S. HRG. 116–208

CONFRONTING EBOLA: ADDRESSING A 21st CENTURY GLOBAL HEALTH CRISIS

HEARING

BEFORE THE

SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH POLICY

OF THE

COMMITTEE ON FOREIGN RELATIONS UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

JULY 24, 2019

Printed for the use of the Committee on Foreign Relations

Available via the World Wide Web:
http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
40–600 PDF WASHINGTON : 2020

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CONFRONTING EBOLA: ADDRESSING A 21st CENTURY GLOBAL HEALTH CRISIS

WEDNESDAY, JULY 24, 2019

U.S. SENATE,
SUBCOMMITTEE ON AFRICA AND GLOBAL HEALTH POLICY,
COMMITTEE ON FOREIGN RELATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:35 p.m. in room SD–419, Dirksen Senate Office Building, Hon. Lindsey Graham, chairman of the subcommittee, presiding.

Present: Senators Graham [presiding], Kaine, Menendez, Coons, and Murphy.

OPENING STATEMENT OF HON. LINDSEY GRAHAM, U.S. SENATOR FROM SOUTH CAROLINA

Senator GRAHAM. Thank you. The hearing will come to order. I apologize for being late. It is one of those days where you start late and you wind up late.

Really an impressive panel. And what brings us here is we had the 10th outbreak, the second largest in history, in the Republic of Congo, in areas that have been, without a doubt, have been conflict zones. This is sort of the worst case situation. There is no governance in these places. It is a war torn region. Thousands have been killed and displaced. In the middle of all this mess, you have an Ebola outbreak without a whole lot of governance to deliver relief. And this hearing is going to focus on what we can do and should do and what are the consequences of doing nothing.

I just appreciate Senator Kaine very much being a good partner. And I will introduce the panel after your opening statement.

STATEMENT OF HON. TIM KAINE, U.S. SENATOR FROM VIRGINIA

Senator KAINE. Great. Thank you, Mr. Chair, and thanks to all the witnesses.

The chair and I talked about doing this hearing after a hearing 6 weeks or so ago with the USAID Administrator, Mark Green. And it is very, very timely. He talked about the need for us to focus more on this.

And 1 week ago today, the World Health Organization, after an Ebola case was discovered in the City of Goma, declared this outbreak of Ebola a public health emergency of international concern. For those who do not follow the WHO terminology, they have just done this five times in their history—has there been an outbreak of such significance that they have declared a public health emer-

gency of international concern. The earlier instances were a polio virus in 2014, swine flu in 2009, Ebola in West Africa in 2014, and the Zika outbreak in 2016. So this was an outbreak that started, I believe, in August of 2018 in Uganda and the DRC, but it has now significantly affected 1,700 deaths, more than 1,700 deaths, 2,600 cases. And so the WHO has now weighed in, and we have to decide what to do about it, what the U.S. can do in tandem with other partners.

The chairman made a good point. This is a public health emergency, but the solution is not just a health care solution because we are dealing with conflict. We are dealing with failed democracy. We are dealing with failed systems. And so how do we end that situation to deal with this significant health emergency. The answer will be broader than just narrow health. Certainly health expertise and creativity can be part of it, but it is going to have to be bigger than that.

And so the idea today is to hear from each of you in your own areas of expertise and get your advice for what we can do in Congress to be helpful.

So thank you, Mr. Chair. I look forward to the hearing today.

Senator GRAHAM. Thank you.

And to put a fine point on what Senator Kaine said, this is a case study, exhibit A, as to why you cannot withdraw from the world. To those who believe that things over there are not our problem over here, you are going to learn pretty quickly that when it comes to diseases like this, if you do not get ahead of it, you are going to regret it. And this is not just about a medical problem. This is a governance problem. This is a whole-of-government problem.

So when you start cutting developmental budgets, you are going to get more of this, not less. So every time I hear somebody wanting to cut foreign assistance which is $30-something billion of a $4 trillion dollar budget, I keep thinking what world are you looking at. So that is my commercial for our committee.

So to people who know what they are talking about far more than I do when it comes to Ebola, we are going to start with Dr. Mitch Wolfe, a medical doctor, Chief Medical Officer, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. He is the technical and medical lead for the response.

We have Rear Admiral Tim Ziemer, USN, Retired, Senior Deputy Assistant Administrator, Bureau for Democracy, Conflict, and Humanitarian Assistance, USAID, providing assistance to the U.N. and NGOs fighting Ebola.

The Honorable Marcia Bernicat, Principal Deputy Assistant Secretary, Bureau of Oceans and International Environmental and Scientific Affairs, U.S. Department of State. She is the lead for the interagency in diplomatic response.

And finally, Assistant Secretary Tibor Nagy, Bureau of African Affairs, U.S. Department of State, who will focus on the regional political aspects of Ebola.

Let us start with Dr. Wolfe.

STATEMENT OF MITCH WOLFE, MD, CHIEF MEDICAL OFFICER, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. WOLFE. Good afternoon, Chairman Graham, Ranking Member Kaine, and members of the subcommittee. I am Dr. Mitch Wolfe, Chief Medical Officer of the Centers for Disease Control and Prevention. I am a rear admiral in the U.S. Public Health Service, and I have worked with the Department of Health and Human Services for 21 years, 18 of those with CDC, including 10 years overseas in Vietnam and Thailand working on addressing infectious disease threats and helping to build the capacity for countries to address these threats at their source.

Thank you for the opportunity to update you on the Ebola outbreak in the DRC and outline what CDC is doing to prevent, detect, and respond to this and other emerging global health threats. CDC's efforts are grounded in over 40 years of Ebola research and more than 20 Ebola outbreak responses. I want to emphasize our goal is to end this outbreak as soon as possible.

This Ebola outbreak, first reported in the DRC in August 2018, is continuing to spread. As of July 24th, there are a total of 2,597 cases and 1,743 deaths, with recent cases in Goma and Uganda. The outbreak now encompasses 25 health zones in the DRC, and in the past 21 days, we have seen 253 active cases in 19 health zones. Of these cases, about a third were known and monitored contacts, and even more concerning, roughly 30 percent were cases identified as community deaths that occurred outside of the health care system. A substantial percentage of cases were acquired in health care settings, and 137 health care workers have been infected. In light of this regional spread, last week WHO's Director General declared the DRC Ebola outbreak a public health emergency of international concern.

This is the first outbreak in DRC that is occurring in a densely populated area that has also experienced decades of continuing conflict and civil unrest. DRC has reported nine previous outbreaks of Ebola, but the two currently affected provinces have never experienced an Ebola outbreak and have busy, porous borders with Uganda, Rwanda, and South Sudan. These challenges make this outbreak extremely difficult to contain, and it is not yet under control at this time.

Over the course of this outbreak, we have deployed 204 experts from CDC to the DRC and neighboring countries and WHO headquarters. And for the past several months, CDC has deployed staff to Goma in support of surveillance, vaccination, border health, and risk communication. CDC scaled up efforts following the announcement of the first Ebola case in Goma, and our staff are working directly with responders on the ground there to assist with core public health interventions.

Availability of an Ebola vaccine is a new development since the West Africa outbreak. CDC is actively working with the WHO, providing technical support for the vaccination program, and over 165,000 people in DRC have been vaccinated.

While vaccine is important and has likely had a mitigating effect on the outbreak, vaccination complements but does not replace

basic and critical public health response activities such as contact tracing and rapid identification and isolation of ill patients.

Based on experience from previous outbreaks, an effective response depends on early case identification and effective isolation of about 70 percent of all cases and sustaining this for several months. The fact that we are seeing so many cases discovered as community deaths means that we are missing contacts and missing the chains of transmission that must be identified to bend the curve of the outbreak.

CDC's work in this outbreak reflects our extensive expertise in disease control to inform the response, and CDC works in three main avenues organizationally in this outbreak: providing direct assistance to the DRC Ministry of Health in Kinshasa and in Goma where the incident command is located, with the WHO in Geneva, and as the public health lead in the disaster assistance response team, or DART. Our work with border countries focuses on their ability to quickly identify, isolate, and effectively respond to a possible case of Ebola. The rapid Ugandan containment of three imported Ebola cases in June of this year is a demonstration of the effectiveness of these preparedness efforts, which also build on CDC's long-term involvement in disease detection, response training, and capacity development in Uganda, supported by global health security investments.

While this outbreak continues to be an urgent situation in the region, the current risk to America remains low. The most effective way to protect America from emerging threats is to stop outbreaks at their source before they reach our borders. CDC continues to improve the public health workforce abroad, having trained over 12,000 public health professionals now in 70 countries. More than 260 of these professionals are from the DRC and many are responding to this outbreak.

CDC is committed to this response and will continue to position our assets globally to quickly respond to emerging threats and disease hotspots around the world.

Thank you for your continued commitment and support to CDC and our critical global health security mission.

[The prepared statement of Dr. Wolfe follows:]

PREPARED STATEMENT OF DR. MITCH WOLFE

Good morning Chairman Graham, Ranking Member Kaine, and members of the Subcommittee. I am Dr. Mitch Wolfe, Chief Medical Officer of the Centers for Disease Control and Prevention (CDC). Thank you for the opportunity to testify before you on the Ebola outbreak in the Democratic Republic of the Congo (DRC), and thank you for your continued commitment to supporting CDC's work in global health security.

This is the tenth and largest outbreak in DRC, and the second largest outbreak of Ebola ever recorded since the virus was discovered in 1976 in DRC. On July 17, 2019, the World Health Organization declared the outbreak a Public Health Emergency of International Concern (PHEIC). CDC has worked since last summer, in collaboration with interagency and international partners, to end this outbreak and ensure the health and security of our country. On June 13, CDC announced the activation of its Emergency Operations Center to support the response to the ongoing Ebola outbreak in Eastern DRC, which 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 end the outbreak. We have comprehensive Ebola response capabilities developed over 40 years at the forefront of Ebola virus research and further refined by direct engagement in more

than 20 Ebola outbreak responses globally. In the wake of the worst Ebola outbreak in history, the 2014–2016 outbreak in West Africa that claimed over 11,000 lives, CDC has made significant advancements in Ebola science, surveillance, and response. For example, we confirmed that live Ebola virus can persist in specific body fluids, such as in seminal fluids, for over a year following infection. We have also trained epidemiologists and laboratory scientists, and provided testing materials for African countries at greatest risk of an Ebola outbreak.

In addition, in June 2015, we established CDC's Global Rapid Response Team, a cadre of over 500 highly-trained CDC responders ready to deploy on short notice anywhere in the world to respond to global health threats and emergencies.

As of July 17, CDC expert disease detectives and other staff had completed 313 deployments to the DRC, neighboring countries, and the World Health Organization (WHO) headquarters in Geneva to provide leadership and expertise in surveillance, laboratory testing, data analytics, vaccine implementation, emergency management, infection prevention and control, behavioral sciences, health communications, and border health. In addition, we support coordination of activities among response leaders including the DRC Ministry of Health and WHO. Our operational expertise allows us to quickly and efficiently identify the unique scientific and social variables of outbreaks and address them with proven interventions.

However, the unique challenges of this Ebola outbreak mean this fight is even more difficult than past responses. The complex security challenges in North Kivu and Ituri provinces have severely limited CDC's direct participation at the outbreak's epicenter, which is located far from the capital city of Kinshasa in an area threatened by armed conflict, crime, and civil unrest, as well as heavy cross-border movement into neighboring countries. Violence in the impacted communities has hampered Ebola disease surveillance, contact tracing, and vaccination efforts. The affected population has low levels of trust in the government and the international community. The DRC is also experiencing other serious infectious disease outbreaks, such as cholera, measles, and malaria, further stressing its health system. Additionally, disease control in the impacted area is challenging because of weak healthcare and public health infrastructure.

STATUS OF THE EPIDEMIC

On August 1, 2018, the DRC Ministry of Health and Population reported an outbreak of Ebola virus disease (EVD) in North Kivu Province. As of July 21, the number of cases reported was 2,592, with 1,737 deaths (a 67 percent fatality rate). Due to challenges in case detection and reporting posed by the security situation, CDC suspects that the true number of cases could be much larger. As of July 21, cases have been reported in 25 health zones of North Kivu and Ituri provinces. On June 11, the Ugandan Ministry of Health reported its first confirmed case of Ebola; two additional cases, from the same family who crossed into Uganda from DRC, were then confirmed on June 12. There are currently no additional confirmed cases in Uganda, and contacts of these cases were closely monitored for 21 days (the incubation period for Ebola). More than 3,000 people were vaccinated in Uganda to help prevent disease spread from the cases in Kasese District, as well as over 4,000 frontline healthcare workers vaccinated across the country. To date, no cases of Ebola have been confirmed in any other provinces in the DRC or in the other neighboring countries. The current outbreak is, however, already the second-worst Ebola outbreak ever recorded, with case counts continuing to increase and key response indicators showing little improvement.

Past outbreaks of Ebola in the DRC typically occurred in sparsely-populated, rural areas. The current outbreak—like the 2014–2016 outbreak in West Africa—includes densely-populated urban areas, increasing the likelihood of human-to-human spread. The outbreak initially affected the Mandima health zone and then spread to the town of Beni, which has a municipal population of 340,000 and a greater area population of about one million. More recently the outbreak has been heavily affecting the adjacent North Kivu health zones of Katwa and Butembo, which together also encompass an urban area with a population of approximately one million. The highly mobile population in this area of DRC poses challenges for Ebola responders' contact tracing efforts. Affected health zones have experienced reintroduction of Ebola cases to areas where disease transmission was previously halted or slowed. The number of affected health zones is also increasing; on June 30 an Ebola case was identified in a previously unaffected health zone of Ituri Province, close to the South Sudan border. On July 14, an Ebola case was confirmed for the first time in the city of Goma, which has a population of approximately two million people and is on the border with Rwanda. CDC staff already embedded in the Goma Emergency Operations Center provided direct support to the case investigation, including inter-

viewing contacts to establish their level of risk, performing an assessment at the health care facility visited by the patient, and strengthening the screening process at the Goma airport. In each instance, CDC experts were able to quickly identify and correct weaknesses in the response, reducing the risk of onward disease transmission.

Escalating violence in some areas has generated significant population displacement within DRC as well as across borders. Ongoing insecurity limits the effectiveness of public health interventions such as case investigation, contact tracing, and vaccination efforts. Many of the new cases that are reported each day are identified in later stages of illness, meaning that they spent much of their infectious period outside of isolation and potentially infected others. Moreover, from June 27 to July 17, among the 245 new cases with contact-related information, 61 percent were either unknown contacts (not known as contacts of previous Ebola patients) or known contacts but not being followed by responders at the time of symptom onset. This means that contact tracers may be missing chains of transmission and Ebola cases may not be identified by responders early enough to prevent further transmission.

STATUS OF RESPONSE EFFORTS

The Government of the DRC is leading the response, with strong assistance from WHO. CDC is providing technical guidance to the DRC government, bordering country governments, WHO and partners, bringing to bear decades of experience, global health investments, and lessons learned in the West Africa Ebola response. For example, CDC is working with WHO and DRC's Ministry of Health to standardize training materials and operating procedures for triage and isolation, decontamination of healthcare facilities, and routine patient care. All partners are working together toward one goal: to end this outbreak as soon as possible.

In August 2018, CDC and USAID briefly deployed Ebola experts to Beni for a few days, but they were pulled back due to security concerns. In the context of a December 2018 DRC presidential election, where several areas of the country experienced a deterioration in the overall security situation, U.S. Embassy Kinshasa went on Ordered Departure of non-emergency U.S. Government staff and all eligible family members on December 14, 2018. When this was lifted on Jan. 31, CDC staff returned to DRC to directly support the DRC government, WHO, and the integrated U.S. Disaster Assistance Response Team (DART), where CDC serves as the public health lead for the DART. As of July 19, 15 CDC staff were working with Ministry of Health counterparts in DRC in the capital of Kinshasa and especially in the North Kivu provincial capital of Goma, which has become the DRC government's base of operations to respond to the outbreak. Goma is about 300 kilometers from the main outbreak areas, and is considered to be more secure. As an example of how we work, in March, with U.S. Embassy Kinshasa concurrence, two CDC staff deployed to the town of Bunia in Ituri Province for 2 weeks to assist with the investigation of a newly confirmed Ebola case. CDC made local responders aware that there may be unrecognized chains of transmission in Bunia, and CDC advised local Bunia staff to better standardize and share information across vaccination and contact tracing teams. CDC works closely with the U.S. Embassy in Kinshasa to ensure the safety of deployed personnel, and routinely defers to the State Department to assess the security situation and determine access to the outbreak areas. While not currently operating within Beni, Butembo, and other outbreak areas, CDC remains prepared to return when it is deemed safe to do so by the U.S. Department of State.

CDC also has deployed staff to augment our existing country offices in the neighboring countries of Uganda, Rwanda, and South Sudan. As evidenced by the cross-border transmission in Uganda last month, these countries are all vulnerable to the possibility of imported cases arriving from the DRC. From August 6, 2018 through July 17, 2019, 199 CDC staff have participated in a combined 313 deployments in response to the Ebola outbreak: 98 deployments to DRC; 91 to Geneva; 55 to Uganda; 40 to Rwanda; and 29 to South Sudan.

RISK COMMUNICATIONS AND HEALTH EDUCATION

While the context of the response still presents many challenges, efforts to improve cooperation and engagement with local communities remains a critical aspect of this Ebola response, and continues to be a focus of our work. CDC social and behavioral scientists have deployed to DRC, WHO headquarters, and several countries bordering the DRC to guide risk communication and community engagement strategies. Experts from CDC, WHO, the International Federation of Red Cross and Red Crescent Societies (Red Cross), and ICEF continue to work toward improving the quality of engagement activities by standardizing approaches and developing and delivering communications training to all implementing partners.

A key component of improving community engagement is fulfilling the information needs of the community by answering and addressing their questions and concerns. Since May, CDC deployers have worked with the DRC Ministry of Health and UNICEF on message development and testing, analyzing and promoting the use of community feedback data in content and strategy development, and long-term risk communication and community engagement planning. CDC has also posted multiple Ebola prevention-oriented fact sheets, posters, and flip books translated into French, Swahili, Kinande, and Kinyarwanda, and recently released a video public service announcement (PSA) video featuring Congolese native and former NBA star Dikembe Mutombo delivering Ebola prevention messages.

CONTACT TRACING

Contact tracing is the effort to find everyone who comes in contact with a sick Ebola patient, either directly or through contaminated materials. The goals of this process are to monitor contacts daily for signs of illness and to isolate ill persons before they can infect others. One missed contact who develops disease can keep the outbreak going. When a case is not known to be a contact, they are usually identified in a late stage of illness and may have already spread the infection to others. On July 21, a total of 17,253 out of 20,302 (85 percent) known contacts of people with Ebola were being followed. However, as noted earlier, among the new cases with contact information from June 27 to July 17, 61 percent were either unknown contacts or known but not followed at the time of symptom onset. The high proportion of cases that are not known contacts or that are lost to follow-up indicates that the quality of contact tracing must improve if the outbreak is to be contained; contact tracing efforts have been hindered by the volatile security situation. To strengthen contact tracing, CDC designed "train-the-trainers" courses for frontline response workers, focusing on contact tracing methods. CDC also created an Ebola "Exposure Window Calculator" smartphone app in use by case investigators.

INFECTION PREVENTION AND CONTROL IN HEALTHCARE SETTINGS

Healthcare settings have played an important role in amplifying transmission in this and many prior outbreaks. Implementing proper infection control and prevention practices is critical to stopping the spread of the virus within the healthcare delivery system and to the community. Prompt identification and isolation of patients arriving at healthcare facilities with possible Ebola virus infection is essential so that they may be safely evaluated and, if necessary, transported to an Ebola Treatment Unit for further care. Infected people who are not initially recognized to have Ebola may receive care at multiple facilities before Ebola is suspected, exposing numerous patients and healthcare workers to the virus. As of July 21, 34 percent of cases identified in the preceding 21 days had visited two or more health care facilities before being confirmed with Ebola.

Unfortunately, patients often arrive at specialized Ebola Treatment Units late in their illness, and other healthcare facilities in the area are not necessarily prepared to effectively or safely care for Ebola patients. Patients are more likely to infect others during this time, and less likely to survive if treatment is started late. As of July 21, 137 local healthcare workers have contracted Ebola in the DRC. Within DRC, CDC is collaborating with WHO and the Ministry of Health to improve the use of standard procedures for correct patient assessment, triage, and infection prevention and control (IPC) practices across health facilities and to strengthen the supportive supervision and mentoring of healthcare workers.

In the bordering countries of Uganda and Rwanda, CDC is providing assistance to response partners to improve the capacity of healthcare facilities to rapidly identify and isolate suspected Ebola cases, train personnel, and improve infection prevention and control. At least 150 healthcare personnel have been trained by CDC in Uganda and Rwanda since October 2018. Using information from interviews conducted at border crossings, refugee transit centers, and district health offices, CDC identified clinics and hospitals in border districts of neighboring countries that would be most likely to receive an imported case of Ebola from the outbreak area.

CDC assessed triage practices at these facilities, interviewed and informed staff about risks of imported Ebola, and prioritized facilities for additional training and support.

BORDER HEALTH

The two DRC provinces affected by this outbreak, North Kivu and Ituri, both border Uganda. North Kivu also borders Rwanda, and Ituri province has a relatively short border with South Sudan. There is substantial population movement across these country borders. The Mpondwe Border Crossing is the busiest official ground

crossings on the border between Uganda and the DRC, with a peak of 35,000 travelers passing through each day. At the Rubavu District Point of Entry between Goma, DRC and Gisenyi/Rubavu City, Rwanda, an estimated 50,000 people cross daily. This high volume, which includes pedestrian, commercial car, and truck traffic, poses significant concerns for potential cross-border transmission of infectious diseases. The WHO assesses that there is a very high risk of regional spread. Preparedness activities in bordering countries are ongoing and CDC is providing technical assistance on their border health security efforts. Building on long-term in-country CDC presence as well as collaborations from the earlier 2018 outbreak, CDC is working with the DRC Ministry of Health and Population and other partners to adapt and implement screening protocols at country-prioritized airports and ground crossings, and to map population movement into and out of the outbreak zone to determine where surveillance and other public health interventions could be enhanced. As of July 22, over 77 million travelers have been screened at 80 priority ports and crossing points in the DRC since the outbreak began.

VACCINE IMPLEMENTATION

CDC conducted a clinical vaccine trial in Sierra Leone during the West Africa Ebola outbreak, enrolling and vaccinating nearly 8,000 healthcare and frontline workers. This and several other studies have suggested that the rVSV–ZEBOV (Merck) investigational vaccine is safe and protects against infection with the Ebola virus. While the vaccine is not yet licensed, the vaccine is being used in the current outbreak in expanded access trials, predominantly in a ring vaccination strategy that targets contacts of Ebola case patients for vaccination as well as secondary contacts. WHO and the DRC Ministry of Health co-lead the vaccination effort, with CDC contributing expert advice. While security concerns have prevented CDC from participating in field activities, CDC staff are embedded in the DRC Vaccine Commissions in Kinshasa and Goma and at WHO headquarters to analyze data and improve the quality of ring vaccination efforts.

CDC has also collaborated with WHO colleagues in Rwanda, South Sudan, and Uganda to implement preventative vaccination of health care workers in geographic areas near the DRC border, and has provided technical assistance to these countries. To date, over 9,000 healthcare workers have been vaccinated in the border countries of Rwanda, Uganda and South Sudan. In addition, we have applied our expertise to update Ebola vaccination protocols, operating procedures, and training and communications materials for use at national and local levels, and facilitated trainings for national staff. Our work across multiple countries has helped standardize procedures and facilitate the use of best practices. As of July 17, over 164,000 individuals had been vaccinated in DRC.

On May 7, the WHO Strategic Advisory Group of Experts (SAGE) on Immunization published interim recommendations to expand Ebola vaccination strategies and address security concerns. Their recommended vaccination strategies include ring vaccination, using "pop-up vaccination" sites at a distance from the residences of contacts, and targeted geographic vaccination, where all individuals in a given village or neighborhood are invited to receive vaccine. These SAGE recommendations also include alternative dosing to help ensure vaccine continues to be available. Following the SAGE recommendation, the DRC ethical review board approved a protocol to implement vaccination for new populations (pregnant women beyond the first trimester, lactating women, and infants down to 6 months of age) and to implement vaccination at half the previous DRC dosage, which provides a similar potency to the vaccine used in the West African outbreak. These changes have been implemented in the field since early June 2019.

With expanded vaccination efforts we continue to underscore that strengthening implementation of basic public health measures, especially effective engagement and comprehensive identification of contacts, will be essential in conjunction with any vaccination strategy.

OUTLOOK OF THE EPIDEMIC

Ebola transmission can be stopped and the outbreak terminated when at least 70 percent of cases are effectively isolated; that is, moved to an Ebola Treatment Unit before they have infected anyone else, or have their contacts and secondary contacts fully vaccinated. This needs to be sustained for at least two to three months in order to end the outbreak. While we have the public health knowledge and tools to complete this task, we have not been able to fully implement these tools in the field. Neither the outbreak nor the security situation on the ground has improved in recent months and it is difficult to predict with certainty what will happen. Without substantial and continued improvements, the DRC could soon be facing an epidemic

that rapidly increases; at that point, the possibility of the outbreak spreading to neighboring countries—in numbers much higher than the three confirmed cases in Uganda we have already seen—will increase. CDC is committed to leveraging its resources and global health security expertise to help end the outbreak.

RISK TO THE UNITED STATES

CDC understands that an international outbreak of Ebola puts the United States at risk and we appreciate the trust placed in CDC to keep Americans safe from public health threats both at home and abroad. At this time, we believe the direct risk to the United States remains low based on the travel volume and patterns from the outbreak areas to the United States and the implementation of border screening measures at key airports and ports in the DRC and neighboring countries. CDC helped organize exit screening workshops in Kinshasa and Goma in DRC to bolster screening efforts and prevent spread of disease. On average, of the approximately 325,000 air travelers arriving in the United States daily, about 43 travelers are from the DRC, largely from regions unaffected by the Ebola outbreak.

CDC continues to implement routine border health security measures at U.S. Ports of Entry and has issued a Level 2 (Practice Enhanced Precautions) travel health notice for the DRC that informs travelers and clinicians about the outbreak and what types of precautions they should take if traveling to the affected areas of the DRC. CDC has been in regular contact with the non-governmental organizations operating in the outbreak areas, and we provide recommendations on monitoring and pre-departure health assessments for healthcare workers. In addition, the U.S. Department of State has identified the outbreak area as a "do not travel" zone because of armed conflict, crime, and civil unrest. Current CDC guidance for managing Ebola cases in U.S. healthcare settings has been reviewed and communicated to healthcare facilities as part of domestic preparedness efforts. CDC's Laboratory Response Network stands ready to perform testing on Ebola specimens should any need arise, with testing kits deployed across the United States.

BIG PICTURE: GLOBAL HEALTH SECURITY

The ongoing response to Ebola in DRC and surrounding countries demonstrates CDC's continued commitment to strengthen global health security. CDC has been engaged in global health security work for over 7 decades and is able to leverage the essential public health assets developed by notable initiatives like the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative, and global polio eradication to support core global health security programs and ensure the safety of Americans. With an understanding of the increasing threats posed by infectious diseases globally and in the context of the West Africa Ebola outbreak, CDC received $582 million in supplemental funding for a five-year effort in support of the Global Health Security Agenda (GHSA). GHSA was launched by a growing partnership of nations, international organizations, and non-governmental stakeholders in 2014 with a stated vision of a world safe and secure from global health threats posed by infectious diseases. Since GHSA's launch, CDC's global health security work has helped partner countries build and improve their public health system capacity. With CDC's support, partner countries were able to effectively contain meningitis in Liberia, Marburg virus in Uganda, multidrug-resistant tuberculosis in India, and vaccine-preventable diseases including measles and pertussis in Pakistan and diphtheria in Vietnam, among other threats across the globe. These outbreaks were stopped at their source, saving lives and reducing the amount of time it takes to effectively respond from months and weeks to days.

We appreciate the continued commitment of Congress to global heath security. Support for global health security enables CDC to continue protecting Americans by detecting and preventing infectious disease threats before they reach our borders. We are seeing progress in the 17 priority countries where we have invested our global health security resources: all 17 have improved rapid response to disease threats through established or expanded public health workforce training of field-based epidemiologists, 13 have improved prevention of vaccine-preventable diseases through increased community immunization coverage, 15 have ensured effective public health emergency operation centers through training of emergency management officials, and 9 have increased their ability to identify country-prioritized pathogens through improved national laboratory testing capacity.

The DRC serves as an example of a country where CDC investments have built capacity since program operations began in 2002, including activities specifically to prepare for an Ebola outbreak. These efforts have also fostered strong relationships with the DRC and surrounding countries' ministries of health that have proved critical in times of crisis. The May–July 2018 outbreak of Ebola in the Equateur prov-

ince of the DRC raised international concern due to logistical challenges caused by the large and remote area. That outbreak ultimately led to 53 cases and 29 deaths. The swift response, which included CDC and other U.S. Government personnel in the field, ensured it was quickly controlled. Without a doubt, our global health security activities in the DRC enabled a faster, more effective and successful response to the May–July 2018 outbreak, and provide an important foundation in the current Ebola response, even considering the complex security situation and special difficulties posed by this outbreak.

The DRC Field Epidemiology Training Program (FETP), developed with assistance from CDC and modeled after CDC's own training programs, has trained around 260 frontline and advanced disease detectives who are crucial to accurately detecting and identifying outbreaks. The DRC graduated its first cohort of FETP residents in 2015. These disease detectives are supporting the current Ebola outbreak and serve as an example of how CDC supports sustainable capacity development of countries to respond to outbreaks within their own borders.

There are presently 42 FETP-trained staff deployed in nine outbreak health zones. Training programs like these work effectively because they are complemented by decades of field experience that CDC experts bring, teaching new epidemiologists how to rapidly identify diseases and respond effectively to prevent spread. CDC maintains long-standing collaborations in the DRC for priority diseases, including monkeypox virus response and prevention, building capacity and skills that have been beneficial for Ebola response. Sustainable investments, such as resources and expertise to train laboratory technicians, renovate and upgrade two laboratories, and establish a National Emergency Operations Center in the DRC, are all being leveraged in the current Ebola response.

Our global health security work is enhancing the world's ability to respond to other emerging health threats. More than 70 countries have an FETP program, resulting in more than 12,000 graduates around the world. In Liberia, improved laboratories, epidemiology training, surveillance, and surge capacity resulted in the identification of an April 2017 meningitis outbreak within one day of the first discovery of a case. By comparison, it took 90 days for the country to recognize the first Ebola case in 2014. The Uganda Virus Research Institute has emerged as a regional reference laboratory for viral hemorrhagic fevers thanks to collaboration with CDC and its subject matter experts. In addition, Uganda's Public Health Emergency Operations Center, established with CDC support in 2013, is a model for other global health security program countries. This center has been activated for over 75 outbreaks and public health events. With this improved capacity, Uganda has detected 16 viral hemorrhagic fever outbreaks as of July 2018, and responded quickly to keep outbreaks small and contained, including the three Ebola cases identified in June 2019. They also detected a yellow fever outbreak in spring of 2016 in only four days, compared to over 40 days that it took to identify the yellow fever outbreak of 2010.

Another important component of CDC's global health work is the agency's ability to monitor threats globally and to provide rapid response through deployment of staff from across the agency. CDC's Global Emergency Alert and Response Service (GEARS) closely monitors 35 to 45 outbreaks a day through event-based surveillance and supports emergency deployments to respond to selected outbreaks. GEARS brings together the Global Disease Detection Operations Center (CDC's electronic surveillance analysis and response system for global threats) and the Global Rapid Response Team, which has trained over 500 CDC personnel who have provided nearly 22,000 person-days of response support.

One way that CDC ensures our domestic preparedness is through building global capacity in health security. As we saw during the West Africa Ebola epidemic, the current measles outbreak, and the Middle East Respiratory Syndrome (MERS) outbreak, infectious disease threats do not respect borders. An outbreak that starts in another country could reach us in a matter of hours; this is why CDC works globally to stop health threats before they enter the United States.

CONCLUSION

CDC's number one priority during any public health emergency is to save lives. CDC never loses sight of its primary mission to protect the health and safety of the American people, and we know that global health security is national security. CDC works overseas to ensure that health threats do not reach the U.S., most importantly by working to stop these threats where they start. CDC works to protect the United States from direct health threats, protect U.S. interests in global economic security, and ensure that lessons learned overseas can be applied here to increase the strength of the U.S. public health system. While significant progress has been

made, we know that we will continue to see the emergence of both known and unknown threats that will require the laboratory and surveillance infrastructure that CDC continues to support. The current Ebola outbreak remains a particular challenge for DRC and the global health community, and there are no signs that the outbreak is slowing. However, CDC's global health programs have allowed us to build strong working relationships with the DRC and surrounding countries' ministries of health, and we will continue to work with USAID and our sister agencies in the Department of Health and Human Services, as well as WHO and other international partners, until we stop this particularly challenging outbreak.

The ability to rapidly detect and effectively respond to threats to the public's health is a top priority for CDC. CDC works around the clock to not only ensure its readiness but the readiness of those on the front lines. CDC remains vigilant, because at any given moment, thousands of infectious diseases are circulating in the world. We don't know exactly which outbreak or potential pandemic threat is coming next, but we know it is coming. The work we do now ensures that, when the next major outbreak or pandemic threat does arrive, we are able to protect the health of Americans and save lives.

STATEMENT OF REAR ADMIRAL TIM ZIEMER, USN, RETIRED, SENIOR DEPUTY ASSISTANT ADMINISTRATOR, BUREAU FOR DEMOCRACY, CONFLICT, AND HUMANITARIAN ASSISTANCE, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT, WASHINGTON, DC

Mr. ZIEMER. Chairman Graham, Ranking Member Kaine, members of the subcommittee, thanks very much for this opportunity to speak to you about the U.S. response to this Ebola outbreak.

Senator Graham, you have already summarized the challenge. This deadly virus has appeared in one of the most insecure areas of the world, endangering lives of people made vulnerable by deadly violence and contributing to the population's distrust of outsiders. It is really a perfect storm. Reaching affected communities with proven and tested health interventions has been undermined and interrupted by attacks on health care workers. Over the last couple days, 14 deaths were reported, not all on health care workers.

While mostly contained in two provinces, the Ebola outbreak is now a regional issue, as punctuated by the World Health Organization's declaration of the public health emergency.

USAID has been at the forefront of this response since the outbreak began. With the additional $38 million that we announced today, USAID's contribution to the Ebola response is $136 million. Our partners have strengthened infection prevention and control in over 360 health facilities and dispensaries, trained more than 19,000 health care workers, patient screening, isolation, and triage, and have reached over 2.1 million people with key health messages.

As the lead coordinator of the U.S. Government response in DRC supporting Ambassador Hammer, the DART team works very, very closely with CDC, the State Department, and our other government agencies.

I traveled to DRC in May, followed quickly by the trip by Administrator Green that you mentioned. Our visits confirmed while a lot has happened, a shift in strategy was needed. And I am pleased to say that reset is underway. And it takes a more comprehensive humanitarian approach. With strong leadership from Ambassador Hammer and coordinated efforts across the entire interagency, the reset is supporting a greater cross-border response, and it is also

strengthening the health response and tightening financial accountability and transparency. Progress is being made. The emphasis on border surveillance and local capacity has helped quickly contain the virus, as illustrated by the cases that popped up in Uganda a couple weeks ago.

So in the last several weeks, other significant adjustments have been made such as the assignment of Mr. David Gressly as the U.N. Emergency Ebola Response Coordinator to preside over the entire coordination and leadership of the response. We are expecting the release of the new strategy in a couple weeks that aligns the humanitarian objectives with the public health efforts. This strategy will set funding requirements which the U.S. Government will use to solicit increased funding and burden sharing from other governments.

So in the near term, cases will likely increase, but we expect that the approaches outlined in the reset will help DRC turn the tide and contain this deadly virus.

So in the long term, through the Global Health Security Agenda that Admiral Mitch Wolfe just mentioned, USAID will continue to work with CDC, as well as the Department of State and other agencies, to build the capacities of countries to prevent, detect, and respond to future outbreaks. A threat anywhere is a threat everywhere. And we are committed to containing this outbreak and other outbreaks at the source. So we are working closely with our interagency partners in a very coordinated effort to bring our funding, our technical assistance, and all the U.S. Government resources to bear. To bring this outbreak to an end is a challenge, but it is not insurmountable.

So thanks for your time, most importantly for your interest in calling this hearing, and for your leadership. And we look forward to answering your questions.

[The prepared statement of Mr. Ziemer follows:]

PREPARED STATEMENT OF REAR ADMIRAL TIM ZIEMER, USN, RETIRED

Chairman Graham, Ranking Member Kaine, members of the subcommittee, thank you for the opportunity to speak with you today about the U.S. response to the ongoing Ebola outbreak in the Democratic Republic of the Congo (DRC), and for your interest in this important issue. Since August 2018, the DRC has been facing what is now an unprecedented Ebola outbreak in the country, with 2,578 confirmed and probable cases and 1,737 deaths as of July 21, 2019. It is the world's second-largest recorded outbreak of the disease, eclipsed only by the 2014 West Africa outbreak that resulted in nearly 29,000 cases and killed more than 11,000 people. On July 17, 2019, the World Health Organization (WHO) declared it a Public Health Emergency of International Concern, a status only announced when there is an "extraordinary event" that is determined "to constitute a public health risk to other States through the international spread of disease" and "to potentially require a coordinated international response." This declaration is only the fifth one of its kind that the WHO has made since the adoption of the International Health Regulations in 2005.

This ongoing Ebola outbreak is more than just a public health crisis—it is happening in the midst of a complex humanitarian crisis that has left 12.8 million people in need of assistance in the DRC. While the DRC has faced nine previous Ebola outbreaks, this is the first in Provinces that already suffer from chronic humanitarian needs—like the lack of food, safe drinking water, and shelter.

In May, I traveled to Eastern DRC and saw the scale and complexity of this outbreak and the response firsthand. I have traveled extensively in my career, from my 3 decades with the U.S. Navy and in the roles I have held since. This trip to the DRC was one of the most important trips I have ever taken. I heard directly from local traditional and religious leaders, as well as our partners, about the ongo-

ing violence and community distrust towards the response driven by years of corruption and political and governance failures in the region, which makes this outbreak more difficult to contain.

This outbreak is far from controlled. In recent weeks, it has become clear that this could become a regional issue, as we have seen cases move dangerously close to neighboring Rwanda and South Sudan. In Uganda, three cases were detected in June 2019, although those cases were later recorded officially as DRC cases since that is the country where they originated. The U.S. Government is aggressively adapting our strategies, and working with our interagency and international partners, including the Government of the DRC the WHO, and the U.N. humanitarian agencies to help reset our approach to the response to stop the spread of the disease.

USAID has contributed more than $98 million for the response efforts to date, and will continue to invest and provide vital support until this disease is contained. Bringing an end to this devastating outbreak is a top priority for the U.S. Government, because we are committed to reducing the suffering of those affected by Ebola, and because effective efforts to contain and end the outbreak can prevent it from reaching the broader region, as well as our borders.

UPDATE ON THE OUTBREAK IN THE DRC

Next week, we will mark one year since the Government of the DRC declared the current Ebola outbreak in North Kivu Province in Eastern DRC. Within 2 weeks of that declaration, confirmed cases were reported in neighboring Ituri Province. By mid-October, increased transmission in hospitals and health facilities led to a spike in cases in Beni, which made it the epicenter of the outbreak at the time. Today, Beni is a hotspot for transmission, alongside Mabalako, Katwa, and Butembo, as the virus continues to spread in the region as a result of community deaths, high population mobility, and other factors, with 25 Health Zones throughout North Kivu and Ituri Provinces affected as of July 15.

Regional spread remains a very serious concern. On July 14, the DRC confirmed its first case in Goma, a city of more than a million people near the border with Rwanda and a major transit hub in the region. In addition, a case was recently confirmed in the DRC's Ariwara Health Zone, in Northern Ituri Province, fewer than 45 miles from South Sudan and 7 miles from Uganda.

Complicating an already difficult response to this deadly disease, this outbreak is occurring in areas with ongoing fighting between multiple armed groups, which leads to access constraints and the intermittent suspension or modification of ongoing activities, including those of USAID partners. A little more than a week ago, two health care workers were deliberately targeted and killed in Beni, which highlights how dangerous this outbreak has been for the brave people who are risking their lives in responding. In the week following my recent visit, the Katwa Ebola treatment unit (ETU) was attacked—not for the first time—killing one guard, and a militia attacked a hotel in Butembo housing Ebola responders, killing several people and halting response operations for several days. Every day that health teams are absent from an outbreak area because of a security incident is a lost day of critical response activities that can save lives.

The outbreak is also spreading in an area with a long history of deeply-rooted community distrust—which at times has exploded into violence against frontline workers—of the central government, foreigners, and people from other regions in the DRC because of decades of neglect, corruption, exploitation, and violence. This deep mistrust has also fueled misconceptions that Ebola was created to wipe out populations or extort money from people. Faith and community leaders told me about feeling exploited by the "Ebola economy" and about their deep suspicion regarding the motives of the sudden and dramatic presence of outsiders. This was a sobering reminder for me that communities do not trust the response.

RESPONSE AND RESET

There is no question that our interventions thus far have saved lives and prevented a much larger outbreak. The more than $98 million USAID has provided for the Ebola response in the DRC to date has been supporting life-saving assistance, including activities to prevent and control infections, training for health care workers, community engagement, the promotion of safe and dignified burials, and food assistance for affected people, including Ebola contacts under monitoring and their families, patients in Ebola treatment centers, and discharged survivors.

Last September, the U.S. Government deployed a Disaster Assistance Response Team, or DART, which built upon early assistance from USAID and the Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services (HHS). The DART is the lead coordinator of the United States'

whole-of-government response to the Ebola outbreak in the DRC. This expert team—composed of disaster and health experts from USAID and HHS—is working tirelessly to identify needs and coordinate activities with partners on the ground. By augmenting ongoing efforts to prevent the spread of disease and by providing aid to help Ebola-affected communities, the DART provides a forward-leaning, flexible, efficient, and effective operational and coordination structure to mount the U.S. Government response.

There has been clear progress because of their efforts and the work being done by our partners on the ground to stop the spread of Ebola. We have helped train 1,680 community health care workers to conduct surveillance, equipping them with knowledge and tools to track the disease and stop the chains of transmission. We have also trained more than 19,000 Congolese health care workers in patient screening, triage, isolation, appropriate waste-management, and other practices that prevent the transmission of disease. These practices are helping strengthen measures to prevent and control infections in at least 309 health facilities across at least 18 Health Zones. Our partners continue to provide treatment and care that help increase the chance of survival for people with Ebola, and USAID is ensuring they have the supplies they need to operate, including by providing 53 metric tons of personal protective equipment at more than 100 health facilities. Additionally, USAID has funded the provision of enough food to meet the needs of 300,000 people—including Ebola patients, contacts, survivors, and their family members.

Our experience with this outbreak so far, and the 2014 West Africa outbreak, has shown us that community acceptance and ownership is crucial to the success of this response. USAID is funding partners to dispel rumors about the disease through community outreach—including by working with trusted community leaders—to increase acceptance of public health response activities. Our partners are working to reach 508,000 households, or 2.1 million people, with key health messages to engage communities in conversations about Ebola, debunk myths, and raise awareness about the transmission of Ebola.

Despite all of our efforts, it became clear during my trip to the DRC that insecurity, poor coordination, the underutilization of key partners like non-governmental organizations (NGOs) and faith-based groups, and insufficient community engagement were hindering response efforts. This is in part why, soon after my return to Washington DC, the U.S. Government began to shift towards a complete reset of the U.S. response towards a more comprehensive humanitarian and development approach that responds to the broader needs of the community to help improve the community's perceptions and attitudes towards the public health interventions. Following my trip in June 2019, Administrator Green also travelled to Butembo to see the Ebola emergency first-hand, and it was very clear to him that this was a development emergency in the DRC.

With this critical context in mind, the U.S. Government has four key strategies to achieve this reset: (1) enhancing response leadership and coordination; (2) strengthening community engagement; (3) addressing the complex security environment; and (4) strengthening preparedness, in both the DRC and the surrounding countries.

First, strong leadership and coordination is critical to making this response more effective, which is why we are optimistic about the appointment of United Nations Emergency Ebola Response Coordinator David Gressly in May. USAID has emphasized the need for clear lines of leadership and accountability to strengthen his ability to oversee response functions to support the Government of the DRC's and the WHO's lead of the public-health response. Overall, leadership for this response must be more inclusive, and directly involve the local and international NGOs that are vital to the response. These organizations must be better engaged and active in coordination efforts, because they deliver assistance that complements efforts by the Government of the DRC and U.N. agencies and because they have the trust of the affected communities. The U.S. Government, along with other lead donors, also continues to advocate for strategic shifts, like including civil society, faith-based organizations, and NGOs in coordination structures. USAID is also closely collaborating with our interagency partners—like HHS and the HHS National Institutes of Health—along with the Government of the DRC, other donors, the WHO, the U.N., international partners, and civil society to battle this disease. For example, we worked with these key partners to provide input into the development of the latest Strategic Response Plan for the outbreak, the public-health portion of which was just released earlier this month, to guide efforts over the coming months. We are also continuing to encourage other donors to contribute resources to this Ebola response, including governments that have already provided modest assistance.

Second, Congolese communities must be at the center of what we do, which is why we are working to shift the response from a top-down approach to one that elevates

the communities' role and prioritizes their needs and feedback. As such, the U.S. Government is continuing to emphasize community engagement across the response—from the DRC Ministry of Health to the WHO and USAID partners, many of which have found innovative ways to connect with communities. One of our partners, for example, worked with a music festival in Goma to get Ebola-prevention messages out, which reached more than 37,000 people with handouts and fliers; musicians even incorporated these messages into their sets. USAID's partners are also engaging with journalists, to get them to take to the airwaves, create mini movies, and organize groups on the WhatsApp social messaging platform to educate people about Ebola and stimulate discussions. We are increasing emphasis on community dialogue and actively looking to involve a wider cross-section of organizations, like local women's, youth, and faith-based groups. One of our partners is working with young people to change their perspectives on Ebola-related rumors, and has trained them to communicate about Ebola and mobilize their peers in the response. Our partners have also hired local people—including Ebola survivors—to be a part of the response in their own communities, and are reaching out to respected local leaders to deliver Ebola prevention messages in local languages. Ultimately, we are working to listen to local needs, incorporate feedback, and ensure we are doing all we can to foster positive changes in the relationship between communities and Ebola responders.

Third, we must do more to address the complex security environment. This is imperative to fully earning the trust of communities and gaining their participation in the response. The affected communities have long experienced armed conflict, and have suffered for years prior to this outbreak. Our response must acknowledge how this insecurity has affected them and their beliefs about the disease. Given all that these communities have been through, we must be cautious of militarizing the response. We should energize leading responders to utilize common humanitarian techniques, including transparent information-sharing, negotiations on how to gain access to affected communities, and engaging local community leaders in discussions and tactics on security that benefit the entire community, not just responders.

Fourth, with the continued threat of spread to countries that neighbor the DRC, we must do more to strengthen preparedness both in other high-risk areas in the DRC, as well as in Burundi, Rwanda, South Sudan, and Uganda. This is why we have been looking outside of the DRC's borders to provide the support and expertise needed to keep the disease from spreading. Part of this line of effort must be a more aggressive approach to vaccination, which should include the use of the second available vaccine to help build a firewall around the outbreak zone.

PREPAREDNESS AND PREVENTING EBOLA FROM CROSSING BORDERS

We are intensely concerned that this outbreak could soon become a regional issue, as it moves closer to the borders of countries that neighbor the DRC. We are continuing to strengthen health surveillance activities at borders, as well as train health workers and strengthen local capacity within the countries to respond efficiently and effectively to case alerts. In these neighboring countries, we are supporting Ebola preparedness efforts that strengthen local capacity to detect the disease; train screeners and screen travelers at key points of entry; track cases if they occur; maintain water, sanitation, and hygiene facilities; improve the prevention and control of infections in health facilities: vaccinate at-risk workers; and conduct public awareness and sensitization campaigns about Ebola.

USAID is also funding Ebola preparedness efforts in Goma, as well as in Provinces adjacent to North Kivu and Ituri, to help ensure that the virus does not spread any further within the country. Our efforts also account for how the humanitarian situation in the DRC affects the movement of people. Factors such as poor infrastructure, forced recruitment into armed groups, and ongoing violence have contributed to the deterioration of humanitarian conditions and triggered mass internal displacement and refugee outflows.

These efforts have never been more critical: With the confirmed case in Goma at the beginning of last week, the outbreak is now nearing the Rwanda border. Earlier this month, a confirmed case in Ariwara Health Zone brought the outbreak fewer than 45 miles from the South Sudan border. Most concerning, three confirmed cases of Ebola, in individuals all of whom later died, were detected in Uganda in June, which marked the first cases of the deadly disease detected outside DRC since the start of the outbreak in August 2018. These cases serve as a reminder that we must stay vigilant. USAID continues to monitor the situation closely, and we will continue to work with partners to support preparedness efforts in these neighboring countries.

Preparing for disease requires a whole-of-society approach across multiple sectors to prevent, detect, and respond to infectious-disease threats as our national Biodefense and Global Health Security Strategies make clear. When crises happen—like the current Ebola outbreak—we work to ensure response groups have the tools and operational structures necessary to respond quickly and effectively.

USAID is also working to promote global health security at the local level by helping at-risk communities develop preparedness plans and train community volunteers to detect and respond to infectious-disease threats in their own neighborhoods. We have developed an emergency supply-chain playbook designed to build country capacity to quickly provide and manage essential emergency commodities, like personal protective equipment, that are critically needed during outbreaks. We are helping countries establish risk-communication programs that provide communities the information needed to reduce disease spread.

CONCLUSION

In conclusion, USAID and the rest of the U.S. Government are well-equipped to help the DRC and neighboring countries respond to this disease, and have begun to reset our response to better adapt to these key challenges on the ground. We have been providing humanitarian and development assistance in the DRC for more than 3 decades, and are familiar with the operating environment and access challenges. While responding to this outbreak is complex, this is a whole-of-government response, which is making the most of each Department and Agency's knowledge and expertise. We are all united in the same goal of helping the people of the DRC to bring this outbreak under control as soon as possible while demonstrating our continued support for the people, families, and communities affected by this devastating disease.

We know that this is more than just a public-health crisis: This is occurring on top of an extended, complex, and violent humanitarian crisis. By placing community needs at the forefront of the response, we can strengthen the relationship between communities and the so the public health interventions can be more effective. Thank you for your time. I look forward to answering your questions.

STATEMENT OF HON. MARCIA BERNICAT, PRINCIPAL DEPUTY ASSISTANT SECRETARY, BUREAU OF OCEANS AND INTERNATIONAL ENVIRONMENTAL AND SCIENTIFIC AFFAIRS, U.S. DEPARTMENT OF STATE, WASHINGTON, DC

Ambassador BERNICAT. Chairman Graham, Ranking Member Kaine, distinguished members of the committee, thank you for inviting me here to speak today. I am honored to appear as part of a team of officials and colleagues who represent the whole-of-government approach that the United States brings to the Ebola response.

The ongoing Ebola outbreak in the Democratic Republic of Congo is the second largest in human history. For nearly a year, brave responders, with strong U.S. support, have been working to stop Ebola's spread and treat the ill. Their efforts have saved countless lives, but new cases continue to emerge. We are now at a critical juncture. Ebola cases continue to rise. Ebola patients continue to die, and local communities and responders have not been taking all the necessary steps to end the outbreak. And in some cases, as we have noted, communities are actively, even violently, resisting Ebola response efforts. The risk of Ebola spreading to additional areas of the DRC or neighboring countries remains high, as demonstrated by the three confirmed cases in Uganda in early June and the case in Goma last week.

At the same time, there is reason for hope. The DRC and neighboring governments are taking action to prevent Ebola cases, detect possible infections, and respond quickly to treat patients. The World Health Organization and the United Nations are improving coordination with nongovernmental organizations and local commu-

nities. And the United States, as it has since the first Ebola cases emerged, continues to take a leading role to end the outbreak.

As you noted, Senator Graham, ending this outbreak is not only a global health security priority—it is a U.S. national security priority. And as my colleague said, an infectious disease threat anywhere can be an infectious disease threat everywhere, as we saw vividly in 2014. The United States Government is firmly committed to stopping this pandemic. We are the largest single country donor, and we have continuously deployed staff to the DRC and neighboring countries to enable a more effective response.

Our whole-of-government approach is critical to stopping this outbreak, which is occurring in the midst of a complex humanitarian crisis and tremendous security challenges from local armed groups. The Government of the DRC and the WHO have led the response since the first cases emerged nearly a year ago. Government officials in Uganda, Rwanda, Burundi, and South Sudan have also demonstrated leadership by increasing preparedness efforts to prevent, detect, and respond to Ebola cases. And the United Nations' designation of David Gressly as U.N. Emergency Ebola Response Coordinator on May 23 is enhancing the response coordination and addressing the broader humanitarian and security conditions impacting the response. The World Bank has provided significant resources and helped ensure financial accountability of response efforts. Other core donors include the United Kingdom and the European Union. And NGO staff and the Congolese citizens themselves are the backbone of the on-the-ground response efforts to identify and treat Ebola patients and their contacts.

The State Department has also raised international awareness of the DRC Ebola outbreak and is encouraging the international community to fully fund the response. We convened a meeting of the DC diplomatic corps on June 14 where USAID, CDC, and State Department officials briefed on the outbreak's trajectory and underlined the urgent need for funds. On July 14, the DRC Government and World Health Organization released a partial new response plan requesting $287 million over the next 6 months to fund the public health response. Additional appeals for support in other sectors beyond health are forthcoming.

The State Department and our embassies' country teams are regularly engaging our foreign counterparts from the DRC to the WHO to the DRC's neighbors at the highest levels to make the Ebola response a priority and to enhance coordination across governments and donors.

Thank you for your time, your consideration, and your interest. I welcome the opportunity to respond to your questions.

[The prepared statement of Ambassador Bernicat follows:]

PREPARED STATEMENT OF HON. MARCIA BERNICAT

Chairman Graham, Ranking Member Kaine, and distinguished members of the Committee, I want to thank you for inviting me to speak today. I am honored to appear as part of a team of officials who represent the whole-of-government approach that the United States brings to the Ebola response.

The ongoing Ebola outbreak in the Democratic Republic of the Congo (DRC) is the second-largest in human history, with more than 2,500 cases and over 1,700 deaths since August 2018. For nearly a year, brave responders—with strong U.S. support—have been working to stop Ebola's spread and treat those infected. Their efforts

have saved countless lives, but new cases continue to emerge. We are now at a critical juncture. Ebola cases continue to rise, Ebola patients continue to die, and local communities and responders are not taking all necessary steps to end the outbreak. In some cases, local communities are actively, even violently, resisting Ebola response efforts. The risk of Ebola spreading to additional areas of the DRC or neighboring countries remains high, as demonstrated by the three confirmed cases in Uganda in early June and the case in Goma last week.

At the same time, there is reason for hope. The DRC and neighboring governments are taking action to prevent Ebola cases, detect possible Ebola infections, and respond quickly to treat Ebola patients. The World Health Organization (WHO) and the United Nations are facilitating improved response coordination with nongovernmental organizations and local communities, taking security and humanitarian needs into account. And the United States—as it has since the first Ebola cases emerged in eastern DRC—continues to take a leading role to end the outbreak.

At the outset of my testimony, I would like to make one point clear. Ending this outbreak is not only a global health security priority—it is a U.S. national security priority. An infectious disease threat anywhere can be an infectious disease threat everywhere as we saw vividly in the 2014 West Africa Ebola outbreak. The U.S. Government is firmly committed to stopping Ebola's transmission, supporting the treatment of those infected, and minimizing the loss of life in this outbreak. The United States is the largest single-country donor to response efforts, and we have deployed staff to the DRC and neighboring countries to enable a more effective response.

We have seen time and again how critical a whole of government approach is to stopping epidemics and pandemics. This is especially true for this Ebola outbreak, which is occurring in the midst of a complex humanitarian crisis and tremendous security challenges from local armed groups. Stopping Ebola transmission in this case also requires a multi-government approach. The Government of the DRC and the World Health Organization (WHO) have led the response in the DRC since the first cases emerged nearly a year ago. Government officials in Uganda, Rwanda, Burundi, and South Sudan have also demonstrated leadership by increasing preparedness efforts to prevent, detect, and respond to Ebola cases. The United Nations designated David Gressly as U.N. Emergency Ebola Response Coordinator on May 23 to enhance response coordination and address broader humanitarian and security conditions impacting the response. The World Bank has provided significant resources and helped ensure financial accountability of response efforts. Other core donors include the United Kingdom and the European Union. And NGO staff and Congolese citizens themselves are the backbone of on-the-ground response efforts to identify and treat Ebola patients and their contacts.

The State Department has championed efforts to raise international awareness of the DRC Ebola outbreak and encourage the international community to fully fund the response. My bureau convened a meeting of the DC diplomatic corps on June 14 where USAID, CDC, and State Department officials provided a briefing on the outbreak's trajectory and underlined the urgent need to fund response activities. On July 14, the DRC government and World Health Organization released a partial new response plan requesting $287 million over the next six months to fund the public health response. Additional appeals for support in other sectors beyond health are forthcoming, and it is imperative that we diversify the donor pool to meet resource needs. On July 17, WHO declared the outbreak a Public Health Emergency of International Concern (PHEIC), which we hope will mobilize more resources. All countries must contribute to ensure global health security.

The State Department has also been regularly engaging foreign counterparts in the DRC, the United Nations, the WHO, and the DRC's neighboring countries to enhance response coordination. Our embassies and country teams are engaging foreign counterparts at the highest levels to make the Ebola response a priority—and to enhance coordination across government ministries and donors.

Thank you for your time and consideration of this important issue, and I welcome the opportunity to answer any questions you may have.

STATEMENT OF HON. TIBOR NAGY, ASSISTANT SECRETARY, BUREAU OF AFRICAN AFFAIRS, U.S. DEPARTMENT OF STATE, WASHINGTON, DC

Ambassador NAGY. Mr. Chairman, Ranking Member, and distinguished members, thank you for the opportunity to testify today on the State Department Bureau of African Affairs' efforts to combat

the ongoing Ebola outbreak in eastern Democratic Republic of Congo.

This panel serves as a reminder that the Ebola response is a whole-of-U.S. government effort, and I am grateful that my colleagues and I are in this fight.

My remarks today briefly summarize the longer and more detailed statement which was previously submitted for the record.

The Ebola outbreak in eastern DRC, now declared by the World Health Organization to be a public health emergency of international concern, continues to devastate the region. The DRC successfully handled nine previous Ebola outbreaks with capacity and expertise built up over decades of close cooperation with the United States. However, this 10th outbreak, now the second longest in history, is different as it is in a conflict zone.

Eastern DRC is not new to instability. Longstanding regional and local tensions fueled wars that killed millions in the 1990s and 2000s. Clashes persist to this day in Ituri and North Kivu where the Ebola outbreak continues to spread. Local populations have faced decades of armed group attacks, food in security, poverty, outbreaks of measles, cholera, other diseases.

The recent surge of international attention on the Ebola response stands in stark contrast to a record of neglect on these other problems. This glaring dichotomy has led local militia and frustrated community members to lash out and target health care facilities and workers. It underscores more than ever the necessity of engaging communities and local leaders to garner buy-in for the response.

The United States is working closely with the DRC Government, U.N., and WHO on this response. The historic transfer of power to President Felix Tshisekedi in January opened a new chapter in the U.S.–DRC bilateral relationship. With President Tshisekedi, we are optimistic that we have a willing partner receptive to U.S. and international support to contain the outbreak.

Embassy Kinshasa is fully engaged in supporting the entire U.S. Government response in the DRC. The Kinshasa team has not only kept up with increasing policy and logistical demands from the Ebola outbreak, but also accelerated its diplomatic overreach, oversight, and reporting. The embassy has expanded its operations to support a surge of U.S. temporary duty personnel to Kinshasa and Goma where we did not previously have an established presence. Ambassador Hammer has proactively supported a constant stream of high level U.S. and U.N. visitors to the East, to increase attention and demonstrate U.S. commitment to this response. From our embassy in Kinshasa, we engage in diplomacy across the entire country, which in distance stretches almost from my driveway in west Texas to here in Washington, DC.

At the same time, our Embassies Bujumbura, Juba, Kampala, and Kigali have consistently urged the most senior members of their host governments to strengthen efforts to prevent the outbreak's spread. Burundi, South Sudan, Uganda, and Rwanda are vulnerable to the spread of Ebola and must remain vigilant, evidenced by recent cases in Uganda and in Goma City, a major transportation hub.

The existing humanitarian crisis and Ebola outbreak has already caused tremendous harm to Congolese people and threats to the broader region. Our response must address the complex, underlying factors exacerbating the outbreak and impede its spread. The Bureau of African Affairs is here to offer the full suite of diplomatic tools to assist Congo and facilitate the work of our partners.

Thank you for your time and consideration, and I look forward to your questions.

[The prepared statement of Ambassador Nagy follows:]

PREPARED STATEMENT OF HON. TIBOR NAGY

Mr. Chairman, ranking Member and distinguished Members, thank you for the opportunity to testify today on the State Department Bureau of African Affairs' efforts to combat the ongoing Ebola outbreak and humanitarian crisis in eastern Democratic Republic of the Congo (DRC). I am pleased to be here with my colleagues. This panel serves as a reminder that the Ebola response is a whole-of-U.S.-government effort, and I am grateful that my colleagues and I are in this fight.

The Ebola outbreak in eastern DRC, now declared by the World Health Organization (WHO) to be a Public Health Emergency of International Concern (PHEIC), continues to devastate the region, with tragic loss of life and disruption of social and economic livelihoods. The DRC successfully handled nine previous Ebola outbreaks, with capacity and expertise built up over decades of close cooperation with the United States, especially CDC. However, this 10th outbreak in eastern DRC—now the second largest in history—is different, as it is in a conflict zone. Health responders have been attacked and we mourn the loss of heroic Congolese and WHO health workers who have been killed. This insecure environment has challenged the international community's standard operational response, strengthened after the 2014–2016 West Africa outbreak, and hampered the U.S. Government's ability to stop the outbreak at its source. As a result, the Africa Bureau and Embassy Kinshasa have worked closely with technical and policy experts across USAID, the Department of Health and Human Services, and the U.S. interagency to demand a fresh start and "reset" of the response to better address the unique context in which this outbreak is occurring.

EASTERN DRC CONTEXT

Eastern DRC is not new to instability. Longstanding regional and local tensions with deep-rooted grievances have fueled wars that killed millions in the 1990s–2000s and clashes persist to this day in Ituri and North Kivu provinces, where the Ebola outbreak continues to spread. Numerous armed groups operate in the region, conducting attacks that have harmed and killed thousands of Congolese civilians over decades. Despite the DRC being home to tremendous natural resource wealth, the Congolese people have seen little economic benefit, particularly in the mineral-rich and agriculturally fertile current outbreak zone.

Food insecurity plagues local populations, and outbreaks of cholera, polio, and malaria continue to take the lives of innocent Congolese throughout the country. Although not specific to the East, the current measles outbreak in the DRC has sickened over 110,000 people and killed over 1,800 in 2019 alone. This overall humanitarian crisis and intercommunal violence has led to significant internal displacement as well as to Congolese fleeing to neighboring countries.

With poor infrastructure, rampant corruption, economic stagnation, and years of governance failures in the East left unaddressed by the previous DRC administration, local populations are disillusioned and fed up. An "Ebola economy" is developing, where despite our best intentions, the international response is exacerbating economic divides in a historically impoverished area. The surge of international attention on the Ebola response stands in stark contrast to a record of neglect on other health, political, and social problems the East faces.

This glaring dichotomy has led local militia and frustrated community members to lash out and target healthcare facilities and workers. It underscores more than ever the necessity of engaging communities and local leaders to garner buy-in for the response.

U.S. EMBASSY ENGAGEMENT

The DRC government, alongside the U.N. and WHO, is leading this response, building on their decades of experience. The historic transfer of power to President

Felix Tshisekedi in January 2019 has opened a new chapter in the U.S.–DRC bilateral relationship, defined by our statement announcing a Privileged Partnership for Peace and Prosperity that elevates our bilateral relationship and strengthens cooperation on issues ranging from anti-corruption to human rights to institutional strengthening, among others, and including the Ebola response. With President Tshisekedi, we are optimistic that we have a willing partner and new administration receptive to U.S. and international support to contain the outbreak.

I heard this commitment firsthand during President Tshisekedi's visit to Washington in April and have seen it since demonstrated by his recent travels to eastern DRC. There, he has personally advocated for Ebola response efforts and encouraged popular local figures to lend a voice in support of community acceptance and participation in response and preparedness measures.

The U.S. Government will continue to work closely with new U.N. Emergency Ebola Response Coordinator David Gressly, the WHO, the DRC Presidential Steering Committee on Ebola led by Director Dr. Jean-Jacques Muyembe, and the DRC Ministry of Health, to improve communication and coordination across the public health and humanitarian response. We are thankful to be working alongside Congolese medical professionals who have for years navigated logistical and bureaucratic obstacles, limited resources, community sensitization, and other challenges to protect not only the Congolese people, but the world as a whole, from the spread of Ebola.

Embassy Kinshasa is fully engaged in supporting the entire U.S. Government response in the DRC. Amidst challenging circumstances, the team in Kinshasa has not only kept up with increasing policy and logistical demands from the Ebola outbreak, but also accelerated its diplomatic outreach, oversight, and reporting on the issue. The Embassy hosted permanent USAID and CDC missions prior to this outbreak. As part of the response, it has expanded its operations to support a surge of USAID, CDC, NIH, and other temporary duty personnel to Kinshasa and Goma, where we did not previously have an established presence or robust mission support. Ambassador Hammer has proactively supported a constant stream of high-level U.S. and U.N. visitors to the East, to increase attention on the outbreak and demonstrate U.S. commitment to the response. Our team has leveraged its close ties with the Tshisekedi administration to encourage the closest coordination possible for information sharing, facilitate access to permissive outbreak zones, and ensure smooth logistical processes from visas to equipment turnover. From our Embassy in Kinshasa, we engage in diplomacy across the entire country, which in distance stretches almost from my driveway in Texas to here in Washington, DC.

While Embassy Kinshasa has carried much of this weight, our Embassy teams in Bujumbura, Juba, Kampala, and Kigali have consistently urged the most senior members of their host governments to strengthen efforts to prevent the outbreak's spread. Burundi, South Sudan, Uganda, and Rwanda are vulnerable to the spread of Ebola and must remain vigilant. Our embassies are working at national, state, and local levels to provide technical and strategic assistance, support preparedness efforts, build trust in communities, improve information exchanges, strengthen border screenings and entry points, and coordinate leadership across ministries of health, elected officials, NGOs, the U.N., and others. These neighbors are suffering from preparation fatigue, despite the WHO's July 17 PHEIC declaration and the recent cases in both Uganda and in Goma city, which shares the busiest pedestrian border crossing in the world with Rwanda. Clearly, the Ebola outbreak requires we redouble our efforts. Few countries are prepared to handle a challenge like Ebola alone, so we call on all our partners to join these efforts.

LOOKING FORWARD

The existing humanitarian crisis and Ebola outbreak has already caused tremendous harm to Congolese lives and livelihoods and taken a significant toll on economic, social, and healthcare services across eastern DRC. Our response to this public health emergency must also address the complex underlying factors exacerbating the outbreak and impeding its control. The State Department's Bureau of African Affairs is here to offer the diplomatic tools in our U.S. Government toolbox, and work alongside host government, U.N., and U.S. interagency colleagues for a unified and comprehensive Ebola outbreak response.

Thank you for your time and consideration. I welcome the opportunity to answer any questions you may have.

Senator GRAHAM. Well, thank you all very much.

This may be one of the hearings that they play the tape back down the road, and I hope not.

Dr. Wolfe, give us sort of the ABCs of Ebola for those that are not as informed as they should be, beginning with me. What causes it? How deadly is it? And why does it keep recurring here?

Dr. WOLFE. Sure. Ebola is endemic in many parts of Africa. Scientists believe it may have reservoir in bats. It is very difficult to predict when outbreaks will happen. It has an incubation period of 2 to 21 days, normally between 8 and 10 days, and has severe symptoms with vomiting, diarrhea, hemorrhagic symptoms, and has a very high mortality.

Senator GRAHAM. Thank you.

Admiral, a national security issue is not much a leap here. Tell us how the whole-of-government approach, the governance part of it, is essential to solving this problem because as I understand it, you got members of parliament basically telling people not to be vaccinated and there is a real effort to chill out health care here.

Mr. ZIEMER. Senator, there are many complicating factors. The role of the government in DRC in transition and their ability to influence the work on the ground is questionable.

In terms of the U.S. approach, we do have a well coordinated approach to that. As I have monitored this——

Senator GRAHAM. But did you not say 35 health care facilities were attacked?

Mr. ZIEMER. More than that, sir, since the beginning of the year.

Senator GRAHAM. So who is doing the attacking?

Mr. ZIEMER. There are an estimated 70 to 90 armed groups. They vary from structure to gangs to just youth members. So there is a variation of the type of activity that is imposing threats.

Senator GRAHAM. Are they looting the facilities or just——

Mr. ZIEMER. Intimidating the health care workers. They have gone in and damaged the Ebola treatment units.

Senator GRAHAM. Are there any African Union forces present?

Mr. ZIEMER. In many cases, there are, and local security as well.

Senator GRAHAM. So the security footprint has to be enhanced. Right?

Mr. ZIEMER. Yes, sir.

Senator GRAHAM. What are we doing to enhance the security footprint?

Mr. ZIEMER. Part of the coordination effort that David Gressly is overseeing is to leverage the existing security.

Senator GRAHAM. What is it? What is the existing security?

Mr. ZIEMER. It is the use of government troops, as well as the MONUSCO troops.

Senator GRAHAM. I mean, do they have a real army they use? Mr. Nagy?

Ambassador NAGY. The security presence has provided several different layers. First, we have the United Nations forces, MONUSCO. They have about 20,000 forces throughout the DRC. In the actual Ebola zone, they have about 3,000.

This gentleman we have been talking about, David Gressly—his previous assignment was to head MONUSCO. Now he has gone over as the chief U.N. coordinator.

Senator GRAHAM. Are these 3,000 troops effective?

Ambassador NAGY. Three thousand troops. They are about as effective as they can be, given the circumstance. I had a conversation

this morning with our Ambassador, and he was actually in the Ebola zone. And I asked him the very same question, and he said that with the recent reset, he is much more optimistic than he has been in the past because of the whole new approach of engaging the villagers.

The fundamental problem in the past—I think we all alluded to it, Senator—was this huge decades of mistrust that had been built up between the communities and any outside government force.

Senator GRAHAM. That seems to me as big a problem as Ebola.

Ambassador NAGY. Absolutely. That is why the complexity that everybody has been talking about—it is like a house of cards. Everything impacts everything else, sir.

Senator GRAHAM. Well, let us just talk about the security. I want to know about this new government. We have hope. Is that correct?

Ambassador NAGY. Yes. President Tshisekedi's new government, yes, sir.

Senator GRAHAM. Do you agree with that, Ms. Bernicat?

Ambassador BERNICAT. Yes, I do, sir. He has visited Washington, DC and met with Secretary Azar. He visited the affected area. He has allowed for the return of one of the political exiles from the region who actually came back to the region, and very publicly received a vaccine. And so he has begun to show leadership in ways that we had not seen——

Senator GRAHAM. What can we do to help him that we are not doing on the security front?

Ambassador BERNICAT. One other aspect that I think is worth pointing out on the security front is that there are any number of people who have distrust of all individuals wearing military or police uniforms.

Senator GRAHAM. I understand that.

Ambassador BERNICAT. Exactly. The government has a very difficult dilemma of how to increase security without increasing distrust. Putting more boots on the ground in many cases is the answer. In this case, it can be a complicating factor.

Senator GRAHAM. Do we have any U.S. forces involved?

Ambassador BERNICAT. No.

Senator GRAHAM. Do we need U.S. forces involved?

Ambassador BERNICAT. No.

Senator GRAHAM. Everybody agrees with that? Okay.

So we have got a new partner. He is doing things that we like. From the Congress' point of view, from the Senate's point of view, I think everybody up here wants to help you. Give us a very quick shopping list with the things we can do to help you in this cause that we are not doing. Not all at once.

[Laughter.]

Senator GRAHAM. Yes, Mr. Nagy.

Ambassador NAGY. I wish money could help in this regard, but the truth is I think that more than anything else, time is going to help. He is having to undo the tremendous damage done by his predecessors. For the first time, we have had President Tshisekedi come to us and say that he wants to engage with the United States as partners for his security.

Senator GRAHAM. We just need to thank him and encourage him to keep doing what he is doing.

Ambassador NAGY. Pardon me, sir?

Senator GRAHAM. We need to thank him and encourage him to do what he is doing.

Ambassador NAGY. Absolutely.

Senator GRAHAM. All right.

Dr. Wolfe, you said before it is not a threat to the United States at this moment. What would make it a threat to the United States?

Dr. WOLFE. Yes, Senator. Currently the risk to the U.S. is low. We analyze transmission dynamics of the epidemic, and when there is a change in the epidemic, we do a risk assessment and look at the strategy that matches that risk assessment. Currently we believe that addressing the outbreak at its source is the best way to prevent spread, and we have many activities to prevent the spread.

Senator GRAHAM. My question is what would be the conditions that would make it a threat to the United States. What are we afraid of?

Dr. WOLFE. There are many different scenarios. And so the best way to prevent spread is to assess the situation and do a risk assessment and look at what strategy is necessary at that time. We have a number of activities that are looking at screening on the border, screening at airports.

Senator GRAHAM. Will you tell this committee when it gets to be a higher threat? How do we know? Will you all tell us?

Dr. WOLFE. Absolutely. So when we do the risk assessments and look at the strategy, we will let you know what our strategy is and what needs to be done.

Senator GRAHAM. Senator Kaine?

Senator KAINE. Dr. Wolfe, I am going to stay with you. You used a phrase in your testimony, "community deaths," that I am not familiar with. Are these deaths that occur not in health care facilities so it is a little hard to track them? Or what does "community deaths" mean?

Dr. WOLFE. That is correct, Senator. So these are deaths that we identify Ebola in somebody who is dead. That means that they were not identified when they were a case. And what is going to control this outbreak is the rapid identification and isolation of cases.

Senator KAINE. I hear you.

Let me ask about vaccination. Over 160,000 people have been vaccinated against Ebola as of July 15, and that includes more than 31,000 health workers. I gather that the vaccination is somewhat experimental.

And I also understand that just in the last week, the health minister of the DRC has resigned. Largely, as I gather, there is sort of a dispute about which vaccine should be used, should both vaccines be used. To have a health minister resign in this situation obviously is a significant challenge. Talk a little bit about what that means and what we are doing, if anything, to help promote stability in the health ministry there. That may be a question more for the State Department side.

Ambassador NAGY. Sure, Senator. Yes, indeed, the minister has resigned because the president was moving away from him. The president had appointed a special Ebola coordinator reporting di-

rectly to the president, a Dr. Muyembe, who has himself been involved with these Ebola emergencies, going back to the initial one in 1976. There is going to be a new health minister anyway when the entire new government is announced hopefully this next week, sir.

Senator KAINE. So you do not view that resignation as a problem. In fact, it may actually be an improvement to the situation. Is that——

Ambassador NAGY. Yes, sir. It may be an improvement to the situation.

Senator KAINE. My understanding is that Rwanda and Burundi, as neighboring nations—they have not dealt with an Ebola outbreak before. So as we are looking at neighbors, some have dealt with it, some have not. What is your assessment of the capacity and preparation among neighboring nations to deal with the outbreak?

Ambassador NAGY. My colleagues can also chime in on that. But from our point of view, Uganda and Rwanda are in very good shape to be able to deal with it. The disaster would be is if it got to South Sudan. With the large refugee populations there, the totally disorganized, dysfunctional, nonexistent government, that could be a disaster.

Senator KAINE. And that goes back to the question the chairman was asking Dr. Wolfe. The things we would need to worry about are travel or people moving into other countries, especially into places that are fairly chaotic, and then that could lead to transmission to all kinds of places, including the United States. Is that a fair concern?

Dr. WOLFE. Since the outbreak started, we have augmented our presence in the neighboring countries to work on preparedness activities with those countries. Some countries are better prepared than others. In Uganda, we have worked there for many years. It highlights the importance of work on global health security and the Global Health Security Agenda, which is a U.S. Government effort and a multinational effort to build capacity of countries to prevent, detect, and respond to infectious disease threats.

Senator KAINE. And this is sort of a sweet spot for this committee because this committee is not just the Subcommittee on Africa, it is also the Subcommittee on Global Health Policy. So that is why this is sort of a little bit of a textbook problem for us to resolve and then use as a template.

Tell us about the status of the vaccine. So there are vaccines that are sort of experimental. I mean, are the vaccines proven. Talk about the quality of the vaccine in terms of dealing with this, and then talk about quantities. Is there sufficient vaccine? Do we need dramatically more? Share that with us.

Dr. WOLFE. So evidence suggests that the investigational vaccine that is being used has efficacy to protect against Ebola, and we feel that it has had a mitigating effect on this outbreak.

Senator KAINE. And this is the vaccine that is a Merck product?

Dr. WOLFE. Correct.

Senator KAINE. There is a second vaccine that is a Johnson & Johnson product that has not yet been used in the DRC. Is that correct?

Dr. WOLFE. Correct. We provide technical assistance to WHO and ministry of health to look at all available resources, and we have been pushing for an aggressive vaccination campaign. I want to highlight that the ministry of health is in charge of the epidemic, and they have decided that they are not ready to use that vaccine.

Senator KAINE. Talk to us about the available quantity of the vaccine in terms of trying to meet the challenge.

Dr. WOLFE. Our goal is to ensure that there is sufficient vaccine to address this outbreak.

Senator KAINE. I know that is the goal, but give yourself a grade on that one right now. Are we at a C minus, or are we at an A? Do we have sufficient quantity?

Dr. WOLFE. We currently have sufficient quantity to address the outbreak. I do not have the additional information on numbers. We could get back with you on that.

Senator KAINE. Admiral Ziemer?

Mr. ZIEMER. There are over 800,000 doses between now and March of 2020 that are in the pipeline. So based on the use and the scale-up strategy, we are watching that very closely. I do know that HHS is working very closely on production schedules and the production line to look at future requirements. When this Ebola outbreak is ended, the use of a vaccine is clearly going to be an essential tool. So Secretary Azar and his team are looking at that.

Senator KAINE. Talk to us a little bit about the community resistance. So I know that with political turmoil, contested elections—is the community resistance connected to political factions, political divides, or rumors that were spread about what the vaccine does or does not do. Share that with us a little bit.

Ambassador NAGY. Yes, sir. It is all of the above. Part of it is historical because historically anytime you see somebody in a uniform, they are there to kill you, rob you, or rape you. The various different militias, the misery and the lack of development that has been in that region now almost since independence. And part of the community's thinking is, okay, we have been through decades of malaria and poverty and abuse, and all of a sudden, there is this new disease and we have all these Westerners showing up with all their resources because they tell us it is so important. We had the same thing in West Africa partially, but it is so much more intense here because of the horrendous abuse that that population has been through and the succeeding governments of the DRC, which just did not care at all about their population, especially that isolated part of the DRC.

Senator KAINE. Thank you, Mr. Chair.

Senator GRAHAM. I think the first vote is about to end. Do you want to adjourn, vote, and come right back? Is that okay, or do you want to keep going? I think we need to vote. What do you want to do, Chris?

Senator COONS. We could have some more questions and then go.

Senator GRAHAM. Well, but the first vote is over. So they are holding it for us. So why do we not vote and come right back. So we will be back in about 15–20 minutes.

[Recess.]

Senator KAINE. We will get the hearing started up again. Senator Graham is on his way back and said we could go ahead and continue. Senator Menendez will question next.

Senator MENENDEZ. Thank you, Mr. Chairman.

Thank you all for your testimony.

Doctor, disease knows no borders or boundaries. Is that fair to say?

Dr. WOLFE. Yes, that is correct. That is how we use the phrase that diseases know no boundaries, and a threat anywhere could be a threat everywhere.

Senator MENENDEZ. So even though, in answer to the chairman's question, you said it is a low risk right now, obviously a greater outbreak of the Ebola virus produces a greater risk. It can be just one flight away—right—from someone who is contaminated before they show the symptoms.

Dr. WOLFE. Yes, sir. Some of the things we look at are the transmission dynamics in the area and what the response capability is and also what the travel patterns are from the areas in the outbreak. So that is something we are constantly——

Senator MENENDEZ. My point in just raising that is that this is about more than being a good global partner. We have self-interests here as well.

It seems to me that the major obstacle to contain the Ebola outbreak in the eastern Democratic Republic of Congo appears to be the lack of adequate access to the affected communities and the decades of insecurity, coupled with political marginalization, has resulted in conditions where not only our health care workers are unable to reach areas subject to militia attack, the very communities that we are trying to have access to have rejected health interventions, even attacking and killing health care workers.

The U.S. intervention in West Africa during the Ebola crisis of 2014 was, I think, instrumental in stopping its spread.

However, in the DRC, the U.S. has to date been unable to provide a full suite of interventions. The administration, for example, refused for months to issue a waiver for sanctions imposed on the DRC as a result of the DRC's tier 3 ranking under the Trafficking Victims Protection Act. USAID briefed committee staff in May on plans for engaging with communities to assess basic needs they may have in addition to Ebola, both in the health care sector and beyond as an improved strategy for gaining access to these communities. It is no good to have you go to a health care center. You may not have Ebola, but you have some other significant disease and you cannot be treated. People do not necessarily find that a reason then to go.

So actions that, until very recently, could not be fully undertaken due to the Trafficking Victims Protection Act sanctions, which were never really meant for that purpose, as one of those who were fully engaged in the TVPA, which brings me to my questions.

Admiral, is any of the fiscal year 2018 funding that was being held by the administration now being used to fund USAID's strategy to go beyond the health sector so as to provide health workers with better access to these communities?

Mr. ZIEMER. Senator, thanks for the question. And first of all, I just want to thank you and the other members for your strong support in this area. It is very much appreciated.

The current investment that has been made by the U.S. Government and USAID, the $136 million, has not been affected by TVPA. I believe you and your staff were aware of that.

The interagency is reviewing the implication of TVPA, particularly as a result of this outbreak and the implications not only in DRC but also in Burundi and South Sudan, which are on the tier 3 list. And we expect to hear a resolution on that very soon, and we will keep you and your staff——

Senator MENENDEZ. So 2018 funding that was being held— is it being used now or not?

Mr. ZIEMER. No, sir, not all of it.

Senator MENENDEZ. Not all of it.

So how long is it going to take for money for those activities to reach the ground?

Mr. ZIEMER. As soon as we get the disposition on the funding and the release of the funding, then——

Senator MENENDEZ. And that is still being held up because of determining whether or not the TVPA is going to continue to affect them?

Mr. ZIEMER. Yes, sir.

Senator MENENDEZ. That is not acceptable.

Is there fiscal year 2018 money that is being reprogrammed out of the DRC, to your knowledge, or Secretary Nagy?

Ambassador NAGY. I do not know, Senator. I can certainly check on it, but I do not know.

Senator MENENDEZ. Admiral, do you know if there is?

Mr. ZIEMER. No, but we will double check the specifics and get back to you.

Senator MENENDEZ. Has fiscal 2019 money been approved for Ebola response activities?

Mr. ZIEMER. On the IDA account, we are continuing to expend funding.

Senator MENENDEZ. Well, I would like not to dwell on it right now, but I would like to get the administration's response to us about—the Trafficking Victims Protection Act was meant to ensure that countries were doing the right things in terms of making sure they were not trafficking in persons. But it certainly was not meant to withhold money in a health emergency like this. That was never envisioned by the Congress. And I hope we can get to that. I know that some of us are offering language to make that clear for now and in the future, but in the interim, we cannot wait for the Ebola virus to break out even more significantly before we respond to it.

Let me ask you, Mr. Secretary, what affect did the cancellation of elections have in terms of further straining relations between Kinshasa and the disenfranchised communities in areas affected by Ebola?

Ambassador NAGY. The eastern DRC was not that significantly affected by the elections. You are referring, sir, to the ones that were won by Tshisekedi?

Senator MENENDEZ. Yes.

Ambassador NAGY. There was not any serious election/ post-election violence there. Unfortunately, that had always been a disaffected region of the DRC. The population there for decades has been very cynical about political developments. Luckily, President Tshisekedi is the first president to have actually visited now the Ebola region. He has been there several times to get the local authorities dynamized to confront it. So his image has really gone up since the inauguration and since his presidency.

Senator MENENDEZ. Is there any impact about our endorsement of Mr. Tshisekedi's questionable victory had on the credibility and our ability to undertake the full range of Ebola-related activities in eastern Congo?

Ambassador NAGY. Senator, from my information and from talking to Ambassador Hammer, it has been just the opposite. The United States' image has actually been much improved because post election, President Tshisekedi's popularity goes up and up.

Senator MENENDEZ. Let me ask you this. On July 2nd, the DRC's minister of health, Oly Ilunga, resigned in protest over President Tshisekedi's decision to take over the Ebola response. By all accounts, he was an effective administrator, a good interlocutor. How does the resignation affect the Ebola response? You mentioned there will be a new health minister at some point, but when do we expect that to happen and why is this taking place when you have somebody who seemed to be working well in the job?

Ambassador NAGY. Senator, my colleagues may be able to chime in also on the technical parts of this, but the president did not have confidence in the health minister. There was going to be a new one anyway. So he brought the whole Ebola issue to the presidency's office by appointing a coordinating committee, I think I mentioned, headed by Dr. Muyembe, who has Ebola expertise going back to 1976. So right now, the Ebola is still being directed out of the presidency, and the truth be told, it has been going on for over a year. So the previous health minister has not been all that effective.

Senator MENENDEZ. So we did not consider her effective or a good interlocutor.

Ambassador NAGY. I think she was a good interlocutor, but as far as the results, I think for the effectiveness speak for themselves, sir.

Senator MENENDEZ. Last question. So we are all in with Tshisekedi then.

Ambassador NAGY. We are very guardedly optimistic, and if you would like, I would be happy to submit a list of President Tshisekedi's positive accomplishments since assuming office, sir.

Senator MENENDEZ. That is not my question. We are all in with Tshisekedi.

Ambassador NAGY. For now, we are. Yes, sir.

Senator MENENDEZ. All right. Thank you, Mr. Chairman.

Senator GRAHAM. Senator Coons?

Senator COONS. Thank you, Chairman Graham, Ranking Member Kaine, for holding this important hearing.

As we have all been discussing, the Ebola outbreak in eastern DRC has now grown into the second worst such outbreak in history, and this is not something we can afford to ignore. The combination of disaffection from the central government, poverty,

under-development, chaos, and distrust makes this an exceptionally dangerous area in which to have a disease of this potential lethality spreading.

This is, I think, an opportunity for us to, again, demonstrate the best of American leadership by helping support and lead a multilateral effort to combat what is a potentially global health and security threat. I do think it is a chance for us to mobilize our traditional allies, as well as others, like China who benefit from the international system, and to strengthen our efforts to make the world more capable of fighting global pandemics.

We have already seen this outbreak cross international borders, and I think if we do not step up now and get ahead of this outbreak, there is a chance it could spread into even more countries, as our witnesses have testified.

I also think it is important we help the DRC and other countries across the region build their resiliency and their capacity to resist further outbreaks. I think the question is not where and if, but when the next major Ebola outbreak will occur.

In 2014, I traveled to Liberia and witnessed the suffering caused by Ebola firsthand and saw a genuinely inspiring, well-coordinated, multilateral effort where the United States played an absolutely essential role, but the Liberian people and their ministries and government did as well, as did many nonprofits and arms of the United Nations.

Ultimately many of us here fought for an emergency spending package which amounted to more than $5 billion, but those costs, both human and fiscal, were well beyond what they could have been had we really confronted it earlier as it grew. And some of those funds, if I understand correctly, are still being used today to combat the current outbreak.

As I said in 2014, that outbreak would not be the last and certainly this will not either. There are very promising developments, as you have said, in terms of two potential effective, widely usable vaccines. But I think we need to prioritize investments in resiliency that will reduce the risks of the next outbreak.

So let me ask, if I could, just a few questions.

First, we have got real tensions with China across a wide range of issues, but Assistant Secretary Nagy, I would be interested in whether you think combating pandemics is an area where we could actually cooperate. There was some Chinese participation in the West African counter-Ebola efforts. Have we encouraged or engaged with the Chinese? Their hesitancy to step up and actually bear the costs and challenges of a world leader I think we should call to question.

Ambassador NAGY. Senator, maybe some of my colleagues know as to what extent if we have had any discussions on the Hill side with the Chinese, but I absolutely support your proposition because there is no reason why we cannot work together with them in those areas where we can. Obviously, we do have trade and other competition with them throughout the world, especially in Africa, but there certainly can be areas of cooperation like in health.

Senator COONS. I think the Global Health Security Agenda is something that deserves a few minutes of focus. It is a partnership of 64 countries. There are stakeholders across CDC, USAID, NIH.

Over the last 5 years, there was a billion dollars in GHSA funding that has supported efforts to build global health capacity to effectively combat infectious disease.

Admiral Ziemer, my understanding is that this pool of funding expires in September. If funding for GHSA is not maintained at current levels in fiscal year 2020, will all the agencies you represent be able to maintain current global health security programming, or will you be required to scale back operations either at CDC, AID, or at State?

Mr. ZIEMER. Senator, thanks for your recognition of the significance of the Global Health Security Agenda. And, yes, the funding that got that started, the $1 billion, came from the original supplemental.

The Global Health Security Agenda is part of this administration's priority. There is funding in the current budget. While modest, it allows us to continue the program.

Senator COONS. How modest, and how does it align with the need?

Mr. ZIEMER. I will have to get back to you on the specific budget.

Senator COONS. But I will take the fact that you described it as modest to suggest that it is well below what may be necessary to sustain robust investment and resiliency in the face of a potential pandemic.

Mr. ZIEMER. Yes, sir. And I think your other point that you made earlier—there is an expectation of burden sharing, other countries stepping up to the plate. In terms of contributions to the current Ebola outbreak right now in DRC, the Government of China has contributed $1 million.

Senator COONS. One.

Mr. ZIEMER. One million, yes, sir.

Senator COONS. Has the WHO not said that funding for Ebola response needs to triple, and that their most recent estimate was there needs to be a total investment of about $320 million to get ahead of the virus?

Mr. ZIEMER. Yes. Senator, the good news is that we have a plan coming together that has specifically identified $384 million—we can get you the figure—to move the health response through the end of the year. The good news is it also is built on four other components, pillars, if you will. The latter one is a $70 million call for country preparedness. For the first time, we are going to have a comprehensive picture of the projected requirements in terms of funding this Ebola response.

The good news this morning, the World Bank made an announcement that they are going to provide $300 million. So with our $36 million, plus what the U.K. has committed, and we are seeing a gradual uptick in some of the other countries, there is an expectation that we will be able to move forward with the current plan.

Senator COONS. That is very encouraging.

I will just say that the United States has now for decades been the principal, the leading funder of public health challenges on the continent at the same time that China has eclipsed us as the largest trading partner, the largest investor on the continent. They are present in literally every country I have been to on the continent. They have expanded their footprint and, frankly, their extractive

relationships with a number of countries. I will be pressing to see them step up to some of this responsibility. The idea that they are investing $1 million and we are investing tens, if not hundreds, of millions strikes me as an opportunity for us to partner.

Mr. ZIEMER. Thank you for your support on that.

Senator COONS. Can I ask a last question, Dr. Wolfe and Admiral Ziemer or Assistant Secretary Nagy, if have any, about the decision to allow U.S. Government personnel either close to or not close to the hot zones? One of the things that really turned the tide in Ebola was the uniformed U.S. Public Health Service setting up a facility right at the edge of the Monrovia airport to guarantee that public health workers in Ebola treatment units, if they contracted Ebola, would get prompt and effective treatment. That was a key piece, the deployment of U.S. military testing labs out into the field into remote areas so that people did not have to come into the capital to confirm whether they had Lassa fever, Ebola, or something else.

Where are we in terms of allowing either CDC or other U.S. personnel to actually be engaged on the ground, and what, if any, recommendation have you made and what do you think we should be doing?

Dr. WOLFE. Yes, Senator. For the past year, we have deployed 200 people to support the outbreak with the ministry of health in Kinshasa, in Goma, in Geneva, and in surrounding countries. So we do have extensive activities there. It is true we have not been able to go directly into the outbreak zone because of security concerns, and we defer to State. We are under chief of mission authority in countries, and they determine where we can deploy.

One thing I would like to highlight is in the recent case in Goma, we were able to deploy directly into outbreak and we were able to provide on-the-ground, real-time strengthening of the response.

Senator COONS. And are you deployed in places like Burundi, South Sudan, in the region that may not have the resiliency that Uganda does where you previously described as if it gets into South Sudan, given the chaos there——

Dr. WOLFE. Yes. We have country offices in South Sudan, Uganda, and Rwanda, and we have augmented those to work on preparation activities with those countries.

Senator COONS. Assistant Secretary, you look as if you could add to this.

Ambassador NAGY. Yes, indeed.

The problem is not with Goma or Kinshasa, but it is with Beni and Bunia. And given the dynamics of the situation and how it changes day to day, we have a very careful policy under chief of mission, under Ambassador Hammer, where the regional security officer, diplomatic security, looks at the proposed travel, evaluates the threats, and then gives their blessing or recommends against it just like we were talking earlier about the CDC person just receiving permission today to shadow the U.N. overall coordinator. It was not an easy decision, and the whole emergency action committee had to take a look at it because of all the armed groups. There is one ISIS-linked terrorist organization operating in North Kivu. So it really is a case-by-case basis and how much has the situation changed.

Unfortunately, as you said, sir, the West Africa situation was so different because of accessibility.

Senator COONS. Do you have any sense how many Americans are in this immediate area who are there perhaps through Samaritan's Purse or Save the Children or Doctors Without Borders?

Ambassador NAGY. I do not have an exact number, but I can certainly find out because I know that there are some that are not under chief of mission authority.

Senator COONS. Because they certainly were in West Africa, literally hundreds of Americans deployed.

Ambassador NAGY. Exactly.

Senator COONS. Admiral, did you have any closing thoughts on what is the most important thing we are not doing that we should be doing to get ahead of this?

Mr. ZIEMER. The ideal situation would be to get the CDC personnel on the deck. We all support that.

I just want to echo what the Ambassador has said, that we are working very hard with the Ambassador and the RSO to look at places that we can flex. The fact that we are in Goma today with a robust CDC and USAID team reflects a forward-leaning strategy. And just within the last couple weeks they have extended the curfew so that teams can get out and operate. So this is an ongoing issue. It is appreciated, and we are doing everything we can to make the right assessment in terms of getting our folks in the field.

Senator COONS. I just want to thank all of you. I really appreciate your testimony, and I appreciate the patience of the chairman and my colleagues on the committee. Thank you very much.

Senator GRAHAM. Thank you. It has been great.

One follow-up question and I will turn it over to my colleagues.

Generally speaking, do you think, with the current resources and engagement, that we got a handle on this? Dr. Wolfe?

Dr. WOLFE. Well, currently the outbreak is not under control, and what we need to do is increase the core public interventions, you know, rapid case identification, rapid isolation.

Senator GRAHAM. So we do not have a handle.

Dr. WOLFE. So we need to improve these core public health interventions. It continues to expand, and we continue to have cases.

Mr. ZIEMER. The current plan, focusing in on the health response, has brought in aspects on how to improve our community engagement, how to improve the political interaction and the security, as well as perimeter support.

So the jury is still out on whether or not this new effort, this international combined effort, will deliver the progress that we need. Right now, I am optimistic that we have mechanisms in place to move us forward, much improved over where we were 6 months ago.

Senator GRAHAM. Ms. Bernicat?

Ambassador BERNICAT. I would say that the aspect we do have a very firm handle on is our policymaking process back here and the number and the quality of people we have deployed in the field who are working not only on the response efforts, as best we can under the conditions, but also to involve more of the international

community by broadening and diversifying the funding sources going forward.

Ambassador NAGY. My perspective, Senator, is more on the governance issue. What they desperately need is positive governance and a professional military. And if Tshisekedi can succeed in that, it will take years not months, but that would flip the Democratic Republic of Congo from being a perennial area of instability to actually exporting stability for a change.

Senator GRAHAM. Do you think that is remotely possible without American leadership?

Ambassador NAGY. Sir, I guarantee you American leadership is there. Our Ambassador is fully engaged with the president, with his government. So I am guardedly optimistic, sir.

Senator GRAHAM. Thank you.

Senator KAINE. If I could just ask one follow-up. Ambassador Nagy, you mentioned the ISIS connection in one of the regions just briefly and I want to get into it because from the security standpoint, it is important. Senator Menendez and Chairman Risch did a hearing in this room earlier this morning about the current military authorizations against al Qaeda and ISIS. We were talking a lot about it. There was an attack in April. DRC soldiers were killed in parts of the country where Ebola has been very widespread. I guess it was the Allied Democratic Forces that claimed responsibility, but then ISIS also claimed responsibility. And the ADF says, or at least are saying, that they want to have more of an ISIS tie. So this, obviously, is the security complicator of getting our people in place. It is not just the health risk. It is now also the risk of these groups with an ISIS connection.

Give us an assessment of ISIS activity. Is that a group in name only that is not particularly effective? Is the ADF really connected to ISIS? Share that with us.

Ambassador NAGY. Obviously, I think we could provide more facts in a different setting. But in this setting, I can say that the ADF is the single one of the many armed groups in that area that has affiliated with ISIS. ISIS has embraced them. There are potentials for exchanges with other ISIS groups, individuals in the area receiving resources. But the ADF is a rather bizarre group because they do not range much beyond their territory because of the ethnic identity, and they do not specifically target Ebola efforts. It just happens that if they are undertaking a violent campaign, that people involved in the Ebola campaign could get caught up in that. So it is definitely a group worth watching. And as I said, I think we could provide additional details in a different setting, sir.

Senator KAINE. Thank you.

Senator GRAHAM. Thank you all. You represent our country very well, and we are here to help. I appreciate your knowledge and level of attention to this. If we are successful, it will be because of your efforts. And if we are not successful, it will not be because you did not try.

So we will hold the record open till Friday for any further comments or questions. Thank you.

[Whereupon, at 4:10 p.m., the hearing was adjourned.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

RESPONSES OF HON. TIBOR NAGY TO QUESTIONS SUBMITTED BY SENATOR ROBERT MENENDEZ

22 U.S.C. Chapter 78, Section 4 of the Trafficking Victims Protection Act provides for the continuation of assistance that would otherwise be sanctioned for failing to meet the minimum standards on trafficking when it is in the National Interest of the United States to waive sanctions. Paragraph Section (d)(5)(B) of TVPA states: "The President shall exercise the authority under section (4) when necessary to avoid significant adverse effects on vulnerable populations, including women and children." According to the World Health Organization, the Ebola virus disease has a mortality rate of 50 percent.

Question. Do we consider the people in eastern Democratic Republic of Congo (DRC) living in Ebola affected regions, or living near those infected with Ebola vulnerable? How many women have been infected with Ebola in this outbreak, and how many have died as a result of the infection? How many children have been infected with Ebola in this outbreak? How many children have died as a result of being infected?

Answer. The current Ebola outbreak in an active conflict zone in eastern DRC is affecting a vulnerable population that is extremely poor and historically neglected and abused. The outbreak is disproportionately affecting women due to their role as primary caretakers. Community resistance and a large number of community deaths further exacerbate the impact on women and children. According to the WHO, as of July 31, 56 percent of the total 2,612 confirmed and probable cases were women, and 29 percent were children under 18 years. While we do not have data on the number of women fatalities, according to Save the Children, over 500 children have died since the outbreak began in August 2018.

Question. Do we consider the morbidity resulting from Ebola a significant adverse effect?

Answer. Yes.

Question. Why hasn't the waiver cited above been exercised as required by the law?

Answer. The United States is the largest single-country donor to the current Ebola outbreak response, including support through the U.S. Agency for International Development of more than $136 million since August 2018. Most assistance to the Ebola response is not subject to the TVPA restrictions. The U.S. Government is committed to global health security as outlined in the National Security and National Biodefense strategies, and is working with partners to provide the assistance needed to contain this outbreak. The process of evaluating assistance affected by restrictions for FY 2020 TVPA is ongoing.

Question. How effective will the international response be if we are not able to engage in actions that will help lower community resistance?

Answer. The current Ebola outbreak is the tenth in the DRC. Against the backdrop of a complex humanitarian crisis, community resistance—evidenced by the high number of community deaths—is complicating response efforts. Community engagement and buy-in are critical to containing this outbreak, and to preventing it from spreading to populous regions and neighboring countries. We support broader engagement by the United Nations and outreach to community leaders and civil society, including faith-based groups and religious leaders, to lower community resistance.

Question. What polling data exists to support claims that Tshisekedi continues to grow in popularity in eastern Congo?

Answer. In June, the New York University-based Congo Research Group (CRG) released new polling data that confirmed the optimism of the Congolese people towards President Felix Tshisekedi. The data highlighted that 61 percent of Congolese are optimistic about DRC's future and 67 percent have a favorable view of the new president's first 100 days in office. The CRG poll confirms average Congolese are hopeful about the future for the first time in many years and suggests that U.S. support is a key factor to ensure President Tshisekedi is able to consolidate the democratic transition and enact reforms encompassing human rights, accountability, anti-corruption, security sector professionalization, and fiscal transparency. During insecurity-driven protests this week in Beni territory, civil society called on President Tshisekedi to travel again to the region to personally assess the situation. This

is notably different from the protests that occurred frequently during the previous regime calling on Kabila to step down.

Question. According to a fact sheet released by the Armed Conflict Location & Event Data Project (ACLED), "Six months into the new presidency of Felix Tshisekedi, ACLED data show that overall political violence is rising at even higher rates than last year, at the conclusion of Joseph Kabila's nearly 20-year rule." To what do we attribute this uptick in violence?

Answer. South Kivu and Ituri saw major escalations in longstanding communal grievances in the last few months, which may account for some of the uptick as ACLED does not seem to clearly distinguish between purely political and ethnic violence, which are often intertwined in local conflicts. In terms of the ACLED data set between January and June, armed clashes and attacks dwarfed traditional political violence by the state against peaceful opposition and demonstrators. The U.N. reported that after the inauguration of President Tshisekedi in late January a number of armed groups turned themselves in to MONUSCO and the GDRC. More than 1,000 fighters requested demobilization, as they no longer feel threatened by the national government. Our focus is on ensuring MONUSCO and the GDRC have the personnel and funding resources to leverage these gains by implementing sustainable options for reintegrating former militia members into their communities.

MONUSCO's Joint Human Rights Office (JHRO) documented 9 percent fewer human rights violations over the first six months of 2019 compared to same period in 2018. This is an encouraging sign of improvement during President Felix Tshisekedi's first few months in office. In particular, the JHRO noted state security forces were responsible for notably fewer violations when compared to the same period in 2018. Political violence in the Haut Uele and Bas Uele provinces decreased due to military pressure by the FARDC. Violence has been curbed in areas of North Kivu where MONUSCO supported local authorities' efforts to facilitate dialogue between warring groups and re-instituted a local conflict resolution mechanism. MONUSCO and the GDRC also made strides in quelling ethno-political conflict and displacement in South Kivu in June by brokering cease-fire agreements and fostering dialogue between ethnic armed group leaders and the local communities. In addition, MONUSCO and the FARDC recently addressed longstanding violent conflict and significant displacement in Ituri by fostering an agreement to turn an armed group (Ituri Patriotic Front Resistance) into a political party.

RESPONSES OF HON. TIBOR NAGY TO QUESTIONS SUBMITTED BY SENATOR EDWARD J. MARKEY

The ongoing Ebola outbreak and other Infectious disease threats, such as measles and antibiotic resistance, help reinforce the importance of the Global Health Security Agenda (GHSA)—a partnership of over 64 nations and stakeholders to help create a world safe and secure from infectious disease threats. Across CDC, USAID, and NIH, $1 billion in GHSA funding between 2014 and 2019 has supported efforts to build global health capacity to effectively combat infectious diseases.

Question. As you know, this pool of funding expires in September. Can you speak to the importance of maintaining adequate funding for the GHSA?

Answer. Achieving global health security remains a foreign policy priority for the Department of State. Agencies other than the Department are the primary implementers of the funds made available for U.S. Government Global Health Security Agenda (GHSA) activities. The State Department regularly highlights U.S. Government investments in the GHSA, and their lifesaving impact, in diplomatic engagements with partner countries.

Question. If funding is not maintained at current levels in the FY 20 spending bill, will your agencies be able to maintain current global health security programming, or will you be required to scale back operations?

Answer. The Department of State is not a primary implementer of the overseas capacity-building activities to prevent, detect, and respond to infectious diseases. Department staff will continue to conduct outreach, promote global health security, and coordinate implementation of the interagency Global Health Security Agenda activities through U.S. missions.

Question. Ongoing conflict, violence and community mistrust have been identified as the main reasons complicating the current response in a country that is no stranger to Ebola outbreaks. However, former Minister of Health Dr. Oly Ilunga Kalenga identified additional weaknesses in response efforts, including a lack of co-

ordination and communication among actors, lack of actionable data, and weak operational plans. What are your agencies doing to help the Ministry of Health address these weaknesses and strengthen the response from an implementation standpoint?

Answer. The State Department, in coordination with USAID, CDC, and other agencies, is working with the DRC Ministry of Health and the U.N. system (including the WHO) to improve coordination among Ebola responders and strengthen the response effort. Ambassador Hammer and his team at Embassy Kinshasa and in Goma are in constant contact with DRC and other actors, assessing the response effort and providing guidance on how to improve it. A particular focus is to ensure the transition of DRC leadership overseeing the response—from former Minister of Health Ilunga to lead Ebola coordinator Dr. Jean-Jacques Muyembe—is smooth and leads to a better-coordinated response.

Question. The World Health Organization has identified a funding shortfall of $54 million for response efforts to control the outbreak and prevent further spread. U.S. contributions thus far have come out of existing Ebola emergency supplemental funding from the 2014 outbreak. Are there any plans for the U.S. to make an additional contributions on par with increasing challenges?

Answer. The United States is the largest single-country donor to the Democratic Republic of Congo, contributing approximately $500 million in development and humanitarian programming annually, and more than $136 million to the current Ebola response. Working with the international community, the U.S. Government is constantly assessing the humanitarian needs and gaps in the response and may make further contributions where we are best placed to fill a need. We continue to engage members of the international community to fully fund the response. We are also supporting Ebola preparedness efforts in unaffected areas in the DRC and neighboring countries through the Global Health Security Agenda and other mechanisms.

Question. As one the largest and longest-lasting U.N. peacekeeping missions, the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) has been criticized for its cost, effectiveness, and various allegations of misconduct on-the-ground. In March, the United Nations Security Council called for a security review of the mission, including a drawdown and exit strategy. In April, the mission scaled back operations in various parts of the country, due to budget cuts. At the moment, do you think that MONUSCO is equipped to handle the on-going Ebola crisis, amid these on-going and possible future changes? If so, how can the U.S. assist in this regard?

Answer. MONUSCO has successfully consolidated its activities from electoral support throughout the country to focus eastward on protection of civilians, provision of good offices to mitigate conflict, and neutralizing the over 100 armed groups that operate in the eastern DRC. MONUSCO has made notable strides in quelling ethnopolitical conflict in South Kivu and Ituri by brokering cease-fire agreements, fostering dialogue between agents of conflict and local communities, as well as producing an agreement to turn an armed group (Ituri Patriotic Front Resistance) into a political party. These efforts complement the overall effort to control the current Ebola outbreak.

MONUSCO also provides invaluable logistical, security, good offices and leadership support to the Ebola response itself, including providing escorts and securing road access for humanitarian operations and personnel. In May, at the United States' suggestion, U.N. Secretary General Guterres appointed former MONUSCO Deputy Special Representative of the Secretary General David Gressly as the U.N.'s Ebola Emergency Response Coordinator (EERC), responsible for coordinating the international response including U.N. agencies, NGOs and donors, in partnership with the government of the DRC. Gressly's professional background and substantial DRC experience give him the tools and expertise to navigate a complex response in an even more complex environment. Since his appointment, Gressly has introduced complementary, multi-sector humanitarian programs that aim to enhance community acceptance of Ebola response activities. He formalized political and security management protocols under what he describes as a "complex public health emergency." Gressly's proposed security reforms for the response, while ambitious to implement quickly, mirror USG priorities for de-militarizing the response by reducing security escorts and shifting to long-range perimeter security. In response to recent increases in Ebola-related insecurity in the Beni-Butembo epicenter area, MONUSCO has also deployed additional peacekeepers there.

Question. In 2019, the United Nations Refugee Agency estimated that DRC has over 856, 043 refugees and the 4.5 million internally displaced. How has the Ebola

crisis further worsened the on-going refugee and IDP situation in the Congo and its neighboring states? What bilateral and multilateral efforts can the U.S. take to reduce the migration of peoples both in and out of DRC?

Answer. The Ebola outbreak is occurring in eastern DRC, one of the most geopolitically complex areas in Africa. A combination of decades of neglect by the central government, socio-economic marginalization, and political tensions has led to persistent conflict by armed groups and spontaneous attacks between intercommunal groups and youth groups. While the U.S. Government has not observed additional displacements due to the Ebola outbreak, the response to it is complicated by insecurity and large-scale population displacement. The U.S. Government continues to respond to the complex emergency, supporting humanitarian protection and the provision of basic services, such as food assistance, health care, psychosocial support, and water and sanitation, which help reduce some displacement.

We encourage all countries to follow the World Health Organization (WHO) recommendations to address the Ebola outbreak, which is a Public Health Emergency of International Concern. The WHO advises against placing travel and trade restrictions on or closing borders with the DRC.

The United States continues to call on other donors to increase their support for humanitarian assistance in the DRC and for Congolese refugees in the region. Ultimately, durable solutions for most displacement in the country and region depend on resolution of the political conflicts that are driving people from their homes in the DRC, Burundi, Central African Republic, Rwanda, and South Sudan.

RESPONSES OF HON. MARCIA BERNICAT TO QUESTIONS SUBMITTED BY SENATOR ROBERT MENENDEZ

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Answer. The United States is the largest single-country donor to the current Ebola outbreak response, including support through the U.S. Agency for International Development of more than $136 million since August 2018. Most assistance to the Ebola response is not subject to the TVPA restrictions. The U.S. Government is committed to global health security as outlined in the National Security and National Biodefense strategies, and is working with partners to provide the assistance needed to contain this outbreak. The process of evaluating assistance affected by restrictions for FY 2020 TVPA is ongoing.

Question. How effective will the international response be if we are not able to engage in actions that will help lower community resistance?

Answer. The current Ebola outbreak is the tenth in the DRC. Against the backdrop of a complex humanitarian crisis, community resistance—evidenced by the high number of community deaths—is complicating response efforts. Community engagement and buy-in are critical to containing this outbreak, and to preventing it from spreading to populous regions and neighboring countries. We support broader engagement by the United Nations and outreach to community leaders and civil society, including faith-based groups and religious leaders, to lower community resistance.

Question. What polling data exists to support claims that Tshisekedi continues to grow in popularity in eastern Congo?

Answer. In June, the New York University-based Congo Research Group (CRG) released new polling data that confirmed the optimism of the Congolese people towards President Felix Tshisekedi. The data highlighted that 61 percent of Congolese are optimistic about DRC's future and 67 percent have a favorable view of the new president's first 100 days in office. The CRG poll confirms average Congolese are hopeful about the future for the first time in many years and suggests that U.S. support is a key factor to ensure President Tshisekedi is able to consolidate the democratic transition and enact reforms encompassing human rights, accountability, anti-corruption, security sector professionalization, and fiscal transparency. During insecurity-driven protests this week in Beni territory, civil society called on President Tshisekedi to travel again to the region to personally assess the situation. This is notably different from the protests that occurred frequently during the previous regime calling on Kabila to step down.

Question. According to a fact sheet released by the Armed Conflict Location & Event Data Project (ACLED), "Six months into the new presidency of Felix Tshisekedi, ACLED data show that overall political violence is rising at even higher rates than last year, at the conclusion of Joseph Kabila's nearly 20-year rule." To what do we attribute this uptick in violence?

Answer. South Kivu and Ituri saw major escalations in longstanding communal grievances in the last few months, which may account for some of the uptick as ACLED does not seem to clearly distinguish between purely political and ethnic violence, which are often intertwined in local conflicts. In terms of the ACLED data set between January and June, armed clashes and attacks dwarfed traditional political violence by the state against peaceful opposition and demonstrators. The U.N. reported that after the inauguration of President Tshisekedi in late January a number of armed groups turned themselves in to MONUSCO and the GDRC. More than 1,000 fighters requested demobilization, as they no longer feel threatened by the national government. Our focus is on ensuring MONUSCO and the GDRC have the personnel and funding resources to leverage these gains by implementing sustainable options for reintegrating former militia members into their communities.

MONUSCO's Joint Human Rights Office (JHRO) documented 9 percent fewer human rights violations over the first six months of 2019 compared to same period in 2018. This is an encouraging sign of improvement during President Felix Tshisekedi's first few months in office. In particular, the JHRO noted state security forces were responsible for notably fewer violations when compared to the same period in 2018. Political violence in the Haut Uele and Bas Uele provinces decreased due to military pressure by the FARDC. Violence has been curbed in areas of North Kivu where MONUSCO supported local authorities' efforts to facilitate dialogue between warring groups and re-instituted a local conflict resolution mechanism. MONUSCO and the GDRC also made strides in quelling ethno-political conflict and displacement in South Kivu in June by brokering cease-fire agreements and fostering dialogue between ethnic armed group leaders and the local communities. In addition, MONUSCO and the FARDC recently addressed longstanding violent conflict and significant displacement in Ituri by fostering an agreement to turn an armed group (Ituri Patriotic Front Resistance) into a political party.

RESPONSES OF HON. MARCIA BERNICAT TO QUESTIONS SUBMITTED BY SENATOR EDWARD J. MARKEY

The ongoing Ebola outbreak and other Infectious disease threats, such as measles and antibiotic resistance, help reinforce the importance of the Global Health Security Agenda (GHSA)—a partnership of over 64 nations and stakeholders to help create a world safe and secure from infectious disease threats. Across CDC, USAID, and NIH, $1 billion in GHSA funding between 2014 and 2019 has supported efforts to build global health capacity to effectively combat infectious diseases.

Question. As you know, this pool of funding expires in September. Can you speak to the importance of maintaining adequate funding for the GHSA?

Answer. Achieving global health security remains a foreign policy priority for the Department of State. Agencies other than the Department are the primary implementers of the funds made available for U.S. Government Global Health Security Agenda (GHSA) activities. The State Department regularly highlights U.S. Government investments in the GHSA, and their lifesaving impact, in diplomatic engagements with partner countries.

Question. If funding is not maintained at current levels in the FY 20 spending bill, will your agencies be able to maintain current global health security programming, or will you be required to scale back operations?

Answer. The Department of State is not a primary implementer of the overseas capacity-building activities to prevent, detect, and respond to infectious diseases. Department staff will continue to conduct outreach, promote global health security, and coordinate implementation of the interagency Global Health Security Agenda activities through U.S. missions.

Question. Ongoing conflict, violence and community mistrust have been identified as the main reasons complicating the current response in a country that is no stranger to Ebola outbreaks. However, former Minister of Health Dr. Oly Ilunga Kalenga identified additional weaknesses in response efforts, including a lack of coordination and communication among actors, lack of actionable data, and weak operational plans. What are your agencies doing to help the Ministry of Health address these weaknesses and strengthen the response from an implementation standpoint?

Answer. The State Department, in coordination with USAID, CDC, and other agencies, is working with the DRC Ministry of Health and the U.N. system (including the WHO) to improve coordination among Ebola responders and strengthen the response effort. Ambassador Hammer and his team at Embassy Kinshasa and in Goma are in constant contact with DRC and other actors, assessing the response effort and providing guidance on how to improve it. A particular focus is to ensure the transition of DRC leadership overseeing the response—from former Minister of Health Ilunga to lead Ebola coordinator Dr. Jean-Jacques Muyembe—is smooth and leads to a better-coordinated response.

Question. The World Health Organization has identified a funding shortfall of $54 million for response efforts to control the outbreak and prevent further spread. U.S. contributions thus far have come out of existing Ebola emergency supplemental funding from the 2014 outbreak. Are there any plans for the U.S. to make an additional contributions on par with increasing challenges?

Answer. The United States is the largest single-country donor to the Democratic Republic of Congo, contributing approximately $500 million in development and humanitarian programming annually, and more than $136 million to the current Ebola response. Working with the international community, the U.S. Government is constantly assessing the humanitarian needs and gaps in the response and may make further contributions where we are best placed to fill a need. We continue to engage members of the international community to fully fund the response. We are also supporting Ebola preparedness efforts in unaffected areas in the DRC and neighboring countries through the Global Health Security Agenda and other mechanisms.

RESPONSES OF REAR ADMIRAL TIM ZIEMER, USN, RETIRED TO QUESTIONS SUBMITTED BY SENATOR ROBERT MENENDEZ

22 U.S.C. Chapter 78, Section 4 of the Trafficking Victims Protection Act provides for the continuation of assistance that would otherwise be sanctioned for failing to meet the minimum standards on trafficking when it is in the National Interest of the United States to waive sanctions. Paragraph Section (d)(5)(B) of TVPA states: "The President shall exercise the authority under section (4) when necessary to avoid significant adverse effects on vulnerable populations, including women and children." According to the World Health Organization, the Ebola virus disease has a mortality rate of 50 percent.

Question. Do we consider the people in eastern Democratic Republic of Congo (DRC) living in Ebola affected regions, or living near those infected with Ebola vulnerable? How many women have been infected with Ebola in this outbreak, and how many have died as a result of the infection? How many children have been infected

with Ebola in this outbreak? How many children have died as a result of being infected?

Answer. Anyone living in proximity to a disease outbreak is vulnerable to infection, including persons vulnerable to Ebola in at-risk areas in the Democratic Republic of the Congo (DRC). USAID continues to support Ebola response assistance to support vulnerable populations in DRC. We defer to the Centers for Disease Control and Prevention (CDC) on the latest case numbers for women and children.

Question. Do we consider the morbidity resulting from Ebola a significant adverse effect?

Answer. Yes, the morbidity resulting from Ebola is a significant adverse effect of infection. USAID continues to support the Ebola response, providing assistance under available authorities, including the exception to the TVPA restriction, as well as by relying on funding not impacted by TVPA.

Question. Why hasn't the waiver cited above been exercised as required by the law?

Answer. Ebola-related assistance is continuing through available authorities and exceptions, and as such, the exercise of the TVPA waiver is not necessary in order to avoid significant adverse effects of the TVPA restriction on vulnerable populations.

Question. How effective will the international response be if we are not able to engage in actions that will help lower community resistance?

Answer. Effectively engaging communities remains integral to ending the outbreak. USAID is engaging in actions that will help lower community resistance along with international partners ECHO, DFID, and the World Bank. For example, USAID has provided $5.3 million to support UNICEF in engaging communities affected by the Ebola virus disease (EVD). UNICEF is the co-lead for risk communication and community engagement in the response and plans to strengthen community engagement through social and behavioral change, local community participation, and mental health and psychosocial support. UNICEF will work with affected and at-risk communities and address community concerns and rumors, among other activities. UNICEF will further conduct research and implement evidence-based communication in the development of a Communication Strategy.

Additionally, USAID is undertaking a number of actions to address community resistance, such as supporting primary health care or providing basic water, sanitation and hygiene. USAID emphasizes the importance of an expanded community-based response strategy that operationalizes community feedback, increases local ownership of Ebola response activities, and helps address broader, community-prioritized needs to improve community acceptance and access. Under this approach, to build local ownership, USAID will support hiring more persons from the local community, including Ebola survivors, as well as engage a wide range of local stakeholders in core response strategies and communications—from women's groups and faith leaders to traditional leaders and youth. The goal is to change perspectives so that members of the community themselves can spread messages related to the response, which will help reinforce community acceptance and engagement in the response.

USAID's Office of Inspector General released two reports in January of 2018 assessing lessons learned and gaps in the last response. Two of the reports pointed to challenges in filling staffing vacancies during the last Ebola response. One report pointed to the "lack of an Agency wide system for capturing and sharing program and project data" which "challenged internal communication and coordination."

Question. What are the major lessons learned from the 2014 Ebola response in the areas of staffing, programming and planning, and how are these lessons being incorporated in this response?

Answer. States must be prepared to quickly respond to infectious disease outbreaks that could pose a global danger, in some cases even before the World Health Organization (WHO) declares an official PHEIC. USAID has committed to the continual strengthening of the Agency's policies, practices, structures, and systems to prepare for, respond to, and learn from global infectious disease outbreaks. For example, on October 31, 2018, an Agency Notice was issued titled, "USAID Response to Global Infectious Disease Outbreaks". The Agency Notice clearly outlines the roles and responsibilities of USAID staff when preparing for and responding to infectious disease outbreaks, including a requirement to USAID Missions and Offices overseas to be aware of local outbreaks and to notify outbreak@usaid.gov when there is an outbreak that may require international or additional assistance. On July 26, 2019, an Agency Notice was issued titled "Process for Programming Re-

sources during a declared Public Health Emergency of International concern". The notice outlines the process at the U.S. Agency for International Development (USAID) for programming resources during a Public Health Emergency of International Concern (PHEIC) declared by the World Health Organization (WHO). USAID's broad-based and multisectoral approach allows the Agency to leverage the technical expertise to strengthen local capacity around the world to prevent, detect, and respond to infectious diseases.

USAID has established partnerships across the U.S. Government, with relevant international, non-governmental, and other organizations, to strengthen preparedness and response efforts for potential disease outbreaks that could require an international emergency response. While we are applying lessons learned wherever possible, we are also accounting for key differences in the outbreaks and responses, including the fact that the current response is taking place in an active conflict zone. Many personnel responding to this outbreak also responded in 2014 and have leveraged their expertise in this response. WHO has adopted emergency response reforms over the last several years, with the strong backing of the United States, which have enabled the organization to improve their operational capacity and more effectively and rapidly respond to this and other outbreaks.

Question. Have USAID and the Interagency worked to develop an overarching framework and strategy for improved leadership, staffing, and coordination for this and future global health security responses? If so, how has this improved framework and approach helped in this current DRC outbreak?

Answer. USAID maintains several mechanisms, such as interagency agreements, with key interagency partners to rapidly pull in and leverage unique capabilities across the U.S. Government to support response efforts. Additionally, we support the roles and responsibilities of federal agencies for this kind of emergency, as outlined in the 2019 U.S. Government Global Health Security Strategy. USAID remains in an ongoing dialogue with Centers for Disease Control and Prevention (CDC) to further formalize coordination for future public health emergencies that become humanitarian crises.

Question. What do you see as remaining challenges in U.S. Government preparation for improved coordination and implementation in future international public health emergencies?

Answer. There are myriad challenges to effectively coordinating the response to future public health emergencies. While USAID continues to build up its staffing and systems for public health emergency responses, including: having the right people with the necessary skills (foreign language and previous outbreak experience) for immediate assignments which may last for months or longer is a challenge. It is even more difficult in light of the growing number of humanitarian responses and increasing demands on USAID.

Question. Have all programs and activities currently underway using International Development Assistance funds been shared with bureaus in the Agency, such as the Africa and Global Health bureaus to better support coordination with ongoing programs and inform planning for future programs? Did those bureaus help plan the Office of Foreign Disaster Assistance programs and activities currently underway in eastern Congo? Are recovery activities being incorporated into our disaster response activities?

Answer. Coordination within USAID is excellent, with both Global Health and Africa bureau staff fully integrated into the Response Management Team (RMT) led by the Bureau for Democracy, Conflict and Humanitarian Assistance. Programs and activities currently underway in eastern Democratic Republic of the Congo (DRC) using International Disaster Assistance funds are shared with the Africa and Global Health bureaus to better support coordination with ongoing programs and inform planning for future programs. USAID is currently focusing its efforts on response activities in the affected provinces of the DRC as well as bolstering the preparedness capabilities of unaffected parts of the DRC and neighboring at-risk countries (Uganda, South Sudan, Rwanda, and Burundi).

Question. How many team members are there on the Disaster Assistance Response Team (DART)? Which agencies are the team members from? How many DART members are in each of the locations where USG personnel are assigned? How long have each of the team members been deployed and what is the length of their deployment? Is turnover of deployed members at all affecting the response? Did any of the current DART team members participate in the 2014 response?

Answer. There are currently 17 DART members deployed in the DRC, including 7 in Kinshasa and 11 in Goma. In addition, the Disaster Assistance Response Team

(DART) has consultants supporting the local surveillance and IPC commissions and reporting to the DART. Members of the team include USAID and CDC staff. Average rotations of DART team members are two to three months. The turnover does not affect the response. A number of DRC Ebola DART team members also participated in the 2014 West Africa response.

Question. Has USAID made changes or taken specific steps to better coordinate, track, and execute financial and human capital resources among the Office of U.S. Foreign Disaster Assistance, Global Health, and regional bureaus? How has the availability (on unavailability) of the appropriate resources—both funds and human capital—from these bureaus and various accounts helped, or hindered, USAID's response to the outbreak in DRC?

Answer. Coordination across different bureaus occurs through regular meetings with the intra-agency technical working group, regular discussions on high level policy issues, mission collaboration with the mission liaison position to the DART, and through the Global Health and Africa Bureau liaisons to the RMT. The Bureau for Global Health, Africa Bureau, and USAID's Office of Foreign Disaster Assistance (USAID/OFDA) budget offices regularly coordinate with each other, and the Bureau for Resource Management and State/F to execute accurate financial tracking across the entire response architecture.

To date, USAID has sufficient funding to adequately support the response, thanks in part to the Congressional Ebola supplemental funding provided during the West Africa Ebola outbreak. Specifically, the availability of these funds has supported technical expertise to partners for disease surveillance, case investigation, contact tracing, emergency health care, patient management in Ebola treatment units, water, sanitation, and hygiene, infection prevention and control, border health, community engagement, risk communication, the promotion of safe and dignified burials, and other technical support. We continue to evaluate requests for assistance and are coordinating with the Government of the DRC and other international partners to ensure the disease is contained. Our goal is to provide the most efficient and effective support possible to our partners to bring this outbreak to an end as soon as possible.

Since the 2014 West Africa Ebola outbreak, USAID/OFDA has undertaken multiple steps to ensure USAID staff receive training on USAID's Response Management System (RMS), which codifies authorities, structures and responsibilities for the Disaster Assistance Response Team and Response Management Team. In July 2017, OFDA launched the On-Ramp Program, which prepares qualified USAID staff to become a part of USAID/OFDA's emergency staffing pool to broaden the number of available surge personnel. USAID/OFDA now also regularly offers humanitarian assistance and disaster response training to orient USAID staff to the broader humanitarian architecture and interagency structures. In addition to the additional training and On-Ramp program, USAID/OFDA is developing and launching the Personnel, Experience, and Training, Equipment, and Readiness (PETER) system. PETER is a readiness and deployment database which supports the unique qualification, activation, and human resource requirements of both USAID/OFDA and USAID's Office of Food for Peace. PETER will assist managers in identifying and tracking the qualifications, experience, and availability of personnel for all types of disasters and complex emergencies.

Question. USG personnel are not currently authorized to deploy to the epicenter of the outbreak in DRC due to insecurity. Given that security constraints prevent U.S. personnel from being deployed the affected regions, how are we ensuring that we effectively monitor activities undertaken with USG funds?

Answer. With the Emergency Operations Center relocated to Goma, most of the Disaster Assistance Response Team (DART) staff are now based there as well. The response reset also recommends the continued use of Goma, given that it is the optimal location to continue to support response efforts in Eastern Congo. U.S. staff in Kinshasa and Goma continue working closely with the Democratic Republic of the Congo Ministry of Health, WHO, and key response agencies providing daily support and technical recommendations for improving the response. Additionally, they remain in constant contact with partners and responders located in the affected areas. USAID partners with many entities that are able to access affected areas and implement key response activities. The DART in Goma meets regularly with partners and receives weekly reports on implementation.

RESPONSES OF REAR ADMIRAL TIM ZIEMER, USN, RETIRED TO QUESTIONS SUBMITTED BY SENATOR EDWARD J. MARKEY

The ongoing Ebola outbreak and other Infectious disease threats, such as measles and antibiotic resistance, help reinforce the importance of the Global Health Security Agenda (GHSA)—a partnership of over 64 nations and stakeholders to help create a world safe and secure from infectious disease threats. Across CDC, USAID, and NIH, $1 billion in GHSA funding between 2014 and 2019 has supported efforts to build global health capacity to effectively combat infectious diseases.

Question. As you know, this pool of funding expires in September. Can you speak to the importance of maintaining adequate funding for the GHSA?

Answer. Maintaining adequate funding for the GHSA is important to help prevent avoidable outbreaks, quickly detect new ones, and rapidly and effectively respond to infectious disease outbreaks. The U.S. Global Health Security Strategy, released in May 2019, provides guidance and an operational framework for current and future USAID global health security engagement.

Question. If funding is not maintained at current levels in the FY 20 spending bill, will your agencies be able to maintain current global health security programming, or will you be required to scale back operations?

Answer. Should Congress not maintain current appropriated levels for GHSA, USAID will adapt and focus efforts to strengthen global health security in priority countries.

Question. Ongoing conflict, violence and community mistrust have been identified as the main reasons complicating the current response in a country that is no stranger to Ebola outbreaks. However, former Minister of Health Dr. Oly Ilunga Kalenga identified additional weaknesses in response efforts, including a lack of coordination and communication among actors, lack of actionable data, and weak operational plans. What are your agencies doing to help the Ministry of Health address these weaknesses and strengthen the response from an implementation standpoint?

Answer. USAID understands that an effective response to the Ebola outbreak requires enhanced coordination between the Government of DRC (GDRC), including its Ministry of Health (MoH), World Health Organization (WHO), non-governmental organizations (NGOs), and other humanitarian stakeholders. April 30, 2019, the U.S., with other lead donors to the response, sent a letter to the WHO Director General and U.N. Under-Secretary General for Humanitarian Affairs/Emergency Response Coordinator (ERC) citing the severity of the outbreak and gaps in leadership and coordination and requesting urgent action, including the appointment of an empowered senior leader for the international response. In May 2019, a delegation from USAID and the Centers for Disease Control and Prevention (CDC) travelled with Ambassador Michael A. Hammer to eastern DRC and met with civil society, traditional and faith-based leaders, and representatives of the GDRC, United Nations (U.N.), NGOs, and donors. The visit confirmed analysis that security issues, leadership challenges, poor coordination, underutilization of NGOs and faith-based groups, and insufficient community engagement were hindering response effectiveness.

As a result of a whole of U.S. Government engagement pressing for changes with the U.N. and WHO, in coordination with other lead donors, the U.N. Secretary General appointed David Gressly as the U.N. Ebola Emergency Response Coordinator (EERC) to oversee the coordination of international support for all Ebola Virus Disease (EVD) response-related and enabling operations, and on May 30, 2019 the ERC activated a System-Wide Scale-Up for the Control of Infectious Disease Events. The activation targets health zones in the DRC in which transmission is occurring and likely to occur, with the possibility of including other geographical areas should the disease spread. The scale-up has five strategic priorities: (i) strengthened political engagement to create an enabling environment for the response; (ii) strengthened multi-sectoral humanitarian coordination that fosters greater community engagement; (iii) timely and sustainable financing, monitoring and reporting on the use of funds in collaboration with the World Bank and key donors; (iv) enhancing the public health response, working with the Ministry of Health; and (v) leadership for a contingency cell in Goma and redouble preparedness efforts in other countries (Burundi, South Sudan, Rwanda and Uganda).

The USAID Disaster Assistance Response Team (DART) is working closely with EERC Gressly to improve coordination and communication among response actors and the GDRC. This includes pressing for a unified international and national response, currently led by the MoH out of the Emergency Operations Center in Goma.

The DART meets regularly with the EERC and WHO leadership, bilaterally and weekly with other lead donors, to monitor this response "reset" and ensure improved leadership and coordination progresses to improve the trajectory of the outbreak. This includes close tracking of the development of Strategic Response Plan 4.0.

On July 20, President of the DRC Felix Tshisekedi announced the DRC MoH is no longer the lead response entity and the creation of multisectoral Ebola committee led by the Director of the National Institute for Biomedical Research that will oversee day-to-day response activities. On July 22, the DRC Minister of Health Dr. Oly Ilunga resigned. The U.S. continues to press for appointment of a Minister of Health, while supporting the EERC in bringing about an effective response with the GDRC and current leadership in place.

USAID is collaborating with the CDC to provide community engagement assistance to the MoH-led and WHO-coordinated response based on previous Ebola responses, as well as community feedback to tailor community engagement approaches based on unique community dynamics across the response. USAID has also contracted private health sector experts to serve as our eyes and ears on the ground, to provide technical support to the DRC MoH, and reinforce response efforts in the outbreak zone. USAID staff in Kinshasa and Goma continue to work closely with the MoH, WHO, and key response agencies providing daily support and technical recommendations for improving the response.

Since arriving in May, EERC Gressly has established the Ebola Emergency Response Team (EERT), which will implement the U.N.'s scale-up strategy and bridge the public health response with multi-sector humanitarian activities. EERC Gressly and WHO Assistant Director-General Dr. Ibrahim Soce Fall co-chair the EERT, which meets on a weekly basis. As a result of USAID advocacy, many NGOs are participating on the EERT, ensuring a broad representation of perspectives and bringing a different set of knowledge and expertise to the response.

USAID has also been working with EERC Gressly, the U.N., and the GDRC to release a comprehensive response plan, the aforementioned SRP 4.0, which includes the cost requirements for both public health interventions and multi-sector humanitarian activities to end the outbreak. We expect the GDRC to release a revised comprehensive plan that will include input from various response actors and present a financial appeal for strengthened public health response, political engagement, security support, complementary humanitarian assistance, community engagement activities, and financial planning and monitoring in the coming days.

Question. The World Health Organization has identified a funding shortfall of $54 million for response efforts to control the outbreak and prevent further spread. U.S. contributions thus far have come out of existing Ebola emergency supplemental funding from the 2014 outbreak. Are there any plans for the U.S. to make an additional contributions on par with increasing challenges?

Answer. On July 24, the U.S. Government (USG), through USAID, announced an additional $38 million in assistance to help end the ongoing Ebola outbreak in Eastern Democratic Republic of the Congo, including $15 million in new funding to the World Health Organization. Since the beginning of the outbreak in August 2018, USAID has provided more than $136 million to the Ebola response, making the USG the largest single country donor to the response. We look forward to reviewing the revised comprehensive strategic plan and stand prepared to provide additional contributions as necessary.

Question. As one the largest and longest-lasting U.N. peacekeeping missions, the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) has been criticized for its cost, effectiveness, and various allegations of misconduct on-the-ground. In March, the United Nations Security Council called for a security review of the mission, including a drawdown and exit strategy. In April, the mission scaled back operations in various parts of the country, due to budget cuts. At the moment, do you think that MONUSCO is equipped to handle the on-going Ebola crisis, amid these on-going and possible future changes? If so, how can the U.S. assist in this regard?

Answer. USAID believes that MONUSCO's ongoing support to the Ebola response efforts is sufficient, based on the current mandate language related to humanitarian access and logistical support. However, even the perception of the militarization of the Ebola response through the provision of security by MONUSCO could aggravate the situation. We defer to the Department of State on how the U.S. can assist amidst these challenges.

Question. In 2019, the United Nations Refugee Agency estimated that DRC has over 856, 043 refugees and the 4.5 million internally displaced. How has the Ebola crisis further worsened the on-going refugee and IDP situation in the Congo and its

neighboring states? What bilateral and multilateral efforts can the U.S. take to reduce the migration of peoples both in and out of DRC?

Answer. The Ebola outbreak is occurring in eastern DRC, one of the most geopolitically complex areas in Africa. A combination of decades of neglect by the central government, socio-economic marginalization, and political tensions has led to persistent conflict by armed groups and spontaneous attacks between intercommunal groups and youth groups. While the U.S. Government has not observed additional displacements due to the Ebola outbreak, the response to it is complicated by the insecure environment and large-scale population displacement. The U.S. Government continues to respond to the complex emergency, supporting humanitarian protection and the provision of basic services, such as food assistance, health care, psychosocial support, and water and sanitation, which help reduce some displacement.

We encourage all countries to follow World Health Organization (WHO) recommendations to address the Ebola outbreak, which is a Public Health Emergency of International Concern. The WHO advises against placing travel and trade restrictions or closing borders with the DRC.

The United States continues to call on other donors to increase their support for humanitarian assistance in the DRC and for Congolese refugees in the region. Ultimately, durable solutions for most displacement in the country and region depend on resolution of the political conflicts that are driving people from their homes in the DRC, Burundi, Central African Republic, Rwanda, and South Sudan.

RESPONSES OF DR. MITCH WOLFE TO QUESTIONS SUBMITTED BY SENATOR EDWARD J. MARKEY

The ongoing Ebola outbreak and other Infectious disease threats, such as measles and antibiotic resistance, help reinforce the importance of the Global Health Security Agenda (GHSA)—a partnership of over 64 nations and stakeholders to help create a world safe and secure from infectious disease threats. Across CDC, USAID, and NIH, $1 billion in GHSA funding between 2014 and 2019 has supported efforts to build global health capacity to effectively combat infectious diseases.

Question. As you know, this pool of funding expires in September. Can you speak to the importance of maintaining adequate funding for the GHSA?

Answer. The FY 2015 emergency appropriation for implementation of the Global Health Security Agenda and National Public Health Institute Development ($597M) was a substantial investment towards CDC's global health security efforts. Those resources have been put to use as intended—to address an urgent need for accelerating progress towards a world more prepared to stop infectious diseases at their source before they pose a threat to us here at home. The five-year supplemental will be fully obligated, as planned, by the end of this year (FY 2019). Although we have made considerable progress through the investment of these funds, most of the world is still under-prepared to effectively prevent, detect, and respond to infectious disease health threats. Building health security capacity, particularly sustainable capacity over which partner countries exhibit ownership without significant decrease in quality, can take years of effort. [Please note that the NIH was not a recipient of GHSA-designated funding.]

CDC's FY2020 request includes $99.762 million, an increase of $49.8 million above FY2019 Enacted for Global Health Security activities that will protect Americans through partnerships and other activities that support public health capacity improvements in countries at risk from uncontrolled outbreaks of infectious diseases. CDC will implement an approach to global health security investments that is informed by lessons learned over the last 5 years. CDC is proactively planning its future global health strategy to strengthen our ability to respond more rapidly and effectively to health threats wherever they occur and balance our commitment to our core mission of protecting Americans. Ultimately, this plan strikes a balance between responsible sustainability and maximum impact through CDC presence overseas.

Question. If funding is not maintained at current levels in the FY 20 spending bill, will your agencies be able to maintain current global health security programming, or will you be required to scale back operations?

Answer. CDC has primarily supported these activities using supplemental funding received in FY 2015, which will expire at the end of FY 2019. Congress has also provided CDC with $50 million in global health security funding in both FY 2018 and FY 2019. The FY 2020 President's Budget request for CDC includes $99.762

million for global health security activities, an increase of $49.8 million above the FY 2019 enacted level. In FY 2020, CDC's GHS funding will be directed towards activities in countries receiving intensive and targeted support, as defined in the Global Health Security Strategy. Funding will also be directed towards the most pressing, cross-cutting disease threats and global capacity requirements that will maximize outcomes for these countries. CDC will maintain its focus on building capacity in these core areas in alignment with the Global Health Security Strategy's objective of sustainability and transition to country ownership. It is also important to note that CDC is planning for FY 2020 while also playing a key role in the USG response to a persistent Ebola outbreak in DRC that is likely to extend into FY 2020.

Question. Ongoing conflict, violence and community mistrust have been identified as the main reasons complicating the current response in a country that is no stranger to Ebola outbreaks. However, former Minister of Health Dr. Oly Ilunga Kalenga identified additional weaknesses in response efforts, including a lack of coordination and communication among actors, lack of actionable data, and weak operational plans. What are your agencies doing to help the Ministry of Health address these weaknesses and strengthen the response from an implementation standpoint?

Answer. As part of the administration's whole-of-government effort, CDC experts are supporting the DRC government, neighboring country governments, WHO, and other partners by providing technical guidance and expertise in contact tracing, surveillance, laboratory testing, data analytics, vaccine implementation, emergency management, infection prevention and control, behavioral sciences, health communications, and border health. CDC continues to deploy staff who are embedded with the DRC Ministry of Health in both Goma and Kinshasa, and at WHO headquarters, to strengthen these activities and support coordination among response leaders. In addition, CDC and USAID are supporting community engagement activities based on lessons learned from previous Ebola outbreaks, including incorporating feedback from affected populations and tailoring the response approach based on unique dynamics within Ebola-affected communities.

CDC's operational expertise allows us to quickly and efficiently identify the unique scientific and social variables of outbreaks and address them with proven interventions. Working directly with partners on the ground, CDC has been providing guidance to standardize response actions, streamline implementation of public health measures, improve the effectiveness of training and educational materials, and assist with coordination and communication across the public health response.

For example, CDC continues to provide technical assistance to the Ministry of Health and WHO in the implementation of vaccination strategies, including assistance with protocols, operating procedures, data analysis, and training and communications material for use at national and local levels in DRC and neighboring countries. CDC is collaborating with WHO and Ministry of Health colleagues in Rwanda, South Sudan, Uganda, and Burundi to implement preventative vaccination of health care workers in geographic areas near the DRC border. CDC staff have embedded into teams with the DRC Ministry of Health and at WHO headquarters, to analyze data and to help improve the quality of vaccination efforts.

Over the course of the response, CDC has also been working with U.S. Government partners, the DRC Ministry of Health, WHO, and others to identify gaps in infection prevention and control (IPC) systems, assess healthcare provider IPC knowledge and skills, and improve IPC practice. CDC is helping DRC Ministry of Health and WHO to finalize a standardized set of infection prevention and control resources for use across the response, which includes training modules, standard operating procedures, and job aids. CDC is also designing and preparing to implement a training course for IPC partners and DRC Ministry of Health infection prevention and control supervisors. Where security conditions have allowed, as demonstrated with recent confirmed cases in Goma, CDC experts have been able to work directly with local case investigation teams on the ground to identify areas for improvement in surveillance, vaccination, and other aspects of case management.

Question. The World Health Organization has identified a funding shortfall of $54 million for response efforts to control the outbreak and prevent further spread. U.S. contributions thus far have come out of existing Ebola emergency supplemental funding from the 2014 outbreak. Are there any plans for the U.S. to make an additional contributions on par with increasing challenges?

Answer. CDC defers to USAID for this response.