Second deadliest Ebola outbreak on record spreads across the eastern Congo

Benjamin Mateus
21 August 2026

The Democratic Republic of the Congo (DRC) had recorded 5,290 confirmed cases of Ebola and 2,516 confirmed deaths as of August 19, across 56 of 151 health zones in six provinces, according to DRC health ministry figures compiled by the European Centre for Disease Prevention and Control.

On August 18, following the second meeting of the International Health Regulations (IHR) Emergency Committee, World Health Organization (WHO) Director-General Tedros Adhanom Ghebreyesus announced that the epidemic remains a public health emergency of international concern (PHEIC), the determination he issued on May 17. He told the committee this is the second-largest Ebola outbreak ever recorded and is moving faster than any before it, fueled by insecurity and by population movement along roads, rivers and mining routes.

It is now the second deadliest as well. Only the West African outbreak of 2014 to 2016, which killed 11,325 people, has taken more lives. The 2018 to 2020 Kivu epidemic in the eastern DRC killed 2,287 over almost two years, of whom 2,134 were laboratory-confirmed, and the present outbreak passed both figures in the second week of August, in its third month.

The Africa Centres for Disease Control and Prevention (Africa CDC), in an August 17 statement, warned that the outbreak risks becoming the deadliest ever recorded globally. The agency reported that the epidemic grew from eight confirmed cases in three health zones of a single province on May 15 to more than 5,000 cases across six provinces in three months, that it is taking approximately one life every 30 minutes, and that each day of avoidable delay costs around 50 lives.

At a press briefing on August 20, Africa CDC set the outbreak against its predecessors at a comparable stage. By week 13 it had recorded 5,125 confirmed cases and 2,422 confirmed deaths, 9.7 times the cases and 7.1 times the deaths of the next-highest outbreak at the equivalent point. West Africa in 2014 had recorded 528 cases and 337 deaths by its own week 13.

WHO reported that epidemiological week 32, August 3 to 9, was the worst of the outbreak on both counts, with 579 cases and 304 deaths. Ituri province accounts for 84 percent of confirmed cases and 79 percent of deaths, and Bas-Uélé became the sixth affected province this month. DRC health authorities put the national case fatality ratio (CFR) at 47.5 percent as of August 18, and it rises to as high as 70 percent where the response is weakest, including North Kivu, according to the Associated Press. WHO assesses the risk of further spread within the country as very high.

Tedros told the Emergency Committee that what concerns him most is where people are dying: at home, in their communities, outside treatment centers and outside any list of known contacts. Each such death marks a chain of transmission the response never found. Facing the same virus, Uganda closed its outbreak on July 28 with 20 confirmed cases and two deaths. Survival turns on whether the sick are found and reach care in time.

Conditions for the health workers staffing those centers are lethal. By August 9, at least 155 health workers had been infected and 45 had died, a fatality ratio of 29 percent among them.

On August 17, the International Coordinating Group on Vaccine Provision informed the DRC government of an immediate initial release of 70,000 doses of Ervebo, announced jointly by WHO and Africa CDC on August 20. Twenty thousand doses are set aside for a Phase 3 clinical trial to establish whether the vaccine has any effect against the Bundibugyo virus. The remaining 50,000 are for frontline and health workers.

Ervebo is licensed against Ebola virus disease caused by Zaire ebolavirus, a different species of the same genus. WHO stated that it is not known whether the vaccine protects against Bundibugyo virus in humans, and that early laboratory and animal data suggest it may offer some protection. Anyone offered a dose, inside the trial or outside it, must be informed of the risks and limitations and give consent. The DRC government reports 2,000 doses already available in Tshopo province and has requested a further 500,000.

Two vaccines designed specifically against the Bundibugyo virus entered human trials this year for the first time. The WHO-sponsored PARTNERS treatment trial, which opened on July 2, has enrolled more than 100 patients across three treatment facilities in Ituri. At week 13 of a mass-casualty epidemic, the response is being improvised out of a vaccine developed against another species and trials that began after the dying had started.

Until such a vaccine exists, everything depends on beds and staff reaching the sick in time. But both are being withdrawn. In the gold-mining town of Mongbwalu, roughly 20 hospital beds bound for maternity and pediatric wards sit boxed in a courtyard, the last that Action Against Hunger (ACF) will deliver, *Le Monde* reported on August 20. Issoufou Hamadou, the organization’s field coordinator there, said US money had covered 70 percent of its programs in the DRC. The withdrawal of more than €47 million in American funding, a third of ACF’s global operating budget, forced the suspension of 50 projects worldwide, the layoff of about 100 staff in the DRC and the closure of its Mai-Ndombe office in

© World Socialist Web Site

December 2025, abandoning 200 children with severe acute malnutrition.

The World Food Programme, which drew 60 percent of its funding from Washington, now serves only those classified very or extremely vulnerable. One million people received food aid in the DRC in 2025 against the 2.3 million targeted. Food security, the humanitarian response plan's stated first priority, has received 25.2 percent of the money it requires, according to the United Nations Office for the Coordination of Humanitarian Affairs. Camp management, the sector hit hardest, has received 13.7 percent, $3 million of $22 million. The United Nations refugee agency identified 792,000 people in the eastern DRC in urgent need of shelter and reached 25,000 of them in 2025.

The epidemiological consequences are immediate. At the Plaine Savo displacement camp, a third of the latrines are out of order, and those built were sized for 20,000 people rather than the 76,000 living there. At Kigonze, in Bunia, the 2026 assessments found a deficit of more than 589 latrines that went unmet for lack of resources, and Ebola has killed at least three displaced people in the camp. A virus transmitted through bodily fluids has been introduced into settlements without working sanitation, thrown up by a conflict that has displaced a million people in Ituri alone.

The surveillance that might have caught it earlier was defunded first. A humanitarian official in Kinshasa told *Le Monde* that many projects in the DRC, those focused on community disease surveillance above all, were halted in 2025, and that the response to Ebola could have been faster had that funding not dried up. The virus circulated in eastern communities from late February, nearly three months before the outbreak was declared on May 15.

What has reached the response is a fraction of what has been announced. The US State Department's August 5 announcement of a further $242 million brought Washington's announced total above $500 million, but the department describes money it intends to provide "working with Congress." Congress has still not voted. The $1.4 billion requested for the Ebola response on June 24 sits inside an $87.6 billion emergency supplemental, of which $67.1 billion is to replenish the Pentagon amid the war on Iran. The epidemic is 1.6 percent of that request. The same document sets aside $500 million for construction projects in and around Washington.

United Nations humanitarian chief Tom Fletcher released an additional $30.5 million from the Central Emergency Response Fund this month, on top of $24 million allocated earlier to the DRC and its neighbors. The United Nations Development Programme projects the epidemic will cost the country more than $1 billion in economic output and some 55,000 jobs.

The permanent machinery to detect and suppress Ebola and other infectious diseases has been systematically dismantled over the past 18 months by the fascistic Trump administration. The United States Agency for International Development (USAID) was abolished in 2025, and Washington has withdrawn from the WHO. On September 30, support from the Centers for Disease Control and Prevention (CDC) to the President's Emergency Plan for AIDS Relief (PEPFAR), whose laboratories and epidemiologists diagnose Ebola across the continent, converts to a fee schedule, and any government receiving more than $125 million in US aid, the DRC and Uganda among them, must purchase a minimum package.

This is the DRC's 17th Ebola outbreak. The 16th was declared over on December 1, 2025, five and a half months before this one began, and was held to 53 confirmed cases because a licensed vaccine existed for the Zaire strain and doses were already in the country. Nothing comparable existed for Bundibugyo, 19 years after the species was identified, because there was no market in developing it. The gold, cobalt and coltan of the eastern Congo find buyers on every continent; the disease that circulates among the workers who dig them found none.

The intervals between these epidemics are shortening, and each one meets a surveillance system with less capacity than the last. What was once a rare event in a few villages is becoming a permanent danger across the eastern Congo and the region beyond it. The means to change that are not missing. They are being withheld, priced out and dismantled by governments that have weighed their cost against Congolese lives and made their choice. This is social murder, and it is the lesson the ruling elites took from COVID-19, and took quickly: that mass death, when it falls on the poor and the distant, carries no political price.

That calculation must be answered. The resources to end this epidemic exist in abundance, and prying them out of the hands of the governments and corporations rationing them requires a struggle against the profit system itself. The only social force capable of carrying that out is the international working class, which faces the same enemy in Ituri, in Kinshasa, in Europe and in the United States.

To contact the WSWS and the Socialist Equality Party visit:

wsws.org/contact

© World Socialist Web Site