International Development Committee

Oral evidence: Ebola Crisis and DFID's Humanitarian Response in Iraq, HC 801

Tuesday 11 November 2014

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Members present: Sir Malcolm Bruce (Chair); Fiona Bruce; Hugh Bayley; Fabian Hamilton; Jeremy Lefroy; Sir Peter Luff; Mr Michael McCann; Chris White

Questions 1-86

Witnesses: Dr Javid Abdelmoneim, Medecins Sans Frontieres, recently returned from MSF's Sierra Leone Ebola project, Professor John Edmunds, Department of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine, and Mr Andre Heller Perache, Head of UK Programmes, MSF UK, gave evidence

Q1 Chair: Good morning and welcome. Thank you very much for coming to give evidence to us. I apologise for being slightly late. We have a lot of ground to cover, so please can we have both crisp questions and crisp—but hopefully very informative—answers? We really do appreciate you coming along. Will you introduce yourselves?

Professor Edmunds: I am Professor John Edmunds at the London School of Hygiene and Tropical Medicine.

Dr Abdelmoneim: I am Dr Javid Abdelmoneim of Médecins sans Frontières—Doctors without Borders.

Mr Heller Pérache: I am André Heller Pérache. I am the head of programmes at MSF UK office.

Q2 Chair: Thank you again. First of all, Professor Edmunds, you warned in September of a potential "nightmare doomsday" scenario. Do you feel that that has been averted? And, to the extent that we have—at least in Liberia and Guinea—some indication of a levelling off, how has that happened and can that be maintained?

Professor Edmunds: Do I think that that nightmare scenario has been completely averted? No. I think that it is much less likely now; I was extremely worried back in September, which is why I said that. Things have improved dramatically in Liberia in particular, so whereas the epidemic was doubling every two weeks or so, it has now turned over and declined quite significantly, particularly in Monrovia, which was the main focus.

That is certainly coincident with the very large increase in the number of treatment beds available that occurred, particularly in and around Monrovia at that time, so I think that has had something to do with it.

The numbers of cases now in Liberia have flattened out, so although the increase has stopped and come down, we have not got rid of Ebola in Liberia. There is a very long way to go. In Guinea and Sierra Leone, the rate of increase has not really changed much at all for months: it is continuing to increase gradually. The doubling time in both those countries was significantly longer and really hasn't changed very much.

Q3 Chair: So we still have very serious cause for concern. On MSF, I think we all recognise that you led the response; you were on the ground and were absolutely in the front line at the beginning. You said that the response generally was too little and too late. The international community in the wider world has woken up in terms of awareness, but do you feel that it has woken up in terms of response? To the extent that we have made progress, how can that be maintained? Picking up from Professor Edmunds, although I am not denying that the other two countries are not out of the woods by any means, why do you think that Sierra Leone is proving more difficult than those two countries?

Dr Abdelmoneim: I was in Sierra Leone until 18 October, outside my incubation period. Sierra Leone has always been following Liberia in terms of the statistical increases in the number of cases. On the question of why we think it is doing so much worse right now, from what I saw on the ground, it is simply because there is too little of everything being done in terms of interventions into this epidemic. I shall give you a small illustration of a daily occurrence in our treatment centre there in Kailahun, which is in the far east of the country. An ambulance arrives that we expect to have dead bodies inside, so we are dressed in our full protective equipment. That ambulance would be coming from Bombali or Tonkolili, 10 hours across the country, because there were only two—although now there are three, with UKGov—treatment centres. Usually a patient is dead. I open the door and there are three patients inside: a dead woman and two patients who are alive. They are definitely now cross-contaminated with a lot of virus and have watched the poor woman dying a wretched death. That is what is happening. They are thinking to themselves, "I am going to die that way".

I have to watch this. If that woman fell out of the back of the ambulance, she would drop to the ground and we would not help her. That is a high level of indignity and human suffering going on. That perfectly illustrates the real, unmet need that is on the ground today in Sierra Leone—numbers of ambulances, numbers of treatment centres, numbers of safely operating health care workers.

Mr Heller Pérache: To go beyond that, we consider that there are a number of standard pillars of response to an epidemic of Ebola in its management. Sierra Leone is the example where all the pillars need to be worked on at once. By that I am referring to contact tracing, surveillance in general, health messaging, referral systems, access to health care, safe burial, and running the safe operation of treatment facilities. We are still being outpaced on all fronts. Progress has been made in the sense that there are more actors on the ground. More is happening: more people are deployed and engaged in the crisis. However, we are still

being outpaced, as indicated in all the statistics that are coming forth. Sierra Leone is the most concerning case that we have.

There are a few things to highlight in particular that we are concerned about. What needs to be looked at are all the transit centres, or holding centres as they are called, where suspected cases will be screened, vetted and moved on to other centres. That feeds into what Javid described with the ambulance.

Q4 Fabian Hamilton: I wonder how you would characterise the role played by DFID to date in the fight against Ebola.

Professor Edmunds: Since about September, they have been very active and engaged and have done a great job. They were just a bit late, frankly. Now, particularly in Sierra Leone, they are really in the lead in building new treatment centres, which is essential, and other facilities which my colleagues from MSF just mentioned. So since the autumn they have been really excellent. The issue is—as with many other responders, apart from MSF—that they are months too late and it takes a lot of catching up. You have to get ahead of the epidemic, in terms of the numbers of treatment beds available, which takes time to build. DFID's response of trying to build the larger treatment centres, but also a number of smaller units, is probably the right approach now, because we need to get treatment facilities closer to patients. This idea of transporting patients for many hours in the back of uncomfortable ambulances is both dangerous and not conducive to patients coming forward to get early treatment.

Q5 Fabian Hamilton: What should DFID be doing differently, if anything—apart from having started earlier?

Mr Heller Pérache: I want to highlight that MSF, on 2 September, made a call for Governments to intervene directly with assets that would normally be housed within the Ministry of Defence, as well as within the civil service and medical systems. We asked, on that date, for member states of the United Nations, as well as the UK Government, to take direct responsibility for it. What was produced, from the UK Government's response to Sierra Leone, was putting DFID in the lead, working with some MOD assets and with NGO partners to implement a strategy.

It was not exactly what we asked for in the beginning, in terms of what we had imagined. That was quite some time back and we didn't really know what was going to come from it, but in terms of the role they are playing, how good a job people are doing, we are not keeping a scorecard on DFID's performance. They are present on the ground, they are engaged and working hard, and improvements are happening—we just still maintain the image of reality that we are still being outpaced, whatever those efforts are, effectively, in the field.

Q6 Fabian Hamilton: Thank you for that. There has been some criticism of high-specification British hospitals taking many weeks to build, when what is needed is urgent access to basic sanitary facilities. Do you think that is a fair criticism?

Dr Abdelmoneim: It may take time to build something, but don't forget that the most critical moment in starting a treatment centre, if that is what we are talking about, is the opening of that centre. If you are putting your health care workers and your sanitation experts in there, at risk of cross-infection, then you mustn't do it quickly. It is critical, so you might take two weeks, three weeks, four weeks to build a 100-bed centre, but that doesn't mean that you are operating at 100 beds from day one. You will operate at five beds for a week, make sure that no accidents happen, check the flow, see that everything works, and step up in increments. So the rate-limiting step might be the building—if that can be done quicker, fine—but it is the opening that is always going to be slow thereafter and needs to be done safely and in an efficient manner for the health care workers.

Q7 Fabian Hamilton: That is a very good point. We had a recent report on health system strengthening, in which we concluded that DFID should make better use of NHS expertise in its work. Is it easy enough for those who want to volunteer to help in the fight against Ebola to do so?

Dr Abdelmoneim: It is easy enough, in my experience with my colleagues, to volunteer. I am an emergency medicine doctor here in London and a number of my colleagues are on the trauma register; they go off to earthquakes and so forth. I believe that that trauma register is now being opened, at least through UK-Med, for the Ebola crisis. It is easy enough to volunteer; whether they can get the time away from their trusts and that position backfilled is an altogether different question—that is the rate-limiting step there.

Q8 Fabian Hamilton: Is enough being done to do that?

Dr Abdelmoneim: I can't say. I don't know.

Professor Edmunds: There aren't many UK health care workers out there at the moment, so I suspect the answer to that is no. DFID are building these new treatment centres; there's no point opening new treatment centres if there's nobody there to staff them. This needs to be taken with more urgency at the NHS level, for their own good: if we don't stop this epidemic in west Africa, then we will get cases here in the UK and the NHS will have to cope with that. It is much better for everybody to stop this epidemic in west Africa.

Q9 Fabian Hamilton: My next question is fairly relevant, then. Our report also concluded that developing countries' health systems would benefit from more advice from health system management specialists. I think you have already answered this, but is the right mix of expertise finding its way to west Africa from the UK?

Professor Edmunds: MSF would be the best ones to answer that.

Mr Heller Pérache: I don't think MSF can comment on that.

Fabian Hamilton: Or from anywhere, for that matter?

Mr Heller Pérache: Our lines have been consistent in terms of what we have been asking for: an increased response on the ground towards the crisis. This is still what we are asking for and what we observe as an organisation.

In terms of preparedness for epidemics, a treaty was passed following the SARS epidemic, which was ratified by most countries in the world, emphasising eight basic principles that needed to be in place in every country. Many countries simply do not have that. There are systemic issues. There are issues with deployment of people and development. There are a lot of different issues contributing to this.

Chair: Jeremy, you had a supplementary?

Q10 Jeremy Lefroy: Yes. Thanks, Chair. Good morning. We are extremely grateful for and respectful of the work that MSF are doing across the region at the moment. As a Committee—my colleague has already referred to our report—we were there in the middle of June. We went to Bo and met the Minister of Health, the President and a lot of DFID officials. We also went to Liberia, where we met the Minister of Health and the President. Although there was a lot of concern about ebola in Sierra Leone, I did not feel—my colleagues may disagree with me—that anybody there had a great sense of urgency.

Back in March, you had already raised the alarm on this, and I am constantly questioning why we could not be more forceful. We were fairly forceful in our report, which was written a little later, but why, even by the middle of June, did there not seem to be any great sense of urgency either in the Government in Sierra Leone—and possibly that of Liberia, although I detected more urgency there—or among the international community? Do you have any views on that?

Mr Heller Pérache: In the month of June, we announced that the epidemic had grown to a historically unprecedented proportion. This was not recognised. In the beginning, the WHO did not recognise it; it took the WHO a number of weeks to come along and agree with us that things had gone beyond our scope of understanding and our ability to respond.

In the past, MSF had been the only non-governmental organisation to work with other experts housed in different research institutes, hospitals and so on to respond to epidemic crises in the world. That competence did not exist within Ministries of Health in west Africa, because Ebola had not struck there. Generally speaking, ebola was in the equatorial belt in central Africa, around the Congo basin and up towards Uganda. It was also a new thing. A number of different factors contributed to things going the way they did.

Professor Edmunds: The old view of Ebola, up until about June, was that it was not very transmissible in the community, but was spread primarily in a hospital environment if there was poor infection control. That just isn't the case, but it was how we viewed Ebola, so people's reaction was, "If we can get cases into hospital and improve our infection control mechanisms, then it will go away and it won't spread very much in the community." That is clearly not the case. It is transmissible in the community, and in fact one of the early pieces of work that we did around June was to look at the original data from the 1976 outbreak using

modern mathematical and statistical methods. We found that actually, it was very transmissible in the community even back then. This is a problem that has been waiting to happen. A large-scale community outbreak of Ebola has been an accident waiting to happen for decades.

Q11 Jeremy Lefroy: Given that MSF had a clear view on this and that MSF is a highly respected organisation which is on the front line all the time, is there a problem that what you say—not only in this case—is not listened to by WHO or DFID, despite your track record? I want to tease out a more general response than just in this case.

Mr Heller Pérache: You are basically asking why people did not come to help. People had come forward to try to take on some activities supporting some centres in the beginning, but it is not the kind of thing that is easily done. Everyone who has looked into this witnessed some of the cases where some doctors with another organisation from the United States were infected. They were running a centre. On building the capacity in-house within a non-governmental organisation, to do such a job would require restructuring, at a minimum, the human resources department, as well as many of the very technical arms that would be required to do the medical support.

Just building up that architecture, being able to assume the responsibility of safely operating a place like that, taking on the liability of sending out health care workers to be a part of a search capacity, and operating these facilities in a way that you can really guarantee will be safe, is a very difficult thing for agencies to do. This is precisely why, when we did not see a lot of others coming forth to try to take on the management of isolation and treatment facilities, we made the call directly towards military and state assets, because we assumed that, with their level of human resources, sustained logistical capabilities and command and control, those people would be able to deploy more easily than a non-governmental organisation would.

Professor Edmunds: WHO had cut their outbreak response capabilities over the last few years, and that is one of the problems. If you do not have a major outbreak, one of the things that you are likely to cut is your outbreak response capabilities, and then, of course, what happens when you get an outbreak?

Chair: That is a useful comment.

Q12 Hugh Bayley: My first question has to do with the epidemiology, so perhaps I should start with Professor Edmunds. If you look at the rate of infection and the spread of the disease in Sierra Leone as opposed to Guinea or northern Nigeria, it seems that it spread more quickly in areas with poorer health systems. Do you agree with that conclusion?

Professor Edmunds: It is difficult to say. I would not know how good the health system is in different parts of, say, Sierra Leone. It is probably safe to say that it is spreading more quickly in urban centres than it is in rural areas.

Q13 Hugh Bayley: That does seem to be the case, as it has been in previous outbreaks. I suppose the first question is: have you got a faster spread of the disease once you take into account the concentration of population?

Professor Edmunds: In Sierra Leone?

Hugh Bayley: Yes, that underpins my question. If you have got a poorer or weaker health system in Sierra Leone, is that a cause? You would need to look at the rate of infection.

Professor Edmunds: I do not know how Sierra Leone's health system stacks up next to Liberia's and Guinea's. I imagine that they are all pretty much the same and not very good. I think the wider thing is that that is why you have had this major epidemic, because the health systems generally in the region are very weak, but perhaps others here would be able to say whether parts of Sierra Leone or Sierra Leone itself is worse. I do not know.

Dr Abdelmoneim: My personal opinion is that even if the health systems were weak, it takes a lot of technicalities, logistics and know-how to keep Ebola out of your health centre. Even we in MSF have not tried to run paediatric and obstetric services in Bo, which we had been doing for many years before the Ebola outbreak. We failed to keep it out of our centres and had to close our services there. Ebola in this context has been overwhelming for the health systems in place, including ours.

Mr Heller Pérache: Beyond that, I just want to make one point. In considering what you can attribute this epidemic to, it is much easier to find contributing factors than it is to attribute it to one specific factor. It is a confluence of many things, from the way in which their marketplace and the health care system function to the way in which cultural practices function, with burials. There are so many different factors that contribute to this, and those are all different within the three states that are most heavily affected. It is difficult to put the lion's share on one specific facet of this.

Q14 Hugh Bayley: I understand clearly what you are saying—you are facing a crisis, you will focus on the crisis and, in a sense, lessons learned can come later—but in the Committee's report on health systems strengthening, we came to the view that some donors seem to have put too much emphasis on vertical interventions, rather than system-wide approaches. Do you share a view that one needs to correct that imbalance and one needs to be aware, with a vertical programme, what the dangers are for that health system. Is that a lesson you have learnt from this?

Mr Heller Pérache: MSF does not have any comment on that.

Professor Edmunds: I think that is probably fair to say to some extent that it is easier to raise money—I think—for a single cause and I think that is what has happened in the recent past. Some of those causes are very well worth supporting—Global Alliance for Vaccines and Immunisation and immunisation programmes, and so on—but, yes, you need to be careful, in doing that, that you build on that. The immunisation programme is the bedrock on which many other parts of the health service, and primary care, in many countries is built.

That is the way to do it: not to pull out of supporting the immunisation programme, but to build wider health systems around them.

Hugh Bayley: Thank you.

Q15 Mr McCann: Good morning. You have already answered some of questions that I was going to ask about the challenges faced by the health systems. Perhaps I can ask Javid a particular question—your recent experience can hopefully help us. There are reports that people are dying of routine conditions, because all efforts are being directed towards Ebola. Is that your experience from your time there?

Dr Abdelmoneim: It is not my personal experience, simply because I was in the Ebola management centre and not in other health facilities, but it is my knowledge of what is going on there and what is being reported about. Obviously, measles and meningitis vaccinations have not happened this season, as I have said. I know that our paediatric and obstetric facilities in Bo had to be closed, because we cannot safely admit a woman, for example, who is having a haemorrhage in pregnancy if she has a fever. How can you make sure that she is not an Ebola patient within hours and then admit her to your facility and perform a caesarean that is necessary? It is very tricky. So obstetric and paediatric care have gone down—just from what I know about our own programmes in the area—and vaccination programmes have not been in place since March.

Q16 Mr McCann: When we were there in June, I was taken aback by what the Health Minister said when I asked, "Where do you see health systems go in future?" She said that she hoped that there would be a time when people could pick up a telephone and get an ambulance in just the same way as they could in the UK. It seemed to me an Olympian detachment from reality. In terms of a realistic response, what more can be done to strengthen the health systems, while continuing to combat Ebola in the short and medium term?

Mr Heller Pérache: There are a few efforts that we have underway to try to do this. One of them is prophylaxis against malaria. We already distributed in Monrovia—and we intend to in Freetown—simple measures that do not require a lot of patient contact for curative care. But regarding what can be done with the health system while the Ebola epidemic is under way, the answer is to stop the Ebola epidemic first and then you can put it back together afterwards. That is why we have emphasised, really, a full press on stopping the spread of the virus and stopping the epidemic in its tracks, so that we can go back to other things.

It is such a danger for health care workers, when Ebola is in an environment, to run a facility. It requires so much training specialisation for triage to be able to separate potential Ebola-positive patients from non-positive patients and to run a waiting area in a clinic where you can guarantee that there will not be cross-contamination of those who would be positive for Ebola from those who are negative.

If you poorly run health care facilities in such an environment, you can actually risk amplifying the epidemic, as opposed to turning it around. This is why we have emphasised

the efforts first to stop the epidemic. That being said, we really do recognise that the rest of the impact of the partial collapse of health care systems surrounding it may be taking a toll as large as that of the viruses.

Q17 Chris White: The outbreak has had a wider impact, in both Sierra Leone and Liberia, on the local economies, and most significantly on tourism, the service sector and agriculture. What do you think the priorities should be for state reconstruction?

Professor Edmunds: Where to start? If schools have been closed for six months or more, so I would probably start there, otherwise a whole generation will miss out on education. It is a huge task. As my colleagues from MSF say, we need to get rid of Ebola first. Nothing can be done until that task is achieved, and that will take many months. This is not going away in the next few weeks. In the best case scenario, it will take many months, and we will then have to rebuild the health system, particularly taking into account infectious diseases and immunisation programmes—measles epidemics will follow quickly if we do not immunise rapidly following this. Polio is on the threshold of elimination or eradication, but one of the focuses, in terms of where it still spreads, is Nigeria. Polio immunisation needs to be rolled out very rapidly in West Africa afterwards, and so on. Emergency things need to be done from a health point of view, and then it is about reconstructing all kinds of areas of the economy, from agriculture to schooling and so on.

Q18 Chris White: Do you see any work being done on that at the moment? Is there any thinking happening?

Professor Edmunds: I am not aware of it. I am sure there is, but I am not aware of it.

Mr Heller Pérache: I would just like to emphasise that people's thinking will happen in phase with the impact of the epidemic, so the longer the epidemic goes unchecked and unabated, the longer you will have to continue to develop deeper plans for more sectors of the Government, the economy and the region. It will spread farther than the three affected countries eventually if we cannot turn this around, so the longer this goes on, the more problems you will have and the more priorities will emerge from those problems. As soon as you stop the epidemic, you can figure out your real priorities.

Q19 Chris White: Going back to both your points, what do you think can be done—this is an enormous question, in terms of reconstruction—to ensure that there is no repeat of the epidemic?

Professor Edmunds: There are many things that we can do. If we are talking about the UK's response, I think that the UK must have a better response mechanism for outbreaks. We are reliant on MSF and perhaps CDC to investigate outbreaks and be on the ground, and I do not think that that is sufficient. We need to be able to respond much more effectively, to investigate outbreaks and to respond with colleagues, particularly MSF, much more effectively than we have. We effectively did not really do anything until the WHO finally

made their announcement in August that this was a serious concern. I do not think it is acceptable that we should be doing that again.

There are other steps we can take. Vaccines will be developed and will probably play a part in stopping this epidemic. They should be stockpiled and used to help, if only just to protect health-care workers and other front-line responders in future outbreaks. We need vaccines for the future, but that will be expensive and, again, you need to stockpile it and to refresh that stockpile when it goes out of date. That is expensive, and somebody at some point is going to say, "Why are we spending all this money on the stockpile?" We are, because this will happen again. Ebola has not gone from the fruit bats, or wherever its natural host is, and it will come back; every now and then, we will get a big epidemic. We need to be able to respond far better than we have to this.

Q20 Chris White: You have talked about a better response mechanism. Do either of you have recommendations for how that can be put in place? You have mentioned vaccines. Is there anything in terms of education? Do you have other suggestions?

Mr Heller Pérache: We would like to see a deeper, critical review of how the world in general responds to epidemic outbreaks—what mechanisms come into play and how this would operate. We do not have any clear recommendations for the world that I am prepared to deliver to the Committee today. In terms of epidemic response, in the case of Ebola versus other disease outbreaks in the world, this is particularly visible and high-impact, so maybe it is much more noticed than other kinds of epidemics, given how damaging it has been and how far it has reached, in terms of the other consequences that have followed it and how little margin of error you have when actually treating it. I suppose this is indicating systemic problems in our response capacity in the world in general, particularly in environments that are resource-poor. We should consider that. As an organisation, we have been asking for an increased amount of support and investigation, and for people to get out on the front lines to help with treatment. What form could that take? It could take many forms.

Q21 Fabian Hamilton: I want to come back briefly to some of the points I was making earlier. DFID has committed itself to supporting the creation of 200 community treatment centres in Sierra Leone. Does MSF think that that is the right approach to tackling the epidemic? I gather you have had a few criticisms.

Mr Heller Pérache: MSF does not want to stand in the way of other entities—governments, local authorities, DFID or other actors such as research institutes—and prevent them from creative thinking and coming up with new, fresh strategies to check this unprecedented crisis. It is without precedent, and there is not an easy solution. We have engaged in discussions regarding the community care models that have been proposed. From my understanding, this is still being elaborated by those who are leading this initiative. MSF is not participating in those community care centres.

Q22 Fabian Hamilton: Why not?

Mr Heller Pérache: We are sticking to our way of working. We want to guarantee the safety of those who will be working within a facility first. We will not run a facility unless we can guarantee the safety of those who are operating that facility. Although the community care centre discussion is going on, it is still in a hypothetical phase at this point for Sierra Leone. But there are holding centres and transit centres throughout the country. They need support. They are overcrowded and they need places to refer the patients to, so there are various components to take a look at. The community care model is exactly that. It is something that is being discussed, but MSF is not a part of its implementation.

Q23 Fabian Hamilton: But the fact that you are not part of it does not mean that you do not think it is a good idea.

Mr Heller Pérache: The model has not been delivered as such. They are not in existence right now. We are not going to shoot down other people's ideas and other people's efforts. The way that this is operating, the way that it puts responsibilities on the community, and the way that they are designed at this point is not something that MSF is behind. We are behind re-emphasising the work on the centres that we are currently engaged in; having more beds overall that can be safely run throughout the country; stronger referral systems; and fixing the transit centres and making them safer.

Professor Edmunds: The model for the care centres has evolved over the last few weeks from something that was quite basic to the model now being rolled out, the mini-treatment centres. A couple have been opened in Liberia. I personally think that they are essential to bring treatment closer to the cases, because we need to get cases into treatment as fast as possible. They have two roles: first, expanding the number of treatment beds available more rapidly perhaps than in a larger unit and, secondly, bringing those units closer to the patients. There are stories of patients travelling for hours in ambulances. The problem of then waiting for their test results is terrible.

Dr Abdelmoneim: Why build 200 new centres when there are holding centres already that need input? They need the full logistical back-up: the laboratory, safe burial, disposal of materials, food. Why use ambulances to bring the patients to them? If they are there already, why build 200 others? Why don't you get those ones working well? They are proximate to the patients already. For me, that would be a much more practical solution and something that is along the lines of what you are thinking. That is my personal non-MSF opinion, having been there.

Q24 Chair: Thank you. When we went to Sierra Leone, we were looking at post-conflict reconstruction and development, of which strengthening health systems was an aspect. Obviously, events have moved on to the point where we have to have a legacy for the health system, to ensure that it is much stronger than it was and much faster. You have given us some very interesting pointers. Obviously, we then have to redevelop and reinvest in the country, to ensure that it is robust, and that is a whole different programme.

You have given us some good pointers. I also want, through you, to thank your people for the dedicated work they do, the sacrifices they make and for the risks they take on behalf

of all of us. We would like it to be recorded that we appreciate what you do and we very much admire and respect it. Thank you very much indeed for coming in and giving evidence.

Examination of Witnesses

Witnesses: **the right hon. Justine Greening MP**, Secretary of State for International Development, **Chris Lewis**, Health Adviser and Ebola Crisis Strategy and Policy Lead, DFID, and **George Turkington**, Head of Conflict, Humanitarian and Security Department, DFID, gave evidence.

Q25 Chair: Good morning, Secretary of State, and welcome. Thank you very much for coming in. Briefly, for the record, although we know who they are, could you introduce your team?

Justine Greening: I will ask my two colleagues to introduce themselves.

George Turkington: My name is George Turkington. I am the DFID director for the Ebola crisis.

Chris Lewis: My name is Chris Lewis, health adviser and the lead on strategy and policy for the Ebola crisis.

Q26 Chair: I repeat, welcome and thank you. I can appreciate that the Ebola issue will have risen right up to the top of your priority list over the last few weeks. Obviously, we want to explore the scale of the problem and the UK's response. Our information at the moment is that nearly 14,000 cases have been confirmed so far. Indeed, I gather that there has been a spike of deaths, even over the weekend, in Sierra Leone. What is your current reading of the latest state of the epidemic as you see it right now?

Justine Greening: I think we all recognise that this is an unprecedented outbreak of Ebola. To date, in Sierra Leone, the total number of confirmed cases is just under 4,000 as at the end of October, and deaths were around 1,000. As you say, we have expected to see more cases and more incidents of Ebola, and we will continue to see this disease get worse before it gets better.

Q27 Chair: The previous evidence we had confirmed that that was the situation, and we are certainly not out of the woods, by any means. The implication was that the situation appeared to have peaked in Liberia and Guinea, which does not mean it is under control, and the situation in Sierra Leone appears to be still growing exponentially. Is that your reading of it? How do we maintain the progress in Liberia and Guinea, and how do we get it under control in Sierra Leone?

Justine Greening: It is probably fair to say that the data that we see on Ebola cases is not necessarily 100% accurate. It is hard to get data on the ground. However, the mechanics

of what we have put in place have been very comprehensive. I am sure we can come on to this in more detail. Within Sierra Leone, we are working with the Government on treatment beds; on making sure burials can take place safely; on increasing community care; and on so-called social mobilisation, which is about how we can work with communities so that they can minimise the risks to themselves by changing behaviour. It is probably too early to say what the impact of those interventions are. Nevertheless, we are seeing in some districts the level of incidence starting to level off and the rate of increase lessen. The picture is not uniform across countries and within countries. Perhaps Chris can give a clinical perspective on that.

Chris Lewis: As the Secretary of State has said, the picture within countries is very diverse. In Sierra Leone, we originally saw the peak a few months ago in the south-east of the country around the Kenema area. We have seen that area start to come under control, and we are seeing the cases increase towards the west of the country. So we are seeing a district-specific, geographic-specific situation in Sierra Leone at the moment, which is why we are trying to tackle it on a district-specific level.

Chair: Before I bring in Sir Peter Luff, I want to say that we will have two minutes' silence at 11 o'clock.

Q28 Sir Peter Luff (Mid Worcestershire) (Con): In addition to our support for international agencies, we have committed £230 million to fighting Ebola itself. Which budget is this money drawn from?

Justine Greening: We have a number of contingencies in place, as you can imagine. At the departmental level, we always have some level of contingency funding that we can draw upon for these sorts of crises. Also, within regional budgets, we have contingency, so the funding for this Ebola crisis has come from that contingency planning. It is also fair to say that within the overall budget there are always things that happen slightly later than we expect, and some happen slightly sooner, so there is always some scope to be able to respond to this sort of crisis, and that is what we have drawn on this time.

Q29 Sir Peter Luff: So that £230 million is all DFID money?

Justine Greening: Yes.

Q30 Sir Peter Luff: The MOD contribution is on top of that?

Justine Greening: That is correct. We would ordinarily reimburse the MOD on a marginal cost basis.

Q31 Sir Peter Luff: So you will have to fund the MOD's additional efforts?

Justine Greening: That is right. It is too soon to say what that will add up to. We are still in the middle of responding to this crisis, obviously, but we have an agreed protocol in place that works very well.

Q32 Sir Peter Luff: How do you decide how much to spend?

Justine Greening: The key with this particular outbreak of Ebola has been to try to get ahead of the disease itself. The point I made very clearly when I was at the World Bank meetings in October was that if we are all agreed that we need to tackle Ebola and that we need to bear down on this disease, then it is nonsensical to wait to do that, because it will cost twice as much, it will kill twice as many people, and it will devastate the economy in places such as Sierra Leone even more, so what was needed was an urgent response. We can be very proud of the role that the UK has played, particularly in Sierra Leone, in leading that response. One of the other elements of our work has been to push the international community to join that, not least holding the Ebola donor conference in London at the beginning of October.

We have seen, in pulling together the overall strategy that we are now working hand in hand with the Sierra Leone Government to deliver, that that has become an investable strategy. So we are seeing other countries—for example, Norway—providing health care workers that can then be part of the UK response that we are co-ordinating with Sierra Leone on the ground over there.

Q33 Sir Peter Luff: Do you foresee the need to spend more money on combating Ebola? For example, at the weekend we have seen news of a dramatic spike in cases in Sierra Leone. How will you decide how much more to spend? What criteria do you apply?

Justine Greening: I will ask Chris to comment briefly on that spike. We will stand ready to provide additional resourcing in relation to Ebola. That is the right thing to do—to continue to stay the course with the strategy that we have put in place on the ground—and, of course, there is already work under way looking at the impact this will have on Sierra Leone in the medium term in relation to health care system strengthening, and some of the issues around what has happened to the economy and livelihoods. As the biggest bilateral donor to Sierra Leone, we will also look to ensure that our work continues after this crisis has passed.

Chris Lewis: In terms of the spike, whenever we look at weekly case reports, particularly recent ones, there is considerable variation. Also, when we have just had weekly case reports, it often takes time for the accuracy to improve. We only start seeing accurate reports three to four weeks after the situation. So the spike needs to be taken in the full curve of the epidemic, rather than as a one-off spike.

Justine Greening: The other point to make, going back to my original point on data, is that as the strategy we have in place kicks in at district level, we are likely to reach more of the actual cases, which, up until now, have possibly been happening off-line, and going unidentified. So there is a twofold piece here: one is the rate of the pace of the outbreak itself; and the second is the fact that we are on the ground, and able to catch and help more of the people who have been affected by it.

Q34 Sir Peter Luff: A lot of work has been done by MOD, of course, on the ground, dealing with the particular crisis. What mechanisms are you using to ensure effective co-ordination between your staff and MOD?

Justine Greening: Essentially, they are working in a so-called inter-agency taskforce, based in Freetown. They are essentially working in one team, so they are not having to liaise, per se, because they are working together on a day-to-day basis. Of course, we also have COBRAs regularly, at the ministerial level, to ensure that at official level and ministerial level we are joined up.

Finally, it is also fair to say that this is not the first time that we have worked with MOD. They did a fantastic job helping us to respond the crisis of typhoon Haiyan in the Philippines. At that point, the MOD had one of its people embedded in our crisis response team. So, we have now got tried and tested mechanisms to ensure that we can work hand in hand. Indeed, we do, and I pay tribute to the MOD for the fantastic work that it has already done on the ground in overseeing the delivery of the Kerry Town facility.

Q35 Sir Peter Luff: The joint inter-agency taskforce is just DFID and MOD?

Justine Greening: No. It also includes Public Health England and, of course, the Foreign Office too.

Q36 Sir Peter Luff: We live in a dangerous and difficult world at present, with many threats to our security and health. We now have more military personnel fighting Ebola than fighting ISIL or the Taliban. How do we decide where to put our resources in these battles against dangers?

Justine Greening: Any time we respond to a crisis, ordinarily we will look to work through UN agencies and NGOs on the ground, and working with MOD for us is, in many respects, a last resort when there are no other options available to us. It is clear to me that there would have been no way to make the progress on delivering treatment beds, on the command and control, on the logistics and on the health care training that the MOD has helped us to do with the World Health Organisation, had we not been able to access MOD personnel. But, Peter, you are absolutely right that we can set out what we think the needs and scoping is, with help from MOD, and of course we need agreement that those resources can be made available to us.

Q37 Hugh Bayley: Can you describe what role the Army Medical Services Training Centre in York has had in preparing military personnel to go to Sierra Leone? Are the training facilities also being used to train civilian personnel? I heard at the weekend that some American personnel were being trained there. Can you describe what is going on?

Justine Greening: Yes. The training that has happened up in Yorkshire was meant, to a large extent, to have replicated the conditions that people would be training in. So they have

been training in tents that are heated up to a temperature that people can be expected to work in, even in Sierra Leone.

A number of different pieces of training happened. One is the basic PPE training on how to do infection control, and all of that. The second piece is the "train the trainer" approach, one of the core bits of training we are doing. There has also been the roll-out of that module—how we do the train the trainer approach—which is what the Royal Army Medical Corps, which I flew out with about three weeks ago, is now doing. The final piece is making sure that we can train international health care workers and also domestic health care workers in Sierra Leone. So people have been going through the training to be able to deliver that. You are right—we have made it more broadly available where that has been appropriate.

Q38 Hugh Bayley: Can you say a bit more about that? Are civilians being trained there? For instance, do any volunteers from the NHS use the replicated facilities in Yorkshire—the heated tents? What about United States personnel? Are any other foreign personnel being trained there?

George Turkington: As the Secretary of State has said, the facility at York is about preparing people to deploy in Sierra Leone. We are trying to replicate the conditions so that they can practice putting on their PPE—personal protection equipment—and taking it off safely, and so on, for example.

Absolutely, for those international partners, such as Norway, who are working with the UK on our treatment centres, we have offered to train their staff through the York system. When staff are deployed in Sierra Leone, there is another acclimatisation process and further on-the-ground training, including training at the site that they will be deployed on.

I should also say that, working with the WHO, the UK military, with our support, is also providing a training facility to train hundreds of health workers for this response. That is everything from cleaning staff, through to preparing the clinicians who will deploy in the treatment centres that we are building.

I cannot comment specifically on US staff being deployed there being trained in York—we can check that and get back to you. But certainly for those international staff that are supporting the UK effort, we are happy to do what we can to help them prepare for deployment.

Q39 Hugh Bayley: Thank you. When you get back, if you could respond to the question, "What international staff are being trained there?", rather than just about the United States, it would be useful.

The UK has spent less than a third of the £306 million that we have pledged so far, whereas the United States has disbursed almost 90% of the £423 million that it has pledged. Why is our rate of disbursement slower, and when will we get up to the US rate of disbursement of funds?

Justine Greening: I do not think that is particularly the case. We have—

Hugh Bayley: These are the latest figures from the EU funding transparency tracking data.

Justine Greening: Well, the figure they have captured is what we have announced so far. That does not necessarily mean we have announced absolutely everything on every occasion that we are already getting on and doing. So I think we are well on track in meeting our commitments and, particularly in relation to the EU and broader EU member states, I think everyone would agree that if one country has been at the forefront of the response to the Ebola outbreak, it has been the UK.

Our role at the EU level has been very much to encourage other member states to join us in meeting that response. In fact, at the EU Council at the end of October, the Prime Minister was successful in getting pledges of around €1 billion from other member states, which was vital in making sure that we can have a broader-based response to this.

Mr McCann: Good morning, Secretary of State. Jeremy Lefroy asked the previous panel a question about our preparedness for the crisis, given that when we were there in June it was just starting, and predictions had been made before June that a crisis was on the way. As lead donor to Sierra Leone, what is your assessment of why we find ourselves in this position? How would you respond to the charge, for example, that funding three new testing labs is behind the curve?

Justine Greening: As I said at the beginning, the scale of this outbreak has been unprecedented. It is not per se unusual to have outbreaks of Ebola—in fact, there is a second, slightly different strain of an outbreak in the Democratic Republic of the Congo at the moment. What was different about this one was the way it took hold and then spread far more rapidly. Back over the summer, we really had looked at doing two different things. One was to see how we could rework our own work on the ground in Sierra Leone. As you point out, we are the biggest bilateral donor—in fact, I think the second biggest country bilateral donor behind us is Japan, and it does about a quarter of what we do, so we had already looked to do that. We also worked with the WHO and partners like the Red Cross, and the diagnostic work that we are doing now in the labs—one of which is already open—will quadruple the testing capability in Sierra Leone. It has been a comprehensive response from us to what has been a unprecedented outbreak. As the strategy has steadily evolved, it has got more elements to it to make sure that it has all the pieces in place to be successful, which I think it does.

Q40 Mr McCann: Do you think that the DFID response to the Ebola crisis was hampered in any way at all by the fact that we have not had a permanent head of office out there in the past year? The allegation put to us very strongly when we were there was that that was causing difficulties on the ground, and the suggestion was that the Sierra Leonean post was not seen as being a prime position, given that there was no longer the attachment of the civil war in the area.

Justine Greening: No, I don't at all. Whichever country you talk to, whether Nigeria or countries more badly affected such as Liberia or Sierra Leone, everyone will say that this outbreak of Ebola has just simply overwhelmed health care systems. Almost any country would have had a challenge in trying to combat this virus, and that is why it will take the international community supporting these countries to help bring it back under control. In

countries like Sierra Leone, where health care systems are simply at a lesser stage of development—this is a country that was in a civil war comparatively recently. It has come a very long way since but from a very low base, and it was always going to be particularly difficult for it to cope with this very virulent outbreak.

Q41 Mr McCann: On that point, when we met the Health Minister, I was underwhelmed by comments that she made to the question that I put to her about the future of health services in the country. She said, "We hope to be in a time when people can pick up a telephone and have an ambulance at the door that will take them to a hospital or a clinic." We had just come back from Bo, where we had seen the difficulties in transportation around the country, and that just seemed so detached from the reality. It was generations and generations away, even if they could even attain that. Do you think there is any help that we can give them in terms of making them more realistic about their health systems?

Justine Greening: As I understand it, a different Minister is now heading up the Ministry of Health. I think that in time, once we have got through this more immediate response to the Ebola outbreak, there will be first of all lots of learning, and secondly, yes, it will particularly give us a clear sense of where the needs are in the Sierra Leonean health care system, and also of the capacity building at the Ministry of Health level that you point out.

Q42 Chair: Who is actually in charge of the joint British working group? Who is heading it up?

Justine Greening: What I talked about to Peter was, if you like, the HMG team. That is within the national Ebola response centre, which is the overarching Sierra Leonean command and control that we have helped put in place. Donal Brown, who is the lead person from the Government, is essentially one of the key people involved in the NERC, as it is simplified down to, and it is staffed up between the UK, but more importantly, also Sierra Leonean officials. All of our work docks into that overarching command and control structure.

Q43 Chair: But Donal Brown is our lead.

Justine Greening: Correct. The challenge now is to replicate that, which we are doing at the district level, because it is key that we can drive through district-level strategies and tailor them to particular communities. We have already done that in Western Area and we are already in three other districts. The command and control that we have been able to set up with the Sierra Leoneans has proved absolutely vital in getting quick decisions taken that mean we can actually get action on the ground.

Q44 Mr McCann: My final question is about DFID's promise of 700 beds and 200 community care centres and what progress has been made. I don't know whether your officials had the opportunity to hear the previous panel, during which the MSF made some

gentle criticism about whether we should be investing in the structures that are already there, rather than setting up 200 community centres. Do you have a comment on that?

Justine Greening: I will ask George Turkington—

Mr McCann: My former boss in DFID many years ago. How things have changed, George.

George Turkington: You were a fantastic pupil.

Justine Greening: The tables have turned.

I think you are right, Michael. You need a combination of things alongside putting in place what will ultimately be six treatment centres. We have already opened the first one, and I have asked George to give you a brief update on the progress of the other five. We have also done a lot of work to enable quick availability of existing beds for Ebola patients. That has sometimes been done by bringing existing buildings into service or by helping existing hospitals to expand. We are working on a combination of things. In total, we will have created six new Ebola treatment centres.

George Turkington: Just to build on what the Secretary of State has said, we have the six centres, which will provide over 700 beds. We hope that all the centres will be open during December. We are also thinking about what we need to do at district level with community care centres. Early isolation is key, so that when people are infected they are isolated at the community level through a basic community care centre. We are looking at converting existing facilities into holding centres, which are not quite as formal in terms of the treatment that they provide as a formal treatment centre. We are deploying all the tools flexibly, so that we can get on top of the hot spots in Sierra Leone as the disease progresses.

This is a huge effort for us. We have never been involved in anything of this scale before. With the Secretary of State, we are leading the international effort. It is a fantastic contribution, and we will be supported in delivering the treatment units by the hundreds of NHS staff who have volunteered to deploy throughout the opening of the treatment centres themselves.

Chris Lewis: As I described earlier regarding epidemiology, we have seen the outbreak move from one district to another, so we need flexibility in our response that enables us to deal with an outbreak that changes on a district-by-district and month-by-month basis. The community care centres and the more flexible response described by the Secretary of State actually give us the flexibility that establishing larger-scale treatment centres does not have in the same way. It adds to the response in terms of the flexibility and reactive nature.

Justine Greening: It is worth pointing out that the treatment centres are in the districts that are suffering the highest incidence, so we have broadly got them in the right place. As Chris says, we need to tailor our strategy at the district level. There is a difference in how we are going to deal with this in the mix of interventions between urban and rural settings. In a rural setting, the more dominant mode of transfer of the disease is at funerals, so if we can get safe burial practices in place, that can be an enormous help alongside social

mobilisation. In Freetown and Western Area, which probably covers about a third of the population, where we already have district command and control in place, it is more of a combination of safe burial, which we are now doing: 100% of bodies are being buried safely in Freetown now. But community care, social mobilisation—

Chair: Order. We will stand to observe the two-minute silence.

Two-minute silence.

Q45 Chris White: My question to the Secretary of State is, what is your Department doing to ensure that local institutions and communities are involved in the response to Ebola, particularly how they are involved in designing and implementing any preventive initiatives?

Justine Greening: That is an excellent question. It highlights how important it is to work with Sierra Leoneans on this. This is not a strategy we are doing to Sierra Leone. At every step of the way, we have had to put in place structures and get decisions taken by senior Ministers and, indeed, the President within Sierra Leone. That has to percolate all the way down to community level. We are achieving that in various ways. First, many of our DFID staff are local Sierra Leonean staff, so they can provide a significant input into helping us make sure we get this right, and we need to. Making sure that we can address cultural sensitivities, particularly on safe burials, and actually have a strategy that can work on the ground is vital to being successful.

We are working with locally based NGOs that have been there for many years. We work with organisations such as UNICEF, which has a network of health workers who are already embedded in communities and can help make sure we get this right. The district level command and control is, if you like, the institutions that we need at district level to make sure that we can quickly get a sense of whether expected interventions are working effectively on the ground. It is absolutely vital that the work that President Koroma has been doing with paramount chiefs and also with religious leaders who can readily influence local communities is key to making sure that we can get community buy-in. We are training 1,000 youth leaders who can also be out there talking to local communities about how they can be part of keeping themselves safe, alongside all of the clinically driven changes that we are putting in place.

Q46 Chris White: Further to that, what expertise from other Departments—Ministry of Defence, Department of Health, Home Office and so on—are you drawing on?

Justine Greening: Well, MOD, in terms of command and control and providing that logistical effort, is absolutely key. In relation to tailoring the public health messaging, Public Health England is clearly a really important partner for us, but at the end of the day, this is a different place from the UK, and we have to work with partners on the ground there.

Chris Lewis: In the UK an anthropology platform has been established, which is one of the governmental scientific sub-groups that draws on anthropologists who are based in the UK but have significant experience in Sierra Leone. As part of this, feeding into the anthropology platform are a number of Government Departments. That anthropology platform is feeding directly into the UK response at community level—we are funding £3

million to a social mobilisation consortium. The scientific anthropology thinking in the UK by some leading academics, and others, is feeding directly into our NGO response at community level.

Q47 Hugh Bayley: The WHO has come in for criticism of its response, early on at least. What mistakes were made in your view?

Justine Greening: I don't think now is the time for us to be debating mistakes; I think that the focus has to be on actually responding to this crisis and getting through. It is unprecedented. There will be a time for lessons to be learned, and time for us to take stock of the international response to a public health emergency such as the one we are confronted with now, but my sense is that it is almost too soon to do major analysis of how we can improve. My focus has been on making sure, alongside the Department, that we have put in the resources against this, and the time, to ensure that we have a sensible strategy in place to combat Ebola on the ground.

Q48 Hugh Bayley: But you need a strategy to deal with this kind of crisis in the future, and your job, above all else, is a strategic job. Other people will manage the immediate response to the crisis.

Justine Greening: We are actually managing the immediate response to the Sierra Leone crisis, so this is a different way of working for us. It is certainly not business as usual.

Q49 Hugh Bayley: The question I am asking is: what lessons do we learn about the strength of the international health system? The budget of the WHO for a crisis response, for instance, is half what it was two years ago. Why was the WHO left in a situation where it lacked the flexibility to deploy resources quickly?

Justine Greening: I think it might be worth the Committee taking evidence at some point from the WHO, as it can probably speak more effectively on this than I can. I do think that whether the budget had been what it was two years before, or what it is now, it would still have been a ginormous challenge for the WHO and the broader international community to respond to this particular outbreak of Ebola. I think there are some lessons to be learned around how we ensure that we have a policy approach that looks at preparedness. If I analogise this crisis with some of the work that we do in other crises, and in mitigating the risk of other crises, we would look at preparedness for disaster. There is a question about health care systems that we had already been working on with Sierra Leone, and there is a regional aspect to that. There is then an international architecture piece around how you mobilise funding quickly in those sorts of instances, and there is a private sector piece. Of course, we might potentially want to bring the use of a vaccine to bear in combating the Ebola outbreak, so there are some international architecture and resourcing questions.

My sense, though, is that our experience, simply working on the ground and working internationally through this crisis, is that it is helping us develop our sense of what probably needs to change, but we are still in the middle of that process, so the focus for the moment is:

let us make sure that we have a successful strategy on the ground, and also ensure that we consider how the responses in Liberia and Guinea worked and how the broader regional risk response worked, to make sure that other countries around were able to cope and not have the outbreak spread any further.

There are many different parts to this that we will need to come to, but in a sense the priority for us, and for me, has been to ensure that we are working on the ground to save lives and stop the disease spreading in Sierra Leone right now.

Q50 Hugh Bayley: I believe that the work you are doing to learn lessons from the way the response to a crisis has been mobilised—and the way it has been mobilised in different countries—is extremely important; I agree. However, a wider strategic response is needed to look at the WHO, or international, system. Why were these weaknesses in capacity at the WHO not picked up in your last multilateral aid review? How could you change that process to identify these weaknesses better with the UN and other international agencies in future? What changes would you want to see within the capacity of the WHO, and will the UK be a partner in funding those systems-strengthening changes at the WHO?

Justine Greening: Of course, the multilateral aid review has been an immensely helpful mechanism for the Department, enabling it to look across the piece at what can be very different multilateral institutions that we work through, and to understand value for money and delivery capability. That multilateral aid review in relation to the WHO did flag up the need for reform. Indeed, since then the UK has been one of the leading proponents for pushing the WHO to reform over time. However, I say again that the scale of this outbreak was at a level that would have been challenging for any WHO that was overseeing global public health.

Q51 Fabian Hamilton: Secretary of State, you mentioned earlier the money that Japan and other countries made available to fight Ebola, but what steps have you taken to prompt EU Governments to take their fair share of the burden, in terms of financing? Could you give us more details of the €1 billion package that was agreed at the last European Council?

Justine Greening: My point about Japan was in relation to bilateral programmes that were already in existence. I will make sure that I provide an up-to-date assessment of the existing commitments that have come from European member states in relation to the €1 billion, but they are multifaceted. For example, some of them relate to money. We have had additional commitments also in relation to health care workers. Additionally, other countries, such as Germany, have also played a role in providing domestic beds for potential medevac patients who might need to come home. So there has been a relatively broad-based response from Europe. The key now is to follow up on all commitments that have been made and make sure that they do come through.

I have a breakdown of the commitments made in Europe—and, of course, now I am desperately trying to find it in my pack, so I can give you more of the detail. Why don't I write to the Committee with a more detailed breakdown?

Q52 Chair: And can you indicate what the UK's contribution is out of that €1 billion, specifically, when you write to us?

Justine Greening: Yes, I can do that. Publicly, we have announced £230 million so far, but as I have already set out to our Committee, our work on Ebola will be in excess of that.

Q53 Chair: I would suggest that €1 billion is not enough in terms of proportionality; more should be forthcoming.

Justine Greening: We want a broader international response, and that does not just include Europe. However, we are now finding that the fact that the UK has a strategy in place with Sierra Leone is making it easier for other countries to come forward with contributions, because essentially we have an investable strategy and they now understand how they can fit in their contribution to it.

Q54 Chair: On Thursday last week, I had the opportunity to hear and question Federica Mogherini on this issue, and she specifically said that she agreed that we had to tackle the problem, but we also had to ensure we left a legacy. Have you had conversations with her along those lines, or will you have such conversations?

Justine Greening: I spoke last week with Stylianides, who is the EU co-ordinator leading the Ebola response, and everybody recognises that alongside the priority of bearing down on Ebola right now, there will need to be some thought about what the longer-term response is. For example, if you look at the work that my DFID Sierra Leone team are doing, again I pay tribute to the fact they are working round the clock on this issue. We have virtually doubled the team in Sierra Leone to ensure we have the right level of resourcing on the ground to run our strategy. However, there is a part of that team that is about looking at the medium-term needs and the work that we will expect to be done after we have combated this Ebola outbreak.

Q55 Fabian Hamilton: The G20 will hold its summit next week in Brisbane. What commitments you will be seeking from G20 leaders on Ebola?

Justine Greening: The Prime Minister will take a similar approach to the one that he took in the recent EU Council, which was very successful. That approach was to lobby for a more comprehensive response from countries to the Ebola crisis. The summit is also a good opportunity to provide some reassurance around all the structures that are now in place, such as medevac, and the strategies that are now operating on the ground—for example, what we are doing in Sierra Leone and what the US is doing in Liberia, which are much easier now for countries to come in and support. Now is the time for countries that have not already made commitments to come forward with them, and fulfil them.

Q56 Fabian Hamilton: Do you think there is any risk of a sudden flood of donors into West Africa, and who is co-ordinating all this?

Justine Greening: First, we are seeing now a steady stream of commitments being followed up by countries; those pledges are coming through. We need more, but it is fair to say that over time the pieces are now being delivered.

The co-ordination is probably happening at two different levels. First, there is, of course, the UN Ebola co-ordinator. I spoke to David Nabarro last night; that was the most recent time. Countries can work through the UN, but as we have seen at the European level, countries are approaching, for example, the UK directly with help that they can provide.

Q57 Fabian Hamilton: Have the pledges that were made at the Defeating Ebola Conference in London been fulfilled, Secretary of State?

Justine Greening: Again, let me write to the Committee with a broader update. However, we have seen countries deliver on promises that they made. For example, Norway is now pledging 200 health care workers to take one of our Ebola centres in Moyamba, and it is also providing a base camp to accommodate around 100 health care workers. Australia and New Zealand are also now delivering on their pledges to provide health care workers. In fact, the Australians already have a scoping team on the ground in Freetown. As for Denmark, I spoke to the Danish Development Minister earlier this week about their contribution to heath care workers. Estonia, South Korea, the Netherlands, Canada—all these countries are coming forward with proposals, having made commitments to do so at the London conference, which we want to see.

Fabian Hamilton: That is very reassuring. Thanks. We will look forward to hearing more detail from you.

Q58 Chair: Just before I call Chris White, I understand, Secretary of State, that you are meeting a Sierra Leonean delegation at 12. Is that correct?

Justine Greening: I am not meeting the Sierra Leonean delegation. I have another meeting.

Chair: But you have to leave at 12.

Justine Greening: Yes.

Q59 Chris White: I will be brief. What are you doing to ensure that the UK health professionals who want to get involved and help are given the chance to do so?

Justine Greening: We have had a fantastic response to the need for clinicians and health care workers, with over 1,000 coming forward since we put the call out. Many of them are now being trained up and will be heading out to Sierra Leone to be part of the overall UK

support. Of course, we have also worked with NGOs such as Save the Children, and if people want to, they can go to those NGOs to provide support.

The main call that we have made, which has been recognised internationally, is for health care workers. We can provide the beds and a lot of the logistics and have the right command and control structures in place, but the real challenge on the ground in Sierra Leone has been the breakdown of the health care system in the face of Ebola. Building up domestic health care worker numbers again, and getting international health care workers helping not only to provide health care directly, but to ensure that we have levels of infection control and expertise, has been an important part of the strategy. That has been our focus when asking for assistance.

Q60 Chris White: Thank you. On that point, how are we ensuring that the volunteers have the correct training and medical supplies to be able to do the job properly?

Justine Greening: Where appropriate, they will be going through a screening process to work out their skill sets and what is required. There is then relevant training, as we talked about, happening in York. As you can imagine, some of the money that we have been investing in the response to Ebola has gone on ensuring that people have the right levels of protective equipment.

Q61 Chris White: Thank you. May ask a quick, perhaps irregular question to the officials? An organisation in my constituency has been trying to send out educational materials, but the usual, traditional method—using Royal Mail to send resources—does not currently work. Where would you suggest that organisations and NGOs should go if they wanted to send something directly out to support the fight against Ebola?

George Turkington: I would suggest that they contact NGOs or speak to the Sierra Leonean diaspora organisations. I am afraid that we cannot be a conduit, because our focus is really on the scale of what we are trying to deliver.

Q62 Jeremy Lefroy: In mid-October, I raised in the House the fact that there were now no direct commercial flights between the UK and Sierra Leone. The Leader of the House responded that there is a case to be made for having them back, but that there would also be great risks. Is DFID looking at the possibility of charter flights, as I have heard, being initiated from Brize Norton? Aid workers would have an easier way to get out there and people would have some ability to conduct normal—in so far as that is possible—business with Sierra Leone. This is something that was raised with us by both the aid community and the British and Sierra Leonean business community.

Justine Greening: Obviously, we've worked hand in hand with a number of NGOs, so we will continue to look at any options to ensure that we can assist travel by NGO workers out to affected areas. To date, people have certainly managed to get out on existing commercial options perfectly well, including myself when I made my own trip to Sierra Leone and came back via Brussels. We recognise some of the additional challenges, but they

do not seem at all to be hampering people's ability to get out to the region and help. It was important to ensure that we took the necessary steps we felt we needed to take to ensure we were able to manage the risks to the UK public and put in place all those screening procedures as well.

Q63 Jeremy Lefroy: But would you not think that the same risks apply to the Belgian public or the French public, who still have direct flights? Britain has taken a lead and been the major supporter of Sierra Leone over many years, yet we have decided to withdraw those flights, certainly in the case of Gambia Bird. In the case of British Airways, it took the decision to withdraw, which I regret.

Justine Greening: We were the first EU country to put in place screening measures. Belgium has now done that with its direct flights, but I reiterate that in terms of people actually getting to and fro, it has not particularly made any difference.

Jeremy Lefroy: Can I just ask one—

Chair: It had better be quick. We are running out of time.

Q64 Jeremy Lefroy: We are in this position—you rightly said earlier that this is a different way of working; it is not business as usual—because we have taken a substantial lead in working with the Sierra Leonean Government to help with the country post-civil war. It has brought upon us a responsibility, which I am delighted that you and your colleagues have stepped up to. When you are considering the future after the event and our response, could you also look at other countries where we have taken a lead in responding over many years? When a crisis such as this hits, we are looked to as being the people to take the major responsibility, as the Americans have in Liberia and as the French have in Guinea. It is perhaps an unintended consequence.

Chair: Quickly.

Jeremy Lefroy: I beg your pardon. I have made my point.

Justine Greening: I think we should be immensely proud of all the work that is being done. I am very proud of what my Department is doing, but there are also the cross-Government response and the UK public response to the DECC appeal that is running. Should we take the lead whenever crisis hits? I think broadly we do take the lead when crisis hits. There is no doubt that, in our relationship with Sierra Leone, the work we are doing now is immensely appreciated. When I went to Sierra Leone, I was struck by just how many Union Jacks you see popping up around the place. It is symptomatic of the fact that we have been a country that has stood by them, not just in difficult times today, but in the past. It is a special relationship, and it did make sense for us to lead.

I am pleased that we are a country that runs towards those sorts of problems and is prepared to help when help is required. Having said that, we need an international community that steps up to the plate far more in the future than we have seen in recent years. Britain cannot do all these things on its own. We see why tackling things such as Ebola are so

important in minimising risk to the UK public, but whether it is working in Sierra Leone or our work in the Middle East and Iraq, which we are about to talk about, we need a much broader international response to these sorts of crises. The UK can be proud of the role that we play, but we should not be on our own doing it.

Chair: We do also want to talk to the Secretary of State about Iraq, and we are running out of time.

Q65 Fabian Hamilton: To what extent, Secretary of State, do you think the scale of the ongoing Ebola epidemic is a consequence of the lack of investment in health systems?

Justine Greening: Well, as I have said, Sierra Leone and Liberia are both countries that recently came out of civil war—I have been to both of them—and while they have made an immense amount of progress in the past decade, they still have weaker health systems. That is almost inevitable given the recent history of both countries. The good news is that we see other countries nearby, such as Nigeria, which have had longer term investment and now have much more of a wherewithal to combat Ebola when it arrives in their country. In a sense, what it shows is that when we do long-term work with countries to help them steadily develop, ultimately they are able to take responsibility and look after themselves. It is perhaps not surprising that Sierra Leone and Liberia, in particular, found it much more of a challenge. That is why it is right that the UK and the US are partnering with them to help them tackle the Ebola outbreak.

Q66 Fabian Hamilton: This Committee has expressed our shock about the fact that the bilateral programmes to some of Africa's poorest countries, including Sierra Leone, have been cut. Once the Ebola crisis is diminished and resolved for now, do you plan to reinstate our previous budget for Sierra Leone and Liberia?

Justine Greening: It is worth pointing out that we have spent more on our bilateral programme in Sierra Leone. The other point is that over time, perhaps more in health care than in any other area of development, the delivery of development is changing. There is the forthcoming replenishment of GAVI, which is an international mechanism that has proved highly successful at mobilising international support and delivering it cost-effectively and at scale. We use the GAVI mechanism. We were a core funder of the Global Fund, which tackled AIDS, TB and malaria, in particular. Simply looking at work of the bilateral funds in isolation without looking at the broader work that we and the international community do through multilateral mechanisms such as GAVI and the Global Fund gives you only a partial view.

Returning to the point I just made, if you look at the international community's work in Sierra Leone, we are by far and away the biggest bilateral donor. The challenge is not about whether Britain is doing enough, but about how to persuade more donors to work alongside Britain and put in place bilateral programmes to strengthen health care. Again, we cannot do all this on our own. We can be proud of the work we are doing, which shows the way for other countries and enables them to step up to the plate, but other countries must now be prepared to do more work in this area. That is the message that I want to get across to the Committee.

Q67 Fabian Hamilton: Thank you for that. Finally, am I right in thinking that the Ebola epidemic has made you rethink DFID's approach to health?

Justine Greening: Every time we are confronted by a crisis, we are given a fresh insight into particular areas of development. The crisis in Syria, where we are doing work to ensure children get into education, is telling us that in chronic, long-term humanitarian crises we need to think more about the medium-term impact on people. Too often, such crises do not clear themselves up and allow refugees to return home in one or two years.

There are also the lessons on the international response to health emergencies that Hugh was asking about. That is a different kind of problem, but it shows that we must get more co-ordinated. We must look at what international funding mechanisms need to be in place, how we mobilise quickly, how we do early warning and how we look at preparedness in high-risk countries. In time, I hope that once we get through the response to this crisis and get Ebola under control in the countries that are suffering from it, we can put in place a positive agenda and ask, "How can we do a better job next time? How can we be better prepared? How can we work to stop these risks being quite so catastrophic when they take place?"

Q68 Fiona Bruce: Secretary of State, what are your Department's strategies for preventing violence against women and girls in Ebola-affected areas and for protecting orphaned and separated children?

Justine Greening: It is hugely important. As you know, we as a country and DFID as a Department have pushed the international community and the UN agencies to look at how we can take care of women and girls in emergencies, including in this case.

The UN country team in Sierra Leone launched an Ebola gender mainstreaming strategy on 30 October. We are also supporting local NGOs to do Ebola awareness raising, but also prevention and response, and the distribution of hygiene materials. I spoke with the Marie Stopes International team last week about the work they are doing on maintaining family planning and ensuring that that remains in place, although it is fair to say that all of these things are more challenging on the ground at the moment.

On orphans, you are right to raise this particular issue. We are already working through the UNICEF appeal to help provide not only life essentials like food, but psycho-social and social protection to 150,000 children. We are providing bilateral support to the NGO Street Child. We are also making sure that, as we develop community care, we look at how we can particularly cater to the needs of children who have been orphaned. When we talk about what we will need to do in the future with Sierra Leone, making sure that for families that have been affected, particularly children who have been left with no parents, that actually needs to be part of that overall "beyond Ebola" work.

Q69 Chair: Secretary of State, there are one or two questions that we have left unasked, but we can perhaps have an exchange in writing.

Justine Greening: Of course.

Chair: We need to move to the situation in Iraq, but thank you for those answers, which have been helpful.

Examination of Witnesses

Witnesses: **the right hon. Justine Greening MP**, Secretary of State for International Development, and **Lindy Cameron**, Director of Middle East, Humanitarian and Conflict, Department for International Development, gave evidence.

Q70 Chair: We have spent a lot of money in the Middle East, which clearly has to come from somewhere. You will be aware that we have been perhaps testing the Department a bit. You have a budget. How do you decide how to respond to humanitarian demands when you do not know what is happening? Should you not be setting a limit or saying in advance what your framework is? You announce you are putting money in. We do not disagree that there is a challenge, but we are not clear where the money is coming from now that we have a fixed budget, and we are concerned about the extent to which it may have a knock-on impact on other spending plans.

Justine Greening: Perhaps I can ask my new DFID colleague to introduce herself to the Committee.

Lindy Cameron: I am Lindy Cameron, director of Middle East, humanitarian and conflict for DFID.

Justine Greening: I have set out broadly how we make sure we can quickly respond to these crises financially. I reiterate the points that I made on Ebola, which is that we have an overall contingency at the departmental level that we can draw upon, and also at the regional level. That is what we would generally use.

Q71 Chair: Will you tell us what it is, because that is what we have not been able to establish? If I am honest, the impression we get is that the Department knows, but when we ask what it is, we do not get an answer.

Justine Greening: It is generally about 1.5% of our budget, but, on top of that, you then have the inevitable day-to-day situation of some things happening at slightly different times to when you have planned them, and there is always some ability to look at the underspends and whether we can use those effectively. You look at, for example, some of our work in Libya, which is perhaps harder to deliver at the moment, so we can perhaps do less of it as fast as we expected. That is investment that is not going in at the same rate we had anticipated in our budget. At the regional level, and also at the departmental level, we can draw upon all of those overs and unders to make sure that we respond overall. Perhaps Lindy can give her sense of how we make sure we broadly balance off responding to needs on the ground with the underlying development programmes that we have in place.

Lindy Cameron: Sure. We plan at the beginning of the year for what we can anticipate, but there are some needs we know we cannot plan for. For example, in my area, in the Middle East humanitarian and conflict area, I held about £25 million at the beginning of this year to be able to respond to the likely specifics that I could not plan for. For example, that was spent this year on a combination of Iraq and Gaza. I also got an increased allocation from the central contingency to respond to the additional needs that went beyond that.

Obviously, there are some things that go down as well as up in the course of the year, and there are programmes that we cannot progress at the speed that we originally anticipated because of either partner issues or disbursements, but in general our response to humanitarian crises is to plan on the basis of need, the vulnerability of the population, the capacity of the Government affected and, if appropriate, UK interests. We have a framework of how we make those decisions, rather than a specific cap on the amount.

Q72 Chair: But there must be some constraint—you do not have an unlimited resource.

Lindy Cameron: Absolutely.

Q73 Chair: I would like to pursue the second, more detailed point. We have pledged £23 million for humanitarian relief in Iraq, but clearly Iraq and Syria are now blurring in practical terms, so is that going to be enough? Are you going to move money between Syria and Iraq, or will you have to find additional funds from elsewhere?

Justine Greening: Right now, we are working on ensuring that we can respond to some of the challenges that winter brings for internally displaced people in Iraq. I am sure that Lindy can reiterate this: Iraq is slightly different, in that, as a middle-income country with significant oil resources, its Government really should be in the driving seat, providing the necessary resources to meet people's needs. We are seeing some resources coming through from the Government of Iraq—I think I am right in saying more than $130 million. Two of the best things that we can do are: first, we must have advisers on the ground helping to shape the response so that the right plans are in place; and secondly, we must really press the Iraqi Government to meet its own people's needs with its own resources so that we do not have to put more resources into supporting displaced people than is absolutely necessary.

Q74 Hugh Bayley: As a combatant country in Iraq, we have responsibilities under the Geneva Conventions for the humanitarian rights of the civilian population in the country. What assessment have the Government made of the steps we need to take to fulfil our duties under the Geneva Conventions?

Justine Greening: As the Committee will know, we did a significant amount of challenging work over the summer, in particular to reach the people who were stranded on Mount Sinjar. Since then, we have worked with agencies that have been helping to set up refugee camps so that displaced people can have homes, as well as working with the Kurdistan Regional Government so that their approach to dealing with the IDPs in Iraq—they

probably have just over half of them—is a sensible one. It is also worth pointing out that more than 2 million people are living in ISIL-controlled areas that are very hard—essentially impossible—to access. As I said, we are working with the Iraqi Government and looking at how we can meet needs for people who can be accessed, but a significant number of people cannot.

Q75 Hugh Bayley: Thank you. I know that you have answered this question fairly recently in a written answer to a question that I asked, but things change, so I would like to ask it again. During earlier UK military operations in Iraq and Afghanistan, British NGOs working in those countries expressed concerns that the fact that the UK was a belligerent country made it hard for them to do humanitarian work because some people interpreted them as being part of a British force of occupation or engaged in military action. Have any similar concerns been expressed by NGOs working in Iraq since the commencement of military operations?

Justine Greening: I believe that we have had effective relationships with the NGOs that we have worked with. I will ask Lindy to elaborate, not least because she spent a number of years in Iraq working on DFID programmes.

Lindy Cameron: As you know, there are a range of NGOs, some of which are more careful than others about how they define their neutrality, and some of which use that neutrality very carefully. We have had a spectrum of responses: some are concerned; some are uncomfortable. It is up to each individual NGO to decide how to respond. For example, some of our NGOs are happy to be named in public, while others are concerned to keep that support more private in order to assure their ability to work in dangerous areas, some of which are still changing hands on a regular basis.

Q76 Hugh Bayley: Following the previous conflicts in Iraq and Afghanistan there appears to have developed a consensus that, in these sorts of situations in conflict states, you need a comprehensive, combined approach: diplomacy, defence and development. Is there a comprehensive approach underpinning our new military strategy in Iraq and, if so, what is DIFD's role in it?

Justine Greening: Obviously, I sit on the National Security Council. The decisions that we take in relation to a country like Iraq are taken in the round. Of course, as I have said, one of the key areas we need to see progress in is making sure that the Government or Iraq itself uses its resources that it can access to provide humanitarian support to people in need, and we are seeing that happening, although we need more of it to happen over time. The other key part of this is a political settlement that sees Iraq have an inclusive and transparent, but a democratic, Government. We have a very new Government that is in place.

I had a chance to meet al-Abadi when I was in Iraq over the summer. I also had the chance to meet the President of the Kurdistan Regional Government as well. I think they are conscious of the fact that, too often, the previous Government had simply not been running Iraq in a way that was inclusive and that, actually, that had been a real issue for many of the Sunni tribes. We have seen some of the legacy of that in recent months.

We will have to wait and see whether an Iraqi Government can deliver an inclusive Government. If so, it would be the first time. I think we all recognise that Iraq has distinct parts; obviously, Kurdistan is one part, but you also have Sunni and Shi'a elements of it, too. This new Government needs to find a way to knit together those different constitutions, if you like, into one overall state. It is important that it does that, because of the severe challenges that ISIS poses to it right now.

Q77 Hugh Bayley: Finally—this relates back to before the present Government were in office—would it now be timely to review the impact of UK development assistance and governance work in Iraq over, say, the past 10 or 11 years? For instance, are there things we could or should have done in the past that might have reduced the threat that ISIL, al-Qaeda and other extremist groups now pose in Iraq?

Justine Greening: Well, the Iraq inquiry is still yet to be published and I think that will also give us some assessment, if you like, of the broad sweep of UK Government action.

Q78 Hugh Bayley: Is that comment based on your having read the report?

Justine Greening: Excuse me?

Hugh Bayley: Is that comment made based on your having read the report and seen what it says about our development—

Justine Greening: No, that is a comment based on the fact that there is an overarching inquiry that has happened and actually, in many respects, that will point the way to making sure that we can learn from that initial experience that a number of Departments, including my own, had in Iraq.

Hugh Bayley: Thank you.

Q79 Mr McCann: Secretary of State, the Prime Minister has said that the fight against extremist jihadism is a struggle over a generation. Does DFID have a long-term strategy for Iraq in a wider Middle East and, if it does, what is it?

Justine Greening: Well, the work that we are doing right now is around helping people with their immediate needs. The longer-term questions as to how you can get stability in the region have, at their heart, a political answer and in the meantime also, clearly, a military aspect in relation to the air strikes that are currently happening on ISIL.

What is also clear is that this needs a regional response. In relation to foreign policy, the UK, the US and other countries can clearly have an influence, but ultimately the region itself needs to rise to the challenge of looking at what steps it can take collectively to get to stability and security. That is absolutely needed now. We are seeing the region responding. Ultimately, however, the solutions will come from within.

Mr McCann: Thank you.

Q80 Fiona Bruce: How certain are you that the £23 million UK aid package being provided for Iraq is reaching the Christian community? They have been in the country for thousands of years, but are in considerable fear now; they are attacked and displaced as a result of their faith. Apparently, there were 1.2 million of them in the 1990s; there are now just 300,000, and many of them are homeless.

Justine Greening: We were deeply concerned to see the plight of the Yazidis, particularly during the summer, when they were so clearly in need of support, with a number of them stranded on Mount Sinjar. As you know, ultimately we made nine air-drops, to provide people with life-saving support, alongside other countries. That work also sat alongside work on the ground militarily by the Peshmerga, and collectively the work enabled those people to finally get off the mountain.

Our humanitarian assistance is based on need, but we all recognise the huge challenges that some communities, including the Christian communities, face. When I was in Erbil in Iraq, I went to a Christian church that had become essentially a home for a number of displaced Christians, and they talked to me about some of the dreadful experiences they had been through, which underlined why, alongside pushing the Iraqi Government to take care of their people, we are right to directly provide support ourselves where that support is needed.

Q81 Fiona Bruce: Thank you. I will just broaden that out for a moment. Pope Francis has described religious freedom as a fundamental right of man, and the Patriarch of Baghdad recently asked the UN to recognise the current genocide against Christians in Iraq, and to provide help. Also, evangelical leaders in the Middle East have called for a strategy to support the Christian presence in the Middle East before it is completely eliminated. What is DFID's response to those comments, and to the view that promoting freedom of religion and belief as a basic humanitarian right must now be given greater priority?

Justine Greening: As I've just said, Fiona, we absolutely have responded to the plight that many Christians in Iraq have found themselves in; I think you saw that extremely clearly during the summer. And if I go back to my earlier responses to earlier questions, ultimately what Iraq needs is an inclusive Government, but that has to include everyone, including those of other faiths, such as members of the Christian community. As you pointed out, although that community is perhaps smaller in number now, it has been there for a very long time indeed.

Q82 Fiona Bruce: Perhaps with that in mind, is DFID looking again at how it can build capacity to strengthen, say, civil society groups in areas where extremism might develop? Is it looking at how it can train more experts in conflict resolution, so that we can protect freedom of religious belief and perhaps stop some of the violence that has occurred, not only in Iraq but in many countries, as a result of differences in beliefs? Those differences should be reconciled, so that we can see minorities living in peace along with the majority populations.

Justine Greening: Where we have seen on the ground an ability to do that effectively, we have looked at how we can bring communities together. We have a faith-based strategy paper, which we published about two or three years ago and which sets out how we approach this particular area of human rights.

The last thing I would say is that we recognise not only the complexities that these particular communities often face, but the complexities on the ground of an external country such as the UK being able to successfully come in and do this sort of work. Much of the lead work on this is at a Foreign Office level on the advocacy and influencing agenda, to press Governments to take the right stance on allowing religious freedom, which, as you know, is exactly what we do. That comes back to why having an inclusive Government in Iraq is so important. It is hugely important now that that Government is stable and can address some of the challenges of having the Kurdistan Regional Government and some of the financial questions around how its relationship can work effectively. Essentially, it is about how it can have a more decentralised approach if that is the best way of delivering effective government on the ground for people in Iraq. All those questions are massively important if we are to see a Government that can really deliver for everyone in that country in a way that will mean that it can get the support of the broad base of people.

Q83 Fiona Bruce: Thank you. Finally, I certainly share the view of many others that the Foreign Office has indeed commendably prioritised the issue over the last few years. In light of recent developments, however, would DFID consider refreshing that plan, which is now two to three years old? Many people consider that the struggle for religious liberty, particularly in the region of which we speak, is the defining issue of our age.

Justine Greening: I am sure that we will look to ensure that our existing approach, which is thoughtful and methodical, remains one that can deliver the sorts of results on the ground that we want.

Chair: Jeremy, you are running against the clock. Do you know that?

Q84 Jeremy Lefroy: I realise that, but I have not had a question on this so far.

Following on from what Fiona said, I absolutely welcome the emphasis that DFID places on the protection of religious freedom. It is important that DFID has that role, because not many other governmental agencies seem to take it seriously and there may be others active in the region that actually go in the opposite direction. I encourage you in that, Secretary of State—it is much appreciated.

Justine Greening: Thank you. I think I have probably said everything that I can on the topic at the moment. In a sense, what speaks loudest is the actions that we have taken over recent months.

Q85 Chair: Thank you, Secretary of State. You said, quite rightly, that solutions must come from within the region. It is a middle-income region, which is a point that the Committee has consistently highlighted. I hope that we have not given any kind of

impression or that the questions do not suggest that we do not value what is being done, but we do nevertheless monitor the concern that the more we draw into that region, the more other regions may not get what they should. I think that you would expect the Committee constantly to do review that.

The other thing is that while this is a regional problem with an international, global dimension, there are players in the region and others with engagement in the region who are not pulling their weight. I hope that they do not step back because we step up and that we can keep the pressure on.

Justine Greening: Yes.

Q86 Chair: The same applies in west Africa, where we are absolutely taking a lead. There is only question left on that. Once we have tackled Ebola, we presumably then need to consider the redevelopment of the region. Jeremy and I met some Tanzanian MPs, who are calling for a Marshall plan or something. That is a grand scheme, but I take it that what happens next is something that you are actively considering at the moment.

Justine Greening: Yes, and in fact it was discussed at the World Bank meetings. I think that Christine Lagarde recognised that the IMF has a role to play here in working with countries that have been affected by the Ebola crisis. I think that everybody is seized of the need to ensure that the economic ramifications are understood and then examined in terms of how we can ensure that the economies bounce back.

My final point is that the growth rate in Sierra Leone pre-Ebola was getting on for 12% per annum. To put that in context, we expect that to go down to some 6%. Both Liberia and Sierra Leone had economies that were coming on in leaps and bounds. We should work to get them back on track as a matter of urgency. All of the energy and entrepreneurship on the ground in Sierra Leone that led to that 12% growth rate will still be there. The key thing is to take some swift action to ensure that it bounces back.

Chair: Just to correct the record, I said Tanzania, which is in my mind because that is where we are going, but I was of course talking about Sierra Leone. We have had a lot of engagement, as you have, with parliamentarians and others from Sierra Leone and I think we can put it on record that we have also picked up that what we are doing is hugely appreciated. As I said to MSF, an awful lot of people from the UK are giving an awful lot in terms of time, energy, risk and potential sacrifice and, through you, we thank and appreciate them. I hope that we can reverse and illuminate the epidemic and then move to a situation where we can reconstruct and do what we were doing beforehand and perhaps do it better and make it last. Thank you very much for giving evidence.

Justine Greening: Thank you.