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The latest Ebola outbreak: what has changed in the international and U.S. response since 2014?

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In early May 2018, a new Ebola outbreak was declared in the central African nation of the Democratic Republic of Congo (DRC). DRC has experienced multiple Ebola outbreaks since the virus was first discovered within its borders in 1976, but this latest one has raised concerns due to its size (58 cases and 27 deaths reported to date), and its spread to a large city.

In addition, it is the largest Ebola outbreak 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 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.

Thus far, however, the USG has played a much less prominent role in the DRC outbreak. On the one hand, this has led some to raise questions about the U.S. response, suggesting that more is needed; there are already broader questions about the future of U.S. commitment to global health security efforts. On the other, today's context is quite different from that of 2014and there is an improved international response capacity resulting in quick action by the World Health Organization, the DRC, and other partners to the latest outbreak.

This brief examines what has changed in the larger international Ebola response landscape since 2014, and the current status of the USG engagement, including comparing the U.S. response now to a similar point in the trajectory of the 2014 outbreak.

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.

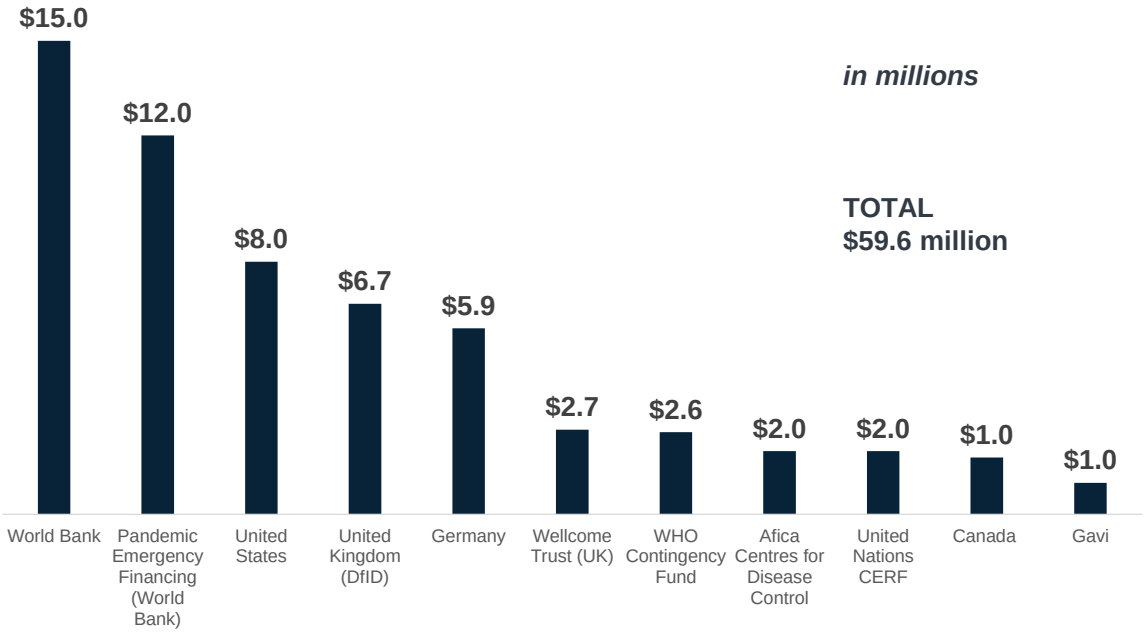
In 2014, according to dozens of published reviews, WHO was slow and ineffective in its early handling of the emerging Ebola outbreak in West Africa. A number of factors contributed to this poor initial response, including: a budget for outbreak response that had been reduced by more than 50% in two years 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 these and other factors, 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 response. To date they have taken the following actions:
  - On May 18, WHO requested $26 million from international donors to support its response efforts in DRC; this request was met within a few days, including $2.6 million released by WHO itself from the CFE. Overall, donors have provided a total of $59.6 million in support of the response in DRC so far (see Figure 1).
  - Peter Salama, Deputy Director-General for Emergency Preparedness and Response, has been visiting and working with the DRC since the first cases were identified, and Director-General Tedros has made unprecedented visits to Ebola-affected areas and has provided regular public updates.
  - 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.
  - WHO quickly 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, and to assess the threat and calibrate the appropriate response; on May 18 the committee found that, at this time, the situation in the DRC is concerning but does not meet the criteria for an international emergency.

Figure 1

International Donor Pledges of Financial Support for DRC Ebola Response (as of May 24, 2018)



Notes: Based on May 23 exchange rates. World Bank's $15 million is a reallocation of funds previously planned as a three year investment in disease surveillance in the country. DRC=Democratic Republic of Congo, CERF=Central Emergency Response Fund, DfID=Department for International Development, WHO=World Health Organization, UK=United Kingdom, Gavi= Gavi, the Vaccine Alliance
Sources: Press releases and announcements from the World Bank, U.S. Agency for International Development, U.S. Department of Health and Human Services, DfID, German Ministry of Health, Wellcome Trust, WHO, Africa CDC, United Nations, Government of Canada, and Gavi.

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The affected country has experience with Ebola outbreaks

The DRC, the currently affected country, has experienced more Ebola outbreaks – 9, including the current one, 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 contain outbreaks in the past, as it did most recently when an Ebola outbreak in 2017 was 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

In the DRC, an Ebola vaccine is being used to control an outbreak for the first time, an important and historic step forward in combatting the disease. Development of the vaccine was accelerated during the West African outbreak four years ago, recently resulting in a successful candidate. While the vaccine is still considered experimental and for use on an emergency basis only, it has been shown to be very effective and the DRC and WHO agreed to deploy it in the current response. Over 7,500 doses have already been shipped to the country with more on the way; the first doses of the vaccine were given on May 21. Using the vaccine, however, 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. 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 relatively early, though is not at the forefront

Multiple US agencies are already involved in the current DRC outbreak response, including CDC (providing epidemiological and other support) and USAID (providing technical assistance such as mobile laboratories). USAID announced $1 million in support for the response on May 18, and on May 22, HHS Secretary Azar announced an additional $7 million for the response from that department – an amount which essentially fills the gap in the WHO's requested response budget. The U.S. is not leading the response on the ground – the DRC government and WHO, along with key partners such as MSF and the International Red Cross, are – but is providing valuable assistance and financial support at a moment when the outbreak has reached 58 reported cases.

By contrast, U.S. engagement in West Africa in 2014, as measured by personnel and funding, occurred at a later point in that outbreak, in part because the affected countries and global community were generally not prepared for such an event. 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, with a multi-departmental response led by

USAID, which included deploying more than 3,700 staff of CDC 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. In fact, the White House submitted a budget rescission proposal on May 8 to reduce remaining Ebola response funds at USAID by $252 million; Congress has yet to act on this proposal, which is part of a larger $15 billion federal spending reduction proposal.

Still, 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 recently 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 DRC Ebola outbreak was declared. Without this position,

other NSC staff have been tapped to lead the U.S. response to the outbreak but have not made any public statements, and no public statements have been made by the current CDC Director.

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 future trajectory of the outbreak, which is still unpredictable at this point, 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 the DRC, 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.