

International Development Committee

Oral evidence: Ebola in the Democratic Republic of Congo, HC 2214

Tuesday 21 May 2019

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Members present: Stephen Twigg (Chair); Richard Burden; Mr Nigel Evans; Mr Ivan Lewis; Mark Menzies; Lloyd Russell-Moyle; Paul Scully; Mr Virendra Sharma.

Questions 1 - 48

Witnesses

I: Dr Josie Golding, Epidemic Preparedness and Response Lead, Wellcome Trust; Johan Eldebo, Regional Security Director, World Vision.

II: Harriett Baldwin MP, Minister of State for Africa at the Foreign and Commonwealth Office and Minister of State for International Development; Yolande Wright, Senior Ebola Virus Disease Lead; Charlotte Watts, Chief Scientific Adviser, Department for International Development.

Examination of Witnesses

Witnesses: Dr Josie Golding and Johan Eldebo.

Q1 **Chair:** Good afternoon and welcome. This is a one-off evidence session on Ebola in the Democratic Republic of Congo. We have two panels of witnesses. I am very pleased to welcome our first two panellists. Thank you both for your assistance in coming before us today at very short notice and in our preparation for today's session. We have a number of questions that we are going to put to each of you over the next 45 minutes. Perhaps I could first ask each of you to introduce yourselves.

Dr Golding: I am Dr Josie Golding. I work at the Wellcome Trust where I lead on epidemics across the Wellcome. We focus on basic research, product development, policy, public engagement and other areas.

Johan Eldebo: My name is Johan Eldebo. I am the regional security director for World Vision, focusing on the region of southern Africa, which effectively, for us, is Congo and downwards. I oversee security management and training for World Vision there.

Q2 **Chair:** Thank you both very much indeed. Can I invite you with a pretty open first question to start with your respective perspectives on the key challenges posed by the current Ebola outbreak? In particular, can you draw attention to any elements of this that are different to the west African outbreak in 2014? When we have done this, I will move to my colleagues who will go into some of the points of detail.

Dr Golding: It is clear to say that this particular outbreak is very concerning. This has been going on now for over 10 months, and that is the longest after the west Africa Ebola outbreak. It is very concerning. The key challenges partly relate to this being in a region of the Congo where we have not seen Ebola before, so we have communities that are not familiar in dealing with this, alongside the healthcare workers.

The real difference between this outbreak and the west Africa outbreak relates to the current security situation that stems from longstanding issues in that region as well as mistrust within the Government and the political system, so this is something that is very different.

On a positive note, one thing that is very different in this outbreak is that we do have tools that we did not have before. This includes the use of a vaccine that we did not previously have, which was assessed in the west Africa Ebola outbreak but was probably developed too late to be really effective. We also have potential treatment options that are being assessed. Although not proven yet, they are being assessed. We have a lot of positives that we bring to this but in this particular situation, within the communities in that region, there are a lot of challenges.

Chair: Thank you very much indeed. You have briefly covered each of the areas that we are going to go into in more detail so that is very helpful. Thank you.



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Johan Eldebo: Building on that excellent start, in eastern Congo we are now seeing three different crises directly interfacing with each other. One of the big ones is chronic poverty, which has been there for a very long time. World Vision has been operating in this area for more than 15 years now, which is indicative of the need that was already there before this happened, and the weak infrastructure and the needs of the general population that have existed there for a long time.

The second crisis that exists is that of conflict and instability. Like I said before, we have an environment that is not safe, not just for people responding to the Ebola outbreak but for the general population, which has increased the lack of education and infrastructure. They have a weak economy. All of that is effectively working together to make the response more difficult, and is enhancing the problems we see with access and trust in the authorities and the organisations trying to stem the third crisis, which is the Ebola outbreak now.

We have these three crises happening at the same time. We are finding that addressing one of them without addressing the other two is quite difficult. That is why we have a complex situation that requires quite a complex and advanced response. I was also involved with the crisis in Sierra Leone, back at that time, and poverty was present there as well but we did not have conflict in the same way, which made access easier. We have more medical knowledge now than we had back then but we also have the problem of trust and access.

In my role in security management, I am seeing quite a lot of security challenges, almost on a daily basis sometimes. One day it might be perfectly safe to go to one part of an area or one village, and the next day it is not, which means we have to reassess those types of planning and security aspects, both for us and for the general communities, almost on a daily basis. That is making this outbreak a lot more difficult to manage. It means we have to draw on areas of our organisation and partners that can address the poverty, the conflict and the Ebola outbreak at the same time.

Chair: Thank you very much indeed. We are now going to seek a bit more detail from you on the challenges that each of you has set out, looking at some of the challenges of the outbreak itself and the health aspects, then engagement and trust with the local communities, and some of the issues around security and safeguarding.

Q3 **Paul Scully:** Josie, I wonder if I can come to you. Following the west Africa epidemic, your organisation developed a vaccine and I know you had DfID funding for that. It has been used in the North Kivu province. How effectively is the vaccine itself working?

Dr Golding: Yes, you are right. Wellcome, along with DfID and other funders, supported the development of that Merck vaccine back in the west Africa Ebola outbreak. This was used in both the outbreak that



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happened in May in the Congo and then the new outbreak that started from last August.

The WHO has a strategic advisory committee that reviewed the data from all the different Ebola vaccines that were being assessed during that time. They put forward this particular vaccine, the Merck one, as having the greatest success and the greatest efficacy data, so it was the most effective in protecting people from Ebola. That had already been recommended so the WHO and partners knew this would be put forward.

The WHO has released some interim analysis and that has been shown to be very effective. I think it was greater than 97% effective in those who had received it. They had cited that those who had not received the Ebola vaccine were 70 times more likely to fall ill with Ebola, so it has been very effective.

Q4 Paul Scully: You used the ring vaccination method. I wonder if you can tell us a little bit about that and whether you are using that in the DRC as well.

Dr Golding: Yes. From the trial that happened in west Africa back in 2015, they had suggested a ring vaccination. This means vaccinating the contacts of that infected person, and then going to the next ring and vaccinating the contacts of those contacts, so that you now have two rings around the original affected person. That has been used. It was used in May and was shown to be effective in dealing with that outbreak, and continues to be used. The advice was updated by the WHO strategic advisory group very recently, taking on board the recent security issues and the desire to engage more with the communities, to now have what they call a tertiary ring, so it covers even more people, who are at a relatively low risk of transmission, to show to the communities the willingness to vaccinate and to reduce that very low risk.

Q5 Paul Scully: Are these networks of people quite close? You are talking about security, trust and the difficulty, and why it is not working as effectively here because of the security and trust issues that you both raised. I wonder if you can tell us a little more about why you feel it is not working and how close that ring is.

Dr Golding: The evidence that has come out from the vaccinations with the WHO and the partners on the ground, together with the Congolese Government, is that over 90% of those who have been at risk from Ebola and then offered the vaccine have consented to the vaccine. Of those who have consented and taken the vaccine, around 90% have participated in the safety follow-up afterwards. It has proven to be very successful in that sense where the communities are engaging on the vaccination side.

You asked how big those rings are. That really is one of the challenges. They can be quite big. They are asking, "Who have you been in contact with?", et cetera, and they make those lists. That is probably one of the



barriers at the moment for this vaccine to be truly effective in combating the outbreak. We need to reach really high numbers and follow through on those contacts and, at the moment, the latest WHO figures for following up and closing those rings are from 56% to 84%. That is one of the issues at the moment.

Q6 Mr Evans: It is clearly a colossal and urgent task that you have there. In areas outside of conflict, do you have the capacity to provide as much vaccine as is necessary, and the wherewithal and the trained personnel to deliver the vaccines?

Dr Golding: That is a very good question. In areas that are deemed high risk, particularly neighbouring countries, those who are eligible for and have received the Merck vaccine are very much the healthcare workers. In Uganda, over 5,000 healthcare workers have received it. That is preparing for the event if it were to spread further.

Outside of the area of North Kivu and further away from where the outbreaks are, up until now there has been concern over the limited vaccine stockpile. The new recommendations should address that. There has been a change in dosing—dose-sparing—and the vaccine should go further while still giving the same robust immune response. That should mean that more people are being vaccinated but that is more in the area of the outbreak.

Another recommendation from the WHO strategic advisory committee was to investigate the use of a second vaccine that works in a different way. It requires two doses so it needs more time to generate a good immune response. That is currently being considered. The WHO is informing them, but it is also being organised through the Coalition for Epidemic Preparedness Innovations, which is moving vaccines forward through the product pipeline, as well as the London School of Hygiene and Tropical Medicine and various other partners. That vaccine, if it were to go forward, would be vaccinating people who are at very low risk of contracting Ebola and are outside of the outbreak zone.

Q7 Chair: Can you develop that a little further? Ultimately, is there an aim with that two-dose vaccine for universal coverage?

Dr Golding: Ultimately, for any type of outbreak disease, you need more than just one tool—more than one vaccine. That is absolutely essential for protecting populations. The Merck vaccine is very successful at producing a very quick immune response, while the Johnson & Johnson vaccine takes more time. These are just two different ways of using a vaccine: to be reactive or to be preventive. I could not say how this vaccine could be used beyond the Ebola outbreak or whether it would be targeted more at preventive measures for healthcare workers in high-risk countries. This is something that will be discussed at a later point.

Chair: Johan, do you want to add anything on this particular aspect?



Johan Eldebo: I would add the importance of preparing as well as reacting to the current outbreak. We are seeing the majority of efforts going into areas that are currently affected by this, but we have learned from many other types of humanitarian crisis that preparedness is much better, more effective and cheaper than reacting to it. That is why we are looking at those areas around the cities and towns that are most affected and seeing if we can, at the basic level, create trust with the authorities, by which I mean both public authorities, and humanitarian organisations and responding agencies, so that, when the time comes for the need to teach people why vaccines work, why they should be used and why they are so important, the step to do that at that point is smaller than it is at the moment. At the moment we are playing catch-up, in some ways.

We should have learned, and in some ways we have learned, from the previous crisis that we do not have to do that if we have put steps and measures in place in advance of that actually happening. As Josie said, we have the tools to do that but we just need to prioritise those correctly now and deploy them where they are the most strategically useful at this point.

Q8 **Mr Lewis:** It is clear that the multinational medical mission is not trusted by the local population. Many people are reluctant to seek their help. There is even a view that the outbreak is fake news being spread by NGOs and the UN, et cetera. This is incredibly difficult, obviously. I just wondered what strategies you feel could be deployed to tackle that particular problem.

I also have a question linked to that, although not directly relevant. There has obviously been a change in regime in the DRC with an election and a new President. Has that changed any of the dynamics at all in terms of the system's capacity to respond, and the public confidence or lack of confidence, now that there is a new President, or has it really made little difference to this whatsoever?

Johan Eldebo: That is a very important question and there are a couple of different answers to it. One of the key methodologies that we as World Vision are deploying at this point is an approach we have developed, titled Channels of Hope. As a child-focused Christian organisation, we often work through faith leaders, which can be quite effective in this part of the world because they are trusted in the community, they live there and they do not come from somewhere else. They have been there for a long time and they have the trust of local communities. We work with faith leaders, teachers and local health workers, and we effectively teach them how to teach what this disease actually is, how it works, what can be done to prevent it and how to avoid getting it. We have seen quite good results in terms of how they can then share that message with their communities, their congregations and their school classes, and then spread that knowledge onwards from there.

At World Vision we have now reached more than 250,000 people that way, by training trainers who then train other people, and then building



on that model.

Q9 **Mr Lewis:** Is that on this particular issue of Ebola?

Johan Eldebo: Yes, on this particular issue. This is also an approach we used in Sierra Leone with the previous outbreak there. It worked quite effectively there. It works in multiple ways because it addresses the immediate topic and it sets up a platform that can work in a preventive way for future outbreaks as well. If another type of disease was to appear at some point, or if there was some other problem that required the same methodology, we would have those methods in place, they would have been tried and tested, they would work and they would be quite cheap to implement in a sense. That is our main approach at this point in this outbreak.

Dr Golding: Part of the change of WHO strategy is to be more engaged with the local actors in the community. In the regions of Katwa and Butembo, security incidents have been happening, so there has been more engagement with church leaders, religious leaders, youth groups and women's groups, trying to engage them in the response so that they have a role.

On the change of Government, there has been a presidential commission to show leadership in the Congo. Jean-Jacques Muyembe-Tamfum, who is the director of the national research institute, is leading on that, which shows that there has been a real commitment to respond better to this Ebola outbreak.

Q10 **Mr Lewis:** The only strategy at the moment, which is a good strategy, is through faith leaders. They are figures of trust in their communities. There is a recognition that the local population do not trust the global mission, so the single response to that is to try to use faith leaders as a counter to that.

Dr Golding: From my understanding—and I am not the best person to speak on that—that is one approach, but it is also about working with youth groups, local colleges and various groups within the communities.

Q11 **Mr Lewis:** Is there evidence that that is working? Are faith leaders signed up?

Johan Eldebo: Yes. It is not only faith leaders but that is one of the approaches. This is the same methodology of training trainers, where someone who is an expert on a topic comes in and trains a local leader who has some sort of standing in the community, has access to the population and has their trust. This can be a faith leader—that is how we developed our approach initially—but it has been expanded to teachers, community leaders and other places. It can be any person in a position of authority where they have access to people who need that type of information, and that turns out to be quite a lot of people. We use whatever is the best setup to make that happen. It can be local authorities as well.



- Q12 Lloyd Russell-Moyle:** Violence against health workers has been a particular problem and was mentioned in the statement yesterday as well. Can you tell us a bit about the severity of these attacks and the impact that they are having on the Ebola response?

Dr Golding: I can start on the health side and the impact it is having there. It is having a big impact on the vaccination strategy and access to these populations that are being affected and those at risk of Ebola. Because of the security incidents, vaccination teams cannot identify those who may be at risk and cannot vaccinate them.

On the treatment side, a randomised controlled trial was established back in November. It has been stop and start for this clinical trial, which has worked across different areas in the region of North Kivu, particularly because the Ebola treatment centres, and the cold chain and the ability to look after those drugs to give to those patients, have been destroyed. It is having an impact on treating people and preventing further spread of the disease.

Johan Eldebo: In my role as regional security director, one of my key responsibilities is to figure out how to support our staff in staying safe in these types of areas while enabling them to reach people in need of aid. That balancing act in this particular situation has been a challenging one and remains so.

- Q13 Lloyd Russell-Moyle:** What more could be done to provide that safety and security for people to be able to continue their necessary day-to-day work?

Johan Eldebo: We have quite a few measures on a short-term basis. From a long-term perspective, the main strategy for most humanitarian organisations in reaching communities is acceptance. We want to be seen as being welcome in an area and therefore have the security for our staff in that way. The way we create that type of safety in a situation like this is by making sure people know and understand why we are there, and see a benefit in our presence in those areas. For us, it is primarily a long-term strategy of having those connections in place. Not to repeat my previous statement but this is the Channels of Hope approach of engaging with local leaders who then explain to their communities why we are there in the first place. If someone who looks like me comes into a village, I will obviously look like an outsider and a foreigner. If I am invited by someone who is respected in that community who vouches for me and says, "This person should be here, he is trusted and he will help", that has a huge impact on how we can maintain our presence and our acceptance in those areas.

- Q14 Lloyd Russell-Moyle:** There is local community engagement that really needs to happen and be built up. Is there anything that the UK in particular should be doing, either in the short term or the longer term, to aid that process or the wider security processes for health workers?



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Johan Eldebo: There is a similar issue across many crises that we have, which is that the building and maintaining of trust with people that I have just described takes time. We need to have programmes that have a long-term perspective to have those long-term relationships. If we come in for a few months and then leave, come back and leave, come back and leave, it creates problems, particularly in communities where things are generally, from a relationship angle, quite stable, where we have people from the outside coming in and going out.

Q15 Lloyd Russell-Moyle: Is that what has happened because of the way the UK funds these issues?

Johan Eldebo: Humanitarian crisis operations are often quite reactive and quite short term. Our model as World Vision is that we are both long term and short term in our operations. We have been in these areas for almost 20 years. Our Ebola response, because it is a new outbreak, is quite new. We have had access to provide normal education in these areas for many years and we are using the same areas, the same channels and the same staff in many cases to do Ebola education now. That means that, in some areas, we have the same trust that we have built up over 15 years by doing education and we are now reapplying that to teach local communities how Ebola works and why vaccines, for example, are important.

Q16 Lloyd Russell-Moyle: Where that trust has built up, have there been fewer attacks on health workers or have these attacks been arbitrary?

Johan Eldebo: There has been a combination. Some of the attacks have come from groups that are not stationary in the same way that our presence will be. When armed groups move back and forth, for example, or when you have political turmoil, people move around a lot. We might have been in an area for a long time but then people will show up in the same area. When that happens, it is unpredictable as to what happens. In areas where we have had acceptance, we have been able to maintain our presence.

Q17 Lloyd Russell-Moyle: In the areas where you have had acceptance, you have maintained it. Do other strategies need to be employed for more transitory populations? Have you managed to find methods that work to reduce attacks on health workers in those transitory populations?

Johan Eldebo: The most effective way for us to create trust and to create relationships with people is by doing what we are doing now, which is having conversations face-to-face in person. When that is not possible, we are also deploying strategies such as radio broadcasting, for example, which can share messages without necessarily putting individual people in harm's way. That can work as well. To do that, you have to set it up, of course. If you have a radio message one day but you cannot maintain it for a while, that is less effective.

All of this builds into the long-term presence but also builds into the sense that, when conflict increases or decreases, which happens regularly



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in areas like this, the intensity of how you approach the creating and maintaining of acceptance changes as well. In some places you might only need to talk to one person to maintain access in an area if that area trusts just one individual. In some of these areas, if you want to drive from one town to the next town, there may be several different checkpoints along the way, each of which listen to different people, which means you have to negotiate that access several times on the same road. When that happens, you have to have the time, the connections and the acceptance with each of those individuals to actually get from A to B, and that takes more time and more effort, and it costs more. It is the same strategy but with a different level of intensity in how we actually deploy it.

- Q18 **Lloyd Russell-Moyle:** Is it desirable—maybe you have considered this, or maybe it is not a good idea—to embed health workers in some of those militia people that you are saying are sweeping in and out? It is common practice when you are at war with states that you embed medical people in those teams and then that trust is built up. Is that a possibility here or am I just barking up the wrong tree?

Johan Eldebo: I am tempted to delegate that question.

Dr Golding: I do not think I can answer that sufficiently but I would just point out that there is a distinction here between criminal activity and the opportunity that Ebola is affording for those events to occur, given the militant aspect that has been ongoing for some time. That is something that we always need to be careful about.

To follow on from the previous question, Wellcome and our partner, DfID, are very interested in researching what actually works and what is effective in engaging with communities, and then feeding that back into the operational response. We have a lot of ideas of where this could be going. We funded these rapid briefs on these communities that are being affected, but it is also stretching to border communities with other countries. We are thinking about how we make that fit into the actual operational response and then assess the effectiveness. Unfortunately, it takes time to see the results of the effectiveness. That is where we are at the moment. There has been a change of strategy and approach, and we need to see whether that is all we can be doing and whether it is effective, and then do more of it.

- Q19 **Lloyd Russell-Moyle:** You said that DfID is funding that research.

Dr Golding: Yes, we co-fund with DfID.

- Q20 **Mark Menzies:** What precautions are being taken to ensure that Ebola does not find its way into UN camps, for example in Kenya, from the large numbers of refugees from the DRC? We visited one of those camps in Kenya last year. What is the filter to make sure it is not finding its way into the camps?



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Dr Golding: From my understanding with the WHO, one of the preparedness plans is identifying those communities across the borders of the countries. That has been going on now beyond this outbreak. It started in the May outbreak, working with the countries and those particular regions. There has been an identification of the particular towns and the particular at-risk areas like illicit trading. There has been vaccination of the healthcare workers. There has been work to help the communities understand Ebola in their educational campaign. Some work has been done and I am sure a lot more could be done.

Q21 **Mark Menzies:** This is a part of the world where people have other complex health issues such as tuberculosis, HIV and so on. If someone is suffering from HIV, for example, and they then contract Ebola, are vaccines at that point much less effective or does it not make any difference?

Dr Golding: It is a good point. The first thing to do, when someone presents with Ebola symptoms, is to check whether it is actually Ebola, or whether it is malaria or other diseases that could be co-existing in that area. Depending of course on the health of the person, it could impact on the treatment and how successful the treatment and vaccine would be.

Q22 **Chair:** Bringing together the last two sets of questions on trust and attacks on health workers, we have heard that, for understandable reasons in the security context, the Ebola response itself is increasingly using armed actors to provide protection. That is clearly understandable but is there a downside to that in terms of building trust with communities? On the assumption that there is, not least because you are nodding, what can be done about it?

Johan Eldebo: There is a difference between a doctor coming to your house by himself and a doctor coming to your house in an armoured vehicle with guns. In most parts of the world, that is not seen as a good thing. In this part of the world where there has been a distrust of people with weapons for a very long time, it creates huge challenges to creating that trust. You can see why an Ebola doctor would want to have protection in some of those parts of the world as well. We try to do it with trusted locals instead who do not need that level of protection. I cannot speak specifically for those people who do it from a medical angle, because we would be one step removed from that angle. From a trust in the community angle, most of these communities want to be healthy, want peace and want their children to be able to play safely. Adding weapons to that combination is usually, at least, difficult for them to handle and, most often, not desirable.

If the UN comes in with lots of weapons, there can be a good reason for it, but, when people see weapons coming at a distance, given their past experiences, their reaction to it is not always positive, even if it might actually have, at least temporarily, a positive impact for them or the people with those weapons do not have malign intent at that point. It is something that should not be taken lightly.



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Dr Golding: On the way that the WHO has changed the strategy around vaccination, I can only add that there is a lot of stigma attached to Ebola. One of the changes in the strategy is around using the local healthcare facilities to be able to vaccinate there. They refer to them as pop-up clinics so that people can go there instead of people going to their homes. There has been a change there.

Q23 **Richard Burden:** There have been some reports that at least some health workers have been demanding sexual favours in return for treatment. Has any instance of that sort come to your attention?

Johan Eldebo: To our knowledge, no, not for us.

Dr Golding: To our knowledge, no. When that report came out, we did our due diligence to check.

Q24 **Richard Burden:** It has also been suggested that some people have been offered jobs working in the Ebola response sector, again in return for sexual favours. Again, has that been checked out and what is the response on that?

Johan Eldebo: We have clear policies that state that we do not engage in that type of behaviour and we verify that that is not the case when we hire people. We have due diligence processes in place to prevent that type of behaviour.

Q25 **Richard Burden:** Did the reports come to either of your organisations directly or was it hearsay?

Dr Golding: No, but, because we took the responsibility that we fund the WHO, we of course followed through with that to ensure we had those conversations with the WHO. Our policies, our grant petitions and how our funding is being used were checked out with those partners.

Richard Burden: Is that the same for World Vision?

Dr Golding: Yes, that is the same for us.

Q26 **Chair:** You will understand that part of the reason we have asked about this is that we have picked it up as potentially something that has happened, but it is in the broader context of the much greater focus on these issues since the events of last year. You have both given very confident answers in terms of your own organisations. Is that something that would have been different if we were sitting here 18 months ago? Have you changed your systems so you are more robust about safeguarding than perhaps was the case previously?

Johan Eldebo: We have, at the request of DfID and as part of our due diligence, reviewed all our policies over the last year on that. We have revised and renewed our training. Every time we hire someone, there is due diligence in place as part of the hiring process. If someone gets hired, there is mandatory training on acceptable behaviour and what is not acceptable behaviour. In our operations, we have hotlines in place so



that our own staff can report any suspected misbehaviour. Perhaps more importantly, if someone in the local community in an area where we work feels that our organisation has done something we should not do, they have a way to report that as well. We have those procedures in place.

Dr Golding: Taking on board what has happened in the past, we have reviewed our grant conditions and how we award funding. We had produced an update to our bullying and harassment policy earlier than that to reflect on anti-bullying. Yes, we have. The answer is that, yes, things have changed from recent events.

Q27 **Chair:** Can I take you both back to an answer that Johan gave earlier about the importance of preparedness and the difference that that makes? It has been put to us in some of the preparation for today's session that one of the risks with the response is that we could see the creation of a parallel health system rather than something that serves to strengthen and reinforce existing health systems. Is that a risk and, if it is a risk, what can be done to try to prevent that from being an unintended consequence?

Johan Eldebo: That is a very important question. It is one that we face in many humanitarian operations around the world. At the risk of partially repeating my previous answers, capacity building of local health workers and local leaders, who will be there long after our responses end, is one of the most crucial things for us to do. That is why we have those long-term relationships in place and why the main aim for us is to strengthen their capacity to respond.

That is not always enough and this is one of those instances where, from our side, it seems that the local leaders and the local health clinics need external support and international support to handle this particular crisis. You will then have extra support that will at least appear as a parallel system for a while. One of the key elements for us when that happens, and one of the facets of such a response, is that it works together with the local response and that it builds their capacity at the same time. That way, once the big intense response scales down, that capacity can be transferred into the local structures and remain with that population so that, if something similar were to happen again later on, we do not start from zero because we have already built that capacity up. Then the early signs can be recognised and the response can be faster.

Chair: That is an encouraging response.

Dr Golding: I would echo that about long-term capacity building in these regions. For research, particularly with these types of diseases, it is absolutely essential to have a long-term view. You are not going to be able to have a successful demonstration of how effective a treatment or a vaccine could be, although that is not needed here, so you have to continuously invest in having those types of clinical trials and clinical research happening.



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The standard of care that someone receives when they enter an Ebola treatment centre will vary, of course, between treatment centres but, in general, you are receiving a good standard of care as much as possible in that context. The issue is to continue to make sure that those who do not reach those treatment centres also receive a good standard of care. This is probably an outstanding issue but it is a longstanding issue for all these types of diseases.

Q28 Chair: Our second panel in a moment is with the Minister for Africa and her officials from the Department for International Development. Could I invite each of you, in the remaining time that we have, to suggest anything that you think the British Government could be doing further to enhance efforts to tackle this outbreak?

Dr Golding: Wellcome works very closely with DfID, in particular on the research side. That is Wellcome's primary focus. These conversations are continuing and we have areas that we know we want to develop further, particularly related to the use of a second vaccine and, very importantly, related to community engagement and the social science needs. These conversations are already on track so we need to keep going with these conversations.

Johan Eldebo: From my side, I would come back to my first statement about this being three crises at the same time with poverty, conflict and instability, and Ebola all happening together. This would be my question: how can DfID best approach those three crises at the same time and make sure we make progress on all three of them? We will have a bigger likelihood of being successful if we have a response that takes those three challenges together and that sees how we can decrease poverty and prevent or mitigate the conflict that goes on at the same time as we address Ebola. Then we will leave a better, more long-term impact in that context.

Chair: That is how you started and is an excellent way to finish this first panel. I am very grateful to both of you for the evidence that you have provided to us today. There is a lot that we, as a Committee, will want to take from your evidence about in the immediate situation, but also some broader lessons about approaches to healthcare strengthening, not just in the DRC but in other countries. Thank you both very much indeed for being with us today. Feel free, if you can, to stay to listen to the second panel but, if you have to go, thank you very much indeed.

Examination of Witnesses

Witnesses: Harriett Baldwin MP, Yolande Wright and Professor Charlotte Watts.

Q29 Chair: Thank you very much for being here with us, as I said to the first panel, at short notice. We have a number of questions for you, following up the evidence we took from the first panel but also, of course, the



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Secretary of State's statement to the House yesterday. Let me really kick off, Minister, by giving you an opportunity to summarise how DfID is responding to this Ebola outbreak in the DRC and to tell us how much has been allocated to the UK's response.

Harriett Baldwin: Thank you very much, Chairman, and to the Committee for spending time and focusing on this, because it is very much a preoccupation, as demonstrated by the fact that we gave a statement yesterday to Parliament. Can I introduce Professor Charlotte Watts, who is our chief scientific officer, and Yolande Wright, who is the DfID lead on the Ebola crisis at the moment? I use the word "crisis" advisedly. The first key point that I would like to highlight in the introductory remarks is that we have chosen, as far as the DfID response is concerned, to respond really early. We wanted to get in there very early.

The second point I wanted to bring to the Committee's attention is this. Because, arguably, the amount of money that is now being spent in the international response is having a significant impact, fortunately on the response, but also on some of the actors who are intervening—and 119 health workers have been attacked during this response—the Government of the Democratic Republic of Congo have specifically requested that we not mention amounts of money to the Committee. I would like to find a way, if we can, to mention the amounts of money that DfID has given and to whom, but it would need to be in a way that was redacted and not made public.

We have been told by the Government of the Democratic Republic of Congo that, because this is a very poor area and a lot of money is flowing in through some of the actors in this response, they believe that mentioning amounts of money puts a target on the head of some of the responders. I would not want to disagree with them in their assessment. We have already had the very sad loss of Dr Mouzoko Kiboung and, as I say, 119 attacks altogether on health workers. I am sure the Committee would respect that request. What I can say to the Committee is that you will have seen, as a matter of public record, how much has been asked for in terms of the overall price of the response. You should be pleased that the UK has been one of the leading contributors to that response and, indeed, the top contributor in the regional response. That is the second point I would make.

The third point is that the reason the response is not working effectively—and I do not think anyone would deny there are real problems here—is not so much due to any lack of funding but is, to some extent, due to the fact that it is now quite hard to find health workers who want to be on the front line of this response. That is a fair assessment and my colleagues will want to elaborate on that. It is also because this is a very conflict-afflicted area in the first place, even before this outbreak.



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I am sure the Committee will have seen the study in the *Lancet* of almost 1,000 local people, one in four of whom believe Ebola is made up and half of whom believe that, although it is not made up, it is actually done by outside intervention to exacerbate the violence. Bear in mind the political context that there were elections in the DRC at the end of December, and that one of the reasons the elections could not take place in this region is that the central Government were unable to find volunteers to come up and man the polling stations, so they got postponed. It got tied up in all this political manipulation, which is why we have been encouraging opposition leaders to put out some strong messages, which they have done in the last few days, to emphasise to the local population the seriousness of this outbreak, and the need to respect what health workers have to do and the response by health actors.

Chair: Thank you, Minister. That is an excellent first answer that really anticipates the line of questioning through the session. There is a set of issues around attacks on health workers and security, the broader political context and the actual Ebola outbreak itself.

Q30 **Mr Lewis:** Good afternoon, Minister. We are wondering what work DfID has done to contribute to strengthening health systems in the DRC, particularly since 2014.

Harriett Baldwin: We have done a lot. When I last visited the DRC, I was able to visit a health centre in Katanga down in the south. We have had a programme running that has covered 52 different regions in the DRC. That is coming to an end; we are just going through the process of finalising what the new approach will be, informed by what has worked well and what has not worked well. Again, without mentioning amounts, we are a significant contributor to strengthening health systems in the DRC. I should let the committee know that I am planning to visit the eastern part of the country myself over the Whitsun recess. Yolande, do you want to add anything to the DfID health system reply?

Yolande Wright: I would emphasise that DfID is a major partner in health system strengthening in the DRC and we very much recognise that this is an endemic problem in the DRC. This probably will not be the only outbreak of Ebola that they face so the long-term capacity of the country to handle this sort of response is essential.

Professor Watts: What is coming out as part of the challenge of the response is that it is about not only the core health systems but the extent to which people go to informal health providers. In terms of strengthening the response, we need to pay attention to those very small little clinics that people go to when they feel sick.

Q31 **Mr Lewis:** Is there evidence that the health systems have improved at all in recent years?

Harriett Baldwin: The results of the programme that we have just come to the end of have been positive. We think that there are some things that work better in that than others. For the new programme that we are



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building up, we are going to put more money into the preparedness and response aspect of the health programming. We are also going to have more of a geographical focus on some of the more needy areas. That is the way in which things are likely to be shifting.

- Q32 **Mr Lewis:** In terms of the political changes we have seen, has the fact that the population was not able to participate in the elections and the subsequent election of a new President played out at all in the way the public feel about the country's response to Ebola and the Government's response to Ebola? Obviously they do not trust the international community, and there is a real trust problem, as we spoke about earlier, but have the political challenges had any impact?

Harriett Baldwin: Considering how well you know the country, you will appreciate—I do not want to make sweeping generalisations, but it is fair to say this—that the eastern part of the DRC has always suffered from a range of different armed groups and a range of different aspects of conflict. I do not want to put words in their mouth, but it is more of an opposition area than one where the Government in Kinshasa holds significant sway. There has been not only the distrust of international actors but there is, to some extent, a population that has suddenly found a very extensive health response in an area where they have felt underserved in terms of their health needs for a period of time, coming on top of what was already a difficult election for the whole of the DRC but particularly difficult because this region voted three months later than everybody else. That context and all the underlying drivers of the conflict that exist in this part of the DRC have not helped very much.

Yolande, you have just visited recently. Do you want to drill down into my sweeping generalisations?

- Q33 **Mr Lewis:** Before you respond, you rightly talked about the opposition but, of course, the person who has become President was symbolically associated with the opposition for a very long period of time, even though we know there are question marks about where his alliances are these days. I am just wondering whether that has changed. Does the local population have any more confidence in the national Government's determination and commitment to tackle these problems now that there is a change of President or has it made no difference whatsoever?

Harriett Baldwin: You were there when he visited. It was the week before I visited.

Yolande Wright: Yes. I had the fortune to meet the President during my visit and I would say that he is very apprised of the issue of the Ebola outbreak. He visited the week before. He is making it very clear that this is a priority for him. However, we are aware that there are some issues ongoing around his ability to nominate Ministers et cetera. It would be very difficult for us to speak with any evidence base about how the local population is feeling at this point in time. We can see the evidence of efforts being made to reach out to those populations, and efforts being



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made by both the opposition and the new Government to be really clear that Ebola is a problem that the community needs to face up to and that we need to have local people understanding what is going on and coming forward. A key lesson from west Africa is that the community has to come on board with this for it to really work.

- Q34 **Mr Lewis:** Are some of the local politicians reinforcing the notion that this is all fake news and that the international health mission is not to be trusted? Are local politicians whipping that up to some extent or is this genuinely an instinctive public feeling?

Harriett Baldwin: We have had public statements from Fayulu and Katumbi in the last week. Some of the local mayors are very helpful in getting the message across. The church actors have also been very helpful in getting the message across. However, clearly, if you take at face value that survey that was published in the *Lancet*, there is still a lot of work to do in terms of community trust for the response.

- Q35 **Richard Burden:** Staying on the issue of fake news and communities having very little confidence, Harriett, in your opening remarks you talked about the scale of the numbers of people who just do not believe that Ebola is anything other than made up. Could you say a bit more about what DfID is doing to build that confidence? You talked about the liaison with opposition politicians and something about engagement with local politicians, but could you say a bit more about what is being done and whether it is very much reactive or whether there is a plan behind it?

Harriett Baldwin: One of the major lessons from the west Africa outbreak was how important that community work was. Yolande, you saw at first hand how we are stepping up on that alongside the rest of the international community.

Yolande Wright: Shall I give you a few concrete examples of that? In general, at the very beginning of this response, there was literally a four-day gap between the outbreak ending in Équateur and the outbreak being declared in the east of the DRC. To some extent, the response team's approach was taken and put to work in a different part of the country. However, as we are going along, we are really learning about this challenging conflict environment and the response is adapting. The UK has been a real leader in pushing the international community to adapt. We have research that we have been funding through DfID on the social and anthropological lessons, how communities are feeling and what they are hearing, and then we are trying to push those lessons into the response: we are using local radio stations; a song has been produced by a local pop group about Ebola; and we are working with churches, as we mentioned. There is a real push now to try to build this community trust. We recognise that there is a very wide range of different ethnic groups in that area. Butembo has an ethnic Nande community with a particular grouping and a particular leadership, distinct from other towns in the area. The response has been learning that this is a really important aspect. It is a big challenge but we are pushing the responders and the



teams, such as UNICEF, that we are funding to strengthen that aspect of the response because it is so essential.

Professor Watts: What we have done well this time is to really commission and try to ensure we are getting the insights from social science on the ground about what is working and what is not working. That is work that we have supported along with the Wellcome Trust. The challenge we have had is how to then get that operationalised by the key actors. How do we step up and get stronger comms, get the right players to communicate what the response is really trying to do, and think operationally about how those insights are translated into action and different ways of working?

Q36 **Richard Burden:** Presumably the anthropological resource that you are talking about is the one developed in west Africa. Is it called SAGE?

Yolande Wright: Yes.

Q37 **Richard Burden:** You also developed an Ebola platform there. I suppose there is a bit of a dilemma here, is there not? On the one hand you have been trying to adopt a more systematic approach to building confidence and using tools like that to be able to build that. At the same time, what may work in west Africa might just not work in the DRC. Where is the balance between trying to adopt a consistent approach and ensure there is enough impetus coming from the centre, and empowering local decision-makers and local actors to make decisions and take risks to do what seems to be appropriate in the specific situation of the DRC?

Harriett Baldwin: In the case of community engagement, it really does have to be a locally informed response in different languages with different cultural practices. There are some similarities. There has been an adaptation in terms of the hazmat clothing and the wrapping of the bodies that are infected. Yolande, you can elaborate on that.

Yolande Wright: You are absolutely right that a balance has to be struck. This is what we are trying to do really carefully. One important thing, and why we are pushing the overall response co-ordination mechanisms, is to make sure we have adaptive management in the approaches that we are using and we are really listening to the different communities.

One positive example I can give is exactly about safe and dignified burials. The IFRC, which is one of the major implementers of those burial practices, has been really listening to local communities and adapting. For example, the burial bags that we used in west Africa were white and you could not see through them. In this outbreak, they have been adapted so that you can unzip the bag without exposing the body and see through a visible window that it is the loved one who has deceased and that there has been no harvesting of organs or damage done to the body, et cetera. We are also encouraging family members to learn about the process of the burial. We are mixing the chlorine solution in their



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households so that they can see it is not a mysterious chemical. We are also encouraging family members to dress in the protective equipment and participate in the burial ceremony. We are trying to build up trust in the process and understanding so that it is more accepted.

Professor Watts: If I think about what we have learned, there is the core epidemiology about how this disease spreads and what we do to control it. If we want to control this epidemic, we need to be able to identify people who are infected very quickly. We then need to isolate them. We need to find their contacts and vaccinate those. We also need to ensure that we have safe and dignified burials and to sustain infection control. Those things are transferrable in terms of what we basically need to do to curb the epidemic.

The difference here, particularly thinking about case detection, is that it is much harder for us to get into communities to identify those cases and to identify those contacts. That is why we really have to adapt the response to support communities, to encourage communities to own this response and to incentivise them to recognise the value of finding people who are sick and who might be infected, and encouraging them to come through for treatment, as well as supporting contact tracing. There are huge benefits. If you get vaccinated, that vaccine will really reduce your risk of catching Ebola. We also have evidence that the vaccine reduces the mortality rate if you are infected.

Getting those messages out and supporting community responses is what we are really trying to push for.

Q38 **Mark Menzies:** Has any work been done to try to forward project how the outbreak would develop if we were not able to land these messages about the need to get vaccinated or to come forward to be diagnosed and so on? What does that look like?

Harriett Baldwin: It is tricky because the science base is affected by the fact that this is the first time this experimental vaccine has been used in this widespread an outbreak. The evidence so far suggests that it seems to be reducing the impact by about 70% in terms of contagion. Lots of people are doing lots of work on this, Charlotte, in the scientific community.

Professor Watts: Yes. On the projection side, we have been liaising very closely with Imperial College and others who are producing the formal assessment for WHO. That modelling is very much using existing data and projecting forward in the short term, and they estimate that an infected person is infecting, on average, one and a half to two other people. That means the epidemic is growing. The challenge with any kind of projection is that we are in this environment where not all cases are getting reported. Our big risk is if Ebola goes to an urban area. What is fuelling the geographic spread is not necessarily everybody but the "sparks" as we call them: somebody who does not get vaccinated, who then moves to a neighbouring village and then might seed another new



set of infections. That is what we are trying to get on top of, and what we need to get on top of, in terms of the response.

Q39 Lloyd Russell-Moyle: Learning from previous outbreaks, what lessons have we learned in terms of the next steps, both going forward with this outbreak and looking forward to further outbreaks?

Harriett Baldwin: A big lesson was that we needed to invest in brilliant science and that the brilliant science has come up with not just one but several prototype vaccines. The current experimental vaccine that is being used is the Merck variant. Lessons have been learned in the Équateur outbreak about the fact that you have to establish a cold chain for the vaccine at minus 60 degrees because it has to be kept at very low temperatures. Charlotte, you probably want to add more on the brilliant science and the research that we are doing.

The other point is that you need to try to react as quickly as possible. There is the point around community messaging as well. Charlotte, what else would you want to add on the science?

Professor Watts: We continue to learn with every Ebola outbreak that we experience. Early on, following 2014 to 2016, one thing we invested in very strongly with the WHO is setting up something called the WHO blueprint, which is basically a mechanism to look forward and ask, "What are the lessons and the products that we might want to take forward and test when we get the next Ebola outbreak?" In 2014 to 2016, we evaluated whether the Merck vaccine worked. We showed that it worked. There were lessons about how you deploy it that we are using now in this outbreak. We are in the process of discussing with CEPI, Wellcome and others about testing another vaccine so that we are not just dependent on one but we have other options. We are quite likely to be moving forward with research linked to that, involved in testing improved therapeutics and improved treatments for people with Ebola, because we want to reduce the mortality rate as well.

One of those things is that we learn both on the new technologies but also on how we bring in the social science. What are the issues that you need to think about if you are trying to introduce a vaccine into a community who are frightened or worried about Ebola? We are getting those insights every time we have these outbreaks. One of the lessons we are trying to figure out is how you feed that effectively into the decision-making on the front line linked to the response.

Harriett Baldwin: There is also the clean water and sanitation point, which we may be coming to.

Q40 Lloyd Russell-Moyle: One of the things that the report talked about from the west Africa outbreak was a commending of the personnel, volunteers, international civil society and the people, in that case, of Sierra Leone in their collaboration and assistance working together in a co-ordinated sense. Is there evidence that we have managed to



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implement that level of co-ordination on the ground in this particular outbreak in the DRC?

Harriett Baldwin: As Charlotte said, the World Health Organisation did a lot of lessons learned and organisational change, but it is fair to say that we are also advocating for some change in terms of co-ordination and focus on the ground from the UN system, which has found itself very stretched. Yolande can give you the latest on that.

Yolande Wright: Thank you. You are absolutely right. Some of the key messages management-wise are that it is really important that there is clear leadership, empowered leadership and co-ordination of the many key actors, because there are obviously the very important key transmission chain-breaking activities, but then there are supplementary activities that help to build trust and community engagement.

There has been co-ordination but this is something that we are actively pushing on through the UN now. We know that OCHA is stepping up the number of its staff into this response to specifically build up better co-ordination capacity so that civil society, as we were just witnessing earlier, can better engage into the response and we can make sure that we also bring in other actors. The issue of security, for example, that was raised earlier is a really important one. That may not be a WHO strength; it is a strength, say, of OCHA and others in the UN to provide a security framework to enable the health responders to work. We are trying to strengthen that in this outbreak and it is a really important lesson from the west Africa outbreak that that should be strengthened.

Lloyd Russell-Moyle: It has not yet happened but we are working on it.

Yolande Wright: There have been some co-ordination efforts but the assessment of even the IOAC that just visited the DRC, as well as my own assessment from visiting and that of my team in the country, is that it definitely needs to be strengthened.

Q41 **Lloyd Russell-Moyle:** Aside from strong UN working and the collaboration there, the other thing that came out of that report was about deepening relationships across Whitehall. You touched on this earlier, Minister. Do you think that we have seen the fruits of that collaboration across Whitehall in this particular outbreak or is there still more to gain from cross-Whitehall collaboration on this issue?

Harriett Baldwin: The key area of collaboration for us is with the Department of Health, and that is where the team that goes in earliest to come up with a plan of action is located. The other point that is worth highlighting to the Committee is our role in peacekeeping in the Democratic Republic of Congo. MONUSCO is the single biggest UN peacekeeping deployment and much of it is in this part of the country. Of course, the UK there plays a crucial role, being one of the largest funders of peacekeeping in Africa. Rather than providing any of our own forces, we fund more local forces.



Q42 **Lloyd Russell-Moyle:** Correct me if I am wrong, but in the west Africa example we did mobilise some of the forces there and we did mobilise some of the Foreign Office work to try to co-ordinate that as well. Are we doing the same kind of mobilisation, alongside health, particularly in the MoD? Is there consideration around planning how they could support this?

Harriett Baldwin: As I said, we do play a role; it is just a more indirect role. For historical reasons, we played a different role in Sierra Leone with a different context.

Lloyd Russell-Moyle: That involved grants directly from DfID to the UN through its peacekeeping work. That is not via the MoD support, if I am right.

Harriett Baldwin: At the current time, there is not an active MoD specialist embedded in this part of the world.

Yolande Wright: We have a cross-Whitehall group. Given the seriousness of the situation, I have stepped that up and I chair it weekly now. We have fantastic collaboration. I would point out the Department of Health, as the Minister said, for their rapid support team but also for all the analysis of the risk to the UK. At the moment it is still assessed as negligible and low but they do all that assessment on the preparedness of the UK.

The Foreign and Commonwealth Office has been a huge help on things like lobbying. We are a leading donor but we are really pushing the international community to come forward. The FCO has helped us hugely with lobbying posts and we have seen the fruit of that at the World Health Assembly this week. Germany has stepped up. Sweden is taking a mission there next week. We have heard of at least two others committing funding. That FCO assistance in lobbying and the work in Geneva and New York has been fantastic.

The Ministry of Defence has been engaged all along as well but, exactly as the Minister said, there are different comparative advantages of the UK in the Sierra Leone outbreak than in this one. Our assessment with the UK Government has been that we are working through our partners more effectively in this region. We will be deploying additional technical support but only in areas where we feel the UK has a comparative advantage.

Q43 **Chair:** Is there any engagement with the Congolese diaspora here?

Harriett Baldwin: Yes, absolutely. I had a meeting with them last week. We did not just cover this particular issue but this was one of the issues that we covered.

Q44 **Chair:** Fantastic. Did they raise any particular concerns about the situation with Ebola based on any messages from back home or perhaps more broadly about the political situation?



Harriett Baldwin: They were just very grateful for the way that the UK has been willing to get stuck in very early on, in terms of what is clearly needed as a response.

Q45 **Chair:** Brilliant. To go back to the lessons from west Africa, each of you has touched on this to some extent. There was a lot of concern, when we as a Committee, as well as the Government, looked at the west Africa response, that the international system itself required urgent and serious reform. You have touched upon it but not really addressed it quite in that form. Can you update us on where things are on reform of the WHO and the broader international system?

Harriett Baldwin: I can give you the headlines and I can see if my colleagues have more detail on that. The headlines are that we did feel that the WHO needed significant reform in response to the lessons learned from the west African response. Those reforms have happened and are proving to be valuable in the current context. Charlotte, do you want to go into more detail on that?

Professor Watts: As a result of the learning from the 2014 to 2016 outbreak, there was strong engagement with the WHO. They really have stepped up and strengthened their systems to manage emergency responses. There is the science piece that I am most closely involved with but, more broadly, their capability has been substantially strengthened. We also ensure that they have rapid response funds so that, if there is an emergency, they can step in straight away and they do not have to mobilise additional funds straight away. There is a lot that has been strengthened. One of the real strengths of the response is that they did step in very early, and that was one of our lessons from previously, on the need for immediate action.

Now that we are seeing such a sustained and ongoing epidemic, it is challenging and it is in a very challenging context. I am sure that there will be further learning as we evolve on how to bring together the security and the rapid health response effectively for future epidemics.

Harriett Baldwin: Dr Tedros has been out there eight times already, I believe, to be part of ensuring that there is live management of emerging issues there.

Q46 **Chair:** Charlotte, you talked about bringing together the security and the health response. That brought to mind the discussion we had with the first panel around this difficult balance in terms of the appalling attacks on health workers, which the Minister rightly highlighted at the beginning, and the issues of trust in communities. Our witness from World Vision made this point. If a doctor turns up, you will probably engage; if a doctor turns up with someone with a gun, that is a different situation. How is DfID dealing with this in conversations with the authorities there, with MONUSCO and other donors? Is it on your radar as potentially a barrier to the health effort?



Harriett Baldwin: It is definitely one of the big barriers. We certainly would say we were engaging on all these issues. We would welcome the Committee's insights into what more we should be doing to get greater trust in the health response in the area, because we are clearly not where we need to be at this point.

Yolande Wright: I can give some specific examples. One of the things we have pushed for is for the wider UN system to support the WHO more. We talked about OCHA and co-ordination but there is also UNDSS work, especially on security. We have heard from the UN that it is going to put additional people in that role as well. We have listened very carefully to NGOs and we talk to them all the time both here and in the DRC. We have been weaving into our lobbying strategy with the Government and with the key local stakeholders this really important point about the right of health workers to be protected and to feel safe, but not through the use of force to coerce people into complying with behaviours.

We have picked up and talked to the Government and other local forces about these things: "We want people to come forward to treatment centres, but you cannot be forcing them to come to an ambulance and to go to the treatment centres". It is exactly what Charlotte was talking about. How do we try to create incentives for people to come forward and get treatment but not coerce them? The same thing applies with burials. There have been some unfortunate incidents at burials where people who were not complying with best practice were coerced. There has even been an unfortunate shooting at a burial. We have been really clear that this is absolutely not the way in which security forces should be used and this is not how to build community trust in those processes. We have been working on those issues very closely.

Harriett Baldwin: We should put on record the incredible bravery of these health workers, not only going into this very dangerous situation but taking an experimental Ebola vaccine for the first time. These are really brave things to do and we salute them for doing that.

Chair: Absolutely. Thank you.

Q47 **Richard Burden:** There have been some quite disturbing reports of, on the one hand, some health workers allegedly offering sexual favours in return for treatment. In other cases there have been reports that some people may be being offered jobs in the Ebola response sector in return for sexual favours. Have those reports come to your attention? If so, what have you done to check them out and what have you found?

Harriett Baldwin: This is a top priority for DfID's work. We heard these allegations but as yet there have been no formally reported cases. We are trying to push our implementing partners to make sure that, in their response, they are really following all the safeguarding protocols that they are all part of delivering and signing up to at last year's conference. We are, of course, aware of the allegations.



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Yolande, when you were out there you would be emphasising these messages as well.

Yolande Wright: Absolutely. I met with community groups, including some groups of women. Unfortunately, sexual violence is extremely prevalent in that part of the world. We have built, as you know, into all our standard agreements that we fund a high standard of expectation of our partners. We have just announced in Parliament yesterday additional funding. Without disclosing the amounts, you should be aware that my teams in country are working very hard to look at which things we should be funding and we want to be strengthening those aspects around protection because we recognise that that is a particularly highly risky environment in which we are working. We are looking to strengthen that aspect of the response.

Harriett Baldwin: On the more general issue of sexual violence and what works to prevent sexual violence, in our research we have had a very successful pilot programme in the Democratic Republic of Congo, which Charlotte can let you know about. We are also exploring how we can take what has been a very successful pilot and try to widen that in this area where there is a high prevalence. Charlotte, do you want to talk about the successful research?

Professor Watts: Yes. As part of the research investments we invest not only in things like diagnostics for Ebola but also in interventions to tackle issues such as violence against women. We are just coming to the end of a large programme that has been testing different types of intervention to prevent violence. There was a great example from a different region in the DRC that showed that a community-based intervention involving religious leaders and key leaders challenging the acceptability of violence and talking about alternatives had had a significant effect. It substantially reduced women's experiences of violence. We are very keen to think about the insights and the ways to transfer some of those core social change processes and to deploy those in the east where we know there are high levels of sexual violence happening in communities.

Q48 **Richard Burden:** I am trying to get to the bottom of this. Are the reports that have been circulating hearsay only, or have there been specific allegations made against specific organisations or specific people that have been investigated with nothing found to be in them?

Harriett Baldwin: My understanding is that there have not been any formally reported cases. Yolande, you were there very recently.

Yolande Wright: Not formally reported to the UK under any of our funding. We immediately follow up anything that is reported or any allegations that are made.

Chair: Thank you very much indeed, all three of you, for coming to us today. I would echo, Minister, what you said about the health workers and the amazing work that they are doing. As an initial reflection from



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me, it seems that lessons are being learned from what happened in the response, particularly the initial response, to the 2014 outbreak in west Africa. Returning to the theme that we closed the first panel with, clearly this reinforces the importance of strengthening health systems so that we can be preventing these sorts of things from spreading in the way that they have spread in the DRC. Clearly, in the specific context of the Congo, that it is a huge challenge. We are very grateful to you.

Harriett Baldwin: What I take away from this is that, although it is a very difficult context and some amazing people are doing some amazing work, the fact that there now seems to be a vaccine that is having the kind of impact that it is having is a measure of human progress that we ought to acknowledge in this Committee.

Chair: Absolutely. Excellent. Thank you very much indeed.