CORONAVIRUS DISEASE 2019: THE U.S. AND INTERNATIONAL RESPONSE

HEARING
BEFORE THE
SUBCOMMITTEE ON ASIA, THE PACIFIC AND NONPROLIFERATION
OF THE
COMMITTEE ON FOREIGN AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTEENTH CONGRESS
SECOND SESSION

February 27, 2020

Serial No. 116–105

Printed for the use of the Committee on Foreign Affairs

or http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
WASHINGTON : 2022
COMMITTEE ON FOREIGN AFFAIRS
ELIOT L. ENGEL, New York, Chairman

BRAD SHERMAN, California
GREGORY W. MEERS, New York
ALBIO SIRES, New Jersey
GERALD E. CONNOLLY, Virginia
THEODORE E. DEUTCH, Florida
KAREN BASS, California
WILLIAM KEATING, Massachusetts
DAVID CICILLINE, Rhode Island
AMI BERA, California
JOAQUIN CASTRO, Texas
DINA TITUS, Nevada
ADRIANO ESPAILLAT, New York
TOM LIEU, California
SUSAN WILD, Pennsylvania
DEAN PHILLIPS, Minnesota
ILHAN OMAR, Minnesota
COLIN ALLRED, Texas
ANDY LEVIN, Michigan
ABIGAIL SPANBERGER, Virginia
CHRISSY HOUHAN, Pennsylvania
TOM MALINOWSKI, New Jersey
DAVID TRONE, Maryland
JIM COSTA, California
JUAN VARGAS, California
VICENTE GONZALEZ, Texas

MICHAEL T. McCaul, Texas, Ranking Member
CHRISTOPHER H. SMITH, New Jersey
STEVE CHABOT, Ohio
JOE WILSON, South Carolina
SCOTT PERRY, Pennsylvania
TED S. YOHO, Florida
ADAM KINZINGER, Illinois
LEE ZELDIN, New York
JIM SENSENBERGNER, Wisconsin
ANN WAGNER, Missouri
BRIAN MAST, Florida
FRANCES ROONEY, Florida
BRIAN FITZPATRICK, Pennsylvania
JOHN CURTIS, Utah
KEN BUCK, Colorado
RON WRIGHT, Texas
GUY RISCHEITHALER, Pennsylvania
TIM BURCHETT, Tennessee
GREG PENCE, Indiana
STEVE WATKINS, Kansas
MIKE GUEST, Mississippi

JASON STEINBAUM, Staff Director
BRENDAN SHIELDS, Republican Staff Director

SUBCOMMITTEE ON ASIA, THE PACIFIC AND NONPROLIFERATION
BRAD SHERMAN, California, Chairman

DINA TITUS, Nevada
CHRISSY HOULAHAN, Pennsylvania
GERTALD CONNOLLY, Virginia
AMI BERA, California
ANDY LEVIN, Michigan
ABIGAIL SPANBERGER, Virginia
TED YOHO, Florida, Ranking Member
SCOTT PERRY, Pennsylvania
ANN WAGNER, Missouri
BRIAN MAST, Florida
JOHN CURTIS, Utah

DON MACDONALD, Staff Director
# CONTENTS

## WITNESSES

<table>
<thead>
<tr>
<th>Witness</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fritz, Jonathan, Deputy Assistant Secretary, Bureau of East Asian and Pacific Affairs, U.S. Department of State</td>
<td>7</td>
</tr>
<tr>
<td>Brownlee, Ian, Principal Deputy Assistant Secretary, Bureau of Consular Affairs, U.S. Department of State</td>
<td>13</td>
</tr>
<tr>
<td>Walters, Dr. William A., Executive Director and Managing Director for Operational Medicine, Bureau of Medical Services, U.S. Department of States</td>
<td>18</td>
</tr>
<tr>
<td>Redfield, Dr. Robert, Director, U.S. Centers for Disease Control and Prevention</td>
<td>23</td>
</tr>
</tbody>
</table>

## APPENDIX

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Notice</td>
<td>81</td>
</tr>
<tr>
<td>Hearing Minutes</td>
<td>82</td>
</tr>
<tr>
<td>Hearing Attendance</td>
<td>83</td>
</tr>
</tbody>
</table>
Coronavirus Disease 2019: The U.S. and International Response

Thursday, February 27, 2020

House of Representatives
Subcommittee on Asia, the Pacific and Nonproliferation
Committee on Foreign Affairs
Washington, DC,

The subcommittee met, pursuant to notice, at 2:56 p.m., in room 2172 Rayburn House Office Building, Hon. Ami Bera (chairman of the subcommittee) presiding.

Mr. Bera. The subcommittee will come to order.

First-off, I appreciate the audience’s patience given votes. We do not control voting schedules, so thank you, and thank you to the witnesses.

Without objection, all members have 5 days to submit statements, questions, extraneous materials for the record, subject to the length limitations in the rules.

I will now make an opening statement and then turn it over to the ranking member for his opening statement.

I want to thank Mr. Yoho, my ranking member, for his longtime friendship and partnership in this issue. Also, I want to thank the members of the CDC and senior State Department officials for taking the time to come up here. Obviously, this is a very timely subject. This is our second hearing on the topic. A couple weeks ago, we had the first hearing in Congress on coronavirus and this will be my second hearing.

As I think about this issue I apply my background as a physician, but more importantly, my background as the former chief medical officer for Sacramento County who was in charge of the public health delivery system there. I also use my expertise as a former faculty member in my last home institution, the University of California Davis School of Medicine.

The reason why I give that background because is last night it became personal for me and it is now hitting close to home. The first novel coronavirus case potentially person-to-person, non-transmission is in Sacramento County as we speak. That patient is housed at U.C. Davis. And I have been in communication with my former colleagues that were over there.

There are a couple concerning issues that are happening over there. There are a couple of concerning issues that as we go through the hearing, I am going to want to ask questions about. But if I think about this particular case, it initially arose in Solano County, which is close to where Travis Air Force Base is, and is one of the points of entry where we are quarantining patients as we evacuate them from overseas. Thus far, we do not know how
the patient was infected; this patient did not have any travel his-
tory, and we are not aware of any contact tracing.

That work continues.

The patient arrived at U.C. Davis last Wednesday or Thursday
and was intubated at the time on a ventilator. At that juncture, the
doctors at U.C. Davis medical staff did not have a concrete diag-
nosis and had requested testing for coronavirus. It was determined
that this patient did not fit the criteria for testing for the
coronavirus.

This past Sunday, the doctors and the medical staff insisted on
the test. The test was performed. Last night we got the results
back and the news that all of you have heard. This is the first pa-
tient testing positive where we do not have confident contact trac-
ing.

One thing that I will want to talk about, and perhaps with Dr.
Redfield during our questioning can discuss, is the testing criteria.
Also, I would like to discuss the rapidity of getting testing capabili-
ties quickly to every State, and the distribution of test kits.

I was chatting with the Ambassador from Korea earlier today
and found out that Korea is testing 15,000 people a day right now.
So, we should be doing whatever we can do to assist our scientists
in get testing capabilities up and running as quickly as possible.

There are a couple of other areas that I would like to focus on
in this hearing as well. I do applaud President Trump, although I
think the was delayed in announcing and identifying someone as
the head, he did not use the term “czar” but I will use that term,
who is the focus point to work across the interagency and who has
direct access to the President and Vice President.

That said, I really do want to applaud Dr. Birx’s appointment an-
nouncement. She is very well qualified and has our support.

I also appreciate the Administration’s funding flexibility. I did
think the initial amount of $2.5 billion was not going to be suffi-
cient. I know the Senate suggested $8.5 billion. That may not be
enough. And I think we are allocating this funding in a bipartisan
way, we should just be ready to make sure that our scientists and
the folks that are on the front line, particularly the folks that are
in public health systems and hospitals on the front line, have the
resources and support that they need. Our No. 1 job is protecting
domestic national security. And at this juncture, while we do not
know a lot about this rapidly evolving public health threat, we
have to be ready to make sure that our communities, our public
health infrastructure, and our global health leadership has the
funds and ability to do their jobs.

In addition, as we are thinking about the dollar amount to appro-
priate, we have to do a quick assessment of public health infra-
structure and assess the needs as well as the gaps. Having been
in charge of the public health system in a large county, I know we
run on shoestrings. Given the state of our infrastructure, a bad flu
season would overwhelm our hospitals and emergency room capa-
bilities. Slap on potentially what we do not know about
coronavirus. We just have to be prepared for the worst and hope
for the best here.

I also want to make sure, and I talked about this with some of
my colleagues on both sides of the aisle earlier this morning, that
we keep politics out of this. This has to be a non-partisan effort. This has to be about looking at the science, following the facts, and doing what we have to do to keep the American public safe, but then also to focus in on the international community. That is going to be extremely important.

In addition, we have to make sure, in this era where it is easy to put out false information, and with a very concerned public, that we communicate clearly. We are all leaders as Members of Congress and have the ability to communicate effectively. So, we must coordinate with the CDC and others to get accurate information out there to make sure the public is accurately informed. This will help us quickly dispel any misinformation and will allow us to do our jobs, allow you to do your jobs, and our scientists to do their jobs better.

Lastly, this is the Foreign Affairs Committee and global health security is something that we look very closely at. In this sense, American leadership has to be central to how we approach this in a global aspect. So, Dr. Redfield, I will be curious to get an update on how our scientists are doing, how our CDC workers are doing in China in the hot zone, and if they have accommodated our workers. We have got to have an international response, with everyone working together in a transparent way and sharing information so we can get ahead of this.

So, again, I appreciate the witnesses for taking their time to come down here to inform us as Members of Congress but also to inform the general public on what is rapidly evolving here. And, again, I appreciate the members that are here.

And with that, let me turn it over to the Ranking Member Mr. Yoho for your opening statement.

Mr. Yoho. Mr. Chairman, I appreciate those words. And this is like yesterday, it is deja vu all over again; right? We had the opportunity to meet with the chief of missions yesterday, and Chairman Bera opened up pretty much with the same thing about we are all on one team. This is Team America and we have to work forward. And we have to be like a virus or a bacteria: we know no borders; we do not care what your political affiliation is; this is something we need to come together and make sure we have the right response for America.

We had this meeting, this hearing 3 weeks ago. And you look around about the concern because I think that speaks loudly with the attendance here for people to wait as long as they did. This is something that we need to be prepared for. And we want to make sure that we are in that.

I am a veterinarian by trade. We dealt with herd situations. That is not to mean we should treat people like animals, but we should make sure we put in the proper safeguards so that we protect our population.

We have a bill that we have sponsored, it is called the One Health bill, which coordinates animal diseases with human diseases. And this is why: seven out of ten human diseases originate with the animals. We have dealt with coronavirus for the last 30, 40 years in horses, cattle, dogs, cats, and other species. And so we know what viruses do.
And I think the important thing that comes out of this, we lived through the Zika virus up here, and we saw the misinformation that was going out, the panic, the media, politics got put into that and it was a disaster. What I have seen in this response is there's a level, kind of a calm—I do not want to say a calm, but there is more of a rational approach. And I hope we can do that in this hearing. I think it will help this and help inform the American people.

Other things that we are doing is this is appropriations season, and we are putting in appropriations for NIH, for NSF, for the research and development, but also for organizations like Gavi that does vaccinations around the work, and organizations like CEPI, the Coalition for Epidemic Preparedness. They are looking at the new and upcoming diseases to have vaccine models already ready for when something like this happens, because we can all rest assured this is not going to be the last time we are faced with something like this.

And then I think the collaboration that we have with other countries. And we brought up the epidemiology last meeting that we had here, we had two epidemiologists, and we looked at the origin of where this was supposed to have come from in that province in Wuhan. And it was the fish market or fresh market. And we asked the epidemiologists if enough research was done. And they felt, no, it had not. But yet, the Chinese Government came and removed that market.

And so those start raising questions. I mean, you look at the amount of response, the severity of the response of the quarantines and people isolated, it sometimes does not match what we are looking at as the disease or what we are being told: it is not that severe; we can control it. But yet when you have, you know, that province that was under quarantine, it is about 20 percent of the United States of America under quarantine. And then we have heard it is over 100 million people under quarantine.

And what we want to make sure is that we have a measured, accurate response, and that we have readiness that we are ready to respond to this in the appropriate ways. And I think so far what we have seen I am kind of proud of what our country has done. And I said our country not an administration, but it was the country. And a lot of that comes from you guys here in this audience. And so we appreciate that.

And then as I was talking about collaboration with other countries, we want to make sure no countries are excluded, countries like Taiwan that was so instrumental in the SARS epidemic. For a country like China to put pressure on other countries to exclude them from this process and the WHA, World Health Assembly, or the WHO, I think that is, I just think that is a wrong move. You know, this is, again, viruses do not care what your political affiliation is, we need all hands on deck to deal with this.

And so, with that, Mr. Chairman, I am going to yield back. And thank you.

Mr. Bera. Thank you to the ranking member.

I am very pleased to welcome our witnesses to today's hearing. We are joined by four excellent public servants.
Jonathan Fritz serves as Deputy Assistant Secretary for the Bureau of East Asian and Pacific Affairs. He will be followed by Principal Deputy Assistant Secretary for the Bureau of Consular Affairs, Ian Brownlee.

The final State witness will be Dr. William Walters, the Executive Director and Managing Director for Operational Medicine at the Bureau of Medical Services.

Finally, we are honored to be joined by Dr. Robert Redfield, the Director of the Centers for Disease Control and Prevention.

Please summarize your written statements in 5 minutes. And without objection, your prepared written statements will be made part of the record.

Mr. Fritz, if you would like to begin.

STATEMENT OF JONATHAN FRITZ, DEPUTY ASSISTANT SECRETARY, BUREAU OF EAST ASIAN AND PACIFIC AFFAIRS, U.S. DEPARTMENT OF STATE

Mr. Fritz. Thank you, Chairman Bera and Ranking Member Yoho. Thank you for the opportunity to testify today regarding the outbreak of the COVID-19 novel coronavirus and the Department of State’s response.

Throughout this global public health emergency the Department has worked around the clock on what has always been mission No. 1 for us: ensuring the safety and security of U.S. citizens abroad. The Secretary and the senior leadership team have been personally engaged in directing and supporting the U.S. response to this outbreak, in close consultation with our colleagues at the Department of Health and Human Services, including our CDC colleagues; at the Department of Homeland Security; the Department of Defense and others.

Utilizing their expertise, our diplomats and staff serving in the region executed evacuation plans, provided consular services, engaged foreign governments, and reported on economic issues arising from this outbreak. We simply could not have done so much to care for U.S. citizens and our own personnel in China without a department-wide effort. U.S. diplomats in China, Seoul, Tokyo, Phnom Penh, and elsewhere contributed to our evacuation efforts, ably aided by our locally employed staff, including those at our Consulate General in Wuhan.

Throughout it all, we regularly engaged with the People’s Republic of China at the most senior levels, including President Trump’s February 7th conversation with President Xi. Secretary Pompeo also spoke with his counterpart about the evaluations from Wuhan, and stressed that protecting U.S. citizens in times of crisis is our No. 1 priority.

Our Ambassador to China Terry Branstad worked directly with the Ministry of Foreign Affairs of China to facilitate evaluation flights and U.S. deliveries of donated assistance. Our team in China was on the ground helping obtain permissions for our flights and processing passengers, operating in often difficult conditions. This work was instrumental in evacuating U.S. citizens and even some of our allies to safety.

We faced challenges in evacuating U.S. citizens from the quarantine zone in China, and additional complexities supporting U.S.
citizens on cruise ships. The Department worked closely with our allies in Japan to ensure the health and safety of U.S. citizens onboard the Diamond Princess cruise ship docked in Yokohama. The U.S. Embassy Tokyo coordinated closely with the Japanese Government, with Carnival Corporation, and CDC and other components of the Department of Health and Human services to assist U.S. citizens on the ship.

After a high number of COVID–19 cases were identified onboard, and out of consideration for Japan’s already overburdened health system, the Department of Health and Human Services made an assessment that the U.S. citizens and crew onboard were at high risk of exposure and should be repatriated to minimize risks to their health going forward.

In Cambodia we organized response teams in Sihanoukville and Phnom Penh to assist U.S. citizens on the cruise ship Westerdam. Working in close coordination with Holland America, Cambodian authorities, and the embassies of other countries with citizens onboard the ship.

Embassy teams included consular, medical, and logistics experts to facilitate health screenings, lodging, and travel needs of more than 600 U.S. citizen passengers. Our embassy also utilized its consular messaging platform and social media accounts to provide timely updates to passengers.

In coordination with these efforts, USAID has provided an initial tranche of funding for affected and at-risk countries to address critical gaps in COVID–19 country readiness, including risk communication and community engagements, laboratory detection, enhanced surveillance, and infection prevention and control.

In addition, USAID is arranging shipments of essential personal protective equipment to selected countries in coordination with the World Health Organization.

Our efforts continue apace. We are continually engaging with host governments in the Asia Pacific region to ensure they are informed of our policies and that we can share information and best practices to address this outbreak. We successfully encouraged Beijing to accept U.S. experts in the WHO mission to China.

On February 7th, 2020, the U.S. Government announced that it is prepared to provide up to $100 million in existing funds to assist countries, including China, impacted by and at risk from the virus. Assistance to contain and combat COVID–19 will be provided bilaterally and through multilateral organizations. This commitment, along with the hundreds of millions generously donated by the American private sector demonstrates strong U.S. leadership in response to the outbreak.

Thank you, Mr. Chairman. I look forward to answering your questions and those of other members of the subcommittee.

[The prepared statement of Mr. Fritz follows:]
Testimony of Jonathan Fritz, Deputy Assistant Secretary,
Bureau of East Asian and Pacific Affairs
U.S. Department of State
House Committee on Foreign Affairs
Subcommittee on Asia, the Pacific, and Nonproliferation
Thursday, February 27, 2020

Chairman Bera, Ranking Member Yoho, thank you for the opportunity to testify today regarding the outbreak of COVID-19 (novel coronavirus) and the Department of State’s response. Throughout this global public health emergency, the Department has worked around the clock on what has always been mission number one: ensuring the safety and security of U.S. citizens abroad. The Secretary and his senior leadership team have been personally engaged in directing and supporting the U.S. response to this outbreak, in close consultation with our colleagues at the Department of Health and Human Services (including the Centers for Disease Control and Prevention), the Department of Homeland Security and others.

Utilizing their expertise, our diplomats and staff serving in the region executed evacuation plans, provided consular services, engaged foreign governments, and reported on economic issues arising from this outbreak. We simply could not have done so much to care for U.S. citizens and our own personnel in China without a Department-wide effort. U.S. diplomats in China,
Seoul, Tokyo, Phnom Penh, and elsewhere contributed to our evacuation efforts, ably aided by our locally employed staff.

Throughout it all, we regularly engaged the People’s Republic of China at the most senior levels, including President Trump’s February 7, 2020 conversation with President Xi. Secretary Pompeo also spoke with his counterpart about the evacuation from Wuhan and stressed that protecting U.S. citizens in times of crisis is our number one priority. Ambassador Branstad worked directly with the Ministry of Foreign Affairs to facilitate evacuation flights and U.S. deliveries of donated assistance. Our team in China was on the ground, helping obtain permissions for our flights and processing passengers, operating in often difficult conditions. This work was instrumental in evacuating U.S. citizens, and even some of our allies, to safety.

We faced challenges in evacuating U.S. citizens from the quarantine zone in China, and additional complexities supporting U.S. citizens on cruise ships. The Department worked closely with our allies in Japan to ensure the health and safety of U.S. citizens onboard the Diamond Princess cruise ship docked in Yokohama. The U.S. Embassy in Tokyo coordinated closely with the Japanese government, Carnival Corporation, and the Centers for Disease Control and Prevention and other components of the Department of Health and Human Services to assist U.S. citizens on the ship. After a high number of COVID-19 cases were identified
onboard, and out of consideration for Japan’s already overburdened health system, the Department of Health and Human Services made an assessment that the U.S. citizens and crew on board were at high risk of exposure and should be repatriated to minimize risks to their health going forward.

In Cambodia, we organized response teams in Sihanoukville and Phnom Penh to assist U.S. citizens on the cruise ship *Westerdam*, working in close coordination with Holland America, Cambodian authorities, and the embassies of other countries with citizens on the ship. Embassy teams included consular, medical, and logistics experts to facilitate health screenings, lodging, and travel needs of more than 600 U.S. citizen passengers. Our embassy also utilized its consular messaging platform and social media accounts to provide timely updates to passengers.

In coordination with these efforts, USAID has provided an initial tranche of funding for affected and at-risk countries to address critical gaps in COVID-19 country readiness, including risk communication and community engagement, laboratory detection, enhanced surveillance, and infection prevention and control. In addition, USAID is arranging shipments of essential personal protective equipment to selected countries in coordination with the World Health Organization.
Our efforts continue apace. We are continually engaging with host
governments in the Asia-Pacific region to ensure they are informed of our policies,
and that we can share information and best practices to address this outbreak. We
successfully encouraged Beijing to accept U.S. experts in the World Health
Organization’s mission to China. On February 7, 2020 the United States
government announced that it is prepared to provide up to $100 million in existing
funds to assist countries, including China, impacted by and at-risk from the virus.
Assistance to contain and combat COVID-19 will be provided bilaterally and
through multilateral organizations. This commitment - along with the hundreds of
millions generously donated by the American private sector - demonstrates strong
U.S. leadership in response to the outbreak.

Thank you, Mr. Chairman. I look forward to answering your questions and
those of other members of the Subcommittee.
Mr. BERA. Thank you, Mr. Fritz.

Mr. BROWNLEE.

STATEMENT OF IAN BROWNLEE, PRINCIPAL DEPUTY ASSISTANT SECRETARY, BUREAU OF CONSULAR AFFAIRS, U.S. DEPARTMENT OF STATE

Mr. BROWNLEE. Chairman Bera, Ranking Member Yoho, thank you for the opportunity to testify today.

The consular mission has always been the safety and security of U.S. citizens at home and abroad. We have worked in recent weeks hand-in-hand with our colleagues from the CDC, HHS ASPR, NIH, DHS, and others to provide critical information and travel alerts for U.S. citizens overseas, to help arrange repatriations of U.S. citizens from two countries, and to provide in-person consular services to U.S. citizens impacted by the outbreak in many other countries.

In China, U.S. Embassy and consular staff made thousands of phone calls and corresponded tirelessly via email and various online platforms to reach U.S. citizens in Hubei Province. We worked with the Chinese Government to help Chinese grandmothers accompany their U.S. citizen grandchildren on evacuation flights.

As the Chinese Government locked down Wuhan, our team in China coordinated with local authorities to allow U.S. citizens to travel to the airport to be evacuated. Using State Department chartered evacuation flights, and working with our interagency partners such as HHS, CDC, and DoD we brought approximately 800 U.S. citizens from Wuhan back to the United States.

In Japan, U.S. Embassy staff created a dedicated webpage for U.S. citizens quarantined on the cruise ship Diamond Princess, and reached out to them individually by email and phone. As some U.S. citizens developed health problems, not all related to COVID–19, consular officers worked with Japanese hospitals to ensure U.S. patients received appropriate medical care.

In collaboration with our interagency partners, the Department transported over 300 U.S. citizens back to the United States on February 16th. We remain in close communication with Japanese authorities and the cruise line to assist those U.S. citizens who remained in Japan after the evacuation.

In Cambodia, U.S. Embassy staff met the cruise ship Westerdam in the port city of Sihanoukville. Our staff coordinated—excuse me—our staff provided key liaison roles, ensuring U.S. citizens were connected to the appropriate cruise ship authorities and Cambodian health care professionals. We also sent a team to the airport in Phnom Penh to provide consular services.

Consular personnel in Kuala Lumpur, Karachi, and Amsterdam worked late into the night to help 91 of those stranded U.S. citizens get home last week.

We are supporting U.S. public health authorities’ efforts to contain the virus outside the United States. These officers have implemented Presidential Proclamation 9984, which suspends the entry into the United States of any aliens who were present in China, except Hong Kong and Macau, during the 14 days before any attempted entry into the United States.

The Bureau of Consular Affairs is entirely fee funded. And most of those fees come from these applicants. Under our current au-
authorities, we use these fees to cover most of the costs of providing services for U.S. citizens abroad such as those I just described. However, based on what we now know, we anticipate a loss of approximately 100—excuse me, of 98 million, a loss of 98 million dollars in visa revenues this year as a result of COVID–19.

To ensure we can help U.S. citizens in distress, despite falling visa revenues, I would ask that you grant the Department greater flexibility in spending existing fees.

We remain committed to protecting the health and welfare of U.S. citizens overseas, and working actively with the governments and international partners to achieve this goal in this crisis.

Thank you, Mr. Chairman. I look forward to answering your questions or those of the other members of the subcommittee.

[The prepared statement of Mr. Brownlee follows:]
Testimony of Ian Broulee, Principal Deputy Assistant Secretary, Bureau of Consular Affairs, U.S. Department of State
House Committee on Foreign Affairs
Subcommittee on Asia, the Pacific and Nonproliferation
Thursday, February 27, 2020

Chairman Bera, Ranking Member Yoho, thank you for the opportunity to testify today.

As Deputy Assistant Secretary Fritz said, mission number one has always been the safety and security of U.S. citizens abroad. In response to this outbreak, the Bureau of Consular Affairs has provided critical information and travel alerts for U.S. citizens overseas, arranged evacuations of U.S. citizens from two countries, and provided in-person consular services to U.S. citizens impacted by the outbreak.

To keep U.S. citizens informed in the face of fast moving developments, we have issued numerous Travel Advisories in recent weeks, including the Level 4 Do Not Travel Advisory for China recommending that U.S. citizens depart China by commercial means. Our embassies and consulates in the region have issued multiple health and safety alerts to U.S. citizens regarding specific conditions in their respective countries.

In China, we made extraordinary efforts to evacuate U.S. citizens out of Hubei province. U.S. Embassy and consulate staff made thousands of phone calls and corresponded tirelessly via email and various online platforms to reach U.S. citizens in Hubei province. We worked with the Chinese government to facilitate travel to the United States of certain immediate family members of U.S. citizens, such as Chinese grandmothers who accompanied their U.S. citizen grandchildren on the evacuation flights. As the Chinese government locked down Wuhan to prevent the spread of the virus, our team coordinated with Chinese authorities to ensure that U.S. citizens would be allowed to travel to the airport to be evacuated. We even ensured that Chinese police officers had license plates of individual U.S. citizens, allowing them to drive to the airport.
on roads closed by the quarantine lockdown. Using State Department chartered evacuation flights, and working with our interagency partners such as HHS, CDC, and DoD, we were able to bring approximately 800 U.S. citizens from Wuhan back to the United States.

In Japan, U.S. Embassy staff created a dedicated webpage for U.S. citizens quarantined on the cruise ship Diamond Princess and reached out to them individually by e-mail and phone. As some U.S. citizens developed health problems (not all related to COVID-19), consular officers worked with hospitals in Tokyo and neighboring cities to ensure U.S. patients received appropriate medical care. In collaboration with our interagency partners, the Department transported over 300 U.S. citizens back to the United States on February 16, 2020. Working with U.S. Embassy and CDC staff in Japan, we remain in close communication with Japanese authorities and the cruise line to assist U.S. citizens who remained in Japan after the evacuation.

In Cambodia, U.S. Embassy staff met the cruise ship Westerdam in the port city of Sihanoukville. Our staff provided key liaison roles, ensuring our citizens were connected with appropriate cruise ship officials and Cambodian health care professionals. We also sent a team to the airport in Phnom Penh to provide consular services.

In addition to assisting U.S. citizens abroad, the U.S. government has a responsibility to protect our citizens at home. The President signed Presidential Proclamation 9984, which suspends the entry into the United States of any aliens who were present in the People’s Republic of China, excluding the Special Administrative Regions of Hong Kong and Macau, during the 14 days preceding their entry or attempted entry into the United States. There are some exceptions in the proclamation, including for legal permanent residents, certain immediate family members of some U.S. citizens and legal permanent residents, adoptees, and others. Due to limited staffing and the current Chinese government restrictions on large public gatherings, our Embassy
and Consulates in China have suspended normal visa operations, although they are accepting some emergency visa appointments for applicants who may qualify for an exception to the proclamation. This allowed us to focus all of our energy on American Citizen Services and meet the President’s directive to protect the homeland. We have also worked to complete adoption cases for parents who were already present in China.

Most of the State Department’s consular funding comes from visa fees collected from applicants. Under our fee authorities, we can also use these fees to cover most of the costs of providing essential services to U.S. citizens abroad. However, based on what we know now, we anticipate the loss of at least of $98 million in consular visa revenues from China this year compared to last year as a result of SARS-CoV-2. As it is essential to ensure our ability to assist U.S. citizens in distress despite falling visa revenues, I would ask that you grant the Department greater flexibility in spending existing U.S. passport security surcharge fees and visa fees, by implementing the authorities proposed in the President’s FY2021 budget. This would enable us to support American Citizen Services more broadly.

We remain committed to protecting the health and welfare of U.S. citizens overseas and are actively working with governments and international partners to achieve this goal in this crisis.

Thank you, Mr. Chairman. I look forward to answering your questions and those of other members of the Subcommittee.
Mr. Bera. Thank you, Mr. Brownlee.

Dr. Walters.

STATEMENT OF DR. WILLIAM A. WALTERS, EXECUTIVE DIRECTOR AND MANAGING DIRECTOR FOR OPERATIONAL MEDICINE, BUREAU OF MEDICAL SERVICES, U.S. DEPARTMENT OF STATES

Dr. Walters. Chairman Bera, Ranking Member Yoho, and distinguished members of the subcommittee, thank you for the opportunity to testify today.

As my colleagues have stated, the Department of State is committed to taking all necessary steps to protect the health of our overseas work force and promote the well-being of U.S. citizens around the world. Between January 28th, 2020, and February 16th, 2020, the Department executed the most complex non-military evacuation of U.S. citizens in its history. The safe and efficient rescue of 1,174 people from Wuhan, China, and the Diamond Princess cruise ship in Japan is a testament to the agility, proficiency, and dedication of our work force, our interagency partnerships, and others to accomplish our core mission: advancing the interests of the American people.

Following the SARS outbreak of 2004, the U.S. Government Accountability Office recommended that the Department work with interagency partners and the private sector to develop capabilities to support the medical evacuation and transportation of U.S. citizens from areas impacted by the sudden outbreak of infectious disease.

And the 2014 Ebola virus disease outbreak again served as a reminder that the Department must have a standing crisis response aviation capability to protect U.S. employees and citizens when emergency situations arise.

Such a prompt repatriation of U.S. citizens from quarantine conditions could not have been possible had it not been for the Bureau of Medical Services’ existing aviation contract and solid corporate partners. The MMS contract is the Department’s only standing response aviation support and critical care medical evacuation capability, and the U.S. Government’s only standing biocontainment transport capability.

Upon receipt of the mission directives, we managed to configure and simultaneously choreograph the movement of five aircraft, including the coordination of all flight clearances, overflights, and other required logistics. Department of State personnel onboard these aircraft were trained and equipped to manage these operations.

The Department successfully directed and executed a total of seven flights over four missions, with evacuees transported to five different locations within the United States equipped to safely receive, evaluate, and house persons exposed to the virus. This operation involved close coordination with our interagency partners, including the Federal Aviation Administration and the Departments of Defense, Health and Human Services, Homeland Security, and others.

We also coordinated with international partners, including the Governments of the People’s Republic of China, Japan, the Repub-
lic of Korea, and Canada. I was the lead medical service officer overseeing these missions from the second and third mission on the ground in Wuhan.

Some 41 countries and territories have reported cases of COVID–19 infection, placing the health of our employees and U.S. citizens in these countries and territories at risk. In these unprecedented times, the Department’s medical professionals are committed to doing everything we can for the health and safety of our work force and the U.S. citizens overseas.

In summary, I would like to thank each of you for your continued support as we keep pace with this international emergency. We know that your support to the Department, the Bureau of Medical Services in particular, has made this all possible, and that your continued support will be critical in the months and years to come.

Thank you.

[The prepared statement of Dr. Walters follows:]
Chairman Bera, Ranking Member Yoho, and distinguished Members of the subcommittee, thank you for the opportunity to testify today. As my colleagues have stated, the Department of State is committed to taking all necessary steps to promote the well-being of U.S. citizens around the world. Between January 28, 2020 and February 16, 2020, the Department executed the largest non-military evacuation of U.S. citizens in its history. The safe and efficient evacuation of 1,174 people from Wuhan, China and people onboard the Diamond Princess cruise ship in Japan is a testament to the agility, proficiency, and dedication of our workforce to accomplishing our core mission – advancing the interests of the American people.

Following the SARS outbreak in 2004, the U.S. Government Accountability Office recommended that the Department work with interagency partners and the private sector to develop capabilities to support the medical evacuation and transport of U.S. citizens from areas impacted by the sudden outbreak of infectious disease. The 2014 Ebola Virus Disease Outbreak again served as a reminder that
the Department must have a standing crisis response aviation capability to protect
U.S. employees and citizens when emergency situations arise.

Such a prompt repatriation of U.S. citizens from quarantined conditions
could not have been possible had it not been for the Bureau of Medical Services’
extisting Multi-Mission Aviation Support Services (MMASS) Contract. The
MMASS Contract is the Department’s only standing crisis response aviation
support and critical care medical evacuation capability, and the U.S. government’s
only standing biocontainment transport capability. Upon receipt of the mission
directives, we managed the configuration and simultaneous choreography of five
aircraft, including the coordination of all flight clearances, overflights, and other
required logistics. Department personnel onboard these aircraft were trained and
equipped to manage these operations. The first mission for Wuhan was staged and
ready within 36 hours’ notice, the second and third missions for Wuhan were
staged and ready in 24 hours’ notice, and a fourth mission for Japan was staged
and ready within 6 hours’ notice.

The Department successfully directed and executed a total of seven flights
over four missions, with evacuees transported to five different locations within the
United States equipped to safely receive, evaluate, and house persons exposed to
the virus. This operation involved close coordination with our interagency
partners, including the Federal Aviation Administration, Departments of Defense,
Health and Human Services, and Homeland Security. We also coordinated with international partners including the governments of People’s Republic of China, Japan, the Republic of Korea, and Canada. I was the lead Medical Services officer overseeing these missions and led the second and third missions on the ground in Wuhan.

Some 29 countries and territories have reported cases of COVID-19 infection, placing the health of our employees and U.S. citizens in these countries and territories at risk. In these unprecedented times, the Department’s medical professionals are committed to doing everything we can for the health and safety of U.S. citizens overseas.

In summary, I would like to thank each of you for your continued support as we keep pace with this international emergency. Please know that your support to the Department, and to the Bureau of Medical Services in particular, has made this all possible, and that your continued support will be critical in the months and years to come.
Mr. BERA. Thank you, Dr. Walters.
Director Redfield.

STATEMENT OF DR. ROBERT REDFIELD, DIRECTOR, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. REDFIELD. Well, thank you, Chairman Bera and Ranking Member Yoho, and the members of the committee for the opportunity to speak to you today.

CDC, the Department of Health and Human Services, the State Department, and other U.S. Government partners are fully committed to confront the serious level health threat presented by coronavirus disease 19. CDC’s public health approach to COVID–19 is built on decades of infectious disease expertise and prior public health emergencies such as SARS, MERS, Ebola, and pandemic influenza. Our goal is to keep America safe and to slow the introduction of this new virus into the United States.

Our response involves multi-layered, aggressive containment, and potential mitigation measures, as needed. These proven health—proven effective public health interventions include early diagnosis, isolation, and contact tracing. These public health interventions also include targeted travel restrictions as well as the use of quarantine for individuals returning from transmission hot zones such as Hubei Province, China, and the Diamond Princess cruise ship docked in Japan.

Internationally, CDC is working with the World Health Organizations and ministries of health across the globe to continue to combat this outbreak. CDC has deployed over 600 staff to the response, including staff supporting Japan, South Korea, and our country office in China.

This outbreak underscores our national leadership role on the global scale and the necessity of strengthening our global capacity to stop disease threats at their source before they spread. When this outbreak was first reported in December 2019, China reported 27 cases of pneumonia linked to a seafood market. Today there are more than 78,000 cases and over 2,700 deaths.

Over the past few months we have seen confirmed cases reported in 46 international locations, including the United States. And several of these countries now are supporting—are reporting sustained community spread.

In the United States, 15 cases have been confirmed by our Nation’s public health and medical community based on clinical guidance provided them by CDC. On February 26th, CDC confirmed the infection with the virus caused by COVID–19 in a person who reportedly did not have any relevant travel history or exposure to other COVID patients. It is possible this could be an instant—an instance of community spread of COVID, which would be the first time this has happened in the United States.

Three cases have been detected among the Americans repatriated from Wuhan, and another 43 cases were confirmed among the cruise ship passengers that were repatriated from Japan.

We commend the efforts of the Government of Japan to institute quarantine measures onboard the ship, and we appreciate Japan’s cooperation with the U.S. Government to evaluate and care and evacuate American citizens. CDC works in partnership with the
State Department to assist in this repatriation effort of American citizens, both from China and Japan.

All of the individuals repatriated from Wuhan by the State Department charters have now been released from their mandatory quarantine. These individuals are not at risk of spreading the virus to others and should return to their normal lives. Passengers from the Diamond Princess are in the process of completing their quarantine at several locations across the United States.

We are grateful to all the Americans who have and still are undergoing quarantine for their patience and their cooperation, as well as their willingness to ensure that they, their families, their communities and our Nation remain safe.

We also want to thank the Department of Defense, the military personnel, their families on the installations where the evacuees have been quarantined for their hospitality and service to our Nation.

Efforts to direct flights from mainland China to 11 U.S. airports continue. CDC is working closely with Customs and Border Protection to screen arriving passengers from mainland China for illness, and to identify people at high risk of exposure to this new virus and ensure that they are referred for the appropriate public health followup.

To inform future travelers of the virus and where it is spreading, CDC continues to post travel advisories and alerts. Specifically, China and South Korea are now Level 3 warnings that advise travelers against non-essential travel.

Finally, CDC’s current assessment, including the United States, is the risk of this infection remains low. However, we do anticipate new community cases. We have implemented a successful containment strategy, but we must be prepared to move to a blended containment mitigation approach. We also need to make sure we continue to strengthen our public health infrastructure, as alluded to by the chairman, and be ready for broader community spread.

CDC and HHS will continue to keep Members of Congress informed of new developments. We recognize that you are trusted leaders in your community, and communication with the public is essential during this emergency.

Thank you. And I look forward to your questions.

[The prepared statement of Dr. Redfield follows:]
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Hearing on Coronavirus Disease 2019: The U.S. and International Response

Witness appearing before the
House Foreign Affairs Subcommittee on Asia, the Pacific and Nonproliferation

Robert R. Redfield, M.D.
Director, Centers for Disease Control and Prevention

February 27, 2020
Good afternoon, Chairman Bera, Ranking Member Yoho, and members of the Subcommittee. I am Dr. Robert Redfield, Director of the Centers for Disease Control and Prevention (CDC). Thank you for the opportunity to testify before you, and for your commitment to supporting CDC’s work in protecting public health.

Since President Trump took office, his work to protect the health and safety of the American people has included a specific focus on monitoring, preparing for, and responding to biological threats, such as infectious disease outbreaks. As soon as the United States became aware of a novel coronavirus at the end of 2019, the U.S. Government was tracking its spread and began preparing necessary responses.

Within the first two weeks of China’s initial report of the outbreak in December 2019, China reported 45 pneumonia cases and two deaths. The outbreak has since expanded to over 78,064 cases and over 2,715 deaths in China, with the majority of cases still centered in Hubei Province, where the outbreak originated. Globally, 38 countries have reported a total of 80,969 cases and 2,760 deaths. More recently, there has been an increase in cases outside of China.

COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans. This new disease, officially named Coronavirus Disease 2019 (COVID-19) by the World Health Organization (WHO), is caused by the SARS-COV-2 virus, which is in the same family of viruses as that cause the common cold. There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. Coronaviruses are a large family of viruses. Some cause illness in people, and others, such as canine and feline coronaviruses, only infect animals. Rarely, animal coronaviruses that infect animals have emerged to infect people and can spread between people. This is suspected to have
occurred for the virus that causes COVID-19. Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) are two other examples of coronaviruses that originated from animals and then spread to people. As of February 26, 2020, 14 cases have been reported across 6 states, and 45 cases have been detected among people repatriated from Hubei, China and the Diamond Princess We expect to see additional imported cases and limited person-to-person spread. While community-wide transmission has not been documented yet in the United States, it is expected, and we are aggressively preparing for it.

Most cases of COVID-19 in the United States have been associated with travel from China, but some person-to-person spread among close contacts of travelers has been seen. It’s important to note that this virus is not spreading within American communities at this time. The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low. The greater risk is for people who have recently traveled to China or been exposed to someone with COVID-19.

On January 29, 2020, President Trump announced the formation of the President’s Task Force on the Novel Coronavirus, which is chaired by the Secretary for Health and Human Services and coordinated through the National Security Council. The President’s Task Force is composed of subject matter experts from the White House and several United States Government agencies, and it includes some of the Nation’s foremost experts on infectious diseases. The Task Force is leading the Administration’s efforts to monitor, contain, and mitigate the spread of COVID-19 while ensuring that the American people have the most accurate and up-to-date information to protect themselves and their families.

The President’s top priority is the health and welfare of the American people, and his Administration has made it a priority to prepare for infectious disease outbreaks that can cross
borders. In 2018, President Trump launched the National Biodefense Strategy, which lays out a framework for coordination among agencies, with the Secretary of the U.S. Department of Health and Human Services (HHS) as Chair of the Biodefense Steering Committee, and helps identify gaps in preparedness and response. As the situation around the new coronavirus evolves, the Administration will continue its coordinated response, in collaboration with state and local governments and the private sector, and adjust its positioning as needed.

Within HHS, the Centers for Disease Control and Prevention (CDC), the Assistant Secretary for Preparedness and Response (ASPR), the National Institute of Allergy and Infectious Diseases (NIAID), and the Food and Drug Administration (FDA) play critical roles in responding to COVID-19 by preventing and slowing the spread of the disease, assisting repatriated Americans, protecting the supply of food, drugs, and devices, and developing diagnostics, therapeutics, and vaccines.

**Centers for Disease Control and Prevention**

In late December 2019, Chinese authorities announced a cluster of pneumonia cases of unknown etiology centered on a local seafood market in Wuhan, China, with an estimated case onset in early December. CDC immediately began monitoring the outbreak, and within days – by January 7, 2020 – had established a Center-led Incident Management Structure. On January 21, 2020, CDC transitioned to an Agency-wide response based out of its Emergency Operations Center. This allows CDC to provide increased operational support to meet the outbreak’s evolving challenges and provides strengthened functional continuity to meet the long-term commitment needed to curb the outbreak.

As of February 20, 2020, CDC has deployed over 800 staff to work full time on the COVID-19 response, including those working on the response from CDC headquarters, overseas
offices, and field deployments. This includes CDC staff supporting China through the CDC country office in Beijing, China; that office has a 30-year history of collaboration with the China National Health Commission and China Center for Disease Control on emerging threats and respiratory illness. Beyond China, CDC is assisting ministries of health in countries in every region of the globe with their most urgent and immediate needs to prevent, detect, and respond to the COVID-19 outbreak.

CDC’s most expert and practiced infectious disease and public health experts are dedicated to this response 24/7 to protect the American people. CDC is a disease preparedness and response agency, and this work is fundamental to our mission both domestically and internationally. The Agency’s approach to COVID-19 is built upon decades of experience with prior infectious disease emergencies including responses to SARS, MERS, and Ebola, and to pandemic influenza.

To mitigate the impact of COVID-19 within the United States, CDC is working alongside Federal, state, local, tribal, and territorial partners, as well as public health partners. This public health response is multi-layered and includes aggressive containment and mitigation activities with an objective to detect and minimize introductions of this virus in the United States so as to reduce its the spread and impact. It is impossible to catch every single traveler returning from China with this virus – given the nature of this virus and how it’s spreading. Our goal continues to be slowing the introduction of the virus into the United States as we work to prepare our communities for more cases and possible sustained spread.

To accomplish this, CDC is also working with multiple countries, in collaboration with U.S. Agency for International Development (USAID) and other federal agencies and WHO to support ministries of health around the globe to prepare and respond to the outbreak. For
example, the U.S. Government is helping to support countries to implement recommendations provided by WHO related to the identification of people who might have this new infection, diagnosis and care of patients, and tracking of the outbreak. CDC staff are also starting to work together with interagency colleagues in those countries to conduct investigations that will help inform response efforts going forward.

The Agency is using its existing epidemiologic, laboratory, and clinical expertise to gain a more comprehensive understanding of COVID-19. CDC is leveraging prior programmatic investments in domestic and global public health capacity and preparedness to strengthen the Agency’s response to COVID-19. Thus far, this response has been built largely on the foundation of our seasonal and pandemic influenza program’s infrastructure. The ongoing response to COVID-19 also demonstrates CDC’s continued commitment to strengthen global health security. CDC has been engaged in global health security work for over seven decades. Thanks to investments in Global Health Security, the U.S. Government’s work has helped partner countries build and improve their public health system capacity. This global effort strengthens the world’s ability to prevent, detect, and respond to infectious diseases like this new coronavirus.

This outbreak also underscores the need for the United States to continue to play a leadership role on the global stage, and to strengthen global capacity to stop disease threats at their sources, before they spread. Furthermore, the outbreak demonstrates the importance of continued investment in our nation’s public health infrastructure. Despite years of progress in domestic disease prevention and response, efforts to help modernize our federal, state, and local capability and health systems that are crucial to responding to and understanding unprecedented threats continue.
Within a week of China posting a genetic sequence online, CDC had developed a real-time Reverse Transcription-Polymerase Chain Reaction (RT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens. On Monday, February 3, 2020, CDC submitted an Emergency Use Authorization (EUA) package to the FDA in order to expedite FDA permitted use of the CDC-developed laboratory test kit, called the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel. The next day, FDA approved the EUA and the test kit began shipping on February 5, 2020 to select, qualified U.S. and international laboratories. As states began validating the kit in their laboratories, an issue with one of the testing components was discovered. This issue was immediately reported to CDC and no further domestic or international kits were shipped. In addition, in response to this issue, CDC has significantly increased its test throughput in Atlanta allowing for continued monitoring of the outbreak without disruption. CDC is working on remanufacturing the test kit, which will help improve the global capacity to detect and respond to the 2019 novel coronavirus.

In addition to the development of a diagnostic test, CDC has publicly posted the assay protocol for this test. Availability of this resource is a starting place for greater commercial availability of these tests. CDC continues to upload the entire genome of the viruses from all reported cases in the United States to GenBank as sequencing was completed. CDC has also grown the COVID-19 virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to the National Institutes of Health’s Biodefense and Emerging Infections Research Resources Repository for use by the domestic and international scientific community.

The U.S. Government has taken unprecedented steps to prevent the spread of this virus and to protect the American people and the global community from this new threat and allow
State, local, territorial, and private partners time to prepare for any necessary response and mitigation activities. Since February 2, 2020, pursuant to arrival restrictions imposed by the Department of Homeland Security, flights carrying persons who have recently traveled from or were otherwise present within mainland China, not including Hong Kong, Macau, or the Island of Taiwan) have been funneled to designated U.S. airports with CDC quarantine stations. At these airports, passengers are subject to enhanced illness screening and self-monitoring with public health supervision up to 14 days from the time the passenger departs China. As of February 25, 2020, CDC, with assistance from the U.S. Department of Homeland Security, has conducted 46,884 passenger screenings at airports. This enhanced entry screening serves two critical purposes. The first is to detect illness and rapidly respond to symptomatic people entering the country. The second purpose is to educate travelers about the virus and what to do if they develop symptoms. Travelers who have been in Hubei Province in the past 14 days are either taken to a medical facility for treatment if symptomatic, or, if asymptomatic, are placed under a Federal, state, or local quarantine order for a 14-day period. For travelers from other parts of China, outside of Hubei Province, asymptomatic travelers are asked to monitor their health for a period of 14 days at their final destination, in coordination with their local health departments.

Furthermore, in an effort to slow the spread of COVID-19 in the United States, CDC issued its highest level of travel guidance for China, Level 3, recommending that travelers avoid all nonessential travel to the country. CDC has supported the Department of State in the safe and expeditious departure of U.S. citizens and other exempted persons.

As of February 26, 2020, this includes 7 chartered flights that returned passengers from Wuhan City, China and most recently, passengers from a cruise ship docked in Japan. These
measures are part of a layered approach which includes our other core public health efforts, including aggressively tracking COVID-19 around the globe, building laboratory capacity, and preparing the national healthcare system for community spread. These core capabilities and expertise are essential to CDC’s comprehensive approach to addressing this outbreak.

While CDC believes that the immediate risk of this new virus to the American public is low, CDC is preparing the nation’s healthcare system to respond to identification of individual cases and potential person-to-person transmission of COVID-19 in the community, at the same time ensuring the safety of its patients and workers. CDC has developed guidance on appropriate care and infection control for patients with COVID-19 and is engaging regularly with clinical and hospital associations to confirm that its guidance is helpful and responsive to the needs of the healthcare system.

Furthermore, understanding the current constraints of the global supply of personal protective equipment (PPE), CDC is working with industry and the U.S. health system to comprehend possible effects on facilities' abilities to procure the needed levels of PPE, and to provide strategies to optimize the supply of PPE.

Effective disease surveillance enables countries to quickly detect outbreaks and continuously monitor for new and reemerging health threats. CDC continues to monitor the COVID-19 situation around the world.

CDC has begun working with domestic public health laboratories that conduct community-based influenza-like illness surveillance and leveraging our existing influenza and viral respiratory surveillance systems so that we may begin testing people with flu-like symptoms for the SARS-COV-2 virus. HHS is developing plans to expand this effort.
This collaboration with domestic public health labs is another layer of our response that will help us detect if this virus is spreading in a community. All of our efforts now are to prevent the sustained spread of this virus in our communities, but we need to be prepared for the possibility that it will spread. Results from this surveillance could necessitate changing our response strategy.

CDC has issued guidance for people at high risk of exposure to the virus, including flight crews, recent travelers to China, and healthcare workers. Through its extensive Health Alert Network, CDC shared guidance for clinical care for healthcare professionals and state and local health departments. Health departments, in consultation with healthcare providers, can evaluate patients and determine whether someone may have the illness and should be subjected to additional diagnostic testing.

The current outbreak meets two criteria for a pandemic. It is a new virus, and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside China, this will increase the likelihood that the WHO will deem it a global pandemic. Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic. Influenza pandemic preparedness platforms and plans are appropriate in the event that the current COVID-19 outbreak becomes a pandemic. Public health partners have been encouraged to review their pandemic preparedness plans and begin planning for community spread.

CDC has a demonstrated record of innovative science and evidence-based decision-making, and an experienced and expert workforce that is working 24/7 to combat this public health emergency. The COVID-19 outbreak is evolving rapidly, and the U.S. Government is constantly making adjustments to respond to the changing nature of this public health
emergency. Our goal continues to be slowing the introduction of the virus into the United States and preparing our communities for more cases and possible sustained spread. While leaning forward aggressively with the hope that we will be able to prevent community spread, CDC remains vigilant in confronting the challenges presented by this new coronavirus.

**Assistant Secretary for Preparedness and Response**

Currently, there are no vaccines or therapeutics approved by the FDA to treat or prevent novel coronavirus infections. The Biomedical Advanced Research and Development Authority (BARDA), part of ASPR, is working with counterparts across the government, including within HHS and with the Department of Defense (DOD). The team is reviewing potential vaccines, treatments, and diagnostics from across the public and private sectors to identify promising candidates that could be developed to detect, protect against, or treat people with coronavirus infections. BARDA is working closely across the U.S. Government to assess and identify potential partners and technologies suitable to address the COVID-19 outbreak – both for prevention and treatment.

This has allowed BARDA to leverage existing partnerships, accelerating the development of COVID-19 medical countermeasures, including diagnostics, therapeutics, and vaccines. Established partners, including Regeneron, Janssen, and Sanofi Pasteur, have shown success in developing both prophylactic and therapeutic medical countermeasures for emerging infectious diseases.

BARDA is collaborating with Regeneron to leverage their partnership agreement to develop multiple monoclonal antibodies that, individually or in combination, could be used to treat this emerging coronavirus. Regeneron’s monoclonal antibody discovery platform, called VelocImmune, was used to develop a promising investigational three-antibody therapeutic which
was deployed to treat Ebola in the most recent outbreak in the Democratic Republic of the Congo, and an investigational two-antibody therapeutic to treat MERS. The technology shortened multiple aspects of the product development timeline for therapeutics to treat MERS and Ebola from years to months. The technology helped shorten certain stages of drug development, including the process of antibody discovery and selection, preclinical-scale manufacturing, and clinical-scale manufacturing. BARDA and Regeneron are working to utilize these monoclonal antibodies, produced by a single clone of cells or a cell line with identical antibody molecules, which will bind to certain proteins of a virus, reducing the ability of the COVID-19 virus to infect human cells.

BARDA is working with Janssen to leverage their Ebola, Zika, HIV vaccine platform to expedite development of vaccines that protect against the SARS-CoV-2 virus. Using existing resources, BARDA will share research and development costs and expertise with Janssen to help accelerate Janssen’s investigational COVID-19 vaccine into clinical evaluation. Janssen will also scale-up production and manufacturing capacities required to manufacture the candidate vaccine. This same approach was used to develop and manufacture Janssen’s investigational Ebola vaccine with BARDA support; that vaccine is being used in the Democratic Republic of the Congo as part of the current Ebola outbreak response. Additionally, BARDA and Janssen are working together to help develop treatments for coronavirus infections. Janssen will conduct high throughput screening on thousands of potential antiviral compounds in order to identify medicines that could safely and effectively be used to reduce the severity of illness and treat COVID-19 infections, as well as identify compounds that have antiviral activity against SARS-CoV-2 as an initial step in developing new treatments. These products include those in
development to treat and prevent MERS or SARS, which are caused by coronaviruses also related to COVID-19.

Finally, in their work with Sanofi Pasteur, BARDA is able to leverage a licensed recombinant influenza vaccine platform to produce a recombinant SARS-CoV-2 vaccine candidate. The technology produces an exact genetic match to proteins of the virus. DNA encoding the protein will be combined with DNA from a virus harmless to humans, and used to rapidly produce large quantities of antigen which stimulate the immune system to protect against the virus. The antigens will be separated and collected from these cells and purified to create working stocks of vaccine for advanced development.

BARDA has initiated early steps of medical countermeasures development with partners and will continue to work to accelerate this process. Availability of these medical countermeasures is essential to save lives and protect Americans against 21st century public health threats.

Our nation’s healthcare system is better prepared than it has ever been. For example, all 50 states have Pandemic Plans, as a requirement of CDC’s Public Health Emergency Preparedness Program (PHEP) and ASPR’s Hospital Preparedness Program (HPP). HPP was established after the September 11, 2001, terrorist attacks, with the goal of improving the capacity of local hospitals across the country to deal with disasters and a large influx of patients in an emergency. Using HPP funding, state grantees initially purchased equipment and supplies needed for emergency medical surge capacity. Over time, the program has successfully evolved to support local, coordinated healthcare coalitions, including hospitals, public health facilities, emergency management agencies, and emergency medical services providers. Investments administered through PHEP and HPP have improved individual health care entities’
preparedness and have built a system for coordinated healthcare system readiness. HPP is the only source of federal funding to prepare the nation’s mostly private health care system to respond to emergencies, including COVID-19.

Beginning in 2018, ASPR has been supporting Regional Disaster Health Response Systems (RDHRS) pilot projects. The RDHRS concept aims to provide funding directly to hospitals and healthcare systems to establish multi-state regional partnerships to increase preparedness and response capability and capacity for hospitals and healthcare facilities in advance of, during, or immediately following incidents, including emerging infectious diseases. Two sites were selected in September 2018 to begin development of RDHRS pilots. In 2019, two grants were awarded to support new centers of excellence pilots focused on pediatric disaster care. The RDHRS and Pediatric Disaster Care Center of Excellence cooperative agreement requirements are intentionally aligned to ensure synergy between the programs and collaboration between all sites and facilities. Ultimately, these efforts inform best practices to help ready healthcare delivery systems for disasters and emergencies and are critical in aiding response and limiting the impact of disaster. As you all are aware, the United States is in the middle of influenza season. Many emergency departments are at 90 percent capacity. If influenza worsens, or if COVID-19 intensifies domestically, emergency departments would be severely strained, which is why supporting models such as the Hospital Preparedness Program healthcare coalition network is so important.

The National Ebola Training and Education Center (NETEC) combines the resources of healthcare institutions experienced in treating Ebola to offer training, readiness consultations, and expertise to help facilities prepare for Ebola and other special pathogens. The regional Ebola and other special pathogen treatment centers, of which ASPR and CDC funded 10 across the
country, all have respiratory infectious disease isolation capacity or negative pressure rooms for at least 10 patients, including pediatric patients. The NETEC and the regional Ebola and other special pathogen treatment centers are being used to support the ongoing quarantine effort. Should the coronavirus infections increase domestically, these centers will become critical in isolating infected persons and providing adequate treatment.

ASPR and CDC also work to enhance medical surge capacity by organizing, training, equipping, and deploying Federal public health and medical personnel, such as National Disaster Medical System (NDMS) teams, and providing logistical support for federal responses to public health emergencies. NDMS was originally created during the Cold War to take care of military casualties from overseas in U.S. civilian hospitals. Today, NDMS teams are deployed to strategic locations across the country, caring for U.S. citizens evacuated from China who may have been exposed to SARS-CoV-2, effectively providing medical care and limiting the potential spread of the disease.

Currently, to assist in the repatriation effort, ASPR has stood up a National HHS Incident Management Team (IMT) located in Washington, DC. The IMT serves as the national command and control element. Currently, HHS has deployed 606 Public Health Service Commission Corps Officers and NDMS personnel:

- March Air Reserve Base (in Riverside County, California): 39 personnel onsite
- Travis Air Force Base (in Solano County, California): 214 personnel onsite
- Marine Corps Air Station Miramar (in San Diego, California): 127 personnel onsite
- Lackland Air Force Base (in San Antonio, Texas): 150 personnel on site
- Camp Ashland (in Omaha, Nebraska): 76 personnel onsite
In addition, HHS is providing cache equipment, (e.g., medical supplies and resources) to Travis AFB, Marine Corps Air Station Miramar, Lackland, Air Force Base, and Camp Ashland. HHS deployed one Disaster Medical Assistance Team (DMAT) and one IMT on February 12, 2020 to support American citizens in Japan on the Diamond Princess cruise ship, as well as the U.S. Embassy, to provide medical care, prescriptions, and behavioral health support. Regarding the cruise ship, the Department of State facilitated voluntary repatriation of over 300 U.S. citizens and family members who were passengers. During the evacuation process, after passengers had disembarked the ship and initiated transport to the airport, U.S. officials received notice that 14 passengers, who had been tested 2-3 days earlier, had tested positive for COVID-19. For the flight, these passengers were kept in a specialized containment area on the evacuation aircraft to isolate them in accordance with standard protocols. After consultation with HHS officials, including experts from ASPR, Department of State allowed the 14 individuals, who were in isolation, separated from other passengers and continued to be asymptomatic, to remain on the aircraft to complete the evacuation process. All passengers were closely monitored by medical professionals throughout the flight, and any who became symptomatic were moved to the specialized containment area. Upon landing in the United States, passengers deplaned at either Travis AFB or Joint Base San Antonio and will remain under quarantine for 14 days. The 14 individuals who had tested positive for COVID-19 continued to the University of Nebraska Medical Center in Omaha, Nebraska. Every precaution to ensure proper isolation and community protection measures are being taken, driven by the most up-to-date risk assessments by U.S. health authorities.

Many active pharmaceutical ingredients and medical supplies, including auxiliary supplies such as syringes and gloves, come from China and India. This outbreak demonstrates
why ASPR is seeking innovative solutions and partnerships to better protect national security. ASPR is working to increase access to personal protective equipment (PPE) by:

- Coordinating with CDC and other Federal agencies to share information about optimization of PPE, to prevent overbuying and overuse of existing supplies
- Engaging private sector partners who manufacture and distribute PPE to share information and concerns, and to explore options to anticipate and meet the needs of the U.S. healthcare sector more effectively. During recent discussions, for example, distributors informed us that they have implemented allocations to help prevent stockpiling at healthcare facilities. The allocation is a percentage of a customer’s previous orders and is designed to help protect the healthcare supply chain and ensure the right supplies are available for those who need it.
- We are also partnering with other Federal agencies such as DHS, DOD and the U.S. Department of Veterans Affairs who are large buyers of PPE, to develop acquisition strategies that incentivize industry to expand PPE production while not exacerbating supply challenges.

The Strategic National Stockpile (SNS) holds thousands of deployable face masks, N95 respirators, gloves, and surgical gowns that could be deployed if state and local supplies are diminished due to the current COVID-19 response and commercial supplies are exhausted. The SNS is working hand-in-hand with commercial supply chain partners and other Federal agencies to continue monitoring supply levels and to prepare for a potential deployment of SNS personal protective gear if it is needed.

**The National Institutes of Health**
The National Institutes of Health (NIH) is the HHS agency leading the research response to the global health emergency of COVID-19. Within the NIH, the National Institute of Allergy and Infectious Diseases (NIAID) is responsible for conducting and supporting research on emerging and re-emerging infectious diseases, including COVID-19.

NIAID is well-positioned to respond rapidly to infectious disease threats as they emerge by leveraging fundamental basic research efforts; a domestic and international research infrastructure that can be quickly mobilized; and collaborative and highly productive partnerships with industry. NIAID provides preclinical research resources to scientists in academia and private industry throughout the world to advance translational research for emerging and re-emerging infectious diseases. These research resources are designed to bridge gaps in the product development pipeline, thereby lowering the scientific, technical, and financial risks incurred by industry and incentivizing companies to partner in the development of effective countermeasures including diagnostics, therapeutics, and vaccines.

NIAID also supports the Infectious Diseases Clinical Research Consortium, which includes a network of Vaccine and Treatment Evaluation Units (VTEUs). The VTEUs conduct clinical trials to investigate promising therapeutic and vaccine candidates when public health needs arise. NIAID collaborates with other Federal agencies, including through the HHS Public Health Emergency Medical Countermeasures Enterprise (PHEMCE), to help advance progress against newly emerging public health threats. In addition, partnerships with academia, the biotechnology and pharmaceutical industries, domestic and international researchers, and organizations such as the World Health Organization (WHO) are integral to these efforts.

NIAID has a longstanding commitment to coronavirus research, including extensive efforts to combat two other serious diseases caused by coronaviruses: SARS and MERS. This
research has improved our fundamental understanding of coronaviruses and provides a strong foundation for our efforts to address the challenge of SARS-CoV-2, the novel coronavirus that causes COVID-19. NIAID has responded to the newly emerging COVID-19 outbreak by expanding our portfolio of basic research on coronaviruses. NIAID scientists have rapidly identified the human receptor used by SARS-CoV-2 to enter human cells. In addition, NIAID investigators and their collaborators recently identified the atomic structure of the spike protein, an important SARS-CoV-2 surface protein that is a key target for the development of vaccines and therapeutics. NIAID scientists also are evaluating the stability of SARS-CoV-2 on various ordinary surfaces and in aerosols to better understand the potential for viral spread throughout the community.

NIAID-supported researchers are assessing the risk of emergence of bat coronaviruses in China, including the characterization of bat viruses and surveys of people who live in high-risk communities for evidence of bat coronavirus infection. Such research is necessary to better understand this emerging infection and to investigate optimal ways to diagnose, treat, and prevent COVID-19.

The NIAID Centers of Excellence for Influenza Research and Surveillance (CEIRS), which conduct influenza risk assessments in multiple sites throughout the world particularly in Asia, have responded rapidly to the COVID-19 outbreak. CEIRS researchers at the University of Hong Kong are evaluating the epidemiology, transmission dynamics, and severity of COVID-19. These scientists also have performed environmental sampling of the Wuhan market where the first COVID-19 cases were reported.

NIAID is working with CEIRS collaborators and the CDC to obtain additional virus and biological samples from patients to further advance research efforts on COVID-19. Recently,
the NIAID-funded BEI Resources Repository made samples of SARS-CoV-2 available for distribution to domestic and international researchers at Biosafety Level 3 laboratories. In addition, CEIRS researchers and other NIAID-supported scientists are developing reagents, assays, and animal models that can be used to evaluate promising therapeutics and vaccines. These research resources also will be shared with the domestic and international scientific community as soon as they become available.

On February 6, 2020, NIAID issued a Notice of Special Interest regarding the Availability of Urgent Competitive Revisions for Research on the 2019 Novel Coronavirus. This notice encourages existing NIAID grantees to apply for supplements for research project grants focused on the natural history, pathogenicity, and transmission of the virus, as well as projects to develop medical countermeasures and suitable animal models for preclinical testing of COVID-19 vaccines and therapeutics.

NIAID has responded to public health concerns about COVID-19 by increasing ongoing coronavirus research efforts to accelerate the development of interventions that could help control current and future outbreaks of COVID-19. These activities build on prior NIAID research addressing other coronaviruses, such as those that cause SARS and MERS.

The CDC has developed a real-time Reverse Transcription-Polymerase Chain Reaction (RT-PCR) test that can detect COVID-19 using respiratory samples from clinical specimens. NIAID is accelerating efforts to develop additional diagnostic tests for COVID-19, and NIAID-supported investigators are developing PCR-based assays for SARS-CoV-2 to facilitate preclinical studies and aid in the development of medical countermeasures. NIAID scientists also are developing reagents for an enzyme-linked immunosorbent assay for SARS-CoV-2. CEIRS researchers at the University of Hong Kong have developed a separate RT-PCR
test and made their protocol publicly available through the WHO. These NIAID-supported investigators also have distributed assay reagents to 12 countries to facilitate the diagnosis of COVID-19.

NIAID is pursuing the development of antivirals and monoclonal antibodies for potential use against SARS-CoV-2. NIAID has launched a multicenter, randomized controlled clinical trial to evaluate the safety and efficacy of the antiviral drug remdesivir for the treatment of COVID-19 in hospitalized adults with laboratory-confirmed SARS-CoV-2 illness. The adaptive design of this trial will enable the evaluation of additional promising therapies. NIAID plans to assess other existing antivirals for activity against SARS-CoV-2, and NIAID scientists are working to identify monoclonal antibodies with therapeutic potential from COVID-19 patient samples as well as historical SARS patient samples. NIAID-funded scientists also aim to delineate new viral targets to facilitate the development of novel therapeutics with broad activity against coronaviruses. Finally, NIAID is expanding its suite of preclinical services to add assays that investigators can use to accelerate research and development of therapeutics for COVID-19.

A safe and effective vaccine for SARS-CoV-2 would be an extremely valuable tool to stop the spread of infection and prevent future outbreaks. Public and private entities across the globe have announced plans to develop SARS-CoV-2 vaccine candidates following the release of the SARS-CoV-2 genetic sequence. NIAID is supporting development of several SARS-CoV-2 vaccine candidates, and is utilizing vaccine platform technologies that have shown promise against the coronaviruses that cause SARS and MERS.

The NIAID Vaccine Research Center (VRC) is collaborating with the biotechnology company Moderna, Inc., on the development of a vaccine candidate using a messenger RNA (mRNA) vaccine platform containing the gene that expresses the VRC-designed spike protein of
SARS-CoV-2: NIAID anticipates the experimental vaccine will be ready for clinical testing in the NIAID VTEUs within the next two months and will conduct preclinical studies as well as a first-in-human study of this COVID-19 vaccine candidate. The Coalition for Epidemic Preparedness Innovations (CEPI) will fund the manufacture of the first clinical production lot of this mRNA-based vaccine candidate using the Moderna rapid manufacturing facility.

NIAID Rocky Mountain Laboratories (RML) scientists are collaborating with Oxford University investigators to develop a chimpanzee adenovirus-vectored vaccine candidate against SARS-CoV-2; in addition, they have partnered with CureVac on an mRNA vaccine candidate. RML investigators also have launched a collaboration with the University of Washington and have begun early-stage testing of an RNA vaccine candidate against SARS-CoV-2. In addition, NIAID-supported scientists at Baylor College of Medicine and their collaborators are evaluating an experimental SARS-CoV recombinant protein vaccine to determine if it also provides protection against SARS-CoV-2. NIAID is exploring additional collaborations with extramural research and industry partners on other vaccine concepts. NIAID also is supporting the development of standardized assays and animal models that will be utilized to evaluate vaccine candidates.

With all these efforts, NIAID is coordinating closely with colleagues at the CDC, BARDA, FDA, DOD, and other federal and international partners.

To achieve the ultimate goal of having a SARS-CoV-2 vaccine available to the public, it is important that NIAID and the entire biomedical research community pursue a range of vaccine strategies in order to be better positioned to overcome the scientific or technical challenges associated with any particular vaccine approach. In this regard, NIAID has dedicated resources toward preclinical research to advance a robust pipeline of vaccine candidates into Phase 1.
clinical evaluation. Further vaccine research, including Phase 2 clinical trials, will then be required. Additional research also is needed to better understand the fundamental biology of coronaviruses and to facilitate the design of vaccines that elicit optimal immune responses and protect against infection.

While ongoing SARS-CoV-2 vaccine research efforts are promising, it is important to realize that the development of investigational vaccines and the clinical testing to establish their safety and efficacy take time. Although we plan to begin early-stage clinical testing of an NIAID-supported vaccine candidate in the next few months, a safe and effective, fully licensed SARS-CoV-2 vaccine will likely not be available for some time. Currently, the COVID-19 outbreak response in the United States remains focused on the proven public health practices of containment – identifying cases, isolating patients, and tracing contacts.

NIH is committed to continued collaboration with other HHS agencies and additional partners across the U.S. government and international community to advance research to address COVID-19. As part of its mission to respond rapidly to emerging and re-emerging infectious diseases throughout the world, NIAID is expanding our efforts to elucidate the biology of SARS-CoV-2 and employ this knowledge to develop the tools needed to diagnose, treat, and prevent disease caused by this virus. NIAID is particularly focused on developing safe and effective COVID-19 vaccines. These efforts also help to expand our knowledge base and improve our continued preparedness for the next inevitable emerging disease outbreak.

Food and Drug Administration

The FDA plays a critical role in overseeing our Nation’s FDA-regulated products as part of our vital mission to protect and promote public health, including during public health emergencies. Our work primarily focuses on four key areas: first, actively facilitating efforts to
diagnose, treat, and prevent the disease; second, surveilling product supply chains for potential shortages or disruptions and helping to mitigate such impacts, as necessary; third, conducting inspections and monitoring compliance, including of facilities that manufacture FDA-regulated products overseas; fourth, helping to ensure the safety of consumer products. I will be providing an update of our ongoing work as well as tools that could help enhance the FDA's response capabilities.

A key focus area for the FDA is helping to expedite the development and availability of medical products needed to diagnose, treat, and prevent this disease. We’re committed to helping foster the development of critical medical countermeasures as quickly as possible to protect public health. We provide regulatory advice, guidance, and technical assistance to sponsors in order to advance the development and availability of vaccines, therapies, and diagnostic tests for this novel virus.

On February 4, 2020, the FDA issued an emergency use authorization (EUA) to enable immediate use of a diagnostic test developed by the CDC, facilitating the ability for this test to be used in CDC-qualified laboratories. The FDA is dedicated to actively working with other COVID-19 diagnostic developers to help accelerate development programs and requests for EUAs. We have developed an EUA review template for tests to detect the virus, which outlines the data requirements for a Pre-EUA package that is available to developers upon request. To date, we have shared the EUA review template with more than 65 developers who have expressed interest in developing diagnostics for this virus.

The medical product supply chain is always potentially vulnerable to disruption, which makes our surveillance work and collaboration with industry critical and why the Agency takes a proactive stance on any potential impact or disruption to the supply chain. An outbreak of this global scale has an impact on the medical product supply chains, including potential disruptions to supply or shortages of critical medical products in the United States. We are in contact with manufacturers; global regulators, like the European Medicines Agency; health care delivery organizations, and other participants in the medical product supply chains to quickly identify and address any supply concerns that come from issues related to China and other locations in Southeast Asia sourcing raw materials for manufacturing drugs.

We are also tracking reports of increased ordering of some essential medical devices through distributors, such as personal protective equipment (PPE) (e.g., respirators and surgical gowns, gloves and masks). FDA is working proactively to stay ahead of potential shortages or disruptions of medical products. The agency will use all available authorities to react swiftly and mitigate the impact to U.S. patients and health care professionals as these threats arise.

Monitoring the safety of FDA-regulated product supply chains is one of the FDA’s highest priorities. The FDA utilizes risk-based models to identify firms for inspection and prioritizes inspections based on specific criteria. Because of travel restrictions to China, the Agency has postponed planned inspection activities in China. However, we are currently continuing inspection and enforcement activities as normal for the rest of our operations. Inspections of facilities in China remain prioritized in our site selection model and, when travel restrictions are lifted, inspections of facilities in China will resume. Any travel to China that is deemed to be mission-critical is being assessed on a case-by-case basis in close coordination with other HHS components and with the Department of State. FDA is committed to
maintaining its scheduled inspections around the globe to the extent possible, while maintaining the safety of the staff involved. We will revisit this approach and adjust as necessary as this outbreak continues to unfold. In the meantime, FDA is working with our partner government agency, U.S. Customs and Border Protection (CBP), to evaluate and adjust our risk-based targeting strategy to ensure FDA-regulated products are safe when entering the United States.

While the outbreak is impacting our ability to conduct inspections in China, it’s important to underscore that the FDA’s regular risk-based process of surveillance testing of imported products, including those from China, continues.

Inspections are one of many tools that the Agency uses to inform its risk strategy for imported FDA-regulated products and to help prevent products that do not meet the FDA’s standards from entering the U.S. market. Other tools include: import alerts, increased import sampling, and screening. Inspections are also part of, among other things, the new and generic drug approval process. While such pre-approval inspections are on hold in China, we are working to mitigate the impact on new and generic drug approval decisions by requesting records that may be used in lieu of an inspection, depending on the circumstances. Based on our evaluation of previous FDA inspection history, a firm’s previous compliance history and information from foreign health authorities with which we have mutual recognition agreements, we determine if the totality of the information would suffice in lieu of such a pre-approval inspection.

All products offered for entry into the United States, including items for personal use, are subject to the regulatory requirements of CBP. Imported shipments of FDA-regulated products referred by CBP, including those from China, are then reviewed by the FDA and must comply with the same standards as domestic products. At this time, we want to reassure the public that
there is no evidence to support transmission of COVID-19 associated with imported goods, including food and drugs for people or pets, and there have not been any cases of COVID-19 in the U.S. associated with imported goods.

We established a cross-agency task force to closely monitor for fraudulent FDA-regulated products and false product claims related to COVID-19 and we have already reached out to major retailers to ask for their help in monitoring their online marketplaces for fraudulent products with coronavirus and other pathogen claims.

FDA is utilizing all our existing authorities to address COVID-19 and we welcome the opportunity to work with Congress to strengthen our response capabilities. There are four specific proposals included in the President’s Budget that would better equip the Agency to prevent or mitigate medical product shortages.

(1) Lengthen Expiration Dates to Mitigate Critical Drug Shortages

Shortages of critical drugs can be exacerbated when drugs must be discarded because they exceed a labeled shelf-life due to unnecessarily short expiration dates. By expanding FDA’s authority to require, when likely to help prevent or mitigate a shortage, that an applicant evaluate, submit studies to FDA, and label a product with the longest possible expiration date that FDA agrees is scientifically justified, there could be more supply available to alleviate the drug shortage or the severity of a shortage.

(2) Improving Critical Infrastructure by Requiring Risk Management Plans

Enabling FDA to require application holders of certain drugs to conduct periodic risk assessments to identify the vulnerabilities in their manufacturing supply chain (inclusive of contract manufacturing facilities) and develop plans to mitigate the risks associated with the identified vulnerabilities would enable the Agency to strengthen the supply chain
by integrating contingencies for emergency situations. Currently, many applicants lack plans to assess and address vulnerabilities in their manufacturing supply chain, putting them, and American patients, at risk for drug supply disruptions following disasters (e.g., hurricanes) or in other circumstances.

(3) Improving Critical Infrastructure Through Improved Data Sharing: Requiring More Accurate Supply Chain Information

Empowering FDA to require information to assess critical infrastructure, as well as manufacturing quality and capacity, would facilitate more accurate and timely supply chain monitoring and improve our ability to recognize shortage signals.

(4) Device Shortages

FDA does not have the same authorities for medical device shortages as it does for drugs and biological products. For instance, medical device manufacturers are not required to notify FDA when they become aware of a circumstance that could lead to a device shortage or meaningful disruption in the supply of that device in the United States, nor are they required to respond to inquiries from FDA about the availability of devices. Enabling FDA to have timely and accurate information about likely or confirmed national shortages of essential devices would allow the Agency to take steps to promote the continued availability of devices of public health importance. Among other things, FDA proposes to require that firms notify the agency of an anticipated meaningful interruption in the supply of an essential device; require all manufacturers of devices determined to be essential to periodically provide FDA with information about the manufacturing capacity of the essential device(s) they manufacture; and authorize the temporary importation of certain devices where the benefits of the device in mitigating a shortage outweigh the
risks presented by the device that could otherwise result in denial of importation of the
device into the United States.
Mr. Bera. Thank you, Director.

I will now turn to my opening questions. And then I will recognize the ranking member and our other members for 5 minutes for the purpose of questioning the witnesses.

Director, in my opening statement, as well as as you alluded to it in your opening statement, I mentioned this potential first patient community spread. And it is in my home county, Sacramento County, and the patient is housed at the hospital that I used to attend, and have taught lots of medical students in.

In talking to my colleagues earlier today and getting a sense of the time lines of this patient, one thing is a bit consuming. I have taken care of patients like this who get transferred up, who are intubated, whose respiratory diagnosis is unknown cultures are coming back negative, et cetera. And in this case, it does seem like last Wednesday the medical staff asked for a test of coronavirus and were told this patient did not meet the criteria and this was not a coronavirus patient.

As the patient worsened, it does sound like this past Sunday there was an insistence and a strong push, and ultimately the patient did get tested. And we know the results that came back 72 hours later as a positive test.

A question that I have, and maybe it is twofold, is No. 1, what current criteria are we using to determine who is going to get a test and who is not going to get a test? When a doctor caring for this patient and they are looking at a patient and they request it, it is a no-brainer, we ought to do that test based on the medical expertise of the folks that are trying to confirm a diagnosis.

At a minimum, with this new case, we ought to rethink what those criteria are. I would be curious to hear what criteria are we using today and if the CDC is updating that criteria?

And the second component is that our testing capabilities seem a bit too slow at this juncture. And I would be curious to hear what we are doing to increase the rapidity and availability of tests, if we are getting testing kits out to all 50 States as well as more broadly to cities and others.

And then another issue is that it did take 72 hours from testing to get the results. If we could get those testing facilities a little bit closer, the results might come back quicker. I’d be curious to see how the CDC is thinking about that.

I am also told that one of my sister institutions, GCSF, have produced a more rapid test. We need the ability to get some samples to confirm the specificity and sensitivity of that test. And there are some private sector companies that are also working on rapid diagnostic tools as well.

So, Dr. Redfield.

Dr. Redfield. Mr. Chairman, thank you for the questions.

First, I think you know when this outbreak started, for better or worse, even in China, it was linked to whether you were exposed to the sea market, so, or food market. So, obvious every confirmed case was from the market.

And then in discussions I had with the Chinese CDC director I suggested they go out and look at other people with flu-like illness. And, of course, then they reported that there were many cases that were not around the market.
When the United States began this PUI, we had the epidemiological advantage of the link to Hubei initially, where most of the cases came from. Clearly what has been demonstrated by the recent case is that is no longer operational.

I will tell you that as soon as that case was recognized we met and we revised our case definition for persons under investigation. And I am, you know, today that has been posted, along with a new health advisory, that the recommendation should be when a clinician or a public health individual suspects coronavirus then we should be able to get a test for coronavirus.

So, that is the current guidance that went out today.

And this is a fluid situation.

And your second question is also critical: how do we expand the availability of testing?
We think it was an accomplish to, within a week to develop a test so we could get eyes on this. And I think the CDC scientists were able to do that. But that was not to take away the broader responsibility to the private sector to come in to be able to provide broader testing for the non-public health community.

We have had aggressive discussions about how to expand that. And we are continuing. We have shipped our kits, as you know, initially out to many, many jurisdictions. We had trouble with one of the controls. That has now been corrected, and there are now 40 jurisdictions that have the ability to do the test modified with the FDA approval. And in the next today, tomorrow, we anticipate more kits from the private sector that have been contracted by CDC to get out. And, hopefully, our real goal is that LabCorp and Mayo Clinic and others.

But you get at the root of it: why is there a difference? And I used to run a diagnostic lab and developed tests. The other countries have the ability for someone like me to develop a laboratory test and to deploy it. In our country, we develop a laboratory test and we need to go through a regulatory process in order to get it deployed. And, again, I'm not criticizing the regulatory process, I am just saying that is the difference.

And many labs in this country, many hospitals could stand up—as you mentioned, San Francisco and others, your own Davis—could stand up a test within several days. Because we have published the sequences and the methods and exactly how to do this, and that is how that one company IDT is now ready to sell a test, which is really basically a copy of the CDC test.

So, I do think we have to look at that because this is an example where we were slowed in a sense because of the way we want to assure accuracy of these diagnostic tests. And I know you all are wrestling with that. But we are having work kits out later today that are going to be sent to the States.

The State of California, I talked to your secretary of health just today because they were down to 200 tests, we are sending more out there. There are three laboratories now, I am told, in California that have the ability to do the testing.

But both of your points are very, very important. We take them very seriously. One at least we are not going to let happen again because we corrected it after the first case, and the other we are working hard to get these tests out and hoping that the private sec-
tor comes in for the clinical use. CDC develops them for the public health use, and we need the private sector to come in for the clinical.

Mr. Bera. Director, I appreciate the change in the criterion and applaud that.

I do think this is a unique situation where we need all hands on deck. And we do need to take a look at speeding up the regulatory process. We do need to allow the academics and those that have the ability to develop their own testing capabilities to quickly move through the process to make sure these are sensitive, specific, and accurate diagnostic tests.

And then if the private sector can augment our ability, especially now that there may be community spread, we have to stop the bottleneck and get these tests out to all parts of the country.

So, we can take that up here, but looking at the Administration, we all need to do whatever we can do to speed up that regulatory process to make testing readily available to the practitioners that are out there.

And with that, let me recognize the ranking member.

Mr. Yoho. And I appreciate it. And I appreciate you all's testimony. And I think what you are just bringing up is a lot of the questions I had. You know, I assume it is PCR test, analyze test. Okay.

The variation in those, you guys created that. And I think along that line there should be provisional approvals quickly. And that is the thing, if you guys are in a bottleneck where you cannot get that, let us know so we can help relieve that and then do the testing and verification down the road. But you have to have a place to start.

And then when we get to the point where we have private manufacturing of these, we just need to make sure that we are all on the same page, it is the same test so we do not have a variation in sensitivity or specificity. And that we need to make sure that other countries are doing the same.

My concern is, you know, with so much of the APIs being created in China—about 80, 85 percent plus is what I have heard—you know, I look at it from a national security standpoint or a national health standpoint, not just our country but other countries. You know, if somebody needs Advil and you have a population of 1.3 billion people, you know, are they going to service their customers first before over here?

And I think this is a wake-up call for American manufacturers and our pharmaceutical companies not to be dependent on a country.

What are your thoughts about that? Whoever wants to tackle that? Mr. Fritz, you are the one.

Mr. Fritz. Thank you, Ranking Member Yoho.

There is clearly going to be all sorts of economic impacts as the outbreak continues to develop. We are paying very, very close attention to not just the general macroeconomic impacts that are going to occur with regard to the United States economy and other economies around the world, but also to the impacts on supply chains and, particularly, as you mentioned, supply chains that are
important to our ability to react to future instances, future outbreaks.

I do not have anything that I can share with you right now, ranking member, in terms of what those responses will look like, but it is something that we are looking at very carefully. We have people across the interagency process who are actively considering ways we can make sure that we are able to make sure that we do have access to the necessary supply chains.

Mr. YOHO. Right. Let me ask about the cooperation. Do you guys feel that the cooperation is adequate with the Chinese Government as far as transparency, just working side by side? Or do you feel like it is here is the information we will give you, and kind of guarded?

Mr. FRITZ. Sir, why do not I take a first——

Mr. YOHO. Go ahead.

Mr. FRITZ [continuing]. Shot at that on certainly with regards to the evacuation of our personnel and American citizens, very diplomatically and logistically challenging. I would have to say that we were able to achieve a very high level of coordination with the relevant Chinese authorities to make the five flights that we got into and out of Wuhan happen. They weren't easy, but we did in fact, we were able to rely on our Chinese counterparts working with us to make sure that those succeeded.

Mr. YOHO. Do you feel like they are treating all the countries that way? Because they heard reports that they were not letting the Taiwanese out.

Mr. FRITZ. I would not be able to characterize whether they have been able—whether they have been treating everyone as well as they have been treating us. I do know that they have worked well with a number of other partners, but I, I have heard similar reports about our friends from Taiwan being treated differently with regard to their evacuation plans.

I would say in general, however, I think the PRC authorities have generally made good faith efforts to help evacuate folks from Wuhan of other nationalities.

Mr. YOHO. Does anybody have reports about this being in North Korea, which I would assume it is? I mean, do we have any definitive proof?

Dr. REDFIELD. We do not have any confirmed reports, no.

Mr. YOHO. Okay. Let's see. I think with that, Mr. Chairman, I am going to yield back. And I appreciate everybody here. I look forward to the questions, and I am going to gather some more information.

So, thank you all. And I know working together as you are, we will be prepared for this in the United States. And, hopefully, we can be the ones that help the other countries the most.

Thank you.

Mr. BERA. Great. The gentleman from Michigan, Mr. Levin, is recognized to question the witnesses for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman.

On Tuesday, Nancy Messonnier, the Director of the National Center for Immunization and Respiratory Diseases at the CDC said this of coronavirus:
“Ultimately, we expect we will see community spread in” the United States. “It’s not . . . a question of if this will happen . . . but . . . when this will happen, and how many people in this country will have severe illness.”

But National Economic Council Director Larry Kudlow then said: “We have contained this, I won’t say (it’s) airtight but (it’s) pretty close to airtight.”

And also, this is all on Tuesday, President Trump said the coronavirus in the United States “that it’s under control.” And a “problem that’s going to go away.”

So, that was all on the same day.

Americans are scared of this situation. And they want to know what is being done to keep them safe. And hearing mixed messages like this within the span of hours is not reassuring.

Dr. Redfield, how can the virus be both a problem that is going away and also not a question of if but when?

What should we be telling our constituents about what to expect?

Dr. REDFIELD. Thank you very much. I think it is a very, very important question.

Right now at this stage, and I have said this and I continue to say it, the risk to the American public is low. We have an aggressive containment strategy that really has worked up to this time—15 cases in the United States. Until the case that we just had in Sacramento, we had not had a new case in 2 weeks.

We do believe we are going to continue to see new cases, and we do believe now there may be the initial cluster occurrence of a community acquisition.

Some countries this has moved very quickly, like we saw in Korea now where we had more cases in Korea last, in the last 24 hours than we had in all China.

Mr. LEVIN. Right.

Dr. REDFIELD. We see it in Italy, it is moving fast. Iran it is moving fast.

But other countries have really used a containment and a blended mitigation strategy, like Singapore and Hong Kong, and they have really limited the spread after the initial introduction from China.

We are of the point of view that we are still in aggressive containment mode, and which is dependent on early case recognition, isolation, and contact tracing that now is going to be looking to identify these community introductions, and practice public health to minimize them.

But at the same time, we have done this to give us time. And I think what Dr. Messonnier was trying to say, I think it maybe could have been done much more articulately from what the American public heard, what she was trying to say it is also a good time for us to prepare if we have to go to more mitigation. We are still committed aggressively to get aggressive containment.

And I think I want the American public to know at this point that the risk is low. I want them to know that we are going to start identifying more cases, like we did the other day. I am going to ask them to, obviously, accelerate their own view of the standard things that we do for flu: handwashing often, do not go to work or school if you are sick.
And we are, we have launched a larger, for our next level of our multi-layered public health response, is to now institute broad surveillance. And we have initiated it. We are planning over the, hopefully, the new, in the next 4, 8 weeks, obviously linked to the supplemental, to actually make our surveillance for corona the same as flu nationwide. So, we can be, you know, very quickly picking up when there is an introduction in the community, go in and try to stop it.

So, I think that is our position at this point.

Mr. LEVIN. Good. But let me quickly ask you one other question in my limited time.

I want to ask you to speak about the danger of xenophobia in the situation like this. CNN reported last month on a disturbing example from the SARS outbreak when, and quoting now, “people of Asian descent were treated like pariahs in the west. There were reports of white people covering their faces in the presence of Asian co-workers, and real eState agents who were told not to serve Asian clients.”

We saw similar incidents during the H1N1 swine flu outbreak in 2009, and during the 2014 Ebola outbreak. And, sadly, I have heard reports of incidents like this around coronavirus.

So, I would like you to talk about why it is so important to avoid stereotyping people as carriers of the coronavirus and how incidents like these can be avoided, and how they are dangerous really for public health.

Dr. REDFIELD. I could not agree with you more. For those who have heard me talk before, I have always said that stigma is the enemy of public health in all its forms. Whether it is in dealing with HIV, whether it is dealing with drug use disorder, whether it is dealing with obesity, whether it is dealing with a response to coronavirus at this time, stigma has no role, no place in public health. It is counterproductive.

Mr. LEVIN. So, I think we are going to have to proactively get that message out to the American people so that we do not harm our own public health with stereotypes folks may have. Don’t you agree?

Dr. REDFIELD. Yes, I, I will continue to echo it. And I think you make an important point because we have, you know, we have seen those reports. And I think, again, we have to re-echo that stigma has no role in public health.

Mr. LEVIN. Thank you. And thank you, Mr. Chairman. I yield back.

Mr. BERA. Thank you.

The gentleman from Florida, Mr. Mast, is recognized for 5 minutes.

Mr. MAST. Thank you, Mr. Chairman.

Mr. Redfield, I want to start with you. And you spoke specifically about early diagnosis being part of the positive that is going on here. Can you discuss with me what are early symptoms which lead to early diagnosis?

Dr. REDFIELD. You know, I think the first thing I want to say is there is a lot we do not know. And we are learning more each day. That is what concerns those of us that are confronting this. If it was flu, we understand flu. But there is a lot we do not know.
But what we have learned in the last 8 weeks is that this virus can actually cause asymptomatic infection, no symptoms. Now, that is complicated when you are dealing with a public health threat if you can have it. And on the Princess ship over 50 percent of the individuals that were diagnosed in the process in Japan lacked symptoms.

Now, there may be an ascertainment issue because if they thought if they had symptoms they would be treated different. But, clearly, there is a significant percentage of people that lack symptoms. And there is clear evidence now that we have learned, those individuals can actually transmit the virus.

So, as the chairman knows, from a public health point of view that, that makes this more complicated.

The other side of it, its symptoms can be as negligible as a scratchy throat, a dry cough. And you can see that is why initially we had PUI definitions that were pretty narrow because if all of a sudden everybody with a scratchy throat or a dry cough were during flu season came, then we have some complexities.

At the severe end it can cause really a very significant pneumonia, respiratory compromise requiring critical care. And overall it does look like 5 to—5 percent of individuals in the China situation are critical, 15 need critical care. Other countries are starting to show similar. But on the other spectrum there can be this asymptomatic illness.

So, we are still earning. It is complicated. Obviously, in the individual case that we talked about here where severe pneumonia in an otherwise healthy individual, in light of what we now know that can prompt the medical community to consider coronavirus in a differential diagnosis. But a lot of individuals may just present with a sore throat and a dry cough.

Mr. MAST. Let me go to the other side of the table. Eighty-plus thousand cases diagnosed. And the number that I have read is 33,000 recovered in mainland China, recovered from having the diagnosis. Can you say what has been a chief factor that has led to those that have recovered through it? Is that something that we know?

Dr. REDFIELD. I think there is probably two major factors. One—or maybe three—one is age, and one is comorbidities. So, individuals that happen to have diabetes, or hypertension, or chronic obstructive lung disease, and happen to be elderly, these individuals have a much higher mortality.

But the other issue that needs to be stressed is the effectiveness of the health care system. So, in Wuhan the mortality right now is somewhere over 4 percent. Their health system is beyond strained. Before this outbreak they had 132 I think isolation beds for infectious disease. Today they have over 20,000.

Now, you can go from 132 beds to 20,000. You can build the structure. But, as the chairman knows, where are the doctors? Where are the nurses? Where are the ventilators? Where is the trained health care professional?

So, we see a mortality and we believe it is the integrity of the health system that is a major factor. Because if you just go to the rest of China, the mortality is probably about a half a percent.
Okay. So, I think, I think the major factors I would say were co-
morbidities, age, and the resilience of the health system that you
happen to be in when you get sick. If you do not have access to
oxygen, the mortality is going to be a lot higher. This is why we
are worried about Pakistan, Afghanistan, Bahrain, you know,
North Africa, all the countries that have come on board recently,
many of them do not have health systems that are going to be able
to sustain life in the presence of pulmonary compromise.

Mr. Mast. And this is something you have a lot more faith in our
health system, obviously, than Wuhan, or pick any of the other
countries that you just listed off?

Dr. Redfield. Yes. I think we have, we are in a strong position,
we have an effective health care system. You know, I think, you
know, at this stage if we can continue to do what we are trying—
early identification, find these community cases, get our arms
around them—I think we can continue to respond. Obviously, if the
numbers get to the point that we cannot control, then that is a dif-
f erent, a totally different part, totally different issue. But right
now——

Mr. Mast. I will pause you there because my time is about to
end just to say I think you, you mentioned something that is im-
portant to realize about this, that our health system has a different
starting point than that health system of Wuhan and many other
places. Certainly does not make us impervious to this but it is a
better starting place to be.

I thank you for your comments.

Mr. Bera. Thank you, Mr. Mast.

The gentlelady from Pennsylvania, Ms. Houlahan, is recognized
for 5 minutes to question the witnesses.

Ms. Houlahan. Thank you. I am actually going to start, I know
that it is my obligation in some ways to ask complicated questions
about policy, but, Dr. Redfield, I would actually like to start and
lead off with Mr. Levin’s conversation for the human beings who
are at home, you know, my kids, my family members, my commu-
nity, and ask the doctor, you are the 18th director of the Center
for Disease Control and Prevention, and Administrator of the Agen-
cy for Toxic Substances and Disease Registry. And in your capacity
could you help me to answer a few questions that I frequently get
asked.

The first—and they can be any answer, I do not know the an-
swers, I am just asking on behalf of my community—should people
be afraid?

Dr. Redfield. No.

Ms. Houlahan. Thank you. Could you turn on your microphone.

Dr. Redfield. No.

Ms. Houlahan. Should people engage in regular hand washing
and coughing into their sleeves?

Dr. Redfield. Absolutely.

Ms. Houlahan. Should people be stocking up on cleaning sup-
plies?

Dr. Redfield. No.

Ms. Houlahan. Should people be stocking up on prescription
medications that they have?

Dr. Redfield. Not at this time.
Ms. Houlahan. Should people be stocking up on food supplies?
Dr. Redfield. Not at this time.
Ms. Houlahan. Should you wear a mask if you are healthy?
Dr. Redfield. No.
Ms. Houlahan. And is there a website—and you can answer this later if you do not know it by heart—where people can go to access good information about these questions?
Dr. Redfield. Absolutely, in the CDC. CDC.gov we have all of the information on that website, and a sub thing can take you to coronavirus and where we are in any preparedness, and all our recommendations.
Ms. Houlahan. And, sir, is there anything else that I should have asked you that is a regular, everyday person kind of question?
Dr. Redfield. The one comment I would make, because I do see people feeling a need to go buy masks, and I would ask them—and some people scoff at me when I say this—we need to make sure those N95 masks are available to the doctors and nurses that are going to be taking care of individuals that have this illness.
And it really does displease me to find people going out. There’s no role for these masks in the community. These masks needs to be prioritized for health care professionals who as part of that job are taking care of individuals and/or individuals who have this virus and are in home isolation or home quarantine for those family members.
I would like to have them prioritize the uses that we recommend and get people to realize that that is what these masks need to be reserved for.
Ms. Houlahan. Thank you. I appreciate that.
And with the last couple minutes of my questioning, I think this is either for Mr. Fritz or for Dr. Redfield based on how people have answered questions, I am going to follow up on the line of questioning that has to do with prescription and pharmaceutical supply chains and the integrity of the supply chain.
Is there a place, a way that we have historically been tracking various supply chains? In my old business we would make sure that you had at least or three suppliers of the same material just in case. Is there something that we have, a data base or other system that tracks those kinds of suppliers and where they are geographically?
Mr. Fritz. Thank you, Congresswoman, for the question.
As I mentioned, there is a very intense interagency process under way. I think HHS in particular, the Food and Drug Administration, and other relevant agencies are all looking very carefully at this exact question and making sure that the answer to that question going forward is that we do have access to whatever we need to sustain ourselves in the current outbreak and to make sure that we are ready for future ones.
Ms. Houlahan. So, I understand that the FDA largely is, you know, sort of lead on this, but is there a role that the State Department can play on this? Is there something that we in this body can do to be helpful in that?
Mr. Fritz. What the State Department is doing is we are looking very closely at the impact of the outbreak on our global supply
chains. And, of course, we are working with some of our other foreign affairs and trade-related agencies to map that out.

And then we are, again, together with HHS and others looking at how that impacts our ability to access what we need in time of crisis here in the country.

Ms. Houlahan. Yes. And I am just looking for this to be sort of a sad lessons learned, you know, how can we take this experience and make sure it does not happen to us again? And how can we make sure we know where our supplies—suppliers are and how to make sure that we are safe from this kind of exposure again.

Mr. Fritz. Yes, ma’am. I think this crisis is teaching us that we need to pay very, very close attention to this in the era of globalized supply chains. And we are bound and determined to make sure that whatever lessons are learned from this are applied going forward.

Ms. Houlahan. Thank you. And with my last half a minute of conversation I just wanted to kind of take off on something that we were happy that our health care system was better than Wuhan. That is awesome. But can you comment a little bit more about how we need to work with other nations to make sure all of our health care systems are working together in tandem on this?

Mr. Fritz. Thank you for that question, ma’am.

I would like to point out that U.S. foreign assistance over a number of years now has focused in large part on helping countries around the world build public health systems that are able to be resilient in the face of these crises. Of course, that is being put to the test in many instances.

I think what we can say is things probably would be much worse if it had not been for our efforts over a number of years to share best practices and actually make resources available to build capacity around the world in this aspect. And, of course, we have announced up to $100 million of assistance for partners around the world to respond to the COVID–19 crisis. And——

Mr. Fritz. Thank you. I have run out of town. I yield back.

Mr. Bera. Thank you, Ms. Houlahan.

The gentleman from Ohio. Mr. Chabot, is recognized to question the witnesses for 5 minutes.

Mr. Chabot. Thank you very much, Mr. Chairman.

Mr. Fritz, I will direct my question at you if I can. I was one of the original founding co-chairs of the congressional Taiwan Caucus. And I am now one of the co-chairs of that caucus. And as you know, and as we all know, the PRC, China, considers Taiwan a breakaway province. Taiwan, for all intents and purposes, conducts itself as an independent nation, not necessarily recognized by the world as such, but it is. And the people there are free. They ought to be a model to other countries around the globe. They have been bullied by the PRC for many years now.

But my question is this: they have sought to be recognized as an observer status basically at the WHO for many years. In my view they ought to be essentially a fully recognized participant in the WHO. It is kind of a gap in our world health system in not recognizing them, not letting them fully participate. But at this point China has still blocked them from so participating.
With something as serious as the coronavirus and, obviously, its origins in the PRC, in China, and Taiwan being right next door, and Taiwan having some of the top medical institutions and doctors, medical personnel in the world there, you know, it seems to make no sense that China continues in this effort. Taiwan could be helpful, even more helpful to China.

So what gap does this create in the world’s response to this very serious medical and the situation we have with the coronavirus, what is the problem with what China is doing relative to Taiwan?

Mr. FRITZ. Thank you very much for the question, Congressman. As you said, Taiwan is a robust democracy. It is a model in that respect. It is a reliable partner on public health and a number of other concerns that we share. And it is a force for good in the world. I could not agree more.

And I think this COVID–19 outbreak only further underlines the unacceptability of Taiwan being excluded from the World Health Organization and the World Health Assembly because the People’s Republic of China blocks every attempt for it to do so.

As you mentioned, not only has the COVID–19 outbreak affected Taiwan, they have 30 some cases there, and to the extent that they are unable to get timely information from the WHO, that impacts public health on Taiwan.

On the other hand, as you pointed out, Taiwan has a lot of expertise, and they have some experience. And, in fact, they have their own epidemiological track record now dealing with COVID–19. And to the extent that that is not being shared in a complete and timely fashion with other WHO members, clearly that does not do anything for the public health of the rest of the international community. Which is, of course, why the United States has and continues to push very hard for Taiwan to have meaningful participation in the WHO and to be granted observer status at the World Health Assembly.

China, it is worth pointing out that the People’s Republic of China was okay with Taiwan being an observer back when a different party was in power in Taiwan. So, through 2016 Taiwan did have observer status at the WHA. It is only when, when the democratic, the DPP party came into power in 2016 that China began blocking across the board Taiwan’s participation.

And we continue to push back very, very hard against that with as many of our like-minded partners as possible. And I think our argument is only bolstered now by the COVID–19 outbreak.

And I would point out that, you know, this push by the U.S. is fully with our U.S. One China policy and, of course, with the Taiwan Relations Act which governs unofficial relations between the United States and Taiwan.

Mr. CHABOT. Thank you very much. My time is almost expired, so let me just reiterate what you said. I agree with all the points that you made. Thank you for that. And I want to thank the Administration for continuing to be a friend of Taiwan. And we would encourage that they continue to do so, even step that up.

And it is a shame that the PRC, China, allows its intransigence with respect to Taiwan to put not only the people of Taiwan and its own people but the rest of the world more at risk than we ought to be. So, they ought to, they ought to do the right thing here and
allow Taiwan not just to be observer status but to be a full member of the World Health Organization, the WHO.

Thank you very much.

Mr. Bera. Thank you, Mr. Chabot.

The gentleman from Rhode Island, Mr. Cicilline, is recognized to question the witnesses for 5 minutes.

Mr. Cicilline. Thank you. And, Mr. Chairman, I want to thank you for the courtesy in allowing me to participate in this hearing.

Thank you to our witnesses for their testimony.

Dr. Redfield, I want to ask you kind of to followup a little bit on Ms. Houlahan’s question about the supply chain because, as you described this potential pandemic becoming really a global challenge—I guess it already is by most estimates—what are we doing to assure that there is a sufficient supply of medical supplies? You mentioned oxygen. Do we have a coordinating body that is figuring out if this pandemic proceeds in a serious way in this country that we will have access to the resources we need both for the kind of containment we’ve spoken about and treatment? Is there someone doing that sort of planning?

Dr. Redfield. Yes, that is not really within what I do at CDC, but I will tell you that the Assistant Secretary for Preparedness and Response, ASPR, has done extensive work. And as was mentioned by Mr. Fritz, there is an interagency group that is really going through this in quite detail with the FDA and ASPR in terms of many of the medical issues. But there is a broader intergovernmental group going in the broader issues.

And so I can tell you that is ongoing. And we could obviously get to you who is the leadership on it, but I know ASPR and FDA have done it on the medical side. And there is a broader intergovernmental working group to really get down to all of these issues.

Mr. Cicilline. Right. And you also made reference to the China CDC or counterpart. Can you speak a little bit about the relationship between the CDC in the U.S. and the Chinese, particularly as it relates, particularly just in this health care worker transmission. Two weeks ago China reported 1,700 health care workers had been infected by coronavirus. And just wondering what we are learning about that transmission and whether or not that is informing protocols here in this country to protect our health care workers?

Dr. Redfield. Yes. Thank you.

CDC has had now over a 30-year working relationship with China’s CDC. There is a reason they call it China CDC. And I actually have a U.S. CDC component that is affiliated with the embassy but is attached to the China CDC.

The chairman, the head of CDC China and I have been in regular discussions since the very beginning when this happened on New Year’s Eve, and had very open scientific discussions about what he knew at the time, what he was learning so we could use that information. And that continues bi-directionally, as I said.

From the be—you know, at the beginning there was not a thought that there was human-to-human transmission and nosocomial transmission. They saw that, you know, in the first week, they did not see any in the second week. But, remember, they were using, you know, a definition of whether people were
very severely ill. They were not recognizing that this could be mildly symptomatic.

Since then there has obviously been extensive hospital-based transmission. One series that was published in one of our journals, in JAMA, recently showed that up to 40 percent of the cases got infected either because they were health care workers or because they went into a hospital where they were infected after they got there.

So, health care transmission is really a high, high risk, particularly in areas that really are not vigilant in the importance of infection control. We are happy to say to date we have not had a health care worker.

Obviously, the new case as was mentioned by the chairman, raises concern because people were intubated and not necessarily in precaution, so we are aggressively evaluating that health care setting.

Mr. Cicilline. Thank you.

And, Dr. Redfield, could you just give us a quick update on the vaccine development status and whether or not additional resources are necessary, what the timetable looks like for that? I think lots of people are interested in that.

Dr. Redfield. Sure. Well, the NIH, Dr. Fauci has the lead on this. But I can tell you what he has told us and others is that they do have a candidate product that they are planning to move into a phase one trial, hopefully in the next 6 weeks, which will evaluate immunogenicity and safety. Assuming that that candidate—and they have partnered already with a private sector company—and assuming that goes well, then they would move into an expanded phase two trial.

And in reality, if everything goes really well and they get the strategic partners that they need, he is saying he looks at a year to 18 months before we could have it.

We do believe scientifically that this is a virus that should be able to have a successful vaccine based on the coronavirus as opposed if we were trying to do this, say, for HIV, you know, we would say, well, we do not know because we are not sure how that is going to work or not. But for this virus there is a lot of scientific reason to think that it will be successful. And the NIH is really moving forward very aggressively to try to make that happen.

Mr. Cicilline. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. Bera. The gentlelady from Virginia, Ms. Spanberger, is recognized for 5 minutes.

Ms. Spanberger. Thank you very much. Thank you to the witnesses for being here.

And, as you might imagine, I am very concerned about this, the issue of this virus, and constituents across central Virginia, the district I represent, are deeply concerned. So I want to start by saying thank you, Dr. Redfield, for what you said to my colleague Representative Houlanah which is that they should not be afraid. I think that is incredibly important. I appreciate you being here today to talk about this important issue but also to mention that because so much of how we are handling this, this disease, this
outbreak, will also be determined by how we are communicating and what the temperament and feeling on the ground is.

I wanted to speak very briefly about some local preparedness. And, Dr. Redfield, I will start with you.

The coronavirus is expected to put additional strain on our health care system. And you have noted that our health care providers are already at near max capacity due to a bad flu season. How is the Federal Government ensuring that medical providers across the country have what they need and the resources that they need? And what else could we be doing?

Dr. REDFIELD. A very important question. And I want to say that my partnership agency in the Health and Human Services, ASPR, has been working and continues to work to see that hospitals begin to get prepared. That is one of their central missions to the Assistant Secretary for Response and Preparedness, ASPR. And so they are going through that in great detail. They have had dialogs with different hospital corporations, with hospital leaders to begin to see that.

Because you do say that this, you know, for us there is not a lot of flex in our health system right now. And most hospitals right now because of influenza if you are looking at them they may be at 95, 96, 97 percent capacity. This is why I stress that our current public health response, that multi-layered response is containment, containment, containment, containment, to try to buy us time for the fruits of labors by NIH, and Dr. Fauci, and the private sector. So, hopefully, in the not-too-distant future, in a year, year-and-a-half, 2 years we will have a vaccine.

But I can tell you ASPR is very aggressively working and evaluating this and trying to, the term they use is “resilience,” to try to make sure they can build resilience into the system.

Ms. SPANBERGER. And following up on that notion of containment, in order to contain we need to identify it, in your written testimony you noted the importance of using illness surveillance systems. Can you tell us a bit more about how we are applying existing systems to this virus and our U.S. public health agencies developing new surveillance, illness surveillance systems specific to coronavirus?

Dr. REDFIELD. Yes. This is really important. This is really one of the most important components from CDC’s perspective in the recently requested supplemental.

We have an excellent surveillance system in this Nation for flu. We have multiple surveillance system, as you have just mentioned. We have the—we have multiple. And rather than recreate the wheel, what we have proposed, and we have actually begun this in to at least initiate it, is we are really adapting our entire respiratory disease surveillance systems and now interfacing coronavirus–19.

And, you know, I am very hopeful in the next 8, 12 weeks we will be in a position that we will have your flu surveillance system, if you follow that, and you are going to have your national coronavirus system.

I am more interested in this as I am hoping is the canary in the mine field—in the mine that I can see when and if we are getting community, I do not have to wait until an individual gets hospital-
ized and is on a ventilator. You know, I have to be honest with you, we do not know what we are going to find when we start this, but we are very anxious to get this broad coronavirus surveillance system using all the systems that we have right now for respiratory disease and get that operational as soon as possible.

Ms. SPANBERGER. And to be able to see the trends that we may be seeing that in fact demonstrate that we are looking at potentially an outbreak in a locality or in a State?

Dr. REDFIELD. Absolutely. And then, and then be able to put the full power of the public health approach of case recognition, isolation contact tracing to try to make sure that that cluster is contained.

Ms. SPANBERGER. And do you have the financial resources and the employee capacity for this surveillance system and what you need into the future?

Dr. REDFIELD. Well, I will say that is one of our major components of the supplemental that was put forward——

Ms. SPANBERGER. Okay.

Dr. REDFIELD [continuing]. Was to be able for us to roll this out nationally.

Ms. SPANBERGER. Great. Thank you so much to the other witnesses. I know I concentrated my question on Dr. Redfield, but I do appreciate your time and your presence here today.

Thank you. I yield back.

Mr. BERA. Thank you, Ms. Spanberger.

The gentleman from California, Mr. Lieu, is recognized to question the witnesses for 5 minutes.

Mr. LIEU. Thank you, Chairman Bera, for calling this important hearing.

Thank you, Dr. Redfield, for your public service, including your service to the U.S. military.

The Washington Post published an article, headline is “A Faulty CDC Coronavirus Test Delays Monitoring of Disease’s Spread.” So, my first question to you is does the CDC’s test for coronavirus work?

Dr. REDFIELD. Yes.

Mr. LIEU. Okay. What is the error rate on that test?

Dr. REDFIELD. So, we created a test really very rapidly based on the sequence of the virus, within really a week of the sequence being published. And it is a PCR-based test. And the way it was designed at CDC was it actually measures three different, if you will, components.

Mr. LIEU. I just need to know the error rate about, if you know it.

Dr. REDFIELD. Yes. The problem was in when the test sent to the States one of the components had a contaminant in it. That is what had to be corrected.

The test at CDC works fine. When it was given to a manufacturer to scale up for the States——

Mr. LIEU. Has the CDC fixed it?

Dr. REDFIELD. It has been corrected and there are tests that are being shipped out as we speak.

Mr. LIEU. Okay. So, in fact that first test did not work?
Dr. REDFIELD. First test works because it was developed at CDC, and it works fine. We test every one in the country. When the manufacturer scaled to send to the States, when the States got it they could tell positives, they could tell negatives, but because of one of the contaminants in the control there was another group that was we do not know if it is positive or negative; it was inconclusive.

And at that time the FDA requested that we not use that test and have people send it to CDC where the initial lots that we made were quite functional and there was no contaminant. And that is the test we continue to use today.

There are now over——

Mr. LIEU. All right, I just needed so the current test works?

Dr. REDFIELD. Current test works.

Mr. LIEU. Okay, great.

So, it is they are reporting now that 48 countries have coronavirus cases. In Italy it has skyrocketed now to 650 cases. South Korea has now 1,700 cases, as you yourself stated. There are more new cases in South Korea than in China. Why is it that we are only testing people who have traveled to China? That seems to make not a lot of sense to me.

Dr. REDFIELD. Well, when this outbreak originally occurred——

Mr. LIEU. I am talking about right now, not when it occurred. Right now. Why aren't we testing people——

Dr. REDFIELD. Well, we are going——

Mr. LIEU [continuing]. That traveled to South Korea, traveled to Italy, traveled to——

Dr. REDFIELD. Right.

Mr. LIEU [continuing]. The 11 European countries where there are now coronavirus cases?

Dr. REDFIELD. We are continuing the travel restrictions that were initiated——

Mr. LIEU. No, no, I am just talking about testing people. Why do not you expand the test? Because there is a person in Northern California that doctors recommended get the test and CDC said no because the person had not traveled to China. That is just really stupid because, you know, this has extended way beyond China to 48 countries, every continent except Antarctica has these cases. We really should be testing not just those that have traveled to China. Can you commit to expanding the test to beyond those that have just traveled to China if they have the symptoms that look like they have coronavirus?

Dr. REDFIELD. Congressman, I mentioned earlier, I think before you were here, just so you know we initially had a geographic restriction. We have changed that. We have posted there is no geographic restriction. That if a clinician or a health department official considers the coronavirus in the differential diagnosis, that now meets our criteria for——

Mr. LIEU. When did you make that change?

Dr. REDFIELD. We made that, well, yesterday we did it and posted it today.

Mr. LIEU. Thank you for making that change. Okay.

So, in terms of transmission, because earlier you said people should not be afraid, my understanding based on the articles, Reuters reported that coronavirus contagion rate makes it hard to con-
trol. And there are these two scientific studies that show essentially each person infected with coronavirus is passing the disease on to between two and three other people on average at current transmission rates. And then you have this long incubation period, potentially 14 days or more. You could have an exponential explosion of cases rather quickly such as in Italy; isn’t that correct?

Dr. REDFIELD. I think we have seen that, obviously, in Italy, Korea, and Iran. And yet——

Mr. LIEU. All right. So, this person in Northern California who did not travel to China, where we do not know where he got the coronavirus, he could have passed it on to two more people, who passed it on to two more people, who passed it on to two more people. So, there could be a whole cluster of cases. But until as of yesterday we do not know because we were not testing anyone who did not travel to China. Am I understanding this correctly?

Dr. REDFIELD. The current public health evaluation of the case in the chairman’s district is being led by the State public health system of California. We are supporting it. We have a large number of contacts that have been evaluated, that are being isolated, that are being tested to really look at the full extent of the potential transmission around that case.

Mr. LIEU. Thank you.

I am going to conclude by saying Donald Trump has attempted to minimize the coronavirus outbreak. There is an article in the Daily Beast titled “Coronavirus May Explode in the U.S. Overnight Just Like in Italy.” I will request that when the data and science contradicts what Donald Trump says that you follow the data and the science.

I yield back.

Mr. BERA. Let me recognize the gentleman from California, Mr. Sherman.

Mr. SHERMAN. Thank you. China failed to, well, actually hid this disease at the beginning. China continues to try to exclude Taiwan from the WHO. There are number of things China could be doing. We need Chinese cooperation to start clinical trials. Dr. Redfield, are we getting it?

Dr. REDFIELD. There is a drug called Remdesivir that is now in clinical trials in China and Japan. And it has been extended actually to the United States for the repatriated individuals.

Mr. SHERMAN. There are similarities, vague similarities to the flu. As flu is often seasonal, is this disease—our president has said, oh, it is going to be gone by April. How confident are we that transmission will be substantially less when the winter is over?

Dr. REDFIELD. It is unknown.

Mr. SHERMAN. There are various treatments that are used for flu such as Theraflu. Is there any reason to think that there is some chance that that would be helpful in reducing the effect of the disease?

Dr. REDFIELD. Not for the coronavirus–19.
Mr. SHERMAN. And, likewise, the SARS vaccine, would that provide any protection?

Dr. REDFIELD. It is unlikely that they cross-reacted. But the methods that they used to develop that vaccine is the reason that Dr. Fauci has been able to accelerate the vaccine he is developing.

Mr. SHERMAN. And what is the earliest we could have a vaccine?

Dr. REDFIELD. Well, Dr. Fauci has said 1 year to 18 months, if everything goes well.

Mr. SHERMAN. Got you.

Let’s see, how well are we cooperating with China today? Are they providing the information we need and our people on the ground, Mr. Fritz?

Mr. FRITZ. Thank you, Congressman.

I pointed out a bit earlier that we did get a very—we got good faith cooperation from Chinese officials as we worked to send in and get out our five planeloads of evacuees.

Mr. SHERMAN. I am not talking about—yes, but do we have people on the ground at the epicenter of this epidemic getting information that is helping Dr. Redford do—Redfield do his job?

Mr. FRITZ. I will defer to my colleague on the actual—

Mr. SHERMAN. Are you getting what you need from China?

Dr. REDFIELD. I have regular discussions with my counterpart George Gao, who is the head of CDC. We do have a CDC U.S., a CDC that is embedded into the China CDC, so we are having daily interactions. I have a team of respiratory experts that are there working there.

At a scientific level we are having good dialog.

Mr. FRITZ. Congressman, if I could, I would point out that, you know, Secretary Pompeo and others have also, of course, made it clear that China’s allergy to freedom of speech, freedom of expression, et cetera, have been obviously had a very negative impact on the ability of——

Mr. SHERMAN. The initial response of local officials was to try to keep it under wraps, and the failure to be a free society. That is why this thing got going. And we are now in a position that perhaps could have been avoided if China had a different policy toward free expression versus hide things and hope that you can keep them under wraps.

Let’s see, why does the Administration request for additional funding rely overwhelmingly on transferring funds from other disease-fighting accounts? Dr. Redfield, do we need to spend any money on Ebola? Can we just grab that money, no problem?

Dr. REDFIELD. Obviously we have an ongoing Ebola outbreak right now in the Congo. I really cannot——

Mr. SHERMAN. Do you think it is wise then to take all the money that we had appropriated for Ebola and not spend any money on Ebola?

Dr. REDFIELD. I really cannot comment on the budgetary decisions that were made.

Mr. SHERMAN. Are you doing useful work that will save lives or may save lives with regard to Ebola? If we leave the money in the budget will you spend it effectively in ways that help save lives?

Dr. REDFIELD. We currently have an ongoing Ebola outbreak in the eastern DRC where we have a substantial number of CDC peo-
ple deployed. And we are, if you will, and I say this in knock-on-wood, we are finally close to winning. Okay. We are down to really in the last week we did not have a single case.

So, we now, we now project based on our models that we might actually end this outbreak by the end of June. But, obviously, when instability happens again we could be right back where we were 2 months ago, so.

Mr. SHERMAN. And if this Ebola outbreak expands in the eastern Congo, it could be a threat to the United States, just as a Chinese-epicentered problem has been a threat to the United States and in California?

Dr. REDFIELD. Well, we have been fortunate with Ebola in that there is very little movement from the Ebola eastern Congo where this outbreak is and the United States. But we obviously have had to invest significantly in what we call exit screening from the Congo as we have dealt this.

As you know, we have been in this outbreak now for almost about to start the third year.

Mr. SHERMAN. If we do not fight Ebola in Africa does that mean Americans are safe and everything is fine, and you are assuring me that we can just not worry about Ebola, and we are not going to have a problem this year or next year?

Dr. REDFIELD. I think one of the most important things our Nation can do is build a robust global health security capacity, all right, so that we can detect, prevent, and respond to these outbreaks at their source. And this is exactly what we are doing with Ebola. And the more that we can expand that capacity, and I believe strongly it is a core mission of CDC, we are the tip of the spear to identify these infectious disease threats, and obviously we appreciate your continued support in that regard.

Because what we are seeing with the coronavirus is just another example of why it is so important that we have global leadership and the ability to detect, prevent, and respond to these outbreaks.

Mr. SHERMAN. I would just comment that the outbreak of this coronavirus demonstrates the importance of your work and the absolute folly of pulling the plug on some of your work because of an unwillingness to fund the additional work that we need to do for the coronavirus.

With that, I will yield back.

Mr. BERA. Thank you.

I am going to use the chairman’s prerogative to ask a couple questions because I feel bad, Mr. Brownlee, Dr. Walters. I appreciate your coming down. See, I do not know if I am doing a favor asking you questions or if the goal as witnesses is to slide out of here with no questions. But I appreciate your coming down.

Mr. Brownlee, I hear your concerns, and we will continue an ongoing conversation about flexibility and consular functions. I have been honest in my concerns with the Administration in announcing travel restrictions for individuals coming from China. I understand the rationale and reasoning behind it, but also have some concerns about whether it is going to do what we hope it does with regards to containment.
Mr. Brownlee, going forward are we considering similar measures against other nations? And if we are, under what specific circumstances?

And then the last question is has the CDC and the State Department issued travel advisories for countries who have been impacted by coronavirus?

What specific objective criteria are we using to make these determinations? Dr. Redfield, that is a question for you.

Mr. Brownlee. Thank you very much for your question, Chairman.

With regard to further possible proclamations, this remains the prerogative of the White House. They are gathering information from all available sources as to whether further restrictions might be necessary to help contain the virus.

As Dr. Redfield has noted now several times, we are still in the containment phase. Whether CDC and other health care provide—public health authorities will recommend that is beyond my scope.

With regard to travel advisories, this too is something we revisit constantly in the Bureau of Consular Affairs. We are looking at a variety of different issues with regard to any single country. Health is one, crime is another, risk of terrorism another, natural disaster, et cetera.

We look at information that we draw from a variety of sources. The U.N. provides some information on health issues. We talk with the Bureau of Diplomatic Security with regard to the crime and terrorism risks. We pull information from the intelligence community, in other words, from a variety of different sources. We talk to our friends, the five like-minded countries, U.K., Australia, et cetera.

We gather all this information. We use a fact-based metric—matrix to decide whether we are going to rank a country one, two, three, or four.

Mr. Bera. Okay. Thank you.

Mr. Brownlee. I hope that answers your question, sir.

Mr. Bera. Dr. Redfield.

Dr. Redfield. The purpose of the CDC levels is really a different purpose: it is really for public health purposes only. And we actually have three levels that, you know, makes it confusing.

We have the first, which is just an alert to let the American public know that there is an ongoing infectious disease issue. And so right now for the alert, Singapore, Taiwan, Thailand, Vietnam.

Once we see that there is significant human-to-human transmission, so it is not just say there is something going on there, we go to what we call Level 1. And right now that is Hong Kong.

When there is actually multiple clusters of human-to-human transmission, then we go to a Level 2. And that really tells people, particularly if you have your older or if you have any comorbidities, you really ought to reconsider travel. And that right now for us is Iran, Italy, and Japan.

Now, this changes every day, as we said.

And then Level 3 we are telling people—this is when we have broad community-based transmission—we are telling the American public that we recommend they do not travel.
So those are our levels. And we reevaluate them every day based on the data that we see of what is happening in the country at the time really around human-to-human transmission, how isolated it is, how broad it is. And right now, obviously, in Korea we have very broad transmission throughout the country. It has moved to a Level 3. China, very broad transmission throughout the country.

But you should anticipate that these are going to continue to change. They can go up or down. I would not be surprised if we do not have changes even in the next 24, 48 hours based on what is happening in these countries.

Mr. BERA. Thank you, Dr. Redfield.

And, Mr. Fritz, I know you are on a tight time-line. So, we appreciate your being here. If you have to leave the panel, thank you.

If I can ask Dr. Walters a question because, again, I appreciate your coming down here and making yourself available to us.

In thinking through the evacuation of some of the Americans on the Diamond Princess and so forth, there were reports that positive-testing patients—and again it may be that those results were not communicated—were commingled with negative-testing patients. I am curious how that might have happened, and then how we avoid that happening in the future?

Dr. WALTERS. Mr. Chairman, thank you for the question.

The time line matters. So, the Diamond—the decision to evacuate American citizens from the Diamond Princess was not based on, you know, there is an outbreak of COVID–19 on the ship. The decision was based on there was evidence of ongoing person-to-person transmission. This was a problem that was not getting better, it was getting worse, and despite the best efforts of the Government of Japan.

Once the decision was made that it was safer to move these American citizens, many of whom were in an age range that puts them at the greatest risk, we followed a protocol. This was I think the sixth flight that we had done in, like, 2 weeks. Each of those individuals, each of the 329 individuals that we took off that ship were evaluated by a medical officer from either the State Department or Health and Human Services, ASPR, within that 24-hour period.

The embassy in Tokyo had reached out to the Ministry of Health, Welfare, and Labor and asked that all lab results be reported by 4:30 that afternoon. The evaluations were done. The evacuees then were handed from the Government of Japan over to the care of the U.S. Government. They were disembarked from the ship. They were loaded onto buses. And this was to be one single movement of 15 buses from the ship to the airport.

It was only once those evacuees were, 329 people on 15 buses, and in the minutes after midnight on the docks at Yokohama that an official from the Government of Japan approached the embassy personnel with a list. And on that list were 16 names. And of the 16 names, 14 people were manifested and somewhere on 15 different buses. And the buses were already in movement.

In the movement from the docks at Yokohama to the airport there was some discussion, hey, we have got this problem, we are working through it. And that is only a 40 or 45 minute movement.
Once they arrived at the airport the 14 were identified in a way that was efficient but protected their privacy. And it is important to remember, none of these individuals had symptoms. They were not coughing, sneezing, you know, they did not have fevers. That had all been confirmed. They were removed from the bus. They were taken to the only place—now, imagine, morning is breaking at that airport, it is raining, these are 60 to 80 year old American citizens that are helped off the buses and put into an isolation area aboard the aircraft.

The way the aircraft is set up, the air flow moves from the nose to the tail. So, the most at risk area is near the tail of the aircraft. We had already partitioned off, as we had in previous flights, an area to protect other passengers from any contagion that might be with those folks. And they were placed there. And then there was a robust interagency discussion.

Much has been made about the discussion, but at the end of the day we reached consensus. And there was consensus between the Department, our partners that we rely on from Health and Human Services, State Department, and others that yes, these are evacuees; yes, they have been placed in the care of the U.S. Government; yes, they are contained and they pose no further threat. And with that, we brought them back to the finest quarantine facility in the world to receive the best care available.

Mr. Bera. Thank you for that explanation.

And now the ranking member had additional questions.

Mr. Yoho. Yes. And that is for State Department, because we heard over in China I think it was 1,600 health workers came down and they were sick. We had talked to our Ambassador from Cambodia, we had a discussion with him today and he was saying what a stellar response our State Department did, working 24/7 at six different locations moving people out.

What kind of protections do we have for our State Department personnel? Because I know when we go on details you guys work your tails off, and we appreciate it, and we want to make sure you have the coverage and the health care that you need. Do you feel adequate?

Dr. Walters. Yes, sir. Thank you for the comments and the question.

Here is what I would say. This is an international emergency that signals——

Mr. Yoho. Right.

Dr. Walters (continuing). A domestic risk. But in 220 locations around the world we have a work force of 75,000 people, some of whom are in countries that have active cases. Others are in countries that may tomorrow find themselves with active cases.

Mr. Yoho. Right.

Mr. Fritz. We learned our lessons in 2004. We learned our lessons again in 2014–2015. And we are thankful to Congress for the support we have had in the preparedness side of this. There is PPE at every embassy. Our health care workers, our work force is almost 700 in all these locations. They are well educated, they are well prepared.

We continue to look at our resource requirements. And we continue to look at our authorities, not just to take care of American
citizen—to the chief of mission personnel, but really in that global picture to protect Americans abroad.

Mr. Yoho. And we feel confident that if, you know, an embassy were to come down and the workers get exposed that we can get the supplies needed in there? If it is in an area that is more remote where we do not normally have good health care maybe, that we can get it in there in sufficient numbers, we feel like we are protected there; right?

Mr. Fritz. So, there are two parts to that answer. The first part is the same aviation contract that made these evacuations possible is the same aviation contract that makes delivery of critical supplies possible.

The second part to that is actually a greater risk. And the greater risk here is when you look at the way we do medical evacuations of chief of mission personnel around the world, they do not typically come back to the United States. They go to medivac centers with established relationships in South Africa or U.K.

Mr. Yoho. Okay.

Mr. Fritz. Those countries are now making it more and more difficult in a way that you can understand to bring non-U.K. citizens or non, you know, South African citizens in if there is any risk that they have COVID–19. So, we continue to work with our international partners to keep those diplomatic platforms open so that Dr. Redfield's teams have a place to work and the resources and relationship to do it, but still be able to medivac our chief of mission people home when the time comes.

Mr. Yoho. Okay, thank you.

Dr. Redfield, again there is this cloud of lack of transparency that we keep getting from China. What signals can we see from China to see what the real extent of damage is behind the containment?

You know, the National People's Congress meeting has recently been canceled. I mean, that is a pretty strong signal to show that that threat is really—they are really that concerned about it as they should be.

But then with the people over there not getting, you know, an open press where they can get reliable information, do we feel like they are being forthright with you. I man, you are working with them on a more of a scientific platform. Do you feel comfortable with the information you are getting?

Dr. Redfield. From my colleagues, the scientific interaction we are having with our CDC colleagues and from the China CDC I am very comfortable with what we have. As I said, I have my own director of the American CDC in China. They are regularly interacting.

So, at the scientific level we are having collaboration. I really cannot really comment beyond that.

I will say it is worth nothing that they have probably introduced some of the most aggressive containment strat—mitigation strategies that we have ever seen——

Mr. Yoho. Ever seen on the planet, I think.

Dr. Redfield [continuing]. In the history of the world, you know. But and I would like to say, just so people are feeling better, that there is a reduced number of cases in China. Just last night——
Mr. Yoho. If that is accurately reported.

Dr. Redfield. If accurately reported. But even then it was 434 people and over somewhere between 25 and 30 deaths last night. So they still have a major problem despite everything they have done in mitigation.

Mr. Yoho. I want to throw one thing out, and I do not really expect an answer on this. Being a veterinarian, we have seen the porcine viral diarrhea syndrome broke out several years ago. Within a year it was in America. Lost about 300,000 sows in America.

African swine fever broke out I think it was May 2018. I cannot remember the exact date. We have not seen that here. But we do know this: it is a very hardy virus that can be transmitted in different fomites. It can resist freezing, it can resist heat, and it can make the transshipping from China to the United States in containers, in different materials, whether it is feed, packaging. And so this is something we need to be alert through APHIS, or USDA, through CDC that we are monitoring these things better than we ever have before because that is a port of entry that we might not even be looking about.

We are looking at people, but we also need to look at containers and fomites coming in that way.

Dr. Redfield. Yes. The only comment I would make for this virus, just so you know, we are aggressively evaluating how long this virus can survive and be infectious. And where on copper and steel it is pretty typical, it is really pretty much about 2 hours, but I will say that on other surfaces, cardboard or plastic, it is longer. And so, we are looking at this because we do not know the role of fomite transmission.

Now, I do not think it is going to impact cargo, OK, unlike maybe some of the other viruses that you talked about. But I do think that it may have contributed to the huge outbreak we saw on that Diamond Princess. It may not have all have been aerosolized. It could have been fomites.

So, we are aggressively evaluating that to understand how well this virus survives in different conditions.

Mr. Yoho. We would appreciate you keeping us informed on that. Thank you.

Mr. Bera. I understand Ms. Spanberger has additional questions.

Ms. Spanberger. Yes. Thank you, Mr. Chairman.

Since we have been in this hearing there is a breaking story with the Washington Post, and I do not expect that you all have seen it yet. But it is there is a whistleblower report that a senior HHS official who oversees workers at the Administration for Children and Families has now filed a whistleblower report that HHS employees were sent to an airplane hangar to meet evacuated Americans at the March Air Force Base in Riverside, and that they were not given any PPEs or protective equipment while they were interacting directly with those who were potentially impacted.

I raise this, recognizing that we are dealing with different agencies here present today. But I think this speaks to a general concern. It is a little bit of a followup to Congressman Bera’s question related to whether or not State Department officers have what they need to stay safe.
And I would, so I will pose that question.

But then also wanted to make sure to make the point that this is deeply concerning because as we are dealing with a significant outbreak, something that is personally causing great fear in our communities among individuals, we need to ensure that our constituents have faith that the Administration and the U.S. Government is doing everything possible.

And there are already some concerns about whether or not that is the case, and what—how people can keep themselves safe. And so, finding out that the U.S. Government might have put its own personnel in harm’s way is deeply concerning to me.

So, if you could comment both whether or not your agencies are ensuring that their personnel are safe, and then comment on, you know, what we can do in light of this when we are back in our districts and people are saying, How can we trust the government to keep us safe if this is happening to its own people? I would love your comments on that.

Dr. WALTERS. Yes. Thank you for the question and the concern.

I can speak, having been on those missions, and certainly the first trip out of Wuhan, the second, the third, the Diamond Princess, and based on a relationship that I have had with HHS ASPR and CDC dating back to 2014. Every precaution has been taken.

Ms. SPANBERGER. So, was it your experience that you did not witness any individuals who were not wearing PPE?

Dr. WALTERS. No, I can say unequivocally that everyone involved with those evacuations was appropriately equipped and trained.

Ms. SPANBERGER. Okay. Well, and I do not seek, I do not seek to be argumentative with you, sir, I am reading breaking news in the Washington Post. But that is good to hear.

And then specifically with State Department officials and the availability of protective gear and the attention to detail there?

Dr. WALTERS. We take every precaution. We have the equipment and the training that we need to do this safely.

Ms. SPANBERGER. Thank you.

And would you care to comment as well, Mr. Brownlee?

Mr. BROWNLEE. Yes, please.

My consular colleagues in China, Japan, and elsewhere have been working on an ongoing basis with people. So, for example, in Japan there are still 100-plus U.S. citizens from the Diamond Princess in the country. A number of those are hospitalized. We are regularly engaging with those people but we are doing so in a safe fashion, taking professional advice.

So, whereas initially some of the visits were taking place in person, that became cumbersome because they were having to suit up. Now these visits are taking place on a telephonic basis.

I have here a photograph, I gave the chairman a copy of it, that shows my colleagues standing on the quayside. As they were processing people coming off the Diamond Princess they were properly taken care of.

Ms. SPANBERGER. I can see the photo from here that they are——

Mr. BROWNLEE. I will leave you a copy.

Ms. SPANBERGER [continuing]. That they are equipped.

And then the general concern about, again this is just a report that is breaking news, the veracity of it will be determined later,
but it is in the news and people are reading it as adding to this story, are there other comments that you all would like to make related to ensuring that our constituents, people we represent have faith that we are handling this, that all involved agencies are handling this virus and concerns in the way that it should be handled? And just in light of what might otherwise be some concerning news.

Dr. WALTERS. What I would say is that the psychology in dealing with highly infectious disease is often worse than the pathology. We have the best medical care in the world. And whether it is Ebola or coronavirus, the American health care system is ready to receive and ready to take care of our health care workers and our public.

From the State Department’s perspective, we have a work force that is at the front line. We are happy to be there to facilitate the relationships that are going to be critical for containing this overseas, whether it is a delivery of foreign assistance of the exchange of technical information.

What I tell my family is that you live in the best country in the world and that people who know how to do this are in positions where they can advise State, local, and international health care workers.

Ms. SPANBERGER. Thank you. I thank you for the indulgence of the second question, Mr. Chairman.

And to the witnesses, thank you so much for all of the work I know that you are putting in on this. Thank you for your continued service to our country, and to keep us all safe and healthy. I truly appreciate it.

I yield back.

Mr. BERA. Thank you.

Let me recognize the gentleman from California, Mr. Sherman.

Mr. SHERMAN. Doctor, what is your best estimate as to the mortality rate of this disease among those who are healthy and under age 65?

Dr. REDFIELD. Again, I think the most important thing in that scenario, under 65 and healthy, is whether you are health system functional or not. So, as we have seen with the Wuhan health system——

Mr. SHERMAN. Healthy health system, healthy human under age 65.

Dr. REDFIELD. Yes, well——

Mr. SHERMAN. My constituents.

Dr. REDFIELD. Yes, I think, again, you know, we do not have the data. But I, we suspect if you look at the mortality rate of this disease outside of China, we are probably looking right now at somewhere around a half a percent. Right? But, again, we will have to see more data to really be clear on that.

Mr. SHERMAN. And seasonal flu has a mortality rate of?

Dr. REDFIELD. About .1 per , .1 per thousand.

Mr. SHERMAN. Point one per thousand or .1 percent?

Dr. REDFIELD. Point 1 percent. I am sorry. Yes, .1 percent.

Mr. SHERMAN. The Chinese are telling us that there is a decline. Should I, should we believe them, Doctor?
Dr. REDFIELD. I think that there probably is a decline. Again, I do think some of the mitigation strategies are starting to have impact, particularly out of Hubei. Most of the cases now are in the Hubei area.

Mr. SHERMAN. Want to ask you about masks. It is funny, I went onto Amazon. Buy 50 masks is 50 bucks which, and you know, they are not very heavy, less than a pound. And then Amazon wants to charge an additional $400 for shipping and handling.

Needless to say we will be in touch with Amazon on this. But I do not think that Amazon has ever charged $400 to ship a box, and not a rush basis actually, a delay for 2 weeks from now, on less than a pound $400 shipping and handling seemed an extraordinary charge. But, you know, given Mr. Bezos’ need for food and the necessities of life, I can understand.

We see pictures from all over the world, people wearing these masks. Who should wear the masks in the United States?

Dr. REDFIELD. Yes, as I mentioned earlier, the masks, the N95 masks really need to be reserved for health care providers that are taking care of these patients in the hospital, as well as confirmed individuals that are in home isolation to minimize the spread while they are in home isolation.

We would not recommend the American public go out and get these masks. And I——

Mr. SHERMAN. Does the mask protect the person wearing it or protect others from the person wearing it?

Dr. REDFIELD. Well, there is really the issue here is to protect the individual who is being exposed to someone who has the pathogen. And we believe that that is where the mask should be.

A lot of the people you see wearing these masks they are really not going to have a functional impact whatsoever in terms of transmission. These surgical masks that you see everybody wearing on the—even when I, you know, was traveling today here in the city I saw people again even in our own city wearing masks.

Some of them do it, they have a cold or an illness that they think it might minimize them. I would tell those people to stay home. That would be more effective than trying to feel that you have to go to work and wear a mask.

So I think the CDC has on its website really good guidance on the appropriate use of masks. And I encourage people to go look at it.

Mr. SHERMAN. It looks like the Chinese have had a decline. They dealt with extraordinary lockdowns of entire areas. Should we be locking down any neighborhood where we find that someone—what level of lockdowns do we need, if any?

Dr. REDFIELD. Yes, the backbone of our response right now, and really the most important part of our multi-layered response, even though sometimes people do not recognize it because it is not like travel restrictions or screening at airports, the backbone is the American medical community and public health community. As I mentioned, of our 15 cases that we diagnosed in this country, 14 of them were diagnosed by our medical public health community.

So, I am going to maintain confidence on early diagnosis, isolation, and contact as our major mechanism to confront this.
Mr. SHERMAN. To test for this is it sufficient to just take people's temperature as they were doing? Or is it contagious before it is symptomatic, and do we need to give a lot of people blood tests?

Dr. REDFIELD. Yes, so the issue on how infectious this virus is at different States of symptomatology is still unknown. But we do know that you can transmit this virus before symptoms.

Does that contribute meaningfully? We do not know. And I think that is what we are trying to learn.

Clearly, we and the CDC is working on another, other task which the chairman would understand, we are trying to develop serological tests so that we can understand the extent. Like, in China right now what they are doing is they are measuring the active virus, and that is what we are doing, but that does not really tell us what the denominator is of who has really been infected. You need a serological test to do that.

We are currently working on——

Mr. SHERMAN. I know the chair, the chairman understands what you are saying.

Dr. REDFIELD. Okay.

Mr. SHERMAN. You are saying we want to test to see which people have been exposed, have the antibodies, and may have been asymptomatic throughout the whole process——

Dr. REDFIELD. Yes, sir.

Mr. SHERMAN [continuing]. And just did not know they had the disease.

Got you.

See, now you are not the only member——

Mr. BERA. There you go.

Mr. SHERMAN [continuing]. Up here who understands it.

I yield back.

Mr. BERA. Well, thank you.

Once again, I just want to recognize the witnesses and say I that appreciate your service to our country. And, obviously, this is a very fluid situation.

I did just want to make reference to the breaking story that Ms. Spanberger identified. I am fully confident that we do everything we can to protect our personnel and our workers as we were evacuating folks from China, putting them on airplanes, bringing our citizens back home. It does sound like there was someone who did see some personnel that did not have protective gear and were released.

I hate to use the term whistleblower because it has gotten politicized. But it is important that if there are folks that are raising issues, we must address them. And I do feel that it is very important for this body to say publicly we want to encourage folks who see things, for the sake of bettering ourselves, to report the issue. Those whistleblowers are those individuals that are raising issues.

We are fully committed to protecting them. And we fully want folks that are seeing things to feel comfortable and protected coming forward. I am not commenting on whether this story is accurate or inaccurate, but I am commenting on the fact that it is important for folks that see things to identify them and not fear retribution for coming forward. That is our law. That is the way this process works.
Dr. Redfield, I appreciate your coming up to the Hill and keeping us informed. Again, we look forward to working very closely with the CDC.

And, you know, as one doctor to another, you know, as we work through the regulatory process to speed up our testing capabilities and availability of diagnostic tests throughout this country, we look forward to working with—well, you are not the one holding it up necessarily, but we do look forward to speeding up that regulatory process to make sure we get these tests out and are able to do it.

And, again, I appreciate updating the folks that we are testing. I do think that is going to be helpful. And trusting our doctors that are on the front line if they do suspect coronavirus, being able to get that test done.

Dr. REDFIELD. I just want to make one comment for the record, that we have been working very closely with the FDA. They have been very supportive. I just want to make sure but they are operating within the regulatory framework that we have.

And I think the point that I wanted to make is that the loss of laboratory development tests to be used when we are developing new tests and responding to new emergencies I think is something that should be re-looked at.

Mr. BERA. I appreciate that.

And, again, thank you and thank all three of you as well as your colleagues at HHS, USAID, and Homeland Security for regularly coming up to the Hill to brief Members of Congress. And again, this is fluid, so let’s maintain close contact and dialog.

And with that, this hearing is adjourned.

[Whereupon, at 4:56 p.m., the subcommittee was adjourned.]
APPENDIX

SUBCOMMITTEE HEARING NOTICE
COMMITTEE ON FOREIGN AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515-6128

Subcommittee on Asia, the Pacific, and Nonproliferation

Ami Bera (D-CA), Chairman

February 27, 2020

TO: MEMBERS OF THE COMMITTEE ON FOREIGN AFFAIRS

You are respectfully requested to attend an OPEN hearing of the Committee on Foreign Affairs, to be held by the Subcommittee on Asia, the Pacific, and Nonproliferation in Room 2172 of the Rayburn House Office Building (and available live on the Committee website at https://foreignaffairs.house.gov/).

DATE: Thursday, February 27, 2020

TIME: 2:00 p.m.

SUBJECT: Coronavirus Disease 2019: The U.S. and International Response

WITNESSES:

Mr. Ian Brownlee  
Principal Deputy Assistant Secretary  
Bureau of Consular Affairs  
U.S. Department of State

Mr. Jonathan Fritz  
Deputy Assistant Secretary  
Bureau of East Asian and Pacific Affairs  
U.S. Department of State

William A. Walters, Ph.D.  
Executive Director and Managing Director for Operational Medicine  
Bureau of Medical Services  
U.S. Department of State

Robert Redfield, Ph.D.  
Director  
U.S. Centers for Disease Control and Prevention

By Direction of the Chairman

The Committee on Foreign Affairs seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-2125 at least four business days in advance of the event, whenever practicable. Questions with regard to special accommodations in general (including availability of Committee materials in alternative formats and assistance hearing devices) may be directed to the Committee.
COMMITTEE ON FOREIGN AFFAIRS

MINUTES OF SUBCOMMITTEE ON Asia, the Pacific, and Nonproliferation HEARING

Day: Thursday    Date: 2-27-2020    Room: 2122
Starting Time: 2:55 PM    Ending Time: 4:55 PM

Recesses: ______ to ______, ______ to ______, ______ to ______, ______ to ______, ______ to ______

Presiding Member(s)
Chairman Ami Bera

Check all of the following that apply:
Open Session [ ]    Executive (closed) Session [ ]    Electronically Recorded [ ]    Stenographic Record [ ]
Television [ ]    To select a box, mouse click it, or tab to it and use the enter key to select. Another click on the same box will deselect it.

TITLE OF HEARING:
"Coronavirus Disease 2019: The U.S. and International Response"

SUBCOMMITTEE MEMBERS PRESENT:
See attached.

NON-SUBCOMMITTEE MEMBERS PRESENT: (Mark with * if they are not members of full committee.)
David Cicilline    RI; Ted Lieu, CA; Steve Chabot, OH

HEARING WITNESSES: Same as meeting notice attached? Yes [ ] No [ ]
(If "no", please list below and include title, agency, department, or organization.)

STATEMENTS FOR THE RECORD: (List any statements submitted for the record.)

Testimony by the Witnesses

TIME SCHEDULED TO RECONVENE ______
or TIME ADJOURNED ______

Clear Form

Note: If listing additional witnesses not included on hearing notice, be sure to include title, agency, etc.

Subcommittee Staff Associate
### House Committee on Foreign Affairs

**Subcommittee on Asia, the Pacific, and Nonproliferation Hearing**

<table>
<thead>
<tr>
<th>Present</th>
<th>Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Ami Bera, CA</td>
</tr>
<tr>
<td>X</td>
<td>Brad Sherman, CA</td>
</tr>
<tr>
<td>X</td>
<td>Dina Titus, NV</td>
</tr>
<tr>
<td>X</td>
<td>Chrissy Houlahan, PA</td>
</tr>
<tr>
<td></td>
<td>Gerald Connolly, VA</td>
</tr>
<tr>
<td>X</td>
<td>Andy Levin, MI</td>
</tr>
<tr>
<td>X</td>
<td>Abigail Spanberger, VA</td>
</tr>
<tr>
<td>X</td>
<td>David Cicilline, RI</td>
</tr>
<tr>
<td>X</td>
<td>Ted Lieu, CA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present</th>
<th>Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Ted Yoho, FL</td>
</tr>
<tr>
<td>X</td>
<td>Scott Perry, PA</td>
</tr>
<tr>
<td>X</td>
<td>Ann Wagner, MO</td>
</tr>
<tr>
<td>X</td>
<td>Brian Mast, FL</td>
</tr>
<tr>
<td>X</td>
<td>John Curtis, UT</td>
</tr>
<tr>
<td>X</td>
<td>Steve Chabot, OH</td>
</tr>
</tbody>
</table>
OPENING STATEMENT

Opening Statement
The Honorable Ami Bera
Chairman, Subcommittee on Asia, the Pacific, and Nonproliferation
House Committee on Foreign Affairs

Coronavirus Disease 2019: The U.S. and International Response
Thursday, February 27, 2020
2:00pm, 2172 Rayburn House Office Building

I want to thank Ranking Member Yoho, the members of this subcommittee, our witnesses, and members of the public for joining us at today’s hearing. I’m glad that senior officials from the State Department and the Centers for Disease Control and Prevention (CDC) are here today to describe to the American people what steps our government is taking to keep the public safe from this growing public health crisis. This subcommittee held Congress’ first hearing on this virus over three weeks ago and we are here today to examine how the administration is responding to coronavirus disease 2019.

We were reminded last night that this outbreak can touch every one of our communities. Last night, I learned that it touched my own community. This was the first case of community transmission in the United States - the individual had not traveled to any of the impacted areas abroad or had contact with any individuals known to have coronavirus. They are being treated in my community, at University of California Davis (UC Davis), where I worked, and by my former colleagues.

Reports indicate that there was a delay in testing that case for coronavirus because the patient failed to meet the CDC criteria for testing. We also know that testing kits in the U.S. have had problems which has limited testing, while our partners, like South Korea, have been able to test tens of thousands of people. We need to start testing in our communities and we need to fix our testing issues, and we need to do this now.
The individual being treated in Sacramento County would not have been tested, even belatedly, without quick thinking clinicians at UC Davis who pressed the CDC to conduct that test. That underscores how important our local responders are in these efforts. I want to thank our state and local healthcare workers, our doctors and our nurses, who are taking care of those patients who have been quarantined and affected, like those in my hometown of Sacramento.

I also know our federal employees are also working hard. Individuals from the Departments of State, Health and Human Services, Homeland Security, Defense, and of course the CDC, United States Agency for International Development (USAID), and National Institutes of Health, have been working around the clock.

This disease has now reached almost every corner of the globe. This is a human crisis and the Chinese people have borne the brunt of it. Tens of thousands have been infected. Many have died. The people of Italy, South Korea, Iran, and others are now being tested. Our hearts are with them, and we are hopeful we can prevent similar outbreaks in the U.S.

Congress has been engaged from the start and I appreciate the administration’s willingness to brief us. But Congress’ job is to exercise oversight over the response and key questions remain unanswered, and the American people deserve to hear those responses.

In considering the outbreak, I draw on my own experience as a doctor and as the former Chief Medical Officer of Sacramento County. I am also a member of the CSIS Commission on Strengthening America’s Health Security. A lifetime of experience has made me fight, time and time again, for increased funding and coordination to combat emerging infectious diseases, like coronavirus.

For that reason, I was glad that the President designated one senior level White House official to coordinate the interagency response. Nearly two years ago, my colleague Mr. Connolly and I were two of the lone voices in Congress who raised the alarm about the absence of senior leadership at the White House when the administration disbanded its global health security
That directorate helped coordinate how the U.S. prepares for these epidemics.

That restoration of leadership is long overdue. But we need to remember that this leadership should be based on science, not the stock market. Vice President Pence needs to listen to the experts.

At the beginning of the outbreak, I made three recommendations and they remain more relevant than ever.

First, we need to get our best scientists to the epicenter of the response. Our CDC employees represent the best of the best, and we have a long history of working in China. The CDC needs to draw on that experience and work side by side with their Chinese counterparts. Yes, we have a couple of people with the WHO team in China -- but that’s not enough. There is a lot we don’t know about coronavirus, including about healthcare worker transmission. Being on the ground means better data and better cooperation, which means better preparation and response. We should be using every diplomatic tool in our kit to ensure the Chinese are working with us and providing that data. The President said last night he’s talking to Mr. Xi on the phone - he should be calling him daily if that’s what’s needed to get the right people the right access.

Second, we should effectively resource the response. As a former Chief Medical Officer of Sacramento County, I know that public health systems often operate on shoestring budgets - $2.5 billion is not enough. We need to work together to determine the right number now. I have been told by experts, including public health experts, that the administration’s request is woefully inadequate.

The administration has not requested additional funding for the international response. This administration previously tried to withdraw Ebola funds through a rescissions package and suggested we send them back to the Treasury instead of putting the funds back into ensuring our global partners and the U.S. could use the funds to continue to strengthen our global health systems to prepare for pandemics and other global health threats. I pushed back on this effort and
Congress reversed the proposal. I’ve fought for increased CDC and USAID global health security funds, and restored funding for the Department of Defense’s international bio programs when the administration proposed to reduce funding in this area. If this virus spreads as we now think it might, it is clear to me that our partners will need our help. It is critical we deliver it to them.

Finally, we need to work with our state and local partners to make sure they have the support they need. That means providing them with adequate funding and that means coordination and planning. They are the frontlines of this fight. Should this disease become widespread in the U.S., the state and local level is where the fight will be won or lost in places like UC Davis Medical Center.

We must be honest with our constituents and those tasked with responding to the virus about how this disease may spread, what steps they should take, and ensuring they have proper response plans and protective equipment. If we don’t do this, and the disease becomes more widespread, this could overrun our health systems. While we don’t want to panic – we also don’t want to find ourselves underprepared for the worst-case scenario.

I continue to believe that the risk to the American people is low at this time. But this disease is global in scope and it is impacting our communities and our economy. Tackling it will require our communities, our government, and our international partners working together. With American leadership, we can do it. But it will require proper planning, coordination, and resourcing. It’s not too late.

I look forward to the testimony of Director Redfield and senior State Department officials today so that they can take our questions and explain to the American people how and what they will need to get it done. With that, I will turn it over to the ranking member, Mr. Yoho.