments tied disease screening to visas, keeping the virus out of the countries it had not yet reached.

The paper is evidence of what was known by 2020 and, like the official reckonings with COVID-19, an example of the thinking that ensured its recommendations went unfunded. Its model weighs eight determinants equally, setting health system quality and government policy alongside culture, tradition and sexual behavior. It documents the real material causes: gutted health systems, absent protective equipment, no drug supply. It then sets them in a flat field alongside African burial customs, so that causation dissolves and no one is responsible.

Under capitalism, which diseases get medicines is decided by profit and national security priority. In the United States, countermeasures against Ebola are funded not as public health but as biodefense. The trigger is a determination by the Department of Homeland Security that a pathogen poses a material threat to national health security, which releases procurement money through the Biomedical Advanced Research and Development Authority (BARDA) and the Pentagon's chemical and biological defense office.

In July 2023 BARDA awarded Emergent BioSolutions a 10-year contract worth up to $704 million for Ebanga, a monoclonal antibody indicated only for infection caused by Zaire ebolavirus. Emergent manufactures and distributes it in the US and Canada for Ridgeback Biotherapeutics, which developed the drug. Emergent's own announcement cited that Homeland Security determination as the basis for the award. The company's portfolio runs to anthrax, smallpox, botulism, mpox and Ebola, a roster of presumed biological weapons in which Africa's leading causes of death do not appear. On May 28 it received a further $64.5 million for botulism antitoxin, and on June 29 $52.7 million for the smallpox and mpox stockpile.

Work that would have covered Bundibugyo was funded, but only so far. A 2016 study in the *Journal of Virology* reporting antibodies cross-reactive against the Ebola, Sudan, Bundibugyo and Reston viruses was supported by a contract from the Pentagon's Defense Threat Reduction Agency and grants from the National Institutes of Health (NIH). Its authors stated plainly that filovirus immunotherapeutics had concentrated on Zaire ebolavirus alone, largely driven by US biodefense funding programs, and named Bundibugyo among the species left unprotected.

Ten years later there is still no licensed Bundibugyo vaccine and no treatment, while the Zaire-directed products were carried the full distance to licensure and bought into a national stockpile. Discovery is funded cheaply across the field. Only the designated national threat is carried through to a product. That is the operating principle of a system in which the means of preventing mass death are developed only insofar as they serve national security procurement and shareholder return.

The international working class must take the pharmaceutical and biotechnology industries out of private hands and place them under its own democratic control, so that what is developed answers to human need. It must turn the wealth now consumed by the war over eastern Congo's minerals to the health infrastructure the Congolese population has been denied. This requires a unified political struggle by workers in Africa, Europe and the Americas against the imperialist order that has organized global medicine around its own security, and the building of sections of the International Committee of the Fourth International. The capacity to build a defense against Bundibugyo has existed for a decade. It was never pointed at the people now dying of it.