Special Session of the World Health Organization

Long-Term Solutions for Ebola Epidemics

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Introduction

How to improve global responses to outbreaks of the Ebola Virus, one of the world's deadliest infectious diseases? Threatening the lives of millions of people in Central and West Africa, with the danger it could spread globally, Ebola endangers hopes for regional economic development. It poses a direct danger of uncontrolled spread throughout the continent and around the world. The challenge delegates at ODUMUNC 50 is how to achieve international agreement to prevent or contain outbreaks of a disease so deadly it often kills medical personnel treating its victims.[1]

The Ebola virus causes severe haemorrhagic fever (with uncontrollable bleeding) causing death in fifty to ninety percent of cases.[2] Since the first recorded outbreak in 1976, the virus has countries poorly equipped to respond, and shown it can rapidly spread internationally. Outbreaks typically occur in Central and West Africa, but local outbreaks can become international or broader regional emergencies.

Nobody questions the severity of Ebola outbreaks. But there is wide-ranging disagreement on how best to respond. In an era when funding for international humanitarian assistance is declining, any problem faces declining resources, typically requiring funding with money taken from other programs.

Host governments struggling to prevent and contain outbreaks have limited capabilities and require international support. But the international assistance is less available than just a few years ago. Countries fearing Ebola could spread to their own territory—through international travelers, cargo or other routes—may prefer to concentrate their public resources at home. Negotiating an effective international response will be difficult.

In May 2026, the Democratic Republic of the Congo (DRC) and Uganda confirmed an outbreak of the rare Bundibugyo variety of Ebola, for which there is no approved vaccine or treatment. By early October 2026, the DRC alone had reported more than 8,700 confirmed cases and more than 4,200 deaths, making this the second-largest Ebola epidemic ever recorded.[3] On 6 October 2026, Kenya confirmed its first imported case. In August, the UN's humanitarian chief, Tom Fletcher, put it bluntly: "Ebola is winning."[4]

[4] UN News, '"Ebola Is Winning": Epidemic Now Killing One Person Every 30 Minutes', 14 August 2026, https://news.un.org/en/story/2026/08/1168148

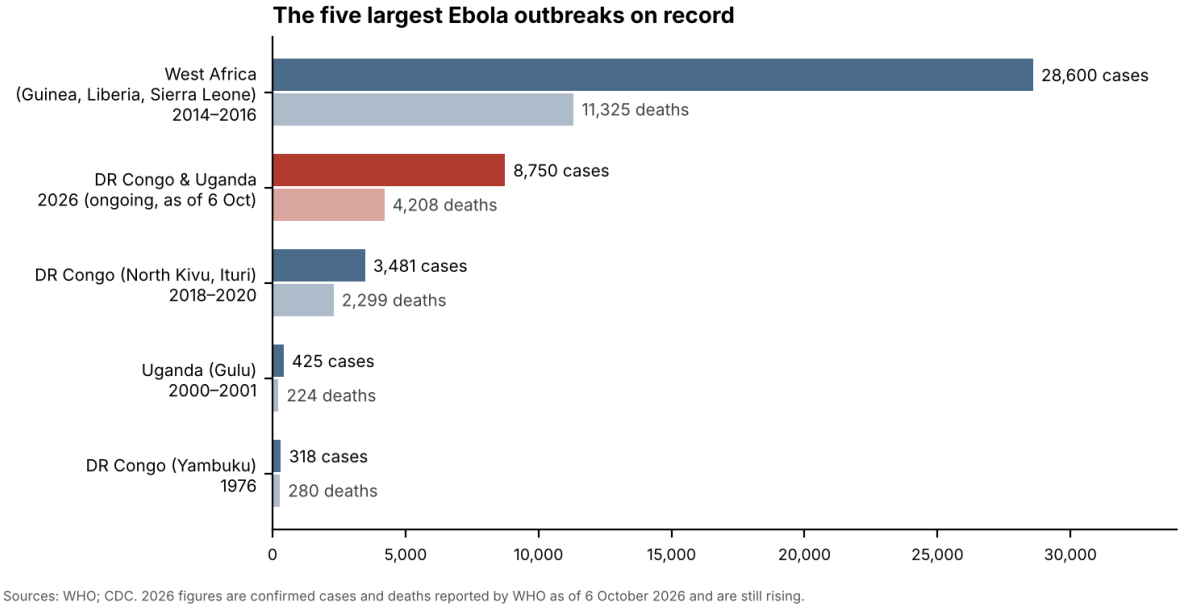


Figure 1. *The five largest Ebola outbreaks on record*

Ebola is also a test of the whole United Nations system, not only of the World Health Organization (WHO). The Security Council has twice treated Ebola as a matter of international peace and security. The General Assembly created the first-ever UN emergency health mission in 2014. Today, UN peacekeepers fly medical supplies into eastern DRC, the World Food Programme feeds patients in treatment centres, and the UN's emergency fund pays for burial teams.[5] Delegates must decide what this system should do differently so that the next outbreak is stopped while it is still small.

Background

Ebola is caused by a group of viruses, known as orthoebolaviruses. Without treatment, these viruses often result in death. The virus was discovered in 1976 in the Democratic Republic of Congo. It still is found mostly in Sub-Saharan Africa, in the region around the Ebola river. Scientists believe fruit bats serve as the primary ~~reservoir; outbreaks began~~ after humans came in contact with infected wildlife, specifically bats or non-human primates.

The virus then travels human-to-human, by touch or other vectors spreading fluid from the body of an infected victim, such as mucus, clothing, bedding or medical equipment.[6] Four species of the virus make people sick. The most common is the Zaire species (Ebola virus). The others are Sudan virus, Bundibugyo virus and Taï Forest virus. This matters for policy, because vaccines and medicines developed for one species do not reliably protect against the others. Fatality rates vary by species and by access to care; across all outbreaks, WHO puts the average at around 50 percent.[7]

[7] WHO, 'Ebola Virus Disease'.

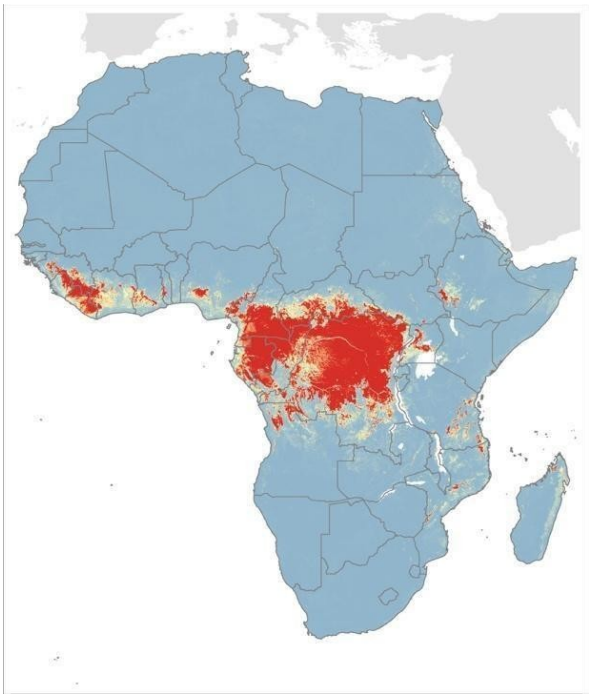


Figure 2. *Ebola outbreaks 2024-26*

The largest outbreak was 2014-16 in Guinea, Liberia, and Sierra Leone. Over 28,000 people were infected. More than 11,000 died.[8] This made the outbreak the deadliest recorded in history. The effects were felt by national economies, overwhelmed healthcare systems, disrupted education, and diminished public confidence in government institutions. This also showed that certain infectious diseases can spread rather quickly and evolve from local health emergencies into international security and developmental concerns. The international response to that epidemic was widely judged to have been too slow. WHO waited until August 2014, five months after the outbreak was confirmed, to declare a Public Health Emergency of International Concern (PHEIC). An independent panel later concluded that WHO lacked the capacity, the money and the political backing to act quickly.[9]

The second major test came in North Kivu and Ituri, in the eastern DRC, from 2018 to 2020. That outbreak killed nearly 2,300 people in an active war zone. Armed groups attacked treatment centres, and many residents distrusted responders who arrived with armed escorts. It was also the first large outbreak in which a vaccine was widely used: more than 300,000 people received the new Ervebo vaccine, which helped bring the outbreak under control.[10]

Advancements such as the Ervebo vaccine were developed against the Zaire strain and monoclonal antibody therapies drastically improved survival rates if administered early enough. Emergency response systems were also strengthened. The improvement of surveillance networks, lab capacity and rapid response teams helped drastically; however, the virus continues to re-emerge. Armed conflict, weak healthcare systems and environmental pressures have proved vaccines by themselves won't be able to eliminate the disease.

Ebola is a zoonotic disease, this means it spreads between animals and people. Thus, as long as animals carry and humans come in contact with the carrier, the virus will continue to reemerge and spread.[11]

[8] CDC. n.d.-c. 'Ebola Outbreaks', CDC, accessed 14 August 2026, https://www.cdc.gov/ebola/outbreaks/index.html
[9] WHO. 2015b. 'Report of the Ebola Interim Assessment Panel', WHO, July 2015, https://www.who.int/publications/m/item/report-of-the-ebola-interim-assessment-panel---july-2015
[10] CDC, 'Ebola Outbreaks'.

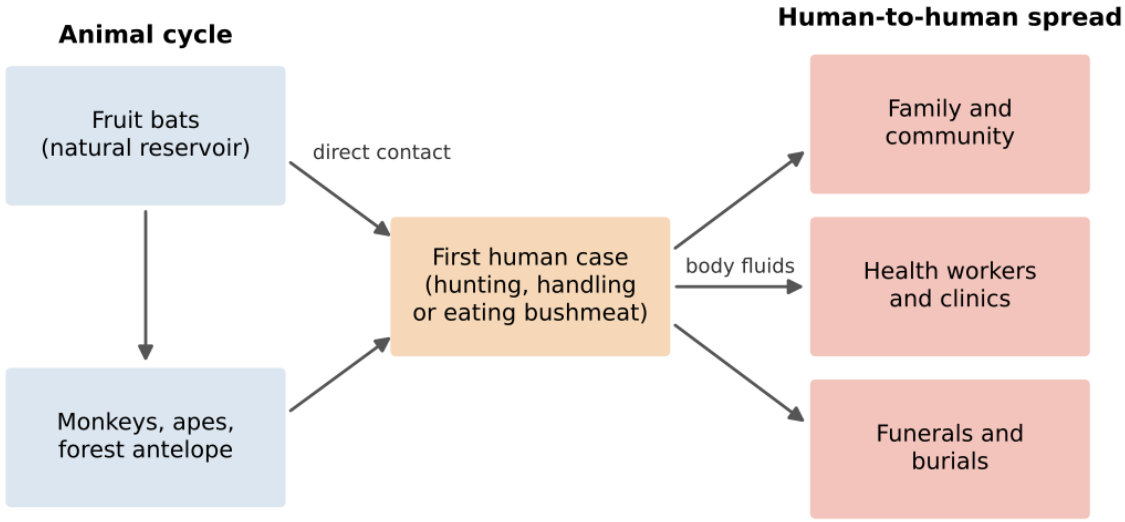


Figure 3. *How Ebola spreads from animals to people, and between people*

Current Situation

Nonetheless, with the considerable scientific and humanitarian advances achieved over the past decade, Ebola continues to be one of the most challenging viruses affecting the international community. The development of effective vaccines, rapid diagnostic technologies, and increasingly coordinated emergency response mechanisms have undoubtedly reduced mortality rates during recent outbreaks. Yet, as remarkable as these achievements may be, the issue of the virus being zoonotic continues to prevent its eradication, thus giving the virus a chance to reemerge and overwhelm healthcare systems.

Most member states affected by the virus tend to have weak infrastructure, strained financial resources and political instability. Meaning, even though international emergency interventions have become more sophisticated, long term prevention remains at the hands of the structural weaknesses rather than at quick response.

Unlike other diseases that can be eradicated solely by vaccines, the Ebola virus has persistent animal reservoirs, notably several species of fruit bats. Because of this, there is periodic spillover into the human population. This has resulted in the shift from reacting to preparing and recognizing the presence long before the first patient presents for treatment.

The 2026 Bundibugyo Epidemic

The current epidemic shows every weakness described in this brief at once. Scientists now believe the virus passed from animals to people in Ituri Province around February 2026 and spread for weeks without being noticed.[12] When WHO was alerted to suspected cases on 5 May, the first laboratory tests came back negative, because they were designed to detect the Zaire species rather than Bundibugyo. The DRC declared the outbreak

[11] CDC. n.d.-b. ‘About Zoonotic Diseases’, CDC, accessed 14 August 2026, https://www.cdc.gov/one-health/about/about-zoonotic-diseases.html
[12] CDC. 2026. ‘Notes from the Field: Outbreak of Ebola Disease Caused by Bundibugyo Virus — Democratic Republic of the Congo and Uganda, May 2026’, Morbidity and Mortality Weekly Report 75, no. 22, 2026, https://www.cdc.gov/mmwr/volumes/75/wr/mm7522e3.htm

on 15 May. WHO declared it a PHEIC on 17 May, and the Africa Centres for Disease Control and Prevention (Africa CDC) declared a continental emergency at about the same time.[13]

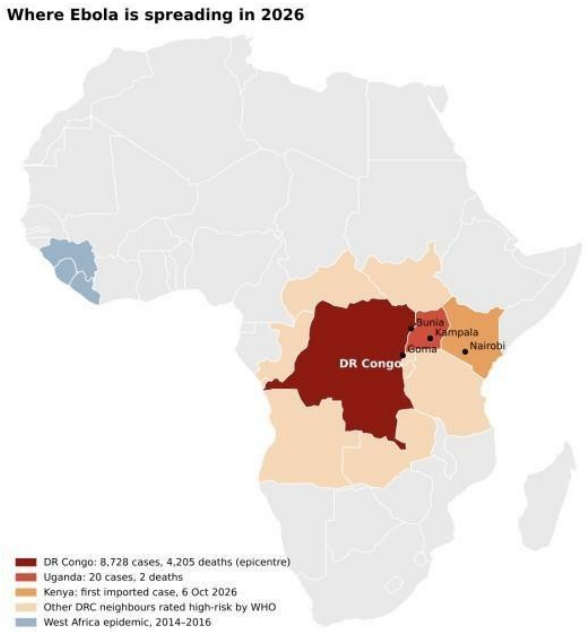


Figure 4. *Where Ebola is spreading in 2026*

The outbreak then grew quickly. As of 6 October 2026, WHO reported 8,728 confirmed cases and 4,205 confirmed deaths in the DRC, spread across 64 health zones in seven provinces. Ituri is the epicentre, followed by North Kivu. Uganda has reported 20 cases. Infected travellers or aid workers have been treated in France, Germany and the Netherlands, and Kenya confirmed an imported case on 6 October.[14] WHO officials have said the true number of infections is probably at least twice the official count.[15]

Three conditions make this outbreak especially hard to stop:

- **No vaccine or cure.** Ervebo and antibody treatments that transformed the 2018-20 response target the Zaire species. Against Bundibugyo, responders can only isolate patients, trace contacts, provide supportive care and bury the dead safely. The first human trial of a Bundibugyo-specific vaccine began only in July 2026.[16]
- **War.** Ituri and the Kivus are among the most violent places in Africa. The Rwanda-backed M23 rebel group controls Goma, and other armed groups, including the ADF and CODECO, operate across the region. Nearly seven million Congolese are internally displaced, around five million of them in the three most affected provinces.[17]
- **Distrust.** Within the first weeks, residents burned Ebola treatment tents in Rwampara and Mongbwalu, and burial teams were attacked in Bunia, Katana and Mongbwalu.[18] Rumours that the disease is a hoax, or was brought by foreign aid workers, have spread widely.[19] As of early October, responders were following up only about 80 percent of known contacts, below WHO's target.[20]

Money is the fourth problem. In June, WHO and Africa CDC launched a $518 million continental response plan; by September, the DRC's revised

[13] Africa CDC. 2026. 'African Leaders Mobilise Funding and Regional Response as Ebola Outbreak Escalates', Africa CDC, 26 May 2026, https://www.globalsecurity.org/security/library/news/2026/05/sec-260526-africacdc01.htm
[14] WHO, Disease Outbreak News, 8 October 2026.
[15] Reuters, 'WHO Says It Has Less than Half Funding Needed to Fight Ebola', The Star, 14 July 2026, https://www.thestar.com.my/news/world/2026/07/14/who-says-it-has-less-than-half-funding-needed-to-fight-ebola
[16] ARY News, 'UK Begins First Human Trial of Bundibugyo Ebola Vaccine', 13 July 2026, https://arynews.tv/uk-begins-first-human-trial-of-bundibugyo-ebola-vaccine
[17] CFR. 2026. 'The Ebola Outbreak in the DRC Is Spreading. Here's What to Know', CFR, updated 13 July 2026, https://www.cfr.org/articles/africa-has-faced-a-rare-ebola-outbreak-for-months-heres-what-to-know
[18] Wikipedia, '2026 Central Africa Ebola Epidemic', accessed 9 October 2026, https://en.wikipedia.org/wiki/2026_Central_Africa_Ebola_epidemic
[19] CFR. 2026. 'The Ebola Outbreak in the DRC Is Spreading'.
[20] WHO, Disease Outbreak News, 8 October 2026.

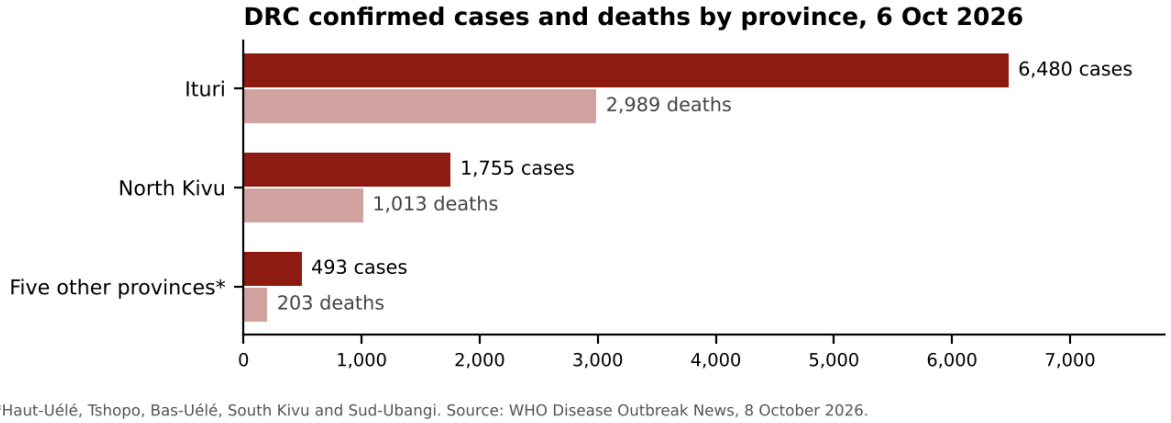


Figure 5. *The 2026 epidemic is concentrated in Ituri and North Kivu*

Weak Healthcare Infrastructure

One significant obstacle in the eradication of the Ebola virus is the inadequacy of healthcare infrastructure through affected regions. Rural communities, especially, lack consistent access to hospitals, diagnostic labs and trained healthcare professionals. Because of this, patients have to travel far and wide to receive medical attention; this significantly delays the diagnosis and inadvertently increases community transmission.

Along with that, healthcare workers are increasingly vulnerable during outbreaks due to a lack of Personal Protective Equipment (PPE), insufficient infection-control training and shortage of personnel. The shortage of personnel increases overworking, which increases vulnerability through a weakened immune system via lack of sleep and restoration. Exhausted staff are also more likely to make mistakes when putting on or removing protective equipment. As frontline workers become infected, healthcare capacity degrades, routine medicine slows thus leaving the public to become more wary of hospitals.

Furthermore, regional armed conflict, political unrest and humanitarian emergencies contribute to a complicated environment. As such, establishing treatment centers, distributing medical supplies and implementing surveillance systems become more difficult; this allows outbreaks to expand before effective containment measures can be put in place. In 2026, local hospitals in Bunia were overwhelmed within days, and field hospitals had to be built in tents.[24]

[21] The Independent (Uganda), 'DR Congo Launches Updated 180-Day Ebola Response Plan, Seeks 1.3 Bln USD Funding', 5 September 2026, https://independent.co.ug/dr-congo-launches-updated-180-day-ebola-response-plan-seeks-1-3-bln-usd-funding
[22] Reuters, 'WHO Says It Has Less than Half Funding'.
[23] U.S. Department of State, 'G20 Chair's Statement: Ebola Ministerial on Accelerating Collective Action to Defeat Ebola', 30 September 2026, https://www.state.gov/releases/office-of-the-spokesman/2026/09/g20-chairs-statement-ebola-ministerial-on-accelerating-collective-action-to-defeat-ebola/

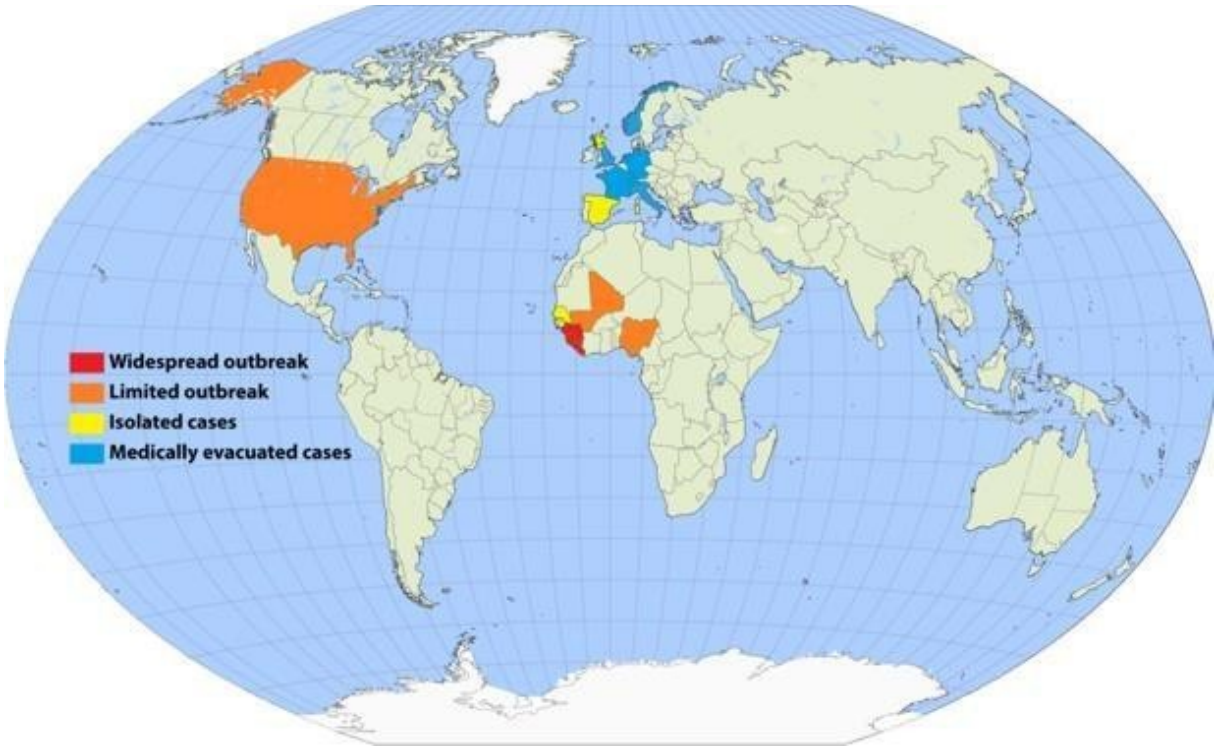


Figure 6. *Ebola outbreaks in 2014*

Disease Surveillance and Early Detection

Being able to quickly identify an Ebola case is currently the most effective means of stopping transmission. However, due to limited laboratory capacity and insufficient reporting mechanism several member states experience a delay in detecting outbreaks. The main issue is with detecting the clinical presentations. Early symptoms include a fever, fatigue, headache and muscle pain. These closely resemble that of malaria, typhoid fever and several other endemic illnesses. Because symptoms resemble common illnesses, they are often misinterpreted as other common illnesses. This results in the infected individuals remaining in their communities before isolation protocols are initiated.

With that being said, the World Health Organization (WHO), Africa Centers for Disease Control and Prevention along with other international partners have invested substantial amounts in efforts to expand laboratory networks, strengthen digital reporting systems and enhance tracing capabilities. But, even still, surveillance remains uneven, especially within remote communities where healthcare is far and wide. Cross-border migration, informal trade and humanitarian displacement make it even harder to monitor the disease. These conditions call for regional cooperation rather than isolated national responses.

The 2026 epidemic shows the cost of late detection. The virus circulated for about three months before it was identified, partly because standard tests missed the Bundibugyo species. By the time responders arrived, the disease was already spreading in several towns.[25]

[24] Wikipedia, '2026 Central Africa Ebola Epidemic'.
[25] CFR. 2026. 'The Ebola Outbreak in the DRC Is Spreading'.

Vaccination & Medical Countermeasures

In this century, the introduction of highly effective, licensed Ebola vaccines is one of the greatest accomplishments in public health. The use of vaccination methods; especially the ring vaccination, where people who were in contact with an individual that had a confirmed case of Ebola are vaccinated along with those that were around them, has shown to decrease the amount of infections during recent outbreaks.

Still, vaccines alone cannot provide a solid solution. Currently, only certain strains of the Ebola Virus are susceptible to existing vaccines. This means maintaining vaccine stocks demand a high financial investment and careful planning. Transportation continues to be a problem in many high risk areas; this is the result of poor roads, a scarcity of health professionals and cold-chain infrastructure. However, therapeutic medicine such as monoclonal antibody treatments have substantially improved patient survival rates when administered quickly. The caveat, these special medical facilities along with their resources are beyond the reach of the healthcare systems most vulnerable to the Ebola outbreak.

Furthermore, while vaccines and therapeutic medicine have transformed outbreak response, they are not a substitute for investing in resilient healthcare institutions capable of providing care and preventing the epidemic before it escalates.

The 2026 epidemic exposed the gap directly. Because no Bundibugyo vaccine exists, WHO had to issue guidance in August on whether the Zaire vaccine might be used, with no proof that it would work.[26] The Coalition for Epidemic Preparedness Innovations (CEPI) is funding several Bundibugyo vaccine candidates, but these will take months or years to test.[27] Who pays for vaccines against rarer species, and who gets them first when supplies are scarce, are questions delegates will need to address.

Community Trust and Public Education

Despite every technological advancement made, without the public's trust and confidence outbreaks will continue to spread. In the past, vaccination campaigns have suffered greatly due to the lack of trust in government, historical grievances, misinformation, and cultural misunderstanding. These reasons also have impacts on contact tracing and safe burial practices. In some communities, even though treatment centers were available, they were seen as infection petri dishes rather than a place of healing. Such rumors spread causing fear and panic along with resistance to foreign medical professionals by the public. Another problem includes traditional funeral processions. Traditionally close physical contact is expected, this creates a line for which the disease to spread.

With such, public health experts will have to figure out how to embed themselves among the community to ease any apprehension and increase preparedness. Having close relations with public figures such as religious leaders, educators, and traditional authorities have shown much more success than centralised messaging. Public health campaigns that are conducted in the local languages and blend with cultures have fostered trust, thus encouraging early-treatment seeking behaviour, which increases the acceptance of vaccination programmes.

Cross-Border Cooperation

Ebola outbreaks do not remain within political boundaries, as population movement for various reasons such as commerce, employment, family reunions or humanitarian reasons continue to prove an issue. With movement such as these, infected individuals travel before symptoms become significant and need medical attention. Consequently, regional cooperation has taken an increasingly prominent role in international preparedness.

[26] WHO. 2026b. 'Ebola Outbreak – DRC 2026', WHO, accessed 9 October 2026, https://www.who.int/emergencies/situations/ebola-outbreak---drc-2026
[27] Wikipedia, '2026 Central Africa Ebola Epidemic'.

Even so, finances continue to be a major issue. However, WHO and the African Centers for Diseases Control and Prevention have facilitated collaborations to improve prevention of outbreaks.

Cooperation has limits when governments are frightened. In 2026, Uganda closed its border with the DRC, Rwanda imposed mandatory quarantine on travellers from the DRC, and the United States, Canada and several Asian states restricted entry.[28] WHO advises against such travel and trade bans. They rarely stop the virus, push travelers toward unofficial crossings where no one screens them, and they punish affected countries for reporting outbreaks honestly. Kenya's first case, a traveler who reached Nairobi from the DRC through Uganda, showed how hard borders are to seal.[29]

Role of the United Nations System

No single UN body is in charge of Ebola. WHO sets the technical rules and leads the health response. The Security Council can treat an outbreak as a threat to peace and security. The General Assembly sets broad political direction and approves the UN's budget. The Secretary-General and the humanitarian system raise and distribute emergency money. UN agencies and peacekeepers deliver much of the work on the ground. Understanding who does what, and where the gaps between them lie, is the starting point for any resolution.

World Health Organization (WHO)

The WHO is the primary authority for global public health and is responsible for coordinating international responses for Ebola Outbreaks. The organization helps in monitoring outbreaks, deploying emergency response teams and coordinating laboratory networks. WHO is responsible for declaring major outbreaks as a Public Health Emergency of International Concern (PHEIC) which allows additional resources and expertise to be promptly mobilized along with the coordination of scientific research, and the evaluation of vaccines and medical treatments.

While the organisation is a vital necessity, it's also severely limited as it's not a world government. The emergency recommendations are generally not legally binding, thus the organization cannot enter a sovereign state without invitation. In order to launch investigations, impose vaccination programs, obtain information from governments Member States must give WHO permission to access their resources and information.

Ebola has now been declared a PHEIC three times: in West Africa in 2014, in the eastern DRC in 2019 and in the DRC and Uganda in 2026. Each declaration comes with "temporary recommendations" from an expert Emergency Committee, covering issues such as exit screening and safe burials, and almost always advising against travel bans. In 2026, WHO also released $3.9 million from its Contingency Fund for Emergencies within days, flew in supplies and led the response with Africa CDC.[30]

WHO enters this crisis weaker than before. The United States, historically its largest funder, left the organization in January 2026, and WHO cut its 2026–2027 budget by about a fifth and reduced staff. The Health Emergencies Programme now has to manage the second-largest Ebola epidemic in history with less money than it had before the epidemic began.[31]

[28] Wikipedia, '2026 Central Africa Ebola Epidemic'.
[29] WHO, Disease Outbreak News, 8 October 2026.
[30] CFR. 2026. 'The Ebola Outbreak in the DRC Is Spreading'.

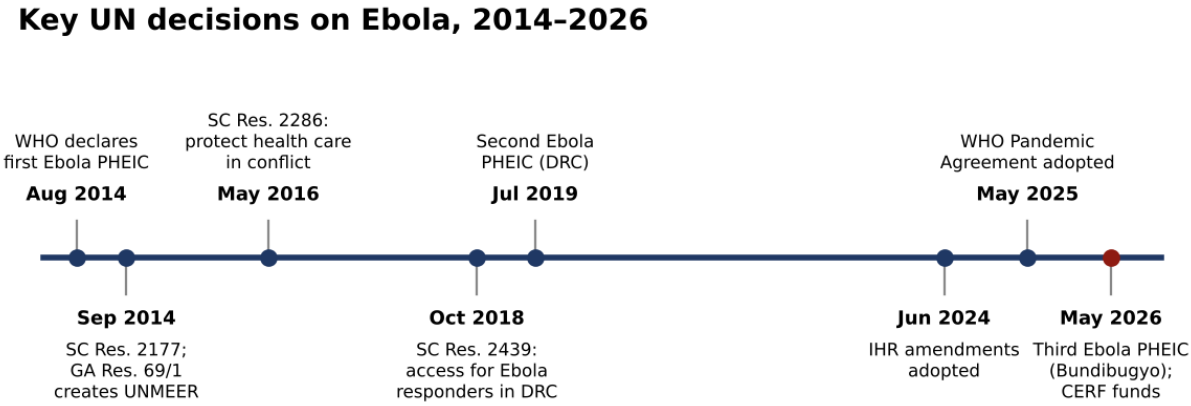


Figure 7. *Twelve years of UN decisions on Ebola*

Security Council

The Security Council's role in Ebola is unusual and politically sensitive. In September 2014, it adopted Resolution 2177 unanimously, declaring the West African outbreak a "threat to international peace and security." It was the first time the Council had said this about a public health emergency, and a record 134 Member States co-sponsored the text. The resolution called on states to lift travel and border restrictions and to send medical staff and supplies.[32]

In October 2018, the Council adopted Resolution 2439, again unanimously. It condemned attacks by armed groups in the eastern DRC, demanded an end to hostilities and called for safe access for Ebola responders.[33] Resolution 2286 (2016), on protecting health care in armed conflict, gives the Council a further legal basis for demanding the protection of doctors, nurses and burial teams.[34]

The Council's most practical tool in the current crisis is the UN peacekeeping mission in the DRC, MONUSCO. In May 2026, MONUSCO set up an "air bridge" from Nairobi to Bunia and moved nearly 30 tons of WHO supplies in its first days. Peacekeepers have also run awareness campaigns in villages near Bunia.[35] Yet as of early October 2026, the Council had discussed Ebola only during its regular DRC briefings and had not adopted an Ebola-specific resolution. Some members are reluctant to "securitize" health issues, which means treating them as security threats, while others are divided over the DRC–Rwanda conflict and MONUSCO's future. whether to give the mission an explicit Ebola-support role.

General Assembly

The General Assembly acts more slowly than the Security Council, but it speaks for all 193 Member States and controls the UN's budget. On 19 September 2014, one day after Resolution 2177, it adopted Resolution 69/1 without a vote, welcoming the Secretary-General's decision to create the UN Mission for Ebola Emergency Response (UNMEER), the first-ever UN emergency health mission. UNMEER coordinated

[31] Reuters, 'WHO Chief to Cut Costs, Reset Priorities after US Exit, Document Shows', Deccan Herald, 2025, https://www.deccanherald.com/amp/story/world%2Fwho-chief-to-cut-costs-reset-priorities-after-us-exit-document-shows-3371169
[32] UNSC. 2014. 'Peace and Security in Africa', S/RES/2177, New York: United Nations, 18 September 2014, https://undocs.org/S/RES/2177(2014)
[33] UNSC. 2018. 'The Situation concerning the Democratic Republic of the Congo', S/RES/2439, New York: United Nations, 30 October 2018, https://undocs.org/S/RES/2439(2018)
[34] UNSC. 2016. 'Protection of Civilians in Armed Conflict', S/RES/2286, New York: United Nations, 3 May 2016, https://undocs.org/S/RES/2286(2016)
[35] UN News, 'UN Agencies Step Up Ebola Response'.

the UN system's response in Guinea, Liberia and Sierra Leone until it closed in July 2015.[36]

The Assembly also hosts the annual "Global Health and Foreign Policy" resolutions and the high-level meetings on pandemic preparedness held in 2023 and planned again for 2026. These texts are not binding, but they shape what governments promise in public and what donors fund. A General Assembly resolution is often the easiest for consensus-based commitments, such as more predictable preparedness funding or better protection for health workers.

Secretary-General and the UN Humanitarian System

The Secretary-General can call attention to an emergency, appoint special envoys or coordinators, and mobilize the UN system. In 2014, Secretary-General Ban Ki-moon created UNMEER and appointed a UN System Senior Coordinator for Ebola. In 2019, Secretary-General António Guterres appointed an Ebola Emergency Response Coordinator for the eastern DRC.

The Office for the Coordination of Humanitarian Affairs (OCHA) manages the UN's Central Emergency Response Fund (CERF), the fastest source of UN emergency money. In 2026, CERF allocated $24 million and then a further $30.5 million in August. OCHA also sent extra staff to the epicenter, and the Inter-Agency Standing Committee, which brings together UN and non-UN humanitarian agencies, agreed to scale up the response.[37] Because Ebola hits areas that already face war, displacement and hunger, the humanitarian system argues that it must be treated as part of a wider crisis, not as a separate health problem.

Other UN Agencies

- **UNICEF** leads much of the community engagement and risk communication work, working with local leaders to counter rumours. It also supplies water, sanitation, hygiene and protection kits, and cares for children orphaned by the disease. In May 2026, it moved nearly 50 tonnes of supplies to the outbreak zone.[38]
- **The World Food Programme (WFP)** runs much of the logistics, including flights and transport for responders, and feeds patients, survivors and quarantined families. Food is part of disease control: contacts who have nothing to eat leave quarantine to find food. By August 2026, WFP had served more than 260,000 hot meals in treatment and isolation centres.[39]
- **The International Organization for Migration (IOM)** helps run health screening at border crossings and along migration routes.
- **The World Bank** hosts the Pandemic Fund, created in 2022 to pay for preparedness in lower-income countries, and provides emergency financing through its Crisis Response Window. It pledged $90 million to the 2026 response.[40]

Recent WHO and UN General Assembly Action

Based on recent reforms, governments recognize the weakness revealed by Ebola and COVID-19. In 2024, the World Health Assembly adopted major amendments to the International Health Regulations creating a new category labeled "pandemic emergency"; this strengthened provisions on access and called for National IHR Authorities to improve coordination. Most of the

[36] UNGA. 2014. 'Measures to Contain and Combat the Recent Ebola Outbreak in West Africa', A/RES/69/1, New York: United Nations, 19 September 2014, https://undocs.org/A/RES/69/1
[37] UN News, '"Ebola Is Winning"'.
[38] UN News, 'UN Agencies Step Up Ebola Response'.
[39] UN News, '"Ebola Is Winning"'.
[40] U.S. Department of State, 'G20 Chair's Statement'.

amendments took effect on September 19, 2025.[41] These changes are important because they strengthen surveillance, information sharing and coordination before a health emergency becomes a global catastrophe. It's also recognized that an emergency disease outbreak can not only cause deaths but social and economic disruption.

Despite these precautions, a major weakness remains as WHO's temporary recommendations are not binding and cannot impose domestic measures on Member States; the international community has the right to sound louder alarms but action is dependent on governments. The WHO Pandemic Agreement was also adopted by the World Health Assembly in May 2025; this document seeks stronger cooperation on pandemic prevention, preparedness and response, including more equitable access to vaccines, therapeutics and diagnostics.[42] In addition, the agreement explicitly protects national sovereignty and does not give the WHO secretariat authority to order national laws, lockdowns, vaccination mandates or other domestic policies. The protection was politically necessary to obtain agreements and illustrates the basic dilemma delegates must confront as the world wants a rapid collective response while states insist that final authority remains national.

The 80th (2025-26) General Assembly *resolution 80/117* showed a similar pattern where it was focused on noncommunicable diseases and mental health,[43] while resolution 80/265 addressed disease driven by social determinants of health[44] and resolution 80/268 concerned HIV/AIDS.[45] These are important global health priorities, but high-consequence epidemic preparedness received limited attention once it was no longer dominating headlines.

The General Assembly can establish political expectations and financing initiatives; however, the resolutions generally depend on Member States for implementations and this is the central institutional problem. Preparedness is politically difficult because its success is invisible and governments are asked to spend a large amount of money to prevent a disaster that may never occur during the current administration. Along with this, states are also scared of losing control over sensitive health data or allowing an international organization to judge their domestic performance and the world repeatedly spends enormous sums after outbreaks become emergencies while underinvesting in the quieter systems that could have stopped them earlier.

One piece of the Pandemic Agreement is still unfinished. The annex on Pathogen Access and Benefit-Sharing (PABS), which would set rules for sharing virus samples and the vaccines developed from them, is still under negotiation. The agreement cannot open for signature until it is adopted.[46] For a disease like Bundibugyo Ebola, the outcome will decide whether African countries that share virus samples are guaranteed access to the resulting vaccines.

[41] WHO. 2025a. 'Amended International Health Regulations Enter into Force', WHO, 19 September 2025, https://www.who.int/news/item/19-09-2025-amended-international-health-regulations-enter-into-force
[42] WHO. 2025c. 'World Health Assembly Adopts Historic Pandemic Agreement to Make the World More Equitable and Safer from Future Pandemics', WHO, 20 May 2025, https://www.who.int/news/item/20-05-2025-world-health-assembly-adopts-historic-pandemic-agreement-to-make-the-world-more-equitable-and-safer-from-future-pandemics
[43] UNGA. 2025b. 'Political Declaration of the Fourth High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases and the Promotion of Mental Health and Well-Being', A/RES/80/117, New York: United Nations, 18 December 2025, https://undocs.org/A/RES/80/117
[44] UNGA. 2026a. 'Global Health and Foreign Policy: Accelerating the Fight against Diseases Driven by Social Determinants of Health', A/RES/80/265, New York: United Nations, 4 June 2026, https://undocs.org/A/RES/80/265
[45] UNGA. 2026b. 'Political Declaration on HIV/AIDS: United to End AIDS by 2030', A/RES/80/268, New York: United Nations, 23 June 2026, https://undocs.org/A/RES/80/268
[46] WHO. 2026d. 'WHO Member States Agree to Extend Negotiations on Pathogen Access and Benefit-Sharing Annex', WHO, 1 May 2026, https://www.who.int/news/item/01-05-2026-who-member-states-agree-to-extend-negotiations-on-pathogen-access-and-benefit-sharing-annex

Landmark UN Resolutions

- *Security Council Resolution 2177 (18 September 2014).* Declared the West African Ebola outbreak a threat to international peace and security, the first time the Council had done so for a disease outbreak. Adopted unanimously, with 134 co-sponsors.[47]
- *General Assembly Resolution 69/1 (19 September 2014).* Welcomed the creation of UNMEER and called for a coordinated, system-wide UN response. Adopted without a vote.[48]
- *Security Council Resolution 2286 (3 May 2016).* Condemned attacks on medical personnel and facilities in armed conflict and demanded that all parties protect them. Adopted unanimously.[49]
- *Security Council Resolution 2439 (30 October 2018).* Called for an end to hostilities in the eastern DRC and for safe, unhindered access for Ebola responders. Adopted unanimously.[50]
- *World Health Assembly amendments to the International Health Regulations (1 June 2024).* Created the new "pandemic emergency" category and required National IHR Authorities. Adopted by consensus; most provisions entered into force on 19 September 2025. The United States formally rejected the amendments.[51]
- *World Health Assembly adoption of the WHO Pandemic Agreement (20 May 2025).* Set out commitments on prevention, preparedness and equitable access while preserving national sovereignty. Approved in committee by 124 votes to none, with 11 abstentions, then adopted by the Assembly.[52]
- *WHO declaration of a PHEIC for Bundibugyo Ebola (17 May 2026).* The third Ebola PHEIC. Temporary recommendations were reissued after the second Emergency Committee meeting in August 2026.[53]

Country and Bloc Positions

African Union (AU): The African Union (AU) promotes sovereign equality among its 55 Member States. The AU takes very general positions on major international issues like governance, peacebuilding and development. AU resolutions tend to stress general principles, relevant to all of its Member States. It occasionally gets involved in regional conflicts, even authorizing peacekeeping missions, but not consistently.

Member States of the African Union are committed to the UN's Sustainable Development Goals and the African Union's Agenda 2063, their 'blueprint and master plan for transforming Africa into the global powerhouse of the future.' They generally see all issues before the UN in terms of those priorities. Also important are the anti-colonial priorities of the Non-Aligned Movement. African countries generally welcome foreign development assistance, but increasingly demand sovereign national control over specific projects, a demand that often creates tension with would-be

[47] UNSC. n.d. S/RES/2177.
[48] UNGA. n.d. A/RES/69/1.
[49] UNSC. n.d. S/RES/2286.
[50] UNSC. n.d. S/RES/2439.
[51] WHO. 2024b. 'World Health Assembly Agreement Reached on Wide-Ranging, Decisive Package of Amendments to Improve the International Health Regulations', WHO, 1 June 2024, https://www.who.int/news/item/01-06-2024-world-health-assembly-agreement-reached-on-wide-ranging--decisive-package-of-amendments-to-improve-the-international-health-regulations--and-sets-date-for-finalizing-negotiations-on-a-proposed-pandemic-agreement
[52] WHO, 'World Health Assembly Adopts Historic Pandemic Agreement'.
[53] WHO. 2026c. 'First Meeting of the IHR Emergency Committee regarding the Epidemic of Ebola Bundibugyo Virus Disease in the Democratic Republic of the Congo and Uganda 2026', WHO, 22 May 2026, https://www.who.int/news/item/22-05-2026-first-meeting-of-the-ihr-emergency-committee-regarding-the-epidemic-of-ebola-bundibugyo-virus-disease-in-the-democratic-republic-of-the-congo-and-uganda-2026-temporary-recommendations

donors, who have their own priorities, especially regarding democratization and accountability.

Above all, the member states of the AU work to ensure African voices are an important part of all UN decisions. Like the Arab League, the African Union leaves actual policy-making up to its Member States. On most issues, each state's parallel membership in the Non-Aligned Movement (below) also can be a reliable guide to their positions.

Africa CDC, launched by the African Union in 2017, is now a co-leader of the Ebola response, not a junior partner. It declared a continental emergency in 2026, co-wrote the continental plan with WHO and is helping coordinate funding.[54] The African Union wants Africa to control its own health security, including producing 60 percent of the vaccines it uses by 2040, and supports the 2023 Lusaka Agenda, which calls on donors to fund African priorities through African institutions. **Assessment:** doing more than ever, and growing in influence, but still dependent on outside money.

Arab League: Because of sharp differences among its 22 Member States, the Arab League tends to act cautiously on all matters. Member States tend to be strongly committed to multilateral diplomacy, but restrained by divisive national interests.

There are sharp disagreements between Islamist and more secular governments, between Shi'ite dominated Iraq and other Sunni dominated countries, and disputes over influence such between Saudi Arabia and the United Arab Emirates. On divisive and controversial issues the Arab League is especially likely to leave policy-making up to each of its Member States, who are free to pursue their own distinctive policies.

The biggest exception is any issue relevant to Palestine, on which it is more unified, especially regarding criticism of Israel. Arab League states are likely to see debate on almost any issue in terms relevant to their support for Palestine. On most other issues, each state's parallel membership in the Non-Aligned Movement (below) can be a more reliable guide to their national positions.

China: While others are reducing their reliance on the UN, China is increasing its UN engagement. For China, the great appeal is the UN Charter's emphasis on national sovereign equality, which China sees as supporting its authority at home, and facilitating working with other countries as legal equals. China supports goals established by the UN. It supports international institutions. In the UN, China emphasizes solidarity with the Global South and the member states of the Non-Aligned Movement. China stresses the UN as a tool for increasing its influence over global values, a key element in its campaign to make the world more like China itself.

China examines all proposals to be certain they cannot infringe its sovereignty. It rejects proposals that limit its freedom of action. China defends the sovereignty of all countries, fearful that any chip in the wall of state sovereignty and control could create a precedent that might someday be used against China.

In 2026. China's National Health Commission sent a first team of medical experts to the DRC on 2 June, two weeks after WHO declared the emergency. Its stated task was to share experience and help the DRC strengthen prevention, control and treatment.[55] A third team arrived in August, along with emergency supplies.[56] China has not announced large financial pledges comparable to those of the United States or Europe, preferring to send people and goods directly to the DRC government.

[54] Africa CDC. 2026. 'African Leaders Mobilise Funding'.
[55] National Health Commission, 'China to Send Medical Expert Team'.
[56] Belt and Road Portal, 'China's Third Medical Expert Team Arrives in DR Congo to Support Ebola Response', August 2026, https://eng.yidaiyilu.gov.cn/p/0HRKIQ2O.html

At the UN. China supports WHO's central role, voted for the Pandemic Agreement and presents itself as a partner of the Global South. It defends national sovereignty firmly, a position shaped partly by the dispute over investigating the origins of COVID-19, and opposes outside investigations without government consent. China also has large economic interests in the DRC, where Chinese companies control much of the country's cobalt and copper mining. That gives Beijing a direct stake in stability in the country, though the mines are far from the outbreak zone.

European Union: For the 27 Member States of the EU, multilateral politics always is primarily about universal values, ideas that apply to all states equally. EU Member States can be expected to stress an approach that serves the entire international community, not the interests of any particular state, with all countries working toward agreed goals and standards. It often is the most visionary of actors within the UN system. The European Union also is the most generous funder of global development projects, offering grants or subsidized, low-interest loans for major initiatives.

But even the European Union is not as generous as it used to be. Aid money is going down, as it switches funding to national security. And European aid is highly conditional, with careful oversight to ensure it is spent as planned, efficiently, without fraud. Many EU donor states also make their aid conditional on basic national goals, including strengthening democratic government, rule of law, respect for minorities and equal rights for women.

European Union member states are committed to multilateral decision-making, but will work for their distinct national interests. For example, they a UN declaration pledging international collaboration preparing for and responding to pandemics, because its language on vaccinations threatened to undermine the copyrights of European pharmaceutical firms. Unlike the United States, the EU supported the multilateral goals, but it insisted that intellectual property rights be respected.

In 2026. The EU's response has been broad and largely multilateral. By June, Team Europe had committed more than €260 million directly.[57] This included more than €210 million in humanitarian and outbreak aid, a further €15 million in emergency humanitarian funding, and support for surveillance through Africa CDC and WHO. The EU Humanitarian Air Bridge flew 11 flights carrying more than 860 tonnes of supplies to Bunia, Goma and Juba.[58] The EU Health Task Force sent experts to support Africa CDC and teams in the DRC and South Sudan. The EU also committed up to €73.7 million to CEPI for vaccine research and is building a European reserve of experimental filovirus vaccines.[59] European hospitals have treated evacuated aid workers.

At the UN. The EU strongly supports WHO, the 2024 IHR amendments and the Pandemic Agreement. It generally favors stronger rules on reporting and transparency, combined with long-term preparedness funding for lower-income countries. France holds the pen on DRC resolutions in the Security Council, which gives Europe extra influence over any Council text on the eastern DRC.

Non-Aligned Movement: The 120 Member States and 18 Observer states of the NAM, the UN's dominant voting bloc, are primarily interested in issues that serve their needs as developing economies and post-colonial states. They seek to reduce poverty and demand faster economic development. The NAM generally supports universal values, such as Chinese or EU efforts to create global standards on these issues.

[57] EC. 2026. 'EU Response to Ebola Bundibugyo Outbreak', factsheet, June 2026, https://health.ec.europa.eu/document/download/8ea2332b-c2c1-4210-a744-dd9779ca36e0_en
[58] EC. 2026. 'EU Response to Ebola Bundibugyo Outbreak'.
[59] Ibid.

Most are post-colonial states, demanding compensation for past colonial rule.

Where the NAM departs from the EU and other advocates of multilateral action, is on funding and national control. Although many of its members are not poor—its membership includes wealthy oil exporters—the NAM routinely demands that any proposal for action come with increases in foreign aid from wealthier countries, especially Western donors.

While the NAM welcome foreign funding, they resist the oversight and control that normally comes with it. Donor countries may offer assistance, but will make it conditional. Such oversight—whether intended to ensure progress toward program goals, to prevent fraud, or the direct investment back to the countries volunteering the money—is seen by NAM members as a threat to their national sovereignty. They welcome the money, in other words, but not the oversight. This sets up a confrontation, a diplomatic challenge, as sides struggle to advance their rival goals.

Russian Federation: Outside the Security Council, Russia can be an unpredictable actor in UN bodies. Its primary goal in all UN fora is insulating Russian freedom of action in its war with Ukraine, the Special Military Operation, to ensure other issues cannot become a wedge allowing discussion of the war or its effects.

Russia's general goal at the UN is defeat of the West, meaning Europe, Japan, the United States and other English-speaking democracies. In the words of Foreign Minister Sergei Lavrov, 'The Western minority, which dominated for 500 years thanks to others' resources, continues to try to maintain its privileges and impose its own rules on everyone else.' Quoting President Vladimir V. Putin, he asserted that 'the dictatorship of one hegemon is spiraling out of control – it's dangerous for everyone else'.

Russia usually votes with the Non-Aligned Movement. It can rely on support from socialist countries like Cuba, Nicaragua, Venezuela and sometimes Vietnam. South Africa and African countries that depend on Russian military help also can be sympathetic.

In 2026. In late May, Health Minister Mikhail Murashko said Russian scientists had developed a vaccine against the Bundibugyo species and that he had discussed supplying it with WHO Director-General Tedros. Rospotrebnadzor said it would send specialists and diagnostic tests to Africa.[60] No published trial data showed that the Russian vaccine works against Bundibugyo, and Russia has not announced financial pledges of the size made by Western donors. Its role in the 2026 response has been small, focused on offers of technology and expertise.

At the UN. Russia supports cooperation through WHO but emphasizes state sovereignty, opposes verification without government consent and criticizes what it describes as Western control of global health institutions and funding. It has expanded its political, military and economic ties in Africa in recent years and uses health cooperation to build goodwill with African governments.

United Kingdom: The United Kingdom led the international response in Sierra Leone during the 2014–2016 epidemic, sending military medical staff and building treatment centres. British universities are leaders in vaccine research: the University of Oxford developed the AstraZeneca COVID-19 vaccine.

In 2026. The UK pledged up to £20 million in May[61] and raised its total to more than $100 million by late September, one of the largest contributions after the United States and the EU.[62] On 13 July, Oxford began the first human trial of a Bundibugyo-specific vaccine, ChAdOx1 BDBV,

[60] GxP News, 'Russia Offers Vaccines and Diagnostic Tools to DRC and Uganda amid Ebola Emergency', May 2026, https://gxpnews.net/en/2026/05/russia-offers-vaccines-and-diagnostic-tools-to-drc-and-uganda-amid-ebola-emergency/
[61] Reuters, 'UK Commits £20 Million to Contain Ebola Outbreak in DRC', Free Malaysia Today, 21 May 2026, https://www.freemalaysiatoday.com/category/world/2026/05/21/uk-commits-20mil-to-contain-ebola-outbreak-in-drc

with 50 volunteers. The vaccine uses the same technology as the Oxford COVID-19 vaccine, the doses were made by the Serum Institute of India, and CEPI is funding the work.[63]

At the UN. The UK supports WHO and the Pandemic Agreement but, like the EU, prefers voluntary funding to new mandatory contributions. As a permanent member of the Security Council, it has backed every Council resolution on Ebola.

United States: The United States works to minimize the role of the UN in all international issues. Cutting UN budgets is a prominent American goal, applied to any issue. Expect American diplomats to emphasize reducing the cost and impact of any UN initiative. The ideal UN initiative, from their perspective, allows each Member State to do as they please.

Under President Trump, the United States rejects core values of the UN Charter, stressing instead the sovereign right to maximize American power. In the President's words, 'The United Nations has great, great potential. I've said that for many years, but it must stop imposing the far left agenda of globalist bureaucrats who nobody ever elected.' The American approach gets international support from conservative governments in countries like Argentina, Colombia, El Salvador, Ecuador, Israel, and Serbia and sometimes from heavily dependent countries like Estonia, Georgia, Lithuania, Moldova and Ukraine. Sometimes the Russian Federation will support the United States on specific issues.

A major United States goal is defeating initiatives it associates with Diversity, Equality and Inclusion (DEI, or *wokeness*), usually meaning support for previously marginalized social groups, including women, ethnic minorities, gender minorities, etcetera. U.S. officials at the UN also oppose resolutions that appear to help marginalized groups.

American UN diplomacy often is very personal, stressing measures to enhance the personal wealth of President Donald Trump, his family and friends. The United States generally prefers working with authoritarian leaders, who usually are more responsive than democracies. A real estate deal with the President's family, involving territory in a host country, might bring American support on other issues. US leaders also value money-making opportunities through cryptocurrency deals and control over oil and mining.

The United States led the global response to the West African epidemic. It deployed about 3,000 military personnel to Liberia, and USAID and the U.S. Centers for Disease Control and Prevention (CDC) ran much of the international effort. It led the response again in the eastern DRC in 2018–2020.

In 2026. The U.S. position is the most consequential and the most contradictory. The United States has left WHO, rejected the 2024 IHR amendments and closed USAID. It has imposed entry bans on travelers from the DRC, South Sudan and Uganda, against WHO advice. It has also refused to bring exposed American aid workers home, setting up a quarantine site for them at a military base in Kenya, and in July it barred U.S. citizens who had been in the DRC within 21 days from boarding flights home.[64] Aid groups report that these rules have sharply reduced the number of American volunteers: at Samaritan's Purse treatment centres, Americans fell from about 80 percent of staff to about 20 percent.[65]

Yet the United States remains by far the largest single funder. The State Department had committed $887 million in direct assistance by

[62] U.S. Department of State, 'G20 Chair's Statement'.
[63] ARY News, 'UK Begins First Human Trial'.
[64] Reuters, 'How Trump's America First Policy Hit the Ebola Response in Congo', Daily Monitor, October 2026, https://monitor.co.ug/uganda/news/how-trump-s-america-first-policy-hit-the-ebola-response-in-congo-5622504
[65] Reuters, 'How Trump's America First Policy Hit the Ebola Response'.

late September, mostly through non-governmental organizations, and gave $50 million to CEPI for vaccine research. More than 120 CDC staff are working in the DRC and Uganda. As G20 president, Washington hosted a ministerial meeting on 30 September that raised more than $470 million in new pledges.[66] The White House has asked Congress for a further $1.4 billion, but the bill has stalled.[67]

What to expect. U.S. delegates are likely to support practical measures they can fund directly, such as treatment units, burial teams and vaccine research. They will oppose language that endorses WHO's authority or the Pandemic Agreement, criticizes travel bans or creates new mandatory financial obligations. Other delegations face a real dilemma: they need U.S. money, but they disagree with much of U.S. policy.

Some Possible Proposals for Action

As sovereign countries, the Member States of the UN General Assembly are free to develop the resolutions they can agree on. In practice, this usually means uncontroversial resolutions, stressing the importance of previous agreements, encouraging cooperation, but minimizing actual commitments.

Even on a topic as dire as responding to Ebola epidemics, this remains the most likely option for the General Assembly; doing what comes easiest, minimizing disagreement and ensuring its resolutions attract support, if not enthusiasm.

But more ambitious options also can be considered. The following are meant only to guide deliberations. Delegates, representing sovereign Member States, are free to develop their own ideas.

- **Ask or demand that donor governments**—mostly in Europe and North America—make emergency Ebola epidemic assistance to affected countries unconditional. Instead of sending aid missions and aid workers, donors could be asked or told they should give all available money, human resources, supplies and equipment directly to the affected host country governments. This will reduce bureaucracy and accelerate aid delivery in emergencies. For host governments, this will assure them much greater control, enhances their national capacity building and sovereignty.

Donor governments will resist this proposal, fearing their humanitarian aid will be lost in corrupt practices, diverted for secondary goals, and do little to help victims. They may respond by threatening to reduce or end assistance programs.

- **Establish an emergency Ebola epidemic fund** to be controlled by the World Health Assembly, the decision-making body of WHO. A standing, permanent fund would guarantee resources, ensure teams of health experts, potentially train between outbreaks and deploy quickly, with host-government consent.

An emergency fund would be especially popular with the Member States of the Non-Aligned Movement, who dominate and effectively control the WHO. By shifting day-to-day control away from donor governments, this would be unpopular with the donors. They may respond by threatening to reduce or end assistance programs.

Others will worry that diverting resources permanently to Ebola response will distort global public health spending. It might mean less money to deal with other global health crises, such as Alzheimer's, cancer, malaria, plague and tuberculosis.

- **Agree to fund Ebola epidemic response preparations with long-term loans** provided at discretionary rates by donor governments. Relying on loans would reduce the financial danger of large-scale investment in Ebola preparations. Instead of taking aid money

[66] U.S. Department of State, 'G20 Chair's Statement'.
[67] Reuters, 'How Trump's America First Policy Hit the Ebola Response'.

away from other areas, difficult trade-offs could be avoided. This approach might be especially popular with donor governments, including those that are most enthusiastic about sponsoring long-term lending, led by China and Middle Eastern oil exporters.

- **Create a protected fund with an automatic trigger** that releases money as soon as WHO flags a high-risk Ebola event. How that trigger works—possibly with a triggering threshold number of infected victims, or just a statement of concern by the WHO Assembly, will determine how this actually works.
- **Declare Ebola epidemics a threat to international peace and security,** with a demand for guaranteed safe access for international health workers in affected regions, such as eastern DRC, and give international peacekeeping forces (MONUSCO) an Ebola-support role. This will be strongly supported by non-governmental organizations and local constituencies, the people most directly affected by Ebola epidemics. But it may face opposition from host governments, afraid they will lose control and influence over Ebola responses.
- **Store vaccines, diagnostics, PPE and treatments in key regions, and expand local manufacturing.**
- **Fund community health workers, local-language messaging** and safe burials, and strengthen regional information sharing.



Figure 8. *The last Ebola patient of a DRC outbreak leaves a treatment centre*

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