

July 2026 | Issue Brief

Comparing U.S. Ebola Outbreak Response Capabilities and Practices Over Time

Josh Michaud and Jen Kates

The current [Ebola outbreak](#) centered in the Democratic Republic of the Congo (DRC), first identified in May 2026, has rapidly developed into the third largest Ebola outbreak on record. It presents particular challenges for responders because there are no readily available [vaccines](#) or [treatments](#) for the species of Ebola causing this outbreak, which is also taking place in a region with [active conflict](#) and multiple [concurrent humanitarian crises](#). It is also the most significant international infectious disease outbreak the Trump administration has had to face in its second term. Given [major changes](#) made by the administration to U.S. global health and pandemic response mechanisms over the past year and half - including [reducing funding](#), [cutting staff](#), [changing priorities](#) and [shuttering USAID](#) - some [have raised concerns](#) that U.S. international disease response capacity has been compromised and the [effectiveness](#) of the U.S. response has been limited. Others have observed that the U.S. has, in comparison to previous Ebola responses, [mobilized relatively quickly](#) this time. To help put U.S. capacities and actions in further context, this analysis compares the current U.S. Ebola response to those of the two prior largest outbreaks - the West African outbreak of 2014-2015 and the DRC outbreak of 2018-2020¹ - looking across a range of indicators and categories. Even so, such comparisons are complex, as there are many interrelated factors that affect any governmental response - including the severity and size of the outbreak itself, the response of other international and domestic actors, whether there are medical countermeasures available, and whether the outbreak is occurring under exceptionally difficult conditions, such as active conflict.

Taking these dimensions into consideration, this analysis finds that:

- The speed of the U.S. government's response to the current outbreak is on par with the prior two outbreaks. In all three cases, the U.S. mobilized an initial response, including funding and personnel, within days of cases first being reported.
- Initial U.S. funding amounts are already surpassing the prior two outbreaks. The U.S. provided \$21 million in the first six months of the West African outbreak, \$98 million in the first year of

the 2018-2020 DRC outbreak and has already pledged \$375 million in the first two months of the current outbreak. Given that it is still relatively early in the current outbreak, which could become protracted, final U.S. funding levels will likely grow; the administration has already asked Congress for emergency funding of \$1.4 billion.

- Across all outbreak responses including the current response, the U.S. has consistently supported research and development (R&D) for Ebola countermeasures such as diagnostics, tests, treatments, and vaccines, which has been instrumental in identifying and testing new vaccine and treatment candidates; given that there is no vaccine or specific treatments for the current species of Ebola, this work is quite critical.
- At the same time, a significant difference between current and past responses is in the U.S. organizational structure and approach, resulting from the changes made last year by the administration. Past responses were led by USAID and its Office of Foreign Disaster Assistance (OFDA), with a major role played by CDC. Given the dissolution of USAID in 2025, the response lead has shifted to the State Department and its Bureau of Global Health Security and Diplomacy (GHSD) and Bureau of Disaster and Humanitarian Response (DHR), both of which have seen their staffing reduced over the past year. Past responses also had White House National Security Council (NSC) level offices and staff with specific responsibilities for international infectious disease response coordination, something initially absent this time. The current relative lack of specified inter-departmental coordination mechanisms could affect the U.S. response over time, particularly if the outbreak is protracted and the U.S. response scales up further, although there are indications that the administration may seek to name an Ebola response coordinator.
- In addition, while the U.S. has had pre-existing global health programs in these countries when each outbreak has occurred, the current U.S. response takes place after significant upheaval in U.S. global health programs, and as the administration implements its new [America First Global Health Strategy](#), including through a new memorandum of understanding (MOU) the U.S. [signed with the DRC](#) in February, three months before the current outbreak was identified. That new agreement will reduce U.S. funding over time and shift financial and operational responsibility to the country.
- Another notable difference is in U.S. multilateral engagement. In the past, the U.S. was directly engaged with the World Health Organization (WHO) and synced to the strategic pillars identified by WHO and other partners in Ebola response plans. Having [left WHO membership](#) last year, the U.S. is, for the first time, not formally coordinating with the agency, although it is

[coordinating](#) with other United Nations (UN) agencies including the Office for the Coordination of Humanitarian Affairs ([OCHA](#)), the International Organization for Migration ([IOM](#)), the World Food Programme ([WFP](#)), and the United Nations Children's Fund ([UNICEF](#)). The lack of formal relations with WHO, however, could have implications as the response continues to unfold, and present barriers to communications or coordination at times.

- There is also a marked difference in how the U.S. has approached domestic border protection in the current outbreak compared to the past. During prior outbreaks, the U.S. relied on country exit screening, screening at U.S. ports of entry, and follow-up monitoring of travelers from affected countries but not outright travel bans. At present, the administration has imposed a more restrictive posture barring incoming travelers altogether (U.S. citizens and non-citizens that have been in DRC within the last 21 days, as well as non-citizens that have been in Uganda or South Sudan in that time period).

While it is still early to take full stock of the U.S. response to the current outbreaks, based on this analysis some key questions and areas to watch going forward include:

- Will this escalate and potentially require more long-standing U.S. engagement?
- Will the level of U.S. international engagement shift, particularly if the outbreak worsens significantly and/or spreads beyond DRC borders in a more substantial way?
- If the outbreak does expand significantly, will the U.S. support greater mobilization of U.S. staff?
- Will Congress appropriate emergency funding?
- How might the outbreak affect other U.S. supported health efforts in the DRC including the recently signed MOU on global health?
- What will happen with the approach to U.S. border security, especially if more Americans become infected? What other domestic response would be put in place if Ebola cases are identified in the U.S.?

Table 1. Comparing U.S. Responses to Three Ebola Outbreaks

	2014-2015 West Africa Ebola Outbreak	2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
Key Outbreak Characteristics			
Date of initial case report/confirmation	March 21, 2014 (First lab confirmed cases from Guinea)	August 1, 2018 (Outbreak declared by Democratic Republic of the Congo (DRC) Ministry of Health (MOH)) August 7 (lab confirmed cases reported).	May 5, 2026 (DRC notified World Health Organization (WHO) of possible outbreak) May 15, 2026 (lab confirmed cases reported)
Date of first WHO Emergency Committee (EC) Meeting to Assess This Outbreak	August 7, 2014	October 17, 2018	May 19, 2026
Date of Initial WHO “Public Health Emergency of International Concern (PHEIC) declaration	August 8, 2014 (141 days after initial cases identified)	July 17, 2019 (almost 1 year after first case reports, due to the WHO EC initial determination the outbreak was not a regional threat, a key criteria for PHEIC determinations).	May 17, 2026 (16 days after first cases identified, 2 days after first cases confirmed). PHEIC declaration was made by Director-General before Emergency Committee met.
Virus species	Zaire	Zaire	Bundibugyo
Primary countries affected	Guinea, Liberia, Sierra Leone	DRC	DRC and Uganda
Total number of reported cases and deaths	28,610 cases, 11,323 deaths over 28 months (outbreak declared over in June 2016)	3,470 cases and 2,287 deaths over 22 months (outbreak declared over in June 2020)	3,200 cases, 1,405 deaths (over 8 weeks, through July 25, 2026)

	2014-2015 West Africa Ebola Outbreak	2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
Vaccine availability	No vaccine available initially. Clinical trials with candidate vaccines began in in West Africa in February and March 2015 . A candidate vaccine was made available under a compassionate use protocol for broader community “ ring vaccination ” purposes in March 2016 in Guinea.	Yes. Over 236,000 people vaccinated in DRC during the outbreak response.	No vaccine availability at this time. Trials with candidate vaccines began in July 2026 .
Therapeutics availability	No therapeutics available initially. Limited use of experimental therapeutics began in August 2014 ; clinical trials began in March 2015 .	Limited use of experimental therapeutics in 2018; a trial of several candidate treatments began November 2018 .	No therapeutics available at this time. Clinical trials of experimental candidates began in July 2026.
Active conflict/instability in affected areas	No	Yes	Yes
U.S. Funding for Response			
Speed of initial U.S. response funding (time from outbreak detection to mobilization of U.S. response funds)	Initial U.S. Agency for International Development (USAID)/Office of Foreign Disaster Assistance (ODFA) funding provided in March 2014, soon after initial outbreak reports. Centers for Disease Control and Prevention (CDC) supported initial staff deployments to affected areas in late March/early April. As the outbreak worsened considerably over subsequent	Initial USAID funding provided in August 2018, within weeks of the initial announcement of confirmed Ebola cases in eastern DRC. CDC also supported staff deployments and response activities in August. As outbreak worsened considerably in March/April 2019, U.S. response funding scaled up.	Initial funding announced on May 19. (four days after initial case confirmation and two days after PHEIC declaration).

	2014-2015 West Africa Ebola Outbreak	2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
	months, U.S. funding scaled up, particularly from August 2014 on.		
Amount and source of initial response funding	Between March and August 2014, \$21 million in cumulative response funding reported from USAID. By October 2014, CDC had committed >\$16.7 million for its Ebola response activities. Initial funding drawn from USAID International Disaster Assistance funds	As of September 5, 2018, USAID had provided at least \$2 million for response activities. Over the first 11 months of the response (through July 2019) USAID reported \$98 million in support for the response. Funds drawn from unspent FY2015 Ebola emergency supplemental funds.	State Department announced \$23 million in initial Ebola response funding on May 19, drawn from existing FY2026 State Department humanitarian assistance funds.
Total U.S. response funding amount and source	Approximately \$2 billion in U.S. international response funding obligated by the end of 2015, primarily through emergency/supplemental appropriations provided to USAID and CDC.	From August 2018 to June 2020, USAID provided over \$342 million for response activities, drawn from USAID International Disaster Assistance, USAID/Global Health, USAID/Food for Peace, and USAID Mission funds. USAID used unspent FY2015 Ebola emergency supplemental funds.	\$270 million was committed by the State Department as of June 12, drawn from State Department's existing FY2026 humanitarian response funds. The U.S. has made an overall pledge of \$375 million in support of the response as of June 19.
Emergency / supplemental funding requests and appropriations	White House requested \$6.2 billion in emergency supplemental funding in November 2014. In December 2014, Congress appropriated \$5.4 billion, including \$3.7 for international response activities.	None requested.	White House requested \$1.4 billion in emergency supplemental funding in June 2026. As of July 2026, Congress had not yet appropriated additional funding.
U.S. funding share of overall international response funding	The U.S. was the largest donor to the response, providing \$2.4 billion (41%) of the \$5.81 billion in overall donor funding provided between 2014 and 2016.	The U.S. was the largest donor to the response, providing \$252 million (34%) of the \$734 million in overall donor funding provided between August 2018 and December 2019.	The \$375 million pledged \$375 million by the US for Ebola response activities represents 41% of the \$910 million in overall donor funding pledges made by international donors in support of the joint continental Ebola response plan.

	2014-2015 West Africa Ebola Outbreak	2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
U.S. Staff deployments, EOC Activation			
Staff Mobilized/ Deployed	Prior to the outbreak, USAID and CDC presence in the three most affected countries “very limited.” On March 31, 2014, a 5-person CDC team deployed to Guinea. In August 2014, 28-member DART team deployed (staff from USAID, CDC, the Department of Defense (DoD), other agencies). By the end of the outbreak, over 3,500 personnel from DoD, CDC, U.S. Public Health Service (USPHS) Commissioned Corps, USAID, and National Institutes of Health (NIH) were deployed.	First 5 CDC staff deployed to North Kivu August 2018 (pulled back after a few days). By May 2019, CDC had 17 staff in Kinshasa and Goma. USAID established a DART team on September 21, 2018. During response, U.S. staff kept away from front lines due to security concerns.	CDC reports it has 23 field staff in DRC and over 100 staff in Uganda. State Department has deployed an unknown number of staff from GHSD and DHR via DART to DRC and Uganda.
CDC Emergency Operations Center (EOC) Activation	EOC activated on July 9, 2014. (110 days after initial case confirmations). On March 31, 2016, CDC officially deactivated the EOC for this response.	EOC activated in June 2019. (10 months after initial case confirmations). The EOC was deactivated some time in 2020, no official announcement made.	EOC activated on May 17, 2026 (two days after case confirmations) Raised to “highest alert level” June 26, 2026.
U.S. Organizational Approach			
Agencies involved and coordination	USAID/OFDA, CDC, DoD, NIH, and State Department. In May 2014, the White House asked the HHS Office of Global Affairs to coordinate the U.S. government	USAID/OFDA, CDC. No NSC-level leader designated for coordinating U.S. response, as the global health security team at NSC was disbanded in May 2018 during a	USAID was dissolved in 2025, making the State Department the primary response agency along with CDC. At the State Department, the Bureau of Global Health Security and Diplomacy (GHSD), and Bureau of Disaster and Humanitarian

2014-2015 West Africa Ebola Outbreak		2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
response, with USAID as operational lead and CDC as lead on technical and public health issues. As the outbreak continued to expand in West Africa, and several Americans working in West Africa became infected with Ebola, President Obama became directly involved, offering to send U.S. troops in September, and appointing an Ebola Response Coordinator in October 2014 who eventually led coordination of U.S. agencies through a position at the National Security Council (NSC)		reorganization process under the first Trump Administration. Primarily, coordination occurred at the department/agency level.	Response (DHR) are the key bureaus overseeing response activities. No specific NSC GHS staff/office designated initially to provide coordination, though a director for bioresponse at the National Security Council was named in July. In June, Secretary of State Rubio stated the administration is considering naming an Ebola response coordinator to oversee the U.S. response.
Pre-existing U.S. Global Health Programs in Affected Countries			
Amount of U.S. GH funding in affected countries in the fiscal year prior to initial outbreak (amounts are disbursements for the indicated fiscal year)	In FY2014, U.S. GH funding by affected country was: -Guinea: \$18.8 million, primarily for malaria and family planning/reproductive health (FPRH), plus maternal and child health (MCH), and HIV/AIDS. -Liberia: \$26.2 million, primarily malaria, MCH, and FPRH, plus HIV/AIDS, and Nutrition. -Sierra Leone: \$750k for HIV/AIDS.	In FY2018, U.S. GH funding for DRC was \$146.4 million, primarily for malaria, HIV/AIDS, MCH, FPRH, tuberculosis (TB), Global Health Security (GHS), and Nutrition.	In FY2025, U.S. GH funding for DRC was \$165.8 million, primarily for malaria, HIV/AIDS, MCH, FPRH, GHS, and Nutrition.
U.S. Communications Practices			

	2014-2015 West Africa Ebola Outbreak	2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
USG public communications on Ebola response	Regular communications from USAID, CDC and other federal agencies on international response activities, domestic public health guidance. National press conferences and televised briefings were featured. Notable White House involvement in communications starting in August 2014 due to significant public interest in the topic following identification of Ebola cases in the U.S. USAID had the lead for communications regarding U.S. response operations in West Africa, while HHS (including CDC) and the National Security Council handled communications about domestic Ebola cases.	Comparatively less U.S. public attention compared to 2014. Still, CDC and USAID provided situation updates, travel notices, technical guidance. WH public facing engagement was not apparent.	CDC has conducted media briefings, technical briefings, publication of updates, guidance , risk assessments. State Department has provided press conferences, semi-regular posts about U.S. activities and support. President Trump mentioned U.S. support for international response in public remarks.
U.S. Research & Development Support			
U.S. support for countermeasures R&D, including vaccines	NIH provided accelerated early clinical trials of vaccine candidates, and field efficacy studies in Guinea and Liberia . U.S. supported evaluation of several experimental therapies, including ZMapp, TKM-Ebola, Favipiravir, and convalescent plasma.	NIH supported ZMapp investigational treatment R&D in DRC. The rVSV Ebola vaccine was used extensively during the response, under expanded-access, with the U.S. supporting vaccine logistics, effectiveness monitoring, operational research, ring vaccination strategy, and other related activities.	U.S. research response has focused on evaluating cross-protection of existing vaccines/treatments, development of multivalent vaccine candidates. USG committed \$50 million to the Coalition for Epidemic Preparedness Innovations (CEPI) to advance Bundibugyo vaccine R&D. BARDA/Mapp Biopharmaceutical announced a transfer of investigational doses of MBP134 monoclonal antibody to DRC.

	2014-2015 West Africa Ebola Outbreak	2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
U.S. Multilateral Engagement			
U.S. multilateral engagement on response activities	The U.S. led much of the response, especially in the early stages in 2018, as the WHO-led multilateral response took time to scale up. U.S. response primarily bilateral, with a focus particularly on supporting activities in Liberia As the multilateral response expanded, the U.S. engaged as active, partner for WHO, UN agencies, and the UN special mission for Ebola response known as UNMEER that was created in September 2014. U.S. activities and engagement spanned all major “response pillars” outlined in multilateral response plans. The U.S. was the largest donor to WHO’s Ebola response activities, providing \$73.9 million, and largest donor overall to Ebola response in the region.	The U.S. played an important, though more supporting role as WHO and the DRC government primarily led the response. U.S. activities supported the Ebola response plan developed by DRC, WHO and other international partners. U.S. agencies (including NIH, USAMRIID, and CDC) as well as U.S. funded NGOs were listed as supporting partners across most of the response sectors/pillars, though the U.S. CDC was the only U.S. agency listed as a co-lead (along with WHO) for one of the main response pillars (“Health Information and Analytics”).	Following U.S. withdrawal as a WHO member state, communication and engagement with WHO is limited. The U.S. has direct engagement with UN humanitarian response organizations including OCHA, WFP, UNICEF. The multisectoral continental response plan released by DRC, WHO, and Africa CDC lists the following USG entities as partners across response activities: CDC as co-lead for the surveillance and epidemiology & laboratory systems and genomic sequencing response pillars, and NIH as a partner organization for the clinical trials/R&D sub-pillar.
Domestic border protection measures			
U.S. government border policies during Ebola response	Focused on exit screening of travelers from at-risk countries, and entry risk assessment and management for incoming travelers. Travelers from West Africa were primarily directed	CDC implemented routine border health security measures at ports of entry. No additional measures imposed.	The U.S. has barred entry for all travelers on commercial flights who were recently in DRC – including U.S. citizens – and non-U.S. citizen travelers who were recently in Uganda or South Sudan. U.S.

2014-2015 West Africa Ebola Outbreak	2018-2020 DRC Ebola Outbreak	2026 DRC Ebola Outbreak
through five US airports where they went through CDC-designed screening and follow-up with active monitoring of at-risk contacts. In limited cases, there were state-imposed quarantines/isolation.		officials have stated they do not wish to repatriate any Americans who become infected with Ebola overseas. Already, two U.S. citizen health care workers infected with Ebola in DRC have been transported to Germany for monitoring and treatment, rather than brought to the U.S., and seven American aid workers working on the Ebola response in DRC have been sent to a facility in Kenya to quarantine rather than allowed to return to the U.S. immediately.

¹ There was an earlier, smaller Ebola outbreak in 2018 in the northwestern Equateur Province in DRC, initially identified in May 2018. The Equateur outbreak was contained by the end of July 2018, just weeks before the before another, separate, and eventually much larger, outbreak was identified in the Ituri Province in eastern DRC in August 2018. This analysis does not examine the U.S. response to the Equateur outbreak.