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Chairman Bass, Ranking Member Smith, members of the subcommittee, thank you for the opportunity to speak with you today about the U.S. response to the ongoing Ebola outbreak in the Democratic Republic of the Congo (DRC), and for your interest in this important issue.

Since August 2018, the DRC has been facing what is now an unprecedented Ebola outbreak in the country, with 1,954 confirmed and probable cases and 1,312 deaths as of May 30. It is the world's second largest recorded outbreak of the disease, eclipsed only by the 2014 West Africa outbreak that resulted in nearly 29,000 cases and killed more than 11,000 people.

Last month, I traveled to eastern DRC and saw the scale of this outbreak and the response firsthand. I have traveled extensively in my career, from my three decades with the U.S. Navy and in the roles I've held since. This trip to the DRC was one of the most important trips I have ever taken. I heard directly from local traditional and religious leaders, as well as our partners, about the challenges communities and response actors are facing. There continues to be ongoing violence and community distrust towards the response driven by years of political and humanitarian failures in the region. The U.S. Government has been working closely with the Government of the DRC, the World Health Organization (WHO), and other international partners to control the spread of disease since the outbreak began, and we're taking the concerns of our partners into account as we adapt our response. Bringing an end to this devastating outbreak is a top priority for the U.S. Government, because we are committed to reducing the suffering of those affected by Ebola, and because effective efforts to contain and end the outbreak can prevent it from reaching the broader region, as well as our borders.

This outbreak is not yet controlled. It has recently gotten worse, and it is expected to continue to expand. This significant increase in cases is extremely concerning, as it has wide geographic dispersion, and a high percentage of the new cases are unknown contacts and community deaths occurring outside of the health system. In response, the U.S. Government is aggressively adapting our strategies, and working with our interagency and international partners to help reset and redirect the response to stop the spread of the disease.

Overview of the DRC Ebola Outbreak

The Government of the DRC declared the current Ebola outbreak more than ten months ago, in North Kivu Province in eastern DRC. Within a short period of time, the virus had begun to spread through communities and eventually reached the city of Beni. Within two weeks, newly confirmed cases were being reported in neighboring Ituri Province. By mid-October, increased transmission in hospitals and health facilities led to a spike in cases in Beni, making it the new epicenter of the outbreak. In other areas, the virus continues to be transmitted quickly and has

now spread, with 22 health zones throughout North Kivu and Ituri provinces affected as of May 30—including Katwa and Butembo—which has proven to be a difficult environment to operate in due to physical attacks and threats against health care facilities and health workers, exacerbated by a high degree of community mistrust.

This outbreak is occurring in areas with ongoing fighting between armed groups, leading to access constraints and the intermittent suspension or modification of ongoing activities, including those of USAID partners. There have been multiple, persistent security incidents affecting response activities since the beginning of the year, including the armed group attack on a hospital in Butembo in April that killed a WHO staff member. In the week following my recent visit to the DRC, the Katwa Ebola treatment unit (ETU) was attacked—not for the first time—killing one guard, and a militia attacked a hotel in Butembo housing Ebola responders, killing several people and halting response operations for several days. Every day that health teams are absent from an outbreak area due to a security incident is a lost day of critical response activities that can save lives.

The outbreak is also spreading in an area with a long history of deeply-rooted community distrust of the central government, foreigners, and people from other regions in the DRC due to decades of neglect, exploitation, and violence. This widespread distrust has fueled misconceptions about the disease, including beliefs that Ebola was created to wipe out populations or extort money from people. In meetings during my visit with faith and community leaders, they spoke openly about feeling exploited by the "Ebola economy" and about their deep suspicion regarding the motives of the sudden and dramatic presence of outsiders responding to Ebola. This was a sobering reminder for me that communities do not trust the response. At times, community mistrust and resistance has exploded into violence against frontline workers .Engaging communities in the response is absolutely essential to gain the community acceptance necessary to control this outbreak and increase the effectiveness of contact tracing activities, vaccination campaigns, and other key response activities.

Complicating matters, the Ebola outbreak has been unfurling in the middle of a protracted humanitarian crisis in the DRC, where 12.8 million people are currently in need of assistance. While the DRC has faced nine previous Ebola outbreaks, this is the first outbreak occurring in areas like Ituri and North Kivu province that already suffer from chronic humanitarian needs—like food, safe drinking water, and shelter. Factors such poor infrastructure, forced recruitment into armed groups, and ongoing violence that reduces access to agricultural lands and markets have contributed to the deterioration of humanitarian conditions and triggered mass internal displacement and refugee outflows.

U.S. Government's Ebola Response

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

the DART provides an efficient and effective operational and coordination structure to mount the U.S. Government response.

The DART, as the lead coordinator of the U.S. Government response in the DRC, is helping to oversee a whole-of-government response that is forward-leaning and flexible. USAID has experience responding to Ebola because we've responded to the deadly disease before. We are constantly adapting lessons learned to this challenging context. From 2014 to 2016, USAID deployed its expert DART to lead the U.S. response to the unprecedented Ebola epidemic in West Africa that killed more than 11,000 people. Our flexible strategy during that response allowed us to respond effectively to changing conditions as we learned more about the social aspects of the crisis. For the DRC Ebola response, and previous responses in the DRC, USAID is closely collaborating with our interagency partners—like CDC and the National Institutes of Health—along with the Government of the DRC, other donors, the World Health Organization, the U.N., international partners, and civil society to battle this disease.

The U.S. Government is working with partners, not only to provide vital assistance, but also redirect the response to overcome some of the key challenges I have noted today, which have made this outbreak difficult to contain. As such, the USG is supporting a multi-pronged approach to: (1) stop the spread of infection and provide vital care to Ebola patients; (2) support community outreach and education programs to dispel rumors and earn the trust of community members in areas affected by the disease; (3) enhance coordination with international and interagency partners; and (4) broaden the response to address communities' non-Ebola humanitarian needs in an effort to increase community trust that is so critical if we are to improve the effectiveness of our public health interventions. In addition, we are working to shift the response from a top-down approach to one that elevates the community's role and increases local acceptance and ownership of Ebola response activities.

Because stopping the spread of Ebola is a first step in ending the response, we've helped train 1,680 community health care workers to conduct surveillance, equipping them with knowledge and tools to gather the information needed to track the disease and stop the chains of transmission. We're also providing technical guidance and operational support to four teams to provide safe and dignified burials for people who have died from Ebola. Infected bodies are highly contagious. However, changing deeply- held cultural traditions —like washing the body before burial—during such an emotional time of loss has proved challenging. Some burial teams have even been physically attacked, hindering their ability to help families safely bury their dead. Our partners are working with community leaders to help encourage safe practices that can save lives, while also being respectful to the local culture. USAID is also strengthening infection prevention and control measures in more than 280 health facilities across at least 18 health zones by training nearly 3,000 health care workers in patient screening and isolation, appropriate waste management, and other practices that prevent disease transmission as well as enhancing triage and isolation infrastructure. USAID also has supported these partners with 53 metric tons of personal protective equipment at more than 100 health facilities, and our partners continue to provide treatment and care for those who have contracted Ebola to help increase their chances for survival. Additionally, USAID is providing enough food monthly to meet the needs of approximately 45,500 beneficiaries—including Ebola survivors, patients, contacts, family members, as well as frontline responders. Our assistance helps people grow or stay healthy and

allows potential contacts to stay put, as they won't need to travel to maintain livelihoods or get food.

Our experience with this outbreak so far, the West Africa Ebola outbreak, and other humanitarian emergencies has shown us that community acceptance and ownership is crucial to the success of this response. USAID is supporting partners to dispel rumors about the disease through community outreach—including by working with trusted community leaders—to increase acceptance of public health response activities. We've seen the impact of these efforts: At one meeting, one of our partners heard from young people, community leaders, and women, some of whom expressed concern about rumors that burial teams were harvesting organs from the deceased to use in illegal trade. Through presentation and discussion, our partner was able to dispel these rumors, and the community pledged support for Ebola prevention efforts and agreed to alert surveillance teams of possible cases. Another one of our partners is working to reach 500,000 households, or 1.5 million people, with key health messages to raise awareness about Ebola transmission. And another partner has created more than 90 radio pieces in three local languages that are being broadcast across more than 50 radio stations. USAID's partners are engaging with journalists, taking to the airwaves, creating mini movies, and organizing groups on the WhatsApp social messaging platform to educate people about Ebola and stimulate discussions. As many of our partners have been doing since the beginning of the outbreak, we are continuing to increase emphasis on community dialogue and actively looking to involve a wider cross-section of organizations, such as local women's, youth, and faith-based groups. To illustrate, USAID recently committed new funding to work directly with faith leaders in one of the affected areas. One of our partners, for example, is working with religious leaders to change their perspectives on Ebola-related rumors. Once trained, these local leaders then spread messages related to the response to help broaden community acceptance of the activities. In addition, our partners have hired local people—including Ebola survivors—to be a part of the response in their own communities. And, our partners are reaching out to respected local leaders to deliver Ebola prevention messages in local languages.

USAID's vast experience working with international organizations and other donor governments promotes coordination and efficient use of resources to save lives. We're applying our longstanding knowledge of the humanitarian system and the DRC context to guide improved international efforts and provide vital support to partners, so they can implement public health programs at a scale that will contain this outbreak. We're also drawing on the unique capabilities of our partners—like logistics support to move urgently needed supplies and personnel into the region.

For the past few years, USAID has been working closely with the U.S. Department of Health and Human Services—specifically CDC— and the U.S. Department of State to align and strengthen the U.S. Government's engagement with WHO. We've also been working alongside other donors to influence the response's overall strategic management. To illustrate, the United States joined other donor governments to advocate the DRC Ministry of Health to allow NGOs to have an increased role in Ebola sub-commissions, in order to improve coordination and the impact of programs in affected communities. In addition, we're encouraging other donors to contribute resources to this Ebola response effort, including countries that have already provided assistance.

Lastly, this Ebola outbreak is not just a public health crisis—it is an outbreak in the midst of a complex crisis demanding our full attention. It requires a holistic, broader humanitarian approach to more effectively address a crisis of this scale. This includes utilizing humanitarian response systems and partners that place community needs at the forefront of the response, as well as addressing other pressing-- and often long-standing community needs —we can increase the community acceptance essential for more effective public health interventions. We have been providing humanitarian assistance in the DRC for more than three decades, and are uniquely familiar with operating in this difficult context. Working with the international community to help meet the basic needs of already hard-hit communities may help reduce their suspicion of "outsiders" and bring more acceptance to the ongoing Ebola response, while taking this critical window of opportunity give them more security and stability.

There is no question that our interventions thus far have saved lives and prevented a much larger outbreak. There are countless people who have been spared from getting the disease because of the programs we've helped put into place. However, as noted above, the outbreak is ongoing and the U.S. Government should continue to help contain and control the outbreak. In addition to the troubling increase in weekly case numbers, it's becoming increasingly difficult to trace where these cases came from, and who may be at risk to fall ill next. While this has grown into a larger humanitarian crisis, we cannot lose focus on the critical health interventions on the ground, and we will continue to collaborate with the CDC and the WHO to adapt the response to address the myriad of challenges. . During my visit to the region, I saw firsthand how hard our partners are working--and how emotionally and mentally exhausted they are by their tireless efforts to bring this outbreak under control. Response groups on the ground care deeply for the people in eastern DRC, and they will continue to work to help them long after this outbreak is over.

Response Redirect and Reset

During my trip to the DRC it became clear that insecurity, poor coordination, underutilization of key NGOs and faith-based groups, and insufficient community engagement greatly hinder response efforts. This response is in need of a complete reset and redirect towards a more holistic humanitarian approach that responds to the broader needs of the community to help increase acceptance and ownership of the public health interventions. The U.S. Government has several recommendations for how we can do this:

First, we must do more to enhance response leadership and coordination. For example, we've recommended that the United Nations (UN) designate a high-level representative dedicated to lead a more holistic UN-led Ebola response. In response to our request, the UN appointed an Emergency Ebola Response Coordinator to coordinate the international response effort in support of the Government of the DRC -led response . The UN also recently initiated a system-wide scale up to mobilize additional resources to support this more holistic, broader humanitarian response. We are also working to support the new DRC Government's response lead, and will continue to push for an incident management system that unifies UN and government operations. The U.S. Government, along with other lead donors, also continues to advocate for the operationalization of civil society, faith-based organizations, and NGOs in coordination structures and the development a long-term strategic response plan . We are making gains on some of these strategic shifts.

Second, we must enhance community engagement. We know that community acceptance is the best form of security. As such, the USG is emphasizing enhancement of community engagement across the response—from the DRC Ministry of Health to WHO and USAID partners, many of which have been focusing on community engagement from the onset of the response. To increase community acceptance, we recommend addressing broader humanitarian needs by supporting quick-impact projects-- coordinating with other donors on long-term investments; improving utilization of community feedback; increasing local participation and ownership; and expanding NGO and civil participation in response coordination activities.

Third, there must be operational improvements in the public health response. This includes expanded vaccination coverage using the investigational Merck vaccine; improving surveillance of community deaths; pressing to reinstate the use of rapid diagnostic tests; expanding community-based surveillance; and implementing further training for frontline Ministry of Health workers in addition to other critical activities necessary to break chains of transmission.

We must also intensify response readiness in Goma and along the Goma-Butembo corridor, which is why the USG continues risk communication, community engagement, infection prevention and control, health care worker training, and other activities in this region. The United States will continue to address preparedness gaps and push for increased vaccinations among health care workers in high-risk areas surrounding the outbreak.

Next, it has become very clear that improved security for responders is needed. However, we must do so without greater militarization of the response. More armed security services have the potential to deepen community distrust . USAID will support a shift in security strategies by increasing the role of humanitarian security actors in analysis, advising, and communication -- similar to what we do in other complex emergencies .

Preparedness

In addition to stopping the spread of Ebola in the DRC, the U.S. Government is supporting Ebola preparedness efforts in at-risk neighboring countries: Burundi, Rwanda, South Sudan, and Uganda. These efforts are helping to strengthen local capacity to screen for Ebola at borders, detect cases if they occur, improve infection prevention and control practices in prioritized health facilities, and educate and engage communities, among other activities. While there have been no Ebola cases detected outside of the DRC during this outbreak, these efforts are vital to making sure the region is prepared for any potential advancement of the disease. USAID is also providing support to the DRC to bolster Ebola preparedness efforts in Goma, as well as in provinces adjacent to North Kivu and Ituri, to help ensure that the virus doesn't spread any further within the country.

Preparing for disease requires a whole-of-society approach across multiple sectors to prevent, detect, and respond to infectious disease threats. USAID has worked with CDC and interagency colleagues to implement the Global Health Security Agenda (GHSA), which was launched in 2014, to prevent and mitigate disease emergence and spread. The goal of GHSA is to build the

capacities and strengthen health systems to detect infectious disease events early, respond rapidly and effectively to new outbreaks, and to prevent avoidable outbreaks.

When crises happen—like the current Ebola outbreak—we also work to ensure response agencies have the tools and operational structures necessary to respond quickly and effectively. These is why, in 2017, USAID invested $35 million into operationalizing WHO's Health Emergencies Program and constantly work with other partners to make sure they are ready to respond.

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

In our response to outbreaks like Ebola in the DRC, USAID will continue to work to help build the long-term capacity of countries to respond. This includes building health systems, training the health workforce, expanding the reach and effectiveness of community health workers and programs, establishing supply chains for essential health supplies, improving infection prevention and control in all health facilities, etc..

Conclusion
In conclusion, there is no silver bullet to stopping the DRC's tenth Ebola outbreak, but USAID and the U.S. Government are well equipped to help DRC and WHO respond to this disease and are currently pressing for a response reset to better adapt to key challenges on the ground. For the 2014-2016 West Africa response, our DART—together with our interagency and international partners, as well as the affected countries—helped bend the epidemiological curve in Liberia, Guinea, and Sierra Leone, and avert the worst-case scenarios initially predicted. In addition, because we have been providing humanitarian assistance in the DRC since 1984, we are familiar with the operating environment and access challenges and have long-standing experience coordinating with the DRC government, other donors, and partners during high-profile emergencies, and we're well-prepared to continue providing vital humanitarian aid.

However, we fully acknowledge that despite the lessons learned during the West Africa outbreak, this particular response poses difficult and unique challenges that will require us to be forward-leaning and flexible to continue adapting to changing conditions on the ground. While responding to this outbreak is complex, this is a whole-of-government response, making the most of each agency's knowledge and expertise. We are all united in the same goal of helping DRC and WHO to bring this outbreak under control as soon as possible and demonstrating our continued support for the people, families, and communities affected by this devastating disease.

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