6 months of the Ebola outbreak in the Congo: War, hunger, disease and profit

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16 November 2026

"The virus is the spark. The structural conditions are the accelerant." These words from Dr. Tyler Evans, an infectious disease specialist who worked in West Africa and the eastern Democratic Republic of the Congo (DRC), summarize the unfolding catastrophe.

Six months ago, on May 17, the World Health Organization (WHO) declared a public health emergency of international concern (PHEIC) over eight laboratory-confirmed cases across three health zones in Ituri Province. Today, official bulletins record 11,254 confirmed cases and 5,505 confirmed deaths across 68 health zones in eight provinces, establishing this outbreak as the second-largest Ebola epidemic on record.

Beneath the Ebola crisis lies relentless warfare, acute hunger, mass displacement and unpaid health workers, even as the imperialist powers continue looting the Democratic Republic of the Congo for valuable minerals and corporate profits. The people of Congo-DRC have been left defenseless, but where other states possessed functioning health systems to trace and isolate contacts, transmission was stopped.

Modeling by the US Centers for Disease Control and Prevention (CDC) places the first infection between late January and February, while Médecins Sans Frontières (MSF) recorded 55 deaths dating from early April before the first laboratory confirmation. The WHO finally declared an international emergency on May 17.

The epidemic reached 1,000 confirmed cases in 37 days and 1,000 deaths in 67 days, compared with 142 days in the 2014 West African epidemic. It passed the 3,470 cases of the 2018–20 Kivu outbreak in 76 days, against Kivu's 23 months, making this the fastest-growing Ebola epidemic on record. At the current pace of 400 to 500 new cases a week, the cumulative laboratory-confirmed count would surpass West Africa's 15,261 confirmed cases by early next year.

Beyond the Congolese border, the outbreak was contained wherever functional public health machinery could trace and isolate contacts. Uganda recorded 20 cases and two deaths before transmission ended, Kenya logged nine cases with every secondary infection occurring among contacts already quarantined, and an isolated case in Nigeria was medically evacuated to Geneva. The Africa Centres for Disease Control and Prevention (Africa CDC) is investigating whether the Kenyan and Nigerian infections trace back to Entebbe airport in Uganda, through which both patients passed on October 3. Infected foreign aid personnel were evacuated to specialized hospitals in Germany, the Netherlands, Switzerland and Britain, but Congolese healthcare workers face the virus without an evacuation route.

Among laboratory-confirmed patients whose illness has ended, 64.3 percent have died, matching the 62.9 percent recorded among confirmed patients with a recorded outcome during the 2014–16 West African epidemic. In its six-month release, WHO reported that two-thirds of confirmed deaths occurred in the community, outside clinical facilities. The agency claimed transmission has slowed in initial epicenters, such as Mongbwalu, Nyankunde and Butembo, while stating new cases in Bunia have halved. These claims stand beside the agency's own admission that contact follow-up remains persistently below target and that widespread community mortality suggests infections are identified too late.

Fewer than one in four newly diagnosed patients emerge from registered contact lists, while WHO's Patrick Otim estimates that about one-third of deaths occur outside treatment centers among people never tested.

The lessons of West Africa

In their 2017 study of the West African epidemic using WHO's patient database, Garske et al. found that 62.9 percent of 8,413 laboratory-confirmed patients with a recorded clinical outcome died across Guinea, Liberia and Sierra Leone. Those never admitted to a hospital died at a rate of 90.6 percent, while children under the age of five experienced a case fatality ratio of 75.6 percent. In the Congo today, WHO reports that seven in 10 confirmed children under five have died, with children making up more than a quarter of all confirmed cases and a third of recorded deaths. During the West African crisis, the fatality ratio declined over time as treatment units expanded, while in specialized United States and European hospitals, Uyeki et al. documented that only 18.5 percent of 27 patients died. Clinical survival required aggressive supportive interventions, including continuous intravenous fluids, electrolyte correction, nutritional support, blood products and advanced critical care for organ failure.

In the Congo, official bulletins from late October recorded that Ituri's blood banks were exhausted, seven patients in Mandima were left entirely without food, and treatment centers across North Kivu were 86.3 percent full, with 154 patients treated outside them. The fatality figures vary widely: Bunia documented a 34 percent fatality rate among confirmed cases, while Beni reached 67 percent, North Kivu stands at 55.3 percent, and MSF recorded that 24 of 30 children admitted to its Butembo facility died. Survival tracked access to advanced care then, and it tracks access to care now.

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Beneath the epidemic: war and hunger

WHO has counted more than 80 attacks on healthcare since the outbreak was declared. More than 100 armed groups operate across the eastern provinces, with the ADF, an Islamic State affiliate, financing its operations through the illicit gold trade, while the March 23 Movement (M23) controls Goma and Bukavu, whose closed airports block the main route for vaccines to the east. Frontline personnel face extreme isolation and physical danger. In Mangala, the central government stopped paying clinical staff at the onset of the crisis, and a veteran nurse in Bafwasende, Tshopo, was killed by youths with machetes on October 23 during community outreach.

The biological crisis collides directly with severe social deprivation. Approximately 28.8 million people face acute food insecurity across the country, with Djugu territory in Ituri classified at emergency levels, and 4.18 million children under five require urgent clinical treatment for acute malnutrition. Hunger on this scale reflects institutional collapse: a healthcare system that cannot treat starving children cannot give Ebola patients the supportive care they need to survive. In May, Tedros observed that “people weakened by hunger are far more vulnerable to infections.”

Minerals before medicine

Imperialist extraction accelerated alongside the healthcare collapse. Following the June 2025 Washington Accords between the Democratic Republic of the Congo and Rwanda, Washington signed a strategic minerals partnership with Kinshasa on December 4, 2025, trading security commitments for critical mineral access. Days after the December signing, M23 captured Uvira. Talks with M23 have produced only a roadmap, agreed to in August. As the deals advanced, Archbishop Fulgence Muteba, president of the Catholic bishops’ conference, condemned them as “selling off the minerals of an entire nation to save a regime or a political system.”

The terms of international public health collaboration replicate this subordinate relationship. A five-year bilateral health agreement signed in February and kept secret requires the Congolese government to surrender patient biological specimens and epidemiological data within five days of an American request, explicitly permitting Washington to share them with commercial pharmaceutical companies. Under the pact, the United States will cease paying the salaries of Congolese healthcare workers by December 31, a payroll cutoff the health ministry’s chief of staff estimates will take at least six months to absorb into the national budget. The agreement also explicitly subordinates deliveries of medical countermeasures and vaccines to the domestic requirements of the United States government.

Financial resources remained persistently withheld as the pathogen spread. Of $962 million disbursed to organizations running the response, Africa CDC reported that more than $700 million remains unaccounted for, as only about a third of organizations have reported their spending. The UN humanitarian appeal for the Congo remains $1.08 billion short.

Vaccines held back

No licensed vaccine exists for Bundibugyo ebolavirus because international medical countermeasure funding has historically followed Western biodefense priorities rather than public health need. Agencies like the US Biomedical Advanced Research and Development Authority financed Zaire-specific monoclonal antibodies and vaccines to guard against bioweapon threats, leaving the Bundibugyo species without commercial interest.

However, evidence for repurposing Merck’s Ervebo vaccine emerged early. Laboratory studies showed partial cross-protection in non-human primates. The *New England Journal of Medicine* reported in July that Ervebo produced cross-reactive antibodies in volunteers, though five times weaker than against Zaire, and *Lancet Infectious Diseases* documented Bundibugyo-reactive T cells in 13 of 20 vaccinees in October.

Despite these potentially important findings, the operational response moved slowly against the pathogen. WHO and Africa CDC announced the allocation of 70,000 Ervebo doses on August 20, but the first contacts in Bunia were vaccinated only on October 23, two months after the announcement and more than five months after the national declaration. In November, MSF was still asking WHO’s vaccine advisory group to lift the research-only restriction and authorize broader vaccination. Meanwhile, Oxford University and the Serum Institute of India began human trials of a Bundibugyo-specific candidate in July, manufacturing about 620,000 doses by early October that remain sidelined awaiting regulatory approval. In the two weeks to November 12, deaths averaged 33 a day.

The present epidemic was foreseeable but allowed to start. In June, CDC modelers calculated that isolating seven in 10 cases would very likely hold deaths under 2,000; laboratory-confirmed deaths reached 2,642 by August 22. UNDP warned the same month of a high probability of exceeding 10,000 cases and 2,000 deaths by the fourth quarter if fewer than half of cases were isolated. Disease surveillance programs were dismantled, the UN humanitarian appeal was cut 45 percent before the outbreak was declared, clinical staff were left unpaid, and an armed conflict fueled by mineral plundering was left to burn.

For the capitalist powers, the epidemic becomes visible only when it breaches quarantine at an international airport, touches a diplomatic household in Abuja or requires an infected Western doctor to be flown into London’s Royal Free Hospital. The uncounted dead in Mangala, the civilians massacred in Cantine-Aloya and the starving children in Djugu do not enter their political calculations.

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