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Ebola Outbreaks in the Democratic Republic of Congo: Emergencies or Enduring Threat?

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Ebola Outbreaks in the Democratic Republic of Congo: Emergencies or Enduring Threat?

On June 25, 2020, the World Health Organization (WHO) announced the end to an Ebola outbreak that began nearly two years earlier in eastern Democratic Republic of Congo (DRC). The outbreak—DRC’s 10th on record—was concentrated in a conflict zone, complicating containment efforts, and became the world’s second-largest Ebola outbreak ever. Attacks on health workers repeatedly impeded containment efforts, as did political tensions, local community suspicion of government officials and international actors, and local frustrations at perceived profiteering by responders. Eventual success in containing the outbreak was attributable, in part, to the deployment of new vaccines first pioneered during the West Africa outbreak, advances in experimental therapeutics, and changes in the coordination of response efforts on the ground.

Relief over ending the 2018-2020 eastern DRC Ebola outbreak was muted, however, by the detection of a new outbreak, DRC’s 11th to date, in the western part of the country in the same month—and by the global Coronavirus Disease 2019 (COVID-19) pandemic, which has posed new health challenges in DRC and severely affected the country’s economy. The DRC government and international partners also face other health challenges, including intermittent outbreaks of measles, cholera, and malaria, and relatively high preventable death rates (particularly in the areas of maternal and child health) resulting from inadequate access to clean water, sanitation, and hygiene (WASH) and primary health care. Poor conditions at health facilities continue to frustrate efforts to convince individuals with Ebola symptoms to seek diagnosis and treatment. According to the U.N. Office for the Coordination of Humanitarian Affairs (UNOCHA), fewer than 30% of health facilities in the country are equipped to provide basic medical care, including vaccines, antidiarrheal treatment, undernutrition, or prenatal and postnatal care.

The prolonged battle to contain the Ebola outbreak in eastern DRC, coupled with what appear to be more frequent outbreaks in the country, raise questions about the allocation of U.S. global health resources and bilateral aid for DRC. New vaccines and therapeutics are potential game-changers in responding to new Ebola outbreaks, yet local health system weaknesses, community mistrust, and barriers to humanitarian access have continued to present obstacles. Among the issues that Congress might consider include the relative ranking of U.S. global health priorities in the context of COVID-19, the implications of frequent Ebola outbreaks for the global health security agenda, and lessons that may be gleaned from DRC about pandemic response in other complex conflict settings.

The United States was the largest country donor to the international Ebola response effort in eastern DRC, with the U.S. Agency for International Development (USAID) and U.S. Centers for Disease Control and Prevention (CDC) playing a lead role. If responding to and preventing Ebola outbreaks remain congressional priorities in the future, Congress may consider how such efforts may be funded. Notably, USAID drew on unobligated International Disaster Assistance (IDA) funds that Congress had provided in FY2015—in the context of the 2014-2016 West Africa Ebola outbreak—as its core source of funding for Ebola response in eastern DRC. Since June, USAID has allocated resources for countering the new outbreak in the west, but since March 2020, the agency also has drawn on remaining unobligated FY2015 emergency Ebola appropriations to fund COVID-19 response efforts in developing countries worldwide. The CDC, for its part, also drew on 2015 Emergency Ebola supplemental appropriations, along with more recent appropriations for global disease detection and infectious disease response that, likewise, may be focused elsewhere in the current context. Total USAID funding for emergency response to the eastern DRC Ebola outbreak, at \$342 million, also exceeded the U.S. annual bilateral health assistance budget for DRC (\$217 million allocated in FY2019). Much of the U.S. bilateral health aid budget for DRC is focused on other disease-specific initiatives, namely HIV/AIDS, malaria, and tuberculosis, although DRC also receives U.S. health system strengthening aid through global programs.

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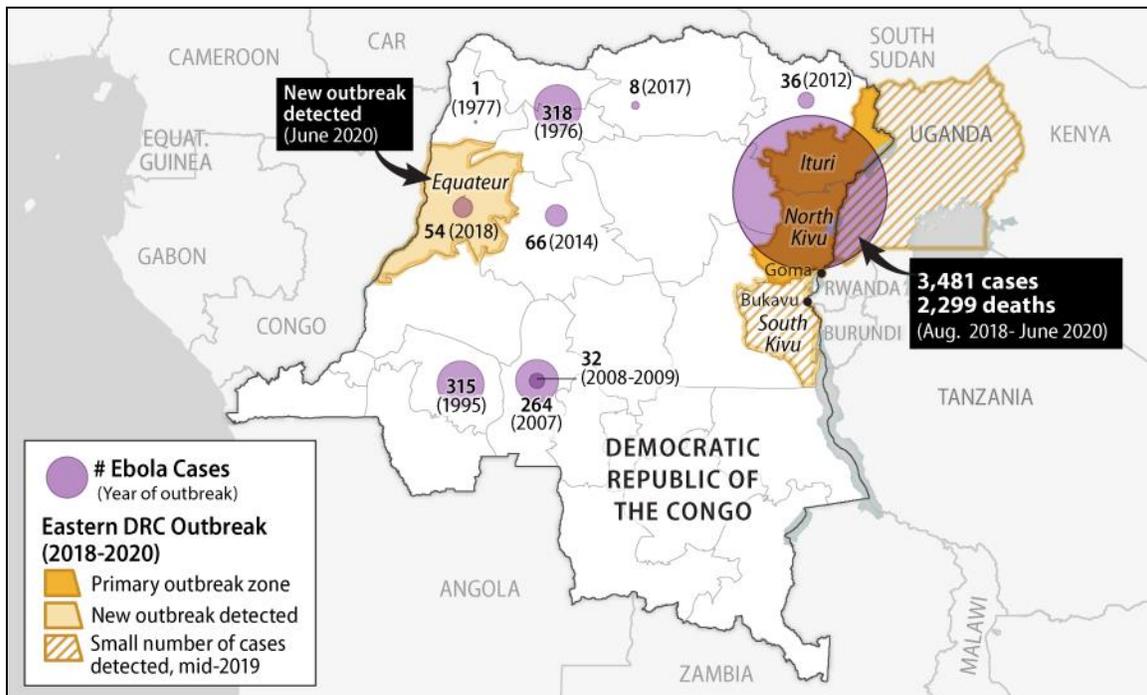
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Introduction

On June 25, 2020, a nearly two-year Ebola virus outbreak in eastern Democratic Republic of Congo (DRC) was declared over, after claiming the lives of nearly 2,300 people.¹ A new outbreak emerged the same month in the west of the country, marking the 11th documented Ebola outbreak in the country since the virus was first identified in DRC in 1976 (**Figure 1**).² The eastern DRC outbreak (the country's 10th) unfolded in an area without recent experience with the disease, and which was already experiencing complex armed conflicts and a protracted humanitarian crisis.³ The multilateral Ebola response effort confronted stark obstacles and frequent setbacks, including attacks on health workers, political tensions, local disinformation campaigns, intense community mistrust, and resource constraints, particularly in public health facilities.⁴ The outbreak, which peaked in mid-2019, became DRC's largest ever, and the world's second-largest after the 2014-2016 West Africa outbreak (which infected over 28,000 people and killed more than 11,000).

Figure 1. Documented Ebola Outbreaks in DRC to Date



Source: CRS graphic. Base map drawn from Esri (2016); case data from the WHO, as of August 2020.

¹ Per World Health Organization (WHO) guidance, Ebola outbreaks are declared over when 42 days (twice the known incubation period) pass, with no new cases, after the discharge of all known Ebola patients.

² See U.S. Centers for Disease Control and Prevention (CDC), "Years of Ebola Virus Disease Outbreaks," at <https://www.cdc.gov/vhf/ebola/history/chronology.html>. Ebola is named after a river in DRC, and a Congolese scientist, Dr. Jean-Jacques Muyembe, played a key role in the virus's discovery in 1976. Dr. Muyembe currently heads DRC's National Institute for Biomedical Research and was appointed DRC's national Ebola coordinator in mid-2019.

³ As of October 2018 (before the outbreak had substantially spread), 4.3 million people were in need of humanitarian aid in the two provinces, according to U.N. Office for the Coordination of Humanitarian Affairs (UNOCHA) data.

⁴ See National Public Radio (NPR), "It was unmistakably a directed attack': 4 Ebola workers killed in Congo," November 28, 2019.

The deployment of new vaccines and therapeutics, improved coordination of response efforts on the ground, and community-level engagement appear to have been key factors supporting containment of the eastern DRC outbreak. Yet, flagging donor commitment and competing needs—including the novel Coronavirus Disease 2019 (COVID-19) pandemic—have complicated and arguably diverted national and global resources from controlling the new outbreak in western Equateur province and ensuring adequate disease surveillance elsewhere the country.⁵ In early August 2020, the WHO issued a donor appeal requesting \$18.4 million to control the new (11th) outbreak, which, at that point, was reportedly growing steadily with new health zones affected in hard-to-reach, remote villages.⁶ As in the 10th outbreak, Ebola responders have faced local resistance, particularly in reporting of cases, referring suspected cases to health facilities, and following safe and dignified burial practices.

The prolonged battle to contain the Ebola outbreak in eastern DRC, coupled with what appear to be more frequent outbreaks in the country, raise questions about the allocation of U.S. global health resources and bilateral aid for DRC. Vaccines and therapeutics are potential game-changers, yet health system weaknesses, community mistrust, and barriers to humanitarian access remain obstacles. Among the issues that Congress might consider include the relative ranking of U.S. global health priorities in the context of COVID-19, the implications of frequent Ebola outbreaks for the global health security agenda, and lessons learned from DRC about pandemic response in complex conflict settings. If responding to and preventing Ebola outbreaks remain congressional priorities, Congress might also consider how such efforts may be funded.

Successes in Ebola Control

The extraordinary conditions in eastern DRC, particularly significant infrastructure constraints and security threats, limited the implementation of conventional infection control and prevention measures and required ever-evolving strategies for containment. Classic Ebola outbreak control protocol entails

- infection prevention control (IPC) in health care facilities;
- management and isolation of patients, ideally in specialized Ebola Treatment Centers (ETCs);
- fever surveillance with rapid diagnosis;
- tracing of Ebola cases and their contacts; and
- community awareness and adherence to IPC protocols, safe patient care, safe body transport and burials, and household and environmental decontamination.

To overcome barriers caused by insecurity, inaccessibility, and poor IPC compliance in some health settings, Ebola responders adopted modified approaches, including expanded application of Ebola vaccines, deployment of innovative Ebola therapeutics, and local outreach to secure access and protection of health workers.

Vaccines. During the 2014-2016 West Africa Ebola outbreak, health workers deployed a “ring vaccination” strategy for the first time, using an experimental vaccine (unlicensed at the time) under a “compassionate use” protocol. Ring vaccination entails vaccinating those who have come in contact with a known Ebola case, as well as their contacts. The same strategy was employed

⁵ In March, the WHO appealed for donors to fill “an immediate US\$20 million funding gap,” or risk running out of money, and possibly missing new cases, before the outbreak was fully over. WHO, Remarks by Dr Ibrahima Socé Fall, “End in sight, but flare-ups likely in the Ebola outbreak in the Democratic Republic of the Congo,” March 6, 2020.

⁶ UNOCHA, “Republique Demoratique Du Congo,” Note d’information, rapport #56, 18 août 2020.

during the 2018-2020 outbreak in eastern DRC, although population mobility, suboptimal IPC practices in local health clinics, gaps in rapid diagnosis and isolation of infected individuals, and resistance by some communities limited its effectiveness.

In February 2019, the World Health Organization (WHO) Strategic Advisory Group of Experts (SAGE) noted the “exceptional circumstances” of the eastern DRC outbreak (summarized above) and recommended adding geographic-targeted vaccination, entailing vaccinating residents in the area immediately surrounding an Ebola case, such as a village or neighborhood. In May 2019, the WHO SAGE recommended additional adjustments to the vaccine strategy, including

- “pop-up” vaccination to make the process faster, more secure, and more responsive to local feedback;
- streamlining implementation of the vaccination protocol;
- modifying follow-up for safety monitoring; and
- adjusting the dose of the vaccine to ensure vaccine availability (i.e., primary and secondary contacts would receive one-half the previously used dose and tertiary contacts would receive one-fifth of the previous dose).

By the end of the outbreak, over 300,000 people had been vaccinated in the main outbreak zone (Ituri and North Kivu provinces) with the aforementioned experimental vaccine, rVSV-ZEBOV (brand name Ervebo, produced by Merck). In December 2019, Ervebo became the first Ebola vaccine to be approved by the U.S. Food and Drug Administration (FDA).⁷ In September 2019, Congolese officials approved use of a second vaccine candidate, Ad26.ZEBOV/MVA-BN, developed by Janssen Pharmaceuticals (a subsidiary of Johnson & Johnson) and Bavarian Nordic. As of August 18, 2020, more than 22,000 people had been vaccinated against Ebola in the new outbreak zone, Equateur province.⁸

Therapeutics. The FDA has not approved any antiviral drugs to treat Ebola, though experimental treatments (known as REGN-EB3 and mAb114) were used to care for Ebola patients during the 2018-2020 outbreak.⁹ Caretakers had otherwise primarily focused on addressing Ebola-related symptoms (e.g., through the provision of fluids intravenously, oxygen therapy, fever suppressants, and pain relievers). In August 2019, a study by the U.S. National Institutes of Health (NIH), the WHO, and the DRC National Institute of Biomedical Research reported that REGN-EB3 and mAb114 had proven effective in improving survival outcomes for Ebola patients during an investigational trial. While several other candidate therapies are also being evaluated, the WHO announced in August 2019 that it would follow the recommendations of an independent Data and Safety Monitoring Board to use only the two aforementioned therapies when treating Ebola patients.¹⁰ Over 2,100 people were treated with these therapies during the eastern DRC outbreak.¹¹

⁷ WHO, “Ebola Virus Disease—Democratic Republic of the Congo, *Weekly Epidemiological Record*, Volume 27, Issue 95, pp. 301-324, July 3, 2020; U.S. FDA, Ebola Preparedness and Response Updates from FDA, at <https://www.fda.gov>. FDA approval followed a determination by the European Medicines Agency to grant conditional marketing authorization for the Ervebo vaccine.

⁸ UNOCHA, “Republique Demoratique Du Congo,” Note d’information, rapport #56, August 18, 2020.

⁹ CDC, Ebola Virus Disease, “Treatment,” at <https://www.cdc.gov/vhf/ebola/treatment/index.html>; and NIH, *Independent Monitoring Board Recommends Early Termination of Ebola Therapeutics Trial in DRC Because of Favorable Results with Two of Four Candidates*, August 12, 2019.

¹⁰ WHO, *Update on Ebola Drug Trial: Two Strong Performers Identified*, August 12, 2019.

¹¹ WHO, “Ebola Virus Disease—Democratic Republic of the Congo, *Weekly Epidemiological Record*, Volume 27, Issue 95, pp. 301-324, July 3, 2020.

Local Engagement and Coordination of Response Efforts. Local resistance to Ebola response activities was a persistent feature of the eastern DRC outbreak—at times amounting to armed attacks and seemingly organized sabotage. While the extent of armed group involvement may have been unique to the geographic location of the outbreak, community resistance remains an obstacle in the new outbreak and likely in the future (see “Challenges in Ebola Control” below). Because willing local participation in efforts to prevent, identify, and rapidly isolate Ebola cases is crucial to containment, strong engagement with local communities has been a top priority among organizations responding to Ebola outbreaks in DRC, and in Ebola response generally.¹²

Steps by the DRC government in 2019 to address internal coordination and accountability problems may have helped improve coordination and local perceptions of responders. Notably, after former opposition figure Felix Tshisekedi was inaugurated president in early 2019, he centralized and elevated the coordination of response efforts to the office of the presidency, appointed an expert virologist to lead these efforts, and pursued investigations into health sector corruption under the previous DRC administration (see text box below). Donors, including the U.S. Agency for International Development (USAID), invested in efforts to improve and coordinate messaging around Ebola response efforts. In 2019, the U.N. peacekeeping operation in DRC took on a greater role in ensuring financial, logistical, and policy coordination among those involved in responding to the outbreak (see “The International Response to the 2018-2020 Eastern DRC Outbreak” below). Donors, including the United States, also expanded response efforts to include support for broader health and food security initiatives in Ebola-affected areas, both in response to local needs and as an effort to build local support for containment efforts.

Challenges in Ebola Control

Post-Outbreak Health Concerns. Scientists do not yet know whether Ebola infection confers lifelong immunity in all cases, as had been assumed prior to the 2014-2016 West Africa outbreak. Rare cases of relapse have been documented in West Africa and eastern DRC, while experts are continuing to investigate whether other cases were reinfected or relapsed.¹³ The persistence of the virus in the body has also raised questions about the risk for the reemergence of Ebola outbreaks after their containment, including in West Africa, which has over 17,000 Ebola survivors, and in eastern DRC, which has over 1,100 survivors.¹⁴ Noting that “survivor-linked transmission, undetected chains of transmission, and new introduction of Ebola virus into the human population from an animal reservoir” were possible, USAID reported in June 2020 that “response actors aim to continue supporting critical activities to detect and respond to additional cases that may emerge following the official end of the outbreak.”¹⁵

Health Infrastructure Constraints. DRC’s weak national health system posed a key challenge to Ebola response efforts during the tenth outbreak, notwithstanding the country’s prior experience and expertise in Ebola control. According to the U.N. Office for the Coordination of Humanitarian Affairs (UNOCHA), as of early 2020 fewer than 30% of health facilities had the

¹² See WHO, “Ebola in the Democratic Republic of the Congo: North Kivu, Ituri 2018 – 2020,” at <https://www.who.int/emergencies/diseases/ebola/drc-2019>; and WHO et al, *Risk Communication and Community Engagement Preparedness and Readiness Framework: Ebola Response in the Democratic Republic of Congo in North Kivu*, September 2018.

¹³ WHO, *Ebola Virus Disease-Democratic Republic of the Congo: External Situation Report 72*, December 17, 2019.

¹⁴ C. Raina MacIntyre and Abrar Chughtai, “Recurrence and Reinfection-A new Paradigm for the Management of Ebola Virus Disease,” *International Journal of Infectious Diseases*, volume 43, (2016), pp. 58-61.

¹⁵ USAID, “Democratic Republic of the Congo – Ebola Outbreaks,” FY2020 Fact Sheet #7, June 29, 2020.

operational capacity to provide basic medical care, significantly limiting the ability to provide preventive care, including the provision of vaccines, maternal and child health care, and control of measles, cholera, and malaria.¹⁶ Deaths and illness from these causes in DRC have, for years, exceeded regional and global averages (**Table 1**). Faced with limited health resources, authorities redirected local health resources to Ebola control in some hotspots, including those for regular vaccination campaigns, deepening mistrust by some of government authorities. Between 2019 and mid-2020, DRC experienced the world’s worst measles epidemic at the time, which killed over 7,000 children. Health system capacity has likely been further weakened by Ebola deaths among health workers: the WHO reported in December 2019 that Ebola had killed at least 34 health workers in eastern DRC since the outbreak in that region began.¹⁷

Table 1. Key Health Statistics: DRC, Africa, and the World

	Maternal Mortality Ratio^a (per 100,00 live births)	Child Mortality Rate^b (per 1,000 live births)	Stunting Among Children Under 5 (%)	New HIV Infections^b (per 1,000 uninfected pop.)	New Malaria Infections^b (per 1,000 pop. at risk)	New TB Infections^b (per 100,000 pop.)	Physician Density^c (per 10,000 pop.)
DRC	473	88	42.7	0.21	319.8	321	0.7
Africa	525	76	32.5	1.07	229.3	231	3.0
World	211	39	21.3	0.24	57.4	132	15.6

Source: WHO, *World Health Statistics 2020: Monitoring Health for the SDGs [Sustainable Development Goals]*, 2020.

- a. Data collected in 2017.
- b. Data collected in 2018.
- c. Data collected in 2016.

Security and Governance Challenges. At the height of the eastern DRC outbreak in mid-2019, U.S. officials and other health experts identified local tensions and political grievances, along with security threats, as key challenges.¹⁸ Attacks by local militias and criminal groups, political protests, health worker strikes, and security force abuses repeatedly disrupted and impeded response efforts. In 2019, then-USAID Administrator Mark Green urged a multifaceted “development approach” toward the outbreak, referring to DRC as a “failed democracy” that had undermined “the Congolese people’s trust in institutions.”¹⁹ From the start of the outbreak in August 2018 through March 2020, the WHO documented 420 attacks on health facilities in the main outbreak zone, resulting in 11 deaths and 86 injuries.²⁰ In many cases, assailants were never conclusively identified.

Local mistrust of government officials and perceived outsiders (including Congolese responders from other parts of the country) contributed to community resistance. The first year of the

¹⁶ UNOCHA, *Democratic Republic of the Congo*, Health Cluster Report, March 2020.

¹⁷ WHO, Disease Outbreak News Report on the DRC, December 12, 2019.

¹⁸ See, for example, House Foreign Affairs Subcommittee on Africa, Global Health, Global Human Rights and International Organizations (“HFAC Africa Subcommittee”), hearing, “Eradicating Ebola: Lessons Learned and Medical Achievements,” June 4, 2019; and WHO, “High-Level Event on Ebola Virus Disease in DRC,” July 15, 2019.

¹⁹ Mark Green, testimony before the Senate Appropriations Subcommittee on State, Foreign Operations, and Related Programs, hearing, “Review of the FY2020 Budget Request for USAID,” April 30, 2019; and “How to End the Ebola Crisis [Op-Ed],” CNN, August 22, 2019.

²⁰ WHO, Remarks by Dr Ibrahima Socé Fall, March 6, 2020, op. cit.

outbreak also coincided with a fraught political transition process, during which the outgoing national government's decision to delay and, in some cases, cancel elections in the outbreak zone (an opposition stronghold) heightened tensions and spurred conspiracy theories.²¹ Perceptions that outsiders were profiting financially from the response effort, or that international interventions were driven more by Westerners' fear of contagion than by concern for locals' wellbeing, also appear to have fueled local mistrust, as well as kidnappings of Ebola responders.²²

Corruption Concerns in the Ebola Response

From the start of the eastern DRC outbreak, the DRC government's health responses were coordinated by the Ministry of Health (MoH), as in past Ebola outbreaks in the country. In July 2019, newly elected President Etienne Tshisekedi transferred coordination responsibilities to an expert committee headed by the director of DRC's national biomedical research institute, Dr. Jean-Jacques Muyembe. Dr. Muyembe is a renowned expert on Ebola who helped investigate the first known outbreak of the disease in DRC in 1976. Health Minister Dr. Oly Ilunga resigned following Dr. Muyembe's appointment, complaining of a dilution of his authority, confusion about the lines of coordination, an insufficient focus on the health system, and opposition to introducing a second vaccine as part of the response. A DRC government investigative commission subsequently issued scathing criticism of Dr. Ilunga, indicating, among other things, that the minister and his team had displayed an "aggressive and ostentatious attitude" when visiting the outbreak area and had squandered Ebola response funds on fancy cars and hotel rooms.²³ In March 2020, a DRC court sentenced Ilunga to prison for allegedly embezzling Ebola response funds.²⁴ This was not the only case of apparent misappropriation of funds and other abuses by various actors involved in responding to the eastern DRC outbreak. As of mid-2020, investigative journalists, U.N. agencies, and NGOs had identified a range of problematic behavior that likely contributed to local mistrust of responders, including alleged sexual exploitation, petty corruption, and inflated fees and kickbacks paid to DRC state security forces (who have repeatedly been implicated in gross human rights violations).²⁵ Overall, perceived profiteering and corruption among DRC officials and others came to be known as the "Ebola business."

The International Response to the 2018-2020 Eastern DRC Outbreak

The Congolese government has led the response to successive Ebola outbreaks in DRC, with support from the World Health Organization, nongovernmental organizations, donors, and other partners. National and international nongovernmental organizations partnered with the Congolese government to provide direct support for activities such as IPC training, communication campaigns, and disease surveillance, while U.N. agencies (including the WHO), other multilateral entities (including the World Bank), and foreign governments provided funding, technical expertise, coordination, and/or logistical assistance. Most of the direct patient care was provided by Congolese nationals. As a WHO official noted at the height of the outbreak in June 2019, "If you go into the treatment facilities now it is Congolese doctors and nurses in the front line. There may be NGO or WHO badges on the tents but the doctors and nurses are Congolese; surveillance officers are Congolese; 80% of the vaccinators in this response are Congolese."²⁶

²¹ See CRS Report R43166, *Democratic Republic of Congo: Background and U.S. Relations*.

²² *New York Times*, "Ebola Outbreak Reaches Major City in Congo, Renewing Calls for Emergency Order," July 15, 2019.

²³ *New York Times*, "In Congo, a New Plan to Fight Ebola Follows a Government Power Struggle," July 26, 2019.

²⁴ Reuters, "Former DR Congo Health Minister Convicted of Embezzling Ebola Funds," March 23, 2020.

²⁵ *The New Humanitarian*, "How 'Ebola business' threatens aid operations in Congo," June 18, 2020.

²⁶ WHO, "Ebola Outbreak in the Democratic Republic of the Congo," Press Briefing, June 6, 2019.

The African Union (AU) Africa Centers for Disease Control and Prevention (Africa CDC) also deployed members of its voluntary response corps to DRC and neighboring countries to provide technical assistance. The U.N. Stabilization Mission in Congo (MONUSCO) provided logistical and security support to Ebola response efforts while also seeking to fulfill its otherwise wide-ranging civilian-protection and stabilization mandate.

Starting when the WHO declared the eastern DRC outbreak to be a Public Health Emergency of International Concern (PHEIC) in July 2019 (about 11 months after the first cases were identified), the WHO sought emergency donor funds, as well as international support for addressing local political and security challenges. Over a series of appeals to donors from August 2018 through mid-2020, the WHO sought a total of \$570 million to support public health response and regional preparedness efforts, of which donors ultimately provided about \$276 million.²⁷ The WHO appeals aimed to support clinical care, disease surveillance, contact tracing, vaccinations, laboratory capacity, infection prevention and control, clean water and sanitation, safe and dignified burials, psychosocial care, operational preparedness, and coordination.²⁸

In May 2019, in response to concerns (including among U.S. officials) that a lack of operational coordination and transparency were stymying efforts to improve humanitarian access and address security threats, the U.N. Secretary-General established a new position of U.N. Ebola Response Coordinator. David Gressly, a U.S. citizen serving as the Deputy Special Representative of the U.N. Secretary-General within MONUSCO, was appointed to the post. He sought to strengthen financial tracking, humanitarian coordination, political engagement, and “preparedness and readiness planning,” while the WHO continued to lead on health operations and technical support activities.²⁹ Gressly returned to his regular position within MONUSCO in March 2020, at which time the U.N. response coordinator position was deemed no longer necessary.

U.S. Role and Funding: The 2018-2020 Outbreak in Eastern DRC

The United States was the largest country donor to the international Ebola response effort during the outbreak in eastern DRC. USAID and CDC were the primary federal entities involved. The Trump Administration largely restricted U.S. government personnel from traveling to and within the main outbreak zone for most of its duration due to security concerns, with some exceptions for high-level visits. (U.S. personnel were stationed in Kinshasa, in the eastern DRC city of Goma, and in neighboring countries, while U.S. implementing partners used U.S. resources to conduct activities within the outbreak zone.) The Trump Administration deployed a USAID-led Disaster Assistance Response Team (DART) to the region starting in September 2018 to coordinate the U.S. response in support of the DRC government, the WHO, and other partners, and established a Washington, D.C.-based Response Management Team to support the DART. CDC staff supported and participated in these effort, while NIH supported trials of Ebola vaccines and therapeutics in partnership with the WHO and DRC’s National Institute of Biomedical Research.

Over the duration of the eastern DRC Ebola outbreak (August 2018-June 2020), USAID provided over \$342 million in support of response and preparedness activities in DRC and neighboring countries. The bulk of these funds were drawn from unobligated FY2015 International Disaster Assistance (IDA) that Congress had appropriated on an emergency basis for Ebola response during the West Africa outbreak under P.L. 113-235. USAID also drew on foreign assistance

²⁷ See WHO strategic response plans, at <https://www.who.int/emergencies/diseases/ebola/drc-2019/funding>.

²⁸ See WHO and DRC Ministry of Health, *Strategic Response Plan for the Ebola Virus Disease Outbreak in the Provinces of North Kivu and Itur, Democratic Republic of the Congo, July – December 2019*.

²⁹ Ibid. See also Ziemer testimony before the HFAC Africa Subcommittee, “Eradicating Ebola,” June 4, 2019, op. cit.

funds provided under the Global Health Programs (GHP) and Food for Peace (FFP) accounts. CDC, for its part, allocated approximately \$36.7 million in support of Ebola control efforts in eastern DRC, drawing on the 2015 Emergency Ebola supplemental appropriations, 2018 and 2019 appropriations for global disease detection, and the Infectious Disease Rapid Response Reserve Fund.³⁰ CDC provided technical assistance through its personnel in the field and at headquarters in the United States.

According to the U.S. Embassy in DRC, total U.S. federal funding allocated in response to the eastern DRC Ebola outbreak reached \$600 million, including CDC and NIH activities as well as other U.S. Department of Health and Human Services contributions.³¹ More broadly, the United States is the top country donor of emergency humanitarian assistance to DRC and the top financial contributor to MONUSCO (see “Issues for Congress” below).

Issues for Congress

In FY2015, at the height of the West Africa Ebola outbreak, Congress appropriated \$5.1 billion for Ebola response and preparedness on an emergency basis, including \$1.436 billion in multiyear International Disaster Assistance (IDA) funds (Title IX of Division J, P.L. 113-235). USAID primarily used the unobligated balance of these IDA funds to respond to the 2018-2020 eastern DRC Ebola outbreak. As of August 2020, it was unclear whether any of these funds were being used to support Ebola control efforts in Equateur (western DRC) after a new outbreak was detected there in June 2020. USAID’s heavy reliance on FY2015 emergency appropriations for Ebola response may raise questions about how the agency would provide additional support for Ebola control if the Equateur outbreak is not rapidly contained or if another outbreak occurs in the near term, in DRC or elsewhere.

Looking ahead, and weighing the threat of Ebola against other global pandemic threats such as COVID-19, Congress may consider what funding mechanisms, if any, the United States might use to support Ebola prevention and preparedness in the future. Members may also examine the U.S. role, vis-à-vis other actors (including other countries, multilateral entities, and private sources), in financing Ebola prevention and preparedness activities, and may debate strategies for securing additional contributions from other sources.

Additional issues Congress might consider are discussed below.

Implications for U.S.-DRC Policy and Aid

The prospect of potentially larger and/or more frequent Ebola outbreaks, alongside competing global pandemic response needs, may raise questions about where Ebola response fits into broader U.S. health and stabilization priorities and approaches toward DRC, and Africa more broadly. This includes the extent to which Ebola-related foreign assistance should continue to be funded via global emergency response mechanisms, as opposed to being integrated into annual bilateral aid budget planning. The U.S. Embassy in DRC reported in June 2020 that, the United States would be able “to build up the DRC’s longer-term preparedness capacity amidst the varied health-security threats the DRC faces,” as a U.S. Global Health Security Agenda (GHSA)

³⁰ CDC response to CRS query, July 2020.

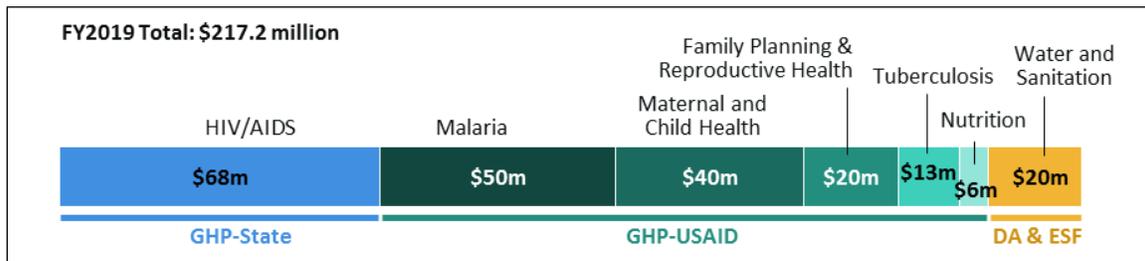
³¹ U.S. Ambassador Mike Hammer, “Together We Stopped Ebola in the East; Together We Can Advance a Better Future for the DRC,” U.S. Embassy Kinshasa, June 25, 2020.

intensive support country.³² U.S. GHSA aid programming is generally funded through globally allocated resources, as opposed to bilateral foreign assistance planned at the country level.

DRC is a significant recipient of U.S. bilateral aid in sub-Saharan Africa, with \$284 million allocated in FY2019 appropriations. Of that total, \$217 million (76%) was for health assistance (see **Figure 2**), roughly the same proportion as for U.S. bilateral aid to sub-Saharan Africa generally.³³ The United States is also by far the top country donor of emergency humanitarian assistance for DRC, with programs focusing on conflict-affected populations and those suffering from acute food insecurity. Excluding funds primarily targeted at Ebola response, U.S. emergency humanitarian aid obligations for DRC in FY2019 totaled \$344 million.³⁴

Figure 2. U.S. Bilateral Health Aid for DRC, by Program Objective

State Department + USAID, Allocations of FY2019 Appropriations



Source: Created by CRS using data provided to CRS by USAID, February 2020.

Notes: Does not include funding administered on a global basis (including Global Health Security Agenda and pandemic preparedness funds) or U.S. contributions to multilateral initiatives. DA=Development Assistance; ESF=Economic Support Fund; GHP=Global Health Programs.

Given that the lengthy and costly international response to DRC’s 10th outbreak was prolonged, in part, by armed conflicts and political instability, Members of Congress may weigh the scale and prioritization of aid and diplomatic resources devoted to addressing these challenges. DRC is a significant recipient of U.S. aid for peace and security and for democracy and governance activities: the State Department and USAID allocated \$12 million in FY2019 bilateral aid appropriations to support the professionalization and capacity of DRC’s military, police, and internal security forces, and \$17 million in support of democracy, governance, and human rights-related programs in the country.³⁵ The United States is also the top provider of funds for MONUSCO (as with all U.N. peacekeeping operations), allocating \$313 million in FY2019.³⁶

Whether enduring problems illustrate that existing donor aid is insufficient, or, alternately, that existing aid programs are ineffective, may be debated. The Trump Administration has repeatedly proposed to decrease U.S. bilateral aid for DRC—although not as much as for many other African countries, and its bilateral health aid budget proposals have varied. In foreign aid appropriations measures between FY2018 and FY2020, Congress generally did not enact the Administration’s

³² U.S. Ambassador Mike Hammer, “Together We Stopped Ebola in the East; Together We Can Advance a Better Future for the DRC,” U.S. Embassy Kinshasa, June 25, 2020.

³³ CRS Report R46368, *U.S. Assistance to Sub-Saharan Africa: An Overview*, coordinated by Tomas F. Husted.

³⁴ USAID, “Democratic Republic of the Congo – Complex Emergency,” FY2019 Fact Sheet #2, September 30, 2019.

³⁵ CRS calculation based on data provided by USAID (February 2020) and published in the State Department Budget Justification for FY2021.

³⁶ State Department Congressional Budget Justification for FY2021; see also CRS In Focus IF10597, *United Nations Issues: U.S. Funding of U.N. Peacekeeping*, by Luisa Blanchfield.

global foreign aid budget proposals, including with regard to DRC. For example, Congress provided at least \$80 million in Development Assistance (DA) budget authority for DRC in FY2020 appropriations, nearly twice the Administration’s budget proposal for bilateral economic aid to the country.³⁷

Despite its regular criticisms of U.N. peacekeeping worldwide, the Administration also voted in the U.N. Security Council to extend MONUSCO’s mandate for at least one more year on December 19, 2019, via a Resolution that recognized the mission’s “positive role” in coordinating international Ebola response efforts.³⁸ At the same time, the Administration secured a decrease in MONUSCO’s authorized troop level in the same Resolution, along with language calling on the mission to plan to draw down further in the coming years, with an eye toward full exit.

Lessons Learned for Pandemic Response in Conflict Settings?

With its many setbacks, the 2018-2020 Ebola response effort may contain lessons for pandemic preparedness and response efforts in other conflict-affected settings where central government authority is weak or contested. Many of the challenges that confronted Ebola responders in eastern DRC are not unique to the area, and are reminiscent of challenges facing efforts to contain COVID-19 in many parts of the world, including in some parts that are ostensibly peaceful.³⁹ These include persistent misinformation and conspiracy theories about the disease, corruption in the allocation of public health resources, a lack of coordination among responders, community resistance to public health measures, and local mistrust of public authorities.

Greater prioritization of local community engagement—including efforts to address perceived exclusion of local residents in hiring decisions—and improved transparency and coordination of international aid activities arguably led to a turning point toward Ebola containment in late 2019. (Whether local hiring initiatives specifically contributed, knowingly or not, to kickback schemes and other alleged corruption in the response effort is unclear.⁴⁰) USAID’s decision to broaden its emergency Ebola response funding to include resources, for example, for broader health initiatives and food aid for affected communities within the outbreak zone, as well as stepped-up resources for communication and messaging, may also have helped alleviate local rejection of the Ebola response effort.

Global Health Security

The Ebola outbreak in eastern DRC prompted the resumption of discussions about strengthening health systems worldwide, particularly with regard to pandemic preparedness. During that outbreak, several Members introduced legislation aimed at bolstering U.S. engagement in the multilateral GHSA—through which the United States has prioritized pandemic preparedness and response in DRC—and for strengthening health systems worldwide. In 2014, during the Obama Administration, the United States and the WHO co-launched the GHSA to improve countries’ ability to prevent, detect, and respond to infectious disease threats.⁴¹ The United States, the largest

³⁷ Explanatory statement accompanying Division G of H.R. 1865 (P.L. 116-94). For FY2020, as in prior years, the Administration proposed to replace the DA foreign assistance account and several others with a consolidated Economic Support and Development Fund (ESDF) account.

³⁸ U.N. Security Council Resolution 2502 (2019).

³⁹ See also CRS Insight IN11285, *Fostering Behavior Change During Disease Outbreaks: Insights from Ebola Response in Africa*, by Alexis Arieff, Tomas F. Husted, and Nicolas Cook.

⁴⁰ *The New Humanitarian*, “How ‘Ebola business’ threatens aid operations in Congo,” op. cit.

⁴¹ For more information on the GHSA, see CRS In Focus IF10022, *The Global Health Security Agenda (2014-2019)*

donor to this multilateral effort, pledged to support it with \$1 billion from FY2015 through FY2019. In 2019, the White House released the *United States Government Global Health Security Strategy*, which outlined the U.S. role in extending the GHSA and improving global health security worldwide.⁴² Although the Trump Administration, through the strategy and public statements, has signaled support for extending the GHSA through 2024, officials have not provided comprehensive information on what that support would entail. Congress might consider funding provided for global health security and pandemic preparedness through regular appropriations. Over time, appropriations for preventing and responding to pandemics have totaled far less than the billions spent on responding to pandemics and infectious disease outbreaks.

Given U.S. endorsement of the GHSA across two Administrations and the emphasis the United States has placed on DRC through the initiative, Members of Congress may consider what role, if any, the United States should play in supporting the GHSA, including whether to codify U.S. engagement in the GHSA. President Obama issued an executive order in November 2016 that established an interagency Pandemic Preparedness and Response Directorate to bolster pandemic preparedness capacity at home and abroad.⁴³ The executive order named the National Security Council as the chair, specified \$1 billion for advancing the GHSA, and outlined the role of participating agencies and departments. The Trump Administration has provided verbal support for the GHSA but has dismantled some of the structure established through the executive order.⁴⁴ A number of bills have been introduced in the 116th Congress to codify a coordinated approach to pandemic preparedness and support for the GHSA. The Global Health Security Act of 2020 (H.R. 2166 and S. 3302), for example, would call for establishing a Special Advisor for Global Health Security within the Executive Office of the President to coordinate U.S. federal government global health security activities, convene and chair a Global Health Security Interagency Review Council, and submit a biannual report to Congress on related activities, among other things.

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and International Health Regulations (2005), by Tiaji Salaam-Blyther.

⁴² White House, *United States Government Global Health Security Strategy*, 2019.

⁴³ White House, “Advancing the Global Health Security Agenda to Achieve a World Safe and Secure from Infectious Diseases Threats,” November 4, 2016.

⁴⁴ Ronald Klain, Testimony before the Asia, Pacific and Non-Proliferation Subcommittee of the House Committee on Foreign Affairs, “Lessons from the West African Ebola Response: How to Save Lives and Protect Our Nation During the Novel Coronavirus Epidemic of 2020,” February 5, 2020.

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