next 3 years. This prolonged increase in risk is similar to that seen in low-incidence countries,[8] suggesting that even in this high-burden setting, reactivation rather than reinfection dominates the risk in these initial years. Together, these results support giving preventive treatment to adult household contacts in high-incidence settings. Moreover, household interventions provide a platform for delivering preventive treatment in adults, who are already being assessed as part of contact investigations and whose children or younger siblings might already be receiving preventive treatment.

Comprehensive approaches that actively detected, prevented, and treated all forms of tuberculosis were key to pronounced declines in tuberculosis in New York in the 1990s[9] and in Alaska decades earlier.[10] Achieving the Sustainable Development Goal of ending the global tuberculosis epidemic by 2030 will require proactive use of the full arsenal of interventions available today, and rapid integration of innovation, to promptly reach high-risk and vulnerable populations with preventive and curative treatments.[11,12] Tuberculosis has long been recognised as a disease linked to inequality; active case-finding strategies that promote equity are essential to disrupt that link.

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Ebola: public trust, intermediaries, and rumour in the DR Congo

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See **Articles** page 529

In *The Lancet Infectious Diseases*, Patrick Vinck and colleagues[1] report on institutional trust and misinformation in relation to the most recent Ebola outbreak in the DR Congo. This Article is timely and important. As the authors imply, the Congolese people have been taught by bitter experience to distrust authority, in ways that make it difficult to sustain public health interventions. The cancellation of the 2018 presidential election in the Ebola-affected regions of Beni and Butembo is, for example, strongly linked in the public mind with the rigging of the national ballot.

Solutions to the problems of trust are more difficult than identifying them. The Article proposes engaging with "locally trusted leaders", but establishing whom these might be is no simple matter. I would like to encourage the researchers to pursue one implication of the paper—that the effort to discern the wishes of the community should not confuse the general will of the population for the wishes of a few local intermediaries. The role of an intermediary, who trucks between powerful outsiders and the interior is a recurrent feature of west and central Africa's violent,

centuries long, integration into the world economic system.[2] The benefits accruing to those who are able to occupy this intermediary role have meant that different performances for internal and external audiences by local leaders are common. In Butembo, for example, the city's powerful business class, the so-called Nande traders, have carefully presented themselves and been accepted by outsiders as entrepreneurial problem-solvers, practical people who offer a model for the wider DR Congo.[3] In fact, research shows that the business class have repeatedly used violence to sabotage or hijack development projects to preserve their trade monopolies and political power.[4,5]

It seems to be widely accepted that interacting with customary authorities in Sierra Leone was effective in stemming the Ebola epidemic, yet there is some evidence, albeit highly contested, that chiefs were sometimes part of a counterproductively militarised response to Ebola.[6] Although such findings might be selective and need to be approached cautiously, I would urge those interested in public health not to dismiss the claims pre-emptively, as they align with much that is known about the violence and ambivalence associated with authority in the region. Interacting with such local gatekeepers might be inevitable, but these people should not be mistaken for the community in what is a violently divided society. The strength of the paper by Vinck and colleagues is the attention given to ordinary people.

I would, however, urge future contributions to substitute the term "misinformation" used here for "rumour". One advantage is that the notion of "rumour" is connected to an extensive local vocabulary around the malign circulation of information.[7] Anyone wanting to intervene in local debates on disease would immediately be made to consider a set of ideas about how forms of speech can do harm. But the concept of rumour is also useful for thinking through popular responses to disease. Rumours are not simply false (although they often are); they are complex social phenomena. Extensive participant observation fieldwork might not be an immediate option here, but more qualitative knowledge might be useful: what it is about how a rumour acts in a social context that makes it harmful? In many cases, I suspect that establishing common ground on the basis of genuine attempts at communication, as shown in the Article by the extensive questioning of local people, might be more important in securing positive outcomes than dispelling misinformation.

The DR Congo's experience with HIV/AIDS is illustrative. HIV first emerged in central Africa, but rates of infection have long been lower in DR Congo than in surrounding countries, and much lower than they are in southern Africa.[8] The reasons for these differences seem to include important behavioural changes, such as having stable sexual partners or increased condom use.[8] Rumours about the origins of HIV are strongly at odds with biomedical knowledge—a Japanese scientist who had sex with a monkey is often referenced as the origin of the disease, celebrities who have the disease are often suspected of paying the price for satanic contracts—but this does not conflict with widespread appreciation of the need to use condoms with transient sexual partners. This study should be welcomed for its attempt to talk to local people. Framing their views as misinformation is less helpful. This is not to argue that doctors should abandon biomedical conceptions of disease, but it is to insist that there is much that public health officials can learn from local views, especially about local power structures and beliefs. These structures and beliefs will determine how people respond to health interventions and it is only by listening and understanding, free of the kind of prior judgements that the term misinformation implies, that interventions can be made more effective.

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