Ebola deaths near 2,000 as WHO concedes the outbreak is outrunning the response

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Following a high-level mission to Kampala, Bunia and Kinshasa on August 4 and 5, World Health Organization (WHO) Director-General Dr. Tedros Adhanom Ghebreyesus, Africa Centres for Disease Control and Prevention (Africa CDC) Director-General Dr. Jean Kaseya and WHO Africa Regional Director Dr. Mohamed Janabi issued a joint statement on August 6. In some eastern areas of the Democratic Republic of the Congo (DRC), Tedros said, "the Ebola outbreak is outpacing our response." As of August 8, 2026, BNO News recorded 4,141 confirmed cases and 1,889 deaths. Confirmed deaths now sit within roughly a hundred of the 2,000 the CDC's own model projected in May as a worst case within three months.

This is the second-largest Ebola outbreak ever recorded, behind only West Africa in 2014 to 2016, and the largest in the DRC's history. It passed the 2018 to 2020 Kivu total of 3,317 confirmed cases around July 27. Kivu took 23 months to reach that threshold; this outbreak took 74 days. It is adding 75 cases and 35 deaths a day.

Contact tracing, the mechanism containment depends on, has thinned to the point of futility. At an August 6 press briefing, Kaseya reported that the response is registering roughly 10 contacts for every confirmed case, against the more than 40 Uganda listed before closing its outbreak on July 28 at 20 cases, and the 57 documented during the Kivu epidemic. The lists, he said flatly, "don't mean anything because it is not accurate."

The consequence is that the sick arrive unannounced. Doctors Without Borders (MSF) reported on August 5 that 90 percent of patients admitted to its Bunia treatment center appeared on no contact list at all, and more than 70 percent of new cases and two-thirds of deaths now surface from the community rather than from anyone under observation. The WHO's own measure, a follow-up rate of 75 percent on August 4 against a target of 95 percent, tracks only how closely the response watches those it has already found, not how many it never did. Nor is it keeping pace geographically: treatment centers in North Kivu run at 139 percent occupancy while those in Ituri, the epicenter, sit at 57.

Corroboration for this analysis of capitalist public health comes from an unexpected quarter. In "The Inequality-Pandemic Cycle", published in the *New England Journal of Medicine (*NEJM*)* on August 6, Nobel laureate economist Joseph Stiglitz, UNAIDS Executive Director Winnie Byanyima, Michael Marmot and colleagues argue that preparedness has been measuring the wrong thing. The United States ranked first on the Global Health Security Index, then recorded a COVID-19 death rate more than double the global average, while lower-ranked countries fared far better. They concluded: "The missing element, we believe, is inequality."

They cite 2014 as precedent: constrained fiscal capacity in Guinea, Liberia and Sierra Leone let a regional outbreak reach three continents. And they locate the barrier to containing disease not in any lack of scientific capacity but in the global rules protecting pharmaceutical monopolies. Yet having identified a self-reinforcing cycle of exploitation, the authors stop at debt suspension and other limited measures that leave untouched the property relations that are the fundamental problem.

Where the NEJM authors look for the cause in the distribution of resources, the Ebola response's own leadership has begun looking for it in the virus. At the same briefing, Kaseya proposed studies to determine whether the pathogen has mutated. The sequencing is worth doing, since a drifting virus could defeat the tests that already failed once in Bunia. But raising it here, as though a change in the genome might account for the mounting death rate, obscures the elephant in a very small room. Filoviruses accumulate perhaps one or two genetic changes a month, too few over twelve weeks to alter how a virus behaves. And the same virus produced a fatality ratio of about 10 percent in Uganda, where fifteen of twenty cases were imported directly from the DRC. A pathogen does not turn lethal at a border.

What differs across that border is the health system. Survival from Ebola turns on how fast a patient reaches care: fluids, electrolyte replacement, management of organ failure, none require a licensed drug and all require beds, personnel and supplies. Uganda found its 20 cases early and hospitalized them. In the DRC most of the dying never reach a bed at all.

There is still no vaccine or treatment licensed for Bundibugyo, the strain of virus implicated in the current outbreak. Nineteen years after the species was named, the first candidates entered human safety testing only last month. On July 31 the WHO reversed the guidance it issued in May and called for Ervebo, licensed against the unrelated Zaire strain, to be put into a trial in the DRC, drawing on the 500,000 doses Gavi already holds in stock. This response means reaching for what is available on the shelf, not what is proven to work.

The exploitation of the Congolese working class is most visible among the frontline responders. Tedros raised the compensation of health workers with President Félix Tshisekedi on August 5. The next day Kaseya told reporters that paying them is the national

government's responsibility rather than that of its partners, and that "we will not hear again about the strikes of health workers" because officials had assured him the funds were secured. That same day, health workers in Ituri protested outside the governor's residence in Bunia, having received neither salaries nor hazard allowances since May.

The protest followed a series of wildcat strikes. Staff at Bunia General Hospital walked off the job in mid-July; health workers and gravediggers at Rwampara General Hospital struck in early July. Some back pay was distributed in the week to August 6 under pressure from the strikes and the international visit, but workers continue to demand wages matching the conditions they face.

Those conditions are lethal. As of July 30, at least 151 health workers had been infected and 44 had died, a 29 percent fatality ratio among them. A treatment center in Bunia was attacked in mid-July. MSF maintains more than 1,400 staff on the ground, while the International Medical Corps reported that its 80-bed Bunia center is over capacity and its new 100-bed facility at Rwankole amounts to 1.3 days of new cases.

On August 6 authorities quarantined a river vessel carrying more than 200 passengers at Maluku, 65 kilometers upstream from Kinshasa, after a passenger disembarked and died with Ebola-like symptoms. The National Institute of Biomedical Research announced on August 8 that all tested negative. However, the near miss exposed the Congo River corridor's vulnerabilities. Because roads were never built under Belgian colonial rule or the regimes that followed, the river is the country's transport artery, traveled by barge convoys carrying hundreds of people for weeks without manifests. Transit routinely exceeds the virus's 21-day incubation period.

When the outbreak reached Tshopo province, whose capital Kisangani sits at the head of navigation, it reached that waterway's on-ramp. At the far end lies Kinshasa, a city of more than 17 million, with Brazzaville, the capital of the neighboring Republic of Congo, across the water. An introduction into Kinshasa would instantly become a two-country emergency. The interception worked only because a mobile laboratory could reach Maluku. No such capacity exists 1,000 kilometers upstream at Pimu, where the dead passenger disembarked nearly three weeks before anyone connected him to the boat, and officials still cannot agree which province he boarded in. These waterways were engineered to carry rubber, copper and timber outward, never to connect Congolese communities. The surviving infrastructure of that imperialist plunder now threatens to help spread the Ebola virus.

Washington has pledged more, and faster, than in previous epidemics: $21 million in the first six months of the 2014 outbreak, against $375 million in the first two months of this one. But a pledge is not a disbursement. The State Department's August 5 announcement of $242 million more, bringing its total past $512 million, describes money it "intends to provide … working with Congress," which had not acted on the $1.4 billion emergency supplemental requested in June.

The United States Agency for International Development was dissolved in 2025. Washington has withdrawn from the WHO. In February 2026, three months before the first Bundibugyo case was confirmed, the State Department signed an America First Global Health Strategy agreement with the DRC reducing US aid over time. And on September 30 CDC support to the President's Emergency Plan for AIDS Relief, whose laboratories and epidemiologists diagnose Ebola, Marburg and drug-resistant tuberculosis across the continent, is priced out: health ministries will purchase what they need at set fees, and any government receiving more than $125 million in US aid, the DRC and Uganda included, must buy a minimum package.

Meanwhile the population faces economic ruin. A June 30 United Nations Development Programme assessment found the epidemic functioning as a highly regressive poverty shock, with DRC gross domestic product losses projected above $1 billion and some 55,000 jobs eliminated, roughly twice what Washington has announced. UNICEF's emergency plan is 80 percent unfunded. Yet the $1.4 billion requested for Ebola was never sent to Congress on its own. It arrived on June 24 inside an $87.6 billion supplemental, $67.1 billion of it to replenish the Pentagon after the war on Iran, and it has sat there since. The epidemic response is 1.6 percent of the package. The same request sets aside $500 million for restoration and construction projects in and around Washington.

The unchecked spread of the Bundibugyo virus is a conscious capitalist decision rather than a failure of science, and the final toll will be written in the dead. To end this cycle of preventable devastation requires a revolutionary socialist solution. The international working class must take the pharmaceutical and biotechnology industries out of private hands and place them under their own democratic control, so that research answers to human need rather than shareholder return and biodefense threat designations. Public health must be taken out of the market entirely. The mineral wealth consumed in the imperialist wars over eastern Congo's gold, cobalt and coltan must be expropriated and the proceeds directed toward the medical and sanitation 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 national security, and the building of sections of the International Committee of the Fourth International.