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Tools without trust: public health diplomacy and the 2026 Bundibugyo Ebola outbreak in East Africa

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Introduction

Public health emergencies test relationships as much as laboratories. On 15 May 2026, the Democratic Republic of the Congo (DRC) confirmed an outbreak of the *Bundibugyo virus* in Mongbwalu, Ituri Province, and the World Health Organization (WHO) declared a Public Health Emergency of International Concern (PHEIC) on 17 May [1, 2]. As of 2 September 2026, the DRC epidemic had reached 6,342 confirmed cases and 3,072 confirmed deaths [2]. Uganda, by contrast, had successfully interrupted transmission, and both the WHO and Uganda's Ministry of Health subsequently declared the outbreak over. Nevertheless, Uganda continued to face travel-related restrictions, prompting Africa CDC Director-General Jean Kaseya to call for their removal at the July 2026 African Union health summit [3]. His argument that countries should not be penalized for transparent reporting names the gap this editorial addresses. We use *public health diplomacy* narrowly: the standing legal and institutional arrangements between neighboring states and their regional blocs that let cross-border responses operate under political stress. The *trust* at stake is the Ministries of Health's confidence that transparent reporting will result in regional support rather than unilateral penalties. The expectation of rapid notification under the International Health Regulations (IHR) (2005) is not always matched by protection from its economic and political consequences. Public health diplomacy of this regional kind must be built as peacetime infrastructure, not improvised in an emergency.

This gap is legal, and its consequences extend well beyond data governance. Cross-border surveillance scholarship distinguishes four dimensions of interoperability on which such a response depends: technical, semantic, organizational, and legal [4]. In the Bundibugyo response, East Africa drew on functioning arrangements across the first three. Africa CDC's genomic platforms circulated sequences between reference laboratories [4, 5]; harmonized case definitions and open standards supported cross-border data exchange [4]; and Uganda's national Public Health Emergency Operation Centre coordinated operationally with the DRC. What is comparatively under-institutionalized is the legal layer. The existing East African Community (EAC) health sector instruments provide important mechanisms for coordination and surveillance, yet they primarily appear to rely on policy guidance and administrative cooperation rather than on enforceable sub-regional obligations governing outbreak notification, cross-border data exchange, mutual assistance, and dispute resolution during public health emergencies.

Where such arrangements are absent, the same technical capacity performs unevenly under political stress.

The collateral damage of IHR compliance is clear: transparency can carry substantial political and economic penalties. Despite Uganda's prompt reporting and effective containment, third-country quarantine mandates forced KLM to suspend Entebbe flights on 1 June 2026. This suspension occurred even as the airline conceded that the outbreak posed no direct risk [6]. The Africa CDC subsequently argued that restrictions should be evidence-based, proportionate, regularly reviewed, and that blanket measures divert movement toward informal and unmonitored routes, potentially increasing public health risks rather than reducing them [7]. Together, these developments reveal a recurring dilemma in global outbreak governance: when transparency is associated with economic or mobility penalties, incentives for timely reporting may be weakened, potentially undermining the objectives of the IHR. Public health diplomacy is therefore not supplementary to outbreak control; it is one of the conditions that enables it.

These arrangements would not, on their own, resolve every determinant of outbreak response. Financing, workforce capacity, community engagement, and biomedical countermeasure development remain decisive factors [8]. In July 2026, the Africa CDC estimated that approximately USD 1.4 billion was required for containment [9], while pledged support has been slow to arrive, and workforce disruptions have complicated response efforts in Ituri [10]. Regional legal architecture cannot substitute for these investments. It can, however, provide a more reliable framework through which they are coordinated and deployed across borders.

The Bundibugyo outbreak suggests that, in addition to persistent resource and capacity constraints, a substantial gap remains in the legal and institutional framework governing cross-border cooperation. Existing instruments, the IHR (2005), EAC Health Sector protocols, and Africa CDC's continental initiatives, provide political scaffolding, but they do not, individually, generate binding sub-regional obligations between neighboring states that are most likely to share an outbreak. An EAC Joint Operations Compact for cross-border pathogens, formalized as an amendment to existing EAC health instruments rather than as a parallel body, could close that gap: it would be triggered by notification from any EAC Ministry of Health or by a WHO PHEIC; it would be overseen by the EAC Council of Health Ministers through a dedicated Secretariat; and it would be operationalized across the four interoperability dimensions, including a no-blanket-restriction solidarity clause on early notification. Africa CDC's August 2024 mpox declaration showed that regional incentive structures can reward early notification [5]. Kaseya's Ghana appeal articulated the political imperative. If countries that comply with international reporting obligations continue to bear disproportionate costs, the credibility of the global outbreak notification system may be eroded.

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