"Lessons from the West African Ebola Response:

How to Save Lives and Protect our Nation

During the Coronavirus Epidemic of 2020"

Testimony before the

Emergency Preparedness and Response Subcommittee

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By

Ronald A. Klain

White House Ebola Response Coordinator, 2014-15

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Chairman Payne, Ranking Member King, other members of the Subcommittee:

Thank you for inviting me to participate in this hearing today. I want to commend the Subcommittee for moving quickly to gather information and educate the public about the coronavirus epidemic that originated in China and has now spread to countries around the world, including our own. It is a privilege to be able to present my perspective on this, and to answer your questions about the emerging US response.

Before I begin my substantive presentation, I want to make two preliminary points.

First, as frustrating as it may be, it is important to understand that what we know about this epidemic and the virus that causes it remains uncertain. We know much less about coronavirus today than we did about Ebola in 2014. Scientists in the US and around the world are working at unprecedented speed to improve our understanding about the virus and its spread; new papers are being published every day, literally. Nonetheless, there are critical questions about the virus, how quickly it spreads, how infectious it might be, how lethal it will be – and others – for which we still do not know the answers, and that – once learned -- will have huge impacts on our response. Part of this is due to a lack of full transparency and cooperation by the Chinese government. But part of this is due to the fact that it takes time for science to learn key facts about a new virus. As someone who was once coordinated the policymaking and implementation of a response to an epidemic, I know that these information gaps are vexing: many decisions cannot wait, and have to be made on the best information available. But it is important that we understand this limitation, understand that policy choices will have to change as our fact base changes, and that we be careful not to make definitive or declarative pronouncements when the science does not justify such statements.

Simply put, at present, we do not know how serious this epidemic will become, how many people will contract the virus, how many will die, and how grave the threat is to our country. Such a lack of knowledge does not counsel a lack of action, indeed, perhaps it counsels just the opposite. But it does advise modesty in the forcefulness of our conclusions, and awareness of the need to make changes in policy choices as we gain more information.

Second, a point about partisanship and the response. I am an outspoken political partisan – that is well known. But I come here today in the same way that I approached my tenure as White House Ebola Response Coordinator: putting partisanship and politics aside. The coronavirus will not ask any person's partisan affiliation before infecting them. There is no Democratic or Republican approach to fighting infectious disease; only sound and unsound measures.

That does not mean demurring about calling out failures when they appear: I have been critical of many aspects of the Trump's administration response to the coronavirus epidemic because they reflect failures in execution and communication. Likewise, I have praised positive steps taken by the administration, such as bringing in Ambassador Birx for a leadership role, or getting strong bipartisan support for the Emergency Supplemental that recently passed Congress. Putting politics aside does not mean putting judgment aside, both good and bad.

My point about non-partisan approaches here is illustrated by what we did during the Obama administration's Ebola response. There, we relied heavily on lessons learned and expertise acquired during the Bush administration's efforts to fight AIDS and malaria in Africa. Key players in the Ebola

response were veterans of both Democratic and Republican administrations. President Obama's emergency funding package passed this House with strong, bipartisan support; our implementation of it domestically involved close work with state and local officials from both parties; and the input of Members of Congress of all political and ideological camps. Saving lives, abroad and at home, turns on putting politics aside and allowing science, expertise, and sound decision making to govern our actions.

With these two preliminary points made, I want to move on to the subject of my testimony today: how the lessons we learned during the Ebola response in 2014-15 should shape how our government – in the Executive and Legislative branches – approaches the threat now posed by the novel coronavirus.

To be clear, the Ebola response was not without its own problems and mistakes. Particularly early on, the danger to Africa and the world was underestimated; early signs of progress in containing the disease in the Spring of 2014 led to a false sense of security. The fact that no Ebola outbreak prior to 2014 had ever involved more than 500 cases of the disease also led to a false confidence that a large-scale epidemic was unlikely. Early initiatives in West Africa lacked a full understanding of the complexities of implementation there and cultural and religious barriers to some aspects of the response. And confusion and a lack of preparation led to missteps when the first case of Ebola arrived in Dallas, Texas, in late September, 2014.

But ultimately, the US got the response organized; quickly adapted and improved its approach; and made adjustments to what responders were doing in Africa and here at home. President Obama mustered an all-of-government response to the challenge, authorized the first-ever deployment of US troops to combat an epidemic ("Operation United Assistance"), appointed me to lead a team of dedicated and talented professionals at the White House to coordinate this effort, implemented novel and innovative policies on travel screening and monitoring, and won Congressional approval of a $5.4 billion emergency package to fight the disease abroad and improve our preparedness at home and around the world for future such epidemic threats.

In the end, the epidemic in West Africa was tragic: an official death toll of over 11,000, with the real count likely higher. But the backdrop for this loss of life must be considered. In September of 2014, experts forecast that the death toll could be over 1 million people; thus, the response succeeded in helping to reduce the projected loss of life dramatically. America's actions – as part of a global response, with Africans playing the largest part, deserving the greatest credit, and suffering the harshest losses to its health care workers – saved hundreds of thousands of lives. It was a great humanitarian achievement.

Here at home, after the initial missteps in Dallas, no one contracted Ebola on US soil, and Americans evacuated for medical care in the US were successfully treated and released, with only a lone fatality. Once implemented, our monitoring system successfully insured no domestic transmission of the disease, routed suspected cases to prepared medical facilities before those patients could be infectious, and enabled ample time for successful testing and response.

The ongoing legacy of this response is likewise enormous. With Congress' support, we implemented a national four-tiered network of hospitals and medical facilities that remain prepared to this day to identify and isolate cases of dangerous infectious disease, and to provide treatment to those who are infected – nothing like this existed in 2014 when the Ebola epidemic began, as many earlier investments made after the anthrax attacks in 2001 had been allowed to dissipate. The capacity to test for and

promptly identify diseases like Ebola grew from three laboratories in the US in September 2014 to almost 100 by the end of that year. We developed rapid diagnostics that ended the risky practice of having patients wait days to learn if they were sick and/or infectious. Vaccines against Ebola were tested and developed, and as a result of that work, an effective vaccine now exists and is being used in the field. New therapeutics were developed that helped reduce the mortality rate of Ebola dramatically.

It is no wonder that this effort – without in any way minimizing the devastation in West Africa – is seen today as a huge success. Tom Friedman wrote last year that that West African Ebola response was:

> "[President Obama's] most significant foreign policy achievement, for which he got little credit precisely because it worked — demonstrat[ing] that without America as quarterback, important things that save lives and advance freedom at reasonable costs often don't happen."

From mid-October 2014 to mid-February 2015, I was proud to lead the team at the White House that coordinated this response. We saw the weekly new case count in West Africa drop from about 1,000 a week to fewer than five a week, at which point the President announced the end of Operation United Assistance and began the withdrawal of US troops serving in that mission.

This was a truly global response, with tremendous contributions by government officials, NGOs, and volunteers from around the world, and particularly close partnership with our allies in the United Kingdom and France. With regard to the US part of this global effort, special thanks should go to the men and women on the frontlines. This includes our members of the 101st Airborne (who constituted the bulk of Operation United Assistance), and also, civilian responders -- via US AID DART teams and CDC employees deployed to the region, and contractors who supported them. It includes the men and women of the US Public Health Service who staffed the Monrovia Medical Unit in Liberia. It includes our career Ambassadors and other diplomats who served in all three effected countries with skill and played such a large role in the response. It includes the doctors, nurses and other health care workers – many volunteers -- who served in Ebola treatment units, hospitals, and other facilities – treating the sick under extreme conditions. It includes the scientists of the NIH and the CDC who pioneered new diagnostics, therapeutics, and vaccines. The US response put over 10,000 people – soldiers and civilians, government workers and NGO teams, contractors and volunteers – on the ground in West Africa in 2014-2015. It was a gargantuan undertaking, and a story in which all Americans should take pride.

To make that effort effective, and to match it with preparation and protection here at home, it took talented teams in Washington, in Atlanta at the CDC, and in government agencies and private health care facilities around the country. Public servants of all ranks and all levels worked around the clock. And as I mentioned before, Congress acted swiftly and on a bipartisan basis to approve most of the Obama administration's request for $6 billion in aid, less than five weeks after it was sent to Capitol Hill.

I would be remiss if I did not say that, of course, President Obama, too, deserves credit for this success. He weathered sharp criticism for his actions during the Ebola response, and had to ignore pressures to put aside the advice he was getting from top scientists and medical experts. He made difficult decisions about the actions we took abroad and at home. He communicated openly and directly with the American people, and chaired repeated meetings of the National Security Council as the response took shape. He used every tool at his disposal – from his bully-pulpit (to destigmatize survivors by publicly hugging Ebola patient Nina Pham in the Oval Office after her discharge from the hospital), to authorizing the massive deployment to West Africa, to personally engaging numerous world leaders to activate their

resources and support for the response, to pressing Congressional leaders to approve his emergency spending package, and much more: he did so much to achieve these results.

The challenge we face from the coronavirus epidemic now rapidly accelerating contains many similarities, but also, many differences from the challenge posed by the Ebola epidemic in West Africa in 2014-15. It would be a mistake to simply repeat what we did at that time, given those many differences. But likewise, it would also be a mistake to ignore the lessons that can be learned from that response, given the similarities. And hence, I am grateful for the opportunity to talk about the lessons I think are most applicable from this experience, to be applied in the current circumstance.

Among the many possible lessons that should be employed now, there are seven in particular that I would like to call out today. I will do so briefly, but I am happy to go into more depth on any of them in response to your questions or any subsequent follow-up from the Subcommittee.

First, in a complex, rapidly evolving scenario like the one we are seeing, there is no substitute for White House coordination and leadership. While the centralization of leadership of the response in Vice President Pence and his team is an improvement over where things stood days ago, there remains confusion with the structure, and the lack of a single, full-time official inside the National Security Council at the White House overseeing our response.

At the end of my tenure as Ebola Response Coordinator, I said that there should never be another specific "Disease Czar" at the White House. Instead, I recommended to President Obama that he create a permanent "Pandemic Preparedness and Response" directorate inside the NSC, led by a Deputy National Security Adviser-level appointee with direct access to the President as needed, to oversee ongoing work to prepare for the inevitable next time, and to coordinate a response to an epidemic when it arrived.

President Obama accepted this recommendation, and set up such a unit in 2015. President Trump continued with the structure, and named Admiral Tim Ziemer – a respected long-time public servant – to fill this post. If Admiral Ziemer were still in place, I believe that America would be much better positioned to respond to the coronavirus threat today.

But unfortunately, in July of 2018, when John Bolton took over as head of the NSC, he disbanded this unit, and Admiral Ziemer was reassigned to US AID. As a result, there has been no special unit at the NSC to oversee preparedness for epidemics, or the current response. In addition, the Trump administration has dismantled the Homeland Security Advisor structure that Presidents Bush and Obama used to deal with complex transnational threats, further undermining our preparedness for events like these.

The administration's sequential decisions to first say no special structure was needed to manage the response; then to create a "Task Force" to oversee the response, led by Secretary Alex Azar; then to replace Secretary Azar with Vice President Pence as the official in charge of that Task Force; and then to bring in Ambassador Birx as the Coordinator of the Response, part-time, reporting to VP Pence, has produced uneven results. The response is likely to be a massive undertaking of multiple agencies, state and local governments, private and public sectors, and international partners. We are still in the early days, with many tasks left undone.

But it seems that already the largest fiasco in the US response – the failure to promptly enable widespread testing for the virus – is at least in part a product of this coordination problem, with CDC blaming FDA, other officials pointing fingers at CDC, and a delayed engagement of state and local labs and private alternatives. There is simply no reason – none – why testing in the United States should lag nations like South Korea or Singapore.

For these reasons, and many more, an effective response to a challenge like coronavirus must be led by a full-time appointee at the White House. Ideally that decision would be made by the Executive Branch, but another avenue to achieve this structure would be for Congress to move ahead on the Global Health Security Act (HR 2166), introduced by Reps. Connolly and Chabot, as that bill which impose much of this apparatus by statute.

Second, the administration must ensure that science and expertise guide our actions, not fear, wishful thinking, or politics. One of the first casualties in an epidemic is rational thinking, replaced by fear, bias and poor decision making. We saw this in 2014 with calls for needless travel bans and baseless quarantine restrictions; President Obama was right to reject these misguided calls, and to implement travel and monitoring policies based on the scientific advice he got from the nation's leading experts.

In this case, there are troubling reports that the advice of senior officials of the Centers for Disease Control have been ignored with regard to travel advisories and public awareness. The President himself has suggested that passengers on a cruise ship with many infected persons aboard are being handled in a fashion -- not governed by medical considerations -- but by a desire to keep tallies of US-cases low. Officials who spoke publicly and truthfully of the "inevitability" of spread of the disease in the US have been sidelined. We do not yet know whether this mindset – trying to minimize the disease, and downplay warnings – is contributing to the sluggish response of our government. But in my experience, the tone set at the top governs how key players respond, and it seems unlikely that what we have heard from the President has been helpful.

More generally, there will be many policy decisions to be made in the days and weeks ahead. Science, medicine and expertise should guide them. The American people are lucky to have the world's leading experts on infectious disease working in their government, led by men and women like Tony Fauci at NIH and Anne Schuchat at CDC. They have served Democratic and Republican administrations, and helped Presidents with a wide variety of political perspectives save lives and protect our nation. This expertise should be paramount in decision making at all levels of government.

Third, the US must "lean forward" to fight this epidemic overseas, using all of the tools and leverage that we can commit to the effort. Unlike West Africa in 2014, today in 2020, China, South Korea, Italy, Iran and Japan – the hardest hit countries to date -- probably do not need, and/or would not accept, thousands of US responders on the ground treating patients, testing new approaches, conducting research, providing infrastructure, and helping bring the disease under control. This is a huge difference.

But that should not get us off our toes, or have us sitting back and believing that our only sphere of action is the homeland. Dr. Tony Fauci of NIH has publicly urged the deployment of medical researchers and investigators to China, and key administration leaders should apply pressure to encourage the most open access possible. Nations less advanced or well-resourced than South Korea or Italy may experience significant coronavirus outbreaks and require more direct forms of US assistance, akin to

what we provided during the 2014 Ebola epidemic. We should send CDC experts wherever they would be helpful, and task US AID to determine where DART teams and other assistance could be usefully deployed. Likewise, we should bolster preparedness in low income countries now – before the disease spreads further – to avoid spread in places where local containment efforts might fail. The danger of a coronavirus epidemic in Africa is enormous, and its potential consequences catastrophic. Our diplomats should be empowered and engaged around the globe, and our government must press WHO – which has stronger leadership today under Dr. Tedros Adhanom Ghebreyesu than it had during the 2014 Ebola epidemic – to do the right thing.

This is a global challenge, and America must provide global leadership. There is no room for isolationism or withdrawal. The best way to keep Americans safe is to combat the virus overseas. We should do this not only because it is generous or humanitarian – though it would be generous and humanitarian, both great American traits – but because it will make America safer and reduce the spread of the epidemic here.

Fourth, the administration must move quickly to implement the emergency funding package passed by Congress last week, to ensure that there are no further delays in responding to the coronavirus challenge. As Congress recognized in passing this bill, fighting the coronavirus will cost money. Key federal agencies will have costs. State and local governments will feel a pinch from monitoring contacts of those who have the virus, and tracking and monitoring individuals who have been in effected countries. Hospitals treating patients with the virus will need assistance of all sorts. Research and deployment of new therapeutics and vaccines needs government support, and funding for private-public partnerships. The list of needs goes on.

As I will discuss in a minute, Congress acted with unprecedented speed in passing an Emergency Supplemental Funding package to help address these needs. But passage of that package is only the first step. As we learned during the Ebola response, that funding only makes a difference if the administration acts with speed in putting the funding to work: with focus and pace, and a plan for implementation that has clear metrics and accountability. At the top of my list would be testing, and preparing the health care system for an influx of cases – to increase capacity and to avoid the danger of an overwhelmed system suffering failure.

The White House Task Force led by Vice President Pence should report regularly to the American people on the pace of deployment of the Emergency Supplemental: what has been put to work and where. Not all of the money will be spent immediately, nor should it be: our needs will develop and change in the months ahead. But quick action by Congress in passing this package must be matched by quick action in putting it to work.

Fifth, Congress must continue to do its own work in dealing with the coronavirus. The burden of action does not rest entirely with the Executive Branch; Congress too must do its part.

Congress has already acted admirably in passing with impressive speed an Emergency Supplemental funding plan to power the coronavirus response. That this happened in a matter of days after the administration made such a request, at a level substantially more robust and detailed than the administration's request, all are to Congress' credit. It was also encouraging to see that action come with strong bipartisan support, as it should be.

But Congress' role does not end with acting on the emergency funding question. There are a number of other elements of the response that demand Congressional attention. Hearings like today's are important, to help ascertain how the response is going and where it needs to be improved. Congress wisely funded the Public Health Emergency Fund last year – but did so only on a limited basis. Adding to that funding, and funding a second emergency fund specific to the development of therapeutics and vaccines in public-private partnerships, should be considered. In addition, action to address the economic consequences of the outbreak will also be needed.

Moreover, as I wrote in the Post with Dr. Syra Madad in December – before the coronavirus hit -- Congress is overdue to renew the funding for the network of "Ebola and Special Pathogens" Hospitals. This network was created during the Ebola epidemic in 2014, and funding for it expires in May of 2020. Pending legislation would fund only the 10 most advanced such facilities, and would end federal funding for the 60 other hospitals that screen, test, and provide initial treatment for these cases. Allowing this funding to expire in May would be a huge mistake.

Sixth, both the Executive Branch and the Congress should take this as a wake up call to finish the work we need to do on pandemic preparedness and readiness. Recently, America marked the 100th anniversary of the single largest mortality event in our history: the Spanish Flu epidemic of 1918-19. More Americans died from this epidemic than from World War I, World War II, the Korean War, and the Vietnam War - -combined. While, on the one hand, science has made great strides since 1918, on the other hand, increased global travel, human incursion on animal habitats, and the stresses of climate change have raised the risk that we will face such a "great pandemic" once again, sooner or later.

At present, it seems very unlikely that the coronavirus poses such a threat to the United States – but we cannot know for certain. Moreover, even if this current epidemic is not "the big one" that is coming, it is a reminder that this danger lurks, and our preparedness for it is lacking. As Dr. Ashish Jha of the Harvard Global Health Institute often says, "Of all the things that can kill millions of Americans quickly and unexpectedly, an epidemic is probably the most likely … and the one in which we invest the least to prevent."

The Global Health Security Agenda, legislation such as HR 2166, Blue Ribbon Commission reports, table top exercises, proposals from members of this Subcommittee – and my own extensive writing over the past five years – have set forth detailed agendas of what we need to do to prepared for this event. These bipartisan calls for action have been largely ignored. The current public focus on infectious disease generated by the coronavirus should spur us into action. The time to act on this agenda is now. If we wait until the catastrophic pandemic arrives, it will be too late.

Seventh, public officials of all parties and at all levels of government need to be on the watch for discrimination against people in our country of Chinese descent, and speak out strongly against any such fear-driven racism. The coronavirus strikes humans – not people of any particular ethnicity or race. Chinese-Americans or Chinese people in America are no more likely to get the disease, carry the disease, or transmit the disease, than any other group of people.

Yet we have already seen signs that such people are the targets of discriminatory fear – with some already being hassled, threatened with expulsion from schools and other mistreatment. As fears of the coronavirus accelerate, so too will these incidents. This kind of discrimination not only is wrong, but also makes it harder to combat the disease. If some members of the Chinese-American community feel

that they are likely to face hostility, they are less likely to come forward when symptoms appear, and less likely to heed advice of public health experts.

It is incumbent on every person in authority in this nation to speak out against such racism, and to ensure that this does not become part of our civic life during the coronavirus epidemic. Americans need to pull together to fight a disease, not pull apart to fight one another.

In closing, I want to again thank the Subcommittee for holding this hearing, and for inviting me to participate. I stand ready to answer your questions about any of these points, or any other aspects of the response.

America has the tools, the talent, and the expertise to combat the coronavirus, both abroad and at home. The question now is whether our leaders, in the Executive Branch and the Congress, will deploy them effectively; act promptly and wisely; rely on expertise – not bias and fear; organize and implement our response appropriately; and allow science and medicine to be our touchstone. For the sake of people around the world, and for the sake of the American people, let us work to see that it is so.