

# The Latest Ebola Outbreaks: What Has Changed in the International and U.S. Response Since 2014?

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This Issue Brief describes what has changed in the broader international Ebola response landscape since 2014, and considers the status of U.S. government (U.S.) engagement in responses to the Ebola outbreaks in the Democratic Republic of the Congo (DRC).

Just days after the World Health Organization (WHO) [declared](#) the end to an Ebola outbreak in the Equateur Province of DRC, a new, separate outbreak was [reported](#) in a different region of that country, centered in the North Kivu Province. Investigations into the full extent of this new outbreak continue, but as of [August 11](#) there have already been 52 cases and 39 deaths reported, making the North Kivu outbreak of equal or even greater magnitude compared to the prior Equateur Province outbreak.

These Ebola outbreaks in DRC are the largest since 2014, when a major Ebola [epidemic](#) hit West Africa and highlighted weaknesses in the ability of international institutions and governments to respond to such events. At that time, the United States ended up playing a major, leading role in helping to control the outbreak, providing more financial assistance than any other donor, mobilizing large numbers of U.S. staff from multiple departments and agencies, and jump-starting a broader, worldwide effort to strengthen global health security.

So far, the U.S. has played a much less prominent role in responding to these recent DRC outbreaks. While this has led some to [raise questions](#) about the U.S. response, suggesting that more engagement from the U.S. was needed, today's context is quite different compared to 2014, with an improved international response capacity resulting in quicker action by the World Health Organization, the DRC, and other partners, and new tools available to contain outbreaks. The successful containment of the Equateur Province outbreak was yet another indicator that national and global responses have improved since 2014.

Even so, the new outbreak in North Kivu presents some unique, additional complications that are challenging response efforts. North Kivu is a [complex and insecure](#) region of the country, making it more difficult to access populations at risk and track suspected Ebola cases and their contacts. The region has a large number of refugees (an estimated [1 million](#) of the 8 million population in the province is comprised

of refugees), is home to 100 armed groups (some [20 of which](#) are “highly active”), experiences high levels of population movement and migration, and borders the countries of Uganda and Rwanda.

## What is different about international Ebola response capabilities now compared to 2014?

### WHO has addressed important shortcomings

The World Health Organization (WHO) is the key international actor in any response to a global public health emergency including a disease outbreak. The agency is designated to serve as the coordinating body for such responses and to also provide technical assistance, expertise, and other material support. While WHO [still faces challenges](#), the agency has undergone important changes in its outbreak response capacities since 2014, many of which were instituted to address the very weaknesses revealed from that experience.

In 2014, according to [dozens of published reviews](#), WHO was slow and ineffective in its early handling of the emerging Ebola outbreak in West Africa. A number of factors contributed to this poor initial response, including: a budget for outbreak response that had been [reduced](#) by more than 50% in two years and a corresponding [loss of staff](#) with relevant experience; little [funding available](#) on a short-term basis to support the cost of an unexpected, major response operation; a [bureaucratic structure](#) that made rapid coordination and decision-making difficult; and a [leadership vacuum](#) that caused delays in coordinating and directing resources, people, and organizations where and when they were needed.

Since then, multiple steps have been taken and key reforms instituted to address shortcomings, including:

- **WHO reorganized.** WHO has [reorganized](#) the offices involved in emergency response, which has helped clarify the organization’s role, streamline its deployment of resources during an emergency response, and allow for more staff who are ready to be mobilized during outbreaks;
- **WHO Emergency Fund created.** There is now a mechanism allowing WHO to quickly release funds for emergency response, known as the Contingency Fund for Emergencies (CFE). The CFE is [funded](#) by donor countries;
- **New leadership engaged in response.** The Director-General of WHO, Dr Tedros Adhanom Ghebreyesus (appointed in July 2017) has helped foster organizational changes at the agency, and he and other leaders have been heavily and directly [engaged](#) in the Ebola responses. To date they have taken the following actions:
  - In May WHO [requested](#) \$26 million from international donors to support the response in Equateur Province; this request was met within a few days. By the end of the Equateur outbreak in July, WHO had received over [\\$63 million](#) in response funding from donors and WHO itself released \$4 million from its CFE. After WHO learned of the new outbreak in North Kivu, it released an [additional \\$2 million](#) from the CFE. As of August 12, WHO had not yet requested a specific amount from donors

for the North Kivu response, though a draft response plan [estimates](#) that \$40 million may be needed and a call to donors could be coming soon.

- Peter Salama, Deputy Director-General for Emergency Preparedness and Response, has been visiting and [working](#) with the DRC since the initial outbreak was identified, and continues to travel and work there in support of the North Kivu outbreak. WHO Director-General Tedros made unprecedented [visits](#) to Ebola-affected areas and has provided regular public updates about the response. In North Kivu, he has [called for](#) warring parties to allow access to affected communities.
- WHO staff have worked to [harmonize activities](#) among key responders, including the government of the DRC and other multilaterals, such the World Food Programme (providing transportation and logistics support), Gavi, the Vaccine Alliance ([supporting](#) deployment of an Ebola vaccine - see more below) and others.
- Early in the Equateur response, WHO [convened](#) an emergency committee meeting at the behest of the Director-General to determine whether the DRC outbreak constituted a public health emergency of international concern; the committee [found](#) that, at the time, the outbreak there was concerning but did not meet the criteria for an international emergency. So far there have been no calls for another emergency committee meeting to discuss the North Kivu situation, though it could occur in the future depending on the trajectory of the current outbreak.

## The affected country has experience with Ebola outbreaks

The DRC has experienced more Ebola outbreaks – 10, including the current one in North Kivu, since 1976 – than any other country in the world. While it still faces enormous challenges in terms of poor healthcare infrastructure, ongoing civil conflict and political turmoil, limited funding, and some community [mistrust](#) of health authorities, the country's prior experience means it has important resources and capacities available to address Ebola. DRC has been able to respond effectively to recent outbreaks, as it did with the Equateur Province outbreak and a prior outbreak in 2017. These were [quickly contained due to](#) rapid action by local authorities, quick testing of samples, early acknowledgement of the outbreak by the government, and coordinated response by local and national health authorities with support of international partners.

In contrast, the three countries at the epicenter of the West African Ebola outbreak in 2014 - Guinea, Liberia, and Sierra Leone - had never before reported an Ebola case. In addition, the disease spread across borders and affected large cities in these countries. The lack of prior exposure to Ebola, coupled with poor outbreak response capacities in these countries generally, meant that needed resources were not in place, such as epidemic response plans, experienced clinicians and epidemiologists, or laboratories with a history of testing for the disease.

## An effective Ebola vaccine is available and being used

The response to the Equateur Province outbreak marked the first time an Ebola vaccine was [used](#) for the purposes of epidemic control, representing an important and [historic step](#) forward in efforts to combat the

disease. While the vaccine is still considered experimental and for use on an emergency basis only, it has been shown to be very effective in trials, so the DRC and WHO agreed to deploy it for its outbreaks this year. In the Equateur response an [estimated 3,300 people](#) were vaccinated, none of whom subsequently developed Ebola, though it is still not clear the extent to which vaccination was responsible for curtailing the outbreak. The North Kivu outbreak is caused by the same type of Ebola as was seen in Equateur, meaning the vaccine can be used to prevent it; the DRC and WHO [began](#) vaccinating at risk populations in the region on August 8.

Using an Ebola vaccine presents major [logistical](#) and [communications](#) challenges, including the fact that the vaccine must be maintained at a very cold temperature and delivered to difficult-to-access areas that have little to no electricity, and that recipients must provide consent after understanding the risks and benefits of receiving the vaccine. Even so, an estimated [98% of people offered](#) the vaccine in the Equateur response agreed to be vaccinated. Other outbreak control measures such as attending patients in special treatment and isolation units, tracing of close contacts of those infected, and education and communication campaigns for affected communities, remain central to stopping transmission as vaccination alone is probably [insufficient](#).

## What is different about U.S. government involvement now compared with 2014?

### The U.S. has engaged in DRC responses relatively early, though not at the forefront

Multiple US agencies have been involved in the DRC outbreak responses. In the current North Kivu outbreak, the CDC has so far played a [supporting role](#), providing technical assistance. In the Equateur response, [CDC](#) also provided epidemiological and other support, USAID provided technical assistance such as mobile laboratories, and the USG overall [provided](#) \$8 million in assistance. In responses in both regions, the DRC government and WHO, along with key partners such as MSF and the International Red Cross, have been at the forefront, not the U.S.

By contrast, U.S. engagement in West Africa in 2014, as measured by personnel and funding, occurred at a later point compared to the responses in DRC, in part because the affected countries and global community were generally not prepared for that event. In 2014, a team of responders from CDC first [arrived in Guinea](#) at the end of March, by which time there were already a reported [112 cases](#) and 70 deaths; the first CDC teams in Liberia [arrived there in mid-July](#) when there had already been [over 150 cases](#) reported in that country and over 900 cases across the three affected West African nations. Later on, as case numbers grew and two Americans became infected in Liberia in late July, and in the absence of a robust response from other international actors, U.S. involvement dramatically scaled up in West Africa, with a multi-departmental response led by USAID, which included deploying [more than 3,700 CDC staff](#) and nearly [3,000 active duty members](#) of the U.S. military to affected countries and, eventually, dedicating unprecedented amounts of funding (see below).

Today, the increased capacity of WHO to address Ebola outbreaks and its quick response in partnership with DRC mean that the current landscape, as well as the potential role for the U.S., may be quite different from four years ago.

## **Yet, the Administration's recent budget moves on global disease outbreak prevention and response send mixed messages**

The US was the largest donor to the 2014 West African Ebola outbreak. In November 2014, near the epidemic's peak, the Obama administration [requested](#) a large emergency appropriation from Congress to help address the disease, and in December 2014, Congress [approved](#) \$5.4 billion in emergency funding, the majority of which (\$3.7 billion) was designated for international activities. Further, about \$1 billion of this \$3.7 billion in funding was designated for U.S. [global health security programs](#) to help build countries' capacities over the longer term to prevent, detect, and respond to emerging health threats such as Ebola.

At this point most of the emergency appropriation from 2014 has already been expended or is set to expire at the end of the 2019 fiscal year, and it is an open question as to whether or not additional funds will be requested by the White House and provided by Congress to continue these efforts going forward. The White House submitted a budget [rescission proposal](#) on May 8 to reduce remaining Ebola response funds at USAID by \$252 million, coincidentally the same day the DRC outbreak was declared; on June 5, this request was withdrawn from the proposal.

Despite questions about funding and the recent rescission request, in its most recent budget proposal to Congress, for FY 19, the White House did include an [increase](#) for global health security programs at CDC, the only requested increase for any global health program. Taken together, these recent funding moves have created an air of uncertainty about the U.S. commitment to global health security more broadly, brought into stark relief in the midst of a new Ebola outbreak.

## **And, no senior U.S. government leader for U.S. international outbreak response has been designated**

The situation in DRC is nowhere near as dire as that in West Africa in 2014, but it is worth noting there is currently no senior U.S. government leader designated to lead a U.S. international response, whether it be for Ebola in DRC or any other outbreak that could occur. The Trump Administration had installed a well-known global health expert, Admiral Tim Ziemer, as the lead on biosecurity and global health at the National Security Council (NSC) in 2017, but his position was [eliminated](#) as part of an overall reshuffling of NSC staff under the leadership of new National Security Advisor John Bolton; the move was coincidentally announced the same week the first DRC Ebola outbreak was declared. Without this position, other NSC staff have been tapped to lead the U.S. responses to the outbreaks.

In contrast, as the 2014 West African outbreak emerged, a senior Obama administration official – former CDC Director Tom Frieden – took on a [highly visible](#) role in the response by visiting the affected countries

multiple times, speaking to the media and the public on the topic, and raising concerns about the outbreak to the White House and Congress. As the West Africa epidemic worsened and U.S. support for the international response grew, the Obama administration [named](#) Ron Klain the government's "Ebola Czar" with a mandate to coordinate across U.S. government departments and agencies; critical to his success in this role was the support he received from President Obama and other leaders in the White House and Congress. Whether and how to designate a point person on outbreaks is a debate that predates the DRC Ebola outbreak, but the ongoing outbreak has added some urgency to this discussion.

## What happens next?

The Equateur Province outbreak was successfully contained by quick and effective local and international action, and use of new tools such as the vaccine. The trajectory of the new North Kivu outbreak is unpredictable at this early stage, and how it unfolds will shape how the international community and the U.S. government respond going forward. If Ebola does not spread much further and is quickly contained in North Kivu as it was in Equateur, little additional action would be required from other external actors for this outbreak, save meeting funding needs. However, if the outbreak expands significantly, and especially if it crosses borders, there will likely be more need for external assistance and greater funding, and the U.S. may be asked to scale up its engagement.