

International Development Committee

Oral evidence: Humanitarian crises monitoring: coronavirus in developing countries: secondary impacts, HC 292

Tuesday 13 October 2020

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Members present: Sarah Champion (Chair); Mrs Pauline Latham; Navendu Mishra; Mr Virendra Sharma.

Questions 220 - 239

Witnesses

[I](#): Aaron Oxley, Executive Director, RESULTS UK; Katie Husselby, Co-ordinator, Action for Global Health; Mike Podmore, Director, STOPAIDS.

Examination of witnesses

Witnesses: Aaron Oxley, Katie Husselby and Mike Podmore.

Q220 Chair: This session is the first oral evidence session we are having in the second part of our inquiry into the humanitarian impacts of coronavirus. We are specifically looking at the secondary impacts. Today's session is focusing on health: both the health system but also ongoing vaccine and immunisation programmes and how Covid has impacted on that.

We are joined by Aaron, Katie and Mike. Could I ask you all to introduce yourselves and your organisations? We will then start with the formal questions.

Aaron Oxley: My name is Aaron Oxley. I am the executive director of an organisation called RESULTS UK, which works on advocacy for a number of different international development issues. One of the other hats I wear is that I also represent developed country civil society on the board of the Stop TB Partnership, which works on ending TB globally.

Katie Husselby: Thank you very much to the Committee for inviting me to be here today. I am Katie Husselby. I am the co-ordinator for the Action for Global Health network. We are a network of more than 50 UK-based organisations, working across the full spectrum of global health issues. We also act as the official convener with the Foreign, Commonwealth and Development Office on global health issues, and we have been co-convening a global health taskforce focused on the Covid response with FCDO colleagues since April. We have also created a database that has been tracking the impacts of Covid-19, particularly the secondary impacts, which we will obviously talk about today. Finally, we recently published a stocktake review analysing the UK Government's political, financial and programmatic commitments to global health.

Mike Podmore: Good afternoon. My name is Mike Podmore, and I am the director of STOPAIDS, which is a network of 70 UK agencies working on the global HIV response and related issues, including issues like access to medicines. I am also chair of Action for Global Health and I work closely with Katie. As such, I sit on the civil society FCDO Covid steering committee, which seeks to consult civil society on all Covid-related issues. I also co-convene the global civil society platform that supports civil society representation across the Access to Covid-19 Tools Accelerator. It is a pleasure to be with you this afternoon.

Chair: The pleasure is all ours. We have a fantastic panel in front of us.

Q221 Mrs Latham: This question is specifically for Aaron. We know Covid-19 has affected health in other countries and developing countries. How has it actually disrupted health in developing countries, in your view?

Aaron Oxley: As you can imagine, there have been some fairly large disruptions to health broadly. I would use the example of TB to give you some concrete numbers. We have done some modelling that shows that a



three-month lockdown with a 10-month recovery period, which was what was done earlier this year, would create 6.3 million additional cases of TB over the five-year period between now and 2025 and 1.4 million additional deaths. This would effectively wind back the global response on fighting the disease by five to eight years.

There are a number of different studies that have been done for other health areas that show very comparable setbacks. We are seeing similar things in terms of vaccination. We are predicting that at least 80 million children under the age of one are at risk of missing out on routine vaccines for diseases like measles, polio and diphtheria. The impact is really quite huge. I could go on and on, but I know we are short on time so I will try to keep my responses brief.

Q222 Mrs Latham: Obviously the situation was easier before, but how has it specifically changed in relation to TB and polio, which you have mentioned? Could you answer with reference to specific situations, like countries or conflict-affected areas like refugee camps, for example?

Aaron Oxley: Polio is probably my best example around conflict-affected countries, in the sense that, if we look at where the pockets of polio have persisted, that has been a feature there. We are looking at something like 50 million children in Pakistan and Afghanistan who are going to miss the polio vaccine as a result of Covid. There have been very big disruptions there.

Q223 Mrs Latham: What about in refugee camps?

Aaron Oxley: I am afraid we are not specialists on health in refugee camps.

Q224 Mrs Latham: Mike, what is the view of the global health group on the pandemic's disruption of healthcare provision in other diseases—you mentioned HIV/AIDS—and conditions

Mike Podmore: Maybe I can just respond in relation to HIV. The latest data has not yet been published by some of the key agencies, but it would appear that the impact of Covid on the global HIV response has been significant. It has not been as bad yet as the worst projections originally laid out at the start of the pandemic. For example, WHO and UNAIDS projected at the start of the pandemic that a six-month 50% disruption in HIV treatment could lead to an additional 300,000 AIDS-related deaths in sub-Saharan Africa alone in a one-year period. We have not met that yet, but of course we have not reached the end of the one-year period yet and we are about to go into further lockdown.

Many of the countries hardest hit by Covid-19 are also extremely hard hit by HIV, TB and malaria—for example, India, South Africa, Bangladesh, Pakistan, Philippines or Indonesia. Early indications show that the response so far has mitigated many additional deaths, which is positive, but there has been an increase in HIV acquisitions. According to a WHO survey conducted between April and June, 36 countries reported



disruptions in the provision of ARV services. That affects 11.5 million people, which is about 45% of people on ART globally. The Global Fund is producing regular updates on what it is finding, and it was finding that 75% of its programmes report moderate to high levels of disruption to HIV service delivery. You can see the big picture.

In terms of people's personal experience, I just want to share something with you. There was a very interesting report of interviews with 30 women from southern and eastern Africa who were women living with HIV. They were saying that they are not able to get viral-load testing. They are having difficulties accessing contraceptives, STI-protection services, cervical cancer screening and access to antenatal-care clinics and maternity services. The challenge is clearly significant. Going into further lockdown, it seems like things could definitely get worse.

Q225 **Mrs Latham:** Yes, they will get worse before they get better, unfortunately. Katie, which would you say is the biggest problem in developing countries: the overwhelming of health facilities and systems by Covid or the fact that patients with other diseases and conditions, as is the case here, are staying away out of fear of infection or other reasons? They might have lost trust or confidence in the help that might be there.

Katie Husselby: It is a mixture of both. Certainly, countries have been reporting disruptions in terms of a lower demand from patients to access care. In a recent WHO survey, 76% of countries reported seeing lower demand from patients. From consulting with our members, we believe that is due to fear of contracting the virus, a lack of public confidence in health systems or unclear or inaccessible public health information being available, which is all stopping patients from seeking treatment either for Covid-19 or to receive other essential health services.

There are a number of other reasons as well. Clearly, lockdown is having an impact. Movement restrictions and border closures are negatively impacting supply chains, procurement mechanisms and logistics efforts. We have seen examples of shipping delays and stockouts of essential health goods and equipment. We are also seeing redeployment of health personnel, health systems infrastructure and funding away from essential health services and towards the Covid response, and examples of insufficient PPE being available for health workers, which obviously then leads to unsafe health environments, which is then further exacerbating the issue and leading to more shortages of health workers.

Finally, we are seeing financial difficulties both in terms of increasing programme costs, which we are seeing across our members' programmes, but then also at the individual level in terms of the economic impact of Covid leading to increased financial hardship, particularly for vulnerable communities, and that leading to increased financial barriers for people to access care, particularly where there are user fees involved.



Aaron Oxley: Just to come in off the back of what both Mike and Katie have said, we may not have seen some of the worst predicted outcomes on HIV yet, but we are seeing them in TB. We need to be realistic about the overall trajectory of the global pandemic. In comparison, we are seeing something like a 40% to 70% decrease in case notification of TB, because people are staying away from clinics and not getting testing for reasons of stigma and fear.

We see that this is not currently recovering. If we are talking about people staying away, left untreated, each person is going to pass the disease on to 10 to 15 more people over the course of a year. This is across the board. We are seeing this in almost all countries: notifications are going down. *The Lancet* concluded, "These disruptions could lead to a loss of life-years over five years that is the same order of magnitude as the direct impact from Covid in places with a high burden of malaria and large HIV and tuberculosis epidemics". I am really pleased that we are having this inquiry. Thank you for the space, because the secondary impacts are going to be really quite tremendous.

Mike Podmore: Just to add on that question around the dynamic, obviously there is huge disruption due to lockdown. There are also struggling health systems and therefore poor hospital preparedness, but there are also issues around poor health messaging. We have seen that globally, including in this country. It is a real challenge. For example, women living with HIV do not have clarity about whether living with HIV puts them at more risk, if they get Covid, because they might be immuno-compromised.

For key populations, of course, many of the community services were going to the key populations rather than expecting them to come into clinics and health services. Those kinds of services are finding it very difficult to continue now. As Aaron rightly mentions, there are huge issues in terms of stigma and discrimination, which have just built on top of the existing stigma and discrimination that a lot of criminalised populations were already experiencing.

We have also seen a lot of countries really clamping down with considerably higher levels of authoritarianism. They have used the opportunity of lockdown and similar to persecute those communities that have often been persecuted. For example, LGBT groups in many countries have had orchestrated attacks against them.

The last thing I want to highlight is the impact on mental wellbeing and people's ability to even access services, if they are even there, just because of the impact of isolation, depression, harmful substance use and self-harming or suicidal behaviour, et cetera.

It is not all bleak. I will give one positive example. Even in really distressing circumstances, community organisations are responding in really innovative ways. In Ecuador, one of the most distressing areas, where bodies were being left out on the streets for days, Frontline AIDS



reports that the community-based organisation Kimirina responded by setting up a telemedicine system and using mobile units to deliver essential drugs to people so that they do not have to leave their houses. They are also giving teletraining to sex workers on entrepreneurial skills so that they can perhaps make a living in other ways. There are some really good examples that we need to grab hold of and replicate.

Q226 Mr Sharma: Aaron, does the affordability of treatments and drugs play a role in people's willingness to seek healthcare, especially during the pandemic?

Aaron Oxley: In general, it is pretty well understood that any user fees for health present a very large barrier to access for populations that are seeking care. We have a longstanding campaign in our sector to remove fees at point of use in health globally, and certainly that is not something that is going to make the response under Covid any easier if people are having to pay for care. What is going to be really interesting—and here is where I will maybe defer to Mike, because he has been doing quite a lot of thinking about this—is what this means for the potential cost of Covid treatments and the new tools that are being developed there. Ultimately, if we can get a bunch of treatments, vaccines, diagnostics and drugs, but they are unaffordable for countries and individuals that need to access them, then we are really in trouble.

We have literally a once-in-a-generation opportunity to examine exactly what a global public health response calls for in the way that we bring new treatments to market and how we make sure that they can reach people. Mike could speak to that a lot more.

Mike Podmore: Aaron has covered it really well. Maybe I will just give a particular lens from an HIV perspective. The HIV response can be particularly informative in this regard. It has been a bit of a shining light in terms of what is possible if we have a combination of ground-breaking ambition for universal access to medicines; we forced a reduction of prices and we expanded generic production. TB has also been making great headway in this regard.

As Aaron said, it is absolutely now about taking the opportunity to really rethink the system of research and development. We have already seen worrying trends of vaccine nationalism in terms of the Covid vaccine in the Covid response. Without deliberate safeguards in place, it is likely that we are going to see history repeat itself when it comes to unaffordable prices preventing access to therapeutics, diagnostics and vaccines.

We really hope that the UK will support all necessary measures to facilitate technological transfer, i.e. the know-how about how to manufacture Covid-19 health technologies, so that we are able to meet the global demand. There is no way that that is going to happen if we continue with the current model of allowing pharmaceutical companies to operate within intellectual property. This includes championing the Covid-



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19 technology access pool. I know the UK Government were interested in it, in finding out more about it. The WHO has, over the summer, produced some more information about how it would actually work. We really hope the UK Government will get behind that. It will enable IP research data and manufacturing knowhow to be shared.

There are also key proposals on the table at the moment. For example, India and South Africa put on the table at the WHO the idea of having a TRIPS waiver. That is at the TRIPS Council this week, so we really hope the UK will support that, but also that the UK will actively support public health safeguards within the TRIPS agreement more broadly.

Katie Husselby: I wanted to go back to the original question about financial barriers. For us, it really underscores and underlines, as Aaron alluded to, the need for universal health coverage everywhere. We are certainly seeing case studies and examples of people being unable to access the essential health services that they need, whether Covid or non-Covid-related, because of increased financial barriers. This is something that we understand in the UK, with the national health service, and something where the UK can really play a prominent role in terms of promoting the need for efforts to achieve universal health coverage globally. In our recent stocktake review, we found that the UK was not doing enough in its programmes to ensure financial risk protection for people trying to access essential health services. That was a key area where we felt improvements could be made towards achieving universal health coverage.

Q227 **Mr Sharma:** Noting the connections between Covid-19 and TB programmes in particular, how can the Government ensure that money spent on Covid-19 now contributes to stronger health systems in the long run, for example on TB testing? Aaron, could you answer, with your TB hat on?

Aaron Oxley: I hate to use the word “opportunity”, because it makes it sound as though it is something positive, when in fact it is rather a horrible situation to be in, but if we look at the kinds of responses that we need to make to Covid, almost universally we can find ways to make sure they benefit the building-up of the health system that Katie identified. This is perhaps most obvious for something like TB, which is also a deadly airborne infectious disease. There, we are talking about things like making sure that clinic waiting rooms have space for social distancing and are well ventilated. For example, in terms of diagnostic infrastructure, it just so happens that one of the Covid tests that exists can be run on the same chassis as a tuberculosis testing machine.

If we look at what we have to do in terms of community health and outreach, doing contact tracing in the community while respecting people’s rights and removing stigma, the cohorts of health workers that are being trained on contact tracing can be deployed for contact tracing on all sorts of other diseases as well, including TB. This is something that



we have been struggling with in the world of TB for many decades now, getting enough contact tracers out there.

This represents an opportunity to take a holistic view of health, going broad rather than going narrow and deep. It is an opportunity to look at how we can build health systems that are locally owned, that have real local leadership and are grounded in the communities that they serve. In that sense there are many things that the UK Government could be doing there.

I would also say, just to throw this in there, that we have not mentioned nutrition at all yet. This is something that quite often gets left out of the health risks column. I could talk for quite a long time about some of the numbers in terms of impact there, in terms of the number of children who are going to be going hungry and so on. These can all be integrated into a really strong human development response, and we can come out of here perhaps further behind on the sustainable development goals than we were going in, but certainly on a better trajectory.

Katie Husselby: Just to echo what Aaron was saying, TB is a fantastic example of where you can integrate services across the board. As Aaron alluded to, it is about integrating the Covid response with broader health-systems-strengthening efforts. The same issues that we are seeing negatively impacting the Covid response, whether that is shortages of health workers, inadequate PPE and supplies or no access to water and sanitation in health facilities, also impact the ability to maintain other essential health services. Investments in longer-term health systems strengthening and efforts to achieve universal health coverage will address both the immediate Covid response and the ability to maintain those other essential health services and avoid some of those secondary impacts that we have been hearing about today. We have been calling on the UK Government to maintain funding for non-Covid health interventions. The smart move is to integrate funding for the Covid response with broader health systems strengthening—to do both.

Q228 **Mr Sharma:** What influence have historical investments in mechanisms like the Global Fund had on the Covid-19 response?

Aaron Oxley: The Global Fund had been essential in being able to drive a rapid response from the donor community. The amount of funding that was immediately made available, \$500 million from savings and \$500 million in flexibilities, was incredibly powerful. The fact that both the Global Fund and Gavi are forming anchor organisations for the Access to Covid Tools Accelerator processes around therapeutics, diagnostics and vaccines is a real testament to the capacity that they have to move things quickly.

When we look at how, as more funding becomes available, we are going to get that money into the field, I always come back to the Global Fund in particular. The way that the Global Fund operates is very different from many other multilaterals, in the sense that it has community voices and



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communities in affected populations engaged not just in its governance structures but also in its country-level decision-making, planning, and strategy structures, through country co-ordinating mechanisms and other mechanisms.

If there is one thing that we really need to continue to do in global health, it is to make local people, the people being affected by the diseases and by health, engaged in bringing about the solution. The time of patriarchal, donor-led initiatives that do not involve local people and do not have their buy-in is very much over, and we should be mindful of that in this response.

Mike Podmore: I will just add to that. Aaron has covered it well. The Global Fund has played a critical role, both in its immediate response to Covid, particularly in terms of applying existing funding through the fund for adjustments to enable HIV, TB, and malaria programmes to adjust to Covid and respond directly to it. That immediate response is really critical. Its role within the ACT Accelerator has been really important. Aaron mentioned that already \$1 billion has been directed towards the Covid response within the Global Fund, utilising funds that it had from its very successful replenishment. However, those funds are at an end. Now the Global Fund is actually making a renewed request for a further \$5 billion to be able to cover other aspects, particularly in terms of therapeutics and diagnostics. The UK already has made a really strong leadership contribution to the Global Fund, but unfortunately it may need to look to see if it can find additional resources for the Global Fund.

Just to add to Aaron's point around the Global Fund's championing of the inclusion of civil society and communities, both in its own programmes and work and governance, it has also been doing that within the ACT Accelerator. I really welcome its championing of civil society representation within the ACT Accelerator. Unfortunately I cannot say the same and give the same plaudits to Gavi, WHO, and CEPI in terms of the vaccine pillar. The WHO has actually been quite obstructive to civil society inclusion and representation, so the Global Fund voice on this has been great.

Mr Sharma: Chair, I must declare my own interest in TB, as a chair of the APPG. That is why I was putting more emphasis on TB. I am sure Pauline will put more emphasis on malaria.

Chair: I am very grateful for your experience in this.

Q229 **Mr Sharma:** What are the urgent priorities for mitigation or extra resources or attention?

Aaron Oxley: The challenge we have, of course, is that there is urgency everywhere. We could probably spend a long time looking at where we need to put funds in. One thing that I would like to highlight would be nutrition. We have a great legacy of Nutrition for Growth from the UK Government. Nutrition, as you are probably aware, is essential for health.



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If you are malnourished, you are much more likely to suffer death or extreme complications from a number of different conditions.

Q230 **Chair:** Aaron, could I just pause you? We will be focusing on nutrition in our future sessions, so if you could just give us the headline, we would be grateful.

Aaron Oxley: The headline is that the UK Government's pledges to nutrition expire at the end of this year.

Katie Husselby: To echo what Aaron has said, there have been disruptions across the board. Obviously we have focused on communicable diseases in some detail today, but the WHO did a rapid survey analysing the effect of Covid on essential health services in August and unsurprisingly found that all services were affected across immunisation on communicable diseases. As Aaron said, it is hard to prioritise when you are seeing things being affected across the board.

A key learning from Ebola was not to shift funding and attention from one health crisis to fight another. We have already discussed the need for an integrated response to Covid that also maintains essential health services at the same time.

The second point I would make is about the need for community-based interventions. Evidence from the Ebola epidemic and the practical implications of lockdowns and restrictions on movement suggest we need to focus emphasis on community and locally owned interventions, which also have much more trust in terms of communicating public health information, particularly to vulnerable and marginalised groups.

Mike Podmore: Building on what colleagues have said, there needs to be a continued focus on the community at the centre of the response. That is in terms of not only supporting local community organisations and responses but also making sure that they are included in and connected to national Governments' mechanisms, as well as having their voice heard at the global level. We have to invest in responses that are grounded in human rights and equality, doing work to remove any legal, punitive policy measures.

I definitely support the point that Katie made about the interrelatedness of these different pandemics and different diseases. We have to invest in all of them in an integrated way to really get where we need to go.

I must also say that the upholding of sexual and reproductive health and rights is essential through this. We need to continue to ensure provision of those services. It is really non-negotiable.

The last point is about investing in innovative ideas that take advantage of the realities that we are in under Covid. How can technology support us to provide services, either through phones or through computers, whilst always being very careful to ensure that we are not further



marginalising the poorest as we are using those alternative ways of engaging people?

Q231 **Mr Sharma:** Katie, what do you see happening six months to one year from now in the best case and in the worst case?

Katie Husselby: As you have heard, there has been a lot of modelling and data being collected that shows that the secondary impacts are fairly severe across the board and across the full spectrum of health services. The worst-case scenario is that we fail to recognise these secondary impacts and to prioritise addressing them through this integrated approach that we have spoken about, and we end up far off the goals that we want to achieve by 2030 in terms of SDG 3 and universal health coverage.

A more positive route, and one that I hope we will take, is that Covid will highlight how humanity is bound together in the sense that health connects to all aspects of our lives, and so ultimately make the case for the need for investments in health, not just in a very narrow focus on the Covid response but in the need to invest in these longer-term ambitions that we have spoken about: creating strong, resilient health systems around the world that are able to deal with Covid, deal with future global health threats and keep all of the other essential health services going.

I hope particularly that this is something that the UK Government will be at the forefront of, constantly raising this issue of secondary impacts. The Prime Minister's speech at the United Nations General Assembly was really welcome for its focus on vaccine collaboration and work with the ACT Accelerator, but it had a fairly narrow focus on global health security in the Covid response. We really need to expand it to much bigger thinking about a long-term vision for global health that creates strong health systems and UHC that is resilient against future threats.

Mike Podmore: The worst case, as Katie has outlined, is that there will be just a focus on short-term interventions but not system-building, and a reduced focus and funding for other disease and health issues. We will not be learning the lessons from the previous pandemic responses and will repeat the same approaches that got us into trouble last time. At the global level, we see further fragmentation and nationalism and protectionism, and not really collaborating and working together, and that feeds into the issues around new ways of doing things in research and development.

In terms of the positive outlook, there are maybe three areas. First, on financing, we have really concerted effort around debt relief and global financial support against recession, which is fundamental. We have financing for Covid vaccines, but also diagnostics and therapeutics, which are being forgotten, frankly, and ongoing funding for health issues like HIV, TB, and malaria through great mechanisms like the Global Fund. Crucially, in terms of access and availability, we need to ensure that enough vaccines can get to everyone who needs them and that we really



ensure that the poorest and marginalised are targeted first. Global solidarity and political leadership are necessary here. As Katie mentioned, Boris Johnson has really made some important steps in that regard, both in terms of funding and in his statement at the UN, but there is much more that the UK can do.

Aaron Oxley: Mike is right to point out that there are some positives that we can count on. I would like to just mention the elephant in the room, which is an up to £2.9 billion cut to our aid budget, announced by the Government. That is a colossal contraction of our aid. It is understandably tied to our GDP, and in that sense that is where it is, but where those cuts fall and what programmes do not get funded really matter. I hope that what you are hearing from us is that human development in general and health in particular are really important to maintain in a time when the overall aid budget is shrinking. We have made some world-leading commitments to instruments like Gavi and the Global Fund. Hopefully, we have nutrition coming up, potentially. We have just announced we are going to be co-hosting the Global Partnership for Education replenishment next summer with Kenya.

These are all incredibly important things that really matter to people. One of the things about this pandemic is that you start to realise really quickly what is the most important thing in your life. It is your health, your loved ones and being able to get your kids off to school. For me and for us, it is incredibly important that we mirror that in our aid budget and really do focus it in on the human development aspects, including health and education. We can make these choices and we can direct the UK's funding in this way. That is what is going to have some the biggest impact on people's lives.

Q232 **Mr Sharma:** Who is working on assessing the healthcare deficit—the time-bomb being stored up for the future?

Mike Podmore: Can you say a bit more?

Chair: The weaknesses in the existing healthcare system have really been exposed by the pandemic, and we have been told that healthcare institutions have absolutely been run into the ground because of it. Looking forward, is there an organisation that is looking at those weaknesses and trying to assess what the impact is going to be?

Mike Podmore: It is a good question. All of us are. In terms of leadership, we would look to the WHO, and there is going to be a really interesting discussion that will come in terms of what the role of WHO should be when it comes to the global co-ordination of issues like this pandemic and global health. Crucially, there are a number of different key mechanisms and agencies. We have talked about the Global Fund and Gavi. Multilateral agencies, civil society, other partners, donor countries and implementing country Governments all need to be at the table to actually discuss this. In terms of existing mechanisms for bringing these to the table, in the immediate sense the ACT Accelerator is



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going to be a crucial mechanism in relation to Covid, and in the longer term, as I mentioned, the WHO and other agencies.

Katie Husselby: To echo what Mike has said, clearly the World Health Organisation has a really important role to play in assessing the healthcare deficit and the impact on health systems that we are seeing. Clearly civil society needs to be feeding into those mechanisms. What we are hearing and finding on the group and on our databases is one way that we are trying to track that and see what is happening at a more localised level. As Mike said, there is a health systems connector within the ACT Accelerator. It is still a little bit unclear how exactly that mechanism is working and taking forward their assessment of health systems. In a way, the question is flagging a bit of a gap and a need for better international co-ordination between lots of different bodies that we have just mentioned, to ensure that health systems do not fall through the gaps.

Aaron Oxley: Mike and Katie have covered it well. I would just add one small piece of data. In Sweden, for example, the number of people who were applying to enter into healthcare in the first half of this year reached record highs. People were keen to re-train, to help out and to engage in bringing health to their communities. We should not be worried about demand. We should be worried about supply. Can we create enough places in nursing training schools and training facilities around the world to train the healthcare workers that we need? Healthcare is a right, but it also needs money to be put into it in order to realise that right. As Katie mentioned earlier, one of the long-term strategic positive outcomes from our shared global trauma of Covid will be a recognition that we need to continue to prioritise health in all countries and to build the system that will provide healthcare to all people and leave no one behind.

I am particularly thinking of people with a disability, for example, who are always the last to receive care. It is almost impossible for certain people with certain disabilities to socially distance, because they need hands-on care. We need to make sure that our global health response is holistic and reaches everyone.

Mr Sharma: I do not want to debate that. If you look internationally, healthcare systems in some countries are right at the bottom, and with Covid-19 they have actually collapsed. I do not want to mention the countries, but you are fully aware, especially in south-east Asia, that there are countries that are at the lowest level. That is what our worry is: is anybody thinking about a mechanism to have a global look at whether the health systems can survive, whether there is extra training or the Swedish approach can be adopted?

Chair: I will move on to Navendu now, but maybe you can feed back into it later. Virendra, I agree; the pandemic has shown all the weaknesses in our healthcare systems around the world.



Q233 Navendu Mishra: Thank you to all the panellists for making time for this session. I would like to go to Aaron first with this question, but I am more than happy to come to Katie and Mike in a moment. What is the FCDO doing to tackle all or any aspects of the disruption to pre-Covid health programmes? That goes for immunisation, infant and maternal health, HIV/AIDS, and any other aspects.

Aaron Oxley: It would be really good to get some FCDO folks in here to answer your question directly.

Chair: We would love that.

Aaron Oxley: They are clearly doing a lot. All the civil servants that we are interacting with at the FCDO are absolutely flat out—they are working incredibly hard and are incredibly dedicated—at a time when, if I can speak frankly, they are changing the organisational arrangements that they are operating under, which was pretty tough.

In terms of some of the things that I would like to see them continue to do, we have made a lot of pledges to health organisations over the last couple of years, and congratulations to the Government for doing that. It is excellent. It is vital that those funds get out the door on time and in full. That probably is the single biggest bread-and-butter thing that they can do right away.

Katie Husselby: I would quite like to address this question by breaking down politically, financially and programmatically how the UK is responding. Clearly, the UK Government have a strong history on global health. They are the second largest Government donor to global health, which involves programmes across a range of essential health services, some of which we have touched on today in terms of secondary impacts. However, politically there is more that the FCDO particularly, and the UK Government more broadly, could be doing to focus down on the secondary impacts. As an example, earlier this year when cuts to the ODA budget were announced, the Foreign Secretary announced a list of priorities. The Covid response was listed, but not global health more broadly. The Government's manifesto commitment to end the preventable death of mothers, newborns and children, which encapsulates a lot of the areas where we are seeing significant secondary impacts, was the only development manifesto commitment that was missing from that list of priorities.

First, championing this issue politically and putting it at the forefront as a priority for the new Department would be really important. One way that we think that they could do that is by publishing a cross-Government global health strategy. I know this is not new information to the International Development Committee and that you have been a strong supporter of the need for a cross-Government global health strategy, but we think it is so crucial for a number of reasons: from policy coherence to outlining their approach and their commitment to things like the



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secondary impacts, as well as the Covid response, and how they are integrating them as an outline for their work.

Financially, as Aaron said, budget cuts are a critical issue here. We are yet to see the detail and the breakdown of what cuts mean, but there is early analysis that is suggesting that, whilst health funding more broadly may be maintained, there will be a shift within the health budget from the essential health services that we have been describing towards the Covid response. There is a real financial risk there.

That then impacts programmatically. We would like to see more emphasis on this integrated approach that we have spoken about today. Our analysis has shown that there has been underfunding of core health system components in the UK's programmes and around things like financial risk protection within their efforts to achieve universal health coverage.

Q234 Navendu Mishra: The point about underfunding is very important. Aaron made the point earlier on about the significant cuts to the ODA budget, and the points you made about talking more about international aid politically and making sure that poorest people get support are vital. Mike, did you want to say anything on this matter of the FCDO and what it is doing to tackle other aspects and the disruption due to Covid-19?

Mike Podmore: Just to touch on HIV, we have been campaigning for a number of years to look again at the financial, political, and programmatic commitments of the UK. As we have cited before, its real leadership around the Global Fund has been fundamental multilaterally, but bilaterally, unfortunately, there has been a long-term trend of funding cuts for HIV. In the context of ODA cuts, we are watching very carefully to see whether that continues even further. We have not seen the evidence yet of exactly where that is going. The UK needs to proudly maintain and continue its investment in the three diseases and really ensure that solutions are community-led responses to the HIV pandemic and focused on key populations. The UK previously has given a great deal to the Robert Carr Fund, and we hope that it will continue to do so again next year.

I echo all of Katie's points about the need for a global health strategy and co-ordination. Something to highlight, which I am hoping that the FCDO will really get behind, is a continued commitment to leave no one behind and to develop a framework and a set of principles that can be used to look at all of their investments and ask whether they are really targeting all of their money for the poorest and most marginalised, addressing not just poverty but also inequality. I also really hope that we are going to see the benefits of the FCDO's strength on diplomacy and human rights coming together with its development agenda to have a bigger impact.

Aaron Oxley: In terms of unlocking the diplomatic part of our newly formed Department, we are hosting the G7 next year, and that is a critical opportunity to advance this agenda through all of the dimensions



that Mike and Katie have just mentioned. It would be very easy to have an overly narrow focus on certain elements of the Covid response rather than being able to use that bigger frame.

Q235 Navendu Mishra: Katie, I will come to you first with this question and then I am happy to take brief contributions from the other two witnesses. Are you aware of any new programme, or adaptations of existing programmes, designed specifically to tackle the negative impacts of the pandemic on other aspect of healthcare provision?

Katie Husselby: Yes. As I said, we have been collecting a database of case studies from across our members' programmes, many of which are funded by FCDO. We have seen lots of innovative examples of adaptations and mitigation efforts to respond to Covid 19. To give one example, Marie Stopes International, one of our members, got in touch to say it was pleased that the impact on the programmes had not been as grave as initially expected due to adaptation mechanisms that it was able to put in place.

To give another specific case study, we heard from Malaria No More about a case study in Benin, where international co-ordination between the Global Fund, WHO and in-country partners enabled essential health service provision to go ahead. They were able to distribute bed nets ahead of the high malaria transmission season and reached 13.5 million people with that programme.

There are definitely positive examples of programmes adapting and mitigating the impact of Covid-19, but even in the Marie Stopes case, 1.9 million fewer women were reached by MSI's programmes between January and June than they had anticipated. Mitigation is working to a certain extent but there are still factors that mean we are seeing secondary impacts.

Aaron Oxley: We belong to a network called ACTION Global Health Advocacy Partnership, and we did a survey recently looking at tuberculosis healthcare workers around the world. Of the people we spoke to, 75% of those workers reported that they had made some efforts to adapt programming to provide additional support to people with TB so they can continue their treatment. You are seeing places like Sierra Leone, for example, that have actually integrated TB and Covid screening so that if somebody is presenting with a cough, they get tested for both. These are exactly the kinds of ways that we can integrate services and build health systems off the back an increased focus on Covid.

To be clear, at the moment those adaptations are not going nearly far enough to ameliorate the damage being done. Out of those same healthcare workers, 43% of them were reporting that they were being reassigned to the Covid response rather than the TB one, which is not surprising given that it is also a lethal respiratory pathogen. About half also reported decreases in access to medicines and personal protective



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equipment. There are still some very big mountains to climb even as these programmes adapt and do smart integration.

Q236 Navendu Mishra: What key measures are the UK, other donors or global partnerships putting in place to ensure that non-Covid-19 immunisation and global health programmes continue to be delivered effectively?

Aaron Oxley: The vast majority of the UK's immunisation work is going out through two agencies, one being Gavi, the other being the Global Polio Eradication Initiative. On the Global Polio Eradication Initiative, GPEI, the primary need there is, as far as we can possibly manage it, to front-load the disbursement of funds. We are in a relatively short-term crunch here. We have made a pledge from 2019 to 2023. Sorry to keep bringing it back to money, but unfortunately that is actually what is needed there right now. This is definitely a case where, if we do not front-load expenditure, there is every chance that the eventual eradication of polio will be delayed and longer-term costs will be much higher.

The UK has a very powerful voice on Gavi's board. As Mike mentioned, we would love to see more space opened up for communities and civil society to engage in Gavi, both in terms of its work in ACTA and more broadly in the routine work that Gavi does. There has never been a better time to really use the UK's leadership voice in these big health multilaterals to push for more and better integration of services. The big fear that I have, and that most of my colleagues have, is that because Covid is literally on the front page of the newspaper every day, that is what is taking up all the oxygen, and what we have referred to as routine immunisation, but which I like to refer to as essential immunisation, is something that just is not getting the political attention that it needs.

As you mentioned earlier, health services and health actors around the world are currently run absolutely ragged. Everybody is exhausted. Finding the space to do all of this additional work as well really risks taking efforts away from the core work. This is just a real plea to make sure that does not get missed. Let us do the bread and butter right.

Katie Husselby: Aaron has covered the question thoroughly. I would just highlight the global vaccine summit that the UK Government hosted back in June as a key successful example, which I hope will be repeated, of bringing together development and diplomacy successfully to leverage further funding for global health.

Q237 Navendu Mishra: Are you aware of any new programmes aimed at reducing fear and anxiety about engaging with health systems or programmes in developing countries?

Mike Podmore: I do not have specific examples that I can share, but it is perhaps important to highlight, as I was mentioning earlier, mental health issues that increasingly have been getting a lot more global attention. The UK Government have been very strong in this regard and



have really tried to push this agenda. STOPAIDS, my organisation, has also been doing quite a bit of work on that, looking at much broader conceptions of health that really actively include mental health and concepts of quality of life. To your question, it is exactly building up and integrating mental health with physical health; having a more holistic approach to health is so important. Immediately, with Covid, both in terms of getting the health messaging that people are hearing right to reduce that anxiety, but also crucially around social media around the anti-vaccine movements and misinformation that is being spread around so freely, we need to have programmes and messaging and movements that are really trying to address those.

Peer support programmes have been a mainstay of the HIV response for decades, and we need to find ways for that to continue. There is a great example not internationally but here in Hackney. My wife is working for Hackney Council, and what they have been trying to do is support individuals who answer the phone for council services, to be able to ask people how they are. It is just simple things like that. Take a note of it—“How are you doing? Are there any other issues that you have?”—and then be able to signpost. It does not need to be whole new standalone programmes. We need to integrate an awareness of mental health.

Q238 Navendu Mishra: That is really interesting to hear what you said about the UK leading when it comes to mental health and integrating it with physical health and the messaging. Across the world, including in the UK, a lot of people do not pay enough attention to mental health. That is why anti-vaxxer campaigns and misinformation on social media is more and more prevalent these days.

Have any lessons from the recent Ebola outbreak been learned in terms of maintaining the trust of local communities in medical and healthcare interventions provided by the international aid sector? In the previous panel we had a few questions about Ebola as well, and the Committee would be interested to know if there are any lessons from the Ebola outbreak and any information about the campaign to fight Ebola and building trust with local communities. It can be challenging in some parts of the world. I understand if you do not want to comment.

Chair: We are talking from a health perspective here.

Mike Podmore: There are a couple of aspects that are strong lessons from the Ebola response. It has been mentioned before: do not throw all your eggs in the Ebola basket, or the Covid basket, and forget about the other issues. For example, more women were dying in childbirth than died of Ebola. If you have just a complete shift in focus of health systems, then you create this dynamic. Of course, then you create a lack of trust in the health service, because people do not think that they are going to get the services that they need. The other big lesson from the Ebola pandemic was the importance of investing directly in local communities. By doing that you are building the knowledge and the effectiveness of community leadership, which then also builds trust



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around accessing services. Those might be two very strong lessons. I do not know if colleagues have others.

Katie Husselby: Just to build on Mike's point there, there is a really critical point about the need for more direct funding going to southern actors and organisations. Our recent stocktake report found that more than 90% of health ODA going to both civil society and private sector actors was going to institutions that were based in the UK. Less than 10%, both in terms of civil society and private sector, was going directly to southern organisations for health. Those numbers are quite stark and show that there is need for the UK Government to rethink or to provide a strategy for how they are going to shift funding directly towards southern actors.

Aaron Oxley: Coming in off the back of that, for both this question and the previous question, I would love for one of my colleagues who is actually based in the Global South to be sat in this seat. That is a challenge to the Committee in general, and to all actors working in global development: to make sure that we can get the voices of people who are directly affected in country to be able to speak and lift their voices into the debate.

One of the things that Mike was relatively modest about when talking about the HIV response was what it means to combat stigma. The world has learned some big lessons from HIV activists and advocates about that. This is something we see coming in with all public health interventions and issues. The increases that we have seen in stigma, in shame and what that means for care-seeking behaviour, what that means for trust in the health system, what that means for what you are willing to reveal, is absolutely massive.

As Mike was talking about mental health, what that is really speaking to is that we need to be treating patients as people. Overly medicalising the healthcare response is hugely problematic on many levels. As a data point on it, half of the people who we surveyed in the TB response were saying that they were not getting enough non-medical support to enable them to isolate and to complete treatment. That is probably only going to get worse, as a lot of those people are relying on family members for support. With the global recession, pressures on family members' time because of having to earn money so that people can eat are only going to get greater. We have been talking a lot about health. We have managed to mention a few other things about nutrition, education, and so on. Really it is human development, and it is about being able to treat the whole person.

Q239 **Mr Sharma:** In the absence of a global health strategy, how can the Government's performance against global health objectives be measured?

Katie Husselby: In two words, it cannot. That is part of the crucial reason that we are calling for a global health strategy. As I have said, we think there are a number of reasons why there should be a global health



strategy. It creates a roadmap for how the UK Government's investments are achieving SDG 3 and universal health coverage. It strengthens policy coherence: health ODA is not just spent by the FCDO; it is also spent by the Department of Health and the Department of Business, Energy and Industrial Strategy. Mike spoke earlier about leaving no one behind. We hope a global health strategy would enable the UK Government to say how they are putting their leave-no-one-behind principles into action in their health programmes.

Crucially, as you have just said, it is an accountability piece. It is very difficult to have transparency or accountability around the UK's role in global health without having an outline of what the UK is trying to achieve. This has been further compounded by the fact that there are not any other comprehensive documents outlining the UK's approach to global health. A health-systems-strengthening position paper has been in development for more than four years now. That is something that the International Development Committee has called for the publication of previously. Back in January, earlier this year, the UK Government announced an action plan on ending preventable deaths, as outlined in their manifesto commitments, but again no date for publication has been confirmed. There is really a complete absence around the UK outlining any strategy or document outlining their approach to global health, and it is a huge gap.

Mike Podmore: I completely echo all of Katie's points. In the absence of that strategy—and we very much hope that the UK will invest in one—there are key mechanisms that we need to have oversight of to actually ensure that the UK is delivering its stated commitments that it has made, whether Dominic Raab, Boris Johnson or civil servants.

The fact that ICAI is still in the picture is really important. It can do evaluations of specific areas of FCDO's work on global health. It is important that there is a continuing ODA Select Committee; I am devastated that this Committee will not be continuing. It is so important that we have a Committee with a specific focus on ODA, and so I would really encourage the UK Government to support that going forward.

I also want to highlight the importance of the strong collaboration and relationship between UK civil society and the UK Government. If we can work very collaboratively and with very clear mechanisms, we can really be critical friends and get stronger co-ordination and hopefully support the FCDO to have the most effective approaches.

Lastly, I just want to mention that what we really need—and this is referring to Aaron's point—are clear mechanisms for the UK to hold itself accountable, not just to the taxpayer, which it does at the ballot box and politically, but also, in the context of ODA, to the people that it is seeking to support in the Global South. The UK thinking through the mechanisms through which it holds itself accountable to them is really important.



Aaron Oxley: I would echo Mike in terms of the work of this Committee. It is even more important that a cross-Government ODA Committee is set up. I would strongly support that, if only because the ambition we now have is greater. If we look at what we want to do in aid and development and how we can drive that, we do have to start to go beyond the very, very impressive number of lives saved. Our investment in the Global Fund saves a life every two minutes. Our investment in Gavi saves a life every two minutes. We need to go further than that, though. We need to leverage the whole of the UK, including organisations like THET, which connects NHS staff with health workers in low-income countries for knowledge and skills transfer.

We need to be able to leverage the UK's phenomenal health research and development infrastructure, not just for Covid but for all of the other diseases that we do not have good diagnostics, drugs and vaccines for. We need to keep engaging in partnership with international instruments like, dare I say it, some of the European ones. The Europeans have this wonderful instrument that we used to be part of called the European and Developing Countries Clinical Trials Partnership, which has been absolutely instrumental in making sure that we can take great research and actually get that to people and communities. We cannot lose that as we go forward. I am looking forward to being able to continue to work in partnership around all of that and show the world how we can be expanding FCDO to be all that it can.

Katie Husselby: I just want to add one extra mechanism, which is the global health oversight group. That was a group that existed before the merger, which recognised that health ODA is spent across multiple Government Departments. It was an oversight group that enabled co-ordination, collaboration and policy coherence in the absence of a global health strategy. We are really keen to see that global health oversight group maintained and retained by the FCDO to continue enabling that co-ordination and, hopefully, policy coherence.

Chair: May I, as a point of order, tell our witnesses that we are fighting very hard to change our remit so that we become the ODA scrutiny Select Committee? Please have our assurance on that. Can I also thank the witnesses and the Committee members for this session? This was our first witness session on our new inquiry into the secondary impacts of Covid-19 and the humanitarian support we provide. It has been incredibly informative but also rather chilling. I take from you the statement, early on, that the secondary impact of Covid could lead to the same number of loss of life as the pandemic itself, and also the perverse, dark irony that the hardest hit in the Global South by Covid are also the hardest hit by HIV, TB, and malaria.

Aaron, I think it was you who gave the figures of 6.3 million additional cases of TB in the next five years because of the impact of Covid and 80 million children missing out on their essential vaccines. It is so important the Governments around the world do not lose sight of that.



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I was particularly taken by the fact that all of you brought up a universal health system and a global health strategy, but of course that needs staff and investment and will. I very much hope that this inquiry will add more force to that call, and I thank you all very much for contributing to that today.