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"Combating the Ebola Threat"

House Subcommittee on Africa, Global Health, Global Human Rights & Int'l Organizations
Chairman Chris Smith
Excerpts of Remarks
August 7, 2014

I have called this emergency hearing today, during recess, to address a grave and serious health threat which has in recent weeks gripped mass media attention and heightened public fears of an epidemic – the Ebola virus.

What we hope to gain from today's hearing is a realistic understanding of what we are up against, while avoiding sensationalism.

Ebola is a severe, often fatal disease that first emerged in 1976 and has killed 90% of its victims in some past outbreaks.

Since March of this year, there have been more than 1,700 cases of Ebola, including more than 900 fatalities, in Guinea, Liberia, Sierra Leone and Nigeria.

This time, the average fatality rate in this outbreak is estimated at 55%—ranging from 74% in Guinea to 42% in Sierra Leone. The disparity in mortality rates are partially linked to the capacity of governments to treat and contain the disease and per capita health spending by affected country governments.

There is also concern that, given modern air travel and the latency time of the disease, the virus will jump borders and threaten lives elsewhere in Africa and even here in the United States.

In my own state of New Jersey, at CentraState Hospital in Freehold, precautions were taken. A person who had traveled from West Africa began manifesting symptoms, including a high fever. He was put in isolation. Thankfully, it was not Ebola, and the patient has been released.

New Jersey Health Commissioner Mary O'Dowd reiterated to me yesterday that New Jersey hospitals have infection control programs in which they train and are ready to deal with potentially infectious patients that come through their doors. She also told me that physicians and hospital workers follow very specific protocols on how to protect themselves as well as other patients, and how to observe a patient if they have any concerns, which

includes protocols like managing a patient in isolation so that they are not around others who are not appropriately protected.

The commissioner also underscored that the federal government has U.S. quarantine stations throughout the country to limit the introduction of any disease that might come into the United States at ports of entry like New Jersey's Newark Liberty International Airport

I also hope our distinguished witnesses with confirm whether sufficient resources are available and are being properly dispensed to assist the victims and contain the Ebola disease. Are there gaps in law and policy that Congress needs to address? To the government witnesses especially—my pledge to you is that if legislation is needed I will work with you to write it.

As you know key symptoms of Ebola include fever; weakness; head, joint muscle, throat and stomach aches, and then vomiting and diarrhea, rashes and bleeding. These symptoms are also seen in other diseases besides Ebola, which makes an accurate diagnosis early on uncertain.

Ebola punches holes in blood vessels by breaking down the vessel walls, causing massive bleeding and shock. The virus spreads quickly before most people's bodies can fight the infection, effectively breaking down the development of antibodies. As a result, there is massive bleeding within 7 to 10 days after infection that too often results in the death of the infected person.

Fruit bats are suspected of being a primary transmitter of Ebola to humans in West Africa. The virus is transmitted to humans through close contact with the blood, secretions, organs or other bodily fluids of infected animals.

Some health care workers—such as heroic American missionary aid workers Dr. Kent Brantley and nursing assistant Nancy Writebol—have contracted the disease despite taking every precaution while helping Ebola patients. Both of them are now being treated at Emory Hospital in Atlanta, Georgia, in an isolation unit after having been flown to the United States in a specially equipped "air ambulance."

While there is no known cure for Ebola, both Dr. Brantly and Ms.Writebol have been given doses of the experimental anti-viral drug cocktail ZMapp, developed by a San Diego company called Mapp Biopharmaceutical. They are reportedly both feeling stronger after receiving the drug, but it is considered too early to tell whether the drug itself cause improvement in their condition.

Mapp Biopharmaceutical has been working with the National Institutes of Health and the Defense Threat Reduction Agency, an arm of the military responsible for countering weapons of mass destruction, to develop an Ebola treatment for several years. The drug, which attaches to the virus cells much like antibodies their compromised immune systems would have produced, has never been tested in humans before Dr. Brantly and Ms. Writebol, who gave their consent to be the first human trials.

There will be great hope if ZMapp works on the two Americans who bravely agreed to test its effect. Still, that won't mean that it will be produced in great quantities quickly and sent to infected people in West Africa. It is still an experimental drug. Those who use it must

be given the complete information on its use. Informed consent is vital in the use of any drug, but certainly one that has such limited trials among humans.

There is also promising research done by the Tekmira Pharmaceuticals Corporation—funded by the U.S. Department of Defense—on their TKM-Ebola, an anti-Ebola virus RNAi Therapeutic. TKM is on clinical hold, yet earlier preclinical studies were published in the medical journal, The Lancet and demonstrate that when siRNA targeting the Ebola virus and delivered by Tekmira's LNP technology were used to treat previously infected non-human primates, the result was 100 percent protection from an otherwise lethal dose of Zaire Ebola virus (Geisbert et al., The Lancet, Vol 375, May 29, 2010).

Unfortunately, there are other issues that impact on the ability of the international community to assist the affected governments in meeting this grave health challenge. Some of the leading doctors in these countries have died treating Ebola victims. The non-governmental medical personnel who are there say they feel besieged—not only because they are among the only medical personnel treating this exponentially spreading disease, but also because they are under suspicion by some people in these countries who are unfamiliar with this disease and fear that doctors who treat the disease may have brought it with them.

The current West African outbreak is unprecedented—and an anomaly. Many people are not cooperating with efforts to contain the disease. Some, such as Liberian-American Patrick Sawyer, refused to accept that they may be infected. His death sent chills through those outside the affected region who feared infected people leaving the area and arriving in metropolitan areas somewhere else in the world.

Because of the stigma of Ebola, many people in the affected region are reluctant to acknowledge the possibility of having the disease and don't seek medical treatment. This phenomenon was common in the early days of the HIV/AIDS epidemic. Traditions also play a role in people not accepting suggested protocols. Many people are handling the bodies of their relatives who died of Ebola and burying them without taking proper precautions, and themselves become victims of this deadly disease.

Medical missionaries, such as the two Americans now attempting to recover in Atlanta, Georgia, have given of their time and talent at great risk to their health and their very lives to apply the Christian principles to which they have committed themselves. The two families, who met in Atlanta this week, have prayed for each other, and have asked us to join in their prayers for the success of the treatment of their gallant, compassionate family members. Countless others who have this disease or who remain threatened by it also must be praying for the success of these first human trials of ZMapp. After risking so much to help save the lives of those afflicted with Ebola, they continue to serve the needs of so many by agreeing to be part of human trials of the only available drug that might arrest the impact of this deadly disease.

As we consider what we can do to meet this health challenge, I would suggest we need to reconsider the funding levels for pandemic preparedness. In the restricted budget environment in which our government operates today, funding to meet these pandemics has fallen from $201 million in fiscal year 2010 to an estimated $72.5 million in fiscal year 2014. The proposed budget for fiscal year 2015 is $50 million, and we must not shortchange vital efforts to save the lives of people in developing countries, but also protect the health security

of the American people. There are both practical and compassionate reasons to adequately fund pandemic response.

Dr. Tom Frieden, one of today's witnesses, has tried to assure the American public that our government is doing what we can to address the Ebola crisis. He has announced the dispatch of at least 50 public health experts to the region in the next 30 days. USAID, WHO; the World Bank; DFID, the British development agency; the African Development Bank, and many other governments, international organizations and companies are joining to meet this crisis.

To those who say there is no plan, I would say that planning is underway to overcome obstacles to effective efforts to contain this virus. We have seen great success in treating HIV/AIDS, malaria and tuberculosis. Polio has been largely eliminated. Tropical diseases are being treated through a public-private partnership. Still, we must take more seriously the research, surveillance, treatment and prevention of diseases that limit the lives of people in developing countries.

This is why I have introduced the End Neglected Tropical Diseases Act. HR 4847 establishes that the policy of the United States is to support a broad range of implementation and research and development activities to achieve cost-effective and sustainable treatment, control and, where possible, elimination of neglected tropical diseases. Ebola is not on WHO's list of the top 17 neglected tropical diseases, but it does fit the definition of an infection caused by pathogens that disproportionately impact individuals living in extreme poverty, especially in developing countries.

Ebola had been thought to be limited to isolated areas where it could be contained. We know now that is no longer true. We need to take seriously the effort to devise more effective means of addressing this and all neglected tropical diseases. I plan to explicitly include Ebola in a redrafted bill that will be introduced in the coming weeks, and we hope Congress will act on this important issue as soon as possible.