The number of fatalities in the Congo Ebola outbreak reaches 3,226

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The Ebola epidemic in the Democratic Republic of the Congo (DRC) had killed 3,226 people as of September 5. According to DRC national reporting carried by the European Centre for Disease Prevention and Control (ECDC), 6,604 confirmed cases had been recorded across 61 of the country's 151 health zones in six provinces, a case fatality ratio (CFR) of 48.1 percent. The Ministry of Public Health, Hygiene and Social Welfare declared the outbreak on May 15, meaning these figures were reached on the 113th day.

Only the West African epidemic of 2014 to 2016, which produced 28,616 cases across all categories and 11,325 deaths, has been larger or more lethal. That outbreak did not reach the Congo's present case total until roughly its 185th day, nor its present death toll until the 187th.

Speaking at a media briefing in Geneva on September 2, World Health Organization (WHO) Director-General Tedros Adhanom Ghebreyesus confirmed that this is now the fastest-moving outbreak of the disease ever recorded, and the second largest in its history.

Tedros identified the tracing of transmission chains as the central unresolved problem. Around 60 percent of deaths, the WHO estimates, occur outside treatment centers, many of the dead are still buried without safe protocols, and a large proportion were never registered on any contact list, meaning chains of transmission are running through the population unobserved.

The Africa Centres for Disease Control and Prevention (Africa CDC) has been more cautious still. Wesam Mankula, who leads its Continental Incident Management Support Team, said on September 3 that it remains far too early to describe the outbreak as under control. Modeling by the DRC National Institute of Biomedical Research with Imperial College London, presented on August 20, estimated that only 30 to 40 percent of infections are being detected at all, and Yap Boum II, the agency's head of emergency preparedness, reported that fewer than 40 percent of confirmed cases could be linked to any previously known case.

These deficiencies have been documented for weeks. On August 5, Philippa Boulle of Medecins Sans Frontieres (MSF) said the response had to be scaled up without delay, noting that 90 percent of patients admitted to the organization's center in Bunia had never been registered as contacts and that only 59 percent of contacts were being traced across Ituri. A month later, MSF emergency coordinator Kate White reported that North Kivu still had one functioning testing laboratory, that kits were not reaching the field, and that results were returning too slowly to be of clinical use.

The intervening period measures what these warnings were worth. WHO had recorded 1,587 deaths as of July 30; by September 5 the toll stood at 3,226. The epidemic killed as many people in the five weeks following MSF's warning as in the eleven weeks preceding it.

Nor did the resources materialize. The WHO leader acknowledged on September 2 that the response plan faces a shortfall of more than $1 billion against a $1.3 billion target, and that the appeal is being made as humanitarian financing contracts generally. UN humanitarian chief Tom Fletcher had told member states the previous day that he was releasing $57 million from the Central Emergency Response Fund. “We can control this epidemic if we choose to,” Tedros said, a formulation that concedes the essential point: the constraint is not a medical one.

What was presented as forward movement was a schedule of clinical trials. Two vaccines against the Bundibugyo species are in Phase 1 safety testing, by Oxford in Britain and Moderna in Canada, with efficacy trials in the DRC slated for October or November. Neither will yield a licensed countermeasure while this epidemic is running. In the interim Congolese health workers are given Merck’s Ervebo, licensed against an entirely different species, which 1,124 had received by September 1 under compassionate use. It is not yet known whether it works against Bundibugyo at all.

Meanwhile the geography of the epidemic is shifting. Cases in Ituri fell by 12 percent over the three weeks to September 3, while in North Kivu cases more than doubled and deaths rose by 98 percent. That province now records a CFR of 67.7 percent, the highest of any affected province.

The province at the center of the epidemic is also a goldfield, and the industry working it has continued without interruption. Congolese gold generated $2.28 billion in export revenue in 2025, more than 90 percent of it from a single mine. Kibali, 140 kilometers north of the epicenter, is owned in equal 45 percent shares by Barrick and AngloGold Ashanti, the remaining 10 percent held by the state company Societe Miniere de Kilo-Moto (SOKIMO). Barrick’s attributable profit from its share alone came to $172 million in the second quarter of 2026, while royalties to the Congolese state amount to roughly 5.3 percent of sales.

Extending that single quarter across both foreign partners and across four quarters, a back-of-the-envelope calculation places their combined annual take from Kibali somewhere in the region

of $1.4 billion. The six-month response plan for an epidemic that has killed 3,226 people cannot raise the $1.3 billion it would cost.

The wage bill is instructive for a different reason. Kibali has paid $621 million over thirteen years, roughly $48 million annually, which across 7,600 employees and contractors comes to some $525 a month per worker. Set beside $172 million of profit booked by one partner in a single quarter, labor is a minor charge on the operation. What that wage secures, in a country where 73.5 percent of the population subsists on less than $2.15 a day, is a workforce held apart from the population surrounding it.

Within five days of the declaration of the epidemic, the mine had instituted daily screening of all 7,600 workers and required each to declare where they had traveled from. It has recorded no infections, and its health zone no cases at all. This was not solicitude for the workforce. An outbreak inside the perimeter would halt production, and the measures protect the ore body, and the miners incidentally, in the manner of equipment. Kibali possesses a clinic, an airstrip, logistics, laboratory access and 7,600 people under daily observation, which is the apparatus the national response conspicuously lacks. None of it has been extended beyond the fence line, and no contribution from the mining industry to the national response has been recorded.

No such arrangements exist to the south. In Mongbwalu, the gold town of 130,000 where the outbreak was first identified and which has since recorded 632 confirmed cases, National Public Radio found in June that the pits were operating without protective equipment, sanitation controls or medical oversight, and Oxfam reports only 20 percent of residents have safe water. At Iga-Barriere in August, the Associated Press documented an 11-year-old boy earning two dollars a day. SOKIMO takes 30 percent of what the artisanal miners bring up.

What Kibali demonstrates is that the containment of this epidemic is entirely feasible in Ituri today. It is being carried out, competently and at scale, 140 kilometers from a town where 632 people have been confirmed infected. The capability exists, and it is deployed where it protects profit accumulation and nowhere else. Nothing has been shut. On September 4, two days after the death toll passed 3,000, the Congolese mines minister received a SOKIMO delegation to review progress on a new industrial gold project at Mongbwalu, targeted for production in mid-2027.

The same logic governed the reopening of the schools. Classes resumed across the DRC on September 1, with nearly 31 million pupils expected. Education Minister Raissa Malu had announced a three-tier system under which schools in red zones would switch to printed worksheets and community radio, and a ministry document seen by Reuters placed more than 1,000 schools in Ituri alone in that category. The plan was abandoned and schools opened as normal, provincial authorities having objected that red-zone pupils would fall behind the curriculum.

None of this is an aberration, and none of it is peculiar to the Congo. The negligence is the policy, and nowhere is it written more plainly than in the United States, where measles has reached 3,134 confirmed cases as of September 3, against 2,289 in all of last year. Two unvaccinated residents of Pennsylvania died in August, yet the CDC's 2026 deaths table records none, and the agency is now drafting a standardized definition of what will count as a measles death. Kindergarten vaccination coverage has meanwhile fallen to 92.4 percent, leaving some 280,000 children unprotected.

Roughly 29,000 Americans have contracted cyclosporiasis since May across 48 states, with 922 hospitalizations and two deaths. A third of confirmed cases have no identified source, for the straightforward reason that the surveillance which would have found it was made optional in July 2025 and the traceability rule that would have traced it has been deferred to 2028.

More than 1.2 million Americans have died of COVID-19, with a central excess mortality estimate closer to 1.45 million.

Measles is preventable by a vaccine that has existed for more than sixty years. Cyclospora arrives on imported salad leaves. Ebola kills half of those it infects. None of this bears on what is done, because what is done is not determined by the pathogen. It is determined in advance by the requirement that the daily operation of profit-making business be neither interrupted nor curtailed nor made to absorb any part of the cost. Schools and workplaces stay open, produce and gold keep moving, and the counts are revised downward, published less frequently, or never compiled at all. The danger a disease actually presents has been rendered a matter of no consequence.

The gold leaves Ituri and the epidemic remains. The mines, the trade routes and the war are the mechanism through which the wealth of the eastern Congo is extracted, and the workers who produce it are carried on the ledger as an expense. What is described as a failure of public health is in reality a series of accounting decisions, taken repeatedly, in Kinshasa as in Washington.

The obstacles are not technical. The Serum Institute of India manufactured 620,000 doses of an experimental Bundibugyo vaccine in a fortnight once a buyer had been found. Laboratories can be built, water piped, latrines dug, and the workers capable of doing all of it are already in Ituri. What is absent is any financial return to those who would have to authorize the expenditure.

The productive capacity that exists today is more than sufficient to end this epidemic and prevent the next one. It is organized instead around what can be extracted, and under that arrangement the working class of the Congo, of Europe and of the Americas figures as an expendable input. Bringing epidemics of this kind to an end requires that the pharmaceutical industry and the research laboratories be taken out of private hands, and the resources now committed to extraction and to war redirected toward the medical and sanitary infrastructure the Congolese population has been systematically denied. That task falls to the international working class.