Written Statement of Rear Admiral Tim Ziemer
Assistant Administrator, U.S. Bureau for Democracy, Conflict, and Humanitarian Assistance,
U.S. Agency for International Development
Before the Senate Foreign Relations Committee, Subcommittee on Africa and Global Health Policy
July 24, 2019, 2 pm

Introduction

Chairman Graham, Ranking Member Kaine, 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 2,578 confirmed and probable cases and 1,737 deaths as of July 21, 2019. 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. On July 17, 2019, the World Health Organization (WHO) declared it a Public Health Emergency of International Concern, a status only announced when there is an "extraordinary event" that is determined "to constitute a public health risk to other States through the international spread of disease" and "to potentially require a coordinated international response." This declaration is only the fifth one of its kind that the WHO has made since the adoption of the International Health Regulations in 2005.

This ongoing Ebola outbreak is more than just a public health crisis—it is happening in the midst of a complex humanitarian crisis that has left 12.8 million people in need of assistance in the DRC. While the DRC has faced nine previous Ebola outbreaks, this is the first in Provinces that already suffer from chronic humanitarian needs—like the lack of food, safe drinking water, and shelter.

In May, I traveled to Eastern DRC and saw the scale and complexity 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 have 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 ongoing

violence and community distrust towards the response driven by years of corruption and political and governance failures in the region, which makes this outbreak more difficult to contain.

This outbreak is far from controlled. In recent weeks, it has become clear that this could become a regional issue, as we have seen cases move dangerously close to neighboring Rwanda and South Sudan. In Uganda, three cases were detected in June 2019, although those cases were later recorded officially as DRC cases since that is the country where they originated. The U.S. Government is aggressively adapting our strategies, and working with our interagency and international partners, including the Government of the DRC the WHO, and the UN humanitarian agencies to help reset our approach to the response to stop the spread of the disease.

USAID has contributed more than $98 million for the response efforts to date, and will continue to invest and provide vital support until this disease is contained. 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.

Update on the Outbreak in the DRC

Next week, we will mark one year since the Government of the DRC declared the current Ebola outbreak in North Kivu Province in Eastern DRC. Within two weeks of that declaration, confirmed cases were reported in neighboring Ituri Province. By mid-October, increased transmission in hospitals and health facilities led to a spike in cases in Beni, which made it the epicenter of the outbreak at the time. Today, Beni is a hotspot for transmission, alongside Mabalako, Katwa, and Butembo, as the virus

continues to spread in the region as a result of community deaths, high population mobility, and other factors, with 25 Health Zones throughout North Kivu and Ituri Provinces affected as of July 15.

Regional spread remains a very serious concern. On July 14, the DRC confirmed its first case in Goma, a city of more than a million people near the border with Rwanda and a major transit hub in the region. In addition, a case was recently confirmed in the DRC's Ariwara Health Zone, in Northern Ituri Province, fewer than 45 miles from South Sudan and seven miles from Uganda.

Complicating an already difficult response to this deadly disease, this outbreak is occurring in areas with ongoing fighting between multiple armed groups, which leads to access constraints and the intermittent suspension or modification of ongoing activities, including those of USAID partners. A little more than a week ago, two health care workers were deliberately targeted and killed in Beni, which highlights how dangerous this outbreak has been for the brave people who are risking their lives in responding. In the week following my recent visit, 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 because of 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—which at times has exploded into violence against frontline workers—of the central government, foreigners, and people from other regions in the DRC because of decades of neglect, corruption, exploitation, and violence. This deep mistrust has also fueled misconceptions that Ebola was created to wipe out populations or extort money from people. Faith and community leaders told me about feeling

exploited by the "Ebola economy" and about their deep suspicion regarding the motives of the sudden and dramatic presence of outsiders. This was a sobering reminder for me that communities do not trust the response.

Response and Reset

There is no question that our interventions thus far have saved lives and prevented a much larger outbreak. The more than $98 million USAID has provided for the Ebola response in the DRC to date has been supporting life-saving assistance, including activities to prevent and control infections, training for health care workers, community engagement, the promotion of safe and dignified burials, and food assistance for affected people, including Ebola contacts under monitoring and their families, patients in Ebola treatment centers, and discharged survivors.

Last September, the U.S. Government deployed a Disaster Assistance Response Team, or DART, which built upon early assistance from USAID and the Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services (HHS). The DART is the lead coordinator of the United States' whole-of-Government response to the Ebola outbreak in the DRC. This expert team—composed of disaster and health experts from USAID and HHS—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 a forward-leaning, flexible, efficient, and effective operational and coordination structure to mount the U.S. Government response.

There has been clear progress because of their efforts and the work being done by our partners on the ground to stop the spread of Ebola. We have helped train 1,680 community health care workers to

conduct surveillance, equipping them with knowledge and tools to track the disease and stop the chains of transmission. We have also trained more than 19,000 Congolese health care workers in patient screening, triage, isolation, appropriate waste-management, and other practices that prevent the transmission of disease. These practices are helping strengthen measures to prevent and control infections in at least 309 health facilities across at least 18 Health Zones. Our partners continue to provide treatment and care that help increase the chance of survival for people with Ebola, and USAID is ensuring they have the supplies they need to operate, including by providing 53 metric tons of personal protective equipment at more than 100 health facilities. Additionally, USAID has funded the provision of enough food to meet the needs of 300,000 people—including Ebola patients, contacts, survivors, and their family members.

Our experience with this outbreak so far, and the 2014 West Africa outbreak, has shown us that community acceptance and ownership is crucial to the success of this response. USAID is funding 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. Our partners are working to reach 508,000 households, or 2.1 million people, with key health messages to engage communities in conversations about Ebola, debunk myths, and raise awareness about the transmission of Ebola.

Despite all of our efforts, it became clear during my trip to the DRC that insecurity, poor coordination, the underutilization of key partners like non-governmental organizations (NGOs) and faith-based groups, and insufficient community engagement were hindering response efforts. This is in part why, soon after my return to Washington DC, the U.S. Government began to shift towards a complete reset of

the U.S. response towards a more comprehensive humanitarian and development approach that responds to the broader needs of the community to help improve the community's perceptions and attitudes towards the public health interventions. Following my trip in June 2019, Administrator Green also travelled to Butembo to see the Ebola emergency first-hand, and it was very clear to him that this was a development emergency in the DRC.

With this critical context in mind, the U.S. Government has four key strategies to achieve this reset: (1) enhancing response leadership and coordination; (2) strengthening community engagement; (3) addressing the complex security environment; and (4) strengthening preparedness, in both the DRC and the surrounding countries

First, strong leadership and coordination is critical to making this response more effective, which is why we are optimistic about the appointment of United Nations Emergency Ebola Response Coordinator David Gressly in May. USAID has emphasized the need for clear lines of leadership and accountability to strengthen his ability to oversee response functions to support the Government of the DRC's and the WHO's lead of the public-health response. Overall, leadership for this response must be more inclusive, and directly involve the local and international NGOs that are vital to the response. These organizations must be better engaged and active in coordination efforts, because they deliver assistance that complements efforts by the Government of the DRC and UN agencies and because they have the trust of the affected communities. The U.S. Government, along with other lead donors, also continues to advocate for strategic shifts, like including civil society, faith-based organizations, and NGOs in coordination structures. USAID is also closely collaborating with our interagency partners—like HHS and the HHS National Institutes of Health—along with the Government of the DRC, other donors, the

WHO, the UN, international partners, and civil society to battle this disease. For example, we worked with these key partners to provide input into the development of the latest Strategic Response Plan for the outbreak, the public-health portion of which was just released earlier this month, to guide efforts over the coming months. We are also continuing to encourage other donors to contribute resources to this Ebola response, including governments that have already provided modest assistance.

Second, Congolese communities must be at the center of what we do, which is why we are working to shift the response from a top-down approach to one that elevates the communities' role and prioritizes their needs and feedback. As such, the U.S. Government is continuing to emphasize community engagement across the response—from the DRC Ministry of Health to the WHO and USAID partners, many of which have found innovative ways to connect with communities. One of our partners, for example, worked with a music festival in Goma to get Ebola-prevention messages out, which reached more than 37,000 people with handouts and fliers; musicians even incorporated these messages into their sets. USAID's partners are also engaging with journalists, to get them to take to the airwaves, create mini movies, and organize groups on the WhatsApp social messaging platform to educate people about Ebola and stimulate discussions. We are increasing emphasis on community dialogue and actively looking to involve a wider cross-section of organizations, like local women's, youth, and faith-based groups. One of our partners is working with young people to change their perspectives on Ebola-related rumors, and has trained them to communicate about Ebola and mobilize their peers in the response. Our partners have also hired local people—including Ebola survivors—to be a part of the response in their own communities, and are reaching out to respected local leaders to deliver Ebola prevention messages in local languages. Ultimately, we are working to listen to local needs, incorporate feedback, and ensure

we are doing all we can to foster positive changes in the relationship between communities and Ebola responders.

Third, we must do more to address the complex security environment. This is imperative to fully earning the trust of communities and gaining their participation in the response. The affected communities have long experienced armed conflict, and have suffered for years prior to this outbreak. Our response must acknowledge how this insecurity has affected them and their beliefs about the disease. Given all that these communities have been through, we must be cautious of militarizing the response. We should energize leading responders to utilize common humanitarian techniques, including transparent information-sharing, negotiations on how to gain access to affected communities, and engaging local community leaders in discussions and tactics on security that benefit the entire community, not just responders.

Fourth, with the continued threat of spread to countries that neighbor the DRC, we must do more to strengthen preparedness both in other high-risk areas in the DRC, as well as in Burundi, Rwanda, South Sudan, and Uganda. This is why we have been looking outside of the DRC's borders to provide the support and expertise needed to keep the disease from spreading. Part of this line of effort must be a more aggressive approach to vaccination, which should include the use of the second available vaccine to help build a firewall around the outbreak zone.

Preparedness and Preventing Ebola from Crossing Borders

We are intensely concerned that this outbreak could soon become a regional issue, as it moves closer to the borders of countries that neighbor the DRC. We are continuing to strengthen health surveillance activities at borders, as well as train health workers and strengthen local capacity within the countries to

respond efficiently and effectively to case alerts. In these neighboring countries, we are supporting Ebola preparedness efforts that strengthen local capacity to detect the disease; train screeners and screen travelers at key points of entry; track cases if they occur; maintain water, sanitation, and hygiene facilities; improve the prevention and control of infections in health facilities: vaccinate at-risk workers; and conduct public awareness and sensitization campaigns about Ebola.

USAID is also funding Ebola preparedness efforts in Goma, as well as in Provinces adjacent to North Kivu and Ituri, to help ensure that the virus does not spread any further within the country. Our efforts also account for how the humanitarian situation in the DRC affects the movement of people. Factors such as poor infrastructure, forced recruitment into armed groups, and ongoing violence have contributed to the deterioration of humanitarian conditions and triggered mass internal displacement and refugee outflows.

These efforts have never been more critical: With the confirmed case in Goma at the beginning of last week, the outbreak is now nearing the Rwanda border. Earlier this month, a confirmed case in Ariwara Health Zone brought the outbreak fewer than 45 miles from the South Sudan border. Most concerning, three confirmed cases of Ebola, in individuals all of whom later died, were detected in Uganda in June, which marked the first cases of the deadly disease detected outside DRC since the start of the outbreak in August 2018. These cases serve as a reminder that we must stay vigilant. USAID continues to monitor the situation closely, and we will continue to work with partners to support preparedness efforts in these neighboring countries.

Preparing for disease requires a whole-of-society approach across multiple sectors to prevent, detect, and respond to infectious-disease threats as our national Biodefense and Global Health Security

Strategies make clear. When crises happen—like the current Ebola outbreak—we work to ensure response groups have the tools and operational structures necessary to respond quickly and effectively.

USAID is also working to promote global health security at the local level by helping at-risk communities develop preparedness plans and train community volunteers to detect and respond to infectious-disease threats in their own neighborhoods. We have developed an emergency supply-chain playbook 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 the information needed to reduce disease spread.

Conclusion

In conclusion, USAID and the rest of the U.S. Government are well-equipped to help the DRC and neighboring countries respond to this disease, and have begun to reset our response to better adapt to these key challenges on the ground. We have been providing humanitarian and development assistance in the DRC for more than three decades, and are familiar with the operating environment and access challenges. While responding to this outbreak is complex, this is a whole-of-Government response, which is making the most of each Department and Agency's knowledge and expertise. We are all united in the same goal of helping the people of the DRC to bring this outbreak under control as soon as possible while demonstrating our continued support for the people, families, and communities affected by this devastating disease.

We know that this is more than just a public-health crisis: This is occurring on top of an extended, complex, and violent humanitarian crisis. By placing community needs at the forefront of the response,

we can strengthen the relationship between communities and the so the public health interventions can be more effective.

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