

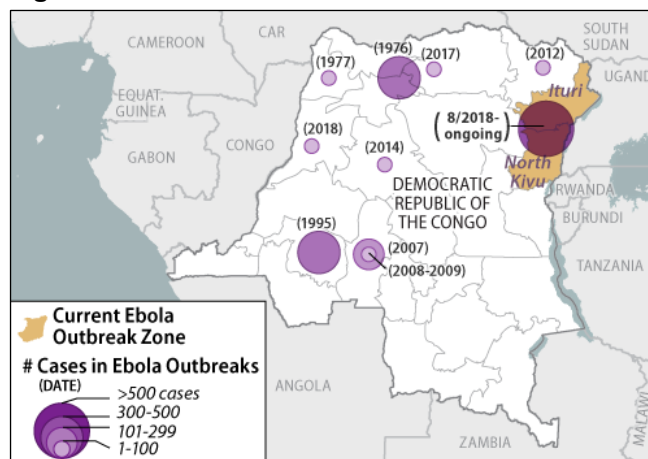
Updated April 2, 2019

Ebola Outbreak: Democratic Republic of Congo

Congress has provided funds to prevent, detect, and respond to infectious disease threats, including those with pandemic potential like Ebola. From FY2014 through FY2018, Congress provided annually \$72.5 million to the U.S. Agency for International Development (USAID) for such efforts and increased funding to \$100 million in FY2019. From FY2015 to FY2017, Congress appropriated annually \$55.1 million to the U.S. Centers for Disease Control and Prevention (CDC); in FY2018 and FY2019, it provided \$108.2 million; and from FY2008 through FY2020, it authorized an additional \$50 million for global health security efforts. The Trump Administration's FY2020 budget request included \$90 million and \$100 million for USAID and CDC global health security programs, respectively. 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 unspent funds have been used to contain two Ebola outbreaks in DRC since 2018.

On August 1, 2018, the World Health Organization (WHO) reported a new Ebola outbreak in eastern DRC, about a 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 March 31, 2019, WHO reported 1,089 Ebola cases, including 679 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, or 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 March 26, 2019, 324 patients had recovered and been discharged. As of March 23, 2019, roughly 96,000 people had been vaccinated, including 27,000 health workers (HWs) and front-line workers (FLWs) in the outbreak zone and over 15,000 HWs and FLWs in Goma, South Sudan, and Uganda. Plans are underway to vaccinate HWs and FLWs in Burundi and Rwanda. 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. In February 2019, WHO called for \$148 million to contain the outbreak within six months. As of March 19, 2019, \$74 million had been received.

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 Ministry of Health (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: USAID is supporting 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, Uganda, and South Sudan.

Department of Defense (DOD): DOD has supplied laboratory training to Ugandan researchers and has partnered with them to conduct clinical trials of Ebola vaccines.

Challenges

Insecurity. Ebola cases have been concentrated in North Kivu, a site of armed conflict since the 1990s. Dozens of armed groups are active in the most heavily affected area, including the Allied Democratic Forces (ADF), a nebulous organization implicated in attacks on U.N. peacekeepers, local military forces, and civilians. Elements of the state security forces 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 prompted community resistance to Ebola control efforts. Health workers and facilities have repeatedly been attacked, and community resistance to conducting safe burials has hindered containment efforts. Political unrest related to DRC's national elections in December 2018 also posed challenges. The DRC government postponed voting in opposition-leaning Beni and Butembo districts, citing risks of contagion (a decision many viewed as politically motivated)), which spurred 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 September, USAID and CDC withdrew their personnel from the outbreak zone pursuant to security concerns, despite CDC's stated preference to maintain staff in the field. U.S. personnel continue to provide technical assistance from the capital, Kinshasa, from Goma (as of early 2019), 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 March 26, 2019, 78 health workers had contracted Ebola, 27 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 of concern 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 ninth month, and control efforts have shown mixed results. Recent days have seen a spike in new cases, many of which are occurring outside known transmission chains. 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 (GHPA) in 2014. The United States, the largest donor to this multilateral effort, pledged to support it with \$1 billion from FY2015 through FY2019. The emergency appropriations that have been used in support of GHPA and to control the ongoing Ebola outbreak are expected to be largely expended by the end of FY2019. The Trump Administration has signaled support for continuing the GHPA, has requested \$90 million under the USAID Global Health Programs (GHP) account, and sought \$100 million through CDC for related efforts in FY2020.

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 GHPA. 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.

Tiaji Salaam-Blyther, Specialist in Global Health
Alexis Arieff, Specialist in African Affairs

IF1100

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.