Legal Preparedness for Public Health Emergencies: Lessons from the 2026 Bundibugyo Ebola Outbreak in East Africa

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ABSTRACT

The 2026 Bundibugyo Ebola outbreak in East Africa, declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization, exposed systemic weaknesses in legal preparedness at international, regional, and domestic levels. Within weeks, over 1,000 confirmed cases were reported in the Democratic Republic of the Congo and Uganda, underscoring deficiencies in surveillance, reporting, and coordinated response, particularly in the absence of a licensed vaccine for this strain.

This paper advances a doctrinal and policy analysis of legal preparedness, interrogating the adequacy of the International Health Regulations (2005), the fragmented domestic statutes of East African states, and the limited enforceability of regional frameworks under the East African Community and the African Union. It demonstrates how weak enforcement mechanisms, disparities in state capacity, and insufficient integration of human rights principles constrained effective outbreak management.

Drawing lessons from COVID-19, the study highlights continuity in legal failures, delayed declarations, inequitable access to countermeasures, and fragmented governance that persisted during the Ebola crisis. It argues that legal preparedness must be reconceptualised as a central pillar of health security, not a peripheral concern.

The paper proposes targeted reforms: (i) embedding compliance monitoring and enforcement mechanisms within the IHR and the emerging pandemic treaty; (ii) enacting binding regional instruments to govern cross-border surveillance and emergency coordination; and (iii) modernising domestic public health legislation to align with constitutional guarantees, particularly the right to health and proportionality limits on emergency powers. By situating these reforms within comparative jurisprudence and constitutional doctrine, the study offers a normative agenda for resilient, rights-based, and enforceable legal frameworks capable of managing future public health emergencies.

INTRODUCTION

The twenty-first century has been marked by recurrent transnational public health emergencies, ranging from the Ebola outbreaks in West and Central Africa to the COVID-19 pandemic, and most recently, the 2026 Bundibugyo Ebola outbreak in East Africa. These crises have consistently tested the adequacy of legal and institutional frameworks designed to safeguard public health. While scientific advances have enhanced diagnostic and surveillance capacities, legal preparedness remains fragmented, reactive, and under-prioritised.[1]

The Bundibugyo Ebola outbreak of 2026 provides a particularly instructive case study. Confirmed in May 2026 in the Democratic Republic of the Congo (DRC) and Uganda, the outbreak rapidly spread to urban centres,

[1] O'Neill Institute for National and Global Health Law, *Strengthening Legal Capacity for Public Health Emergencies* (10 May 2024) https://oneill.law.georgetown.edu/strengthening-legal-capacity-for-public-health-emergencies/ (oneill.law.georgetown.edu in Bing) accessed 27 June 2026.

including Kampala, with more than 1,000 confirmed cases within weeks.[2] Declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO), the crisis was compounded by the absence of a licensed vaccine for the Bundibugyo strain, necessitating reliance on legal containment measures such as quarantine, surveillance, and movement restrictions.[3]

This paper advances the central argument that the 2026 outbreak exposed structural deficiencies in legal preparedness across international, regional, and domestic levels. These deficiencies are rooted not only in normative gaps within instruments such as the International Health Regulations (2005) (IHR), but also in weak institutional capacity, fragmented governance, and insufficient integration of human rights principles.[4] By adopting a doctrinal analytical approach, supplemented by comparative and policy analysis, the study seeks to contribute to ongoing debates on strengthening legal frameworks for global health security.

Conceptualising Legal Preparedness in Global Health Law

Legal preparedness has emerged as a central yet underdeveloped pillar of global health governance. It refers to the existence, coherence, and effective implementation of legal frameworks that enable states to prevent, detect, and respond to public health threats. This encompasses statutory provisions, regulatory mandates, institutional capacity, and enforcement mechanisms.[5]

Historically, legal preparedness has been reactive, often receiving attention only during or immediately after crises.[6] This reactive posture undermines timely response, coordination, and public trust. The Bundibugyo Ebola outbreak of 2026 exemplifies this weakness: despite binding obligations under the International Health Regulations (2005), delays in detection and reporting revealed the fragility of legal systems when confronted with fast-moving emergencies.[7]

Doctrinally, legal preparedness can be situated within the broader framework of global administrative law and international regulatory governance. The IHR, adopted under Article 21 of the WHO Constitution, represent the principal multilateral instrument governing cross-border health threats.[8] Yet their normative strength is undermined by weak enforcement mechanisms and disparities in state capacity. Unlike trade or security regimes, global health law lacks robust compliance structures, leaving implementation dependent on political will.

Thus, legal preparedness must be conceived as a dual construct: normatively, it requires coherent and enforceable legal rules; functionally, it demands institutions capable of operationalising those rules with speed and legitimacy. The Bundibugyo Ebola outbreak revealed the failure to align these dimensions, exposing the fragility of current frameworks. This doctrinal insight provides the foundation for the subsequent critique of the International Health Regulations (2005), where questions of normative strength and structural limitations become most apparent.

The International Health Regulations (2005): Doctrinal Strength and Structural Limitations

The International Health Regulations (2005) (IHR) constitute the principal legal framework governing public health emergencies of international concern. Binding on 196 States Parties, they impose obligations to develop minimum core capacities for surveillance, reporting, and response, including the duty to notify the WHO of events that may constitute a PHEIC.[9] The Regulations were designed to balance public health protection with

[2] Centers for Disease Control and Prevention, 'Ebola Outbreak: Current Situation' (26 June 2026) https://www.cdc.gov/ebola/situation-summary/index.html (cdc.gov in Bing) accessed 27 June 2026.
[3] World Health Organization, 'Ebola Outbreak – Democratic Republic of the Congo, 2026' (2026) https://www.who.int/emergencies/situations/ebola-outbreak---drc-2026 (who.int in Bing) accessed 27 June 2026.
[4] World Health Organization, *International Health Regulations (2005)* (3rd edn, WHO 2016).
[5] O'Neill Institute for National and Global Health Law, *Strengthening Legal Capacity for Public Health Emergencies* (10 May 2024).
[6] Ibid.
[7] Centers for Disease Control and Prevention, 'Ebola Outbreak: Current Situation' (26 June 2026)
[8] World Health Organization, *International Health Regulations (2005)* (3rd edn, WHO 2016).
[9] Ibid

minimal interference in international traffic and trade, reflecting the tension between state sovereignty and collective responsibility.[10]

Enforcement Deficits

Yet, doctrinal analysis reveals that structural weaknesses undermine the IHR's normative strength. First, enforcement deficits: unlike trade or security regimes, the IHR lacks sanctioning mechanisms. Compliance depends on political will and peer pressure, leaving states free to delay reporting or underinvest in preparedness without consequence.[11] The Bundibugyo outbreak illustrated this vividly, with delays in detection and inconsistent cross-border coordination despite binding obligations.

Inequality and Differential Capacity

Second, inequality and differential capacity: the IHR imposes uniform obligations on states with vastly unequal resources. The WHO's 2026 health statistics underscore persistent disparities in access to healthcare and surveillance infrastructure.[12] This doctrinal flaw, which imposes equal duties without accounting for unequal capacities, renders compliance aspirational rather than enforceable.

Functional Misalignment

Third, functional misalignment: while the IHR provides normative rules, they fail to ensure institutional functionality. States often lack the administrative, financial, and technical capacity to operationalise obligations. The Bundibugyo outbreak demonstrated how weak health systems and fragmented governance structures undermine the functional dimension of preparedness.

Thus, while the IHR remain the cornerstone of global health law, their doctrinal limitations, absence of enforcement, disregard for inequality, and failure to bridge normative and functional dimensions make them ill-suited to regulate fast-moving crises. The Bundibugyo outbreak confirms that without reform, the IHR risks remaining a symbolic framework rather than an effective instrument of global health security.

Domestic Legal Frameworks in East Africa: Fragmentation and Constitutional Gaps.

Domestic legal preparedness in East Africa remains characterised by fragmentation, inconsistency, and outdated statutory regimes. While most states maintain public health statutes, these laws often lack clarity on emergency powers, coordination mechanisms, and accountability structures.[13] The Bundibugyo outbreak revealed how such deficiencies undermine rapid and legitimate responses.

Doctrinally, the weakness lies in the absence of integrated emergency legislation. Many frameworks fail to define the legal threshold for declaring a public health emergency, the scope and limits of executive powers, or mechanisms for inter-agency coordination.[14] This normative vagueness creates uncertainty, allowing discretionary and sometimes arbitrary measures that risk violating constitutional rights.

Constitutional jurisprudence underscores the problem. In Kenya, Article 43(1)(a) guarantees the right to the highest attainable standard of health, transforming preparedness from a policy aspiration into a justiciable duty.[15] Yet outdated statutes fail to operationalise this constitutional guarantee, leaving gaps between rights and enforceable obligations. Similarly, Article 24 of the Constitution of Kenya requires that any limitation of rights be lawful, reasonable, and proportionate.[16] Emergency measures such as quarantine and movement restrictions

[10] Ibid
[11] O'Neill Institute for National and Global Health Law, *Strengthening Legal Capacity for Public Health Emergencies* (2024)
[12] World Health Organization, *World Health Statistics 2026: Monitoring Health for the SDGs* (WHO 2026).
[13] WHO, *Ebola Outbreak – Democratic Republic of the Congo, 2026* (2026).
[14] O'Neill Institute for National and Global Health Law, *Strengthening Legal Capacity for Public Health Emergencies* (2024).
[15] Constitution of Kenya, 2010 Article 43(1)(a).
[16] Constitution of Kenya, 2010 Article 24.

during Bundibugyo were often imposed without clear statutory safeguards, raising questions of legality and proportionality.

Comparative jurisprudence reinforces this critique. In *Coalition for Reform and Democracy (CORD) v Republic of Kenya*,[17] the High Court held that national security and public interest cannot justify arbitrary limitations of rights without satisfying constitutional criteria. This principle applies directly to public health emergencies, where extraordinary powers must remain subject to constitutional discipline.

Thus, domestic legal frameworks in East Africa suffer from doctrinal fragmentation and constitutional gaps. Without modernised, rights-anchored statutes, states remain ill-equipped to manage emergencies in a manner that is both effective and legitimate. The Bundibugyo outbreak demonstrates the urgent need for harmonised, constitutionally grounded legislation that bridges normative obligations with functional capacity.

Regional Governance and Coordination: Declaratory Norms and the Case for Binding Obligations.

Regional organisations such as the East African Community (EAC) and the African Union (AU) occupy a critical intermediate space between global norms and domestic implementation. Their role in facilitating cross-border cooperation is indispensable, particularly in outbreaks that transcend national boundaries. Yet doctrinal analysis reveals that their legal frameworks remain largely declaratory, lacking binding obligations or enforcement mechanisms.[18]

The Bundibugyo Ebola outbreak exposed this weakness. Fragmentation of regional regimes contributed to delays in coordinated action, as member states relied on divergent national statutes rather than harmonised regional standards.[19]The absence of binding instruments governing surveillance, data sharing, and emergency coordination meant that regional institutions could issue recommendations but not compel compliance.

Doctrinally, this reflects a structural flaw: regional health law has remained aspirational, privileging political consensus over enforceable legal duties. Unlike regional trade or security regimes, which often embed binding obligations and dispute resolution mechanisms, public health law in East Africa has been relegated to soft law declarations. This imbalance undermines collective security in precisely the domain where cross-border solidarity is most essential.

The normative agenda must therefore prioritise the development of binding regional instruments. Such frameworks should establish enforceable obligations for cross-border surveillance, mutual assistance, and coordinated emergency response.[20]In addition, regional public health authorities with defined legal mandates should be institutionalised, empowered to coordinate member state responses and allocate resources. Without such reforms, regional governance will remain reactive and fragmented, perpetuating the deficiencies revealed during Bundibugyo.

Human Rights and Public Health Measures: Doctrinal Balancing of Necessity and Proportionality.

Public health emergencies present a fundamental tension between collective security and individual rights. Measures such as quarantine, travel restrictions, and surveillance inevitably interfere with rights to liberty, movement, and privacy. The International Health Regulations (2005) explicitly require that public health measures respect human dignity, human rights, and fundamental freedoms.[21] Yet doctrinal analysis reveals that their application during the Bundibugyo outbreak was inconsistent and often disproportionate.

Restrictive measures disproportionately affected vulnerable populations, including informal workers and displaced communities.[22] This raises critical legal questions regarding proportionality and necessity. Under

[17] *Coalition for Reform and Democracy (CORD) v Republic of Kenya* [2015] eKLR.
[18] African Union, *Africa Health Strategy 2016–2030* (AU, 2016).
[19] WHO, *Ebola Outbreak – Democratic Republic of the Congo, 2026* (2026).
[20] O'Neill Institute for National and Global Health Law, *Strengthening Legal Capacity for Public Health Emergencies* (2024)
[21] WHO, *International Health Regulations (2005)* (3rd edn, WHO 2016).
[22] WHO, *Ebola Outbreak – Democratic Republic of the Congo, 2026* (2026).

international human rights law, limitations on rights must satisfy established criteria: legality, legitimacy, necessity, and proportionality.[23] In practice, however, many emergency measures lacked clear statutory authority, were imposed broadly without tailoring, and failed to demonstrate that less restrictive alternatives had been considered.

Constitutional jurisprudence in East Africa reinforces this doctrinal critique. Article 24 of the Constitution of Kenya requires that any limitation of rights be lawful, reasonable, and justifiable in an open and democratic society.[24] The High Court in *Coalition for Reform and Democracy (CORD) v Republic of Kenya* affirmed that public interest objectives cannot justify arbitrary limitations without satisfying proportionality standards.[25] Applied to Bundibugyo, this principle underscores that extraordinary measures such as quarantine must remain subject to constitutional discipline.

Comparative jurisprudence provides further guidance. The South African Constitutional Court in *Minister of Health v Treatment Action Campaign* held that the right to health imposes positive obligations on the state to take reasonable measures to ensure access to healthcare services.[26] This case illustrates that rights-based approaches enhance legitimacy and compliance, strengthening rather than undermining public health outcomes.

Thus, doctrinal balancing reveals that effective legal preparedness requires embedding human rights safeguards into emergency measures. Without adherence to proportionality and necessity standards, public health law risks eroding legitimacy, undermining compliance, and ultimately weakening outbreak response.

Lessons from COVID-19: Continuity of Doctrinal Failures.

The COVID-19 pandemic exposed profound weaknesses in global health law, many of which persisted during the Bundibugyo Ebola outbreak. These include delays in emergency declarations, inequitable access to vaccines and countermeasures, and fragmented governance structures.[27]The recurrence of these failures in 2026 demonstrates that global health law has not successfully institutionalised lessons from prior crises.

Doctrinally, this continuity reflects three structural failures. *First,* enforcement: both COVID-19 and Bundibugyo revealed the inability of the International Health Regulations (2005) to compel compliance, leaving states free to delay reporting or under-invest in preparedness.[28] *Second,* equity: inequitable access to vaccines during COVID-19 was mirrored in Bundibugyo by the absence of a licensed vaccine, with no binding mechanisms to ensure equitable distribution of countermeasures. *Third,* governance: fragmented coordination during COVID-19 re-emerged in Bundibugyo, with weak cross-border cooperation and limited regional harmonisation.[29]

This doctrinal continuity underscores a broader failure of global governance: the inability to translate empirical experience into binding reform. The persistence of identical legal deficiencies across successive crises suggests that global health law remains reactive, aspirational, and structurally incapable of learning. Unless reform embeds enforceable obligations, equity mechanisms, and coordinated governance structures, future emergencies will reproduce the same failures.

Emerging Health Risks and the Future of Legal Preparedness: Doctrinal Stress-Tests.

Legal preparedness must be adaptive to emerging risks. Climate change, conflict, and displacement are not peripheral concerns but doctrinal stress-tests for existing frameworks. They reveal whether legal regimes can withstand complex, multi-layered pressures that exacerbate disease transmission.

[23] International Covenant on Civil and Political Rights, Article 4
[24] Constitution of Kenya, 2010 Article 24.
[25] *Coalition for Reform and Democracy (CORD) v Republic of Kenya* [2015] eKLR
[26] *Minister of Health v Treatment Action Campaign (No 2)* 2002 (5) SA 721 (CC).
[27] O'Neill Institute for National and Global Health Law, *Strengthening Legal Capacity for Public Health Emergencies* (2024).
[28] WHO, *International Health Regulations (2005)* (3rd edn, WHO 2016).
[29] -WHO, *Ebola Outbreak – Democratic Republic of the Congo, 2026* (2026).

Climate change is increasingly recognised as a driver of zoonotic disease emergence. The World Economic Forum's 2025 report highlights the growing link between environmental change and global health risks, including Ebola.[30] Doctrinally, this raises the question: can current legal frameworks integrate environmental determinants of health into preparedness obligations? The answer, as Bundibugyo demonstrated, is limited.

Conflict and displacement further expose structural weaknesses. Gavi's 2026 analysis identifies conflict-associated outbreaks as a major global threat.[31] Yet regional and domestic laws remain ill-equipped to regulate emergency responses in fragile or conflict-affected settings. The Bundibugyo outbreak, occurring amid insecurity and humanitarian crises, revealed how legal fragmentation undermines containment.

Thus, emerging risks should not be treated as external challenges but as doctrinal tests of preparedness. A resilient legal architecture must embed forward-looking obligations: integrating climate-related health risks, codifying protections for displaced populations, and mandating adaptive governance mechanisms. Without such reforms, future emergencies will replicate Bundibugyo's failures under even more complex conditions.

Reforming Legal Preparedness: Towards a Layered Doctrinal Blueprint.

The deficiencies revealed by the Bundibugyo Ebola outbreak underscore the need to reconceptualise legal preparedness as a central pillar of global health security. Reform must move beyond incremental adjustments and embrace a layered doctrinal framework that integrates international, regional, domestic, and constitutional dimensions.

International level

At the international level, reform begins with strengthening the International Health Regulations (2005). Their binding nature is undermined by weak compliance mechanisms and reliance on state discretion. Embedding structured compliance monitoring, akin to the Universal Periodic Review in human rights law, would transform the IHR from aspirational norms into enforceable obligations.[32] Parallel negotiations for a pandemic treaty provide an opportunity to codify equity, technology transfer, and coordinated emergency response as binding duties, addressing gaps exposed by both COVID-19 and Bundibugyo.[33]

Regional level

At the regional level, the declaratory nature of EAC and AU instruments must give way to binding frameworks. Harmonised obligations on cross-border surveillance, data sharing, and emergency coordination are essential.[34] Regional public health authorities with defined mandates should be institutionalised and empowered to coordinate responses and allocate resources. This would embed collective security into regional law, reducing fragmentation and delay.

Domestic level

At the domestic level, outdated statutes must be replaced with integrated public health emergency legislation. Such laws should define thresholds for declaring emergencies, scope and limits of executive powers, mechanisms for inter-agency coordination, and accountability structures. Constitutional guarantees, such as Kenya's Article 43(1)(a) right to health and Article 24 proportionality limits, must anchor these statutes, ensuring that preparedness is both enforceable and rights-compliant.[35] Jurisprudence such as *CORD v Republic of Kenya* confirms that extraordinary powers cannot override constitutional discipline.[36]

[30] World Economic Forum, *The Top Global Health Stories from 2025* (18 December 2025).
[31] Gavi, the Vaccine Alliance, *Six Major Health Threats that Could Shape 2026* (19 February 2026).
[32] WHO, *International Health Regulations (2005)* (3rd edn, WHO 2016).
[33] O'Neill Institute for National and Global Health Law, *Strengthening Legal Capacity for Public Health Emergencies* (2024).
[34] African Union, *Africa Health Strategy 2016–2030* (AU, 2016).
[35] Constitution of Kenya, 2010 Articles 43(1)(a) and 24.
[36] *Coalition for Reform and Democracy (CORD) v Republic of Kenya* [2015] eKLR.

Rights-based approach.

A rights-based approach must permeate all levels. Comparative jurisprudence, including *Minister of Health v Treatment Action Campaign* in South Africa, illustrates how constitutional health rights impose positive obligations on states.[37] Embedding proportionality standards into emergency law enhances legitimacy, public trust, and compliance.

Financial and accountability

Finally, financing and accountability are indispensable. Without dedicated emergency funds, automatic budgetary triggers, and transparent oversight, even the most sophisticated legal frameworks remain ineffective. WHO's 2026 health statistics highlight slowing progress towards universal health coverage, underscoring the need to embed financial solidarity into law.[38]

Taken together, these reforms form a layered doctrinal blueprint: stronger international obligations, binding regional frameworks, constitutionally grounded domestic statutes, rights-based safeguards, and sustainable financing. The Bundibugyo outbreak demonstrates that only such an integrated architecture can bridge the gap between normative commitments and functional capacity, ensuring resilience in future public health emergencies.

CONCLUSION

The Bundibugyo Ebola outbreak of 2026 exposed the fragility of global health law. Despite the binding framework of the International Health Regulations (2005), enforcement deficits, inequities, and fragmented governance persisted. Regional instruments remained declaratory, domestic statutes outdated, and rights safeguards inconsistently applied.

Doctrinally, the outbreak demonstrates that preparedness cannot rest on aspirational norms. It requires enforceable international obligations, binding regional frameworks, constitutionally grounded domestic statutes, and sustainable financing. Anchoring these reforms in rights-based principles ensures both legitimacy and effectiveness.

The central lesson is clear: legal preparedness must be reconceptualised as a core pillar of health security. Without integrated reform, future emergencies will reproduce the same failures, eroding both public health outcomes and the credibility of law.

Declaration:

This manuscript is an original work of the author and has not been published elsewhere nor submitted for consideration in any other journal. All sources have been appropriately acknowledged in accordance with OSCOLA referencing standards.

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