Congo Ebola outbreak becomes second largest ever recorded

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The Bundibugyo Ebola outbreak in the Democratic Republic of the Congo (DRC) has become the second largest ever recorded, surpassed only by the 2014 to 2016 West Africa epidemic and its 28,616 confirmed, probable and suspected cases. According to the World Health Organization (WHO) Disease Outbreak News, with data as of July 30, the country has reported 3,605 confirmed cases and 1,587 deaths, a crude case fatality ratio (CFR) of 44 percent. It is now the largest Ebola outbreak ever reported in the DRC, passing the 2018 to 2020 Kivu epidemic's total of 3,470 cases in 76 days. Kivu took 23 months.

It spans 49 of 140 health zones across Ituri, North Kivu, South Kivu, Haut-Uele and Tshopo. Epidemiological week 30 was the worst yet, with 567 cases and 296 deaths, roughly 42 deaths a day. Dr. Thierno Baldé, the WHO incident manager, said Ituri accounts for more than 90 percent of cases and roughly 80 percent of deaths. Uganda declared its own outbreak over on July 28, having recorded no confirmed case since June 21, at 20 cases and two deaths, a fatality rate of about 10 percent.

The confirmed tally is a floor. Placide Mbala-Kingebeni of the National Institute of Biomedical Research has said the outbreak was building for months before detection and that health zones remain unreachable because of insecurity. WHO modeling puts true infections at two to four times the confirmed count. Doctors Without Borders reports that because Bundibugyo virus disease is rare, manufacturers do not routinely produce enough specialized test kits, leaving hundreds of samples untested.

Contact tracing has gone backwards. As of July 28, 78.3 percent of identified contacts were under follow-up, down from 82 percent in mid-July, against a WHO target of 90 to 95 percent cited by Dr. Abdi Mahamud. That figure counts only the people the system already knows about. The Africa Centers for Disease Control and Prevention (Africa CDC) estimates that fewer than 9 percent of the contacts that ought to be traced are monitored at all. Roughly 80 percent of new confirmed cases appear outside any known transmission chain, Jon Cohen reported in *Science*, and the WHO has said, as reported in *STAT*, that two-thirds of confirmed deaths never sought care and were tested only after death.

The case fatality ratio has tracked that failure. It stood at about 23 percent in mid-June, 25.9 percent on June 19, 31.0 percent on July 1, 39.0 percent on July 15 and 44.0 percent on July 30. The two previous Bundibugyo outbreaks recorded 25 to 40 percent. The virus has not changed in six weeks. What the rising ratio records is a response reaching people later and later, capturing the dying while mild and moderate infections pass through undetected.

The trajectory was modeled in advance. On June 5, Eric Q. Mooring and colleagues published "Modeled Scenario Projections for the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026" in the *Morbidity and Mortality Weekly Report*. Their branching-process model, calibrated to death counts as of May 24, when roughly 50 had been reported, placed the probable spillover in mid to late February, three months before the outbreak was declared on May 15.

The model ran four scenarios turning on one variable: the share of symptomatic patients found, isolated and treated before infecting anyone else. Under poor isolation, set at 20 percent, it projected a 65 percent likelihood of more than 20,000 cases within three months alongside more than 2,000 deaths. Under high isolation at 70 percent, about one in 20 simulations exceeded 10,000 cases. Jason Asher of the Centers for Disease Control and Prevention (CDC) Center for Forecasting and Outbreak Analytics called the work a planning tool rather than a forecast.

Two months on, the response is operating at or below the poor branch, and the projection has held. Confirmed deaths stood at 1,587 on July 30, against a worst-case scenario of more than 2,000 within three months of May 24. That figure counts only the laboratory-confirmed dead.

On cases the arithmetic requires care. The model counted all infections, not laboratory-confirmed ones, and 3,605 is far short of 20,000. But the WHO's own multiplier implies between 7,200 and 14,400 infections as of July 30, which places the outbreak inside the worst-case band. The CDC wrote on June 5 that this was already the largest known Bundibugyo outbreak and could become one of the largest Ebola epidemics on record. The confirmed toll then stood in the hundreds.

What the agency has escalated since then is the American border. Travelers who have been in the DRC, Uganda or South Sudan within 21 days are screened at four designated airports, non-citizens who have been in those countries are barred from entry, and a joint list with Homeland Security keeps designated travelers off aircraft. The order has been renewed three times on a rolling 30-day cycle, most recently on July 13. Yet, at each renewal the risk to the American public has been assessed as low.

Within the DRC the agency describes its role as technical assistance: contact tracing, laboratory sequencing and infection prevention. Dr. Satish Pillai, the CDC's Ebola incident manager, put the deployment in May at about 100 staff in Uganda and nearly 30 in the DRC. For the Kivu epidemic, the agency's anniversary release of August 1, 2019 recorded more than 200 experts sent to the DRC, neighboring countries and WHO headquarters, with a further 294 supporting from Atlanta.

WHO director-general Tedros Adhanom Ghebreyesus put the

funding gap in the joint WHO and Africa CDC continental plan at more than $400 million on July 16 and said the outbreak continued to outpace the response.

Kivu was fought with licensed weapons: the Ervebo vaccine, deployed to more than 300,000 people, and the monoclonal antibodies Ansuvimab and Inmazeb, both shown to improve survival in the randomized PALM trial. Nothing is licensed for Bundibugyo.

On July 30, Hilleman Laboratories, a joint venture between the Wellcome Trust and MSD, known as Merck in North America, announced it would advance a single-dose rVSV Bundibugyo vaccine to human trials with MSD, which developed and manufactured Ervebo, as technical adviser. Oxford began a Phase 1 trial on July 13. The PARTNERS trial enrolled its first patient on July 2, the first randomized trial ever conducted for the disease, testing two drugs neither of which is licensed for it.

The outbreak reached a health system already gone. Congolese and South African researchers who left Goma days before the M23 militia seized it described, in *BMJ Global Health*, a syndemic of cholera, mpox and measles in displacement sites where six latrines served more than 800 people. The United Nations Children's Fund recorded 64,427 cholera cases and 1,888 deaths nationally in 2025, the country's worst outbreak in 25 years. At least 112 health workers had been infected by Ebola and 35 had died as of mid-July. Staff at the Rwampara treatment center struck over two months of unpaid wages while the toll approached 600. In late June an Ituri treatment center was attacked and burned.

United States Agency for International Development funding to the DRC fell from nearly $1.2 billion in fiscal 2024 to $715 million in fiscal 2025, and to $67 million in the final quarter of that year, as *STAT* reported. That was the ground the virus emerged onto. This is the DRC's 17th Ebola outbreak since 1976, with the previous one ended in December 2025, five months before this one began.

Yet, the public health assistance withdrawal is not finished.

On Sept. 30, under State Department guidance, CDC technical support to the President's Emergency Plan for AIDS Relief (PEPFAR) ends in most countries, and what ends in the DRC is not only HIV work. In March 2025, two Kinshasa laboratories became the first internationally accredited clinical laboratories in the country, which the agency's own country page calls the culmination of a decade of PEPFAR support and credits with enabling faster outbreak detection. Those laboratories received the samples when field assays in Bunia, built for Zaire ebola virus, came back negative, and where Bundibugyo was confirmed on May 14.

What replaces that support is a commodity market for public health. Under bilateral agreements already signed, including the DRC's, money goes directly to governments and the CDC offers technical assistance for purchase, item by item, from a menu of about 30 services. Countries receiving more than $125 million a year must buy at least six of those services. HIV surveillance, laboratory quality assurance and specimen transport are among the items for sale. From October, a country in the middle of the largest Ebola outbreak in its history, its health budget cut by more than a quarter, must buy back the laboratory and specimen-transport capacity that found the outbreak, from the agency that built it with public money.

Everything needed to stop this outbreak was known before it began. Ebola's transmission routes were mapped decades ago. In June the CDC named the variable that would decide the outcome: the share of the sick found and isolated before they infect anyone else, and it was right about what would follow if that went unmet. What the agency scaled afterward was screening at four American airports. Uganda has closed its own outbreak at twenty cases, eighteen of whom lived, by tracing contacts and treating the sick, across a border from provinces where the dead are counted in thousands.

Nothing in Ituri was prepared. The drug in the trial there was donated by Gilead after the outbreak began. The antibody beside it has no human efficacy data. The first vaccine to be studied only entered Phase 1 trials on July 13, nineteen years after the virus was named and two months after the outbreak was declared. Every element was assembled in the middle of the emergency by institutions that had eighteen years to assemble it beforehand.

Nothing was improvised about the evacuations either. While Congolese doctors have been treating Ebola patients for two months without pay, Western governments flew their own nationals to hospitals in Frankfurt and Berlin. The United States found $87.6 billion for a military supplemental in a week but could not provide the mere $115 million for the WHO's budget. Such actions define a calculated and psychopathic social murder: the foreseeable, documented and accepted killing of a population whose lives were weighed against procurement priorities and found to be worth less.

Epidemic detection has been made a commodity, and a commodity goes to whoever can pay for it. That is the same reasoning that left Bundibugyo without a vaccine for nineteen years, a species too rare to constitute a market, applied now to whether the dying can be counted at all.

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 gets developed answers to human need rather than to shareholder return and threat designation. It must take public health out of the market altogether. It must turn the wealth now consumed in the war over eastern Congo's minerals toward 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 outbreak is now the second largest ever recorded. It reached that mark in seventy-six days. That is not a failure of capacity. It is a decision, and its result will be counted in the dead.