

engaged in Ukraine's struggle for political, economic and social stability. They have brought attention to injustice and lobbied public officials to take action. I am incredibly proud of this community and to have been made an honorary Ukrainian by my constituents. I have been pleased to work on their behalf during my years in Congress.

While Ukraine still has many miles left on its journey for peace, prosperity, and democracy, I am encouraged by the progress the Ukrainian people have made and their courage to continue fighting. I'm also reminded of their quest this year as we mark the bicentennial of the birth of the great Ukrainian poet Taras Shevchenko, whose strong advocacy for Ukraine as an independent state left a lasting impression on the people of Ukraine for generations.

As Mr. Shevchenko wrote in the 1858 poem *Fate*, "So let's march on, dear fate of mine! My humble, truthful, faithful friend! Keep marching on: there glory lies; March forward—that's my testament."

I ask my colleagues to join me in congratulating Ukraine on its 23rd Independence Day, and honoring and thanking the Ukrainian community of Rochester, NY, for their tireless work to promote a stable, democratic, prosperous and sovereign Ukraine at a time of tremendous adversity. I am honored to represent such a passionate and dedicated community.

IN HONOR OF THE 25TH ANNIVERSARY OF THE NONPROFITS INSURANCE ALLIANCE OF CALIFORNIA (NIAC)

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, September 8, 2014

Mr. FARR. Mr. Speaker, I rise today to recognize the 25th anniversary of the Nonprofits Insurance Alliance of California (NIAC), a remarkable organization that provides essential risk-management services to enable nonprofit organizations to meet the needs of our citizens and contribute to our economy.

NIAC was conceived by Pamela Davis in her Master's thesis at UC Berkeley Graduate School of Public Policy in 1987. Despite no insurance background, she recognized the growing inability of nonprofit organizations to obtain necessary insurance coverage from commercial insurers. This, in turn, limited nonprofits' ability to fulfill their missions of service to our communities. During the mid-1980s, many insurance companies dropped coverage for nonprofits when, at the same time, evidence of insurance was required as a condition of providing government funded services to communities. As a result, nonprofits lost funding and were unable to offer many essential services to children, seniors, and our most fragile citizens because the insurance industry believed that the risk posed by these operations was too great.

Ms. Davis challenged insurance companies to produce data that would demonstrate the riskiness of nonprofit operations. When no such information was forthcoming, she concluded that the risk of nonprofits had not been properly evaluated. Looking ahead, she proposed that the nonprofit sector could better serve its own insurance needs by pooling to-

gether and creating their own insurance companies—essentially self-insuring each other.

The Davis thesis led directly to the formation of NIAC. It was published by the California Community Foundation and widely distributed as a possible solution to a difficult problem. With California Association of Nonprofits serving as fiscal agent, Ms. Davis spent two years raising funds and putting together all of the required infrastructure for NIAC. On November 1, 1989, with loans of \$1.3 million from foundations including Ford and Packard, NIAC's charitable risk pool welcomed its first member-insured.

Now, 25 years later, NIAC insures 8,500 nonprofits in California and holds an A (Excellent) rating from AM Best. It has demonstrated not only that nonprofits are eminently insurable, but also that the insurance prices that were being charged during the mid-1980s were too high. NIAC successfully reduced prices over its 25 years and returned \$31 million in dividends to its 501(c)(3) nonprofits because of better than expected claims experience. Those nonprofits have, in turn, been able to use those funds to bring more services to their communities.

Congress, in consideration of the public benefits provided by the nonprofit sector, passed legislation in 1996 to grant organizations like NIAC 501(c)(3) tax-exempt status. By this legislation, Congress recognized the value of keeping funds at work in the nonprofit community.

Heeding the call in the late 1990s to assist nonprofits outside of California, NIAC was instrumental in creating the Alliance of Nonprofits, Risk Retention Group (ANI). ANI's formation in 2000 was enabled with grants of \$10 million from the Gates and Packard foundations. The company now insures nearly 5,000 nonprofits in 30 states for all types of liability insurance, just as NIAC has done in California.

In her thesis, Ms. Davis had proposed that if more resources could be allocated to providing training and risk management assistance, fewer accidents would occur and less money would be needed to pay for claims and litigation. From their inceptions, NIAC and ANI have provided free services to help nonprofits avoid injury and accidents to their clients and members of the public. They provide free driver training, webinars, in-person consultations and many, many other services to help nonprofits do their work more efficiently and safely. These programs have demonstrated the success of that idea.

Mr. Speaker, I have supported NIAC's efforts through its history and have watched the Nonprofits Insurance Alliance Group grow in its ability to serve our vital and vibrant nonprofit sector. Too often we fail to acknowledge the work of people and organizations who are dedicated to serving our community needs and making our neighborhoods a more livable and tolerant place for all of us. Today, I would like to recognize NIAC and its dedicated employees and volunteer board members for their work to help strengthen an important part of our economy—nonprofit organizations.

COMBATING THE EBOLA THREAT

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Monday, September 8, 2014

Mr. SMITH of New Jersey. Mr. Speaker, last month, I convened an emergency hearing, 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 gained from the 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 is 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.

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 Brantly and nursing assistant Nancy Writebol—contracted the disease despite taking every precaution while helping Ebola patients. Both of them were 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 were given doses of the experimental anti-viral drug cocktail ZMapp, developed by a San Diego company called Mapp Biopharmaceutical.

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, had 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, ZMapp is 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.

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 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.

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 the witnesses we had, has tried to assure the American public that our government is doing what we can to address the Ebola crisis. 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. H.R. 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.

IN MEMORY OF ALETHA HOWELL
BARSANTI

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Monday, September 8, 2014

Mr. BURGESS. Mr. Speaker, I rise today to honor the life of Aletha Howell Barsanti, who

passed away July 13, 2014. She was a devoted army wife, an exceptional mother and a loyal companion and friend to many.

Aletha was a Texas native and was born on September 27, 1920 in Corsicana, Texas. After graduating from high school in the west Texas town of Rankin, she followed her two older sisters, Fleda and Frances, to the University of Texas. While working at her father’s law office she met Olinto Mark Barsanti, a career officer in the United States Army. They were married on October 22, 1942 at Fort Sam Houston in San Antonio, Texas. Olinto went on to become a decorated combat veteran of World War II and Korea and also served as the Commanding General of the prestigious 101st Airborne Division in Vietnam. While Olinto served and protected our country, Aletha was an army wife who diligently and lovingly raised their daughter, Bette, on her own.

After the General’s death in 1973, Aletha settled in Montgomery, Alabama in the late 1970s. There she met Colonel Lonnie Martin, a retired member of the United States Air Force. For the next twenty years she and Lonnie traveled, attended the symphony, golfed and enjoyed retirement with one another. While residing in Montgomery, she also spent much of her time with a group of women who included her in their bridge games and other social activities and made her feel like a Montgomery native. The retired military community also welcomed her.

Aletha was a proud member of the Daughters of the American Revolution and the Magna Carta Dames. She will be greatly missed by her family, including her daughter and son-in-law Bette and Bob Sherman of Denton, Texas.

HONORING FUTURE INC. DAYCARE
& EARLY CHILDHOOD LEARNING
CENTER

HON. BENNIE G. THOMPSON

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Monday, September 8, 2014

Mr. THOMPSON of Mississippi. Mr. Speaker, I rise today to honor the remarkable Future Inc. Daycare & Early Childhood Learning Center (F.U.T.U.R.E.).

Future Inc. Daycare & Early Childhood Learning Center (F.U.T.U.R.E.) was established on August 1, 2005. This is a Walk of Faith Church Ministry Product that offered a program that is child oriented. Children “learn by doing” in an environment which encourages the development of a joy for learning. Recognizing the uniqueness of each child, age-appropriate learning experiences are provided in an accepting, warm environment.

The play environment encourages positive development across a wide range of domains while building self-confidence, independence, and self-discipline.

Opportunities are provided for discovery, learning through concrete experiences, imaginative free play, observation, and positive peer and adult interaction.

F.U.T.U.R.E., Inc.’s Mission Statement is: To build competent families, competitive children, complimentary communities, and convincing futures. To provide a high quality early childhood program in a safe, nurturing environment that promotes the physical, social,