



Ebola Containment in Central and West Africa: Development Assistance, Outbreak Response and the 2026 Counter-Example

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This research study briefing is a comparative analysis of four Ebola Zaire/Bundibugyo virus disease outbreaks in Democratic Republic of the Congo (DRC) and West Africa (2012, 2014–2016, 2018–2020, 2026), assessed against the mechanisms funded by Official Development Assistance (ODA) in place at the time of each event.

This briefing will explore the relationship between **Official Development Assistance (ODA) and epidemic outcomes across four Ebola outbreaks** spanning more than a decade, all involving the same virus family. Rather than assuming a single cause and effect story, it sets out to understand the **pathways through which ODA funded surveillance and research translate into faster detection and contained transmission**, and what happens to that pathway when funding is reduced or withdrawn. The question

underneath is **how development resources can be used to maximum effect, which investments in health security deliver the most protection per dollar committed, and which risks emerge when they are cut.**

The approach is comparative; for each outbreak, we look at the funding committed, the response it enabled, and the outcome it produced, so the four episodes can be read alongside each other rather than as separate stories. We have chosen four episodes illustrate the comparison:

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- **DRC (Isiro, Province Orientale), 2012** (Ebola/Bundibugyo virus): a small, rapidly contained outbreak of the same rare, vaccine-less Ebola species now circulating in 2026; the most relevant historical comparator for the current event.
- **West Africa, 2014-2016** (Ebola/Zaire virus): the largest Ebola outbreak in history; the case that contributed to the modern ODA-funded global health security architecture.
- **DRC (Kivu/Ituri), 2018-2020** (Ebola/Zaire virus): the second-largest outbreak on record prior to 2026; fought in an active conflict zone using the first large-scale deployment of ring vaccination.
- **DRC (Ituri/North Kivu) and Uganda, 2026** (Ebola/Bundibugyo virus, ongoing): presented here not as a success story but as the documented consequence of withdrawn ODA funding, occurring in the same country, the same rare virus species, and overlapping provinces.

1. The Ebola/Bundibugyo Outbreak in Isiro, DRC, 2012

“This is the case study’s “invisible win” in its purest form. The outbreak was contained before it could generate international news coverage, which means the infrastructure that made containment possible received no political credit for the crisis it prevented.”

The 2012 DRC outbreak is the most important historical comparator for understanding the 2026 crisis, and the clearest illustration of what functioning ODA-funded surveillance infrastructure looks like from the outside: quiet. Caused by **Bundibugyo ebolavirus** (a species first identified in Uganda in 2007 for which no approved vaccine or treatment exists) the outbreak was detected in August 2012, confirmed within days, and declared over on 21 November 2012. With a **total number of cases of 59** (38 confirmed, 21 probable) and 34 deaths, it had a case fatality ratio of approximately 58%, consistent with the pathogen’s established lethality.¹

No emergency fundraising campaign was needed because none of the infrastructure used in the response had to be built from scratch. The CDC had maintained a field presence in DRC through ongoing bilateral ODA programming, and

because the Uganda Virus Research Institute’s researchers had themselves characterised Bundibugyo ebolavirus during the original 2007 outbreak, specialist virological expertise was available immediately without the weeks of diagnostic uncertainty a novel pathogen would normally impose. Tellingly, no disaggregated emergency ODA figures were ever published for this event, precisely because no emergency fundraise was triggered.²

The response team was accordingly compact. A CDC field laboratory unit reached Isiro Health Zone within days of the initial report, the Public Health Agency of Canada (PHAC) contributed epidemiological support, Uganda Virus Research Institute (UVRI) supplied its filovirus expertise, and WHO and the DRC Ministry of Health coordinated the field response while *Médecins Sans Frontières* (MSF) handled clinical management. Contact tracing began within days of confirmation.¹

¹ World Health Organization. Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda. May 16, 2026. Accessed July 2, 2026. <https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON602>

² CDC. Ebola Outbreak: Current Situation. Ebola. June 26, 2026. Accessed July 2, 2026. <https://www.cdc.gov/ebola/situation-summary/index.html>

The agencies involved —CDC (field laboratory), the Public Health Agency of Canada, the Uganda Virus Research Institute, WHO, the DRC Ministry of Health, and MSF— formed one close specialist team rather than a large-scale mobilisation.

This is the case study’s “invisible win” in its purest form. The outbreak was contained before it could generate international news coverage, which means the infrastructure that made containment possible received no political credit for the crisis it prevented. That asymmetry between visible cost and invisible benefit is the thread connecting this quiet 2012 success to the very loud 2026 outbreak. It is worth reflecting on

why that asymmetry matters beyond this one outbreak. Prevention spending of this kind rarely produces a ribbon-cutting moment or a headline; its return shows up as an absence, an outbreak that stayed at 59 cases instead of becoming a regional emergency. **Development budgets are not well built to reward absences, which is precisely why this kind of ODA investment is chronically vulnerable to being read as a saving rather than as insurance.** The subsequent outbreaks, described below, show the evolution of ODA funding and outbreak response over time, providing key insight into the systems in place and what factors could make or break a successful response.

2. The Ebola/Zaire Outbreak in West Africa, 2014-2016

“Reactive containment at the scale West Africa required is not a cheap alternative to prevention; it is an expensive one that happens to arrive after the fact instead of before it.”

The largest Ebola outbreak in history. The epidemic took place between 2014 and 2016 in Guinea, Liberia, and Sierra Leone, and resulted in **more than 28,600 cases and over 11,300 deaths.**³ Over the course of the outbreak, cases spread to seven additional countries: Italy, Mali, Nigeria, Senegal, Spain, the United Kingdom, and the United States. Containment measures mobilised the largest ODA investments in the disease’s history.

Funding moved at a scale that matched the crisis. Of the \$5.4 billion the United States (US) had committed by December 2014,⁴ only \$3.7 billion (69%) actually left the country as international assistance: the United States Agency for International Development (USAID) and the State

Department together received roughly \$2.5 billion of which \$1.6 billion was destined to outbreak response activities, including \$411.6 million for 131 recovery projects, and \$73.9 million was channelled directly to the World Health Organization (WHO). The US Centers for Disease Control (CDC) received \$1.2 billion for their own international response and preparedness work. Moreover, the WHO’s own Ebola response drew more than \$370 million in donations.⁵ The United Kingdom (UK) committed £230 million through its Department for International Development (DFID), most of it directed to Sierra Leone, and the European Commission and its member states together mobilised over €1.8 billion.⁵

³ CDC. History of Ebola Outbreaks. Ebola. June 4, 2026. Accessed July 2, 2026. <https://www.cdc.gov/ebola/outbreaks/index.html>

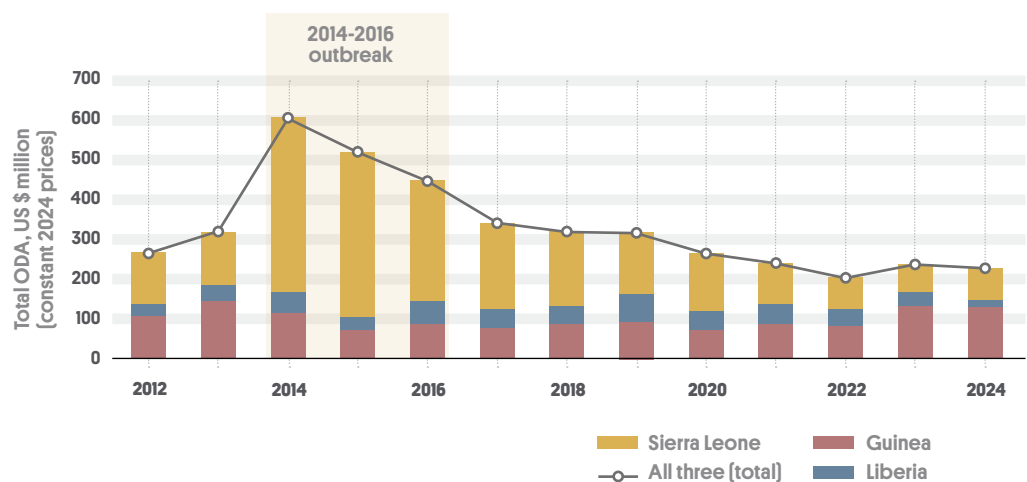
⁴ Dahl BA. CDC’s Response to the 2014–2016 Ebola Epidemic — Guinea, Liberia, and Sierra Leone. *MMWR Suppl.* 2016;65. doi:10.15585/mmwr.su6503a3

⁵ World Health Organization. *Building the Legacy of Ebola.* 2017. <https://www.afro.who.int/sites/default/files/2017-06/ebola-response-report-2016.pdf>

In general terms, funding flows converged into an upward trend of ODA for the main countries suffering from the epidemic: combined bilateral ODA for Guinea, Liberia and Sierra Leone across all DAC donors doubled between 2013 and 2015, mostly at the expense of the latter two countries, driven largely by contributions from the US (to all three recipients) and the UK (to Sierra Leone), before dropping quickly after the outbreak ended. **Figure 1** shows that the same

rise-and-fall shape holds when the lens is narrowed to just three European donors — France, Germany and the UK, Europe's largest donors to these countries and the ones whose health-sector funding fell the most — and that the decline didn't stop when the outbreak ended: **funding kept falling well past the immediate post-outbreak period, and further still through the years leading up to 2026.**

FIGURE 1.
Bilateral ODA
disbursements to
Guinea, Liberia and Sierra
Leone, from France,
Germany and the United
Kingdom only, extended
to 2024.



Source: OECD.Stat, Creditor Reporting System (CRS), disbursements, constant 2024 US\$ millions. Donors covered: France, Germany, United Kingdom. Extracted 13 Jul 2026.

In terms of resource deployment, the US Centers for Disease Control (CDC) deployed more than 1,400 professionals in the first year alone, the US Department of Defense (DoD) sent around 3,000 military personnel, the African Union added 196 Nigerian public health professionals, and MSF scaled from roughly 60 workers in the first two weeks to more than 1,000 by year's end.⁵ Altogether, the response spanned every layer of the global health security system: the WHO and UNICEF on the technical side, the World Bank behind the financing, USAID, the CDC, the US DoD and UK DFID carrying the bilateral load, the EU and ECHO (European Civil Protection and Humanitarian Aid Operations) working alongside the

African Union as the regional layer, and MSF, the International Federation of Red Cross and Red Crescent Societies (IFRC) and Save the Children supplying frontline and community capacity.

What the funding achieved becomes clear in what it produced; that is, better coordination of the response, improved surveillance, laboratory capacity, contact tracing, and infection control in Ebola treatment units and healthcare facilities. **It is also the clearest historical proof that the European exposure pathway is real, but that it can be closed.** Hundreds of EU/EEA (European Economic Area) humanitarian and military personnel were deployed to the three most affected countries (Guinea, Liberia

and Sierra Leone) placing them on the exposure pathway; yet only ten cases were ever confirmed in the EU.⁶

That containment, despite direct and sustained exposure, is what this resource mobilisation actually achieved.

3. The Ebola/Zaire Outbreak in DRC's Kivu and Ituri Provinces, 2018-2020

“Success, in this case, did not mean adequate funding; it meant that ring vaccination was effective enough to compensate for a persistent shortfall.”

The second-largest Ebola outbreak in history unfolded under exceptionally challenging circumstances. Over nearly two years, more than 3,400 people were infected and over 2,280 died of Ebola³ in an active conflict zone where distrust of public institutions ran deep and responders were repeatedly attacked. Containment should have failed, but it didn't. Not because the conditions improved, but because **a specific ODA-funded tool, ring vaccination**—a public health strategy used to stop the spread of an infectious disease by vaccinating only the people most likely to get it—**had been refined enough by 2018 to be deployed at scale for the first time**, and it held the line against spread into Rwanda and Uganda.

The funding trend reflects an operation built and rebuilt as it evolved: roughly \$734 million was mobilised between August 2018 and December 2019, climbing to around \$1 billion by the time the WHO declared the outbreak over in June 2020. The US, through USAID, was the largest bilateral donor contributing more than \$340 million, while the CDC added \$37 million drawn from emergency appropriations left over from the 2014–2015 response,⁷ as a reminder that **funding committed to one outbreak**

can still be used years later. The World Bank gave \$170 million, the UK \$78 million, and the EU \$52 million. The WHO, seeking \$570 million for its own public health response and regional preparedness work, ultimately received \$276 million.⁷ This last figure is worth reflecting on. Even the multilateral body leading the response that is now regarded as a containment success was underfunded during the outbreak, gathering less than half of its target funding. Success, in this case, did not mean adequate funding; it meant that **ring vaccination was effective enough to compensate for a persistent shortfall.**

On the ground, **the WHO deployed more than 1,500 international staff alongside an estimated 16,000 local frontline workers**, and in the early stages the WHO, MSF, IFRC and International Medical Corps together fielded over 500 personnel. **The human cost of operating in a conflict zone was severe**, as nearly 100 health workers were killed or injured across hundreds of attacks on health facilities.⁷ The agencies involved (the WHO, MONUSCO—the United Nations Organization Stabilization Mission in the DRC—, UNICEF, International Medical Corps, the World Bank, USAID/DART—Disaster

⁶ European Centre for Disease Control. *Annual Epidemiological Report for 2016: Ebola and Marburg Fevers*. 2018.

⁷ Salaam-Blyther T, Arieff A. Ebola Outbreaks in the Democratic Republic of Congo: Emergencies or Enduring Threat? Published online September 10, 2020.

Assistance Response Team—, the CDC, the DRC Ministry of Health, MSF and the IFRC) had to layer public health work on top of active peacekeeping and security operations.

In this case, scientists were already familiar with the virus; **what stood in the way of containment was armed conflict and public distrust in the government and scientific community, rather than a diagnostic gap.**

International funding leveraged exponential gains by providing stronger operational preparedness and coordination, laboratory surveillance, improved infection prevention and control in health facilities, contact tracing, clean water and sanitation. However, **the most effective measure was a ring vaccination campaign that reached more than 300,000 people with the experimental rVSV-ZEBOV vaccine**, later licensed as Ervebo, with a second vaccine subsequently approved by DRC authorities.⁷ Recognising that health commodities alone would not overcome community mistrust, donors also funded targeted community

engagement, combining Ebola messaging with health and food security initiatives to rebuild local support for the response. Two lessons arose from this outbreak. First, **investment in health research and development of new vaccines only becomes an operational tool when matched by a surveillance infrastructure precise enough to find contacts**, and each element loses much of its value without the other. Second, **ring vaccination did not appear out of nowhere in 2018. It was the payoff of years of ODA-funded research** that had no guaranteed timeline and no guaranteed way to prove itself against; the kind of investment that is easy to defer precisely because its returns seem uncertain, until they aren't anymore.

4. The Ebola/Bundibugyo Outbreak in DRC and Uganda, 2026

“What makes the current outbreak a counter-example rather than simply a tragedy is a documented link between the 2025 ODA cuts and the scale of what followed.”

On 5 May 2026, the WHO was alerted to a cluster of high mortality illnesses, including deaths among healthcare workers in Mongbwalu and Rwampara health zones, Ituri Province, DRC. **Bundibugyo virus** was confirmed on 15 May. This was the 17th DRC Ebola outbreak since 1976. Uganda confirmed an imported case in the same week.³ The WHO declared a Public Health Emergency of International Concern (PHEIC) on 17 May, only the eighth such declaration since the framework's 2005 adoption.¹

By 29 June, DRC had recorded 1,333 confirmed cases and 399 deaths; Uganda had 20 confirmed cases and two deaths; and France had one confirmed case, a humanitarian healthcare worker who returned home and was placed under monitoring.² **The trajectory implied by the modelling is what makes this outbreak different in kind, not just scale.** The CDC's scenario modelling shows that with only 20% of patients successfully isolated and no additional interventions, there is a 65% probability for the outbreak to exceed 20,000 cases

within three months, which would make it the largest Bundibugyo outbreak by a wide margin, and among the largest Ebola-family outbreaks ever recorded.⁸

Multiple independent modelling groups cited by the European Centre for Disease Prevention and Control (ECDC) suggest that **the true size of the outbreak is larger than reported**, and one of them estimates true cumulative infections may already be 3-10 times the reported confirmed case count.⁹ It is believed that in this outbreak there were very lengthy lapses from when the first infection happened to when the outbreak was identified. **Some models estimate that it could have started as early as February 2026.**¹⁰ **These data point to severe surveillance challenges.** In this occasion, this outbreak faces severe challenges, as had the 2018–2020 response: ongoing active conflict in the region and widespread community distrust, including attacks to the healthcare community.¹¹

The international response has been substantial. On 17 June, during the G7 meeting, several commitments were made to support the emergency response to the 2026 Ebola outbreak.¹² The US deployed more than \$370 million in health and humanitarian resources and has committed additional \$500 million for Ebola response efforts. The EU has provided 493 million euros in emergency aid, vaccines, treatment and health security in the Great Lakes and Uganda region. This includes 84 million euros in immediate humanitarian aid, development and research funding in response to the outbreak. The African Union has started the Continental

Preparedness and Response Plan that is mobilising \$518 million dollars to support African countries for outbreak preparedness and response in preparing for, rapidly detecting, and responding to the outbreak.¹²

Adding the US, EU and African Union commitments together, roughly \$1.9 billion was pledged within about six weeks of the WHO's emergency declaration, **a faster mobilisation than either the 2014–2016 or 2018–2020 responses managed in their opening months.** That speed is itself a data point. It shows that the institutional reflex to fund a declared emergency is intact and fast; **what had been dismantled was the slower, less visible funding that might have kept the emergency from being declared** in the first place.

The documented role of 2025 ODA cuts

What makes the current outbreak a counter-example rather than simply a tragedy is a documented link between the 2025 ODA cuts and the scale of what followed. Some of the withdrawn funding has since been redirected to a new “America First” agreement between the US State Department and DRC that will disburse \$900 million over the next five years, on different terms than the preparedness funding it replaces. The scale of the prior cuts is surprising in raw numbers alone:

8 Eric Q. Mooring S, William T. Koval P, Isobel Routledge P, et al. Modeled Scenario Projections for the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026. *MMWR Morb Mortal Wkly Rep.* 2026;75. doi:10.15585/mmwr.mm7522e1

9 Overview of available modelling evidence to inform the scale and potential spread of Bundibugyo virus in the current Ebola disease outbreak. June 17, 2026. Accessed July 2, 2026. <https://www.ecdc.europa.eu/en/publications-data/overview-available-modelling-evidence-inform-scale-and-potential-spread>

10 Update on Ebola Outbreak in the Democratic Republic of the Congo and Uganda, 6/5/2026 | CDC Newsroom. Accessed July 2, 2026. <https://www.cdc.gov/media/releases/2026/update-on-ebola-outbreak-in-the-democratic-republic-of-the-congo-and-uganda-6-5-2026.html>

11 Haq Z ul. Ebola control is weakened by mistrust and cultural insensitivity. *BMJ.* 2026;394:e100190. doi:10.1136/bmj-2026-100190

12 G7 Group. *Leader's Call for a Coordinated Response to the Bundibugyo Ebola Outbreak.* 2026. <https://www.consilium.europa.eu/media/vyfn35cx/leaders-call-for-a-coordinated-response-to-the-bundibugyo-ebola-outbreak.pdf>

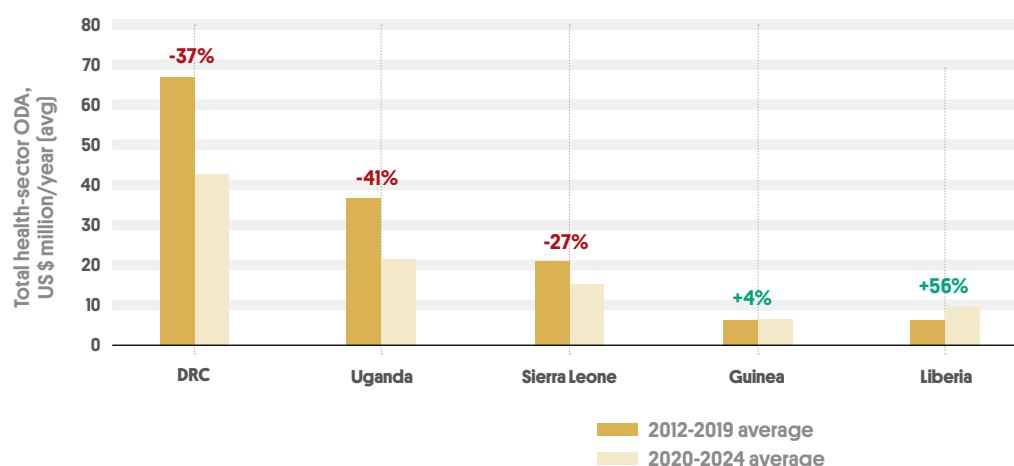
Funding stream	Before	After cuts
USAID foreign aid to DRC	~\$1.2 billion (FY2024)	~\$715 million in FY2025 ¹³
HHS (US Department of Health and Human Services) foreign aid to DRC	~\$33 million (FY2024)	<\$10 million (FY2025) ¹³

In proportional terms, the table above describes **something closer to a cliff than a slope**. USAID funding to DRC fell by roughly 40% across fiscal 2025 as a whole, from \$1.2 billion to \$715 million. That average, though, hides how unevenly the decline was spread across the year: had the FY2024 total simply stayed at the same amount every quarter, each quarter of FY2025 would have received around \$300 million. The final quarter of FY2025 alone received just \$67 million, a roughly 78% drop against that flat-run-rate baseline, concentrated at the very end of the year rather than spread evenly across it. HHS funding to DRC fell by at least 70% over the same period.

This pattern is not confined to the United States. Combined health-sector ODA from **France,**

Germany and the UK to the same five outbreak-affected countries also fell, from an average of \$137 million a year in 2012–2019 to \$95 million a year in 2020–2024, a 31% decline (Figure 2) — a milder version of the same pullback documented above for USAID and HHS, affecting four of the five countries in this comparison. Part of this decline overlaps with the COVID-19 pandemic, when donor governments faced competing domestic and global health priorities. But the year-by-year data do not point to COVID alone. 2020 itself shows no unusual spike or drop, and the steepest fall comes in 2021 and continues through 2024, well after the acute phase of the pandemic, suggesting a more durable shift in donor priorities rather than a temporary pandemic effect.

FIGURE 2.
Total health-sector ODA
to the five outbreak-
affected countries
from France, Germany
and United Kingdom
combined, 2012–2019
average vs. 2020–2024
average.



Source: OECD.Stat, Creditor Reporting System (CRS), disbursements, constant 2024 US\$ millions. Donors covered: France, Germany, United Kingdom only (not all of Europe). Extracted 13 Jul 2026.

¹³ Payne D. Trump's cuts to foreign aid are undermining the Ebola response, insiders say. STAT. May 19, 2026. Accessed July 2, 2026. <https://www.statnews.com/2026/05/19/us-aid-cuts-hamper-drc-ebola-response/>

The timing of that concentrated drop matters, because independent modelling estimates place the outbreak's true start as early as February 2026, meaning **the steepest phase of the funding withdrawal ran directly into the months in which the outbreak is now believed to have been silently spreading, undetected.** It is worth being precise about what that overlap does and does not show; timing alone is not proof that one caused the other, and the US State Department disputes the causal claim outright. What can be said, more modestly, is that this overlap is exactly what a surveillance-funding argument would predict if the argument is correct.

Alongside that quantitative picture sits a qualitative one. Dennis Carroll,

former director of USAID's Emerging Pandemic Threats programme, said the infrastructure USAID and CDC built in the region had allowed outbreaks to be "picked up much quicker" and that the support sustaining it disappeared.¹⁴ The International Rescue Committee reports that US funding for its eastern DRC outbreak-preparedness work "ended in March 2025";¹⁵ and former USAID officials told CNN that "almost everyone" on the USAID team that handled the prior 2025 Ebola outbreak in Uganda had been fired by the time the 2026 outbreak began.¹⁶ Capacity training for identifying and responding to emerging disease is also reported to have been affected by the cuts. All these claims have been rebutted by the US State Department.¹⁷

5. Understanding the Four Outbreaks Together

"The problem is that "nothing happened" is indistinguishable, in budgetary terms, from "nothing was at risk". The investment that prevented a crisis and the investment that was simply unnecessary look identical in the accounting, which is precisely why the former keeps getting cut."

The comparison between the 2012 and 2026 DRC's outbreaks is the closest thing to a controlled experiment that epidemic history tends to produce. Same virus, same case fatality ratio —the pathogen has not changed. What changed was the infrastructure available when it emerged, and the difference in outcome is not a matter of degree. Three months of undetected spread in 2026 against weeks of detection in 2012 is the difference between a system that worked and a system that had been taken apart.

The 2014–2016 West Africa epidemic is what established the infrastructure that made later

responses possible. Before it became a public health emergency, it was an infrastructural failure due to surveillance gaps and health systems in the three affected countries not built to detect and contain a novel haemorrhagic fever. The billions mobilised in response produced the modern ODA-funded global health security architecture, and put the European exposure pathway on the record as ten cases reached EU/EEA territory despite the full weight of international containment. The pathway was interrupted, but the cost of interrupting it reactively, rather than preventing it upstream, was extraordinary.

¹⁴ Rascoe A, Mistich D, Douglas D. How funding cuts to USAID are impacting the Ebola outbreak in DR Congo. *NPR*. May 24, 2026. Accessed July 2, 2026. <https://www.npr.org/2026/05/24/nx-s1-5830015/how-funding-cuts-to-usaid-are-impacting-the-ebola-outbreak-in-dr-congo>

¹⁵ Ebola outbreak in DRC: What to know and how to help | The IRC. Accessed July 2, 2026. <https://www.rescue.org/article/ebola-outbreak-drc-what-know-and-how-help>

¹⁶ Not for Sale. Ebola Outbreak in DRC: A Public Health. Not For Sale. June 13, 2026. Accessed July 2, 2026. <https://wearenotforsale.org/human-trafficking/first-outbreak-post-usaid-era-ebola-drc-2026/>

¹⁷ Lambert J. U.S. aid cuts may have delayed detecting this Ebola outbreak. *NPR*. May 21, 2026. Accessed July 2, 2026. <https://www.npr.org/2026/05/21/nx-s1-5828951/aid-cuts-may-have-contributed-to-delay-in-identifying-current-ebola-outbreak>

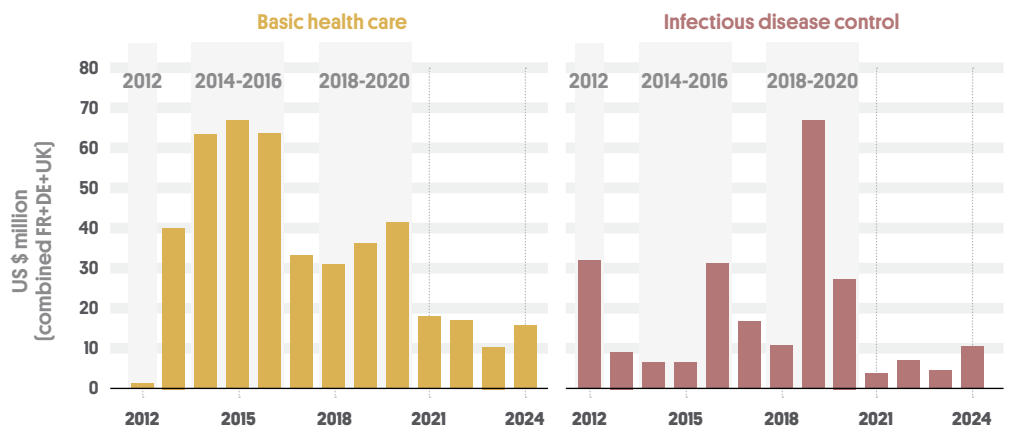
The 2018–2020 DRC outbreak tested that architecture under the worst possible conditions, active armed conflict, attacks on health facilities, and deep community distrust of health officials. It held, imperfectly. Mainly, it held because of ring vaccination, the product of a decade of ODA-funded research and development, which was deployed at scale for the first time and demonstrably limited transmission, and prevented spread into Rwanda and Uganda. What this episode established is that ODA investment in health R&D translates into operational tools, and that those tools work when the surveillance infrastructure is precise enough to identify contacts. Remove either element, and the other loses much of its value.

The 2012 DRC outbreak sits before these crises and is almost never discussed, which is itself the point.

Bundibugyo ebolavirus appeared in Isiro, was confirmed within days, and was gone within three months. The infrastructure that made that possible generated no political reward, no media story, and no institutional memory among the publics it protected. The problem is that “nothing happened” is indistinguishable, in budgetary terms, from “nothing was at risk”. The investment that prevented a crisis and the investment that was simply unnecessary look identical in the accounting, which is precisely why the former keeps getting cut.

Figure 3 illustrates this dynamic. Combined France, Germany and the United Kingdom spending on infectious disease control spikes sharply in 2019, right in the middle of the Kivu/Ituri response, then drops back down in the years after. **Funding appears when the emergency is declared, and recedes once it’s over.**

FIGURE 3.
Combined France, Germany and the United Kingdom ODA for basic health care and infectious disease control, across the five outbreak-affected countries examined in this briefing (DRC, Uganda, Guinea, Liberia, Sierra Leone), by year, 2012–2024.



Source: OECD.Stat, Creditor Reporting System (CRS), disbursements, constant 2024 US\$ millions. Donors covered: France, Germany, United Kingdom only (not all of Europe). Extracted 13 Jul 2026.

This is what makes 2026 legible as a policy consequence rather than an epidemiological event only. When Bundibugyo ebolavirus appeared again in the same region with no approved vaccine, and with the same lethality, the infrastructure that had enabled the 2012 response was gone. **The three-month detection gap, assuming the timeline is confirmed, would coincide with a budget decision recorded upstream**

as a saving. The emergency financing that followed (over \$650 million to date, including a vaccine development programme for a pathogen first documented in 2007) is the deferred cost of preparedness mechanisms not in place, arriving later and at a higher price.

This is where the European dimension becomes concrete rather than hypothetical. European health

security runs through surveillance infrastructure in Ituri and Isiro, some of it historically financed by European ODA, much of it by USAID. When that infrastructure is present, the exposure pathway documented in 2014 can be interrupted before a PHEIC is declared. When it is withdrawn, the ECDC issues threat assessments for elevated risk to European humanitarian workers and travellers as it did in May 2026. The accounting system that records ODA cuts in development

budgets without registering the corresponding increase in European epidemiological exposure and its derived costs, generates a systematic misattribution. The mechanisms linking ODA investment to European health security are already documented. What is missing is an assembly of that evidence in terms that speak to the audiences who hold the relevant budget decisions. The tale of these four outbreaks does that work with a clarity that modelling rarely achieves.

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