



House of Commons
International Development
Committee

Ebola: Responses to a public health emergency

Second Report of Session 2015–16



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to a public health
emergency**

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*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons to be printed
12 January 2016*

International Development Committee

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Summary

The deadliest outbreak of Ebola virus disease in history, and the first to hit epidemic levels, struck the West African countries of Guinea, Liberia and Sierra Leone in 2014, killing 11,315 people. Despite being diagnosed in March 2014, there was a slow initial response to the epidemic. This was attributed by many witnesses to our inquiry to delays in WHO sounding the alarm and declaring a Public Health Emergency of International Concern (PHEIC), something which WHO must carry primary responsibility for. As a result, the international community did not fully mobilise until September, in the wake of the World Health Organization's designation of the outbreak as a Public Health Emergency of International Concern in August. We praise those who risked their lives to bring the epidemic under control and pay tribute to all those who lost their lives in the fight against Ebola.

The Department for International Development (DFID) played a strong leading role in co-ordinating the response in Sierra Leone, but it responded late due to the WHO designation delay and an over-reliance on the international public health system to sound the alarm. Médecins sans Frontières raised serious alarm as early as June 2014. We recommend that DFID in future should be able to react to warnings from a wider range of sources, not just the established international system.

DFID, in collaboration with the Ministry of Defence, Public Health England and the NHS, operated effectively once its response began in earnest. We commend this co-ordinated response, which represents a fine example of cross-Government working. We nevertheless wish to see improvements in DFID's flexibility, especially in its ability to disburse small amounts of money early on in a crisis when it could be more cost-effective.

We were told throughout the inquiry about the importance of community engagement in achieving an effective response. Two significant factors in the spread of the disease were cultural practices, such as unsafe burial, and distrust in the authorities and health sector. We recommend therefore that DFID engage communities earlier in future outbreaks, especially through trusted local, tribal and faith leaders, established voluntary organisations and civil society. DFID could also use anthropologists to facilitate this. Now that the Ebola crisis is over, it is vital that every effort is made to eradicate FGM in Sierra Leone and worldwide.

The Ebola epidemic exposed serious deficiencies in the international public health system. The World Health Organization has acknowledged its shortcomings in dealing with the crisis and that it requires radical reform to improve its outbreak capacity. We agree and urge DFID to lead efforts and make this reform a priority. The International Health Regulations have also been shown to be inadequate. Many countries are not taking their legal obligations under the regulations seriously; and there are differences in understanding over the purpose of the designation of a Public Health Emergency of International Concern. We support the creation of a transparent and clearly understood grading system for public health emergencies.

1 Introduction

Background

1. Beginning in late 2013 an epidemic of Ebola virus disease in West Africa, concentrated in Guinea, Sierra Leone and Liberia, infected 28,637 people and caused 11,315 deaths.¹ This was the deadliest outbreak of Ebola in history and the first time that such an outbreak had reached epidemic levels. While nearly all of the reported cases occurred in the three epicentre countries, this was also the most geographically widespread Ebola outbreak in history with a small number of cases reported in seven other countries (Italy, Mali, Nigeria, Senegal, Spain, the United Kingdom, and the United States of America).

Box 1: Dr Jeremy Farrar, Director, Wellcome Trust speaks about epidemics

“The key priority is to appreciate that these will happen with increasing frequency in the new world. Climate change, migration, movement of people, urbanisation, different relationships between humans and animals and the agricultural sector will inevitably mean we have more epidemics. The capacity to spread these around the world at a rate that we have not had before means we will be challenged by them wherever you live in the world, and we have seen that over the last 12 years.”

Source: Q19

2. The first case occurred in December 2013 in Guinea, followed by a formal diagnosis and declaration of an outbreak in March 2014. The disease spread to Liberia in late March 2014 but by May the number of new cases being reported each week had dwindled, leading to “a sense that the outbreak had in fact subsided.”² In late May 2014 the first cases were officially reported in Sierra Leone and the number of cases across the region began to surge again. By the middle of June the outbreak had killed 337 people, making it the deadliest in history. On 7 August the World Health Organization formally declared the epidemic a Public Health Emergency of International Concern (PHEIC).

3. The Department for International Development (DFID) committed funding to the frontline response in July 2014, prior to the declaration of a PHEIC, before becoming directly involved in August and rapidly increasing efforts in September. This included the deployment of British military personnel and the building of six Ebola Treatment Centres in response to a UN request that it “take on leadership of the international effort to contain Ebola in Sierra Leone.”³ The epidemic peaked in late November 2014 and then steadily declined. Liberia was declared Ebola-free on 9 May 2015, defined by the World Health Organization as 42 days after the last reported case completes treatment, but a small number of new cases were again reported in late June and July. It was again declared Ebola-free on 3 September, but again a small number of new cases emerged in late November. Sierra Leone was declared free of Ebola on 7 November by the World Health Organization; Guinea was declared free of Ebola on 29 December; and Liberia will be declared free of Ebola for a third time on 14 January if no new cases arise, which will mark the end of the outbreak.

1 World Health Organization, ‘[Ebola Situation Report - 30 December 2015](#)’, accessed 31 December 2015

2 Q49

3 DFID ([EBO0019](#)) para 8

4. We reiterate the previous International Development Committee's commendation of all those who worked to tackle Ebola. We praise those who risked their lives to bring the epidemic under control, including the Sierra Leonean people and UK personnel who volunteered. We also pay tribute to all of those who lost their lives in the fight against Ebola.

Our inquiry

5. Our predecessor Committee visited Sierra Leone in June 2014, before the full scale of the epidemic was clear, as part of its inquiry into *Recovery and Development in Sierra Leone and Liberia*.⁴ As a result, and building on its related report on *Strengthening Health Systems in Developing Countries*,⁵ it carried out a short inquiry into *Responses to the Ebola Crisis*.⁶ Its report was published in December 2014, commenting on the then-current efforts to bring the epidemic under control. We decided that we should follow-up on that report in order to take stock and determine what lessons had been learned from the outbreak and the response to it. The Science and Technology Committee has also recently inquired into lessons drawn from the Ebola outbreak, in particular “concerning the use of scientific advice in the UK for similar disease outbreak emergencies in future.”⁷ Our report therefore focuses primarily on DFID's role and the international response to the outbreak. We look forward to the publication of their report.

6. We launched our inquiry on 13 July 2015 and asked for written submissions on what lessons had been learnt from the events in Guinea, Liberia and Sierra Leone, specifically with regards to the following terms of reference:

- Timeline of response—what could have been done better and quicker? How can this be prevented from happening again? Does DFID have the capacity to deal with future outbreaks? Is there enough expertise in DFID?
- How did Ebola get to the stage it did, what failed in the three months preceding DFID involvement? What can be done in future to assess and diagnose diseases more rapidly?
- What impact did cultural practices have on the spread of Ebola?
- What can be done to address such issues in the future?
- What was the decision-making structure between DFID and the MOD? Who was ultimately responsible? Was using the military more efficient than using NGOs? How successful were the setup of the hospitals, how many patients were treated?
- Was all the funding spent? How was it spent? How was it monitored?

4 International Development Committee, Sixth Report of Session 2014-15, [Recovery and Development in Sierra Leone and Liberia](#), HC 247

5 International Development Committee, Fifth Report of Session 2014-15, [Strengthening Health Systems in Developing Countries](#), HC 246

6 International Development Committee, Eighth Report of Session 2014-15, [Responses to the Ebola crisis](#) HC 876

7 House of Commons Science and Technology Committee, [Science in emergencies: UK lessons from Ebola inquiry](#), accessed 31 December 2015

- How will Sierra Leone recover and rebuild itself? Is there a plan for schools and children who have missed out on a year of education? How will orphaned children who have been left on the streets be reintegrated into communities? Does Sierra Leone need a form of Marshall Plan for reconstruction? What is DFID doing?
- What is DFID and international community doing to improve the international response for future disease outbreaks? The Committee recommended an urgent review of the WHO, has that happened?
- What is the UK doing on drugs, especially in relation to antimicrobial drug resistance?
- FGM in Sierra Leone came to a halt during the Ebola crisis; how can the practice be prevented from coming back?

Relevant Sustainable Development Goals

7. The Sustainable Development Goals have been agreed by the international community to provide the foundation for international development over the next 15 years. As such, we will use the Goals as a foundation for our work over this Parliament, to consider how well DFID is performing in its implementation of the Goals. The Goal most relevant to this inquiry is:

- Goal 3—Good health and well-being—Ensure healthy lives and promote well-being for all at all ages.
 - 3.3—By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
 - 3.8—Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
 - 3.c—Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.
 - 3.d—Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.⁸

2 DFID's response to the crisis

DFID's initial response

8. Most of the responses to our inquiry agreed that the initial international response to the outbreak (including the UK's) was too slow. Médecins sans Frontières (MSF) told us that, despite its own warnings, “the global alarm was sounded painfully late” and that “a real mobilization effort did not begin until September [2014], resulting in the loss of a critical time window to prevent the epidemic's spread.”⁹ Dr David Nabarro told us, with reference to WHO's approach to the epidemic:

[...] there were certainly problems because eyes were not focused on the Ebola outbreak, particularly in June/July. There were announcements made, but they were not pushed hard enough by the organisation and, in retrospect, all of us feel, if only there had been a louder shouting three months early, the situation would have been much better.¹⁰

The Wellcome Trust echoed this, noting:

The slow international response was partly the result of a significant delay in the declaration of a 'Public Health Emergency of International Concern' (PHEIC) by the [World Health Organization (WHO)], which was not made until 8 August 2014. However, national governments could have done more to call on the WHO to make such a declaration.¹¹

9. In light of MSF's early warnings when it was almost a lone voice, and for which we commend it, we asked Andre Heller Perache of MSF UK when the international community should have mobilised:

[...] even in the early days of the outbreak we had explained that it was the largest outbreak of Ebola that we had ever faced. [...] In July, there should have been a massive mobilisation, but, as it stands, it was not really until mid-September that there was an effective mass mobilisation from powerful western Governments, as well as eastern Governments.¹²

10. Rt Hon Justine Greening MP, Secretary of State for International Development since September 2012, defended the speed of DFID's response:

[...] we did react quickly to the Ebola outbreak. Our initial funding, working with people like MSF, was going on in July, and we were already looking at action on the ground in June, so we did respond quickly. It was right for us, initially, to really push the international system to respond.¹³

9 Médecins sans Frontières ([EBO0025](#)) para 4

10 Q49

11 Wellcome Trust ([EBO0024](#)) para 7

12 Q2

13 Q110

11. As evidence to the Committee indicated, “The trigger to UK rapid response activities was the WHO announcement [of a PHEIC]”.¹⁴ This announcement politically escalated the crisis, as Dr David Nabarro told us:

At the beginning, there was a sense in DFID that we would do what we could do, where we had capacity to do it, but we would not bend over further, because that would be exposing us and the British to the possibility of things that might not be helpful, and we do not want to make big mistakes. That was the correct response of public servants.

Then the politicians got engaged. It got above the civil servants. It was when Justine Greening and then Philip Hammond and then the Prime Minister, obviously together with others in the upper level of the apparatus, got engaged. It happened very quickly at the beginning of September, stimulated often by bilateral dialogue between, for example, the Prime Minister and the President of the US, or trilateral dialogue involving the Secretary-General of the UN, who spoke to both separately and, on some occasions, jointly. It was then that the position shifted; we will put in a much bigger response, because we appreciate the need to get massively scaled up to get ahead of this geometrical increase in the outbreak. That occurred in the first two weeks of September.¹⁵

Dr Nabarro went on to say:

Justine Greening took it to the Foreign Secretary. The Foreign Secretary took it to the Prime Minister, and then a different kind of stance was taken. I am massively grateful for this. It is absolutely impossible to find the words to express it. [...] This was good political leadership.¹⁶

12. When we asked the Secretary of State about what DFID had done to ensure that it could respond more quickly in future, in addition to talking about improved capacity and teams of emergency response staff, she said:

Alongside that, in the region, we are part of an overall WHO effort that is putting in place much better early-warning surveillance and response, and of course that sits alongside broader World Health Organization reform, which is looking at how that organisation can get better than it was at its own emergency response.¹⁷

13. Surveillance systems play an important part in catching outbreaks at an early stage in order to respond quickly. The Medical Research Council told us that “improved global surveillance for infections and better shared access to surveillance data would enable stronger more rapid research outputs to be delivered promptly.”¹⁸ The Malaria Consortium also emphasised the importance of improving surveillance systems, especially through using communities “in the collection and use of surveillance data”.¹⁹ In March 2015, as part of the Budget, the Government announced the Fleming Fund, a £195 million fund to build laboratory capacity, surveillance networks and response capacity in low- and

14 Medical Research Council ([EBO0013](#)) page 2

15 Q60

16 Q60

17 Q109

18 Medical Research Council ([EBO0013](#)) page 2

19 Malaria Consortium ([EBO0005](#)) para 3.2

middle-income countries.²⁰ While the fund’s main focus is on antimicrobial resistance, any building of wider surveillance-capacity is encouraging.

14. As a result of WHO announcing a declaration of a Public Health Emergency of International Concern too late, DFID reacted slowly to early warnings, albeit from a limited number of actors, notably Médecins sans Frontières, that this outbreak of Ebola was on an unprecedented scale. Its initial delay was due to an over-reliance on the existing international public health system to sound the alarm at a political level. Improvements to global surveillance networks are needed and welcome. The fact remains that, in the case of the Ebola epidemic, warnings were given but were not heeded. Had they been heeded, DFID would have been able to respond much faster, as evidence shows from DFID’s response after the PHEIC was announced when the UK demonstrated strong and swift political leadership, which we commend. We note that improvements are being made to the international early-warning surveillance and response systems. We are concerned however that DFID is still relying too much on improvements to the international system, without improving its own ability to independently assess international public health risks. *DFID must ensure that it has the ability to listen and react to information and warnings from a range of sources, not just the World Health Organization, in order to assess the severity of public health and humanitarian emergencies.*

The response capacity of DFID and the UK

15. DFID told us that it “drew on its standing humanitarian capacity as well as surging in capability of over 200 surge staff, to respond to the Ebola outbreak”, alongside “1,300 military personnel, [...] over 150 staff from the National Health Service (NHS) and other agencies co-ordinated by Public Health England (PHE), and over 100 specialists from PHE.”²¹ Health Poverty Action expressed some uncertainty about the expertise of these surge staff,²² and the Wellcome Trust similarly had “concerns regarding the lack of expertise of Public Health England to act in affected countries”.²³

16. Despite these concerns, we heard many positive things about the UK response after full mobilisation, including that involvement and coordination of Ministry of Defence, Public Health England and NHS staff was an example of good practice. Dr David Nabarro stated that “It was a superb operation. In particular, it recognised that you need good quality co-ordination at district level.”²⁴ World Vision, from its experience of being actively engaged on the ground teaching safe burial practices, “noted that using the British military has worked well.”²⁵ The Wellcome Trust said, “Collaboration in affected countries between DFID, MoD, Department of Health and clinical researchers worked well.”²⁶

20 “Fleming Fund launched to tackle global problem of drug-resistant infection”, Wellcome Trust press release, 18 March 2015

21 DFID (EBO0019) paras 16 and 13

22 Health Poverty Action (EBO0015) para 2

23 Wellcome Trust (EBO0024) para 29

24 Q60

25 World Vision UK (EBO0004) para 23

26 Wellcome Trust (EBO0024) para 29

17. We asked the Secretary of State about DFID's response capacity, and how it was building on its experience of the epidemic. She told us that the UK Government "have developed three cadres of emergency response staff, who now can respond."²⁷ DFID told us that it "is now working with the Department of Health (DH) to build on the Ebola experience to enable the UK to provide further global leadership on health emergencies",²⁸ and that the experience has "helped [it] put in place much stronger processes between UK military and DFID".²⁹ The Secretary of State also assured us that the use of surge staff did not impact on DFID's ordinary operations.³⁰

18. The UK Government should be commended for the way it responded after the declaration of a Public Health Emergency of International Concern. In particular, we applaud all of the staff who worked in Sierra Leone and the region to bring the epidemic under control. The UK's response to the Ebola crisis represents a very good example of cross-Government working, in terms of displaying the advantages of a co-ordinated effort as well as showing how such an effort can be well co-ordinated. We welcome DFID's work with other departments to improve the UK's readiness and capacity for future outbreaks and humanitarian emergencies; this work should continue and the lessons and best practice on cross-Government working learned from this response should be disseminated across Government.

19. Notwithstanding this praise, we have been told of a small number of issues which arose in DFID's handling of the crisis, relating to the importance of resources being deployed in the right ways and at the right time. An evaluation by the Institute of Development Studies (IDS) of community care centres, which "were set up with beds for the purpose of allowing local people to voluntarily be isolated if they suspected that they had the disease", found that "by the time DFID and its partners had implemented the [community care centres] the outbreak had reached a level whereby the need was greater than beds."³¹ While communities "appreciated the care for non-Ebola related health problems that [the community care centres] provided", DFID had ended up dedicating resources in an area where they were no longer best placed.

20. We heard evidence that the reason behind resources not always being best targeted was that prediction models did not account for the effects that engaging communities ultimately had. Annie Wilkinson, one of the researchers involved in the IDS evaluation of community care centres explained:

[...] towards the end of 2014, there were models and predictions saying there would be millions of cases, far above the current capacity for safe isolation. One response to that was to put a lot of money into building medical facilities. [...] But what those models did not show was how instrumental local organisation, local learning and responses and behaviour change were going to be.³²

Professor John Edmunds added that, therefore, more flexibility within DFID "unquestionably needs to happen. You discussed earlier about treatment centre beds being built long after the epidemic had passed. [...] It would have been better, in some instances,

27 Q109

28 DFID ([EBO0019](#)) para 19

29 Q120

30 Q115

31 Institute of Development Studies ([EBO0001](#)) para 2

32 Q21

though not very many [...] it would have been better to do something else. Some flexible funding is essential.”³³

21. A similar issue involved attempts to get small amounts of funding for early efforts to bring the outbreak under control. Dr Oliver Johnson told us about difficulties he had had in June 2014, when he requested £7,500 from DFID for eight isolation units. He said, “I could not get a penny from the British Government, despite repeatedly asking. I could not get £7,500. If I had been able to do that, that would have had the impact of hundreds of thousands of pounds later on.”³⁴

22. A recurring theme in our scrutiny of DFID is the difficulty it has in disbursing and managing small amounts of money. This issue was present at the start of the Ebola epidemic and may have hampered some early efforts to tackle the disease. Evidence suggests that small amounts of money disbursed at the start of a crisis, in order to bring that crisis under control quickly, can be very effective. In general small early interventions will deliver good value for money and can reduce the amount of money required further down the line. In contrast, a response that is playing catch-up is very likely to cost more. DFID should ensure that it can operate more flexibly to respond to rapidly changing circumstances, including developing a mechanism to allow country offices to authorise the spending of small amounts of money without fear of negative consequences. This should apply not only during crises, and should involve devising easier means for applications to DFID to be made for smaller sums.

Community engagement

23. Much of the evidence we received suggested that cultural practices in the affected countries played a large role in the spread of Ebola and the scale of the epidemic. Ritual burial practices, including of the victims of the disease, involved physical contact with the deceased when bodies were still highly contagious. This made teaching safe burial practices a vital aspect of the response.³⁵ All three of the epicentre countries were affected by conflicts in recent history. Save the Children said, in relation to Sierra Leone, “Although the civil war ended 12 years ago, there are still high levels of post-conflict distrust in the authorities and in health services”.³⁶ This led to a high reliance on traditional healers and drug peddlers instead of the conventional health services which response efforts focused on.³⁷ The Royal College of Paediatrics and Child Health called the impact of these cultural practices on the spread of the disease “significant”.³⁸

24. Levels of distrust did not only flow in one direction; in some cases responders also mistrusted local communities. The Institute of Development Studies wrote in its submission:

One of the main issues connected to cultural practices during the Ebola crisis was trust, or distrust between the medical response teams and local authority and community institutions and vice versa. Just as local populations have their

33 Q33 [Professor John Edmunds]

34 Q33 [Dr Oliver Johnson]

35 DFID ([EBO0019](#)) para 25

36 Save the Children ([EBO0014](#)) para 4.3

37 Overseas Development Institute ([EBO0009](#)) para 13

38 Royal College of Paediatrics and Child Health ([EBO0002](#)) page 3

own understandings of, and don't trust hospitals and biomedical approaches; so medical response teams have their views of, and don't trust 'culture', community institutions and local authority.³⁹

Dr Oliver Johnson said, "I agree that there was a real sense of communities being a blockage, which at times I probably shared. It was unhelpful, and that is an important little learning."⁴⁰

25. Now that the Ebola crisis is over, it is vital that every effort is made to eradicate FGM in Sierra Leone and worldwide. As the Secretary of State told us:

Having said that, there are other areas, actually, where in its own way Ebola unlocked some progress: for example on FGM, where we saw FGM largely stop during the Ebola crisis. Sierra Leone has now signed the Maputo Protocol. It is the final country in West Africa to do that, and of course we are very keen to now work with Sierra Leone to keep that progress in place.⁴¹

26. As a result of these factors, much of the evidence we received has emphasised the importance that community engagement played in eventually tackling the outbreak. The All-Party Parliamentary Group on Africa submitted written evidence to us based on its own inquiry into community-led approaches to health systems strengthening and lessons from the Ebola outbreak. It found that, "due to the complexity of coordinating international aid, especially during a crisis, the support of bottom-up capabilities is often overlooked by governments".⁴² The APPG called for "DFID and the wider development and humanitarian sectors to put community ownership at the centre of response efforts during health crises, and more broadly of health systems, as a critical component of health systems strengthening."⁴³ Christian Aid agreed, "More involvement of communities at the beginning of the response would have reduced their fear of ambulances, protective suits and health facilities, and would have mitigated the effects of Ebola."⁴⁴

27. One aspect of community engagement which has been highlighted to us is the opportunities presented by engaging with faith leaders in countries affected by crises. A joint submission by CAFOD, Christian Aid, Islamic Relief and Tearfund noted, "Once evidence emerged that traditional and religious beliefs and practices were a significant contributory factor to the spread of the Ebola virus, attention by responding agencies rapidly turned towards understanding faith teaching and engaging with faith leaders as mobilisers."⁴⁵ The ReBUILD Research Programme Consortium contrasted earlier Ebola outbreaks in Nigeria and DR Congo, which were more effectively controlled, with the recent epidemic, and told us, "The faith based sector has also been identified as a key resource that has enabled effective response to Ebola outbreaks in DRC."⁴⁶

28. We heard calls for the use of social scientists and anthropological expertise to inform how best to engage with communities in an outbreak. The Wellcome Trust funded the Ebola response anthropology platform with DFID, which used social scientists to help develop the

39 Institute of Development Studies ([EBO0001](#)) para 3

40 Q32

41 Q112

42 Africa All-Party Parliamentary Group ([EBO0022](#)) para-4

43 Africa All-Party Parliamentary Group ([EBO0022](#)) para-5

44 Christian Aid ([EBO0006](#)) para 4.6

45 CAFOD, Christian Aid, Islamic Relief and Tearfund ([EBO0011](#)) para 3.1

46 ReBUILD Research Programme Consortium ([EBO0017](#)) para 9

response, and emphasised, “The importance of sociological and anthropological support in the epidemic cannot be underestimated.”⁴⁷ The Africa APPG echoed calls for greater use of anthropological expertise in order to better understand cultural practices, how they affected the spread of the disease, and how to engage communities, “The inclusion of social science expertise was especially crucial given the breakdown of trust between communities and health systems.”⁴⁸

29. Engaging communities early is vital to responding to a public health emergency. It is unhelpful just to see cultural practices as a barrier to tackling an outbreak, as this can foster distrust between medical professionals and communities. Local and faith leaders can provide a valuable avenue for spreading important public health information and good practices. *In future outbreak responses, DFID must engage communities early and build community engagement into the fundamentals of its response. To assist with this, DFID should build its anthropological capacity and work with anthropologists in its work on strengthening health systems and on outbreak response. This would help it better understand the ways that people access and comprehend health services, so that it can build appropriately. To further facilitate this, DFID should also work more closely with local civil society and voluntary organisations, many of whom have long-established relationships with local communities over many years.*

Health systems strengthening

30. Another major factor in the Ebola outbreak reaching an unprecedented scale, identified by most of the evidence we received, was the weak state of the health systems in the affected countries. Dr Oliver Johnson told us that, “with the structures that the Ebola response inherited in the country, it was a very bad starting place in terms of how fragmented the health system was and some of the structures around that.”⁴⁹ Christian Aid said, “The system was therefore unable to cope with the enormous pressure placed upon it by the Ebola outbreak.”⁵⁰ The Tropical Health & Education Trust wrote in its submission that responses to the epidemic “highlight the important task of building resilience into health systems for the longer term.”⁵¹

31. Witnesses also warned against health systems strengthening purely for health security, and argued for a more balanced approach directed at good health in local communities. The Sustainable Development Goals contain a goal focused on good health and well-being, including a target to achieve universal health coverage, showing the importance which the international community places on this. Andre Heller Perache of MSF emphasised this purpose:

Again, what I worry about sometimes, when we talk about looking forward, is health being subordinated to economic development or now to health security as well, which is more about our health than it is about their health. We should really focus on health for the sake of itself and building that infrastructure strongly.⁵²

47 Wellcome Trust ([EBO0024](#)) para 25

48 Africa All-Party Parliamentary Group ([EBO0022](#)) para 32

49 Q33

50 Christian Aid ([EBO0006](#)) para 4.3

51 The Tropical Health & Education Trust ([EBO0012](#)) page 1

52 Q27

32. We were told that the way that countries build health systems needs to improve and be smarter, and that countries need to take ownership of and prioritise investment in health systems strengthening. The Overseas Development Institute, in its submission, focused on capacity-building as part of health systems strengthening. It criticised the current method of capacity-building as being “practiced in a narrow, technical way which ignores the capacity of systems, the human face of service delivery, and the complexities of seemingly simple change processes.” As a result it said that “the delivery of quality services demands a smarter model of capacity-building that is both people-centred and systemically aware.” This would not only include greater community engagement, which we discussed earlier, but would also require “engagement with the complexity of how the health system actually functions.”⁵³

33. In addition to the evidence we heard on the need for health system capacity building, we were told of the dramatic impact the crisis had on existing health services. Save the Children noted, “In Sierra Leone, coverage of the measles vaccine has fallen by 20% across the country in a year. There was a surge in measles cases in affected countries—three to four times more than in the previous year.”⁵⁴ Dr Oliver Johnson said, “We are still working out some of the data on excess mortality—the number of extra deaths there were—because of Ebola from things like malaria or surgical problems, but it seems to have been significant. I would not be surprised if it was greater than the burden of Ebola itself.”⁵⁵

34. Weak health systems in the affected countries were a major factor in the rapid spread of Ebola. Robust health systems do not just allow for better control of an outbreak, but also for better treatment of more conventional illnesses, minimising the overall effect. The importance of a broad approach of building quality health systems for the sake of good health itself is recognised in the Sustainable Development Goals. Health systems strengthening should form a core part of recovery efforts in the affected countries. DFID should use its position as a world leader on health systems strengthening to ensure that this is the case and to press for affected countries themselves to invest in and take ownership of improving their health systems. It should push for an intelligent approach to implementation of Sustainable Development Goal 3 which focuses on building robust health systems, taking into account how those systems work as a whole and how people access those services, and share its expertise in this area with other countries and partners to maintain that focus.

Research and development

35. A vaccine for Ebola is currently being trialled, with early results showing it to be highly effective.⁵⁶ ActionAid UK stated that “if there had been a vaccine or medicine for Ebola in 2014, it would have been possible for the affected countries to stop the epidemic in its tracks. [... Drug and vaccine trials were fast tracked only] once it was clear that an epidemic was out of control.”⁵⁷ GSK echoed the criticism that Ebola was a neglected disease: “Behind many of these factors [contributing to the scale of the outbreak] is the reality that Ebola had not been identified as a disease requiring priority action by the international

53 Overseas Development Institute ([EBO0009](#))

54 Save the Children ([EBO0014](#)) para 3.4

55 Q40

56 “[World on the verge of an effective Ebola vaccine](#)”, World Health Organization press release, 31 July 2015

57 ActionAid UK ([EBO0010](#)) paras 5 and 8

community, particularly in the area of vaccine research and development.”⁵⁸ Regarding a vaccine, Professor John Edmunds said to us, “We should have gone through Phase I trials. [...] There is no reason why we could not have done that before this epidemic.”⁵⁹

36. In addition to the previously mentioned Fleming Fund, the UK Government has announced the Ross Fund, a £1 billion fund to fight malaria and infectious diseases, including £100 million support for research and development into products for infectious diseases.⁶⁰ **We welcome the UK’s commitment to research and development into infectious diseases through the Ross Fund. We look forward to the publication of the Science and Technology Committee’s report on Science in emergencies: UK lessons from Ebola.**

Recovery and rebuilding

37. On 23 November 2015 the UK Government published a new aid strategy, alongside its Strategic Defence and Security Review, which set out “how tackling poverty and serving Britain’s interests are linked”; one aspect of this was a commitment to allocate at least 50% of DFID’s budget to fragile states and regions, such as Sierra Leone.⁶¹ DFID has committed £339.5 million to recovery efforts in the region, of which £240 million is committed to Sierra Leone over the next two years. The first phase of the recovery plan, set out by the Government of Sierra Leone, focuses on economic development and jobs, and making adequate basic services available to all (including health, education and water).⁶² According to ActionAid UK, the crisis has had a strong negative effect on existing development efforts in Sierra Leone, Liberia, and Guinea, “setting back development in three of the world’s poorest countries by decades, with ongoing impacts on agriculture, education and the economy.”⁶³

38. In relation to the potential difficulty of rebuilding, the Institute of Development told us:

The term ‘reconstruction’ is slightly problematic; the very high figures (20% and upwards) for pre-Ebola economic growth in Sierra Leone were to some extent illusory, growth was not stable, and benefits were not well distributed. The hit has not just been Ebola but also the dramatic drop in global iron ore prices which has seen the economy dive, and key companies go bankrupt (e.g. London Mining). Even in recent apparent boom years for economic growth, Sierra Leone suffered from basic lack of broad-based infrastructure and functioning health systems. Rather than re-building, it is therefore more appropriate to speak of ‘building differently’, through investment and development approaches directed to inclusive health systems, education and employment opportunities.⁶⁴

58 GSK ([EBO0020](#)) para 4

59 Q45

60 “[Chancellor George Osborne and Bill Gates to join forces to end malaria](#)”, HM Treasury press release, 22 November 2015

61 “[Development spending will meet UK’s promises to world’s poor while serving national interest](#)”, HM Treasury press release, 23 November 2015

62 “[The UK will stay the course in Sierra Leone until Ebola is defeated](#)”, Transcript of a speech by Rt Hon Justine Greening MP (10 July 2015)

63 ActionAid UK ([EBO0010](#)) para 3

64 Institute of Development Studies ([EBO0001](#)) para 6.4

39. Education was one area which was particularly badly affected. DFID noted that, “Formal education for 1.8 million children was interrupted when all schools were closed in July 2014 due to Ebola.”⁶⁵ Save the Children therefore argued for action on education as part of the recovery effort: “There is an education recovery plan, designed to run until July 2016 [... but] there is little visibility on longer term funding for development activities. [...] Future responses must ensure plans are in place for other sectors beyond health.”⁶⁶

40. We also heard evidence highlighting the importance of economic development and governance reform as part of the redevelopment of Sierra Leone. Christian Aid recommended that work be done with the Government of Sierra Leone “to develop a broader national tax system. [...] Broadening the Sierra Leonean tax base would enable more income that could be spent on health and education. It would also help to move Sierra Leone towards a future free of aid dependency.”⁶⁷ Adam Smith International told us, “The issues laid bare by the Ebola outbreak are those of governance, management, human capacity and Sierra Leone’s unique political economy. [...] What is needed are the same kinds of reforms that DFID has been supporting before the outbreak—on governance, institutional and public sector reform, PFM, and private sector development. These reform efforts need to be intensified.”⁶⁸

41. Development after the Ebola epidemic is a complex and daunting task, and the aim should not just be to restore Sierra Leone to its pre-Ebola situation, but to take the opportunity to rebuild and develop further. DFID has made a clear commitment to development in Sierra Leone, which we welcome and commend. We judge DFID’s focus on economic development and basic services to be correctly placed to support the objective of development to a higher level, although a greater emphasis is needed on long-term support for education. *In order to fully achieve this, though, DFID’s commitment must be a long-term one. In addition, and in light of the Government’s new aid strategy, we urge DFID to ensure that strengthening health and education systems remain high priorities for the Department across its portfolio.*

65 DFID ([EBO0019](#)) para 53

66 Save the Children ([EBO0014](#)) para 6.4

67 Christian Aid ([EBO0006](#)) para 7.2

68 Adam Smith International ([EBO0018](#)) para 6.1

3 The international public health system

The World Health Organization's response

42. We have already mentioned the slow initial response to the epidemic. This was attributed by many witnesses to delays in WHO sounding the alarm and declaring a Public Health Emergency of International concern; something which WHO carries primary responsibility for. WHO was involved in the initial diagnosis of Ebola in March 2014, at which point it classified the outbreak as a Grade 2 crisis under its internal system (which has 3 grades). Dr Bruce Aylward identified some difficulties WHO faced: "In terms of the real challenge [...] part of it was an organisation that was not designed to be an operational field-based organisation being asked to play such a role."⁶⁹

43. In September 2014 the UN created its first emergency health mission, the UN Mission for Ebola Emergency Response (UNMEER), to oversee the scaling up of the response on the ground, including the humanitarian response. Dr Aylward spoke about the necessity and purpose of this model in leveraging political support in extraordinary circumstances:

I believe that parts of that were necessary and would be necessary in future were we dealing with a rapidly escalating infectious pathogen or high-threat pathogen that has the capacity to destabilise on a multi-country level, or even a regional or global level. We have to look very carefully at what parts of the architecture internationally already exist that we should have been using much earlier and more effectively and then, when we do bring in something like a Secretary-General-led mechanism, we should be very, very clear that that role is going to be really around leveraging the political assets and support needed for this, as well as having executive authorities over the agencies that would play a role going forward. That would really only be in the extraordinary circumstances, as Ebola was.⁷⁰

44. Evidence indicates WHO struggled to cope, partly, though by no means exclusively, because it was operating in a context of reduced funding. The Institute of Development Studies told us, "The failures by WHO, including delayed visas and payments and poor communication, occurred in the context of the job losses and funding costs that saw the WHO lost \$1 billion in core funding after the financial crisis."⁷¹ Dr David Nabarro echoed this, when explaining why WHO's response was slow. He said that "perhaps most importantly, the World Health Organization's outbreak and emergency operations have been declining in capacity for many years."⁷² He also stated, however:

Through the governance of the WHO, there has been a steady shift away from preparedness to deal with these quite rare events of outbreaks.

There was a pandemic in 2009-10 of what was called swine flu or influenza H1N1. An inquiry of WHO's response to that showed that it was ill prepared

69 Q64

70 Q81

71 Institute of Development Studies ([EBO0001](#)) para 1.2

72 Q49

to deal with a pandemic, and suggested a number of changes. However, the governing bodies of WHO still chose to encourage the organisation to prioritise the high-mortality conditions, which is a very sensible governance decision, and money for these outbreaks was not preserved.

In summary, there were certainly problems because eyes were not focused on the Ebola outbreak, particularly in June/July. There were announcements made, but they were not pushed hard enough by the organisation and, in retrospect, all of us feel, if only there had been a louder shouting three months early, the situation would have been much better. The organisation has had to experience a decline in its resources for outbreaks and emergencies. Those are in part due to the governance decisions and the financing structure of the organisation, where money is attached to particular priorities by the donors.⁷³

45. When we asked Dr Aylward what level of funding WHO would need to respond fully to outbreaks, he estimated that it would be around \$500 million, of which about \$150 million would have to be additional funding.⁷⁴ The Secretary of State told us, “We have been part of how some of that money is being provided. As ever, the UK can show leadership but we need other countries to be prepared to step up to the plate.”⁷⁵

46. A major WHO reform programme has been ongoing since 2011; parts of which have accelerated since the Ebola epidemic. Dr Jeremy Farrar expressed his opinion that:

[...] if now is not the time to reform the WHO, I do not believe there will ever a time to do it. I have been involved in each of the major epidemics of the last 12 years, going back to SARS. I was very involved in that and lost a lot of very good friends during SARS. We have called, after all of those, for reform, and yet we have not grasped that nettle after each of them. This must surely now be the wakeup call that that is required.

His recommendation was “to reform the issues related to epidemics, preparedness and capacity to respond, because I think that is doable in the next two years [in the remaining time of Dr Margaret Chan’s leadership of WHO].”⁷⁶

47. A number of high profile reports have been released over the course of the past year, which have looked in detail at WHO in the wake of the Ebola epidemic. These include the Report of the Ebola Interim Assessment Panel (the Stocking report)⁷⁷ and the Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola.⁷⁸ Those reports have broadly agreed on a number of areas where reform of WHO is required, including in the need for improved capacity to deliver an emergency public health response, as part of a dedicated centre for outbreak response. We do not repeat their conclusions and recommendations here, but we do support them.

73 Q49

74 Q90

75 Q124

76 Q18

77 World Health Organization, *Report of the Ebola Interim Assessment Panel* (July 2015)

78 Moon et al., “Will Ebola change the game? Ten essential reforms before the next pandemic. *The report of the Harvard-LSHTM Independent Panel on the Global response to Ebola*”, *The Lancet*, vol 386, Issue 10009, pp 2204-2221

48. **The World Health Organization has acknowledged its shortcomings in dealing with the Ebola epidemic, due to inadequate funding, a structure which was ill-suited to responding to such a crisis, and a reform process which has been too slow to achieve results. This is a failing on the part of the international community and all of its Member States, including the UK. WHO needs radical reform and quickly. We fully endorse the proposals which have been put forward by both the Ebola Interim Assessment Panel and the Independent Panel on the Global Response to Ebola, and stress that these need to be implemented with great urgency. *The UK should lead efforts for radical reform of the World Health Organization, including for greater funding from its Member States; it should maintain the pressure on WHO to be efficient and effective, even after the reforms are achieved, to ensure that it can properly fulfil its role as the lead organisation for responding to public health emergencies. We ask that DFID give us regular updates on the progress of the reform process, beginning with the response to this report.***

The International Health Regulations

49. The International Health Regulations (IHR) are the legally binding regulations which govern how all WHO Member States work together for global health security. They were agreed in 2005 and include commitments to build capacities to detect, assess and report public health events. The Stocking report found that “the global community does not take seriously its obligations under the International Health Regulations.”⁷⁹ The Secretary of State told us that “there are about 80 countries that still have not really complied with those regulations, but many of them are the ones who are the least able to deal with outbreaks.”⁸⁰ She went on to say that DFID is “working alongside the G7 and the WHO in their work in making sure that countries that have not implemented the IHR are able to do that. As ever, we cannot do it all but we are playing a key role in that more international lobbying side too.”⁸¹ In the wake of the epidemic, in May 2015, WHO set up a Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response which aims to assess the effectiveness of the IHR and recommend reforms.

50. The IHR also describe the process for the Director-General of WHO to declare a Public Health Emergency of International Concern (PHEIC). The WHO Secretariat response to the Report of the Ebola Interim Assessment Panel did not “fully agree with the Panel’s assessment that the determination of PHEIC was delayed”.⁸² Dr Aylward explained to us that a PHEIC “is not designed to grade an escalating crisis”, but rather “is to prevent inappropriate restrictions on travel and trade, [meaning] there is almost by definition a reticence to declare until absolutely necessary [...] The IHR and PHEIC are not well designed.”⁸³ He also described WHO’s three-tiered grading system, but noted that “this was not a trigger for the international community.”⁸⁴ Given the criticisms of WHO made to us by witnesses, and WHO’s delay in declaring a PHEIC, its understanding of what a PHEIC is and is for appears to be at odds to the wider understanding in the international community.

79 World Health Organization, [Report of the Ebola Interim Assessment Panel](#) (July 2015), page 5

80 Q123

81 Q126

82 World Health Organization, [WHO Secretariat response to the Report of the Ebola Interim Assessment Panel](#) (August 2015), page 2

83 Q66

84 Ibid

51. **International health security requires that countries take their obligations under the International Health Regulations seriously; this requires the current review process to come up with meaningful reform. In addition, there is a clear difference of understanding, between the World Health Organization and others, in what purpose a declaration of a Public Health Emergency of International Concern serves. A clear warning system for public health emergencies is needed, to facilitate the political escalation of a crisis and mobilise the international community when necessary. DFID should work to make sure that the countries in which it works take their obligations under the International Health Regulations seriously and commit fully to implementing the core capacities. As part of the process of reform of the International Health Regulations, the UK should press for a more transparent and clearly understood grading system for public health emergencies.**

4 Conclusion

52. We are grateful to our predecessor International Development Committee for laying the foundations for this inquiry. Its reports on Strengthening Health Systems in Developing Countries and Recovery and Development in Sierra Leone and Liberia were not only topical, but identified many of the issues explored in this report long before they became as apparent as they are now. It is clear that many of those issues still require addressing. *We reiterate all of the recommendations made in those reports, especially with regards to ensuring that DFID's health systems strengthening objectives are met and the need for DFID to take on a leadership role in pushing for health systems strengthening. DFID should provide us with an update on its progress against those recommendations.*

53. The Ebola epidemic has acted as a practical test of the international community's ability to respond to a public health emergency. It has exposed great weaknesses across the international system. This is especially unfortunate considering the remarkable effectiveness of the response after it had been scaled up. However, that mobilisation came far too late, by which point the response was already playing catch up.

54. If any good is to come of the outbreak it must be that, in operating as a practical test, it has functioned as a stark wake-up call to the international community. The first priority must be to ensure a fully functioning international system for responding to public health emergencies, through reform of WHO and the International Health Regulations. However, DFID cannot only rely on these reforms and must improve its ability to independently recognise public health emergencies in the countries in which it operates, and continue to build on its own ability to respond. Responsibility for identifying and reacting rapidly to such events rests with the entire international community, including the UK. Such an outbreak can never be allowed to occur again, or to develop so catastrophically due to international inaction.

Conclusions and recommendations

1. As a result of WHO announcing a declaration of a Public Health Emergency of International Concern too late, DFID reacted slowly to early warnings, albeit from a limited number of actors, notably Médecins sans Frontières, that this outbreak of Ebola was on an unprecedented scale. Its initial delay was due to an over-reliance on the existing international public health system to sound the alarm at a political level. Improvements to global surveillance networks are needed and welcome. The fact remains that, in the case of the Ebola epidemic, warnings were given but were not heeded. Had they been heeded, DFID would have been able to respond much faster, as evidence shows from DFID's response after the PHEIC was announced when the UK demonstrated strong and swift political leadership, which we commend. We note that improvements are being made to the international early-warning surveillance and response systems. We are concerned however that DFID is still relying too much on improvements to the international system, without improving its own ability to independently assess international public health risks. (Paragraph 14)
2. *DFID must ensure that it has the ability to listen and react to information and warnings from a range of sources, not just the World Health Organization, in order to assess the severity of public health and humanitarian emergencies.* (Paragraph 14)
3. The UK Government should be commended for the way it responded after the declaration of a Public Health Emergency of International Concern. In particular, we applaud all of the staff who worked in Sierra Leone and the region to bring the epidemic under control. The UK's response to the Ebola crisis represents a very good example of cross-Government working, in terms of displaying the advantages of a co-ordinated effort as well as showing how such an effort can be well co-ordinated. (Paragraph 18)
4. *We welcome DFID's work with other departments to improve the UK's readiness and capacity for future outbreaks and humanitarian emergencies; this work should continue and the lessons and best practice on cross-Government working learned from this response should be disseminated across Government.* (Paragraph 18)
5. A recurring theme in our scrutiny of DFID is the difficulty it has in disbursing and managing small amounts of money. This issue was present at the start of the Ebola epidemic and may have hampered some early efforts to tackle the disease. Evidence suggests that small amounts of money disbursed at the start of a crisis, in order to bring that crisis under control quickly, can be very effective. In general small early interventions will deliver good value for money and can reduce the amount of money required further down the line. In contrast, a response that is playing catch-up is very likely to cost more. (Paragraph 22)
6. *DFID should ensure that it can operate more flexibly to respond to rapidly changing circumstances, including developing a mechanism to allow country offices to authorise the spending of small amounts of money without fear of negative consequences. This should apply not only during crises, and should involve devising easier means for applications to DFID to be made for smaller sums.* (Paragraph 22)

7. Engaging communities early is vital to responding to a public health emergency. It is unhelpful just to see cultural practices as a barrier to tackling an outbreak, as this can foster distrust between medical professionals and communities. Local and faith leaders can provide a valuable avenue for spreading important public health information and good practices. (Paragraph 29)
8. *In future outbreak responses, DFID must engage communities early and build community engagement into the fundamentals of its response. To assist with this, DFID should build its anthropological capacity and work with anthropologists in its work on strengthening health systems and on outbreak response. This would help it better understand the ways that people access and comprehend health services, so that it can build appropriately. To further facilitate this, DFID should also work more closely with local civil society and voluntary organisations, many of whom have long-established relationships with local communities over many years.* (Paragraph 29)
9. Weak health systems in the affected countries were a major factor in the rapid spread of Ebola. Robust health systems do not just allow for better control of an outbreak, but also for better treatment of more conventional illnesses, minimising the overall effect. The importance of a broad approach of building quality health systems for the sake of good health itself is recognised in the Sustainable Development Goals. (Paragraph 34)
10. *Health systems strengthening should form a core part of recovery efforts in the affected countries. DFID should use its position as a world leader on health systems strengthening to ensure that this is the case and to press for affected countries themselves to invest in and take ownership of improving their health systems. It should push for an intelligent approach to implementation of Sustainable Development Goal 3 which focuses on building robust health systems, taking into account how those systems work as a whole and how people access those services, and share its expertise in this area with other countries and partners to maintain that focus.* (Paragraph 34)
11. We welcome the UK's commitment to research and development into infectious diseases through the Ross Fund. We look forward to the publication of the Science and Technology Committee's report on Science in emergencies: UK lessons from Ebola. (Paragraph 36)
12. Development after the Ebola epidemic is a complex and daunting task, and the aim should not just be to restore Sierra Leone to its pre-Ebola situation, but to take the opportunity to rebuild and develop further. DFID has made a clear commitment to development in Sierra Leone, which we welcome and commend. We judge DFID's focus on economic development and basic services to be correctly placed to support the objective of development to a higher level, although a greater emphasis is needed on long-term support for education. (Paragraph 41)
13. *In order to fully achieve this, though, DFID's commitment must be a long-term one. In addition, and in light of the Government's new aid strategy, we urge DFID to ensure that strengthening health and education systems remain high priorities for the Department across its portfolio.* (Paragraph 41)

14. The World Health Organization has acknowledged its shortcomings in dealing with the Ebola epidemic, due to inadequate funding, a structure which was ill-suited to responding to such a crisis, and a reform process which has been too slow to achieve results. This is a failing on the part of the international community and all of its Member States, including the UK. WHO needs radical reform and quickly. We fully endorse the proposals which have been put forward by both the Ebola Interim Assessment Panel and the Independent Panel on the Global Response to Ebola, and stress that these need to be implemented with great urgency. (Paragraph 48)
15. *The UK should lead efforts for radical reform of the World Health Organization, including for greater funding from its Member States; it should maintain the pressure on WHO to be efficient and effective, even after the reforms are achieved, to ensure that it can properly fulfil its role as the lead organisation for responding to public health emergencies. We ask that DFID give us regular updates on the progress of the reform process, beginning with the response to this report.* (Paragraph 48)
16. International health security requires that countries take their obligations under the International Health Regulations seriously; this requires the current review process to come up with meaningful reform. In addition, there is a clear difference of understanding, between the World Health Organization and others, in what purpose a declaration of a Public Health Emergency of International Concern serves. A clear warning system for public health emergencies is needed, to facilitate the political escalation of a crisis and mobilise the international community when necessary. (Paragraph 51)
17. *DFID should work to make sure that the countries in which it works take their obligations under the International Health Regulations seriously and commit fully to implementing the core capacities. As part of the process of reform of the International Health Regulations, the UK should press for a more transparent and clearly understood grading system for public health emergencies.* (Paragraph 51)
18. We are grateful to our predecessor International Development Committee for laying the foundations for this inquiry. Its reports on Strengthening Health Systems in Developing Countries and Recovery and Development in Sierra Leone and Liberia were not only topical, but identified many of the issues explored in this report long before they became as apparent as they are now. It is clear that many of those issues still require addressing. (Paragraph 52)
19. *We reiterate all of the recommendations made in those reports, especially with regards to ensuring that DFID's health systems strengthening objectives are met and the need for DFID to take on a leadership role in pushing for health systems strengthening. DFID should provide us with an update on its progress against those recommendations.* (Paragraph 52)
20. The Ebola epidemic has acted as a practical test of the international community's ability to respond to a public health emergency. It has exposed great weaknesses across the international system. This is especially unfortunate considering the remarkable effectiveness of the response after it had been scaled up. However, that mobilisation came far too late, by which point the response was already playing catch up. (Paragraph 53)

21. If any good is to come of the outbreak it must be that, in operating as a practical test, it has functioned as a stark wake-up call to the international community. The first priority must be to ensure a fully functioning international system for responding to public health emergencies, through reform of WHO and the International Health Regulations. However, DFID cannot only rely on these reforms and must improve its ability to independently recognise public health emergencies in the countries in which it operates, and continue to build on its own ability to respond. Responsibility for identifying and reacting rapidly to such events rests with the entire international community, including the UK. Such an outbreak can never be allowed to occur again, or to develop so catastrophically due to international inaction. (Paragraph 54)

Formal Minutes

Tuesday 12 January 2016

Members present:

Stephen Twigg, in the Chair

Fiona Bruce

Helen Grant

Dr Lisa Cameron

Wendy Morton

Nigel Evans

Virendra Sharma

Draft Report (*Ebola: Responses to a public health emergency*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 54 read and agreed to.

Summary agreed to.

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

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

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

[Adjourned till Tuesday 19 January at 10.00 a.m.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's [inquiry page](#).

Tuesday 10 November 2015

Question number

Andre Heller-Perache, Head of Programmes, Médecins Sans Frontières UK, **Annie Wilkinson**, Post Doctorate Researcher, Institute of Development Studies, and **Dr Jeremy Farrar**, Director, Wellcome Trust

[Q1–27](#)

Dr Oliver Johnson, Former Programme Director, King's Sierra Leone Partnership, and **Professor John Edmunds**, Faculty of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine

[Q28–47](#)

Wednesday 25 November 2015, Morning Session

Dr David Nabarro, United Nations Secretary-General's Special Envoy on Ebola

[Q48–62](#)

Wednesday 25 November 2015, Afternoon Session

Dr Bruce Aylward, Special Representative for the Ebola Response, World Health Organization

[Q63–101](#)

Monday 30 November 2015

Rt Hon Justine Greening MP, Secretary of State for International Development, **Marshall Elliott**, Director, Joint Inter Agency Taskforce for Ebola, Department for International Development, **Brigadier Tim Bevis**, Head of Strategic Studies, Ministry of Defence, and **Tim Baxter**, Deputy Director, Health Protection Programmes, Department of Health

[Q102–141](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's [inquiry web page](#). EBO numbers are generated by the evidence processing system and so may not be complete.

- 1 Actionaid Uk ([EBO0010](#))
- 2 Adam Smith International ([EBO0018](#))
- 3 Africa Appg ([EBO0022](#))
- 4 CAFOD ([EBO0021](#))
- 5 CAFOD - Christian Aid, Islamic Relief and Tearfund Joint submission ([EBO0011](#))
- 6 Christian Aid ([EBO0006](#))
- 7 Department for International Development Annex A ([EBO0027](#))
- 8 Department For International Development Annex B ([EBO0028](#))
- 9 Department for International Development ([EBO0019](#))
- 10 Glaxosmithkline ([EBO0020](#))
- 11 Health Poverty Action ([EBO0015](#))
- 12 Institute of Development Studies ([EBO0001](#))
- 13 Malaria Consortium ([EBO0005](#))
- 14 Marie Stopes International ([EBO0003](#))
- 15 Médecins Sans Frontières ([EBO0025](#))
- 16 Medical Research Council ([EBO0013](#))
- 17 Pamoja Communications ([EBO0007](#))
- 18 Rebuild Research Programme Consortium ([EBO0017](#))
- 19 Riders For Health ([EBO0023](#))
- 20 Royal College of Paediatrics and Child Health ([EBO0002](#))
- 21 Save the Children ([EBO0014](#))
- 22 The Overseas Development Institute ([EBO0009](#))
- 23 THET ([EBO0012](#))
- 24 Unison ([EBO0016](#))
- 25 United Nations Development Programme (UNDP) ([EBO0026](#))
- 26 Wellcome Trust ([EBO0024](#))
- 27 World Vision UK ([EBO0004](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/indcom.

Session 2015–16

First Report	Syrian refugee crisis	HC 463
First Special Report	The Future of UK Development Co-operation: Phase 2: Beyond Aid: Government Response to the Committee's Tenth Report of Session 2014-15	HC 339
Second Special Report	Jobs and Livelihoods: Government Response to the Committee's Twelfth Report of Session 2014–15	HC 421
Third Special Report	DFID's bilateral programme in Nepal: Government Response to the Committee's Fourteenth Report of Session 2014–15	HC 422
Fourth Special Report	Department for International Development's Performance in 2013-14: the Departmental Annual Report 2013-14: Government Response to the Committee's Fourteenth Report of Session 2014–15	HC 420