

## Dropping the Fence: Ebola as a displaced travel risk event.

Something important has shifted in the Ebola story this week.

Until now, much of the reporting followed the familiar outbreak script, but over the past few days, the message from WHO, Africa CDC, infectious disease specialists and public-health agencies has become sharper: *the outbreak is spreading faster than containment efforts are controlling it.*

WHO Director-General Dr Tedros Ghebreyesus has issued several statements carrying essentially the same message. Africa CDC officials, CDC-linked experts and public-health physicians have too. Predictably, the media has latched onto that language and amplified it with terms like “spiralling” and “out of control”.

This week I've noticed I'm being asked the same question by people in travel and tourism:

*How serious is this?*

The answer is: Serious.

The better answer is: Serious, depending on what you are doing.

This is a major public-health event in the outbreak region. Health systems are operating amidst conflict, weak infrastructure, lack of equipment, trained staff shortages and disrupted networks. Ebola is a terrible disease. For the human communities bearing the brunt, it's more than serious.

The next question follows:

*Are travellers at risk?*

The answer is: Which travellers?

In our context, in our sector, the answer is a clear “No”. For healthcare and aid workers it's a “Yes.”

The public record is unusually clear:

**In fifty years of public records documenting Ebola outbreaks, there has never been a recorded case of a leisure traveller contracting Ebola during ordinary travel, lodge stays, wildlife viewing, conservation tourism or normal airport transit.**

*Not one.*

Every documented case of an international contracting Ebola involved doctors, nurses, direct caregivers, burial teams, patient transporters, humanitarian responders, or people working directly inside outbreak environments.

Advisories call the risk “low”, which when used for the general public, is appropriate. But in eco/safari/conservation travel we are unusual in that our context is highly constrained and extremely specific. For a foreign traveller, flying into an airport, being transferred to a park or reserve, experiencing a wildlife product and returning home, the term “low risk” is not accurate. “Low risk” implies a plausible exposure pathway. **In safari travel, there is no plausible exposure pathway at all.**

One could argue that “theoretically” anything is possible, but the historical record is clear: it has not happened.

Ebola has never been, and is not now, a risk story that is relevant to leisure travel.

But it is an impact story for public health systems, and the emotional and commercial consequences are now spilling into travel and tourism.

When this reality settles in, phrases like “outpacing containment”, “spreading faster than response”, and “emergency” sound alarmist. It even might look like the WHO is knowingly fuelling travel fear. It can be really hard to understand why there is this rhetoric when there are obvious consequences.

Why then the alarmist messaging that hurts travel?

The key is that the WHO is not speaking to safari travellers.

It is speaking to governments, funders, health ministries, outbreak-response systems and political leaders.

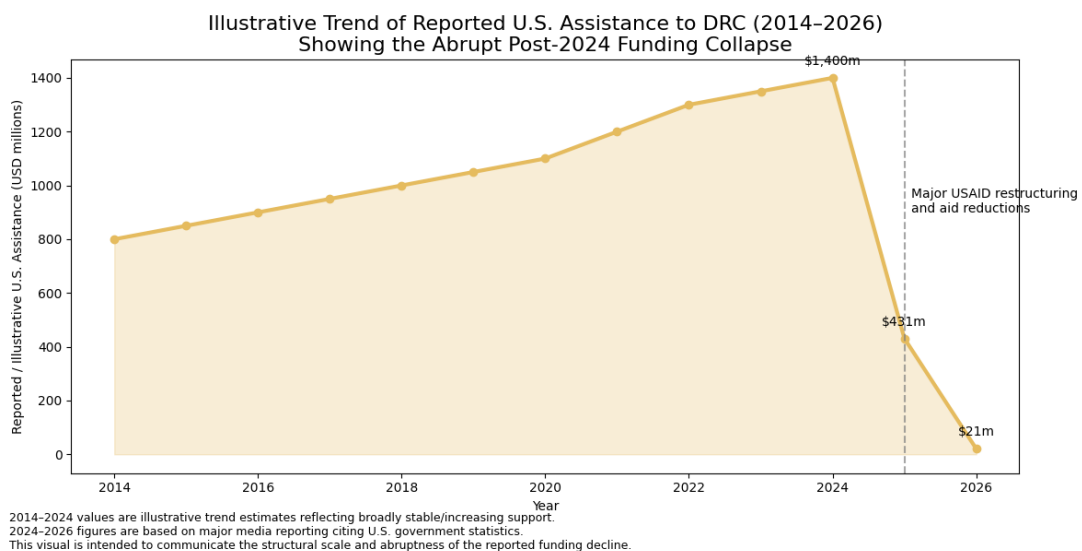
The WHO, the CDC and others don't really have much choice. They are saying what is.

The real story underneath this outbreak is the progressive dismantling of outbreak surveillance and containment infrastructure over recent years.

The USAID cuts are the most visible example, but they are not the only one. This is not simply about reducing cashflow. What's happened is dismantling systems: laboratories, field epidemiology teams, surveillance networks, logistics chains, contact tracing units, genomic sequencing capacity, coordination structures and trusted community relationships built over decades.

Public reporting has described U.S. support to DRC falling from roughly \$1.4 billion in 2023, to approximately \$21 million following cuts and restructuring.

To demonstrate, this is mathematically equivalent to cutting the budget of a 500 room resort complex and replacing it with the budget of an eight room guesthouse.



The most significant feature of this graph is the cliff face. It has been violently fast. That shock has reproduced the effect that a major war has on healthcare systems.

## What causes large outbreaks

All previous Ebola outbreaks have been small, 300 cases or less, but two were substantially bigger:

The 2014 outbreak in west Africa caused nearly 30 000 deaths. It occurred a few years after the intense decade of civil wars in Liberia and Sierra Leone during which there was near total destruction of the medical infrastructure in the region, hospitals and clinics often being deliberately targeted. Nurses and doctors were killed, or fled as refugees. At the time of the outbreak Liberia had 1 doctor per 100 000 people in the country.

The 2018 event caused around 3 500 cases, which is mainly because it broke out in an active war zone. Health workers attempted contact tracing under armed military escorts; despite this protection, dozens of healthcare workers were killed and clinics shelled or burned. A few hundred thousand people were displaced from their homes, scattering the infected sick.

In both prior events, the detection of the outbreak was delayed by about two or three months.

In the 2026 outbreak we are seeing this same perfect storm, active conflict, health system destruction, delayed detection.

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## It was predicted

The dismantling of the outbreak detection and containment infrastructure is analogous to 'dropping the fence' in conservation. It's that fence that screens, remains alert, finds new spillover events, mobilises resources, contains and extinguishes disease. It works very well. Ghebreyesus has also said, this week:

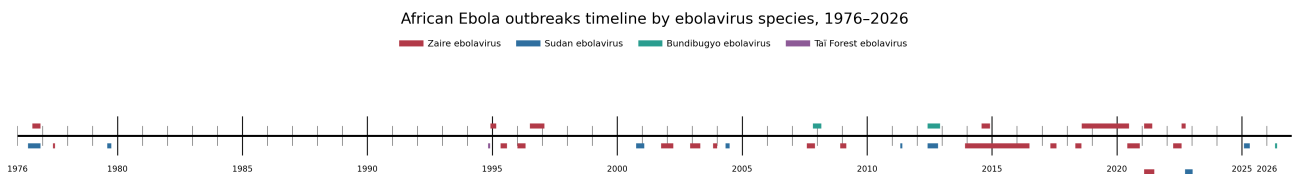
"We know how to fight this virus"

It's called "ring-fencing". A phrase so common because it's a strategy used so commonly. It's used in risk management, the financial sector - and - in Covid-19 and in the eradication of smallpox.

Of course, when the fence is removed, the next outbreak is going to run and responders are reduced to running after it to try to catch up.

A question that logically comes next is whether this could be seen as a 'calculated risk', judging that removing funding would force someone else's hand and hopefully a new fence would be erected before another outbreak occurred. If outbreaks are rare and random that could be rational.

But when the outbreaks are mapped on a timeline, it's clear they are not rare, or random. They look more like the ticking of a metronome.



Each coloured segment marks the approximate start and stop of a documented African Ebola outbreak. Colours indicate the ebolavirus species associated with the outbreak.

*So did the public health community know this would happen?*

The answer is: Yes.

There is a dense stack of warnings in the scientific literature. A handful of examples are:

1. Cavalcanti *et al.*, publishing in the Lancet under the title "Evaluating the impact of two decades of USAID interventions and projecting the effects of defunding on mortality up to 2030" projected more than **14 million additional and unnecessary deaths** by 2030, which includes **4.5 million children**.

*To quote: "Our estimates show that, unless the steep funding cuts announced and implemented in the first half of 2025 are reversed, a staggering number of avoidable deaths could occur by 2030"*

If this creates a rising feeling of anger, perhaps it should.

2. Stover *et al.* modelled the effects of collapsed disease-specific programs, showing that the effect of a sudden shock to health systems causes widespread impacts:

*"Effects of reductions in US foreign assistance on HIV, tuberculosis, family planning and maternal and child health."*

They predict, amongst other impacts, **tens of millions of additional malaria cases** annually.

3. Nature published a warning piece called:

*"It's chaos: US funding freezes are endangering global health"*

This piece also raised a warning about malaria and HIV. The reappearance of malaria statements in media is not a disconnected event. It's more evidence in the chain.

4. The title of "Abandoned in Crisis: The impact of the US Global Health Funding Cuts in the Democratic Republic of Congo" (Physicians for Human Rights, 2025), speaks volumes.

With that backdrop one might fairly argue that the WHO, the CDC and the world's global health community are exhibiting professional restraint in their statements.

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## The displaced risk irony

The original logic behind U.S. and international investment in outbreak detection and containment systems in places like DRC was not simply altruism. It was also clear systems thinking. In an interconnected world, risks do not stay politely inside national borders or even the sector that created them. A spillover event in a remote forest is a health-system risk that can impact health systems back home. The US doctrine of 'soft power' abroad is a political doctrine and a debated gain, the control of displaced risk however, is deeply rational.

The irony in this story is that it was a displaced risk policy shift, specifically the defunding of health infrastructure sufficiently rapidly to cause a health crisis, specifically a zoonotic epidemic; a health event capable of causing a media storm, which triggers a travel-confidence problem and lands an economic shock - in a sector that had nothing to do with creating the risk.

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## Where to now?

We would be prudent to expect a protracted effort and large numbers. The famous 2014 event lasted around 2.5 years. The 2018 event around 2 years. This is set up to be a marathon.

*(For comparison, the Equateur event in 2018, was contained in 2 months and 54 cases)*

For this outbreak, the uncomfortable reality is that the money almost always arrives eventually, but often only after a public crisis discourse, collateral impacts and no small chaos.

Africa CDC Director-General Dr Jean Kaseya announced this week that approximately \$480 million has been pledged toward a containment proposal that needs \$319 million. Yesterday he announced half of those pledges had been removed again. Following on he said:

***"We cannot afford to stop this outbreak without resources.. and more importantly, we cannot afford to stop this outbreak with travel restrictions that Western countries start impose on African countries."***

A final question then might be:

*Is there anything we can do about this risk?*

The answer for now, as best we can see, is "No".

The answer for the next event (ie probably next season) is "We can be better forewarned"

*And could we modify this risk in the future?*

The best answer would be that we don't yet know how to exert mitigating influence over this class of displaced risk, but if we are not aware, alert, informed - and sitting at the table - we will never find a way. If we are, then opportunities will present themselves and then one day, perhaps we will.

In effect we have enjoyed a decade of protection from a fence someone else, somewhere else, once erected. Now that it is taken down we should be asking ourselves these questions.

Ebola is containable. Ghebreyesus is not as widely quoted for this sentiment, but it is said perhaps more often: "we know this virus, and we know how to stop it."

Addressing the Congolese people prior to his arrival in Kinshasa yesterday he said:

*"16 times, this country has defeated Ebola. The 17th will be no different."*

He then quoted:

*"As President Ramaphosa said, this can only be done with unity."*



Dr Simon King