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EDITORIAL ANALYSIS

Ebola and the Politics of Vaccines

DOWN TO EARTH

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Ebola and the Politics of Vaccines

Down to Earth 25 August 2026 GS2 GS3

INTERVIEW ANGLE

"A vaccine exists for one Ebola strain and not for the others, and the difference is not scientific difficulty but who was expected to pay. What does that tell us about how the world sets its research priorities?"

Source: Original editorial ↗ Down to Earth

Every fact web-verified against primary sources

THE LIFT LINE

The world has a vaccine for one strain of Ebola and none for the others. The difference was never laboratory difficulty. It was who was expected to buy it.

WHY THIS EDITORIAL MATTERS FOR YOUR EXAM

Global health governance, vaccine equity and the North-South distribution of research capacity are recurring GS2 themes, and this editorial supplies a case study sharper than the usual COVID-19 framing.

GS Paper 2: Important international institutions and fora; issues relating to health; effect of policies of developed countries on developing countries' interests.

GS Paper 3: Science and technology, indigenisation, intellectual property.

CONCEPT	MEANING	WHY IT IS TESTABLE
CEPI	Coalition for Epidemic Preparedness Innovations, founded 2017, funds vaccines with no commercial market	The institution created precisely to fix this failure
Advance Market Commitment	A binding promise to purchase a product at a set price if developed, creating a market that does not otherwise exist	The standard pull-incentive remedy
Pathogen access and benefit-sharing	The principle that countries supplying pathogen samples receive access to the products derived from them	The equity question at the centre of pandemic negotiations

BACKGROUND AND CONTEXT

The Disease

ATTRIBUTE	DETAIL
First identified	1976, near the Ebola River in what was then Zaire, with a simultaneous outbreak in Sudan
Species causing human disease	Zaire, Sudan, Bundibugyo, Tai Forest. The WHO notes three of these, Zaire, Sudan and Bundibugyo, cause large outbreaks; Tai Forest has caused a single documented human case
Transmission	Direct contact with body fluids of infected people or animals; suspected fruit bat reservoir
Major epidemic	West Africa, 2014-16, with over 11,000 deaths across Guinea, Liberia and Sierra Leone

The Vaccines, and the Gap

The licensed product, **rVSV-ZEBOV**, marketed as **Ervebo**, protects against the **Zaire** strain and was approved in **2019**, following the West African epidemic. A separate two-dose regimen also targets the Zaire strain.

The critical examination point: **there is no licensed vaccine against the Sudan or Bundibugyo strains**. An outbreak of either finds the world reliant on investigational products and ring-vaccination trials rather than a licensed stockpile.

The Institutions

BODY	FOUNDED	ROLE
Gavi, the Vaccine Alliance	2000, Geneva	Vaccine financing for low-income countries; maintains the global Ebola vaccine stockpile
International Coordinating Group (ICG)	Multi-agency	Manages emergency release from vaccine stockpiles
CEPI	2017, announced at Davos	Funds vaccine development against epidemic threats with no commercial market
WHO	1948	Declares Public Health Emergencies of International Concern under the International Health Regulations, 2005

THE ANALYSIS

1. The strain gap is the argument in a single fact. If the obstacle were scientific, progress would be roughly even across strains, since they are closely related viruses requiring similar platforms. Licensure against Zaire alone, with none against Sudan or Bundibugyo, points to where money was directed rather than where science was hard.

2. The successful vaccine advanced on security funding, not health funding. Development owed much to biodefence-oriented research support. That is a revealing detail: the candidate moved when a wealthy state perceived a threat to itself and stalled when the risk was framed as African. The incentive was never public health; it was self-protection, and it worked exactly as such an incentive would predict.

3. The timeline contrast is not explicable by science. COVID-19 vaccines moved from published sequence to authorisation inside a year, supported by guaranteed advance purchase agreements that removed commercial risk. Ebola, identified in **1976**, waited until **2019** for a licensed vaccine, and required an epidemic that killed over eleven thousand people to get there. The scientific platforms overlapped considerably. The financing did not.

4. The counter-argument is genuinely strong and must be engaged. Ebola outbreaks are episodic, geographically contained and involve small case numbers. Conventional randomised efficacy trials are extremely difficult to run under those conditions, which is why the ring-vaccination trial design had to be developed. Commercial development for a product that may be needed rarely, in populations that cannot pay, is not viable on ordinary terms. This is a real explanation, not an excuse.

5. But the counter-argument concedes the conclusion. If the market genuinely cannot serve diseases without markets, then relying on the market is the error. Gavi stockpiles and CEPI financing are mitigations layered on an unreformed incentive structure. They ration scarcity rather than removing it, which is why each new outbreak of an unaddressed strain reproduces the same emergency.

DATA AND INSTITUTIONS VAULT

PRELIMS-GRADE FACTS:

Ebola virus disease first identified in 1976, near the Ebola River in what was then Zaire (now the Democratic Republic of the Congo), with a simultaneous Sudan outbreak.

Four species have caused human disease: Zaire, Sudan, Bundibugyo, Tai Forest; the WHO notes only Zaire, Sudan and Bundibugyo cause large outbreaks.

rVSV-ZEBOV (Ervebo), approved 2019, protects against the Zaire strain only. No licensed vaccine exists for the Sudan or Bundibugyo strains.

West Africa epidemic, 2014-16: over 11,000 deaths across Guinea, Liberia and Sierra Leone.

Gavi, the Vaccine Alliance: founded 2000, headquartered in Geneva; maintains the global Ebola vaccine stockpile, released through the International Coordinating Group.

CEPI: founded 2017, announced at Davos.

Public Health Emergency of International Concern (PHEIC) is declared by the WHO Director-General under the International Health Regulations, 2005.

Do not write that "a vaccine for Ebola exists" without qualification. Licensure covers the **Zaire** *strain only. Also distinguish* **Gavi** *(financing and procurement of vaccines for low-income countries) from* **CEPI** *(financing vaccine research and development), and both from* **COVAX***, which was a COVID-specific allocation mechanism co-led by Gavi, CEPI and the WHO.*

THE DEBATE

FOR (the gap is a failure of political economy): Licensure against one strain and not its close relatives reflects funding, not science. The successful candidate advanced on biodefence money. COVID-19 proved that guaranteed purchase collapses development timelines, which means the timeline is a policy variable rather than a scientific constant.

AGAINST (the gap reflects epidemiological reality): Episodic outbreaks with small case numbers make efficacy trials genuinely difficult and commercial development genuinely unviable. The international system did respond after 2014-16, licensing a vaccine and building a stockpile. Attributing the delay to indifference understates a real structural problem.

Balanced verdict: The counter-argument is correct on the diagnosis and wrong on the implication. Episodic, low-volume, low-income disease burdens are exactly the category the market cannot serve, so demonstrating market failure is an argument for replacing the mechanism rather than for accepting the outcome. The reforms follow directly: advance market commitments and priority review vouchers extended to

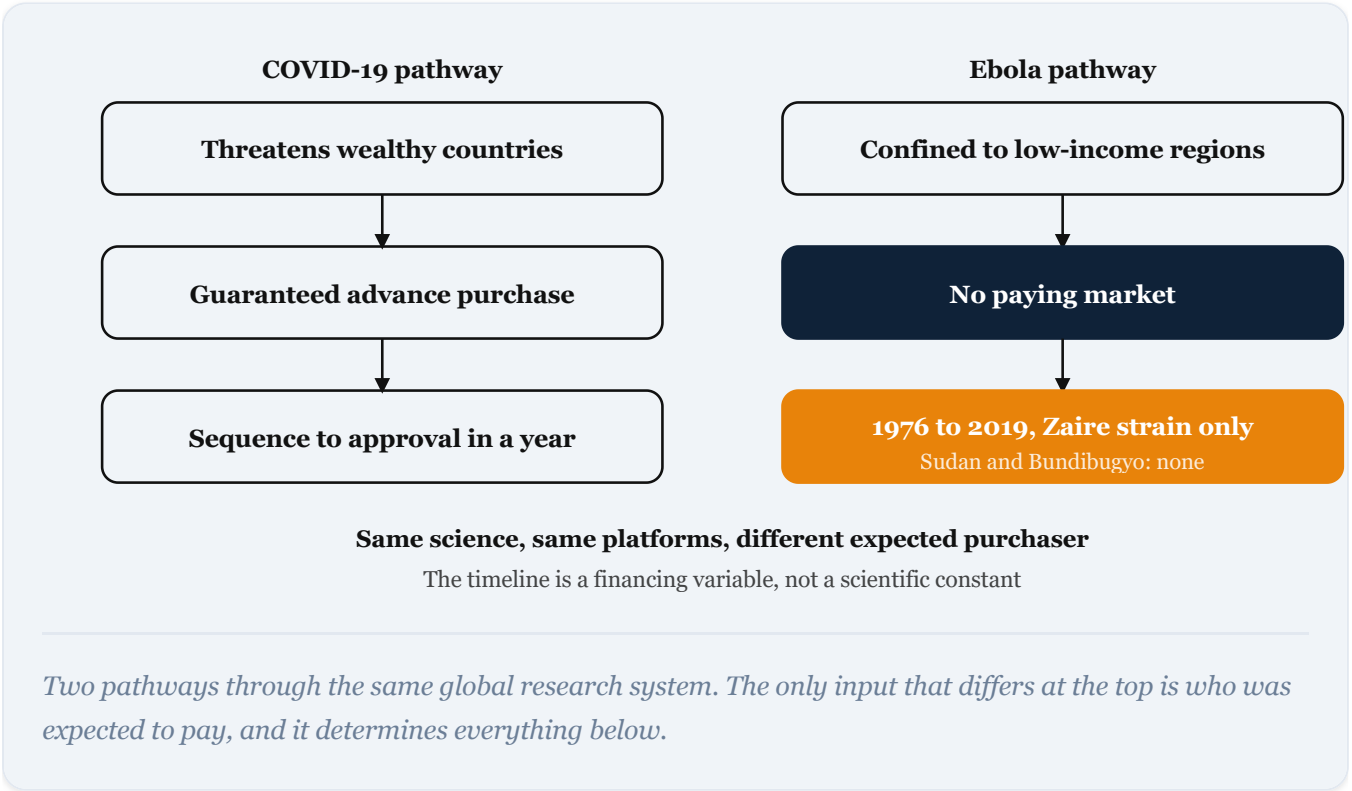
all Ebola strains, sustained CEPI financing for non-commercial candidates, **regional manufacturing capacity in Africa** so that supply does not depend entirely on externally held stockpiles, and operational **pathogen access and benefit-sharing** so that countries providing samples are guaranteed access to what is developed from them.

HOW TO THINK ABOUT THIS

When a technology exists for one variant of a problem and not for a closely related variant, the explanation is almost never technical. Compare the two cases on funding, expected purchaser and perceived threat to wealthy populations before reaching for a scientific explanation.

This diagnostic generalises well beyond vaccines. It applies to neglected tropical diseases, to antibiotic development, where the commercial return on a drug meant to be used sparingly is structurally negative, and to crop research for subsistence versus commodity crops. In each case the pattern is the same: capability is present, and the incentive to deploy it is absent. Naming that distinction precisely is what separates an analytical answer from an indignant one.

DIAGRAM-IN-WORDS



Same science, same platforms, different expected purchaser

The timeline is a financing variable, not a scientific constant

Two pathways through the same global research system. The only input that differs at the top is who was expected to pay, and it determines everything below.

TAKEAWAY BOX

The world has a vaccine for one strain of Ebola and none for the others. The difference was never laboratory difficulty. It was who was expected to buy it.

Ebola identified 1976 near the Ebola River in Zaire; four species have caused human disease (Zaire, Sudan, Bundibugyo, Tai Forest), of which three cause large outbreaks; rVSV-ZEBOV (Ervebo) approved 2019 covers the Zaire strain only; West Africa epidemic 2014-16 with over 11,000 deaths; Gavi founded 2000 in Geneva; CEPI founded 2017; PHEIC declared by the WHO Director-General under the International Health Regulations, 2005.

If a country supplies the pathogen samples from which a vaccine is developed, what claim does it have on the resulting product?

Connects to past UPSC Mains questions on global health governance, on India's role as pharmacy of the developing world, and on intellectual property and access to medicines.

"Markets allocate medical research to those who can pay, not to those who are most at risk." Critically examine with reference to vaccine development for epidemic diseases.

KEY ARGUMENTS AT A GLANCE

Writing in Down To Earth, Latha Jishnu argues that COVID-19 attracted lavish and extraordinarily rapid vaccine funding because it threatened wealthy countries, while recurring African outbreaks such as Ebola have faced decades of neglect, slow research and profit-driven delay, and that Africa's renewed exposure to the Bundibugyo strain, despite Gavi stockpile arrangements and CEPI-backed trials, shows the financing and policy gaps in global vaccine equity remain unclosed.

✓ SUPPORTING

- The one Ebola vaccine that reached licensure protects against the Zaire strain alone, so an outbreak of the Bundibugyo or Sudan strain finds the world without a licensed product, which reflects the allocation of research funding rather than any distinctive scientific obstacle.
- The vaccine that did emerge owed much of its early development to biodefence funding rather than to public health investment, meaning it advanced when a wealthy state perceived a security threat and stalled when the risk was seen as confined to Africa.
- The contrast in timelines is stark and cannot be explained by science alone, since COVID-19 vaccines moved from sequence to authorisation within a year under guaranteed advance purchase, while Ebola vaccines took decades after the virus was first identified in 1976.

⚠ COUNTER

The counter-view is that the comparison understates genuine differences: Ebola outbreaks are episodic, geographically contained and involve small case numbers, which makes conventional efficacy trials extremely difficult to run and commercial development genuinely unviable, and that the international system did in fact respond after the 2014-16 West African epidemic by licensing a vaccine and creating a global stockpile. On this reading the gap reflects epidemiological structure and trial feasibility rather than indifference.

→ WAY FORWARD

The argument implies that market-based development cannot serve diseases without markets, so the response must be structural: push and pull incentives such as advance market commitments and priority review vouchers extended to all Ebola strains, sustained CEPI financing for candidates with no commercial prospect, regional manufacturing capacity in

> Africa so supply is not wholly dependent on external stockpiles, and operationalisation of pathogen access and benefit-sharing so that countries supplying samples receive guaranteed access to what is made from them.

✍ MAINS ANSWER FRAMEWORK

QUESTION

The global vaccine ecosystem responds rapidly to threats faced by high-income countries and slowly to those confined to low-income ones. Examine this asymmetry with reference to Ebola, and discuss the institutional reforms that could address it. (250 words)

INTRODUCTION

The global vaccine system demonstrated during COVID-19 that it can move from genetic sequence to authorised product in under a year when the incentive exists. Writing in Down To Earth, Latha Jishnu uses Ebola to show what happens when it does not, arguing that the difference between the two responses is a matter of who was expected to pay rather than of scientific difficulty.

BODY

Ebola virus disease was first identified in 1976 near the Ebola River in what was then Zaire, alongside a simultaneous outbreak in Sudan. Of the species now recognised, four have caused disease in humans: Zaire, Sudan, Bundibugyo and Tai Forest, though the WHO notes that only the first three cause large outbreaks, Tai Forest having caused a single documented human case.

The decisive fact for this argument is that licensure has been achieved only against the Zaire strain, through rVSV-ZEBOV, marketed as Ervebo, and a separate two-dose regimen, leaving outbreaks of the Sudan and Bundibugyo strains without any licensed vaccine. That asymmetry does not track scientific difficulty; it tracks where development funding went.

The vaccine that did succeed advanced substantially through biodefence-oriented research support, that is, it progressed when a wealthy state perceived a security threat to itself, and stalled through the long periods when the risk was understood as confined to central and west Africa. Even the 2014-16 West African epidemic, which caused over eleven thousand deaths, was required before licensure followed in 2019, more than four decades after the virus was first described.

Institutional responses have since been built: Gavi, the Vaccine Alliance established in 2000, maintains a global Ebola vaccine stockpile released through the International Coordinating Group, and the Coalition for Epidemic Preparedness Innovations, founded in 2017, funds candidates that no commercial sponsor would pursue. The editorial's point is that these are mitigations layered on an unreformed incentive structure rather than a correction of it.

CONCLUSION

A balanced answer should concede the counter-argument that episodic outbreaks with small case numbers make efficacy trials genuinely hard and commercial development genuinely unviable. That concession, however, strengthens rather than weakens the conclusion: precisely because the market cannot serve these diseases, the remedy must be structural, through guaranteed pull incentives, sustained public financing, regional manufacturing capacity in Africa, and enforceable benefit-sharing.

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