

# Ebola cases exceed 10,000 with case fatality approaching 50 percent

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The Congolese health ministry's situation report for October 28, day 166 of the Ebola epidemic, records 10,274 laboratory-confirmed cases of Bundibugyo ebolavirus disease and 4,992 confirmed deaths, a case fatality ratio of 48.6 percent. The virus has reached 67 of 178 health zones in eight provinces, from Ituri and North Kivu to Yakoma on the border with the Central African Republic. On October 28 alone the bulletin reported 78 new cases and 32 deaths, 18 of them among people who never reached a treatment center. It is now the second-largest Ebola epidemic on record, after West Africa's epidemic of 2014–2016.

It has also become a regional one. Uganda recorded 20 cases and two deaths before declaring an end to its outbreak in late August. Kenya has confirmed nine cases and two deaths, all in a single cluster, and Nigeria confirmed its first case on October 20. Counting a case diagnosed in France, the US Centers for Disease Control and Prevention (CDC) counts 31 cases outside the Congo as of October 27. At a virtual summit of African health ministers on October 28, Africa CDC Director-General Jean Kaseya conceded that the continent is “not winning” the fight against Ebola.

Of the 7,758 confirmed patients whose illness has ended, 4,992 have died and 2,766 have recovered (about two in three fatalities.) That is the same rate recorded among confirmed patients in West Africa in 2014–2016, 62.9 percent, 12 years after that epidemic was supposed to have taught the world its lessons.

The ministry's headline ratio of 48.6 percent is lower only because it still counts some 2,500 patients who are ill or whose outcome has not been recorded. At the start, the ratio was artificially low. On May 24 the bulletin counted 10 deaths among 105 confirmed cases, while listing 223 suspected deaths that were never tested. Many patients are still confirmed only after death, from a swab of the body. On October 9, 25 of the 47 new positives in Ituri came

from the dead. These are people the response never reached while they were alive.

Within the Congo, the ratio follows access to care. In Bunia, Ituri's provincial capital and the hub of the response, 34 percent of confirmed patients have died. In Beni, in North Kivu, the figure is 67 percent. North Kivu's treatment centers are 86.3 percent full, and 154 of the province's patients are being treated outside them, underscoring the need for critical care and public health support in these regions.

Outside the Congo, the 31 cases have produced four deaths, about 13 percent, and much of that difference lies in time to detection and delivery of supportive care. Kenya's first patient had been ill for about a month before he traveled by road from Beni, in the Congo, across the border to Kampala, Uganda, and flew to Nairobi, where he died on October 5. Every case after him occurred among relatives and health workers who, according to the CDC, were already in quarantine when diagnosed. They were found at the first fever because health workers were checking on them every day. One, a 65-year-old relative, died after supportive care in a Nairobi infectious disease unit. In the Congo, teams saw 87.2 percent of the 36,095 contacts under follow-up on October 28, against a target of 95 percent, and only 69 percent in Tshopo, where health staff are on strike.

The Nigerian case shows what is mobilized for a patient of a different social standing. A 42-year-old Ugandan woman married to a Swiss diplomat returned to Abuja from Uganda on October 3 and sought care for malaria-like symptoms three days later, according to the *New York Times*. She was not tested for Ebola until October 20, after 17 days in a capital with daily flights to Europe, the United States and the rest of Africa. Nigerian teams treated her through the acute phase, and on October 26 she and her husband were flown by air ambulance to Switzerland. WHO's Africa director, Mohamed Janabi,

said the evacuation was arranged because the couple are Swiss citizens.

Three other patients have been evacuated to Europe, two to Germany and one to the Netherlands, all health or humanitarian workers. Congolese health workers have no such route out. By October 18, the ministry had recorded 269 frontline workers infected. In Ituri, the October 28 bulletin reported the blood supply exhausted, seven patients in Mandima left without food, and 38 in critical condition.

Those carrying out the response face violence and unpaid wages. In Bafwasende, Tshopo, youth armed with machetes and batons killed a longtime nurse on October 23 as he and a teacher carried out community outreach, accusing them of spreading the virus through toilets and rivers. The hospital's staff now sleep there under police guard. The same bulletin that records 22 contacts in Bafwasende abandoning preventive treatment because of insecurity records that screening staff in Mandima have not been paid for September.

The vaccines follow the same pattern. A vaccine designed against Bundibugyo by Oxford University and the Serum Institute of India was first given to volunteers in Oxford in July, and the Serum Institute had manufactured about 620,000 doses by early October, according to Rwanda's *New Times*. Yet when the WHO-backed Tumaini trial began vaccinating contacts in Bunia on October 23, five months after the outbreak was declared, it started with Ervebo, a vaccine licensed against the Zaire species of Ebola with no proven protection against Bundibugyo. The vaccine designed for this virus, already manufactured in the hundreds of thousands of doses, will join the Congolese trial only after regulatory approval while people in Ituri and North Kivu die every day.

The money, too, has been disbursed. On October 15, Africa CDC Director-General Jean Kaseya acknowledged that donors had given \$962 million to the organizations running the response, and that more than \$700 million of it cannot be accounted for because most of the organizations have not reported how it was spent. Three-quarters of the money has vanished from public view while the response runs short of blood, beds and wages.

None of this was unforeseen. In June, CDC scientists published projections showing that a response isolating seven in 10 cases would very likely hold deaths under 2,000. By August 22, the bulletin had confirmed 2,642 deaths, already above that ceiling. The authors found no evidence that the virus was unusually transmissible and

warned that the response might need resources comparable to West Africa's. Today the *Associated Press* reports that fewer than a quarter of new cases come from people known to be contacts of a patient, meaning most chains of transmission are invisible to the response.

Spillover of Bundibugyo virus from animal reservoirs in the region will recur. It caused earlier outbreaks in Uganda in 2007 and in the Congo in 2012, and the CDC's modelers place the first infection in this epidemic between late January and February, three months or more before it was confirmed. That makes broad-based, permanent surveillance in the areas where these viruses are known to circulate a basic requirement of international public health: laboratories able to identify every species, health workers trained and paid to test the sick and the dead, and the means to report within days. No one should become infected with Ebola, and prevention on this basis protects the Congo and every country connected to it.

The regional character of the epidemic should be setting off alarms. The woman diagnosed in Abuja had not been to the Congo. Switzerland's foreign ministry believes she was infected in Uganda, which declared its own outbreak over in August, and Africa CDC is investigating whether her infection and the Kenyan patient's trace back to Entebbe airport, through which both passed on October 3. If they do, the virus has moved undetected through a regional transport hub. Yet the official response has been one of complacency. Nigeria has placed no limits on public gatherings, including campaign rallies for its January election, and European health authorities rate the risk to their own populations as very low, as though the danger stopped at their borders.

When outbreaks occur, the disparities they expose in who is tested, who is treated and who survives reveal far more about the social character of a society than about the virus. In this epidemic, survival has depended on citizenship and class, while the response in the Congo runs short of blood, beds and wages. Nothing it needs is beyond reach. The money has been disbursed and the vaccine doses manufactured. That none of it has reached the people of Ituri and North Kivu reflects the priorities of a capitalist order that treats the lives of Congolese workers and peasants as expendable.



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