

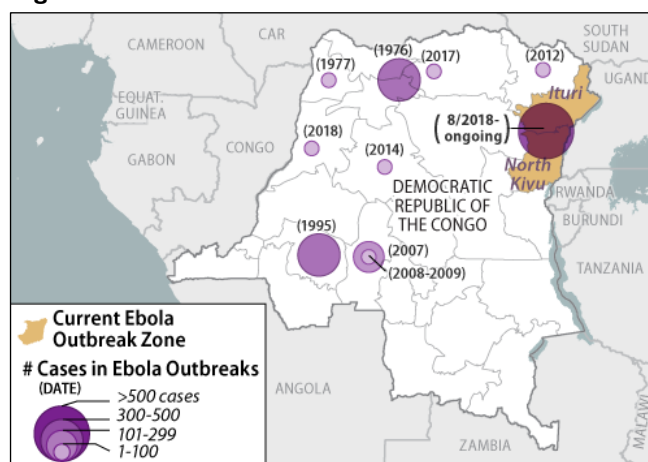
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Ebola Outbreak: Democratic Republic of Congo

For years, Congress has provided funds to prevent, detect, and respond to infectious disease threats, including those with pandemic potential like Ebola. In regular appropriations, since FY2014 Congress has annually provided \$72.5 million to the U.S. Agency for International Development (USAID) for such efforts. From FY2015 to FY2017, Congress appropriated annually \$55.1 million to the U.S. Centers for Disease Control and Prevention (CDC); in FY2018, it provided \$108.2 million, including an authority to spend \$50 million over three years for global health security efforts. (See CRS Report R43115, *U.S. Global Health Appropriations: FY2001-FY2019*.) In FY2015, Congress also provided over \$5 billion in emergency funds for domestic and global efforts to contain the 2014-2015 West Africa Ebola outbreak (P.L. 113-235). Some of those unspent funds were used to contain a 2018 outbreak in western Democratic Republic of Congo (DRC) and are being used to fight the ongoing outbreak (see CRS Report R44507, *Status of the Ebola Outbreak in West Africa: Overview and Issues for Congress*).

On August 1, 2018, the World Health Organization (WHO) reported a new Ebola outbreak in eastern DRC, about one week after declaring that a separate outbreak had ended in western DRC. The ongoing Ebola outbreak—the 10th to be documented in DRC—is the largest in the country’s history and has continued to spread (**Figure 1**). It is occurring in North Kivu and Ituri provinces, where a protracted conflict has caused a long-running humanitarian crisis: as of mid-2018, 4.3 million people were in need of humanitarian aid. In addition to classic public health response tools (surveillance, contact tracing, isolation, and safe burials), health workers (HWs) are using an investigational vaccine to counter the spread of disease. Unpredictable armed conflict and intermittent community resistance to these efforts are hindering all aspects of outbreak control.

Figure 1. Ebola Virus Outbreaks in DRC: 1976-2019



Source: CRS graphic, based on WHO data.

As of February 4, 2019, WHO reported 785 confirmed and probable Ebola cases in Ituri and North Kivu, including 484 deaths. Observers are concerned that the outbreak could spread to Goma, the capital of North Kivu, a city of over 1 million people that is also an operational hub for the United Nations (U.N.) peacekeeping mission and international relief efforts in DRC, as well as to neighboring countries. While Uganda (which borders the most affected areas in DRC) has prior experience in Ebola control, Rwanda and Burundi do not. South Sudan’s current minimal state capacity and protracted armed conflict suggest a coordinated disease control response would be highly challenging.

International and U.S. Responses

Confirmed Ebola cases are being treated with experimental Ebola therapeutics in Ebola Treatment Centers (ETCs). As of January 28, 2019, six ETCs and two isolation treatment units were operational, with occupancy rates ranging from 60% to 110%, with additional ETCs being constructed. Between August 2018 and early February 2019, the DRC’s Ministry of Health (MoH) and partners vaccinated roughly 73,000 Ebola cases and their contacts. In bordering countries, over 2,600 health workers (HWs) have been vaccinated in Uganda, more than 1,400 HWs in Rwanda are designated to be vaccinated (once the protocol is approved), and approximately 300 HWs have been vaccinated in South Sudan. The WHO has conducted readiness assessments in neighboring countries, and the U.N. Central Emergency Response Fund has contributed \$10 million toward regional Ebola control and preparedness efforts.

When the outbreak began, USAID and CDC deployed staff to DRC and the region. In October 2018, USAID announced it had deployed a Disaster Assistance Response Team (DART) to coordinate the U.S. government response in support of the MoH, WHO, and other international partners. The United States, more broadly, is the top bilateral humanitarian donor to DRC and the top financial contributor to the U.N. peacekeeping operation there, which has provided “life-saving logistics support to the Ebola response” in North Kivu and Ituri, according to U.S. officials. U.S. support for outbreak control also includes the following:

USAID: As of February 5, 2019, USAID has provided more than \$33 million in FY2018-FY2019 to nongovernmental organizations (NGOs), U.N. agencies, and other partners for Ebola response in DRC and Ebola preparedness in neighboring countries. USAID funds are supporting disease surveillance, infection protection and control, risk communication and community engagement, safe and dignified burials, water and sanitation aid, and prepositioning of medical supplies.

CDC: CDC personnel provide direct support to the MoH, WHO, and the DART and are supporting disease surveillance, contact tracing, data management, infection protection and control, risk communication and community engagement, laboratory strengthening, emergency management, and surveillance at points of entry. CDC staff are also supporting Ebola preparedness efforts in Rwanda, South Sudan, and Uganda.

U.S. Department of Defense (DOD): DOD supplies laboratory training to Ugandan researchers and partners with them to conduct clinical trials of Ebola vaccines.

Challenges

Insecurity. Ebola cases are concentrated in Beni and Butembo districts in North Kivu, a site of armed conflict since the 1990s. Dozens of armed groups are active in the area, including the Allied Democratic Forces (ADF), a nebulous armed group implicated in attacks on U.N. peacekeepers, local military forces, and civilians. Elements of the state security forces also reportedly maintain ties with armed groups and have been implicated in serious abuses. Road travel is often dangerous, with frequent reports of militia attacks, armed robbery, and kidnappings.

Fear and misinformation have also prompted community resistance to Ebola control efforts. Health workers and facilities have been attacked, and community resistance to conducting safe burials has hindered containment efforts. Political unrest related to DRC's national elections in December 2018 has also posed challenges. The DRC government postponed voting in Beni and Butembo, citing risks of contagion (although the MoH had earlier suggested such risks would be mitigated), spurring protesters to ransack and burn down part of an ETC in Beni.

The U.S. government has placed constraints on the movement of U.S. personnel due to security threats in the east and political unrest throughout the country. In September, USAID and CDC withdrew their personnel from the outbreak zone pursuant to security concerns. The CDC Director stated to the press that the CDC's preference would have been to maintain staff in the field. U.S. personnel continue to provide technical assistance from the capital, Kinshasa, and from neighboring Rwanda and Uganda, while implementing partners (WHO and NGOs) are continuing Ebola control efforts with U.S. resources.

Health System Constraints. Low health worker density, low health spending, and prolonged conflict have weakened DRC's health system and hindered Ebola control efforts. A ratio of at least 2.3 health workers per 1,000 people is often used as a proxy for measuring minimum health delivery capacity in a given country. According to the latest available data from WHO, DRC had roughly 1.1 health workers per 1,000 people as of 2009. WHO reported that as of 2015 (latest available), health spending accounted for 5% of government spending, which would amount to roughly \$3.30 per capita, one of the lowest rates in the world.

The WHO suggests that Ebola transmission may be occurring in ill-equipped, untrained, and/or understaffed health facilities. Inconsistent adherence to infection prevention and control, periodic disruptions in the personal protection equipment supply chain, and limited access to water for handwashing in some health facilities is putting

health workers and patients at risk. As of February 3, 2019, 65 health workers had contracted Ebola in the current outbreak, 22 of whom died. From December 1, 2018, through January 28, 2019, 18% of confirmed Ebola cases reported having visited a health center before developing symptoms, suggesting they may have been exposed to the virus at the facility. The MoH, WHO, and other partners have identified health facilities where Ebola transmission may have occurred and are addressing lapses around triage, case detection, and infection prevention and control.

Early symptoms of Ebola and malaria are similar, and a spike in malaria cases in and around Beni City has compounded pressure on its health facilities and ETCs. A January 2019 WHO report indicated that up to 50% of people screened in ETCs had malaria. In November 2018, the DRC National Malaria Control Program, supported by WHO, the United Nations Children's Fund (UNICEF), the Global Fund, and the U.S. President's Malaria Initiative, launched a prevention and treatment campaign to curb malaria deaths and reduce pressure on the health system.

Outlook

The ongoing Ebola outbreak is in its seventh month, and control efforts have shown mixed results. While the number of new cases have declined in some areas, infection rates have risen in others. Insecurity in North Kivu has disrupted response activities, raising questions about how to carry out disease control in unsafe settings. Protracted conflict in Pakistan and Afghanistan, for example, has stymied global polio eradication efforts, while political instability in Venezuela has contributed to the resurgence of malaria in the country, imperiling the rest of the region.

Political instability aside, the inability to control disease outbreaks is largely a symptom of weak domestic health systems. To address this challenge and improve countries' ability to prevent, detect, and respond to infectious disease threats, the United States and WHO co-launched the Global Health Security Agenda (GHSA) in 2014. The United States, the largest donor to this multilateral effort, pledged to support it with \$1 billion from FY2015 through FY2019. Much of the emergency appropriations that have been used in support of GHSA and to control the ongoing Ebola outbreak is expected to be expended by the end of FY2019. The Trump Administration has signaled support for continuing the GHSA. Clearer signals of how the Administration proposes extending U.S. engagement may be found in the forthcoming FY2020 budget request.

In the 115th Congress, H.R. 7290, Global Health Security Act of 2018, would have codified an Obama-era executive order setting out agency roles in supporting the GHSA. In the 116th Congress, H.R. 826 would seek to facilitate research and treatment of neglected tropical diseases, including Ebola. Members may continue to debate what role, if any, the United States should play in supporting global health system strengthening efforts to bolster global health security and whether to adjust funding levels to meet ongoing and looming infectious disease threats.

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