HOUSE OF COMMONS

International Development Committee

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

Friday 15 May 2020

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Watch the meeting

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

Questions 1 - 54

Witnesses

I: Bob Kitchen, Director of Emergency Preparedness and Response, International Rescue Committee (IRC); Robert Mardini, Director-General, International Committee of the Red Cross (ICRC); Marian Schilperoord, Senior Operations Manager, UN High Commission for Refugees (UNHCR).

II: Nick Dearden, Director, Global Justice Now; Rosemary Forest, Senior Advocacy Officer, Peace Direct; Gwen Hines, Executive Director of Global Programmes, Save the Children; Aleema Shivji, Executive Director, Humanity and Inclusion.

Examination of witnesses

Witnesses: Bob Kitchen, Robert Mardini and Marian Schilperoord.

Q1 **Chair:** I would like to start the first session on the impact of coronavirus on the humanitarian situation. This will be an ongoing inquiry, as we are aware that COVID-19 is going to have quite strong impacts, particularly on the global south. I am very grateful that we will have two witness panels today. The first one is three people: Bob Kitchen, who is from the International Rescue Committee, Robert Mardini from the International Committee of the Red Cross, and Marian Schilperoord from the UN High Commission for Refugees. Thank you all very much for joining us.

As you can imagine, it is slightly more complicated having a virtual Committee session than it is around the table in Parliament; I appreciate your patience. The Committee members will each ask you blocks of questions, some of which may be to the whole panel and some directed to an individual. Because we have a lot of questions for you and this is a very fast-moving topic, can I ask you to give full answers but to give relatively direct answers? That would be most appreciated. The Committee members may well come in with follow-up questions or other Committee members may well have a follow-up.

Could I start by asking you to introduce yourselves and to give a little overview of your organisation? We will start with the first questions.

Bob Kitchen: I am Bob Kitchen. I am the vice-president for emergencies for the International Rescue Committee. We operate in 40 countries around the world, including 21 crisis-affected countries across Africa. We employ 30,000 frontline staff and have volunteers across 200 field sites.

Robert Mardini: I am Robert Mardini. I am the director-general of the ICRC—International Committee of the Red Cross. It is an organisation working in 105 countries around the world. The mandate is alleviating the suffering of people and communities affected by war and other situations of violence. We are part of the broader family of the Red Cross and Red Crescent Movement, which includes the 192 national Red Cross or Red Crescent societies and the international federation. We work in a very complementary fashion in situations of armed conflict and natural disasters.

The ICRC has 20,000 personnel working in 105 countries. Today, 85% of our colleagues across the world are operational and able to respond to the needs stemming from war and COVID-19.

Marian Schilperoord: My name is Marian Schilperoord. I am the acting deputy director for the division of resilience and solutions at the UNHCR in Geneva. UNHCR is an organisation working with people forcibly displaced, be it refugees or internally displaced persons, as well as stateless persons.

Q2 **Mr Sharma:** Does the UN, the ICRC or anyone have the mechanisms and relationships in place to get useful, honest data on coronavirus infections, fatalities and recoveries across the global south, to enable the planning of an effective humanitarian response?

Bob Kitchen: The answer is that that is emerging. Right now, we are really struggling with the amount of testing that is available across the global south. I was struck last week to see that the entirety of Africa has achieved just under 200,000 tests across the whole of the continent. I live in New York City and we are currently doing about the same—190,000—every two weeks. New York City has 18 million people and the continent of Africa has 1.2 billion. The amount of testing in place is woefully small.

We are starting to see pockets of very clear COVID-19 symptoms and deaths emerging. Kano State in Nigeria is a clear hotspot right now. There are lots of numbers cropping up there. The presidential task force on coronavirus initially confirmed more than 600 people had died as a result. Save the Children has just cited 360 people dying with coronavirus symptoms in Aden in Yemen over the last few weeks. Even with the absence of testing, we are starting to see anecdotal information coming forward that is quite alarming.

Marian Schilperoord: We are working together with the WHO, as well as other organisations, to work together with ministries of health to train the capacity and to improve the monitoring through the systems that have been set up.

Robert Mardini: On our side, we are working really as a last-mile organisation, crossing front lines and working in places such as Syria, Yemen and Somalia, where, very often, only 50% of the health infrastructure is operational. That shows how difficult it is to get access to credible and systematic data in normal times, let alone in times of COVID-19. It is extremely hard to get any sensible sets of data. We get anecdotal data and very often we only get to see the tip of the iceberg.

This is why we are really focusing on a preventative approach, trying to reduce the probability of the spread of the virus, through hygiene, water and sanitation, and supporting existing hospitals to deal with the caseload of COVID-19. In fragile places such as prisons and IDP camps, we are trying to improve and reinforce hygiene conditions for all the people to reduce the probability of the spread of the virus.

Q3 **Mr Sharma:** Where is good data most difficult to gather?

Robert Mardini: I will give an example. In Yemen, a couple of weeks ago we got the confirmation of one case. We knew also that, at the same time, only 100 tests were performed. A couple of weeks later, there is maybe more testing done but, again, it is extremely difficult. It is the same in Syria as in Yemen. You are seeing a trend of an increase in cases in some African contexts, such as Nigeria, the DRC and others. Today, it

is very hard to get a meaningful set of data and evidence on which we can base and prioritise our work.

Q4 **Chair:** How are you targeting your resources? What are you basing it on?

Robert Mardini: We try to target our resources where we think we have the most added value. This means places of detention, central prisons and informal places where people are deprived of their liberty, because these are hotspots and high-risk areas for infectious diseases and COVID-19.

We also focus on leveraging our dialogue with non-state armed groups, crossing the front line and trying to influence armed groups in order to spread the right messages. Communication is aid. We are, for instance, leveraging our contacts with some Muslim scholars in the Middle East and in the Sahel, so that they can get messages across that will save lives and that will resonate within their communities.

We also support hospitals where we are already there and we know the context. In the hospital in Maiduguri in Nigeria, we know now that there are COVID cases but, at the same time, there are people wounded because of the ongoing conflict. None of the conflicts that they were grappling with before COVID-19 were solved. It is the same in Juba. Over the past weeks, we had hundreds of people wounded coming to the hospital. At the same time, we are now trying to support the hospitals to be able to deal with COVID-19 cases.

Another example is in Lebanon where our longstanding support to Rafik Hariri University Hospital over the past five years is paying off today, because this is the only hospital in the country that can really treat COVID-19 cases while at the same time support other patients; there are different paths. So far, this has been well managed. We really try to focus where we have an added value.

Of course, another aspect is supporting Red Cross and Red Crescent societies. This is a network of 13 million volunteers working in 192 different contexts who are at the very front line of this crisis and who are saving lives day in and day out.

The last aspect, which is perhaps an unreported aspect, is the challenge of the dignified management of the dead. We see that this is a massive challenge for authorities in high-income countries. At the International Red Cross and Red Crescent Movement, we have experience in forensic science and in the dignified burial of the dead. We have a body of experience and practice from our response to the Ebola crisis, which is very helpful to support local authorities and communities in dealing with the management of the dead.

Bob Kitchen: On the first question about where we are most worried and where it is most difficult to get data, I echo Robert's point. I am very worried about places that Governments do not have access to, so places

that are controlled by non-state armed actors. Large portions of north-east Nigeria, large portions of Somalia and some portions of Sudan, et cetera, are very concerning, because we have zero visibility or standard surveillance systems.

Almost half of IRC's portfolio around the world is operating in frontline health facilities. We are really reinforcing those right now, doing training and distributing personal protective equipment as rapidly as we can to equip ministries of health and IRC staff to be ready to triage, test and isolate clients and patients as they come in.

The other place that I am very worried about—it is timely that we are meeting today—is refugee camps, where the first confirmed case in Cox's Bazar within the Rohingya community has sent a ripple of foreseeable but still incredibly serious concern through our organisation yesterday, with such a large population of vulnerable refugees living in such a constrained environment with very little space. Social distancing in a refugee camp is essentially not possible.

What we can do about that, as Robert was saying, is invest heavily in prevention, which is now turning into response. IRC, along with a few other organisations in the camps in Cox's Bazar, has already built isolation centres. We are ready for the first cases. My concern is that, as it gets going in a camp like that, it will be very difficult to keep up.

The priority for us right now, to your question about how we are making decisions, is to have a clear view on risky places. We are very clear about locations that Governments do not have access to and refugee camps. We are monitoring the spread as best we can and looking at how that is multiplied by underlying vulnerabilities. Places such as Somalia, CAR and Liberia have no more than 10 ventilators across the countries. As Robert said, in CAR and in South Sudan more than three quarters of the health system is supported by the ICRC and NGOs. We really have to lean into this, and we need flexible funding that allows us to pivot and to adjust as this outbreak continues to evolve.

Q5 **Mr Sharma:** What are the main challenges to good data? Is it capacity and capability or political reluctance?

Robert Mardini: From our experience in contexts affected by war, it is first and foremost capacity. There is a huge capacity problem and sometimes, from one place to the other, you might have the political challenge weighing in because, of course, everything is political. The capacity and the dynamic of the conflicts are, by definition, preventing and hampering access. It is hampering humanitarian access but it is also hampering the access of the officials from the ministries of health or the local health authorities.

Logistical constraints and capacity means that the lead times to get supplies are much longer. The good news today is that we just got supplies reaching Bangladesh, so that will be used heavily to support the

Bangladesh Red Crescent Society, which is very active in the Cox's Bazar camp. That has been a massive challenge for humanitarian players as well as for states that are struggling to get the same equipment, be it the testing equipment, the reagents or the personal protective equipment.

Q6 **Mr Sharma:** Is it helpful or unhelpful that, unlike Ebola, the coronavirus challenge is a global one, in fact experienced by major donor countries first?

Bob Kitchen: The IRC has been around for 87 years. We have responded to all of the world's conflicts since the second world war. We have never had a global crisis like this before. I have never had the challenge of figuring out where to send staff or where to send resources on a global level. This conversation is unprecedented in our lifetimes.

This goes to answer your previous question a little. The fact that it has affected first-world countries, northern countries and donor states first has placed strain on how we can prioritise funding. Donors, both Government and private, around the world have felt the impact of this crisis already.

At the country level, southern states' populations are seeing how drastically this has affected first-world countries and northern states. That, combined with misinformation on the ground, means that we are very worried about how people will be willing to come forward to sustain health-seeking behaviour. There are high levels of fear about coming to clinics and getting tested. Whether there is testing capability or not, people are not coming forward, and that is because of what they have seen on the news. It has caused strain on our systems, which I really hope we can break through. The time for funding and the time for action is immediate and now.

It has also changed the dynamic in the field. This is seen right now in many places as a foreign disease that has been imported into their countries, which has given real fuel to misinformation that is difficult, but not impossible, to counter; it will take hard work.

Q7 **Pauline Latham:** I have three quick questions; do not feel you all have to answer each of them. In terms of trying to prevent and treat coronavirus infections, what are the most challenging settings or environments for this? Have you made any assessments or estimates about how bad the outbreaks and the resulting fatalities could get in the countries where you are each working?

Marian Schilperoord: From the prevention point of view, we are all working in extremely difficult circumstances, often in very remote areas. We are working under the constraints of weak health systems. As was already mentioned, we already had a lot of logistical constraints to get goods in and then suddenly we were faced with a global crisis with total lockdowns. It has been very hard. We are there on preparedness, to a certain level.

On the assessments and the estimates, UNHCR has been working on some modelling. However, we constantly need to adapt as well, because we are learning as we are moving along in this pandemic. On a daily basis, we are learning from the virus. We have been able to come up with some estimates to see what the needs are and what the expected hospitalisation rates are. Based on that, we have been working together with our partners and the ministries of health in the countries to look at the expansion of health facilities, isolation centres, quarantine, et cetera.

Robert Mardini: On our side, prevention is absolutely critical because the major logic of the WHO to isolate, prevent, treat and trace becomes extremely challenging in places where confinement is by definition a reality, such as in prisons and displaced camps. We, of course, try to do as much as possible. In many prisons in the Philippines, we have been supporting the detention authorities to establish new quarantine or isolation centres. At the same time, we also try to influence some of the policies to reduce the probability of the spread of the virus. For example, we are rethinking the ways that family visits can be performed in prisons in order to reduce the spread from outside to inside and vice versa. We have also increased the number of handwashing points so that detainees can have better hygiene, but the treatment is difficult.

Today, we are in a place where the pandemic has hit the most developed countries in a very hard way, and we hope that we will not be facing this scenario in some of the African countries devastated by war, or in the Middle East or Asia. In the high-income countries, we have seen how health systems can be overrun. It would be a catastrophe to face the same type of scenario in places such as Syria and Yemen, where access is problematic and where half of the hospitals have been bombed and shelled. That would be a massive challenge. Juba is a case in point, as are many health structures in Nigeria and Somalia.

Q8 **Pauline Latham:** You have answered part of my final question, which perhaps Bob would like to come in on. We are talking about high-risk settings, such as prisons. What steps do you think could be taken urgently to achieve the most impact in terms of avoiding and treating cases of coronavirus infection in these types of settings? What steps now could be taken to protect and treat vulnerable and very marginalised groups?

Bob Kitchen: I would echo a lot of what Robert and Marian have said in terms of getting as many handwashing facilities as we can into refugee camps, with hygiene promotion to go along with it, to counter the misinformation and the crazy ways that people are trying to protect themselves based on what they are hearing on the streets. Washing hands and protecting water sources is the most important thing.

There are two other parts to the answer. When we are looking at really high-risk locations, we need to be leaning into engaging with the de facto duty holders, which are often non-state armed actors. ICRC and IRC do this a lot, talking to groups to convey the importance of sustaining

humanitarian access and allowing us to work with health workers and to work with community committees to increase the level of understanding and the level of healthcare that is available.

I am sure this will come in subsequent questions so I will not get too far ahead of myself, but speaking to very vulnerable groups, we are really worried about both the direct and the secondary, indirect consequences of COVID on women and girls in particular, and on children. We know Ebola is a different disease but there are commonalities here that we predict will carry across. In west Africa and DRC, we know for sure that there has been a spike in maternal mortalities because health centres have been transitioned to really focus on Ebola. That is the most pressing threat to life and other threats to life are subordinated. Women are not as encouraged to come forward to go to clinics to seek healthcare while they are expecting children or when they are delivering children. That is a clear example.

Over the last three months, we have also seen changes in the reports we are receiving around sexual violence, domestic intimate partner violence and domestic abuse, where we are starting to see, in some places, increased reports and, in other places, reports just going silent. Both of those speak to changing dynamics under lockdowns with people feeling a loss of control and taking it out in the home.

It is about sustaining a flexible approach and keeping our staff able to work. We are really concerned about the restrictions that Governments have put in place that are well intentioned to lock down the population but that are impacting aid workers in the same way. In places such as Jordan and Afghanistan, we have negotiated special waivers, where we are seen as frontline responders, so we can continue to programme. We need to do that and I want the UK Government's help to reach out to embassies around the world to encourage Governments to see aid workers as the front line and give us the ability to work.

Robert Mardini: Part of our work is also COVID diplomacy. This has two components. The first is with the states, to speak about the importance of impartial humanitarian access and to lift some of the restrictions. Some of them are legitimate but we should get humanitarian exemptions for staff rotation and logistical shipments. The second aspect is with the armed groups, which is the hard nut to crack. The ICRC is having a dialogue with close to 500 different armed groups across the globe today. Of course, this comes with challenges but sometimes it also generates breakthroughs in terms of access to communities and populations.

Building on what Bob said, the secondary and the socioeconomic consequences are as deadly as the primary consequences. Our economic security team developed an economic vulnerability index in all the countries the ICRC has a presence in, and we have seen that those countries where the economic situation is dire and/or contact is affected by war are the most vulnerable. The three most vulnerable countries in

this study were Venezuela, South Sudan and Haiti, where people today have difficulties generating an income and bringing food to their families' tables. We need to take a very clear look at these dynamics going forward. The livelihood support programmes are extremely important, as important as anything we can do to prevent and to support hospitals and health centres.

Q9 **Navendu Mishra:** This is specifically for Marian from UNHCR. What are the most serious indirect impacts arising from the steps perceived to be necessary to combat the pandemic?

Marian Schilperoord: In UNHCR, we are actually referring to a triple crisis. One is the health crisis that we have discussed.

Secondly, for UNHCR, the protection risks arising from this crisis are also important. This goes back to inclusion and the restrictions on the right to seek asylum and border closures. UNHCR feels that border closures and access to territory do not automatically go hand in hand with the pandemic. There are the increased rates of sexual and gender-based violence that were already referred to by Bob. There is also the mental health and psychosocial support.

The third emergency that we are really seeing is the loss of livelihoods. Many people get by with day-to-day jobs. While we have seen that the virus has not immediately attacked all of the countries in the same space, lockdowns started to happen overnight, often with very limited notice, so people lost their daily jobs. We are seeing a huge amount of increased vulnerabilities. People have lost their jobs and are coming to UNHCR now specifically in urban situations and in the bigger capitals in Africa for assistance, because people have basically lost everything that they had. Children are also out of school. We are seeing an accumulation of very negative impacts.

Q10 **Navendu Mishra:** Building on that, how can these impacts be mitigated without risking uncontrolled infections? How can you strike the right balance?

Marian Schilperoord: As UNHCR, in our response we have outlined four key areas that we are working on. Of course, the first is public health and WASH. The second one is all the protection concerns, so working very closely with Governments on all the protection needs of the populations. We are then focusing on assistance, which is often going back to the scale of our cash assistance programmes, looking at the vulnerabilities and the improved targeting of people who have lost their livelihoods. The fourth pillar is the education pillar, which is very important in terms of looking at the longer-term impacts of a huge number of children all across the world being out of school. We are looking at how we can, where feasible, continue schools as well as how we can support more remote schooling.

Q11 **Navendu Mishra:** How has your organisation coped with the restrictions

imposed by Governments on travel in terms of the operations that you deliver?

Marian Schilperoord: A huge amount of UNHCR staff are based in field operations. The motto has been "stay and deliver", so we are providing a lot of support in field operations and the majority of our people are still working. Many people are working remotely in capitals. We have seen that there is still some access.

In addition, we are working much more remotely as well with refugee populations. We have been able to set up very creatively WhatsApp groups with the refugees. We have increased the number of hotlines to maintain the two-way communication with populations and we have established remote registration methodologies so we can ensure that people can continue to be registered with UNHCR.

Navendu Mishra: That is very useful. Thank you.

Q12 **Chair:** Robert and Bob, could you also speak about the challenges that you are experiencing with travel and within refugee camps?

Bob Kitchen: Similar to UNHCR, we are incredibly fortunate to have such strong teams. More than 90% of our workforce come from affected countries, so they are very mobilised to stay and deliver aid. For the first time in my memory—I have been doing this for 20 years—I have not been able to send an emergency team anywhere. We just cannot get flights. We cannot deploy people. We are therefore having to rely on the expertise that we already have on the front line, which is substantial and now just needs resourcing.

In terms of our access, we have been very fortunate in our ability to negotiate with Governments. We are one of five organisations that have been given permission to establish isolation centres in Cox's Bazar, for example. As I said, in Jordan we are one of the few organisations still doing clinics in the north around Syrian refugee camps. We have sustained access into north-east Syria. We are able to continue working because of the bravery and presence of staff on the ground.

Robert Mardini: 83.5% of ICRC staff are operational today in the field; 43.4% are still working on ICRC premises and 48% work remotely. It is amazing to see that many things can be done remotely, such as our dialogue with detention authorities and health authorities. This is good to see, not only at headquarters but in the field as well.

In terms of contexts, out of the 105 contexts, two contexts are still operating as normal, 35 are moderately impacted with some constraints, 54 are strained in their functioning, 13 are barely functional and one is on hold. Overall, we are still able to operate.

One of the major challenges is the rotation of international staff but, fortunately, the vast majority of our colleagues are resident colleagues, so we are able to move and cross front lines, by and large.

The big challenge, of course, from one context to the other, is to convince authorities and armed groups to operate and to have access to the communities and to have the conversations that will also shed light on the less visible aspects of this crisis, such as stigmatisation, gender-based violence and the prevention of some Government services or humanitarian organisations reaching the most vulnerable of the most vulnerable. This is work in progress.

Q13 **Chris Law:** My question is to Marian, particularly on refugee camps, which we have just touched on. I wanted to know a little bit about the particular challenges that you are finding in providing protection against coronavirus infections in crowded refugee and IDP camps. I wanted to know that from the perspectives of both the refugees and the internally displaced persons themselves and those who are delivering that support on the ground. In particular, we have heard that in Cox's Bazar the Rohingya camps have been fenced in. Is that correct and is that initiative now aimed at keeping COVID-19 out?

Marian Schilperoord: Every country has its own regulations. As you know well from Europe, no country has adopted the same measures, so it differs very much by country.

In most instances, UNHCR has been able to work to ensure that critical services continue to be delivered. In addition, we have been working with refugee communities to continue certain services. People have taken that up as well. We have trained up a significant amount of refugees to be community health workers and hygiene promoters and to reach out with all the key preventative messages within their communities.

In Cox's Bazar, yes, unfortunately last night the first case was diagnosed as positive. All efforts have been made in Cox's Bazar by the entire humanitarian community since mid-March to start all preparedness. At the moment, the contingency planning has started to the next phase in the response. There is very limited access indeed. Facilities are in place and our partners such as IRC are working very hard to continue to provide the services.

Q14 **Chris Law:** It is sad to hear that it has broken out with the Rohingya in Bangladesh. Small numbers have been reported so far, but it is a matter of time before we see a serious coronavirus outbreak. How has UNHCR been able to prepare for that eventuality? Are you getting assistance in this from host country authorities and from donors such as the UK?

Marian Schilperoord: We have been very fortunate to receive funding for Bangladesh. Of course, there is always the need for more, specifically now that we are entering into the phase whereby we need to respond to the potential of a very serious COVID outbreak. All the work up until yesterday morning was really focused on the prevention, such as getting the right equipment in, setting up the isolations and getting the beds ready for people in the event of an outbreak. We are starting the second phase now.

Significant scale of all support is required to continue to respond and to deal with a high number of casualties and people that would need medical support as well as to be able to continue to organise the food distributions and to make sure that people continue to have access to food and that there is a continued supply of water to maintain the hygiene practices in the community.

Q15 **Chris Law:** Can I also ask about information and how people within the camps are getting access to information? We have heard reports, in Bangladesh in particular, that the internet had been cut off for those within these camps, so they are much more vulnerable, I am assuming, to conspiracy theories about how it spreads or how to protect yourself. Is that right?

Marian Schilperoord: Yes, that is indeed a constraint, and we are in constant discussions with the Government because it is not only hampering the communication with the refugee community but also the co-ordination between the different partners working in the camp. We have been able to scale up through radio messages to make sure messages are going out in the community. In addition, a number of refugees have been trained as community health workers and hygiene promoters to continue to give the right messages in the communities.

Q16 **Chris Law:** How has coronavirus affected social and healthcare provision in the refugee and IDP camps? What challenges has that brought about, or has it reinforced existing challenges?

Marian Schilperoord: As Bob referred to earlier, it has been difficult to continue to run all the health services. It is often more difficult for people to access the needed services for maternal and child health, as well as the continuation of services for people with chronic diseases. We have had to make sure that people had access to their medications. If you think about the Middle East, a huge number of people have a chronic disease and so they are in need of their medication for hypertension, diabetes, et cetera. We have been able to support people with a contingency stock for two or three months.

People have worked extremely hard on the ground to make sure that people have this access but it needs to go with very strong messages and community health awareness to the population as to why this needs to work.

Q17 **Chris Law:** I want to open the questions up slightly, because I want to look at cross-border attitudes. How realistic is it that the "nobody left behind" approach will be able to be continued when it comes to this pandemic?

Marian Schilperoord: It is indeed very difficult. We can see that it has an impact on the protection. We are consistently working with Governments, as I mentioned earlier, to make sure that the pandemic is not hampering all the protection work that UNHCR is doing and not hampering the movement of people or the right to seek asylum.

Robert Mardini: In contexts affected by war, COVID is just an additional threat on a long list of vulnerabilities. That is what communities are telling us, from Libya to Sudan to Syria. Sometimes they do not know what it is that they need to protect themselves from: is it COVID, or is it shelling, bombing or looting? It is very important to keep this in mind and to know that, in order to manage this global pandemic, the response should be global. The robustness of the global response will be as solid as the weakest link, and the weakest links, unfortunately, are in those conflicts where you also have climate change and now COVID on top of it, making people extremely vulnerable.

I can only echo what Marian and Bob said regarding funding. The UK has been leading on this. The Red Cross and Red Crescent family received substantial funding here but we need more, and we need more flexible funding in order to be able to adjust priorities as things develop.

Bob Kitchen: We have learned really important lessons through Ebola that are really relevant here. We learned that doing just health programmes is a failed model. You have to accompany those health programmes with community engagement and risk communication programmes, where you engage with communities, do as much as you can to keep your protection programmes online, identifying at-risk and vulnerable parts of the population, and communicate as much as you can about what is going on, what people need to know and what actions they need to take. We are doing that as robustly as we can everywhere, just reaching out and talking to people.

The priority is now funding. As a frontline NGO, we continue to be really worried about how much money is making it to the front line. It is great that UNHCR and ICRC have received robust funding. Of the $900 million that had been committed under the global humanitarian response plan, only $13 million has made it into the hands of NGOs as of 10 days ago. It is slow getting to frontline actors.

Q18 **Chair:** Where is the rest then?

Bob Kitchen: It is moving through the system.

Q19 **Chair:** Is it normal that it would take weeks and months to move through the system?

Bob Kitchen: Sadly, it has taken time in previous emergencies, and at a global scale we are really now feeling it. As NGOs, we try to be as thoughtful as we can be, reflecting on previous crises. We are putting forward large consortia of NGOs that can receive funding directly with commitments to fund local organisations rapidly as a way to unblock the system.

Everybody has a role. The UN agencies are providing incredibly important infrastructure to help us move and to protect people, but, if you look at the numbers over the years, the majority of aid is distributed on the frontline by NGOs. At the moment, we do not have the money or the

stocks to be able to do that. Prioritising getting money to the frontline needs to be a core message that I hope you come away with.

Q20 **Brendan Clarke-Smith:** Good afternoon, everybody. In terms of the international response, is the international community—the UK and DFID in particular—doing the right things at the right time in the right way?

Robert Mardini: DFID has been leading, with £744 million unlocked for the COVID response, which is substantial. The Red Cross and Red Crescent Movement got £55 million of it, and I would also like to remind all of us that Red Cross and Red Crescent volunteers are on the very front line of this response. It is good but much more needs to be done. That was additional money, so it was really appreciated; it is not repurposed money. Much more needs to reach the front line, as Bob said. Our message is that we will need more because this is a protracted crisis. It is not a crisis that will go away any time soon, and it is exacerbating existing vulnerabilities of people who are already in harm's way.

Bob Kitchen: I have been in this industry for more than 20 years and I am so happy to have worked with DFID colleagues around the world. They are among the best, if not the best, most knowledgeable partners we have. Of the approximately £740 million that has been contributed or designated, more than half has gone to vaccination research, which is really important, but we know it will take a long time to get vaccinations developed and it will take even longer to get them to the front line, to people in southern countries. We need to make sure that money is going for prevention and treatment right now.

DFID has released its rapid response facility; £20 million has been pushed through that. It is making its way to the field. That feels like a small, important part of the solution that now needs to be taken to scale, putting money in the hands of primary healthcare clinic staff and community mobilisers going out there to help people keep themselves safe and then treat them if they do fall ill.

Marian Schilperoord: UNHCR has a very strong relationship and partnership with DFID. We have had a number of exchanges with DFID about the response. We are very grateful for the contributions but, as Bob has highlighted, as we are now moving away from preparedness towards a clear response, as in Bangladesh, more funding is needed so that we can continue to meet the needs that are growing at the moment.

Q21 **Brendan Clarke-Smith:** How has the pledging from donors matched up to the assessments of need that were conducted by the UN agencies?

Bob Kitchen: The first global humanitarian response plan was $2 billion. Much more within that needed to go to NGOs. Only a 5% share was designated for NGOs for the frontline, which was concerning. It has now more than tripled to just less than $7 billion. So far, the last number I saw was over $900 million. We were just south of 50% and we are now

just south of 25% of what is needed being pledged and moving through the system. A lot more needs to be done.

As these anecdotal numbers that we have been discussing today come forward, it will be visceral and it will seize the attention of donors, and I really hope they act soon.

Robert Mardini: At the same time, we also fully understand that our donors are facing crises at home. We know that there are no easy answers but this is it; it is time for global solidarity and to reinforce the most vulnerable communities across the globe.

Bob Kitchen: There is something we know about this as a global crisis. While COVID exists in any of these countries—in southern, vulnerable countries—it remains a serious threat to our own countries. With global movement starting to come back online, without vaccinations or clear treatments, we need to treat this as a global problem and invest in it as a global problem. Just saying, "We have the downward trend of the epi curve in our country and that is good news", is not the solution. We have to treat this around the world to get rid of it.

Q22 **Brendan Clarke-Smith:** We were talking about NGOs and this allocation of £20 million of DFID's £744 million response going to frontline NGOs and whether it is an effective use of resources. Robert, what do you think of that?

Robert Mardini: It is most needed. It was new money. Of the £55 million, £17 million went to the ICRC and the rest to the Red Cross and Red Crescent Movement. It is good because it is additional money. It was disbursed quickly. I can tell you that it is being used as we speak because we have a high implementation rate in terms of activities. We are present on the ground and we are supporting volunteers who are at the front line of this.

Of course, we need much more. The Red Cross and Red Crescent Movement came up with a preliminary appeal of $800 million on 26 March. We are now working to revise our appeal that will clearly exceed the $1.5 billion figure, but it is not fully covered. This is money that is being used and reaching the people who need help most. The message is that we are very grateful and we need more.

Q23 **Brendan Clarke-Smith:** There is, perhaps understandably, quite a strong focus in the allocation of aid money to finding a vaccine. Is it appropriate for so much overseas development assistance to be invested in a vaccine for a pan-global public good for the wealthiest and poorest countries alike? Marian, would you like to answer that?

Marian Schilperoord: As highlighted earlier, we need global solidarity. If there is a lot of funding for vaccines, we need to make sure that a vaccine will be made available for anyone in need all across the globe.

Q24 **Brendan Clarke-Smith:** Is it possible that effective vaccines, therapies

and tests might end up being denied to the poorest and most vulnerable due to costs, prices, copyrights and patents? Bob, what do you think?

Bob Kitchen: I truly hope that we will be able to put behind us the bad practices that have seen that for treatments for other diseases. Reflecting what I said earlier, this is a global contagious disease. If we solve it in our countries and do not solve it in other people's countries, it will come back. It is appropriate that the world invests a large amount of money into developing the vaccine but we then need to invest a huge amount of money to make sure that it gets to the people who need it, which means the vulnerable countries that we are all working with, which we have talked about today.

Q25 **Mr Bacon:** Can I direct this question to Robert Mardini? Do you consider that the recent announcements by the IMF and the World Bank about debt cancellation are sufficient to enable improvements in healthcare and social services in developing countries?

Robert Mardini: It will certainly help but I can only emphasise the need to invest more and more in health systems across the planet because those are very much the weakest links that we are grappling with even without the pandemic, at least in the countries that the ICRC is active in. The message here is that more investment needs to go to countries to revamp and upgrade their health systems, not only in capitals and big cities but also in rural areas.

Q26 **Mr Bacon:** I would like to direct this question to Bob Kitchen. What do you think has been the effect on the scale and the coherence of the international response of the apparent ongoing disagreements between China and the US about the handling of the coronavirus outbreak and the role and performance of the World Health Organisation? Marian, you may have a view on that as well.

Bob Kitchen: I will talk to the pieces of that question I feel equipped to answer. I am very worried about how personal protective equipment is seen within this political struggle around the world at the moment. It must not be weaponised as major states have disagreements. We have to make sure that everybody has the personal protective equipment they need, not just in the NHS and the US health system but frontline actors in the world's poorest countries.

Can you repeat the second part of your question?

Mr Bacon: It was about the WHO. That is why I mentioned Marian, because I thought she might feel qualified to answer.

Bob Kitchen: Just as an NGO, let me say that it is incredibly important that the world has a fully funded and fully capable WHO. It has an incredibly important mandate to work with ministries of health to make sure that drug pharmacy supply chains are maintained, that testing gets to the frontline and that surveillance systems are working and are reporting transparently. That is the work of the WHO that we have been

talking about for the last hour around testing and numbers. Without that fully funded, we are really going to be at a deficit. It is incredibly important that it continues to be empowered.

Marian Schilperoord: I just want to underline what Bob is saying. It is more important than ever to have a strong WHO that will co-ordinate and provide us with the information we all need to make decisions in our work.

Q27 **Mr Bacon:** Robert Mardini, if you could ask DFID to effect one change to its strategy, what would it be?

Robert Mardini: It would be even more flexibility of funds because we are in a very volatile situation where we need to adjust. In addition, it could perhaps lighten some of the reporting in times of emergencies. That would be helpful.

Q28 **Mr Bacon:** Robert Mardini mentioned flexibility and Bob Kitchen referred to the £20 million as a small, important start of the response from the rapid response facility. Do you think that could be scaled up using other DFID funds? Would you like to see it prioritise that over other things?

Bob Kitchen: I have been impressed with how DFID and other donors have reached out to existing partners in country and leveraged lessons that we learned from Ebola to build on what is existing already, so extending funding to existing partners.

The problem with that, and why I do not think it scales in a global outbreak that is unpredictable, is that we need to have flexible, nimble funding that is deployed as we see the outbreak worsen country by country. Making bets now that we should be positioning money in country X versus country Y is good, but it needs to be married with centrally administered, rapid funding that can be sent into countries as they worsen.

The RRF is a good model and I hope that this is the first salvo of funding to come through it. I hope that it is scaled up. DFID has a cadre of shortlisted programmes that have not been funded because it is only £20 million but they can rapidly move down that list and fund more programmes, which I hope to see.

I would also say that putting money in the hands of large, global, trusted partners to make decisions ourselves as to where the greatest needs are through consortia is another really flexible way to work.

Q29 **Mr Bacon:** Does that mean you in New York making a decision, or a navigation by judgment at scale on the ground locally?

Bob Kitchen: It means that you have the best of both of those, where global organisations are co-operating to make sure we are seeing the same things, making decisions to ensure deconfliction, and then teams

locally are making decisions on the ground as to where funding is needed.

Robert Mardini: Our key message to all our donors is that we need more COVID response funding and support, but it should not go to the detriment of other programmes and activities that were pre-existing before the pandemic. None of the conflicts that we are dealing with, unfortunately, was solved. This is also an important policy point that we are pushing with all our donors.

Chair: Robert, that is an excellent point to end on. Thank you for raising it. It needs to be heard.

Can I thank all of the witnesses on the first panel? Robert, Bob and Marian, the work you are doing and the work your organisations are doing is amazing and we are incredibly grateful. Can I give thanks to all of you and to all of your staff and volunteers across the world, from myself, the Committee and the British public? Thank you ever so much for all that you do.

Robert Mardini: Thank you very much for your support.

Marian Schilperoord: Thank you.

Bob Kitchen: Thank you.

Examination of witnesses

Witnesses: Nick Dearden, Rosemary Forest, Gwen Hines and Aleema Shivji.

Q30 **Chair:** I would now like to bring in the witnesses for the second panel. We have four witnesses this time. We have Nick Dearden from Global Justice Now, Rosemary Forest from Peace Direct, Gwen Hines from Save the Children, and Aleema Shivji from Humanity and Inclusion. Could I start by asking each of you just to briefly introduce yourselves and to say a little about your organisation?

Nick Dearden: Thank you very much for inviting me. I am Nick Dearden, director of Global Justice Now. We are a campaign organisation. We work on reforms to the global economy, which we believe to be hindering, in the current situation, the kind of development solutions we would like to see. For today's panel, we are particularly interested in debt cancellation in the pharmaceutical system, and maybe in trade, if you are also interested in that.

Rosemary Forest: I am Rosemary Forest. I am the senior advocacy officer at Peace Direct. Our whole focus is on promoting and supporting locally led approaches to peacebuilding. At the moment we are working with 19 partners in 13 countries.

Gwen Hines: Thank you very much for inviting me. I am Gwen Hines. I am head of global programmes for Save the Children. By our mandate, we focus on children in health, education and child protection. Those are the three sets of issues we are focusing on in this response, but we are very much trying to integrate. We also operate at scale like others. We work in 120 countries, including the UK and other parts of Europe, but we specialise in humanitarian and fragile states overseas.

Aleema Shivji: I am Aleema Shivji. I am the UK chief executive for Humanity and Inclusion. Thank you for inviting me as well. Humanity and Inclusion operates in 55 countries around the world, supporting people with disabilities as well as other vulnerable groups, including older people, women and girls, in conflicts, disasters and extreme poverty. Our focus is to make sure that no one is left behind, and that very much extends to our response to COVID-19.

Q31 **Mr Sharma:** My questions are to Gwen and Aleema. To plan your work, do you have access to the data and information on where COVID cases are?

Gwen Hines: I know you were talking about data in the earlier session. It is not perfect at all but, like others were saying, we have very strong teams on the ground, including field offices all over countries, be it Somalia, Yemen or elsewhere. We have thousands of national staff on the ground and we use them to get data to add to official data.

We have recently been going through an exercise of looking country by country and cross-checking that with official sources. You can also use proxies to a certain extent, in terms of what you are hearing from people involved in burials or reporting cases at the village level. We are using that to understand what is happening.

We also have a number of health experts who are involved in the research side. We are tracking that research, which is so important, be it Imperial College London or other very good UK and other universities, and we are trying to understand how much we actually focus on shielding and mitigating versus dealing with the other issues. Just to give one example, at the moment we are not just tracking cases but we are also tracking food security, hunger and poverty, where we have 40 million people at risk, half of whom are children. It is very important to track not just health cases but other data as well.

Aleema Shivji: I completely agree with everything Gwen has said. We are doing similar. Our teams are really concerned about the spikes that we are starting to see. It is about complementing the data that is out there with the modelling that is happening. There is some great modelling that is being done by the London School of Hygiene and Tropical Medicine, for example, here in London.

We are looking at it from the angle of what we are seeing elsewhere in the world. We know that certain groups are particularly vulnerable and

so, even in that sense, it is about specific data, knowing that some people with disabilities that have underlying conditions, most older people, people with noncommunicable diseases and those that are living in refugee camps and informal settlements, as you heard in the last panel, are going to be particularly at risk, based on what we are seeing elsewhere. We are really focusing our efforts in those areas, drawing on our extensive local networks.

It will be difficult to get the data. We heard lots of the challenges in the last panel. It is about looking at how data can be collected, not just through testing but also in terms of what we are seeing locally, but focusing that data collection on areas that are potentially at higher risk. We heard about prisons earlier. We are also looking at dormitories of migrant workers and looking at where there are higher concentrations of disability. For example, 27% of the population in Syria live with a disability and everyone over the age of 65 also has a disability, so you are talking about compounding impacts. Those are micro aspects of data that are also important.

Q32 **Mr Sharma:** Are there any lessons to be drawn from how the coronavirus outbreak has been tackled in China, Europe or the US? Again, that is for Gwen and Aleema.

Gwen Hines: Yes, there are definitely lessons. We are all learning more, day by day and week by week, about this virus, including who might be more or less susceptible and what happens. Early on there was an assumption that children would be less vulnerable and there were some suggestions about how big the impact would be in hotter countries. We are obviously tracking things like that but we are very worried; we should not assume that what exists in one country exists in another. For example, if you look at a disease such as childhood pneumonia, if you are malnourished you are 40% more likely to get that. We also, of course, have people with TB, HIV, poverty and other sorts of issues. We cannot assume that we will get the same instance of disease.

I know you were talking about the Rohingya camp at Cox's Bazar earlier and we are also heavily involved there. There are 36,000 older people in that refugee camp, which is a lot of people living with 900,000.

One of the other lessons we are looking at is to what extent social distancing is possible. In many of the places we work, it is just not possible. Instead, we are focusing more on shielding the most vulnerable.

One of the big issues we are focusing on, at Cox's Bazar and also more generally, which is one of the big lessons from Ebola, is that we should not focus just on specialist treatment at the expense of community healthcare. That is really important. Save the Children already works with 500,000 community health workers around the world. They have been a foundation of the work we do in communities. Part of our global response is to upscale that by another 100,000 people because we believe community health workers are a vital part of that response.

Aleema Shivji: I agree with everything Gwen has said. We are also looking to learn from the secondary impacts. We hear quite regularly, here and around the world, about the mental health impacts. We are putting that at the front line of our response right from the beginning. We already know that many of the vulnerable people in the world already struggle with mental health difficulties, whether that is because they live under bombing and shelling, they live under the poverty line or for whatever reason. Those pieces of learning are as important as how the virus itself is spreading.

The other element of that is looking at the learnings around the mechanisms that are being put in place to mitigate the economic impacts and how we can work locally to have similar mechanisms to make sure that immediate social protection mechanisms are put in place in countries that often do not have them in the first place. We have seen huge injections of money into individuals, companies and organisations here in Europe and around the world, and that is also an area of learning.

The third area that I would highlight here, which we have heard a lot about in the news, is domestic and sexual violence. We heard a little about this from Bob in the last panel. We know, for example, that women with disabilities are twice as likely as other women to experience domestic and sexual violence. Already having that data and knowing that domestic and sexual violence has spiked in other parts of the world means that there is a real importance to redirecting resources there and making sure that those resources continue to be available, accessible and inclusive.

Q33 **Pauline Latham:** I want to talk about the direct impact, so my questions really only affect Aleema and Gwen. In terms of acting first to avoid and then to treat cases of coronavirus infection, what are the key challenges in the environments of which you have experience?

Aleema Shivji: One of the key challenges that we are facing, which is no different than here, is access. We work in 55 countries; in 37 of them, the teams are seeing significant and critical impacts on logistics. That is because borders are shut, international flights have stopped, domestic flights have stopped, movement is not allowed from city to city, supply chains are not working and we cannot get personnel, whether from neighbouring countries across borders or people who are out of their own country coming back home again. We are facing a lot of logistical issues.

It does not mean we cannot work. We are being creative. As some of the others in the panel before spoke about, we are using technology. We are connecting with the communities we work with, using WhatsApp, telephone, radio and different mechanisms to compensate. That does not compensate for everything. You cannot send critical supplies by WhatsApp, obviously, and so there is a huge challenge in terms of supply chain and logistics.

One of the other challenges we are also seeing, tied to the supply chain but also to humanitarian access, is decisions being taken by different Governments that are really worrying. We are seeing evidence that some countries are putting in place mechanisms where their testing and treatment will target nationals and not refugees. We are seeing some Governments focusing their response in particular electoral districts ahead of elections. We are seeing a lot of complications that are actually not directly related to COVID but that are really impacting.

That is something really powerful that the UK can do, directly through DFID and the Foreign Office as well as via their role in the Security Council: to push for a principled humanitarian response, humanitarian access and a UN resolution on the pandemic, as well as calling out all these breaches of a principled humanitarian response.

Gwen Hines: I completely agree. In some ways, we are all very experienced in dealing with refugees, fragile states and very tough situations. We have been working in eastern Congo for the last year on Ebola, where it is very similar in terms of explaining what it is, working with local community workers and working on community education. We reached a million people, so we know we can do it. We know we are on the ground in the tough places and we know we can do it at scale. What is different this time is that you cannot move people between countries.

I should thank the British Government, which helped us recently to get some health experts into Bangladesh, who are part of the Cox's Bazar response that we are doing. That is really important. They are also helping us with things like visas. We all work with international teams who are experts in their field; it is just about getting from A to B. I had people in Kenya transiting through London to Bangladesh. It is not easy right now, but it is really important to be able to do that.

It is also really important to think about how we respond quickly. This was touched on in the previous panel. We have platforms and programmes ready to go all over the world. What we want to do most is to get flexibility so we can build on those. We are already responding through education programmes, to think about how you maintain that learning in a very basic way, be it in the household, at community level or with radios if there is not good technology. Suchana, a programme DFID is funding with us, works with the poorest people in Bangladesh. We have switched funding around some of the ways of working and we are integrating handwashing and hygiene education into that existing programme. That is how we can do it if we are given the flexibility.

Q34 **Pauline Latham:** In the countries you work in, have you made any estimates or assessments about how bad the outbreak might get and the resulting fatalities that will inevitably come about?

Gwen Hines: There is lots of modelling and we are not doing it as individuals. We obviously feed in our information but we cross-check it against ourselves and with other research organisations. There are a lot

of very scary estimates out there. There are estimates of 30 million fatalities in Africa if we do not get this right. So far, thankfully, we have seen fewer cases than we feared at this point in the cycle but we do not yet know whether that is under-reporting or whether lockdown had a good effect. It is very hard to say. As I say, you have to put that in the context of 40 million people who are potentially starving and very poor, which also kills people.

We are tracking those numbers very carefully. We know there is a lot of under-reporting. We know that, once it gets into places like Cox's Bazar in a big way—you already have the first case—that could be very significant.

Aleema Shivji: I would reiterate the same points. We are using a lot of the similar estimates and we are very much concerned about this layering on top of different crises. At the beginning of the COVID-19 outbreak, 170 million people were in need of humanitarian assistance. Despite a global ceasefire, there is still fighting and deaths happening in the Sahel over the last few weeks. We have all these underlying problems as well that are not going away and that are being compounded. We are very much looking at COVID-19 but in the context of a number of ongoing underlying crises that are affecting millions of people worldwide.

Q35 **Pauline Latham:** Could you suggest any urgent steps that might be taken to avoid or treat the cases of COVID-19 in the global south? What are you doing to protect, and be prepared to treat, the particularly vulnerable and marginalised groups that you work with? You work with disabled people particularly, who are obviously very vulnerable in this crisis.

Aleema Shivji: Absolutely. In terms of the steps we need to be taking, it is about making sure that the response is inclusive and intersectional, recognising that certain segments of the population are going to be more at risk, either because of their refugee status, overcrowding in the environment they live in, their age or their underlying health conditions. It is about making sure that the entire response is inclusive. The UK can really play a leading role there. It is already playing a leading role, with many thanks to this Committee for the disability inquiry that led to DFID's first disability framework a few years ago. DFID is really seen as the leader on inclusion and the UK has a real role to play to put that into practice across the entire response.

In terms of doing that at scale and quickly, the UK is contributing significantly to the global humanitarian response plan, which has a big focus on inclusion, which is fantastic. It is about really pushing those commitments practically, making sure that all the data that is collected is desegregated by disability, age and gender. DFID funded us as part of its strategy to develop e-learning for partners on disability disaggregation. This is the time to enforce the use of that tool among all of its implementing partners, the UN included. It is about making sure that the response is inclusive.

In terms of what we are doing, there are a number of different strands. One part of it is making sure that we promote accessible public health messaging. For example, in India and Nepal we have translated the Governments' public health messages into the national sign languages, in partnership with Government. We are also working to make sure that people with disabilities have access at an individual level to care and treatment, signposting them. This is utilising our massive community networks.

The strength of the response going directly to the front line is that frontline organisations, be they international or local, have extensive community networks of community workers that know the grassroots communities, that know the families and that are able to make sure that that messaging reaches them. That is a big step that would be really welcome from the UK. The UK has made a big commitment to localisation but most of the funding for this response has gone to large agencies, in particular the UN. While that is important, as colleagues on the previous panel said, what we need right now is money on the front line. Dedicating a proportion, say 30%, of what has gone to the global humanitarian response plan to go directly to frontline organisations would be an immediate practical step.

Q36 **Pauline Latham:** Gwen, we have enough problems with this virus at the moment with our health and social care provision. How do you think it affects the global south? There are lots of challenges with the global south. Has it created new ones, or is it just more of the same?

Gwen Hines: Yes, it has created some new ones in that, obviously, it is an unknown disease and there are not specialists for this, but the real issue for the global south is that it has reinforced the vulnerabilities that were already there. A vulnerable country such as Malawi had very few doctors, nurses and so on, and there basically is not an intensive care unit. The issue of ventilators is a huge debate in the UK but it is a distraction for many of the places where we work. Frankly, there is not even oxygen, power, basic treatment or doctors and nurses. It is about having appropriate local responses and the way they work.

Think about something like education, which we have not talked about much so far. We already had a huge number of children who were not in school. We now have roughly 1.5 billion children around the world who are out of school. Again, we know that it is the most vulnerable of those who are now at risk in their own communities and who are least likely to go back. We want to maintain that learning now and then we want to focus again on the lessons from Ebola. How do we make sure that girls and other vulnerable children go back to school when this has finished? In the meantime, we have to work with teachers because often they are not being paid at the time. They are very scared and nervous about it. It is some of the same issues that we have in the UK but on a much bigger scale.

Similarly, in the UK there has been a massive economic response. How will that possibly work in very poor countries where their budgets were already incredibly tight? We need to understand the trillions that have gone in in the UK and the US and what that feels like for a very poor country.

Q37 **Navendu Mishra:** This question is more for Nick and Rosemary. What disproportionate effects are faced by the vulnerable groups you work with, arising from steps commonly taken by global south Governments to tackle the COVID-19 outbreak?

Nick Dearden: We have seen quite a rise in measures that have been taken. Some of the measures taken by developing country Governments are the same as measures that have been taken in the global north but, clearly, they have a very different effect when huge amounts of the people in your society are employed in the informal sector. Essentially, if you put them into a lockdown, they cannot earn any money. There is an immediate food crisis in countries where enormous amounts of people work on the land to produce food for a society. If you put people into lockdown, that creates a crisis.

This is all adding on top of the crisis that Gwen was just talking about, where you have seen the largest capital outflows in history from the developing world—four times bigger than the 2008 crash. There is not that capacity, at Government level, to be able to deal with this. That is part of the thing to remember here: for many countries in the developing world, this was an economic crisis before it was a health crisis. We fear the health crisis is coming to many countries but, first and foremost, this has been an economic crisis that will continue for a long time into the future. How do we help those countries mobilise the resources so that they can put things into place similar to what our own Governments are putting into place here?

Debt cancellation is one of the biggies, because that is the fastest way that you can release spending capacity for developing countries in the here and now. I can go on to talk a bit more about that if you want, but I know that your question was more general so I am happy if Rosemary wants to come in.

Rosemary Forest: Right now, we are seeing local peacebuilders report significant impacts on the conflict dynamics in their communities. That is, in part, in relation to the inequalities that are becoming more apparent because of the lockdown measures, but it is also through things like attacks on healthcare workers and a rise in xenophobia leading to attacks on ethnic minorities and migrant groups, for example, which we are concerned could set a precedent for normalising identity-based violence in the longer term.

We are also seeing that programmes and activities that were around fostering social cohesion in particularly divided societies are being challenged by both the social distancing measures and the attempts to

further lock down and some of the Government authoritarian measures that are being put in place, which are being used to target either human rights defenders or opposition leaders, for example.

Although our partners are in very different contexts that have varying levels of the lockdown effects, from full lockdown in Zimbabwe to semi-restrictions in eastern DRC, their work is having to really adapt to very changing situations on a day-by-day level. Going forward, it will be really crucial that all our health and humanitarian interventions have a conflict-sensitive element to them, so that we are not exacerbating existing tensions or potentially fuelling new ones.

Q38 **Navendu Mishra:** Do you think that local or multilateral agencies are sufficiently mindful of the issues that you mentioned?

Rosemary Forest: All organisations are more aware now of the importance of taking a conflict-sensitive approach. At times, there is a challenge that local organisations are often left out of our planning or the response until the last minute, or they are just brought in to deliver specific activities. Building on their knowledge, their expertise and the trust they have with local communities is really crucial to delivering both a conflict-sensitive approach and to build on the community engagement. Both Gwen and Aleema mentioned the importance of community engagement in tackling stigmatisation and tackling the misinformation we are seeing. The local organisations are really well positioned to help convey messages—public health messages as well as those around social cohesion—in a way that can get through, which international organisations are not always able to convey correctly.

We all have a role to play, but I would like to see a greater emphasis on the inclusion of local organisations' perspectives, knowledge and capability in the response.

Nick Dearden: There has increasingly been a recognition that, clearly, this is the biggest crisis that we have seen in decades, if not ever. Therefore, the response that we need to mobilise in reaction to that needs to be absolutely enormous. That has not quite fed through to specific policies yet. Some fabulous work has been done, and I would definitely recommend that the Committee has a look at some of the reports of the United Nations Conference on Trade and Development, which talk about the scale of challenge that is necessary and some of the structural changes that are required in the global economy to meet that.

I am not sure, in terms of the very specific policies that have been put forward by, for example, the International Monetary Fund and the World Bank, that we are there yet. Too much of it is a bit too business as usual. Large amounts of new lending is fine, but I am not sure that the new lending recognises that this is a real structural problem. It is not just a short-term liquidity problem. This is going to be a real structural problem for many economies for many years down the road and, therefore, we need, for example, real debt cancellation and a release of IMF currency—

the special drawing rights that are being currently held up at the US level.

We need more of a focus and more co-ordination around public sector options at a global level. This would be a big message of mine to DFID. DFID has done some great stuff in terms of building public sector capacity around the world, but increasingly it has developed a bit of an obsession with getting private capital into what we traditionally regard as public sectors in developing countries. This crisis shows that that does not build the resilience that societies need in order to be able to deal with a crisis like this. We must build that resilience, and the public sector option is the best way to do that.

Q39 **Navendu Mishra:** This question goes to Aleema and Gwen. How have you coped with the restrictions imposed by Governments on travel and contact, in terms of your operations?

Aleema Shivji: We have done a number of things. First, it is about constant negotiations with Governments locally. In some countries, humanitarian workers are not seen as key workers, so we are trying to negotiate exemptions so that we can move. That has been a massive challenge. There are countries such as Jordan, until it opened up last week, where we were not considered key workers, so it was quite a challenge. In Uganda at one point, there was a restriction of two people per vehicle. When you have a whole team of community workers that go out to a community and mobilise on foot, it makes the logistics really complicated.

We have been trying to talk to Governments locally. We have been managing remotely, a bit like how this Committee is running. Where technology exists, it works quite well. Somalia is quite a surprising context where, actually, everyone is pretty much connected online and so we have been able to stay in touch with the communities we support through online mechanisms.

We have benefited from the first EU air bridge last week, being able to send goods and people into the Central African Republic. We have really been trying it in different ways. We have prepositioned stock, particularly PPE, in our warehouse in Dubai so that, when we can get it to that next leg to particular countries, we will.

It is really about using innovative practices to overcome some of the challenges. While those are definitely possible in the short term, the concern is for how long we can continue to work in this way. Picking up on something I said earlier around acceptance and communities, a sense of mistrust in what is happening has come out from a few people. There is only so long that you can engage with the communities you work with at a distance. At some point you need to have that face-to-face contact. This is something we need to continuously push for.

Gwen Hines: It is definitely case-by-case negotiation and we are seeing exemptions coming through for humanitarian workers, which is fantastic. Anything that the British Government can do to help on that is incredibly important. Because our staff are largely based out of local field offices and work in their own communities, they are able to still move around. What you cannot do is get the links, as Aleema says, in terms of stocks and supplies.

There are a lot of staff not in capital cities who continue to do the work they do embedded in the villages. We are obviously trying to make sure our own staff are safe and that we give them the right guidance, and also that we are not exporting cases into places. The staff we have just sent to Bangladesh, for example, are now in quarantine, to make sure that there is no risk of them passing cases into the Rohingya camps. There are a number of things like that.

We are also doing a lot online. All of us have had to suddenly think about digital in a fundamentally different way. The Humanitarian Leadership Academy's Kaya platform is one that DFID helped us set up as a public good for the sector a number of years ago, to provide humanitarian capacity-building on a mass scale. We have seen thousands of people accessing their free resource and advice on COVID from day one, and we are now pushing out a lot of other things, such as safeguarding, wellbeing and all sorts of other things for free through that platform as well.

It really is changing the way everybody works but it is the biggest humanitarian emergency where a lot of the experts in this cannot actually fly so we are doing a lot of remote work as well.

Q40 **Navendu Mishra:** The digital way of working seems to be a massive factor in all your organisations.

The last question from me is to all the witnesses. How realistic might the "nobody left behind" approach be when it comes to this pandemic? Do you think it is practical that nobody will be safe until everybody is safe, whether by vaccination or eradication?

Rosemary Forest: "Nobody is safe until everyone is safe" is actually a really important aspect that should be guiding all of UK aid policy as well as our defence and security policy going forward. Taking a shared security approach, whether that is our health security or our human security, will be crucial, because we are all so affected and connected. We have seen this from the examples that Gwen and Aleema have shared about the ability the experts have to bring their expertise and the local organisations' ability to share their expertise. We are all going to be affected and that shared approach and that shared security needs to be at the forefront both of our immediate response now as well as looking forward, for example to the integrated review next year. It has to be central.

Nick Dearden: You mentioned a vaccine there, and obviously we are pinning a lot of hopes on a vaccine at the moment. In the meantime, we are trying to make treatments work where they already exist. One of the things getting in the way of that is the fact that, to some degree, we have a very dysfunctional pharmaceutical industry. That is not just coming from a campaigner at an NGO in Britain; Lord Jim O'Neill has been talking about this for several years now, in terms of how the pharmaceutical industry often spends more time sitting on patents and paying out dividends than it does on research and development.

That means the public sector has to put a lot of money in, and it is great that Britain has stepped up and done that, but if we want to make sure that nobody is left behind, it is really important that we put conditions on that funding. They have not done that yet. Those conditions should ensure that, if public funding has gone in, any potential vaccines or treatments cannot be covered by a 20-year patent on behalf of the pharmaceutical industry so that they can charge whatever the market will bear in different countries.

There are lots of proposals on the table for how we can do that at the moment. There is a great proposal that Costa Rica has put forward, which I believe the World Health Organisation will endorse today. They are having a press conference about now about it.

The UK Government have been great at putting money into pots. The more they can do that to leverage change in a system that has been failing us for too long, the better. When it comes to drug production and pharmaceuticals, that is one place where we can really do that and really make our leverage felt.

Aleema Shivji: This is the ultimate test of "leave no one behind". I do not think we could look the world in the eye and say we left the most vulnerable behind. Leaving no one behind is the fundamental principle behind the sustainable development goals. It was one of the fundamental principles behind the world humanitarian summit. It is at the heart of the UK strategy and this is the time when we absolutely have to focus on the world's most vulnerable, whoever they might be and wherever they might be.

Q41 **Navendu Mishra:** Perhaps Gwen might want to take this question, though I am happy to have other people speak on it as well. What are the risks of virus-free countries or communities pulling up the ladder, or other divisive activity occurring at national or local levels?

Gwen Hines: It is obviously a really big risk. You might well see it with countries that feel better off and better able to protect themselves. It is also not possible. We know that you may close an official border but people will still find ways to come through and that is why the point on global security is so important.

I would also encourage you to think below the national level. Whether it is closing off refugee camps or particular excluded groups, we know that there has always been so much inequality and exclusion in many countries at the national level. That is why this focus on working on the front line at community level is so important. You have to do it bottom-up. There are lots of ways of tracking those kinds of things, which local organisations and NGOs do, and feeding in that data. It is inconvenient and it is hard work but it is incredibly important.

Q42 **Chris Law:** You have conveniently left me on the position of frontline NGOs. One of the criticisms DFID has had is that, although its enormous response of £744 million is very welcome, only £20 million is going to frontline NGOs. Is that an effective use of resources? Are you under-resourced? What do we need to do to persuade more of that to go into the hands of NGOs directly, and how soon?

Gwen Hines: We would very much like to see more direct funding going to NGOs. DFID got 12 times more submissions into the rapid response facility than they were able to fund, and we know about many countries where country officers wanted to work with us but did not have the funding to do so. As people said in the earlier session, there is already a shortlist of proposals if more funding is available.

It is also about pushing the UN to get the funding down quickly. DFID's working assumption is that that money will go through the UN to the front line, but every day we are seeing the risks going up and the needs going up. We have already mobilised our own resources. We can get funding out in 24 hours. We have already helped 1.5 million people but we need to get far more and we need to get it now. We know it is a three-to-one return by investing quickly upfront.

Rosemary Forest: While we do support the call for more money, it is not just about how much; it is also about how that money is being spent and used. With that, there is the importance of flexible funding modalities, particularly, as was mentioned previously with the localisation, ensuring that local organisations can apply for that and be eligible. We really need to see an adaption of the compliance and due diligence process that DFID requires so that local organisations are eligible for that funding.

Aleema Shivji: I just want to raise a point that links the two together. We can see on one end of the economic analysis that it is great to put a big chunk of money directly into the Global Humanitarian Response Plan and then earmark it for UN agencies. That is simple on DFID's end. What we heard on the previous panel, and what we have seen in previous crises and what continues to be the case now, is that it then takes weeks for that money to flow down to NGOs, be they local or international.

DFID has a principle that it has agreed to work towards full cost recovery. Money that comes via the UN only gives a 7% overhead, which is much less than the cost recovery of any local or international organisation, so

the amount of money that gets to organisations is not even in accordance with the principles that DFID is trying to uphold when it comes to full cost recovery. One of the big shifts that would be really welcome is for DFID to earmark the money directly towards local and international organisations. That can be done by the global humanitarian response plan as well as through the RRF or other mechanisms.

One last point is that it is actually really hard to know what DFID is spending on the crisis. We have money coming from DFID in country via fund managers, centrally and via primes, and nowhere can you find a picture across all of DFID of where its spend is. One of the asks the Committee can make is to get more transparency from DFID. This is partly a challenge of DFID's decentralised model but actually having a full picture of what is being spent, how it is being spent and how organisations can access it would be hugely valuable.

Q43 **Chris Law:** My next question is to all of you, but I have two questions that I would like to wrap together. A lot of the money that is going towards finding a new vaccine is coming from aid, and quite naturally in some respects because it is for developing countries. The challenge, of course, is that it is ODA funding and it will benefit the public good, not only those who can least afford it but also some of the wealthiest countries as well. I wonder what your thoughts are on that.

Secondly, do you have concerns about vaccines, therapies or tests that are developed with these resources ending up being denied to the poorest and most vulnerable communities due to costs, prices, copyright and patents?

Nick Dearden: This is one of the things we have been working on in recent weeks and we are very worried about it. There are good sounds coming out of the pharmaceutical industry but you have to look at the way they have behaved in the past and even some of the things they are doing at the moment. Gilead, which potentially has one of the antiviral treatments—it is being tested—has applied for special patent status in the United States. It backed down after public protest but we are really worried about this.

When you are putting in a large amount of money—almost all essential medicines developed around the world today require that amount of money, because the pharmaceutical industry is not really fit for purpose, as I said—it is fairly easy to put conditions on that money. That should be very straightforward: to guarantee equitable access, to guarantee an international distribution system, to stop countries threatening action to make sure that their own citizens get drugs ahead of everybody else's—we have already seen that, so we need that system—and to help developing countries to scale up their manufacturing and distribution capacity, because we will simply struggle to have the manufacturing capacity to produce this stuff, even once it is researched. There is a huge amount of stuff that can be done.

My worry to date is that we have put a lot of money into this research, here, in Europe as a whole and in the United States, but with almost no conditions on how this research is used. What we have seen, time and time and time again, is that big companies can then take that research, sit on patents for very many years and essentially charge whatever the market will stand. That is a problem for us. Just here, we will all hopefully get it for free and the NHS has some ability to negotiate, but not much and it will cause an enormous strain. That seems incredible, given that it is public money that has gone into developing this in the first place.

Yes, of course, we are really concerned. One of the drugs at the moment is a hepatitis C drug that could well be used and is being tested for that. We reckon it costs about $5 for a course but it is being sold on the US market for $18,000 per course. That is some of the profiteering that is already going on with some of the drugs that are concerned. There are very serious concerns about this.

A number of Governments have already said, "If this happens, we will override the patents. We will issue compulsory licences, as we are allowed to do under WTO rules, and override those patents". That can send a useful message to the pharmaceutical companies. We would definitely persuade Britain to make that threat, if you like, and to be prepared to do it, but we can actually get in there earlier and just put conditions on this stuff and say, "This intellectual property, the know-how and the science must be pooled", so that we can collaborate, which we are going to need, and so we can ensure equitable distribution of these drugs.

Q44 **Mr Bacon:** I have a question based on something that you said earlier, Aleema, about money going directly to NGOs. Of the available DFID money, are you saying they should be directing it directly towards NGOs rather than, for example, multilaterally through the UN, on the basis that it would get to the front line more quickly if you do it that way?

Aleema Shivji: There needs to be a better balance. It is not one or the other. As we heard in the last panel, there is a real value of money going to the UN and there is an absolute role for every actor in the system. However, there can be an increasing proportion going to NGOs. That can be via the UN but it needs to be fast-tracked, it needs to be flexible and it needs to be full cost recovery. A target of, for example, 30% of DFID's funding going to frontline organisations would definitely be a more reasonable target.

Q45 **Mr Bacon:** Is it not a case that, if you have a finite pot, sometimes it might be one or the other?

Aleema Shivji: I think Gwen will have more to say on this, so I will be really brief and leave it to her to complete. I do not think it is one or the other. Both have worked in the past. DFID has evidence of this. It can work and it is about finding that right balance and making sure that the value-for-money analysis that is being done to make these decisions is

looking at the actual impact on populations and communities and not just what is quicker to get out the door.

Gwen Hines: I know time is tight but I just want to add that a lot of that UN money actually ends up in the hands of NGOs but it takes two or three months to get there and, as Aleema said, we are then finding costs stripped out and we are not able to reclaim the full cost of things like safeguarding and evaluation, which is really important.

The other assumption has been—and I know this is in the DFID submission—that, in order to operate at scale, you need to operate through the UN. As Bob said in the last session, there are coalitions of NGOs operating very successfully in places like Yemen and Somalia that can operate at the same scale as the UN much more quickly.

Q46 **Mr Bacon:** I wanted to come back to Nick Dearden on debt cancellation, because Nick sounded like he had some fairly strong views on that. I was interested in his comment that there has been a huge capital outflow from many developing countries. I take it, Mr Dearden, you meant from south to north.

Nick Dearden: That is what I meant, yes.

Mr Bacon: You are looking for more debt cancellation from the IMF and the World Bank and indeed from individual countries than has hitherto taken place. Is that right?

Nick Dearden: It is right but I would actually like to add an extra element to that. Yes, absolutely, and it is great that Britain took a lead in putting money into the IMF debt cancellation, but much more is needed. It is great that there has been a suspension of debt payments agreed at the G20 by bilateral creditors but we need more than suspension of payments; we are going to need to write down a fair bit of that capital too.

One element that is a real problem is private sector debt, because an enormous amount of the lending that has gone into the south since the crash in 2008 has been private sector debt, because returns were so low in the west that they looked for higher returns in Africa, Asia and Latin America. The problem is we have no system at an international level to compel that kind of a write-down, so you could see the money that has been essentially given in relief by bilateral creditors such as the UK simply flowing into the pockets of the bondholders and the banks back here in the City of London because they refuse to write down that debt.

There is definitely something that the British Parliament can do. The British Parliament has quite an interesting role in this, because so much of the bond payments are contracted under British law. Britain could effectively pass a law that would kind of compel a write-down. It would basically prevent those bondholders and those banks from bringing legal action against the countries, if they default on some of that debt, in British courts. We have done that before. One of the things we would

definitely urge you to consider is to look at that kind of anti-vulture fund legislation.

Longer term, we just need a different mechanism at an international level, because it cannot be right that the public sector always offers debt relief and debt cancellation and the private sector does not have to and, in a way, gets bailed out by that public money coming back around through the debt payments of southern countries.

Q47 **Mr Bacon:** How, though, do we as politicians persuade the tax-paying public to keep on paying more for this when we are seeing capital outflows of the kind you have described from the people in charge in these countries, in the public and private sectors, to the north? You said it was worse than happened in the financial crash. Where is this money ending up when it goes from south to north? Is it ending up in Swiss bank accounts or what?

Nick Dearden: Potentially but not necessarily. It is going back to financial centres, basically, because the investment that was made is seeking safety at a time like this. It is worried. It is worried that the investment will be lost, essentially, so it is flooding back into financial centres where they hope to benefit from Government schemes that we are able to put in place but that developing countries are not.

Q48 **Mr Bacon:** Do you mean it is a northern-driven decision?

Nick Dearden: Yes.

Mr Bacon: I see.

Nick Dearden: By and large. Of course, it is a mix but that is the case by and large. There is a change in thinking on this now. For many years, Governments were told not to put in place capital controls, capital restrictions or whatever. Because so few Governments in the developing world are prepared to do that now, they see money coming in, which is fine, but it can flow out again just as easily and they do not have the ability to regulate that investment and to make it work for the majority of people in their countries. That is something we need to change. The IMF is beginning to change its mind on that and this crisis will probably show all of us that we need to put more regulation into place.

Q49 **Mr Bacon:** Just to take one example, because it illustrates the point, we in the rich west have become very dependent for manufacturing, including for things like PPE, on imports from China. Do you think that this COVID crisis places doubts around the whole globalisation model that we have seen over the last 30 years and, if so, what would you do about it?

Nick Dearden: It does, and one of the things that worries me is that, as a knee-jerk reaction to that, countries start putting export restrictions into place, which makes the whole thing worse.

First, let me say that I am not in favour of export restrictions, by and large, as a way of dealing with this crisis. It will make things worse. However, we have to look at the vulnerabilities that have been created by globalisation over our medical supplies as well as over our food supplies, frankly, which will be an increasing problem as the year and next year wears on. We have to look at more transparency in supply chains—possibly shorter supply chains—and at producing more stuff in country.

That does not mean a complete unwinding of open markets or the international economy, but it does mean that we have to be more responsible about it and we have to look at how we can regulate it in a way that reduces our vulnerabilities and reduces our risk. In that sense, I absolutely agree. I believe it is a bit of a wake-up call for us.

Q50 **Mr Bacon:** This final question is for all four members of the panel. If you could ask DFID for one change in its strategy, what would it be?

Nick Dearden: As I said before, there has been a real push in recent years that, because public money is short, we need to replace that in development terms with private capital. We need to leverage private capital into markets. The problem is that, when you do that in economies where the regulatory ability to control that capital does not exist, it leaves countries extremely vulnerable. We are working at the moment on looking at the ways in which even healthcare and education increasingly are returning to private sector options in many developing countries. I simply do not think it builds the same robust resilience that the public sector does. I would like DFID to look back again at how they can bolster good quality, sure, democratic and transparent public services around the world.

Aleema Shivji: We know that the pot is finite, and actually not so finite in the sense that we know that the 0.7% is tied to broader factors, which no doubt will mean a smaller aid budget. The one thing I would ask would be that those impending cuts, which we know will happen, get pushed back into the next financial year. This is an unprecedented crisis and this is not the time to be cutting funding. We need to have top-up funding for the crisis response that is not being pulled out of existing programmes; otherwise all we will do is widen inequalities, increase the impact of conflict and increase the impact on the world's most vulnerable. That would be my big ask.

Gwen Hines: I would add to those blanket flexibility on existing projects and programmes around the world. At the moment, we have to negotiate programme by programme and senior responsible owner. Other donors, including UNICEF and USAID, have given a blanket flexibility and that enables us to do work much more quickly on the ground.

Q51 **Mr Bacon:** Do you think it is possible to combine blanket flexibility, as you call it, with a very high level of transparency in the way that, say, the Public Accounts Committee or the National Audit Office would want?

Gwen Hines: Yes, absolutely, because we already report in a very detailed level and have full and fantastic engagement with DFID on the country level and globally about what we are doing. We are asking that, rather than having to go with every single line item in the new programme and say what we might do, DFID, like other donors, says, "There is a 20% flexibility on the existing programme. Report back transparently on where it is going". That enables us to do it very quickly without wasting extra weeks now.

Rosemary Forest: In the immediate and long term, we need DFID to continue to prioritise integrating peacebuilding and conflict resolution approaches within their humanitarian health support and to prioritise local actors that are on the front lines.

Q52 **Brendan Clarke-Smith:** Good afternoon, everybody. On the impact on UK NGO charities—and this question is probably better to Gwen and Rosemary—to what extent has the coronavirus influenced your decision making? Which programmes have you ring fenced and which programmes have you terminated?

Rosemary Forest: In the immediate term, Peace Direct is predicting a 20% fall in our projected income this year. With that, we are really ring fencing our support and our work with partners. We are actually also stepping up our game in terms of reaching out on a strategic partnership with Humanity United, in the United States, and Conducive Space for Peace to launch, next week, a fund on digital inclusion, specifically around responding to COVID-19, to allow local peacebuilders and local organisations to do more and engage with each other when they are having to social distance.

At the same time, we are having to tighten our belts and, like many across the sector in the UK and more widely, particularly in peacebuilding, we are seeing cuts to our projected incomes and some of our activities. However, we are ring fencing our work with partners.

Gwen Hines: It is a similar situation for us. The forecast obviously varies but, particularly through having to shut our shops, which were often run by older people and very vulnerable volunteers, we are losing a lot of money and income. In addition, events are not happening. Thankfully, the public giving is holding up and we are very grateful to all the members of the public on that.

We have had to make a lot of cost efficiencies and delay investments and things that are important but not urgent this month or next month so we that can prioritise the front line. We have done a bottom-up, every-single-country assessment of where the greatest needs are in both existing programmes and the new COVID responses, and we have set up a global fund across the whole movement and all the different members, which is being used to target all the resources that we bring in to the greatest need. As I say, we can use that to get resources down to the country office in 24 hours.

We have come together very much across the movement, and that is also looking at where the needs are in places such as the US, Italy, Spain, China and India, as well as very poor countries. We are working very much as one movement but people are tired. It is tough and it is busy but they are coming together to support the front line.

Q53 **Brendan Clarke-Smith:** Perhaps I can open it up to everybody if they could just very quickly, maybe in a sentence or two, sum it up for me. Have you experienced any sudden shortfalls in funding, or are you likely to? What measures have you taken to cope with any such eventualities?

Aleema Shivji: I will speak on behalf of the whole Humanity and Inclusion network, including offices overseas. Similar to what Gwen has said, we have shortfalls in terms of some of our voluntary income schemes completely drying up. The postal network has been impacted differently in different countries so we have not been able to send postal mailings out. We have not been able to run events or do street fundraising, and that has dried up certain elements of our income streams, which has been quite a significant loss in this quarter.

We have also seen a big variability with our funders. While most of our funders have been flexible, DFID included, we have had one or two that have not been flexible, which is quite challenging. As Gwen mentioned, we have really struggled with the time that it is taking to know whether our funders will be flexible. Therefore, at the moment, we are predicting quite a significant loss. Two months in, we are still negotiating line by line with different DFID staff members, offices and all of their fund managers to figure out whether we can continue working or not. That is where the impact is for us.

Rosemary Forest: One area that we are seeing is not so much a complete shortfall now but just delays in communications about decisions around grants or applications that were put in prior to the pandemic being declared, where we are not getting a "no" but we are also hearing nothing. That does not apply specifically to DFID but that is a real concern and it adds a great deal of uncertainty for us, our partners and our colleagues.

Q54 **Brendan Clarke-Smith:** How would you provide accountability and demonstrate value for money if the rules on grants and other funding are loosened? Could additional and flexible funding result in the less effective use of the funds by DFID's delivery partners? I would like to ask that to Gwen and Aleema, please.

Gwen Hines: No, there would not be any less value for money or accountability. We are all very committed and professional organisations. What would be very appropriate in the circumstance is to focus on the objectives we are trying to achieve. Too much of aid management is done as a line-by-line input of how many different sessions and how many people you see. We are now in an incredibly flexible environment, so we need to focus on the outcomes that we are trying to achieve.

As I say, it is about building on the existing platforms. We are not opening in places where we do not have a platform. That does not make sense. We have a good division of labour on the ground with other organisations, so we are building on existing platforms. We have done this bottom-up exercise. We know how much we can spend country by country to achieve our objectives, including this month, next month and six months down the line. We are all very ready to do that and we would be very transparent.

Aleema Shivji: I can only agree with Gwen. One of the things that, unfortunately, we have seen more and more—and this is not just DFID but it is definitely DFID as well—is that more long-term development practices are filtering into humanitarian response, so we spend most of our time writing reports and not delivering services. I do not think the quality of what we are delivering has changed. I do not think the value for money of what we actually deliver, when we get to deliver it, has changed. What has changed is all these extra mechanisms that have been put in place.

Ultimately, we are accountable for every penny. Even when DFID is funding us, some of that money is being co-funded by members of the general public. Just as the UK Government are accountable for every penny that you all spend, we are also accountable for every penny that we spend. It would not change anything in accountability but it would mean that more money would get to people and communities that really need it.

Chair: Thank you very much to the second panel of witnesses. We really appreciate you being so open and honest, and letting us properly understand the pressures that you are under. On behalf of the Committee, we are so very grateful for what you are doing, both on the front line as well as what you are doing to shape policy and our thinking, to truly make sure that no one is left behind in this.

What has been most apparent to me in our first session on the humanitarian response to COVID-19 is three things. First, it is a global issue and it needs a global response. Secondly, DFID is doing a very good job getting the money out but it seems predominantly to be going to the multilateral organisations such as the UN and there is a definite lag in getting it out to the NGOs, and NGOs are suffering because they do not have the cash they need on the front line. Thirdly, an underlying theme that kept coming up was that the issues that the NGOs are set up to deal with originally—for example, poverty, communities in conflict and health inequalities—are still there and still need the funding to continue.

The other thing that is very clear is that there is a window where we can be shoring up and making resilient, and indeed preventing outbreaks of COVID-19, particularly in the global south, but that window is closing very quickly, if not shutting. We need to be much more swift in our response and getting that money out to the front line.

Thank you very much to the Committee. It has been a very interesting session. Thank you for all of your questions.