

International Development Committee

Oral evidence: Humanitarian crises monitoring: impact of coronavirus, HC 292

Thursday 4 June 2020

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Members present: Sarah Champion (Chair); Theo Clarke; Brendan Clarke-Smith; Mrs Pauline Latham; Chris Law; Mr Ian Liddell-Grainger; Navendu Mishra; Kate Osamor; Mr Virendra Sharma.

Questions 55 - 95

Witnesses

[I](#): Farah Kabir, Country Director, ActionAid (Bangladesh).

[II](#): Ndubisi Anyanwu, Country Director, Mercy Corps (Nigeria).

[III](#): Ghassan Abou Chaar, Emergency Director, MSF (Yemen).

Examination of witness

Witness: Farah Kabir.

Q55 **Chair:** I would like to start this Committee session, which is our second day of grilling witnesses on the impact of coronavirus in their countries. We have witnesses from Bangladesh, Yemen and Nigeria. The first witness we have is Farah Kabir from ActionAid. Farah, can you tell us a little about yourself, about ActionAid and, more specifically, about the work you are doing with the Rohingya in Cox's Bazar in Bangladesh?

Farah Kabir: Thank you for having me, Sarah. I am the country director of ActionAid in Bangladesh. I have been working with ActionAid for close to a decade. We are a development organisation, but with a lot of focus on human rights. Women are at the centre of a lot of the work we do—women's leadership and women-led emergency response. We are going to be talking about an emergency, the pandemic, as well as the Rohingya response, so that is what I would like to share. We have programmes on the ground. We have frontline engagement, but we are also involved in policy advocacy and looking for alternatives. Those are our operations generally.

We have been in Bangladesh since 1983. ActionAid's initial reason for coming to Bangladesh was as part of a humanitarian emergency response, and that continues as one of our portfolios. We have made some footprint there. Then we got involved with the Rohingya response as of September 2017. As you are probably aware, this is the biggest refugee camp, in a small place—it is mud hills—where almost 1 million Rohingya refugees are now living. It is extremely congested and very densely populated.

It has changed in the last two years in terms of basic services. The services out there are much more organised, but people and families still have to live in bamboo frames with plastic coverings. I do not think anyone chooses to be a refugee, but they were running away from execution and oppression. We have heard of very horrific incidents and occurrences with those who fled from Rakhine state in Myanmar.

In our work since 2018, we have focused on the protection part. While initially it was about WASH, food and water, ActionAid brings its strength and finds its niche in working with women and girls, and protection. That is where we focus. We have developed women's centres, women's leadership and women-led emergency responses within the Rohingya refugee camps. This has been very useful.

We have always been worried about the climate-led impacts and disasters. As you know, Bangladesh is prone to very frequent and intense disasters. As we are speaking, we are in the monsoon and have just overcome Cyclone Amphan, which threatened both Bangladesh and West Bengal in India. This is the flood season or monsoon season. It is always on the edges that we are working in this area.



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The Covid-19 situation, the pandemic, was like a nightmare, waking up every day and thinking, "Oh, God, let there not be a case. Let there be no positive cases." We knew that was not going to be the reality. Right now, Rohingya refugees have been detected and it is on the incline, with the tests being conducted now. We do not have the capacity in Bangladesh. In a general setting, its health sector and its services are pretty inadequate for 160 million people. In the Rohingya refugee camps, where a lot of efforts have gone in, it is in dire straits. I cannot put it in any other words. We do not have the medical support, the hospitals, the ICUs or the oxygen tents on the ground. We are struggling.

Initially, after the lockdown from 8 April, there was a moment of suspending protection services, as they were not seen as critical, but, all together, we managed to convince both the authorities and the UN agencies, so they continue. While it is a threat and a challenge for life, as well as a challenge for livelihood, that is true across Bangladesh.

To take you away from the Rohingya refugee camps, across Bangladesh it has impacted women and girls very differently, on a much higher scale. Through tele-surveys, we have done research and found that, just in the month of April, domestic violence has gone up. There has been rape. There have been gender-based homicides. This comes from one month of tele-surveys. In one of the surveys conducted in the slum areas, a number of women told us that this is the first time they have experienced domestic violence, because of the pandemic. This was over 1,600 women—unpaid care workers and vulnerable women—and 90% of the women's work is in the informal sector, and they have all lost their livelihood.

They are going back to wherever they came from, the villages and rural areas, and then they do not have an income. The men and the society take out their frustration on women. We are also seeing an increase in child marriages. Health issues are also very high. Services, like sexual and reproductive health services and access to family planning, are suffering. Women are becoming victims of unwanted pregnancies. This is one level.

Chair: Farah, let me pause you there, because you have given us an awful lot of information. We would like to pick away at that in more detail.

Q56 **Mr Sharma:** It is a very detailed answer on Bangladesh. I remember my last two visits to the Rohingya camps and seeing the situation there. She has mentioned quite a lot in her response to your question, Chair, but there are still a few areas she can develop and others can pick up in their own countries. What are the real threats at this moment? What has the actual incidence of Covid-19 done to your humanitarian relief work? What are the biggest challenges that society in general is facing? What are the threats at the moment, what are the actual risks due to Covid-19 and what challenges do you see in your own experience, so that we can share it?



Farah Kabir: The challenges right now, if we just focus on the Rohingya refugee camps, are testing ability, isolation spaces, provision of oxygen tents and setting up specialised ICUs. This is the health side. We also found a lack of information and miscommunication. Immediately after we took on the Covid-19 response, we started working with women-led emergency response and helped them to give accurate or, as far as possible, valid information, from Government sources and so on, on Covid-19, the symptoms and how it impacts.

In terms of other challenges, in the Rohingya camps, the Government have said that the testing should be increased. They have no disagreement with that but, if you are testing any of the refugees, there should be a space to put them in isolation for 14 days. They cannot go back. On one level it seems logical, because it is so densely populated, but it has created fear among the refugees. Even if they have a cough and a temperature, they do not own up to it. They do not come out and say, so there is that fear. "What happens for 14 days? I will have to be in isolation."

The isolation spaces are also not there. We are trying very hard, with all the UN agencies and the local administration and Government, to set them up. Makeshift hospitals are being set up. A 50-bed hospital is there. An oxygen tent is being brought in. This is on the health side.

On the social side, women and girls are at high risk because men are also under lockdown. They are confined in that space. There is acceptance of domestic violence and their right to do that. Child marriage is increasing, and this is leading to trafficking. There have been anecdotal examples of trafficking. On the other hand, all our colleagues, all the frontline aid workers, are also at high risk. They continue to work, but we find that landlords are refusing to let them come and stay. If they are positive, isolation is a huge problem. There is no support system.

If you need to go to hospital, the facilities are not there. We really need facilities to be made available at an emergency speed. I do not know how we are going to do that. Everyone, including the Government and the Prime Minister, is talking about setting up ICUs at district and local level, but that takes time. Some 2,000 doctors have been sent to Cox's Bazar. Talking about the proportion, just the Rohingya refugees are 1 million. Then you have to deal with the 200,000 host community, who are also at high risk. They are also suffering. This is where the challenges are.

We need to focus on the whole health sector, but also on how it is impacting women and girls. In the meantime, they are not getting SRHR or family planning services. Then the referral services are also suffering. The whole focus is on responding to Covid-19, but when there are domestic violence issues or SRHR needs they are getting deprioritised. There have been incidents of pregnant women not being allowed to come into the hospital. There are reports in the media of women giving birth outside the hospital premises. Those are extreme cases, but it has



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happened. There have been cases where, in a family, the mother tested positive and was abandoned on the street-side. Compassion and understanding are being threatened.

Then there is the whole force of trying to revive and get back to livelihood. You have probably seen reports, but no one is complying with social distancing. They are coming in whatever possible way, whether by walking, if they can, through the waterways or on trains. There is no such thing as social distancing. They are not even following the basic instructions of mask and gloves. Where will you get a mask and gloves if you do not have an income? The production cannot go up overnight.

One thing we have done in the Rohingya camps is production of masks. We are trying to provide masks to the Rohingya refugees as quickly as possible, with the support of UN Women and UNFPA. But we need that for 160 million people, so that is another challenge.

Chair: That is a big challenge.

Q57 **Mrs Latham:** I wonder if I can ask a series of questions relating to things you have already said. You talked about people going back to their villages. These cannot be the Rohingya refugees, can they? Are they going back to Burma, to their villages, where they are then experiencing domestic abuse?

Farah Kabir: No, I was referring to Bangladesh in general.

Q58 **Mrs Latham:** That is fine. I just wanted to clarify that, because I want to concentrate on the refugee camps, the direct and indirect impacts we were expecting and whether they have actually happened in the refugee camps. We have heard of one death. Do you think that the count of people who have or have had Covid is accurate? Has there really been only one death with so many thousands of people in close proximity? You have explained that you cannot socially distance, because there physically is not room to do it. How is it that we have heard of only one death? Is that accurate?

Farah Kabir: As far as the WHO and the local authorities are concerned, there is one reported death. As I said earlier, the testing was not available. They are trying to beef up the testing facilities and it is a challenge, because the health infrastructure was not adequate anyway. While they have increased the number of tests, there is also this stigmatisation fear. As I referred to earlier, so far, the tests in the camps are very, very low. We do not know exactly what the number is, but it would be very difficult to hide a death. In the camp, there is a system of monitoring, registration and providing services.

Infection remains a grey area and it is very difficult because we do not have the testing ability. The stigmatisation reasons have also reduced the number of people coming to any of the health clinics or owning up to having a temperature. This, again, puts women at a higher risk, because they are the caregivers.



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Q59 Mrs Latham: You have explained that women and girls in that situation are suffering more than anybody else. You have talked about rape, domestic violence, early marriage and unwanted pregnancies. Is this happening equally within the camp as outside it, or is it an issue outside the camp rather than a Rohingya issue?

Farah Kabir: Child marriage is also a Rohingya issue, and so is trafficking. Trafficking in humans was reported. As you may have heard, in March and April, they were rescued from the sea. That has been going on throughout the last two and a half years. It is very difficult to give exact numbers, but it has been happening. Child marriage and polygamy are very much present among Rohingya refugees.

Q60 Mrs Latham: Where are these girls being trafficked to?

Farah Kabir: So far, from the reports, it could be any of the south-east Asian countries, because there is a thought that they may have a better future. From the recent rescue, there were 183 women and many of them were married, but the husbands were not in the camp. The husbands had already fled to Malaysia, Indonesia or other parts, and this is where they were trying to get to. Some of those being trafficked had been told they would have better marriages and so on, but the anti-trafficking groups are telling us it is sex trafficking.

Q61 Mrs Latham: Within the camp, is there any mechanism for whistleblowing or for people to tell the authorities, or tell anybody, if they have been abused, whether it is domestic violence or sexual abuse? Is there a system that keeps those people safer, because they know where they can go to report this, whether the abusers are their own people, people from within the NGOs or people from Bangladesh?

Farah Kabir: Referral systems were being set up. ActionAid and the UN supported women-friendly spaces are where domestic violence is reported. The Rohingya refugees are much more close-knit in that sense of trying to hide if there is polygamy or child marriage. For aid workers, for any of us, we have access to the camps only from 9 am to 4 pm in a day. Beyond that, it is very difficult. In these women-friendly spaces, we have tried to encourage the women to talk about it. We are providing psychosocial care and counselling.

These referral systems were working and some actions were being taken but, as you know, there is also pride. The refugee community has its own value system and worldview. When the 8 April lockdown came, it was momentarily suspended, but we are very pleased that at least we could put the protection issue back on the agenda. The Government still look at health, WASH and food as more urgent and critical than protection. We are also lobbying the national Government, the human rights commission and others to keep those referral lines ongoing.

Q62 Kate Osamor: Thank you, Farah, for giving us a very quick but in-depth vision of what is happening on the ground. I really appreciate that. I want to take you back slightly to 2018, if you could explain a bit about the



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protection services you were providing for those women and girls in the camps. You have spoken about the suspension, the curfew and the lockdown, but how have those services been able to survive during this pandemic? What would you suggest, if anyone from the Bangladeshi authorities is listening to this, as a way we can work with those women, work with the aid agencies and, more importantly, keep those services going when, from what you have said, nothing has changed and violence against women and girls has continued during this pandemic?

Farah Kabir: In 2018, we prioritised beyond food and WASH. When I went in for the first time, it was like a sea of people coming. It was very traumatic, even for me. I had never experienced anything like this. We did not find the girls. They were inside those little tents, so it was quite clear that they needed certain services. They needed to be able to deal with the trauma; they also needed health, hygiene and so on. We emphasised that and developed, over the two and a half years, a portfolio of services like that. This is happening at the women's centres. Slowly, they talked about the trauma. Psychosocial counselling services were being offered. They were very keen to get back to livelihood. That was always the binding glue, that they wanted to do something. That was our trust-building approach, and they shared whatever the problems were.

As I referred to, on 8 April, when there was a lockdown in Cox's Bazar, they suspended the protection services for a little while. It was very short-lived, because we all came together and said, "This needs to be done." To emphasise the gendered impact, in ActionAid and other organisations, we are also doing studies in the Bangladeshi national context. Those studies are helping to bring out the gender dimension and the increase in domestic violence, with which we go and lobby the Government. We are trying to show the Bangladeshi authorities and the greater Bangladeshi society that this is happening, even in the Rohingya camps: "Please, let us not stop the protection service. Let us keep it within the critical service."

That is quite a uniform voice from the UN and all the INGOs and national groups. We have been able to take it, so they have allowed that, but not to the full extent, because they are still trying to cope with the pandemic. The thrust and focus of the Government is to help on the health issue of the pandemic. It has been because of the trust we have built.

We are also involved in campsite management and camp development. ActionAid manages to continue doing some of this work, but we had to repurpose it. We brought the women back into the women's spaces and they are producing the masks. We had to play it in such a way that the authorities see the value of keeping the women's spaces open, and so on.

We also need paramedic training for the refugee camp. I do not know if WHO or others are offering that. We have to rationalise the process of health support, because not everybody needs to go into hospital. We have to rationalise how best to support them. That can happen through the information we provide and by building up the immunity. There has to



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be a packaging of information that Covid-19 is not going to go away three or six months down the road. We just do not know. It is so complex. So what do we do? We need to build immunity, particularly of women and girls, and support them in the nutrition part of it, but also through messaging.

Chair: Farah, can I pause you there?

Farah Kabir: Sorry, Sarah, I get too emotionally involved.

Chair: So do we.

Q63 **Navendu Mishra:** I found your contribution quite powerful, Farah, so thank you for that. Building on what you have said, do you think you were prepared, or could you have been better prepared, for the coronavirus crisis?

Farah Kabir: That is a very challenging question. Globally, we were not getting enough information. The information was not there, so for the Government to be prepared, and therefore for us to be prepared, it took longer. We could have been better prepared if we had accepted that the health infrastructure and the services had big holes in them and were problematic, and if we had invested in them.

Talking about Cox's Bazar, when the Rohingya came, there was only the Government health complex. There was nothing else. They had to be built, so the Red Cross and the different UN agencies started putting them up. I saw women deliver when I went into the camps in the latter part of 2017. They were given a one-hour rest and were then asked to leave, because the next patient was coming. It was a field hospital kind of operation. It is way better now.

Right now, the Government are involved in a preparedness framework and are developing a plan. That is perhaps where you can all get involved in support. Bangladesh is very good at disaster preparedness. It has brought down the casualties through early warning and so on, but the pandemic is very different. My simple answer to your question is that I do not think we could have prepared, given the resources and, unfortunately, the information we had.

Q64 **Navendu Mishra:** Is there anything specific to be said, negative or positive, about the UK's bilateral response, or the international community overall, when it comes to preparedness?

Farah Kabir: Before I go to the UK, the global leadership has not provided funding for the joint plan. Every year, they have done an assessment and put in a plan for the funding, and it has never been fully funded. In the first year, it was around 40% or a little more. Then 2019 saw a decline in that. For 2020 we do not know. In that sense, the UK Government need to play a global role in advocating for greater investment.



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For the UK Government, it is also about looking at a comprehensive plan on not just Covid-19 but on the gender dimension. You support a lot of work for women and girls, trying to prevent child marriage and provide SRHR services, but we need comprehensive planning and dialogue with our national Government, as well as supporting all the different organisations that are working. It can be done through localised processes of supporting local or national women's rights organisations and channelling some of the funds to women's groups.

Even in the pandemic, society continues to discriminate. The sex workers were not getting any support. The Dalits were not getting the support they need in a greater national Bangladesh context. Then you can imagine the Adivasis or the indigenous communities. As daily wage earners, we do not know how to address the issue of the migrant workers. For us, the migrant workers are those who have been in the Middle East or other parts of the world. When they return and we have close to 10 million, how are we going to provide for them? What will the capacity-building initiatives be? What job alternatives are they going to get? This is where we need to do some future scenario-building, support and investment.

Navendu Mishra: Thank you, Farah. Your comments about the indigenous communities, the Adivasis and the Dalits, are quite helpful in understanding the context. I am of Indian heritage and some of that applies over the border as well, so thank you for that. Your comments about the gender aspect of this are also very important, because the Department for International Development is always bigging up the amount of work it does on that aspect. It is helpful to hear, from your point of view, what you think, so thank you for that.

Q65 **Chris Law:** Thank you, Farah, for so much information on Cox's Bazar, a place I had the opportunity to visit 18 months ago. Very quickly, because I know time is running out, I want to ask really directly whether you think the Department for International Development should prioritise and make imperative, given what is happening across the globe, a global health strategy, something similar to the one it has provided for education? As a little addition to that, should it be bilateral, country to country, or through a multilateral system, or a bit of both?

Farah Kabir: I am not sure I understood your question. Are you saying that the emphasis of UK aid should be on health?

Chris Law: On a global health strategy, yes, to start to focus on it.

Farah Kabir: Absolutely, but it should not be at the cost of any of the other areas. We cannot have a focus only on the health side, and then not look at the education or skills aspect. In the case of Bangladesh, we have a lot of young people. We are in that youth dividend era. They are active and full of energy. They want working opportunity and to contribute, so this is where the emphasis needs to be.



I would say it is not an either/or, but, given the pandemic and the situation we are in now, we need extra measures to look into the health system, health structure and health services. It must be gender-sensitive, because right now the investment in public services does not match the need on the ground.

Q66 Theo Clarke: Picking up on my colleague's point about the UK Government's policy priorities, what would be top of your wish list for the British Government? Today in London we have been hosting this Global Vaccine Summit, and there has been a lot of focus on Gavi and finding a Covid-19 vaccine. What would be top of your list for the UK Government to focus on?

Farah Kabir: I will pick up on the vaccine, if that is what you are focusing on, and making it accessible and available to women and girls, not as a secondary measure but as a priority, to deal with Covid. While we are doing that, it is very important to recognise women's leadership in terms of emergencies and addressing their families and the community. They are given the responsibility of both unpaid care work and nutrition, but how are they going to build up the immunities and help in that area, unless they are supported?

A vaccine, when it comes, will go through a trial-and-error process, and then we will get the results. There is a time between that and now, and this is where we need to emphasise. There should be medium-term planning and then the longer-term planning, as well as ensuring that women do not suffer gender-based violence. We need to invest. Even now, when we talk about isolation spaces, we have women who are lactating mothers. Are you going to isolate the mother and the child? If you do, who is going to feed and look after the child? We need to think of it as a circle and a fully fledged approach.

Chair: Farah Kabir, you have been so open in your answers and given us so much information. We really, really appreciate the time you have taken. Please stay with us if you have time.

Examination of witness

Witness: Ndubisi Anyanwu.

Q67 Chair: I would now like to turn to our second witness, Ndubisi Anyanwu, who is working for Mercy Corps in Nigeria. Ndubisi, can you tell us a bit about the work of Mercy Corps but also what it is like there on the ground at the moment?

Ndubisi Anyanwu: Thank you very much. Good afternoon, distinguished Chair and other members. My name is Ndubisi Anyanwu. I am the country director for Mercy Corps in Nigeria, and I am speaking to you from Abuja. I really want to thank you for this opportunity.



Perhaps I will start by saying a bit about Mercy Corps. Mercy Corps is a global organisation. We work in more than 40 countries around the world, addressing both the devastating impact and the root causes of conflict and fragility. Since 2012, Mercy Corps has been working in the most marginalised and crisis-affected regions of Nigeria to deliver urgent life-saving assistance and promote development. We partner with communities to help them recover and rebuild, while addressing root causes of conflict, insecurity and inequality. Our work impacts over 600,000 people across the country.

With the UK's support, we have been working to support Nigerian adolescent girls to fulfil their potential in education and in work, through an education programme funding by DFID's Girls' Education Challenge fund. We also support social cohesion and address the root causes of violent extremism in the north-east through a programme funded by the Conflict, Stability and Security Fund.

In terms of the situation here on the ground with Covid-19, according to the WHO, as of today, 4 June, we have about 11,000 cases of Covid-19, with up to 315 deaths. Currently, Nigeria is on a lifting process. Our offices started to open some weeks ago. To give you context in terms of the numbers, when I started at Mercy Corps on 1 April, we had about 300 cases in the country. As I speak to you now, we are getting about 300 cases per day.

Of course, we have had to adapt in our work. Even in the lockdown period over recent weeks, we have adapted our DFID-funded programmes to continue implementing them. In some areas, we have had to adapt our programmes to Covid-19 necessities, such as ensuring food security for vulnerable girls. Covid-19 is a threat multiplier, with critical implications in the short, medium and long term. The most pressing issues that I am keen to explore further during our time together are: first, the operational challenges in Nigeria; secondly, the economic impacts on livelihoods, employment and food security; and, thirdly, the issue of social cohesion. When looking at social cohesion, we are looking at state-citizen relations, extremism dynamics, and misinformation and false narratives.

Chair: That is really interesting. As an opener, you have given us a lot to feast on there.

Q68 **Mr Sharma:** What has the threat, the perception of risk and the actual incidence of Covid-19 done to your humanitarian relief work, and what have you found to be the main challenges during this period?

Ndubisi Anyanwu: Thank you, sir, for that very good question. As I mentioned, today we have about 11,000 cases of Covid-19, with 315 deaths. There was an initial lockdown for three weeks in Borno state, in the north-east part of the country, which has been lifted, but there are still certain restrictions in place. Before going into detail about the challenges, I want to remind all of you that Covid-19 is just one crisis on



top of multiple crises. In the north-east, for example, Covid-19 risks having dire consequences. We have 1.8 million people who are internally displaced, and over 7 million people who need urgent life-saving assistance, including food, healthcare and water. The pre-existing humanitarian access in the north-east has also been a challenge. Areas are inaccessible and the roads are insecure.

In such a humanitarian crisis, widespread transmission and the response to Covid-19 risks catastrophic impacts for the population. It exacerbates the current needs and undoes some of the economic progress that has been made in recent years. These crises have escalated in recent weeks, with the most vulnerable populations, like women, children, the disabled, the chronically ill and old people, being heavily impacted.

As I mentioned, we have managed to continue programming, moving and pivoting where necessary. However, we still have a lot of constraints. The lockdown and curfew restrictions have further hindered access for aid workers, which has limited the response by NGOs. Social distance and prevention mechanisms have made aid delivery and Covid-19 response even more challenging. Our capacity to respond effectively has been reduced due to limited funding opportunities for Covid-19 response. The Government of Nigeria are heavily reliant on aid. Supply chain and transportation routes are limited, and non-existent following the Government recommendations on border restrictions and movement.

We are also concerned about staff safety. We have security challenges. We have illegal checkpoints. Kidnapping and terrorism persist. There is an increased risk of humanitarian workers getting infected, especially in the north-east, in the IDP camps. As the previous speaker mentioned, these are congested areas with people in small spaces who risk infection. Once it gets into these camps, it is very fast, because of the issue of social distancing. These are some of the issues we are facing.

Q69 Mrs Latham: One of the good things to come out of the Covid-19 pandemic has been that we are able to talk to people in country, which we never did—they had to come and sit in front of us in Committee. I hope we are able to continue with this, because I think it is a really positive thing. We all know about Nigeria, and we heard about the Chibok girls, but they are not the only girls who are affected by kidnap and brutality, basically, by people out there. Can you tell us how the pandemic is maybe affecting women and girls more than men? We hear lots of dire predictions as to what might happen, but what is actually happening on the ground to these very vulnerable and disadvantaged groups?

Ndubisi Anyanwu: That is a very good point. The issue of women and girls is quite serious. I would like to look at that in terms of the economic impacts. Based on our experience of the Ebola outbreak, we know this epidemic will have an impact on women and girls. There is a dire need for income during an outbreak, which can lead to an increase in adolescent pregnancies and sexual exploitation. We are already seeing a rise in



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gender-based violence at household and societal levels. This is overburdening the GBV referral and response organisations with limited resources and capacity.

Our thinking is that, with the UK's support through DFID, there should be an assurance that women and women's organisations are included and supported meaningfully to participate in all levels of the design, implementation and evaluation of responses to Covid-19 and its secondary effects.

At the local level, we must also ensure that community dialogue includes awareness-raising around the issues facing women and girls, and strengthen community protection mechanisms. Public information campaigns should also include messages that promote shared responsibilities for providing care to sick persons in any information sessions and materials.

Q70 Mrs Latham: Obviously, you have had the Chibok girls and others. Is that still going on? Do you still have groups coming in and kidnapping people who are obviously vulnerable, who have then taken a long time to get back? I know that most of the girls ended up being accounted for, but not all of them. What is the situation there now, particularly when you have a lot going on with internally displaced people? You have quite a few of them in Nigeria. How are they being impacted by this?

Ndubisi Anyanwu: In terms of the Chibok girls, I am not sure I can speak on that. We have been facing pre-existing humanitarian crises in the north-east, as I mentioned. With that, we have had abductions and violence, and all this has occurred. There is evidence to show that women and girls have been abducted and treated with violence. It is just an existing situation that comes with the territory of the pre-existing conditions in the north-east.

Q71 Kate Osamor: Thank you so much, Ndubisi, for your thorough explanation of what is happening in Nigeria. You can tell from my Nigerian surname that it is a subject very close to my heart. Getting back to the evidence-gathering, does Mercy Corps have a good relationship with the Governor in Borno state? Has that relationship helped in ensuring that the necessary work is done on the existing issues of malnutrition and disease? I understand that Lassa fever is rampant in the region at the moment. Was there a relationship with the Governor before Covid-19 that has helped you to do the work, especially because of the dangers that are present, with Boko Haram, the miscommunication and the internally displaced people, who come from all over the region, not just Nigeria but Cameroon and the Lake Chad basin as well?

Ndubisi Anyanwu: Mercy Corps has a cordial relationship with the Government of Borno State, as well as many of the Governments in the north-east. We have a huge presence in the north-east. Of our staff of about 300 in the country, about 90 or so are in the north-east. I have to speak from my perspective, as I just joined Mercy Corps on 1 April.



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Incidentally, 1 April was the first day of lockdown, so I had to have a virtual start. Coming in, one of my first objectives was to go to the field, but, unfortunately, I have not been able to do that because of the restrictions.

If you look across the Africa region, you will notice that there is a big push to bring in leaders who are close to the ground and to raise the African leadership within Mercy Corps. That is also why I was brought in. Like I said, we have a cordial relationship with the Governments in the north-east, but we need to take it a step further and improve on that.

Personally, I have previous experience of working at the World Bank overseas before coming back into Nigeria. I have served in Government at quite a high level and even in the hinterland, so I think there is room for improvement and we are well positioned now, once the lockdown subsides, to fully engage not only the federal Government but the state Governments and local Governments to handle these issues of malnutrition, nutrition and so forth.

Q72 Chair: Nigeria has 774 local government areas and 20 of those account for 60% of the identified Covid outbreaks. Why? What is the logic behind that?

Ndubisi Anyanwu: That is a very good question. There are parts of Nigeria that are more densely populated than others, so that is also an issue. In terms of the numbers, like I said, there has been an exponential increase, and there are also some concerns about testing. Testing has become an issue that we are looking at. As I mentioned, we have about 11,000 cases so far. Given that, as I mentioned, there were only 300 in the country in April, and as we speak we are getting 300 per day, there are some issues around the testing, but it is getting better.

In terms of the numbers, you have a situation where the beliefs of certain groups of people in the country contribute to the rising number, so that has also become an issue. There is a lot of misinformation around. I think these are some of the issues that have contributed to those percentages.

Q73 Brendan Clarke-Smith: Good afternoon, Ndubisi. You touched on this earlier, but have lessons been learned or applied from previous experience with, for example, Ebola? In particular, I am thinking about trust and social cohesion.

Chair: Brendan, I am really sorry, but your line is breaking up. Ndubisi, Brendan is interested in previous experience the country might have on infectious diseases. He is thinking about Ebola, for example. You mentioned trust and the fake news that is going around. Could you speak a little more about that, please?

Ndubisi Anyanwu: I will talk about the previous experience with Ebola. Nigeria was successful in containing Ebola and some key lessons were learned. The NCDC—the Nigeria Centre for Disease Control—has taken actions, which are based on past experience. During Ebola, many states



created isolation facilities, which are now being reused for the Covid situation. While knowledge of Ebola existed in Nigeria, it was highly insufficient to manage the spread of Covid, because of the very nature of the infection. The NCDC was quite quick to come out with protocols and guidance for containing the spread of Covid.

More broadly, from Mercy Corps' experience of responding to Ebola and tuberculosis, and four decades of providing life-saving aid in some of the world's most challenging environments, we have learned a few key lessons on how to mitigate the health crisis. We have to closely monitor perceptions of Government, misinformation, hate speech and other narratives that can incite violence during the pandemic; invest in conflict-sensitive Covid-19 responses; promote access to timely, reliable and trusted sources of information and actively combat disinformation; and connect community leaders with their Governments to build public trust and address grievances.

Community engagement must be a central cross-cutting element of the Covid-19 response. We know that we must partner with the communities we live in for these measures to be successful. There was also an issue around trust. That has come up in the context of social cohesion. When you think of a social cohesion issue in Nigeria, a couple of questions come to mind. You ask how the pandemic is affecting relationships between communities, how the policies the Government put in place are threatening social cohesion and what the post-Covid situation will be like, with the loss of jobs and the increase in crime, as well as the influence of extremist groups.

When it comes to the issue of trust, for instance, the Government are easing restrictions and enforcing the use of masks and social distancing in the community. Again, there still exists a trust deficit, because many of the basic services are not being met. Security is one example. This has led to most communities ignoring the Government's directives on social distancing, and it has affected social cohesion, too. These are some of the issues that threaten trust in Government.

Q74 Navendu Mishra: With regard to the contribution you have made, do you think you were prepared, or could you have been better prepared for the coronavirus crisis?

Ndubisi Anyanwu: That is a very good question. In our opinion, like many countries, Nigeria was not ready for Covid. Many actions in the early days were taken with the view that the infection would not affect Nigeria, or that Nigeria would just manage it in the same way it did Ebola. With the first index case in February and now 11,000 cases, once testing becomes more fully available, the number of positive cases is likely to increase. That will also reveal the level of preparation. Even now, our capacity to respond effectively is being reduced due to limited funding opportunities for the Covid-19 response. As I mentioned, the Government of Nigeria are heavily reliant on aid. There is also the issue of Nigeria's lack of health infrastructure. It was definitely not ready. A



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lesson learned is that the global response must strengthen resilience and leave communities better prepared to tackle the next inevitable shock, including strengthening health infrastructure. We need to be better prepared.

Q75 Navendu Mishra: You made a point about Nigeria being quite dependent on aid. Just building on that, do you think there is anything specific to be said, positive or negative, about the UK's response and also the international community's response?

Ndubisi Anyanwu: That is a very good question. For Mercy Corps, the UK, through DFID, has shown flexibility right from the outset in terms of the spread in Nigeria. When it happened, the mission head of DFID reached out to all the partners to make necessary adjustments to the existing programmes, for which we were very grateful. DFID's rapid response fund allocated about £18 million across 15 countries to NGOs, of which approximately £1 million was allocated to Nigeria. This is inadequate. There is already a huge gap in overall humanitarian funding in the north-east part of Nigeria, in particular. With the repurposing of existing grants to Covid, we anticipate a massive gap in overall humanitarian funding.

For good reason, much of the assistance from donors has been channelled through pooled funding mechanisms and multilateral organisations. However, frontline organisations, including international and local NGOs, urgently need more direct, flexible and longer-term support from donors to fight this pandemic and its effects on hunger, poverty and conflict. Let us keep in mind that the UK has huge investments in Nigeria and now is definitely not the time to take the foot off the pedal in terms of funding. Rather, it is time to increase it so that all the progress and the resilience that has been built is not lost and so that the economic gains are sustained.

As I mentioned earlier, there are pre-existing challenges like the humanitarian crisis, disease, conflict and violence. These are all still ongoing, and they are worsening because of the pandemic. We think that aid should not only be prioritised for the Covid-19 response but should be sequenced so that it also addresses the pre-existing issues. Health and the economy have received relatively more attention in the Covid-19 response to date, while small conflicts in the middle belt of Nigeria and in the north-east have been largely ignored. It is imperative that the UK continues to increase its attention and its investment in conflict-mitigation, peace-building and conflict prevention.

Q76 Navendu Mishra: You said that about £1 million was made available to Nigeria, and you said there was a big shortfall. How big a shortfall are we talking about roughly?

Ndubisi Anyanwu: The funding that is usually given for the Nigerian humanitarian response plan is, I think, £860 million, and we probably get only 60% of that. There has been an increase to £1.1 billion but, still,



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that humanitarian response plan does not necessarily increase. That is where we have the divide.

Q77 Chris Law: I want to ask a straightforward question. Does the Department for International Development now have both the incentive and the imperative to develop a global health strategy? Do you see that being a combination of bilateral and multilateral, or should it be one or the other when it comes to how it is delivered?

Ndubisi Anyanwu: That is a very good question. Given the Covid experience and other similar viral infections, including SARS, MERS and future incidents, it is imperative that the global donor community think through a consistent health policy, and DFID, being a significant donor, has a very important role to play in this further area of intervention once the dust of Covid has settled down.

Mercy Corps is not necessarily a health actor, so it is possibly not best placed to answer, but we have seen catastrophic impacts of Covid-19 on countries such as Nigeria, as well as Ebola in the DRC, with limited health infrastructure. The response must strengthen resilience and leave communities better prepared for the next inevitable shock.

Q78 Theo Clarke: I just want to pick up on Chris's question about DFID's role. Today in London we have been hosting a major Global Vaccine Summit. If you were going to talk to the British Government, what would be at the top of your policy wish-list that you wish the British Government to be focusing on?

Ndubisi Anyanwu: Thank you for your question, and thank you for sticking around—I know you have other meetings. It is all around, like I mentioned, the pre-existing risks and the vulnerabilities in terms of the post-Covid situation.

In terms of my wish-list for the British Government, I would wish for new and additional funding for the Covid response, with a view to long-term recovery efforts for businesses and community cases with primary and secondary-level Covid impacts. We would wish for DFID to invest more in the primary healthcare system, coupled with national-level policy reform in Nigeria.

Last but not least, I want to remind the Committee of the pre-existing humanitarian crisis in the north-east and the fact that there are 1.8 million displaced persons and over 7 million people in need of urgent life-saving assistance. There is therefore a need for programme funding not only for the Covid situation but also for the existing humanitarian challenge in Nigeria.

Chair: Thank you very much, Ndubisi. That has been so informative. I cannot think of a more dramatic start to employment than your starting as lockdown started. We are very grateful that you are where you are, and we wish you luck. All power to you.

Examination of witness

Witness: Ghassan Abou Chaar.

Q79 **Chair:** Thank you very much for joining us, Ghassan Abou Chaar from Médecins Sans Frontières. You are the former head of mission in Yemen. Could you tell us a little about the work you do out there and the situation in Yemen at the moment?

Ghassan Abou Chaar: Thank you for your time. I will speak briefly about the situation that we have been seeing in Yemen over the past month. We have been surprised in our projects in different parts of the country by the surge in the number of deaths and infections, especially in our hospitals in the midst of our staff. The cases started to appear in Aden in the south of Yemen. We heard about cases in the community through rumours, from neighbours and from the people who work with us. There was nothing official at that moment, especially since the testing capacity in the country was very low and still is. Then we started hearing of an increase in deaths and an increase in activity in the different cemeteries in Aden. We have switched some of our staff who worked in a trauma centre in the city, and we activated another structure that was designed to be a cancer centre but is still not operational and installed some beds. We started working on putting in capacity to treat patients with severe respiratory symptoms.

Directly afterwards, we received a big number of cases in which people were basically arriving already suffocating. In the first week, we received around 80 with a big mortality rate. At the same time we were shuffling to have enough specialised staff to be able to treat those patients and to have enough oxygen and other biomedical equipment needed to run an intensive care unit.

Almost a week after this period, we started to see the same in Sana'a, in the north. In the north, there were no cases officially declared. Testing was not possible, or the results of any tests were not shared with our teams, but we saw exactly the same picture, with cases arriving with very severe symptoms. We did not see many cases with light symptoms, so we only saw the tip of the iceberg, which is the worst cases of people seeking hospital care only when they are in a situation where they cannot get help at home from their friends or in a private health structure.

This was happening in a situation where there was still active fighting. At the same time, in Aden, we were receiving a mass casualty plan due to fighting 100km from the city, and there was still bombardment in the north of the country, especially in and around Sana'a.

We were able, two weeks after the beginning of activities, to bring some extra international staff into Aden. We brought some intensive care doctors, ICU specialists and nurses. In the north we were not able to bring in this extra help, so we were running on what we had in terms of



international staff already in the country. Most of the time, those who we could employ as new staff did not have the technical capacity for the job.

In Sana'a, as of the end of last month, we have received 211 severe cases, and in Aden we have received, as of last week, 279 severe cases, those being cases that require around a week in hospital. Half of those cases in Sana'a required ICU and mechanical ventilation. As we saw in Europe, most of the cases that required mechanical ventilation did not survive the hospital.

Q80 Chair: I think Médecins Sans Frontières has 12 hospitals across Yemen. Are you seeing Covid cases in all of those hospitals, or is it in particular regions?

Ghassan Abou Chaar: The biggest number of cases are in the two big cities. In the rest of the cities, like Al Hudaydah, Sa'dah, 'Amran and Taiz, we saw some cases but we did not have a big number. However, we are still not understanding the situation very well, because the number of cases since a week ago has been decreasing a lot in the two hospitals that we have. We are now building another two hospitals to support those because they were full at one point. However, what we hear from all over Yemen is that most of the severe patients are not willing to go to hospital due to fear of the capacity of the health system to take care of them. We see, for example, that today there are no more personal oxygen concentrators that we can buy from pharmacies. They are not present anymore. Everything has been bought. The prices of all the drugs have increased a lot because people have reacted, as a coping mechanism, by getting treatment at home.

At the same time, private structures in Aden and Sana'a that would usually take care of a lot of the severe patients in those two cities closed at the beginning for a month. They opened again a week ago, but during this closure is when we saw the peak in our hospital as well. This closure was due to the lack of protective equipment for the staff of the private hospital, but it was also due to fear of most of the medical staff in the country to treat or to be in contact with Covid patients.

Q81 Mr Sharma: You have touched on this, but there is an opportunity to expand on your answers. What has the threat perception of risk and the actual incidence of Covid-19 done to your humanitarian relief work, and what have you found to be the main challenges in your work?

Ghassan Abou Chaar: It depends on the period. At the beginning of the pandemic, especially when the pandemic started in Europe, our first problem in Yemen, as well as in other countries, was the ability to buy PPE and to supply the rest of our missions. In Yemen, we focused in the first two weeks, for example, on protecting the staff of the 12 hospitals that we already had in the country. Today, this problem has been solved somewhat.



However, as of today, we are still not able to move medical staff easily into Yemen and out of Yemen to keep the rotation of staff who are tired, who need a break or who need to go home, and to bring in new staff. This problem is still occurring, and it is due to the closure of the airspace in Yemen as well as in other countries around the world.

In the country, we had to decrease the number of beds in many of our hospitals due to, at one point, PPE rupture but then due to many of our staff being sick with Covid-like symptoms.

- Q82 **Mrs Latham:** We know this is a terrible situation with Covid-19 throughout the world, and we have also seen that there has been much more domestic violence in all communities, including in the UK. Is this a case where women and girls are disadvantaged more than they normally would be in Yemen at the moment because of lockdown and because of people being more isolated than normal? How is it really affecting the women and girls in the country?

Ghassan Abou Chaar: The Yemen situation is a bit different because there was no lockdown announced in any part of the country by any of the local Governments. The situation up to today is still business-as-usual. However, the country is under lockdown and what happens in many of the villages, especially remote villages, is unknown.

In our hospitals, we see that access to healthcare for women, including pregnant women, and for children is very difficult, and this is due to the health system being completely unable to work or being destroyed because of the war. In terms of our trauma projects where we might receive cases of violence, most of the cases that we still receive are related to war, so trauma due to war. Due to cultural barriers in the country, women, even after being in violent situations, have difficulty accessing healthcare or protection a lot of the time.

- Q83 **Mrs Latham:** Do these women and girls have anywhere to go to report any of this? Is there any access to support from NGOs, or is there anywhere in the country they can go to report abuse, sexual violence or whatever?

Ghassan Abou Chaar: There are NGOs providing this service and trying to provide protection afterwards. In our hospitals, we provide the medical side of the service for women and girls. However, the tribal system is still one of the main issues.

- Q84 **Kate Osamor:** Hello, Ghassan. I wanted to ask you a question about the healthcare system that was in place before Covid-19. Would you say that access to it was harder and more complex, or would you say it is the tribal system that is having an issue with access, or would you say it is the same? I hope that is not too muddled, but I am getting the impression that a lot of the barriers are more about miscommunication as opposed to getting access to the hospital and getting the help that they need when they get there.



Ghassan Abou Chaar: In the last five years, since this war started in 2015, around 45% of the health centres have been destroyed by aerial bombardments. Some of the health centres of Médecins Sans Frontières have been bombarded as well. The rest of the health centres, especially those in rural areas where health-seeking behaviour starts, are not completely functional. Since 2017, health workers have not been paid salaries, and the health workers are dependent on incentives paid by NGOs or by the WHO in some instances, but this is completely insufficient.

The health-seeking behaviour is not the problem; the problem is that there is no health system to go to when there is a need. People have developed different coping mechanisms; those who can pay go to private doctors and those who cannot pay stay home most of the time. In our programmes, especially for rural areas, we provide not only healthcare but also transport for the families to come, because they cannot even afford the taxi to go for two or three hours.

We saw a decrease in the number of people going for diseases or problems not related to Covid. This is due to fear—fear of the virus itself and of the pandemic itself, but also fear of how the healthcare system is dealing with it.

Q85 **Brendan Clarke-Smith:** Have lessons been learned or applied from previous experiences with infectious diseases? In particular, I am thinking about trust and social cohesion.

Ghassan Abou Chaar: It is a very tricky question because every society responds to an epidemic in a different way. In Yemen, infectious diseases and epidemics, such as cholera, diphtheria two years ago and now this, are new to the population. In Yemen, people usually access healthcare and they believe in healthcare when they have a problem. This is changing due to the system, but the people do believe in it.

What we have learned at MSF with previous diseases, especially with diseases that have a lot of rumours around them, such as Ebola and now Covid, is that community activities and good communication with the community is very important in order to detect patients from the beginning. What we are seeing today in Yemen, with people arriving when they are at the end or when they are in such a severe state that it is very difficult to save them, reflects that. It is important that the patient comes when they are at the beginning of the symptoms so that the situation does not get to such a bad state. However, putting that in place in societies and cities as big as Aden or Sana'a is very challenging and is bigger than the NGO scale, although we try to do it in different neighbourhoods and to focus on where we think the biggest vulnerabilities are.

Q86 **Brendan Clarke-Smith:** Can I follow up on that, particularly with regard to narratives and fake news being spread about pandemics? Have you found any issues with that at all?



Ghassan Abou Chaar: Yes, we see it with people rejecting that the virus is real, that this is a conspiracy and that this is a rich man's virus or disease. We try to work on it by direct communication with the people but also by always communicating on what is happening inside the hospitals. For example, one of the designs that we are working on for the Covid centre we are setting up in Herat in Afghanistan provides the possibility for people to visit the patients so that there is not such an unknown in terms of what is happening in those hospitals. This is what we learned from Ebola, where people thought that they were sending their people to die in those centres. We are trying to have a set-up where people can visit safely, for example. The idea is to break the unknown barrier and to show people that this is a disease just like any other.

Chair: That is very interesting.

Q87 Chris Law: Given all you have said about the difficulties on the ground and how people understand new diseases, is now the right time for the Department for International Development to take up a global health strategy and to lead on it in the way it has done with its global strategy on education? If that is the case, should it be country to country in a bilateral way, or should it be much more multilateral?

Ghassan Abou Chaar: That is a very wide question, and it is very difficult for me to answer. First, if we take the Yemen example, we are talking about two different Governments. In the north and the south there are two different Governments that sometimes deal differently with education and with what information can be passed to citizens on epidemics, and there is usually a big limitation in Government on what is being said about diseases.

I believe that, in this pandemic, the approach should be one for all the countries because everyone is surviving the same thing and the same problems, and we are seeing it now starting in different countries. What we did not see two months ago in many countries on the African continent we are starting to see today. Today, the number of severe cases is starting to increase. It is maybe taking much more time but it is starting, so to have one approach for European, Middle Eastern and African countries is the right way forward as the same problem is reaching everyone. It is exactly the same.

Q88 Chris Law: In the last eight weeks, we have heard quite a lot of different things from the UN. One has been that no-one will be safe until everyone is safe and, in addition, that the mutation of this current virus is most likely to come from a conflict zone, and it has asked for a global ceasefire. Yemen, obviously, is at the heart of that. With regards to that, what would you wish for, in terms of either policy or operation? What would be the top thing for you if it was developed? Would it be a treatment, a test or, indeed, a vaccine?

A lot of the money that the UK Government are investing in vaccines is coming from official development assistance money. Should that vaccine



be freely available to all countries around the world, including those who can least afford it?

Ghassan Abou Chaar: Surely, at Médecins Sans Frontières, our position is that vaccines, as soon as they are available, should be distributed to all countries according to vulnerabilities, not according to who can pay more. Today, developing a vaccine is one of the main priorities, but each country can develop different strategies on where to put the priority in terms of testing, treatment or vaccination. However, we do believe, like we have seen in many previous epidemics, that a vaccine is the best way to control it so that we do not get this big number of patients at the end. Our worry is how a vaccine might be developed, used and distributed.

In Yemen, there are problems beyond that. We are surprised at how the epidemic started in this country. The country is already landlocked. There are five international flights a week coming in and out of the whole country, so it is already confined. This is one of the biggest problems of the country, in terms of why the people are not able to have enough to survive and to do business, and for humanitarian aid to be deployed inside the country easily. At Doctors Without Borders, it costs us a lot of money to send medical workers into the country because airports are forcibly closed. We have to deconflict all movements. We cannot move freely. This is having a very big combined effect on what could happen.

Q89 **Navendu Mishra:** Building on Chris's question about the ceasefire, is MSF concerned that the UK military continues to service and resupply the Saudi air force during the Covid-19 crisis, despite calls from the UK Government to engage in a ceasefire?

Ghassan Abou Chaar: We do not have any comment on the UK Government's military actions. The ceasefire did not last in Yemen. The fighting is ongoing today in many parts of the country in the south and the north. Aerial bombardments are still ongoing. Although there has been a decrease in the bombardment over the past couple of months, the war is still ongoing. The blockade is still there.

Q90 **Navendu Mishra:** It was not particularly about the UK Government and the UK military but more about the Saudi-led aerial bombardment. I will not build on that, but I will just highlight that you talked about health centres and aerial bombardment. There were reports on 2 May that there was a bombing of a food convoy in Al-Maljim, so I thought it might be important to ask this but thank you for your contribution.

Do you think Yemen could have been better prepared for the coronavirus crisis? Most of us know the answer, but it would be good to hear from you.

Ghassan Abou Chaar: I want to come back to an example of the Covid pandemic today and what happened in Yemen during the last big epidemic, which was the cholera epidemic of 2018. At that time, the whole focus of international aid went on to the cholera response. However, we saw that the problem was not the cholera epidemic but the



health system as a whole. Providing aid on only one specific disease or issue might take off what is important for the rest of the diseases; this is what happened with cholera and this is what we do not want to happen with Covid. Today, Covid patients can be treated in any hospital with the normal equipment that exists in hospitals. Aid to the country should be on the health system as a whole. It should not only be for Covid patients but for the rest of the patients as well.

Q91 **Navendu Mishra:** Is there anything specific to be said, positive or negative, about the UK's international response or bilateral response?

Ghassan Abou Chaar: No, I do not have input on that.

Q92 **Mr Sharma:** Have you seen, or do you expect to see, negative national or local behaviours coming from a fear of cross-border infection?

Ghassan Abou Chaar: The epidemic is still starting, so at the moment we do not see cases entering from other countries as being a problem, because there is already a large number of active cases and active transmission inside the country. However, the number of Yemenis who are able to cross outside of Yemen and inside of Yemen is very small, due to the blockade and the travel restrictions on the country. I would not say this is a worry for Yemen.

Chair: We still have our witnesses with us. Thank you all very much for investing so much time. Do the Committee members have additional questions that they would like to ask?

Kate Osamor: No, just stay safe and keep up the good work. Thank you.

Chair: I definitely second that.

Navendu Mishra: It has been a privilege to listen to the three witnesses. It has been very helpful and useful.

Q93 **Chair:** I am afraid I do have just a couple of additional questions. The UK Government, through DFID, have put a lot of money in specifically to tackle Covid-19 through the multilateral organisations you work with. Have you seen an increase in funding or resources on the ground?

Farah Kabir: From the updates we get from the UN agencies and so on, resources have definitely scaled up. In Cox's Bazar, I mentioned that they are trying to put together a 50-bed hospital for aid workers, and then in the camp itself they are supporting the production of masks, which is the UN Women and UNFPA; they are providing the oxygen cylinders. They are also negotiating with the Government to make global supply much easier. That is at the camp level but it is also nationwide. There is always the challenge of adequacy and providing for everyone. Just thinking about the masks, we have to produce 800,000 masks just for the camp.

Chair: Thank you. It is very reassuring that it is reaching you.



Ndubisi Anyanwu: For good reason, much assistance reaches the ground through funding mechanisms and through the multilateral organisations. However, in those responding, including the international and local NGOs, there should be more direct funding, more flexible funding and longer-term support to fight the epidemic.

Ghassan Abou Chaar: For around two or three weeks, we have seen an increase in the number of actors pitching in to work on the Covid response, supporting us in the hospitals that we are working in as well as in other activities, especially in terms of giving incentives to healthcare workers and other related activity. There is an increase, finally, in that number.

Q94 **Chair:** Thank you. That is very reassuring. We are also hearing that we expect the peak of the pandemic in the global south to be around July. Is that your experience on the ground?

Ghassan Abou Chaar: We are learning not to trust what we think could happen with epidemics, and especially with a new virus like this one. We cannot say. We are preparing for the worst, for having to live with the virus for a long period. We cannot say for the moment, and each country is starting at a different time.

Ndubisi Anyanwu: I toe the same line. I do not think we can really predict the future. The epidemic and the Covid situation is developing.

Q95 **Chair:** Farah, we know that in Bangladesh the number of cases you are getting is going up dramatically. Is it your belief that that will happen quite quickly within the camps, or do you think in some way that they are protected from that?

Farah Kabir: It is very difficult to say but, with the increase in testing, it is very likely to go up. We are on the incline here and it really depends on the test results.

Chair: Can I echo the thanks from my fellow Committee members? We are so grateful for the work you are doing on the ground. As my colleague, Kate Osamor, said, please keep safe and keep doing what you are doing. It has been an incredibly interesting session to hear your testimonies on the ground in Bangladesh, Nigeria and Yemen.

It is very difficult for us to get that first-hand information, but it seems there are a lot of similar themes that you have raised. One is to remember the underlying weaknesses in the countries rather than just focusing on Covid-19, which of course is exacerbating those. There seems to be a clear need for a global health strategy, and I would that is something DFID would be leading on. You have all mentioned the disadvantages faced by women and girls, which again are being exacerbated by Covid-19, so any strategy needs to be gendered both in terms of the impact but also on the response that we are giving. An interesting point that you all raised, which I had not considered, is around the false information that is out there and how important it is for us to



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get the proper public health advice out so that people are engaging. Of course, you all raised the difficulty of knowing the number of cases because of the lack of testing.

This has been incredibly helpful to enable us to inform and direct our inquiry, which is at the early stages. We hope to be able to amplify all of the points you have made. Thank you so much for the time and the clarity of information that you have all given to us.