

**COVID-19 AND U.S. INTERNATIONAL PANDEMIC
PREPAREDNESS, PREVENTION, AND RESPONSE**

HEARINGS

BEFORE THE

**COMMITTEE ON FOREIGN RELATIONS
UNITED STATES SENATE**

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

—————
JUNE 18 AND JUNE 30, 2020
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COVID-19 AND U.S. INTERNATIONAL PAN- DEMIC PREPAREDNESS, PREVENTION, AND RESPONSE

PART 1: COVID-19 AND U.S. INTERNATIONAL PANDEMIC
PREPAREDNESS, PREVENTION, AND RESPONSE

THURSDAY, JUNE 18, 2020

U.S. SENATE,
COMMITTEE ON FOREIGN RELATIONS,
Washington, DC.

The committee met, pursuant to notice, at 9:33 a.m., in room SD-106, Dirksen Senate Office Building, Hon. James E. Risch, chairman of the committee, presiding.

Present: Senators Risch [presiding], Johnson, Gardner, Barrasso, Young, Perdue, Menendez, Cardin, Shaheen, Murphy, Kaine, and Booker.

OPENING STATEMENT OF HON. JAMES E. RISCH, U.S. SENATOR FROM IDAHO

The CHAIRMAN. The committee will come to order.

Morning, everyone. I want to thank all of you who are attending this important hearing.

Today, we are going to discuss the international response to the COVID-19 pandemic as well as future pandemic preparedness, prevention, and response.

The hearing will focus on Senate bill 3829, which Senator Murphy and I have introduced, the Global Health Security and Diplomacy Act. It is written on paper, not on stone, which we will talk about a little bit in the future here. This is an important endeavor that this committee is going to take up. Indeed, probably one of the weightiest matters that we will deal with as we attempt to create a new shield to prevent a COVID virus-type attack from happening again. The COVID-19 global pandemic has reaffirmed what we have long known, and that is, infectious diseases, particularly those of viral nature, do not respect borders; they are a threat, and a threat anywhere is a threat everywhere. We have been right, here, to focus on our domestic response to this pandemic, but we ignore the spread overseas at our own peril, for obvious reasons.

It is essential that we respond now to help our partners who are not yet experiencing significant spread to get testing, tracing, and quarantine procedures in place, and to help our partners who already are under siege avert a worst-case scenario. We also need to

focus on protecting access to food, livelihoods, water, sanitation, and hygiene.

Protecting existing investments in immunizations, maternal and child health, and other infectious diseases are important at this time, also. And we need to work with partner countries and organizations to ensure that our aid reaches those who need it most, without aiding and abetting corruption, human rights violations, and democratic backsliding, which we all know frequently happens in the world when we start focusing on something else.

At the same time, we need to figure out how to get ahead of the next global pandemic. Indeed, that is what the focus of this hearing is going to be on. And again, the vehicle we are talking about is Senate bill 3829, but it is for discussion purposes, and we look for every possible improvement to that bill that we can make.

This hearing is one of a number that I am going to undertake as we construct Senate bill 3829 going forward. And the purpose of it is to, as I said, construct a shield that is better than the shield that we have. I have repeatedly said that what we need is a fire station and a fire department ready and able to put out a fire before it burns the entire world. Over the years, we have come to expect that the World Health Organization would play a role. The World Health Organization has done great work in many respects. It does play a key role as the guardian of the international health regulations and as the clearinghouse of global health data and best practices, and it has done remarkable work in combating polio and eradicating smallpox. But, its response to fast-moving emergencies, such as Ebola and COVID-19, has exposed significant weaknesses that the WHO has. But, we are not here to demean or to criticize or condemn the WHO. Rather, what we are here to do is to have a fair analysis of what the response was, and how their structure is constructed that has caused the weaknesses we have.

Dr. Tedros and his management team were very kind to spend some time with me early on, and they explained to me what their objectives were and how they were attempting to achieve them. They made some very fair points, and it truly is obvious that they did things that could have been done differently, and they will be the first to admit that.

In addition to reforming WHO—and, truly, there is some reform that is needed—and it should be done, as I said, without demeaning, criticizing, or condemning—but, rather, in the kindest way possible, to make it work better. We need an international financing mechanism that will reenergize action under the Global Health Security Agenda so we can help countries with a high commitment but low capacity to improve their pandemic preparedness and response. And we need a long-term fix to the coordination problems that have long plagued U.S. country teams operating overseas. We need a single accountable entity housed at the Department of State to lead diplomatic efforts and coordinate the efforts of the agencies implementing global health security assistance overseas. This accountable entity would not—I repeat, not—replace the central role of the NSC in coordinating global health security policy across the whole of government here in Washington. Alternatively, it would ensure the effectiveness of global health security programs at the mission level.

We have put these ideas forward in this bipartisan bill, the Global Health Security and Diplomacy Act, and have invited all those who wish to participate to do so. This has to be a bipartisan effort.

It is not too late to get back on track and to restore the long-standing tradition of bipartisanship that has characterized every successful U.S. global health program of the past 20 years. It also is not too late to focus our efforts on addressing the current COVID-19 pandemic overseas in a manner that saves lives and protects the United States from future waves of infection. But, let there be no mistake about it, this bill is designed to look at the future.

There is no doubt this is going to happen again. We have been told that the bat population, particularly in the Wuhan area in China, contains about 2,000 viruses. Of course, this pandemic was caused by one of these viruses jumping from one species to another, from a bat to a human being. What happened after that has been greatly debated, but we know what the result was, and we know that the result was not good, and we know that there were failures along the line. We know that we can do better.

There is no other group more qualified than this committee, the United States Senate Committee on Foreign Relations, to undertake this proposition. This is something that we owe America, that we owe the world. We can do this. I am committed to do that. I would hope that every member on the committee will help focus on this as one of the most important things that we do. It will be a legacy that will be incredibly important for future generations. And we know that the world cannot withstand much more of what we have seen that we got from the COVID-19 infection that went through the world.

So, with that, I hope that we, as a committee, do what we try to do, and that is focus with civility, kindness, understanding, and tolerance as we hear from everyone. We are going to have a lot of different ideas. There is going to be a lot of ideas that people have strong feelings about. I hope people will do their best to listen carefully to what others have to say, and listen to defenses that people make as to what has happened. But, more important, listen carefully to what people tell us that they have learned that will help us in the future. In a bipartisan fashion that is done with kindness and civility, I have every confidence we can develop a bill that can pass this Congress, be signed by the President, become law, and really be a tremendous benefit to our fellow human beings as we go forward.

[The prepared statement of Senator Risch follows:]

PREPARED STATEMENT OF SENATOR JAMES E. RISCH

Today we meet to discuss the international response to the COVID-19 pandemic and the future of pandemic preparedness, prevention, and response.

The COVID-19 global pandemic has reaffirmed what we've long known: infectious diseases do not respect borders. A threat anywhere is a threat everywhere.

We have been right to focus on the domestic response to this pandemic. But we ignore the spread overseas at our own peril.

It is essential that we respond now: to help our partners who are not yet experiencing significant spread to get testing, tracing, and quarantine procedures in place; and to help our partners who already are under siege avert worst-case scenarios.

We need to also focus on protecting access to food, livelihoods, water, sanitation, and hygiene; protecting existing investments in immunizations, maternal and child health, and other infectious diseases.

And we need to work with partner countries and organizations to ensure that our aid reaches those who need it most, without aiding and abetting corruption, human rights violations, and democratic backsliding.

At the same time, we need to figure out a way to get ahead of the next global pandemic.

I repeatedly have said we need a fire station, ready and able to put out a flame before it burns the whole world down. Over the years, we have come to expect the WHO to play that role. And we've been disappointed.

The WHO does play a key role as the guardian of the International Health Regulations and as the clearinghouse of global health data and best practices. And it has done remarkable work in combatting polio and eradicating smallpox. But its response to emergencies, from Ebola to COVID-19, has exposed significant weaknesses. Reform is essential.

In addition to reforming the WHO, we need an international financing mechanism that will re-energize action under the Global Health Security Agenda, so we can help countries with high commitment but low capacity improve their pandemic preparedness and response.

And we need a long-term fix to the coordination problems that have long plagued U.S. country teams operating overseas. We need a single accountable entity, housed at the Department of State, to lead diplomatic efforts and coordinate the efforts of the agencies implementing global health security assistance overseas.

This accountable entity would not replace the central role of the NSC in coordinating global health security policy across the whole-of-government here in Washington. Alternatively, it would ensure the effectiveness of global health security programs at the mission-level.

I have put these ideas forward in a bipartisan bill, the Global Health Security and Diplomacy Act.

I share the frustration expressed by many of our committee members that it has taken so long to get us all here together, but I am glad for the opportunity today.

It is not too late to get back on track and to restore the long-standing tradition of bipartisanship that has characterized every successful U.S. global health program of the past 20 years.

It is not too late to focus our efforts on addressing the current COVID-19 pandemic overseas in a manner that saves lives and protects the United States from future waves of infection.

I thank our witnesses for their efforts to help us get there.

With that, I will ask Ranking Member Menendez if he wishes to make any opening remarks.

The CHAIRMAN. With that, I will turn the time to Senator Menendez.

**STATEMENT OF HON. ROBERT MENENDEZ,
U.S. SENATOR FROM NEW JERSEY**

Senator MENENDEZ. Thank you, Mr. Chairman, for convening today's hearing. As you know, I have been seeking a series of hearings on COVID for quite some time, and I am pleased that we are now having one. And I understand you intend to hold more. And I strongly support that.

But, let me start by speaking to the larger concerns that the Democratic Minority recently wrote to you about. We must have serious and sustained focus on U.S. foreign policy, and a serious oversight agenda. And we want to work with you to make that happen.

Mr. Chairman, we should be having more public hearings. We need to tackle some of the major challenges that confront us—Afghanistan, Venezuela, North Korea, just to mention some. And we need to ensure the Secretary of State testifies before this committee. We should all be shocked and, frankly, offended that the Secretary is refusing to appear, refusing to defend the Administration's foreign affairs budget. And we should all be insisting on his

appearance. This could be the first time in over 20 years that a Secretary of State has not testified before this committee to explain administration priorities. And, I guess, after Ambassador Bolton's book, we probably will never see him again.

This lack of engagement fundamentally undermines our work. Not only does the Secretary of State feel comfortable in refusing to come before us, that refusal apparently extends to other Senate-confirmed officials. We have only heard from one Senate-confirmed official this entire year. And the Administration has repeatedly ignored oversight inquiries, many of them that are even bipartisan.

We do not need to rehash the contentious vote on Michael Pack, but we should all be seriously concerned about what we have seen in the last 10 days and 24 hours at the U.S. Agency for Global Media. Mr. Pack has gone on a wholesale firing spree, removing the heads of the networks, dissolving their corporate boards, only to replace them with unqualified political people, fundamentally undermining the mission and work of the organization. It is now obvious why the White House wanted Pack so badly, so they can transform the agency into their own personal mouthpiece. This is a blow from which it may never recover. Once the credibility is gone, no one will ever trust a report from Radio Free Europe, Radio Marti, nor trust the tools of the Open Technology Fund.

So, Mr. Chairman, I would just urge you to respond to the letter that we sent you and the spirit in which it was offered. On behalf of myself and all the Democratic members of the committee, I can tell you that we want to work with you, and we want to find common ground. We want the State Department to be successful. And we want this committee to take on serious and meaningful work that will make an impact on the national and global stage. So, let us work together to make that happen.

Now, while I thank all of our witnesses for their service, it is disappointing that the White House would not send a member of the Coronavirus Task Force or any of the Senate-confirmed individuals from the State Department, Health and Human Services, or the United States Agency for International Development responsible for Administration's response. The American people deserve to hear from members of the President's handpicked team to understand what it is doing to address the worst pandemic the world has faced in 100 years—more than 8 million cases worldwide, more than 115,000 American lives lost. In my home state of New Jersey, which is the second-largest state in the nation, in terms of COVID deaths, I am vividly reminded of this consequence.

This tragedy has assuredly been a wake-up call to those who question whether we should engage with, and invest in, the rest of the world. So, I would like to use this hearing to understand how we got here, what we knew about the virus, and when, and how we are leveraging our diplomatic relationships and leadership to best respond and protect the American people.

So far, most of what we have seen is a lot of bluster, finger-pointing, and retrenchment. Yes, we should examine the World Health Organization's initial response. I wish we had someone from the State Department's Bureau of International Organizations here to do exactly that. But, we also know that the U.S. was regularly communicating with, and receiving information from, the WHO, includ-

ing through U.S. Government employees embedded at WHO headquarters in Geneva. And, rather than seriously consider how to best leverage our leadership and contributions, the President abruptly announced the U.S. would simply pull out of the organization, threatening not just our ability to confront COVID-19, but risking decades of progress on other global health initiatives, including combating Polio and Ebola.

And yes, China has a lot to answer for. But, the administration's use of racially stigmatizing language to describe COVID-19, in direct contradiction to guidance issued by the Centers for Disease Control and Prevention, has been deeply hurtful to Americans at home, and utterly counterproductive in leading an international response. The Secretary of State's insistence that the rest of the world agreed to use such language has prevented us from reaching consensus of the G7 and in the Security Council. And, while the White House engages in divisive rhetoric, the rest of the world is stepping up without us.

When Chinese President Xi Jinping addressed the World Health Assembly in May, he pledged \$2 billion over 2 years to combat COVID-19. In contrast, when Secretary Azar addressed the Assembly, he attacked the WHO and cast blame on China. The European Union held a pledging conference on vaccines last month, at which over \$8 billion was raised. The White House declined the invitation to participate, for reasons that are beyond me. Is this what the Administration means by "America First"? Well, if this EU consortium comes up with a vaccine before we do, it will mean "America Last." This approach is not only isolationist, shortsighted, and foolish, it endangers American lives.

Finally, as the old saying goes, "An ounce of prevention is worth a pound of cure." I am all for ensuring the U.S. Government is better organized to prevent, detect, and respond to future pandemics both here and abroad, but some of the proposals coming out of the Administration, eerily similar to those coming from some Members of Congress, are ill-thought, destructive, and dangerous, insofar that they would cripple USAID and create a mechanism at the World Bank to which the Administration could channel all of the funding it is withholding from the WHO.

So, I look forward to the first of what I hope are many thorough discussions.

Thank you, Mr. Chairman.

[The prepared statement of Senator Robert Menendez follows:]

PREPARED STATEMENT OF SENATOR ROBERT MENENDEZ

Mr. Chairman, thank you for convening today's hearing. As you know, I have been seeking a series of hearings on COVID for quite some time. I am pleased we are now having one. I understand you intend to hold more, and I strongly support that.

DEM LETTER AND COMMITTEE PREROGATIVES

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We do not need to rehash the contentious vote on Michael Pack. But we should all be seriously concerned about what we've seen in the last 10 days and 24 hours at the U.S. Agency for Global Media.

Mr. Pack has gone on a wholesale firing spree, removing the heads of the networks, and dissolving their corporate boards only to replace them with unqualified political people ... fundamentally undermining the mission and work of the organization.

It's now obvious why the White House wanted Pack so badly—so they could transform the Agency into their own personal mouthpiece. This is a blow from which it may never recover. Once the credibility is gone, nobody will ever trust a report from Radio Free Europe ... or Radio Marti ... nor trust the tools of the Open Technology Fund.

So Mr. Chairman, I urge you to respond to the letter in the spirit in which it was offered. On behalf of myself and all of the Democratic members of the Committee, I can tell you that we want to work with you ... we want to find common ground.

We want the State Department to be successful ... and we want this Committee to take on serious work and make a meaningful impact on the national and world stage. Let's work together to make this happen.

COVID-19 HEARING

Now, while I thank all of our witnesses for their service ... it is disappointing the White House would not send a member of the coronavirus task force, or any of the Senate confirmed individuals from the State Department, Health and Human Services, or the United States Agency for International Development responsible for the Administration's response.

The American people deserve to hear from members of the President's hand-picked team to understand what it is doing to address the worst pandemic the world has faced in 100 years ... more than 8 million cases worldwide, and more than 115,000 American lives lost.

This tragedy has assuredly been a wake-up call to those who question whether we should engage with—and invest in—the rest of the world. So I would like to use this hearing to understand how we got here—what we knew about the virus and when, and how we are leveraging our diplomatic relations and leadership to best respond and protect the American people.

BLAME GAME

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And rather than seriously consider how to best leverage our leadership and contributions, the President abruptly announced the U.S. would simply pull out of the organization; threatening not just our ability to confront COVID-19, but risking decades of progress on other global health initiatives including to combat Polio and Ebola.

And yes, China has a lot to answer for, but the Administration's use of racially stigmatizing language to describe COVID-19 in direct contradiction to guidance issued by the Centers for Disease Control and Prevention has been deeply hurtful to Americans at home, and utterly counterproductive in leading an international response.

The Secretary of State's insistence that the rest of the world agree to use such language has prevented us from reaching consensus at the G7 and in the Security Council.

LOSS OF LEADERSHIP

While the White House engages in divisive rhetoric, the rest of the world is stepping up. Without us. When Chinese President Xi Jinping addressed the World Health Assembly in May, he pledged \$2 billion over 2 years to combat COVID-19.

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Finally, as the old saying goes, an ounce of prevention is worth a pound of cure. I’m all for ensuring the U.S. government is better organized to prevent, detect and respond to future pandemics both here and abroad, but some of the proposals coming out of the Administration—eerily similar to those coming from some Members of Congress—are ill-thought, destructive and dangerous in so far as they would cripple USAID, and create a mechanism at the World Bank through which the Administration could channel all of the funding it’s withholding from the WHO.

So I look forward to the first of what I hope are many thorough discussions. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

We will now proceed to do exactly what I said we were going to do, and that is examine this with an eye towards constructing a shield for the future. And, of course, that does require some discussion of what happened and how we got here. But, nonetheless, I am hoping we will continue to focus the discussion, just as Senator Murphy and my bill has done in Senate bill 3829, and that is: look forward.

So, with that, we have a distinguished panel today, certainly people with outstanding knowledge in this area and who can help us understand the task at hand, and how we can accomplish that task.

So, first of all, we have Mr. James Richardson, who serves as Director of the Office of Foreign Assistance, where he coordinates \$35 billion in foreign assistance across the Department of State and the U.S. Agency for International Development. Prior to this, he coordinated USAID’s Transformation Task Team and served as Assistant to the Administrator for Policy, Planning, and Learning. He has 20 years of government experience and holds a bachelor’s of science and government, a master’s of science and defense and strategic studies, and is a graduate of the United States Air Force Command and Staff College.

Mr. Richardson, thank you so much. Give us the benefit of your wisdom.

STATEMENT OF JAMES L. RICHARDSON, DIRECTOR, OFFICE OF FOREIGN ASSISTANCE, U.S. DEPARTMENT OF STATE, WASHINGTON, DC

Mr. RICHARDSON. Great. Thank you, Chairman Risch, Ranking Member Menendez, and members of this committee. Thank you for inviting me to testify on the international response to the COVID-19 pandemic.

As a former staffer to a member on this committee, it is great to be back, and I look forward to having this opportunity to have a dialogue and answer any of your questions.

First of all, I need to acknowledge the leadership of President Trump, Vice President Pence, Secretary Pompeo, and, really, the myriad of teams we have all around the world at State and USAID who are working together to defeat COVID-19.

For those who may not be familiar, I am the Director of the Office of Foreign Assistance, which is a joint office between both State and USAID, and we coordinate foreign assistance on behalf of the Secretary.

As the Chairman mentioned, prior to that I was at USAID, where I led the agency's historic transformation, looking for ways to strengthen the power of development and improve the institution. As such, I believe deeply in the power of both development and diplomacy. But, together, I think they can be unstoppable.

The United States is the world's undisputed leader in foreign assistance. We have invested \$500 billion over the past 20 years; 140 of that in global health, alone. The United States has built and sustained health systems across the globe, trained millions of healthcare workers, and saved millions of lives. COVID has posed a unique challenge to the United States and the entire world, as you know, impacting both high-income and developing countries, alike. The numbers speak for themselves. The State Department has received nearly 1,000 requests from almost every country in the world.

In the face of COVID, the generosity of the American people has been on full display, with more than 12 billion in financial, humanitarian, scientific, and technical support to combat the crisis. Of that total, Congress has appropriated \$1.6 billion to State and USAID for the international response. First, thank you for that. This money is being well spent. We have committed, so far, 1.3 billion of that, and our assistance has gone to 120 countries, and it is making true impact. Of note, we have obligated over 500 million of that, with a plan to quickly obligate the rest.

We have provided much-needed ventilators in El Salvador. We have trained 20,000 front-line workers in India. We have funded public health service announcements on how to fight the virus in more than 50 languages. State and USAID has undertaken unprecedented coordination in the COVID response. That coordination has not slowed us down, but actually ensured alignment and effectiveness of our resources, for, when people's lives are at stake, we need to make sure we get this right. While the COVID-19 pandemic is certainly not over, I firmly believe that we need to start thinking about, today, what systems the U.S. and the world needs to lessen the likelihood of another outbreak becoming a global pandemic.

When looking across both this pandemic and epidemics and pandemics of the past, I think we can pull some important lessons learned, but the bottom line is that, moving forward, I hope we can all agree that more data, more coordination, and more response functions are necessary to respond to future outbreaks and prevent pandemics.

So, the first lesson learned is that pandemics are not just a development challenge or confined to the developing world. They are truly global in scope, with the risk of severe health and economic impact across the globe. For instance, of the countries with the

highest percentage of COVID-related deaths, almost none of them have U.S. Government bilateral global health programs. As such, U.S. leadership needs to not just focus on the development piece, which is critically important, but has to have a broader scope, focusing on mobilizing countries' own resources, burden-sharing with like-minded donors, and building true accountability into the global system.

The second lesson is that the U.S. Government and the global system must be prepared to respond internationally in strength and accountability. Coordination in the U.S. Government is key. We have to leverage the existing strengths of each department and agency for maximum impact. As I often say, true coordination is not about control, it is about empowerment. We have to unleash the power of our diplomacy, of our development, of our public health efforts in order to maximize our impact. We also need to ensure that global structures can effectively prevent and contain outbreaks from becoming epidemics and pandemics.

The third lesson is, the world needs more effective early-warning systems and data-tracking.

And, lastly, we need to think holistically about preparedness, and be flexible.

We understand that the challenges that we may face can come in many different forms, and that our response will ultimately be multifaceted, so we need to start thinking and planning for all of those inevitabilities today.

In the age of globalization, I fear that the next outbreak will look more like this one than outbreaks that we have dealt with in the past, but we have an opportunity to save lives, promote accountability, and ensure that pandemics are prevented to the greatest extent possible. We need systems that are flexible, focused, and truly global. We need to fill the gaps in the system while coordinating and leveraging the respective comparative advantages and unique strengths of each aspect of the U.S. Government. Time and time again, when there is a global challenge, Americans lead. We are the world's greatest humanitarians that the world has ever seen, and I am committed to working with all of you to strengthen this fact.

Thank you for having me today, and I look forward to your questions in this important conversation.

[The prepared statement of James Richardson follows:]

PREPARED STATEMENT OF JAMES RICHARDSON

Chairman Risch, Ranking Member Menendez, and Members of the Committee—thank you for inviting me to testify today on the State Department and USAID international response to the COVID-19 pandemic. As a former staffer on this Committee at the beginning of my career, it is great to be back, and I'm grateful for the opportunity to have this dialogue and answer your questions. The United States has been a global leader in responding to the COVID-19 crisis, as we have been in numerous other health, humanitarian, and complex crises for decades.

As you are fully aware, the COVID-19 pandemic is unique in that it is causing widespread health and economic devastation across the world: developed and developing countries alike. Unfortunately, scientists and the health security community have been clear that we should be prepared for another outbreak to rise to the level of a global pandemic. Therefore, even amid our significant response, we must begin to look to the future in order to analyze the lessons learned, adapt processes and structures accordingly, and act. Months into the pandemic, we already have important lessons learned that can help to inform our future response and ensure that

our resources continue to be aligned with both our national security and international development goals.

First, I want to acknowledge the leadership of President Trump, Vice President Pence, Secretary Pompeo, Dr. Birx, and our talented teams around the world as we work together to defeat COVID-19, both at home and abroad. The President knows that pandemics like COVID-19 do not respect national borders, and so our All-of-America response must also stretch beyond our borders. We can and must both fight pandemics at home and help our partners overseas.

For those that may be unfamiliar, the Office of Foreign Assistance, which I lead, is a Bureau staffed with personnel from the State Department and U.S. Agency for International Development, responsible for coordinating foreign assistance policy, resources, performance and strategy across the State Department and USAID. My team has been deeply involved in the COVID-19 response effort, ensuring foreign assistance is prioritized and committed to countries in need.

Previous to this role, I was at USAID, where I served as the Assistant to the Administrator for Policy, Planning and Learning and worked extensively with your staff as head of the Agency's historic Transformation. While at USAID, we built several new Bureaus, including the new Bureau for Humanitarian Assistance, which is operational as of this week, unifying and strengthening USAID's humanitarian response. We also created dozens of new policies and strategies, including the Private Sector Engagement Policy, and worked to empower the diverse and brilliant workforce, strengthening the Agency from the bottom to the top. I passionately believe in the power of development and diplomacy individually, but together they can be unstoppable. I am proud to have worked at both organizations during this Administration, now serving as the institutional link between the two.

The United States is the world's undisputed leader in foreign assistance, with \$500 billion invested by American taxpayers in the 21st Century, including over \$140 billion in global health, alone. The United States has built and sustained health systems across the globe, trained millions of healthcare workers, and saved millions of lives. It is no surprise that nearly every country in the world has requested assistance from the United States during this pandemic. They know we will deliver no-strings attached, high-quality interventions and equipment that addresses their greatest challenges.

When it comes to COVID-19, it's important to remember, this is not the first time we've seen an outbreak, and it certainly won't be the last. The United States has led the global fight against HIV/AIDS, tuberculosis, malaria, polio, Ebola, and many other infectious disease health security threats. At nearly \$10 billion dollars each year, the United States provides nearly 40% of worldwide global assistance for health—nearly five times the next highest donor. Without a doubt, our foreign assistance investments over time have laid the foundation for our COVID-19 response today.

We have mobilized as a nation to combat this disease both at home and abroad. With unprecedented destruction, COVID-19 has posed a unique challenge to the United States and the entire world in a way that we haven't seen this generation, affecting both the developed and developing world alike. When we look at the effects of COVID-19, it's important to understand the true challenges not just today in this pandemic, but also for the next pandemic.

In the face of COVID-19, the generosity of the American people has been on full display. Since the outbreak of COVID-19, the U.S. government alone has committed more than \$12 billion in financial, humanitarian, technical, and scientific support across many federal agencies to combat the crisis. As part of this, the State Department, USAID, HHS, DoD, and others are working together to support health systems; humanitarian assistance; and economic, security, and stabilization efforts worldwide with nearly \$2.4 billion in emergency supplemental program funding provided by Congress in March, including nearly \$1.6 billion for State Department and USAID foreign assistance. The U.S. government has no higher priority than the protection of American citizens. On top of our foreign assistance efforts, the State Department has worked to bring more than 100,000 Americans home.

Our efforts are guided by the SAFER package, a comprehensive interagency strategy to support our international partners in combatting COVID-19. The SAFER package is part of an All-of-America approach, leveraging the unique expertise, capacities, and mechanisms of various U.S. government departments and agencies to rapidly deploy and deliver essential support when, where, and to whom it is most critically needed. As part of this package, our foreign assistance funding is saving lives in more than 120 countries by bolstering countries' ability to prevent, detect and respond to the virus, support risk communications, funding water and sanitation services, and preparing healthcare facilities and staff. That coordination does not end at a shared strategy, but experts from USAID, State, and CDC are meeting

regularly to ensure that we implement this strategy in a united way. In addition, thanks to the expertise of American manufacturing, this effort now includes ventilators, delivering on President Trump's generous commitment to meet requests from foreign governments now that we have met our domestic needs for this equipment.

Importantly, our work has made a demonstrable impact, saving lives, with innovation leading the way. For example, in India, the United States has virtually trained more than 20,000 people on the frontlines of COVID-19, leveraging the power of digital technology to help state leaders prepare local COVID-19 response plans and train frontline health workers in strategic messaging, screening activities, counseling of patients, and basic clinical management. The United States has worked with Thailand to create a mobile application where 80,000 health volunteers can now track the location of suspected cases, manage home visits, and deliver relief kits with essential staples such as soap, rice, fish, and safe drinking water. And in many other places around the world, the United States has worked to pivot humanitarian assistance programs to respond to the pandemic, continuing to save lives through emergency food assistance and cash assistance while simultaneously providing access to water and soap for handwashing and critical information on how to stay safe.

While our response has been unprecedented, the COVID-19 pandemic is far from over, and will certainly not be the last outbreak that threatens to become a pandemic. We have a moral obligation to lead and to build a safer system for the next generation. The stakes have never been higher. With a current death toll above 400,000 and increasing and estimated economic losses between \$6 and \$9 trillion, we must seize this opportunity to prepare for the future, and we know where to start. COVID-19 has provided the U.S. interagency and international community a harsh reminder of existing health security gaps and new challenges that we must face. There are lessons to be learned about the way that we've responded to this pandemic and about the way we've responded to previous global health challenges, with great research to pull from think tanks and oversight bodies. Building on lessons from COVID-19, as well as previous challenges—Ebola in West Africa, Zika, H1N1, and so on—various trends emerge time and again. The value of this learning should be clear—the U.S. government can and should do better. While the list is much longer, for the sake of brevity, I'll mention four key lessons learned today.

First, as we have seen with COVID-19, the effects of pandemics are not limited to the developing world, and are truly global in scope, with the risk of severe health and economic impacts across the globe. U.S. leadership must have whole-of-globe reach that focuses on mobilizing partner countries' own resources and should demand transparency and accountability in the global system.

Second, the U.S. government must continue to prevent, detect, and respond internationally to outbreaks. Our historic investments in global health security have been critical in helping partner countries respond to COVID-19, and we will continue those investments to build their national capacities to respond to a variety of disease outbreaks. However, COVID-19 has had a multifaceted impact, with catastrophic health, economic, and humanitarian consequences. Coordination is key, and we must leverage existing strengths of each U.S. government department and agency for maximum impact. It is clear that global health structures alone are not able to effectively prevent or contain outbreaks from becoming epidemics and pandemics.

Third, the world does not have effective early warning systems and data tracking in-country in order to detect and prevent outbreaks from spreading. There is uncertainty on when and where outbreaks may occur at any given time. A robust multi-sectoral approach and transparent coordination with Health and other relevant Ministries will be critical for virus detection and demanding the accountability and transparency that is imperative to stopping a virus in its tracks. Pandemics don't know borders—we must take a close look at both domestic and international systems.

Lastly, we need to think holistically about preparedness, and start preparing for the next serious outbreak that could turn into a pandemic, today. As COVID-19 has proven, an outbreak can strike anywhere at any time. We must ensure our systems are flexible, accountable and meet the challenge at hand.

While there are many more lessons that could be identified, both large and small, these initial four provide a starting place. The question on the table is: how do we use these lessons learned to shape what do we do next? In the past, the world has faced serious infectious disease outbreaks such as HIV/AIDS, malaria, and Ebola. Over the past 20 years, for each of these diseases, the United States has stepped up to lead in response. We have also worked with our allies and partners to prevent, detect, and respond to a wide variety of other disease outbreaks. We have a moral obligation and national security imperative to do the same when it comes to preventing dangerous future outbreaks. However, as I mentioned, the challenge with

COVID-19 is that it's simply different than outbreaks and pandemics most of us have seen in our lifetimes. In this age of globalization, I fear the next outbreak will look more like this one than the ones of the recent past. With proactive thinking, together, we can prepare the U.S. government and international system to ensure the world is prepared for the next outbreak—and work together to prevent a future pandemic.

As we look forward, with history as our guide, we have an opportunity to save lives, promote accountability, and ensure that pandemics of this size and scale are prevented to the greatest extent possible. We need systems that are flexible, focused, and truly global. We need U.S. Government and international systems organized in a way to prevent, detect, and respond to future outbreaks, with better tools and improved whole-of-government coordination. We need to fill the gaps in our systems, while coordinating, leveraging and respecting the comparative advantages and unique strengths of each U.S. Government agency involved in pandemic preparedness, prevention and response. This does not mean taking away funding or responsibilities from any single government agency but mobilizing the collective strengths of each in a way that is truly coordinated and impactful. Lastly, and importantly, out of respect for the lives and livelihoods of Americans, we need to ensure effective oversight, accountability and performance mechanisms to ensure each dollar spent advances our objectives, including protecting Americans at home and abroad, and meets the challenges at hand.

Time and again, when there is a global challenge, Americans lead. We are the world's greatest humanitarians. And our international response does not detract from our ability to protect the homeland; rather, it bolsters it. Thank you for having me today for this important discussion, and I look forward to your questions.

The CHAIRMAN. Thanks so much. Great comments.

Mr. Milligan serves as Counselor to USAID. He previously served as the Acting Mission Director in Madagascar; Mission Director in Burma; Senior Development Advisor for the first Quadrennial Diplomatic and Development Review; a Senior Deputy Assistant Administrator for Policy, Planning, and Learning. He has a bachelor's degree from Georgetown School of Foreign Service, a master's degree from Johns Hopkins School of Advanced International Studies, and is a distinguished graduate of the National War College.

With that, Mr. Milligan, thank you for coming. We would like to hear what you have to say.

**STATEMENT OF CHRIS MILLIGAN, COUNSELOR, U.S. AGENCY
FOR INTERNATIONAL DEVELOPMENT, WASHINGTON DC**

Mr. MILLIGAN. Thank you. Chairman Risch, Ranking Member Menendez, members of the committee, it is really an honor to be here today.

And let me begin, first, by thanking you for your generosity, which has allowed the United States Agency for International Development to mount a robust response to the COVID-19 pandemic.

I have been a Foreign Service Officer at USAID for more than 30 years, and I currently serve as Agency Counselor, which is the senior-most career official at the agency. And, throughout my career, I have seen the United States respond to crises all over the world, and I have led some of those responses, such as the response to the Haiti earthquake.

I have seen how the United States saves lives, how we support our partner countries, and how we stand with them when disaster strikes. The scale of COVID-19 response is unprecedented, but these core American values are constant. In the past 10 years, USAID has been on the front line to fight numerous complex health emergencies, including the outbreaks of Ebola in West Africa, Zika in Latin America and the Caribbean, and the pneumonic plague in Madagascar, one I know quite well. We are continuing

to fight Ebola in the DRC, and we are in this fight for the long term, because that is what we do, and that is who we are as Americans.

Through these experiences, USAID has developed deep operational and technical expertise to respond quickly, rapidly, and appropriately to complex health crises. The United States Government is strongest when we are agile and flexible and well-coordinated, particularly at the country level. I know from my own experience, out-of-control epidemics are a symptom of multiple complex causes, and health emergencies have consequences that can rapidly require broader development assistance to address those deeper root causes of instability and poor governance. Controlling epidemics requires more than a standalone effort, and we have seen that, when we do not address poor governance and conflict, we wipe out the investments in health and education and other basic social services.

USAID has development experience to address these issues and prevent outbreaks from becoming epidemics, but we are hampered. We are hampered when countries such as the People's Republic of China and other malign actors do not disclose information transparently or share pathogen samples, and instead destroy samples and obfuscate facts, imprison medical personnel, and silence journalists. In stark contrast, USAID builds capacity and strengthens healthcare systems and democratic institutions to enable countries, themselves, to respond better to global health crises, and that protects us back home. We appreciate your support for retaining the independence to make these investments ourselves based on data and the best available evidence.

Today, faced with COVID-19, the United States is again demonstrating clear and decisive leadership. USAID is investing \$1.2 billion in emergency supplemental foreign assistance generously appropriated by Congress to finance healthcare, humanitarian assistance, economic security, and stabilization efforts worldwide. This funding is saving lives. It is also improving public health education and protecting health workers, strengthening laboratory systems, and supporting disease surveillance, and boosting rapid response capacity in over 100 countries around the world.

We are leveraging our development programming to complement our global efforts, because we recognize that COVID-19 will have extensive secondary- and tertiary-order impacts. So, taking health out of a broader development approach and isolating it will not lead to success. We must empower our health and development experts to do what they do best in the field, to respond to dangerous infections, diseases. It is imperative that we act proactively and address the ways—the many ways this crisis has not only cost lives, but threatened development outcomes.

We are very concerned about these secondary and tertiary impacts. We are concerned about the more than 113 million people who will need emergency foods assistance in the coming year, which would be a 25-percent increase. We are seeing a disturbing trend of a rolling back of democratic reform and democratic backsliding, closing space for civil society. We are investing not only in food security, but also in combating this democratic backsliding. These investments build responsive, transparent government.

USAID's response to the COVID pandemic contributes to the United States remaining a trusted and preferred partner in countries around the world. No other country can match our unparalleled generosity, our open and collaborative approach, our long-term commitment to helping—the Journey to Self-Reliance. So, that is why I greatly appreciate the ability to be here today and testify in front of this committee.

Thank you very much.

[The prepared statement of Chris Milligan follows:]

PREPARED STATEMENT OF CHRIS MILLIGAN

Chairman Risch, Ranking Member Menendez, and Members of the Committee—Thank you for inviting me to testify today on the international response to the COVID-19 pandemic. It is an honor and privilege to testify in front of the Committee, and I look forward to your questions.

Let me begin by first thanking you for your generosity, which has allowed the U.S. Agency for International Development (USAID) to mount a robust response to an unprecedented global crisis that has touched nearly every person around the world—both at home and overseas.

I have served with USAID as a Foreign Service Officer for more than 30 years in multiple countries, including Burma and the Republics of Iraq, Madagascar, Ecuador, and Zimbabwe. Throughout my career, I have seen how the United States rushes to help during times of disaster and crisis. We bring relief to the affected and hope to the afflicted. We save lives, support our partners to build systems, and stand with them if disaster strikes. The scale of the response to COVID-19 might be unprecedented, but these values—these core American values—are not. USAID is one of the faces of American compassion and generosity overseas, and I am proud to be here on behalf of the men and women who serve and carry out our mission all around the world.

Of course, our assistance goes far beyond relief work. We work with our partners throughout the U.S. government to strengthen democracies, drive economic growth, help send children to school, and keep families healthy.

Our response builds upon these decades of investments in global health. In just the 21st Century alone, the United States has contributed more than \$140 billion in global health assistance. For example, over the past 20 years, USAID's funding has helped Gavi, the Vaccine Alliance, vaccinate more than 760 million children, which has prevented 13 million deaths. This month, the United States committed \$1.16 billion to Gavi over the next 4 years, with the goal to immunize 300 million additional children by 2025. Since 2005, the U.S. President's Malaria Initiative (PMI), led by USAID in partnership with the Centers for Disease Control and Prevention (CDC), has saved more than 7 million lives and prevented more than 1 billion cases of malaria. USAID also recognizes that viruses do not respect borders, as the current pandemic so clearly demonstrates. USAID invests in global health security to address existing and emerging zoonotic diseases—which account for more than 70 percent of new infectious-disease outbreaks. USAID alone has invested \$1.1 billion in this critical area since 2009, in close coordination with other U.S. Government agencies.

In the past 10 years, USAID has been on the front lines to fight numerous complex health emergencies, including the outbreaks of Ebola in West Africa and Zika in Latin America and the Caribbean, and the outbreak of pneumonic plague in Madagascar. Today, even as we cautiously count down towards the end of the 10th outbreak of Ebola in the Eastern Democratic Republic of Congo (DRC), we are now scaling up a response to fight the confirmed 11th outbreak in Northwestern DRC. We are in this fight for the long term—because that is what we do, and that is who we are as Americans.

We know that what happens around the world can affect us here at home. Until now, local authorities, often with U.S. Government support, brought most of these outbreaks of dangerous pathogens under control. Our success has come from the ability to act quickly, rapidly and appropriately. The U.S. Government is at its strongest when we are agile, flexible, and well-coordinated at the country level.

Throughout the years, we have built up our operational and technical expertise and learned some hard lessons. Chief among them, is that we need close partnerships with communities, civil society, non-governmental organizations (NGOs), and faith-based organizations to solicit the support and engagement of local communities

to ensure an effective response, as well as the need to collaborate with researchers and the private sector.

As we continue to learn from this pandemic, we must address the root causes of these outbreaks and apply the lessons learned from COVID-19 and epidemics past. We have also learned that outbreaks and epidemics are directly related to governance, transparency, and capacity considerations. For example, the robust international response to the ongoing Ebola outbreak in eastern DRC was notably challenged by a humanitarian crisis, weak institutions, marginalized and impoverished communities, and insecurity. Yet thanks to healthcare capacity and expertise—supported by millions in USAID and U.S. government long-term investments in the country, the DRC government and international community was able to contain outbreak spread within DRC borders and prevent a global pandemic.

From my own experience, controlling epidemics requires more than a stand-alone effort. And we have seen that when we do not address poor governance and conflict, we wipe out investments in health, education, and other basic social services.

More often than not, we have the tools to prevent outbreaks from becoming epidemics—but we are hampered when countries such as the People's Republic of China and other malign actors do not disclose information transparently or share pathogen samples, and instead destroy samples, obfuscate facts, imprison medical personnel, and silence journalists.

And we recognize that health emergencies have consequences that can rapidly require broader development assistance—whether that is support for orphaned children, protection against sexual exploitation, gender-based violence, and abuse, buttressing sustainable livelihoods or addressing the deeper root causes of instability and governance.

When former Administrator Mark Green last testified before this Committee, he spoke of USAID's overarching mission of helping communities on their Journey to Self-Reliance. Our investments in global health throughout the decades are a cornerstone of this approach. Through USAID, our partners have built capacity and strengthened healthcare and democratic institutions to enable them to respond better to global health crises. We appreciate your support for retaining the independence to make these investments ourselves, based on data and the best available evidence.

Today, faced with COVID-19, the United States is again demonstrating clear and decisive leadership. The United States has mobilized as a nation to combat the virus, both at home and abroad, by committing more than \$12 billion to benefit the global COVID response overseas. USAID is working with the U.S. Departments of Defense, Health and Human Services, and State, as part of an All-of-America response. With \$2.3 billion in emergency supplemental funding generously appropriated by Congress, including nearly \$1.7 billion for foreign assistance implemented by USAID and the State Department, we are financing health care; humanitarian assistance; and economic, security, and stabilization efforts worldwide.

This funding is saving lives by improving public health education, protecting healthcare workers, strengthening laboratory systems, supporting disease surveillance, and boosting rapid-response capacity in more than 120 countries around the world. We are providing high-quality, transparent, and meaningful assistance to support communities affected by COVID-19 and equip them with the tools needed in their efforts to combat this pandemic. We are also using funding to support COVID responses in complex crisis countries and regions and providing health, water and sanitation, and logistics for humanitarian and crisis response.

We are forging partnerships with the private sector, NGOs, and others to help respond. For example, in the State of Israel, USAID has a long partnership with Hadassah Hospital, and a new one with Pepsi and SodaStream is underway to invent a high-flow respirator for COVID-19 patients, which would be available for medical centers in Jerusalem neighborhoods with an especially high incidence of the virus. The open-source designs can be downloaded for free for assembly anywhere in the world, and have already been used in the Republics of El Salvador, Guatemala, and Turkey.

In the Kingdom of Thailand, we have worked with the Thai Red Cross to create an application called Phonphai, which enables users to report locations of people infected with COVID-19 and in need of assistance. Village health volunteers in Thailand are using the app to locate people in quarantine, conduct basic health screening, and collect vital information. Working with Makro, Thailand's Costco equivalent and third-largest retailer, health volunteers have used the app to order and deliver emergency kits, including essential food and hygiene items, to more than 115,000 vulnerable people in quarantine throughout the country.

In the Federal Republic of Nigeria, USAID launched a partnership with cellphone provider Airtel to reach 1 million citizens a day with critical information via voice

and text messages on physical distancing, safe hygiene practices, and other preventive measures to contain the spread of the disease. Now we are able to distribute the latest public-health messaging instantly to millions.

Looking long term, we understand that COVID-19 will continue to have an impact around the world in the months and years to come. We remain committed to helping communities in our partner countries through this pandemic, and its second- and third-order effects. The COVID-19 pandemic is not simply a health crisis, and our response cannot be just a health response. It is an economic one as well.

Because of this reality, USAID is leveraging our development programming to complement our global health efforts. We are including other facets of our development programming to complement our health efforts to mitigate pandemics—because preventing pandemics requires functioning healthcare in the public and private sectors. And functioning health institutions require engagement beyond just the health sector. They require reforms in the gathering of local tax revenue, private-sector development, as well as engaging with patients and a broad set of actors. Taking health out of a broader development approach and isolating it will not lead to success. We recognize that diplomacy is a critical component of fighting epidemics, and we as a government should emphasize the importance of full compliance with the International Health Regulations (2005) in addition to coordinating and empowering our health and development experts to do what they do best in the field to respond to dangerous infectious diseases.

Already, the spread of the novel coronavirus and actions to mitigate COVID-19 have had significant secondary impacts—perhaps none more devastating than in the areas of food security and nutrition. At the beginning of 2020, conflict, poor macroeconomic conditions, and weather shocks were already driving high food assistance needs across the globe. The Famine Early-Warning System Network (FEWS NET), led by USAID, estimates 113 million people will be in need of emergency humanitarian food assistance this year, which represents an increase of approximately 25 percent in the span of just 1 year. The onset and progression of the COVID-19 pandemic, and measures taken to suppress its spread, are likely to increase the magnitude and severity of acute food-insecurity.

It is imperative that we proactively—and comprehensively—address the many ways that this crisis has eroded food security and driven malnutrition worldwide. To that end, USAID is working with the World Food Programme and NGOs to invest over \$165 million of COVID-19 supplemental humanitarian resources to address emergency food needs in 21 countries, including countries such as Afghanistan, Bangladesh, Colombia, Ecuador, and Lebanon and 15 countries in Africa that already were experiencing high levels of hunger before the pandemic. In addition to emergency food assistance, we are addressing disruptions to agricultural production, trade, and local markets; the loss of livelihoods; and the deterioration of essential social services, like water and sanitation, while building longer-term resilience. Each of these plays an important role in strengthening food security and nutrition, as well as fostering long-term resilience.

At the same time, we recognize how important democracy and citizen-responsive governance are in responding to the outbreak, and we are investing funds accordingly. Unfortunately, we are seeing democratic backsliding, closing space for civil society, and crackdowns on media freedom as the pandemic continues to unfold. To counter this trend, through ongoing USAID programming and supplemental funding, we are supporting civil-society organizations and independent media outlets, strengthening the rule of law, working with national electoral commissions, and combatting disinformation—because we know responsive, transparent governments are better-equipped to help their populations address the crisis and eventually help to mitigate the pandemic.

USAID also has begun to think about how we can successfully execute our mission in the post-COVID-19 world, in a way that is flexible and agile. To that end, Acting Administrator Barsa is establishing a temporary Agency Planning Cell and Executive Steering Committee to guide this effort. While the USAID COVID-19 Task Force manages near-term challenges arising from the pandemic, the Agency Planning Cell will perform research, conduct outreach, and prepare analyses around key strategic questions to help USAID prepare for lasting challenges to the development and humanitarian landscape in the medium to long term. It will then provide this information to the Executive Steering Committee, composed of senior leaders from across the Agency, who will craft recommendations for the Acting Administrator's consideration.

We are already planning for the medium- and long-term impacts of COVID-19 because we know the United States will remain a trusted partner, the preferred partner, in countries across the world. No other nation can match our unparalleled gen-

erosity, our open, collaborative approach, or our long-term commitment to helping communities on their Journey to Self-Reliance.

Thank you for the opportunity to represent USAID. I welcome your questions.

The CHAIRMAN. Thank you. It is good information.

Mr. Garrett Grigsby is the Director of the Office of Global Affairs at the Department of Health and Human Services, which leads U.S. engagement with the World Health Organization and its regional offices. He previously served as USAID's Deputy Assistant Administrator for Democracy, Conflict, and Humanitarian Assistance, as USAID's Director of Faith-Based and Community Initiatives, and as Deputy Staff Director for the Senate Foreign Relations Committee.

With that, Mr. Grigsby, we are anxious to hear what you have to say about our relationship with the WHO and how we will move forward.

STATEMENT OF GARRETT GRIGSBY, DIRECTOR, OFFICE OF GLOBAL AFFAIRS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. GRIGSBY. Thank you, sir.

Mr. Chairman, Ranking Member Menendez, and members of the committee, it is an honor to be with you to discuss the World Health Organization and the Global Health Security Agenda, or GHSA.

Last month, Secretary Azar addressed the World Health Assembly, the WHO's governing body, expressing concerns with the WHO and member-state response to the COVID-19 outbreak. The committee is aware of the President's statements and letter expressing his concerns and his May 29th statement that the United States is terminating its relationship with the WHO.

With respect to the WHO, allow me to go back even before the first reporting of the outbreak in Wuhan, China, and highlight the concerns, and then I will address GHSA.

After the SARS pandemic that also originated in China, the International Health Regulations, or IHRs, were revised in 2005 to improve transparency and reinforce obligations of countries to provide accurate, timely, and complete information about outbreaks. After the 2014 West Africa Ebola crisis, the WHO Health Emergencies Program was created, and it has had some success on the ground responding to complex emergencies, but it has not met the goal, the global challenge of COVID-19. Fourteen years after SARS, China failed again to provide accurate, timely, and complete information to the WHO about its COVID-19 outbreak, and, in fact, withheld information that could have helped countries take actions earlier to protect public health. The WHO did not call out the Chinese government, which we believe exacerbated the pandemic. Early statements from WHO leadership praised the Chinese government while criticizing others. When missteps of China and the WHO became apparent, our team compiled information to identify gaps in the WHO's outbreak response toolkit. This led to discussions with partner countries about reform of the WHO.

For example, the WHO's Director General must demand compliance with IHR obligations. The Director General and the WHO's Health Emergency Program must be insulated from malign polit-

ical pressure. Improvements to the process for declaring a public health emergency of international concern are overdue, and linking travel and trade restrictions together must be reexamined so countries can take proactive measures, like the U.S. did to protect our citizens, without criticism or retaliation.

Enacting these reforms, regardless of the United States relationship with the WHO, would be good for the world. The WHO will only live up to its mandate with increased transparency and accountability of all member states.

Switching to the Global Health Security Agenda, 18 months into phase two, called GHSA 2024, the need for a multi-sectoral approach to pandemic preparedness is greater now than ever. GHSA was created in the midst of the 2014 West Africa Ebola crisis to help countries comply with the IHRs. GHSA is a group of 67 countries, international organizations, NGOs, and companies working together to prepare for infectious disease threats. Under GHSA, nations make concrete commitments to elevate health security and improve capacities to prevent, detect, and respond to infectious diseases as a national priority. GHSA members provide support for implementation through advocacy, collaboration, information-sharing, and technical advice.

The U.S. is a leading voice on the GHSA 2024 Steering Group, as chair of the Accountability and Results Task Force, ensuring the focus on addressing gaps and challenges in countries' core capacities. The target is to have more than 100 countries with improved capacities by 2024. It seeks to improve accountability and tracks partner commitments in a transparent manner. We also collaborate with partners as chair of the Sustainable Financing for Preparedness Action Package to mobilize resources for preparedness.

HHS works with many countries to improve health security capacities pursuant to GHSA commitments. This includes helping complete a joint external evaluation to assess preparedness, developing national action plans, and mobilizing resources.

As GHSA core capacities are based on the International Health Regulations, both efforts I have discussed, leading GHSA 2024 and forging ahead on WHO reforms focused on strengthening the IHRs, are mutually reinforcing and will help bring about a safer world.

Thank you, Mr. Chairman. We look forward to working with the committee on global health security.

[The prepared statement of Mr. Garrett Grigsby follows:]

PREPARED STATEMENT OF MR. GARRETT GRIGSBY

Mr. Chairman, Sen. Menendez, and members of the Committee, it's an honor to be with you to discuss the World Health Organization (WHO) and the Global Health Security Agenda, or GHSA.

Last month, Secretary Azar addressed the World Health Assembly, which is WHO's governing body, expressing concerns with WHO and Member State response to the COVID-19 outbreak.

The Committee is aware of the President's statements and letter expressing his concerns, as well as his May 29 statement that the United States is terminating its relationship with WHO.

With respect to WHO, allow me to go back even before the first reporting of the outbreak in Wuhan, China and briefly highlight the concerns of the United States, and then address GHSA.

After the SARS pandemic, which also originated in China, WHO Member States revised the International Health Regulations, or IHRs, in 2005 to improve trans-

parency and reinforce and expand obligations of countries to provide accurate, timely and sufficient information related to outbreaks.

After the 2014 West Africa Ebola crisis, the WHO Health Emergencies Program was created. The program has had some success on the ground, responding to complex emergencies, like Ebola in the Democratic Republic of Congo, but it has not met the global challenge of COVID-19.

Unfortunately, 14 years after SARS, China failed again. We have grave concerns that China did not provide accurate, timely and sufficiently detailed information to WHO in accordance with the IHRs about its COVID-19 outbreak and, in fact, withheld information that could have helped countries take actions earlier to protect global public health. China had a responsibility to share this information with the rest of the world as it was the first to know about the virus.

WHO did not call out the Chinese government on its lack of transparency and timely information-sharing, and we believe that not doing so exacerbated the pandemic we are now experiencing. To the contrary, statements from WHO leadership praised the Chinese government, while criticizing other nations.

As early as February, when missteps of China and WHO were becoming apparent, our team was compiling information about the lack of sharing accurate, timely and sufficiently detailed information for the purpose of identifying gaps in WHO's outbreak response toolkit. This led to an intense discussion with partner countries about reform of WHO relating to outbreak response tools and preparedness programs.

For example, it is critical that WHO's Director-General use his platform to call for compliance with IHR obligations. The Director-General and WHO's Health Emergencies Program must be insulated from political pressure. Improvements to the process for declaring a Public Health Emergency of International Concern are needed. And the practice of linking travel restrictions must be reexamined so countries can take proactive measures, as the U.S. did to protect our citizens, without criticism or retaliation.

If these reforms are enacted, regardless of the United States' relationship with WHO, it would be good for the world by enabling WHO to fulfill its mandate, and increasing transparency and accountability of all Member States, in particular those with responsibility during infectious disease outbreaks in their territory.

Switching to the Global Health Security Agenda—18 months into the second phase of GHSA—called GHSA 2024—the need for a strong, multi-sectoral approach to pandemic preparedness is greater now than ever.

GHSA was created in the midst of the 2014 West Africa Ebola crisis to help countries meet their obligations to comply with the International Health Regulations. GHSA is a voluntary group of 67 countries, as well as international organizations, NGOs and companies working together to prepare for infectious disease threats. Under GHSA, nations make concrete commitments to elevate global health security and improve their capacity to prevent, detect and respond to infectious diseases as a national priority. GHSA members provide support for implementation through advocacy, collaboration, information sharing, and technical advice.

The U.S. is a leading voice on the GHSA 2024 Steering Group, as the chair of the Accountability and Results Task Force, ensuring that GHSA continues to focus on addressing gaps and challenges in countries' core capacities. The GHSA 2024 target is to have more than 100 countries with improved capacities by 2024. It also seeks to sharpen the focus on accountability and tracking country and partner commitments in a transparent manner.

We also collaborate with partners as the chair of the Sustainable Financing for Preparedness Action Package to use momentum from the COVID-19 response to mobilize resources to invest in preparedness.

HHS, alongside U.S. Government partners at State Department, USAID, and beyond, works with many countries to improve their health security capacities pursuant to GHSA commitments. This includes helping complete a Joint External Evaluation to assess their current state of preparedness, developing National Action Plans for Health Security, and mobilizing resources. Since the launch of GHSA, the United States Government has invested over \$3 billion to strengthen national capacity in partner countries to prevent, detect, and respond to existing and emerging-infectious disease threats.

As GHSA core capacities are based on the International Health Regulations, the two efforts I have discussed—forging ahead on WHO reforms focused on strengthening the IHRs, and leading in GHSA 2024—are mutually reinforcing and will help bring about a safer world.

Thank you, Mr. Chairman, for your attention and interest. We look forward to working with the Committee on global health security in the future.

The CHAIRMAN. Well, thanks, to all of you. It certainly looks like we have got the right panel here to give us the information we need to try to go forward.

Mr. Richardson, let me say, first of all, thank you for reminding us of how critical and pivotal the role of the United States is in any kind of a global challenge, and, most importantly, how generous Americans are. The 330 million of us, compared to the 8 billion in the world, contribute an incredibly high percentage of need that is given to less fortunate people.

You made one statement that I would like to focus on a little bit. And I am going to follow up on this with Mr. Grigsby, also. But, you said you fear that future pandemics are going to look a lot more like this COVID-19 than the ones that we have experienced in the past. Could you drill down on that a little bit, why you say that and what do you mean by that?

Mr. RICHARDSON. Yes. I appreciate the question, Senator.

I think when we start looking at what is the real differences with this pandemic—whether it is Ebola or SARS, both of those were fairly localized in scope. The challenges that they presented were probably overwhelmingly focused on the developing world. This pandemic—and, I think, given the globalization realities that we find, the fact that we can easily travel around the world, and that is continuing to accelerate, I fear that that mobility will drive epidemics, the outbreaks somewhere, to then be able to spread more easily through the developed world, in addition to the developing world.

The CHAIRMAN. You know, let me stop you there. As I look at these differences in the viruses—just take Ebola and compare it to COVID. The transmission mechanism is very different on the two, it seems. And the contagiousness of the disease seems to be very different. And with 2,000 viruses kicking around out there, they are probably all going to have idiosyncrasies that are different than others. Is that what you are making reference to?

Mr. RICHARDSON. Yes, absolutely. I think, when you really look at what the challenge we are presented, the likelihood of transmission, the globalization of this world, and the ability for viruses to quickly move outside of a containment area, that is a game-changer. And again, given the fact that it has been able to impact high-income countries, like the way it has, I think, really makes us want to rethink how we approach this.

The CHAIRMAN. Yeah, that is what we are trying to do right here, and that is exactly the focus of what we are doing. And I think your identification there is important.

In a minute, I am going to ask Mr. Grigsby a little bit more about that, because of the system we need to put in place. It seems to me that COVID-19, because of the way it transmitted and the rapidity at which it transmitted, it is so different from those other viruses that we have experienced in the past, and, in the defense of the systems that we are trying to respond to this, they were not ready for that. They did not expect it. They expected that it would behave like SARS or like Ebola or something like that. And what we found out is that it behaved very differently and required a very different response. And that did not happen. Is that a correct characterization?

Mr. RICHARDSON. Absolutely. We are not really sure what the next outbreak or next virus will look like, or what it will do. I will leave it to the scientists to talk about, you know, how it is transmitted or how much more easily it can move. But, I think our systems are not built for this type of outbreak. Clearly, it did not work, right? It did not stop the ability for this to become a global pandemic. So, we really need to think about what kind of flexible mechanisms, both in the international system and in the U.S. Government, that we can put into place now that allows us to be able to respond, both at an outbreak and at a pandemic level, that is to be able to say, you know, regardless of what the virus is, or regardless of where the outbreak starts and where it goes, we need to have an ability to respond. This idea of a worldwide ability to respond is incredibly critical.

The CHAIRMAN. Well, and that is what Senator Murphy and I and this committee are focused on, as far as trying to develop the system, here. And thank you for being part of that.

Mr. Grigsby, you know, in my conversations with Mr. Tedros and his team, they were defensive in one respect. I think it was legitimate. And that is, they said they did not have enough power. And, regardless of our criticism of them, we do have to realize that they are not a sovereign entity, and they cannot really tell a sovereign entity what to do. They can certainly encourage them and try to press them to do the right thing. But, it struck me that, going along with the conversation I was just having with Mr. Richardson, that they, as much as the rest of the world, were taken aback by how COVID-19 reacted, compared to their dealings with polio or AIDS or Ebola. Is that a fair assessment of where they were, as far as being taken aback by what happened?

Mr. GRIGSBY. Thank you, Mr. Chairman.

You know, it is fair to say, as Jim was alluding to, COVID-19 is a novel virus, it is one that had not been seen in human beings before. There is still a lot that we are learning about it. And, by the way, we would be happy to come up and brief you or your staff—not myself, but we have leading scientists in the world at HHS, and they could answer some of these questions very specifically for you. They are still learning about this. I think that is a fair comment.

And it is true, and it is a challenge, that the World Health Organization does not have a police force, it does not have a standing army to go in and enforce international health obligations, which is only one of two treaties that are in the WHO that countries have signed up for and are obliged to comply with.

But, I think what we all know is that, rather than even calling China out, what was really going on is that the leadership of WHO was praising China. This has happened before. We have been in this movie before. If you go back to the SARS situation in the early 2000s, the leadership of the WHO was a little bolder when it was confronting China, in that it did call China out. There were significant problems that happened that led, as I mentioned in my statement, to a revision of the International Health Regulations in 2005. But, there is only so much that it can do. But, it did not even do the minimum it could have done, as in calling out what was really

going on, the information that it needed that it was not receiving. That did not happen at all, unfortunately.

The CHAIRMAN. Thank you.

I am going to end here and turn it over to Senator Menendez.

Before I do, what I want you to think about is. We have focused quite a bit on what did not happen, and why it did not. And what I would like to hear when I come back to you is your thoughts as to what a system would look like if we were designing it now, which we are, hopefully, for the next pandemic, whose transmission is rapid and easily as COVID-19. Because, as we have now, I think, all agreed, this is entirely different than what we have dealt with in the past. We need a system entirely different than what we have had in the past. We want your thoughts on that as to how we would go forward.

Senator Menendez.

Senator MENENDEZ. Thank you, Mr. Chairman.

Mr. Chairman, just a comment. I agree that we need to continue working on a bipartisan approach. Before the last business meeting, we were working well on a bipartisan manager's package. And I, along with all the other Democrats on the committee, introduced the COVID-19 International Response and Recovery Act. And I hope we can find a common ground and a productive path forward. And I look forward to that opportunity.

Mr. Grigsby, I want to pick off, in your last set of comments here as well as your testimony, that China did not share sufficient information about the virus. And you just said that the WHO's words of praise for China actually exacerbated the pandemic because it did not pressure China to be more transparent. But, President Trump, himself, praised China's response multiple times, in speeches, public statements, in tweets, quite explicitly. In one tweet, on January 24th, he wrote, "China has been working very hard to contain the coronavirus. The United States greatly appreciates their efforts on transparency. It will all work out well. In particular, on behalf of the American people, I want to thank President Xi," close quote.

On February 6th, at the WHO executive board meeting, Ambassador Bremberg, who represented the United States, was similarly effusive, saying, quote, "We deeply appreciate all that China is doing on behalf of its own people and the world, and we look forward to continuing to work together as we move ahead in response to the coronavirus," close quotes.

Those are just some of the quotes.

So, was the WHO's praise for China the fatal flaw which necessitated the U.S. withdrawal from the WHO? And, if so, why did the United States make similar statements of praise and support for China at the same time if this was detrimental to the global pandemic response?

Mr. GRIGSBY. Thank you, Senator.

The comments you made are absolutely correct. Early on, the information we were receiving was that China was being cooperative. We were getting those reports from the World Health Organization. I remember having conversations early on at my level and members of WHO telling me how unbelievably transparent China was

being, particularly compared to the SARS problem in the early 2000s.

What happened was, we received more information later, as we all have had, and information is going to continue to come out. And, as that information changed, the tone changed. And that is just a fair comment.

Last month, the World Health Assembly approved a resolution. It is cosponsored by—in fact, because it was a virtual Assembly and much condensed, as opposed to the normal meetings, they were not able to do a lot of business. They had one item, and that was a resolution, cosponsored by 140 countries, expressing concern, but also demanding that there be an independent review of what happened, including about the origins of the disease and its path to transmission to humans.

So, a lot of countries were saying good things about China's response early on, but then as more information came out, and it will continue to come out with these independent reviews—

Senator MENENDEZ. Well, I look forward to the review, and I certainly believe it is important, but the President's praise continued even after the ones I mentioned.

Let me ask you this. You listed several reforms the Administration would like to see at the WHO, including pressure for better compliance of international health regulation obligations and improving the process for declaring public health emergencies of international concern. That would be good for the world. But, the Director General is not the person who decides on those reforms. It is the WHO, which is a member organization. Member countries make those decisions. How does the United States expect to influence other members to achieve reforms of the WHO if it has relinquished its seat at the table?

Mr. GRIGSBY. Senator, that is a good question, and I appreciate it.

The fact of the matter is, the United States is a member of the World Health Organization now. The President has announced that that relationship is being terminated and—

Senator MENENDEZ. Well, if I said, "I am terminating my relationship with you," why should I listen to you? Can you explain that to me? If you tell me you are terminating your relationship with me, why should I listen to you about anything you want to do with the organization that I no longer am going to have a relationship with?

Mr. GRIGSBY. Why don't I tell you what we are actually doing?

Senator MENENDEZ. No, why don't you answer my question.

Mr. GRIGSBY. I am doing that, sir.

As you know, the United States has the presidency of the G7 this year. That provides us an opportunity to speak with health ministries. In fact, Secretary Azar has, since early on in the pandemic, had once-a-week telephone conversations with all health ministers of the G7. As the situation with COVID-19 became more apparent, there was a focus on reform of the WHO. Those conversations continue. And some of the countries have asked us the same question. It is in the interest of the United States, whether or not we are a member of the WHO, to have a WHO that performs better.

Senator MENENDEZ. Well, I appreciate your lengthy answer, which is a non-answer, as far as I am concerned. The reality is, you have not made it clear to me how you are going to effect change in the WHO when you have terminated your relationship.

Let me ask you one other question. If we create a new Global Trust Fund at the World Bank—as I understand it from reading Senator Risch’s bill that is what it would do—would we just be going it alone? The rest of the world, they may be seeking change at the WHO, but they are behind the WHO. So, help me understand why other countries would now support a new mechanism at the World Bank. Would this not just create a parallel mechanism to the World Health Organization?

Mr. GRIGSBY. Senator, we just received a copy of the bill a couple of days ago, and I know our team is looking at that. I do not know that that would be the case. In terms of, for example, HIV/AIDS, there are multiple organizations that have been created, and I believe that they very much complement each other. I assume that the Senator’s proposal would be in that same spirit.

Senator MENENDEZ. Well, we look forward to your further analysis of the bill, because that is what it seems to me.

Let me close.

Mr. Richardson, I know that you have talked about the generosity of the United States. I would just say that, if I look at the President’s proposals for global health in fiscal year 2020, which is more than a 20-percent decrease in the foreign affairs budget, including a 28 percent cut to global health programs at AID and the Department of State, and, similarly, the proposal for FY–2021 includes, by some estimates, a 34 percent reduction to the State Department and USAID’s global health funding, and the budgets of the President for the last 3 years, had they been enacted, the U.S. would have, by some accounts, \$7 billion less to spend on humanitarian assistance in the last 3 years. So, to the extent that the American people have been generous—and they have—it has been because the Congress of the United States has put forward these funds, not because the Administration has proposed it. And I have serious concerns, which I will wait for the second round, as it relates to the actual delays in the obligation of critical humanitarian aid. We have heard, from many partners, that up to 10 weeks in delay. I do not think that there is a good reason for that. But, I look forward to exploring it with you.

Senator Johnson.

Senator JOHNSON. Thank you, Mr. Chairman.

This is a crisis that is really driven by, and really defined by, certain data points, certain metrics. Moving forward, if we are really going to respond properly, I think there are certain metrics that I think we have to key in on. I just kind of want to ask some questions about that.

If you look at recent past viruses, different outbreaks—H1N1, I am not a doctor, but I view that as a flu. Numbers I have seen, about 60 million Americans were affected by that, 200 million globally, but it was not particularly deadly. Ebola, I think, all told now, about less than 50,000 people have been infected with Ebola. It is about a 40-percent fatality rate. MERS was, I think, about 2500 people, about a 32 percent fatality rate. SARS, less than 10,000

people, and about a 10 percent fatality rate. Is it safe to say, Mr. Grigsby, that early on, in December, when this first surfaced in China, the WHO was looking at this, Dr. Fauci was looking at this, we were hoping that this type of new virus would be something similar, on the order of MERS and SARS, where, you know, it might be pretty deadly, but it was not going to spread that much? And I think my main point is, is the main metric there the transmission rate? And how quickly can we really obtain information on transmission rate in a new virus that we have never even seen before?

Mr. GRIGSBY. Well, Senator, I think you have hit upon the problem. And I sort of wish Dr. Fauci were here to answer your questions. He is a lot more knowledgeable than I am.

But, again, the point is, is that it was a novel coronavirus. And there are other coronaviruses that we have dealt with. SARS is an example. So, that is really the only thing that you could go back to and look at.

COVID-19 is not SARS. It behaves differently. But, you do not know that until you get into it. And, frankly, the scientists are still learning a lot more about it, and will be, I am sure, for years. That makes it very difficult to respond to.

Ebola is a scary thing. The mortality rate is high. It is very difficult to deal with. But, at this point, there has been a lot of experience in dealing with that. There have been new tools that have been created, like a vaccine that is effective, and therapeutics that are effective. But, early on, that was not the case. But, once you deal with these things, you become better at it, you learn more about it, and that is what we are in the process of doing.

Senator JOHNSON. We have obviously now seen the economic devastation caused by, you know, global and national shutdowns. I think we have to take that into effect, the human toll of that, as well. I think we are starting to understand that, the devastating human toll of what has happened to our economies.

Early on in these models—for example, the Imperial College of London, I have read the reports, but the one that really drove so many of these shutdowns—in the first report, the introductory summary estimated, without mitigation, 7 billion people would contract coronavirus. Is that not an impossibility?

Mr. GRIGSBY. I confess to you, sir, that I am not an expert on those models. We have people at CDC and NIH and other places that are. We would be happy to bring up those folks and talk with your staff. There is a whole industry that deals with these models.

Senator JOHNSON. I guess, my point being is, what models are we relying on to drive policy? We need to take a serious look at that, and we need to take a serious look back at what drove so much of this economic devastation. And, you know, eventually we will find out what the infection fatality rate is. Right now, according to the Oxford Center for Evidence-Based Medicine, they are saying it is going to be somewhere between 0.1 and 0.41 percent. A bad season of flu is about 0.18. If we are moving forward, in terms of, you know, what our response is going to be, we need to identify these metrics that drive the type of policy—first of all, to address the health situation, but also understand what is happening with our economy as we employ these shutdowns.

Mr. GRIGSBY. Right. You are right, Senator. And again, I would just go back to the fact that this is a novel coronavirus, something that had not been seen in humans before. So, some of it is educated guesswork. There is no doubt about it.

Senator JOHNSON. Thank you, Mr. Chairman.

Mr. RICHARDSON. Senator, if I may, just—

The CHAIRMAN. Go ahead.

Mr. RICHARDSON. I think your point is exactly right, sir, and I just want to sort of reemphasize that this idea of having an early-warning tracking system—we have early-warning tracking systems for families, right? That is an existing program. It is run out of USAID. It is phenomenal. But, we do not have effective early-warning systems and data-tracking systems for outbreaks going into a pandemic. This is a huge vulnerability and a gap in the strategic system, and it is not a gap currently filled by the WHO or any other system out there, and it is something, I think, we certainly need to look at.

The CHAIRMAN. We will take note of that.

Senator Johnson, thank you for bringing this into the area of the economics. It is certainly something that needs to be considered as we go forward with the bill and the metrics that need to be developed to look at that.

Senator KAINE.

Senator KAINE. Thank you, Mr. Chair.

And thank you, to the witnesses.

I want to follow up on Senator Johnson and ask you some questions about data.

So, on January 21st, the United States and South Korea both had their first reported case of coronavirus. And, on that day, the unemployment rate in both nations was fairly similar. It was 4 percent in South Korea, and it was a 3-and-a-half percent in the United States. On March 3rd, we had a hearing in this room, I believe, a HELP Committee hearing, not a Foreign Relations Committee hearing—with a number of the political appointees dealing with coronavirus. And on that day, South Korea had experienced 28 deaths, and the U.S. had experienced 9 deaths, the coronavirus, and the unemployment in both nations was also, essentially, similar.

Today, South Korea has lost 280 people to coronavirus, and the United States has lost, now, more than 119,000. The South Korean unemployment rate has risen to 4.8 percent, while the U.S. unemployment rate has risen to 13.3 percent.

South Korea has one-sixth of the population of the United States. Their GDP is one-twelfth that of the United States. South Korean per-capita income is less than two-thirds of U.S. per-capita income. South Korea is every bit as much affected by any missteps of the WHO and every bit—and possibly more affected by Chinese missteps because of their close proximity to China and the frequency of travel between China and South Korea.

Even with vastly greater resources, the United States now has a COVID-19 death rate per 100,000 population that is 80 times higher—80 times higher—than that in South Korea. I know four people who have died of coronavirus. And our economy has been devastated by this crisis in a way that South Korea's has not.

In a hearing on international response, I think it is important to look at other nations and ask, what did they get right that we got so wrong? So, I would like to ask our panel, how can America and the entire world replicate the more successful strategy that South Korea or other nations—Japan, Canada, Germany, Australia, New Zealand, Vietnam—utilized, as we go forward in fighting COVID-19 and preparing for the next pandemic?

Mr. GRIGSBY. Senator, I am happy to start out.

I think that many years are going to be spent taking a look at lessons learned. The World Health Organization just approved a resolution to take the first steps to do the first one.

Senator KAINE. Is that a good thing? Does the U.S. support that?

Mr. GRIGSBY. Yes, we did. In fact, we negotiated—the EU sponsored it. We worked very closely with them to ensure that that language was, in fact, in there and was not weakened by other states that were seeking to weaken that language. And there were 140 other cosponsors.

I have no doubt that, in our own country, there will be countless studies looking at this, and there will be lots of lessons—

Senator KAINE. Can I ask you, are you guys looking at this? Are you guys analyzing the experience of nations whose death tolls are dramatically less than the United States, and asking yourselves, What do we need to do better right now—not years of analysis; we are still fighting COVID-19—what do we need to do better right now, and what do we need to do better to prepare for the likelihood of future pandemics?

Mr. GRIGSBY. Yes, sir. I mean, we have folks at the CDC in Atlanta who do just that. As you mentioned, you know, South Korea is a very different country than the United States, and, in fact, even their laws allow the government to—

Senator KAINE. They are also similar to the United States in a lot of ways.

Mr. GRIGSBY. Sure.

Senator KAINE. They are an ally; big, messy multiparty democracy, densely urban, but also fairly rural. Every country is different than the United States in some ways, but South Korea is a country that has a lot of similarities to the United States, including a very close working relationship.

Mr. GRIGSBY. And I think that all of us are going to have a lot to learn from the successes and failures of many countries, including what we have done in the United States. So, that is going to be happening for years on something like this that has had this massive of an impact.

Senator KAINE. My time is close to the end, and I do not want to go over, but, Mr. Chair, I think a hearing on best practices, in this committee, and maybe a combined hearing between this committee and HELP would make a lot of sense, because there are things we have done that we could teach others, but there is an awful lot of things that other nations have done that we should learn. To be true to what you say, we are having this hearing to prepare for the near-certainty of future epidemics. We should be trying to learn those lessons as quickly as we can.

The CHAIRMAN. Yes. You know, Senator Kaine, I could not agree with you more. It seems to me, though, that the answer to the

question is relatively straightforward, and that is, how tough does the government want to be, as far as locking people up so they cannot spread the disease? That is a debate that is probably going to be pretty heated, I would think, depending upon the culture of where you come from. But, it needs to be explored. There is no question about it. Because the question is, do you want to go ahead, as Senator Johnson and others have pointed out, that if you compare this to the flu, we go through this every year with the flu, and we take hits as a result of that. What are we willing to do in a pandemic like this? And that is a very fair discussion—

Senator Kaine. And I think, Mr. Chair, just to respond, South Korea is not a China or a Vietnam, it is not an authoritarian state, but a democracy. And so, yes, the government did some things—early testing, and then, if people are sick, contact trace, isolate and treat those who are sick. But, by doing that—and that was heavy government action—they did not have to shut down the economy.

The Chairman. Yes.

Senator Kaine. So, that is why the unemployment rate went from 4 percent to 4.8 percent, where ours went from 3.5 to 13.3. So, you have tough government action on the testing and contact tracing, meant that they needed to do less dramatic government action on shutting down the economy. And other nations are going to have other experiences. And then, we have done things that we can—in, especially, our research institutions, that we could share with others. But, it makes my skin crawl to think of—first case on the same day, similar tiny number of deaths in March, and now 280 deaths in South Korea—and 120,000 in the United States. And so, I know we can do better. And this committee, with the Global Health Subcommittee, together with the HELP Committee, are the places where we ought to be hashing that out, learning those lessons.

The Chairman. Yes. Fair points, across the board. I think, also, a person pointed out to me the fact about how important wearing a mask is in social interaction. And this person also pointed out that, culturally, around the world, there are people that are very comfortable wearing a mask. In some countries—I was told by this person, who is an academic, as far as these things are concerned—that, in many countries, people will wear a mask if they have got a cold or if they have a cough. We never see that in our Western civilization here. But, yet, in other countries, that is the case. So, you are right. I mean, these things absolutely do need to be looked at further.

Dr. Barrasso.

Senator Barrasso. Thank you very much, Mr. Chairman.

Mr. Grigsby, I believe the World Health Organization failed the American people, failed the world during the coronavirus crisis, refused to call out China for its disinformation campaign, lack of transparency, the cover-ups. You made reference to some of this. From the start, I believe the World Health Organization blindly accepted China's leaders' false reporting and understated the threat of the disease. They repeatedly praised China for transparency and spreading accurate and misleading information. January 14th, we know they pushed out a false information that there was no evi-

dence, they said, of human-to-human transmission of the virus, despite clear evidence to the contrary.

But, it continues. I mean, just last week, the World Health Organization announced that asymptomatic spread of the coronavirus was rare, and then that made the national and the international news for a day. And then, the next day, they had to walk back the claim, so they had to change things. Lots of inconsistencies. But, this is not the first instance of the World Health Organization's failure to prevent, detect, or respond to a severe infectious disease crisis. As a doctor, I always thought that the World Health Organization's mismanagement of Ebola and the delay in declaring it an international emergency—and I called them out publicly about it back in, I think it was 2014.

So, due to the leadership failures and the repeated mistakes, I think it is time to reconsider the role that the WHO and its leadership play. I agree with the withdrawing of the funding. Reforms are needed. I agree that reforms are needed to ensure the accurate and transparent data-sharing to members.

So, the question is, how do you do this? Another member of this committee said, what leverage do you have after you have withdrawn the funding? I think you have a lot of leverage, because if you say, "You want the funding restored, you want us to come back and reengage, then give us the kind of credibility and engagement that is necessary."

Fundamentally, what do you see is the problem with the World Health Organization? Is it a lack of political commitment? Is it a lack of capacity or capabilities? Why are they continuing to fail to implement needed reforms?

Mr. GRIGSBY. Thank you, Senator.

Maybe if I could just talk a little bit about some of the reforms that we are discussing with other countries. And it goes beyond G7 health ministers, as well. As I mentioned before, this is not the first time. We have experienced this before with the World Health Organization. And, in fact, I made mention of the SARS earlier—when there were problems, again, in the West Africa Ebola crisis, that led to more reforms, the creation of the Emergencies Program at WHO. The Obama administration, at the time, actually had to redirect funding away from the WHO, because the WHO could not get its act together and even accept the money. So, that went for good work that was going on in those countries through private organizations.

So, this sort of thing is not new. There is a big difference between the COVID-19 pandemic and how that has impacted the world and the West Africa Ebola crisis, which was more regionally focused. But, you know, we have had many encouraging conversations with other countries regarding the need for reform. I mentioned a few of those in my statement. And, really, you answered Senator Menendez's question better than I did. But, the fact remains that if WHO can get its act together, and can make the reforms, and can prove that it has independence from China, I am sure there is every possibility that the relationship that the United States has could be changed. But, the ball is in their court. And there are a number of reforms that they need to undertake. And we have, really, a remarkable amount of agreement and common

ground with other health ministers that we are dealing with on the need for reform, notwithstanding our relationship with WHO. That is beside the point. So, the ball is in their court, and we hope that they will embrace these reform proposals.

Senator BARRASSO. Can I ask about the development of a vaccine? Can you please discuss the steps, Mr. Grigsby, that the Administration is taking to engage with our global partners to ensure that the vaccine can be developed and distributed as quickly as possible?

Mr. GRIGSBY. Well, yes, sir. You know, we have our own projects that are going on, Operation Warp Speed, and we are investing a lot of resources in that. There are other efforts going on globally. We have collaborations and conversations, and share lessons learned, and provide technical assistance. So, really, we are rooting for all of the efforts. We are going to need more than one vaccine, and we are going to need more than one company, because we are going to really need vaccinations for everybody on Earth, ideally, and easy access to them.

There are a lot of different things in play. We have folks whose job is to work on these. I am happy to bring up some folks, technical experts and scientists, who can speak with you and your staff. We are happy to do that anytime. But, there are a number of initiatives going on. And our Department and the White House, as well, they are in discussions with, I am assuming, all of them.

Senator BARRASSO. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Booker.

Senator BOOKER. Thank you very much, Mr. Chairman.

It goes without saying this pandemic has hit the United States of America pretty significantly, and, within that context, my State of New Jersey has seen the worst of this pandemic; and the lives lost, the families facing devastating grief, and the struggles that we have seen have been legion. I am grateful that it was already said in this committee that we have a serious problem—at a time that people were calling into question China's secrecy, we have a President that was praising China. At a time when people were demanding transparency from China, this President was coddling them and encouraging them in numerous public statements, in numerous tweets, and we were failing—as people in New Jersey were dying, we were failing to hold them to account for the challenges that were before them. And so, I continue to be concerned about our policies regarding China that go beyond tough talk, but to really working to get results. According to reporting, China appears, during this crisis, to have nationalized control of domestic production and international distribution of critical personal protective equipment. In early 2020, in response to this crisis, including that of the U.S. companies, such as 3M, which produce PPE, this is a significant challenge. Under their action of nationalizing their control, China required factories that make masks on behalf of American companies in China to produce masks for its own domestic use. Now, China is currently exporting more masks, and these exports seem to relate to political calculations, with the U.S. receiving less priority than other markets. China's mask diplomacy, or

China's distribution of masks and medical equipment in order to curry favor, has been widely reported. I would like to really know, how is China, in your perspective—and maybe address this to Grigsby and Richardson—how is China prioritizing their exports of PPE? And how is the U.S., in your view, benefiting or to the detriment of our country? And, really, the entire world saw the images of our healthcare professionals working without adequate PPE while we waited for China to release the supplies of PPE. What have we learned, as a nation, through the process, in the event that another surge of the coronavirus hits and we find ourselves with heightened demands and needs for PPE? I am very concerned that this problem still is ongoing and that the Chinese policies are still working at a detriment, at a significant detriment, to the United States of America, and we are not doing enough.

So, I would like a response from Mr. Grigsby and Mr. Richardson, if possible.

Mr. GRIGSBY. Thank you, Senator. I think your comments are spot-on. And I do not know that there are many silver linings to this terrible crisis. But, I think one of them is going to be, I can assure you, a reexamination of the supply chains. I believe that everything you mentioned is true, in terms of that. I can assure you—this is not my office that does this, but there are a lot of people, not only in HHS, but across our government, working very hard specifically on the supply-chain issue. It is a big issue. And thank you for raising that.

Senator BOOKER. Thank you, Mr. Grigsby.

Mr. Richardson.

Mr. RICHARDSON. Yes, thank you, Senator. I totally agree with you, and I agree with Garrett.

When you look at China—and I would not just look at it in the context of COVID—but, if you look at their approach to foreign assistance generally, they have a really mercantilist, very strategic approach to what they do. They are looking at strategic medical—mineral rights. They are looking at strategic ports. They are looking at, you know, bribing officials in order to get their companies access to things. That is really the Chinese approach to foreign assistance, writ large. And I think it does set up a really great dichotomy between, you know, if you want to go with China and accept that type of assistance, you are going to go backsliding on your governance and your transparency, and it is not ultimately going to be the most successful for any of our partners.

I think what the U.S. really offers with our donor partners—offers, really, a different solution of transparency, no-strings-attached assistance, and those types of things. It is a critical issue.

Senator BOOKER. So, I am grateful. And I do not think we are sounding the alarm enough. We see the authoritarian regime of China working against our country, from currency manipulation to corporate espionage and stealing secrets. We have seen this behavior consistently in how they deal with foreign relations. But, now, in the nature of a pandemic, it is chilling to see that their actions and what they are doing is putting lives in our country at risk in the past, right now, and especially with the potential for a second wave. I am grateful you are echoing, Mr. Grigsby, what I have been saying in this committee, in the Small Business Committee, is the

supply-chain issues are national security issues, and we need to be acting with bolder, far-greater action to protect our nation from this menace that seems to be the Chinese intention to undermine our safety, our health, and our well-being.

I want to ask, very quickly, about wet markets, because I have great partnerships across the aisle. China CDC announced it found COVID-19 in samples collected in a wet market in Wuhan, China, in January. There is a new outbreak right now in Beijing, but China, yet again, in this outbreak, we see that it is still linking a lot of the challenges to wet markets. These live wildlife markets were also linked to the 2003 SARS outbreak. Scientists studying zoonotic diseases, diseases that jump between animals and humans, have pointed to the close proximity of shoppers, vendors in these markets, as they are being prime locations for the spread of these pathogens. And so, we know, from SARS, which I mentioned, Ebola, monkeypox, COVID-19, MERS, and more, jump from animals to humans. It is clear that wildlife markets that sell wildlife animals for human consumptions need to be shut down.

Senator Graham and I sent a letter to the heads of international organizations, urging them to engage in efforts to shut down these markets. And so, very quickly, and then I will stop—and love to ask this question to Milligan and Richardson—is, how should the U.S. work through international organizations and the international wildlife community to increase the awareness of this risk and, really, to begin to take real measures to shut down and ban wildlife markets so that we do not see this challenge again? I am grateful to be working with Senator Cornyn, Senator Graham, and others, on legislation. But, to me, this has got to be an international priority. And I would love to get your thoughts on that.

Mr. RICHARDSON. Thank you, Senator. I appreciate those comments.

State and USAID have really robust programs when it comes to preventing wildlife trafficking, environmental programs. And we have a fairly broad reach, although a lot of the countries that are the greatest offenders, like China—we do not have a lot of those types of programs in some of these countries. So, I do think we need to expand, not just in the development piece that Chris will have better insight in, but on the diplomatic side. I think that we have got to do a one-two punch here. But, working together, I think we can make real progress.

Mr. MILLIGAN. Thank you. And I think what this shows is that these issues are all interrelated. You cannot look with just a simple health focus. It is all interrelated. We have a tremendous opportunity now to build more commitment behind preventing wildlife trafficking, by action messaging on CITES, and by talking to many of the countries that enable this to happen about the consequences and the downstream effects. So, this is a tremendous opportunity.

And going back to the whole sanitation issue that you raised, we are prioritizing many of our investments in water and sanitation hygiene, particularly for that reason, you know, that we can prevent the spread of this disease as it goes forward. So, Senator Booker, your point is well taken that these issues are all quite interrelated. But, we have an important ability now to message strongly and show these connections, which can help have a broad-

er impact on these important issues, such as countering wildlife trafficking.

Senator BOOKER. Thank you.

Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Thank you, Senator Booker, for raising the supply-chain issue. That is certainly something that is critical.

This ties in a little bit with what Senator Kaine was saying, and that is that one of the things that South Korea did, it had an all-of-government approach to this thing, and they shut down their supply chain out. They hung onto everything that they had. And what has happened in this is, there has been a real underscoring of the weaknesses that we have as a result of a lot of our manufacturing going overseas. And I think some of that manufacturing that is national security, and certainly a health challenge is a national security issue, like anything else. I have no doubt we are going to be looking at that as we go forward. So, thank you for that.

Senator Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman.

In response to a question about global vaccine efforts, Mr. Grigsby said that we are “rooting for these efforts.” And I will, maybe, direct this question at Mr. Richardson, because it probably matters more what the Secretary of State thinks about this than the head of the CDC.

Why should we just be “rooting” for these global vaccine efforts? In fact, we could be a part of these global vaccine efforts. In particular, there is one that is probably the most promising. It is CEPI, the Coalition for Epidemic Preparedness Innovations. All our allies are a part of it. It is, frankly, doing work, as we speak, with U.S. companies. The legislation that Senator Risch and I have would authorize the United States to become a partner with CEPI and put money behind that effort. So, what is the Administration’s specific position on the wisdom of joining this particular global vaccine effort? It just seems to be a lot smarter for us to be at the table, so, if CEPI is the one that produces a vaccine, that we have something to say about where that vaccine goes and who gets it first.

Mr. RICHARDSON. Yeah, I appreciate that, Senator.

You know, CEPI plays an important role, certainly. Gavi also plays an essential role. The Administration just made the largest pledge ever, for an American government, to Gavi, of \$1.6 billion. So, I think our commitment to the international effort for vaccines is pretty strong.

I would say that, if you look at what we have done—and a lot of this actually is on the HHS side—but, \$4 and a half billion of—we have invested through BARDA. We have allocated \$350 million for vaccine efforts, \$1.8 billion for rapid acceleration of diagnostics. I think there is a lot of work that has already been happening in the U.S. Am I going to say that we should not coordinate more closely with our partners and allies around the world? Well, of course we should. That is a great commonsense approach.

I will say—and I do not know if your question was leading to the EU Conference before—but, the U.S. has invested private sector

and public dollars, over \$12 billion so far into vaccine development and therapeutics.

Senator MURPHY. I do not deny we are spending a lot of money on vaccines. My question is not whether we are spending enough money. It is whether we are better off hedging our bets and making sure that we are not only doing that domestically, but we are also joining these international efforts. I hope that the Administration would be open to bipartisan congressional legislation pushing us towards joining CEPI. I think there is bipartisan support here.

Mr. RICHARDSON. Happy to look at that.

Senator MURPHY. Mr. Grigsby, I did want to turn back to this question of the WHO. I mean, I do think it is pretty stunning to hear from the Administration that the problem, early on, was that the WHO was giving cover for China to withhold information about the vaccine. And Senator Menendez covered this, and so we do not need to belabor the point. But, it was not that the President was simply saying nice things about China early on. On 40 different occasions, up to and including the month of April, the President of the United States was the primary global cheerleader for the Chinese response to COVID. He went out of his way, over and over and over again, to say great things about the Chinese response.

Here he is on February 7th. This is far after we all recognized that China was withholding information. He gets a direct question at a gaggle, "Are you concerned that China is covering up for the full extent of coronavirus?" February 7th. He has an opportunity right here to say, "Yes, I am concerned about it. They need to give us information." His answer is, "No. China is working very hard." And I have got 20 pages of this from the President.

And so, it just belies reality to suggest that the problem was the WHO covering up China's response. The president of the WHO is not more powerful than the President of the United States. And we all need to acknowledge that.

My question to you is this. The idea that we are going to try to affect WHO reform through the G7 is a new one. Can we at least just stipulate, for the time being, that it is harder for the United States to impact reform of the WHO if we are not a part of it, rather than a part of it? It might just be good for us to stipulate that. Whether or not you are going to try to pursue reform through the G7, or not, can we at least stipulate that it is more difficult for us to get the WHO to reform if we have withdrawn from it?

Mr. GRIGSBY. Thank you, Senator.

I think, as Senator Menendez or another Senator had mentioned, WHO is a member-state institution. Our conversations with the G7 are important, because it really represents the most significant and influential donors to the World Health Organization.

I would say that if WHO and other countries do not want to see the United States leave WHO, there is no doubt about that—it is important for WHO to embrace these reforms, and at the appropriate governing bodies, meaning for member states to take these reforms up and approve them.

Senator MURPHY. There is one country that is desperate for the United States to leave the WHO, and that is China. They are going to fill this vacuum. They are going to put in the money that we have withdrawn. And, even if we try to rejoin in 2021, it is going

to be under fundamentally different terms, because China will be much more influential because of our even temporary absence from it. And any other construction of reality is just putting the United States in a very, very dangerous position.

Thank you, Mr. Chairman.

Mr. GRIGSBY. Well, I guess I would say to that, sir, that the U.S. has been the most generous donor to WHO, really, since the beginning. It has been remarkable, the increase in China's influence within WHO, really, over a long period of time. That has been with the United States in WHO and being the most generous contributor to WHO. So, the President made a bold decision. There is no doubt about that. Personally, I hope that it will get the attention of the leadership of the World Health Organization, and that the scenario you just described would not come about. That is at least my hope.

Senator MURPHY. I would just, finally, note, we were continuing to fund the WHO for the last 3 years, but we left our seat on the board vacant. So, it does not take a lot of imagination to figure out why China was able to get more influence if we were sending money but not sending anybody to sit on the governing board. So, we invited—listen, I am not defending the fact that WHO has gotten closer to China, but, we essentially invited the Chinese to step in and fill the shoes of the United States, given the fact that we were not sitting on that governing board.

Mr. GRIGSBY. Senator, I actually have something to do with that, so I would like to respond to that.

I am actually the alternate board member, and I am sure I do not do as nearly as good a job as a Senate-confirmed person, but that seat was not vacant, I assure you. And, in fact, Ambassador Bremberg or his predecessor, the Ambassador in Geneva, they are always there to fill that seat. And Dr. Giroir, who is the Assistant Secretary of Health, he was actually nominated—I think it was 2017. So, he was nominated a long time ago, and we sure do wish we could have had him confirmed sooner, but he was just confirmed a couple of weeks ago. He was nominated last year, and had to be re-nominated again this year.

Senator MURPHY. All right. Well, I will not get into an argument over whether it is more effective to have Senate-confirmed positions, or not. I would, obviously, argue that it is.

I am well over my time. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murphy.

Mr. Grigsby, I can tell you that I have got contacts with the WHO, and your suggestion that our talk of withdrawing and withdrawing funds might get their attention. I can assure it has gotten their attention. And it has probably been your experience, too, but it is clearly my experience. So.

In any event, we want to look forward, as opposed to backward. And we are going to talk about it in a few minutes. But, before we do that, Senator Cardin.

Senator CARDIN. Well, I hope I am looking forward.

Mr. Chairman, thank you very much for holding this hearing.

Let me thank all of our witnesses for their service to our country.

On global challenges, U.S. leadership is indispensable if we are going to have the type of outcome that is in the interest of the

United States, in our security interests. And this committee knows that best. So, that is why I was very pleased to see that we are holding this hearing.

It is through U.S. leadership that we have a safer world, a more democratic world, and a healthier world. So, many of us are very concerned as to how the United States responded to this global pandemic. We have seen inconsistent information coming out from the White House—and that is being kind to the President—on a lot of the things that he has done in regards to this pandemic. We have not seen the type of preparation or response to the pandemic that would be used as a model for the world to respond. I think Senator Kaine pointed out that pretty clearly in his questioning.

This is not an isolated example of the Trump administration in regards to global affairs. I could point to the immigration policy of this country. And I was very proud that the Supreme Court ruled the President's actions in trying to end the DACA program were, in their words, "arbitrary and capricious." But, we also could talk about the President's trade agenda that initially put us at odds with our trading partners, our traditional trading partners, rather than trying to isolate China. Or the United States pulling out of the Paris Climate Agreement—the only country in the world, basically, to pull away from that. And now the pandemic.

So, my question starts off with the effectiveness of U.S. global leadership on this pandemic. When other countries look at what is being done here in the United States, how much influence do we really have in the behavior of other countries? Because they look at what is happening in the United States, they see the President holding a political rally, bringing lots of people together, against the advice of the public health officials. So, how can we complain about what is going on in other countries—and my question is going to deal specifically with some of our largest countries in our hemisphere who have, at least publicly reported that their cases of COVID are very much underreported, and they have not taken the steps that public health officials believe are necessary in order to contain the spread of COVID-19? This is our hemisphere, and we know this is a global pandemic. How much influence do we really have? And how much are we concerned with what is happening in our own hemisphere, with other countries that are underreporting COVID-19 and have not taken the steps that public health officials believe are necessary in order to contain this virus?

Mr. RICHARDSON. Yes, Senator, I can start that. I appreciate that question.

You know, we are really, truly committed to the western hemisphere. I think we just announced another \$250 million to be turned on for the Northern Triangle countries. Our commitment to Colombia is unprecedented. Mexico—

Senator CARDIN. I am trying to limit this to COVID-19, if I can.

Mr. RICHARDSON. Sure. Yes.

Senator CARDIN. And you might want to also point out that Congress appropriated almost \$2 billion of aid to deal with COVID-19. Can you tell me how much of that money has actually been spent, and where it has been spent?

Mr. RICHARDSON. We can go and look exactly at the obligations by country—

Senator CARDIN. Not obligations. How much has been spent?

Mr. RICHARDSON. That is how much has been spent.

Senator CARDIN. Spent.

Mr. RICHARDSON. Yes. So—

Senator CARDIN. Can you give me a range of that 2 billion, how much has been spent?

Mr. RICHARDSON. Yes. So, Congress has appropriated \$1.6 billion for State and USAID. So, I can speak to that piece. We have committed about 1.3 billion. Of that, we have committed almost 200 million for the western hemisphere—

Senator CARDIN. And you say “committed.” The money is actually out, and it is being spent?

Mr. RICHARDSON. We have identified which project—

Senator CARDIN. I understand you identified. How much of that has actually been spent?

Mr. RICHARDSON. So, it gets down to the obligation rates, which—USAID actually does their own obligations. I will turn to Chris to answer specifically. But, in general, we have obligated almost over 500—

Senator CARDIN. I am not interested—I want to know how much has been spent. This is a global emergency.

Mr. RICHARDSON. Right. So—

Senator CARDIN. Time is critical. How much has actually been spent?

Mr. RICHARDSON. So, obligation equals spending. It is when we actually hand over the money to the implementing partner to do the work. And so, that is the big picture. And then I can turn it over to Chris, if he has more details on, specifically for western hemisphere, what the obligation rate is.

I will say, you know, one thing. So, each individual bureau and an agency handles their own obligations rate. So, I can speak for the State Department side. State Department has obligated every dollar that we have identified that we want to spend on COVID. So, that is happening. AID has a different mechanism and different approach to this, and so I can let Chris, sort of, elaborate. But, I think—

Well, let me just do that. Chris, if you want to have this conversation.

Mr. MILLIGAN. Thank you, Senator.

The easy answer, from our perspective, is that USAID has put over a billion dollars into the hands of people overseas to respond to the COVID-19. That includes the portion of the supplemental that we are still continuing to put in people’s hands.

Senator CARDIN. How much of the supplemental has been spent?

Mr. MILLIGAN. More than 50 percent, sir. Of the portion that we control. But—

Senator CARDIN. And why has not all of it been allocated?

Mr. MILLIGAN. We have been allocating in tranches, because the virus moves very quickly, and if we—what we need to do is see where the virus is going, and then move ahead of it and prepare, and learn as we go.

Senator CARDIN. Do you need more money? Are you going to be requesting more money?

Mr. MILLIGAN. We are busy obligating the money that we have, and we are very thankful for the generosity of Congress in this. We are not through this pandemic, and we are learning a lot.

One of the things I am most concerned about, sir, are the secondary and tertiary impacts. We are seeing a big rise in food insecurity. We are seeing a democratic backsliding. We see 1.1 billion children out of school. We are alarmed about gender-based violence. So, there is a whole set of secondary and tertiary impacts that we will have to consider, going forward, sir.

Senator CARDIN. I just would ask that you would keep our committee informed as the money is actually spent, and the requests for additional funds, as you see the needs.

Mr. MILLIGAN. Yes.

Mr. RICHARDSON. No, absolutely, Senator.

And just to pick up on what Chris mentioned. We have \$35 billion that is being spent every year on foreign assistance—you know, much of it going to western hemisphere. We want to make sure that every dollar is spent in a COVID-sensitive way. Right? How do we make sure that our gender-based violence programming, our education programming, our health programming takes into effect of what is happening with the virus, right there, right then? And so, it is a really important conversation. So, as Chris mentioned, it is not just the supplemental. We are really trying to bring to bear all of our foreign assistance in order to help countries overcome this virus.

Senator CARDIN. Thank you.

The CHAIRMAN. Let me follow up on Senator Cardin's question.

On the 50 percent of the supplemental money that has been put out, has that been spent on the primary effects of COVID, or is some of it spent on the secondary and tertiary effects that you have quite properly and considerably brought up?

Mr. RICHARDSON. Yes, it is a mix. So, Congress has appropriated a certain amount of money for our Economic Support Fund, which is looking at that tertiary and secondary impacts. Primarily, most of our resources are coming in the form of both global health and humanitarian, which do focus more primarily on the actual virus and providing critical medical supplies, training healthcare workers, looking at best practices, those types of things.

The CHAIRMAN. Thank you so much.

Senator Shaheen.

Senator SHAHEEN. Thank you, Mr. Chairman.

And thank you, to our panelists.

I would like to go back to China. There has been a lot of discussion about China and their role, in the hearing today. We have seen a concerted effort from China to counter any negative narrative that may develop in the international media and within countries on China's role in the pandemic. And I would say, given the discussion this morning, they have been pretty successful. They have demonstrated a clear willingness to use their resources, including the manufacturing of personal protective equipment, to realign national sentiments in countries that may otherwise be inclined to critically examine China's response to the coronavirus. In fact, the Center for Strategic and International Studies released a report earlier this month that surveyed political elites across

Southeast Asia and found that China is gaining ground on political influence and far outstrips the U.S. on economic influence in that region.

So, I have two questions for you, really. One is, how does the lack of U.S. leadership on the pandemic response create a vacuum that allows China to better develop that narrative, where they are the provider, helping countries with needed resources and expertise? And, secondly, how does the pandemic contribute to this dynamic in Southeast Asia in a way that has a negative impact on the United States and our role?

Mr. RICHARDSON. Yes, I appreciate—

Senator SHAHEEN. I am happy to have whoever wants to answer it.

Mr. RICHARDSON. I can start, and then I can pass it on.

I mean, I just totally agree with your premise of your question. I mean, the reality is, China has used this pandemic to advance their strategic interests around the world. As I mentioned earlier, it does need to be seen in the context of their larger efforts. I think we have a lot of work to do, especially on the public diplomacy side, to—one, to counter misinformation, and our Global Engagement Center does a great job of doing that, and also providing—

Senator SHAHEEN. Well, let me—I am sorry to interrupt, but—

Mr. RICHARDSON. Of course.

Senator SHAHEEN. —let me just ask you, Why do you think that is? Why have we been slow? Has it been some of the statements that were read, from the President, that suggest that we have been slow to recognize what was happening in China?

Mr. RICHARDSON. No. Actually, I think what you are seeing is that the United States has outspent China, time and time again, both in its everyday foreign assistance—right? China spends 400 million or so on foreign assistance, and we are at 35 billion. I mean, they are just not a significant player when it comes to what we would consider to be effective foreign assistance. They spend all of their resources trying to build up strategic ports and to engage in bribery and other aspects. And so, I think it is an asymmetrical challenge, from a development perspective, and we need to develop asymmetrical responses, accordingly.

And, you know, Congress was really smart in last year's appropriations bill. They established what is called the Countering China Incentive Fund, and we are going to be spending \$300 million through a bottom-up process, trying to develop best practices across the world to say, How can we effectively counter China in Djibouti and in Malawi and in El Salvador? This is not a Southeast Asia problem, as you know. China's influence has dramatically shifted, and the next battlefield is Africa and western hemisphere. And we want to position ourselves in order to be able to be, one, the partner of choice, always; and two, remind people of the everyday commitment we have been making to countries over the past 40 years. We have been there. We have stood with countries through thick and thin. As I said, we have invested \$500 billion just over the past 20 years.

Senator SHAHEEN. Well, I agree with that. But, a lot of that 500 billion has not been in humanitarian and economic development

aid, is it? And when you are counting that 500 billion, are you not counting the military aid in that, as well?

Mr. RICHARDSON. Yes. So, about 25 percent of—the way that our budgets work, about 25 percent of our foreign assistance is security assistance. And that is not just military, that is also law enforcement—

Senator SHAHEEN. Right.

Mr. RICHARDSON. —and those types of things, 25 percent is global health, 25 percent is humanitarian, and 25 percent is everything else.

Senator SHAHEEN. So, given that, why do you think we have not been more successful and China has been successful?

Mr. MILLIGAN. I would like to, please. I have been working in development for 30 years, and most of that time I have been overseas. And yes, we have seen the quick increase in Chinese influence. But, we are also seeing that China is not now as successful, in many ways. There is a lot of buyer's remorse and more understanding that Chinese investments come with strings attached. The supplemental that we are implementing has a very important public diplomacy side that really shows American leadership. And countries overseas are turning to us and to our embassies for leadership on this issue.

Senator SHAHEEN. So, can I—I am sorry to interrupt again, but I am out of time, and I just want to get an answer to the—what has the pandemic done to allow China to increase its influence, as opposed to our reaction globally to the pandemic, which does not seem to have produced a similar response to American aid?

Mr. RICHARDSON. Yes. I mean, that is a tough question to—obviously, to answer. And we would have to go country-by-country to really determine. Every country is unique in how they approach it and how they think about Chinese assistance. Most countries are willing to accept face masks, or whatever, from China. But, to Chris's point, they often then go around to us and say, "Hey, is this financing deal from China any good?" That we are the trusted partner in choice, even though we have seen China really accelerate. But, if you look at their investments, even in COVID, versus what the U.S. has invested, it pales in comparison. I think they have just really focused on getting those headlines.

Senator SHAHEEN. Well, let me just point out that the State of New Hampshire was able to get personal protective equipment from China when we could not get it from the United States or from FEMA. So, I think we need to examine what is happening there and what we could be doing better in order to address the fallout from the pandemic.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Shaheen.

Now, the tough questions. If you guys were sitting here, each of you, one at a time, what would you do to construct a system for the future? Would it be to rehabilitate WHO, to reform WHO, to create a new division of WHO, to restructure its management? Would it be to create a new international agency? Would it be to use something else, like CDC, or what have you, to construct a system as we go forward?

I want to say that Senator Menendez raised a very legitimate question about parallel spending in another organization. And I think the last thing anybody here wants to do is to create more bureaucracy, as opposed to an effective, nimble response to this in the future.

And so, give me your thoughts. I guess we will go right down the line.

Mr. Richardson, you are up.

Mr. RICHARDSON. Thank you, Chairman.

You know, whenever you deal with these challenges, I always want to make sure we are thinking about what problem we are trying to solve and what results that we are looking for. The solution, and the specifics about the solution, will naturally come, and that is through the legislative process. The Administration has yet to finalize its own proposal in this space. But, let me say that—a couple of things.

You know, first and foremost, having really clear leadership and coordination function is essential. And, as I said, coordination does not mean control, it means empowerment. We should not be—you know, the State Department should not be doing global health programming. That would be a terrible duplication of efforts, and really takes away from what CDC and USAID does. But, the State Department also has global reach, it has embassies in nearly every country in the world. And it has a natural coordination function that is essential.

The other gaps into the system that we have seen in both the domestic and the international systems is data-tracking, is built-in accountability. How do we create true accountability into the international system to hold countries accountable for not meeting minimum standards? How do we make sure that we are encouraging countries to use their own resources in a coordinated and systematic way that allows us to better share data, to be able to create early-warning systems? And how do we bring the very best of our private sector and the U.S. Government to work together? So, those are a couple thoughts.

The CHAIRMAN. Those are all good questions, but not much of an answer. What—who—when the fire alarm goes off, who responds?

Mr. RICHARDSON. The State Department is the functional lead for foreign policy for the United States.

The CHAIRMAN. How about for the world?

Mr. RICHARDSON. For the world, sorry. The CDC is responsible for outbreaks or for public health emergencies. USAID leads on complex crises. So, each one of us has our natural roles or responsibilities. And so, I would guess I would encourage as how we can pull all of our expertise together in order to solve the problem.

The CHAIRMAN. So, the criticism has been made both in this committee here, and for a long time, that the WHO fell down on the job when it was obvious that there was something developing. Should they be the ones to undertake this in a fast-moving pandemic like this, or should there be a different agency that does that, that shines light on it, that attacks it—that goes and gets it? Who should do that?

Mr. RICHARDSON. I appreciate that. I do not think that—look, the WHO has failed the world on multiple occasions. The last Adminis-

tration saw the same thing with the Ebola crisis. We have now seen this with the COVID crisis. You know, when this problem has been brought to us before—this is not the first time we have had to think about, can the WHO do HIV/AIDS response?—for instance. I think the world said, “No.” It does what it does, but it is not going to be nimble, dynamic, respect burden-sharing, bring in private-sector actors, and be able to respond appropriately, with the highest-levels accountability. So, last time, the U.S. led to create the Global Fund in order to do something on the HIV/AIDS side. And so, I think that looking at where are the strategic gaps in the multilateral space, and how the U.S. can lead with our friends and partners and folks around the world in order to strategically fill those gaps, that will be an essential part of that conversation.

The CHAIRMAN. So, is the Global Fund a model?

Mr. RICHARDSON. I think the Global Fund is a tremendous model. I think Gavi is also a tremendous model. I think there are a lot of things to be learned from lots of different options out there. I think really the key here is having worldwide reach, focusing on burden-sharing. You know, right now, the U.S. spends—40 percent of the world’s global public health work comes from the American people. You know, we do not want to back away from that, but, as we take on this new challenge, we really need to surge in both private-sector and other donors into this space. And both the Global Fund and Gavi have tremendous models about how to do that well.

The CHAIRMAN. Do you agree, Mr. Milligan?

Mr. MILLIGAN. Thank you, Senator.

When I think about the future, I think we need to think about, how do we respond to the next pandemic, and how do we prevent, also, as well, an epidemic from becoming a pandemic? And then, how do we structure ourselves to effectively engage in that effort?

We know that, in order to respond, we have to maintain a nimble and effective means to do so. We cannot have an overarching, top-down, bureaucratic bureaucracy engaging in that.

The CHAIRMAN. We have learned that the hard way.

Mr. MILLIGAN. And we need to empower our people in the field, at the country-team level, because that is where a lot of the true coordination and expertise comes due. In order—

The CHAIRMAN. Do you agree with Mr. Richardson that good models for the vehicle are the Global Fund and Gavi?

Mr. MILLIGAN. That depends, sir, because it is a model for what? I do not mean to be cheeky, but a—

The CHAIRMAN. No, no. No, I—fair enough.

Mr. MILLIGAN. Because we are—Preventing is very different than responding. And those are different skillsets and different attributes. So, when I consider prevention, we know that a pandemic is not really a health crisis, it is a governance crisis. We know, where we have epidemics today, we have them because of state fragility. Where is Ebola today? Eastern Congo. Why does polio still exist where it exists today? It exists in fragile states, like parts of Pakistan and South Sudan. So, many times, an epidemic is really a governance crisis masquerading as a health crisis. And we need to make sure that we have an integrated approach.

Senator Booker talked about the link between wildlife trafficking and zoonotic crossovers. So, when we look at preventing, there is

a level of coordination that needs to take place. We cannot have a stove-piped, health-alone approach that creates another layer of bureaucracy. It has to be something that brings everything together.

When we look at the response side, we have to maintain our nimbleness and our ability to actually engage in that international effort at multiple levels.

The CHAIRMAN. And what agency, or what system—what do you recommend in that regard? Again, this is a global—for that part—when the fire alarm goes off and the fire department goes, who is the fire department?

Mr. MILLIGAN. Correct. We do not really have the Global Fund or Gavi set up to be the fire department. The Global Fund is responding to slow-moving epidemics, not—

The CHAIRMAN. So, is there no model, then, that exists for the fire department?

Mr. MILLIGAN. The only model we currently have is the one that we are suggesting needs to be reformed. Currently, when there is a humanitarian assistance crisis—and I have led many of our interactions in them—we work through the U.N. cluster system. The U.N. actually sets and organizes the international parts together. It works well on a—for a regional stage. But, now we do not have a model for the pandemic stage. But, we have principles that we need to incorporate: flexibility, responsiveness, integrated approach, and one that brings the U.S. Government core capabilities that we share at this table into that together.

The CHAIRMAN. Mr. Grigsby.

Mr. GRIGSBY. Yes, sir. Thank you.

I think Jim and Chris have stated it quite well. And I just want to thank Jim and colleagues at U.S. Agency for International Development. We have worked very closely with them in the development of these ideas. We appreciate that.

We do support the coordinator concept being in a non-implementing agency. I would just point out that most of what we are talking about is sort of foreign-assistance-related. The CDC, which would be the agency in HHS that would have the most to do in this area, it is not a foreign-assistance agency. It really is a technical-assistance agency. It operates differently than USAID, and, in fact, in different places. It does have 50 or 60 offices in developing countries. But, it actually operates in every country on Earth. So, rich countries, poor countries. It has all sorts of collaborations.

But, we—

The CHAIRMAN. Are you suggesting CDC is the model for the fire department?

Mr. GRIGSBY. No, not necessarily. It just depends on what kind of fire that the trucks are going out to address, I guess. I mean, CDC is on point when it comes to the pandemics and disease outbreaks. There is no doubt about that. It oftentimes works very closely with U.S. Agency for International Development, particularly in the case—in eastern DRC is a great example—where there is a disease outbreak, and it is happening in a part of the world where there is a war going on, and many other problems, and it is, by definition, a complex emergency. So, we work hand-in-glove with USAID on that.

So, I do not know that there is a one-size-fits-all sort of answer. Kind of case-by-case.

The CHAIRMAN. Well, thanks.

I was hoping to get a clearer answer to the question of, “Who is the fire department?” Because that is what we are trying to do here. I get all the moving parts. I understand that. But, it seems to me that if there was a telephone number that somebody could call and say, “Come and put out the fire,” we want that agency. But, right now, what you are suggesting is, we give them a list of phone numbers to call. And I am not sure that that response makes sense.

Mr. RICHARDSON. Well, Senator, if I could just be very clear. There already is a number that countries call when they have a problem. It is our Ambassador. And that is really where our worldwide reach is really essential. And then, our ambassadors and chiefs of mission around the world, they are naturally lean on the technical expertise, depending on the challenge. Right? And I think as we start thinking about what the next pandemic looks like—is it fast-moving? Is it slow-moving? Does it hit the developing world? Does it hit the high-income countries? How does it work? What are the responses that we need to do? We just do not know. And so, making sure that we have true coordination that can pull the right levers at the right time in order to get to results, I think is essential. But, I certainly would not want to move away from the fact that we do have a worldwide reach today. People know who to call. And that is our chief of mission at the State Department. And we want to just look to strengthen that capacity.

Mr. MILLIGAN. And if I could add briefly to that. I would say that our ambassadors, they are the mayors, and the fireman is the Office of Foreign Disaster Assistance, which mobilizes rapidly through DARTS around the world, but currently responding to very complex humanitarian assistance all around the world, and complex emergencies. So, from our U.S. point of view, we have firemen. But, I think your question, sir, is—should there be, and will there be, an international fireperson?

The CHAIRMAN. That is what we are looking for.

Senator Kaine, anything for the good of the order?

Senator KAINE. Just to follow up, Mr. Chair, on your comment, and then one additional question.

I will put myself firmly in the camp on this, in that I think we ought to stay in the WHO and use our leverage to push reforms. An enormously frustrating organization, like every international organization. The U.S. chose not—the Senate actually chose not to put the U.S. into the League of Nations when President Wilson urged, after World War I, that we do so. And the organization was ineffective. It was more ineffective because the U.S. was not involved. But, it was interesting, during the 1930s, long before World War II, FDR could see the League of Nations collapse coming, and basically said, “It has been ineffective, but if it collapses, we are going to have recreate it. The world needs it,” and started planning for a U.N. Those plans were delayed by World War II, but eventually Presidents Roosevelt and then Truman carried forward on it, recognizing the frustrations. The U.S. pulled out of the U.N. Human Rights Council, for some very legitimate reasons—a history

of anti-Israel bias, and also a more broad history of hypocrisy. The member nations, you know, were fulminating about human rights and doing bad things. But, what has happened as a result of us pulling out—has it gotten better for Israel? No. And things that the U.S. advocated on the Council that did become global priorities—for example, fighting against discrimination against LGBTQ people, that would not have been part of the global human rights agenda if it were not for the United States. Those have gone unaddressed or sort of dormant with the U.S. not there.

I think these organizations are enormously frustrating, but I think it always goes worse for the world if the U.S. is not involved. And I think it generally goes worse for us, as well.

And so, I, like the President—whether it is with NATO or the WHO, lean on them, demand more accountability, more strings have to be attached. But, it just goes worse for the world if we are not there. I am so confident that the U.S. always had such a value-add to any organization that when we back away from it, (a) they lose the expertise that we uniquely have, and then, worse actors elevate their profile in ways that is not good for us or anyone else.

Here is the question I want to ask you quickly, and it follows up on a conversation I think you were having with Senator Cardin. There was a New York Times piece in the last week about on-the-ground agencies feeling frustrated about the slow pace of the delivery of the March CARES Act and other money, this 1.6 billion, out into the field. And you have given us, basically, “An awful lot of it has been committed, a big chunk of it has been obligated.” And I just want to understand this, and maybe we will follow up in writing. But, “obligation” means you put it in the hands of the organization—you know, the U.S. is writing a check to an organization. Is that the same thing as getting to the field? Might some of the complaints of these ground-level—you know, Church World Services, Save the Children, World Vision—might their complaints be, the U.S. has written a check to somebody, but there is a middleman problem, and it is not getting down to the ground yet? Because this was a recent piece in the New York Times, with groups named that were really frustrated. What is the source of their frustration? How can we solve it?

Mr. MILLIGAN. Senator, I think that their source of their frustration is that they want to act as quickly as we want them to act, as well. Without getting very bureaucratic, our different accounts have different abilities to spend money. Here are these concerns from these NGOs, our important partners. With the humanitarian assistance funding that we have, as soon as it is available, they can begin spending it. We contract directly with them. We do not go through middlemen.

Senator KAINE. Okay.

Mr. MILLIGAN. As soon as it is available—this is a unique ability we have with these funds. And so, of the \$535 million in humanitarian assistance funding, they can currently spend 267 million, and, by July 17th, they can spend all of it. So, that is in addition to—that is part of the overall funding that we have made available, which is a billion dollars that we have made available, which it is in their hands to do work now. We are looking at ways of actu-

ally streamlining the process. We are committed to fully obligate all this humanitarian assistance by the end of July.

I have to tell you, these are extraordinary times. Previous to the global pandemic, we were running very large-scale humanitarian assistance efforts in very difficult places, like Yemen, Iraq, South Sudan, and Syria. And the global pandemic has also affected our own workforce, as well. But, we are adapting, and we are streamlining, and we are meeting the challenge.

Senator KAINE. Thank you. Appreciate that.

Thanks, Mr. Chair.

The CHAIRMAN. Thank you, Senator Kaine.

To our witnesses, thank you so much. You have been very patient with us. And this is a part of the puzzle that we are trying to solve, here. We appreciate your thoughts on it. We hope to hold a number of these hearings to try to get as much input as we can and then, as a committee, sit down and try to construct a bill that is going to move us forward and that, when this happens again—and I think we are all under the belief that it is going to happen again, hopefully later rather than soon—that we will be more ready for it. And hopefully we will have some legislation that will address that.

So, with that, thank you again for your service, and thank you for attending this hearing.

The committee is adjourned.

[Whereupon, at 11:41 a.m., the hearing was adjourned.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

RESPONSES OF JAMES L. RICHARDSON TO QUESTIONS SUBMITTED BY SENATOR ROBERT MENENDEZ

Question. The Administration provided a shipment of ventilators to Russia under emergency authority. Does the Administration remain committed to sanctions imposed on Russia in response to its election interference and illegal occupation of Crimea and aggression in Donbas? Would the State Department be willing to put out a statement towards that end?

Answer. Our actions have sent a clear message to those who take part in malign Russian activity: they are on notice. If they continue to pursue election interference efforts, aggression in Eastern Ukraine and Crimea, human rights abuses or other threatening activity, they will suffer consequences. More broadly, the U.S. government has sanctioned more than 350 individuals and entities for their involvement in Russia's malign activities since January 2017.

Most recently, the United States Delegation to the Organization for Cooperation and Security in Europe (OSCE) reiterated on July 2 that the United States does not, nor will ever recognize Russia's purported annexation of Crimea and that sanctions will remain in place against Russia until it fully implements its Minsk commitments and returns full control of the Crimean peninsula to Ukraine. We will continue to impose costs until Russia changes course, and sanctions will remain a key part of that.

Question. A study published in 2016 by Yale University researchers found that there may have been as many deaths from HIV AIDS, TB and Malaria during the 2014/2015 Ebola outbreak in Guinea, Liberia and Sierra Leone as there were from Ebola because the health systems in those countries were overwhelmed, limiting access to health services. Recent reports indicate that as the COVID-19 pandemic continues, there has been a rise in the number of illnesses from preventable illnesses including polio, cholera and diphtheria. Have we provided funding for the Global Fund's COVID-19 mechanism?

Answer. One third of the total resources at the Global Fund were provided by the United States government, as part of our regular contribution. We have not provided additional resources for the Global Fund's COVID-19 Response Mechanism

(C19RM) beyond our regularly planned Global Fund amounts. The Global Fund Board, including the United States, approved up to USD \$1 billion originally intended for HIV, Malaria and TB programs for needed adaptations due to COVID-19 disruptions and for mitigating the COVID-19 pandemic through C19RM. The mechanism currently has been approved to be funded for up to USD \$500 million at this time.

Question. WHO plays a leading role in the provision of vaccines. It is one of the main partners of Gavi, the Vaccine Alliance, which is the critical funding agency supporting vaccine programs in the world's poorest countries where the majority of the world's unimmunized children live: How is our pulling out of WHO going to affect vaccinations, and what impact will disruption of vaccine campaigns have on under five mortality?

Answer. The withdrawal of the United States from the World Health Organization (WHO) will not have a deleterious impact on the ability of Gavi, the Vaccine Alliance, to reach children in lower-income countries with life-saving vaccines. While the U.S. Government (USG) is the third-largest donor to Gavi, historically none of the USG's funding to Gavi has gone to the WHO. Under the terms of the funding agreement between the U.S. Agency for International Development (USAID) and Gavi, Gavi primarily uses the USG's funding for the procurement and delivery of vaccines. I refer you to USAID for further details on its financial and technical support to Gavi and immunization programs globally.

Question. Do the Department and USAID have the resources to help countries bring the pandemic under control? What does Congress need to provide in the next supplemental appropriations bill?

Answer. The pandemic of COVID-19 continues to have an extraordinary impact on the people, countries, and partners that benefit from U.S. foreign assistance. We are grateful to Congress for the emergency supplemental funding already appropriated to the U.S. Department of State and the U.S. Agency for International Development (USAID). The Department of State and USAID are investing these funds to respond to COVID-19 effectively. We look forward to working with Congress to address the significant needs we continue to have to respond to COVID-19, including the secondary and tertiary impacts of the pandemic.

Question. I would like to better understand whether and how the Department and USAID's many understandable COVID-related reprogramming requests are interacting with overall expenditures and obligations, including the possibility of the unintended creation of significant unobligated balances. Congress needs to know if and how certain decisions made by the Administration—such as its decision to withhold funds to the World Health Organization—may be affecting departmental budgeting and financial management for the remainder of the fiscal year. I am also concerned that unforeseen complications related to the pandemic may create situations in which funds expire at the end of the fiscal year before they can be obligated, especially FY19 funds, unless the Department and USAID take action to prevent this from happening. What is the status of obligations for FY 19 funds?

Answer. The U.S. Department of State and the U.S. Agency for International Development (USAID) recognize that the pandemic of COVID-19 currently is affecting, or could affect, the ability to obligate and expend funds appropriated by Congress for Fiscal Year 2019. Following normal practice, State and USAID are working with U.S. Embassies and Missions throughout the world, and Bureaus domestically, to take the steps necessary to obligate all unobligated expiring resources prudently prior to the end of the Fiscal Year. Consistent with statutory provisions, State and USAID are continuing to transmit all required Congressional Notifications for expiring funds, and are committed to working to resolve any questions and concerns that the relevant congressional Committees of jurisdiction raise.

State and USAID both expect to obligate all expiring funds by the end of the Fiscal Year, and we are monitoring obligations closely.

Question. I would like to better understand whether and how the Department and USAID's many understandable COVID-related reprogramming requests are interacting with overall expenditures and obligations, including the possibility of the unintended creation of significant unobligated balances. Congress needs to know if and how certain decisions made by the Administration—such as its decision to withhold funds to the World Health Organization—may be affecting departmental budgeting and financial management for the remainder of the fiscal year. I am also concerned that unforeseen complications related to the pandemic may create situations in which funds expire at the end of the fiscal year before they can be obligated, especially FY19 funds, unless the Department and USAID take action to prevent this from

happening: Can the State Department assure me that the Administration will not seek to pursue a rescission, either by intent or by mismanagement, as we approach the end of this fiscal year?

Answer. State and USAID plan to prudently obligate expiring funds for programs that advance U.S. foreign policy objectives. Consistent with normal practice, State and USAID are working with posts throughout the world and bureaus domestically to take the steps necessary to prudently obligate all unobligated expiring resources prior to the end of the fiscal year.

We remain concerned about being able to obligate expiring International Military Education and Training (IMET) account funds by the end of the fiscal year as those funds support in-person training sessions that likely will not be able to occur due to the threat of COVID-19. The Department is seeking Congress's support to extend the availability for expiring IMET funding to ensure they do not expire at the end of the fiscal year.

Consistent with required congressional notification processes, State and USAID are continuing to transmit all required congressional notifications for expiring funds and are committed to working to resolve questions and concerns raised by the relevant congressional committees.

Question. On April 7, the President declared he would like to put a "powerful hold" on WHO funding and on May 29, the President said the Administration plans to "terminate" the relationship. On April 8, Sec. Pompeo stated that the World Health Organization has "to get the data, they have to share that data with the world's best scientists—many of which are often located right here in the United States—and allow that information to be transferred freely so that we can have a transparent response that will save lives." This is an essential aspect of WHO's work, which has received praise from health experts here and abroad but would be significantly harmed if the U.S. withheld funding: In light of this statement, can you explain the guidance you gave to Sec. Pompeo? Can you detail the implications beyond the COVID-19 response this hold would have?

Answer. The WHO failed to uphold its responsibilities and grossly mismanaged the COVID-19 pandemic response. Even after the President's many public statements and his May 18, 2020 letter, the WHO has done little to respond to the Administration's serious concerns and repeated calls for progress and reform. I shared those views and my concerns about WHO with the Secretary.

The United States accounts for more than 40 percent of total global health funding, and we have given more than \$142 billion since 2001. Only about 4 percent of our annual global health budget is spent through the WHO. Our work in global health does not stop because we have halted funding to the WHO, and we are confident that we will be able to find qualified implementers for any voluntary assistance that was planned for WHO programs. Beyond the WHO, we have an extensive cadre of faith-based organizations, NGOs, contractors, and multilateral organizations that have the ability to implement health programs—for COVID-19 response and beyond. The State Department is committed to ensuring that we find trustworthy, accountable, results-oriented implementing partners on behalf of the American people, whose taxpayer dollars fund our foreign assistance programs.

Question. In an April 8 press conference, Sec. Pompeo stated the need for the World Health Organization to complete "the work they were designed to do." And yet the Administration has consistently delayed tens of millions in funding each year that Congress has appropriated to WHO so it could complete its work. To take one example of many, in Yemen, these delays coupled with a funding cut-off will mean that over 2 million people assisted by WHO, that no one else is able to do, will no longer receive essential care support. This represents 25% of the total population in need to whom WHO has delivered lifesaving services in the last 2 years:

Answer. Since the 1980s, the U.S. Government has paid annual assessed contributions to the World Health Organization (WHO) and many other U.N. specialized and technical agencies for a given calendar year with funds appropriated to the Contributions to International Organizations (CIO) account in the subsequent U.S. government fiscal year. WHO and other U.N. agencies have long since adapted management of their finances to accommodate this delay. Assessed funding goes primarily to headquarters operations, not programs and activities in specific countries such as Yemen. I would refer you to our Bureau of International Organization Affairs for more information on how funding for assessed contributions is managed. Congress has not appropriated any foreign assistance funds specifically for WHO.

The population of the Republic of Yemen is extremely vulnerable to health threats after years of conflict. As COVID-19 spreads rapidly and overwhelms the country's collapsing health institutions, we are using all of the tools and resources we have

available to help. We have made available supplemental funding and resources from the International Disaster Assistance account from FY 2020 to support the response to COVID-19 in Yemen. In addition, the U.S. Agency for International Development (USAID) is financing robust, ongoing programming in health and nutrition in the country, including through other United Nations agencies that can adapt as necessary to the pandemic.

The United States remains one of the largest donors of humanitarian assistance in the Republic of Yemen. For years, the United States has funded emergency health programs in Yemen, as well as made investments in water, sanitation, and hygiene that have lasting impacts and help keep people healthy, stave off disease, and build capacity in health care. In FY 2019, USAID provided more than \$26 million in emergency health funding, along with nearly \$14 million for water, sanitation, and hygiene in communities affected by Yemen's conflict. These efforts, which include training health care workers, supporting medical facilities, and teaching safe hygiene practices, continue to help communities in Yemen to prepare for disease outbreaks and other health threats.

Question. Diseases do not recognize borders, so challenges like the COVID-19 pandemic necessitate a global, collective response. The WHO—through its high level of technical expertise and international legitimacy—is uniquely positioned to lead the international response to public health emergencies like the COVID-19 pandemic. From the outset of the crisis, WHO has been a critical provider of supplies and tests, distributing 1.5 million diagnostic kits and millions of items of PPE to dozens of countries; designed, refined, and distributed technical guidance for communities, hospitals, frontline clinicians, private sector partners, and public health authorities around the world; carried out public awareness campaigns in dozens of languages in 149 countries; and, through its “Solidarity Trial,” has been working to enable rapid and accurate research on the effectiveness of potential therapeutics. People around the world—including Americans—stand to benefit from these types of activities:

What effect will “terminating” our relationship with the World Health Organization have on these efforts? How can we hope to protect Americans from pandemic disease and other health challenges without a multilateral coordinating authority like the WHO?

Answer. As U.S. leadership demonstrated in the Ebola and MERS outbreaks, our diplomatic, health security capacity building, and development efforts enable countries to develop tools for addressing infectious disease. Through these efforts, we filled gaps created by the WHO's inaction to prevent, detect, and respond to outbreaks immediately. The Administration is examining ways to leverage the expertise of key U.S. Government departments and agencies and the American private sector to rapidly deploy and deliver this essential support to other countries to prevent, detect, and respond to infectious disease outbreaks at their source. During the President's May 29, 2020 announcement that the United States will be terminating its relationship with the WHO, President Trump announced that the United States will be redirecting funding planned for the WHO to other global health organizations and urgent needs around the world.

While the United States was by far the leading donor to the WHO, that funding represented a small fraction—just 4 percent—of our total funding to global health assistance every year. This year, it will represent just 2 percent of the health assistance the United States provides worldwide. The United States leads the world in health and humanitarian aid in an “All of America” effort and is committed to ensuring our generosity directly reaches people around the world. We account for more than 40 percent of total global health funding. Since 2001, we have given more than \$142 billion. Every day, U.S. global health funding prevents, detects, and treats HIV/AIDS, malaria, tuberculosis, Ebola, and other diseases. We give an average of \$10 billion per year—and this year, it will be double that as we surge to fight the virus around the world. The United States has allocated more than \$12 billion that will benefit the global COVID-19 pandemic response; more than \$2 billion of this has already been committed.

Question. WHO has been on the frontlines of nearly every global health challenge over the last 70 years, combatting, containing, and eradicating some of the planet's most deadly diseases, viruses, and infections. While the world is rightly focused on defeating COVID-19, other health challenges confronting the world have not disappeared, and it is not in our interest to neglect them. These include WHO-led efforts to control and eliminate malaria, implement global disease surveillance for the polio virus in areas where U.S. government agencies do not have the capacity to reach, support measles immunization campaigns, and strengthen the health sector's response to HIV/AIDS and Tuberculosis. The loss of more than \$400 million in an-

nual U.S. funding threatens to upend these critical activities: What does our withdrawal from these multilateral initiatives say to our allies and partners around the world? Given how far-reaching and complex these challenges are, how can bilateral efforts even hope to begin to make a dent?

Answer. The President's decision to terminate our relationship with the WHO in no way diminishes U.S. leadership on global health and combatting the COVID-19 pandemic. While the United States was by far the leading contributor to the WHO, those contributions represented a small fraction of our total funding to global health assistance every year. This year, it will represent just 2 percent of the global health assistance the United States provides. We account for more than 40 percent of total global health funding. The United States has allocated more than \$12 billion that will benefit the global COVID-19 pandemic response; more than \$2 billion of this has already been committed. To fill in gaps in the WHO's handling of the HIV/AIDS pandemic, the United States set up a far more effective framework for HIV/AIDS called "PEPFAR"—the program started by President George W. Bush two decades ago that has saved literally millions of lives across the African continent and beyond.

Question. With regards to U.S. arrears in our payments to WHO, in a June report to Congress, the State Department noted a number of possible impacts, including: "1. Loss of vote or inability to be a member of governing bodies; 2. Diminished U.S. standing and diminished ability to pursue U.S. priorities; 3. Reduced U.S. ability to promote increased oversight and accountability through reforms that promote efficiency, cost savings, and improved management practices; 4. Reduced standing needed to successfully promote qualified U.S. citizens to assume senior management roles; and 5. Impairments of peacekeeping missions to operate, including addressing objectives that may directly impact the national security of the United States;" Given your experience working with international organizations like the WHO, do you stand by these conclusions from your own Department?

Answer. The Administration is examining ways to leverage the expertise of key U.S. Government departments and agencies and the American private sector to rapidly deliver essential support to other countries to prevent, detect, and respond to infectious disease outbreaks at their source. As the World Health Organization's (WHO) failed response to COVID-19 has clearly demonstrated, we lack the international structures to prevent, detect, and respond to infectious disease outbreaks. Without U.S. global leadership on pandemic preparedness, prevention, and response, future pandemics will continue to severely impact public health and the world economy. As U.S. leadership demonstrated in the Ebola and MERS outbreaks, our efforts enable countries to develop tools for addressing infectious disease. Due to these efforts, we filled gaps created by the WHO's inaction to prevent, detect, and respond to outbreaks immediately.

Question. The U.S. has so far provided only \$5M to the West Bank and no money at all for some of the most COVID-19 vulnerable people living in Gaza. When will the Trump administration release the full amount of funding appropriated by Congress for Palestinians, including \$75 M in aid?

Answer. The \$5 million is in support of immediate, life-saving needs for Palestinian hospitals and households in the West Bank. We are closely monitoring the global response to the U.N.-led Interagency Response Plan, which, along with Israel, is providing vital support to Gaza. We continue to engage with partners on the outstanding needs and ways in which the United States and global community can support.

This decision does not prejudice future decisions about U.S. assistance in the West Bank and Gaza. We will continue to assess how U.S. assistance can best be used to advance U.S. foreign policy and provide value to U.S. taxpayers, consistent with applicable legal requirements.

Question. How is the State Department prioritizing the needs of children and youth (access to education, nutrition, continued basic healthcare) during the pandemic?

Answer. The pandemic of COVID-19 has created serious risks to the safety and well-being of children and young people on an unprecedented scale, including secondary health impacts such as worsening nutritional status; reduced vaccination rates; loss of education; and increased risks of violence, child marriage, inadequate care, income-insecurity, and psychosocial distress and trauma.

To mitigate these impacts, the U.S. Government is prioritizing the well-being of children and youth throughout our response to COVID-19, which includes working with Ministries of Health and other key Ministries to provide basic social services

to marginalized groups. For example, in the Republic of Ghana, the U.S. Agency for International Development (USAID) is working with the Ministry of Gender, Children, and Social Protection and the Ghana Health Service to develop targeted child-protection messages and provide referral information within health facilities for responding to violence against children. Making this information available during routine visits provides an opportunity for women and children to talk with trained staff privately in a safe space in COVID-19 hotspot areas, as well as in underserved and rural areas.

Globally, the U.S. Department of State has provided \$12.46 million to reduce the transmission of COVID-19 in affected countries and mitigate the impact of the pandemic on children, youth, and their care-providers in refugee and migrant settings. This assistance will strengthen risk-communications and community engagement; provide critical medical, water, sanitation, and hygiene supplies to prevent and control infections; support continued access to essential health care for women, children, and young people; support access to continuous education, social protection, and resources on gender-based violence disrupted by the pandemic; and assist with the collection and analysis of data on the secondary impacts of the pandemic on children and women.

USAID's Bureau for Global Health is prioritizing the continuity of essential maternal, newborn, and child health care in the pandemic context, including by supporting routine immunization and restarting measles vaccination campaigns; protecting providers to ensure ongoing health care for children in facilities and the community; increasing support to improve children's nutrition through community outreach; and promoting social and behavior-change communications.

Additionally, school closures have affected the education sector profoundly, which has left nearly 1.2 billion children and young people out of school as of July 7, 2020.¹ In response, the United States is demonstrating global leadership by mobilizing its existing human and financial resources to mitigate and address the negative education impacts of COVID-19, from pre-primary through higher education. The U.S. Government's work in this regard will help governments, faith-based organizations, public and private educators, learners, parents, and communities in our partner countries stay safe and continue to learn during the COVID-19 pandemic and after the crisis subsides.

Question. In what ways are you seeking to expand distance learning services to populations in need of assistance?

Answer. The scope of the impact of the pandemic of COVID-19 on education requires rapid mobilization and a strategy to respond to the shifting needs. In response, the U.S. Government (USG) through the U.S. Agency for International Development (USAID) is leveraging existing resources and programs in 20 different countries, to help pivot our programming during school closures to meet the educational needs of children and youth. This includes supporting Ministries of Education to broadcast educational programs over radio and television, adapting teacher-led curricula to family- or self-led instruction, and encouraging safe and healthy routines that promote the social and emotional well-being of learners. For example, in the Democratic Republic of Congo, USAID has used COVID-19 supplemental funding to expand distance and alternative education for Congolese children and young people so they can continue to learn and maintain protective routines and social connections while schools remain closed across the country.

The U.S. Government Action Plan to Support the International Response to COVID-19 addresses the evolving needs of education in the countries where we provide support and prioritizes that "all children and youth access high-quality distance education." To do so we have curated distance-learning materials, which includes the development of an easy-to-use, centralized resource library for interactive radio and audio instruction. The library now contains materials for 12 countries, including in local languages. As we add more, the Inter-Agency Network for Education in Emergencies (INEE) will formally launch a Global Distance Learning Hub for our implementing partners. We have also published a Literature Review on Delivering Distance Learning in Emergencies, which presents the basic modalities for delivering learning through radio, television, cell phone, and online methods. It presents lessons-learned and recommendations for using these tools to ensure equitable and inclusive continuity of learning through distance formats even during crisis situations. To increase access to books and other reading materials, we created the Global Book Alliance, a cross platform search engine, called FreeLearning, to allow users to find high-quality books and other reading materials. The platform launched in June 2020 with more than 300 titles in 100 different languages.

Question. In April of 2018, U.S. Global AIDS Coordinator Ambassador Deborah Birx announced that PEPFAR would transition 70% of prime awards to local part-

ners by the end of FY2020. Notably, the definition of “local partner” used by PEPFAR does not include locally registered offices of international non-governmental organizations (INGOs), even if the local INGO offices are predominantly governed and staffed by local citizens of that country. The end of FY2020 is just weeks away, which means that USAID is actively moving funding away from effective, high-performing international partners in country at a time when we need established partners—local and international—to quickly adapt and implement COVID-19 activities in HIV settings (which are often some of the strongest health care facilities in these countries). In particular, INGOs can coordinate approaches and share practices across countries, while also working closely with local partners to ensure that interventions tailored for specific communities and country contexts: Does the “all hands on deck” effort needed to address the COVID pandemic necessitate a re-evaluation of the pace and purpose of PEPFAR’s rapid push towards localization? How are you utilizing INGOS and their decades of experience in HIV to help the U.S. global response to COVID?

Answer. To sustain epidemic control of HIV, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact. In line with USAID’s “Journey to Self-Reliance,” PEPFAR has set a bold goal of 70 percent of agency funds directly to local prime partners by the end of FY 2020 and agencies are well on their way—at the start of FY 2020 CDC had 63 percent of their funding portfolio awarded to local partners and USAID had 45 percent respectively. On this goal of localization, PEPFAR has always been somewhat flexible in agencies achieving this goal, and is especially so in the context of dual pandemics. However, PEPFAR is not re-evaluating this goal toward localization. The COVID-19 response has underscored even more how important local partners are on the ground in providing and continuing services to clients. International NGOs also continue to be important in the HIV and COVID responses.

Question. The largest refugee camp in the world is hosting over a million Rohingya people in Bangladesh right now, where families live in cramped and squalid conditions, which makes social distancing during the COVID pandemic impossible. COVID-19 cases have already been confirmed in the camps despite limited testing. Problematically, the government of Bangladesh has also imposed telecommunications and mobile data ban in the camps since September 2019. The ban has hindered humanitarian response efforts and prevented the Rohingya from being able to more freely access information and communicate effectively with their family and friends, all of which are critical in a pandemic. The ban is a concern not only for the Rohingya, but it also negatively impacts and increases risks in the neighboring Bangladeshi communities: How is the State Department prioritizing its response to the dire needs of the Rohingya refugees in Bangladesh and working to reduce impediments to the response, including by ensuring that internet and telecommunications services are restored immediately?

Answer. The Department has placed a high priority on responding to Rohingya refugees in Bangladesh. In the context of the COVID-19 pandemic, the United States has provided nearly \$44 million in assistance for Bangladesh to include more than \$21 million for health and IDA humanitarian assistance to support case-management, surveillance activities, the prevention and control of infections in health facilities, risk communications, water, sanitation, hygiene, and emergency food assistance, and more than \$22 million in MRA humanitarian assistance to support vulnerable people during the pandemic, including refugees and host communities. This is in addition to the nearly \$926 million that the United States has contributed to relief efforts in the Rohingya/Rakhine State crisis since August 2017, of which more than \$776 million has been used in Bangladesh.

The importance of telecommunications to all residents and service providers in Cox’s Bazar District has become more immediate due to the COVID-19 pandemic. While the Government of Bangladesh has restored 3G cellular service in the Cox’s Bazar area, we share your concern that 4G service is not yet reliable. We continue to press the government to improve 4G. We also support the U.N.’s ongoing advocacy with the Government of Bangladesh to provide Rohingya refugees a means for legally purchasing SIM cards.

Question. Conditions set up by the Government of Burma in IDP camps and camp-like settings are prime for rapid and uncontrolled spread of COVID-19 among

vulnerable populations. These conditions include significant overcrowding, limited access to health care, severe movement restrictions, internet bans reducing dissemination of real time information about the virus, and the potential of camp lockdowns reducing the ability of humanitarians to provide essential services: What steps is the State Department taking to encourage rolling back these restrictions so Rohingya populations and other communities living throughout Rakhine State are adequately protected from COVID-19?

Answer. The United States continues to push for the removal of restrictions on humanitarian access and freedom of movement in Rakhine and Chin States, as well as other regions affected by violence. We also continue to push for the removal of restrictions on mobile data services, which have curtailed communication and access to information, including about COVID-19, for as many as 1 million people. These restrictions cut communities off from life-saving humanitarian assistance and information. Humanitarian access, freedom of movement, and access to the Internet and media are fundamental for improving the lives of people in Rakhine and Chin States, particularly in the face of the pandemic.

The United States is also working closely with the Burmese government, health professionals, and civil society actors to contain the spread of COVID-19 in Burma. We have provided \$16.5 million in health and humanitarian assistance for a range of activities, including the prevention and control of infections in health facilities, improved case management, support for laboratories, risk-communications and community engagement, and water and sanitation supplies for internally displaced persons and other vulnerable communities.

Question. Additionally, what is the State Department doing to ensure that COVID-19 is not used as a justification to further restrict freedom of movement throughout Burma for all ethnic and religious minorities, and that these marginalized minorities enjoy equitable access to testing, health care, and that humanitarian aid is maintained throughout this crisis?

Answer. The State Department is coordinating efforts to deter human rights abuses in Burma under the pretext of responding to COVID-19. The Department also is working to ensure all citizens of Burma have access to COVID-19-related information. In response to Burma's ongoing Internet shutdown in Rakhine and Chin States, the United States issued a joint statement with 13 diplomatic missions in Burma and used its social media presence to call for the Government of Burma to end the shutdown. Ending the shutdown will give residents of Rakhine and Chin States easier and more reliable access to information about COVID-19.

The United States continues to work closely with the Burmese government, health professionals, and civil society actors to contain the spread of COVID-19 in Burma. We have provided \$16.5 million in health and humanitarian assistance for a range of activities, including the prevention and control of infections in health facilities, improved case management, and support for laboratories for internally displaced persons and other vulnerable ethnic and religious minority communities.

Notes

¹United Nations Educational, Scientific, and Cultural Organization. COVID-19 Impact on Education. Accessed July 7, 2020.

RESPONSES OF CHRIS MILLIGAN TO QUESTIONS SUBMITTED BY SENATOR ROBERT MENENDEZ

Question. In 2017, within 5 months of receiving nearly \$1 billion in emergency appropriations for International Disaster Assistance, the Trump administration had effectively obligated the bulk of that funding, and leveraged an additional \$1.5 billion from humanitarian funding accounts to respond to four famines, each of which occurred in differing, complex, and non-permissive environments. As of late May, little of \$550 million in emergency appropriations from the same account had been obligated to respond to humanitarian needs related to COVID-19. These delays undoubtedly have cost lives in countries severely impacted by the pandemic. What constraints have led to the extended time to obligate funding in comparison to past crises?

Answer. We are in unprecedented times right now, with a rapidly evolving situation on the ground in almost every country. We are working aggressively to obligate all of our resources for COVID-19 as swiftly and effectively as possible. At the same time, we want to ensure we are accountable for the effective use of funds for

COVID-19 and are good stewards of U.S. taxpayer dollars. USAID is resolving all the issues and the IDA funds are on track for being obligated by July 30th, 2020.

Question. How has the process within USAID to obligate supplemental International Disaster Assistance funding changed between this crisis and the 2017 famines?

Answer. USAID is working to ensure that IDA funds are available to our partners on the ground as quickly as possible. For example, the USAID Bureau for Humanitarian Assistance (USAID/BHA) has expedited its proven systems and procedures to program humanitarian resources to frontline partners, with supplemental funding being obligated on average within 37 days from proposal receipt, approximately 40 percent faster than non-expedited obligation timelines.

Question. When do you anticipate spending down supplemental funds that Congress has already appropriated for the crisis?

Answer. We intend to obligate the entirety of the \$558 million in COVID-IDA supplemental funds appropriated by Congress by July 31, 2020.

Question. I have seen actions that actively undercuts international efforts to respond. Mr. Barsa, the Acting Administrator of USAID sent a letter to U.N. Secretary General Antonio Guterres that offers nothing by way of support to combat the most deadly pandemic of the last century, but does internationalize the Administration's ideologically driven attack on women's reproductive rights. What is USAID doing to contribute to and support the U.N.'s Global Humanitarian Response Plan?

Answer. The United States is a top donor to the COVID-19 pandemic response, and has made available \$558 million in COVID-19 International Disaster Assistance (IDA) supplemental funding directed to support humanitarian interventions. Much of this funding supports the U.N.'s Global Humanitarian Response Plan (GHRP) that addresses food, health, protection, and other critical humanitarian needs and has been provided to U.N. agencies such as the World Food Program and UNICEF.

While some USAID funding goes toward projects not listed in the appeal, we work closely with in-country teams and partners to ensure that programming reaches the most vulnerable populations and addresses critical humanitarian gaps. USAID is also working with partners to adapt existing programs, as necessary, to address needs that have arisen due to the COVID-19 pandemic.

USAID coordinates closely with the U.N. Office for the Coordination of Humanitarian Affairs (OCHA) to advance improvements in the GHRP, such as prioritizing response activities to address acute needs and better promoting linkages between humanitarian and development efforts.

Question. In March, Congress appropriated \$558 million to the International Disaster Assistance (IDA) account to address COVID-19 overseas, which is managed by USAID, and \$350M to the Migration and Refugee Assistance account (MRA), overseen by State's Bureau of Population, Refugees, and Migration (PRM). I understand that a large portion of these funds have yet to be obligated and expended due to unusual bureaucratic delays from senior levels. These funds, generally speaking, are the most nimble at our disposal. By comparison, during the Ebola response in 2014-15, it typically took between 30-45 days for humanitarian money to reach partner agencies. How many IDA and MRA dollars have you obligated to date from the additional appropriations we provided in March?

Answer. As of June 18th, USAID had obligated \$201 million in International Disaster Assistance to respond to the pandemic. USAID planned and obligated all \$558 million of IDA funding by July 30th, 2020. Regarding MRA funds, I would defer to the Department of State Bureau for Populations, Refugees, and Migration for the most recent update on the status of obligations of those funds, as they are responsible for programming that account.

Question. Why is it taking longer than usual for life-saving humanitarian funds to reach the ground and prevent the spread of COVID-19?

Answer. USAID's ability to obligate COVID-19 supplemental funding effectively and quickly remains our highest priority. Providing our implementing partners with the necessary resources to support critical emergency health, WASH, protection, and food assistance programs on the frontline of the pandemics is at the core of our response strategy. Several unexpected challenges impacted the ability to obligate funding quickly.

These challenges included the need to accurately address the policy on Personal Protective Equipment (PPE) as well as the relationship with the World Health Or-

ganization (WHO). In both cases, USAID worked to adapt operational responses and collaborate with partners to support these policies.

In coordination with the Department of State, USAID issued additional PPE guidance on June 9 that allows USAID implementing partners to procure PPE for their staff, and to continue critical programs as long as the PPE is produced locally or regionally and not intended for the U.S. market.

I assure you that we are working as hard as possible to ensure that IDA funds are available to our partners on the ground as quickly as possible.

For example, the USAID Bureau for Humanitarian Assistance (USAID/BHA) has expedited its proven systems and procedures to program humanitarian resources to frontline partners, with supplemental funding being obligated on average within 37 days from proposal receipt, approximately 40 percent faster than non-expedited obligation timelines.

Question. What is the USG doing to ensure the money moves in an expeditious and transparent manner moving forward?

Answer. We understand the concerns about delays in funding, and we are working to make resources available as quickly as possible. I assure you that we are working aggressively to obligate COVID-IDA as swiftly and effectively as we can. At the same time, we want to ensure we are accountable for the effective use of COVID-19 funds as stewards of U.S. taxpayer dollars.

To accelerate the pace of processing awards and our obligations, USAID/BHA is taking concrete actions, including implementing the following measures:

1. **Quicker Turnaround:** Impose stricter deadlines on partners to develop applications, and for USAID to provide technical approval.
2. **Prioritization:** Fast-track all COVID-19 proposals for review over non-COVID applications.
3. **All Hands on Deck:** Ensure Agency buy-in across the spectrum of USAID business processes, from USAID/BHA field teams/headquarters staff, General Counsel, and M/OAA.

Since implementing these measures in early July, obligations have increased significantly and we expect to obligate the entirety of COVID-IDA funds by July 31, 2020.

Question. USAID has received explicit instruction from the NSC to expend funds provided in the CARES Act on ventilators destined for countries hand selected by the President based on conversations he has with foreign leaders. What analysis is informing the decisions about which countries are given ventilators? Are ventilators given to countries that most need them based on case load?

Answer. President Trump has pledged ventilator assistance to countries in need across the world. The Head of State or Ministry of Health in each country that is receiving ventilators has requested this equipment, and the U.S. Government is offering it as an in-kind contribution. After pledges to partner countries, USAID mobilizes to fulfill pledges under direction from the NSC. For additional information on the decision-making process, we refer you to NSC.

Question. Were health experts at USAID, other agencies or elsewhere consulted, and did they or do they agree that these are the countries in most need of ventilators?

Answer. USAID is committed to supporting countries in need around the world and leading the global COVID-19 response through an All-of-America approach. This includes coordinating closely as part of the U.S. Government interagency around all COVID-19 activities, including ventilators. USAID health experts are closely involved in this process and are consulted frequently.

Question. What assurances is USAID seeking or requiring from countries receiving ventilators that they will provide equitable access to U.S. provided ventilators and that the country is in fact following proper protocols and implementing health security measures to prevent the spread of COVID-19?

Answer. USAID is offering ventilators as an in-kind contribution. Once delivered, USAID transfers the title to the ventilators to the host government. The host government then distributes ventilators based on a number of factors including where it determines the greatest need is to care for the most critically ill patients affected by COVID-19 and which facilities are best-suited to use ventilators. USAID is coordinating with host country Ministries of Health to assess overall capacity to provide respiratory care for critically ill patients suffering from COVID-19, as well as health facilities' capacity to provide critical care and use ventilators safely and ap-

propriately. USAID health experts are providing regular input and guidance to promote the safe and effective use of ventilator donations in recipient countries. USAID offers targeted technical assistance where needed, using assessments conducted with ministries of health and implementing partners to guide this support. In addition, USAID is providing access to a global distance learning portal and a technical hotline for health providers to tap into subject matter expertise.

Question. It is my understanding that USAID is procuring nearly all ventilators, and that the NSC is requiring them to purchase them from two companies (Zoll and Vyair). Is USAID competitively bidding this procurement?

Answer. NSC allocates recipient countries to specific vendors identified by the U.S. Department of Health and Human Services (HHS) and the Federal Emergency Management Agency (FEMA) within the U.S. Department of Homeland Security (DHS). These vendors include Vyair, Zoll, and Medtronic. USAID then works with assigned vendors and countries to coordinate the necessary county-specific customizations and fulfill assigned ventilator orders. For more details on the bidding process for these vendors, we refer you to HHS and FEMA.

Question. How many of these orders have been fulfilled?

Answer. As of 18 June 2020, 800 of 8,482 ventilators have been delivered to El Salvador (250), India (200), Russia (200), and South Africa (50).

Question. If the decisions on which countries are being given ventilators are being made by the White House weeks before the ventilators can be delivered, why is USAID using authorities that allow it to waive the regular 15 day Congressional notification process on these procurements?

Answer. USAID has occasionally relied on emergency authority to obligate funds when we have identified an urgent need to obligate funds and when notifying these funds to Congress in accordance with the regular procedures would pose a substantial risk to human health and welfare. Specifically, funds are needed in advance for the manufacturers to start production on country-customized ventilators.

Question. Does USAID have adequate resources to help countries bring the pandemic under control? What does Congress need to provide in the next supplemental appropriations bill?

Answer. USAID is extremely grateful for the generous supplemental appropriations from Congress on behalf of the American people. Besides the immediate health impacts of COVID-19, many countries are also experiencing an increase in conflict, as well as humanitarian, economic, and social challenges.

Countries with weak health systems are suffering from a lack of laboratory systems, infection prevention and control in health facilities, case management, contact tracing, surveillance, and behavior change and risk communications. USAID's other global health programs across areas such as maternal and child health, nutrition, HIV/AIDS, tuberculosis, malaria, global health security, population and reproductive health, and neglected tropical diseases are also seeing additional costs and challenges rise from supply chain delays and shutdowns, pauses in health services and immunization campaigns, inability to reach health facilities to pick up medicines, as well as due to misinformation.

Food insecurity, unemployment, education, and economic shutdowns have left many already-vulnerable families even more at-risk. Countries with already volatile and conflict-ridden situations are experiencing increasing humanitarian challenges. Women, girls, and youth are particularly at risk from a rise in gender-based violence, and child abuse as a result of economic pressures, stress, and mental health challenges resulting from COVID-19.

Malign actors are using the growing economic, social, and health challenges in many countries to spread disinformation and misinformation, reverse democratic gains, further violent extremism, and increase their influence.

USAID is committed to addressing the aforementioned development challenges to the best of our ability with available resources.

Question. The U.S. has suspended aid to northern Yemen amid a pandemic. While some "life-saving" activities are carved out from the suspension, other programs key to preventing and treating COVID-19, including hygiene promotion, public education, basic healthcare, epidemiological surveillance, and the provision of safe drinking water, are not. How can the U.S. lay claim to leading the global response when it is undercutting core prevention and treatment activities in the world's largest humanitarian crisis?

Answer. The United States remains one of the largest donors of humanitarian assistance in Yemen despite severe access restraints and deliberate operational im-

pediments imposed by the Houthis on U.S. humanitarian partners in northern Yemen. Ongoing interference in international aid operations by Houthi officials in northern Yemen has prevented millions of people from receiving the assistance they need to survive.

Yemen is now confronting what the U.N. says is the country's "greatest threat in the past 100 years"—COVID-19. The pandemic is spreading rapidly through the country, where prolonged conflict has decimated the country's health system and left people malnourished and extremely vulnerable to disease. Despite this unprecedented crisis, the Houthis have not only failed to end their longstanding obstruction of aid, we are hearing reports that, in some cases, they have instituted even more brazen measures to seize control of international aid operations. Now more than ever, we need to ensure critical resources reach those who need them most.

Our priority remains delivering life-saving aid to the most vulnerable populations in Yemen. While we have reduced certain NGO programs that have become untenable due to the Houthis' ongoing interference, we continue to support critical life-saving activities in northern Yemen, including COVID-19 response activities, and remain fully operational in the south. These activities—such as providing safe water at sites for displaced families and treating malnourished women and children—are helping to keep people healthy and prevent diseases, such as cholera and COVID-19.

The United States remains one of the largest donors of humanitarian assistance in Yemen. Given the constrained operating environment in the north of Yemen, some of our partners have not been able to program at their anticipated levels. As a result, USAID currently has some Fiscal Year 20 humanitarian funding available to support new COVID-19 response efforts without needing to request additional COVID supplemental funds, and allowing these critical resources to be prioritized for other life-saving responses. Our Yemen response also has robust ongoing programming that is able to adapt as necessary to respond to this outbreak.

We are working to safely and responsibly program all funding in Yemen funding, and expect to announce new humanitarian assistance that will support COVID-19 response efforts in Yemen in the coming weeks. The United States continues to carefully monitor the situation in close coordination with Yemeni health officials, the United Nations, and other donors. We also continue to fully support the U.N.'s countrywide services that underpin the humanitarian response and are critical to COVID-19 response efforts, including the U.N. Humanitarian Air Service, Logistics Cluster, and coordination mechanisms. We are also working with our partners to adapt existing programs, as necessary, to address additional needs due to COVID-19. Longstanding U.S. health and water, sanitation, and hygiene programs—which include training healthcare workers, supporting medical facilities, and teaching safe hygiene practices—have and continue to help communities to be better prepared for disease outbreaks and other health threats.

As COVID-19 threatens communities in Yemen that are already extremely vulnerable, the United States remains committed to providing humanitarian assistance whenever and wherever conditions permit.

As a donor accountable to U.S. taxpayers, the U.S. cannot responsibly fund aid operations if our partners are prevented from monitoring and protecting the humanitarian integrity of these programs. We must be able to operate without interference in program operations, including the ability to assess actual needs on the ground and to protect resources being diverted from the most vulnerable; absent that, we cannot be sure resources will get to those who need them most. This suspension was thoughtfully planned with our partners to ensure they were ready to safely and responsibly adjust their programming. We are working closely with partners to ensure they resume operations as quickly as possible once we are confident that they can deliver U.S.-supported assistance without undue interference.

Question. NOAA's Climate Prediction Center predicts 2020 to have an above-average number of hurricanes. How is USAID increasing support for disaster risk reduction and preparing for a compound emergency like hurricanes during a pandemic?

Answer. USAID's Bureau for Humanitarian Assistance (USAID/BHA) is actively planning and preparing for an above-normal hurricane season this year in the Atlantic and eastern Pacific. A key aspect of this preparation has been adapting USAID's standard operating procedures for responding to multiple hurricane scenarios, particularly in the Latin America and Caribbean (LAC) region, while also addressing the operating constraints of the COVID-19 pandemic.

USAID/BHA and the interagency have conducted table-top exercises to review response procedures and the added challenges of responding in the COVID-19 environment. Consultations with U.S. embassies and USAID missions throughout the LAC region reviewing factors related to staff deployment, access restrictions,

COVID-19 status, as well as coordination to expedite clearance processes, quarantine, and other anticipated changes are ongoing. USAID/BHA is also providing a Mission Disaster Preparedness six-session online learning series geared towards USAID staff and Mission Disaster Relief Officers (MDRO) and alternates (A/MDRO) in the Latin America and Caribbean (LAC) region. These trainings are designed to ensure effective coordination between Embassies and USAID/BHA during a disaster, and improve access to the appropriate tools and resources.

USAID has strategically pre-positioned disaster experts and emergency relief supplies throughout the LAC region in preparation for the 2020 hurricane season. Disaster experts in the region and in Washington, DC will assess needs and determine whether USAID should provide humanitarian assistance immediately following hurricanes and other disasters, even in the event that a Disaster Assistance Response Team (DART) is not required.

Through its Regional Disaster Assistance Program, USAID/BHA has a network of disaster risk management specialists (DRMS) in the LAC region that have provided training and technical assistance to national disaster management organizations and first responders. There are 29 DRMSs and more than 400 local surge capacity consultants located throughout the region. This capacity-building effort has increased the ability of countries in the region to manage disasters without U.S. assistance. Due to potential COVID-19 access restrictions, USAID/BHA is expanding communications capacity, including satellite phones, in order to enhance response efforts using this network.

To facilitate any potential response, USAID/BHA has an email alert system that provides up-to-date information on entry protocols/restrictions for response personnel, in addition to storm locations, development probabilities, and projected trajectories to MDROs and other relevant U.S. Government (USG) personnel.

USAID/BHA will embed an advisor with Joint Task Force-Bravo (JTF-B) at Soto Cano Air Base in Honduras this year, from July–November, to ensure seamless coordination, communication, and information sharing between USAID/BHA and forward-deployed Department of Defense (DoD) teams in the LAC region. JTF-B has capacity for rapid response throughout the region and has responded to major events with USAID in the past, including Hurricane Matthew in 2016. Additionally, USAID/BHA has participated in hurricane response coordination activities and communications in the COVID-19 context with SOUTHCOM and Caribbean Disaster Management Agency (CDEMA).

Question. Refugee populations, like the Rohingya communities that have settled in Bangladesh, who are restricted to living in densely populated internally displaced persons camps or camp-like settings that restrict health care, movement, access to hygiene materials and sanitation, do not allow for social distancing or self-isolation, and provide no clear mechanism for referrals of severe COVID cases. How does the U.S. COVID action plan account for this vulnerable population who are forced to live in conditions ripe for COVID to take root?

Answer. According to the Inter-Sector Coordination Group—a Cox’s Bazar coordination body that comprises U.N. agencies and NGOs—health partners have delivered Infection Prevention and Control (IPC) training to staff in all clinics and facilities serving the Rohingya camps. In addition, health partners have trained over 1,500 refugee community health work volunteers on COVID-19 to conduct household-level health screenings and referrals, and are working with Imams and local leaders to disseminate key messages on virus transmission, how refugees can protect themselves and their families, and symptoms and proper care-seeking behavior.

Since May, humanitarian organizations have established 14 Severe Acute Respiratory Infection Isolation and Treatment Centers near camps to treat both the refugee and host community populations, according to the Inter-Sector Coordination Group. In addition, all health organizations working in the camps ensure that water and soap are readily available by increasing the number of hand-washing facilities in distribution centers, health points, and nutrition centers. U.N. agencies and NGOs continue to clean and disinfect communal areas and neighborhoods throughout the camp, while physical distancing measures are now required at distribution points, as well as mandatory hand washing before entering distribution lines.

USAID’s Bureau of Humanitarian Assistance (USAID/BHA) continues to provide support in the camps in coordination with State/PRM. While food assistance has continued, USAID/BHA partners are adapting measures to minimize the spread of COVID-19 by providing a full month’s food ration, rather than biweekly, and implementing social distancing measures at distribution sites. Each sponsored food vendor is required to have two months of food in stock to prevent shortages and keep refugees from congregating in markets. In April, IOM, with support from USAID/BHA, began using pre-positioned USAID plastic sheeting for the construction of

temporary COVID-19 isolation and treatment centers and upgrades to existing health facilities in host communities and refugee camps, increasing local capacity to isolate and treat vulnerable patients exhibiting symptoms of COVID-19.

In addition to ensuring existing programming is COVID-19 sensitive, USAID/BHA is programming \$5 million in COVID-19 International Disaster Assistance supplemental funding to support vulnerable communities hosting Rohingya refugees with health; water supply and hygiene; and protection services. In host-community health facilities, USAID/BHA is providing critical inputs such as pharmaceuticals, personal protective equipment (PPE), and handwashing inputs. In addition, USAID/BHA partners support water, sanitation, and hygiene (WASH) infrastructure repairs, and training on IPC and case management. Following recent reports by the U.N. Children's Fund (UNICEF) and other protection actors, USAID/BHA is also scaling-up programs to combat harmful coping mechanisms, such as early marriage and domestic violence.

Question. After years of eradicating extreme poverty, the World Bank is predicting that 71 million to 100 million people will be pushed into extreme poverty due to COVID-19. What is the U.S. strategy to mitigate the secondary impacts of COVID-19, especially in fragile and conflict-affected places?

Answer. The COVID-19 pandemic starkly illustrates the linkage between public health outcomes and its impact on fragility and conflict. While immediate international responses are focusing on medical and humanitarian assistance, these alone will not be insufficient to meet needs and respond to this crisis.

COVID-19 impacts are being felt across a range of sectors, including governance, the economy, civilian security, education, energy, tourism, agriculture, and food security, with both short-term and long-term repercussions. USAID is working to address urgent COVID-related conflict prevention and stabilization challenges to preserve development gains and prevent backsliding in regions critical to U.S. national security. USAID has prioritized support for citizen-responsive governance, economic support, and peace and stability. Economic support funds from the COVID-19 supplemental funding have gone towards combating misinformation and disinformation, reducing the influence of malign actors, strengthening economic opportunities, improving workforce training and development, and enhancing private sector adaptability and productivity so that populations are better equipped to respond to the pandemic and not fall into deeper economic and social vulnerabilities. Funds have also gone towards improving good governance, ensuring the free flow of media and independent journalism, countering violent extremism, counter-narcotics efforts, and providing social support to the most vulnerable populations. These efforts will help improve stability and peace in conflict-ridden regions.

Where and when violence and conflict do arise, USAID's programs will aim to not only address the immediate conflict, but also to prevent longer-term economic, governmental, and social effects of conflict.

Question. What additional resources will be needed to ensure that USAID and the State Department can address the secondary impacts of the crisis?

Answer. USAID is working in close coordination with the State Department on future programming needs and related budgeting priorities to ensure they align with U.S. strategic priorities, including our economic, security, and diplomatic interests.

Question. How will implementation of the Global Fragility Act support these efforts?

Answer. The Global Fragility Act and subsequent Strategy can serve as a framework for addressing second order impacts due to COVID. The Global Fragility Strategy (GFS) aims to strengthen U.S. efforts to stabilize conflict-affected areas, prevent violence, and address global fragility, in line with the Global Fragility Act of 2019. It reinforces the National Security Strategy commitment to strengthen the resilience of communities and states "where state weakness or failure would magnify threats to the American homeland." America's prosperity and security depend on our ability to stabilize conflict-affected areas, prevent violence, and reduce fragility globally. The interagency sees the GFS as a framework any USAID mission can utilize to shape their programs to the changing environment amidst the COVID pandemic, even if they are not one of the countries selected as part of the GFS.

USAID's transformation elevated many of the issues outlined in the Global Fragility Act and has begun building a new organizational structure designed to spearhead this very challenge. For example, the Bureau for Conflict Prevention and Stabilization (CPS) will engage dedicated senior leadership within USAID and the interagency for peacebuilding; preventing conflict and violence; and implementing programs in political transition and stabilization, while also conducting civilian-mili-

tary coordination to support U.S. foreign- and national-security policy priorities in high-priority countries.

Question. How is USAID prioritizing the needs of children and youth (access to education, nutrition, continued basic healthcare) during the pandemic? In what ways are you seeking to expand distance learning services to populations in need of assistance?

Answer. As a result of the global pandemic, the education sector has been negatively affected by school closures, leaving more than 1.68 billion children and youth out of school at the height of the pandemic, equaling more than 91 percent of enrolled learners worldwide. In response, and to prevent development backsliding, USAID is mobilizing its existing human and financial resources to mitigate and address the negative education impacts of COVID-19, from pre-primary through higher education. USAID's work will help our partner countries, learners, and communities to stay safe and continue to learn both during the COVID-19 pandemic and once the crisis subsides.

In 20 different countries, USAID is leveraging existing resources and programs to pivot programming during school closures to meet the educational needs of children and youth. This includes supporting ministries of education to broadcast USAID-funded educational programs over radio and television, adapting teacher-led curricula to family- or self-led instruction, and encouraging safe and healthy routines that promote social and emotional wellbeing of learners.

For example, in the Democratic Republic of Congo COVID-19 supplemental funding has enabled USAID to expand distance education and alternative education for Congolese children and youth so they can continue to learn and maintain protective routines and social connections while schools are closed across the country.

USAID is also working with partner countries to adapt approaches to the context of each country's education system to ensure they are resilient during future crises. Specifically, USAID is coordinating and leveraging resources through partnerships with international education actors. For example:

- USAID's commitment to launch a Global Distance Learning Hub supports governments, schools and parents to keep children and youth learning during times of crisis.
- USAID's support to the Inter-Agency Network for Education in Emergencies (INEE) enables the curation and global dissemination of tools, resources, and guidance on education and COVID-19.
- USAID's investment in Education Cannot Wait (ECW) supports an immediate response to COVID-19 of about \$1 million per country in all 27 existing ECW partner countries. The specific response will vary by country.
- USAID's investment in the Global Partnership for Education (GPE) supports GPE's phased COVID-19 response, which includes \$8.8 million for contingency and response planning for all 87 GPE member countries and a second phase that includes a \$250 million funding window for immediate COVID-19 response.

Question. The Stop TB Partnership has reported a major decrease in the number of people accessing tuberculosis services globally, following the emergence of COVID-19, and this risks a major setback in our efforts to control the disease internationally—and ultimately to protect the U.S., since TB knows no borders. For instance in India, the country with the highest number of TB cases, the TB case notification rate has fallen 80%, indicating a massive drop in diagnosis and treatment. Similar figures have been reported by Indonesia and South Africa. How is USAID helping countries rapidly shore up and adapt their TB programs to help patients get rapidly and properly diagnosed and stay on their course of treatment, despite lockdown conditions?

Answer. As the spread of COVID-19 was confirmed around the world, USAID/Washington quickly developed and distributed tuberculosis (TB) technical guidance on best practices for adapting TB programs and their platforms to combat COVID-19, especially for TB patients, who are at high risk. The technical guidance is being updated regularly as the pandemic evolves and shared with USAID Missions and Advisors embedded in country National TB Programs (NTP). USAID Missions are working with NTP and partners to adapt and adopt the guidance developed by USAID/Washington on continuity of TB services during the COVID-19 pandemic. Missions are also supporting the NTP to rapidly assess the extent of TB service disruption and develop appropriate mitigation plans.

For example, USAID/South Africa supported the NTP to conduct a data analysis and quantification of impact of COVID-19 on the TB program, including any disrupt-

tions in TB drug supply, case finding, and treatment support. As a result, the Mission is intensifying TB and COVID-19 case finding in communities and health facilities, including the development of integrated programs for TB and COVID-19 case finding, treatment, and infection prevention control. In Uganda, USAID supported the development of a TB-COVID-19 screening algorithm and the training of health care workers to screen for both COVID-19 and TB; developed a remote case finding mentorship for District TB programs to better support facilities and communities in continuing TB services; worked with partners and facilities to increase the number of TB medicines dispensed from weekly to monthly through the Family DOT practice; and extended the supply of TB medicines to lower-level facilities (Health Center Level II) to dispense first- and second-line medicines closer to patients. In Ukraine, USAID scaled-up video-observed therapy options, allowing patients to stay home and reduce the number of contacts with medical and social staff.

USAID also commissioned modeling from the STOP TB Partnership to quantify the impact COVID-19 mitigation efforts could have on TB activities.

USAID is committed to continuing to monitor programs and adapt our strategies during the COVID-19 pandemic to address the challenges for TB program implementation.

Question. USAID's Standards of Conduct state the Agency strives to foster a "respectful, diverse, inclusive, and collaborative environment that promotes professional and personal growth for everyone," and requires employees to "promote and support a respectful and inclusive work environment in which all individuals are treated with dignity at all times. Employees shall ensure that both their verbal and non-verbal communications comport with this standard." Please explain how publicly-reported comments by Mark Kevin Lloyd and Merritt Corrigan are consistent with those principles. For example, Mr. Lloyd has referred to Islam as a "barbaric cult" and Ms. Corrigan referred to the "tyrannical LGBT agenda." As a career USAID foreign service officer, I understand that you may not be personally responsible for selecting political appointees for USAID or monitoring compliance with USAID's Standards of Conduct, but you are the official that the agency sent to testify before this Committee, so I appreciate your comments on this matter.

Answer. USAID has long held our employees, regardless of hiring category, to the highest legal, moral, and ethical standards, and the Agency will continue to do so.

Question. Given the difficult discussion about racial injustice taking place in our nation right now and across the world, along with reports of diplomats and foreign service officers abroad struggling to represent the United States to the world in the face of ongoing injustice, do you agree that our international development agencies, including USAID, have an important role to play in supporting diversity, speaking out against racial injustice, and supporting those serving around the world? Please provide all messages and guidance that senior USAID leadership and Acting Administrator Barsa have provided on these topics.

Answer. Last year, USAID issued a policy statement on diversity and inclusion stating that, in accordance with USAID's core values, we remain fully committed to the fundamental principles that underpin a workplace in which all employees are proud of their work; are encouraged to collaborate, innovate, and learn; are respected for their uniqueness; and are valued for their different perspectives. To achieve our mission, one that promotes and demonstrates democratic values abroad and advances a free, peaceful, and prosperous world, we must draw from the strength of a workforce that represents these American values. As such, we strictly prohibit discrimination, harassment, and retaliation in all employment-related decisions including recruitment, hiring, promotions, employee development, and retention. I work day in and day out with my fellow foreign service officers, as well as all USAID staff, to strengthen our core values as we remain mission focused and committed to these principles.

RESPONSES OF MR. GARRETT GRIGSBY TO QUESTIONS
SUBMITTED BY SENATOR ROBERT MENENDEZ

Question. WHO plays a leading role in the provision of vaccines. It is one of the main partners of Gavi, the Vaccine Alliance which is the critical funding agency supporting vaccine programs in the world's poorest countries where the majority of the world's unimmunized children live. How is our pulling out of WHO going to affect vaccinations, and what impact will disruption of vaccine campaigns have on under five mortality?

Answer. The United States continues to be a leader in promoting and providing vaccines, including through its support of GAVI and other international partners. The United States will focus on and strengthen other partnerships on vaccine issues. In addition, we are continuing to review all collaborations to discover if there are certain activities that only WHO can undertake and, if this is the case, decisions will be made about how to deal with this situation.

Question. On April 7, the President declared he would like to put a “powerful hold” on WHO funding and on May 29, the President said the Administration plans to “terminate” the relationship. On April 8, Sec. Pompeo stated that the World Health Organization has “to get the data, they have to share that data with the world’s best scientists—many of which are often located right here in the United States—and allow that information to be transferred freely so that we can have a transparent response that will save lives.” This is an essential aspect of WHO’s work, which has received praise from health experts here and abroad but would be significantly harmed if the U.S. withheld funding. In light of this statement, can you explain the guidance you gave to Sec. Pompeo? Can you detail the implications beyond the COVID-19 response this hold would have?

Answer. HHS works closely with the Department of State and other interagency partners on global health policy and programs. We continue to provide input to the interagency and the impact of our activities on COVID-19.

Question. Diseases do not recognize borders, so challenges like the COVID-19 pandemic necessitate a global, collective response. The WHO—through its high level of technical expertise and international legitimacy—is uniquely positioned to lead the international response to public health emergencies like the COVID-19 pandemic. From the outset of the crisis, WHO has been a critical provider of supplies and tests, distributing 1.5 million diagnostic kits and millions of items of PPE to dozens of countries; designed, refined, and distributed technical guidance for communities, hospitals, frontline clinicians, private sector partners, and public health authorities around the world; carried out public awareness campaigns in dozens of languages in 149 countries; and, through its “Solidarity Trial,” has been working to enable rapid and accurate research on the effectiveness of potential therapeutics. People around the world—including Americans—stand to benefit from these types of activities. What effect will “terminating” our relationship with the World Health Organization have on these efforts? How can we hope to protect Americans from pandemic disease and other health challenges without a multilateral coordinating authority like the WHO?

Answer. The United States is, and will continue to be, a leader on global health issues, whether or not we are a WHO Member State. The United States is leading on the research and development of vaccines, diagnostics and therapeutics to combat COVID-19 and will work with our partners to exchange information and understanding.

Technical collaboration between the United States and WHO through the Global Influenza Surveillance and Response System (GISRS) has been used for global virus surveillance and selection of viruses for use in vaccines to protect Americans from seasonal and pandemic influenza. We are continuing to review all collaborations to discover if there are certain activities that only WHO can undertake and, if this is the case, decisions will be made about how to deal with this situation.

Question. WHO has been on the frontlines of nearly every global health challenge over the last 70 years, combatting, containing, and eradicating some of the planet’s most deadly diseases, viruses, and infections. While the world is rightly focused on defeating COVID-19, other health challenges confronting the world have not disappeared, and it is not in our interest to neglect them. These include WHO-led efforts to control and eliminate malaria, implement global disease surveillance for the polio virus in areas where U.S. government agencies do not have the capacity to reach, support measles immunization campaigns, and strengthen the health sector’s response to HIV/AIDS and Tuberculosis. The loss of more than \$400 million in annual U.S. funding threatens to upend these critical activities. What does our withdrawal from these multilateral initiatives say to our allies and partners around the world? Given how far-reaching and complex these challenges are, how can bilateral efforts even hope to begin to make a dent?

Answer. While the United States was by far the leading contributor to the WHO, those contributions represented a small fraction—just 4 percent—of our total funding of global health assistance every year.

It is important to underscore that the United States continues to lead on global public health issues and provides generous funding to initiatives to eliminate malaria, global disease surveillance for polio, immunization and addressing HIV/AIDS

and Tuberculosis. Since 2001, the U.S. has provided more than \$142 billion in global health funding, and an average of approximately \$10 billion per year in recent years. Our global health efforts, whether in concert with the WHO, or with other partners will continue. There are many important partners working on global health in addition to the WHO. We plan to communicate and coordinate, as appropriate, with all stakeholders to continue the global response.

Question. With regards to U.S. arrears in our payments to WHO, in a June report to Congress, the State Department noted a number of possible impacts, including: “1. Loss of vote or inability to be a member of governing bodies; 2. Diminished U.S. standing and diminished ability to pursue U.S. priorities; 3. Reduced U.S. ability to promote increased oversight and accountability through reforms that promote efficiency, cost savings, and improved management practices; 4. Reduced standing needed to successfully promote qualified U.S. citizens to assume senior management roles; and 5. Impairments of peacekeeping missions to operate, including addressing objectives that may directly impact the national security of the United States.” Given your experience working with international organizations like the WHO, do you stand by these conclusions from your own Department?

Answer. We defer to Jim Richardson, the panelist from the Department of State, to answer the above question about a State Department report.

RESPONSES OF JAMES L. RICHARDSON TO QUESTIONS
SUBMITTED BY SENATOR BEN CARDIN

Question. COVID-19 poses a significant threat to low and middle-income countries. Recognizing this need, Congress appropriated almost \$2 billion for foreign assistance in the emergency supplemental packages. Nonetheless, we are increasingly hearing from foreign aid implementers that very little of this assistance has been disbursed to those who need it most: What is causing these delays?

Answer. Of the nearly \$1.7 billion in foreign assistance, State and USAID have obligated more than \$800 million across State and USAID, with that level increasing every day. The State Department’s Bureau for Population, Refugees, and Migration confirms that nearly all of the committed State Department humanitarian assistance funding has been obligated to date. I have also personally committed to responding to funding allocations and proposals from State Department and USAID bureaus in 24 hours. We are committed to moving quickly, while still ensuring every dollar is used wisely, effectively, and strategically.

Question. Of the \$1 billion that USAID has pledged, how much has actually been obligated?

Answer. Across the State Department and USAID, the Secretary has committed more than \$1.3 billion for COVID-19 foreign assistance to date. Of this total, more than \$800 million has been obligated across both agencies, with that level increasing every day. We refer you to USAID for further information on USAID obligations.

Question. What are State and USAID doing to ensure funds get disbursed as quickly as possible?

Answer. I have committed to responding to funding proposals from State Department and USAID bureaus in 24 hours. Budget should move at the speed of policy, which is why I’ve focused on speeding up our processes in the Office of Foreign Assistance, ensuring every dollar is coordinated, effective, and efficient.

Question. Are State and USAID concerned with the potential long-term impacts these delays could cause?

Answer. We are in unprecedented times right now, with a rapidly evolving situation on the ground in almost every country. The State Department and USAID are working aggressively to obligate all of our resources for COVID-19 as swiftly and effectively as possible. At the same time, we recognize that our agencies are accountable for the effective use of funds for COVID-19 response, and must be good stewards of U.S. taxpayer dollars. We refer you to USAID for further information on obligations.

Question. Is the State Department concerned that a U.S. withdrawal from the WHO will further strengthen China’s role at the organization and other multilateral bodies?

Answer. In May, Chinese President Xi pledged \$2 billion over the next 2 years to help in the COVID-19 response—he did not say how much money will be given to the WHO. This pledge is less than what China borrows every year from the

World Bank. China's pledge falls well short of the U.S. commitment of \$10 billion to the COVID-19 response. The President's decision to terminate our relationship with the WHO in no way diminishes U.S. leadership on global health and combatting the COVID-19 pandemic. The United States leads the world in health and humanitarian aid in an "All of America" effort and is committed to ensuring our generosity directly reaches people around the world. We account for more than 40 percent of total global health funding. The United States has allocated more than \$12 billion that will benefit the global COVID-19 pandemic response; more than \$2 billion of this has already been committed.

Question. How can we hope to protect Americans from pandemic disease and other health challenges without a multilateral coordinating authority like the WHO?

Answer. As the COVID-19 pandemic and the WHO's failed response have clearly demonstrated, we lack the international structures to prevent, detect, and respond to infectious disease outbreaks. As U.S. leadership demonstrated in the Ebola and MERS outbreaks, our diplomatic and development efforts enable countries to develop tools for addressing infectious disease. Due to these efforts, we filled gaps created by the WHO's inaction to prevent, detect, and respond to outbreaks immediately. The Administration is examining ways to leverage the expertise of key U.S. Government departments and agencies and the American private sector to rapidly deploy and deliver this essential support to other countries to prevent, detect, and respond to infectious disease outbreaks at their source. In addition, President Trump announced on May 29 that the United States will be redirecting funding planned for the WHO to other global health organizations and urgent needs around the world.

Question. Do you believe that a bilateral approach to complex and far-reaching global health crises is the most effective and efficient way to spend tax payer dollars?

Answer. Achieving global health security remains a foreign policy priority for the U.S. Government. The U.S. Government implements many of its capacity building programs at the country level, including our coordinated whole of government investments in support of the Global Health Security Agenda (GHSA). U.S. Government investments have and continue to build foundations to prepare and respond to the current COVID-19 pandemic, and help countries more broadly prevent, detect, and respond to infectious disease threats. Building upon decades of investment in life-saving health and humanitarian assistance, the American people should be proud of the real results we are achieving through our help to nations around the world, which also helps protect the homeland. Stopping outbreaks at their source protects U.S. national security, and the lifesaving impact of our bilateral efforts remain fruitful components in our diplomatic relationships.

Question. With the world experiencing the worst public health disaster in the last 100 years, it is difficult to understand why the Administration would decide now is the right time to suspend funding and withdraw from the World Health Organization. While China has been used as the pretext for this withdraw, this decision will play into China's hands and possibly strengthen their role at WHO: How does the Administration plan to allocate funding that would otherwise be obligated to WHO, particularly in countries like Venezuela and Yemen that are particularly difficult for U.S. implementers to operate?

Answer. On May 29, 2020, the President announced that the United States will be terminating its relationship with the WHO and redirecting WHO-related funding to other deserving and urgent global health organizations and needs around the world. While the United States was by far the leading contributor to the WHO, those contributions represented a small fraction—just four percent—of total U.S. funding to global health assistance every year. There is a wide range of excellent implementing partners available to us, partners that value transparency and are better able to provide value for American taxpayers. In many cases, our teams in the field and here in Washington have already identified alternate implementers in challenging environments, such as World Vision in Afghanistan, the International Medical Corps in Iraq and the International Rescue Committee in Syria, and in environments where we do not discuss the names of our partners due to safety and operational considerations.

Question. How do you assess the role of PAHO in providing support to Latin America and the Caribbean countries during the pandemic?

Answer. PAHO plays a critical role in the Americas to prevent, detect, prepare and respond to a COVID-19 outbreak. PAHO has activated regional and country incident management system teams to provide direct emergency response to regional

Ministries of Health and other national authorities for surveillance, laboratory capacity, support to health care services, infection prevention control, clinical management and risk communication; all aligning with priority lines of action. PAHO has developed, published, and disseminated evidence-based technical documents to help guide PAHO Member States' strategies and policies to manage this pandemic in their territories. PAHO has also been critical to advancing lab support and detection in the region, including inside Venezuela and throughout the Caribbean. PAHO is the only Organization in the region supplying COVID-19 testing kits and supplies.

Question. In light of the pandemic, will the Administration reconsider its PAHO budget request that would cut funding so significantly?

Answer. We remain committed to PAHO and understand it plays a critical role in the Americas to prevent, detect, prepare and respond to a COVID-19 outbreak. The United States is the largest funder of PAHO, providing 59.4 percent of assessed contributions to PAHO, in addition to voluntary funding from USAID and the HHS Centers for Disease Control (CDC). That said, the United States remains deeply troubled by the role PAHO played in facilitating the provision of Cuban doctors for Brazil's Mais Medicos program. This is the basis of a pending lawsuit filed by several Cuban doctors against PAHO in U.S. federal district court. The United States must ensure U.S. tax dollars are in no way contributing to any program that may have involved human trafficking, as alleged in the lawsuit. At the same time, Secretary of State Pompeo has approved the continuation of limited U.S. foreign-assistance health-related funding to PAHO to implement critical health-related activities in the region, including in Venezuela.

Question. How would a U.S. withdrawal from the WHO impact our support for PAHO?

Answer. A withdrawal from the WHO does not affect our relationship with PAHO. The United States remains a member state of PAHO and supports its unique and important role in the region as the oldest public health organization of its kind. While PAHO serves as a regional office of the World Health Organization (WHO), a U.N. Specialized Agency, PAHO is also an independent organization with its own Constitution, membership, and legal personality. PAHO is also recognized by the Organization of American States (OAS) as a specialized organization of the inter-American system.

Question. I am particularly concerned about the impact of COVID-19 on Venezuela, as the country's health care system was collapsing even prior to the pandemic. How much U.S. humanitarian assistance may be required for Venezuela beyond the \$12.3 million announced, as of late May 2020, to address COVID-19?

Answer. The COVID-19 crisis has exacerbated humanitarian needs among vulnerable populations in the Bolivarian Republic of Venezuela. As you noted, Senator, health care in Venezuela was already near collapse prior to the pandemic of COVID-19 because of the emigration of healthcare workers during the ongoing crisis, interruptions of electricity and water that have resulted in the deterioration of hospital infrastructure, and the acute shortage of medicines. Further, assessing the extent of the impact of COVID-19 in the country is challenging because of the lack of transparency from the illegitimate Maduro regime. Venezuelan health actors continue to express concern that the COVID-19 caseload and death rate are significantly higher than the numbers officially reported.

A further strain on health care in Venezuela during the pandemic is the return of more than 80,000 Venezuelans from Colombia and other neighboring countries since March, many of whom require additional health, financial, and livelihood support. In addition, the Maduro regime has enforced mitigation measures on returnees who arrive through formal border crossings; they must quarantine in overcrowded, unsanitary makeshift shelters, often operated by the Venezuelan military, where they face heightened protection risks and cannot follow proper physical-distancing protocols.

Not only are Venezuelan health institutions ill-equipped to manage the outbreak, but the ongoing nationwide restrictions imposed by the Maduro regime have reduced livelihood opportunities and the availability of food and fuel. Beyond providing direct humanitarian assistance, the U.S. Government (USG) continues to advocate for unfettered humanitarian access and improved coordination and information-sharing.

Since Fiscal Year (FY) 2017, the USG has provided more than \$856 million in development and humanitarian assistance for programs inside Venezuela and across 17 neighboring countries. Since the beginning of FY 2020, the USG has provided more than \$76 million in lifesaving humanitarian assistance and over \$12.3 million in COVID-19 support inside Venezuela. This includes directly supporting the crit-

ical response to the pandemic, improving water and sanitation in schools and hospitals, distributing food for children and families, and protecting vulnerable groups inside Venezuela. The U.S. Agency for International Development is examining options for providing additional funding for health-related interventions against COVID-19 inside Venezuela.

While the USG continues to be the largest humanitarian donor in Venezuela, a significant scale-up in funding and support is required to mitigate the impact of the pandemic of COVID-19 on the existing political and economic crisis. On May 26, 2020, the European Union and the Government of the Kingdom of Spain convened an international donors' conference to mobilize resources in support of Venezuelan migrants and refugees. The governments in attendance pledged nearly \$3 billion at the conference; the USG announced more than \$200 million, the single largest commitment. The conference largely focused on how COVID-19 is exacerbating the ongoing humanitarian crisis caused by the corruption and tyranny of the Maduro regime. The USG continues to advocate for other donors to increase their financial contributions to respond to the crisis, especially inside Venezuela.

Question. What is your assessment of the recent shipment of COVID-19 aid that Iran sent to Venezuela?

Answer. We see the increased Iranian shipments to Venezuela as Iran acting opportunistically to obtain desperately needed cash, while marketing the trade as primarily humanitarian in nature. However, recent shipments of food may have been accompanied by equipment for Venezuela's failing refinery infrastructure. To pay Iran for its assistance, the Maduro regime looted nine tons of gold, worth \$500 million.

Question. How has COVID-19 impacted the obligation of other development, humanitarian, and global health funds? Please provide us with an update on the status of FY19 and FY20 funding.

Answer. The State Department and the U.S. Agency for International Development (USAID) recognize that the COVID-19 pandemic is currently affecting, or could affect, the ability to obligate and expend funds appropriated by Congress for Fiscal Year (FY) 2019 and FY 2020. Following normal practice, State and USAID are working with posts throughout the world and Bureaus domestically to take the steps necessary to obligate all unobligated expiring resources prudently prior to the end of the Fiscal Year. Consistent with statutory provisions, State and USAID are continuing to transmit all required Congressional Notifications for expiring funds, and are committed to working to resolve any questions and concerns that the relevant Committees of jurisdiction raise.

State and USAID both expect to obligate all expiring funds by the end of the Fiscal Year, and we are monitoring obligations closely.

Question. What policy actions does the State Department intend to take to push back against negative trends in democracy and human rights that are tied to government responses to COVID-19?

Answer. The United States is committed to the protection of democracy and human rights in the global response to the COVID-19 pandemic. Strong respect for human rights is a necessary part of the solution to public health crises. Government responses to the COVID-19 epidemic must focus on protecting public health, rather than using the disease as a pretext for repression of people or ideas.

As a member of the Freedom Online Coalition, Media Freedom Coalition, Global Action on Disability network, Community of Democracies, and Open Government Partnership, the United States, with its partners, has called upon governments to respect democratic values and human rights in their responses to COVID-19. The State Department will continue to lead multi-stakeholder initiatives, as well as leverage bilateral and multilateral diplomacy and foreign assistance, to advance democratic norms and combat authoritarian responses to the COVID-19 pandemic.

Question. Will you commit to the importance of equitable and affordable vaccines for the whole world regardless if it is developed for COVID-19?

Answer. In February, the United States pledged \$1.16 billion to Gavi, the Vaccine Alliance, over 4 years. This marks the largest U.S. commitment to Gavi to date, and reaffirms our commitment to strengthening global health security and combatting the spread of infectious diseases through the delivery of safe and effective vaccines to at-risk populations across the world. On top of investments in Gavi, the United States supports the work of UNICEF and has invested over \$2 billion towards Polio eradication, including through investments in the Global Polio Eradication Initiative, which seeks to end polio by 2023 through delivery of routine and targeted vaccination campaigns in endemic and outbreak countries.

LGBTQI RIGHTS

This month marks Pride Month—which recognizes people of varying sexual orientations and gender identities across the world. I am deeply concerned that the United States has abdicated its historic leadership role in upholding the human rights of all people. Already facing stigma, violence, and discrimination in their communities prior to the pandemic, there have been multiple reports that LGBTQI+ people are being scapegoated for the spread of the disease. Notably, last month for the International Day against Homophobia, Biphobia, Intersexism, and Transphobia, the United States did not sign onto U.N. statements about the unique risks that LGBTQI+ people face in the context of COVID-19:

Question. Why did the United States fail to join these statements?

Answer. U.S. policy on LGBTI human rights around the world is focused on mitigating violence and the decriminalization of LGBTI conduct. The statements issued by the Core Group included broad language that went beyond the scope of the Department's policy mandate. The United States' longstanding commitment to protecting the human rights and fundamental freedoms of all people, including LGBTI persons, is well-known. So too is its sovereign interest in ensuring that any statements it joins are consistent with U.S. law and policy.

In this case, a virtual abbreviated negotiation process for a lengthy statement made it preferable to release our own statement, which was posted on the USUN Mission's website and social media accounts.

Question. How is the United States promoting the human rights of LGBTQI+ people in the context of COVID-19?

Answer. The State Department and USAID have been at the forefront of the U.S. Government's response to the impact of the global COVID-19 crisis on democracy and human rights. The Department has established a COVID-19 Working Group spearheaded by the Bureau of Democracy, Human Rights, and Labor (DRL) to track foreign governments' autocratic and abusive responses to COVID and to coordinate and promote democratic and human rights-respecting responses instead.

Since the launch of our COVID working group on April 9 at a large NGO virtual roundtable, DRL has hosted more than 50 additional external consultations with more than 100 NGOs. Our partners have highlighted COVID-19-related disinformation and other malign influence, growing authoritarianism, crackdowns on fundamental freedoms, expanded use of surveillance tools, and targeting of vulnerable groups, including LGBTI persons.

These consultations have been instrumental in helping the Department adapt and implement programming in response to the crisis. We recognize that the LGBTI community is often a target of abuse where governments conveniently cloak crackdowns on fundamental freedoms as efforts to respond to the pandemic. The Department is working with our civil society partners to make current LGBTI programs flexible and responsive to the impact COVID-19 is having on the human rights of individuals in this community.

In response to COVID-19, USAID has worked to ensure that existing funds—both from USAID and bilateral partners such as Canada and Sweden—can be used flexibly to address the most urgent challenges facing LGBTI people in developing countries. Additionally, USAID is working to incorporate LGBTI considerations into broader COVID-19 emergency response efforts.

Question. How is the United States monitoring human rights abuses against LGBTQI+ people in the context of COVID-19?

Answer. The State Department has established a COVID-19 Working Group spearheaded by the Bureau of Democracy, Human Rights, and Labor (DRL) to track foreign governments' autocratic and abusive responses to COVID. DRL has hosted more than 50 external consultations with more than 100 NGOs and is documenting cases of COVID-19-related disinformation and other malign influence, growing authoritarianism, crackdowns on fundamental freedoms, expanded use of surveillance tools, and targeting of vulnerable groups, to include LGBTI persons. These consultations have been instrumental in helping the Department to adapt and implement LGBTI programs that are flexible and responsive to the impact COVID-19 is having on the human rights of individuals in this community.

Question. What steps has the U.S. taken to ensure that our international assistance, especially with respect to global health programming, is being carried out in a non-discriminatory and inclusive manner when other governments may not have protections in place for vulnerable populations?

Answer. USAID integrates inclusion and nondiscrimination principles into its policies and programming, and advances inclusion and nondiscrimination through programs that address the specific needs of marginalized and vulnerable populations. In all programs, USAID continues to enforce its nondiscrimination policies for access to services to beneficiaries, which ensure that no USAID contractor or grant recipient discriminates against any beneficiary for any reason.

RESPONSES OF MR. CHRIS MILLIGAN TO QUESTIONS
SUBMITTED BY SENATOR BEN CARDIN

VENTILATORS

The administration has touted the distribution of U.S.-made ventilators to countries overseas as a large success. However, many are concerned by a lack of details regarding USAID's distribution of ventilators and the strategy behind it.

Question. To date, how much funding has been spent on these ventilators? How many countries have received ventilators? And how is the Administration deciding which countries receive them? Specifically, can you walk us through the decision to provide 200 ventilators to Russia? As you know, ventilators are complex medical machines that require training and maintenance to operate successfully. How are we ensuring that medical professionals in countries receiving these ventilators have the proper training to operate and maintain these machines?

Answer. The total funding spent on ventilators is \$195.7 million. USAID has delivered U.S. manufactured ventilators to ten countries as of June 18, 2020.

The COVID-19 pandemic is worldwide: Nearly all countries are either experiencing the effects of the virus or are at risk of shortly experiencing transmission, morbidity and mortality. Up to 20 percent of all COVID-19 patients are expected to require at least supplemental oxygen; the most-critical patients require intensive care and assisted ventilation. The COVID-19 pandemic has been particularly acute in the Russian Federation.

A total of 44 countries (with NATO) are receiving ventilator donations. USAID does not have visibility into the parameters for country selection within the larger USG ventilator donation program. We would advise engaging HHS and NSC for this status.

In alignment with Pillar IV of the U.S. Government Action Plan to Support the International Response to COVID-19, USAID procured U.S. manufactured plans to use ESF resources to support the Russian Government to implement an immediate, critical, life-saving response to COVID-19 by providing 200 ventilators and related commodities and consumables. The recipient of the equipment is expected to be a Federal State Budgetary Institution, "National Medical and Surgical Center named after N.I. Pirogov" of the Ministry of Healthcare of the Russian Federation. In light of the urgent need for this assistance to address the pandemic in Russia, notifying these funds in accordance with the regular notification procedures would pose a substantial risk to human health and welfare.

USAID is coordinating with host country Ministries of Health to assess overall capacity to provide respiratory care for critically ill patients suffering from COVID-19, as well as health facilities' capacity to provide critical care and use ventilators safely and effectively. USAID is facilitating setup and orientation support for ventilator deliveries led by manufacturers. USAID is also offering targeted technical assistance where needed, using assessments conducted with Ministries of Health and implementing partners to guide this support. In addition, USAID is providing access to a global distance learning portal and a technical hotline for health providers to tap into subject matter expertise.

PPE

I was pleased by the Administration's recent decision to re-allow U.S. international assistance to be used to purchase PPE, like masks and gloves, to protect healthcare workers on the frontlines of fighting COVID-19 overseas. However, the new policy only allows the purchase of PPE that is regionally produced.

Question. Are essential PPE like N95 masks produced in sub-Saharan Africa, southern Asia, and the other resource-limited areas? Will healthcare workers be able to access the PPE they need to protect themselves and patients under the revised policy, or will they continue to face challenges?

Answer. This guidance adheres to the White House's guidance to reduce competition for PPE with the U.S. market, while allowing our countries and staff a great

degree of flexibility and freedom to protect themselves and continue to implement life-saving programs.

A number of countries throughout the regions where USAID works have the manufacturing know-how and capacity to produce essential personal protective equipment, however, which country or region is producing what types of PPE is highly variable. Many regionally-produced types of PPE are emerging from countries such as the Middle East, South Asia, and East Asia, whereas the continent of Africa as a whole may have less experience in producing complex types of PPE such as respirators. For this reason, USAID's PPE guidance allows for exceptions on the regional and locally produced elements. For beneficiaries of USAID programs, Covered Materials should be procured from local or regionally-manufactured sources. However, in the case where a country does not have access to local or regional suppliers, or if they find products with a better price or higher quality elsewhere, they are permitted to procure Covered Materials produced in regions other than the region in which the country itself is located, with written Agreement Officer/Contracting Officer approval and the understanding that these products are not, and reasonably could not, be intended for the U.S. market.

Anyone receiving financial compensation from a USAID implementing partner is considered to be staff, and can therefore procure and use Covered Materials from any source, not just regional or local sources. In many situations, government-employed healthcare workers and Ministry of Health employees are implementing partners of USAID and those healthcare workers are therefore able to procure and use Covered Materials from any source. This guidance enables healthcare workers to access the products and supplies they need to protect themselves and patients. Furthermore, only the items considered "Covered Materials" are under any type of procurement restrictions—other types of PPE, hand sanitizer, and cleaning supplies are not under procurement restrictions.

EBOLA/WHO

USAID and other U.S. agencies, including the CDC, worked closely with WHO in responding to the Ebola outbreak in the Democratic Republic of the Congo since 2018.

Question. With reports of new cases in the western part of the country, how will the U.S. continue to provide assistance in the fight against Ebola outside the WHO framework?

Answer. Historically, USAID's response to outbreaks of Ebola in the Democratic Republic of Congo (DRC) has been coordinated with WHO and U.N. leadership, but we always directly fund U.N. and NGO partners to ensure any gaps in critical response operations are filled.

USAID has more than 20 active United Nations and non-governmental organization partners responding to Ebola in eastern DRC. These partners have the flexibility to respond country-wide, supporting activities to prevent and control infections in health facilities, enhance disease surveillance, train health-care workers, and educate and engage communities on health behaviors. Two USAID partners, the International Medical Corps and the Alliance for International Medical Action, have already leveraged the geographic flexibility and rapid response capabilities in their awards and are currently providing case management support in western Equateur province.

DRC's Minister of Health is leading the response to the Ebola outbreak in Equateur, while the U.N.'s Humanitarian Coordinator and the Office for the Coordination of Humanitarian Affairs (OCHA) is providing critical coordination support to international response actors. USAID is closely tracking the situation unfolding in northwestern DRC and is assessing other potential areas of support. Additionally, USAID is coordinating closely with all response stakeholders, including other donors, to identify needs and ensure an efficient and effective response to this new outbreak.

PROGRAM OVERSIGHT

In March, the State Department authorized the return to the United States of high-risk U.S. government personnel from diplomatic or consular posts abroad. USAID and the Millennium Challenge Corporation followed State Department guidance, while the Peace Corps suspended all operations worldwide.

Question. What has been the impact of these evacuations on program operations, both for existing and new programs? How has reduced staff capacity in the field affected oversight of programming?

Answer. Following the State Department's Global Authorized Departure, U.S. employees at high-risk were evacuated to the United States, where they immediately continued their normal duties by teleworking. Even with staff evacuating on Global Authorized Departure, all operating units had U.S. employees, including supervisors, remaining, with the exception of one small country office. Under the in-country leadership of these remaining U.S. and host country staff, and with the support of employees teleworking from the United States, USAID continues program operations.

USAID has been able to continue operations without reducing program oversight by using available technology. However, restrictions on movement imposed by overseas public health authorities have, in some posts, reduced our ability to engage in-person with beneficiaries, implementers, and host-government officials. USAID has worked to overcome these restrictions by advising our Missions on how to effectively use remote monitoring techniques, including cell-phone monitoring, accessing data from institutional monitoring systems, and direct monitoring through satellite data and geospatial information. USAID has also created an online forum to share monitoring and evaluation best practices as well as lessons learned during COVID-19.

COVID-19 IN LATIN AMERICA

The leaders of Brazil, Mexico, and Nicaragua have played down the threat of COVID-19 and failed to take adequate actions to stem its spread. There are also concerns that several countries in the region are undercounting their COVID-19 death tolls.

Question. To what extent do you share these concerns? How might the United States play a role in convincing governments to adequately address the spread of COVID-19 and be transparent in reporting COVID-19 cases and deaths?

Answer. Combating the COVID-19 pandemic will require an unprecedented level of global trust, transparency, and accountability, particularly in the areas of accurate case and death reporting. With the generous support of Congress, through the COVID-19 supplemental funding, USAID has been able to promote these best practices in many countries around the world. For example, with COVID-19 Supplemental funding in many conflict-ridden and vulnerable countries, USAID is supporting activities to counter misinformation and disinformation, bolster the independent and free flow of media, journalism, and information, and support citizen-led governance, civil society, and good governance efforts. Additionally, USAID has advanced efforts to disseminate in local languages scientific-based risk and behavior change materials, and supports surveillance, digital methods of tracking cases, points-of-entry screening, case reporting, and contact tracing, all of which lead to increased visibility and transparency into the accurate numbers of COVID-19 cases. By working with Ministries of Health and other local leaders in our partner countries, USAID can play a key role in convincing governments and leaders that accurate and timely reporting of COVID-19 cases is a strength that will allow for quicker assistance, better communication and messaging to their people, a reduction in caseload, earlier preparation for infection prevention and control in facilities, and most importantly, a reduction in livelihoods and lives lost due to the pandemic.

IMMUNIZATIONS

The WHO has reported that the pandemic has disrupted routine immunization services in at least 68 countries, putting more than 80 million children at risk of becoming infected with polio, measles, diphtheria and other diseases. The resulting disease burden from outbreaks of vaccine-preventable illnesses may be devastating for already weak and stretched healthcare systems in developing countries.

Question. How has the pandemic impacted USAID's immunization programs, and how will USAID help restore and strengthen immunization services globally?

Answer. COVID-19 and its global spread has resulted in the disruption of immunization services worldwide, including the suspension of campaigns against epidemic-prone diseases, such as polio and measles. Among the 25 high-burden countries prioritized for USAID maternal and child health (MCH) efforts, since March 2020, 20 have experienced or are projected to experience disruptions in campaign activities for polio, measles, yellow fever, and other vaccine-preventable diseases. In addition, USAID partners report reduced demand for immunizations in 14 of 22 MCH priority countries.

To address these challenges, USAID—in partnership with Gavi, the Vaccine Alliance, and others—is supporting country governments to plan for catch-up vaccination campaigns and to promote improved infection prevention and control efforts by immunization service providers to prevent the spread of COVID-19. USAID and

partners are adapting immunization delivery strategies, developing strategies to track and follow-up with individuals who missed vaccinations, monitoring reductions in vaccine coverage, and re-establishing community trust and demand for vaccination. USAID is committed to continuing support to minimize the effects of immunization service disruptions, respond rapidly to outbreaks of vaccine preventable diseases, and protect health workforces, even as we address the direct effects of the COVID-19 pandemic.

RESPONSES OF MR. GARRETT GRIGSBY TO QUESTIONS
SUBMITTED BY SENATOR BEN CARDIN

WHO

I believe freezing aid to the WHO and withdrawing the U.S. is short-sighted and dangerous.

Question. What reforms was the Administration seeking from the WHO?

Answer. The United States is working with other likeminded WHO member states on a number of areas of concern with WHO's preparedness and response that have come to light due to the outbreak of COVID-19. These proposals focus on member state compliance with the International Health Regulations as well as strengthening WHO's leadership, allowing them to be more independent and empowered to call out concerns about member states' failure to comply with the IHRs. Reforming the process for declaring a Public Health Emergency of International Concern (PHEIC) is being discussed, as well as delinking travel from trade restrictions. The President also articulated the specific concerns of the United States in his May 18, 2020 letter to WHO Director-General Tedros.

Question. Why did the administration announce the withdraw from the WHO 10 days after telling the organization it had 30 days to make these reforms?

Answer. The President announced on May 29, 2020 his determination that it was in the best interest of the United States to "terminate its relationship" with the WHO. On July 6, the United States deposited its notice of withdrawal from the WHO with the U.N. Secretary General, the depositary of the WHO Constitution, effective July 6, 2021.

Question. Which alternative implementers has the interagency review panel found who can step into the gap while assistance to the WHO is suspended? Are you worried about a lack of coordination and decreased effectiveness through using non-WHO implementers?

Answer. The United States collaborates with many partners on global health. Funding that was previously provided to WHO will, to the extent permitted by law, be redirected to these partners. We will work to ensure coordination and effectiveness with these partners, as appropriate and feasible. The interagency is reviewing all collaborations to discover if there are certain activities that only WHO can undertake and, if this is the case, decisions will be made about how to deal with this situation.

Question. How does the U.S. plan to partner with other countries on global health initiatives without being a WHO member?

Answer. The United States' partnership with many countries on global health is not dependent upon our membership in WHO. U.S. leadership on global health has been uncontested for decades and that will remain so. In fact, several signature U.S.-led global health initiatives, such as the President's Emergency Plan for AIDS Relief and the President's Malaria Initiative, were created, in part, because the international community, including WHO, were not able to put sufficient resources toward fighting HIV/AIDS or malaria. The United States Government is committed to maintaining and even strengthening our leadership in the field of global health, notwithstanding our relationship with WHO.

Question. The U.S. has invested heavily in WHO-led polio eradication efforts, as the WHO is the only global entity with safe access to polio hotspots in places experiencing conflicts, including Afghanistan. How will the U.S. continue to be a global leader in polio eradication efforts without the support WHO provides?

Answer. The interagency is reviewing all collaborations to discover if there are certain activities that only WHO can undertake and, if this is the case, decisions will be made about how to deal with this situation.

SOLIDARITY TRIAL

Among other activities, WHO is leveraging its global reach and convening power to support an unprecedented effort to identify effective treatments and vaccines for COVID-19. The organization's "Solidarity Trial," in which more than 100 countries are now participating, could—due to its wide geographic breadth and inclusion of diverse demographic groups under one umbrella—reduce the time needed to evaluate the effectiveness of specific treatment regimens by 80%.

Question. Do you think it is important for the U.S. to support these types of global trials? Why is the United States not joining this effort when it could help Americans and American companies?

Answer. The United States has contributed significantly to the establishment of the Solidarity Trial by writing the master clinical trial protocol used. This is critical because the majority of on-going clinical trials globally are observational or underpowered and will not result in data that can be used to support safety and efficacy of investigational therapeutics. The United States, through leadership at HHS' National Institutes of Health, has launched a series of robust clinical trials targeting: (1) the re-purposing of products licensed for another indication for activity against SARS-CoV-2; (2) novel therapeutics; (3) convalescent plasma; and (4) neutralizing monoclonal antibodies targeting the virus. In undertaking these studies directly, the U.S. has moved out significantly faster in enrolling patients in robust clinical trials, making determination of investigational products' efficacy, and sharing these results with the global community.

OPERATION WARP SPEED

The U.S. is focused on developing a safe and effective COVID-19 vaccine through Operation Warp Speed.

Question. In addition to securing a vaccine for domestic distribution, will the U.S. also be a partner in the global effort to develop and distribute a COVID-19 vaccine?

Answer. Although Operation Warp Speed's primary mission is to advance medical countermeasure development to accelerate the availability of products for use by Americans, we believe that such work advances global efforts to develop critical tools to combat COVID-19 and would expect that our commercial partners would ultimately make any approved COVID-19 vaccines available globally as well. Moreover, the Administration is examining ways to leverage the expertise of key U.S. Government departments and agencies and the American private sector to rapidly deploy and deliver essential support to other countries to prevent, detect, and respond to infectious disease outbreaks at their source.

 RESPONSES OF JAMES L. RICHARDSON TO QUESTIONS
 SUBMITTED BY SENATOR CHRIS COONS

Question. In December 2019, the U.S. Congress passed the bipartisan Global Fragility Act (GFA), which calls for a new strategy to address the root causes of violence fragility around the world. The GFA requires a dramatic shift from the status quo and requires a coordinated, proactive, multi-sectoral, locally-driven, and evidence-based approach.

The Trump administration's current strategy to address to global consequences of the COVID-19 pandemic prioritizes four pillars, including: protecting American interests, bolstering health systems, and addressing complex humanitarian crises. The fourth pillar calls for preparing for, mitigating, and addressing second-order economic, civilian security, stabilization, and governance. I am concerned that this strategy does not adequately address the issues of fragility and focuses instead on the emergent needs of the pandemic.

Will you advocate for a U.S. Government strategy to combat COVID-19 that includes a focus on fragility and adequately addressing the issues that will be exacerbated by the global pandemic and contribute to the increased spread of violence and violent extremism?

Answer. Since the outbreak of COVID-19, the State Department and USAID have committed more than \$1.3 billion in emergency health, humanitarian, economic and development assistance to help fight the pandemic. A portion of this assistance helps governments, civil society, and the private sector to prepare for, mitigate, and address the second-order economic, civilian-security, stabilization, and governance effects in fragile states caused by COVID-19. This includes over \$13 million dollars committed thus far to Pillar IV programming in fragile states and an additional \$11

million to peace and security programming. This work will promote democracy in Libya, support media and civil society organization-led awareness campaigns in the DRC and the Central African Republic (CAR), and improve the capacity of host country governments in the Sahel to communicate COVID-19 prevention, management, and response messages. The Global Fragility Act and its associated strategies and plans will be a crucial tool in successfully addressing COVID-19's impact on conflict and fragility.

Question. How will the State Department seek to develop a Global Fragility Strategy that addresses the increased risk that COVID-19 presents in fragile states?

Answer. The White House is coordinating an interagency process to implement the GFA and corresponding Global Fragility Strategy. The Department of State leads the drafting and execution of the GFS, with a five-phase approach that includes initial scoping, consultation, drafting, country and region selection, and country plan development. The GFS will help identify the underlying causes of fragility, violence, and conflict; articulate more effectively how to use U.S. taxpayer dollars; foster greater transparency, accountability, adaptive and locally-based approaches; and demand measurable and meaningful outcomes. Underpinning the development of the GFS is a dynamic analytic approach that can take into account new and evolving developments, including the impact and risks that COVID-19 will have on fragility and conflict. By pursuing an innovative, data-driven, consultative approach through the GFA, the U.S. Government can better mitigate threats to its core national security interests and more effectively address the drivers of global conflicts and fragility.

RESPONSES OF MR. CHRIS MILLIGAN TO QUESTIONS
SUBMITTED BY SENATOR CHRIS COONS

Question. On April 28, Acting Administrator Barsa released a press statement on the New Partnerships Initiative where he focused on the COVID-19 response, saying that "USAID is pursuing all options for an effective response, including by working with new or underutilized partners that can provide innovative, scalable solutions to address the pandemic." What results has the agency achieved in utilizing new and underutilized partners to date in combatting the consequences of the global pandemic around the world?

Answer. Throughout our response to the COVID-19 pandemic, USAID is committed to working with new, underutilized, local, and locally established partners as defined by our New Partnerships Initiative. Thus far, just over 4 percent of our total obligations for COVID-19 funds have gone to new and underutilized partners, totaling over \$26.4 million. Additionally, many of USAID's prime partners are expanding their association with local sub-partners to effectively respond to COVID-19.

RESPONSES OF MR. GARRETT GRIGSBY TO QUESTIONS
SUBMITTED BY SENATOR CHRIS COONS

Question. Do you believe U.S. based, multinational companies will be adversely impacted by WHO policy recommendations once the Trump administration terminates its relationship with the WHO?

Answer. The United States will continue to advocate for U.S. companies, as appropriate, in multilateral fora directly or in collaboration with allies. We will work together to ensure that policy recommendations are based on science and the best available evidence and do not disadvantage American interests.

Question. Do you believe that the United States has more or less leverage to advocate for the interests of U.S. based, multinational companies in the WHO after termination of the U.S. relationship with the WHO?

Answer. The United States will participate actively and advocate effectively for its interests, including, as appropriate, the interests of the U.S. private sector. This is also why the WHO reform package the U.S. Government is leading on is necessary and why we have proposed that trade and travel restrictions be delinked when responding to health emergencies. This particular reform would seek to ensure that private sector partners can continue to deliver products and produce needed health supplies and get these goods into the hands of those who need them.

COVID-19 AND U.S. INTERNATIONAL PANDEMIC PREPAREDNESS, PREVENTION, AND RESPONSE

PART 2: COVID-19 AND U.S. INTERNATIONAL PANDEMIC PREPAREDNESS, PREVENTION, AND RESPONSE: ADDITIONAL PERSPECTIVES

TUESDAY, JUNE 30, 2020

U.S. SENATE,
COMMITTEE ON FOREIGN RELATIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m. by video-conference, Hon. James E. Risch, chairman of the committee, presiding.

Present: Senators Risch [presiding], Menendez, Cardin, Shaheen, Gardner, Udall, Murphy, Merkley, Perdue, and Booker.

OPENING STATEMENT OF HON. JAMES E. RISCH, U.S. SENATOR FROM IDAHO

The CHAIRMAN. Well, good morning, everyone. The hour of 10:00 a.m. having arrived, I am going to call this meeting of the Foreign Relations Committee to order.

And I want to thank all of you for participating. We have very important business for the committee today, and this is the second in a series on the international response to the COVID-19 pandemic and what we can do about it in the future of prevention, preparedness, and response.

Let me take just a moment to talk about what we are attempting to do here. You know, around here in the Senate, exaggeration and hyperbole is kind of the order of the day, and so I am always reluctant to say this truly could be one of the most important things we, as members of this committee, do.

What the world is experiencing today, what the United States of America is facing today, is one of the most significant challenges that a lot of us will face in our lifetime.

The bad news, the really bad news, is that it is entirely possible that it will happen again, and I say this, of course, because the experts tell us that this virus that made the leap from one species to another, from bat species to human species, can very easily happen again and that there are 2,000 of these viruses out there. We have no idea what they can do when they get into a human being.

The bat populations, the experts and scientists tell us, have had identified within their ranks about 2,000 different viruses.

So having said that, we need to look forward, and I want to stress what I am trying to do with this and what I hope all of us will be joining and trying to do is to look forward.

I believe there is a lot of hearings going on. There is a lot of hyperbole going on. There is a lot of finger pointing and a lot of blame assignment.

But that is not what I am trying to focus on here and I hope we would all avoid that. Certainly, a person cannot help but think about how this happened, who is responsible for this, who could have done things better.

We do want to see how we could do things better. But I would hope, I would sincerely hope, that all of us are committed to the idea that what we are trying to do is to keep from happening—keep this from happening again, not trying to tar and feather somebody that should have done things better in the past.

I mean, there has been a number of criticisms levied against the World Health Organization. I have spent a considerable period of time talking to the people at WHO. I have been impressed with the fact that they themselves recognize that things should be looked at, and they, like us, are—would really like to see that things work better in the future. Heaven help us if this happens again.

In any event, to that end, there has been legislation prepared. There has been a number of pieces of legislation, and I am going to urge the committee in the strongest way possible for everyone to get together and pull the wagon on this to get to the place where we can have a piece of legislation that will actually help in the future.

As I said, there is—this future is so important when it comes to how we react next time. It is going to be very important, particularly if it turns out to be a worse virus than what—the world is not going to know probably what we did, and if we fail they probably will not even know that we made an effort at it.

But all of us run for these offices because we want to make a difference, particularly into the future, and this is our opportunity to do this.

This is my 40th year in a Senate body. I led a Senate body over two decades. I know good-faith effort when I see it, and I have seen a lot of good-faith effort here on a bipartisan basis to develop something as we go forward in the future.

There is—of the 22 members on this committee, there is a tremendous pool of talent here on both sides of the aisle.

Ranking Member Senator Menendez has spent many, many years in the service of the United States, dealing with the challenges, and they are challenges that we face with other countries. He brings that to the table, and much more.

Across this committee, we have people who are—have been deeply involved in Committees on Health and Human Services, on Homeland Security, on Armed Services, Intelligence, and other committees. Everybody brings something to the table.

What I am hoping is we have a product that will reflect the best of all of us in bringing the matter into a bill. As I have said over and over again, the bill that myself and Senator Murphy have introduced is written on paper. It is not written on stone.

We want the best possible ideas and the best possible outcomes as we move forward. And everything is on the table and there is no pride of authorship here, and I hope everyone can set aside preconceived notions and move forward when we need, obviously, a more innovative approach to be brought to this problem, as it, hopefully, but probably will exist in the future. Hopefully, it will not, but probably will, exist in the future.

We are fortunate to have with us a panel of experts with an impressive range of expertise today for infectious disease detection and treatment, diplomatic engagement, and emergency response, and we know that all of these are incredibly important as we put together a holistic approach to this problem.

Each of you bring something unique to the table. Thank you for sharing your insights today. In our last hearing, we focused on a number of key issues including the need for World Health Organization reform.

Again, simply because we talk about the World Health Organization reform we do not want to demonize people who have made incredible efforts to try to address the problems we have today.

I am aware of the challenges and differences that several of our panelists faced when they worked with World Health Organization during the Ebola outbreak in West Africa, which, ultimately, led to a number of things that bring us to where we are here today.

While some structural improvements have been made to the World Health Organization since the Ebola situation, it appears we may be repeating history today, though on a much grander and deadlier scale. After Ebola, of course, the Global Health Security Agenda was formed and it did not get us where we need to be either.

Some have suggested that the World Health Organization has neither the mandate nor the capacity to hold countries accountable for failing to uphold obligations under the international health regulations, and that probably can be fixed.

Indeed, as I talked with the World Health Organization, they made credible cases as to why they could not do some of the things that they really wanted to do. Those are things that we really need to—others have suggested that the World Health Organization does not have the will. That is a harder fix. But, again, we need to focus on what we could do about it.

And so it is only appropriate for us to recognize what the World Health Organization is. It is a convening mechanism, a guardian of things, and a clearinghouse of norms and best practices, and we probably out to examine our own consciences and ask us if we are asking the World Health Organization to be something that it is not.

I have repeatedly asked what entity to call when an outbreak begins before it gets out of control. What entity is the fire department?

Again, I want to especially say that we should avoid condemning what happened in the past and look forward to the future. I have repeatedly been disappointed by the response as to who is the fire department.

One thing is clear. It is not the World Health Organization, at least not as it exists today. That does not mean it cannot be fixed.

So what entity is it and what entity responds to the alarm? The mandate capacity and will do not yet exist to whom and where should that be vested.

That question is wide open and the answer that we need and the right answer is not an answer that is dictated by politically taking sides.

What entity raises the alarm? How can we approve and expand early warning at a global level so we can get ahead of an outbreak before it gets out of control?

The Global Health Security Agenda provides a useful and only a framework for addressing these issues. How can we more effectively operationalize it?

As I said, our suggestions to point is only for discussion and written on paper, not stone. And how can we incentivize countries to prioritize global health security, strengthen preparedness and response, and share critical global health data? Is there a way we can better support countries that have demonstrated will but a low capacity to operationalize?

More importantly, how do we incentivize innovation including from development, manufacturing, and equitable deployment of vaccines are a couple of the issues.

These are difficult challenges that require serious solutions. Though we are rightly focused on the immediate COVID-19 response, particularly as the Southern Hemisphere moves into the winter months, we cannot afford to wait.

This is not our first pandemic, and unless we can figure out some solutions, it will not be our last. We have put a number of ideas forward in a bipartisan bill, the Global Health Security and Diplomacy Act.

It is a bill that we hope everyone will take as a starting point and as a discussion point. I am hopeful that our discussions today will help us further refine the ideas in that bill so we can answer these questions, chart a responsible path forward, save lives, and ultimately protect America from future waves of infection.

I have been impressed by the way the committee had been working together. We are taking ideas from everyone. Senator Murphy and I continue to meet to try to—to try to operationalize the ideas that we are getting from other members of the committee.

I thank our witnesses for their contributions to this inquiry. Yet, I strongly urge that if we are to succeed, and we must succeed for the future of America and the future of the world. We work on solutions and not necessarily on focusing of the failures of the most recent response.

[The prepared statement of Senator James E. Risch follows:]

PREPARED STATEMENT OF SENATOR JAMES E. RISCH

We will now convene the second hearing in a series on the international response to the COVID-19 pandemic, and the future of preparedness, prevention, and response.

We are fortunate to have with us a panel of experts with an impressive range of expertise—from infectious disease detection and treatment, to diplomatic engagement and emergency response.

You each bring something unique to the table. Thank you for sharing your insights today.

During our last hearing, we focused on a number of key issues, including the need for WHO reform.

I am aware of the difficulties several of our panelists faced when working with the WHO during the Ebola outbreak in West Africa—which ultimately led to a decision not to fund the WHO appeal, to request an interim review of the WHO’s performance, and to advance a broader WHO reform agenda.

While some structural improvements have been made since, it appears we may be repeating history—though on a much grander and deadlier scale.

Some have suggested that the WHO has neither the mandate nor the capacity to hold countries accountable for failing to uphold obligations under the International Health Regulations. That can probably be fixed.

Others have suggested that it does not have the will. That’s a much harder fix. And so perhaps it’s time for us to recognize what the WHO is—a convening mechanism, a guardian of the IHR, and a clearinghouse of norms and best practices—and stop asking it to be something it’s not.

I’ve repeatedly asked, “Who do we call when an outbreak begins, before it gets out of control? Who is the fire department?”

I’ve repeatedly been disappointed by the response.

One thing is clear—it’s not the WHO. At least not today.

So who is it? Who responds to the alarm? If the mandate, capacity, and will do not yet exist, to whom and where should they be vested?

Who raises the alarm? How can we improve and expand early warning at a global level, so we can get ahead of an outbreak before it spins out of control?

The Global Health Security Agenda provides a useful framework for addressing these issues. How can we more effectively operationalize it?

And how can we incentivize countries to prioritize global health security, strengthen preparedness and response, and share critical global health data?

Is there a way we can better support countries with demonstrated will but low capacity?

And, importantly, how do we incentivize innovation, including for the development, manufacturing, and equitable deployment of vaccines and counter-measures?

These are serious challenges that require serious solutions.

While we are rightly focused on the immediate COVID–19 response—particularly as our friends in the Southern Hemisphere move into the winter months, and infections accelerate in places like Brazil, India, and across Africa—we cannot afford to wait.

This is not our first pandemic and, unless we can figure out some solutions, it won’t be the last.

I’ve put a number of ideas forward in a bipartisan bill, the Global Health Security and Diplomacy Act. It’s a bill that is written on paper and not on stone, and it continues to evolve.

I am hopeful that our discussion today will help us further refine the ideas in that bill, so we can answer these questions, chart a responsible path forward, save lives, and, ultimately, protect America from future waves of infection.

I thank our witnesses for their contributions to this important effort.

With that, I will ask Ranking Member Menendez if he wishes to make any opening remarks.

The CHAIRMAN. With that, I thank everyone again for joining us today. I will urge everyone to work in good faith to try to actually reach some conclusion. With that said, it is, I think, one of the most important things we will probably do with our service here in the United States Senate.

With that, I want to recognize Senator Menendez for his remarks.

**STATEMENT OF HON. ROBERT MENENDEZ,
U.S. SENATOR FROM NEW JERSEY**

Senator MENENDEZ. Thank you, Mr. Chairman. Thank you for convening another hearing on the ongoing COVID–19 pandemic.

As of June 26, 2020, the World Health Organization had recorded just under 9.5 million confirmed cases of COVID–19 and more than 484,000 deaths worldwide. More than 2 million of those cases are right here in the United States.

This disease has claimed more than 120,000 American lives in the span of 5 months. I know it well because, unfortunately, at

least 14,000 to 15,000 of those are from my home state of New Jersey.

And it has proven resilient and pernicious, with new spikes across the United States and China, and alarming increases in the number of cases in South Africa, India, and Brazil.

This pandemic presents one of the most complex and novel threats the United States, indeed, the world has faced in several generations and it is clear that even if we stop the spread of the disease here, which we certainly have not, without a serious global effort to understand and confront it, COVID-19 can and will return to our shores.

If ever there was a need for the United States to be an active leader in an international coalition to respond to a common threat, it is now. We simply cannot safeguard American lives without one.

Unfortunately, the United States has not yet risen to meet this challenge. We have seen a haphazard response, going so far as to effectively withdrawing from the very international institution best poised to respond to this crisis.

We have alienated critical partners and have been absent at critical convening meetings, all of this at the expense of the health and safety of the American people.

I believe there is more America can and must do, and that Congress has a critical role to play. In good faith, as you referred to, Mr. Chairman, in May all the Democratic members of this committee introduced comprehensive legislation laying out concrete actions the United States could take to lead in the global response.

The COVID-19 International Response and Recovery Act, or CIRRA, presents a clear strategy to confront the ongoing pandemic and prepare the United States to deal with the next and compels the Trump administration to constructively engage with other countries, international organizations, and multilateral fora to stop the spread of this deadly pandemic.

Specifically, our bill authorizes an additional \$9 billion in funding to fight the COVID-19 pandemic through contributions towards vaccine research at the Coalition for Preparedness and Innovations; a contribution to the Global Fund for AIDS, Tuberculosis, and Malaria for its COVID-19 response mechanism; additional funding for emergency overseas humanitarian assistance in response to the pandemic, ensuring that these funds are provided both to the U.N. for its global response plan as well as directly to NGOs working on the front lines; and a new surge-financing authority at the U.S. International Development Finance Corporation that would allow the DFC to expedite decisions and make strategic investments quickly to aid in COVID-19 reconstruction efforts.

CIRRA also puts in place mechanisms to help us better prepare for the next pandemic. It requires an annual intelligence estimate on pandemic threats and establishes a White House advisor for global health security to coordinate a whole of government U.S. response to global health security emergencies aimed at improving both domestic and international capacity to prevent, respond, and detect epidemic and pandemic threats.

It clearly delineates the role for the State Department, USAID, and the Centers for Disease Control and Prevention in responding to pandemic threats, and it directs the U.S. executive director to

the World Bank to begin negotiations to establish a trust fund at the World Bank designed not to compete with or supplant the World Health Organization, but to work in tandem with the World Health Organization on incentivizing countries to mobilize their own resources for epidemic and pandemic preparedness.

Mr. Chairman, more than 700 Americans are dying each day. Neither the finger pointing blame game, race-baiting statements linked to the origins of the disease, nor a strategy centered on denial will win the battle against COVID-19.

It is painfully apparent that Congress will have to lead in this effort, just as it led in domestic relief and recovery efforts.

I enjoy, appreciate, and embrace your call for us to develop a proposal in the committee that boldly and robustly addresses the current crisis, ensures that we are adequately prepared for the next one, and aids countries across the globe with recovery.

Anything less falls short of the legacy created through initiatives such as the president's emergency plan for AIDS relief and the Marshall Plan.

So I welcome our witnesses as well and look forward to our discussion.

[The prepared statement of Senator Robert Menendez follows:]

PREPARED STATEMENT OF SENATOR ROBERT MENENDEZ

Mr. Chairman, thank you for convening another hearing on the ongoing COVID-19 pandemic. As of June 26, 2020, the WHO had recorded just under 9.5 million confirmed cases of COVID-19, and more than 484,000 deaths worldwide. More than 2 million of those cases are right here in the United States. This disease has claimed more than 120,000 American lives in the span of 5 months. And it has proven resilient and pernicious, with new spikes across the United States and China, and alarming increases in the number of cases in South Africa, India and Brazil.

This pandemic presents one of the most complex and novel threats the United States—indeed the world—has faced in a generation. And it's clear that even if we stop the spread of the disease here—which we certainly have not—without a serious global effort to understand and confront it—COVID-19 can *and will* return to our shores. If ever there was a need for the United States to be an active leader in an international coalition to respond to a common threat, it is now. We simply cannot safeguard American lives without one.

Unfortunately, the United States has not yet risen to meeting this challenge. We have seen a haphazard response . . . going so far as to effectively withdrawing from the very international institution best poised to respond to this crisis. We have alienated critical partners, and have been absent at critical convening meetings. All this at the expense of the health and safety of the American people.

I believe there is more America can—must—do, and that Congress has a critical role to play. In May, all the Democratic members of this Committee introduced comprehensive legislation laying out concrete actions the United States could take to lead in the global response. The COVID-19 International Response and Recovery Act, or CIRRA [SEAR-Ah], presents a clear strategy to confront the ongoing pandemic and prepare the United States to deal with the next; and compels the Trump administration to constructively engage with other countries, international organizations, and multilateral fora to stop the spread of this deadly pandemic.

Specifically, our bill authorizes:

- An additional \$9 billion in funding to fight the COVID-19 pandemic through contributions towards vaccine research at the Coalition for Preparedness and Innovations;
- A contribution to the Global Fund for AIDS, Tuberculosis and Malaria for its COVID-19 response mechanism;
- Additional funding for emergency overseas humanitarian assistance in response to the pandemic, ensuring that these funds are provided both to the U.N. for its global response plan as well as directly to NGOs working on the front-lines;

- And a new surge financing authority at the U.S. International Development Finance Corporation (DFC) that would allow the DFC to expedite decisions and make strategic investments quickly to aid in COVID-19 reconstruction efforts.

CIRRA [SEAR-ah] also puts in place mechanisms to help us better prepare for the next pandemic. It requires an annual National Intelligence Estimate on pandemic threats, and establishes a White House advisor for global health security to coordinate a whole of government U.S. response to global health security emergencies, aimed at improving both domestic and international capacity to prevent, respond and detect epidemic and pandemic threats.

It clearly delineates the roles for the State Department, USAID and the Centers for Disease Control and Prevention in responding to pandemic threats. And it directs the U.S. Executive Director to the World Bank to begin negotiations to establish a trust fund at the World Bank designed not to compete with or supplant the World Health Organization, but to work *in tandem* with the WHO on incentivizing countries to mobilize their own resources for epidemic and pandemic preparedness.

Mr. Chairman, more than 700 Americans a day are dying. Neither the finger pointing blame game, race-baiting statements linked to the origins of the disease, nor a strategy centered on denial will win the battle against COVID-19. It is painfully apparent that Congress will have to lead in this effort, just as it's led domestic relief and recovery efforts.

I encourage us to develop a proposal in this Committee that boldly and robustly addresses the current crisis, ensures that we are adequately prepared for the next one, and aids countries around the globe with recovery. Anything less falls short of the legacy created through initiatives such as the President's Emergency Plan for AIDS Relief, and the Marshall Plan.

I welcome our witnesses, and look forward to our discussion.

The CHAIRMAN. Thank you, Senator Menendez. Well spoken. I think that your reference to the success that we have in addressing the AIDS pandemic is appropriate.

When I started out to construct the bill, it was, as I said, a starting point. I used the successes that PEPFAR had. Certainly, if we can replicate that for future pandemics, I think we will all be given a great credit—that is another issue.

Your remarks about the United States being the leader in this are absolutely right. We have a moral obligation based on our standing in the world and we should come together to do that.

Those ideas—some of the ideas that you have had are novel to me. Your discussion about an annual threat assessment of the pandemic I think is appropriate. We have that every year on the Intelligence Committee.

But, unfortunately, it is mixed with every other threat to the United States and they are regional, and it gets a nod that there is a threat of a pandemic it frequently takes the form of assessing what terrorists would do or malign influences would do and do not really focus on what a pandemic might look like.

And I think that part of that may be due to the fact that these pandemics are different. Each one is different. It has things that they are the same. But each virus has a different way of acting and reacting in the world.

So it gets short shrift in the Intelligence Committee it probably ought to be undertaken by either Health and Human Services or by us or by someone who could spend a little bit of time with it. So that is a great idea.

So with that, let us move to our panel. We have a very impressive panel here today, and I must say that the last panel, I thought, was good. It helped clear up my thinking on this.

One of the things I learned, I think, from the last panel about how there just is not a silver bullet, that it is going to take a co-

ordinated effort by many, many different agencies and countries, and today we are going to take a little different approach on that.

But these people have great experience. If we were to go through each of their accomplishments, we would be here all day. So with each of their forgiveness I am going to give just very brief introductions first.

Our first witness is Ambassador Mark Dybul. He is an accomplished diplomat physician and medical researcher. He currently serves as a professor in the Department of Medicine and as co-director of the Center for Global Health Practice and Impact at Georgetown University.

He previously served as the executive director of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and as the U.S. Global AIDS Coordinator. Certainly an impressive resume as he joins us today.

So with that, Ambassador Dybul, the floor is yours.

STATEMENT OF HON. MARK DYBUL, M.D., CO-DIRECTOR OF THE CENTER FOR GLOBAL HEALTH PRACTICE AND IMPACT AND PROFESSOR IN THE DEPARTMENT OF MEDICINE, GEORGETOWN UNIVERSITY MEDICAL CENTER

Dr. DYBUL. Thank you, Chairman Risch, Ranking Member Menendez, members of the committee. It is a great privilege to be back before this important body.

I would like to thank the committee, the entire Congress, for its steadfast bipartisan efforts to ensure the U.S. has been the ongoing leader in global health for decades.

COVID-19 has made clear that a global pandemic requires a global response and we are not quite there yet. But there is good news. What is needed is not rocket scientists.

A number of countries who did well in the early stages of COVID-19 were not faster at setting up systems. They already had them. They were prepared. Therefore, they never had to enforce total lockdowns.

Other countries rapidly put in place test, trace, and quarantine systems, and as a result they were able to safely begin reopening within 6 weeks, identifying and containing additional outbreaks as they occur.

I am very grateful to the chairman as bipartisan co-sponsors as well as to the ranking member for putting forward proposals to help ensure the U.S. coordinates international bilateral programs and to ensure non-duplicative multilateral institutions.

I listened with great interest to the hearing the committee held on June 18th. From my experience, I would like to offer with all humility one perspective on the chairman's question, who is the fire department; who may we call.

From a bilateral perspective, the proposal to create a coordinator at the State Department resonates. From the perspective of legislative oversight, the coordinator would seem to be the fire department for bilateral engagement.

When PEPFAR was developed, and I was fortunate to be involved in the creation of the small group that put together the plan, we struggled with where to house it.

A coordinator at State was, to paraphrase Churchill's quip on democracy, the worst approach except for everything else. Multiple parts of the U.S. government must be engaged in global health, as you noted, including pandemics.

USAID is deeply involved in many aspects of health as well as those that impact health and, of course, USAID leads on humanitarian responses.

CDC is the premier government health organization in the world. It is the only agency in the U.S. government armamentarium that spans domestic and global engagement, including pandemics, and is involved with, provides technical support to, and is looked to and respected by governments and institutions in high, middle, and low income countries. And as we know from this pandemic, we must be involved with every country.

CDC is built for what is most needed for; global and national pandemic preparedness and response. However, more than with PEPFAR, the national security apparatus is needed, as you both noted.

That requirement complicates full coordination from the Department of State. In that regard, it is important to note that both of the proposals identify the essential role of the National Security Council, as has been noted.

Perhaps there is also an opportunity for cross-committee authorization and preparation legislation, which is now without some precedent.

From a multilateral perspective, the world has come together and created the Global Health Security Agenda, or GHSA, as has been noted.

However, GHSA is not the fire department. GHSA provides an action plan for every country to have an Emergency Operation Center, or EOC, capable of mounting a response to an outbreak within 2 hours.

At least in my view, the EOC must also be responsible for continual surveillance down to the community level with systematic reporting to rapidly detect an outbreak.

We need a global EOC as the fire department. The global EOC should be multi-sectoral and the principal functions of it would be to learn from the past what has worked and not worked during previous epidemics and pandemics to conduct regular simulations of local outbreaks with national, regional, and global responses to them, rigorously interrogating gaps and weaknesses, to support regional and national EOCs to be fully operational, and coordinate with a financing mechanism, what we will call the fire hydrant, to help ensure optimal use of resources.

A global effort on pandemics and a global EOC cannot be effective without the deep engagement of WHO. It is a necessary although not sufficient player. In my view, WHO has done a good job under the circumstances and has vastly improved from Ebola.

I have known the director general, Dr. Tedros, since 2004 when he was the newly-installed junior administrator. I watched him systematically transform one of the worst-performing ministries of health in the world to one of the best.

He has been a steadfast partner and ally of the U.S. and global health, and he has taken on a difficult vast task of reforming WHO and has made significant strides.

As the first African director general, he also has the unwavering support of African countries, and as the second most populous continent, Africa's total engagement is essential for pandemic detection and control.

Finally, I know from experience that the U.S. can best drive reform when we are fully engaged. You cannot place a bet if you are not at the table, and if we are not at the table others are ready to step in and take our place, including China and Russia.

In my view, a financing facility, the fire hydrant, related to but organizationally separate from a global EOC, would create the optimal conditions for success.

One already exists to procure vaccines for low- and middle-income countries, Gavi, the Vaccine Alliance. However, there is a great deal of preparedness, detection, and response that needs to be funded before and after a vaccine becomes available and for future pandemics.

The principal function of the fire hydrant would be to finance the priorities identified by the global, regional, and national EOCs, the fire departments.

I appreciate the discussion of Gavi and the Global Fund models during the government panel hearing. Of course, the World Bank houses catalytic and trust funds, as the ranking member noted, and something could be created new.

All have pros and cons. It seems to me the best approach would be for the Administration to play a leadership role, working with key governments and stakeholders in a time bound way with parameters set by Congress to identify the most likely mechanism to succeed, now and for the future; succeed in the tracking funds and implementing pandemic preparedness, detection, and response.

In the short term, Congress has an important opportunity. This committee has a long history of supporting both U.S. leadership and the commitment of significant resources.

Including at least \$12 billion in the HEROES Act will save lives, help protect the U.S. from additional waves of this pandemic and send an important message abroad as well as here at home.

And there is no time to lose. You might have seen the troubling report today of a new swine flu. While there is yet no reported human-to-human contact, there is reason for concern the next pandemic might be upon us.

Mr. Chairman, Ranking Member, members of the committee, no country is safe and no one is safe until everyone is safe.

The good news is that this is one of the most solvable problems facing the world. Throughout history we have seen that when we come together and look forward, outward, and with hope, there is no problem we cannot solve and, in particular, the U.S. has shown that when we take a leadership role, it is in a blessing of enlightened self-interest, serving others while protecting and promoting our interests and our lives.

I thank the committee for what you are doing to lead again.

[The prepared statement of Dr. Dybul follows:]

PREPARED STATEMENT OF THE HONORABLE MARK DYBUL, MD

Chairman Risch, Ranking Member Menendez and members of the Committee: It is a privilege to be back before this important body. I would be remiss if I did not thank this Committee and the entire Congress for its steadfast, bipartisan efforts to ensure that the USA has been the unquestioned leader in global health for decades.

Most people living in the USA, Europe and many other countries are experiencing for the first time the devastating impact of a rapidly spreading and deadly global pandemic. There have been scares—SARS, MERS, H1N1 Influenza and Zika, among others. Fortunately, those epidemics were limited in their scope and scale.

COVID-19 has made clear that a global pandemic requires a global response. While we have the outlines of a global response, it needs to be strengthened by reforming existing structures and identifying financing mechanisms that will build on the uneven response to this crisis. Thank you for taking up the remarkably important issue of controlling this pandemic and focusing on preparedness for the next one.

Unfortunately, it is likely this will not be the last pandemic we will experience. Changes in climate and weather patterns, population growth, increased contact with animals and a highly mobile global population create the conditions conducive to pandemics.

The task before the world is to work to ensure that all countries can respond to the current threat, but also to be ready for the next one.

But there is good news: what is needed is not rocket science. A number of countries that did well in the early stages of COVID-19 were not faster at setting up systems to respond—they already had them.

From the relatively high-tech South Korean to the relatively low-tech Taiwanese approaches taken, the devastating experiences from SARS and/or MERS propelled them to develop, establish and maintain effective systems for sentinel surveillance, testing, contact tracing and quarantine. They performed simulations of outbreaks to identify and fill gaps and to stay alert. They stockpiled key commodities. They were prepared. Therefore, they never had to enforce total lockdowns.

Other countries, for example Germany, rapidly put test, trace and quarantine systems in place. As a result, they were able to safely begin reopening within 6 weeks, identifying and containing additional outbreaks as they occurred—and continue to occur.

I am grateful to the Chairman and his bipartisan co-sponsors, as well as to the Ranking Member for putting forward proposals to help ensure the U.S.A. coordinates its international bilateral programs and to ensure complementary, non-duplicative multilateral institutions so the world can be prepared and rapidly detect and respond to continued and new waves of COVID-19, and to future pandemics.

I listened with great interest to the hearing the Committee held on June 18 with Government witnesses, all good people working hard in challenging times.

From my experience as one of the principal architects, and then as the head, of the President's Emergency Plan for AIDS Relief (PEPFAR) under President George W. Bush, and as someone who has been involved deeply in multilateral organizations, including as the Executive Director who led the transformation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, I would like to offer, with all humility, one perspective on the Chairman's question: "Who is the fire department? Whom do we call?"

For those interested in more detail, please refer to a White Paper on the need for a Global Response to COVID-19 published with colleagues from Georgetown University and Dr. Peter Piot.¹ Please also refer to the Report of the CSIS Commission on Strengthening America's Health Security—co-chaired by a former member of this chamber and former Director of CDC—on which both Ambassador Kolker and I served.²

BILATERAL PERSPECTIVE

Proposals to create a Coordinator at the Department of State resonate. Perhaps that is not surprising since I served as the U.S. Global AIDS Coordinator in the State Department. From the perspective of Legislative oversight, the Coordinator would be the fire department for bilateral engagement.

When PEPFAR was developed, we struggled with where to house it. A Coordinator at State was, to paraphrase Churchill's quip on democracy: the worst approach—except for everything else.

Like COVID-19, the HIV pandemic is caused by a virus that jumped from animals to humans. Fortunately, unlike HIV, COVID-19 is not yet wiping out a generation in Sub-Saharan Africa. We knew what this Committee knows, and what the

Government panel verified a few weeks ago: to be prepared for and combat a global pandemic, multiple parts of the U.S. Government must be engaged. We also knew from reviewing past experiences that selecting one implementing agency to receive all of the funds and then fully embrace, engage and fund other implementing agencies stretches beyond the bureaucratic breaking point.

USAID is deeply engaged in many aspects of health as well as overall development efforts that impact health, such as education, economic security, agriculture and nutrition, water, sanitation and hygiene (WASH) required for hand-washing to prevent COVID-19 and many deadly diseases. And of course, USAID leads on humanitarian responses.

CDC is the premier government health organization in the world. It is the only agency in the U.S. Government armamentarium that spans domestic and global health and that is engaged with, provides technical support to and is looked to, and respected by, governments and institutions in high-, middle- and low-income countries. These unique characteristics are essential in pandemic preparedness and response. It leads in sentinel surveillance, testing, laboratory capacity and public health capacity. It has already supported countries to implement GHSA that resulted in strong responses to COVID-19. CDC is built for what is most needed for global and national pandemic preparedness and response.

More than with PEPFAR, the national security apparatus is needed for other pandemics. While the Department of Defense is a key part of PEPFAR, it is a relatively small piece of the budget and relates mostly to work with HIV prevention, care and treatment in foreign militaries. For global health security, there is a much bigger role including identification of outbreaks, potential in emergency responses, such as transportation, logistics and deployment of field hospitals as was done with Ebola. The need for significant engagement of the national security departments and agencies complicates full coordination from the Department of State. In that regard, it is important to note that both proposed bills identify the essential role of the National Security Council. Perhaps there is also an opportunity for cross-Committee Authorization and Appropriation legislation, which is not without some precedent.

MULTILATERAL PERSPECTIVE

The world has come together and created the Global Health Security Agenda (GSHA), including 67 countries, international organizations, the private sector, communities and others. It provides a good framework and sensible “action packages”. However, GHSA it is not the fire department.

In the limited time available, I would like to focus on two organizations that I believe are needed: the fire department and the fire hydrant.

The Fire Department: A Global Emergency Operations Center

GHSA provides an action plan for every country to have an Emergency Operations Center (EOC) capable of mounting a multi-sectoral response to an outbreak within 2 hours. At least in my view, the EOC must also be responsible for continual surveillance down to the community level with systematic reporting to rapidly detect an outbreak at the earliest possible stage.

We need a global EOC as the fire department. This is not a new concept. Bill Gates, myself and others have been calling for some version of this—often called a Task-Force—for a number of years. Of course, there is a lot involved in a global EOC. Managing the many viewpoints and equities will not be easy. But neither was creating PEPFAR, Gavi (the Vaccine Alliance) or the Global Fund. It is time to exert the energy to get it done.

The global EOC should be multi-sectoral, including key organizations for health, economics, security and include the private sector and civil society communities, including the faith community. In the end, everything will work or fall apart at the community level. The principal functions of the EOC would be similar to national EOCs:

- Learn from the past: what has worked and not worked at the global, regional and national levels during previous epidemics and pandemics (as South Korea, Taiwan and others did after their SARS and/or MERS epidemics);
- Conduct regular simulations of local outbreaks with national, regional and global responses to them, rigorously interrogating gaps and weakness;
- Use the knowledge gained from the past and regular simulations to evolve the global EOC to be maximally effective and to support regional and national EOCs to be fully operational; and

- Coordinate with a financing mechanism, the fire hydrant, to help ensure optimal use of resources.

The Central Role OF WHO

It has been said “If WHO didn’t exist, we would create it.” Perhaps as with the PEPFAR coordinator it is the worst approach—except for every other option. But a global effort on pandemics, and a global EOC, cannot be effective without the deep engagement of WHO. It is a necessary, although not sufficient, player.

In my view, WHO has done a good job under the circumstances. And it has significantly improved. There is no real comparison between the deeply flawed response to Ebola and the initially flawed, but overall improved performance of WHO during COVID-19.

The current Director General, Dr. Tedros Adhanom Ghebreyesus, is a committed public health servant and diplomat. I have known Tedros since 2004 when he was the newly installed junior Minister of Health and I was the U.S. Deputy Global AIDS Coordinator. I watched him systematically transform one of the worst performing ministries of health in the world to one of the best performers. He has been a steadfast partner and ally of the U.S.A. in global health. He has taken on the difficult task of reforming WHO and, only a few years in, has made significant strides, including reorienting an institution resistant to change from headquarters to the countries.

As the first African Director General, he also has the unwavering support of African countries, who for the first time voted in a block to elect him. As the second most populous continent, Africa’s total engagement is essential for pandemic detection and control.

Finally, as an official of the Bush administration, including preparation for G7 Summits, and then as Executive Director of the Global Fund, I know that the U.S.A. can be most effective in reforming institutions when it is fully engaged. In part because we bring deep expertise and financial resources, and in part because I know from experience that you can’t place a bet if you aren’t in the game. And if we are not at the table, others are ready to step in and take our seat: China and Russia.

The Fire Hydrant: A Financing Mechanism

The significant progress on childhood vaccinations, HIV, Tuberculosis and Malaria has demonstrated that a financing mechanism separated from normative and deep-bench technical functions can be highly valuable. In my view, a financing facility related to, but organizationally separate from, a global EOC would create the optimal conditions for success. One already exists to procure vaccines for low- and low-middle income countries: Gavi, the Vaccine Alliance. It was wonderful to see the significant pledge made by the U.S.A. at the recent Gavi replenishment conference.

However, there is a great deal of preparedness, detection and response that needs to be funded before and after a vaccine becomes available.

The principal function of the financing mechanism—the fire hydrant—would be to finance the priorities identified by the global, regional and national EOCs—the fire departments.

I appreciated the discussion of the Gavi and Global Fund models during the Government panel hearing. Of course, the World Bank houses catalytic and trust funds. And something new could be created. All have pros and cons. Again, similar to the PEPFAR Coordinator, and for that matter the structure of many organizations, we might have to settle for the least bad option.

It seems to me that the best approach would be for the Administration to play a leadership role working with key governments and stakeholders in a time-bound way and with direction and parameters set by Congress, to identify the most likely mechanism to succeed now and for the future in attracting funds and implementing pandemic preparedness, detection and response. This was the approach taken with the creation of the Global Fund, in which the U.S. Government was deeply involved, and Gavi.

SHORT-TERM OPPORTUNITY

Global and American partners are looking for a sign that the U.S. will, once again, demonstrate its commitment to a comprehensive global response. It is in our national security interest to do so. Investing in the immediate response now and laying the foundation for the future will require leadership and resources. This Committee has a long history of supporting both. Including at least \$12 billion in the Heroes Act before Congress will save lives, help protect the U.S. from additional waves of the pandemic and send an important message abroad as well as here at home. A recent poll conducted by the U.S. Global Leadership Coalition found that

72 percent of Americans support including \$10 to \$15 billion for international assistance in the next emergency package.

CONCLUSION

We know from the massively destructive global pandemics of history what, sadly, we needed to learn again from COVID-19. No country, and no one is safe until everyone is safe.

But there is good news. This is one of the most solvable problems facing the world—as countries who activated systems they built after their SARS and MERS epidemics, and those who rapidly built those systems and controlled the outbreak in 6–10 weeks and are now safely reopening have shown.

Throughout history, we have seen that when we come together and look forward, outward and with hope there is no problem we cannot solve. And in particular, the U.S.A. has shown that when we take a leadership role, it is a blessing of enlightened self-interest serving others while protecting and promoting our interests—and our lives. I thank the committee for what you are doing to lead—again.

Notes

¹ See <https://georgetown.app.box.com/s/5snwu87gg0szfreu5oaqqdm21qwbs2ty>

² See <https://healthsecurity.csis.org/final-report/>

The CHAIRMAN. Well, thank you very much.

First of all, it is good to hear that when you—when PEPFAR’s structure was put together that you struggled with where to house it because that has certainly been one of the vexing issues that we have struggled with here and, of course, have not reached a conclusion on that yet.

You also—I appreciate your remarks about the importance that we have a place at the table. I think not only have a place at the table but I think it—because of our unique standing in the world, we need a very significant voice in how to construct that.

Thank you. Thank you so much for your remarks.

We are now going to turn to Ambassador Kolker. Before retiring in 2017, Ambassador Kolker served 30 years in the U.S. diplomatic service, including as ambassador to Burkina Faso and Uganda, and as deputy chief of mission in Denmark and Botswana.

He completed his government service as assistant secretary for global affairs at the U.S. Department of Health and Human Services where he represented the United States at WHO meetings and as alternate board member of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

With that, Ambassador Kolker, the time is yours.

STATEMENT OF HON. JIMMY J. KOLKER, FORMER ASSISTANT SECRETARY FOR GLOBAL AFFAIRS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KOLKER. Thank you. Thank you very much, Chairman Risch, Ranking Member Menendez, distinguished senators.

I am Jimmy Kolker and am honored to be with you today. I am very proud to have been a State Department Foreign Service Officer and with the Department of HHS for 5 years, as you said.

And in those jobs I help develop and implement both the President’s emergency plan for AIDS relief and the Global Health Security Agenda in the Obama administration.

These are two exceptional examples of global leadership, which all Americans should be proud of. Starting with the Global Health Security Agenda, some people have dismissed its work because we

did not prevent or adequately respond to the novel coronavirus outbreak.

But five countries took actions because of GHSA with extraordinary results in combating the novel coronavirus.

After mishandling the MERS outbreak in 2015, South Korea became one of the most active members of GHSA, reviewing its own procedures, and when COVID-19 hit it was ready with surveillance and crisis management capacity developed through GHSA efforts.

Uganda and Vietnam were the two pilot countries where the U.S. Centers for Disease Control and Prevention helped develop comprehensive prevention, detection, and response capacity.

Both have been positive examples in their regions of controlling coronavirus and did so without extensive outside help.

Likewise, the Republic of Georgia, through the involvement of CDC and of the Department of Defense through the Lugar Center managed coronavirus better than any other country in the former Soviet Union.

And within the European Union, Finland, the first chair of GHSA and its most enthusiastic initial backer, did an exceptional job of preventing and controlling COVID-19.

So GHSA has some solid successes, and despite some justified criticism, so does the World Health Organization. Its Health Emergencies Program responded immediately to validate and distribute a good diagnostic test for COVID-19.

The World Health Organization was the only organization that could get Chinese approval for independent scientists to enter China, and WHO, as they always would, included American government experts in their delegation.

And the WHO also convened the first multi-stakeholder meeting to look at access to eventual vaccines, treatments, and countermeasures.

You asked, Mr. Chairman, who is the fire department; who responds when there is an outbreak that threatens to become an epidemic. My reply for that question is that there is no alternative to WHO.

Others will be mobile, such as the CDC through the GOARN, the Global Outbreak and Response Network, CEPI, the Coalition for Epidemic Preparedness Innovation, and GISAID, a laboratory network.

But WHO has to be at the core. After Ebola, with U.S. leadership I was involved personally and we helped make WHO more effective and we can do so again. The reforms that need to be made, I can enumerate some of them later if senators wish.

But let me turn also to strengthening U.S. government's leadership and capacity. I mentioned my experience with PEPFAR, initially as ambassador to Uganda.

PEPFAR worked. It worked because it had, one, presidential engagement and leadership; two, bipartisan support; three, implementation organized country by country; four, significant new money, initially, \$15 billion over 5 years; and not least, number five, a State Department coordinator but, I emphasize, who was empowered because of that new money.

I support the establishment of a senior Global Health Security and Diplomacy coordinator at State. But I support that if and only

if there is significant new money. Simply redirecting USAID and CDC appropriations to STATE will result in gridlock.

Additional new appropriations through State, on the other hand, can foster innovation and can incentivize both USAID and CDC to up their game, as PEPFAR did.

So how can experience make U.S. global health leadership more effective? Here is some criteria I would use to evaluate any new proposal.

One, as both proposals of Senator Risch and Senator Menendez do, it should restore White House whole of government expert leadership through a health security senior director at the National Security Council.

It should be bipartisan. It should define responsibility and division of labor for implementation, not just at headquarters level.

It should recognize the unique role that embassy teams play in allocating resources to build on the comparative advantages of USAID, of CDC, and of other parts of the Department of Health and Human Services.

And most important, any new proposal must request, authorize, and appropriate through the appropriate committees enough money for these agencies to do their work.

The proposal of \$3 billion over 5 years is not enough. It is less than the CSIS commission I was a member of recommended—and I will put the cover there, give an advertisement—recommended for preparedness even before COVID hit.

The HELP Committee and HHS appropriators will have to come up with billions more. And global health money in the HEROES Act, as Mark mentioned, will—is likely also to be required to reach health security goals.

Funding should also include more money for the World Health Organization, a U.S. contribution to the Coalition for Epidemic Preparedness Innovation, and an incentive fund for low-interest countries—low-income countries, I am sorry, possibly through the already created Health Emergency Preparedness Fund at the World Bank.

I thank you for your attention and I welcome your questions.

[The prepared statement of Mr. Kolker follows:]

PREPARED STATEMENT OF JIMMY KOLKER

Chairman Risch, Ranking Member Menendez, Distinguished Senators: I am Jimmy Kolker, honored to be with you today and very proud to have been a State Department Foreign Service Officer for 30 years and at the Department of Health and Human Services for 5.

In those jobs, I helped develop and implement both President Bush's Emergency Plan for AIDS Relief (PEPFAR) and the Global Health Security Agenda in the Obama administration.

These are two exceptional examples of U.S. global leadership of which all Americans should be proud.

THE GLOBAL HEALTH SECURITY AGENDA (GHSA)

Starting with the Global Health Security Agenda, I have heard people dismiss its work because we did not prevent or adequately respond to the novel coronavirus outbreak.

Five countries, however, took actions because of GHSA with extraordinary results in combatting the novel coronavirus.

- After mishandling the MERS outbreak in 2015, South Korea became one of the most active members of GHSA, reviewing its own procedures. When COVID-

19 hit, it was ready with surveillance and crisis management capacity developed through GHSA efforts.

- Uganda and Vietnam were the two pilot countries where the U.S. Centers for Disease Control and Prevention helped develop comprehensive prevention, detection and response capacity. Both have been positive examples in their regions of controlling coronavirus and did so without extensive outside help.
- Likewise, the Republic of Georgia, through the involvement of CDC and of DoD through the Lugar Center, managed coronavirus better than any other country in the former Soviet Union
- And within the European Union, Finland, the first chair of GHSA and its most enthusiastic initial backer, did an exceptional job of preventing and controlling COVID-19.

So GHSA has some solid successes.

THE WORLD HEALTH ORGANIZATION

And despite some justified criticism, so does the World Health Organization. Its Health Emergencies Program responded immediately to validate and distribute a good diagnostic test for COVID 19.

The WHO was the only organization that could get Chinese approval for independent scientists to enter China, and WHO, as they always would, included American government experts in their delegation.

The WHO also convened the first multi-stakeholder meeting to look at access to eventual vaccines, treatments and countermeasures.

WHO'S THE FIREMAN

You asked, Mr. Chairman, at the previous hearing “Who’s the Fire Department?” Who responds when there is an outbreak that becomes an epidemic?

My reply to that question is that there is no alternative to the WHO.

Others will mobilize, such as the CDC through GOARN, the Global Outbreak and Response Network, CEPI, the Coalition for Epidemic Preparedness Innovation, and GISAID, a laboratory network. But WHO is at the core.

After Ebola, with U.S. leadership, we helped make WHO more effective and we can do so again. There are reforms that need to be made, and I can enumerate some of them later if Senators wish.

STRENGTHENING THE U.S. GOVERNMENT’S LEADERSHIP AND CAPACITY

But let me turn to strengthening the U.S. Government’s leadership and capacity I mentioned my experience with PEPFAR, initially as Ambassador to Uganda.

PEPFAR worked because it had:

- presidential engagement and leadership;
- bipartisan support;
- implementation country-by-country;
- significant new money, \$15 Billion over 5 years; and, not least
- a State Department coordinator empowered because of the new money.

I support the establishment of a senior Global Health Security and Diplomacy coordinator at State. But if and only if there is significant new money.

Simply redirecting USAID and CDC appropriations to State will result in gridlock. Additional new appropriations through State can foster innovation and incentivize both USAID and CDC to up their game, as PEPFAR did.

WHAT TO LOOK FOR IN NEW PROPOSALS

How can experience make U.S. global health leadership more effective? Here are some criteria I would use to evaluate any new proposal.

- It should restore White House whole-of-government expert leadership through a health security senior director at NSC.
- It should be bipartisan.
- It should define responsibility and division of labor for implementation.
- It should recognize the unique role of embassy teams in allocating resources to build on the comparative advantages of USAID, CDC and other parts of HHS.
- Most important, it requests, authorizes and appropriates enough money for them to do the work.

The proposal of \$3 Billion over 5 years is not enough. It is less than the CSIS commission I was a member of recommended for preparedness even before COVID hit. The HELP committee and the HHS appropriators will have to come up with billions more. Global Health money in the HEROES Act will be required to reach health security goals.

Funding should also include more money for WHO, the Coalition for Epidemic Preparedness Innovation and an incentive fund for low income countries, possibly through the Health Emergencies Preparedness Fund of the World Bank.

Thanks for your attention and I welcome your questions.

The CHAIRMAN. Ambassador, thank you very much.

I think I appreciate your focus on the structure. That is, although, not the most exciting thing in the world, it certainly is one that is absolutely critical here. I think without a structure we really are going to be lost.

I really appreciate all the other suggestions that you have made and I would hope that you put those in writing and get them to us so that as we are discussing this amongst ourselves we can have this in front of us.

Again, thank you for your—thank you for your experience in that regard.

Next, we have Dr. Jha. He is a physician, researcher, and data enthusiast. I am not exactly sure what a data enthusiast is. I have never met one before. But I am glad to hear we have one here.

He is the K.T. Li Professor of Global Health at Harvard, T.H. Chan School of Public Health, and the faculty director of the Harvard Global Health Institute.

He is a practicing general internist and a professor of medicine at Harvard Medical School. He holds an M.D. from Harvard Medical School and an M.P.H. from the Harvard T.H. Chan School of Public Health.

With that, Dr. Jha, we welcome you and maybe you can start off by telling us what a data enthusiast is. So thank you for joining us.

**STATEMENT OF DR. ASHISH K. JHA, M.D., DIRECTOR,
HARVARD GLOBAL HEALTH INSTITUTE, CAMBRIDGE, MA**

Dr. JHA. Chairman Risch and Ranking Member Menendez, and members of the committee, it is indeed an honor to be here this morning.

I do not think I have described myself as a data enthusiast, but I do believe that data and evidence should drive our decision making. So maybe that is—maybe that is the idea.

But let me get to my testimony. We are in the middle of the greatest global public health crisis in a century. Millions of people around the world have gotten sick and hundreds of thousands have died from this disease.

Despite this, our best estimates are that less than 2 percent of the world's population has been infected with this virus. The global pandemic is just getting started.

And the single biggest obligation that I believe we all have is to protect the lives and well-being of the American people and the people around the globe, and this is why I believe that the Administration's decision to withdraw from WHO is so deeply unwise.

You know, Chairman Risch, there is some irony in my testifying today in defense of WHO. You see, for years I have been widely seen as a critic of WHO and rightly so.

I was one of WHO's harshest critics of its disastrous handling of the Ebola outbreak in West Africa, and coming out of that outbreak I co-chaired an international panel that recommended major changes at WHO.

So did WHO change? In some ways, yes, and in other ways, no. And WHO's response to COVID-19 has been better but no perfect. After China informed WHO of a viral pneumonia outbreak in Wuhan, WHO acted quickly and alerted the world.

And because both Ambassadors Dybul and Kolker have talked about what the WHO has done well, let me focus for a minute on what WHO has done poorly.

To me, the single biggest failure of WHO in this outbreak has been the excessive praise for the Chinese government and its handling of the outbreak.

The Chinese government's response is not worthy of praise. They, clearly, hid the virus and silenced doctors and scientists for weeks if not months. They delayed notifying the world.

China is a major world power and we should expect better. So I was disappointed to see WHO's lavish praise for China. Disappointed, but not surprised, because WHO is a membership organization and, as such, it has had a long tradition of showering praise on governments even when those governments are behaving poorly.

One of the criticisms of WHO has been that it did not stand up to China, and I have to say I find this puzzling. I have never understood what that could possibly mean.

WHO has no authority to compel China to do anything, any more than it has authority to compel our government to act in a certain way. WHO is a membership organization. It can only be as effective as its members allow it to be.

And let me be clear in my testimony. I believe WHO can be more effective. One of the areas where I think WHO can be more effective is that its mission is too broad. It literally works on every health-related issue in the world, and I believe WHO should only do those things that only WHO can do.

So let us come back to how that might apply in this pandemic. Walking away from WHO at this moment is an extraordinarily bad idea. It will weaken WHO, which will harm the world and harm Americans because WHO does critical work that we all benefit from.

WHO is running the solidarity trial, which has patients enrolled from 35 countries to find new treatments for COVID-19. WHO is coordinating the procurement and delivery of vaccines once they become available, and WHO is working closely with ministries of health in nearly every low- and middle-income country around the globe.

It takes visiting any ministry of health to realize the integral role that WHO plays. WHO is a trusted partner to ministries around the world, and if other countries struggle to control the outbreak, it will be bad not just for people of those nations but for all of us because the one thing we have learned over and over again

is that an outbreak anywhere can quickly become an outbreak everywhere.

So during this pandemic when we have many, many difficult months ahead of us, walking away from WHO, I believe, makes controlling the virus globally harder and makes it harder to manage the virus here at home.

Walking away from WHO leaves us without a voice at the table to better manage the disease globally and walking away from WHO means we will have little influence on how WHO is shaped and improved when this pandemic eventually comes to an end.

I believe WHO can and should be more effective. But the bottom line is WHO is essential, as you have already heard this morning. There is no substitute.

So for the sake of the health and the well-being of the world and particularly for the health and well-being of the American people, I believe it is critical to use America's leadership to improve WHO's performance in this pandemic and for future ones.

Thank you very much.

[The prepared statement of Dr. Jha follows:]

PREPARED STATEMENT OF DR. ASHISH K. JHA, M.D.

We are the middle of the greatest global public health crisis in a century. The COVID-19 pandemic has wreaked havoc on lives, healthcare systems, and economies around the globe. In most countries around the world, cases and deaths are still rising, and an effective, widely deployed vaccine is likely at least a year away. Yet at this critical moment in global public health, U.S. leadership is lacking. The most striking example of this lack of leadership is our Administration's decision to withdraw the U.S. from the World Health Organization (WHO). This is a decision that will harm not only the health of people around the world, but also U.S. leadership and scientific prowess. And ultimately, the withdrawal from WHO, if it is to be finalized, will harm the health of the American people at a time when Americans are getting sick and dying at an unprecedented rate.

WHO has a unique and incomparable ability to coordinate and support international pandemic response. Now more than ever, we should be investing in and supporting this organization that is uniquely poised to tackle COVID-19.

THE PANDEMIC IS NOT OVER

The COVID-19 pandemic is still accelerating. We are continuing to see record-breaking daily increases in COVID-19 cases, and deaths are also rising worldwide. The pandemic is still in its early stages in most parts of the world, with cases still on their first uphill climb in Latin America, Africa, and large parts of Asia, as well as a resurgence of cases right here in the U.S.

The Latin American region recently reached 2.2 million cases after infections doubled over the past 2 months, and its combined death toll passed 100,000 last week.¹ Brazil has been described as a "worst-case scenario," with overflowing hospitals and morgues;² last week, they saw their largest rise in daily infections and passed 50,000 deaths.³ India is now recording record numbers of single-day cases after easing the strict national lockdown that had been imposed.⁴ Reports of overwhelmed hospitals and lack of access to tests or treatment reveal the dire state of the pandemic there.⁵ South Africa is also seeing an uphill trend and new daily records of confirmed cases.⁶ They are now reporting about 7,000 new cases per day, about four times the number of daily new cases from a month ago.⁷ Israel has seen a rise in cases since easing restrictions at the end of May. During the month of May, they were seeing only dozens of new cases each day; now, daily cases counts hit 400 and 500.⁸

And these are just a few examples. Globally, we are still early in the crisis. Most nations are in the middle of an uphill climb in cases, and some countries that did have some success in battling the virus early are now seeing second peaks after lifting their lockdowns. While the scientific community has made remarkable progress on diagnostics, vaccines, and therapeutics, the disease remains deadly for many. The pandemic is far from over.

THE CRITICAL ROLE OF WHO

The World Health Organization's response to the COVID-19 pandemic has been highly visible and at times, less than ideal. WHO is not perfect, by any means. I have historically criticized WHO a number of times, particularly following their leadership failures during the 2014 Ebola outbreak in West Africa.⁹ Then, WHO's response was slow and diffuse and contributed directly to several thousand preventable deaths. Indeed, the United Nations even created a new entity to coordinate the response, typically WHO's prerogative, when it created the U.N. Mission for Ebola Emergency Response. I co-chaired a commission that examined the failures of the global community to respond effectively to Ebola, and our report specifically called out WHO's shortcomings and failures as a major contributor to the poor outcomes we saw in West Africa.

While the shortcomings of the global Ebola response went far beyond WHO, its poor performance was one critical element. To that end, our commission made a series of recommendations about WHO reforms, many of which have indeed been taken up and implemented, while others have not. As a result, WHO's response to the COVID-19 pandemic has been much stronger than its Ebola response.

But that is still not enough. WHO has made important mistakes in its response to the COVID-19 pandemic. WHO excessively praised China's early response to its outbreak, calling it "transparent" and "responsible" despite early clues that China's response was anything but that.¹⁰

Some have argued that WHO should have refused to take China's claims at face value and done more to independently investigate the early outbreak. For example, WHO probably should have considered it a greater possibility that human transmission was already occurring, even when officials in Wuhan said otherwise.¹¹ Although WHO does not have the power to forcibly investigate their own member states, it may have been beneficial for them to not have so quickly accepted China's data and statements as truth.

Furthermore, WHO remained opposed to implementing travel restrictions until late February. While travel restrictions have not been proven to stop the spread of disease, some studies have found that they may delay its spread,¹² and some have argued that countries could have bought more time to prepare their response if they had not been encouraged to keep their borders open.

So yes, WHO's response has been imperfect, but that doesn't mean it is in our interest—or the world's interest—for the U.S. to leave WHO. Instead, we should stay involved to encourage improvement of the organization as an active member. After WHO's failures during the Ebola crisis—which were far more dismal than any failures related to COVID-19—the U.S. Government engaged deeply with the organization and helped implement necessary changes. These changes included establishing a unified WHO platform for outbreaks and emergencies, creating the WHO Health Emergencies Programme, and implementing a framework for R&D preparedness and capacity.¹³ WHO also worked to address shortages in funding that limited its ability to respond to the outbreak, including through the establishment of a Contingency Fund for Emergencies.

WHO's role in helping countries, particularly low- and middle-income countries (LMICs), cannot be overstated. These nations' ministries of health are heavily dependent on WHO for technical expertise and guidance on pandemic response. WHO is deeply embedded in LMICs—whereas local health officials in the U.S. turn to the CDC for help, health officials in most other countries turn to WHO during an outbreak. For example, WHO has distributed tests to 126 countries around the world,¹⁴ many of which lack the capacity to develop their own test kit quickly enough and thus rely on WHO's technical expertise. When countries receive help from non-governmental organizations (NGOs), it is WHO that helps provide coordination. When countries need access to scientific expertise to inform policies, conduct disease surveillance, and acquire necessary resources and supplies, they turn to WHO. And given the longstanding relationship that local WHO offices have in many LMICs, they are uniquely able to collect and collate new data coming out of these countries. WHO is the primary hub of the knowledge and skills needed to prevent cross-national infectious disease outbreaks. Now is a time when LMICs are relying on WHO the most.

The U.S.'s partnership plays an important role in ensuring that WHO has the capacity to do these things. The U.S. provides about 15% of WHO's funding.¹⁵ Ten percent of WHO's collaborating centers for research and development are hosted in the U.S.¹⁶ And the U.S. CDC has played a critical role in facilitating public health emergency management training events and supporting the deployment of staff and resources to respond to crises. It's clear that cutting U.S. ties with WHO significantly hampers WHO's ability to execute on its mission.

LEAVING WHO HARMS THE U.S.

The decision to leave WHO doesn't just harm the rest of the world—it hurts the United States, as well. By ending our relationship with WHO at this critical moment, the U.S. is removing itself from the most important decisions surrounding this virus. We are sending a message that the U.S. is an undependable partner, that we cannot be counted on for collaboration in a global crisis. And we are leaving a leadership vacuum within WHO for other countries to fill. Some European countries are already starting to step up to fill the space the U.S. has left behind—last week, Germany pledged \$560 million and France pledged \$100 million to support WHO's work.¹⁷ And China may also seize the opportunity to exert more influence over WHO.

Leaving WHO also separates the U.S. from much of the leading research and development around COVID-19. Scientists from countries around the world turn to WHO to share samples and collaborate on quickly building an evidence base. A notable example of this is WHO's SOLIDARITY Trial, the world's largest clinical trial of COVID-19 therapies.¹⁸ Over 3,500 patients have already been recruited into this trial, and WHO is actively supporting 60 countries with ethical and regulatory approvals, identification of participating hospitals, training on usage of the online data system, and procurement of necessary medications. The SOLIDARITY Trial is believed to reduce the time needed to design and conduct a randomized controlled drug trial by 80%.

WHO is also playing a key role in COVID-19 vaccine development and manufacturing.¹⁹ They have created a coalition of 300 scientists, developers, and funders with the goal of expediting exchange of scientific results and reducing duplication of research efforts. They are designing a large international vaccine trial that would ensure faster turnaround of results—around 3–6 months to determine the efficacy of each vaccine candidate. An expert group convened by WHO is working to prioritize the vaccine candidates with the most potential and develop a protocol for later trial phases that can be used around the world. WHO also played a role in creating the ACT-Accelerator, which, in addition to several other goals, is working to ensure that a vaccine will be manufactured and distributed quickly and equitably once it is developed.²⁰ This level of international scientific cooperation is critical to allowing us to rapidly develop tools to fight this virus—but the U.S. will no longer be able to shape or participate in this work.

In addition to hindering U.S. scientific and global health leadership, the decision to leave WHO threatens the health of Americans. As we have so clearly seen during this pandemic, diseases do not respect borders. We can't keep travel restrictions in place forever, and until this pandemic is under control globally, we will continue to be at risk of spread in the U.S. If low- and middle-income countries continue to have large outbreaks, they will become the sources of spread of the disease globally. No level of fortified borders will prevent disease spread from other nations. Unless we shut off all travel and trade from every other nation in the world, a physical impossibility, we will continue to import cases from other countries (and export cases as long as our outbreak remains large). Importing more cases of COVID-19 from other nations puts Americans' health at greater risk. If we really want to protect the health of the American people, a central feature is to control the disease in the U.S. and help other countries control their outbreaks as well.

These implications don't only apply to this current outbreak, but also future ones. WHO provides critical information on most major public health threats, including influenza season and emerging diseases, and we will no longer have the same access to that information. We will no longer be able to inform the global scientific and political response to those outbreaks. Collaborating with other countries to keep future diseases from entering our own borders will be more difficult. While COVID-19 is our major concern currently, the harms to the U.S. of pulling out of WHO are far-reaching.

THERE IS NO SUBSTITUTE

There is no substitute for WHO. Its unique position as an international agency made up of 194 member states gives it an unparalleled legitimacy and capacity to facilitate collective action and political will. Because of its international leverage, WHO is uniquely positioned to set and communicate public health norms and coordinate critical research and development across countries. It also has the ability to coordinate with international institutions from other sectors, like the World Trade Organization or the World Bank—an important asset for an interdisciplinary field like global health.

The leadership of WHO is chosen by member states. The deep relationship between individual nations and WHO, as I have outlined above, makes the organiza-

tion essential for many countries around the world. If we were to get rid of WHO today, we would have to recreate a WHO tomorrow with many of the same features. There is no substitute for the essential work that WHO does.

A U.S.-based global health organization, or even other international organizations like the World Bank, are no substitutes for WHO. There are no other organizations with the same reach into ministries of health. No other organizations have earned the same level of trust from healthcare organizations and frontline health workers here in the U.S. and around the world. WHO's role as a membership organization made up of nearly every nation in the world makes its presence accepted and welcomed in many countries in a way that the presence of a U.S. government organization or even World Bank would not be, at least not in the health sector. And for global issues, you need truly global collaboration.

CONCLUSION

The U.S. potentially leaving WHO has dire consequences for both global health and for the health and well-being of the American people. WHO plays a critical role in providing support during health emergencies and accelerating scientific research. It is irreplaceable. During this pandemic, its response has been extraordinary, although not without some missteps. Some of the urgent reform efforts laid out in the post-Ebola period have yet to be completed. But there is no substitute for WHO. If we were to leave WHO, we would have no legitimacy or ability to make WHO a stronger organization. Instead, we should engage with WHO, support its important mission, and work to improve and strengthen it. Our ability to beat this pandemic—and to improve the health of people in the U.S. and around world—depends on it.

Notes

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The CHAIRMAN. Thank you for those candid and, I think, very helpful remarks. You, I think, quite clearly and correctly noted that WHO has no authority over other countries, and as I discuss this in a robust fashion with Dr. Tedros and with his management team, they stress that over and over again, wishing they had that authority.

I think the criticism perhaps is more correctly directed at the fact that they do have a bully pulpit and, as we all know, the bully pulpit can be as effective and, indeed, sometimes more effective than having actual authority over someone.

And I think, from my own personal standpoint, I was disappointed that—but at the same time understanding—that the minute you step up on the bully pulpit you are going to find yourself in an adversarial position with someone or some country that you are trying to get to cooperate with you. But that may dissipate. It is a fine line. There is absolutely no question about that. I thank you for your remarks and I thank you so much.

We now have Mr. Jeremy Konyndyk and he is a senior policy fellow at the Center for Global Development. He previously served as director of USAID’s Office of Foreign Disaster Assistance during which time he led the U.S. humanitarian response to the 2015–2016 outbreak in West Africa, among other complex emergencies.

He is a member of WHO’s Independent Oversight and Advisory Committee and previously served on the Independent Advisory Group and helped design WHO’s post-Ebola reports.

Mr. Konyndyk, the floor is yours. I am told that they are having a little technical difficulty with your—with the audio. So I hope this works. In any event, the floors is yours.

STATEMENT OF JEREMY KONYNDYK, SENIOR POLICY FELLOW, CENTER FOR GLOBAL DEVELOPMENT, WASHINGTON, DC

Mr. KONYNDYK. Yes. Thank you. Thank you, Chairman Risch and, thank you, Ranking Member Menendez for the opportunity to testify.

I apologize that you cannot see me. I had logged in and then midway through Chairman Risch’s opening statement, my internet completely went down and it seems the provider is not working. But at least we have the phone as a backup.

The CHAIRMAN. Would you like me to repeat the second half of my opening statement?

[Laughter.]

Mr. KONYNDYK. No, I heard it—I heard it perfectly clearly on my phone.

The CHAIRMAN. Okay. Thank you.

Mr. KONYNDYK. So and I greatly appreciated your remarks, Senator.

The CHAIRMAN. Thank you.

Mr. KONYNDYK. I thought you set a wonderful tone.

I want to thank the committee for the opportunity to testify today on this—on this important topic. The COVID-19 pandemic has made incredibly clear the importance of expanding U.S. government investments in global pandemic preparedness and also the linkage between that and our own domestic preparedness, you know, within our own borders.

Investments like this in global outbreak cooperation are not just altruistic. They also serve to keep us safe here at home, and so I commend the many thoughtful ideas that have been put forward by members of this committee, by some of your colleagues in the House, and I am encouraged by some aspects of the plans that are reportedly being developed by the Administration as well.

Because it is clear that the U.S. now needs to take advantage of this moment to go really big on a global partnership for pandemic preparedness, and this means focusing on a number of things.

It means investing more in surveillance diagnostics and early warnings so that we can build the same kind of early warning capacity for infectious disease risks that we currently have for things like hurricanes, famines, or tsunamis.

It means creating—using that risk awareness to create clearer triggers for global and country-level action so that we never again have to see the kind of inconsistent patchwork of country responses that we have seen in response to COVID-19 and I think one of the things that the current pandemic really shows clearly is that that kind of early action is just as important as the baseline national capacity.

The countries that acted early have done better whether or not they have the full capacity we might—that they might want and countries that have waited, even if they had good capacity on paper, have really struggled. So both capacity and early action are incredibly important.

It also means things like investing in the readiness and resilience of medical and public health systems in weak and low-income countries. It means reinforcing supply chains and reserves of PPE and essential drugs.

It means collaborating towards the development of innovative diagnostics, vaccines, and therapeutics on a global level, and I was encouraged to see in Senator Risch's bill the U.S. support for CEPI, which I think is incredibly important.

And, of course, all of these things will require robust U.S. funding behind these priorities, and so I urge Congress to include pandemic response and preparedness funding in the HEROES Act and continue supporting this on a more ongoing reliable basis over time as we have done with things like PEPFAR.

But that, of course, if we are to do all those things it raises the natural question of how should we organize ourselves and how should we organize the global system to deliver on that, and so I want to lay out a few ideas on that, based on my own experience with this over the years.

First, within the U.S. government it is incredibly important to establish a clear interagency division of labor that is built on each agency's comparative advantages, and this is something that has

been a struggle in PEPFAR. It has been—it has produced a lot of turf battles over the years between USAID and CDC.

It is something we did not struggle with so much on Ebola because we laid out a clear division of labor right at the outset of the Ebola response and then we budgeted and allocated funding based on that. So there was, simply, less to fight over between the agencies. Our roles were clear from the beginning.

And so something like an international response framework to parallel what we have domestically with the national response framework could help to clarify and enshrine some of those roles for institutions like the State Department, USAID, CDC, DoD, and others.

I was encouraged to see that Senator Menendez's bill contains some similar language.

Second, the State Department has an incredibly important role in building diplomatic support for pandemic readiness and can play a role also in coordinating broader overseas U.S. engagement.

But I do not believe a heavy PEPFAR style centralized authority at the State Department over programs and budgets of interagency partners is the right template for this particular role.

I believe a lighter approach modeled more on the counter-ISIL envoy would be more effective. That approach was tasked similarly with building a global coalition of allies towards, of course, in that case fighting ISIL, in this case fighting pandemics.

That is a sweet spot role for the State Department and the coordination function that the counter-ISIL envoy used was shared with a senior director at the NSC who could more effectively coordinate with the interagency and I believe that that sort of model would be a better partnership here, hinging, of course, on restoring the White House senior director and accompanying team for global health security, which is as crucially important, as some of the other witnesses have already noted.

Third, as several of these proposals do acknowledge, any new U.S. initiative must be robustly resourced. The pandemic has cost trillions of dollars in emergency economic stimulus and lost productivity and other spending.

So investing in pandemic preparedness on a PEPFAR like scale, which is to say billions of dollars a year, is an extremely good return on investment if it can prevent that kind of economic damage in future pandemics.

Fourth, it is impossible to envision the U.S. succeeding in this kind of ambitious pandemic preparedness agenda without the full engagement of the World Health Organization and, frankly, it is hard to envision the rest of the world working together with us on this effort if they view it as a U.S. alternative or competitor rather than a complement and a supporter and partner to the World Health Organization.

Withdrawing the U.S. from the World Health Organization will be tragic and it is entirely unjustified. In an earlier hearing, Senator Risch, you asked a group of administration witnesses to identify the fire department for global health emergencies.

I agree with the other witnesses who have noted that such a thing already exists. It is called the Health Emergencies Program at the World Health Organization. It was established—and I and

Ambassador Kolker both had a hand in helping to stand it up—it was established following the failures of the 2014 Ebola outbreak.

It is not perfect. It is still a work in progress. But it is making great progress and has succeeded in recent years in addressing several outbreaks like Ebola in the Congo as well as other outbreaks like cholera in Yemen.

There is no question that WHO continues to need further reform, and I would echo what Senator Risch said about the challenges within the limitations that the international health regulations currently put on WHO.

But we should then focus on those problems. We should not abandon the organization and our best chance to focus on those problems is by staying part of the organization despite its flaws and working to improve it.

Finally, it is a bit painful to say this but I think we also have to acknowledge that the U.S.'s credibility to lead a global coalition on pandemic preparedness will really hinge on our ability to contain our domestic outbreak here at home.

Our credibility globally starts with our competence within our own borders, and so to rectify this we need to take the advice that we have given to other countries for many years: depoliticizing public health, following the evidence, communicating risk effectively, building public trust, and deploying competent management structures.

And I think we have to show a degree of humility as well, recognizing that even a country as well prepared and powerful and wealthy as the United States can falter when it departs from these sort of sound public health principles.

With that, I look forward to your questions, and thank you.

[The prepared statement of Mr. Konyndyk follows:]

PREPARED STATEMENT OF JEREMY KONYNDYK

Dear Chairman Risch, Ranking Member Menendez, and distinguished Senators, thank you for inviting me to testify before you today. This hearing comes as the COVID-19 pandemic is proving what public health experts have warned for years: no country in the world is adequately prepared for a lethal pandemic. Many countries today are failing to contain the virus, whether through poor management, weak systems, late action, or all of the above. There is an aphorism that one must never waste a crisis. So even as we work to defeat the current pandemic, we must begin learning from the failures to contain it, and prepare ourselves to be more ready the next time around. We are fortunate that COVID, while highly transmissible, has a lethality far lower than past threats like SARS-1, Ebola, or the Spanish flu. A comparably transmissible virus with a much higher lethality is plausible, and over time even probable. So we must use this moment to marshal the political will to be ready for that.

Being ready for the next pandemic must be a global effort: U.S. readiness at home will be compromised if there are vulnerabilities overseas. As COVID is teaching us, a lethal pathogen will take advantage of any weakness in the world's defenses. The Pandemic All Hazards Preparedness Act, which was reauthorized a year ago, focuses on domestic pandemic readiness but is nearly silent on international aspects. This is a moment to rectify that, for our global and our domestic efforts must be well aligned. We must understand that our investments in global cooperation are not purely altruistic; they also keep us safe. And we must connect those efforts directly into our domestic efforts.

THE GLOBAL OUTLOOK

In an earlier hearing of this Committee, Chairman Risch asked a group of administration witnesses to identify the "fire department" for global health emergencies. While none acknowledged it, the world already has such an institution: the Health

Emergencies Programme of the World Health Organization, guided by the WHO's mandate under the International Health Regulations to "prevent, protect against, control and provide a public health response to the international spread of disease." While WHO is not a perfect institution, it has improved dramatically since its failings during the 2014 Ebola outbreak, and has largely served the world well during the present pandemic. U.S. involvement with WHO is a critical pillar of American and global pandemic preparedness. Withdrawing the United States from the WHO will weaken both the WHO and the United States, and put at risk the health of millions around the world and here at home.

There have been assertions by the Administration, and by some in Congress, that WHO's performance on COVID has been a repeat of mistakes it made during the West Africa Ebola outbreak, and that the U.S. is therefore justified in abandoning the organization as hopeless. This mis-diagnoses both what went wrong in 2014, and what constrained the organization during the early phase of this pandemic.

There is no question that the organization badly mishandled the Ebola outbreak in 2014 during the critical May-August period when the outbreak accelerated across West Africa. The WHO country offices were slow to take the risk seriously, WHO HQ in Geneva was slow to sound the global alarm, and the organization lacked the operational wherewithal to mount a rapid and effective response. The independent panel tasked with evaluating WHO's response to that outbreak concluded that the organization did not "currently possess the capacity or organizational culture to deliver a full emergency public health response."¹ And this glaring gap in the global readiness for complex outbreaks allowed a virus that had never previously produced more than 425 cases in any single outbreak to infect 28,616 people and kill 11,310. It forced the U.S. and other nations to deploy massive civilian and military operations to contain the outbreak, at a cost of billions of dollars.

At the time, I served at USAID as the director of foreign disaster assistance, and my team served as the backbone coordinating the U.S. response in West Africa. Following the outbreak, I was closely involved in U.S. deliberations over what to do with WHO. The interagency debated a range of options, up to and including the creation of a new, separate agency responsible for health emergencies. But we concluded ultimately that that was neither feasible nor advisable, and that the best approach was to press for a fundamental overhaul of WHO's role in health emergencies.

We also recognized, as did other prominent WHO member states, that part of the responsibility for the failure rested with us. WHO is a member state-based organization, and its policies and priorities are not determined in a vacuum: they reflect the guidance and direction that the WHO secretariat receives from WHO members. And for too long, member states had pushed WHO leaders to prioritize non-emergency missions while ignoring the erosion of the organization's emergency response capacity.

So rather than abandon the organization, the U.S. set out to strengthen it. We worked with WHO leadership to develop a plan for a major organizational overhaul; I and a CDC representative sat on the advisory group that helped design the proposed reforms. We also mobilized diplomatic efforts to build support among member states for the emergency reform package, which was passed by the WHO's governing body in May 2016 with broad support. We provided targeted funding to help kickstart the reform process, tied to rigorous accountability requirements to ensure that the organization followed through on reform implementation. And since 2016 I have had a unique vantage point on the implementation of these reforms from another perspective, as a member of the independent oversight board that monitors WHO's Health Emergencies Programme and reports back to the member states on the organization's implementation of the post-Ebola reforms.

These reforms have had a real impact. There is perhaps no clearer contrast between the WHO of 2014 and the WHO of today than the organization's handling of the extremely complex Ebola outbreak that finally concluded last week in Eastern Congo. An agency that had been unable, in 2014, to mobilize a rapid or robust operational Ebola response in three stable and peaceful countries was able, by 2018, to mount a massive field operation in one of the most complex conflict zones on earth. And furthermore, WHO did this without anything like the kind of massive U.S. and UK personnel deployments that had rolled out in West Africa. In fact, WHO received far less technical support and cooperation from CDC and USAID than it customarily would, due to the State Department's fears about security risks to U.S. personnel. WHO meanwhile deployed more than 700 personnel, at significant risk, and lost staff to armed violence. Over the course of the outbreak, WHO and the Congolese government partnered to build an operation that vaccinated more than 300,000 people and at its high-water mark was tracing and monitoring more contacts (in a war zone!) than most U.S. states are today.²

And that in turn is a useful backdrop to understanding WHO's performance during the ongoing COVID pandemic. The organization today remains far from perfect but has made huge strides since its nadir in 2014. And while the Trump administration has criticized the WHO for supposed failures on COVID-19, the main charges do not hold up to scrutiny—and certainly do not justify withdrawing from the institution.

The Administration has made three main accusations: that the WHO is uniquely close and credulous toward China; that it was late to warn the world about the dangers of the virus, particularly its potential for human-to-human transmission; and that it opposed President Trump's imposition of a travel ban on China. Collectively, the Administration has suggested that different behavior from WHO on these fronts would have spared the U.S. and the world from the catastrophe that this virus has wrought.

These accusations are false.

With respect to WHO's supposed closeness to China, it is certainly true that WHO is highly deferential toward member states—but this is not unique to China. Like any multilateral, member-state based organization, WHO is loath to criticize its members in public. This is by design; WHO's members (the U.S. included) have traditionally steered it to be highly deferential toward member state prerogatives. WHO also avoided criticizing shortcomings by the Congolese government, or the governments of West Africa, during Ebola outbreaks there; all of those members states have far less global power than China.

This kind of deference is formally enshrined in the International Health Regulations, the binding treaty negotiated by WHO member states that guides WHO's authorities in major outbreaks. The IHRs make explicitly clear that WHO has virtually no authority to second-guess outbreak reporting by a member state, and can only investigate new outbreaks with the state's cooperation and consent. Furthermore, the IHRs grant WHO no authority to sanction or punish states for inaccurate, late, or incomplete reporting. Again, it is important to emphasize that this situation was created by the choices of the member states that negotiated and adopted the IHRs. As for the notion that China has outsized influence in the WHO, U.S. citizens occupy two senior leadership positions in the organization while only one is occupied by a Chinese national.

The idea that WHO was unjustifiably late in warning the world about COVID-19 also ignores the evidence. China confirmed the outbreak to WHO on December 31 2019. Within days, WHO had released an extensive set of resources and technical guidance on the virus, and on January 12 (unprecedentedly fast compared to previous outbreaks) WHO shared the virus' genetic sequence with the world, with detailed guidance for diagnostic testing released on January 13.³ With respect to human-to-human transmission, WHO stated in a press conference on January 14 that human-to-human spread was a possibility (albeit yet unproven).⁴ WHO subsequently confirmed human-to-human spread was occurring on January 22, a day after WHO staff returned from the first trip that the Chinese government had permitted them to make to Wuhan. Another day later, on January 23, Director General Tedros convened the WHO Emergency Committee (and advisory body composed of outside experts, including a senior U.S. CDC official) to review emerging information from China and advise on declaration of a public health emergency of international concern. The PHEIC is the highest level of alert that WHO is authorized to sound under the IHRs.

The emergency committee was split at that time on declaring a PHEIC; there were fewer than 600 cases officially reported. Nonetheless the WHO's summary of the committee deliberations provided a picture of the virus that was deeply alarming: a novel respiratory coronavirus that was spreading uncontained in the community; had a severity rate of 25% and a preliminary fatality rate of 4%; and had a reproduction number of up to 2.5⁵, making it significantly more transmissible than seasonal flu. In the infectious disease world, this is a highly worrying collection of characteristics. A week later, after China had begun shutting down Wuhan and other major cities, the Emergency Committee reconvened and advised declaring a PHEIC, which Director General Tedros did. At the time, fewer than 100 cases had been detected outside China, and only 5 in the United States.

With respect to on the travel ban controversy, WHO's posture was grounded in the widely held view in public health literature that travel bans are a highly disruptive measure that provides limited real protection against the spread of a respiratory virus. Most research on travel bans has found that in a large and open country like the United States, such bans can at best modestly delay the acceleration of an outbreak by a few weeks. They cannot shield a country from the eventual arrival of a virus, as is now obvious. There was good reason to therefore be wary of such bans, for fear that they foster a false sense of complacency that deters em-

phasis on true readiness for the arrival of the outbreak—which indeed is precisely what happened here. And in fact WHO did not actively oppose such bans; it sent a circular notice to member states on February 6 noting that such bans could be justified if they were used to allow time for countries to implement sustained preparedness and response measures.

Put together then, these accusations have little merit and there is no reason to believe that different behavior from WHO would have produced a different readiness posture by the U.S. Government. The failure of the U.S. to be ready for the pandemic now battering our country is not result of listening to WHO, but rather a result of not listening. China was slow to release information on the virus; but WHO had no authority under the IHRs to compel different behavior. Once WHO verified updated and more accurate information it relayed that evidence to the world, at a time when there was still a sufficient window for preparedness. And it noted that travel bans, if implemented, should be used to buy time for domestic preparedness, advice that the U.S. ignored.

The U.S. withdrawal from WHO is absurd on the merits and will be tragic in its consequences. WHO is a crucial reporting hub for every country in the world, and there are numerous USG secondees working for the organization. Membership provides access to important policy and research bodies; walking away from WHO leaves the U.S. less informed in COVID-19 and future pandemics. The U.S. has also invested heavily over the years in WHO's ability to lead the fight against infectious diseases so that we don't need to carry that burden alone. Global polio, for example, is close to full eradication due to WHO's U.S.-backed vaccination efforts. Withdrawing from WHO will leave the U.S. isolated in global health efforts and unilaterally surrender U.S. influence.

Instead of withdrawing, the United States should focus its efforts on continuing to advance WHO reform. While great progress has been made, much more is needed. The United States' ability to promote those reforms will evaporate with our departure from the institution. The U.S. should focus as well on the bigger weakness that this pandemic has revealed: glaring shortcomings in the International Health Regulations. If we want to see greater country transparency and accountability in outbreaks, the IHRs' tepid handling of those dimensions is the place to start. We should also explore updating the PHEIC mechanism, whose binary structure undermines its usefulness as a true alarm bell for health emergencies. A far better approach would be to rethink the PHEIC as an escalating scale of pandemic risks, with different global and national readiness triggers tied to gradations of risk. These kinds of reforms would make the U.S. and world meaningfully safer in future emergencies; by leaving WHO, we lose the ability to accomplish this.

ORGANIZING THE U.S. GOVERNMENT

As the U.S. focuses on adapting the international system to the lesson of COVID-19, we must also rethink how the U.S. Government itself works to advance global pandemic readiness. I am very heartened to see a flurry of proposals to bolster U.S. Government focus, operations, and financing toward this critically important objective. We must seize this moment to begin building a stronger U.S. and global architecture for health security, just as we did after 9-11 for counter-terror cooperation (although hopefully with greater regard for human rights and civil liberties).

And so I welcome and commend the spirit of the proposals that have emerged—the Risch/Murphy/Cardin bill and the Menendez bill in the Senate; the Connolly bill in the House; and elements of the emerging proposals being formulated by the Administration. However, I have real concerns about the design of some of these proposals. Global health security and pandemic preparedness are whole-of-government functions that must be effectively organized within the U.S. Government and well aligned with our multilateral partners, particularly the WHO. I do not believe that modeling the new initiatives on PEPFAR, as some of these proposals envision, is the best approach. While PEPFAR's robust budget and long-term political commitment are both characteristics we want to emulate here, other aspects of that initiative are poorly suited to pandemic preparedness. I will outline several elements that I believe USG-focused reforms must incorporate.

First, it is important to establish a clear division of labor across the interagency, building on each agency's comparative advantages.

This was not enough of a focus during PEPFAR's inception, and that lay the groundwork for years of interagency friction that continues to plague the USAID-CDC relationship. Due to initial ambiguity over the division of tasks and expertise, each agency built parallel capacities and programs in different countries. Even now it is not uncommon for CDC to lead program areas in one country that USAID leads next door, and vice versa.

In developing the Ebola response in West Africa, my team at USAID and our counterparts at CDC instead sought to explicitly avoid this kind of ambiguity. We defined each agency's roles clearly at the outset, based on our respective comparative advantages—and then OMB developed budget proposals that reflected that pre-arranged division of labor. This led to a much smoother partnership, because we each obtained the resources we needed and had little reason to compete with the other agency for turf. I would urge that as Congress considers how best to authorize a new USG initiative, it establishes up front the respective roles of CDC, USAID, State, and other USG institutions (I was encouraged to see this reflected in the Menendez bill). This will reduce the potential for interagency friction and the need for a heavy coordination infrastructure.

Second, the coordinator role at the State Department should accordingly be a lighter structure modeled on the Counter-ISIL envoy, rather than the heavy and directive model of the PEPFAR Coordinator.

The PEPFAR Coordinator role centers expansive authority over program priorities, evaluation, and most importantly budgetary oversight at the State Department. This centering of interagency authority at State was arguably necessary for two reasons; the Coordinator's role in refereeing the aforementioned interagency turf battles, and to give the Coordinator leverage for interagency coordination. Repeating that model for pandemic readiness would have real downsides. It would prompt resistance from USAID and CDC, who are skeptical of the need for an added budgetary and program layer for initiatives that in many cases they have been investing in for years. And it would put a huge amount of program control in a Department that, outside of the PEPFAR office, has a weak institutional track record on global health.

While PEPFAR has worked well overall, the State Department has struggled with other global health efforts over the years. The Obama-era "Global Health Initiative" launched in 2009 was an earlier attempt by the State Department to improve interagency coherence across the U.S. Government's global health programs. But, as my CGD colleagues wrote at the time, it was "plagued by infighting, leadership questions, and general confusion since its launch" and was quietly shuttered in 2012.⁶ A few years later, during the Ebola outbreak, the State Department performed some tasks extremely well—such as organizing medevac services and providing Embassy-level support to outbreak response in the affected countries. But Main State in Washington struggled with interagency coordination, because the issue had no clear institutional home in the department. Eventually the Secretary recalled retired ambassadors to manage an ad-hoc Ebola Coordination Unit to manage State's contributions and represent in interagency deliberations. It is quite a leap to go from this track record to overseeing and leading the full range of programmatic, strategic, diplomatic, and budgetary functions envisioned in some of these proposals, and in the reported State Department vision.

A lighter approach modeled on the Counter-ISIL envoy would have a higher chance of success. The Counter-ISIL envoy role has numerous parallels to what is needed for pandemics. It emerged from a recognition that protecting the U.S. homeland from ISIL would depend on both a well-aligned U.S. interagency response, and a major global diplomatic mobilization. The U.S. Special Envoy role was established in the State Department and tasked with building a coalition of allies—a classic State Department function. The Envoy's office also co-led the U.S. interagency planning, in close partnership with the National Security Council at the White House. This produced an effective and expansive coordination model, that gave government departments and agencies appropriate space to manage their operations while ensuring alignment and mutual visibility. Like the counter-ISIL campaign, a pandemic readiness initiative must mobilize a surge in global diplomatic outreach alongside agency-level programs and operations. The same kind of decentralized alignment—rather than concentrated bureaucratic power—is what the U.S. government needs for its global pandemic readiness efforts. Lastly, there is simply no substitute for White House leadership. A signature U.S. pandemic initiative needs visible Presidential backing and White House coordination in order to deliver on the ambitious scale that this challenge requires.

Third, as many of the proposals have acknowledged, any new U.S. initiative must be robustly resourced. The pandemic has stripped trillions of dollars from global economic productivity, and cost trillions more in emergency economic stimulus and safety net spending. Investing on a PEPFAR-like scale—which is to say several billion dollars a year—to build the capacity to prevent a recurrence of this kind of catastrophe is an extremely good return on investment.

Whatever the bureaucratic shape of this initiative, its priorities are clear. It must build a global partnership that advances the world's ability rapidly detect and contain future pandemic threats. This means investing in surveillance, diagnostics, and

early warning—building the same capacities for infectious disease risks that we have built for hurricanes, droughts, and tsunamis. It means creating clearer triggers for global and country-level preparedness, so that we never again see the kind of inconsistent patchwork of country response that we have seen on COVID-19. It means investing in the readiness and resilience of medical and public health systems in weak and low-income countries, so that those states can contain disease threats that might reach us here. It means reinforcing critical supply chains of PPE and drugs. It means collaborating toward development of innovative diagnostics, vaccines, and therapeutics as global public goods.

CONCLUSION

All of these priorities will cost money, and all will require multilateral cooperation. To state it plainly, it is impossible to envision the U.S. advancing this kind of agenda without the full engagement of the World Health Organization. And it is hard to envision the rest of the world collaborating with us in this effort if they perceive it as an alternative—rather than a complement—to the WHO.

Finally, it is painful to say this but it must be candidly said: the U.S.' credibility to lead a global coalition on pandemic preparedness will also fall short unless and until we also get serious about containing our domestic outbreak. Our credibility globally starts with our competence at home, yet we are presently a prime example of how not to handle this pandemic. To rectify this, and to be able to credibly reassert our global health leadership, we must start taking the advice we have long provided to other countries: depoliticizing public health, following the evidence, communicating risk effectively, building public trust, and deploying competent management structures. And as we engage with the world going forward, we must show a degree of humility, in recognition that even a country as nominally well-prepared as the United States can falter when it departs from sound public health principles.

Notes

¹ <https://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>

² <https://www.who.int/news-room/detail/25-06-2020-10th-ebola-outbreak-in-the-democratic-republic-of-the-congo-declared-over-vigilance-against-flare-ups-and-support-for-survivors-must-continue>

³ <https://www.who.int/news-room/detail/29-06-2020-covid-timeline>

⁴ <https://twitter.com/UNGeneva/status/1217146107957932032>

⁵ [https://www.who.int/news-room/detail/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))

⁶ <https://www.cgdev.org/blog/failure-launch-post-mortem-ghi-10>

THE CHAIRMAN. Well, thank you very much. First of all, that is a good point, the last point made about if we are going to be the leader in this we need to have things at home covered.

I want to say I have sat through a lot of panels on the Foreign Relations Committee over the years. This is probably the best one that has been put together.

I would like to take full credit for it but, unfortunately, I am going to have to concede that the staff, both the majority staff and the minority staff, had a great hand in this and, clearly, picked out the best possible people on this topic.

I really appreciate the tone of the panel as far as trying to move forward and not being in a condemning mode. I think that one thing that has come clear to all of us and has been evident by all of you is the fact that this is going to take more dollars.

For those of us that are—have a difficult time spending money, other people's money, this is a real challenge. But, obviously, there are things—you do not have any trouble with us most of the time but when it comes to defense spending.

But this is going to fall in the category of defense spending because without it, the consequences are phenomenal. All you have to do is look at what we just do with the wall at \$2.8 trillion, half of the annual budget, to address this one single problem.

And that indicates that we are going to have to be spending more to avoid having to do this again in the future. So I think coming to that realization is difficult. It is painful. But it is the reality.

The Emergency Health Program within the WHO is probably one we are going to have to take a really serious look at. I think if— one thing that has come clear here is as I have tried to identify the fire department there is no fire department, but if there is one it is the Emergency Health Program but they act more like a volunteer fire department than the real deal when you pick up the phone and want the fire department.

Maybe we could go around, just very quickly, and get each of you, give me your brief thoughts on the Emergency Health Program, how we ought to look at it, what it needs to be, and if you would go, please, in the same order from where we started. Then I am going to turn it over to others for comment and questions.

With that, we will start with Mark Dybul. Mark, are you there?

Dr. DYBUL. I am. Thank you, Mr. Chairman.

So within that response there is something called the Strategic Health Operation Center, or SHOC, which is similar to what an EOC, which I put forward in the testimony, we need.

However, it is not funded sufficiently and there will be limitations for some of the reasons that have been discussed that WHO does not have authority to compel countries to act nor, really, would anyone else.

There are limitations that are involved in the private sector. And so, I think, you know, WHO absolutely needs to be involved, likely should host, and SHOC could be the central point of that.

But we would need to supplement the authorities. I think you need to involve heads of state, the private sector, civil society including faith communities, so that we are ready to go.

And then a key piece, and this worked in South Korea, Taiwan, and other countries, they have to do regular simulations, and the national security apparatus, the apparatuses of the world.

The private sector is exquisitely good at these simulations. You identify where your gaps are. So, for example, that SHOC or whatever the EOC would be would literally pick up the phone and call a country and say, you have an outbreak, and then the whole system would kick in and you would see how it worked, whether it worked.

You would have stockpiles, and then you would start to see how to support regional and national EOCs so that they can be ready at the same time.

So I totally agree that WHO has to be central to that and would be a driving force. But I think there is some supplemental things that would need to be done to make it totally effective with national security, private sector, civil society, and other groups, and to have those simulations, which WHO can manage and should run.

But and this would be, I think, a conversation we have to have globally to put together the right pieces.

The CHAIRMAN. Thank you.

Let us see. Ambassador Kolker.

Mr. KOLKER. Thank you very much. I agree with Mark, and there does need—the WHO's budget for the entire operation with

all of the mandates that they have is one-third of the state of Maryland Department of Health budget every year. So we need to—we need to go quantum levels more to let them be anything but a volunteer fire department.

And in that regard, the dependence of the Health Emergencies Program on the overall budget of WHO, the small amount of assessed contributions for which the U.S. is traditionally in arrears—not just now but we are now more than ever in arrears—and the voluntary contributions makes it always dependent on an aspirational budget to do its work.

It has to respond and then raise the money to pay for what it just did, borrowing from other WHO programs.

So I used to work for UNICEF, which has a tremendous ability to raise money from individuals, from foundations, from the private sector, in a way that the WHO does not.

The Red Cross also takes huge advantage of emergencies when people, Americans in particular, really want to respond and donate money.

WHO has just set up a foundation that can scratch that surface. But I think we really need to look at the UNICEF and World Food Program models and look at a way that the World Health Organization can raise money widely from individuals and from organizations that now do not contribute because it is a number of state organizations with assessed contributions, not a funded program like UNICEF and WFPR.

In addition, I think we need to look at the international health regulations, which are the basis on which countries need to cooperate with the Health Emergencies Program.

I think they need to be strengthened maybe through a review conference or through member state effort like we reviewed the Health Outbreaks and Emergencies Program after the Ebola outbreak at WHO.

But there should be a stronger right of international inspection. The International Atomic Energy Agency can require that countries let them inspect facilities if they think something has gone wrong. This will be harder in the health context but I think it is something we need to look at.

And we need more options for declaring levels of public health emergency. We need to be able to prepare a proportionate response, for instance, having to do with travel regulations, for instance, having to do with laboratory requirements so that right now it is either an outbreak or it is a Public Health Emergency of International Concern, which triggers a number of different other requirements for states.

We need to have a traffic light system in which there are more moderate levels of public health emergency that would galvanize states to take action earlier before this Public Health Emergency of International Concern take place.

And I fully endorse what Mark said and others have, that WHO's inability to deal effectively with the private sector, which civil society, and even with finding a way in which other—many other multilateral organizations have to engage Taiwan, all of these are factors that can be addressed and need to be addressed by WHO in order to make the multilateral response more effective.

The CHAIRMAN. Thank you very much. I appreciate those remarks and I am particularly interested in your comparison to—on inspections to the nuclear inspections.

I would respectfully disagree that these may be more difficult than the nuclear inspections would be. You have a lot—you have a lot of experience with that, particularly with Iran and North Korea are probably the poster children for that.

But what we have found is an international agency can use the bully pulpit really to shame countries into doing what needs to be done.

And so I am not so sure that it is more of a challenge. But that is an interesting idea and a novel idea that I had not heard. That is one of the biggest complaints WHO has about their lack of authority is that they cannot go in on these things.

That is really worth taking a look at. Excellent thoughts.

Let us see. Dr. Jha.

Dr. JHA. Yeah. So, Chairman Risch, I am going to just be very brief and echo a few of the points that Ambassadors Dybul and Kolker have made because I agree, largely, with their points, and let me emphasize maybe three.

So, first of all, I do think the Health Emergencies Program is, clearly, underfunded. One of the reasons why it feels like a volunteer fire department is because in some ways it is. It is a little bit of a ragtag.

They do not have—they are always out there asking for money, and if we are going to use them as one of the key pillars of our global response they need sustained and adequate financing.

So I think whatever mechanism we use, that, I think, has to be essential.

Second is on the public health emergency declaration. One of the calls that we had from our report in 2014 was that you do need a graded system because it cannot be an all or none because what that does is it raises the threshold for calling out a problem until it becomes much worse than it needs to be.

And so we called for essentially a version of what the Department of Homeland Security does—you know, kind of green, yellow, orange, red—and I think that would be very, very helpful. It will probably require some looking at IHR and what can be done there.

Last is one of my broader frustrations with WHO, which does come up here again and has been mentioned both by Ambassadors Dybul and Kolker but let me emphasize because I think this is extraordinarily important, is the difficulty WHO has engaging with nongovernment actors, nonstate actors.

It has a framework that it uses. But, largely, WHO really struggles and one of the things that we have learned is that a global response to a pandemic is not just about government action. It is about private sector. It is about civil society organizations.

And so that is a broader and, I think, deeper discussion with WHO, not just about the Health Emergencies Program.

But I would like to see a WHO that is more deeply engaged, that is more favorable, that is more welcoming of nonstate actors, because I think that is something that hinders WHO's effectiveness.

[Pause.]

The CHAIRMAN. Excuse me. Great thoughts.

Lastly, Mr. Konyndyk, you are up.

Mr. KONYNDYK. Thank you, and hopefully you can all see me again. My internet has returned.

So I agree with—I agree with everything that my other colleagues here have said. I think that, Senator Risch, you are framing that it is a fire department but it is a volunteer fire department is a really nice shorthand for the challenges that the World Health Organization's emergency program continues to face.

They have made great strides. They are now at a point where I think the proof of concepts has been demonstrated and now we need to really invest in strengthening and institutionalizing their emergency capacity, and that means more consistent funding.

I have watched them from my perch on their Independent Oversight Committee for the last few years. I have watched them struggle constantly with tradeoffs, of trying to cover all the things that they have to cover within their mandate despite not receiving enough resources to do so. And, you know, they are—they are trying to contend with everything the world throws at them with a budget smaller than most U.S. hospital systems.

Tied to that, they need greater staffing but they also, as other witnesses have said, they need to invest more in partnerships.

And so, you know, WHO should not have to do everything alone and they have made progress, I think, overcoming some of the cultural challenges within WHO around partnership with nongovernmental actors. I think that is an area that needs to—that needs to continue.

And then, finally, it is very, very important to take a look, as Ambassador Kolker said, at the international health regulations and some of the authorities that WHO has to operate under that really do tie their hands and their ability to be more forward leaning and more assertive.

And, in particular, looking fresh at the Public Health Emergency of International Concern mechanism, which right now is a binary mechanism—it either is or it is not—we need to build in more gradations because there is a huge difference between something like the COVID-19 pandemic and the Ebola outbreak that has just finished in eastern Congo.

But within the existing construct of the emergency declaration mechanism that cannot be acknowledged, so a more graded mechanism that looks perhaps more like what we do within the humanitarian sector with famine declarations and famine prediction I think could be very helpful in triggering early action and differentiating between different levels of risk.

Thank you.

The CHAIRMAN. Thank you very much for those remarks, and just let me close. I am going to turn it over to Senator Menendez.

Again, I want to stress that for every member of this committee, the Foreign Relations Committee, and their staffs we are going to be meeting as we have been regularly and talking about ways of moving forward and getting things into the bill that people can embrace so everyone—there is no closed secret meetings.

Everyone is invited to these. Senator Murphy are going to meet with our staffs briefly at noon today to talk about next steps for-

ward. So I want to invite everyone to participate and so we can try to pull this wagon together.

With that, Senator Menendez.

Senator MENENDEZ. Thank you, Mr. Chairman, and thank you all for some very thoughtful testimony.

Dr. Dybul, in your written statement you mention that, quote, “Global and American partners are looking for a sign that the United States will once again demonstrate its commitment to a comprehensive global response. Investing in the immediate response now, laying the foundation for the future, will require leadership and resources.”

So do you or any of the witnesses testifying today believe that the Administration’s response has been commensurate with the scope and nature of the COVID–19 pandemic, domestically or abroad?

Dr. DYBUL. Thank you, Senator Menendez.

I think the only honest answer to that is no, we are not quite there yet. I would say we have some of the best people, and I think we all know all of them, in the Administration and in our civil service capable of mounting a strong engagement internationally, as you saw from the government panel a few weeks ago.

But we do have room to make up in terms of being engaged, our leadership, joining CEPI, which both of your bills called for, and participating there, engaging with WHO, supporting WHO’s reform and engaging with international partners which, as I point out, I think is necessary to establish that fire hydrant.

I know you have put the World Bank trust fund in and maybe that is the best mechanism. But until we talk to the rest of the world and know where they would put money, it is difficult to know that.

So I do think we have the right people. We have got a great team that can do the work. But we have some ground to make up and I really thank the Congress and this committee for the leadership and stressing it because people do look to Congress, not just the Administration, and when they see leadership coming from—and I know this from PEPFAR and the Global Fund—leadership from Congress actually makes a big difference in the world, took and I think we are positioned well to be able to engage and to see this through.

And I would just point out, again, that swine flu report today is very disturbing. I mean, if we have at the same time new waves of the coronavirus, the potential for a bad flu season or swine flu, it is a catastrophic future we could face, and I really thank all of you and the people in the Administration doing the work. But we have some work to do.

Senator MENENDEZ. So let me ask you all, what lessons should we learn from watching other countries who have successfully responded to the COVID–19 pandemic?

I open that up to anyone who wants to give any insights.

Dr. JHA. Well, Senator Menendez, maybe I can—this is Ashish Jha. Maybe I can begin.

There are lots of lessons, but the single most important one is countries that have taken the virus seriously and have moved aggressively have done better. This is a virus that is unforgiving if

you fall behind and, unfortunately, for much of the time that we have been battling this virus I think we have been behind and we have been playing catch up.

But, certainly, South Korea, New Zealand, Germany, and Taiwan, Hong Kong, Singapore, there is a list of countries. They have not all done the exact same thing. Some of them have pushed more in testing and tracing, others sort of more aggressive lock down.

But they all took it much more seriously than we have and that has been the single biggest difference, in my opinion, between countries that have done well and countries like ours that have really struggled.

Mr. KONYNDYK. Senator, this is Jeremy Konyndyk. Quick thoughts on those two questions.

First, I would agree with Dr. Jha. The countries that have done the best are the countries that have acted the earliest had have been the most robust in using public health engagement, that they have used upstream public health capacity, testing, tracing, and strong public health systems to prevent overwhelming their hospitals.

We have a weak public health system in the United States compared to most other developed countries and that is an area that needs more focus. But we also just have to act early and be guided by evidence and I think it is clear we waited too long and that has really hurt us.

On the international scene, you know, you asked if it has been commensurate to the scope of the pandemic. I do not think our engagement has.

We have been uncharacteristically absent from international leadership on this pandemic and I look at the contrast with the Ebola outbreak a few years ago or past outbreaks under the Bush administration where, you know, the U.S. is really showing leadership, engaging with the world, trying to convene and bring the world along with us around a common vision.

We do not see anything like that here. Instead, we see the Administration attacking WHO, moving very slowly to disburse the aid funds that Congress has appropriated to it and going it alone on things like vaccine development where the rest of the world is collaborating.

So I think we really do need to step up into the customary leadership role that we have shown in past outbreaks.

Senator MENENDEZ. Well, thank you.

Now, moving into what this should look like then, recent articles in Devex and Politico reported that the Trump administration is proposing an initiative as called the President's Response to Outbreaks, which would consolidate international pandemic preparedness under a new State Department coordinator and establish a new central fund to fight pandemics, using money out of the COVID supplemental.

And let me go back to you, Mr. Konyndyk. You state clearly in your testimony that you do not believe that modeling a new initiative on PEPFAR as proposed by the Administration or as the chairman's bill envisions is a good approach.

Would taking budgetary authority and programs from USAID and moving them to the State Department at all improve the abil-

ity of USAID or the U.S. in general to respond to epidemics and pandemics?

What impact would further stove piping pandemic response funding for prevention and response efforts have on global health programs and the relief to development continuum?

Mr. KONYNDYK. Thanks for that question, Senator.

Yeah, I do not think that creating a PEPFAR style highly empowered centralized coordinator at the State Department is the right model for what we need to do here.

I think that the—something like the counter-ISIL coordinator is more the sort of function that we need here, and that was a lighter touch structure.

It has some coordination authority but it led that in close conjunction with the White House and it left the budgetary and program decision making and line management to the agency themselves, and I think that that is a much better way to go as long as right from the outset we clearly define who is on the hook to do what across the interagency.

And that was one of the challenges within PEPFAR and one of the reasons the PEPFAR coordinator has had to be so empowered is because that was kind of a free for all in the early years of PEPFAR between USAID and CDC and it set the foundation for a long—many years of turf battles between those two agencies and forced the PEPFAR coordinator role to be more of kind of referee for some of those interagency fights.

But if we design it well up front, I do not think we need quite that heavy structure and that will be—you know, in the Ebola outbreak when we did that it worked very well and we got along because we did not have that much to fight over.

If we leave them a lot to fight over by not outlining roles clearly, that is when you need that kind of heavy-handed coordination function.

Senator MENENDEZ. Very good.

And then, finally, Dr. Jha, on May 18th, President Trump called for WHO reform within 30 days. Eleven days later he announced that the United States withdraw from the WHO.

Former Deputy Secretary of State Bill Burns, one of America's preeminent diplomats who served for 33 years, commented that, quote, "You do not reform the fire brigade when the fire is raging out of control."

So as someone who has both been a severe critic of the WHO but today's testimony balances with some of the realities, what is your assessment of the Trump administration's efforts to reform the WHO, have they been effective, and what lessons can we learn now from the United States efforts to work with and reform the WHO during and following the 2014 Ebola outbreak?

Dr. JHA. So, Senator Menendez, thank you for that question.

To stick with Chairman Risch's analogy of a fire brigade, a fire department—a fire department that, let us say, is struggling to manage a blaze that is engulfing our neighborhood, it is important to look at how that fire brigade is doing and assess its performance. But to distract it in the middle of fighting the fire is probably not ideal.

And so I believe that we have to do a very thorough and careful examination of what did WHO do well, what did it do badly, and how we make it better.

Interim assessments as have been proposed may be reasonable as long as they are not hugely distracting. I believe at this moment all of us have one job and one job only, which is to try to manage this pandemic and try to bring it to a close as quickly as possible. Anything that helps is a good thing to do and anything that distracts is a bad thing to do.

I believe at the end of this pandemic, which I hope will be within a year with vaccines that are widely available or at least, let us say, controlling the pandemic by then, I think there will be plenty of opportunity to do a very deep dive on what WHO did well, badly, what reforms are needed.

Again, after Ebola it took both independent commissions and U.S. leadership to make those changes, and I suspect that we will need both of those, both independent assessments as well as U.S. leadership to make the necessary reforms to make WHO a more effective organization yet.

Senator MENENDEZ. All right. Thank you. I have a lot of questions I am going to submit for the record. I would love to have your expertise on it, all of you.

And with that, Mr. Chairman, I turn it back to you.

The CHAIRMAN. Thank you, Senator Menendez. I think we all have questions we will be submitting for the record and I think those will be helpful as we try to put a path forward.

Unfortunately, technology has not helped me know who is on the line here. So I am just going to go—I am going to do this on seniority and I am going to move as quickly as I can through these until we—so we can get through these.

Senator Rubio, are you on?

[No response.]

The CHAIRMAN. Senator Johnson.

[No response.]

The CHAIRMAN. Senator Gardner.

[No response.]

The CHAIRMAN. Senator Romney.

[No response.]

The CHAIRMAN. Senator Graham.

[No response.]

The CHAIRMAN. Senator Barrasso.

[No response.]

The CHAIRMAN. Senator Portman.

[No response.]

The CHAIRMAN. Senator Paul.

[No response.]

The CHAIRMAN. Senator Young.

[No response.]

The CHAIRMAN. Senator Cruz.

[No response.]

The CHAIRMAN. Senator Perdue.

[No response.]

The CHAIRMAN. Senator Cardin.

Senator CARDIN. I am here, Mr. Chairman.

The CHAIRMAN. Oh, thank you. Senator Cardin, thank you for being on, number one. Number two, thank you for your work on this. Your work has been very helpful, very instrumental in moving the entire issue forward.

Both yours and Senator Portman's work in that regard is greatly appreciated and, again, on a bipartisan fashion I hope we could all move forward to get a bill, whatever that bill may look like, that would move the ball downfield.

So thank you, Senator Cardin. The floor is yours.

Senator CARDIN. Thank you, Mr. Chairman, and I agree with your assessment. I think this panel has been an excellent panel and I thank each of them for their contribution.

A couple of observations, then I am going to ask a specific question on what we should be doing in the United States Congress.

Observations, as you have all said, that if you are in a country, you are not going to be safe unless all countries are safe to be in because it will spread; that U.S. leadership is indispensable; and that the United States pulling out of WHO during the middle of this pandemic made no sense whatsoever, recognizing that the WHO definitely needed to be reformed.

We also recognize that the United States must lead by example, and when we live in a country where we have the continuation of the first wave and the escalating number of cases, we are not the example that the world is going to look to as the best way to handle this pandemic.

All of that are facts we have to deal with. The Senate Foreign Relations Committee has a strong record of the independence of the Congress in leading our nation. And yes, you have all mentioned the fact that we need to provide greater resources and I could not agree with you more. We do need to provide the resources and Congress has the responsibility to provide the resources.

But we can do more than just provide resources, and that is my question to you, is what should the United States Congress do? By example, during the previous Administration, we disagreed with the policies in regards to Iran. We passed the bill to be much stronger against the regime of Iran.

In this Administration, we disagreed with the Administration's policy in regards to Russia. We passed a strong bill to stand up to Russian aggression.

We acted independently. Now, we may have some different views, but I believe that the President has been very inconsistent—that is being kind—but has not given the leadership we need for the global community in order to effectively deal with this pandemic.

What should Congress do? What concrete steps should we take in order to exercise U.S. global leadership to protect the health of not just the global community but, clearly, the health of Americans?

What action would you like to see come out of Congress?

Mr. KOLKER. Senator, this is Jimmy Kolker. I would like to take a first stab at that. Is that—

Senator CARDIN. Sure.

Mr. KOLKER. Okay. Sure. First of all, many people said, oh, the U.S. was the best prepared country in the world, and in another

book, the Nuclear Threat Initiative, Johns Hopkins, and the Economist published a study in which we did get the highest score, 83 out of 100, which is not an A grade.

But if you look at the—if you look at the areas in which we failed, we got a grade of 60 or less in three of the 34 indicators in that study, Global Health Security Index.

One was in the preparedness of our clinics and hospitals for a pandemic outbreak in terms of supplies, training, personnel, and all those things. We got a score of 60.

We got a score of 23 out of 100, a phenomenally bad grade, in terms of health care access; how easy is it for the most vulnerable populations to get access to health care in the United States. A low score.

And we got an even lower score in exercising our team, and we have seen that all three of these that we did not have a team in place that was used to working with each other on outbreaks and emergencies.

We did not have access for the most vulnerable populations and our hospitals have been struggling to meet the demands that had been placed on them.

So, domestically, Congress needs to look at this holistically. But I also want to make one other point about China. It is absolutely true China was not wholly transparent or cooperative in the way they looked at this.

But, historically, the United States is not reliant and has not been reliant on Chinese government official statements or even on World Health Organization information about China.

After the SARS outbreak in 2003, China systematically set up the CDC model on their own CDC. We had CDC people co-located in China and in 2016 there were 47 of them on the campus of the Chinese CDC in daily contact with their counterparts about outbreaks and epidemics training, sharing information.

In 2013, with H7N9, bird flu outbreak, which many people thought was going to be an epidemic, we surged 40 CDC people to China to help the Chinese epidemiologists control that epidemic and they did.

But two things happened. One is the post-Benghazi move of all U.S. government personnel onto embassy compounds, which at HHS or during the Obama administration I actually fought saying this was not in the interests of our public health preparedness, and indeed, in China we have moved all of CDC off of the Chinese CDC campus into the embassy compound.

Then the Trump administration talked about reducing our footprint of health presence in China and those 47 people have been reduced to 14, of who only three are Americans.

So when we had this outbreak, we had—we had none of the three protocols. We did not use any of the three protocols that we could have used to engage China in direct bilateral collaboration, and the last one of those three, I have to say, which is an emerging infectious disease protocol, expires today.

June 2020 is the expiration date. But emerging infectious disease protocol, we have not convened a meeting under that protocol since 2017.

So we have a protocol which would have facilitated the sharing of information directly to us. We have not used those authorities.

Senator CARDIN. I have limited time. Let me just see if any of the others want to respond.

Dr. DYBUL. Senator Cardin, if I could.

As a constituent, I live in Kent County.

Senator CARDIN. Sure—you first.

[Laughter.]

Dr. DYBUL. I would say your direct question on what can Congress do is very pointed and I would say what you are doing. One is to link domestic and global much more clearly, which would mean working across committees.

And that is one thing I would emphasize because this crosses CDC in our domestic response. It crosses, you know, our international activity, both at the State Department and in Defense. It becomes complicated and it is very important to work across those committees as I know you have begun to do.

The second thing is to do precisely what you are doing with the legislation that has been proposed. Put forward how the U.S. government can lead in both a bilateral and a multilateral way, and open that up for discussion and then ultimately pass the legislation and work with the appropriators to ensure it gets funded.

But I do believe this committee is actually taking the steps that are necessary and, again, there are people in the Administration who can work with what you can do.

But if it is clear that Congress is acting I can tell you that matters both here but abroad because people understand our system of government, and clear action from Congress on financing structure, activity, what you want to see done, makes a big difference in terms of how the rest of the world views the U.S. response.

So I thank this committee for initiating that process. The key is to drive it forward, get it done, and then it can make a big difference.

Senator CARDIN. Considering you just complimented the committee, I am sure the chairman did not mind I ran over a little bit of time.

Thank you, Mr. Chairman.

The CHAIRMAN. If that had not been so complimentary I would be very angry about your going over time. But thank you for those remarks and I want to underscore again this is a—this is a full committee response to this.

With that, Senator Shaheen, are you on?

[No response.]

The CHAIRMAN. I know she was with us earlier.

Senator Coons.

[No response.]

The CHAIRMAN. Well, Senator Coons is not here but I can see Senator Udall sitting in front of a beautiful New Mexico state flag and the mountains behind him reminds me of home.

Senator UDALL. —you can hear me, I take it, right?

The CHAIRMAN. I can.

Senator UDALL. Great.

Ambassador Kolker, first, I would like to thank you for your previous work as HHS's chief health diplomat. The COVID-19 pan-

demic demonstrates how crucial it is for us to engage early on with our international allies and neighbors to address emerging public health issues. Only with open communication and focused coordination can we effectively take on this virus.

The U.S.-Mexico Border Health Commission has a tradition of working bilaterally to tackle shared public health challenges. That is why I introduced bipartisan legislation with Senator Cornyn and others, the Border Health Security Act, to better coordinate our public health response along the northern and southern borders by increasing emergency preparedness, developing stronger health surveillance, and strengthening our public health infrastructure by providing additional resources, as the chairman has talked about.

Our bill uses the recommendations of the commission to help effectively guide resources along with input from the Administration.

Ambassador Kolker, in your opinion, will providing additional resources to build public health infrastructure or better coordinate early warning infectious disease surveillance at our borders, which my bill does, improve our ability to combat COVID-19 and future pandemics?

Mr. KOLKER. Senator, thanks for your question and, of course, the answer is yes. I did represent the secretary of Health and Human Services and was co-chair with the Mexican minister of health to lead these sessions of the U.S.-Mexico Border Health Commission when I worked at HHS.

And it is a little known operation but it—when we think about border security it is really important also to think about border cooperation, and this is a great example of where the four U.S. border states and the five Mexican border states meet regularly to exchange information about health threats with a direct involvement of the populations that live across the border and the state departments of health.

And in that capacity we were able in the past to give small grants, a total of only about \$2 million a year, to state health departments to enable them to leverage state support and to support state and local efforts to do things like surveillance, TB control, which is especially difficult across the border, and looking for infections and outbreaks.

And this, unfortunately, with the reduction in budget for the secretary's office at HHS, these grants to the states have ended. So your efforts to—earmarks of money to do something that I really saw good results from, especially in this time when health security is national security, I really appreciate.

Senator UDALL. Great. Well, I hope I can persuade Chairman Risch and Senator Menendez to put this border health security package into the next COVID relief package that we are going to be working on because I think it would make a real difference, as you have said, on all of the issues that impact us on the northern border and the southern border.

Dr. Jha, in your opening remarks you said that the Latin American region recently reached 2.2 million cases after infections doubled over the last 2 months and its combined death toll passed 100,000 last week.

Yet, the Trump administration has repeatedly cut funding to the Latin American region. Furthermore, instead of helping our neigh-

bors in Cuba, the Administration has cut off communication to family support networks. These cuts simply were not prudent in light of the current pandemic.

What impact will these cuts have on our effectiveness in dealing with the pandemic here at home and across Latin America?

Dr. JHA. So, Senator, thank you for your question and your comment.

You know, Latin America is our neighbor. These are our neighbors, in Mexico and Cuba and, certainly, across the entire Americas.

And when I look across the entire globe, Senator, I see what is happening in Mexico and Peru and Brazil and Chile but other countries as well as incredibly concerning. These have really become, along with the United States, the hotspots of the world.

And so if you think of this as a fire raging across an entire city, and these are our neighbors, we have got to work with our neighbors to put the fire out, because if there is a fire, a raging fire, in our neighbor's home, there is nothing we can do to protect our home that will not require us also working with our neighbor.

So I believe deeply in American engagement globally but I believe particularly in our engagement locally in our own neighborhood. It is a good thing to do. It is in tradition with what America has always done and it helps protect the American people.

Senator UDALL. Thank you, Chairman Risch, very much for this hearing.

The CHAIRMAN. Thank you, Senator Udall. Appreciate that.

Senator Murphy, are you with us?

Senator MERKLEY. Yes, I sure am.

The CHAIRMAN. Senator Merkley, the floor is yours.

Senator MERKLEY. Mr. Chairman, were you calling on Chris Murphy or Senator Merkley?

The CHAIRMAN. I am sorry. Chris Murphy.

Senator MERKLEY. That is not me. This is Senator Merkley speaking.

The CHAIRMAN. I am sorry.

Senator Murphy, are you with us?

[No response.]

The CHAIRMAN. Senator Kaine.

[No response.]

The CHAIRMAN. Senator Markey.

[No response.]

The CHAIRMAN. Looks like you are going to get your chance after all, Senator Merkley. You are up.

Senator MERKLEY. Okay. Very good, Mr. Chairman. Thank you very much.

I want to start by asking for some thoughts on some of the secondary impacts that we are facing, and perhaps Mr. Konyndyk, I will address this to you at the Center for Global Development.

One of the secondary impacts is a potential massive increase in food insecurity, an estimated doubling of severe food insecurity, an estimated 150 million more people driven into extreme poverty.

Is this an area where America could really show some international leadership and take that on?

Mr. KONYNDYK. Thank you, Senator, for that question.

I think you raised a really important point, which is that the—you know, the full impact of a pandemic like this is not simply the infections that it causes. It is also the second order impact so things like the economic damage, the food security damage.

And, you know, we are seeing increasing reports of food security impacts, particularly, you know, in countries that have resorted to lockdown tactics without having the ability to cushion the economic impact of that the way that a wealthy country like the U.S. or the European countries have been able to.

So I am particularly concerned about what that will mean for much of the developing world as they try to contain this virus and we need to then—we need to support them not just with—not just with fighting the pandemic but we also need to provide more comprehensive support.

And, you know, one of the areas where I have been concerned, and I wrote a piece about this last week, is that not much aid funding, whether from the U.S. or from other donors, is reaching NGOs and front line local organizations in developing countries and they have a very important role in cushioning those impacts.

So, you know, I would urge the U.S. and other global donors to focus on getting money really as expeditiously as possible to those front line local partners who play such an important role while also supporting organizations like the World Food Program, which have an enormously important responsibility on the kind of macro side of the food impact.

Senator MERKLEY. Thank you.

I wanted to turn to another aspect, and Dr. Jha, perhaps I will direct this your way, which is there was reports that international refugee camps are starting to show the signs of outbreaks that could move very quickly.

I have been in some of those refugee camps around the world where people are densely populated, most recently in Cox's Bazar, and is that an area where the United States could really help focus world attention and resources on the refugee camps?

Dr. JHA. Yes. So, Senator Merkley, thank you for that question, and absolutely. You know, refugee camps—we have more people displaced in the world right now than we have ever had since World War II, about 70 million around the world, and refugee camps are breeding grounds for large outbreaks of this virus because it is, obviously, very difficult to socially distance.

They do not have strong health infrastructure and you have a very mobile population, often people with a lot of chronic illness.

So I think this is an area of extreme concern to me as a public health person and an area that I think has gotten very little attention globally. And so U.S. leadership in this area, I think, would be very helpful.

We are not talking about a small group of individuals—70 million people around the world who are internally or externally displaced—and we really do need a concerted effort to make sure that we manage disease outbreaks in those communities.

Senator MERKLEY. Thank you. I think about how in Oregon we are looking at the high-risk areas—farm worker camps, old folks centers, prisons, and so forth, and how our committee—our Foreign

Relations Committee could be looking at those high-risk areas around the—around the globe.

Let me turn to another piece of the puzzle, and perhaps, Mr. Dybul, I will ask you to respond to this, and that is vaccine strategy.

There is some hundred groups pursuing a vaccine. There has been a conversation about if a United States organization develops a vaccine that is approved whether we should insist on, essentially, all the vaccine being available in the United States first before it can be exported, or whether it should be available to be developed or reproduced in, I guess, in factories—drug factories around the world to quickly spread it.

And so in terms of vaccine strategy, what is the—assuming we get an effective approved vaccine what is the best way to pursue the production and distribution of that vaccine?

Dr. DYBUL. That is an excellent question, Senator Merkley, and I do not think any of us would agree that we should just give it to the U.S. first before we give it to anyone else because that does not make us safe. If other countries have widespread virus worst and we do not, we are stuck here. You need vaccination across the world.

What is happening actually here is very exciting. In the research world, the international collaboration is very strong across the private sector.

We have three candidates that are moving, and there is a significant investment both by the United States government through NIH, BARDA, and other mechanisms, and also through the Gates Foundation, through CEPI, which, unfortunately, the U.S. did not participate in, to actually basically put bets on seven vaccines, and we do not know if they are going to work but begin creating the production facilities now.

The hope is that we would have more than one approach. For example, there is about three major approaches that are being taken to vaccine development.

You cannot just switch one factory from one type to other, and so people are investing billions of dollars, including the Gates Foundation, and Bill said, “I am going to lose a couple billion dollars” because he is going to actually create the production capacity now for those vaccines should they become available so he can mass produce.

So there is great work being done there and I think support from the U.S. Government, including financially, in addition to NIH, which is hugely important, but to CEPI and others, which both bills call for, will be important.

And secondly, to understand that just waiting until we get to every last person in the United States is not the best way to protect us from the virus. We actually need the world to have the vaccinations so that we can have the open global economy that we need if our economies are going to grow.

And the last thing I would say to that, which is something I actually said to Senator Cardin, it is important that the WHO be at the table, and so something Congress can do is make sure we do not withdraw from WHO.

Senator MERKLEY. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Merkley.

We have got less than 15 minutes left but we have had a couple of members join us who want to participate.

And we will do that starting with Senator Shaheen.

Senator Shaheen, you are up.

Senator SHAHEEN. —but I had to leave for a few minutes, and I very much appreciate the thoughtful discussion and all of our panelists' testimony this morning.

Dr. Jha, I want to begin with you because one of the things you talked about was that you have been critical of the World Health Organization for the way they praised China's response to the coronavirus.

Given what has been said about the lack of carrots and sticks that the WHO actually has, what do you think they should have done in response to the way China behaved?

Dr. JHA. Yeah. Senator Shaheen, this is a very difficult question because WHO—you know, people have often said, well, WHO should have chastised China, and I think, well, I am sure that would have worked out well in terms of WHO's ability to get in and do things.

So I think the balancing act, as Chairman Risch brought up, would have been, one, to acknowledge the information, demand that China let WHO investigators in. But they did not have to go as far as to praise China as the model.

I remember listening to those early WHO press conferences and being struck by what I thought was an excessive level of praise.

I suspect it was done with the motivation of getting the Chinese government to then be more open to WHO's engagement, and so I think the motivation was probably good.

But it also, I think, led a lot of people to be less suspicious of the data coming out of China than probably should have been. So I think it had costs, and it is always easy to armchair quarterback but I do think they went too far and I wish they had not.

Senator SHAHEEN. And could the international community, could the United States, have done more at the time to criticize and demand that China provide accurate data?

Dr. JHA. Yeah. You know, I always believe that direct engagement by global leaders on issues like this and moments like this is really important.

Harsh criticism may not work so well with the Chinese government, just as it would not work with our government if another government or WHO criticized us harshly. I am not sure we would be amenable to working closely.

But I think direct engagement and more of a demand for accountability and sharing of information coming from the United States, coming from other European leaders, would have been helpful.

The Chinese government, I think, responds to pressure when it is done respectfully, as I think most organizations and governments do, and I think that could have been done more effectively than it was.

Senator SHAHEEN. Thank you.

One of the questions that I asked at the last hearing that we had about the current pandemic was what opening the United States withdrawal from the global stage has provided to China to extend their influence in other parts of the world as they respond as the country that is there to provide materials, to provide medicine, to provide guidance based on their experience.

Can any of you comment on the opening that you see that that has given China and what the United States has sacrificed in our not being the leader on the global stage right now?

Dr. DYBUL. Well, Senator Shaheen, this is Mark Dybul, and having run an international organization I can tell you it is significant. And it is not just China. It is actually Russia, too.

They have both been, over the last 3 or 4 years, been increasing their footprint in global health significantly and particularly in Africa.

And this is a real risk, I think, to the United States. There should be a balance. We need China involved. They have got lots of resources and they have got a lot to offer.

We cannot just open up the door to them, and wherever we have stepped back, they have stepped in, and not just in the WHO but in other areas.

And so we are at great risk around the world if we do not stay actively engaged and at the table, and I would just emphasize it is not just China. Russia has also been increasing their footprint in the multilateral and in specific countries in terms of health because they know countries value health, and the U.S. has been the preeminent leader unquestioned in global health and we need to maintain that role for many reasons, including who are going to be our trading partners in the future, and we need—we want to have those relationships maintained not only for health but for many reasons that are important to our security and our economic strength.

Mr. KOLKER. This is Jimmy Kolker. If I can just reinforce what Mark said.

You know, I was in the Foreign Service for 30 years, and the U.S. is the aspirational nation. People in many, many countries, especially in Africa, where I served for 14 years, look to the U.S.

How do you solve that problem in the U.S.? How can we get U.S. partners, U.S. expertise, and U.S. energy, involved in our projects? And that is especially true with health.

And it seems to me that if we see this as mercantilist, if it is zero sum, we miss opportunities that we took advantage of working with China, for instance, on the Ebola response in Liberia where there is a Chinese facility and ours worked together with the African CDC, which was set up after Ebola and has responded well.

So there are opportunities bilaterally with China but, particularly, in the WHO and the rest of the world. People look to us for expertise, guidance. We are the best prepared delegation. We have the resources they want. If we are not there, they are going to find somebody else and China, certainly, is eager to play that role.

Senator SHAHEEN. Well, thank you very much.

Mr. Konyndyk, do you want to add to that?

Mr. KONYNDYK. Yeah. I agree with everything the other witnesses have said. I would just say as well I think that the U.S. pos-

ture globally has been a real coup for China on this because, you know, what the world has seen over the past few months is China, because they controlled their outbreak fairly—you know, relatively quickly, has been able to go around the world distributing PPE and other supplies to developing countries while for most of that period the U.S., rather than providing aid as we customarily would, has actually been competing with a lot of these same countries for scarce supplies or testing materials and PPE, and it is only recently that that has begun to reverse.

You know, so what the world has seen is they are competing with the U.S. that they are usually accustomed to partnering with and instead they are getting help from China, and China has been very happy to step into that gap and they have made a lot of hay in terms of the public diplomacy, about really playing that up.

I think that, you know, that is something we need to be very wary of and the sooner we get our outbreak domestically under control the sooner we can return to that customary role of supporting the rest of the world.

Senator SHAHEEN. Well, thank you all very much. It seems to me that as we talk about the importance of health around the world, it is something that some of us in Congress seem to have missed because it is also a huge issue here at home, and we need to make sure that we are also looking towards the health of the American people as well as globally.

Thank you all very much.

The CHAIRMAN. Thank you, Senator Shaheen.

We are down to about 5 minutes, and I have Senator Kaine and Senator Booker, particularly Senator Booker, who has been with us the entire meeting.

But, Senator Kaine, you are first in seniority so have at it.

Senator BOOKER. Seniority and looks, by the way.

The CHAIRMAN. Yeah. Right.

Senator Kaine, are you with us?

[No response.]

The CHAIRMAN. Looks like, Senator Booker, you are up.

Senator BOOKER. I am grateful. Make sure somebody tells Senator Kaine that I was saying nice things about him behind his back.

The CHAIRMAN. Oh, I will. Believe me.

[Laughter.]

Senator BOOKER. All right.

I want to thank everyone on the panel for being here. It has been a really substantive discussion and dialogue. I want to get real quick to Mr. Konyndyk, and just ask you, you were also a member of the CSIS Task Force that Senator Young and I co-chaired just last year, and your expertise in producing the report was really invaluable, frankly, and I just thank you for your engagement and your commitment to easing suffering around the world. It was a great experience for me and my team, quite frankly.

I would like to ask you just some quick questions and, hopefully, getting succinct answers, knowing that we have a time limit.

Understanding that we really need global coordination and information sharing to bring COVID-19 and other pandemics under

control, what would be less costly to the American taxpayer? And that is something, I think, is a good lens with which to look for.

Is it less costly to remain in the WHO, in your opinion, or setting up a whole new international global health organization?

Mr. KONYNDYK. Thanks. That is a very easy question that I can answer quickly. It is much cheaper and easier to stay in the WHO and try to fix it than to set up something new.

And we—you know, when I served in the last Administration we looked very hard at this question, as Ambassador Kolker will remember, trying to figure out what to do with WHO after it really dropped the ball badly on Ebola in 2014.

And we gave serious consideration to a range of options and what we came back to was both the—kind of the least expensive but also the most effective solution was to try and make WHO work and that prompted the creation of the Health Emergencies Program, which over the last 2 years, I think, has proven—has proven the concept.

I would point most to the Ebola outbreak in Congo over the last 2 years, an incredibly complex outbreak which WHO was able to handle, you know, largely, without the kind of intensive support it got from the U.S. and UK during the West Africa outbreak.

You know, there was no deployment of 3,000 U.S. military personnel. There was no deployment of hundreds of CDC and USAID civilian personnel, and WHO still got the job done and the U.S. spent far less—contributed far less to the Congo outbreak than we had to do in the billions of dollars that we spent containing the West Africa outbreak.

So I think there is very good return on investment in working to make WHO work.

Senator BOOKER. Well, let me ask you the same kind of balance sheet cost benefit analysis. What would demand less resources from the State Department, working through the existing system to reform the WHO or corralling the entire international community to join a new organization to do what the WHO already does?

Mr. KONYNDYK. Yeah, of course, it is the same answer, and I would add I think the rest of the world is not as upset with WHO as the Trump administration is. You know, we are not seeing other countries threaten to abandon WHO or even lodge criticism towards WHO the way the U.S. has.

So I do not think there is any appetite for that. The U.S. would really be, you know, banging its head against a brick wall if we are trying to create a new organization without consensus from the rest of the world on that.

Senator BOOKER. But it is more than just banging your head against the wall. You know, it is so resource intensive, correct, to try to go out and develop relationships—

Mr. KONYNDYK. Absolutely.

Senator BOOKER. —with every health minister in every country in the world as opposed to just tapping into the relationships that the WHO has already developed over decades and where its presence, frankly, is already accepted and welcomed when some of the countries our presence, understandably, with a lot of state of the globe right now would not be welcomed. Is that correct?

Mr. KONYNDYK. That is very well stated. You know, one thing I have seen in my years doing this work is that the WHO is almost an extension of the health ministry in many developing countries, and that is not a—you know, that is not a role that a new organization could just take over.

We need to capitalize—that is a huge advantage for WHO. It is one that they could capitalize on better with their emergency work and they are beginning to do so.

But I do not think you could just create something new and expect to have that same sort of deep relationship and trust that WHO has with the health ministries that need to be partners on it.

Senator BOOKER. And in terms of just making America less safe, is it—you know, trying to replicate the WHO's solidarity trial, which is, you know, the world's largest clinical trial of COVID-19 therapies, coalition of 300 scientists exchanging scientific results as they test vaccines, we are really being sort of isolating going at it to determine the efficacy of vaccines ourselves. That does not seem a wise way to go.

Mr. KONYNDYK. Yeah. We should be spreading our bets when it comes to vaccines. I mean, I am glad to see the Warp Speed program that the Administration has launched. We need that.

But we should not be putting all our eggs just in that basket, and if there are other mechanisms that might pay off sooner, you know, we do not know which of these things ultimately is going to hit first. So we want to have a hand in all of them.

Senator BOOKER. Yeah, and that is the challenges. I hear this idea of using taxpayer dollars wisely, and it just seems on a lot of levels just so deeply unwise, not to mention wildly fiscally irresponsible to try to remove ourselves from the WHO and then think that we are going to be able to replicate that without extreme expense, putting ourselves in jeopardy, putting American health and well-being at risk.

And so I just, really quickly, in the last seconds I have remaining I want to go to Dr. Jha. I do not—I am not sure if Americans really know the role that WHO plays in just the seasonal flu vaccine, for example, and ending our involvement in the WHO will, for the first time, cut the government—U.S. government, rather—out of the development of the seasonal influenza vaccine from the Southern Hemisphere, which is a process that is actually coordinated by the WHO in partnership with the United States.

So just really quickly, do we know for sure how or if U.S. would maintain access to the most up-to-date information needed to develop a vaccine?

How important it is—is it for the U.S. and for Americans, in your opinion, to take the flu shot every year and what would be the consequences for the world of not sharing and coordinating information and the processes themselves for the development of the seasonal flu vaccine?

If you could just give me a window on that and then I will yield back to the chairman.

Dr. JHA. Senator Booker, thank you.

A couple of very quick remarks on that. Yes, we develop a new flu vaccine, the world does, every year. Ten institutions from

around the world come together to collaborate, including American institutions, and it is all done under the aegis of the WHO.

I have no idea whether we would continue to be able to be engaged and have a hand. But what I know is that if we could not access that information and if we had to go it alone, our ability to make the right bets, create the right vaccine every year would be substantially diminished.

And that would—as you know, the flu, while, you know, nothing like the current coronavirus, is still a deadly virus and especially affects older Americans, and a vaccine is incredibly helpful.

And if our vaccines became far less effective the main people who would suffer from that are the American people.

So there are a lot of questions about what we would be able to continue to engage in. Walking away from WHO, in my mind, it is a no-brainer. It would leave the American people much worse off and the influenza vaccine is just one example of how the American people would be hurt by this decision.

Senator BOOKER. I am grateful for that, and thank you, Mr. Chairman. I will yield back.

The CHAIRMAN. Thank you. Thank you, Senator Booker, and thank you for being with us for this entire hearing.

We are past time, but Senator Murphy has joined us. I know he is supposed to be in a very important meeting with a distinguished member of the body right now. But we will certainly welcome him and give him a shot at this.

So, Senator Murphy?

Senator MURPHY. Thank you very much, Mr. Chairman, and I will just ask one question. I know I am a little late to the party here.

But there is one topic that we have not covered that I think might be important to hear from at least Ambassador Dybul on, and that is the status of global health infrastructure.

What we learned in combating viruses in West Africa is that fragile local public health infrastructure makes it very, very difficult to respond to new and evolving diseases.

And I know, Ambassador, you were involved in the creation of the Global Fund for AIDS, Tuberculosis, and Malaria, which has been a huge success in tackling those diseases. But the mandate of the fund is really limited to those diseases.

Right now, there is not a robust global financing mechanism by which we can muster partners together to go and just help build and rebuild local public health infrastructure and then also partner with nations to try to prompt reforms in the way that they govern their public health infrastructure space.

So one of the things we have talked about across the aisle is whether there is a need for the United States to stand up that kind of capacity with other partners and on a nondisease-specific basis go in and work with nations where we know there is vulnerabilities and we know there is likely going to be future viruses and pandemics and just use some basic building block work of public health infrastructure where it is lacking.

So I just wanted your thoughts, quickly, on, you know, how we go about doing that work, whether that can be done at the Global

Fund or whether we need to do that kind of work through another entity, the WHO, new authority prompted by congressional action. Your thoughts?

Dr. DYBUL. Thank you, Senator Murphy, and it is an extraordinarily important question, especially right now.

A couple of quick points. From a technical perspective, technical support, WHO plays a critical role. As was mentioned, often the WHO is an extension of the ministries of health in countries.

So they do play a critical role on the technical side, but not on the financing side and so the financing piece is a little bit different.

The Global Fund would have the capacity, certainly, with new money now to scale up support to countries for infrastructure, for procurement, for the pieces that are necessary to respond to COVID right now.

I think for the longer term, it would be an open question where the best international facility is, and we had a little discussion about that a little bit earlier.

I would also point out that, you know, there are different approaches, and we saw this, right. Taiwan had a relatively low-tech approach versus South Korea's relatively high-tech approach.

Because of the investments the U.S. and others have made in HIV, TB, malaria vaccination, maternal and child health, South Africa has fielded 28,000 community health workers to go out and do contact tracing. Sierra Leone has 9,000.

In the Ebola crisis, it was those workers that went around, that were repurposed, in a sense, from what had gone into the institution building.

But we absolutely need more laboratory capacity. We need more structure, and this is where the complementary opportunities for CDC and which does this all the time, and GHSA, USAID, bilaterally but then multilaterally.

Without a financing institution to complement the technical institutions, we will not be able to get there, and I believe—and I am a little biased, having run the Global Fund, but I also ran PEPFAR so I have both perspectives—they could do—they could absorb money now while the conversation is going on for what it would do for the future.

Senator MURPHY. Thank you, Mr. Chairman. I appreciate the time.

The CHAIRMAN. Thank you, Senator Murphy.

That pretty much runs us out of time.

But, Senator Menendez, did you want to—first of all, let me thank the panelists. This has been an incredibly frank and good-faith honest broker exchange of ideas, and we really appreciate that.

On behalf of the committee, I want to thank each and every one of you for spending—

Senator Menendez, did you want to add anything—

Senator MENENDEZ. Mr. Chairman, with your indulgence, if I could ask Mr. Konyndyk one quick question just so I could—

The CHAIRMAN. Sure.

Senator MENENDEZ. —devise responses to what you are trying to do, and then with my thanks to everybody because it has been—

I echo the chairman's remarks—been extraordinarily helpful and insightful.

Mr. Konyndyk, you mentioned in your testimony that your team at USAID and the counterparts at CDC define each agency's roles clearly at the outset of the response to the Ebola outbreak in West Africa based on each institution's respective comparative advantages.

A provision that we have in the legislation that we drafted clearly spells out the roles of State, USAID, and CDC in the pandemic response.

Is such a provision useful, in your view, and if so, why? And, secondly, another provision creates a special advisor at the White House rather than the State Department.

What is your view on having a coordination function at the White House?

Mr. KONYNDYK. Thank you, Senator. I will be very brief.

I would say that defining—

Senator MENENDEZ. Unmute yourself because I cannot hear you.

Mr. KONYNDYK. How about now? Are you able to hear me now?

The CHAIRMAN. This is Jim Risch. I can hear you. Go ahead.

Mr. KONYNDYK. Okay. I will try this again.

So I think that it is not just helpful, I think it is essential to define each agency's comparative advantages up front and I think the provision in your bill is—you know, it is on the right path there.

You know, when it is clear what each agency is supposed to do there is far less to fight over. There is far less turf battling that I saw during the Ebola outbreak.

On the—on the White House piece, I would not say that you need the White House coordinating instead of the State Department. I think, you know, one of the helpful things with the counter-ISIL model was the—it was a sort of partnership.

I spoke earlier this week with Brett McGurk, who served in the envoy role, just to pick his brain a little bit on how that worked in preparing for this hearing.

You know, and he talked about the partnership he had in his team with the NSC, because the NSC has coordination leverage that, frankly, the State Department just does not have vis-à-vis other agencies.

So I think that you need both. I think a coordinator based at the State Department synced with a restored global health security director and an empowered senior director at the White House is probably the best structure.

Senator MENENDEZ. Well, thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Menendez, and again, thank you to our panel. I think we have all learned a lot that is going to help us move the ball down the field and try to get to a place that will make the world a better place and America a better place.

Thank you all, and with that, the hearing is adjourned.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

RESPONSES OF THE HONORABLE MARK DYBUL, M.D. TO QUESTIONS
SUBMITTED BY SENATOR ROBERT MENEDEZ

THE U.S. INTERNATIONAL RESPONSE

On June 7, The New York Times published an article which revealed weeks of delays in getting emergency funding appropriated in the CARES Act to fund our international response out the door to our partners. Implementing partners themselves report waiting up to 10 weeks as opposed to our usual 3 and a half weeks. And more than \$200 million in COVID aid is being spent on ventilators for countries handpicked by the President with little to no examination as to whether this was the best use of funds, and whether countries have the facilities and medical personnel to put the ventilators to use.

Question. Did these types of funding delays happen while you were in government? To your knowledge, what accounts for the current delays in pushing funding out the door?

Answer. There can be delays following appropriation of funds even when the executive functions are fully staffed. COVID itself could be slowing use of funds.

Question. Based on your knowledge of the capacity constraints of healthcare systems in developing countries, would healthcare facilities serving rural or underserved communities in a given develop country have the technical capacity or medical staff to safely and successfully employ a ventilator?

Answer. Rural communities would not likely be able to manage ventilators. However, this is true for many more advanced services, e.g. c-sections, drugs needed to treat women during complications during pregnancy, PCR for HIV or drug resistant TB, etc. For this reason, health services in low income settings—including in the U.S.A.—are designed with a “hub and spoke” approach. Several countries in Africa have fewer than 10 ventilators. There is no question they are desperately needed. However, many other less expensive commodities and services are also needed. Oxygen, which can save many lives and prevent progression requiring ventilators, is relatively inexpensive and can be provided in many settings. It is important to prioritize in a pandemic crisis and to ensure that countries with the highest risk of an explosive epidemic and most in need rapidly receive support for commodities and services, e.g. support for testing, contact tracing and quarantine. In addition, there has been a long standing, bipartisan agreement that politics and political issues should not come into play for humanitarian relief.

Question. Is the expenditure of more than \$200 million on a few thousand ventilators for a select set of countries the best investment for protecting the most lives and preventing the spread of COVID-19?

Answer. As noted above, ventilators are definitely needed. As are many other commodities and services. The prices per unit of a ventilator, and any other commodity or service, should, of course, be reasonable and within standards and procurement procedures.

Question. What assurances on equitable access to care, when it comes to U.S. supported response activities, should USAID seek from host country governments?

Answer. In general, because much of the programming by USG bilateral funding, and in particular USAID funding, is performed through implementing organizations, e.g. non-governmental organizations (NGOs), the USG can directly set standards and requirements for equity, including where and to whom services should be provided. International organizations, e.g. the U.N. family, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), Gavi (the Vaccine Alliance) have strong equity provisions as part of their mission. Regarding direct support to governments, the U.S. is often successful at negotiating agreement on funding to ensure equity consistent with national priorities and plans. CDC works closely with ministries of health around the world and is a trusted partner and source of technical support welcomed by countries. CDC also plays an important role in ensuring equitable access to care.

It is important that U.S. support through NGOs and international organizations also fit within national priorities and plans wherever feasible.

Question. What else should we be doing to help end the pandemic—are there programs and activities that the Administration should be funding that it currently is not?

Answer. The legislation introduced by the Chairman with his bipartisan co-sponsors and the Ranking member advance the two areas that require coordination and funding—better coordination for U.S. bilateral support and for international efforts. The Administration seems to have similar approaches. The Center for Strategic and International Studies Commission on Strengthening America’s Global Health Security, for which Ambassador Kolker and I serve as Commissioners, issued an important report with additional recommendations which can be accessed at: <https://healthsecurity.csis.org/final-report/>.

More specifically, an effective pandemic response requires coordinated and effective efforts to: 1) control spread, including testing, tracing and quarantine and implementation of social distancing and masks, and; 2) care and treatment for those who progress with symptoms. Both control and care and treatment requires trained personnel and varying degrees of personal protective equipment. In addition, because it is likely that the pandemic will continue, potentially with a second large wave beginning between August and October, it is important for the U.S. to support efforts to understand the global movement of the virus and genetic drift so that we, and the rest of the world can be better prepared for the future. For a more complete analysis, please see the White Paper published by Georgetown University: <https://gumc.georgetown.edu/covid-19-a-global-pandemic-demands-a-global-response/>

GLOBAL REACH OF THE WHO

The WHO has been on the frontlines of nearly every global health challenge over the past 70 years, combatting, containing, and eradicating some of the planet’s most deadly diseases. The WHO serves as both a repository of global expertise as well as a critical implementation partner for local health ministries and organizations on the ground. In many places with weak health systems, the WHO’s role is indispensable in ensuring the delivery of adequate health services and responses.

Question. From your perspective, what makes the WHO a critical, or even indispensable, partner?

Answer. There is remarkably wide agreement on the indispensable role of WHO in pandemic preparedness, detection and response. Many have come together to summarize the key strategic values of WHO as summarized below:

Preeminent Technical Guidance—With a presence in over 150 countries and the trust of governments around the world, WHO is uniquely positioned to both collect new evidence emerging from anywhere in the world and use it to develop, refine and disseminate technical and normative guidance essential to battling COVID–19.

Global Clinical Trials—WHO is the only agency in the world capable of coordinating unprecedented global trials on therapeutics and vaccines, including the groundbreaking scope of the “Solidarity Trial (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/global-research-on-novel-coronavirus-2019-ncov/solidarity-clinical-trial-for-covid-19-treatments>),” with more than 100 countries participating. As important, the Solidarity trial will reduce the amount of time it normally takes for a drug trial to determine effectiveness by 80%.

Communication—WHO is the only organization with the technical expertise and capacity, global membership, credibility, access and—most important of all—trust, to launch pandemic awareness campaigns throughout the world. Billions of people have access to WHO’s evidence-based information in dozens of languages.

Distribution—At least 133 countries are relying on WHO to globally procure millions of pieces of personal protective equipment (PPE) and other vital health commodities like tests and testing supplies, including more than 4.5 million items of vital PPE.

Equity and Access—Only WHO is working to pre-position manufacturing capacity and distribution channels to ensure countries will have access to COVID–19 vaccines and treatments as quickly as possible and at a fair price.

Developing world engagement—The WHO has a particularly important role to play in helping poorer countries fight COVID–19. Out-of-control outbreaks in the developing world will threaten the United States and could spark second waves of disease.

Question. What challenges do we face in responding to a global pandemic without the WHO as a partner?

Answer. The challenges would be insurmountable given the key roles WHO plays, and must play, as noted in the previous question. In addition, the risk to the world—and the U.S.—for future pandemic preparedness and response would be significant.

Every agency can always do better, and no doubt mistakes have been made by WHO and every organization involved in COVID–19. However, overall the WHO has

done a very good job in challenging circumstances. Action was taken from January 1 onward. And WHO has significantly improved under the leadership of the Director General, who was elected on a reform platform. The responses to the recent Ebola outbreak in the Democratic Republic of Congo and to COVID-19 have been substantially better than the response to the Ebola epidemic in West Africa several years ago.

Question. What barriers will the United States face in trying to set up an effective alternative to the WHO?

Answer. There is no effective alternative to WHO as a global normative, guidance, technical agency. No other organization would have the credibility, access, network of country offices or authority needed.

I have not seen any proposals by the Administration to establish an alternative, perhaps understanding that any attempt to create an alternative would be technically and politically impossible. However, WHO is not ordinarily an implementing or financing agency (In unusual circumstances it can fill a vacuum, for example during Ebola Congo when it got too dangerous and the NGO's left Butembo). Those key pieces must be established as discussed in the hearing and as noted in the legislation put forward.

INTERNATIONAL COOPERATION

In addition to efforts to combat COVID-19 at the WHO, there have been a number of other international efforts to combat the virus, including the European Commission's Coronavirus Global Response Summit on vaccines, which the United States conspicuously did not join. In fact, since the start of the pandemic the United States has failed to lead the international efforts to respond. We blocked consensus on a statement from the Security Council, and from the G7 by insisting on using divisive racially inflammatory rhetoric to describe the infection. The President himself used offensive terms to describe the disease at a political rally in Tulsa.

Question. What kind of international engagement is necessary for the United States to be best prepared to combat COVID-19?

Answer. As discussed at the hearing, and addressed in proposed legislation and, it seems, being considered by the Administration, a coordinated U.S. Government bilateral effort combined with a global fire department—a multi-sectoral global Task Force or Emergency Operations Center—and a separate financing agency (the fire hydrant) are needed. The U.S. has been the unquestioned leader in global health with strong bipartisan support for two decades. It is important that the U.S. play a strong leadership role again.

For more detail, please refer to the White Paper released by Georgetown University: <https://gumc.georgetown.edu/covid-19-a-global-pandemic-demands-a-global-response/>.

Question. How can we use our international relationships to improve the situation for U.S. citizens as well as our partners?

[No Response Received]

WESTERN HEMISPHERE

Over the past few months, there have been multiple reports documenting that the Trump administration has deported dozens of Guatemalan, Mexican, and Haitian nationals who tested positive for COVID-19 upon arrival in their home countries. Just this week, it was reported that despite an agreement to deport only those with medical certificates showing a negative test, Guatemalan authorities say that at least 28 deportees have tested positive since early May. Thirteen of my colleagues and I sent a letter to the State Department and Department of Homeland Security highlighting this very issue, though we have yet to receive a response. This question is for any of our panelists:

Question. How, in your view, does deporting COVID-19 positive individuals to countries with weak or limited health system capacity affect our strategic interests in the hemisphere?

Answer. The most sound scientific and medical approach is to quarantine and care for and treat anyone who is positive for SARS-CoV-2, and to conduct rigorous contact tracing and testing related to the sentinel person. Deportation of someone who is actively positive for the virus risks further spread in the region and damages our reputation.

Question. What policy approach would you recommend regarding removals during a pandemic? How have U.S. Government policies relating to deportation addressed previous epidemics, such as the Ebola crisis?

Answer. There is no scientific or medical basis for deportations of any kind.

Question. What is the scientific or medical evidence supporting the Trump administration's closure of U.S. borders to asylum seekers, but not other "essential" travelers such as truck drivers and family members?

Answer. There is no scientific or medical basis for such a restriction.

IMPACT ON OTHER GLOBAL HEALTH PRIORITIES

A study published in 2016 by Yale University researchers found that there may have been as many deaths from HIV/AIDS, TB and Malaria during the 2014/2015 Ebola outbreak in Guinea, Liberia and Sierra Leone as there were from Ebola because the health systems in those countries were overwhelmed, limiting access to health services. Recent reports indicate that as the COVID-19 pandemic continues, there has been a rise in the number of illnesses from preventable illnesses including polio, cholera and diphtheria. This question is for any of our panelists:

Question. What should we be doing to prevent the disruption of health services, including service for those affected by HIV/AIDS, TB and Malaria?

Answer. The reality is that until there is pandemic control, other health services will suffer. As during the Ebola crisis, pandemics can lead to significant disruptions to health services including HIV, TB and malaria, vaccinations, etc. There is fear among health providers and those at risk, leading to decreased availability of health services. There are reports of 70 percent declines in, for example, identification of new cases of tuberculosis. Because virtually every country has been effected by COVID-19, it has also been reported that COVID-19 could wipe out the significant gains the world has made against the HIV, TB and malaria pandemics, with strong leadership and bipartisan support of the U.S.

However, it is also important that the U.S. do what she can to minimize the collateral damage by supporting bilateral and multilateral organizations and efforts to ensure as many HIV, tuberculosis and malaria services are provided, including through PEPFAR, PMI, other health programs supported by USAID, the Global Fund to Fight HIV, Tuberculosis and Malaria, Stop TB, Roll Back Malaria, Gavi, and importantly, as noted above, WHO.

The most important and effective approach the U.S. can take is lead global efforts to control the global pandemic and to lead in preparing for the next one. With population growth, changes in climate and temperature patterns, and increased proximity to animals, another pandemic in the near- to mid-term is highly likely.

Question. Should the U.S., provide funding for the Global Fund to Fight AIDS Tuberculosis and Malaria's COVID-19 mechanism?

Answer. Yes. The Global Fund consistently receives high marks for results, transparency and accountability. It has the capacity and mechanisms to rapidly support national responses including procurement and supply chain, laboratory and human capacity, data collection and analysis and other key aspects of efforts to control the pandemic and provide care and treatment to those who become infected. It also can support countries to maintain and even strengthen their HIV, tuberculosis and malaria responses, helping to protect massive and highly successful U.S. investments over the past two decades. In that regard, during the West African Ebola epidemic, the Global Fund supported a community-led national malaria bed net campaign in Liberia and, with WHO leading the normative, guidance and technical aspects, the presumptive treatment of malaria at the height of the epidemic.

RESPONSES OF THE HONORABLE JIMMY J. KOLKER TO QUESTIONS SUBMITTED BY SENATOR ROBERT MENENDEZ

THE U.S. INTERNATIONAL RESPONSE

On June 7, The New York Times published an article which revealed weeks of delays in getting emergency funding appropriated in the CARES Act to fund our international response out the door to our partners. Implementing partners themselves report waiting up to 10 weeks as opposed to our usual 3 and a half weeks. And more than \$200 million in COVID aid is being spent on ventilators for countries handpicked by the President with little to no examination as to whether this was the best use of funds, and whether countries have the facilities and medical personnel to put the ventilators to use.

Question. Did these types of funding delays happen while you were in government? To your knowledge, what accounts for the current delays in pushing funding out the door?

Answer. The June 7 NYT article refers mostly to USAID, where I did not personally work, and, needless to say, every crisis and every appropriation has some unique features which make comparison difficult. I nonetheless understand the frustration that urgently needed funds are not getting to their intended beneficiaries.

In the current case, the differences include that we are facing the same public health crisis at home as other countries are experiencing, that most U.S. government employees and most NGO partner staff are working from home, that embassies overseas are working with reduced staff, including the local staff who are essential in the response, and that the demands are truly global, not centered on one country or region, thus requiring more clearances and trade-offs in setting priorities. Each of these factors probably resulted in some delays in moving funds to many overseas partners and American implementers working overseas.

In addition, I have a concern, maybe specific to my time as ambassador and with HHS, when I hear “pushing funds out the door.” The emergency supplemental Ebola funds, that were appropriated for a 5 year period, are an example. USAID was able to obligate a large percentage of those funds during the first weeks and months because 1) OFDA has lots of “notwithstanding” authority which CDC, for instance, does not have, and 2) USAID works primarily through grants and contracts, where all of the money is “obligated” and thus “out the door” up front, but expenditure and implementation may not start immediately and is phased over many months or years. HHS, by contrast, does most of its work through USG employees. The salaries and expenses of these people cannot be sent “out the door” all at once, but we had a very accurate idea of what the multi-year costs would be. and this was in a clear multi-year budget. However, when Congress (and some in the Administration) looked at 2014 Ebola emergency funds as a source for reducing the Administration’s request for Zika funds in 2016, the USAID 5-year money was mostly “spent” while the HHS money was deemed “unspent” even though progress on actual programs in the field was comparable.

That said, the groups quoted in the article, Catholic Relief Services and International Rescue Committee, are essential partners and responsible actors in emergency situations. If they experienced procedures, timetables or motivations different from the imperfect systems we had in past USG administrations for “moving money out the door,” the comparison is instructive—and disappointing if harmful to getting results.

Question. Is the expenditure of more than \$200 million on a few thousand ventilators for a select set of countries the best investment for protecting the most lives and preventing the spread of COVID-19?

Answer. Not in my opinion.

It is hard to recognize any public health strategy, needs assessment or realistic logistics plan in selection of partner countries and ventilator destinations within those countries. Equipment that can only be used in tertiary hospitals with specialist medical supervision raises questions of access for the poorest, most vulnerable and the greatest numbers, who rightly are the target beneficiaries of most U.S. global health programs.

Question. What assurances on equitable access to care, when it comes to U.S. supported response activities, should USAID seek from host country governments?

Answer. Such assurances, naturally, depend on the circumstances, partner and resources provided. My experience is that we sometimes worked through non-government, including faith-based, organizations or multilaterals, such as UNICEF or UNHCR, because they could reach target populations more directly than governments could, so the analysis needs to extend beyond host country government “assurances.”

Nonetheless, with the novel coronavirus affecting everyone, everywhere, serious thought at all levels of government and among non-government actors to allocation of supplies, access to prevention, testing and treatment and to disparities is essential. We in the U.S. are in a precarious position to make demands on others because our domestic response has been so weak in this area. Tellingly, the indicator for access to care and treatment in the 2019 Global Health Security Index for the United States was 23 out of 100, a poorer score than many African countries. The consequence has been dramatic racial, ethnic, income and social disparities in our own outbreak and the outcomes for patients.

The message both at home and abroad needs to be: collect the data on who has access and who does not, look at what it tells you; address inequities and keep in

mind that social determinants of health are not abstract. They determine how well the health system can respond. This is a role the World Health Organization often plays well in countries. We might not need to do this work bilaterally if we cooperate with the WHO to see that it is done.

Question. What else should we be doing to help end the pandemic—are there programs and activities that the Administration should be funding that it currently is not?

Answer. As Jeremy Konyndyk said in the hearing, we are recommending that others around the world listen to experts whose advice we are not following at home. Paying closer attention to the science and scientists in our response at home will help end the pandemic.

We should contribute to the Coalition for Epidemic Preparedness Innovation and look at setting some better guidelines for public benefits in terms of cost, availability or other benefit from USG investment in research which leads to blockbuster drug development by private sector firms which develop, patent, manufacture and market these discoveries.

I also support Senator Udall's effort to fund Covid-relevant activities through the U.S.-Mexico Border Health Commission. The Administration has discontinued using discretionary funds to support the border areas' health needs.

GLOBAL REACH OF THE WHO

The WHO has been on the frontlines of nearly every global health challenge over the past 70 years, combatting, containing, and eradicating some of the planet's most deadly diseases. The WHO serves as both a repository of global expertise as well as a critical implementation partner for local health ministries and organizations on the ground. In many places with weak health systems, the WHO's role is indispensable in ensuring the delivery of adequate health services and responses.

Question. From your perspective, what makes the WHO a critical, or even indispensable, partner?

Answer. It is the pre-eminent global health normative and consultative agency, with a broad mandate and near universal membership. It has been effective in getting countries to work together on priorities (smallpox, polio, childhood immunization) and has helped the United States leverage our resources, expertise and soft power to make health a priority and to base interventions on evidence.

WHO processes are cumbersome, its budget far below what is needed to cover its responsibilities and its structure, antiquated. But these are solvable problems, and considerable progress was made 2015–16 improving processes that proved problematic in the Ebola response.

WHO's was the first specialized agency of the United Nations and the premier example of how the U.S. helped create a rules-based, science-based order for addressing trans-national problems. That should remain the cornerstone of our international engagement, even as the structures of WHO are updated and the funding increased to meet 21st century challenges, including health issues far beyond infectious diseases.

Question. What challenges do we face in responding to a global pandemic without the WHO as a partner?

Answer. There are many, but I will highlight three.

The biggest challenge in my view is that we are not working with WHO and the broad international community that it convened to consider equitable access to and allocation of vaccines, treatments and cures for COVID-19 that are under development.

The U.S. public and private sector systems for research do not align with the WHO's focus on global health equity priorities. Market forces can be at odds with WHO's desire to assure vaccine and treatment affordability for low and middle income countries. In the past, the U.S. has taken a "problem-solving" approach to discussing these situations and working together to share information, define roles and reach accommodations, so that divergent interests are recognized, even if never fully satisfied.

By boycotting the WHO meeting that set up the Access to Coronavirus Tools (ACT) Accelerator and the subsequent European Commission and UK-led conference to collaborate on practical solutions, we missed the chance to have our priorities taken into account as well as to benefit from the conclusions reached for vaccine deployment. If the U.S. is the first to develop a safe and effective vaccine, our monopolization of the supply will be seen as illegitimate by other nations. If we are not

the first, we will have reduced leverage to meet our domestic needs equitably, as we were not at the table.

Second, experts from the U.S. have always in the past been included in WHO panels and delegations, reviewing public health emergency responses, gathering key data or recommending remedial actions. Not being included in these groups will inhibit our ability to gather and analyze the data, bring our perspective to the discussion and influence the recommendations. An example is the expert group that will go to China to review their handling of the novel coronavirus outbreak. The WHO has the authority to organize the delegation and report on results. This knowledge is important, but we may be getting it second-hand.

Third and related, is that there are many collaborative activities, such as development of a seasonal flu vaccine (cited by Senator Booker in the hearing) that are jointly convened and acted upon by the WHO and by, in this case, the U.S. CDC. Relinquishing our role as co-convenor and lead vaccine developer may severely handicap our deploying the most effective possible flu vaccine at exactly the time the dual threat of seasonal flu and COVID-19 may have the most devastating effect on our population and health systems.

Question. What barriers will the United States face in trying to set up an effective alternative to the WHO?

Answer. We have a lot of allies wanting to improve the World Health Organization. We have no allies on abandoning it. There is no support by other major countries for an alternative to WHO, although it is clear to all that WHO alone is not adequate to address the world's response to a pandemic, given its social, economic and political facets.

As we look at existing and potentially new structures that can add value and impact to the domestic and international capacity, it is essential that these be seen as supplements to or reinforcing WHO, not as alternatives. Numerous studies looking into WHO's weaknesses and missteps, for instance in the initial Ebola response, all concluded that there is no multilateral alternative that could assume or duplicate the WHO's mandate, reach and embedded collaborations. Their conclusion, which I think is even more pertinent today, is that trying to create a global health structure as a replacement for WHO would be politically impossible to negotiate. It is especially important to recognize that any alternative proposed unilaterally by the U.S. Government has no chance of winning wide support.

I advocated in my testimony for a review conference or revision meeting to update the International Health Regulations. I think this would be the best place to start if we are looking for more effective multilateral platforms for dealing with outbreaks, epidemics and member state obligations when they occur. Any new or improved arrangements would also depend on robust and sustainable financing, with the U.S. government as a core guarantor.

INTERNATIONAL COOPERATION

In addition to efforts to combat COVID-19 at the WHO, there have been a number of other international efforts to combat the virus, including the European Commission's Coronavirus Global Response Summit on vaccines, which the United States conspicuously did not join. In fact, since the start of the pandemic the United States has failed to lead the international efforts to respond. We blocked consensus on a statement from the Security Council, and from the G7 by insisting on using divisive racially inflammatory rhetoric to describe the infection. The President himself used offensive terms to describe the disease at a political rally in Tulsa.

Question. What kind of international engagement is necessary for the United States to be best prepared to combat COVID-19?

[See response to next question below.]

Question. How can we use our international relationships to improve the situation for U.S. citizens as well as our partners?

Answer. I will reply to the two questions together.

COVID-19 struck first and has had its most widespread consequences in countries with advanced health systems. This reality reinforces my belief that we must approach global health and international health engagement as a technical partner and not as a "donor". I mentioned in a previous reply the importance of U.S. participation in discussions and decisions about vaccine access, and I am in favor of proactive U.S. leadership on health in the U.N. Security Council, G7, G20 and the many other fora that can shape world opinion and national action.

But I also advocated in my testimony a stronger role for the State Department, with a permanent senior coordinator for health security and diplomacy. My foreign

service experience is that we have phenomenal resources in our embassies and missions overseas, which are often under appreciated and underused for health goals.

This is not a suggestion that State should take over health work done by USAID or anyone else. It is a recognition that traditional diplomatic skills and attention can greatly expand our influence and ability to deal with health challenges. We have underappreciated the value of health and scientific partnerships as a priority in bilateral relations as well as multilateral. Our ambassadors and embassy teams can gather information, alert our own and foreign governments to health conditions and needs, find counterparts in civil society, academia and the private sector, recognize best practices and build coalitions to respond, nationally, regionally and globally.

It was of course important to address the needs of American citizens in our initial coronavirus response activity around the world, But as we devoted priority embassy resources to evacuations of American employees and their families and of private citizens, I don't believe we paid enough attention to the diplomatic priority Coronavirus had become and remains. In China, for example, the health attache and all American FDA and NIH staff were evacuated. Shouldn't these have been considered essential, even "emergency" employees to protect our national security? Where was the Office of Global Health Diplomacy in instructing embassies, analyzing information and leading the diplomatic response to coronavirus? Lodging this Office within the Office of the Global AIDS Coordinator has severely limited its responsibility and potential influence.

Furthermore, cutbacks in funding and staff required CDC and, to a lesser extent, USAID, to cut back health security staff and programs in partner countries. This now seems very short-sighted, and we need to look holistically at health diplomacy as a component of U.S. interests in most countries around the world and reinforce both traditional diplomacy and soft-power expeditionary diplomacy to promote and protect those interests.

WESTERN HEMISPHERE

Over the past few months, there have been multiple reports documenting that the Trump administration has deported dozens of Guatemalan, Mexican, and Haitian nationals who tested positive for COVID-19 upon arrival in their home countries. Just this week, it was reported that despite an agreement to deport only those with medical certificates showing a negative test, Guatemalan authorities say that at least 28 deportees have tested positive since early May. Thirteen of my colleagues and I sent a letter to the State Department and Department of Homeland Security highlighting this very issue, though we have yet to receive a response. This question is for any of our panelists:

Question. How, in your view, does deporting COVID-19 positive individuals to countries with weak or limited health system capacity affect our strategic interests in the hemisphere?

Answer. Any non-emergency, non-therapeutic transport of people who have an active contagious disease is a questionable public health practice and almost inevitably a source of tension between sending and receiving countries. Even if the deportation legality and mechanisms are established and mutually agreed (which may or may not be the case here), these need to be re-examined in the current circumstances of high U.S. infection levels and many international travel restrictions.

Question. What policy approach would you recommend regarding removals during a pandemic? How have U.S. government policies relating to deportation addressed previous epidemics, such as the Ebola crisis?

Answer. The precedents of the Ebola crisis are not very relevant because travelers from the affected countries could not reach the U.S. overland, and the transmissibility of the pathogen was different. To my knowledge, there were no Ebola-specific deportations or instances of individuals who contracted Ebola in or en route to the U.S. who were deported, nor any deportations to the three West African countries during the Ebola epidemic. (We strongly advised Nigeria not to put the arriving Ebola-stricken Liberian airline passenger back on a flight to Liberia, which was their original intention). The system of screening passengers for fever and visible symptoms at airports of departure in Liberia, Sierra Leone and Guinea and then monitoring arrivals through state health department check-ins when they reached the U.S. worked well—better, in fact, than we had anticipated within the Administration.

Question. What is the scientific or medical evidence supporting the Trump administration's closure of U.S. borders to asylum seekers, but not other "essential" travelers such as truck drivers and family members?

[No Response Received]

IMPACT ON OTHER GLOBAL HEALTH PRIORITIES

A study published in 2016 by Yale University researchers found that there may have been as many deaths from HIV/AIDS, TB and Malaria during the 2014/2015 Ebola outbreak in Guinea, Liberia and Sierra Leone as there were from Ebola because the health systems in those countries were overwhelmed, limiting access to health services. Recent reports indicate that as the COVID-19 pandemic continues, there has been a rise in the number of illnesses from preventable illnesses including polio, cholera and diphtheria. This question is for any of our panelists:

Question. What should we be doing to prevent the disruption of health services, including service for those affected by HIV/AIDS, TB and Malaria?

Answer. One of the advantages of the standing, funding and track record of the U.S. PEPFAR program and the Global Fund to Fight AIDS, TB and Malaria is that we have resources and partnerships that can be and are being directed to this priority.

U.S. leadership, through financial commitment, consultation with front-line partners and UNAIDS and WHO guidance and policies, can contribute substantially to keeping these diseases on governments' and communities' agendas and assuring the supply chain and health facility capacity to minimize disruptions due to COVID-19. The AIDS 2020 conference this month provided a broad platform for innovative ideas toward this goal.

The increase in illness and death due to other causes while West African states were fighting Ebola in 2014-15 is well documented, but it is not evident that we learned the necessary lessons. It was because of the Ebola outbreak that I recognized the success of Last Mile Health, an organization supporting community health workers in some parts of Liberia, which uniformly had better Ebola and non-Ebola health outcomes than the rest of the country. That model is being used in Liberia and some nations now to maintain routine health services, and should be expanded. [Disclaimer: I am a member of the Last Mile Health Advisory Board].

Question. Should the U.S., provide funding for the Global Fund to Fight AIDS Tuberculosis and Malaria's COVID-19 mechanism?

Answer. Yes.

THE COMMITTEE RECEIVED NO RESPONSE FROM DR. ASHISH K. JHA, M.D. FOR THE FOLLOWING QUESTIONS BY SENATOR ROBERT MENENDEZ

THE U.S. INTERNATIONAL RESPONSE

On June 7, The New York Times published an article which revealed weeks of delays in getting emergency funding appropriated in the CARES Act to fund our international response out the door to our partners. Implementing partners themselves report waiting up to 10 weeks as opposed to our usual 3 and a half weeks. And more than \$200 million in COVID aid is being spent on ventilators for countries handpicked by the President with little to no examination as to whether this was the best use of funds, and whether countries have the facilities and medical personnel to put the ventilators to use.

Question. Based on your knowledge of the capacity constraints of healthcare systems in developing countries, would healthcare facilities serving rural or underserved communities in a given develop country have the technical capacity or medical staff to safely and successfully employ a ventilator?

[No Response Received]

Question. Is the expenditure of more than \$200 million on a few thousand ventilators for a select set of countries the best investment for protecting the most lives and preventing the spread of COVID-19?

[No Response Received]

Question. What assurances on equitable access to care, when it comes to U.S. supported response activities, should USAID seek from host country governments?

[No Response Received]

Question. What else should we be doing to help end the pandemic—are there programs and activities that the Administration should be funding that it currently is not?

[No Response Received]

GLOBAL REACH OF THE WHO

The WHO has been on the frontlines of nearly every global health challenge over the past 70 years, combatting, containing, and eradicating some of the planet's most deadly diseases. The WHO serves as both a repository of global expertise as well as a critical implementation partner for local health ministries and organizations on the ground. In many places with weak health systems, the WHO's role is indispensable in ensuring the delivery of adequate health services and responses.

Question. From your perspective, what makes the WHO a critical, or even indispensable, partner?

[No Response Received]

Question. What challenges do we face in responding to a global pandemic without the WHO as a partner?

[No Response Received]

Question. What barriers will the United States face in trying to set up an effective alternative to the WHO?

[No Response Received]

INTERNATIONAL COOPERATION

In addition to efforts to combat COVID-19 at the WHO, there have been a number of other international efforts to combat the virus, including the European Commission's Coronavirus Global Response Summit on vaccines, which the United States conspicuously did not join. In fact, since the start of the pandemic the United States has failed to lead the international efforts to respond. We blocked consensus on a statement from the Security Council, and from the G7 by insisting on using divisive racially inflammatory rhetoric to describe the infection. The President himself used offensive terms to describe the disease at a political rally in Tulsa.

Question. What kind of international engagement is necessary for the United States to be best prepared to combat COVID-19?

[No Response Received]

Question. How can we use our international relationships to improve the situation for U.S. citizens as well as our partners?

[No Response Received]

WESTERN HEMISPHERE

Over the past few months, there have been multiple reports documenting that the Trump administration has deported dozens of Guatemalan, Mexican, and Haitian nationals who tested positive for COVID-19 upon arrival in their home countries. Just this week, it was reported that despite an agreement to deport only those with medical certificates showing a negative test, Guatemalan authorities say that at least 28 deportees have tested positive since early May. Thirteen of my colleagues and I sent a letter to the State Department and Department of Homeland Security highlighting this very issue, though we have yet to receive a response. This question is for any of our panelists:

Question. How, in your view, does deporting COVID-19 positive individuals to countries with weak or limited health system capacity affect our strategic interests in the hemisphere?

[No Response Received]

Question. What policy approach would you recommend regarding removals during a pandemic? How have U.S. government policies relating to deportation addressed previous epidemics, such as the Ebola crisis?

[No Response Received]

Question. What is the scientific or medical evidence supporting the Trump administration's closure of U.S. borders to asylum seekers, but not other "essential" travelers such as truck drivers and family members?

[No Response Received]

IMPACT ON OTHER GLOBAL HEALTH PRIORITIES

A study published in 2016 by Yale University researchers found that there may have been as many deaths from HIV/AIDS, TB and Malaria during the 2014/2015 Ebola outbreak in Guinea, Liberia and Sierra Leone as there were from Ebola because the health systems in those countries were overwhelmed, limiting access to health services. Recent reports indicate that as the COVID-19 pandemic continues, there has been a rise in the number of illnesses from preventable illnesses including polio, cholera and diphtheria. This question is for any of our panelists:

Question. What should we be doing to prevent the disruption of health services, including service for those affected by HIV/AIDS, TB and Malaria?

[No Response Received]

Question. Should the U.S., provide funding for the Global Fund to Fight AIDS Tuberculosis and Malaria's COVID-19 mechanism?

[No Response Received]

 RESPONSES OF JEREMY KONYNDYK TO QUESTIONS
 SUBMITTED BY SENATOR ROBERT MENENDEZ

STATE USAID REORGANIZATION

Question. How will doing taking budgetary authority and programs from USAID and moving them to State Department impact development outcomes in global health? Will doing so at all assist with health systems strengthening?

Answer. I have grave reservations about shifting program and budget authority from USAID (and potentially CDC) into the State Department. As I noted in my testimony, the State Department does have an important role in promoting global health security and pandemic preparedness, but it is mainly centered on diplomatic engagement to mobilized aligned global action around these issues. That is quite different from asserting State as the overall lead for the initiative; a role that would require greater subject matter expertise at the institutional level than the State Department possesses.

I fear that this approach would increase friction between State, USAID, and CDC, thus weakening programs and undermining health security outcomes. It would also be inimical to health system strengthening, which would be better supported by keeping these programs housed at USAID and CDC, both of which support broader health system interventions. Shifting pandemic authorities to State would turn those into more of a vertical intervention (similar to the PEPFAR model) that can be narrowly useful toward a specific disease or threat but will struggle to align with horizontal system strengthening interventions. A vertical structure would be, in my view, a poor design for this initiative because pandemic preparedness is inherently cross-cutting—it touches on many different structures and capacities across a government, health system, and society.

THE U.S. INTERNATIONAL RESPONSE

On June 7, The New York Times published an article which revealed weeks of delays in getting emergency funding appropriated in the CARES Act to fund our international response out the door to our partners. Implementing partners themselves report waiting up to 10 weeks as opposed to our usual 3 and a half weeks. And more than \$200 million in COVID aid is being spent on ventilators for countries handpicked by the President with little to no examination as to whether this was the best use of funds, and whether countries have the facilities and medical personnel to put the ventilators to use.

Question. Did these types of funding delays happen while you were at USAID? To your knowledge, what accounts for the current delays in pushing funding out the door?

Answer. These kinds of delays in funding emergency appropriations did not happen during my tenure at USAID. In fact, during the 2014 Ebola outbreak, we did nearly the inverse of what the Trump administration has done on COVID. We felt an extreme sense of urgency to roll out programs and interventions quickly that we began doing so using regular annual appropriation money even before the emergency supplemental funds came through. We knew that waiting to roll out programs until we had a special appropriation would mean letting the outbreak spread exponentially further before we acted. So at the direction of the Administrator, my office spent down nearly the totality of our non-OCO appropriation to cover our cash flow

needs for Ebola even before the supplemental came through. We then used the supplemental funding to backfill our normal budget and to continue extending our Ebola programs.

By the time the Ebola emergency appropriation passed in December 2014, the U.S. government had spent over \$750 million on Ebola efforts, of which 362.8 million had been spent through my team in the USAID Office of U.S. Foreign Disaster Assistance (OFDA).¹ This was roughly 4 months after the deployment of the Disaster Assistance Response Team (DART) and corresponding activation of USAID's Response Management Team (RMT) and Agency Task Force. During the COVID-19 response, USAID activated their agency Task Force in early March and their RMT in mid-March, likewise roughly 4 months ago. Over that period, they have announced public obligations of only \$214 million, of which only \$8 million is through the Disaster Assistance account.² They have announced over \$1 billion in "pledged" funding, with few details provided. Pledged funding typically means funding that remains on the agency's books and has not yet determined a specific intended recipient ("committed") or been disbursed to that recipient (obligated).

I do not have full awareness of the reasons for these delays. However, my understanding both from public report and from conversations with USAID partners is that politicization of PPE funding has been among the major bottlenecks between USAID and the White House. The White House was reportedly very wary of allowing aid partners to use U.S. funds to supply PPE to low-income countries while U.S. hospitals remained under-supplied, and so issued a soft prohibition on such usage of funds. However this made it functionally impossible for partners to move ahead with responsible programs, because PPE is a vital component of such interventions (during my time at USAID I directed my team to develop a USAID PPE reserve stock for situations like this; my understanding is that those reserves were diverted for domestic use).

Question. Is the expenditure of more than \$200 million on a few thousand ventilators for a select set of countries the best investment for protecting the most lives and preventing the spread of COVID-19?

Answer. With respect to ventilator donations, I find a number of puzzling dimensions. It is difficult to assess whether USAID has applied consistent criteria to distributing these because there does not appear to be a publicly stated set of criteria for the selection of countries or the proposed volumes of ventilators to each recipient. Meanwhile, USAID documents (as reported by ProPublica) make explicit that some of these donations to middle and high income countries are being made for political purposes. It is not otherwise clear to me why a wealthy country like Malaysia needs 250 U.S.-donated ventilators.

Question. What assurances on equitable access to care, when it comes to U.S. supported response activities, should USAID seek from host country governments?

Answer. The U.S. should allocate its COVID funding based on an evaluation of the degree of need, and of the gaps in country capacity and preparedness. This should include an analysis of whether U.S. aid and health resources more generally are accessible to the population in an equitable manner. In some countries—such as conflict affected states—this may be particularly difficult, and the U.S. should seek to work through partners that can complement or work around government obstructions, where those may exist.

Question. What else should we be doing to help end the pandemic—are there programs and activities that the Administration should be funding that it currently is not?

Answer. This is a challenging question to answer given how little funding has so far been disbursed. But I would broadly see several priorities for U.S. global aid funding on COVID-19:

- Reinforcing fragile health systems.
- Community engagement, communication, and behavior change.
- Logistics and supplies.
- Macroeconomic support to countries taking major economic hits.
- Safety net and livelihood support at household level.
- Supporting frontline aid and civil society organizations.

GLOBAL REACH OF THE WHO

The WHO has been on the frontlines of nearly every global health challenge over the past 70 years, combatting, containing, and eradicating some of the planet's most

deadly diseases. The WHO serves as both a repository of global expertise as well as a critical implementation partner for local health ministries and organizations on the ground. In many places with weak health systems, the WHO's role is indispensable in ensuring the delivery of adequate health services and responses.

Question. What makes the WHO a critical, or even indispensable, partner?

Answer. The Trump administration's decision to withdraw the United States from the World Health Organization is reckless and entirely unjustified. The Administration's accusations against WHO do not stand up to scrutiny, and certainly do not rise to the level of abandoning the organization as the worst pandemic in a century sweeps around the world and hammers the United States. WHO's handling of the pandemic has not been perfect, but has been more than good enough to provide ample early warning and actionable guidance to countries that were paying attention.

The U.S. withdrawal will have damaging consequences both for the U.S. and the world at large. WHO makes vital contributions to the health of Americans, including through vaccine and therapeutic research and coordinating annual flu vaccines. It advances U.S. interests by countering global health threats like Ebola and cholera, carrying the frontline burden in places like Eastern Congo and Yemen where USG personnel cannot safely operate. It has partnered successfully with the U.S. on global vaccine programs and disease eradication efforts. Global polio eradication, which has for years been a U.S. priority, will be imperiled by this decision, as will numerous other longstanding U.S. health investments. And weakening WHO will also reverberate across the developing world, where health ministries rely heavily on WHO technical guidance. WHO covers these and numerous other functions on a budget that is less than the annual budget of a U.S. hospital system, and just a fraction of the annual spending of the CDC and NIH.

Question. What challenges do we face in responding to a global pandemic without the WHO as a partner?

Answer. Despite the Trump administration's claim that it can easily route WHO funds to other equally capable partners, the reality is that WHO's role is unique and there are no viable substitutes for many of its functions. WHO has the ability to mobilize and deploy large teams of public health experts to any country in the world, usually with the eager consent of the host government. That is a critical capability in a global pandemic, and not one that exists within the NGO community or elsewhere in the U.N. WHO's longstanding relationships with health ministries enable its personnel, in many countries, to function as de facto extensions of the health ministry and play a central role in shaping policy and strategy. Again, there is no other institution in the world that could readily step into such a role—and in any case, those national ministries would continue looking to WHO rather than to a U.S. contractor or non-profit.

Question. What barriers will the United States face in trying to set up an effective alternative to the WHO?

Answer. The best way to rectify weaknesses in WHO and in wider global health governance is by remaining engaged and outlining a constructive vision for reform. Past Administrations have responded to previous outbreaks by doing exactly that: after SARS the Bush administration worked to develop the 2005 International Health Regulations, and after Ebola in West Africa the Obama administration led member states to approve sweeping reform and reorganization of WHO's emergency programs. Withdrawing now, particularly on such specious grounds, will destroy U.S. credibility and diminish U.S. influence over the reforms that will inevitably follow the present outbreak.

Withdrawing will also likely sound a death knell for the emerging U.S. proposals for new global pandemic response mechanisms. It will be hard for other countries to align with U.S. efforts if those efforts serve as an alternative or competitor to WHO. Plainly put, other countries expect WHO to play a central role in any future pandemic architecture, and U.S. efforts will fail if they ignore this reality.

INTERNATIONAL COOPERATION

In addition to efforts to combat COVID-19 at the WHO, there have been a number of other international efforts to combat the virus, including the European Commission's Coronavirus Global Response Summit on vaccines, which the United States conspicuously did not join. In fact, since the start of the pandemic the United States has failed to lead the international efforts to respond. We blocked consensus on a statement from the Security Council, and from the G7 by insisting on using

divisive racially inflammatory rhetoric to describe the infection. The President himself used offensive terms to describe the disease at a political rally in Tulsa.

Question. What kind of international engagement is necessary for the United States to be best prepared to combat COVID-19?

Answer. To fully protect Americans, this virus must be contained both within the United States and well beyond our borders. As every country has learned, travel restrictions are not an effective long-term protection against the virus. And in any case, the U.S. and global economies will suffer greatly if long-term travel disruption remains in effect. The fight against the virus in the U.S. cannot be siloed from the global fight.

A globally engaged U.S. COVID policy should cover multiple dimensions:

- *Leadership and convening:* The absence of U.S. presence and leadership in global fora has been palpable throughout this response. Where past Presidents like Obama and Bush put the U.S. at the forefront of global efforts against threats like Ebola and pandemic influenza, the U.S. has been largely absent under President Trump. It makes it hard for global institutions to function effectively when the U.S. is absent from or opposed to efforts to drive international collaboration on the pandemic.
- *Support to poor and fragile countries:* The impact of COVID-19 on low-income and fragile countries will be devastating and will resonate for years. The U.S. should be helping to organize and lead global support, both financial and technical, to enable low-income countries to fight the virus without jeopardizing decades of development progress.
- *Research collaboration:* The U.S. “Warp Speed” vaccine initiative is prioritizing only 5 vaccine candidates. Meanwhile there are currently more than 140 coronavirus vaccine candidates (see <https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines>) being tracked by WHO. There is no way to predict which of these will first prove effective, nor which will eventually prove most effective. It is strongly in the U.S. interest to spread our bets—pursuing our own vaccine candidates while collaborating with a wide range of other vaccine options, so that we are positioned to benefit from whichever one(s) prove effective. The global vaccine trial partnership—led by WHO—may also prove more effective and efficient in identifying a safe and effective vaccine. A large multi-country, multi-population trial can evaluate a large number of vaccines against a common placebo group, enabling a wide range of candidates to be simultaneously evaluated, increasing the prospects of rapidly identifying a viable vaccine.
- *Supply chain:* U.S. supply chains for items like PPE, pharmaceuticals, and testing supplies all depend on global producers and suppliers. This will likely hold for vaccine production as well. The U.S. will need cooperation on vaccine production—as we’ve seen with PPE, we cannot produce everything that is needed solely within our own borders. The U.S. drug supply chain is heavily dependent on global suppliers, and an antagonistic or uncooperative posture towards other countries could harm U.S. access to needed materials.

Question. How can we use our international relationships to improve the situation for U.S. citizens as well as our partners?

Answer. The United States’ global reputation has taken a heavy hit. Perceptions of American competence have eroded as the U.S. struggles to control the virus as well as other high-income and even middle-income countries. But perceptions of U.S. benevolence have suffered as well. Much of the developing world has encountered the U.S. not as a partner on COVID, but as a competitor. The failure to contain case counts in the U.S., combined with the lack of PPE production capacity domestically and the failure to mandate it under the DPA, put the U.S. in a position of outbidding other nations for global PPE supply. The image of the U.S. pricing developing countries out of the PPE market, while China happily provided PPE donations to those same countries, will not soon be forgotten. The U.S. must begin to rebuild credibility by:

- Controlling our domestic outbreak.
- Providing rapid and effective support to nations being hit hard by COVID.
- Re-engaging in global collaboration around COVID containment, including the joint vaccine initiative.
- Revoking our withdrawal from the World Health Organization.

WESTERN HEMISPHERE

Over the past few months, there have been multiple reports documenting that the Trump administration has deported dozens of Guatemalan, Mexican, and Haitian nationals who tested positive for COVID-19 upon arrival in their home countries. Just this week, it was reported that despite an agreement to deport only those with medical certificates showing a negative test, Guatemalan authorities say that at least 28 deportees have tested positive since early May. Thirteen of my colleagues and I sent a letter to the State Department and Department of Homeland Security highlighting this very issue, though we have yet to receive a response. This question is for any of our panelists:

Question. How, in your view, does deporting COVID-19 positive individuals to countries with weak or limited health system capacity affect our strategic interests in the hemisphere?

Answer. Deporting COVID-positive individuals to countries with weak health systems will place further strain on those systems; a particular concern as the outbreaks in South and Central America worsen.

Question. What policy approach would you recommend regarding removals during a pandemic? How have U.S. government policies relating to deportation addressed previous epidemics, such as the Ebola crisis?

Answer. During the Ebola outbreak in West Africa, the Department of Homeland Security authorized Temporary Protected Status (TPS) for citizens of the three principally affected countries. I believe that a similar measure would be appropriate for COVID, in instances where the individual's home country is suffering a major outbreak of COVID-19 and/or lacks the domestic capacity to appropriately quarantine, isolate, and treat cases of the virus.

Question. What is the scientific or medical evidence supporting the Trump administration's closure of U.S. borders to asylum seekers, but not other "essential" travelers such as truck drivers and family members?

Answer. To my knowledge there are no scientific grounds for considering asylum seekers to pose higher risks of the virus than other categories of migrants or travelers.

FOOD SECURITY

USAID has determine that in addition to the pandemic's exacerbation of economic decline across the developing world, the pandemic also stands to drastically increase food insecurity and risk major backsliding in countries that the U.S. has worked hard and invested significantly to improve food security and agricultural based economic opportunities.

Question. USAID's analysis on food insecurity risks is incredibly important and informative, and USAID has a model food security program in Feed the Future, but in light of the pandemic's compounding effects on food security and nutrition, does USAID have adequate resources to prevent food insecurity backsliding related to the impacts of the pandemic?

Answer. We are still formulating an accurate picture of how the pandemic will affected global food insecurity. I find the projections by FEWSNET to be broadly credible, and consistent with the wider picture of economic damage that the pandemic will cause in the developing world. It is impossible to separate the food insecurity challenge from the wider economic impact, and I believe USAID and other aid donors should be focusing heavily on broad-based livelihoods support to enable vulnerable populations to continue to afford sufficient food. Per FEWSNET, global food supply remains around normal levels, although prices have risen somewhat. The combination of sufficient supply with increased prices and reduced household income is concerning, and would indicate that household cash grants and government safety net programs are likely the best tool to use, rather than provision of in-kind food aid. But without question, substantial further resources—both through USAID and the World Bank—will be needed to avert damaging impacts on food security.

Question. Feed the Future is great, but are there additional programmatic needs and considerations USAID should make as it related to preserving food security in regions, countries and communities hardest hit by the pandemic? Are there modifications that USAID needs to make to its food security programs to address pandemic specific impacts on food security (like, strengthening supply chains)?

Answer. As noted above traditional in-kind food aid programs are not likely to be the most appropriate tool. Instead—somewhat as we have done domestically in the U.S.—aid programs should focus on shoring up livelihood support among vulnerable populations to ensure that they can continue meeting their own needs through market mechanisms.

IMPACT ON OTHER GLOBAL HEALTH PRIORITIES

A study published in 2016 by Yale University researchers found that there may have been as many deaths from HIV/AIDS, TB and Malaria during the 2014/2015 Ebola outbreak in Guinea, Liberia and Sierra Leone as there were from Ebola because the health systems in those countries were overwhelmed, limiting access to health services. Recent reports indicate that as the COVID-19 pandemic continues, there has been a rise in the number of illnesses from preventable illnesses including polio, cholera and diphtheria. This question is for any of our panelists:

Question. What should we be doing to prevent the disruption of health services, including service for those affected by HIV/AIDS, TB and Malaria?

Answer. It will be critically important to ensure that health systems in low-income countries remain solvent, have the technical support that they need, and can provide sufficient protection to their frontline personnel. Most COVID services will be delivered through health ministries and health systems, not through aid organizations. The U.S. should work with the World Bank to ensure that health ministries can access the resources needed to maintain adequate health budgets, and provide top-up funding where needed (the U.S. provided salary support to the Liberian health ministry during the Ebola outbreak, for example). U.S. support to WHO is critical to ensure that health ministries in low-income countries can draw on technical support related to COVID while also managing other health priorities. And U.S. aid funds should prioritize supply of PPE and sanitation support to frontline health facilities, to prevent outbreaks among health personnel and ensure continuity of normal health services.

Question. Should the U.S., provide funding for the Global Fund to Fight AIDS Tuberculosis and Malaria's COVID-19 mechanism?

Answer. The U.S. should consider support to any funding mechanism that demonstrates it can quickly route money to frontline needs.

Notes

¹ <https://www.usaid.gov/sites/default/files/documents/1864/12.10.14%20-%20USG%20West%20Africa%20Ebola%20Outbreak%20Fact%20Sheet%20%2311.pdf>

² https://www.usaid.gov/sites/default/files/documents/1860/05.05.20_-_USAID_COVID-19_Global_Response_Fact_Sheet_2.pdf

