

Statement by

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Introduction

Chairman Smith, Ranking Member Rogers, distinguished Members of the Committee: Thank you for the opportunity to testify before you today on the Department of Defense's (DoD's) response to the coronavirus disease 2019 (COVID-19) pandemic. I am honored to be here in the company of Major General Jeff Taliaferro, the Joint Staff's Vice Director for Operations, and Major General Steven Nordhaus, the National Guard Bureau's Director for Operations.

As President Biden's "National Strategy for the COVID-19 Response and Pandemic Preparedness" states: "The federal government cannot solve this crisis alone. Full implementation of the National Strategy for COVID-19 will require sustained, coordinated, and complementary efforts of the American people, as well as groups across the country, including State, local, territorial, and Tribal governments; health care providers; businesses; manufacturers critical to the supply chain, communities of color, and unions." DoD is a critical part of the Federal response, but DoD's efforts rely greatly on partnerships. DoD's provision of key medical and non-medical capabilities, personnel, and supplies to support the States, the District of Columbia, territories, or international partners, was only possible because of strong, mutually supporting partnerships with our interagency partners.

The COVID-19 pandemic has posed an unprecedented challenge to our nation. In the face of this tremendous challenge, Secretary Austin tasked DoD to defeat the COVID-19 pandemic and defend the force against COVID-19, while protecting our nation. In this fight, DoD is fully committed to achieving the seven goals of the National Strategy for the COVID-19 Response and Pandemic Preparedness and carrying out President Biden's direction, that were provided in: Executive Order 13987, "Organizing and Mobilizing the United States Government To Provide a Unified and Effective Response To Combat COVID-19 and To Provide United States Leadership on Global Health and Security," Executive Order 13991, "Protecting the Federal Workforce and Requiring Mask-Wearing," and the President Biden's "Memorandum to Extend Federal Support to Governors' Use of the National Guard to Respond to COVID-19 and to Increase Reimbursement and Other Assistance Provided to States," and the other Executive Orders and Presidential memoranda related to COVID-19.

Unprecedented Incident

The COVID-19 pandemic is one of the greatest public health challenges our nation has faced in over 100 years, since the 1918 flu pandemic. Domestically, most disasters or emergencies either affect a single State or several States in a region. In contrast, COVID-19 not only affected the entire United States, but the entire world (i.e., historically speaking, no President has ever before declared a major disaster for all States, territories, and the District of Columbia). Additionally, typical incident responses last 1-3 weeks and then transition to recovery, whereas the COVID-19 response is more than a year old. Uniquely, the need to stop the spread of the virus eliminated an entire tier of the national response system (i.e., interstate mutual aid and assistance). Likewise, when most incidents occur, responders are able to focus on saving and protecting lives and then transition to recovery in the aftermath. Instead, COVID-19 is a persistent incident that ebbs and flows in intensity.

The response to COVID-19 is distinct from previous disease outbreaks, with the exception of the 1918 flu, because of the harm caused by the virus, the ease of transmission, and the impact of the disease on an interconnected world. In many countries, including the United States, the virus placed unprecedented stress on the capacity of civilian healthcare systems. As of February 16, 2021, there were over 27 million confirmed COVID-19 cases and more than 485,000 deaths in the United States—more lives than those lost in World War II.¹ Vaccination efforts have begun and are steadily expanding, with more than 39.6 million people in the U.S. having received at least one dose.²

In comparison to the general U.S. population, DoD Service members have not been significantly affected by COVID-19. As of February 10, 2021, there have been more than 148,000 cases of COVID-19 and 21 deaths due to COVID-19 among DoD's military population.³ Across DoD's total population (military, civilian, dependent, and contractor), there

¹ CDC COVID Data <https://covid.cdc.gov/covid-data-tracker/index.html#datatracker-home>, As of February 16, 2021.

² CDC COVID Data, <https://covid.cdc.gov/covid-data-tracker/index.html#vaccinations>, As of February 16, 2021.

³ DoD, *Coronavirus: DoD Response*, As of February 10, 2021: <https://www.defense.gov/Explore/Spotlight/Coronavirus//>

have been more than 230,000 cases of COVID-19 and 273 deaths.⁴ The age-adjusted mortality rate among military personnel has been lower than that for the general population. The virus has nonetheless had widespread impacts on the force, including by delaying non-emergency medical treatments, military training (especially collective training), and exercises with allies and partners, and by complicating recruitment and initial entry training. Early studies of COVID-19 suggest that it may have long-term impacts on physical and mental health, so the virus also has the potential to impose long-term health costs on the force.⁵

Protecting DoD Personnel

DoD took aggressive actions early in the pandemic to protect DoD personnel. As COVID-19 spread, the U.S. Centers for Disease Control and Prevention (CDC) began recommending cloth mask use, physical distancing, avoiding crowds, and washing hands as key mitigation strategies to help control the spread of the virus. DoD was doing these things from the start of the pandemic as a way to protect the force and maintain readiness. Over the course of the pandemic, DoD developed and implemented several measures to contain and mitigate effects on the force. These included: issuing force health protection (FHP) guidance (DoD issued the first FHP guidance on January 30, 2020); strategically issuing restriction of movement (ROM) orders; requiring social distancing and mask wearing; instituting telework on an unprecedented scale; employing testing and contact tracing; and implementing sentinel surveillance programs in coordination with DoD's influenza sentinel surveillance program, along with serologic surveillance through the Department's HIV testing program. As a whole, these mitigation efforts were critical to informing DoD senior leadership and allowing leaders to make appropriate risk-based decisions to enable DoD to protect the force, continue operations, and maintain readiness.

⁴ DoD, *Coronavirus: DoD Response*, As of February 10, 2021:

<https://www.defense.gov/Explore/Spotlight/Coronavirus//>

⁵ i, Luming, Fangyong Li, Frank Fortunati, and John H. Krystal. "Association of a Prior Psychiatric Diagnosis With Mortality Among Hospitalized Patients With Coronavirus Disease 2019 (COVID-19) Infection." *JAMA network open* 3, no. 9 (2020): e2023282-e2023282; Li, Sophie, Joanne Beames, Jill Newby, Kate Maston, Helen Christensen, and Aliza Werner-Seidler. "The impact of COVID-19 on the lives and mental health of Australian adolescents." *medRxiv* (2020), As of November 2, 2020:

<https://www.medrxiv.org/content/10.1101/2020.09.07.20190124v1>; UNCLASSIFIED: Chen, Qiongni, Mining Liang, Yamin Li, Jincal Guo, Dongxue Fei, Ling Wang, Li He et al. "Mental health care for medical staff in China during the COVID-19 outbreak." *The Lancet Psychiatry* 7, no. 4 (2020): e15-e16; [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(20\)30462-4/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30462-4/fulltext).

Early in the pandemic, DoD experienced the same shortages in testing supplies as the rest of the nation due to the just-in-time supply chain. Therefore, the Department initially prioritized testing for those who presented with symptoms of the disease. Early global shortages of testing equipment and supplies made it difficult for DoD to conduct a broader range of screening and regular surveillance testing to accurately estimate infection rates among DoD populations and quickly isolate those who contracted the disease. Early testing supply limitations made testing, contact tracing, and isolation less robust than DoD pandemic plans would otherwise have been. To coordinate demand for testing supplies, DoD and the Department of Health and Human Services (HHS) created the Diagnostic and Testing Task Force, which streamlined procurement efforts and developed algorithms derived from U.S. Food and Drug Administration (FDA) and CDC guidance to help ensure evidence-based use of new testing options as they became available.

In April 2020, the Department established a four-tiered COVID-19 testing program that would enable DoD to test a wider segment of the military population, in addition to continuing to test those presenting with symptoms or close contacts, as well as prioritize testing across the force.⁶ Tier 1 testing was designated for those forces involved in critical national capabilities such as strategic deterrence or nuclear deterrence; Tier 2 was for fielded forces around the world; Tier 3 was for forces being forward-deployed or those redeploying; and Tier 4 was for all other forces.

DoD's testing capabilities have increased dramatically over time. As of January 31, 2021, DoD had tested more than 2.5 million DoD personnel over the course of the pandemic, and in early January 2021 was conducting more than 15,000 tests per day. DoD's testing strategy continues to evolve as new tests become available, supply chains change, and new guidance is released on how best to employ COVID tests to execute its full testing strategy. The increased testing capability and the four-tiered testing system have been important tools that enabled DoD

⁶ Garmone, Jim, "DoD Starts Tiered COVID-19 Testing Process to Ensure Safety," *DoD News*, April 22, 2020.

to maintain readiness during the pandemic and to protect the force and the communities where we live and work.

DoD does not view testing as the sole solution, but rather one of several complementary foundational public health measures, including contact tracing, to be used together to limit the spread of the virus and to improve DoD's overall force availability. To that end, Secretary Austin released guidance across the Department to make mask wearing mandatory in any room or area where more than one individual is present. DoD is now also undertaking a thorough review of all COVID-related guidance documents, to include a full review of workplace safety guidelines, to maximize our effectiveness in stopping the spread of COVID-19.

Support to the National and International Response

Overview of National Response

COVID-19 involved unprecedented support to all 50 States, 3 territorial authorities, and the District of Columbia. Since January 27, 2020, the Department of Defense has received 374 Federal Emergency Management Agency (FEMA) Mission Assignments and 47 Requests for Assistance from other Federal departments and agencies in response to the COVID-19 pandemic. To date, the total FEMA obligation amount for DoD medical support is in excess of \$3.21 billion, provided on a reimbursable basis pursuant to the Stafford Act. More than 62,100 military personnel, including National Guard (NG) personnel from all 50 States, 3 territories, and the District of Columbia, have been involved in supporting COVID-19 relief operations. Military personnel have augmented medical staff at hospitals, nursing homes, and assisted living facilities; delivered food to hard-hit communities; supported logistics efforts to supply medical equipment; built alternate care facilities; conducted community-based medical screening; conducted laboratory testing; provided installation support; and assisted with fatality management among other tasks.⁷

Repatriation Efforts

⁷ See National Conference of State Legislatures, "National Guard Assists Response to the COVID-19 Pandemic," NCSL homepage, April 28, 2020.

Beginning in late January 2020, U.S. embassies and consulates around the globe assisted U.S. citizens and U.S. persons in returning to the United States.⁸ After an initial State Department charter flight in January 2020, two flights arrived on February 5, 2020, at Travis Air Force Base (AFB) and Marine Corps Air Station (MCAS) Miramar, and on February 7, flights arrived at MCAS Miramar and Joint Base (JB) San Antonio-Lackland. HHS turned to DoD to provide lodging at five sites, initially: March Air Reserve Base (ARB), Travis AFB, Miramar MCAS, JB San Antonio-Lackland, and Camp Ashland. By the end of this effort, U.S. Transportation Command (USTRANSCOM), in support of the State Department, facilitated the safe return of more than 4,500 Americans, and U.S. Northern Command (USNORTHCOM) and the Military Departments provided housing at 13 military installations for quarantine of more than 3,000 individuals from China and 2 cruise ships in response to multiple HHS requests. The support ended on April 4, 2020, and was provided on a reimbursable basis pursuant to the Economy Act. Installations were also used as support bases for DoD and FEMA responders and logistics.

Medical Surge Support

By the end of March 2020, COVID-19 infections began materializing in key hotspots around the nation, first in Washington, New York, and California, but then quickly spreading across the country. Hospitalizations from COVID-19 began to increase rapidly, creating concerns about insufficient medical capacity to treat the rise in the number of patients, and a subsequent demand from States and localities for both medical facilities and medical providers. HHS and FEMA, through the National Response Framework, turned to DoD to help meet this demand. In response, DoD deployed two Navy hospital ships, several Navy Expeditionary Medical Facilities, Army Combat Hospital Centers, Army Reserve Urban Augmentation Medical Task Forces, and Air Forces Expeditionary Medical Support units to provide surge medical support on ships, at alternate care facilities (ACFs), and in civilian hospitals and nursing homes. Additionally, 38 ACFs were designed and constructed by the U.S. Army Corps of Engineers (USACE) to provide additional capacity. At the peak of this demand, USNORTHCOM deployed almost 15,000 DoD personnel, including almost 5,000 Active Duty and Reserve medical

⁸ <https://www.gao.gov/reports/GAO-20-701/>

professionals (approximately 580 doctors, 1,190 nurses, 130 respiratory therapists, 180 mid-level providers, and 3,200 support services), to 10 different States and multiple locations within some States. Meanwhile, U.S. Indo-Pacific Command provided similar support in Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands.

National Guard Support to the States

In addition to providing medical personnel and medical facilities, in an unprecedented fashion, FEMA requested, beginning in March 2020, but extending throughout 2020 and into 2021, that DoD authorize NG personnel from 52 States and territories⁹ to operate in a Title 32 duty status – funded by the Federal Government but under State command and control.¹⁰ Due to the pervasive nature of the pandemic and its economic consequences, President Biden in his “Memorandum to Extend Federal Support to Governors’ Use of the National Guard to Respond to COVID–19 and to Increase Reimbursement and Other Assistance Provided to States” authorized a 100-percent Federal cost-share to the States and territories under the Stafford Act, extended the support through September 30, 2021, directed FEMA to reimburse DoD fully for the cost of pay and allowances for FEMA mission assignments to DoD related to NG support, and directed the Secretary of Defense to maximize the use of Title 32 to support the States and territories. Under this arrangement, States retain command and control of their NG personnel for their COVID-19 response, while FEMA covers the costs of such support. At the peak of such authorizations, more than 47,000 National Guard personnel supported community-based testing, emergency medical care, medical sheltering, communication of health and safety information to the public, transportation, logistics, and first responder support. As of February 16, 2021, approximately 27,500 National Guard personnel were supporting the COVID-19 response in 49 States (excluding Wyoming) and 3 territories.

⁹ Wyoming has yet to request support from FEMA for the use of their National Guard, and the District of Columbia National Guard does not require a FEMA mission assignment to provide COVID support in Title 32..

¹⁰ Section 502(f) of Title 32, U.S. Code, authorizes the President or the Secretary of Defense to request the Governors order to duty their NG personnel to conduct operations or missions for DoD. Operations or missions conducted in a Title 32 duty status are under the command and control of the Governors with funding provided by DoD. DoDI 3025.22, “The Use of the National Guard for Defense Support of Civil Authorities,” establishes policy for the use of the NG for DSCA missions, which requires another Federal Department to request DoD support. In this case, FEMA requested that DoD support the States and territories and fully reimbursed DoD for the pay and allowances and other costs associated with the use of NG personnel in Title 32 status.

Supply Chain and Acquisition Support

DoD also played a critical role in strengthening the supply chain for medical resources and protective equipment that were in short supply. The effects of COVID-19 made it clear that personal protective equipment (PPE), such as masks, gloves, and gowns, and medical equipment (such as ventilators and respirators), would be critical to protecting medical personnel and for the treatment of patients. Initially, the global demand for these items far outstripped the available supply, due to the just-in-time global supply chain. The primarily overseas nature of PPE and medical equipment supply chains made it difficult to expand production capacity within the United States or use Defense Production Act (DPA) authorities to prioritize domestic COVID-19-related requirements and to expand the industrial base to manufacture critical supplies.¹¹ The national supply chain, including the supply chain for the Strategic National Stockpile (SNS), was unable to meet demand. In order to bridge this gap, HHS and FEMA turned to DoD to take advantage of its acquisition and logistics expertise to support nearly all facets of the national supply chain.

FEMA and HHS established the Supply Chain Task Force (SCTF), led by Rear Admiral John Polowczyk, to focus on reducing the medical supply-chain-capacity gap both to satisfy demand and to relieve pressure on medical supply capacity. This organization was led by and heavily supported by DoD personnel detailed to FEMA who had expertise in supply-chain management and logistics. This organization accelerated acquisition, expanded production by generating new capacity, and allocated resources to ensure that supplies were prioritized to hotspots. The SCTF also worked with major commercial distributors to facilitate the rapid distribution of critical resources. *A key example of this partnership in action is Project Air Bridge.* FEMA created Project Air Bridge to reduce the time it takes for U.S. medical supply distributors to receive PPE and other critical supplies into the country for their respective customers. USTRANSCOM supported this effort and delivered into the private sector supply

¹¹ Senate Homeland Security and Governmental Affairs Committee, “Evaluating the Federal Government’s Procurement and Distribution Strategies in Response to the COVID-19 Pandemic,” June 9, 2020, <https://www.hsgac.senate.gov/evaluating-the-federal-governments-procurement-and-distribution-strategies-in-response-to-the-covid-19-pandemic>.

chain nearly 1.5 million N95 respirators, 937 million gloves, 112.7 million surgical masks, 39.4 million surgical gowns, more than 2.4 million thermometers, more than 2.5 million face shields, 1.4 million coveralls, 109,000 stethoscopes, 370,000 oxygen masks, and more than 160,000 cannulas.

On the acquisition side of the supply chain the Under Secretary of Defense for Acquisition and Sustainment (USD(A&S)) established a COVID-19 Joint Acquisition Task Force (JATF) to serve as the single DoD entity to support interagency acquisition and logistics needs. The JATF supported the immediate response to the national health crisis, leveraging the Department's authorities in supporting FEMA and HHS in the national response. The JATF helped the agencies identify supply chain constraints and manage the industrial bases of critical medical resources and assisted in acquisitions through Defense Logistics Agency (DLA) to restock the SNS. On October 13, 2020, the JATF transitioned interagency assisted acquisition functions to the Joint Rapid Acquisition Cell (JRAC) Defense Assisted Acquisition Cell (DA2) the permanent office to provide acquisition support to agencies outside of DoD. In total, the DA2 (and previously JATF) has awarded over 35 contracts, valued at \$1.8 billion, to expand the domestic medical supply and equipment industrial base and awarded \$781 million worth of contracts to restock the SNS.

Additionally, DLA has a standing arrangement with FEMA to acquire goods and services during disasters and other incidents, and has been a significant contributor to the pandemic response. DLA used its contracting and logistics expertise to assist FEMA and HHS in their support to States and territories for the COVID-19 response. As of January 12, 2021, DLA has executed more than 25,000 contract actions, obligating more than \$3.13 billion worth of medical supplies such as test kits, ventilators, and drugs, as well as masks, gloves, gowns, and other PPE.

Development of Vaccines and Therapeutics

For decades, DoD laboratories have studied infectious diseases of military importance, including HIV/AIDS, Ebola, and coronaviruses such as Middle East Respiratory Syndrome (MERS). In January 2020, DoD began research and development (R&D) on diagnostics, therapeutics, and vaccines for SARS-COV-2, the strain of coronavirus that causes COVID-19.

The U.S. Army Medical Directorate-Armed Forces Research Institute of Medical Sciences led important initiatives to sequence COVID-19 in order to find its genetic “fingerprint.” Scientists used this identification information to develop tests and proposed treatments as early as January 2020, and later to help track the transmission chain as the virus evolved over time. The Defense Health Program Medical R&D funds provided the initial infusion required to support early COVID-19 research efforts. Some of these funds were allocated to the Joint Program Executive Office for Chemical, Biological, Radiological, and Nuclear Defense (JPEO-CBRND) and became an important source of funding for early initiatives such as the development of testing and therapeutics in February and March.¹² One of the early successes was the deployment of high-speed COVID-19 testing equipment to Fort Jackson, South Carolina, that would turn around tests in a day and isolate potentially infected recruits quickly, preventing further transmission while allowing training to safely continue. Ongoing research efforts proved useful for the COVID-19 response, which resulted in publication of Clinical Practice Guidelines developed by the Uniformed Services University of the Health Sciences and the Defense Health Agency (DHA). Additionally, based on these research efforts, JPEO-CBRND worked to achieve FDA Emergency Use Authorization for the BioFire diagnostic test on March 23, 2020. The U.S. Army Medical Research and Development Command (USAMRDC) established the first U.S. treatment protocol for Remdesivir on March 17, 2020; and JPEO-CBRND developed antibody treatments to be used by DoD and the larger national response effort.

Additionally, in 2011, the Defense Advanced Research Projects Agency (DARPA) began focusing research specifically on efforts to reduce the timelines for safe development and employment of vaccines and antibodies. DARPA’s Pandemic Prevention Platform (P3) program, launched in 2017, focuses on rapid discovery, characterization, production, testing, and delivery of efficacious DNA- and RNA-encoded medical countermeasures against infectious disease.¹³ The foundational technology was pioneered by DARPA under its Autonomous Diagnostics to Enable Prevention and Therapeutics (ADEPT) program, which began in 2011. ADEPT funded programs to research how the body could produce antibodies against a new

¹² <https://www.jpeocbrnd.osd.mil/coronavirus>

¹³ <https://www.darpa.mil/news-events/2020-11-10>

biological threat. These DARPA programs funded projects that laid the groundwork for the development of RNA COVID-19 vaccines produced by Moderna and AstraZeneca, and COVID-19 therapeutics manufactured by Eli-Lilly.

DoD and HHS Vaccine Task Force

The joint DoD and HHS Vaccine Task Force (formerly known as “Operation Warp Speed”) was established in May 2020. The Task Force includes the U.S. Department of Agriculture, the Department of Energy, the Department of Veterans Affairs, and private sector companies. The purpose of this partnership is to facilitate, at an unprecedented pace, the development, manufacturing, and distribution of COVID-19 countermeasures. The Task Force coordinates existing HHS-wide efforts, including the National Institutes of Health (NIH) Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV) partnership for vaccine and therapeutic development, NIH’s Rapid Acceleration of Diagnostics (RADx) initiative for diagnostic development, and work by the Biomedical Advanced Research and Development Authority. There are three core areas where the vaccine task force has been accelerating the timeframe for countermeasures, including a vaccine, reaching the American public: 1) development; 2) manufacturing; and 3) distribution. The vaccine task force effort is accelerating distribution, now at approximately 60.7M vaccine doses, 42.4 million of which have been administered. The task force expects to deliver the initial target of 300 million vaccine regimens to States by the end of June 2021.

DoD’s Vaccination Efforts

DoD established a tiered vaccination administration schema that follows CDC guidance for determining priority groups, modified for unique DoD requirements. As of February 11, 2021, DoD has received approximately 970,000 total doses of the Pfizer and Moderna vaccines, both of which have received an emergency use authorization from the Food and Drug Administration (FDA). DoD is in the expanded distribution phase with vaccine administration occurring at 324 locations worldwide. Due to less demanding supply chain and storage requirements for the Moderna vaccine, only the Moderna vaccine is being used at sites outside the United States. As of February 10, 2021, DHA has administered approximately 800,000 of those doses. More than 373,000 personnel have been partially vaccinated, and more than

200,000 have been fully vaccinated (i.e., having received 2 doses). As of February 10, 2021, 15.9 percent of military personnel have been vaccinated with the first dose, and 5.6 percent have been fully vaccinated.

Support to the National Vaccine Program

As Secretary Austin made clear in his Day One message to the force, the Department must move further and faster to contribute to the Federal Government's efforts to counter the COVID-19 pandemic. One such initiative to meet the Secretary's guidance is planning and resourcing support to FEMA to support States' and territories' vaccination efforts. DoD, in collaboration with FEMA, has developed plans to support vaccine centers that could administer up to 6,000 vaccines/day. This enhanced vaccination support will be provided directly to FEMA to support existing State-run centers or to FEMA's new Federally supported, State-run centers. DoD is actively supporting New Jersey and California with approximately 250 personnel at their State-run vaccine centers. FEMA has provided notice to DoD to prepare to support additional sites in New Jersey, Texas, New York, and the U.S. Virgin Islands, totaling approximately 900 personnel. DoD expects to receive additional requirements from FEMA to support other States and territories in the near future.

International Response Efforts

During the COVID-19 pandemic, the Department of Defense supported U.S. allies and partners through the provision and transport of life-saving medical equipment, PPE, and humanitarian aid. As of January 25, 2021, DoD had provided more than \$199 million in assistance to 143 countries to aid testing, diagnostic support, infection control, PPE procurement, contact tracing, and more.¹⁴ DoD's assistance spanned the areas of responsibility for all six Geographic Combatant Commands (GCCs). The first phase of DoD's assistance, from March 2020 until May 2020, focused on supporting countries' immediate response to the pandemic by providing locally procured PPE, medical supplies and equipment, and testing supplies. The second phase of DoD's assistance started in June 2020 and focused on capacity building to support mid- to longer-term pandemic and infectious disease preparedness and response

¹⁴ Jim Garamone, "DOD Uses International Contacts to Help Allies, Partners Combat COVID-19," *DoD News*, October 9, 2020.

capabilities. For example, DoD has provided subject matter expert support to the African Union and the Africa CDC, and has procured 71 field hospitals, diagnostic laboratory equipment, 477 ventilators, and 29 isolation clinics/pods. DoD’s Humanitarian Assistance and Foreign Disaster Relief activities are funded by Overseas Humanitarian, Disaster, and Civic Aid (OHDACA) appropriation funds.¹⁵ The advantage of OHDACA is that use of such funds allows DoD to effectuate a transfer of equipment, materials, or expertise, and thus can provide an immediate boost to a partner nation’s capacity.¹⁶ Throughout the COVID-19 pandemic, GCCs leveraged OHDACA funds and existing global health assets to undertake “minimal cost projects,” which are humanitarian assistance efforts costing up to \$15,000, without higher-level approval.¹⁷ The minimal cost project cap was eventually increased to \$75,000.

Priorities Going Forward

DoD remains focused on the national vaccination efforts including production, distribution, and administration of COVID-19 vaccines to support the States through FEMA. To protect DoD personnel and safeguard DoD’s national defense mission, the Department is continuing to expand its internal vaccine program and refine its vaccination analytics, improving DoD bio-surveillance and testing capabilities, exploring new treatments and testing capabilities through its research and development programs, and continually is refining its school and installation policies for force health protection. The Department is also actively implementing President Biden’s guidance, publishing consolidated guidance for COVID-19 at the Department and Service levels, implementing lessons learned from the pandemic, and updating the Global Campaign Plan for Pandemic Influenza and Infectious Disease. Finally, the Department is ensuring it is postured to support the Administration’s Global Health Security agenda.

¹⁵ Defense Security Cooperation Agency, “Security Assistance Management Manual, Chapter 12: Overseas Humanitarian, Disaster, and Civic Aid (OHDACA)”;

Assistant Secretary of Defense for Special Operations/Low-Intensity Conflict and Interdependent Capabilities, Policy Guidance for DOD Overseas Humanitarian Assistance Program (HAP), November 2009.

¹⁶ Garamone, 2020.

¹⁷ Defense Security Cooperation Agency, “Security Assistance Management Manual, Chapter 12: Overseas Humanitarian, Disaster, and Civic Aid (OHDACA).”

Conclusion

In conclusion, DoD remains committed to fulfilling Secretary Austin's direction to defeat the COVID-19 pandemic and defend the force against COVID-19, while protecting our nation.

Chairman Smith, Ranking Member Rogers, distinguished members of the Committee, thank you for your support to the Department and the opportunity to testify before the Committee. I appreciate the critical role Congress plays in ensuring that the Department is prepared to face every challenge at home and abroad. I especially thank the men and women of the Department of Defense – military and civilian, Active, Guard, and Reserve – and their families for all that they do every day to protect the people of our nation and to keep our nation safe and secure.