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Chairman Blunt, Ranking Member Murray, members of the subcommittee, thank you for the opportunity to speak with you today, alongside my distinguished colleagues from the Department of Health and Human Services.

Since August 2018, the Democratic Republic of the Congo (DRC) has been facing what is now an unprecedented Ebola outbreak in the country. As of March 6, health officials have recorded 907 confirmed and probable cases, including 569 deaths as a result of the outbreak that continues to spread in North Kivu and Ituri provinces in the eastern part of the country. It is now the second largest recorded outbreak of the disease, eclipsed only by the 2014 West Africa outbreak that resulted in nearly 29,000 cases and killed more than 11,000 people. I know you are interested in the recent attacks on health facilities in areas affected by the outbreak. While I will touch on this later, I want to start by saying that our hearts go out to the people affected by these tragedies. We are tracking the effects of these incidents.

Since the outbreak began, the U.S. Government has been working closely with the Government of the DRC, the World Health Organization (WHO), and other international partners to contain the spread of disease. Bringing an end to this devastating outbreak is a priority for the U.S. Government, not only because we are committed to supporting those affected, but also because effective efforts to contain and end the outbreak can prevent it from reaching the broader region, as well as our borders. This latest outbreak also highlights the importance of the U.S. Government's continued investments in global health security.

This outbreak is not yet contained. In this testimony, I will outline the scale of the DRC Ebola outbreak and some of the challenges facing responders, how USAID is responding, and the critical role USAID plays in global health security and responding to emerging disease threats like Ebola around the world.

Overview of the DRC Ebola Outbreak

The Government of the DRC declared the most recent Ebola outbreak more than seven months ago, in North Kivu Province in eastern DRC. Within a few days, the virus had begun to spread through communities and the first cases were reported in the city of Beni, a hotspot for insecurity in the region. Within two weeks, newly confirmed cases were being reported in neighboring Ituri

Province. By mid-October, increased transmission in hospitals and health facilities led to a spike, and cases in Beni had multiplied, making it the new epicenter of the outbreak. While there has only been one case in Beni since the end of January due to the robust response, this outbreak is still uncontained. It has continued to be transmitted quickly, and has now spread to multiple hotspots throughout both rural and urban parts of North Kivu, including Katwa, a particularly difficult environment facing high community reticence, including physical attacks on health care facilities.

Unlike previous outbreaks in the DRC, this outbreak has spread beyond isolated rural areas to urban areas with more dense populations. With multiple concurrent outbreak hotspots across the region, a robust response is more important than ever, given the high mobility of people within the affected region, as well as the risks associated with spread in both rural and urban areas. But responders face considerable challenges to stopping the disease. First, the virus has spread along a fairly busy regional trade route, making the response more difficult to control. Second, this outbreak is occurring in areas with ongoing civil unrest and fighting between armed groups, leading to access constraints. Violence is contributing to the intermittent suspension or modification of ongoing activities—including those of USAID partners. In late December, at least 36 health facilities were looted or damaged in Ebola-affected Beni, as well as others in Butembo, due to civil unrest immediately following the postponement of elections there. The response has also faced troubling violence with recent attacks on Ebola Treatment Units in Katwa and Butembo. Two attacks in late February forced partners to pull staff out of the immediate area while the incidents were further investigated. Every day health teams are absent for an outbreak area is a lost day of critical response activities, like isolation at a treatment center or contract tracing and surveillance, that can help prevent the disease from spreading further. Attacks like this remind us that we must remain vigilant. Not only do they threaten the response and the brave people working to save lives, they also put the very patients we're trying to help in danger.

Third, the long history of violence and marginalization of the local populations in this area contributes to the deeply rooted distrust of the central government and associated efforts to respond to the outbreak, including of Ebola responders themselves. This widespread distrust has fueled misconceptions about the disease, including beliefs that Ebola was created to wipe out populations, extort money from people, or is a political tool to prevent participation in elections. Aid and medical workers on the frontlines of fighting this outbreak feel the brunt of this distrust. Not only do they face the constant threat of contracting this disease, they face resistance in helping those most at risk.

Separately, the DRC has long faced an ongoing humanitarian crisis, with 4.5 million people displaced. Ongoing violence, restricted humanitarian access, poor infrastructure and a weak health care system, forced recruitment into armed groups, and reduced access to agricultural land

and traditional markets have contributed to the deterioration of humanitarian conditions in the DRC and triggered mass internal displacement and refugee outflows.

To date, the global response to this Ebola outbreak has been relatively well-funded through the generous contributions of the United States Government and other donors. In February, WHO and the Government of DRC issued an updated six-month Strategic Response Plan which outlines resource needs and response strategy. We are working with WHO and partner to implement and secure resources for the strategy.

U.S. Government's Ebola Response

In September, USAID deployed a Disaster Assistance Response Team, or DART, to coordinate the U.S. response to the Ebola outbreak in the DRC. This expert team—comprising disaster and health experts from USAID and the U.S. Centers for Disease Control and Prevention (CDC)—is working tirelessly to identify needs and coordinate activities with partners on the ground. By augmenting ongoing efforts to prevent the spread of disease and by providing aid to help affected communities, this work ensures an efficient and effective U.S. Government response.

The DART, as the lead coordinator of the U.S. Government response in the DRC, knows what to do because we've done this before. From 2014 to 2016, USAID deployed its expert DART to lead the U.S. response to the unprecedented Ebola epidemic in West Africa that killed more than 11,000 people. Our flexible strategy during that response allowed us to respond effectively to the changing conditions, as we learned more about the social aspects of the crisis. For example, when we learned that safe burials were likely to have an important effect in reducing the transmission rate of the virus, we quickly worked with partners to establish and support safe burial teams in every county in Liberia. For the DRC Ebola response, as in our West Africa response, USAID is closely collaborating with our interagency partners like CDC, the Government of the DRC, other donors, the U.N. and international partners, and affected communities to battle this disease.

The DART is working with partners, not only to provide vital assistance, but also overcome some of the key challenges that have made this outbreak difficult to contain. As such, the DART is supporting a multi-pronged approach to: (1) contain the disease and stop the spread of infection; (2) provide medical care to patients and training to medical personnel; (3) support community outreach and behavior change activities that dispel misconceptions about Ebola and inform communities how to prevent and detect the disease; (4) increase the pipeline of supplies to the region for use by front-line responders; and (5) coordinate with international partners.

First, contact tracing activities and case investigations have been hampered because of the security situation and lack of community trust, yet they are critical to contain the disease and stop its spread, so we are helping to train 1,330 community health care workers to conduct

surveillance including contract tracing. We're also supporting efforts to ensure safe and dignified burials for people who have died from Ebola. Infected bodies are highly contagious, but burials are deeply emotional experiences, often rooted in cultural patterns not easily changed just because the death was from Ebola. This has proven challenging during the response, and some burial teams have even been physically attacked, hindering their ability to help families safely bury their dead. Our partners are working with community leaders and within the communities themselves to help encourage safe practices and save lives. One partner has even directly engaged with Butembo town's Catholic bishop, who worked with local priests to promote safe funerals, including advocating testing bodies for Ebola before burial.

Next, we're prioritizing treatment to patients and training of medical personnel. Transmission in health care facilities has continued to be a challenge in this response, so we're working aggressively with CDC and other partners to address it effectively. Specifically, USAID is currently providing vital support to more than 220 health facilities across at least 18 health zones by strengthening infection prevention and control measures, and working to train more than 1,800 community health care workers on best practices in case detection, triage, patient screening, and waste management. Additionally, USAID provides resources to improve disease screening, isolation, and triage; and additional supplies such as durable vinyl mattresses to replace foam mattresses that can potentially spread infection. Among the supplies we've transported to support the response are nearly 53 metric tons of life-saving personal protective equipment from our warehouse in Dubai for use by frontline health workers at more than 100 health facilities who are at greatest risk of contracting the disease. We're also providing enough food to meet the needs of 20,000 survivors, contacts, family members, frontline responders, and individuals in treatment and isolation each month, over the course of six months. This assistance helps people grow or stay healthy, as well as prevents potential contacts or cases from traveling throughout the community to get food.

While all of these efforts are important, it's just as critical that the people in affected communities understand the risks of disease so they, too, can be invested in efforts to prevent it. USAID is helping aid groups gain the trust of affected communities and dispel rumors about the disease by supporting community outreach efforts that improve communication within communities and by working with trusted community leaders. Our partners are working to reach more than 93,300 households—or 560,000 people, including more than 270 community leaders, with key health messages that help raise awareness about Ebola transmission.

None of this is possible without resources on the ground to implement these programs. USAID has an unparalleled capacity to provide the response equipment when it's needed, which is why we are increasing the pipeline of people and supplies to the region. USAID's vital support for logistics operations ensures Ebola responders safely get to the affected region and have the equipment and supplies needed to keep the response moving. USAID worked hand-in-hand with

the Department of State to provide critically needed specialized medical equipment to safely isolate and transport patients affected by the deadly disease at the request of the World Health Organization. After State shipped the critical equipment to the DRC, our team in Kinshasa made sure it made it to WHO quickly.

However, it's not just these activities that make our role in this response unique. USAID works with HHS—specifically CDC—to align and strengthen U.S. Government engagement with key multilateral institutions, such as WHO, in this particular response. We also work alongside other donors to influence the response's overall strategic management, while also encouraging additional donors to step up and contribute to this critical effort. We're applying our longstanding knowledge of the humanitarian system and the operational context to guide international efforts and provide vital support to partners that can implement public health programs to a scale that will help contain this outbreak.

Our DART is charged with coordinating all of these interventions, and with such a critical situation, USAID has deployed some of our most seasoned staff with extensive experience battling Ebola in Africa, as well as working in the DRC. One of our team members is a health expert and an infectious disease physician. A few years ago, she treated patients in West Africa, helping to save lives during the worst Ebola outbreak in history. After watching a mother lose her only child to Ebola in Liberia, she has dedicated her career to ensuring no other parent has to lose their child to such a devastating illness. She was also on the ground for several months during this response to help stop the spread of this same virus in the DRC – this time in the country where she grew up. This is the kind of passion and drive that's fueling our disaster team on the ground.

There are signs that these interventions, and the hard work of Ebola responders, are paying off: 304 people have recovered from the disease during this outbreak, as of March 6. However, the disease continues to spread, meaning that we still have much more work to do and must continue to adapt to the myriad challenges facing this response.

Past Experience with Ebola

USAID is no stranger to battling the Ebola virus in Africa. For the 2014-2016 West Africa response, our DART, together with our interagency and international partners —and affected countries—helped bend the epidemiological curve in Liberia, Guinea, and Sierra Leone, and avert the worst-case scenarios initially predicted. This experience, along with our long history of being fast, scalable, operational, and flexible during humanitarian disasters, makes USAID uniquely equipped to respond to this outbreak. We've proven our ability to respond to humanitarian emergencies around the world, and we're applying that leadership here. We have also been providing humanitarian assistance in the DRC since 1984, so we know how to operate in this environment because we have long-standing experience coordinating with the DRC

government, other donors, and partners during high-profile emergencies. However, we fully acknowledge that despite the global lessons learned during the West Africa outbreak, we are faced with a unique and difficult challenge in trying to operate in a highly insecure area.

We are also taking the lessons learned from the West Africa outbreak and applying them to this response. For example, there are improved methods for patient isolation and triage while minimizing the risk to health care workers. Also, many of the people responding to this outbreak also responded in 2014 and have been able to leverage their expertise in this response. And while we are applying these lessons learned wherever possible, we recognize that this context is highly unique and includes an active conflict zone, and are making adjustments to respond to the challenges.

Addressing Emerging Threats and Global Health Security

This outbreak, as well as other recent disease outbreaks like SARS, the 2009 H1N1 influenza pandemic, Middle East Respiratory Syndrome (MERS-CoV), and the West Africa Ebola epidemic are reminders of the global vulnerability to infectious diseases, which have the ability to rapidly spread across the globe and threaten the United States within hours. In addition to the high morbidity and mortality often associated with pandemic and epidemic events, there can be devastating consequences that can adversely impact global trade, travel and commerce around the world. It is critical that the United States continue to use its expertise to respond to these threats to prevent global spread of deadly diseases.

Perhaps the greatest infectious disease threat is the emergence of a novel influenza virus resulting in a severe flu pandemic. The 1918 influenza pandemic, which resulted in more than 50 million deaths worldwide, is an example of this worst-case scenario. While medicine and public health have made great progress since this time, the potential pace and rapid spread of a novel virus in humans with little to no immunity would likely surpass response capacity and existing resources, especially in areas with weak health systems.

This past year, the world continued to experience multiple health emergencies and infectious disease outbreaks. As the DRC was responding to its ninth recorded Ebola outbreak in the summer of 2018, India was responding to a Nipah outbreak in the state of Kerala. Thankfully, both of these outbreaks were contained relatively quickly as a result of concerted efforts, but it was a reminder to the global health community of how two serious diseases with the ability to infect many people and result in a high number of deaths, could have simultaneously spread rapidly in two different regions of the world.

All of these events demonstrate the need for enhanced multi-sectoral coordination and collaboration, before, during, and after outbreaks. Pandemic and large-scale epidemics should not be solely considered the responsibility of the health sector. Recognizing this fact, pandemic

preparedness and response requires a whole-of-society approach to help mitigate these possible consequences and bring together multiple sectors to better prevent, detect, and respond to infectious disease threats.

Under the leadership of the National Security Council (NSC), and in collaboration with CDC and other interagency colleagues, USAID has worked to implement the Global Health Security Agenda (GHSA), which was launched in 2014, to prevent and mitigate disease emergence and spread. The goal of GHSA is to build the capacities and strengthen the health systems of targeted countries to detect infectious disease events early, respond rapidly and effectively to new outbreaks, and to prevent avoidable outbreaks. When things happen—like the current Ebola outbreak—we also work to ensure response agencies have the tools and operational structures necessary to respond quickly and effectively. This is why we invested $35 million into WHO's Health Emergencies Program and constantly work with other partners to encourage adequate operational readiness.

USAID's GHSA program builds upon our development work across sectors such as global health, food security, economic growth, and environmental portfolios; our longstanding work at the community level with local organizations; and our foreign disaster assistance and global resilience programs.

With our in-country Missions, USAID forges strong relationships with host country Ministries, including health, agriculture, finance, and forestry, as well as international organizations—such as the Food and Agriculture Organization and WHO—to help achieve our objectives.

One of our key focus areas is addressing zoonotic diseases and animal health services. This is critical since about 70 percent of new outbreaks come from animals. USAID is doing this by preparing the next generation of local health, agricultural, and environmental professionals to deal with zoonotic diseases. USAID has helped nearly 80 African and Asian universities train more than ten thousand students, faculty, and professionals in zoonotic diseases, antimicrobial resistance, risk communication, and other disciplines. For example, as part of this training, students in Uganda helped respond to the 2017 Marburg, Anthrax, and Avian Influenza outbreaks through community mobilization, contact tracing, and community messaging.

USAID is also helping countries detect viruses in wildlife that have the potential to cause the next epidemic or pandemic. The point is to stop these threats at their source by designing interventions early on to reduce the risk to humans. Since the GHSA launch, USAID has helped detect almost 300 new viruses that could pose threats to human populations, including a new Ebola virus strain (Bombali virus) that was discovered in Sierra Leone in 2018 through the USAID-funded PREDICT Ebola Host Project. In addition, very recently the USAID PREDICT

project also identified the Zaire Ebola virus strain in a bat in Nimba County, Liberia. These discoveries help target disease surveillance activities as well as information for communities.

In addition, we are strengthening more than 40 animal health and other national labs in GHSA countries, including reestablishing central veterinary laboratories in Guinea, Liberia, and Sierra Leone after the Ebola outbreak. For example, in Guinea, USAID helped refurbish the chief veterinary lab, provided diagnostic equipment and access to water, and trained staff on diagnostic procedures and biosafety. These efforts were effective; shortly after opening, Guinean technicians detected an outbreak of anthrax, conducted a livestock vaccination campaign, and rapidly controlled the outbreak without any human cases.

USAID is also working to promote health security at the local level by helping at-risk communities develop preparedness plans and train community volunteers to detect and respond to infectious disease threats in their own neighborhoods. We are developing an emergency supply chain program specially designed to distribute commodities, like personal protective equipment, that are critically needed during outbreaks. We are helping countries establish risk communication programs that provides individuals and communities with the information needed to reduce the spread of diseases and outbreaks. Finally, we are building upon our more than two decades of work addressing antimicrobial resistance by helping to prevent healthcare associated infections. For example, USAID has helped improve infection prevention and control, and waste management in more than 400 health facilities across six countries.

USAID will continue to respond to international outbreaks in ways that build long-term capacity. This includes two stockpiles of emergency non-medical commodities, on-the-ground activities that can be quickly reprogrammed, and the availability of technical experts in water, sanitation, and hygiene; communication; and other areas.

A critical part of the GHSA is the strong collaboration and coordination with the CDC, the Department of Defense, the Department of State, and across U.S. Government agencies both state-side, and in partner countries under the aegis of the U.S. Ambassador, and we're proud of the targeted activities being implemented by U.S. partners on the ground.

Conclusion

In conclusion, USAID is well equipped to respond to Ebola and other disease threats due to our longstanding expertise and leadership in responding to humanitarian emergencies, as well as our commitment and support for implementing programs that strengthen global health security and prevent the spread of infectious diseases. We are able to draw upon decades of experience in this area—from training community health workers to health systems strengthening to supply chain development. By continuing our efforts to improve contact tracing, infection prevention and control, case management, safe and dignified burials, and community engagement, we're

adapting to the unique challenges this outbreak presents, to bring it under control as soon as possible.

Moving forward in this outbreak, we will continue to work alongside the Government of the DRC, WHO, other U.S. Government agencies, and our international partners to provide technical assistance and ensure U.S. support is best accounting for needs and response priorities. While responding to this outbreak is challenging and complex, it is a whole-of-government response, and we are working alongside our partners in the U.S. Government and our partners on the ground to ensure a well-coordinated response that makes the most of each agency's expertise.

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