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VIEWPOINT

Ebola and War in the Democratic Republic of Congo

Avoiding Failure and Thinking Ahead

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The Ebola epidemic in the Democratic Republic of Congo (DRC) is exceptionally dangerous, occurring within active armed conflict and geopolitical volatility, including a million displaced persons. With 421 cases, 240 deaths, and the numbers increasing, this Ebola outbreak is the second deadliest in history.¹ Recent spread to Butembo, home to 1.2 million people, raised concerns. The DRC, World Health Organization (WHO), and partners are leading a vigorous international response, yet despite deploying an experimental vaccine, cases doubled in October 2018 and many cases had unknown origin.

Uncontrolled Ebola outbreaks can expand quickly, as occurred in West Africa in 2014. Averting that outcome in the DRC requires rapid action including a strengthened public health response, security, and community outreach. If violence escalates, it could compromise a fragile response. Yet resources are insufficient. The United States and other countries are not permitting personnel deployment to the epicenter, including from the Centers for Disease Control and Prevention (CDC) and US Agency for International Development (USAID).

In this Viewpoint, we review recommendations of experts convened by Georgetown University and listed at the end of this article. The United States and international community should launch high-level political mobilization, with diplomatic, human, and economic resources. It is critical to recognize that future health crises will occur in fragile, insecure settings. To prepare, the international community needs long-term planning and enhanced capacities to improve the safety and effectiveness of epidemic response operations.

Public Health Amid Active Conflict

Contact tracing, medical isolation, ring vaccination, and investigational treatments are being deployed in the DRC. It is vital to reach all infected people and minimize their time with illness in the community. Of 137 confirmed cases between October 28 and November 26, only 19 were found through contact tracing, 32 were on contact lists but lost to follow-up, and 83 (61%) had no known links to confirmed cases. Those without known links to previous cases averaged 7 days between onset of symptoms and isolation; people who died in the community averaged 9.7 days with symptoms.¹ These data suggest contact tracing and vaccination have not prevented cascading transmission. More than 30 health care workers have been infected. Community distrust is deep after decades-long humanitarian crises, impeding information-sharing and cooperation.²

On October 17, the WHO's Emergency Committee determined the outbreak did not constitute a public health emergency of international concern (PHEIC) under the International Health Regulations. Days later, armed rebels reportedly killed 19 people and kidnapped 12 children in the outbreak epicenter.² The Allied Democratic Forces (ADF) have conducted more than 20 lethal attacks, severely disrupting the response, as have local Mai-Mai militias. The United Nations (UN) Stabilization Mission offers protection to responders but has been ineffectual in stemming ADF attacks; its reputation among communities remains problematic. On November 8, the WHO and UN pledged enhanced security operations.³ Yet, lethal attacks have persisted.

Gaps in the Response

The WHO and partners are leading an energetic international response despite adversity. The World Bank has dispatched financing, while US-supported vaccines, therapies, and laboratory/epidemiology capacity-building are proving essential. The WHO's Health Emergencies Program and contingency fund—restructured since the West Africa epidemic—provide vital tools. Yet, the WHO has neither the mandate nor capacity to fully cope with insecurity and societal alienation.⁴

Foreign health workers with nongovernmental organizations and UN agencies are currently tackling Ebola in North Kivu, DRC, alongside local personnel who offer vital experience and linguistic and cultural awareness. However, significant capacity gaps remain in surveillance, data analysis, laboratories, and clinical response, particularly experienced personnel to expand the response and rotate teams. Responders need greater capacity to work with local leaders to build community trust and communication. The DRC's second Strategic Response Plan requested \$62 million through January, which, while not yet fully funded, is likely insufficient if the epidemic escalates.⁵

Increased security is essential. On October 30, UN Security Council (UNSC) Resolution 2439 demanded warring parties respect international law, ensuring safe humanitarian operations. Yet there has not been high-level international mobilization to reduce armed attacks. The DRC, facing elections on December 23, has not supported internationalizing the security response.

Consensus Recommendations

An expert consultation—with public health, humanitarian, security, anthropology, and human rights expertise—made the following recommendations to deepen US and global engagement, while recognizing key security details are not public.

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First, through the UNSC, the United States and allies should mobilize high-level political attention and resources for the Ebola response. Many lives are at risk if the epidemic is not rapidly contained. The Security Council should engage all parties, including the DRC and African Union, to achieve mitigation of armed attacks by the ADF and other militia; improved security for health workers; a comprehensive aid package to communities; stronger preparedness in neighboring states; and a contingency plan to sustain the response if security worsens. US ambassadors in the region should use all diplomatic tools available to ensure the viability of the response.

Second, the US, along with allies and the UN, should develop a plan to deploy public health personnel to North Kivu. It is in US national interests to control outbreaks before they escalate into a crisis. The cost of addressing this epidemic now is far less than if mass mobilization were required due to international spread of the virus. The WHO and DRC have requested support from experienced personnel supported by US agencies. CDC and USAID experts could, for example, be embedded in the WHO or other UN agencies. The plan should include US security and diplomatic resources, coordinating with the UN, to assess and improve health worker security. Lessons can be drawn from humanitarian operations in unstable settings, including northern Nigeria and South Sudan.

Third, US engagement should be closely coordinated with the WHO and the national government. The WHO is the lead health agency for containing potential PHEICs. When deploying US and other countries' resources in a conflict zone, an uncoordinated response could be counterproductive. Strategic and operational engagement, therefore, should be part of a unified response with clear coordinating authority, starting with the DRC and WHO.

Fourth, the United States should increase funding to the DRC to enhance local response capabilities. Congolese health leaders have much experience in containing Ebola outbreaks, but lack resources to detect, assess, and respond. Many health workers are not reliably compensated. African universities also have anthropology, communications, and health research capacities that could be resourced to deploy. Engaging the Congolese diaspora and using mobile communications for innovations in field epidemiology also may be valuable.

Fifth, with the epidemic likely to continue for many months, the US and WHO should immediately collaborate to expand the re-

sponse workforce. Building on the CDC's Field Epidemiology Training Program, the US and WHO should rapidly train and equip more health workers to sustain a prolonged Ebola response.

Sixth, longer term, the United States should craft a transparent framework for responding to epidemics in conflict zones. Risk aversion can impede early, effective intervention that prevents outbreaks from becoming crises. This is especially true when US agencies represent a significant part of global disease response capacity. The US, working proactively with partners, should develop a transparent framework for assessing and mitigating risk, balanced against the global public good of preventing PHEICs.

Seventh, the US and international partners should ensure sustainable funding for national action plans for health security. The US helped launch the Global Health Security Agenda in 2014 to expand capacities in key countries and recently recommitted at the Global Health Security Agenda Ministerial in Indonesia. Investing in preparedness is much less costly than crisis response and enables burden sharing, "smart" diplomacy, local leadership, and public trust.

Eighth, the UNSC should create a plan to safeguard public health action in conflict zones. In 2016, the UN secretary-general submitted specific recommendations to protect health workers under UNSC resolution 2286, but the council has not acted. It is certain that the UN will be called on to provide security in future health crises. It must prepare and maintain readiness for that eventuality.

Conclusions

The Ebola epidemic in the DRC has reached a dangerous moment, requiring new political and security strategies. Supporting DRC and WHO leadership, the US has capabilities that should be carefully and responsibly deployed. From a humanitarian perspective, the CDC and USAID have experienced personnel and key capacities that could help prevent the epidemic from spreading regionally, which would cost thousands of lives and devastate local economies. The US and partners should also support the UN to adapt and expand its capacity to safeguard health workers and the public. This is the first Ebola outbreak during which armed attacks impede the response, but it will not be the last major health crisis amidst insecurity. The global health playbook must expand to meet that reality.

ARTICLE INFORMATION

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