Ebola and Africa's Health Security: Why Recurrent Outbreaks Remain a Global Concern

Mohanasakthivel J

Mr. Mohanasakthivel J. is a Research Analyst at the Manohar Parrikar Institute for Defence Studies and Analyses

Summary

The article examines the security implications of public health emergencies in Africa, in the context of the recurring Ebola outbreaks in the region. It traces the history of Ebola in Africa, the current outbreak, the factors contributing to the resurgence of the disease, and the need for strengthening the continent's regional health security architecture.

Introduction

The postponement of the Fourth India–Africa Forum Summit, scheduled to take place in New Delhi in May 2026, brought into sharp focus the diplomatic consequences of infectious diseases, as it disrupted the summit, which was taking place after 10 years. India deferred the meeting amid an evolving public health emergency in parts of Africa.[1] The decision demonstrated that outbreaks originating in geographically limited areas can affect diplomatic engagement, international mobility and economic cooperation far beyond the affected communities. It also raised an important question: why does Ebola continue to pose a serious threat nearly five decades after it was first identified?

First identified in 1976 in what is now the Democratic Republic of the Congo (DRC), Ebola has repeatedly tested African healthcare systems. Major epidemics have occurred despite improvements in disease surveillance, diagnosis, vaccination, and treatment.[2] The ongoing 2026 outbreak caused by the Bundibugyo virus in the DRC has made these challenges particularly urgent. Ebola's recurrence cannot be explained by viral characteristics alone. Its consequences emerge from the interaction of biological risks, institutional weaknesses, armed conflict, and public mistrust. Addressing these vulnerabilities requires moving beyond emergency-driven responses towards sustained investment in healthcare infrastructure, community participation, and regional cooperation.

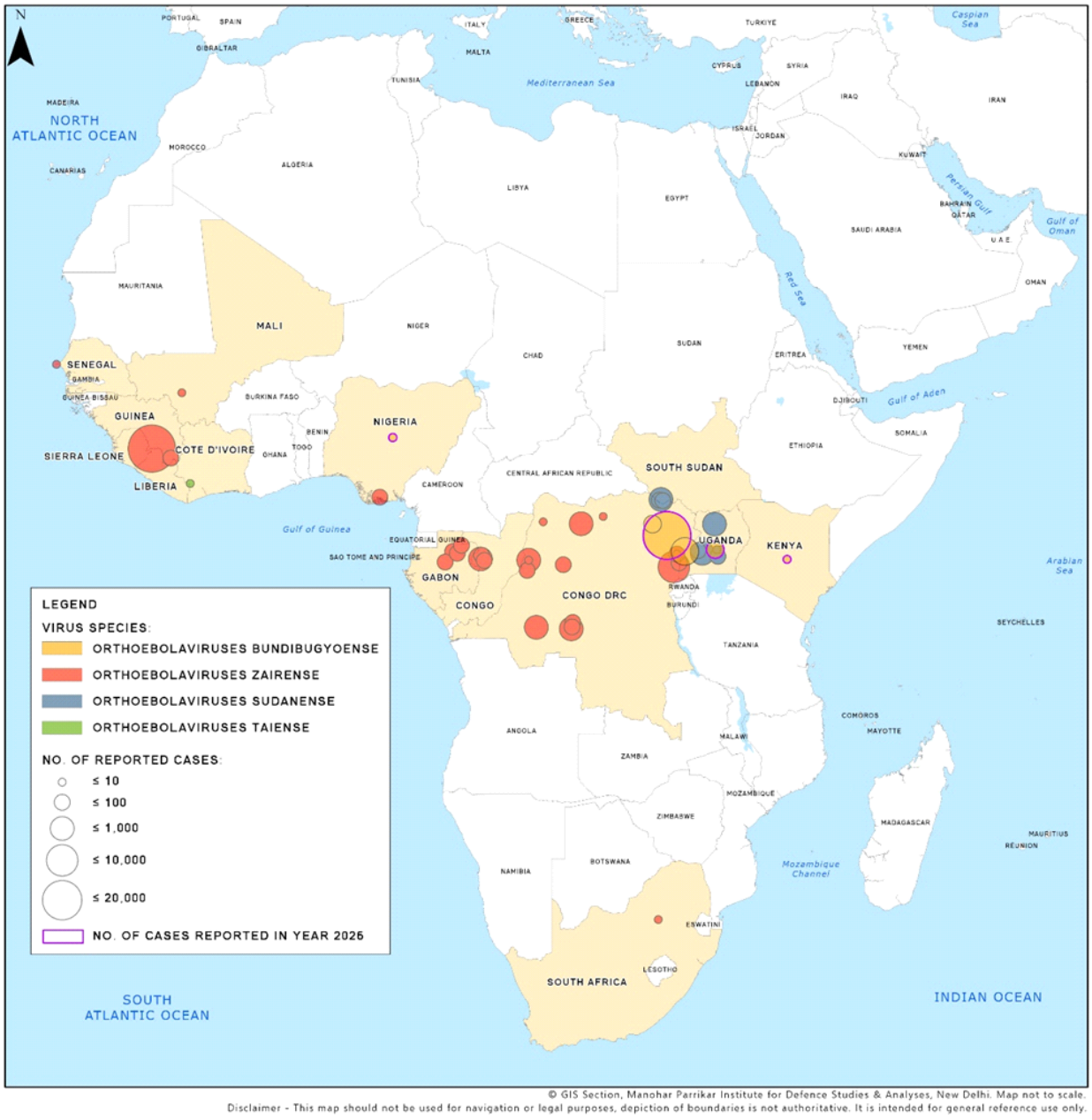
Ebola in Africa: From Earlier Epidemics to the 2026 Outbreak

The 2014–2016 West African epidemic remains a defining episode in the history of Ebola. Concentrated in Guinea, Liberia and Sierra Leone, it caused more than 28,000 cases and 11,000 deaths.[3] A localised outbreak developed into a regional emergency as delayed detection, inadequate treatment capacity, and weak surveillance allowed transmission to accelerate. Healthcare facilities became overwhelmed, while disruptions extended to livelihoods, education and essential medical services. The epidemic demonstrated how weaknesses in national healthcare systems could transform a local outbreak into a wider public health crisis.[4]

The 2018–2020 outbreak in eastern DRC presented a different challenge. The World Health Organization (WHO) recorded 3,481 cases and 2,299 deaths. In North Kivu and Ituri, armed conflict, population displacement, and threats to healthcare workers obstructed contact tracing and access to affected communities.[5] These difficulties were compounded by widespread suspicion of state institutions and international responders. The experience demonstrated that insecurity does not simply accompany disease outbreaks but directly undermines the mechanisms required to contain them.[6]

The 2021 outbreak in Guinea introduced another dimension to understanding Ebola recurrence. Genomic analysis revealed that the virus responsible for the outbreak was closely related to the strain circulating during the earlier West African epidemic. Research suggested that long-term viral persistence in a survivor might explain renewed transmission, although the precise source of infection could not be conclusively established. This challenged the conventional understanding that the end of an outbreak necessarily eliminates all future risks associated with earlier transmission chains. [7]

Figure 1: Geographical Distribution of Ebola Virus Species and Reported Cases in Africa



Source: GIS Section, Manohar Parrikar Institute for Defence Studies and Analyses (MP-IDSA), New Delhi. (Data Sourced from https://www.cdc.gov/ebola/outbreaks/index.html)

The geographical spread of Ebola demonstrates that outbreaks are not confined to a single region or epidemiological setting. Although the virus species and scale of transmission vary across countries, the severity of outbreaks is closely associated with the strength of healthcare institutions, the security environment, and the capacity of authorities to maintain public cooperation. The ongoing 2026 outbreak illustrates the combined effects of these vulnerabilities. The current outbreak of Ebola disease is

associated with the Bundibugyo virus. Recently, the WHO Director-General reported more than 11,000 cases and 5,400 deaths across 67 health zones in eight DRC provinces.[8] The outbreak also resulted in imported cases beyond the DRC, highlighting the importance of cross-border preparedness. These episodes reveal that although Ebola outbreaks differ in their geographical settings and epidemiological characteristics, their severity is closely connected to the strength of healthcare institutions, the security environment, and the ability of authorities to maintain public cooperation.[9]

Why Ebola Remains Difficult to Contain

Ebola's recurrence reflects the interaction of biological, institutional and social factors. Although zoonotic transmission remains an important source of outbreaks, the 2021 Guinea experience demonstrated that the virus may also re-emerge through persistence in survivors. Ebola virus can remain in certain bodily fluids after clinical recovery, creating the possibility of renewed transmission. This finding has important implications for long-term survivor monitoring, medical follow-up, and genomic surveillance.

However, survivor monitoring must also address the social consequences of Ebola. Individuals recovering from the disease may experience stigma, discrimination, and difficulties returning to their communities.[10] Public health interventions must therefore balance surveillance requirements with privacy, dignity and social reintegration. Treating survivors as permanent sources of infection could discourage cooperation and weaken the trust necessary for effective disease prevention.[11]

Weak healthcare infrastructure remains another significant obstacle. Inadequate laboratory networks, shortages of trained personnel, poorly equipped facilities, and difficulties transporting patients can delay diagnosis and treatment. Because early Ebola symptoms resemble those of other febrile illnesses, including malaria, timely laboratory confirmation is particularly important. Delays can allow transmission to continue within households, communities and healthcare facilities.[12]

The challenge is especially severe in conflict-affected regions. Eastern DRC has experienced prolonged insecurity, population displacement and humanitarian distress. [13] Armed violence disrupts healthcare services, restricts humanitarian access and complicates the movement of medical personnel and essential supplies. Communities already struggling with food insecurity, poverty and inadequate healthcare consequently face additional difficulties accessing Ebola-related treatment.[14]

The 2026 outbreak has further demonstrated the relationship between insecurity and epidemic containment. In November, WHO reported attacks affecting healthcare workers and the loss of more than 1,000 contacts from follow-up after violence in an affected area. Such incidents reveal how insecurity can directly interrupt disease surveillance and undermine efforts to contain transmission. Public mistrust presents an equally significant challenge. Where communities distrust government institutions or international organisations, individuals may delay seeking treatment, conceal symptoms or resist contact tracing. Rumours and misinformation can further weaken cooperation.[15]

Cultural practices surrounding death and burial represent a particularly sensitive issue. Since Ebola can spread through contact with the bodily fluids of deceased patients, safe

burial procedures are essential.[16] However, restrictions on traditional funeral practices can generate suspicion and resistance when implemented without adequate community consultation.[17]

Humanitarian organisations have consequently sought culturally sensitive approaches that allow families to participate in mourning while maintaining infection prevention standards. These experiences demonstrate that community engagement is not merely a supplementary component of epidemic management. The participation of local leaders, healthcare workers, and humanitarian volunteers is essential to building trust and ensuring cooperation with disease-control measures.

Medical Progress and Persistent Challenges

Considerable scientific progress has been achieved in combating Ebola. The development of vaccines, improved clinical management, and monoclonal antibody treatments has strengthened the ability to prevent infection and improve patient survival.[18] Better supportive care, including fluid management and timely treatment of complications, has also contributed to improved outcomes.

Nevertheless, mortality remains substantial and varies considerably across outbreaks. Case-fatality rates are influenced by the virus involved, access to healthcare, the timing of diagnosis, and the effectiveness of treatment. The 2018–2020 outbreak in eastern DRC recorded a case-fatality ratio of approximately 66 per cent.[19] Such figures demonstrate that medical advances cannot fully overcome delayed diagnosis, overwhelmed facilities and inadequate treatment capacity. An important limitation concerns differences between the viruses responsible for Ebola diseases. Although effective vaccines and therapeutics have been developed against Ebola virus disease caused by Ebola virus, these interventions cannot automatically be assumed to provide equivalent protection against other related viruses.[20]

This distinction is particularly relevant to the 2026 Bundibugyo outbreak. As of November 2026, no vaccine or virus-specific treatment had been licensed specifically for Bundibugyo virus disease. Clinical trials were underway to evaluate potential vaccines and therapies, including the ChAdOx1 Bundibugyo vaccine candidate and an mRNA-based candidate. Their effectiveness remained under investigation.[21]

The outbreak has nevertheless prompted an expansion of healthcare capacity. According to WHO, the number of laboratories capable of testing for Bundibugyo virus in the DRC increased from two at the beginning of the outbreak to more than two dozen by mid-November. Nearly 2,000 treatment beds had also become available, while clinical research continued. Despite these improvements, hundreds of new infections were still being reported weekly. This contrast highlights the limitations of expanding healthcare capacity only after an epidemic has escalated. Scientific innovation is therefore essential, but it cannot substitute for adequately funded healthcare systems, trained personnel, reliable supply chains and effective community engagement.[22]

Strengthening Africa's Health Security Architecture

The persistence of Ebola demonstrates the need to shift from emergency-driven interventions towards sustained investment in healthcare preparedness. Strengthening primary healthcare, laboratory infrastructure, disease surveillance, and

emergency response capacity is essential to identifying outbreaks early and interrupting transmission.[23] Community-based surveillance is particularly important. Local healthcare workers and volunteers often provide the first opportunity to identify unusual illnesses and alert health authorities. However, these mechanisms cannot be established effectively only after an outbreak begins. They require continuous training, institutional support and public confidence.

A recurring weakness in epidemic preparedness is the tendency to mobilise substantial resources during emergencies while reducing investments once transmission declines. Community surveillance programmes, healthcare training and preparedness initiatives may consequently become difficult to sustain between outbreaks. This creates a cycle in which countries repeatedly expand emergency response capacities without adequately addressing underlying institutional vulnerabilities.[24]

Regional cooperation is equally important because disease transmission does not respect national boundaries. The DRC–Uganda border illustrates the limitations of relying exclusively on restrictions on international movement. Border communities maintain longstanding family, commercial and social relationships that continue despite formal restrictions. Closing official crossings may redirect movement towards informal routes where health screening and surveillance become more difficult. [25]

Effective cross-border preparedness consequently requires coordinated contact tracing, timely information sharing, community-based surveillance and cooperation between neighbouring health authorities. These measures recognise the interconnected nature of border communities while strengthening regional disease-control mechanisms.

The international response to the 2026 Ebola outbreak also witnessed significant engagement by major multilateral groupings. At the G7 Summit in Évian in June 2026, leaders called for a coordinated response to the Bundibugyo outbreak in the DRC and Uganda, supporting international financing, medical research and regional containment efforts.[26] Subsequently, the United States convened a G20+ foreign ministers' meeting in September 2026, which helped mobilise approximately US$2.9 billion in reported international commitments. These developments demonstrated the growing recognition of Ebola as a global health-security challenge.[27] Nevertheless, the continuing gap between financial pledges and actual disbursements raised questions about the effectiveness of international commitments in addressing Africa's public health emergencies.

Institutions such as the Africa Centres for Disease Control and Prevention (Africa CDC), national public health agencies and WHO therefore play an important role in strengthening regional preparedness. In response to the 2026 outbreak, Africa CDC and WHO launched a joint continental preparedness and response plan covering June to November 2026. The initiative sought to mobilise US$518 million to strengthen emergency coordination, surveillance, laboratory testing, clinical care, community engagement and other essential response measures. The initiative demonstrates the growing importance of African-led regional health cooperation. [28]

However, financial assistance should extend beyond immediate emergencies. International attention and funding frequently increase during major epidemics

but decline once transmission is controlled. This pattern risks leaving the underlying weaknesses of national healthcare systems unresolved. Sustainable preparedness requires predictable financing, institutional capacity-building, and continued investment in healthcare infrastructure.

At the same time, Africa should not be viewed exclusively through the lens of disease and vulnerability. Successive outbreaks have enabled African healthcare institutions and professionals to accumulate substantial experience in epidemic management. The development of regional public health institutions, expansion of laboratory networks, and increasing expertise in emergency response demonstrate significant progress. The central challenge is ensuring that these capabilities become sufficiently strong and widely distributed to contain outbreaks before they escalate. Strengthening African healthcare institutions should therefore be understood not merely as humanitarian assistance but as an investment in regional and global health security.

Conclusion

The experiences of West Africa, eastern DRC and Guinea reveal how biological, institutional, political and social factors interact to create conditions in which transmission can emerge and become difficult to contain. The ongoing Bundibugyo outbreak further highlights the limitations of existing medical interventions and the importance of sustained scientific research. Although advances in vaccines, treatments and surveillance have improved outbreak management, their effectiveness ultimately depends on functioning healthcare institutions, timely detection and public cooperation. Africa's health security cannot be separated from global health security. Strengthening the continent's capacity to detect, contain, and respond to infectious diseases is essential not only for protecting affected communities but also for safeguarding international public health.

Views expressed are of the author and do not necessarily reflect the views of the Manohar Parrikar IDSA or of the Government of India.

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