COMBATING EBOLA IN WEST AFRICA: THE INTERNATIONAL RESPONSE

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COMBATING EBOLA IN WEST AFRICA: THE INTERNATIONAL RESPONSE

THURSDAY, NOVEMBER 13, 2014

HOUSE OF REPRESENTATIVES,
COMMITTEE ON FOREIGN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:11 a.m., in room 2172, Rayburn House Office Building, Hon. Ed Royce (chairman of the committee) presiding.

Chairman ROYCE. The committee will come to order. We will ask all the members to take their seats.

We have had Ebola crises in the past. We have seen this situation in the Philippines, in Congo, Uganda, but never have we seen it on the scale, with the reach that this current epidemic has in Guinea and Liberia and in Sierra Leone. There are 14,000 cases on record, there are 5,000 people who have died, there are thousands of children at this time who have been orphaned, and these numbers are very shocking, and the numbers are growing.

What has worked in the past to block Ebola, obviously, is breaking the chain of transmission. But without us doing that, Ebola will continue to spill across borders, and economies will be devastated in Africa. Governments will fail. Tens of thousands will die. And that is no exaggeration, and that means that this isn't just a problem for west Africa, but a problem with far-reaching health and economic and security consequences for the globe.

And I would like to recognize Chairman Smith for convening an emergency hearing we held together during the African summit, African Leaders Summit in August, despite concerns by the administration that it would be a distraction. President Sirleaf, Ellen Johnson Sirleaf of Liberia, called to thank the committee for standing by Liberia.

Chairman Smith, who has been working closely with our ranking member, Karen Bass, on that subcommittee, will convene a hearing next week with the key nongovernmental organizations engaged in the response.

Unfortunately, we are paying the price of early failures. The World Health Organization, which is the U.N. agency charged with leading the response to health emergencies, downplayed the crisis. Inept country office directors ignored warnings by Doctors Without Borders. As a matter of fact, they wrote a rebuttal to the concern raised by Doctors Without Borders. They refused assistance early on from the Centers for Disease Control and from USAID, and they blocked entry for teams of experts. By the time that the World

Health Organization finally sounded the alarm on August 8th, the outbreak was out of control.

Of course, the United States has generously provided support to the WHO. This was a failure of policy, not resources. Our director of the Centers for Disease Control serves on WHO's executive board, and we need to be pushing to reform the organization. Improving accountability would be a very good place to start, and having country directors that are not cronies but, in fact, are ready to stand up and deal with the problem instead of trying to deny it, is a very good place to start.

In contrast to the WHO's failures, USAID immediately activated a disaster assistance response team. It immediately got people to the region. And, today, USAID, supported by the Department of Defense and CDC, is leading a robust disaster response. As we will hear from Administrator Shah, who contacted myself and Mr. Engel after his trip to each of these countries, treatment units are being opened; lab capacity is being expanded; medical workers are being trained; and burial teams are working to reduce transmission.

Reports from Liberia indicate that this is having an impact. None of this could have been done without the commitment and sacrifice of the brave men and women of the doctors and nurses and civilians, both civilian and uniformed personnel, in all of this who have answered the call for help.

But we cannot afford to let up, and we cannot afford to do this alone. Containment will fail in the absence of a robust international effort. Other donors and the U.N. need to step up, just as we are stepping up. They need to step up particularly in Guinea. The WHO needs to be part of the solution, rather than a hindrance. And our Embassies need to put in place additional prudent containment measures that will add a layer of protection while not impeding the Ebola response, including the temporary suspension of visas for non-U.S. nationals coming from the region.

We look forward to learning more about the international efforts to help contain the epidemic at its source and evaluating the administration's request for additional resources in this fight to address one of the most pressing health emergencies of our time.

And I now turn to our ranking member, Mr. Eliot Engel of New York, for any opening remarks he might have.

Mr. ENGEL. Mr. Chairman, thank you for holding this important hearing. Let me say it was good spending time with you this past week.

And to our witnesses, thank you for your service and for your testimony here today. I want to single out Rajiv Shah, the Administrator of USAID, with whom I have worked closely during the past several years.

We appreciate your efforts, Administrator Shah, and the efforts of all the good people who are testifying here today.

Thank you, Ambassador Williams and the others, thank you so much.

Since our Africa and Global Health Subcommittee held a hearing on Ebola in September, the number of cases has nearly tripled. The World Health Organization is reporting over 14,000 Ebola cases as of November 12, 2014, and a total of 5,147 people have died. The

United States has now seen the implications of this outbreak here at home. Several heroic healthcare workers who gave their time and skills to treat Ebola patients in west Africa have contracted the disease and have been successfully treated here in the United States. We are grateful for their selflessness and for their sacrifices. Just as the doctors volunteering to help combat Ebola overseas deserve our recognition, so do our health workers and border and transportation officials who are working tirelessly to prevent an outbreak in the U.S.

As a New Yorker, let me say how proud I am of the staff of Bellevue Hospital and all of the New York public health officials who were involved in successfully treating Dr. Craig Spencer, who was released on Tuesday Ebola free. No matter how diligent we are here at home, there is always a chance of Ebola reaching our shores as long as the disease is thriving in west Africa. To prevent this from happening, we need to stamp out Ebola at its source. Most importantly, this Ebola outbreak is causing tremendous suffering. Our country has a proud tradition of stepping up in the event of a major crisis, and that should continue. That is why I support the strong commitment the U.S. has made to combating and eradicating this outbreak in west Africa.

The United States has been a leader in the response to Ebola, particularly in Liberia. To date, more than $414 million has been disbursed. Our soldiers are building treatment facilities across the country, a high quality 25-bed hospital for healthcare workers who contract Ebola, and providing vital air and logistical support. The CDC has helped establish laboratories that reduce the time it takes to get an accurate diagnosis from days to mere hours. USAID is supporting more than 50 burial teams and more than 2,200 workers, who are doing vital contracting work.

As I have said, the U.S. cannot meet this challenge alone. Ebola is a global challenge, requiring a global response. Fortunately, international efforts to control the epidemic in Liberia, Sierra Leone, and Guinea have increased, both in terms of financial support and on-the-ground assistance. Our partners in Europe and Asia have stepped up their commitment to the region. NGOs and humanitarian organizations, which shouldered most of the burden in fighting this epidemic for months, now have more robust and sustained support from donor countries.

However, despite these positive signs, much work remains before this epidemic is under control, and unfortunately, the significant financial commitments we have already made will not be enough to control this outbreak, but we cannot become complacent. All it takes is one unmonitored and untreated Ebola patient to cause another flare up.

We have all seen the emergency funding request that the administration sent to Congress on November 5th. Given the dire humanitarian impact Ebola is having on west Africa and the global health threat this disease poses, I strongly support this request. Like my colleagues, I would like to get more details from our witnesses: How will this funding be used? Why is it critical not only for the Ebola crisis but for our campaign to respond to emergencies globally? I hope we can shed a little more light on those issues, but Congress should quickly approve this request so that our efforts to

end this outbreak aren't derailed due to a lack of financial resources.

Finally, while controlling the epidemic is our first objective, we cannot lose sight of the fact that the three most heavily affected west African countries have significant long-term needs for assistance. The World Bank estimates that the regional financial impact could reach $32.6 billion by the end of just 2015. This would be catastrophic for a region just getting back on its feet after a prolonged period of conflict. So while the international response must be swift, it must also be sustained.

I also want to mention my gratitude and appreciation for all of our U.S. Government personnel in the region, the men and women who represent and support our missions abroad in west Africa. I thank the military who are here. This is a challenging time for everyone involved, and we appreciate all of their hard work in dealing with this crisis. I know how busy all of our witnesses are, and I appreciate the time that all of you are taking to give us this valuable update.

So, Mr. Chairman, thank you again for convening this hearing and thank you to our witnesses for being here today.

Chairman ROYCE. Thank you.

And I will say to the committee, I agree with Mr. Engel's assessment here.

Let's go to Chairman Chris Smith, chairman of the Africa Subcommittee and Global Health.

Mr. SMITH. Thank you very much, Mr. Chairman, for putting together this very important and timely hearing on the Ebola crisis, and I want to thank our distinguished witnesses for their extraordinary efforts to combat this disease and help the victims and their families.

I especially want to thank Dr. Shah for the work the USAID is doing and for the interest he has taken personally, the leadership he has provided. It has been herculean.

The unprecedented west African Ebola epidemic has not only killed more than 5,000 people with nearly 13,000 known to be infected, and that is probably a significant underestimation, it has also skewed the planning for how to deal with this outbreak. As we all know, in the past Ebola outbreaks have occurred in isolated areas that were much easier to contain. In this instance, the disease quickly spread from a rural area to an international trading center and people from Guinea, Liberia, and Sierra Leone took the disease home with them.

This disease, in early stages appears to do less. It is not recognized as quickly than other diseases, such as malaria, which means initial healthcare workers have been unprepared for the deadly nature of the disease that they have been asked to treat. This has meant that too many healthcare workers, national and international, have been at risk in treating patients who themselves may not have known that they had Ebola. Hundreds of healthcare workers have been infected, many have died, including some of the top medical personnel in the three affected countries.

What we found quickly was that the healthcare systems in these countries, despite heavy investment by the U.S. and other donors, remained quite weak. As it happens, these are countries coming

out of very divisive conflicts or they experience serious political divisions. Consequently, citizens have not been widely prepared to accept recommendations from their own governments. For quite some time, many people in all three countries would not accept that the Ebola epidemic was even real. Even now it is believed that, despite the prevalence of burial teams throughout Liberia, for example, some families are reluctant to identify their suffering and dead loved ones for safe burials, which places family members at grave risk because they often touch the body and show great affection for the recently deceased. The porous borders of these countries have allowed people to cross between countries at will. This has led to problems of people obviously carrying the disease with them.

I want to announce today the introduction of a bill. We have been working very closely with Chairman Royce on this as well as the ranking member, Karen Bass, called the Ebola Emergency Response Act. We have also shared it with the administration, trying to get a best practices bill moving that would affect the three countries but also the total response. This includes recruiting and training of healthcare personnel; establishing fully functional treatment centers; conducting education campaigns among populations in affected areas; and developing diagnostics, treatments, and vaccines. It confirms U.S. policy in the anti-Ebola fight and provides necessary authorities for the administration to continue or expand anticipated actions in this regard. The bill also encourages U.S. collaboration with other donors to mitigate the risk of economic collapse and civil unrest in the three affected countries. And we look forward to input from all members on this important bill, and again, I want to thank my friends on the other side of the aisle for working so closely on its creation.

I yield back, and I thank you, Mr. Chairman.

Chairman ROYCE. Thank you very much, Mr. Smith.

Ranking member Karen Bass of Los Angeles, ranking member on this Subcommittee on Africa and Global Health, for 3 minutes.

Ms. BASS. Thank you, Chairman Royce, Ranking Member Engel, and Chairman Smith, as always for your leadership on this important issue and for calling today's hearing. I also want to thank Dr. Shah and the other members of the panel today, not just for taking the time for your testimony but for your aggressive response and leadership on this issue. I look forward to getting updates directly from you today on how your agencies and organizations continue to combat this deadly outbreak, what trends you are seeing, both positive and negative, and what additional support is needed as you coordinate with governments of impacted countries and the international community.

We all know this crisis has been the largest and most widespread outbreak of the disease in history, creating a great burden on the governments and bringing a greater awareness to the international community about global health security. Striking west Africa for the first time, Ebola quickly overwhelmed the extremely limited healthcare systems of these nations, and quickly spun out of control. Since the beginning of the outbreak, the United States has made a significant and sustained effort, and all of what we are doing was described by Ranking Member Engel.

The question that I have that hopefully the panel will address is, with all of the infrastructure that we are putting in place from the treatment centers, training healthcare workers, burial teams, all of that, after we are past this—and I believe we will get past it—will any of it be left in place? Because I think that what we have all learned from this outbreak is the fact that many of the countries, the reason why it has been so bad is because they lacked a healthcare infrastructure. So do we take out of this tragedy and see an opportunity to begin to address this in the long term?

I think that Ebola has shown us that this isn't about charity, but that a health care crisis in one part of the world can directly affect us. And I am also particularly concerned about the fragile governments and a breakdown in the rule of law.

On the African side, African business leaders pledged to help the African Union train and deploy healthcare workers. And I know the African Development Bank has provided over $44 million to date to assist the global efforts. I understand that more than 2,000 healthcare workers have been pledged from African countries to help fight the outbreak.

I know that the administration has asked Congress for over $6 billion in emergency funds in order to sustain the progress that has been made and to ensure an end to this crisis. I believe that this request will expand assistance to continue to contain the epidemic and safeguard the American public from further spread of the disease.

I look forward to your testimonies, and I am interested in hearing from all of you about what more Congress can do to help you in your efforts to combat the disease. Thank you very much. I yield back.

Chairman ROYCE. Thank you.

We begin this morning, our first witness will be Dr. Rajiv Shah. He is the 16th Administrator of the U.S. Agency for International Development, and previously he served as Under Secretary of Research, Education, and Economics at USAID and as chief scientist at the U.S. Department of Agriculture. And we welcome him back to the committee.

Ambassador Bisa Williams is the Deputy Assistant Secretary of the Bureau of African Affairs, and previously she served as U.S. Ambassador to the Republic of Niger from 2010 to 2013.

Mr. Michael Lumpkin is currently the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict. He previously served as Deputy Chief of Staff for Operations at the Department of Veterans Affairs.

Major General James Lariviere is the Deputy Director for Political Military Affairs for Africa for the Joint Chiefs of Staff. Previously he worked on Capitol Hill as a military legislative assistant, a professional staff member with the House Armed Services Committee, and as both staff director and minority staff director of the House Veterans' Affairs Committee.

Major General Nadja West is the Joint Staff Surgeon. She serves as the Chief Medical Adviser to the chairman of the Joint Chiefs of Staff and coordinates all issues related to health services, including operational medicine, force health protection, and readiness among the combatant commands.

And Mr. Lumpkin will give oral testimony on behalf of the Department of Defense. Major General Lariviere and Major General West are available to answer our members' questions here today.

And, without objection, the witnesses' full prepared statements will be made a part of the record. Members will have 5 calendar days to submit any statements or questions or any extraneous material for the record.

And so we go now to Dr. Rajiv Shah.

STATEMENT OF THE HONORABLE RAJIV SHAH, ADMINISTRATOR, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. SHAH. Thank you, Chairman Royce, Ranking Member Engel, and members of the committee. Mr. Chairman, I want to recognize and thank you for your leadership on behalf of America's efforts to promote our national security and economic prosperity through developmental and humanitarian investments made all around the world, particularly at times of crisis and recognize the historic role you have played in helping support these efforts and reform, in particular the way we provide food assistance around the world.

Thank you, Congressman Engel, for your unwavering leadership and support and friendship, and I value the support you have offered for our global health efforts in this crisis but also all around the world.

And special recognition, of course for Representatives Smith and Bass for your extraordinary and consistent leadership in global health for so many years, which we draw upon now as we face this crisis.

As the chairman noted, today we face the largest and most protracted Ebola epidemic in our history, with more than 14,000 infected and more than 5,000 already deceased. I have had a chance to visit these countries and meet those who have been affected. And I can tell you that the most tragic part of the Ebola crisis is that it strikes those who offer the most care and the most love to those who are affected, a mother who holds a sick child or a son or daughter who kisses a deceased parent.

In Guinea, Liberia, and Sierra Leone, we are facing a crisis of epidemic proportions, and the President has directed us to lead a whole-of-government response in west Africa that can help ensure America's security and safety from this tragic disease. I am proud here to be with members of our team across the interagency who have offered extraordinarily important leadership. You will hear from Assistant Secretary Lumpkin about the really herculean efforts the military has taken, and I hope he will share with you how important it has been to have, amongst other things, the Navy labs in place, greatly accelerating the time it takes to do diagnostics, from 7 or 8 days down to 5 or 6 hours, thus allowing us to accelerate the performance of the response. You will hear from Deputy Assistant Secretary Williams about the more than $800 million in commitments that our State Department has helped to encourage from other countries so that the United States is not, in fact, pursuing this effort alone. And while you won't hear today from the Centers for Disease Control and Health and Human Services, I can tell you that on the ground, our teams operate in an absolutely integrated manner, and in fact, our disaster assistance response

team, which is leading the effort, is co-led; the deputy director of that team is a member of the Centers for Disease Control.

President Obama is requesting $6.18 billion in emergency funding to enhance our efforts to urgently address this crisis right now and for the coming year. These resources are essential to rapidly scaling up activities to control the outbreak at its source, to support recovery in west Africa in health and agriculture and food and other sectors of work to prevent civil unrest and governance collapse, and to strengthen global health security in the region, so, as we just saw yesterday, cases appearing in Mali don't get beyond that area and are effectively controlled.

I would like to share with you just a few quick observations from my trip. In Liberia, I had a chance both to meet first responders and to see the extraordinary results of American investment and effort. As just one example, the 65 burial teams that we now have up and running have tackled this crisis at its most aggressive point of transmission. Seventy percent of all cases get transmitted through the bodies and the handling of the bodies of the deceased. Today, more than 95 percent of dead bodies are disposed of in a dignified manner, but in a safe manner with the proper burial team handling the disposal of that body. That is just one example, but that has clearly helped to bring down the number of new cases so that today we believe the transmission rate has been greatly reduced in Liberia.

In Sierra Leone, I had a chance to visit trainers who are training hundreds of healthcare workers, mostly African and mostly local, in effective protective equipment and performance so they can be on the front lines of the response. Together with the World Health Organization and other countries, we will in fact train thousands of local healthcare workers who are on the frontline of taking on risk and who will be the legacy we leave behind so that there is, in fact, to answer the Congresswoman's question, a legacy of support for global health efforts throughout the region.

And, in Guinea, although they have the fewest number of cases out of the three, perhaps current active cases of 500 to 600, we are working aggressively to scale up efforts in the difficult to reach forest region, difficult to reach rural community, where most of these cases currently exist.

Finally, I just want to highlight that in order to be effective in this response, we have had to do some things very differently across our team. First, we have had to invest in real innovation and science, and just in the next 2 days, we will be reviewing proposals for new protective suits that can help reduce the infection risk when health workers take them off and put them on because the current protective equipment is not designed for tropical disease control. We are sending a real time data team that has already gotten more than 8500 ruggedized android devices, handheld devices so we can get better real-time data on where the cases are and respond even more quickly and rapidly to meeting those needs. And we are using our efforts in agriculture and food in particular to make sure that the backbone of the rural economy in all three countries, which is agriculture based, can be up and running again as soon as possible, using our Feed the Future program to help accelerate performance in that sector.

These efforts taken together and led by our disaster assistance response team leader, Bill Berger, on the ground in Monrovia, is making a tremendous difference at changing the path of this epidemic. If we continue to provide support at the level the President is requesting, we believe we can overcome this crisis by tackling it at its source.

And I want to thank everyone on the committee for your ongoing support of the risks and the leadership being shown by our teams in country every single day. Thank you.

Chairman ROYCE. Thank you, Administrator Shah.

[The prepared statement of Mr. Shah follows:]

Testimony of
Dr. Rajiv Shah
Administrator
U.S. Agency for International Development
Before the
House Committee on Foreign Affairs
"Combating Ebola in West Africa: The International Response"
November 13, 2014

Thank you, Chairman Royce, Ranking Member Engel, and members of the Committee for the opportunity to discuss the U.S. and international response to the ongoing Ebola epidemic in West Africa.

Today, as you know, the world faces the largest and most-protracted Ebola epidemic in history. This devastating virus has infected more than 14,000 people and killed more than 5,000 people across West Africa. The epidemic has spread through Guinea, Liberia, and Sierra Leone—countries with fragile health and economic systems and recent histories of civil war or political instability. In addition, the Ebola virus has spilled over into three neighboring countries where the response has been swift.

Most of the families that have been affected already live in desperate circumstances, where securing clean water and food is a daily struggle. In Liberia alone, 58 percent of the population lives in extreme poverty with very few assets to help them cope. It is within this context that Ebola has emerged—threatening our global security and economy. It represents a national security priority for the United States and every other nation in the world.

Thanks to leadership from President Obama and the United States Congress, the U.S. is helping lead an international coalition to tackle this crisis with an evidence-based strategy. I recently traveled to the region to assess the response and met the heroes serving on the frontlines, including health care workers, humanitarians, and local community leaders, who are saving lives and making a difference every day.

We are starting to see early signs of progress as a result of a strategic and flexible approach, but there is no doubt that we must continue to expand the pace, ingenuity, and scale of our response. That is why President Obama has requested $6.18 billion in emergency funding to enhance our efforts to urgently address this crisis and meet longer-term recovery and prevention needs. This response is designed to fortify domestic public health systems, contain the epidemic at its source in West Africa, speed the development of vaccines and therapeutics, and strengthen global health security. It includes $1.98 billion in urgently needed resources for USAID—out of the $2.1 billion joint USAID and State request—to rapidly scale up activities to control the outbreak, support recovery in West Africa, and strengthen global health security.

This unprecedented epidemic requires an extraordinary international relief effort. We are developing an increasing number of public-private partnerships, including with Johns Hopkins and the Paul G. Allen Family Foundation. Many countries are contributing to the effort through both financial and in-kind donations, including a total of nearly $800 million in commitments from other governments. But far more is needed. As President Obama has stressed, governments, international organizations, and the private sector must step up far more aggressively. Sustained support to all three countries and the broader region is essential to lock in our momentum and ultimately defeat this epidemic.

U.S. STRATEGY AND RESPONSE

The United States has mounted an aggressive effort governed by four key pillars to stop this crisis: control the epidemic; mitigate second-order impacts, including blunting the economic, social, and political tolls; coordinate the U.S. and broader global response; and fortify global health security infrastructure.

Across our response, we are working with agility, speed, and responsiveness in a very dynamic environment. During my visit to the region, I saw this focus and flexibility in my meetings with private sector leaders, non-governmental organizations (NGOs), and the donor community. In my conversations with the Presidents of Liberia, Guinea, and Sierra Leone, we discussed the need for robust engagement and coordination as this crisis evolves. We are learning and adapting our strategy to be highly mobile and scalable to quickly respond to flare-ups in rural and hard-to-reach areas.

This is the largest U.S. response to a global health crisis in history. There are currently more than 2,100 U.S. Government personnel on the ground, including the USAID Disaster Assistance Response Team that President Obama has called the "strategic and operational backbone of America's response." The response brings together the expertise and resources of the whole of the U.S. Government, including USAID, the Department of State, the Department of Health and Human Services, the Centers for Disease Control and Prevention, the U.S. Forest Service, and the Department of Defense. We are also collaborating closely with partner governments, international organizations, including the World Health Organization, the World Food Program, and UNICEF, and NGOs, such as International Medical Corps and Global Communities. Ultimately, the ramp up of civilian, NGO, host country, and international partner capacity will enable our military to transition home.

Our current efforts are intensely focused on controlling the spread of the disease. The President's request includes $1.3 billion to contribute to this pillar of our response. Our rapid-response strategy to break transmission of the virus emphasizes five components: effective isolation of cases in Ebola treatment units and Community Care Centers; burial teams to quickly remove dead bodies to prevent further viral transmission; awareness and behavior change at the individual and community level; improved infection control at general health clinics; and an effective command and control system in each country.

In Liberia, we are seeing encouraging progress in highly affected areas, while new cases are emerging in harder-to-reach areas. Overall, the average reported cases per week have decreased by more than a third in the past month. We believe that the rapid scale-up of burial teams across the country—combined with a significant investment in risk-reduction strategies, including changes in traditional burial practices—has contributed to this reduction in transmission.

We continue to adapt our strategy in Liberia to rapidly address these hard-to-reach cases and remain highly vigilant to further outbreaks. We are advancing the Government of Liberia's fight against Ebola by supporting the medical and non-medical management of Ebola Treatment Units; constructing Community Care Centers; supporting logistics and supply for the international response effort; ensuring nationwide access to safe burials; expanding the mobilization and provisioning of health care workers and supporting widespread community mobilization and information campaigns.

This week, a 25-bed critical care hospital, constructed by the American military and staffed by a 69-person team from the U.S. Public Health Service Commissioned Corps, opened outside of Monrovia. The facility will provide a high level of care to health care workers—both local and international—who contract the virus while treating Ebola patients. Already in Liberia, U.S. support has allowed 8 Ebola Treatment Units to open. In the days and weeks ahead, additional U.S.-built or funded treatment facilities will come on line.

In Sierra Leone, the United Kingdom has surged their response in recent weeks by building on the U.S. model and the lessons we learned in Liberia, including focusing on early gains through burial teams and social mobilizations. With robust engagement from the U.S., the United Kingdom leads international efforts to implement the government's national strategy to construct Ebola Treatment Units, build Community Care Centers, and scale up burial teams. Through our partners, we are helping strengthen the early identification of suspected cases and contacts to break the chain of viral transmission.

In Guinea, which is roughly three times the population and economic size of Liberia, we have expanded our Disaster Assistance Response Team to meet increasing needs and ensure the effective coordination of aid. Guinea's Forest Region remains the epicenter of the outbreak in that country and continues to pose risks of spread to other parts of Guinea and to neighboring countries. We are supporting the scale-up of critical interventions, including contact tracing, community mobilization, and support for Ebola Treatment Units. This package of interventions will make a substantial difference in Guinea, as we have seen demonstrated in Liberia.

Months into this unprecedented response, critical gaps in resources remain, especially in Sierra Leone and Guinea. We continue to remain focused on addressing key challenges, including supporting health care workers on the frontlines and improving data quality and timeliness. The President's request in emergency funding is essential to accelerate and expand our efforts as this dynamic crisis continues.

HEALTH CARE WORKERS

The capacity to respond to a crisis of this scale simply would not exist without the heroic work of health care workers who serve on the frontlines. As President Obama has said, "The medical professionals and public health workers serving in Africa are a shining example of what America means to the world... They make huge sacrifices to protect this country that we love. And when they come home, they deserve to be treated properly."

At a training session in Sierra Leone, I met the heroes of the response, especially local health workers who have stepped forward to fight Ebola, when so many others have fled. I also met a young doctor from Germany who gave up her holiday to put on a personal protective suit in the stifling heat and train others to work in the hot zone. We need hundreds more just like them. We estimate that at least 1,000 international health care workers will be needed each month in West Africa.

We have taken strong steps to facilitate and enable health care workers. As the response continues to scale up, NGOs are more clearly identifying staffing needs and requirements, enabling them to actively recruit necessary staff. We must ensure that when these brave individuals do volunteer to serve, we do not prevent or unduly discourage them from undertaking this indispensable and selfless work.

INNOVATION

Time and again, we have seen the value of innovation in crisis response—from satellite predictive modeling to electronic food vouchers. Through the establishment of USAID's U.S. Global Development Lab, we are sparking similarly creative and bold thinking today. Thanks to champions like Chairman Michael McCaul and Congressman Joaquín Castro, the Lab is uniting a diverse community of partners—from companies to students—in the quest for ingenious ideas in this effort.

That is why President Obama announced *Fighting Ebola: A Grand Challenge for Development*, a grant competition designed to produce better tools to tackle this disease in a matter of weeks, not years. We are exploring advances in diagnostics that reduce the difficulty of rapidly transporting blood samples over terrible roads; new medical options, such as vaccines and therapeutics; improved designs for personal protective equipment (PPE); and real-time data to better predict spikes and valleys in active cases.

This Grand Challenge has already received over 1,250 submissions, over a third of which are focused on improving PPE. The best ideas will be evaluated tomorrow in a "pitch day" before a committee of experts and may be in the field within months. We are also working with the scientific and research communities to encourage innovative diagnostics that will rapidly identify those who are infected at the point of care. We have also formed a Real-Time Data Team that is working with the UN, private sector, and affected governments to improve the data collection and harmonization critical for accurately informing tactics.

APPROACH TO SECONDARY IMPACTS OF THE CRISIS

The consequences of this crisis will persist long after the epidemic is stopped. Trade has slowed, agriculture has been disrupted, and economic systems have been shaken. In a matter of months, Ebola has placed at risk development gains that took years to achieve. Containing Ebola over the long-term and protecting our own national security fundamentally requires us to invest in resilient health and agricultural systems in West Africa.

As a component of our response, we are heavily focused on mitigating the secondary and longer-term impact of the crisis. The President's request includes $388 million to address urgent food insecurity and help avoid the destructive consequences of the epidemic for regional prosperity and stability, which ultimately affects our own national security.

The interventions we are scaling today—from improved hygiene behavior to health infrastructure—have the potential to significantly improve child and maternal survival throughout the region. They will also strengthen the ability of local health systems to report threats in real-time and stop health emergencies before they become epidemics.

We will work with countries to restart services in parallel with containment of Ebola. With the countries' health systems paralyzed by the sheer volume of Ebola cases, communities face many other health threats. Many die from lack of access to safe delivery, treatment of childhood infections, and other diseases. Our assistance during this restarting phase includes giving families access to health information and essential health commodities. To the extent available, we will help develop innovative approaches to providing life-saving services that do not detract from Ebola containment.

Food Security: To help support families affected by Ebola, USAID is providing targeted in-kind food rations to affected households and communities cut off from markets, as well as specialized food commodities to meet the acute need for supplementary and institutional feeding necessary for Ebola treatment units, community care centers, orphanages, and other specialized feeding programs. If the number of people infected continues to rise, so will the acute food assistance needs. Interruptions in the harvest, restrictions on movement, and a slowdown in trade could severely disrupt markets, reduce household incomes, and lead to food shortages.

The Famine Early Warning Systems Network, a USAID-funded predictive system, has issued an alert that a major food crisis may occur early next year—depending on how the epidemic evolves. To prevent this crisis from happening and accelerate economic recovery, USAID is structuring its emergency food assistance to address immediate food needs while also supporting local markets and food production. These emergency activities will complement the longer-term efforts of Feed the Future to accelerate the recovery of health and agricultural systems in the Ebola affected countries. Through a new regional Feed the Future effort, we will help build the medium and long-term agricultural resilience of farmers to future shocks. In recent years, we have had new flexibilities that allow us to use the right tool to provide food assistance in different contexts. In West Africa, the World Food Program plans to purchase 3,600 metric tons of rice on local markets in Liberia to sustain market functionality in the region. This purchase will include approximately 600 metric tons of rice from farmers supported by Feed the Future in Liberia.

Global Health Security: Our investments in global health security focus on two high-priority objectives: preparing unaffected countries to rapidly detect and control any introduction of Ebola during the current epidemic; and preventing and reducing the threat of future outbreaks. Using a combination of regional planning meetings and direct country level technical assistance, we are helping countries develop and test national Ebola Preparedness and Response Plans. By mid-2015, all 14 neighboring West African countries will have detailed Ebola preparedness plans, at least one laboratory capable of detecting the Ebola virus, and trained personnel at border sites to identify and manage suspect cases. This approach can also be used to prepare countries for other public health threats. Nigeria's successful effort to contain the Ebola outbreak demonstrates the effectiveness of a highly engaged government and a rapid and coordinated local response.

Efforts are already underway to plan for rebuilding these health systems in coordination with the Department of Defense's Cooperative Biological Engagement Program. We will support rapid assessments in collaboration with other donors, and we will review lessons from the past decade of health system rebuilding before the outbreak. With country officials and other donors, we will help plan for building back resilient systems that can withstand unexpected disease outbreaks and serve the health needs of the countries' populations.

The President's emergency request will further this effort and build resilience to dangerous pathogens that can "spill over" into humans. Since 2005, USAID has supported the routine monitoring of dangerous new animal pathogens and put in place capacities for their rapid detection and control. This work, which has proven highly effective in reducing threats, has been targeted in a limited numbers of geographic hot spots. This request will be used to build on this success and expand into other hot spots to protect against future spillover events and reducing infectious disease threats.

CONCLUSION

It is not a coincidence that Ebola has taken hold in nations only recently emerging from decades of conflict and poverty. Again and again, we have seen the intersection of extreme poverty and vulnerability push communities to the edge of survival and challenge our own sense of security and prosperity. This crisis only underscores the vital importance of our Agency's mission: to end extreme poverty and promote resilient, democratic societies while advancing our security and prosperity.

Even as we see positive signs in the response, we know that more must be done to keep up our momentum. Every Ebola outbreak in history has been stopped, and the current epidemic will be too. But it will continue to require great speed, cooperation, creativity, country leadership, and—most importantly—courageous men and women serving on the frontlines.

Thank you.

Chairman ROYCE. We now go to Ambassador Williams.

STATEMENT OF THE HONORABLE BISA WILLIAMS, DEPUTY ASSISTANT SECRETARY, BUREAU OF AFRICAN AFFAIRS, U.S. DEPARTMENT OF STATE

Ambassador WILLIAMS. Thank you. Thank you, Chairman Royce. Ranking Member Engel, and distinguished members of the committee. I thank you for this opportunity to testify today regarding the Department of State's role in the U.S. whole-of-government response to the Ebola outbreak in west Africa.

The ongoing Ebola epidemic in west Africa has already resulted in over 14,000 infected and nearly 5,500 deaths. While Liberia, Sierra Leone, and Guinea have borne the brunt of this tragic epidemic, we have also seen isolated cases in Nigeria, Senegal, Mali, Spain, and the United States. This reminds us that Ebola can be a threat anywhere until we end the epidemic at its source in west Africa.

The Ebola epidemic has inflicted human, economic, and social costs across the affected countries in west Africa and has stretched existing health systems to the breaking point. Beyond the epidemic's immediate effects, fewer children are being vaccinated; an increasing number of people lack adequate food; an increasing number of orphans require care; and economies have been badly damaged. All this has occurred against the backdrop of countries still recovering from civil war. In short, the Ebola epidemic is not only a health crisis; it is a potential global security crisis.

The United States Government has stepped forward as a global leader to stamp out this scourge at its source. However, a challenge of this magnitude requires global cooperation. The Department of State therefore plays a critical role in mobilizing international resources and coordinating with partner states, regional organizations, nongovernmental organizations, and the United Nations to build capacity in the affected countries and beyond to respond to this crisis.

In this respect, we are working particularly closely with Dr. David Nabarro, the U.N. Secretary General's Special Envoy on Ebola, and the U.N. Mission for Ebola Emergency Response or UNMEER to identify resource shortfalls and those international donors best placed to contribute needed financial support, manpower, and in-kind contributions. The U.N. has sounded a call for $1.5 billion to finance the U.N. response to the epidemic. And the State Department continues to conduct intensive bilateral and multilateral outreach to urge countries to contribute to the U.N. funding appeal.

In September, we launched a broad outreach strategy at the U.N. General Assembly that raised global awareness of the emergency and emphasized the high priority the United States places on addressing it. In mid October, we followed up with targeted outreach calls from the President, Secretary Kerry, Secretary Burwell, CDC Director Dr. Frieden, National Security Adviser Rice, and U.S. Ambassador to the U.N. Power to their counterparts in a subset of key donor countries, and it worked. Since October 10th, those countries have pledged an additional $793.2 million to the global Ebola response in addition to significant nonmonetary contributions and bi-

lateral contributions approaching $1 billion. Those numbers continue to grow.

We are heartened by this growing support of countries around the globe, from tiny Timor-Leste to giant China. Despite these gains, we know that the fight is far from over and that much more must be done. As the President continues to say, we, the global community, need to do more and do it faster. Therefore, we will continue to push forward over the coming months. This means reinforcing our message at major multilateral events, including the summits of the G20, APEC, ASEAN, and the EAS, to drive action and seed contributions from a larger pool of donors. We are also looking at our partners in the Middle East as well as rising global economic powers, such as India, Indonesia, and Brazil, to do more. We are working with the African Union to bring their pledge of healthcare workers to the affected countries, matching needs on the ground with the skills and numbers of their volunteers. We support the African community's leadership in this response.

Healthcare workers are the linchpin of the fight against Ebola, and recruiting these incredible heroes and removing disincentives for them to volunteer are a key facet of our outreach. So we are working with UNMEER, the World Bank, and our partner governments to provide the logistical support these volunteers require, as well as the laboratory capacity, airlift resources, and personal protective equipment they need to operate Ebola treatment units and other care centers.

I would like to turn now to our work with the private sector in this response. The State Department has focused on three aspects of private sector mobilization, urging businesses to contribute their resources to the Ebola response, urging companies that are doing business in the region to stay, and engaging U.S.-based businesses to consider investing in the region. The State Department has collaborated with groups, such as the Corporate Council on Africa and the Business Council on International Understanding, to convene companies interested in providing specific in-kind donations that would benefit the response. These groups as well as private American medical institutions, such as Morehouse Medical School and the Harvard Medical School, are focusing not only on responding to the short-term needs to combat Ebola but also on providing the infrastructure support that we know is necessary for the long-term economic and social recovery of the affected nations.

One example of such collaboration is the State Department's partnership with the Paul G. Allen Family Foundation, which has not only donated $100 million to the response effort but has offered to pay for the manufacture of new specialized medical evacuation pods on behalf of the State Department.

As another example, we are partnering with American technology firms to bolster information communication technology or ICT infrastructure in conjunction with UNMEER. Coordinating the response in west Africa is a massive logistical undertaking that requires adequate ICT to be successful. The efforts of the State Department and USAID in conveying the substantial ICT needs in affected countries have raised awareness of the need for better ICT infrastructure both to fight the Ebola virus right now and to make future disaster responses more effective.

At the same time, Assistant Secretary Linda Thomas Greenfield has been working to keep diaspora groups informed and to encourage business interests in the region to stay the course through this current crisis. The U.S. Chamber of Commerce Foundation, the Corporate Council on Africa, the Ebola Private Sector Mobilization Group, the Business Council for International Understanding, and many private sector entities with substantial long-term business and investment presences in the affected regions have coordinated closely with the Department of State and USAID. We have advised them how they can not only employ their infrastructure and financial resources in support of this effort but also use examples of their positive partnership to encourage additional corporate engagement within their respective sectors in support of the Ebola response.

As you can see, there are a multitude of actors involved in response efforts. As we recruit and convene them, the State Department is also focused on channeling their efforts to fill known resource gaps, which really brings us back to the U.N.

Chairman ROYCE. Ambassador——

Ambassador WILLIAMS. Oh?

Chairman ROYCE. It has been like 8 minutes.

Ambassador WILLIAMS. I am over time.

Chairman ROYCE. I think what I would like to ask the witnesses to do is if you will just give 5 minutes of testimony, we have got your written report here, and we will have an opportunity to ask you questions afterwards. So maybe we should go to Mr. Lumpkin now.

Ambassador WILLIAMS. I appreciate it. Thank you.

Chairman ROYCE. Thank you, Ambassador.

[The prepared statement of Ambassador Williams follows:]

STATEMENT FOR THE RECORD

MS. BISA WILLIAMS

DEPUTY ASSISTANT SECRETARY

BUREAU OF AFRICAN AFFAIRS

U.S. DEPARTMENT OF STATE

BEFORE THE 113TH CONGRESS

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON FOREIGN AFFAIRS

NOVEMBER 13, 2014

Introduction

Chairman Royce, Ranking Member Engel, and distinguished Members of the Committee, thank you for the opportunity to testify today regarding the Department of State's role in the whole-of-government U.S. response to the Ebola outbreak in West Africa.

The ongoing Ebola epidemic in West Africa has already resulted in over 14,000 infected and more than 5,000 deaths. While Liberia, Sierra Leone, and Guinea have borne the brunt of this tragic epidemic, we have also seen isolated cases in Nigeria, Senegal, Mali, Spain, and the United States. This reminds us that Ebola can be a threat anywhere until we end the epidemic at its source in West Africa.

The Ebola epidemic has inflicted human, economic, and social costs across the affected countries in West Africa, and has stretched existing health systems to the breaking point. Beyond the epidemic's immediate effects, fewer children are being vaccinated against other diseases, an increasing number of people lack adequate food, an increasing number of orphans require care, and economies have been badly damaged. All this has occurred against the backdrop of countries still recovering from civil war. In short, the Ebola epidemic is not only a health crisis – it is a potential global security crisis.

International Outreach

The U.S. government has stepped forward as a global leader to stamp out this scourge at its source. However, a challenge of this magnitude requires global cooperation. The Department of State therefore plays a critical role in mobilizing international resources and coordinating with

partner states, regional organizations, non-governmental organizations, and the United Nations to build capacity in the affected countries and beyond to respond to this crisis. In this respect, we are working particularly closely with Dr. David Nabarro, the UN Secretary General's Special Envoy on Ebola, and the UN Mission for Ebola Emergency Response (UNMEER) to identify resource shortfalls and those international donors best placed to contribute needed financial support, manpower, and in-kind contributions.

The UN has sounded a call for $1.5 billion to finance the UN response to the epidemic, and the State Department continues to conduct intensive bilateral and multilateral outreach to urge countries to contribute to the UN funding appeal. In September, we launched a broad outreach strategy at the UN General Assembly that raised global awareness of the emergency and emphasized the high priority the United States places on addressing it.

In mid-October, we followed up with targeted outreach calls from the President, Secretary Kerry, Secretary Burwell, CDC Director Dr. Frieden, National Security Advisor Rice, and U.S. Ambassador to the UN Power to their counterparts in a subset of key donor countries. And it worked. Since October 10th, those countries have pledged an additional $793.2 million to the global Ebola response, in addition to significant non-monetary contributions and bilateral contributions approaching $1 billion. Those numbers continue to grow.

We are heartened by this growing support of countries around the globe, from tiny Timor-Leste to giant China. Despite these gains, we know that the fight is far from over, and that much more must be done. As the President continues to say, we – the global community – need to do more

and do it faster. Therefore, we will continue to push forward over the coming months. This means reinforcing our message at major multilateral events – including summits of the G20, APEC, ASEAN, and EAS – to drive action and seek contributions from a larger pool of donors. We are also looking to our partners in the Middle East, as well as rising global economic powers – such as India, Indonesia, and Brazil – to do more. We are working with the African Union to bring their pledge of healthcare workers to the affected countries, matching needs on the ground with the skills and numbers of their volunteers; we support the African community's leadership in this response.

Healthcare workers are the lynchpin of the fight against Ebola, and recruiting these incredible heroes – and removing disincentives for them to volunteer – is a key facet of our outreach. So we are working with UNMEER, the World Bank, and our partner governments to provide the logistical support these volunteers require, as well as the laboratory capacity, airlift resources, and personal protective equipment they need to operate Ebola Treatment Units and other care centers.

Private Sector Outreach

I'd like to turn now to our work with the private sector in this response. The State Department has focused on three aspects of private sector mobilization: urging businesses to contribute their resources to the Ebola response, encouraging companies that are doing business in the region to stay, and engaging U.S.-based businesses to consider investing in the region. State has collaborated with groups such as the Corporate Council on Africa and the Business Council on International Understanding to convene companies interested in providing specific in-kind

donations that would benefit the response. These groups, as well as private American medical institutions (such as Morehouse Medical School and Harvard Medical School), are focusing not only on responding to the short-term needs to combat Ebola, but also on providing the infrastructure support that we know is necessary for the long-term economic and social recovery of the affected nations.

One example of such collaboration is the State Department's partnership with the Paul G. Allen Family Foundation, which has not only donated one hundred million dollars to the response effort, but has offered to pay for the manufacture of new specialized medical evacuation 'pods' on behalf of the State Department.

As another example, we are partnering with American technology firms to bolster information communication technology – or "ICT" – infrastructure in conjunction with UNMEER. Coordinating the response in West Africa is a massive logistical undertaking that requires adequate ICT to be successful. The efforts of the State Department and USAID in conveying the substantial ICT needs in affected countries have raised awareness of the need for better ICT infrastructure both to fight the Ebola virus right now and to make future disaster responses more effective.

At the same time, Assistant Secretary Linda Thomas-Greenfield has been working to keep diaspora groups informed and encourage business interests in the region to stay the course through this current crisis. The U.S. Chamber of Commerce Foundation, the Corporate Council on Africa, the Ebola Private Sector Mobilization Group, the Business Council for International

Understanding, and many private sector entities with substantial long-term business and investment presences in the affected regions have coordinated closely with the State Department and USAID. We have advised them how they can not only employ their infrastructure and financial resources in support of this effort, but also use examples of their positive partnerships to encourage additional corporate engagement within their respective sectors in support of Ebola response.

UN Coordination

As you can see, there are a multitude of actors involved in response efforts. As we recruit and convene them, the State Department is also focused on channeling their efforts to fill known resource gaps – which really brings us back to the UN, and the importance of working closely with UNMEER and partner UN agencies, such as the World Health Organization, the World Food Program, and the UN Children's Fund (UNICEF). The U.S. government provides 22 percent of UNMEER's three-month operational budget of $49.9 million, so we have a strong interest in ensuring UNMEER conducts a rapid, coordinated, cohesive, and accountable response. Ambassador Power in New York and Ambassador Hamamoto in Geneva have been particularly effective in advising the UN and building a long-term strategy. On the ground in West Africa, Ambassadors Malac, Hoover, and Laskaris have also provided critical input to guide UNMEER's activities on the ground and in partnership with the affected governments.

UNMEER *is* standing up, and we can already see its abilities broadening. In little over a month since its inception, all of UNMEER's in-country staging areas, main logistics hubs (in or near capitals) and 8 out of 12 Forward Logistics Bases are now operational. UNMEER has already

airlifted 109 tons of cargo, including 400,000 sets of personal protective equipment. We will continue to encourage more rapid deployment and will work with UNMEER to hand over U.S. responsibilities in the long-term.

Under the UNMEER umbrella, various UN agencies are leading different parts of the response. The WHO is leading the public health response and is at the forefront on discovering new cases and contact tracing, laboratory services, case management, coordination of the placement of medical personnel, and coordination of medevac for the UN system. Treatment access and medevac for all responders is improving, allowing more healthcare workers to join the response. We have also engaged WHO and its regional offices in support of efforts to strengthen Ebola preparedness throughout Africa and beyond to non-affected countries around the world.

WFP is providing food assistance and distribution, and has used its established networks to provide critical logistics services for the broader response. UNICEF is at the forefront of social mobilization efforts, working with non-governmental partners and utilizing radio, television, mobile broadcasts, and community outreach to reinforce messaging on Ebola. UNICEF is also providing support for water supply, sanitation, hygiene and solid waste disposal, providing counselling, and advising communities on how to stop the spread of disease and maintain security. UNDP is also providing equipment, running public information campaigns, providing kits to survivors, training police and security services, and working to make cash transfers available to thousands of affected families.

In addition to its mandated support to the Liberian government, the UN Mission in Liberia (UNMIL) has also facilitated the rapid and effective deployment of UNMEER, UN constituent organizations, and NGOs by providing engineering, communications, transportation, security, and logistical assistance. Additionally, UNMIL's field offices serve as hubs for UNMEER and other international Ebola efforts in the 15 counties of Liberia.

Post-Ebola Recovery

Mr. Chairman and Members of the Committee, these *are* signs of progress. Ambassador Samantha Power recently visited Guinea, Sierra Leone, and Liberia, and she saw how the contributions that have been made by the United States and our allies have begun to save lives and offer the first tangible signs that this virus can and will be beaten. But our work has only just begun. This outbreak has exposed the fragility of their health infrastructure and put development progress at risk. In a matter of months, Ebola has reversed years of hard-earned development progress in the affected countries. Since the outbreak began, the number of births in Liberia attended by a medical professional has fallen by roughly 30%, and maternal mortality is rising fast. A new World Bank report concludes that even if the response continues apace, the losses to Guinea, Liberia, and Sierra Leone could reach $359 million by the end of this year.

Liberia and Sierra Leone, as post-conflict countries, were vulnerable even before the Ebola outbreak, and it will require our proactive and sustained attention to ensure they experience a real recovery and avoid a protracted setback. I wish to note also that the economic effects of this crisis extend well beyond the three primarily affected countries. Trade and tourism across Africa

have been slowed by this outbreak. It is our responsibility to draw attention to these problems and to mobilize an effective international response to mitigate their effects.

Conclusion

This is a complex crisis that requires not just a whole-of-government response, but a global response. We stand at an historic juncture, facing one of the worst public health crises since HIV/AIDS. A rapid, robust, and unwavering response is our greatest defense.

STATEMENT OF THE HONORABLE MICHAEL D. LUMPKIN, ASSISTANT SECRETARY OF DEFENSE FOR SPECIAL OPERATIONS AND LOW-INTENSITY CONFLICT, U.S. DEPARTMENT OF DEFENSE

Mr. LUMPKIN. Chairman Royce, Ranking Member Engel, and distinguished members of the committee, thank you for the opportunity to testify today regarding the Department of Defense's role in the United States' comprehensive Ebola response effort, which is a national security priority in response to a global threat. Due to the United States military's unique capabilities, the Department has been called upon to provide interim solutions that would allow other departments and agencies the time necessary to expand and deploy their own capabilities.

United States military efforts are also galvanizing a more robust and coordinated international effort, which is essential to contain this threat and to reduce human suffering. Before addressing the specific elements of DoD's Ebola response effort, I would like to share my observations of the evolving crisis and our increasing response.

Like Administrator Shah, I recently traveled to the area and I was left with a number of overarching impressions that are shaping the Department's role in direct support of USAID.

First, our Government has deployed a top notch team experienced in dealing with disasters and humanitarian assistance.

Second, the Liberian Government is doing what they can with their very limited resources.

Third, the international response is increasing rapidly due to our Government's response efforts.

Fourth, I traveled to the region thinking we faced a health care crisis with a logistics challenge. In reality, we face a logistics crisis focused on a healthcare challenge.

Fifth, speed and scaled response matter. Incremental responses will be outpaced by this dynamic epidemic.

And, finally, the Ebola epidemic we face truly is a national security issue. Absent our Government's coordinated response in west Africa, the virus spread brings the risk of more cases here in the United States.

I would like to now turn to DoD's role in our direct support in west Africa. In mid-September, President Obama ordered the Department to undertake military operations in west Africa in direct support of USAID. Secretary Hagel directed that U.S. military forces undertake a twofold mission: First, support USAID and the overall U.S. Government efforts; and second, respond to the Department of State requests for security or evacuation if needed.

Direct patient care of Ebola-exposed patients in west Africa is not part of the DoD mission. Secretary Hagel approved unique military activities falling under four lines of effort: Command and control, logistics support, engineering support, and training assistance. In the last 8 weeks, DoD has undertaken a number of synchronized activities in support of these lines of effort to include designating a named operation, Operation United Assistance; establishing an intermediate staging base in Dakar, Senegal; providing strategic and tactical airlift; constructing the 25-bed hospital in Monrovia; and constructing 12 Ebola treatment units in Liberia; training local

and third-country healthcare support personnel, enabling them to serve as the first responders in these Ebola treatment units throughout Liberia.

In all circumstances, the protection of our personnel and the prevention of any additional transmission of the disease remain paramount planning factors. There is no higher operational priority than protecting our Department of Defense personnel.

In addition to the activities of United Assistance, the Department will continue to support the Liberian Armed Forces through Operation Onward Liberty and expand the regional efforts of DoD's cooperative biological engagement program. DoD has also increased support to the Department of Health and Human Services and the Department of Homeland Security, the lead agencies for Ebola response here in the United States, by activating a medical support team that can rapidly augment the Centers for Disease Control and Prevention and capabilities anywhere within the country in a 72-hour notice.

In conclusion, we have a comprehensive U.S. Government response and increasingly a coordinated international response. The Department of Defense's interim measures are an essential element of the U.S. response to lay the necessary groundwork for the international community to mobilize its response efforts, and as mentioned earlier by the chairman, I am joined by Major General Jim Lariviere and Major General Nadja West from the Joint Staff, and we look forward to your questions. Thank you.

Chairman ROYCE. Thank you.

[The prepared statement of Mr. Lumpkin follows:]

STATEMENT FOR THE RECORD

HONORABLE MICHAEL D. LUMPKIN

ASSISTANT SECRETARY OF DEFENSE

SPECIAL OPERATIONS AND LOW-INTENSITY CONFLICT

BEFORE THE 113TH CONGRESS

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON FOREIGN AFFAIRS

NOVEMBER 13, 2014

Introduction

Chairman Royce, Ranking Member Engel, and distinguished Members of the Committee – Thank you for the opportunity to testify today regarding the Department of Defense role in the comprehensive U.S. response to the Ebola epidemic. As President Obama affirmed in September, the Ebola epidemic in West Africa is not only a global threat, but a national security priority for the United States. Due to the U.S. military's unique capabilities, specifically speed and scale, the Department has been called upon to provide interim solutions that give the United States Agency for International Development (USAID) and other U.S. Government (USG) departments and agencies the time necessary to expand and deploy their own capabilities. Additionally, U.S. military efforts are helping galvanize a more robust and coordinated international effort, which is urgently needed to contain this threat and reduce human suffering in West Africa.

Before addressing the specific elements of the Department of Defense (DoD) Ebola response efforts, I would like to share my observations of the evolving crisis in West Africa and our increasing response. At the end of September, USAID Assistant Administrator Nancy Lindborg and I visited Liberia. Meeting with the country's civilian and military leaders, United Nations officials, nongovernmental organizations, and our civilian and military responders already operating in the region, I was left with a number of overarching impressions that are shaping the Department's role in our comprehensive, interagency response.

First, the USG has deployed a top-notch team with vast experience in dealing with disasters and humanitarian assistance. The Disaster Assistance Response Team (DART), deployed by USAID, is leading the USG effort to address the Ebola epidemic abroad, and the Joint Force Commander is in direct support of USAID's leading role. This collaborative effort is

making a real difference. This interagency team is synchronizing its activities with the local and international response efforts, which are increasing due to the USG response. The USG, led by the Department of State's diplomatic outreach efforts, USAID's engagement with healthcare and humanitarian organizations, and the Centers for Disease Control and Prevention's public health response activities, continues to see an upswing in international efforts, particularly in the wake of President Obama's remarks in September and with the advent of the United Nations Mission for Ebola Emergency Response (UNMEER).

Second, the Liberian government, although significantly overburdened by this crisis, is doing what it can with every resource available. There is little transportation or health infrastructure outside Liberia's capital, Monrovia. Moreover, the existing infrastructure is in disrepair and dangerously overstressed. With almost 200 inches of rain each year, the roads in many locations are impassible for any movement beyond foot travel and – concomitantly – the Ebola virus.

Third, I traveled to the region thinking we faced a healthcare crisis with a logistics challenge. In reality, we face a logistics crisis focused on a healthcare challenge. The shortage of local transportation, passible roadways, and inadequate infrastructure to facilitate the movement of essential supplies and equipment are hindering the overall global community response to contain and combat the Ebola outbreak. This global threat, with increased international response efforts and contributions, can be overcome.

Fourth, our four lines of effort - Command and Control, Logistics Support, Engineering Support, and Training Assistance – are in support of the DART and well within DoD's capabilities. To date, we have deployed more than 1,900 DoD personnel to the region who are safely executing their assigned missions on a daily basis. Our ability to execute this mission with

speed and a scaled response is critical. Incremental responses will be outpaced by an epidemic dynamic in nature, and that has the potential to increase dramatically with the onset of only a few new cases.

The Ebola epidemic we face is a national security issue – one that requires coordinated domestic and international efforts. Neither the U.S. nor the international community can build a moat around this issue in West Africa, and DoD's efforts in the region are an essential component to contain and reduce the epidemic. Absent our government's continuing response in West Africa, the virus' spread brings the risk of more cases in the United States.

Before summarizing DoD's role in the USG's USAID-led Ebola response efforts, I would like to thank this Committee and the other defense oversight committees for their decision to authorize obligation of up to $750 million of the $1 billion reprogrammed from Overseas Contingency Operations funding to DoD's Overseas Humanitarian, Disaster, and Civic Aid Program. This obligation authority has provided DoD the ability to deploy a joint task force to the region and rapidly undertake logistical, engineering, training, laboratory testing, and other support missions that are helping to turn the tide of this terrible epidemic.

I would also like to highlight the necessity and urgency of the resources sought by the President in his Emergency Appropriations Request for Ebola of last week. Of the $4.64 billion for immediate needs to combat this epidemic, the Department seeks $112 million that will provide immediate funding for Defense Advanced Research Projects Agency (DARPA) initiatives to develop technologies aimed at providing immediate, temporary immunity against Ebola while vaccines are developed. Additional initiatives are working to foster technologies to curtail the development timelines of these same vaccines.

The Department of Defense's Role in United States Government Ebola Response Efforts

In mid-September, President Obama ordered DoD to undertake military operations in West Africa to support USAID-led Ebola response efforts. The comprehensive USG response is predicated upon a multi-pillared strategy: control the outbreak, mitigate second-order impacts of the crisis, foster coherent international leadership and response operations, and improve mechanisms for global health security.

As Secretary Hagel noted at the September 26th meeting of the Global Health Security Agenda, DoD is operating in support of USAID as part of the USG's coordinated response to the Ebola Virus Disease (EVD) outbreak. The Secretary directed that U.S. military forces undertake a two-fold mission – first, support USAID in the overall USG efforts to contain the spread and reduce the threat of EVD; and, second, respond to Department of State requests for security or evacuation assistance if required. Direct patient care of Ebola-exposed patients in West Africa is not a part of the DoD mission.

In support of the mission's main element, Secretary Hagel approved military activities falling under the four lines of effort I mentioned earlier: Command and Control, Logistics Support, Engineering Support, and Training Assistance.

Command and Control are being conducted by a U.S. military joint force command deployed to the region. On September 15th, Secretary Hagel approved a named operation, OPERATION UNITED ASSISTANCE (OUA), for U.S. military efforts in response to EVD. On October 25th, Major General Gary Volesky, the Commander of the Army's 101st Airborne Division, assumed command of the mission from Major General Darryl Williams, the Commander of U.S. Army Africa.

Major General Volesky and the deploying elements of his command bring not only significant operational capabilities to support the mission's lines of effort, but also the command-and-control structure necessary to coordinate U.S. military efforts with other entities. These include: other USG departments and agencies; the Government of Liberia and – in particular – the Armed Forces of Liberia; the United Nations, other intergovernmental organizations, and nongovernmental organizations providing relief in the region; and bilateral partners providing a military response to the epidemic.

DoD's logistics activities are primarily improving transportation capabilities regionally and immediate care capabilities in Liberia. To support transportation efforts, the U.S. military has worked with regional and international partners to establish an intermediate staging base in Dakar, Senegal. U.S. military aircraft are providing strategic airlift into West Africa and tactical airlift within Liberia to move supplies and personnel. To support immediate care capabilities, U.S. military forces constructed a 25-bed hospital in Monrovia as a treatment facility for Liberia-based, non-U.S., non-military healthcare providers exposed to Ebola. This hospital is being manned by United States Public Health Service healthcare professionals, and is prepared to provide care to patients.

Our third line of effort is Engineering Support. In this effort, we have established our joint force headquarters in Monrovia and a training facility proximate to the headquarters, and are prepared to construct up to 17 Ebola Treatment Units (ETUs) in Liberia at which non-U.S. military healthcare professionals can isolate and treat Ebola-infected patients. U.S. military engineers are facilitating site selection and construction of ETUs, and are working closely with Armed Forces of Liberia engineers who are committing their efforts to ETU construction.

Training activities are an additional facet of the joint force command's focus. U.S. military personnel are prepared to train up to 500 healthcare support personnel at a time, enabling the healthcare workers to serve as the first responders in ETUs throughout Liberia. As of November 9th, 133 healthcare workers and support staff had been trained, and a third class of 121 students is scheduled to begin on November 10th. Again, U.S. military personnel will not provide direct care to Ebola patients in West Africa.

In addition to OUA's efforts, the Department continues its enduring programs in the region. In Liberia, OPERATION ONWARD LIBERTY, consisting of approximately 25 U.S. military personnel, partners with the Armed Forces of Liberia to improve the professionalization and capabilities of Liberia's military.

Regionally, we are expanding the efforts of DoD's Cooperative Biological Engagement Program (CBEP) to address urgent needs in the affected countries, and to provide robust and sustainable enhancements to biosafety, biosecurity, and biosurveillance systems in neighboring and at-risk countries in West Africa. The program will also seek to leverage existing partnerships with South Africa, Kenya, and Uganda to bolster regional capacities to mitigate threats associated with the current and potential future infectious disease outbreaks. As an immediate example of these efforts, CBEP, the U.S. Navy, and the U.S. Army have deployed six mobile labs to Liberia that provide diagnostic capabilities essential to containing and reducing EVD. These labs augment the capacity of the Liberian Institute for Biomedical Research lab, at which CBEP has funded the work of three experts. The Department is working through the approval processes for deploying two additional labs to support the UK-led Ebola response efforts in Sierra Leone.

DoD has also expanded its activities to support domestic response capabilities here at home. Last month, at the request of the Department of Health and Human Services (HHS), the Department activated a 30-member medical support team that is prepared to deploy anywhere in the continental United States within 72 hours to augment HHS Centers for Disease Control and Prevention (CDC) public health experts and hospital staff, filling in any clinical staffing gaps in treating EVD patients in U.S. civilian hospitals.

Throughout all of our planning and operations, the safety and well-being of our deployed forces remain of particular importance. On October 10th, the Department disseminated policy regarding the training, screening, and monitoring DoD personnel undergo prior to, during, and after deployments to West Africa. Based on the assessments of our initial operations, we recently updated our force health protection policy to include the addition of controlled monitoring and evaluation procedures for DoD personnel redeploying from the affected region.

Before deployment, all DoD personnel receive a medical threat briefing covering regional health threats and countermeasures. In addition, they receive information on EVD and safety precautions, prevention/protection measures, personal protective equipment use, and symptom recognition and monitoring. DoD medical personnel receive advanced Ebola-related training in the unlikely event they must treat our personnel possibly exposed to the virus.

During the operation, DoD personnel are equipped based on their mission requirements and the likelihood of interacting with local personnel. At a minimum, DoD members have advanced protective masks, gloves, personal protective suits, and sanitizer immediately available. DoD supervisors and healthcare workers monitor personnel for early detection of possible symptoms.

To treat DoD personnel who are injured or fall ill while deployed, we have advanced medical care capabilities deployed in Liberia, and are deploying additional capabilities to Liberia and Senegal. Should the unfortunate occur and a DoD member be exposed to Ebola, we have procedures in place to evacuate DoD patients to CDC-designated advanced care facilities in the United States.

When the mission is complete, DoD will continue to monitor the health of our personnel. Within 12 hours of departure from West Africa, trained DoD healthcare personnel will interview and assess DoD personnel to determine possible exposure. After returning from deployment, our personnel will undergo twice-a-day medical monitoring for 21 days – the maximum incubation period of EVD. Military servicemembers' monitoring will take place at controlled locations at pre-designated military installations in the United States. DoD civilians and contractors will have the option to voluntarily participate in the military's monitoring regimen, or they may follow the guidelines established on October 27th by the CDC. This policy provides exemptions for senior civilian and military officials to ensure that they can continue to discharge their mission oversight responsibilities. In all circumstances, the protection of our personnel and the prevention of any additional transmission of the disease remain paramount planning factors for U.S. military response efforts.

Conclusion

West Africa's Ebola epidemic remains dangerous, but we have a comprehensive United States Government response and – increasingly – a coordinated international response to contain the threat and mitigate its effects. The Department of Defense's interim measures are an essential element of the U.S. response, without which it will be extremely difficult to block the

epidemic's rapid expansion. As President Obama has noted, this global threat requires a global response. He has committed U.S. leadership to international Ebola response efforts, but the United States cannot unilaterally address the situation. Now is the time to devote appropriate U.S. resources – military and civilian – necessary to contain the threat, to reduce and mitigate the suffering of the afflicted, and to establish the mechanisms and processes for better future responses.

Chairman ROYCE. Let me ask some questions here, and if I could start, maybe I will ask this of you, Administrator Shah. In the early days of the response, the World Health Organization really I think failed their donors and failed the people of west Africa, but as I went down those arguments that we heard coming out of the region, that these were politically appointed country directors, and they were downplaying the crisis. They had warnings from credible organizations, and they ignored them. They failed to submit reports back to headquarters in Geneva. They obstructed travel by experts, and they resisted offers of assistance from the Centers for Disease Control as well as from USAID. And you add to that that it was the WHO guidelines on prevention and containment, which our own CDC clung to for far too long in my opinion that proved wholly inadequate. So, today, the WHO continues to serve as the lead agency in the U.N.'s Mission for Ebola Emergency Response, and the administration is seeking more funds for the WHO.

We understand the funds for tackling this problem, but without reform at the WHO, I would just ask, do you have confidence that they are up to the task here, if they are going to be the lead organization? And how has the WHO corrected course over the past several weeks? Are they making changes, especially considering the situation you had on the ground there?

Mr. SHAH. Thank you, Mr. Chairman. I think the most important response to your question is that, yes, there have been very significant changes made at WHO to the quality, the personnel, and the focus on this response. That is true in all three countries. Part of my assessment and my trip was to assess all of our United Nations partners. Most of the investment reflected in the request are personnel, logistics, commodity purchase, like protective equipment, and distribution. Those main cost drivers will end up being deployed by partners like the World Food Programme that actually manage the logistics response over the medium to long term in the region.

WHO plays a critical role on technical issues, on training support, in some cases running Ebola treatment units, and they are working with our NGO partners, like the International Medical Corps, Mercy Corps, Save the Children, and others to execute that function. So they play an essential role. We have worked hard with them to scale up their capacity, and right now, we need them to perform. And we are going to help them perform, and we are going to measure results. And when we have challenges, I am on the phone with my counterpart, the director general there, very often in order to make sure we have an open line of communication about what has to be done to succeed.

Chairman ROYCE. Well, the argument that I understand is that they have the experience, but the people at the helm, the country director for Guinea, the outgoing regional director for Africa in particular demonstrated deadly incompetence in this situation. So the United States is on the executive board. We should figure out a way to reform the personnel process so that cronyism at the U.N. isn't a big part of the problem and, at the same time, perhaps figure out a way to have them bring more doctors and personnel and experts around the globe into this region, into west Africa to con-

front the crisis. And I would just ask you about that besides management reform. Can we push for such a directive?

Mr. SHAH. Well, thank you for the suggestion. I think we will take both of those suggestions on board. The new executive director from the United States is Dr. Tom Frieden to the WHO. He is very focused on those and other issues, and right now, you are right to point out that the World Health Organization is leading the mobilization of international medical support for this mission overall, and your points are well taken, and they are important, and we will continue to push to make sure that function is implemented well.

Chairman ROYCE. Thank you, Dr. Shah.

Another thought we had was that we have, you know, with UNMIL's role, you have 6,000 U.N. peacekeepers deployed in Liberia, and their mandate there is to solidify peace and stability. And prior to this outbreak, they were winding down. But what role is UNMIL playing in the Ebola crisis, and does it have the engineering capabilities there to play a role? The mission's U.N. mandate will be renewed again I think in December. Will we see any changes in the mandate? Are any needed with respect to addressing this challenge?

Mr. SHAH. I will just say, you know, keeping UNMIL both together, well-resourced, and operationally contributing to the response has been a major priority. When Ambassador Power made her trip, that was a point that she really drilled down on. We do believe they have important assets that include logistics support, helicopter lift, some degree of engineering. They are working with the main United Nations logistics provider, which in this case is the World Food Programme, to scale up their contribution to the Ebola response, and we are very hopeful that all of UNMIL's contributing partners will maintain a commitment to keep that entity going and strong into the future.

Chairman ROYCE. And, lastly, Dr. Shah, you spoke of the supplemental request, but leaving the question of resources aside for a minute, and I am supportive on that, are there any additional legal authorities that would improve USAID's mission, and do you have all the authorities you need? What should we do legislatively in terms of policy that would strengthen your ability to tackle this challenge?

Mr. SHAH. Well, thank you, Mr. Chairman. I think there are, in addition to the resources identified in the request, a few specific congressional authorities that we would seek. One is the broad transfer authority that would give us the flexibility to use funds across various foreign assistance accounts as needed over the course of the year. This will allow us to, if the, you know, if the crisis moves to Mali and we need to be responsive there, it allows us to be responsive. This would allow us if the crisis is more intensely on food security and governance and the number of new cases is down, it will allow us to make balanced and appropriate judgments and transitions.

Second, the notwithstanding authority for economic support funds in this context will allow us to move fast and effectively, and so we request that.

And the two priorities, sir, that you have been a champion for in food security around continuing to, you know, allow us to have

more flexibility to do what saves the most lives most efficiently and to promote agricultural investments through Feed the Future will also be helpful, and I know those are in a separate process, but I very much value your leadership and the committee's support in those areas where we have proven that these investments can deliver the kinds of results that then avoid these crises in the future, which ought to be our goal.

Chairman ROYCE. Thank you, Dr. Shah.

We go to Mr. Engel of New York.

Mr. ENGEL. Thank you, Mr. Chairman.

For the first question, I would like to ask a quick question to Administrator Shaw. As I mentioned in my opening statement, I am very pleased to see that the administration has required additional funds to fight this epidemic. Could you please explain to us how fast you are drawing down existing funds, and if Congress fails to approve this budget request in a timely manner, at what point will we lack appropriate resources for the response?

Mr. SHAH. We are drawing down funds faster than I have ever seen us do, and we have had to do that because we know that resources spent now will avoid the kind of catastrophic case numbers that would require far higher resource levels in the future. In just the last few months and going into at the end of the year, USAID alone from its disaster assistance account will expend nearly $500 million. To put that in perspective, the entire annual budget of the disaster assistance, or IDA, account, is $1.1 billion. Right now, we are dealing with massive crises. We are averting a famine in South Sudan. We are supporting 7 million people in Syria and in neighboring countries. We are dealing with an upcoming winter in Afghanistan, where I was just a few days ago, and we are not going to be able to sustain this effort unless we have relief on the resources.

So thank you for your question, sir.

Mr. ENGEL. Thank you very much.

It was very encouraging to see that Africa's most populated country, Nigeria, was successful in containing the recent outbreak of Ebola.

Administrator, could you describe how our foreign assistance programs, particularly those focused on health, have helped to contain Ebola in Nigeria. And tell us what lessons we can learn from their success.

Mr. SHAH. Well, sir, I think your championing, global health investments at USAID and the PEPFAR program have helped, especially in Nigeria, create the capacity to be responsive. In this case, there were a few cases. They quickly spread. I think there were 18 total cases. They had to do almost 18,000 contact tracing activities to make sure that they could identify all of the people who would potentially be affected in Port Harcourt. They were able to quarantine I think more than 80 individuals through the period and, through that very effective response, were able to eliminate Ebola from Nigeria, which as you know if it took off in some of the urban settings there, we would be looking at an even more catastrophic situation.

So our ability to continue to make the investments that we have made over the past several years to build health systems, to train

health workers, to make sure that their medical supplies—they have basic supplies for oral rehydration and malaria control and those types of efforts, make a huge difference in preparedness. They made a difference in Nigeria. They make a huge difference in East Africa, which we are not talking about because of the effectiveness of those existing investments. And I want to thank you and other members of the committee for ongoing support for these global health programs.

Mr. ENGEL. Thank you.

I want to raise an issue that is bound to be raised by others here and that we have heard being raised time and time again since we have had the outbreak of the Ebola crisis. And that is travel bans. There has been a great deal of discussion obviously relating to implementing travel bans or visa bans from west African countries being impacted by the Ebola outbreak. Several Governors, including in my home State of New York, have instituted a mandatory 21-day quarantine period for individuals returning from west Africa. I understand there is a desire to obviously protect Americans from Ebola, and I want to do everything I can to ensure that my constituents are not exposed to the virus, but I want to know what is really happening.

So can you tell me what the impact would be on the Ebola response if travel bans, visa bans, or a mandatory quarantine period were to be instituted? And what do you believe should Congress be doing to best protect Americans? I don't know who would like to take that. Administrator or Ambassador?

Mr. SHAH. I can start, and then I will ask Ambassador Williams to add to this. The President has been very clear that keeping Americans safe is our top priority, and the only way we will do that is tackling this challenge at its source where there have been more than 13,000 cases. We as a team have looked very carefully across a broad range of options and ultimately have determined that a science-based approach to making decisions would allow us to mount the most effective response and keep Americans safe.

When we saw the actions taken in New Jersey in particular, for example, a number of USAID implementing partners immediately had to withdraw their proposals and say instead of building or staffing two or three Ebola treatment units, we can only do one because so many doctors have backed out of going because understandably if they don't know what the situation is going to be like when they return, it is hard to make that commitment.

I and Ambassador Williams and others have spoken to a lot of our international partners, and I think we are convinced that America is the signal decision maker. If we isolate these countries, the rest of the world will isolate these countries. And that will create a much different epidemic curve, and we will all have to come back here and discuss how are we going to handle many, many, many additional cases than what we are looking at now.

The Ambassador may want to add to that.

Ambassador WILLIAMS. Thank you, Mr. Engel, for also raising this. This is an issue that has been under discussion for quite a while, and it is really, really important that we put these things in context. What we are really talking about when you talk about a travel ban, that would mean people are thinking about banning

flights and banning persons. In fact, there are no direct flights from the affected countries to the United States, first of all. So we are really then talking about banning people who come through a visa, through a visa process, more than banning actual flights. And the data shows that basically 60 percent of the persons entering the United States from that region, from the region, are either U.S. citizens or they are green card holders. They are lawfully permanent residents. So now we are looking at a 30 percent portion.

If we ban a visa, our experience shows that preventing access, legal access, really forces people to choose illegal methods. And once you do that, you are then losing the ability to use all the protocols that we have in place that we know work. How do you trace people? Where are people going? What is the contact information? How do you monitor? So one of the reasons that we are really urging that there be no implementation of any kind of a visa ban or travel ban is that we want to know where people are going. First of all, we are talking about a relatively small number of people, and we are talking about implementing the strategies that we know work.

The other aspect of getting the actual healthcare professionals to the region, getting the ability for pilots to be able to transport, to be able to get supplies and healthcare workers in and out of the region, all those kinds of things are impacted by a notion of denying access or denying visas to travelers. So what we have tried to emphasize is that we need to keep the science first and foremost, and we need to watch and see what is working, and so far, our strategies have been working.

The other thing that would happen, we are trying not to isolate. We talked about the secondary effects of this crisis, and there are deep economic effects. So we are trying to use a strategy that helps us to, first of all, stop the spread of this disease and also reinforces the capacities of the people in those places to be able to respond to the spread of the disease.

Mr. ENGEL. Thank you.

Ms. ROS-LEHTINEN [presiding]. Thank you so much, Mr. Engel.

The Chair recognizes herself.

Thank you, ladies and gentlemen.

Last year, State and USAID spent more than $52 million on global health efforts in Liberia, Sierra Leone, and Guinea combined, but I know, in my constituency, they ask where did all that money go? It has become apparent that these countries did not have the healthcare infrastructure in place to handle or contain the Ebola disease. And as we have seen, it can spread to Europe and North America. And with the communist dictatorship in Cuba sending hundreds of forced labor healthcare workers to Ebola-impacted countries, we have got to ensure here in the United States that we are taking every possible precaution. It is appalling that the Obama administration officials are praising the Castro communist dictators for forcing these workers, forcing them, to go to Ebola-impacted countries in Africa. These healthcare officials do not have a choice. Their families face retaliation on the island if they don't go. They are forced to go as part of a coordinated PR campaign orchestrated by the regime for its own political agenda, and it is disgusting and shameful that we should be congratulating

Cuba for forcing people to go to these countries and ask the regime what happens to those workers if they are found to be impacted with Ebola. They are not allowed to go back to Cuba.

Here are some facts about Cuba and its healthcare apparatus. In the 1980s, that same Cuban regime, the same people, sent HIV positive patients to concentration camps. The regime has taken out life insurance policies on behalf of its workers, but instead of naming the families as beneficiaries, any insurance dollars right now go to the regime. The regime is not exporting its workers for free. It receives approximately $8 billion per year that it uses to oppress the Cuban people. Cuban healthcare workers receive less than 25 percent of the money from donors that is supposed to pay for their salary. The rest is confiscated by the regime.

Finally, Dr. Shaw, I have a question for you staying on the subject of Cuba because, earlier this year, in April, you testified before this committee, and I asked you if USAID will remain committed to reaching out to people suffering under closed societies and dictatorships. Your answer was yes. And, in September, President Obama spoke at the Clinton Global Initiative and stated that the administration "will oppose attempts by foreign governments to dictate the nature of our assistance to civil society and oppose efforts by foreign governments to restrict freedom of peaceful assembly and association and expression." That is a good quote.

Yet, this week, there is a column in the Associated Press that says everything to the contrary. According to news reports, USAID is planning on rolling out new regulations that seek to prohibit USAID from working in closed societies. By coincidence, it seems that the new regulations are in line with a certain Senator who has been pushing to normalize relations with Communist Cuba, and these attempts by Castro apologists may be a backdoor deal to secure the release of Alan Gross. I certainly hope not because Alan Gross is innocent and should be released immediately, unconditionally, without concessions to the tyrants who have held him unjustly for over 5 years.

So, Dr. Shaw, is it true that USAID would consider dropping programs wherever USAID was denounced? And if true, it would only benefit thugs like the Castro brothers and Nicolas Maduro, Rafael Correa. They will use this as an opportunity to gloat that they got USAID to cave and run away from its mission. Why is USAID calling and running away from democracy programs in Cuba and Venezuela and Ecuador, Iran, and Russia? And if not, will you come out and set the record straight, Dr. Shah?

Mr. SHAH. Certainly. Thank you, Madam Chairwoman.

And I just want to highlight, I do want to stay focused on Ebola in this context, but I can assure you that I am standing by the answer I gave you previously, that we are going to continue to work in difficult environments on democratic governance programs as we have for years. The framework to which the article refers is one that we are eager to discuss, I know have been discussing with your team, and I am eager to discuss in more detail with you. I do not in any way believe it diminishes our commitment to that objective, and I can discuss how it is being implemented in that context. I appreciate your comments about Alan Gross. And as you

know, we work continually on behalf of articulating why he should be released through our colleagues in the State Department.

I would like to just make reference previously to your comment about the $52 million spent in Liberia, Sierra Leone, and Guinea on health. It is quite worth noting that over the last 5 years in all three countries we have seen rapid reductions in child mortality and maternal mortality because primarily of expanded access to bed nets for children who would otherwise get malaria. Those reductions have saved a lot of child lives. And, in fact, just over the last 8 weeks we have had a massive bed net distribution throughout the region because malaria patients present with the same symptoms as Ebola—fever, nausea, vomiting—and so we want to make sure we keep that under control as we are tackling Ebola.

Ms. ROS-LEHTINEN. Thank you, Dr. Shah.

Mr. SHAH. One thing I will say, what did happen is the healthcare workers got infected early in this response. And that did decimate their healthcare systems, and that is why I think we are dealing with a much more complex situation than we otherwise would.

Ms. ROS-LEHTINEN. I appreciate your answers.

Mr. Connolly is recognized.

Mr. CONNOLLY. Thank you, Madam Chairwoman.

Mr. Shah, the President appointed a Ebola czar, Ron Klain. What is your relationship, and Ambassador Williams, what is your relationship to that Ebola czar?

Mr. SHAH. Ron Klain has come into the administration and is carrying out the function of coordinating policy and oversight of a very complex domestic and international Ebola response. I talk to Ron almost daily, and we are in meetings together quite often. I think he has done a very effective job of helping the President frame decisions and gather the right data and make the right calls over the last—since he has joined, and I know that it is a difficult task, and we are trying to do everything we can to support him in a very important role.

Ambassador WILLIAMS. Thank you. I, too, have spoken with Mr. Klain. I spoke to him actually just yesterday. His role is, as Raj just explained, coordinating the overall U.S. Government interagency interaction while we do the implementing.

Mr. CONNOLLY. Is there a need for coordination, coordination that apparently was not occurring before Mr. Klain's appointment?

Ambassador WILLIAMS. Our view is there is a need for the kind of overseeing coordination that he is providing because this emergency has so many moving aspects to it. It is really a whole-of-government operation. We are used to in the interagency context to meeting together, talking together, and focusing on accomplishing our mission. But we are finding the logistical challenges, the health challenges, and the secondary and third, tertiary effects of this really are quite complex. And so I welcome the insurance that he is giving by making sure all these little pieces are really talking. I can focus on my aspects at State. But it redounds to others. So, yes, I think it is necessary.

Mr. CONNOLLY. The chairman provided a pretty devastating critique of WHO in the early stages of the crisis, in terms of both their competence, their timeliness and an organization he charac-

terized as rampant with cronyism. Do you agree with that critique, Mr. Shah?

Mr. SHAH. You know, I have been very focused on ensuring WHO has the right people, processes, and resources to carry out a function we need them to carry out in the region right now. I can tell you on my visit, I spent time with all of their local staff in all three countries, and I was impressed with—these were technical people, very sophisticated, helping to train hundreds of local healthcare workers on how to use protective equipment, how to carry out their function. I do believe there is going to be room after this to look back and make reforms as to how WHO can be more effective connecting its leadership in Geneva to its on-the-ground eyes and ears and capabilities. And I think there will be time for that, but right now, my focus is making sure we have the right WHO folks in country, they are carrying out their function, working in a team with us and others. And it is working statistically and we are seeing some results.

Mr. CONNOLLY. Do we have the right folks on the ground?

Mr. SHAH. I wish we had more of their capacity to have trainers and disease control experts there. I have communicated that to Margaret Chan, who leads WHO, and we are in constant communication with. Yes, now, I think you are looking at a substantively improved WHO response in all three countries.

Mr. CONNOLLY. Well, it just seems to me—I can appreciate your diplomatic answer, and there will be time after the crisis to try to improve WHO, but if the chairman is right in his critique, we have no reason to be confident in WHO. In fact, WHO contributed to the spread of this virus and to a high mortality rate, frankly, because of its incompetence and cronyism and its lack of focus and its lack of timeliness.

There is a big difference between we can tweak it to make it better and more effective, and it is incompetent to begin with and simply collapsed in the face of this pressing crisis. And it seems to me the American people and the Congress are entitled to know the difference here, Mr. Shah.

Mr. SHAH. We are, in the first instance, the focus for us is making sure that they have the right talent, focus and process, and I can assure you they do now in these three countries. I have learned that that institution ought to have some additional capabilities and more connectivity in terms of command and control. Those were some of the missing early elements that the United States stepped in to provide. And I know as Dr. Frieden and others take forward a process of reform, they will focus on those items.

Mr. CONNOLLY. Well, I would just end by, again, I think it is a fairly dispositive issue. If WHO is going to be the primary international agency with which we need to partner in this kind of crisis, which will not be unique—there will be others—we have got to have confidence that that international partner is competent and has the resources and the talent to respond in a robust and timely manner. Otherwise, lives are lost. And, furthermore, we start from way behind where we needed to in trying to catch up and get ahead of the curve of this terrible disease. So I look forward to hearing a lot more about it later on.

Thank you, Madam Chairwoman.

Ms. ROS-LEHTINEN. Thank you, Mr. Connolly.

I am honored to recognize Mr. Smith of New Jersey, a champion on all of the issues of the subcommittee that he chairs. He is chairman of the Africa, Global Health, Global Human Rights, and International Organizations Subcommittee.

Mr. Chris Smith.

Mr. SMITH. I thank my good friend and the distinguished chair for yielding. Thanks again to our distinguished witnesses for your past and ongoing leadership. In response, and it has been mentioned before but it bears underscoring, to the Ebola outbreak, in March, the World Health Organization fewer than 200 people were infected and that approximately $5 million was needed to contain it. However on October 17, Maria Cheng of the Associated Press wrote a story, headlined "U.N.: We botched the response to Ebola outbreak," and cited a report that blamed incompetent staff and quoted Dr. Peter Piot, one of the co-discoverers of the Ebola virus, who said that the regional office in Africa is "really not competent." Now, in light of that, what role is UNMEER actually playing on the ground? We know about WHO, what they are doing now, but what is UNMEER doing, again, another U.N. initiative?

Secondly, Dr. Frieden testified at my emergency subcommittee hearing on August 7 and laid out the prudent steps that were being taken to detect and to try to mitigate this crisis. When we had the second hearing on September 17, Dr. Fauci said that now this terrible disease had gone exponential. He said in public health, when you put incremental against exponential, exponential always wins. Nobody on the panel has used the word exponential. And I wonder if you could update the committee on what has happened, what have been the game changers, and what are we talking about in terms of numbers, immediate, intermediate, and long term in terms of and projected number of cases of Ebola?

Thirdly, Dr. Brantly testified at our September 17 hearing and talked about home isolation. And thankfully, the military is doing a yeoman's work in building up isolation and treatment units; 1,700 I believe are contemplated. But he pointed out that family members and sometimes neighbors are caring for these sick individuals at home and therefore contracting the disease themselves. We now have to look at interventions that involve educating and equipping these homes and caregivers for their own protection, and he talked about the safety measures. Are we training home healthcare workers to help their loved ones so, one, they do help their loved ones but also so they, too, don't get sick?

General, if you could touch on the issue of protecting our servicemembers. What kind of protective measures are in place? Are they adequate to the task?

You talked about labs, Dr. Shah. What is the goal in the labs? Where are we now in terms of the goal capability? Good news about the 5 to 7 hours, but what is the endgame and how much lab capacity are we looking to establish? I have other questions, but time probably doesn't permit. On the quarantine issue, where are we on quarantine? We know the military talks 21 days. Is that still the situation? What is the quarantine issue as you see it today if somebody is in west Africa?

Mr. SHAH. Okay. I will start very briefly, and thank you, Chairman Smith, for your just unwavering support for global health over decades. We are proud to be associated with your work.

First, on UNMEER, I would note that I think the U.N. in recognition of its need to improve operational performance on the ground, created this mission, resourced it, put Tony Banbury, a former Department of Defense emergency response official, in charge in Accra, Ghana, and has—in fact, since then, we have seen improvements in how UNICEF, the World Health Organization, and the World Food Programme, have organized themselves to do the logistics and operations of this response in those three countries. So that is on UNMEER.

On data and exponential versus incremental, I think our concern is always exponential growth. And what we now see throughout the region is about 3,000 current active cases, roughly evenly split across with 1,300 to 1,500 in each, depending on the numbers, in Liberia and Sierra Leone and with a few hundred in Guinea. Our concern is—we have seen a big reduction driven, as I mentioned, by burial teams, community behavior change, the fact that people are bumping elbows instead of shaking hands, and washing their hands with chlorine. And because we have built out already more than doubling the capacity of Ebola treatment units so that we have enough capacity now in places like Monrovia.

The reality though is we are now seeing micro epidemics throughout the countryside, and any one of those could become exponential if we don't have an adaptable and flexible response, which this funding request and our strategy going forward will support. And that then addresses your question about home healthcare workers and the lab end game. The strategy really is evolving to focus on rapid response capabilities, so when you see that there is a case in a rural community, you can quickly get there with lab support, with personnel, with protective equipment, the ability to quickly set up a community care center or mini ETU that might be 5 to 10 beds and deal with that cluster before it gets to be an exponential problem. And if we are effective at doing that, we will avoid the consequences of exponential growth that Dr. Fauci has spoken about.

Mr. LUMPKIN. If I may, before I turn it over to General Lariviere here, just to reemphasize the protection of DoD personnel is our number one priority as we are continuing to support USAID in west Africa. So we have a robust training program for our service members and DoD civilians prior to going over to the region to serve. We have a very thorough monitoring program while they are there, and then we have a controlled monitoring program when they redeploy back to the United States or their home station.

And as you are aware, the service chiefs as well as the Chairman of the Joint Chiefs of Staff made a recommendation to Secretary Hagel to support a 21-day controlled monitoring quarantine-like situation upon return. The Secretary approved that because of the unique nature of the military, the scope and the size of our footprint over there, and the operational needs on howreintegrate our forces back into home station. So I will turn it over to General Lariviere, who can answer the specifics.

General LARIVIERE. Thank you, sir.

Mr. Smith, as Mr. Lumpkin said, we are taking measures in all phases of the operation, pre-deployment, during deployment and post-deployment. Before deployment, all personnel will receive a medical threat briefing covering all health threats and measures. In addition, they will receive special training on the EVD safety precautions, prevention and protection measures, personal protective equipment use, symptom recognition and monitoring. As Mr. Lumpkin said, they will be monitored continually throughout the deployment with their temperature taken twice a day and obviously with medical checks throughout.

Upon redeployment, as was also mentioned because of the special nature of the military's deployment, the use of our population, et cetera, on the recommendations of the Joint Chiefs, the chairman did recommend to the staff that personnel be put in controlled monitoring once they return. So, again, we are taking measures throughout the deployment to ensure the safety of our troops.

Mr. LUMPKIN. If I may add one more piece. Please keep in mind again DoD personnel are not doing direct patient care.

Ambassador WILLIAMS. And for personnel that are under chief-of-mission authority at our Embassy services in the affected areas, we are following the CDC guidelines and the regular protocol. Our people are going to be screened before they depart post. They will be screened at whatever is the transit point, and they will be screened again upon entry to the United States. And then, unless the State where they are going has a specific protocol, they will be following the health authorities' protocols, which will self-monitoring and temperature checks twice a day. This is in close coordination between MED at State Department and MED's coordination with whatever is the home state of our transferring personnel.

Ms. ROS-LEHTINEN. Thank you.

And, Mr. Smith, the chair allowed you great latitude because it is within your jurisdiction. Thank you, Mr. Smith.

I am now pleased to yield to Mr. Brad Sherman, ranking member of the Subcommittee on Terrorism, Nonproliferation, and Trade.

Mr. SHERMAN. Ebola is a great issue, not only for development in Africa, but for the American people. It sweeps across Africa. Then, every week, someone with Ebola will come into the United States if this becomes an endemic problem not only for three African countries but for all African countries. And it would be a challenge for our public health system if, every week, someone arrives in the United States with Ebola.

With that in mind, I will ask each person on the panel what do you need from Congress? What can we do to help? I will start with Major General West and go straight down.

General WEST. Thank you, sir, for that question. I appreciate the support that DoD has been given and continues to be given from committees such as this and from the general support in general. But, again, I believe DoD and, with Mr. Lumpkin as our lead, we have been given the resources that we need. So I think for now we have got the resources that we need to accomplish our mission. Thank you.

Mr. SHERMAN. I don't know if I need to hear from the rest of DoD if you pretty much match—Mr. Lumpkin?

Mr. LUMPKIN. I would offer that the emergency funding request is what we need. There is a portion of that that is a DoD request for $112 million to do advance vaccine research for DARPA. That would be working in conjunction with NIH and the Defense Threat Reduction Agency. So that would be helpful, but I think across the whole of government, that emergency funding request is phenomenal.

Mr. SHERMAN. Ambassador, anything to add?

Ambassador WILLIAMS. I, too, was going to say we really need the funding of the emergency supplemental request. Part of that for the State Department is going to be focused on the immediate response but also for building up our capacity within MED to be able to effect evacuations and respond to the health emergencies, repatriation of people. So, yes, we need funding of this. It is all explained in our request.

Mr. SHERMAN. Mr. Shah?

Mr. SHAH. Thank you. I would highlight three things. First is the $6.2 billion resource request, which I would point out, while Ebola is far more complex and our responsibilities to respond in west Africa are far more significant than what previously took place with H1N1 or H5N1, this request is geared to be roughly at the same level as Congress provided in 2006 and 2009 in those contexts. So we really do require these resources to be successful, and, frankly, we will not succeed without them.

Second, there are specific authorities, including the transfer authority and the notwithstanding authority, in the request that I think are absolutely essential. Because this is a fast-moving and adaptable viral epidemic, we need to be fast-moving and adaptable in our response. It will ultimately save money, time, lives, and threat.

And then, third and finally, this committee and your leadership has helped us establish a much more robust effort to food, agriculture, and avoiding hunger. And the number one nonhealth consequence of this challenge is going to be a widespread food crisis in this region. Any support the committee can offer for Feed the Future legislation and efforts to reform the way we provide food assistance is much appreciated.

Mr. SHERMAN. Let me get to one more question. And that is, Administrator Shah, have we or our partners produced a video in all relevant languages that will explain to healthcare workers how to put on and take off the suits, perhaps other important points for Ebola health corps workers, given the fact that a very significant portion of those getting the disease are the healthcare workers? And, again, is that video available in all relevant languages? And have we deployed the hardware so that we can show this? No use having a disk if you don't have a DVR, et cetera, or an iPad or whatever. Go ahead.

Mr. SHAH. Thank you, Congressman. I think that is an excellent suggestion. I know there are videos. I don't know if they are in all relevant languages. I will say that, in all three countries now, there are large-scale training programs, and I want to commend the Department of Defense for using its program of instruction to help create a protocol for training healthcare workers. And I think 70 of the first trained workers have come out of that system in Libe-

ria, and it just shows the interagency cooperation. But that is an outstanding recommendation that we will take back and share with our colleagues.

Mr. SHERMAN. Because I believe it is like one-fifth of those with Ebola are the healthcare workers themselves. I have never seen a disease that had that configuration.

Mr. SHAH. That percentage is now coming down, and the rate of infection for healthcare workers in part because this response has focused on effective training is coming down significantly, but it is absolutely a concern that we are focused on.

Mr. SHERMAN. I yield back.

Mr. POE [presiding]. The Chair recognizes himself for 5 minutes.

Thank you, you all for being here. It is always great to see you.

Administrator Shah, again, who is in charge of this Ebola epidemic in the United States? Who is the main person that is in charge?

Mr. SHAH. Ron Klain is the Ebola coordinator and brings all of us together. Each agency has its own discrete responsibility.

Mr. POE. But he is in charge? All these other agencies which you all are sum of. Is that a fair statement?

Mr. SHAH. I think that is a fair statement. If you need an answer to a question, Ron is a good source to go to.

Mr. POE. He was asked to be here today. And he is not here. But you are here, so I can't ask him those questions. He did say yesterday on MSNBC—I mean, he doesn't come to Capitol Hill, but he did say that there will be more Ebola cases in the United States.

I will ask, General West, since you are a medical doctor, do you agree with that statement?

General WEST. Sir, thank you for the question. Sir, I believe there is always a potential that an additional case might enter the United States, so I think his comment was based upon the fact that we have already had one gentleman, Mr. Duncan, who did arrive on the shores of the U.S. with Ebola, though asymptomatic, so it is conceivable that there might be an additional case.

Mr. POE. Conceivable is different than there will be. The possibility is a different answer. Conceivable, to me, is different than an answer is there will be more Ebola cases in the United States.

Let's assume he is correct about that. I personally think we need a visa ban.

In all due respect, Ambassador, I don't believe in the philosophy that if we tighten the rules to get into the United States that with encourage people to come illegally. Then why have any rules for all of the countries in the whole world if that is going to occur?

I was raised, I was taught by folks that, my grandmother, if you are sick don't get around healthy people. And if you are sick, don't let healthy people get around you. But be that as it may, it is assumed that Mr. Klain is correct. The United States' response to this, I think, is we should, for a temporary period, keep folks from the United States with a visa ban.

Dr. Shah, let me ask you this. Are people who are being treated in Africa for Ebola, are any of them being brought to the United States?

Mr. SHAH. Not at this time. Part of the rationale for investing in and building out a 25-person world class hospital in Monrovia,

called the Monrovia Medical Unit, and staffed by U.S. public health service personnel just recently completed and built by the Department of Defense is to have the capacity to provide world class care in west Africa. We have worked with the British to build a similar 12-bed unit in Kerry Town outside of Freetown.

Mr. POE. But are there any plans to bring folks to the United States that are being treated or may have Ebola in Africa? That is the question.

Mr. SHAH. Well, I think if medically indicated from that unit, if an American healthcare worker requires a special treatment——

Mr. POE. I am not talking about healthcare workers. I am talking about African citizens.

Mr. SHAH. No. Any special services are focused on healthcare workers powering the response.

Mr. POE. So the treatment is taking place in the African countries that are affected, and it is not a plan of the United States to bring those folks to treat them in the United States, except for workers from the United States, maybe the military?

Mr. SHAH. Exactly.

Mr. POE. Okay. I just wanted to make that clear as well.

How many Americans are currently travelling from the United States to west Africa? Do we know that number? Not counting military and aid workers, humanitarian workers, but how many other folks are travelling? Do we have number of that, Ambassador Williams or Administrator Shah?

Mr. SHAH. We do. Maybe Ambassador Williams will add to this. I would just note that Secretary Johnson is responsible for those issues of travel and homeland, and so I don't want to speak on his behalf. I have heard him go through the numbers in a lot of detail. I just don't want to get them wrong as I repeat them to you.

Mr. POE. Ambassador Williams is raising her hand. You don't have to raise your hand in here to talk. I will recognize you anyway.

Ambassador WILLIAMS. I don't have the numbers here. I know they are available. I don't have them with me so I can take the question. I am sorry.

Mr. POE. All right. Is anyone besides the military having a 21-day quarantine when they return to the United States?

Mr. SHAH. The medical protocol is, depending on what category of risk you are upon return, you slot into a different protocol. So when I came back from my trip, I was on a 21-day active monitoring, which I cleared a few days ago.

Mr. POE. Thank you.

Mr. SHAH. So I was in daily contact with my Washington, DC, public health service person, but I was also not in the highest level of risk. Those who are are dealt with as required.

Mr. POE. All right. Thank all of you all.

The Chair will recognize the ranking member of the Subcommittee on the Middle East and North Africa, Representative Deutch, from Florida.

Mr. DEUTCH. Thank you, Mr. Chairman. And thanks to the distinguished committee for being here. Each of your agencies is playing a vital response to this crisis, and I would especially like to ex-

press our gratitude to the military personnel and the aid workers who are in west Africa assisting in this crisis.

I wanted to circle back to the numbers. More than 14,000 people have been infected. More than 5,000 have died. Now there are some reports, there were reports yesterday, the WHO said that they believe that in Guinea and Liberia, that there has been some, I think they said that there has been moderating of the number of infections, but they have also said, the WHO had said previously that the actual number of cases may be dramatically higher than currently reported. Our own CDC has said that the toll can be two to four times the WHO's numbers. There was an estimate earlier that there could be as many as 5,000 to 10,000 new infections per week by December. Can you address where we are in terms of what the actual numbers are and what you anticipate they may spike to?

Mr. SHAH. Thank you. Thank you, first, for our comments about our military service personnel and the aid workers who are doing really extraordinary work. I would note, when I note that there are about 3,000 current active cases in the region, that that is a data point that as best we can accounts for potential underreporting of data. And it also tracks against the reality that over the last 8 weeks, we have seen a reduction in the number of new cases in Liberia, which had been the epicenter of the epidemic. The driver of that reduction has been kind of community-based efforts that have handled the management of deceased persons more effectively so that you don't transmit from dead bodies to others in that instance.

Now, it is hard to estimate what future numbers could be or would be. Today, even in Liberia, we see as many as 20 small or micro epidemics throughout the country, and any one of them could become a cluster that then leads to exponential growth.

Mr. DEUTCH. I am sorry, Administrator. I was going to ask about that, but since you brought it up, can you tell us what a micro epidemic is and how it might turn into a broader epidemic throughout the country?

Mr. SHAH. Sure. I was just on the phone yesterday with colleagues from Samaritan's Purse, and they were describing this. They go into a rural community where they think there might be a case or got a report, and they find that in seven or eight homes, people are housing patients that look like they have symptoms and are afraid to come out or are not seeking or reporting care or are not presenting at an Ebola treatment unit. And all of a sudden, that cluster of cases could quite quickly, because those patients are not isolated and they are getting symptoms like vomiting and diarrhea in a highly dense populated home environment, all of a sudden, you can have very rapid growth from that.

And I would point out that back in the spring, this looked like a standard Ebola outbreak, and it, in fact, was burning out. I mean, we all thought it was going away as a problem because the numbers got so small, and then it just exploded in urban Monrovia. So we cannot say with confidence that despite the huge success we have had in the last 6 to 8 weeks at turning the tide in Liberia, that, in fact, we can be confident that we are not going to have an exponential outbreak in any of these settings in the first instance, which is why we are mounting a significant response through next

year and why the emergency request provides the resources for that kind of a responsible, evidence-based response.

Mr. DEUTCH. Do you know, can you estimate how many of these micro epidemics exist throughout the region?

Mr. SHAH. Well, these are just clusters of cases, so, you know, there are as many as 20 independent clusters of cases in parts of rural Liberia. I don't have the numbers off the top of my head, but I do know that the strategy developed is now to have really responsive systems that can go quickly stand up an Ebola treatment unit that is much smaller and more focused, probably less visible but highly important to rapid response.

Mr. DEUTCH. And just, finally, before my time expires, there have been reports of an unrelated outbreak in Congo that has claimed at least 49 lives. Can you talk about that and your concerns about the possibility of that spreading?

Mr. SHAH. Well, in the DRC, we have seen actually cases being handled quite effectively, and they have managed that. In Mali, there is now a case—cases that have come we think from Guinea into Mali. And there is a significant cluster of cases there that now needs to be dealt with as of yesterday. I am not aware of 49 cases in the first, right now in the DRC, unless that happened this morning, and I would have to——

Mr. DEUTCH. It is a report that I read this morning.

Mr. SHAH. We will look into that.

Mr. DEUTCH. Thank you.

Mr. SMITH [presiding]. The Chair recognizes the gentleman from Florida, Mr. Yoho.

Mr. YOHO. Thank you, Mr. Chairman.

I appreciate you all being here. Let's see. I think you just answered the question I had, Dr. Shah, about the number of outbreaks or the number of cases. Are they increasing or decreasing, in the last 6 to 8 weeks?

Mr. SHAH. In Liberia, the number of new cases are decreasing, but the number—and in Sierra Leone and Guinea, they are increasing quite significantly.

Mr. YOHO. All right. So we are seeing focal outbreaks?

Mr. SHAH. I am sorry?

Mr. YOHO. Focal outbreaks, we are seeing, small outbreaks?

Mr. SHAH. Yeah.

Mr. YOHO. What is the expected cost in the next year to treat and contain if things stay pretty static the way they are or, you know, the predicted growth of this, what would you predict that cost would be?

Mr. SHAH. Well, the $6.2 billion request includes approximately $2 billion or so for the response in west Africa against the main element of the strategy, which is controlling the outbreak, and that will provide funding for personnel that need to be trained and deployed. It will provide funding for Ebola treatment units and community care centers, the logistics required to do that. And it will provide funding for the huge amount of product supply, personal protective equipment, oral rehydration solution, intravenous materials, to provide a large-scale response throughout that region.

Mr. YOHO. Okay. I am a veterinarian by background, and we deal with outbreaks all the time in animals. And we have got some

commonsense things we do. And what I see is there is the fear factor from the Ebola outbreak, the tide of fear. And I know the news spreads this, and there is a lot of misconceptions by people without a medical background that think this is Al Pacino in that move with the virus coming out. And it is, it is a deadly virus, but yet it is a virus. We have got hundreds of years of virus, how to deal with these things and how to quarantine them.

And Dr. West, you being a medical doctor also, the response that we are doing, the commonsense thing to me is when you have an outbreak, you have short-term things you do and you have long-term things that we should do. The short-term is the diagnostic, the treatment, the quarantine that we would do in an animal population. And we should do those same things in this, like travel restrictions. I think that is totally—should be acceptable. It shouldn't be a political thing, and I would just like to hear your thoughts on travel restrictions.

I know the Army is doing a great job on that. We know the incubation is 3 to 21 days. But, unfortunately, viruses don't read the manual. I think they ought to extend that to 30 days just to be safe and do testing, you know, whether it is an ELISA test or an SN test or a PCR test, to do that. And I would like to hear your thoughts on that for the short-term attack on this virus.

General WEST. Sir, thank you for the question. As far as travel restrictions, I really can't comment specifically on that. I do concur with your thoughts on how to best tackle it as far as preventative measures once you recognize it to rapidly diagnose and treat; and then, long term, you know, put in measures to prevent, bolster the public health system so if there is another outbreak or similar, it can be identified early and then those treatment and isolation recommendations can be done early on.

Mr. YOHO. Okay. What I have seen here is we have got five hospital areas in the United States. I think we ought to have one hospital that is a quarantine area or treatment area instead of spreading it throughout the country. Just, again, from an epidemiological standpoint, it would make more sense to contain it in a smaller area. I know you are doing that in Africa.

And on the long-term strategy—and this goes back to Dr. Shah, and I would like to get your opinion, too, Doctor. We have known about this virus since the 1970s. And we had the Marburg virus that broke out in Germany. It was rapidly contained. It is a relative of the Ebola virus in the same viral family. Yet we contained it very early because of the testing. And we have got vaccines that are on the shelves that have been approved—or they have been shown effective. They have not been approved—for over 10 years. Why have we not followed up since the role of our Government is to be prepared for the next epidemic or the pandemic, to be prepared with these vaccines. The money that we are spending in the research and development, why has that vaccine not been approved and ready to go so that when we diagnose and treat the individual and we do the quarantine, we can be vaccinating a population that is susceptible? Why has that not happened?

Mr. SHAH. Well, Congressman, actually, the resources in the emergency request will actually allow——

Mr. YOHO. No. I want to know why it hasn't happened because we have known about this since 1970. This is not a new virus. This is something we should have been prepared for as a government, and we have dumped billions of dollars into research and development. Why have we not done that?

Mr. SHAH. Well, let me just describe one thing that is very specific to west Africa and the vaccines. The committee has supported the USAID to create something called the Global Development Lab. And through that, we have worked with Dr. Fauci at NIH and are accelerating the introduction of the vaccine in Liberia for rapid clinical phase II and III testing. That I believe is the Canadian vaccine.

Mr. YOHO. We are starting at a point today. I mean, the horse is already out of the barn, and we have known the horse is out. We should have been prepared for this, and I look at your organization as something that should be ready, not just for this one but for the next one, too. That is foresight. That is oversight. We are doing hindsight. I know you guys will get control of this, and I look forward to helping you and assisting you on this.

And with that, I am out of time, and I yield back.

Mr. SMITH. Thank you.

The Chair recognizes Mr. Higgins, the gentleman from New York.

Mr. HIGGINS. Thank you, Mr. Chairman.

For Administrator Shah, the USAID coordinates the international response with the Department of Defense and State. And the United States is the principal responder in Liberia. It was stated at the outset of this hearing by the chairman that the objective is breaking the chain of transmission. You can't do that without fundamentally dealing with the problems in the countries of origin, that being the inadequate hygiene and sanitation systems and also the lack of or the poor healthcare infrastructure. So specific to USAID in Liberia, what is being done specifically to address those issues, and is there a time frame within which those projects would be undertaken and completed?

Mr. SHAH. Thank you, Congressman.

I think really there are two ways to address that. One is in the context of our ongoing longer-term developmental investments in Liberia in particular, we have been working to build out their health system to improve access to water sanitation and hygiene and to, frankly, get a lot of kids in school. This is a country where 58 percent of the population lives on a dollar and a quarter per day; 80 percent of total disposable income per person is spent on food. So when food prices go up, as they have almost doubled, you see children and women in particular going without enough adequate nutrition. We have been working on those issues and will continue to.

In the context of this response, I believe that some of the rapid reduction in transmission we have seen in Liberia has come from those types of community interventions. The fact that, even when I was there, you wash your hands with chlorinated water before going into any building. People have stopped shaking hands and touching each other. The more that those behavioral practices become the new norm in rural communities, the safer those commu-

nities will be from this outbreak, and, frankly, over the long-term, the more you will see a reduction in very deadly diarrheal disease that still, unfortunately, kill a lot of children who don't need to die in these types of countries.

Mr. HIGGINS. Like any health crisis, this one exacts an economic price on these communities as well. All three of these countries, Liberia, Sierra Leone, and Guinea, were projected to grow pretty impressively. According to the World Bank, because of this crisis, the economic decline in those countries will go from anywhere between 3 percent to 12 percent. Does this undermine the ability of those countries themselves to make investments toward alleviating this problem?

Mr. SHAH. Absolutely. In fact, I think even the World Bank now believes that those initial 3 to 12 percent estimates are underestimates of the true consequence. The public budgets will be down anywhere from 20 to 40 percent. The economic activity will most likely contract by as much as a third. I had a chance to meet with business leaders in each of the three countries who described not being able to continue to employ their personnel and their staff and having largely ceased operations. Expatriate staff have often left the country. So it is a very difficult economic situation that will greatly compound our efforts over the course of the next year to get the epidemic under control.

Mr. HIGGINS. Final question. Infectious diseases notoriously are unpredictable, meaning that the virus entering one person may be genetically different from the virus entering another person. We have been told repeatedly that you can only get Ebola through direct contact with bodily fluids. Could the Ebola virus mutate to become transmissible through the air?

Mr. SHAH. Well, I think it is hard to say no to an event that is a potential event with a low likelihood of happening, but most of the experts we have consulted, and Dr. Fauci and others who have offered their guidance on this, suggest we have to watch for what the genetic mutations are, but that it is unlikely that this will become airborne in the short term. There are a very high number of mutation events because we have never before seen so much transmission of this particular virus, and so we don't make any commitments on that.

Mr. HIGGINS. It would seem to me that that is something that public health officials should be looking at very closely because a lot of this originated from rural areas. Now we are in cities where contact is much more prevalent, and the spread and the change in mutations is much more likely.

So I yield back. Thank you.

Mr. SMITH. Thank you, Mr. Higgins.

Before yielding to Mr. Meadows, I want to thank Mr. Meadows. Meeting in the anteroom just a moment ago was the Foreign Minister of Sudan, Ali Ahmed Karti and Mr. Meadows led the effort that led to the release of Meriam Ibrahim, and I want to publicly thank him again for that extraordinary leadership. Hopefully, a dialogue will ensue with the Sudanese on religious freedom issues.

Thank you, Mr. Meadows.

The Chair recognizes, Mr. Meadows.

Mr. MEADOWS. Thank you, Mr. Chairman, for your kind words and certainly thank you for your efforts in leading on not only that particular issue but a number of humanitarian issues.

And so I thank each one of you for your testimony here today.

Dr. Shah, let me go to you. I know we have requested a lot of money. You feel like the plan that we have in place is a good one, and so I want to direct our attention and focus in on the ETU units and the diagnostic units because right now, it is my understanding there is only two diagnostic units that are put in the same proximity with the treatment units. And what we are seeing is a great delay with regards to the diagnostic side of things as they get to put in the warm units. Are we making a change to that? Will we be putting those diagnostic units along with the ETU units?

Mr. SHAH. Thank you. I would just highlight three things. One is, on ETUs, we have, in fact, already scaled up the capacity of ETUs in all three countries.

Mr. MEADOWS. Yeah. I am talking about specifically diagnostics, not ETUs.

Mr. SHAH. Yeah. I think the labs—I think we have put in place now nine additional labs across the three countries in a certain amount of time. I think four or five are from DoD, and they have made a huge difference.

Mr. MEADOWS. I understand that. My question specifically is why are we not co-placing those along the ETU units? Because what you have is you have people——

Mr. SHAH. You transport issues.

Mr. MEADOWS. You have transport. You have got delays in terms of the diagnostics. You put them in warm zones. They could be with other infected patients. You have got just this whole laborious process. And we, with the most sophisticated healthcare system in the world, have found logistical problems with just a few patients here. Why would we not put the diagnostic units along with the ETU units, so we don't have the cross contamination probabilities?

Mr. SHAH. I think the real answer is we want to do that as much as possible. There are some constraints, and there is a conversation right now about how do we project out that lab capability.

Mr. MEADOWS. So what would be those constraints? You have only got 2 of the 20 right now where they are co-located together in Liberia.

Mr. SHAH. Right. So, for example, in Monrovia if you can get from site to site pretty quickly, you may not need to stand up labs at every one of the ETUs. And what might be the priority is getting more lab capacity that can project into rural communities and elsewhere.

Mr. MEADOWS. That doesn't make logistical sense. In your testimony just a few minutes ago you talked about malaria and how we have these potentials. So you have potentially a malaria patient who is coming into an area with other infected Ebola patients, who could be contracting Ebola, and yet time is not our friend here. So why would you not have the diagnostic units along with the ETU units?

Mr. SHAH. I think we want to have that as much as possible. I will have the team figure out——

Mr. MEADOWS. So you haven't addressed that?

Mr. SHAH. Well, we have. We have actually—we are looking both at a whole range of——

Mr. MEADOWS. Mr. Lumpkin, let me shift to you. You are building these units. Are you building diagnostic units along with the ETU units?

Mr. LUMPKIN. At this juncture, there is more——

Mr. MEADOWS. Yes or no?

Mr. LUMPKIN. I think it is more complex than that. You hit the nail on the head when you said it is a logistics challenge when you work this. So when you have more ETUs than you have diagnostic capabilities, sometimes it is better from a logistics perspective to centrally locate a diagnostic capability——

Mr. MEADOWS. And so it is better to wait 3 or 4 days——

Mr. LUMPKIN. No, no, no——

Mr. MEADOWS [continuing]. For the diagnostics, because that is what is happening. That is the intel that we are getting. They are having to wait 3 or 4 days to figure out whether they have got it and then travel a long distance to get there. So why would that be a logistical problem? If you are building these units, why would you not put the diagnostics along with the treatment unit?

Mr. LUMPKIN. Because it takes longer to get a diagnostic capability in country to have a robust laboratory capability than it does to get an ETU running. To get it configured, trained and everybody in, it takes time.

Mr. MEADOWS. So what you are saying is we are not going to collocate these.

Mr. LUMPKIN. That isn't what I am saying at all. I am saying, from my experience on the ground, the goal is always to get them as close as possible. But if you can't get one at each one, if there are two ETUs that are 15 miles away, if you can get it in the middle, you do, in order to make that limited resource of these diagnostic capabilities go as far as possible.

Mr. MEADOWS. So do you concur that is the best plan, Dr. Shah?

Mr. SHAH. I think the best plan is to have as much laboratory capability as possible.

Mr. MEADOWS. Well, we are asking for $7 billion here, and diagnostics—that that component of it is a very minute component of that. And so if you are asking for $7 billion, why could you not collocate?

Mr. SHAH. We will—I will get back to you with a more specific answer about going forward, but right now, we have three that are collocated, one in Lofa County, one in Bong County, and one in Monrovia, and those collocations——

Mr. MEADOWS. Out of how many treatment units?

Mr. SHAH. That are operational? I think seven are operational in that area right now.

Mr. MEADOWS. Well, I show 20 ETU units in Liberia. Is that not correct?

Mr. SHAH. They are not operational. You have seven operational ETUs.

Mr. MEADOWS. So we have seven operational, three that are collocated——

Mr. SHAH. Three——

Mr. MEADOWS. But when the others come on line, they will——

Mr. SHAH. Our goal will be to get as much lab capacity projected, and we have a synchronization matrix. I will have the team go through and identify how many will have collocated——

Mr. MEADOWS. Okay, I am out of time, but I would ask you to get back to this committee on why we can't do that.

Mr. SHAH. It is an excellent point. Both the assistant secretary and I agree with the basic point.

Mr. MEADOWS. All right. Thank you.

I yield back. Thank you, Mr. Chairman.

Mr. SMITH. Thank you, Mr. Meadows.

I know Ambassador Williams has to depart at noon for a flight. Thank you for your leadership and your participation today.

Ambassador WILLIAMS. Thank you, Mr. Chairman, I appreciate that.

Mr. SMITH. I would like to now recognize the ranking member of the Africa, Global Health, Global Human Rights, and International Organizations Subcommittee, a woman with whom I work very closely with and am very proud to do so, Ms. Bass of California.

Ms. BASS. Thank you. Thank you very much, Mr. Chairman.

I have several questions, most of them are unrelated, but I am just going to go through a little list. For Dr. Shah, you were mentioning changes in protective gear, and I was just wondering if we have been able to improve the temperature monitor. You know, I know that scan is not that accurate, and so I am wondering if there is any improvements to that.

I also wanted to ask, I know that UNICEF has reported that there are nearly 4,000 orphaned children, and I was just wondering if you could give us, anybody on the panel could give us a status report as to what is happening with the children, and then one of the—part of the consequences of the epidemic has been an impact on the economy, which my colleague was mentioning, and I wanted to ask specifically about the cocoa industry in Cote d'Ivoire that hasn't even been hit by Ebola, but yet it has been impacted severely. So maybe various panelists could answer this question, whoever would like to.

Mr. SHAH. Let me try. On the protective equipment, one of the things we have done through our global development lab is a grand challenge on Ebola, and we have seen more than 1,200 proposals come in, including I think more than 50 percent of proposals are for improved protective equipment, so, in the next 2 days, they are actually assessing the top 25 proposals. This has been a real focus for the President, and Motorola has been working with us on a temperature monitor for the suits, and as you point out, we are also working on cooling systems for the suits, breathability, and improved infection control.

Ms. BASS. That is great. Actually, I wasn't thinking about that. I was thinking about that handheld scan.

Mr. SHAH. Oh, the handheld scanner, yes.

Ms. BASS. That you have testified and other people have previously that it is not that great.

Mr. SHAH. Yeah, they are a little low I think. We are looking into that. And there are, I think, a series of existing products that are better than what they are using in west Africa now that we will be able to help support and deploy.

On orphanages, we have and are conducting a review. In particular, when I was in Liberia, I visited an orphanage, and not just the increase in the numbers, but also the lack of access to food, which has been the main constraint for those orphanages, so we are expanding the Food for Peace investment as part of this effort going forward and starting with looking at vulnerable populations, including orphans, to make sure they have enough food.

And on cocoa and the industry, it is true across the board, you know, shipping costs have gone through the roof. You have seen a 70-percent reduction in commercial flights to the region. Transportation is much, much, much more difficult, so any business, local or export oriented, is facing really severe challenges, which is why we are launching a major regional Feed the Future effort to get these industries operational again, and it is one of the reasons we seek the Congress' support for the Feed the Future authorizing legislation to really allow this to be successful.

Ms. BASS. I think it is important that we talk about that because it might be, Mr. Chairman and Mr. Ranking Member, it might be something that we could really try to expedite during the lame duck. I was going to ask you about the transfer authority and how soon you needed that to happen. If those are priorities, maybe we could get them done.

Mr. SHAH. I know we would appreciate the transfer authority as soon as possible. This is a very fast moving epidemic, and just as we note, I think we are every day learning more about which communities need what type of support. And it is not just immediate disease control but also dealing with these secondary consequences of the epidemic to avoid kind of state collapse and fragility from becoming the defining reality of all three places.

Ms. BASS. You know, I spoke a couple of weeks ago with the President of Liberia, and she took major issue with the numbers that are projected, and I was wondering if you had anything to say about that. The other thing that she raised was that they had just celebrated, and this was 2 or 3 weeks ago, they had just celebrated the 1,000th person in Liberia who survived. We are not really talking about that; we are only talking about the death rates. But what about the survival rates in countries, in particular, in Liberia?

Mr. SHAH. Well, I have spoken with President Sirleaf a lot as well, and she makes the point, and I fully agree, that we should be reporting current active cases and investing in real time data systems, which we are doing, to get better information about how many active cases are there. What you read in the press when they say 14,000 cases includes people who have died, unfortunately. It also includes people who have survived, and then that number doesn't really give you a sense of where is the immediate crisis because it is this big aggregated number over time and geography. So we have a team that we sent a whole team of epidemiologists from Johns Hopkins, from CDC, and we have a group going to help give first responders the right handheld devices to collect immediate data and reflect it in real time, and President Sirleaf I think values the fact that we want to stay focused on real data and information as opposed to modeled predictions that might or might not send the right message to folks.

Ms. BASS. In closing, if you could give us some better numbers, it would be great, especially to disaggregate the 14,000 would be great. Thank you.

Mr. SMITH. Thank you, Ms. Bass.

The Chair recognizes Mr. Clawson, the gentleman from Florida.

Mr. CLAWSON. Okay. When I review you all's bios and accomplishments, I am very impressed with what you have done for our country, not just now, but leading up until now, and you could have done a lot of other things with these kind of capabilities, made a little bit more money, but you chose to serve our country, and I want to express to you deep appreciation for that.

I also think that helping people is never—nonpartisan, and so I am here to help, and I heard your earlier question, I heard I think it was Representative Sherman earlier say, ask if you got everything you need, and I heard the answer being yes, so I look at the group sitting in front of me and that answer, and I feel a little bit better, but anything that I can do or that we can do to help because we are always interested in doing so.

I do have a couple questions that you all can help me with. Number one is when I look at the other countries in the region in Western Africa, it seems to me, if we back up a step, that this is a disease that preys on lack of health infrastructure and also particularly dangerous if there is an urban area where people are living close to each other. If you look at kind of when we looked at doctors per, you know, 100,000 residents or inhabitants in the other countries—Senegal, Mali, these kind of places, Ivory Coast—it is not a lot better than where we have an outbreak now. So am I drawing a correct conclusion in saying we have similar circumstances in neighboring countries that could lead to a crisis? And then secondarily to that, do we have enough of a firewall, or are we close to more disasters coming here?

Mr. SHAH. Well, first, Congressman, let me thank you for your initial comments and also point out that in my response to Representative Sherman, I did not intend to indicate that we have what we need. We desperately need these emergency funding resources. My team is very focused on the fact that we will literally be shutting down famine prevention programs in places like South Sudan if we don't get these resources.

Mr. CLAWSON. Okay.

Mr. SHAH. Because we have overspent aggressively and quickly because of the nature of the epidemic and to keep it from getting to be in an exponential phase in order to power this response. We also do seek the authorities and support for the food reform package, including Feed the Future authorization.

In terms of the global health security, I would just note I think you are exactly right that the neighboring countries have weak and fragile health systems. Where they have been successful, like Nigeria, it has been in part because of great leadership there and also strong support from CDC and others that have helped them do an extraordinary amount of contact tracing fast. But we are looking right now at cases in Mali.

You can't really build firewalls. I was in Senegal, and they said, well, we are cutting off the border with Guinea. All that really does is people cross the border and then don't get traced and are not

part of a system where you can identify who is crossing and what their temperature is and are they at risk, and they get lost in the population. So it is very hard to build a firewall in west Africa across west African countries.

Mr. CLAWSON. So should we have more resources going into these neighboring countries?

Mr. SHAH. Absolutely. And this emergency request includes resources for a set of activities we call global health security, where we have worked together with 43 other countries, including other countries that will provide funding, so we can co-invest in building global health security in the region, and it is important that we do that now to protect ourselves for the long term.

Mr. LUMPKIN. If I may add just one piece about the resourcing and having what we need to do, the business we need to do here and eradicate Ebola is that the defense committees were very kind to us in the end of Fiscal Year 2014 that allowed us to do a reprogramming within the Department of Defense of unobligated Overseas Contingency Operations funds of $1 billion, so we could put against this requirement in order to make sure we are fully supporting USAID. So the Congress has been very generous. This has allowed us to get where we are today and to continue our support over the coming months.

Mr. CLAWSON. One more question relative to support. Are our allies doing enough, and does the U.N. give quotas to folks in Europe? I mean, I know we are asking, but if you look at where the money comes from, it seems like most of it comes from us, and are specific requests made to our allies that have historic relationships in Africa?

Mr. SHAH. Yes, and those requests have been made by President Obama directly with counterpart heads of state. They have been made by Secretary Kerry, by Secretary Burwell, I have called my counterparts regularly, and the result of that is we have seen now $800 million committed from a range of other donors, and we welcome that, and we are tracking to make sure that it actually arrives and it is not just a verbal commitment.

In terms of the U.N., the UNMEER mission is assessed based on contribution percentages, so it is an allocation, and the standard U.N. percentages will apply to the cost of that mission.

Mr. CLAWSON. Thank you.

Yield back.

Mr. SMITH. Mr. Clawson, thank you very much.

The Chair recognizes Mr. Cicilline.

Mr. CICILLINE. Thank you, Mr. Chairman.

And thank you to the witnesses for your expertise and for sharing your experiences with the committee today. I think it is very important that you have established clearly that the United States has a national security interest and a humanitarian responsibility to respond to this outbreak and that the best way to respond to this, the best way to protect against Ebola here within our own borders is of course to work with our international partners to help save lives, strengthen the economies of our trading partners, maintain political stability in these countries and stop Ebola at its source, and I thank all of you for the work that you are doing and the agencies you represent.

I also want to just take a moment to acknowledge the extraordinary contributions of our local and international health workers and military personnel who have really helped to combat this outbreak. Experts have stated that the greatest barrier to ending the outbreak in west Africa is an insufficient number of health workers. And today I will introduce a resolution along with my colleague Congresswoman Bass expressing a sense of Congress that health workers responding to the Ebola crisis deserve our profound gratitude and deep respect. And I just want to say that here at this hearing.

Dr. Shah, I want to just start with you. I want to build a little bit on Mr. Clawson's question, but rather than building a firewall, I about a year ago with Mr. Kinzinger visited Liberia and was struck by the lack of a healthcare system infrastructure and can only imagine what the impact is on combating this outbreak with that kind of a frail, very fragile healthcare system. So as you think about this global health security, do we—is the United States really helping to lead kind of a comprehensive plan to kind of assist countries in developing this capacity after this epidemic is concluded, recognizing that is a huge undertaking, but, you know, are there some strategies that we should be looking for to invest in that will help build the capacity not only in the three affected countries but in the region and countries that are particularly vulnerable to an outbreak of an infectious disease?

Mr. SHAH. Well, thank you, Congressman, and thank you for your resolution in particular. That has special meaning for our folks on the ground and our partners, and we really want to say thank you for your leadership.

In terms of global health security over time, President Obama actually started this effort as an international partnership before the Ebola outbreak, and frankly, before the outbreak, President Sirleaf had a very coherent plan for training, hiring, and deploying a few thousand community health workers, building out laboratory capacity, improving the physical infrastructure of the more than 460 primary care facilities throughout the country, many of which we have helped build over the years and stock and supply, and so this has been devastating to the system initially because of all of those initial healthcare worker infections and people no longer coming to work and the consequence of that.

But we do have clear plans in country for what it means to build health system security. It builds off the baseline of our global health investments that have helped to build out this infrastructure. And one of the elements that was not considered before, because it was pre-Ebola, that will now be considered is how we make sure we get protective equipment and training to all of those primary healthcare workers that, you know, previously wouldn't have been thinking about Ebola but now need to make sure they can protect themselves in a setting like that.

The last thing I would say about this is we have worked with 43 other countries. At the end of September, there was a meeting at the White House. Those countries came and made pledges and commitments, so this will take a while to build into the system but is I think particularly important given the crisis that we are dealing with right now.

Mr. CICILLINE. So one of the other things I wanted to follow up on is the number of young children that are being orphaned as a result of this outbreak and whether we are developing strategies to help deal with this real crisis in terms of psychological services, placement, et cetera, particularly in Liberia.

Mr. SHAH. Uh-huh. Yes, we absolutely will. This emergency funding request and the transfer authority will give us the capability to deal with this crisis at scale, and, you know, it is a devastating reality. I have seen children who are unable to communicate or be with their mother because she is infected and in a treatment unit, and they are separated, so it is a tragic reality of this epidemic, and these resources will help us address that.

Mr. CICILLINE. Thank you.

Mr. Lumpkin, I just have one question. It appears that the Department of Defense has a policy in place now for a 21-day quarantine, regardless of the risk because these are individuals who are not having direct contact with patients. That protocol seems to be at odds or at least not the same protocol as the CDC. So is that correct? And why is the Department of Defense doing a quarantine for people that may not be at any risk and certainly are, some of them, not even having direct contact with patients? It seems an odd practice that is quite different from the CDC protocol, and I would love Dr. Shah and Mr. Lumpkin both to respond to that if you would.

Mr. LUMPKIN. Well, Secretary Hagel approved the 21-day controlled monitoring program that you just discussed at the recommendation of the chairman of the Joint Chiefs of Staff as well as the service chiefs—senior leadership in uniform, and it was done for operational reasons based on how we reinnervate our force, and I will let Major General Lariviere kind of go over the guiding principles with, as far as the service chiefs and the chairman.

General LARIVIERE. Thank you, sir. And, again, it was an operational decision, not a medical decision, and I will let General West talk about the medical advice that was given to the chairman which was very similar to the CDC guidance, but because we have got a young and large population, youngest and largest responding to this epidemic, the chairman felt because of the unique role and responsibility of the military and the scale of deployment and the responsibility he has for the personnel and for the families that this was a prudent measure to take, again based on the recommendation of the Joint Chiefs, recognizing that it is not—it is more conservative than the CDC guidelines.

Mr. SHAH. I would just add for USAID employees and staff and partners, you know, we are following the CDC guidelines that do involve direct active monitoring for people that come back from the region and more extensive measures if there is a specific exposure per the guidelines.

Mr. CICILLINE. Thank you.

I thank you, Mr. Chairman. I yield back.

Mr. SMITH. Thank you.

Mr. Keating of Massachusetts.

Mr. KEATING. Thank you, Mr. Chairman, ranking member for having this important hearing. I want to thank our witnesses, not only their own personal involvement but on behalf of their agencies

for the fine work they have done and how important it is worldwide and for our country here.

One of the most concerning reports of the impact of the outbreak in the region is the marginalization of members of vulnerable populations, including the LGBT community. In the Liberian capital of Monrovia, for example, we have heard numerous incidents of harassment, physical altercation, direct targeting of individuals based on their sexual orientation after some religious leaders claimed the outbreak was a punishment from God. This not only affects these vulnerable populations but also our overall ability to control and stem this outbreak.

How are USAID and the State Department working to ensure that the LGBT community is receiving unobstructed care and how are your agencies working to protect all vulnerable groups from discrimination based on gender, disability or sexual orientation?

And I guess, Administrator Shah, you could respond to that first I guess.

Mr. SHAH. Well, thank you for the question. It is an important issue in particular because of, as you identify in a context of fear and lack of information, prejudices can often become defining of behavior, and so, for that purpose and because it is central to the epidemic response, we have had a widespread public messaging campaign throughout all three countries to communicate Ebola is real, how you get it, what it is not, and to avoid those concerns. In addition, our Disaster Assistance Response Team has a special focus on integrating protection concerns for vulnerable populations, including LGBT populations into the grants and programs they are pursuing because this is such an important issue, and it will continue to be our policy, especially with respect to how the services are provided, that everyone has equal access to be a beneficiary of our programs and that this response is driven by science and evidence and not prejudice and fear.

Mr. KEATING. Great.

Do any of the other witnesses want to comment on that? No?

With that, Mr. Chairman, I will yield back my time, and again thank the chair, ranking member, and the members of the committee and our witnesses for their time.

Mr. SMITH. Thank you very much to our very distinguished witnesses for your leadership, for providing insight and counsel to the committee. We all, on both sides of the aisle, deeply appreciate it and look forward to working with you going forward.

The hearing is adjourned.

[Whereupon, at 12:24 p.m., the committee was adjourned.]

APPENDIX

Material Submitted for the Record

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

Edward R. Royce (R-CA), Chairman

November 6, 2014

TO: MEMBERS OF THE COMMITTEE ON FOREIGN AFFAIRS

You are respectfully requested to attend an OPEN hearing of the Committee on Foreign Affairs, to be held in Room 2172 of the Rayburn House Office Building (and available live on the Committee website at http://www.ForeignAffairs.house.gov):

DATE: Thursday, November 13, 2014

TIME: 10:00 a.m.

SUBJECT: Combating Ebola in West Africa: The International Response

WITNESSES: The Honorable Rajiv Shah
Administrator
U.S. Agency for International Development

The Honorable Bisa Williams
Deputy Assistant Secretary
Bureau of African Affairs
U.S. Department of State

The Honorable Michael D. Lumpkin
Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict
U.S. Department of Defense

Major General James Lariviere, USMC
Deputy Director for Politico-Military Affairs (Africa)
Joint Chiefs of Staff
U.S. Department of Defense

Major General Nadja Y. West, USA
Joint Staff Surgeon
Joint Chiefs of Staff
U.S. Department of Defense

By Direction of the Chairman

The Committee on Foreign Affairs seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202/225-5021 at least four business days in advance of the event, whenever practicable. Questions with regard to special accommodations in general (including availability of Committee materials in alternative formats and assistive listening devices) may be directed to the Committee.

COMMITTEE ON FOREIGN AFFAIRS
MINUTES OF FULL COMMITTEE HEARING

Day *Thursday* Date *11/13/14* Room *2172*

Starting Time *10:11 a.m.* Ending Time *12:24 p.m.*

Recesses *0* (____to ____) (____to ____) (____to ____) (____to ____) (____to ____) (____to ____)

Presiding Member(s)

Edward R. Royce, Chairman; Rep. Ileana Ros-Lehtinen; Rep. Ted Poe; Rep. Christopher H. Smith

Check all of the following that apply:

Open Session ☑
Executive (closed) Session ☐
Televised ☑

Electronically Recorded (taped) ☑
Stenographic Record ☑

TITLE OF HEARING:

Combating Ebola in West Africa: The International Response

COMMITTEE MEMBERS PRESENT:

See Attendance Sheet.

NON-COMMITTEE MEMBERS PRESENT:

Rep. Sheila Jackson Lee

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

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

Rep. Gerald E. Connolly

TIME SCHEDULED TO RECONVENE _____
or
TIME ADJOURNED *12:24 p.m.*

Jean Marter, Director of Committee Operations

HOUSE COMMITTEE ON FOREIGN AFFAIRS

FULL COMMITTEE HEARING

PRESENT	*MEMBER*
X	Edward R. Royce, CA
X	Christopher H. Smith, NJ
X	Ileana Ros-Lehtinen, FL
X	Dana Rohrabacher, CA
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X	Joe Wilson, SC
	Michael T. McCaul, TX
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X	Matt Salmon, AZ
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X	Jeff Duncan, SC
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X	George Holding, NC
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	Alan S. Lowenthal, CA
X	Grace Meng, NY
X	Lois Frankel, FL
X	Tulsi Gabbard, HI
X	Joaquin Castro, TX

Statement for the Record

Submitted by Mr. Connolly of Virginia

On Monday, the United States opened an Ebola Treatment Unit (ETU) north of Monrovia. It is the first of 17 ETUs the U.S. plans to build across Liberia. Hopefully, this investment represents further progress for effective U.S. involvement in the international response to the Ebola crisis in West Africa.

West Africa is ground zero for the outbreak of the deadly Ebola Virus Disease. In the countries of Liberia, Sierra Leone, and Guinea, where the disease has taken its greatest toll, 13,300 individuals have been infected and more than 5,000 men, women, and children have succumbed to the virus. Simultaneous outbreaks in multiple countries and the spread of the virus to urban areas have caused the number of infections and transmission rate to reach levels never before seen since Ebola was first identified in 1976.

In this chaotic environment and uncharted territory, healthcare workers serving on the front lines of the pandemic are combatting the disease with the dedication and sense of mission this situation demands. We have all read the harrowing accounts of the remote hospitals that first experienced a trickle of patients infected with Ebola, but were soon overcome by the tide of the epidemic. In the course of their service, over 500 healthcare workers have been infected and at least 233 have died.

The existing health infrastructure in the affected countries was already overburdened and poorly resourced. Per capita annual health spending in Liberia, Sierra Leone, and Guinea is $64. In the U.S., our per capita spending on healthcare is three times that amount every week. As the healthcare system has crumbled around them, the doctors, nurses, hospital staff, and burial teams have remained steadfast in their resolve to treat the infected and protect the broader population.

The international response to the Ebola crisis must include an investment in the people who have driven the response thus far. This means properly training, resourcing and protecting local and international healthcare workers. Personal protective equipment and hospitals for healthcare workers must take priority over travel bans, which actually inhibit efforts to recruit more medical professionals to volunteer their services. Such panic makes poor policy, and it is a distraction from our mission.

Last week, the President requested $6.18 billion from Congress in emergency funding to support the international and domestic response to Ebola. Under the President's plan, the agencies represented here today, the State Department, the U.S. Agency for International Development, and the Department of Defense, would receive a combined $3.01 billion. This is in addition to the $3.18 billion that would be provided to the Department of Health and Human Services for the fortification of domestic public health systems and controlling this and future epidemics abroad. Your three respective organizations would be tasked with a diverse array of missions from refining the logistics of existing healthcare networks and supporting burial teams to innovating new vaccine development techniques and training civil aviation staff in West Africa on safe screening procedures.

Given the nature of this pandemic and its nonlinear growth, I am very interested in the pace at which this new funding would be implemented. In March of this year, when there was a handful of Ebola cases in Guinea, the World Health Organization estimated that containing the outbreak would cost $4.8 million. By August, the number of Ebola cases had risen to 3,685 and the estimated cost of an effective response had grown to $490 million. In just three short months, the number of cases has now quadrupled and we are considering authorizing $6.18 billion in new spending in addition to the estimated $345 million the U.S. has already spent on funding the Ebola response. None of this is to diminish the necessity of this request, quite the opposite actually. I am imploring you towards expeditious implementation of any funding you might receive for the sake of the people of West Africa, the global community, and those who might be swayed by the value of immediate action as a cost- and life-saving measure.

The Administration's initial response to the Ebola threat left much to be desired and undermined the credibility of vital government institutions. What early guidance from the Centers for Disease Control (CDC) lacked in consistency, it certainly made up for in stubborn hubris. The CDC assured the public that "virtually any hospital in the country" could provide isolation for an Ebola case. These assurances came despite vague and potentially inadequate instructions issued by the CDC on isolation protocol. As someone who was deeply involved in emergency response planning during my time as the Chairman of the Fairfax County Board of Supervisors, I would caution that feigned confidence in a crisis is no substitute for honest and straightforward direction.

I pray that our aid workers, Foreign Service officers, and military personnel do not fall victim to similar failings. Up to 4,000 service members have been authorized to deploy to West Africa to deliver supplies and build ETUs. I share the American public's alarm that staff at Texas Health Presbyterian Hospital, and for that matter in hospitals in West Africa, have become infected with Ebola despite their medical training. We want to know that the men and women in uniform who are not medical professionals have the training and resources they require to remain safe while on deployment.

As Congress considers the President's request, we hope the Administration will demonstrate an improved ability to coordinate government action and provide effective guidance to state partners, hospitals, healthcare workers, government personnel, and nongovernmental organizations. Fighting Ebola at the source of the outbreak is the only solution that will ensure our Nation does not confront an Ebola pandemic at home in the coming weeks, months, or years.

Question for the Record
Submitted by the Honorable Ami Bera
To Administrator Shah

Question:

With all the different crises happening around the world – from Syria to South Sudan to ISIL/Iraq and now Ebola, would you please characterize for us the strain on USAID's humanitarian accounts?

Answer:

[RESPONSE NOT RECEIVED AT TIME OF PRINTING]

○