

Congo Ebola epidemic passes 8,000 cases and nears 4,000 deaths as attacks on health workers mount

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On Sunday, September 27, according to a brief report by Reuters, Marie-Celestin Karondwa was beaten by residents of his own neighborhood in Butembo, in the eastern Congolese province of North Kivu. They looted his belongings and set his house on fire, and he died of his injuries. Karondwa was acting president of the local federal committee of the ruling Union for Democracy and Social Progress, and his party says he was attacked for having gone on the radio to tell people that Ebola exists and threatens them.

The day before, armed men walked into a screening post at Vulemba, outside the same city, and shot dead the worker checking travelers for fever.

The Democratic Republic of the Congo's National Institute of Public Health, established by ordinance in March 2023, recorded 8,116 confirmed cases of Ebola and 3,924 confirmed deaths as of September 27, the 135th day of the epidemic, across 63 of 167 health zones in seven provinces.

The bulletin for September 26 reported 78 new confirmed cases against 43 the day before, and 49 deaths against 19. Thirty-four of the dead had never reached a treatment center.

None of this can be read as a measure of the epidemic's direction, which remains unpredictable because so little testing has been done. The 78 cases came from 422 samples analyzed; the 43 the day before came from 474. Fewer tests nonetheless showed more cases: laboratory positivity doubled nationally from 9.1 to 18.5 percent and reached 26.9 percent in Ituri, and a third of the day's national total came from one health zone, Mandima, where reported cases rose from nine to 25 as investigators went looking.

Nor is there anything to measure the epidemic against. No figure for suspected cases under investigation has been published since August 4, eight weeks ago. What the daily bulletin counts is the number of people tested and found positive, which is a record of laboratory throughput rather than of actual transmission.

"The outbreak is not shrinking; it is moving," observed Anthony Kergosien, emergency coordinator for Médecins Sans Frontières (MSF), on September 18.

The clearest measure of the response is who it is watching,

and how few they are. On September 26 there were 31,034 people under active follow-up as contacts of a confirmed case, and tracers saw 23,187 of them, a rate of 74.7 percent, down from 77.8 the day before and 79.2 the day before that. The list grew by a thousand names in a day while the number of people actually visited fell.

Standard practice is to identify around 60 contacts for every confirmed case and watch each for 21 days. At the rate the Congo was reporting cases that week, something like 54,000 people should be under observation. There are 31,034. Two in five who should be listed are not, and a quarter of those who are were not seen.

Jean Kaseya, director-general of the Africa Centres for Disease Control and Prevention, gave the result to Reuters on September 25: more than 80 percent of newly confirmed cases are found among people nobody is tracing. The machinery itself has improved, with testing up roughly eightfold since May, but its reach has not grown with the epidemic. The limits are material.

In North Kivu, seven households had a confirmed case in them and not one received an infection-control kit. In Tshopo, 97 of 99 health facilities failed to reach the basic standard for infection control. Bas-Uélé holds 25 kilograms of chlorine and 80 liters of fuel and has neither a compliant treatment center nor an ambulance to reach one. And 86.6 percent of North Kivu's infection-control staff are not on the list of people the response effort is paying.

Where the cases are being found has moved. For the first six weeks, four of every five were around Bunia, Ituri's capital, on Lake Albert, and in the Kilo goldfield at Mongbwalu and Nizi, whose mining sites draw workers from other provinces; among the first 115 cases analyzed, men outnumbered women and most were aged between 20 and 49, the ages of workers who dig. Since then, North Kivu's share of newly detected cases has risen across four reporting periods from 9 percent to 36 percent, and the center of gravity has traveled about 61 kilometers southwest, down the RN4 from Bunia through Komanda to Beni, Butembo and Katwa. Ituri still holds 76.3 percent of the cumulative total. But Beni, Mandima, Kalunguta and Mambasa

were the principal hotspots of the epidemic that killed 2,287 people between 2018 and 2020, and all four are infected again.

In Butembo, a city of 2 million, all 29 beds at the Kitatumba treatment center run by MSF are full. Its project coordinator, Stephanie Hoffmann, says people who know they have Ebola cannot find a bed; a 10-year-old boy died in triage before he could be admitted. Across North Kivu, 59.5 percent of those diagnosed are dying, against 48.4 percent nationally, two in five of those who reach a treatment center do not leave it alive, and a third of the province's patients are being treated outside a center altogether.

Dr. Michel Paluku Mukuloli, a doctor in the city, says his patients believe that going to the hospital means being sent to the center to die. Two of the nine health checkpoints in his health zone are staffed. Residents burned down a health post they accused of collaborating with the response. A burial worker, Lambert Maboko, had his knee broken with a machete. And provincial authorities have recruited pro-government Wazalendo fighters to enforce compliance on the roads, one of whose commanders said people who keep refusing could be taken to a treatment center by force and whipped.

Pepin Kavota, a civil society coordinator in Beni, explains the refusal. During the 2018 to 2020 epidemic, responders, including people employed by the World Health Organization, sexually abused and exploited the population they were sent to protect. The current response monitors 119 health zones for sexual abuse by its own staff. In 78 of them, however, nobody knows how to report such incidents.

The World Health Organization gave its own assessment of the Ebola crisis on Tuesday. Dr. Janet Diaz of its Health Emergencies Programme told reporters in Geneva that many people are still dying at home or in their communities because they cannot reach a health facility in time, and put this down to delays in seeking care and to difficulties of access and referral. Placing a positive spin on the grave issues, she noted that treatment capacity has grown from a handful of beds at the start of the outbreak to more than 1,600 across 50 centers, she said, and nearly 400 health workers have been trained. However, oxygen, which she called decisive for the survival of the severely ill, remains unavailable or unreliable in many facilities.

None of this was unknown to the governments that gathered in New York for the United Nations General Assembly last week.

On September 23, the United States convened the foreign ministers of the world's largest economies in New York to discuss stopping Ebola in the Congo. The Japanese foreign ministry records that the meeting opened at 3:10 p.m. and lasted about an hour. It produced roughly \$700 million in fresh commitments, bringing the total pledged since the outbreak was declared to about \$2.9 billion, of which the American share is \$886 million.

Two days later, in the same building, those same

governments refused to adopt a political declaration on pandemic preparedness. The document was not binding. It obliged nobody to spend anything. It was blocked all the same.

Erica Schwartz, director of the US Centers for Disease Control and Prevention, told the session the text contained "divisive ideologies lacking definitional consensus" and did not say which. An early draft seen by the *New York Times* shows that Washington had asked to strike out the words "equity" and "solidarity," and the commitment to "universal access to sexual and reproductive health care." The European Union blocked it over intellectual property, objecting to a paragraph reaffirming the 2001 Doha Declaration, which holds that patent rights should be read in a manner that supports the right of states to protect public health.

The declaration they would not sign reports a \$15 billion annual gap in preparedness financing, praises a WHO emergency fund that has received \$5.4 million this year and is nearly empty, and commits governments to delivering vaccines within 100 days of a threat. The Congo is at day 135.

An hour of speeches about defeating Ebola were followed, 48 hours later, by a refusal to sign a statement that would have cost nothing, because it used the word equity and because it touched on patents and royalties.

That sequence is obscene, and it is also entirely consistent with capitalist medicine for profit. What was refused in New York was not money, which had already been found. It was the principle that a Congolese life has the same claim on the world's medicine as any other. "Equity" was struck out because it implies an entitlement. The Doha language was struck out because it implies that a patent might one day be overridden to save a dying population.

These are not drafting oversights. This is what malign neglect looks like written down.

The capacity to end this epidemic and prevent the next exists now. But the current effort is organized around what can be taken out of the ground of eastern Congo rather than around the people who live above it. Until the pharmaceutical industry and the laboratories are taken out of private hands, and the resources now committed to extraction and to war turned toward the medical and sanitary infrastructure the Congolese population has been denied, every epidemic of this kind will end as this one is being conducted: not contained and not counted.



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