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The International Development Committee

The International Development Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the Department for International Development and its associated public bodies.

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Summary

Covid-19 constitutes a substantial challenge and dilemma for the international development community. The pandemic must be tackled but the right tools have not been available and the interim measures, from social distancing to isolation and lockdowns, create their own, very serious, problems. We welcome news that an effective vaccine seems to be emerging from trials but in the meantime much damage is taking place. The former DFID Secretary of State told us that the work of 30 years of development was being undone; and the progress made against the UN Sustainable Development Goals was being rolled back.

Uniquely, for a humanitarian disaster in the last 100 years or so, almost every country in the world has been affected. The countries hit hardest have also been from every income band and continent. Everyone is struggling, trying to balance the risks of restrictions with those of the disease, while waiting for new and effective vaccines, treatments and tests.

The evidence submitted to the inquiry shows, the restrictions imposed by governments, as well as those adopted voluntarily by different agencies have inevitably hampered effective activity in the humanitarian and development sector just as much as in any other area of activity.

At an early stage in this crisis, evidence was submitted to the inquiry on the potential for the pandemic to have serious secondary impacts, including on non-coronavirus health priorities, economies and livelihoods, food security and nutrition, education and training, treatment of women and children, respect for human rights and humanitarian law, community cohesion and tolerance of displaced persons and other minorities. This evidence seems to have proven more accurate, more rapidly, than warnings we also received about Covid-19's primary impacts in terms of morbidity and mortality across the Global South and particularly in Africa. We have launched a second inquiry to consider further certain of these secondary impacts and UK aid-funded interventions and initiatives aimed at their mitigation.

Overall, however, we found there were serious challenges in assembling an accurate picture of the situation in many countries. This was due to a range of factors: the challenge of gathering consistent and reliable data; the incredibly speedy ebb and flow of infections; and the sheer scale of the pandemic; and variations in its effects and impacts which cut across conventional geographic and economic categories for analysis. In addition, with interpretations of the 1918 Spanish Flu pandemic still being debated, it is hardly surprising that the absence of perspective also bedevils a robust and reliable global understanding picture of today's still-raging outbreak.

We welcome the UK's specific contributions to the global response, initially a total of £744 million and, latterly, a further £500 million for vaccines, including their equitable distribution across developing countries. It is fair to set that against the Government's total commitment of public expenditure in response to the pandemic—at home and abroad—which is assessed by the National Audit Office to be around £210 billion. In addition, we note the evidence from the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD) that points out

that funding for global public goods—those activities addressing global challenges such as cancer research—does not count as official development assistance (ODA) because it benefits people in developed countries as much as those in developing countries. This suggests that funds committed by the Government to research and development for coronavirus vaccines, therapies and tests will not necessarily all qualify as ODA.

The coronavirus pandemic has posed a challenge to established structures and assumptions about, not only the international *development* community but the international community as a whole. If the world cannot step up to this test, which so explicitly and literally demands a collaborative, leave no-one behind, solution, then progress on anything less urgent, and less immediately self-interested, seems very far from certain.

In June 2020, in the midst of this crisis, the Prime Minister announced that DFID and the FCO were to be merged, effective from 1st September. The timing of this reform was not stated to be despite the crisis, but rather demanded by it in the form of a more integrated response. We have yet to be provided with compelling examples or argument in support of this thesis. Covid-19 is certainly challenging many aspects of international development policy-making and crisis management. In particular the pandemic has further unveiled many antagonistic and competitive fault-lines running through the international community.

We would echo the Prime Minister's criticism of the international community's lack of cooperative spirit in his speech to the UN General Assembly in September 2020. However, we believe that a clearer statement of the objectives of the merger, providing context for the references to pursuit of the national interest and available opportunities, would have provided a firmer foundation for the Prime Minister's rhetoric. We await such foundations in the outcomes of the Integrated Review, in the UK's continued leadership on development priorities, and the deployment of UK diplomacy to keep Covid-19 from swamping international attention to progress against the Global Goals and other development aspirations.

On the specific next steps, we believe the FCDO should, on behalf of the UK:

- re-commit to its ongoing programmes and provide new funding for the Covid-19 response rather than allowing the transfer of scarce resources from existing programmes, especially those tackling other diseases
- recognise that the eradication of the pandemic everywhere is an integral part of resolving the threat anywhere and therefore switch its financial support for Covid-19 vaccines, therapies and tests voluntarily from its ODA pot to other budgets (thereby freeing up resources for more frontline activity on secondary impacts in developing countries)
- use its significant leverage as top actor in many areas (gender equality, disability inclusion, poverty alleviation) to lead an inclusive and transparent approach by the donor community (both bilateral and multilateral), and

- put local non-governmental organisations (NGOs) and their partner International NGOs at the heart of the global Covid-19 response as they are closest to end-user communities and benefit from existing relationships of trust and confidence.

At a strategic level, we urge the Prime Minister and the Government to be more ambitious for the UK's G7 Presidency than simply calling for better cooperation in spotting, preventing and fighting another pandemic more effectively. Rather, we recommend the Government lead a charge towards the establishment of a holistic global health and nutrition strategy—based around achieving Sustainable Development Goal (SDG) Three more broadly—that will put the world in a position to respond effectively to the next global health challenge, and the one after that, whatever these turn out to be; rather than just the last one we struggled with.

Having said that, we welcome these strong signals of the UK's intent to engage fully with the international community in these matters as well as the concrete evidence provided by the announcement of substantial new funding. In particular, we applaud the increased UK funding for the beleaguered World Health Organisation (W.H.O.), as well as at least £500 million for the W.H.O.-led Covax initiative to guarantee that people in all corners of the world will have access to Covid-19 vaccines, once they are available, regardless of their economic power.

1 Introduction

Inquiry

1. In April 2020, very shortly after being established, the Committee launched an inquiry into the impact of the coronavirus on developing countries and the work of DFID in response.

The coronavirus pandemic

2. On 31 December 2019, the World Health Organization (W.H.O.) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. The first reported fatality was a 61 year old man who failed to respond to treatment and died of heart failure on 9 January 2020. On 12 January, it was announced that a novel coronavirus had been identified and that initial analysis suggested that this was the cause of the outbreak. This new virus was termed 'SARS-CoV-2' and the associated disease, 'Covid-19'. By the end of that month, the W.H.O. had declared the outbreak a "public health emergency of international concern" (its highest level of alarm).

3. During January, the coronavirus spread to all parts of China and cases were reported in the Philippines, South Korea, Thailand, the US, Nepal, France, Australia, Malaysia, Singapore, Vietnam and Taiwan.

4. On 30 January, the W.H.O. declared the coronavirus a global emergency as the death toll in China jumped to 170 and cases were reported in more countries: India, Russia, Spain, Sweden Canada, Germany, Japan, the UAE—and the UK.

5. During February, many more countries reported coronavirus cases for the first time: Egypt (the first country in Africa), Kuwait, Bahrain, Iraq, Oman, Qatar, Norway, Romania, Greece, Georgia, Pakistan, Afghanistan, North Macedonia, Malaysia, Brazil, Estonia, Denmark, the Netherlands, Lithuania, Iran (including two deaths reported within hours after confirming its first cases), Israel, Italy and Japan. Deaths from the virus also began to rise across the world.

6. During March, other places, including Turkey, Ivory Coast, Gaza, Honduras, Bolivia, the Democratic Republic of the Congo, Panama and Mongolia confirmed their first cases and the numbers were rising in Italy, Spain and the US.

7. On 11 March, the W.H.O. officially, designated the coronavirus, "a pandemic" and on 1 April, UN Secretary-General, Antonio Guterres, said that it presented the world with its "worst crisis" since World War II, as the global total of confirmed Covid-19 cases reached one million and the worldwide death toll topped 50,000.[1]

8. As this report was being finalised, the situation was once again looking dire, with a number of countries, including the UK, in the midst of formulating responses to what was clearly a second wave of the pandemic, with some—like India—seemingly still in the grip of a grim first wave.[2]

1 W.H.O. Covid timeline
2 W.H.O. profile of Covid cases in India

Terms of reference

9. The terms of reference for the inquiry initially identified the following priorities:

a) the emergence, incidence and spread of coronavirus virus infections and the Covid-19 disease in developing countries

b) the direct and indirect impacts of the outbreak on developing countries, and specific risks and threats (particularly relating to countries with existing humanitarian crises and/or substantial populations of refugees or internally displaced persons)

c) the UK's response, bilaterally and with the international community, to the spread of coronavirus to developing countries

d) the impact of the outbreak on DFID's operations (staff absences or reassignments, the impact of travel restrictions and other risk mitigation measures)

e) lessons identified and learned/applied from previous experience with infectious diseases (for example, Ebola); the implications for DFID's policy on a global heath strategy

f) whether there are particular risks of transfer of the coronavirus from conflicted and fragile environments to other countries

g) the risks of negative national or local behaviours arising from perceived risks of cross-border re-infections

h) the impact of the outbreak, and consequential mitigation measures, on fund-raising by UK-based development charities and NGOs, and

i) the impact of the outbreak on UK aid funding in the longer term.

Evidence

10. We have been very grateful for the time taken by our witnesses—many of whom were directly involved in responding to the pandemic—to put together well over 130 written contributions[3] and also those who grappled with the challenge of providing oral evidence via digital means.[4] In that vein, we were also grateful for the work of a wide range of House Service staff who played a part in the very swift installation and coordination of the systems, processes and procedures needed to deliver online live broadcast sessions of oral evidence. It is worth noting that this new ability of select committees to gather oral evidence online from interlocutors located around the globe is one very positive development of this experience. In addition to formal hearings we benefited from a number of informal private briefings, for example Dr Grant Hill-Cawthorne, Head of the Parliamentary Office of Science and Technology (POST) and a virologist

3 Written evidence submitted to the Committee
4 Oral evidence given before the Committee

11. In this first phase the Committee took oral evidence[5] about:

- humanitarian relief and development advocacy (15 May and 15 September) and selected crisis environments (4 June) from a range of actors and providers
- non-coronavirus immunisation and health issues (16 June) from Gavi, DFID's Chief Scientific Adviser and the Independent Commission on Aid Impact (ICAI)
- research and development (R&D) into coronavirus vaccines, treatments and tests (2 July) from delivery partnerships and collaborations between public, private and not-for-profit sector organisations
- the UK's contribution to the global response from then new Secretary of State for International Development, Rt Hon Anne-Marie Trevelyan MP, then DFID & FCO Minister of State, Rt Hon James Cleverly MP, and senior DFID officials (initial questions on 28 April and further exchanges on 6 July), and
- the latest situation in selected areas from humanitarian organisations and on the availability of data from epidemiologists from Imperial College and the London School of Hygiene and Tropical Medicine (15 September).

Intervention: window of opportunity

12. Having received urgent representations from a number of humanitarian organisations, and in the light of a specific report on mitigating the pandemic by the International Rescue Committee (IRC), the Chair, Sarah Champion, wrote to the International Development Secretary on 4 May seeking to amplify some concerns. From their experience with Ebola, the relevant NGOs made a compelling case that there was a narrow window of opportunity for action to prepare systems in developing countries for the anticipated challenges of coronavirus; and that they had the agility and trusted relationships on the ground to best exploit that window laying the groundwork for mitigation of both primary and secondary impacts of the pandemic. The then DFID Secretary of State replied that:

- The UK contribution to the global response was £744 million
- Civil society organisations and NGOs were key delivery partners (but not the only ones) for much of this new UK funding
- Global crises demanded work through multilateral organisations for scale and coordination
- DFID was working with the UN to ensure funding gets to NGOs and other recipients as quickly as possible
- use of the Rapid Response Facility should ensure availability for use within a few weeks by expert pre-qualified UK and international NGOs

5 Ibid. The Committee started taking oral evidence in the second phase of this inquiry (secondary impacts) on 13 October 2020.

- other funding would be accessible to UK NGOs downstream (including, £50 million for a DFID-Unilever Covid-19 hygiene initiative and funds freed from some DFID country programmes after Covid-responsive reviews of existing portfolios.[6]

13. In addition, the Secretary of State shared with us her letter to all DFID supply partners on responding to the pandemic, maintaining delivery of essential programmes and the support on offer from HMG, and DFID specifically, to assist the management of the impacts of the pandemic on UK-based organisations and staff.

14. The Committee welcomed many positive aspects in this reply. However, the thrust of our early intervention was about speed, frontline healthcare and also tackling the secondary impacts of the pandemic. The Minister's reference to a turnaround time of 'weeks' for funding channelled multilaterally, contrasted unfavourably with the NGOs' claim of 48 hours for deployment of direct funding; especially in view of the speed at which this pandemic spreads. Also, the headline reference to the UK's £744 million included a large proportion for R&D into vaccines, therapies and tests of which a substantial sum may well not be ODA-eligible. Taken with the anticipated squeeze on ODA (from reduced GNI), this may act to constrain ODA allocated for frontline care and secondary impacts—which were a key concern throughout our evidence.[7]

Interruption: DFID/FCO merger

15. In the midst of the crisis, our inquiry, and the Government's own Integrated Review of international policy—without warning—the Prime Minister announced the merging of the Department of International Development into the Foreign and Commonwealth Office to form the Foreign, Commonwealth and Development Office (effective from 1 September 2020). The Committee had to postpone a planned hearing on R&D into coronavirus vaccines and therapies etc., to be able to hear the Prime Minister's Statement.[8] The Committee had published an interim report from our *Effectiveness of UK Aid* inquiry, a week earlier, recommending strongly against a merger.[9] The Prime Minister's decision flew in the face of the evidence and analyses that the Committee had gathered (and pre-empted the Government's own Integrated Review). Our response to the substantive issues raised by the merger is contained in a further *Effectiveness of UK Aid* report on its implications[10] and a Government reply covering both reports was received in September.[11]

16. In relation to the coronavirus crisis, the explanation provided by the Prime Minister for the timing of the decision, announcement and implementation was that it was needed not *despite* the pandemic but *because* of the coronavirus crisis. However, neither the Prime Minister nor the Foreign Secretary articulated a very compelling case for this position. On 16 June, the Prime Minister told the House:

> Amid this pandemic, the House may ask whether this is the right moment to reorganise Whitehall, but I must say that in reality this crisis has already

6 Committee correspondence, op. cit.
7 See QQ 17–20
8 Hansard, 16 June 2020
9 Op. cit.
10 Op. cit.
11 Effectiveness of UK Aid, Fourth Special Report, Session 2019–21, HC 820: Government Response to the Second and Fourth Reports of the Committee, 2019–21.

> imposed fundamental changes on the way that we operate. If there is one further lesson, it is that a whole-of-Government approach, getting maximum value for the British taxpayer, is just as important abroad as it is at home. This is exactly the moment when we must mobilise every one of our national assets, including our aid budget and expertise, to safeguard British interests and values overseas. The best possible instrument for doing that will be a new Department charged with using all the tools of British influence to seize the opportunities ahead.[12]

And the Foreign Secretary added, in answer to an Urgent Question two days later:

> For too long, we have indulged an artificial line, dividing the goals that our aid budget and foreign policy serve. This coronavirus crisis has confirmed just how artificial that line is. Across Whitehall, I have chaired the international ministerial group, bringing all relevant Departments together to support the most vulnerable countries exposed to Covid-19; to energise our pursuit of a vaccine, working with our international partners; to return stranded British citizens from abroad; and to keep vital international supply chains open. In every one of these areas, we have been compelled to align our development, trade, security and wider foreign policy objectives.[13]

17. It is early days for any assessment of the impact of the UK's new integrated approach to aid and diplomacy, but no witness complained of substantial distraction or upheaval due to the merger. For example, we heard from the Foundation for Innovative New Diagnostics (FIND) that: "FIND has been working closely, and will continue to work closely, with DFID, no matter where DFID eventually ends up and how things work out. We will work with DFID."[14]

This report

18. This report seeks to identify the threats and risks arising from both coronavirus infections and cases (direct or primary impacts) and those arising from official, and unofficial, measures taken to prevent, avoid or reduce infections and the spread of the virus (indirect or secondary impacts).

19. Falling between these categories are various obstacles and challenges thrown in the path of effective humanitarian and development responses to the pandemic—ranging from practical transport difficulties for humanitarian personnel and materiel to the loss of trust and engagement in international medical provision by local communities or dangerous lapses in observance of the basic norms of humanitarian law.

20. The report also considers the UK response, bilaterally, as well as within the wider multilateral effort, such as the UK's role in the multilateral response to the pandemic, including the search for vaccines, treatments and test for Covid-19, and plans, resources and commitments to ensure the equitable global availability of products developed, regardless of economic power.

12 Hansard, 16 June 2020
13 Hansard, 18 June 2020
14 Q138

21. The Committee also aimed at setting out the latest state of play with regard to the spread of coronavirus in DFID's partner developing countries across the Global South. There are certainly a wide range of reports and tracking initiatives available but, overall, in this objective the Committee had to settle for pointing towards the best possible information while setting out the various issues and challenges around the gathering and interpreting of coronavirus and Covid-19 data.

22. We conclude by looking at the impact of the UK's own struggle to contain and deal with the coronavirus pandemic on the resources available for UK aid efforts. Finally, we consider options for next steps.

2 Coronavirus—risks and threats

23. Covid-19 has affected nearly every country in the world, irrespective of income, economic power and geo-political weight. In terms of development, by almost any measure, and in virtually all sectors, progress has stagnated or been driven backwards by the pandemic or crushed by the weight of steps taken to stop the coronavirus spreading.

24. The former DFID Secretary of State, Rt Hon Anne-Marie Trevelyan MP, told us that the Covid-19 pandemic threatened to undo the last 30 years of progress by the international development community and this was echoed throughout our evidence and, more recently, by the Secretary-General of the UN.[15]

What is coronavirus / Covid-19?

25. Covid-19, is an infectious disease caused by a new coronavirus identified in 2019. The virus is one member of a family of coronaviruses which circulate in some animal species and, clearly, can transfer to humans. Covid-19 shares some characteristics with the 2003 SARS disease in China, and with the 2012 MERS disease in the Middle East. However, Covid-19 has spread faster and with more deadly results than either SARS or MERS. After just a month, Covid had overtaken both MERS (866 lives in just under 8 years) and SARS (744 lives in nearly 2 years) in terms of virulence.[16] As of 10 November, 10 months after the first fatality, the W.H.O. was reporting a total of 50,459,886 confirmed cases of Covid-19 and, within that figure, 1,257,523 reported deaths.[17] As discussed later, the figure for Covid cases is likely to be substantially under-reported (thankfully, the—already horrific—recorded death toll is not as likely to be subject to under-estimation in the same way).[18]

26. The coronavirus appears to be principally transmitted through small respiratory droplets (generated by coughing and sneezing but also by singing, cheering, laughing and normal breathing). These exhalations are passed on directly or by touch or by contact with surfaces contaminated by such droplets. In addition to the obvious challenges of absences of vaccines and a definitive treatment, the key complicating factors in tackling the Covid-19 pandemic seem to be:

- lack of clear 'signal' symptoms (people can be infected—and be infecting others—without feeling ill or displaying any outward evidence),
- no clear post-recovery immunity (it is not clear whether and, if so, for how long a recovered Covid-19 victim might be resistant to another bout),
- not enough testing (R&D is continuing but so far in many countries, the pandemic has outstripped capacity and appetite for mass testing with current equipment), and
- a relatively high proportion of mild cases (despite being very infectious, most people do not seem to suffer debilitating or life-threatening symptoms).

15 Q63, 28 April 2020, HC 215
16 National Institute of Allergy and Infectious Diseases
17 W.H.O. Covid data
18 A death, even in fragile and conflicted environments, is an event likely to involve some ritual, process and a record. See QQ195–197

27. Without vaccines, effective therapies, and simple, speedy and reliable tests, the primary response to the coronavirus has been to prevent transmission by reducing contact between people. There is a spectrum between 'shielding', where the vulnerable people are isolated, to 'lockdown' when everyone is isolated in their residential groupings. But fundamentally, the solution is based on reducing contact and interactions between: family and friends; customers and vendors etc.; healthcare staff and patients; social services and vulnerable people; carers and dependents; members of audiences, congregations and sports crowds; and on and on. This involves cutting off the human contact most of us take for granted to maintain our: mental and physical health and well-being; and our livelihoods, societal, political and economic welfare too. This creates the fundamental coronavirus dilemma.

Impacts

28. Our evidence identified a range of specific risks, threats and vulnerabilities in developing countries arising from the coronavirus pandemic. Broadly, these fell into four categories:

- direct impacts from the spread of coronavirus infections and the incidence of cases of Covid-19
- indirect or 'secondary' impacts arising from measures taken by national or local authorities to prevent the spread of infections
- secondary impacts due to decisions and behaviours on the part of communities, families or individuals seeking to avoid infection, and
- constraints on the freedom and capacity of humanitarian actors to provide assistance and relief.

Direct impacts

29. Unsurprisingly, our evidence submitted earlier in the year, was deeply concerned about the direct impact of coronavirus and Covid-19 on lower and middle income countries. Serious suffering and fatalities were predicted to be markedly exacerbated where there were existing diseases and other co-morbidities and poor nutrition, as well as already weaker, damaged–sometimes devastated–health systems and facilities. No country suffering from the pandemic on any sort of scale has escaped having its health system severely tested, no matter how high the national income. However, in some developing countries healthcare systems were ready to fail. One example, referenced throughout our evidence (and discussed later), is Yemen.

30. There were particular concerns about conflict zones and refugee camps that are so often the result of conflict. Bob Kitchen, Director of Emergency Preparedness and Response, International Rescue Committee (IRC), told us:

> I am very worried about places that Governments do not have access to, so places that are controlled by non-state armed actors. Large portions of north-east Nigeria, large portions of Somalia and some portions of Sudan, et cetera, are very concerning, because we have zero visibility or standard surveillance systems …

> The other place that I am very worried about … is refugee camps, where the first confirmed case in Cox's Bazar within the Rohingya community has sent a ripple of … incredibly serious concern through our organisation yesterday, with such a large population of vulnerable refugees living in such a constrained environment with very little space. Social distancing in a refugee camp is essentially not possible.[19]

31. Robert Mardini, Director-General, International Committee of the Red Cross, explained:

> We try to target our resources where we think we have the most added value. This means places of detention, central prisons and informal places where people are deprived of their liberty, because these are hotspots and high-risk areas for infectious diseases and COVID-19.
>
> We also focus on leveraging our dialogue with non-state armed groups, crossing the front line and trying to influence armed groups in order to spread the right messages. …[20]

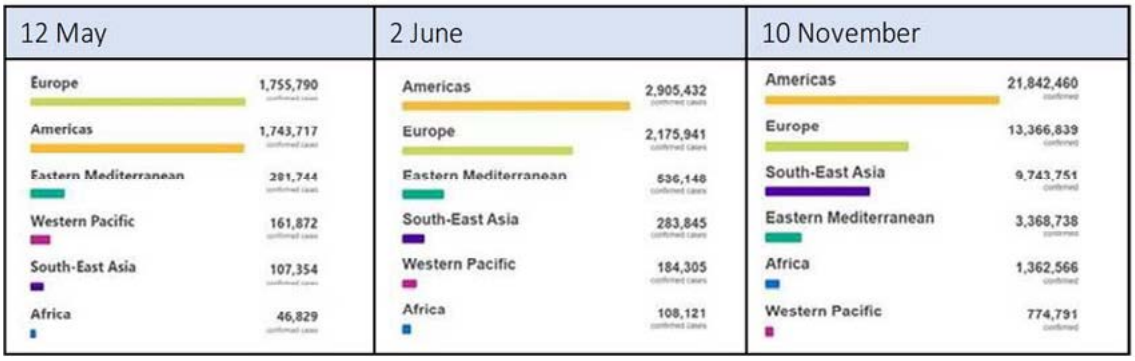
32. The public healthcare systems of developing countries have seemed ill-prepared for this pandemic. BOND told us that, generally, the health systems in many developing countries were "fragile, poorly resourced and lack capacity to respond to the effects of COVID-19."[21] Global Justice Now drew comparisons between available resources, saying "For example, while the UK has 28 doctors per 10,000 people, even relatively rich developing countries have a small fraction of that with 9 doctors per 10,000 people in South Africa, 8 in India."[22] Several witnesses were concerned that developing countries would not have the capacity to undertake widespread testing or treatment of Covid-19 cases, despite the "great strides" made in the last few decades in developing national and international public health institutions such as the Africa Centres for Disease Control (Africa CDC).[23]

33. In addition, preventative measures, common in wealthier countries, would inevitably be more challenging, for instance, in crowded accommodation settings, with limited access to clean water, such as camps for refugees and internally-displaced persons or informal shanty-towns. Here, livelihood, and day-to-day living, relied on contact; isolation with online life management was not likely to be easily, or widely, supportable.

34. However, the direct impacts of Covid-19 are not easy to calibrate in a precise way and comparisons between countries, regions and continents are bedevilled by complications as considered in the next section. The W.H.O. confirmed figures for Covid cases in its regions and selected developing countries are set out below.

19 Q4
20 Ibid
21 Bond (COR0026)
22 GJN (COR0023)
23 For example, Q197. But see How Africa fought the pandemic, Financial Times, 23 October 2020

Cumulative coronavirus cases in W.H.O. regions



Cumulative coronavirus cases in selected developing countries[24]

Country	12 May	10 November	
	Cases	*Cases*	*Deaths*
Pakistan	34,336	344,839	6,977
Bangladesh	16,660	421,921	6,092
Nigeria	4,787	64,184	1,160
Democratic Republic of Congo	1,102	11,607	316
Occupied Palestinian Territories	375	70,841	593
South Sudan	194	2,960	59
Myanmar	180	61,975	1,437
Uganda	126	14,574	133
Yemen	65	2,070	602
Syria	47	6,284	321

35. We discuss the quality and availability of Covid-19 data in the next Chapter.

Secondary impacts

36. At the heart of any response to the coronavirus pandemic in any country is the question of when does the cure become worse than the disease? When do the impacts of the measures taken to control and eliminate the pandemic become worse than those of the pandemic itself; and whether, and how, this coronavirus dilemma can be measured, expressed and resolved?

37. Concerns about the indirect, collateral or secondary impacts of the pandemic were a constant refrain in the evidence submitted to the inquiry. Back in April, the former DFID Secretary of State, Rt Hon Anne-Marie Trevelyan MP, told the Committee:

> My personal profoundest concern is that the secondary impacts [of the coronavirus pandemic] will be felt for years to come and the poorest will be most disproportionately affected.[25]

38. Marian Schilperoord, Senior Operations Manager, UN High Commission for Refugees (UNHCR), echoed this, saying:

24 Countries featuring in recent Committee inquiries.
25 Q63, 28 April 2020, HC 215

> In UNCHR, we are actually referring to a triple crisis. One is the health crisis … Secondly, for UNHCR, the protection risks arising from this crisis are also important. … UNHCR feels that border closures and access to territory do not automatically go hand in hand with the pandemic. There are the increased rates of sexual and gender-based violence that were already referred to … The third emergency that we are really seeing is the loss of livelihoods. … Children are also out of school. We are seeing an accumulation of very negative impacts.[26]

39. Robert Mardini, ICRC, also supported this view and said: "the secondary and the socio-economic consequences are as deadly as the primary consequences. … those countries where the economic situation is dire and/or contact is affected by war are the most vulnerable. … The livelihood support programmes are extremely important, as important as anything we can do to prevent [the pandemic] and to support hospitals and health centres."[27]

40. The key secondary impacts of concern raised in evidence included:

- reduced attention, resources and patient attendance in relation to non-Covid health conditions and initiatives (especially immunisation programmes)
- damage to the economy, industry and business closure, reduced trade, leading to loss of income and livelihoods, leading to reduced food security
- reduced economic performance, globally, will reduce all national income, including remittances,[28] humanitarian relief, official development assistance and other forms of aid
- illness and financial anxiety may increase levels of domestic violence; loss of income, isolation from support and services, may increase sexual exploitation and abuse of women and children, including child marriage, leading to a reduction in engagement with formal education
- reduced community cohesion and respect for human rights, international law, and rights of migrants due to formal and informal measures and behaviours, aimed at controlling the pandemic[29]

Non-Covid health conditions and initiatives

41. Most campaigners against non-Covid diseases were concerned that in the drive to tackle coronavirus, staff, drugs and facilities were being diverted to the Covid-19 response.[30] Such reductions may allow the resurgence of diseases which were being steadily brought under control, such as malaria, polio, TB and HIV/AIDS as well as a range of non-communicable diseases and neglected tropical diseases.[31] Former DFID witnesses were also worried by

26 Q9
27 Q8
28 In this instance, a transfer of money by a foreign worker to someone, often family, in their home country. According to the UN, remittances are worth over three times the amount of official development assistance and foreign direct investment combined (e.g. $529 billion to developing countries in 2018).
29 See for example ODI (COR0048)
30 See for example Action for Global Health (COR0153)
31 See Medicines for Malaria Venture, RBM Partnership to End Malaria, RESULTS UK, TB Alliance

Covid's secondary impacts, especially in relation to inoculation programmes. DFID wrote that it was: " … drawing on lessons learned from such previous experiences with global health emergencies to help … pre-empt and mitigate the secondary impacts of COVID-19 on other priorities, such as the provision of essential health services including for other infectious diseases and sexual and reproductive health and rights." The Department noted that during the 2015–16 Ebola outbreak, preventable deaths from malaria increased by around 50% in Liberia, Sierra Leone and in Guinea. DFID highlighted that the number of additional deaths from malaria—around 10,620—was comparable to the total number of deaths from Ebola during that outbreak: around 11,325.[32]

42. When the last DFID Secretary of State returned to the topic of Covid impacts in oral evidence with us in July, she reported that, since April:

> … the secondary health impacts are starting to be seen. As we have seen in western countries, people are not going to their healthcare providers for things like child vaccinations or maternity support, as well as other more day-to-day primary care activity. … and that is where a great deal of my anxiety lies: that we will have as many preventable deaths through that gap in continuous medical support as we will from that sharp impact of Covid.[33]

43. In particular, Daniel Graymore, formerly DFID's Head of Global Funds (and UK representative at the global vaccine alliance, Gavi), said that Covid was clearly a huge threat and challenge in the countries in which Gavi had been operating with such success. He said a significant number of vaccination campaigns and introductions had already been impacted, disrupted and delayed by the pandemic and this was going to have a huge impact into the future. In addition, there was quite a lot of evidence and data on the damaging impact of a loss of confidence in the vaccination process which would require rebuilding.[34] Professor Charlotte Watts, the former DFID's Chief Scientific Adviser, told us:

> … we are very concerned about the secondary impacts, and those are multiple. There are things like the impact on immunisation levels, but there are also other risks. For example, if people perceive that hospitals are a place of risk, that they might catch Covid there, it could impact on whether women go to health facilities to deliver babies or to access antenatal services. Therefore, the breadth of impacts from Covid are multiple and potentially, in some settings, bigger than Covid itself.[35]

44. The UN has warned that "COVID-related disruptions could cause a spike in illness and deaths from other communicable diseases". Despite the gains made in recent years in many areas, recent service disruptions could cause "hundreds of thousands of additional deaths from AIDS, malaria, tuberculosis and neglected tropical diseases." The RBM Partnership to End Malaria wrote that: "While COVID-19 is the shock pushing 40–60 million people back into poverty, malaria will be the force preventing them from climbing back out again."[36]

32 DFID (COR0060)
33 Q141
34 Q106
35 Q100
36 RBM (COR0010 and COR0083)

45. ***We recommend that, as part of a renewed consistent approach to promoting global health, the FCDO should continue to fund existing programmes aimed at the eradication of previously identified diseases. The Government should use its integrated voice to lobby development allies and partners to stop any transfer of resources from existing programmes, and the Global Fund, to Covid initiatives.***

Economic damage, loss of livelihood, global recession

46. Lockdowns risk severely damaging both formal and informal economies, especially the operation of physical marketplaces (crucial to the latter). Unemployment, loss of income, and resulting food insecurity, will disproportionately affect vulnerable groups. Mercy Corps, argues that the threat to livelihoods may surpass the direct threat of Covid-19. In addition, remittances—often vital to coping in crises—may also dry up, given the global nature of the problem.[37]

47. The ILO has predicted a loss of up to 25 million jobs worldwide. The informal economy, including young people and women, will be hardest hit economically. In Africa for example, 90% of employed women are in informal employment compared to 83% of employed men.

48. In the context of Gavi, specifically, Amanda Glassman, Centre for Global Development, pointed out the potential for countries previously transitioning from low to middle income, or expected to do so, falling back into recipient status.[38] The Foreign Secretary, Rt Hon Dominic Raab MP, wrote to us in July 2020, disclosing a 20 per cent. cut in the aid budget for 2020 in anticipation of reduced GNI. He said:

> So that we can react to the potential shrinkage in our economy, and therefore a decrease in the value of the 0.7% commitment (which is based on the UK's GNI), we have identified a £2.9bn package of reductions in the Government's planned ODA spend so we can proceed prudently for the remainder of 2020. This package includes underspends, delaying activity and stopping some spend. All ODA spending Departments will now work with our respective supply chains to realise these reductions.[39]

Other donors may act likewise.

Domestic violence and sexual exploitation and abuse of women and children

49. Lockdown, family illness and loss of income could all impose disproportionate stress and risks on women, girls and children in terms of violence, abuse and exploitation, including sexual exploitation, with the simultaneous isolation from access to mitigating services. Children might find themselves isolated with an abusive relative. Women traditionally would undertake the lion's share of any nursing duties but also seem to suffer an increase in domestic abuse (something prevalent in locked down settings from the UK[40] to Cox's Bazar).[41]

37 Mercy Corps (COR0008)
38 Q100
39 Op. cit.
40 Covid-related domestic abuse in the UK
41 See for example Bond (COR0157), GFF (COR0140) and passim

50. Farah Kabir, Action Aid's Country Director for Bangladesh, told us that: "On the social side, women and girls are at high risk because men are also under lockdown. They're confined in that space. There is acceptance of domestic violence and their right to do that. Child marriage is increasing, and this is leading to trafficking." She added that this was the case also across Bangladesh and was not a 'camp', or 'Rohingya', problem:

> … just in the month of April, domestic violence has gone up. There has been rape. There have been gender-based homicides. This comes from one month of tele-surveys. In one of the surveys conducted in the slum areas, a number of women told us that this is the first time they have experienced domestic violence, because of the pandemic.[42]

51. Other evidence pointed to risks that loss of income or livelihood could lead to the sexual exploitation of women or children to mitigate that loss.[43]

52. ***Successive UK governments have always stated that safeguarding and action against gender-based violence, including sexual violence, were high priorities for action. We have previously welcomed this stance and recommend that the new Department continues to make it a priority to maintain and strengthen the international alliance around initiatives in this area. We also recommend that the new Department maintains the UK's international leadership on this agenda, preserves existing levels of funding and seeks to identify what further interventions may counteract the effect that Covid has had in increasing levels of domestic violence and sexual exploitation and abuse of women and children.***

Erosion of respect for rights

53. UNHCR described the coronavirus pandemic as a protection and humanitarian rights crisis for the forcibly displaced. The UN organisation said the risks included:

- the entrenchment of repressive emergency laws and policies
- non-adherence to democratic principles and human rights, such as abusive treatment of asylum-seekers and refugees, with deportations and forced returns
- quarantine (of migrants) leading to restriction of movement, detentions and restricted access to, or total suspension of, due procedures[44]

54. The International Committee of the Red Cross wrote that, in conflict zones, it was vital that key provisions of international humanitarian law were respected in order to respond adequately during these unprecedented times–access by humanitarian personnel and movement of medical and relief supplies and access to water must all be protected.[45]

55. ***We recommend that the Government continues to project clearly onto the international stage, the importance it places on the UK's place within the rules-based international infrastructure and the crucial foundations of human rights and the rule of law as fundamental British values.***

42 Q55
43 See for example Save the Children (COR0037)
44 UNHCR (COR0028)
45 ICRC (COR0030)

3 Availability of information

Data challenge

56. It was clear from our evidence that there were enormous challenges in making an accurate assessment of the spread of the coronavirus in many countries, both developed and developing, from the data available. Robert Mardini from ICRC told us that " … , very often, only 50% of the health infrastructure [in countries within which it was working] is operational. That shows how difficult it is to get access to credible and systematic data in normal times, let alone in times of COVID-19. It is extremely hard to get any sensible sets of data. We get anecdotal data and very often we only get to see the tip of the iceberg.".

57. Other witnesses concurred and explained how they tried different approaches. Gwen Hines, Save the Children, told us that: " We have thousands of national staff on the ground and we use them to get data to add to official data. We have recently been going through an exercise of looking country by country and cross-checking that with official sources. You can also use proxies to a certain extent, in terms of what you are hearing from people involved in burials or reporting cases at the village level. We are using that to understand what is happening. … We also have a number of health experts who are involved in the research side. We are tracking that research, which is so important, be it Imperial College London or other".[46] Aleema Shivji, Executive Director, Humanity and Inclusion, praised DFID in general for leadership on disability inclusion and in particular for seeing that through into promoting the collection of data disaggregated by disability age and gender.[47]

58. DFID's Chief Scientific Adviser, Dr Charlotte Watts, also told the Committee that: "It is really hard to get accurate data. We have invested in collection of data, including supporting Africa CDC to provide technical support and improve data. We have also supported the London School of Hygiene and Tropical Medicine and Imperial College, to help us do modelling to give us better projections, at least, of what might be happening. They estimate, for example, for Sub-Saharan Africa, that about 10% of cases are being reported."[48]

59. Professor Azra Ghani, Chair in Infectious Disease Epidemiology, School of Public Health, Imperial College. explained that the task was mainly finding ways of supplementing thin testing data:

> The main challenge is the weakness of the surveillance system, so trying to understand who is getting tested and how many tests are performed. We look at the test positivity rate as an indicator of how many tests are being performed on negative people as well as positive, and that is very helpful.
>
> We focus particularly on looking at reported deaths, because we know that cases tend to be under-reported. Not everybody will be seeking tests or treatment, but even those are very challenging in places that do not have registration systems in place. We are starting to look for other

46 Q31
47 Q35
48 Q142

> sources of data, for example media reports of funerals or other information, particularly looking at excess deaths if that information becomes available, to try to get a better handle.
>
> The reason for wanting to do this is that we need to understand the stage of the epidemic in different countries. In some places we seem to have had very few Covid cases and very few deaths. This may not indicate that the transmission has not happened, but rather that it has happened and has been hidden by the weaker surveillance system.[49]

60. Professor Ghani confirmed the DFID Chief Scientist's reference to a 10 per cent. reporting rate in sub Saharan Africa. She told us that 10% was a good ballpark but it varied from one country to another. For example, the larger epidemic evident in South Africa may mean that infections were confined there "but it may be that the surveillance is better there." Another potential source of data was antibody test results ('seroprevalence surveys').[50]

61. Professor Ghani pointed to a recent survey in Kenya, which indicated that 5% of people had been infected (rising to 8% or 9% in major urban areas).[51] Francesco Checchi, OBE, Professor of Epidemiology and International Health, London School of Hygiene and Tropical Medicine, said that part of his study in Yemen was going to be based on satellite imagery of Aden graveyards as a source of data on Covid deaths in Yemen.[52] This is the manner in which the extent of Iran's Covid epidemic was exposed by the New York Times in March 2020. Dr Timothy Russell, Research Fellow, London School of Hygiene and Tropical Medicine, described a further way of assembling a data picture from fatality data. He told the Committee that the way it worked was fairly simple, using the 'hidden' information in reported death data to infer or reverse engineer an estimate of the number of Covid cases it would have taken to produce those dead bodies. This methodology has assumed an accurate reporting of deaths (but Dr Russell did concede some under-reporting of deaths[53]).

49 Q192
50 Q193
51 Q193
52 Q199
53 Q195 and Q188

Estimated proportion of Covid cases being reported[54]

Country	W.H.O. data for 10 November		Estimated % of cases being reported
	Cases	*Deaths*	
Pakistan	344,839	6,977	97%
Bangladesh	421,921	6,092	89%
Nigeria	64,184	1,160	97%
Democratic Republic of Congo	11,607	316	36%
Occupied Palestinian Territories	70,841	593	99%
South Sudan	2,960	59	81%
Myanmar	61,975	1,437	N/A
Uganda	14,574	133	45%
Yemen	2,070	602	7%
Syria	6,284	321	31%

Case study: Yemen

62. Mired in conflict for years, barely half of Yemen's health facilities are fully functional. Ghassan Abou Chaar, until recently the Médecins Sans Frontières' Head of Mission in Yemen, described the arrival of the first Covid-19 cases, in Aden in the south and soon after in Sana'a in the north, while fighting was still active. He said people arrived 'already suffocating':

> … which is the worst cases of people seeking hospital care only when they are in a situation where they cannot get help at home from their friends or in a private health structure.[55]

63. Ghassan Abou Chaar said they had been surprised that the coronavirus had managed to enter the country. He told us that Yemen's borders were already closed and that "There are five international flights a week coming in and out of the whole country, so it is already confined."[56] According to W.H.O. figures, even in October there had only around 2,000

54 Study to estimate the percentage of symptomatic COVID-19 cases reported in different countries using case fatality ratio estimates based on data from the ECDC, correcting for delays between confirmation-and-death. Centre for the Mathematical Modelling of Infectious Diseases, London School of Hygiene and Tropical Medicine. Data as at 25 August 2020. Overall, the countries with the 20 highest levels of under-reporting were from no single income category:

Country	Percentage of symptomatic cases reported (95% CI)	Country	Percentage of symptomatic cases reported (95% CI)
1. Yemen	7.2% (5.1%-10%)	11. Jersey	31% (8.4%-89%)
2. Mexico	17% (15%-19%)	12. Australia	32% (24%-41%)
3. Kosovo	21% (16%-27%)	13. Bolivia	34% (29%-39%)
4. Belarus	22% (13%-35%)	14. Sudan	35% (22%-55%)
5. Iran	24% (21%-27%)	15. Peru	35% (30%-39%)
6. Egypt	25% (20%-31%)	16. Indonesia	35% (30%-40%)
7. Gambia	27% (19%-41%)	17. Saudi Arabia	36% (30%-49%)
8. Angola	29% (21%-43%)	18. DRC	36% (19%-59%)
9. Syria	31% (21%-45%)	19. Bulgaria	36% (27%-47%)
10. Afghanistan	31% (21%-45%)	20. Italy	38% (30%-47%)

55 Q79
56 Q92

confirmed cases but with 600 deaths. With that ratio it is perhaps not surprising that Dr Russell's study identifies Yemen as the likely worst performer, reporting only an estimated 7.1%. of Covid cases.[57]

64. Yet, in July, a DFID press release announced: "UK calls for drastic action in Yemen as coronavirus infections reach one million" and went on to state:

> Infections may have already reached one million, according to UK aid-funded research by the London School of Hygiene and Tropical Medicine which projects a worst-case scenario of up to 85,000 deaths.[58]

65. The Minister, James Cleverly MP, is quoted as saying during the (virtual) visit that: "This visit has allowed me to hear about the devastating impact coronavirus is already having in Yemen, and I was deeply concerned to hear that there have been over a million cases."[59] However, it seems the study in question was more of a scenario and not to be confused with a forecast or estimate.

66. But returning to Ghassan Abou Chaar's evidence of surprise at the appearance of the coronavirus at all—Professor Checchi shared an interesting theory. He told us:

> Yemen … is really quite an interesting case study that we are working on quite a bit. It is one of the few countries, to my knowledge, where almost no prevention of Covid transmission has taken place, unfortunately, and the anecdotal reports we are getting from inside Yemen are pretty consistent that the epidemic has "passed". There was a peak in May and June across Yemen of cases and of hospitalisation facilities being overwhelmed, and that is no longer the case now.[60]

67. Professor Checchi said that study of the satellite imagery of the graveyards in Aden points to considerable excess mortality peaking in May. With no preventative measures, Professor Checchi's suggestion for the lack of further escalation of infection was:

> A very simple explanation, and one that does not require revisiting any of our current model assumptions, is that quite simply the epidemic burned out. It is possible to imagine that it was introduced into Yemen earlier than initially recognised. Remember, this is probably among all countries on earth one of those with the smallest testing capacity, particularly in the north. Let us imagine that the virus was actually introduced in February as opposed to April, when it was first recognised. You could predict that essentially the epidemic took off, ran its course and has now reached a situation where, at least temporarily, the population has accrued some kind of herd immunity.[61]

57 Study to estimate the percentage of symptomatic COVID-19 cases reported in different countries using case fatality ratio estimates
58 Covid in Yemen
59 Ibid
60 Q200
61 Q199

4 The UK response

Introduction

68. The coronavirus outbreak was a global emergency by the end of January 2020 and an official pandemic on 11 March. The then International Development Secretary published a call to action on 9 April, jointly with northern European counterparts. This statement of intent hit many of the notes which have since come up in our evidence (and in subsequent action). These include collaboration, non-health impacts, gender issues, the importance of W.H.O; equitable access to vaccines, temporary debt service relief, mobilising the private sector, universal health coverage, a global health strategy and long term thinking.[62]

69. The next step was a global pledging conference on 4 May.[63] In total, $8 billion was pledged. This involved:

- $3 billion will have to be spent to develop, manufacture and distribute a possible vaccine against Covid-19
- $2.25 billion needed to develop treatments for Covid-19
- $750 million for testing kits
- $750 million to stockpile protective equipment
- $1.25 billion for the World Health Organisation to support the most vulnerable countries.

70. The UK's reported pledging at this conference was not new money but had already been announced (arguably because the UK had acted faster than other donors to identify and commit resources). The Prime Minister was described as confirming UK's pledge of £388 million in UK aid funding for research into vaccines, tests and treatments–part of a larger £744 million worth of UK aid committed to help ending the pandemic and supporting post-Covid global economic recovery.[64]

71. The Committee was keen to hear about: governance around the public/private partnerships in receipt of UK aid in this initiative, progress towards effective medicines and the mechanisms for guaranteeing affordable and equitable access to the products in every developing country regardless of countries', or individuals', buying power.

CEPI

72. £250 million was allocated to the Coalition for Epidemic Preparedness Innovations (CEPI) to develop vaccines against coronavirus. CEPI is a Norwegian Association, a coalition between public, private, philanthropic and civil society organisations that work in partnership. The pledge consists of £230m from DFID and £20m from the Department of Health and Social Care.

62 Northern European call for joint action
63 Global Covid response
64 Department for International Development (COR0133)

73. The initial tranche (£20) was disbursed in March 2020 and covers the period to 31 May 2020. The balance (£210m) covers the period to 31 March 2021. The funding is allocated by CEPI to organisations identified through the Partnership's competitive calls for R&D proposals. UK funds will be used primarily to support CEPI's vaccine work for the benefit of low/middle income countries. Success will be achieved by the development of an effective vaccine for Covid-19 that is accessible and affordable in developing countries. DFID, now the FCDO, will assess the extent to which this work advances the scientific evidence base through its usual monitoring processes including receipt of reports from CEPI and published peer-reviewed research papers etc. DFID wrote that vaccine research was very high risk and there could be no guarantee that UK funding through CEPI would result in a successful vaccine candidate.

74. Dr Samia Saad, Director of resource mobilisation and investor relations at CEPI told us that the reason for CEPI being founded was that, while there were lots of different efforts towards developing vaccines or other health interventions to fight epidemics, et cetera, there was not enough investment in preparedness.[65] For example, while there was a vaccine for Ebola, the one that ended up being successful had only gone part of the way through development and had then sat on a shelf. The core of CEPI's mission is equitable access and leaving nobody behind. Dr Saad told us:

> The key for a global pandemic is that you need an efficacious vaccine that is going to give you immunity. We still are learning a lot about the disease because it is so new. … Speed, scale and access are the drivers around the portfolio. … We are hopeful, but again, the science does not always do what you want it to do. We are getting good signals that we might have some doses, not billions, but 100 million doses if we are lucky, at the end of the year.[66]

75. Dr Saad was clear also that: "In the short term, nobody is going to make any money out of any of these tools, really. In terms of the [intellectual property] and how we manage it, the focus is on equitable access. There are very stringent global access conditions in the contract."[67]

CTA

76. £40 million was allocated to the Covid Therapeutics Accelerator (CTA), a collaborative initiative, commencing in March 2020, pooling funding for the rapid development of Covid-19 treatments. in low and middle income countries. The accelerator is supporting the development, and scaling up, of a broad range of treatments for Covid-19. The immediate focus is to develop therapies that can be made available within this year, 2020.

77. DFID has pledged up to £40 million to the initiative for 2020/21, alongside the Bill & Melinda Gates Foundation, Wellcome, Mastercard and other funders. The funding is for channelling through the CTA to organisations successfully awarded resources in accordance with the "The Accelerator's" processes. Funds will partly be routed through The Wellcome Trust and partly disbursed directly from DFID.

65 Q118
66 Q121
67 Q132

78. The Accelerator will provide funding for groups to research (i.e. conduct clinical trials), develop and bring effective Covid-19 treatments 'to market', quickly, for use in low and middle income countries (LMICs). Success will be demonstrated by the development of effective therapeutics that are available, affordable and accessible in LMICs. DFID expected to know about the extent to which this work advanced the scientific evidence base through its usual monitoring processes including receipt of reports, published peer reviewed research papers etc. DFID staff are also on the CTA Steering Committee which meets weekly to review the progress of the research.

79. Dr Josie Golding, Epidemics Lead, Wellcome Trust (part of both CEPI and the Covid Therapeutics Accelerator (CTA) partnership), described the CTA's purpose as filling a gap: "While there has definitely been a focus on vaccines over the last few years for epidemics, there has been no coordination effort related to therapeutics; so, this is part of what we saw as a big gap, in particular with Covid. Similar to CEPI, the main function is equitable access, particularly in low-resource settings, making sure these treatment options are available." She emphasised that the CTA was not a new entity but a collaboration of funders—with clear governance arrangements—able to mobilise resources quickly.[68]

80. Dr Golding told us:

> The focus for our funding call was on low and middle-income countries, so our portfolio is around £12 million pounds supporting research carried out on the African continent and in south-east Asia. This research is critical to vaccine development and therapeutics, because it provides the knowledge we need on the risk factors and the immune response against Covid. That sort of research is absolutely essential, so we funded that.[69]

81. Dr Golding highlighted that the Wellcome Trust had various investments across Asia and the African continent, and over decades had been building up clinical research capacity, particularly the trial capacity. She said that this was why they invested and promoted research in the global south; to make sure research for treatment options could use those clinical trial sites.[70]

FIND

82. £23 million was allocated to support the Foundation for Innovative New Diagnostics (FIND), to develop rapid tests for the virus to help identify and slow its spread. FIND is a not-for-profit charitable foundation and product development partnership (PDP) based in Geneva. As a PDP, FIND works closely with industry and academic partners to research, develop and support the accessibility of new health technologies for developing countries.

83. FIND's specific purpose is to drive innovation in the development and delivery of diagnostics to combat major diseases affecting the world's poorest populations. It is the only organisation of its kind solely focussing on diagnostics and has the technical expertise to address the full diagnostics value chain, from end-to-end, from test developers to end-users.

68 Q118
69 Q124
70 Q124

84. DFID pledged up to £23m to FIND for the financial year ending March 2021. Of this funding £11m will be paid in June, £7m November and £5m March 2021 for COVID activities (this is an assumption based on forecasting as funding is core funding and paid upon funding requests).

85. Funds to FIND will be used for the evaluation of new diagnostics, and quality assurance of new tests; capacity-building for Global South partners in laboratory work; piloting a rapidly deployable, mobile laboratory for diagnostics for new outbreaks; support for manufacturing to produce high quality rapid diagnostics tests; market access for LMICs to access diagnostics; and driving further innovation and building of LMIC diagnostic capacity using digital tools.

86. Success will be seen in the development and availability of new diagnostics tests in LMICs. DFID monitored Find via formal and detailed annual reports from the partnership and, in addition, the Department remained in close contact with FIND programme staff. Professor David Heymann CBE, LSHTM and FIND board member, told us that, since establishment in 2003, FIND, had been integral in the development of 24 new diagnostic tools, in turn these had been effective in providing tests to 150 lower and middle-income countries. He added that, while there had not yet been a major breakthrough in vaccines or in therapeutics, there had been a diagnostic test that was useful, not only in identifying people who are sick, but in outbreak containment activities, identifying contacts who are sick and who need to be isolated as well.[71]

87. Dr Heymann emphasised that the whole context of FIND was to work towards tests that were effective in developing countries and can be made available. To operationalise this, FIND had invested quite heavily in a project in Senegal, which would be a transfer of technology—the development of diagnostic tests from Mologic (a UK manufacturer)—to Senegal. There will be development and production of tests, which will then be provided to countries throughout Africa at a fair price within Africa.[72]

88. DFID also provided £75m for the World Health Organization's critical health systems response and said that that the UK had also pledged the equivalent of £330 million per year over the next five years to Gavi, the Vaccine Alliance.

89. DFID also emphasised that it was:

- working with businesses, such as Unilever, to tackle the virus allocating £50 million to raise awareness of the importance of hygiene and distribute hygiene products
- allocating £130 million for UN agencies (£65 million to the World Health Organization which is coordinating international efforts to slow infections)
- providing £50 million specifically for the Red Cross in difficult to reach areas such as those suffering from armed conflict
- allocating £20 million for NGOs to help prevent the virus from spreading in the poorest countries through strengthening health systems and providing essential supplies

71 Q119
72 Q122

- providing £150 million for the International Monetary Fund's (IMF) Catastrophe Containment Relief Trust (CCRT) to help developing countries meet their debt repayments so that they can focus their available resources on tackling Covid-19
- working closely with other G20 creditors and the Paris Club to provide a temporary suspension of debt repayments from the poorest and most vulnerable countries that request relief to assist those countries' capacity to respond to the crisis
- undertaking long term work, as the largest government donor, with Education Cannot Wait (education provision in crises) which is supporting children in 16 Covid-19 hit countries through $15 million of emergency grants, and
- providing support that has been challenging harmful misinformation about Covid-19 in South East Asia and Africa before it can be spread worldwide and harm the initiative

90. DFID also reported that existing bilateral programmes are being adapted to support communities affected by Covid-19 in partner countries. For example, in South Sudan, including support for infection prevention and control as well as water, sanitation and hygiene activities; and in Bangladesh, providing a package of assistance which included help to maintain essential humanitarian services and support Rohingya and host communities for Covid-19 preparedness in the Cox's Bazar refugee camps.[73]

Next steps

91. On the specific next steps, ***we believe the FCDO should:***

- ***recognise that the eradication of the pandemic everywhere is an integral part of resolving the threat anywhere and therefore switch its financial support for Covid-19 vaccines, therapies and tests voluntarily from its ODA pot to other budgets (thereby freeing up resources for more frontline activity on secondary impacts in developing countries)***
- ***re-commit to its ongoing programmes and provide new funding for the Covid-19 response—in particular in relation to secondary impacts—from ODA, freed up from Covid-19 vaccine R&D, rather than allowing the transfer of scarce resources from existing programmes, especially those tackling other diseases***
- ***use its significant leverage as leading development actor in many areas (gender equality, disability inclusion, poverty alleviation) to lead an inclusive and transparent approach by the donor community (both bilateral and multilateral),***
- ***put local non-governmental organisations (NGOs) and their partner International NGOs at the heart of the global Covid-19 response as they are closest to end-user communities and benefit from existing relationships of trust and confidence.***

73 DFID (COR0060)

Official Development Assistance

92. We were interested in whether Covid-19 vaccine, etc., R&D was ODA eligible. According to the OCED's Development Assistance Committee (DAC), its statistical working party (WP-STAT) met in June to discuss this and other matters around the ODA eligibility of COVID-19 related activities. The OECD Secretariat presented a 'Frequently Asked Questions (FAQs)' document, setting out its interpretation of ODA-eligibility based on the DAC Reporting Directives.

93. During the WP-Stat meeting, not all members agreed with the Secretariat's interpretation of the rules in this instance. In particular, two members disagreed with the assessment of the eligibility of research for a Covid-19 vaccine. Several members expressed a preference for a case-by-case approach to assessing ODA eligibility, rather than blanket exclusions.

94. Following the meeting, the FAQs document was posted on the OECD website. The FAQs document is glossed by a note that makes clear that the guidance is preliminary, and will be updated as discussions among DAC members evolve and concrete examples of activities have been assessed for eligibility by the OECD Secretariat. At the relevant point, the FAQ document asks:

> *FAQ3. Does research for developing a vaccine/tests/treatments for COVID-19 count as ODA?*

And the answer given is:

> For research, specific eligibility rules apply [see paragraph 101 in the Reporting Directives, DCD/DAC/STAT(2018)9/FINAL]:
>
> Research into the problems of developing countries is ODA-eligible, conducted whether in the donor country or elsewhere. To be eligible, research needs to be either:
>
> (i) undertaken by an agency or institution whose main purpose is to promote the economic growth or welfare of developing countries,
>
> (ii) commissioned or approved, and financed or part-financed, by an official body from a general purpose institution with the specific aim of promoting the economic growth or welfare of developing countries.
>
> According to the rules, the focus is on problems of developing countries. This ruling has led to the exclusion from ODA of research that benefits developed countries as much as developing countries: ODA includes medical research only in relation to diseases that disproportionately affect people in developing countries.
>
> For example, medical research on cancer is excluded from ODA unless it focusses on cancers with a high burden on developing countries
>
> Similarly, research for a vaccine/tests/treatments for COVID-19 would not count as ODA, as it contributes to addressing a global challenge and not a disease disproportionately affecting people in developing countries. This

> situation may evolve. If research in the future looked into the development of a COVID-19 vaccine specifically for developing countries, it would count as ODA.
>
> Several initiatives are being launched at the moment to collect funds for COVID-19 vaccine research or to facilitate global access to vaccines. They will be reviewed on a case-by-case basis by the Secretariat, as part of the regular WP-STAT and ODA reporting processes, and all elements of their design and objectives will be taken into consideration when assessing their eligibility.[74]

95. In a supplementary submission, the Government said, of all funding allocated to coronavirus medicines research and development, that: "Our assessment of this expenditure, and the vital work it supports, is that it meets the definition of Official Development Assistance."[75] The ODA eligibility of COVID-related activities will be discussed again at the next meeting of WP-STAT in November.

96. **We conclude that, for the time being, it would not be prudent for the Government to work on the basis that funding allocated to research for vaccines, treatments or tests for Covid-19 would count as ODA, as it "contributes to addressing a global challenge and not a disease disproportionately affecting people in developing countries". *Our view is that this frees up a substantial sum from the 2020 ODA pot to be applied to, either alleviate part of the cuts made in anticipation of reduced GNI for 2020, or activity aimed at alleviating secondary impacts of the Covid-19 pandemic. We would recommend the latter course (in so far as the options are mutually exclusive).***

74 OECD (COR0135 and COR0131)

75 Foreign, Commonwealth & Development Office (COR0142)

5 Global health

97. At the virtual UN General Assembly for 2020, the Prime Minister, Boris Johnson, made one of the closing speeches which he used to chide his fellow heads of government for the fractious way he saw the international community dealing with the coronavirus pandemic.

98. The PM made a number of announcements of relevance to the UK's contribution to the global response to the impact of the coronavirus on developing countries.

- He stressed that, despite the common global challenge, and the need for a coordinated global solution, the pandemic had been very divisive in terms of the international community
- There was a practical need to reach a joint understanding of how the pandemic began, and how it was able to spread, to prevent a recurrence
- The UK would be upping its contribution to the W.H.O. by 30% to £340 million over the next four year period.
- The UK was already the biggest single donor to the Coalition for Epidemic Preparedness (CEPI) programme to find a coronavirus vaccine, just as it is the biggest donor to global vaccine alliance, Gavi, and,
- 'because no-one is safe until everyone is safe', the UK would be contributing up to £571 million to COVAX, the WHO-led initiative to guarantee provision of, and access to, coronavirus vaccines across the world (£500 million of the UK contribution will be explicitly for developing countries[76] and £71 million for purchasing for the UK).

99. In the last 20 years, there have been eight outbreaks of a lethal virus, any of which could have escalated into a pandemic. The Prime Minister told the UN General Assembly that the UK would use its 2021 G7 presidency "to create a new global approach to health security based on a five point plan to protect humanity against another pandemic"– in summary: prevention (a global network of hubs to find and prepare solutions for threatening pathogens); prediction (an early warning system to spot new outbreaks ASAP); production (promotion of vaccine, etc. manufacturing capacity); preparedness (development of shared emergency plans & protocols); and partnership (free trade in anti-pandemic products like PPE).[77]

100. ***At a strategic level, we urge the PM and the Government to be more ambitious for the UK's G7 Presidency than simply calling for better cooperation in spotting, preventing and fighting another pandemic more effectively. Rather, we recommend the Government lead a charge towards the establishment of a holistic global health and nutrition strategy based around achieving Sustainable Development Goal Three (ensuring healthy lives and promoting well-being for all at all ages) more broadly. This would put the world in a position to respond effectively to the next global health challenge, and the one after that, whatever these turn out to be—rather than just the last one we struggled with.***

76 £250 million of direct funding and a £250 million leveraging commitment to be released when and as matched by other donors. See COR0142.

77 PM UNGA 2020 speech; and Foreign, Commonwealth & Development Office (COR0142)

6 Conclusion

101. Overall, we applaud the contribution made by the UK to the international community's response to coronavirus; and the Government's recognition that a global pandemic necessitates a global solution. We commend the strong signals of the UK's intent to engage fully with the international community in current and future concerted efforts to tackle global health security as part of wider work on global health in general.[78]

102. We note the Government's recent evidence to us that:

> Decisions about long-term funding for UK ODA on global health security will be taken at the upcoming Spending Review, including how we can best further elements of the PM's 5-point plan through ODA investments. The forthcoming Integrated Review of Security, Defence, Development and Foreign Policy (IR) consolidates much of this thinking on using the aid budget as a force for good and in the national interest, including on global health security.
>
> And that this focus:
>
> … forms part of the UK's wider commitments to global health. These include: the manifesto commitments to end the preventable deaths of mothers, newborns and children and lead the way on malaria; our support to achieve universal health coverage, strengthen health systems and health security; and our objective to promote healthier lives and environments, including safely managed water and sanitation, healthy diets and sustainable food systems.[79]

103. However, we would welcome a clear commitment to the development of a UK global health strategy as an effective, prioritised and costed home for all these relevant strands of work and which would include an explicit set of goals and milestones for assessing progress.

104. We highlight the clear consensus in our evidence that the coronavirus has posed challenges to progress across the full spectrum of development activity. Regaining this lost ground, let alone 'building back better', will require the application of even more energy and innovation as well as resources; resources that should not be diverted unthinkingly from existing activity into coronavirus-only, or coronavirus-specific, programmes. Hence our sympathy with the nascent view of the OECD's Development Assistance Committee that investment into R&D to produce coronavirus vaccines and other medicines—while absolutely vital—may not all be ODA-eligible.

105. In the meantime, we welcome the increase in UK core funding for the somewhat beleaguered World Health Organisation; and also in particular the direct, and the conditional, resources for the Covax initiative aimed at the obviously ODA-eligible goal of ensuring that people in all corners of the developing world will get access to Covid-19 vaccines—once available—regardless of their individual income or the economic power of their country.[80] This initiative may well soon receive its first challenge in the equitable

78 DFID (COR0060)
79 Foreign, Commonwealth & Development Office (COR0142)
80 Foreign, Commonwealth & Development Office (COR0142)

distribution of the first effective vaccine to be emerging from clinical trials.[81] We look forward to tracking progress and performance in this endeavour and reporting further in due course.

106. We hope to be able to scrutinise the unfolding work to implement all the Government's commitments. In the immediate future, a further inquiry will focus on selected secondary impacts of the Covid-19 pandemic, and efforts to contain it, as well as considering available evidence about effective or promising interventions to mitigate such impacts.[82]

81 Media reports of an effective Covid vaccine

82 Humanitarian crises monitoring: secondary impacts of coronavirus: terms of reference

Conclusions and recommendations

Coronavirus—risks and threats

1. We recommend that, as part of a renewed consistent approach to promoting global health, the FCDO should continue to fund existing programmes aimed at the eradication of previously identified diseases. The Government should use its integrated voice to lobby development allies and partners to stop any transfer of resources from existing programmes, and the Global Fund, to Covid initiatives. (Paragraph 45)

2. *Successive UK governments have always stated that safeguarding and action against gender-based violence, including sexual violence, were high priorities for action. We have previously welcomed this stance and recommend that the new Department continues to make it a priority to maintain and strengthen the international alliance around initiatives in this area. We also recommend that the new Department maintains the UK's international leadership on this agenda, preserves existing levels of funding and seeks to identify what further interventions may counteract the effect that Covid has had in increasing levels of domestic violence and sexual exploitation and abuse of women and children*. (Paragraph 52)

3. *We recommend that the Government continues to project clearly onto the international stage, the importance it places on the UK's place within the rules-based international infrastructure and the crucial foundations of human rights and the rule of law as fundamental British values*. (Paragraph 55)

The UK response

4. *We believe the FCDO should*:

    - *recognise that the eradication of the pandemic everywhere is an integral part of resolving the threat anywhere and therefore switch its financial support for Covid-19 vaccines, therapies and tests voluntarily from its ODA pot to other budgets (thereby freeing up resources for more frontline activity on secondary impacts in developing countries)*

    - *re-commit to its ongoing programmes and provide new funding for the Covid-19 response—in particular in relation to secondary impacts—from ODA, freed up from Covid-19 vaccine R&D, rather than allowing the transfer of scarce resources from existing programmes, especially those tackling other diseases*

    - *use its significant leverage as leading development actor in many areas (gender equality, disability inclusion, poverty alleviation) to lead an inclusive and transparent approach by the donor community (both bilateral and multilateral),*

    - *put local non-governmental organisations (NGOs) and their partner International NGOs at the heart of the global Covid-19 response as they are closest to end-user communities and benefit from existing relationships of trust and confidence*. (Paragraph 91)

5. We conclude that, for the time being, it would not be prudent for the Government to work on the basis that funding allocated to research for vaccines, treatments or tests for Covid-19 would count as ODA, as it "contributes to addressing a global challenge and not a disease disproportionately affecting people in developing countries". *Our view is that this frees up a substantial sum from the 2020 ODA pot to be applied to, either alleviate part of the cuts made in anticipation of reduced GNI for 2020, or activity aimed at alleviating secondary impacts of the Covid-19 pandemic. We would recommend the latter course (in so far as the options are mutually exclusive).* (Paragraph 96)

Global health

6. *At a strategic level, we urge the PM and the Government to be more ambitious for the UK's G7 Presidency than simply calling for better cooperation in spotting, preventing and fighting another pandemic more effectively. Rather, we recommend the Government lead a charge towards the establishment of a holistic global health and nutrition strategy based around achieving Sustainable Development Goal Three (ensuring healthy lives and promoting well-being for all at all ages) more broadly. This would put the world in a position to respond effectively to the next global health challenge, and the one after that, whatever these turn out to be—rather than just the last one we struggled with*. (Paragraph 100)

Formal minutes

Tuesday 10 November 2020

Members present:

Sarah Champion, in the Chair

Mr Ian Liddell-Grainger	Dr Dan Poulter
Navendu Mishra	Mr Virendra Sharma
Kate Osamor	

Draft Report (*Humanitarian crises monitoring: impact of coronavirus (interim findings)*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 106 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

[Adjourned till Tuesday 17 November at 2.00 p.m.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Friday 15 May 2020

Robert Mardini, Director General, International Committee of the Red Cross (ICRC); **Marian Schilperoord**, Senior Operations Manager, UNHCR; **Bob Kitchen**, Director of Emergency Preparedness and Response, International Rescue Committee — Q1–29

Nick Dearden, Director, Global Justice Now; **Ms Aleema Shivji**, Executive Director, Humanity & Inclusion UK; **Rosemary Forest**, Senior Advocacy Officer, Peace Direct; **Gwen Hines**, Executive Director of Global Programmes, Save the Children — Q30–54

Thursday 04 June 2020

Farah Kabir, Country Director, Action Aid, Bangladesh; **Ghassan Abou Chaar**, Emergency Director, Yemen, Médecins Sans Frontières; **Ndubisi Anyanwu**, Country Director for Nigeria, Mercy Corps — Q55–95

Tuesday 16 June 2020

Dr Tamsyn Barton, Lead Commissioner, Independent Commission for Aid Impact; **Amanda Glassman**, Executive Vice-President and Senior Fellow, Center for Global Development; **Dr Charlotte Watts**, Chief Scientific Adviser, Department for International Development; **Daniel Graymore**, Board Member for UK/Qatar, Gavi and Head of Global Funds, Department for International Development — Q96–117

Thursday 02 July 2020

Dr Samia Saad, Director of Resource Mobilisation, Coalition for Epidemic Preparedness Innovations; **Dr Josie Golding**, Epidemics Lead, Wellcome Trust (part of both CEPI and the Covid Therapeutics Accelerator (CTA) partnership); **Professor David Heymann CBE**, Board member, Foundation for Innovative New Diagnostics (FIND) — Q118–139

Monday 06 July 2020

Rt Hon Anne-Marie Trevelyan MP, Secretary of State for International Development, Department for International Development; **Dr Charlotte Watts**, Chief Scientist, Department for International Development; **Rachel Glennerster**, Chief Economist, Department for International Development; **Matthew Wyatt**, Head of DFID's Conflict Humanitarian and Security Department (CHASE), Department for International Development — Q140–149

Rt Hon Anne-Marie Trevelyan MP, Secretary of State for International Development, Department for International Development; **Nick Dyer**, Acting Permanent Secretary, Department for International Development — Q150–186

Tuesday 15 September 2020

Professor Francesco Checchi OBE, Epidemiology and International Health, London School of Hygiene and Tropical Medicine; **Dr Timothy Russell**, Research Fellow, London School of Hygiene and Tropical Medicine; **Professor Azra Ghani**, Infectious Disease Epidemiology, School of Public Health, Imperial College — Q187–205

Linh Schroeder, Deputy Regional Director for the Africa Region, International Committee of the Red Cross; **Selena Victor**, Senior Director Policy and Advocacy, Mercy Corps; **Kate White**, Medical Emergency Manager and Covid-19 medical technical lead, Medecins Sans Frontieres — Q206–219

Tuesday 13 October 2020

Aaron Oxley, Executive Director, Results UK; **Katie Husselby**, Coordinator, Action for Global Health; **Mike Podmore**, Director, STOPAIDS — Q220–239

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

COR numbers are generated by the evidence processing system and so may not be complete.

1 Action against Hunger (Miss Kate Munro, Advocacy Manager) (COR0059)

2 Action for Global Health Network (Ms Katie Husselby, Coordinator) (COR0125)

3 Action for Global Health Network, UK Sexual and Reproductive Health and Rights Network, STOPAIDS, ICAN, UK Working Group on Non-Communicable Diseases, andUK Coalition Against Neglected Tropical Diseas (COR0012)

4 ActionAid UK (Joanne O'Neill, Senior Advocacy Manager) (COR0038)

5 ActionAid UK (Ms Isabelle Younane, Senior Advocacy Manager) (COR0116)

6 ACTIVE LEARNING NETWORK FOR ACCOUNTANILITY AND PERFORMANCE / OVERSEAS DEVELOPMENT INSTITUTE (BEN RAMALINGAM, SENIOR RESEARCH ASSOCIATE) (COR0102)

7 ADD International (Mr Jimmy Innes, Chief Executive) (COR0089)

8 ADD International (Mr Jimmy Innes, Chief Executive) (COR0017)

9 Age International (Miss Zoe Russell, Parliamentary Officer) (COR0033)

10 Age International (Miss Zoe Russell, Parliamentary Officer) (COR0066)

11 Amnesty International (Polly Truscott, Foreign Affairs Adviser) (COR0052)

12 Beattie, Dr Amanda Russell, Bird, Dr Gemma, Davies, Dr Thom, Isakjee, Dr Arshad, Obradovic-Wochnik, Dr Jelena, Rozbicka, Dr Patrycja (COR0065)

13 Bond (Ms Alice Whitehead, Advocacy and Parliamentary Coordinator) (COR0026)

14 Bond Disability and Development Group (Ms Alice Whitehead, Advocacy and Parliamentary Coordinator) (COR0069)

15 Bond Disability and Development Group (Ms Lauren Watters, Co-Chair) (COR0016)

16 Border Violence Monitoring Network (Simon Campbell, Field Coordinator) (COR0099)

17 BRAC (BRAC UK Chris Lyne, Advocacy & Communications Manager) (COR0074)

18 British Red Cross (Miss Lucilla Berwick, Humanitarian Policy Officer) (COR0071)

19 British Red Cross (Miss Lucilla Berwick, Humanitarian Policy Officer) (COR0035)

20 Burma Campaign UK (Mark Farmaner, Director) (COR0004)

21 CAFOD (Howard Mollett, Head of Humanitarian Policy) (COR0107)

22 CARE International UK (Francesca Rhodes, Senior Advocacy and Policy Adviser) (COR0034)

23 Catholic Agency for Overseas Development (CAFOD) (Mr Howard Mollett, Head of Humanitarian Policy) (COR0057)

24 CBM UK (Ms Rachel Aston, Policy Manager) (COR0054)

25 Chalkidou, Dr Kalipso, Krubiner, Carleigh, Mitchell, Ian, Saez, Patrick (COR0120)

26 Chemonics International (Jeffrey Wuorinen, Senior Vice President) (COR0097)

27 Chemonics International (Senior Vice President Jeffrey Wuorinen, Senior Vice President) (COR0049)

28 Christian Aid (Ms Jane Backhurst, Senior Humanitarian Adviser) (COR0062)

29 Comfort International (Dr Callum Henderson, Director) (COR0001)

30 Commonwealth Disabled People's Forum (Mr Richard Rieser, General Secretary) (COR0101)

31 Concern Worldwide (UK) (Miss Rachel Hickman, Senior Campaigns and Public Affairs Officer) (COR0109)

32 Concern Worldwide (UK) (Miss Rachel Hickman, Senior Campaigns and Public Affairs Officer) (COR0036)

33 Consortium for Street Children (Ms Lizet Vlamings, Head of Advocacy and Research) (COR0126)

34 Consortium for Street Children (Ms Lizet Vlamings, Head of Advocacy and Research) (COR0022)

35 Department for International Development (COR0133)

36 Department for International Development (COR0060)

37 Drugs for Neglected Diseases initiative (Ms. Michelle Childs, Global Head Policy and Advocacy) (COR0086)

38 Education Development Trust (Ms Cheryl McGechie, Marketing & Public Affairs Director) (COR0106)

39 Fairtrade Foundation (Ms Alice Lucas, Advocacy and Policy Manager) (COR0081)

40 Fairtrade Foundation (Ms Alice Lucas, Policy and Advocacy Manager) (COR0003)

41 Few, Professor Roger, Lake, Dr Iain (COR0082)

42 Foreign, Commonwealth & Development Office (COR0142)

43 Foundation for Innovative New Diagnostics (FIND) (COR0134)

44 Frontline AIDS (Mr Eolann Mac Fadden, Support Officer) (COR0042)

45 Frontline AIDS (Ms Fionnuala Murphy, Head: Influence) (COR0128)

46 Gender Action for Peace and Security (GAPS) (Ms Eva Tabasam, Policy, Advocacy & Comms Coordinator) (COR0014)

47 Gender and Adolescence: Global Evidence (GAGE) Programme, Overseas Development Institute (ODI) (Silvia Guglielmi, Qualitative Researcher) (COR0103)

48 Gender and Development Network (Jessica Woodroffe, Director) (COR0088)

49 Gender and Development Network, Akina Mama Wa Afrika, and The African Women's Network on Communication and Development (FEMNE (Sophie Efange) (COR0093)

50 Global Justice Now (Dr Daniel Willis, Policy & Campaigns Manager) (COR0070)

51 Global Justice Now (Dr Daniel Willis, Policy & Campaigns Manager) (COR0023)

52 Global Witness (COR0130)

53 The HALO Trust (Mr Chris Loughran, Senior Policy & Advocacy Advisor) (COR0096)

54 Health Poverty Action (Jessica Hamer, Head of Policy and Campaigns) (COR0127)

55 Humanity & Inclusion UK (Ms Aleema Shivji, CEO) (COR0005)

56 Institute of Development Studies (Sophie Robinson, External Affairs Officer) (COR0015)

57 International Alert (Mr Julian Egan, Director, Advocacy & Communications) (COR0094)

58 International Committee of the Red Cross (ICRC) (Barbara Jackson, Public Affairs and Policy Adviser) (COR0030)

59 International Disability and Development Consortium, and International Disability Allian (COR0020)

60 International Foundation for Electoral Systems (IFES) (Vice President, Global Growth and Outreach Catherine Barnes, Vice President, Global Growth and Outreach) (COR0087)

61 International Fund for Agricultural Development (IFAD) (Lorenzo De Santis, Consultant, Global Engagement, Partnership and Resource Mobilization Division) (COR0115)

62 International Growth Centre (Mrs Sarah Lyness, Communications and Development Director) (COR0051)

63 International Justice Mission UK (Mr Euan Fraser, Public and Corporate Affairs Manager) (COR0068)

64 International Rescue Committee (Mr Oliver Phelan, Advocacy Officer) (COR0040)

65 Jubilee Debt Campaign (Tim Jones, Head of Policy) (COR0055)

66 Leonard Cheshire (Ms Pauline Castres, Policy Manager) (COR0021)

67 Leonard Cheshire (Pauline Castres, Policy Manager) (COR0114)

68 London School of Hygiene & Tropical Medicine (Anna Kramer, Strategic Research Coordinator) (COR0108)

69 Marie Stopes International (Marie Stopes International Bethan Cobley, Director, Policy and Partnerships) (COR0006)

70 Medical Aid for Palestinians (Mr Rohan Talbot, Advocacy and Campaigns Manager) (COR0084)

71 Medicines for Malaria Venture (MMV) (Vice President, Head of External Relations Neil McCarthy, Vice President, Head of External Relations) (COR0019)

72 Medicines for Malaria Venture (MMV) (Vice-President, head of External Relations Neil McCarthy, Vice-President, head of External Relations) (COR0080)

73 Mercy Corps (Sarah Casteran, Policy and Advocacy Advisor) (COR0008)

74 Médecins Sans Frontières/Doctors Without Borders (MSF) (Miss Elizabeth Harding, Humanitarian Representative) (COR0092)

75 Norwegian Refugee Council (Mr Martin Hartberg, UK Director) (COR0046)

76 OECD (COR0135)

77 OECD (COR0131)

78 Overseas Development Institute (Dan Sharp, Public Affairs Manager) (COR0048)

79 Oxfam GB (Hannah McLean-Knight, Advocacy Officer) (COR0075)

80 Oxfam GB (Mr Sam Nadel, Head of Government Relations) (COR0058)

81 Peace Direct (Ms Rosemary Forest, Senior Advocacy Officer) (COR0018)

82 Peace Direct (Rosemary Forest, Senior Advocacy Officer) (COR0067)

83 Peace Brigades International UK (Mr Adam Lunn, Advocacy Officer) (COR0027)

84 Plan International UK (Kathleen Spencer Chapman, Head of Policy, Advocacy & Research) (COR0050)

85 Protection Approaches (Dr Kate Ferguson, Co-Executive Director) (COR0078)

86 RBM Partnership to End Malaria (Dr Abdourahmane Diallo, Chief Executive Officer) (COR0083)

87 RBM Partnership to End Malaria (Dr Abdourahmane Diallo, Chief Executive Officer) (COR0010)

88 Reall (Ian Shapiro, Chief Executive) (COR0009)

89 Reclaiming Our Futures Alliance, International Committee (ROFA IC) (Michelle Daley, Chairperson) (COR0098)

90 Results UK (Lucy Drescher, Head of Parliamentary Advocacy) (COR0032)

91 Results UK (Ms Lucy Drescher, Head of Parliamentary Advocacy) (COR0073)

92 Save the Children (Mr Alastair Russell, Senior Public Affairs Adviser) (COR0124)

93 Save the Children UK (Joseph Anthony, Public Affairs Adviser) (COR0037)

94 Scotland's International Development Alliance (Lewis Ryder-Jones, Deputy Chief Executive) (COR0110)

95 Search for Common Ground (Eoin O'Leary, European Affairs and Partnerships Outreach Associate) (COR0111)

96 Search for Common Ground (Matilda Flemming, European Affairs Manager) (COR0029)

97 Sightsavers (Alex Voce, Parliamentary Adviser) (COR0076)

98 Social Development Direct (SDDirect) (Harri Lee, Senior Technical Expert - Disability Inclusion Lead) (COR0077)

99 Social Development Direct (SDDirect) (Harri Lee, Senior Technical Expert) (COR0041)

100 Street Child (Ramya Madhavan, Global Head of Education) (COR0122)

101 Sumner, Andy (COR0056)

102 The Syria Campaign (Rebecca Falcon, Campaign Manager) (COR0025)

103 TB Alliance (Ms. Anu Mahalingashetty, Manager) (COR0007)

104 Tearfund (Megan Rowland, Government Relations Officer) (COR0031)

105 Tearfund (Mr Timothy Ingram, Senior Government Relations Adviser) (COR0113)

106 Tim Morris Consulting Limited (Mr Tim Morris, Director) (COR0061)

107 Tony Blair Institute (Anna-Joy Rickard, Head of Projects) (COR0047)

108 UK Working Group on NCDs (Jane Lennon, Individual member) (COR0118)

109 UNFPA (Mr Matt Jackson, Director, UK Office) (COR0085)

110 UNFPA (Mr Matt Jackson, Director, UK Office) (COR0011)

111 UNHCR (Mr Matthew Saltmarsh, Senior External Relations Officer) (COR0090)

112 UNHCR, The UN Refugee Agency (Mr James Bulman, External Relations Associate) (COR0028)

113 UNICEF UK (Claudia Craig, Senior Government Relations Adviser) (COR0072)

114 UNISON (Mr Mark Beacon, International Officer) (COR0121)

115 Unitaid (Polsky, Senior Manager, External Relations) (COR0117)

116 United Against Inhumanity Association in the UK (UAI in the UK) (Dr Martin Barber, Chair) (COR0112)

117 VSO (Heather Alcock, External Affairs and Advocacy Manager) (COR0123)

118 War Child UK (Ms Kafia Abdurahman Omar, Policy and Advocacy Adviser) (COR0013)

119 WaterAid (Johnny Shilton, Advocacy) (COR0095)

120 We Exist!, and Half of Syria Campaign (COR0053)

121 Westminster Foundation for Democracy (Anthony Smith, CEO) (COR0091)

122 Womankind Worldwide (Maria Vlahakis, Policy & Advocacy Manager VAWG) (COR0043)

123 World Food Programme (Elisabeth Faure, Director of WFP London Office) (COR0064)

124 World Vision UK (Amy Johnson, Interim Government Relations Manager) (COR0024)

125 World Vision UK (Ms Amy Johnson, Interim Government Relations Manager) (COR0079)

126 Worldwide Hospice Palliative Care Alliance (Ms Claire Morris, Global Advocacy Director) (COR0129)

127 Youth Coalition for Sexual and Reproductive Rights (Gareth Jones, Member) (COR0045)

128 Zagefka, Prof Hanna (COR0063)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2019–21

First Report	Humanitarian crises monitoring: the Rohingya	HC 259 (HC 658)
Second Report	Effectiveness of UK aid: interim findings	HC 215
Third Report	The Newton Fund Review: report of the Sub-Committee of the work on the work of ICAI	HC 260 (HC 742)
Fourth Report	Effectiveness of UK aid: potential impact of FCO/DFID merger	HC 596
First Special Report	Follow up: sexual exploitation and abuse in the aid sector: Government Response to the First Report of the Committee	HC 127
Second Special Report	Humanitarian crises monitoring: the Rohingya: Government Response to the First Report of the Committee, Session 2019–21	HC 658
Third Special Report	The Newton Fund review: report of the Sub-Committee on the work of ICAI: Government response to the Committee's Third Report	HC 742
Fourth Special Report	Effectiveness of UK Aid: Interim Report & Effectiveness of UK Aid: potential impact of FCO/DFID merger: Government Response to the Second & Fourth Reports of the Committee	HC 820