

# International Development Sub-Committee

## Oral evidence: ICAI's review on the UK aid response to global health threats, HC 801

Wednesday 28 March 2018

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Members present: Paul Scully (Chair); Richard Burden; Mr Ivan Lewis; Stephen Twigg.

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### Witnesses

I: Richard Gledhill, Lead Commissioner, Independent Commission for Aid Impact; Jonathan France, Team Leader, Independent Commission for Aid Impact; Anna Wechsberg, Policy Director, Department for International Development; Nick Adkin, Deputy Director, Global Health Security, Department of Health and Social Care.

## Examination of witnesses

Witnesses: Richard Gledhill, Jonathan France, Anna Wechsberg and Nick Adkin.

**Chair:** Thank you very much for coming, and thank you very much for the report on global health threats, Richard. It is the second time we have done this slightly amended style when we have all the panellists at once so we can have a bit of a wider discussion. I hope it carries on as productively as last time. Could I ask Richard to lead us off?

Q1 **Richard Burden:** Can I start off by giving you an apology? Sadly, as is often the case in this place, I have to get to something else very, very soon. If I leave, hopefully after your answer to me, but if necessary in the middle of it, I hope you will accept my apologies for that.

The first question is to ask you a bit about the methodology of the review and the rationale behind it. Why did you approach the review in the way you did?

**Richard Gledhill:** The methodology is summarised on page 7 in figure 1. I suppose it is broadly similar to the structure of many other ICAI learning reviews. We styled this as a learning review, because of the rapid scale-up of expenditure and the new government strategic framework that was established after the Ebola crisis.

The key features of the methodology were an in-depth review of four countries and visits for country case studies to two countries. Burma and Sierra Leone were the two country case studies. They were selected because of the broad range of programmes that were in place there, which involved the range of actors from the UK Government—DFID, the Department of Health and Public Health England—that are active on global health threats, so that, as well as looking at individual programmes, we could look at inter-departmental co-ordination and influencing work with Government.

In addition to those detailed reviews, we looked more broadly across the full spectrum of activity, in particular through a review of all the departmental plans to look at the extent of involvement on global health threats.

Q2 **Richard Burden:** You mentioned you chose Burma and Sierra Leone for case studies because of the breadth of involvement there. What about the others you looked at in terms of DFID programming, Nigeria and Pakistan? Why were they selected?

**Richard Gledhill:** Perhaps I can ask Jonathan to pick up on that.

**Jonathan France:** Pakistan is interesting, because it has introduced a relatively new approach to surveillance of potential epidemics, which is embedded in its wider health programming. We were looking at the interplay between health programming more generally and the attempt to



build effective surveillance. Nigeria is an interesting case, because they were also impacted by the Ebola crisis. However, they were able to organise themselves and respond relatively rapidly. We were keen to look at some of the wider lessons from Nigeria in comparison with Sierra Leone.

**Q3 Richard Burden:** There were clearly reasons why you chose those countries to look at, because of the specifics that you have outlined, and thank you very much for that. Did looking at those countries provide a good snapshot of what is going on in those countries? Would you say they were a completely representative picture of DFID and Department of Health programming in relation to health threats globally?

**Richard Gledhill:** They clearly provide a comprehensive perspective of activity in those countries. Because we were also looking at centrally managed programmes running in those countries, we got a good understanding of the broader level of activity. That was also informed by the review of other countries' plans. For a learning review, that approach is very justifiable and appropriate. If this had been an impact review, one might have looked more broadly at other countries.

**Q4 Chair:** Richard, what was the response rate to the email survey by DFID country health advisers?

**Richard Gledhill:** I have to say it was lower than we would have liked. We got nine responses out of 24. We chose to do an email survey because it was an efficient way of reaching out across DFID country offices and it also gave an opportunity to verify or triangulate information we got from other sources, for example the country plans and through our external engagement. I suspect the response rate reflected in part the extent of engagement of country teams specifically on global health threats rather than more broadly on health issues. Certainly, we would not normally expect to get a full response, because these are extremely busy people. It would have been nice if we had had more.

**Q5 Chair:** In the review, you noted that there is limited availability of independent evaluations and academic reviews of the Government's approach. As the Government's approach is still relatively new, are you intending to revisit the subject in a few years when more or fuller information will be available?

**Richard Gledhill:** Well, the issue of strengthening evaluation and leveraging that for learning across the portfolio and more widely with other parties involved in global health threats is one of the key findings and the most important recommendation, perhaps, from this review. We will certainly come back to look at it in a year's time as part of our follow-up next year. Whether we need to look at it again will be a matter for the new commissioners when they come in.

**Q6 Stephen Twigg:** I am going to move us on now to the global health threats security strategy. I am going to start with a question for Richard and Jonathan. In the review, you assess the Stronger, Smarter, Swifter



framework positively as “well balanced” and “supported by a strong strategic rationale”. Are there particular areas of good practice that should be retained as the strategy and framework are refreshed in future?

**Richard Gledhill:** Our report highlighted a number of early successes as part of the Stronger, Smarter, Swifter framework: in particular, building surveillance systems in high-risk countries and developing new vaccines for use in those countries. Jonathan, do you want to give some more colour to areas of particular strength?

**Jonathan France:** Yes, we found that the framework is very much founded on strong evidence and a diagnosis of the problems lying behind the Ebola outbreak. It is quite cleverly delineated between strengthening the international health system and improving the science, research and development base, particularly around ensuring a faster supply of new vaccines for new and emerging diseases. Finally, it recognises the issue of encouraging actors, NGOs and donors to respond more rapidly.

It is quite cleverly categorised between those three areas, and that should be retained. Obviously, particularly as new learning is generated, what can be improved are the specific mechanisms and actions that can be taken to meet those objectives.

**Q7 Stephen Twigg:** If I can move now to Anna and Nick, can you tell us a little more about the likely timescale for the refresh of Stronger, Smarter, Swifter and its transformation into a global health security strategy?

**Anna Wechsberg:** The work is just starting now. We have some thinking underway. At this stage I cannot give you a precise timetable, because we do not know ourselves exactly how long it is going to take. But we are kicking it off now, and we want to get it in place as soon as we sensibly can. In addition, one of the comments ICAI has made was about the fact the previous framework was not published. As we said in our response, it is our intention to make the new framework publically available. We recognise that part of the value of this is being able to stimulate dialogue between us and other players on these issues.

**Q8 Stephen Twigg:** That is very important. The current framework places great importance on investing in national health systems. ICAI has said it feels this point could be given greater emphasis in the new strategy. Do you agree? Is that likely to form a part of the new strategy?

**Anna Wechsberg:** It is one of the issues we are looking at. We completely agree that investing in national health systems is vital. We do that in a whole host of ways, including through some of the work the Department of Health and Social Care does on the Fleming Fund, for example, or on surveillance, through our own work in country and, critically, with support through the World Health Organisation.

One of the key lessons from the Ebola crisis was that, if a virus emerges in a country with a strong health system, it does not turn into a disaster;



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if it emerges in a country with an exceedingly weak health system, it does.

**Stephen Twigg:** Absolutely, yes.

**Richard Gledhill:** I wonder whether I could add something to that.

Q9 **Stephen Twigg:** My next question is, to ICAI, "What is your response?" You read my mind.

**Richard Gledhill:** We saw there was a recognition that more needed to be done in this area. Indeed, we were told as part of our visits that there was a plan to produce new guidance, a policy statement or a position paper on health-system strengthening. We were slightly disappointed that was not explicitly mentioned in the management response. It would be good to get an update from DFID as to whether this is going to be issued soon.

**Anna Wechsberg:** We are working on it. We continue to work on it, and we consider it to be a high priority. We have not yet taken a final view of what form it should take, whether a position paper, guidance document or anything else. But that work is going on. I would like to see it conclude and be available in whatever form in the not-too-distant future.

**Nick Adkin:** I was very pleased with the way the ICAI report highlighted the evidence base and the strength of the existing framework, Stronger, Smarter, Swifter. As we go to make it public for an international audience, we want to reframe it in more international language, because that was internal Government driving what we do in response to Ebola, and it has been very good at that. We do not want to lose the core, but we want to start to speak in the "protect, detect, respond" language of global health security more widely. That is a key part of our reframing.

Q10 **Stephen Twigg:** Anna, in your answer just now you referred to WHO and some of the other government department work in this area, and we are going to come to questions on that in a moment.

Can I highlight something particular in the report? That is the benefit of investing in the Nigerian health system, in terms of both the benefits it obviously brings in Nigeria but also the broader regional benefits in west Africa. Are you able to give us a commitment that DFID will at least continue its current funding for health in Nigeria but potentially even look to increase it?

**Anna Wechsberg:** I am slightly reluctant to commit to something that is a little open-ended, but we absolutely do attach importance to health systems, including in Nigeria.

Q11 **Stephen Twigg:** You accept the point that that brings a broader benefit in the region, not only in Nigeria itself.



**Anna Wechsberg:** It is one of the fundamental points. One thing that has been particularly useful about the ICAI report at this stage is that it has prompted us to think about the relationship between country investments, regional investments and what is happening in the global system. How do you integrate what is essentially a set of really important global public goods into your public approach? There is more to do to think that through, which is what the strategy refresh is all about: to think about how that all comes together.

Q12 **Chair:** The review highlights the omission from the framework of a range of relevant cross-Government ODA-funded research programmes. Richard, have these omissions had a negative impact on previous DFID global health programming?

**Richard Gledhill:** The strategy gives a lot of emphasis to scientific research, for example on the development of new vaccines. The UK is very well positioned to make an important contribution there. The particular issue we were flagging was the fact that scientific research in this area needs to go beyond just new medical products, new vaccines and so on. The Ebola crisis underlined the importance of understanding social and cultural aspects of how epidemics spread.

There is an opportunity to take a broader look at scientific research priorities in this area and potentially to involve other ODA research funding mechanisms, such as the Global Challenges Research Fund. That fund's mandate covers health systems, but it is not a major focus at this point in time.

**Jonathan France:** I would echo Richard's point. Indeed, there is recognition within Government and across departments that research more generally could be better co-ordinated to meet development priorities. That is why mechanisms such as the SCOR Board—that is, the Strategic Coherence for ODA-funded Research Board—have been established: to help better drive development prioritisation within ODA-funded research programmes. There is a bit of a gap, and there is a recognition that it needs to improve.

Q13 **Chair:** Anna, what is your response to that?

**Anna Wechsberg:** I agree with what Jonathan said. I would add two things to that. The relationship between DFID and the Department of Health and Social Care, including on research, is getting closer and closer. I am looking at Nick here. You agree, do you not?

**Nick Adkin:** Absolutely, yes.

**Anna Wechsberg:** Genuinely, it is really good between our research teams.

Secondly, we have not talked about anti-microbial resistance, but it is a classic issue where you need research in lots of different areas. All the animal stuff is really important; prescribing habits and social norms



around use of antimicrobials are very important. It would be a mistake, in my view, to try to put this all in one box. You are going to need a broad thing, but it means we need to get better at doing the co-ordination. That is what SCOR and the other mechanisms are about.

**Q14 Chair:** Anna, what steps have you been taking to ensure that ODA research from across Whitehall feeds into the design of global health threat programming?

**Anna Wechsberg:** We have done a number of things. Within DFID, we have dedicated teams who are looking at this, including some of the people sitting behind me.

We are making sure that knowledge then feeds into policy formation. As I say, we have good links between our research teams and our policy teams, and it is the same on the Department of Health and Social Care side. Those links work. We publish everything. I personally signed up to the Gov.uk research alerts. I recommend it if you have not done it. What is going on is fantastic.

Having said that, this is a challenge across everything that we do, across global health but more widely. There is a huge amount being produced. To be able to translate that knowledge into policy and programmes is challenging but very, very important. I would not like to give you the impression that I think we have ticked the box on this. It is a work in progress.

**Richard Gledhill:** The issue of co-ordination of communication needs to happen at two levels. Within DFID, we saw that there is a good community of practice operating with the health advisers at the country level. We think there is an opportunity to broaden that community of practice to involve other Departments and agencies, and to share the knowledge and learning more generally through that process. There are a number of boards and groups there to co-ordinate activity and share information at the strategic level, but our sense was that there is a need for greater strategic co-ordination and leadership.

We were again a little disappointed by the response to recommendation 2, which said that the Government recognise cross-government co-ordination could be made clearer. It goes deeper than just communication. There is an opportunity for the Global Health Oversight Group, which is the leading body at a strategic level, to have wider membership, not just DH and DFID. It could perhaps have a broader remit and show more leadership across Government on global health threats.

**Nick Adkin:** I just wanted to pick up on one thing on the research side. The Strategic Coherence of ODA-funded Research Board is really important. That is just getting going. The department's chief scientific adviser, Chris Whitty, sits on that. It met formally for the first time in March.



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I also met with a newly appointed person under the Global Challenges Research Fund, which was mentioned. It has now appointed a global health challenge leader, who is Professor Helen Fletcher. BEIS brought together the Departments, including DHSC and DIFD representation, to meet with her and to see how we can take that co-ordination piece forward as well. It is worth flagging that.

**Jonathan France:** We saw some excellent examples of what the Government call rapid research calls for evidence. When the Zika crisis emerged, there was excellent flexible use of research funding to fund short-term pieces of research to look at the effects of Zika. That was great, but we are arguing for a bit more long-term visioning and thinking, across the Medical Research Council and the Economic and Social Research Council, for example, about how we can better protect ourselves from future outbreaks through thinking about this longer-term research piece and what is needed.

Q15 **Chair:** Anna, I know you want to come back in, but I will just ask you another question as well, and you can come back to that. You talked about the research alerts. Do in-country health advisers have access to the full range of cross-Whitehall ODA health research?

**Anna Wechsberg:** They absolutely should do, but having access is not the same as having it presented in a way that makes it easy to use. That is where the work needs to happen. Richard referred to the community of practice. It is really good that you are positive about that. We put a lot of work into the health advisers network. The head of profession has weekly lunch and learn sessions, which are open to all advisers and indeed open to people more widely if they want to come.

We had a session in the most recent professional development conference that involved a much wider range of players. Your team was there, PHE was there and others were there. It was designed to focus particularly on global health security and look at it more broadly. There is quite a lot that is going on. That network and making that network function is really critical in making this happen in practice as opposed to just on paper.

I just wanted to comment on the comments you made on the Global Health Oversight Group. It is our intention to look at how we can broaden the membership. I cannot remember whether it was last week or the week before, but we had a workshop with a very wide range of Government Departments to look at how we could do that. Lots of people came; it was very engaging. It was at the Medical Research Council, if that is any comfort. It is completely our intention to do that and to try to provide that strategic oversight.

Q16 **Chair:** That is useful. How can DFID ensure that social science-based research, for example research aimed at understanding the social and cultural aspects of how epidemics spread, is fed into the design of global health programming?



**Anna Wechsberg:** This is a really important point. We rely heavily on our country health advisers to do that. They are the people in our system who will understand the state of readiness of the local system but also be able to think about how this fits in with cultural and social norms. Clearly, in the Ebola crisis that was critical to the way the crisis ended up spreading and the way, in the end, we brought it under control. We rely a lot on the system there.

I think I am right in saying that during the Ebola crisis it was some of the research that had been done in advance around social norms and practices that really helped us identify some of the critical interventions for safe burials, for example, which led to containment of the crisis. That is a very real example of how that social-cultural research fed very directly into the response.

Q17 **Mr Lewis:** Good morning. I have a couple of questions first of all for Richard and Jonathan. The review identifies the need for greater clarity in the role that each Government Department should play in implementing Stronger, Smarter, Swifter. Could you expand on that? That is the first question. Are there specific areas in which you feel cross-departmental working within global health could be improved?

**Richard Gledhill:** There are a number of areas in the report where we highlight good work and good achievements so far, but we identify opportunities for greater improvement. There is a lot around the learning area, which feeds from evaluation through to learning and sharing that learning widely within the UK Government, and indeed sharing it more broadly with other actors. This is an increasingly crowded space, and it is very important that the UK co-ordinates well with other actors, shares learning and ensures that it avoids duplication of effort and gaps in work and programming.

There is a large number of mechanisms, bodies and groups within Government to share information, take decisions and monitor programmes. While those may be effective and may be understood by the people participating in them, the general understanding of how the Government machine works on global health threats just is not there in the outside world, and that is a problem.

It is very important that other donors, multilaterals, private sector players and philanthropists can understand how the UK is working on this issue, and how they can dovetail their work with ours to make two plus two equal five in this really important area.

**Jonathan France:** It is worth saying that in terms of cross-Government co-ordination, what was working well were the efforts to influence the WHO and improve effective and efficient practices within the WHO. For me, the area that needs particular development in terms of cross-Government co-ordination is the interplay with ODA-funded programmes managed by the Department of Health. The Fleming Fund is one example, and the work it has commissioned Public Health England to



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do is another example. How are they co-ordinated on the ground in DFID priority countries with DFID programmes?

There is a lot of opportunity there, but one of the key challenges is capacity, particularly for DFID country staff, who have their own programmes to manage. Increasingly, other cross-Government ODA-funded programmes are impacting them.

**Q18 Mr Lewis:** I have a question to follow on that, and this is for Anna and Nick. What steps are being taken to improve cross-Government working with other ODA-administering Departments?

**Nick Adkin:** On the overarching approach, the Global Health Oversight Group and what we do in terms of expanding it is critical. Where do we go with the governance structure? As Anna said, the workshop we had last week had a large number of other Departments there. How we drive that through into a mechanism that involves everybody properly, so they are sighted and we have a joint approach that can then play out on our refresh strategy, is crucial.

On individual programmes and project boards, having mentioned the Fleming Fund in particular, we have cross-departmental representation. We also did a presentation at DFID's session for health advisers two weeks ago to make sure they were aware of the intentions of the programme and what we will hopefully be asking them to advise us on when we go into an individual country, as we roll out the programme into the 24 countries. We are getting that knowledge and understanding to build a better programme.

You will hear about a lot that represents a real taking-forward of the recommendations from the ICAI report. I thought it was very helpful in steering where we are going at a crucial point in the programme.

**Q19 Stephen Twigg:** You have all touched upon this issue, which is around communication and dissemination. The ICAI review was critical of previous approaches in the area. First of all, to Richard and Jonathan, has the lack of a publically available strategy on global health threats so far hindered the coherence of the UK's work in this area?

**Richard Gledhill:** I am not sure it has hindered the coherence of the UK's work. The point I would emphasise is how that fits in with the bigger picture of international activity. Our experience was that the UK at the centre, but particularly in countries, has very good relationships with its traditional likeminded donors. There is regular interaction, with local committees or forums for engaging with them. We are now seeing in global health threats a much more crowded space. There are new donors coming in, such as the World Bank or ADB, and being more active.

Just publishing the strategy or the framework on the government website is not going to do it. This is about actively engaging with those other international actors and working out where the priorities are, who should



be doing them, allocating responsibility, and ensuring there are no gaps in the totality of effort. That is a big job. It has not hindered the Government's work to date, but it will be a priority going forward.

**Q20 Stephen Twigg:** Anna and Nick, that is essentially a challenge. You are publishing it. That is a necessary first step, but Richard is saying that it is not sufficient if we are going to maximise the impact of it now being a publically available strategy. Can you say a bit more about the tone and the style of the proposed strategy and how it will meet that much broader audience that Richard has just described?

**Anna Wechsberg:** We have not got to the tone and style point in the creation.

**Stephen Twigg:** That is fair enough. I am getting in early.

**Anna Wechsberg:** Having said that, I agree very much with what Richard has said. Just sticking it on a website is not going to do the job. We need to use it as part of the dialogue, which already, as you say, is ongoing in quite an intensive way, about how all the pieces join up. Although it does not seem five minutes since we last had a big replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, another one is coming pretty soon. That is one of the issues at the front of our minds. Similarly, we will be looking at the strategy for Gavi over the next couple of years. Coming up in May at the World Health Assembly, there will be a new programme of work for the World Health Organisation.

All these things are absolutely crucial, because unless the system as a whole joins together and fits together well, we are not going to be able to improve over where we are, and it is incredibly important that we do. Basically, I agree. I do not know whether Nick wants to add anything.

**Nick Adkin:** No, you have covered it well. We will need to ensure that, when our representatives in country are speaking to this subject, they understand the overall approach. We have to not just plonk it on the website but communicate it actively into the community as well. It has to feature in our strategic dialogue with the WHO at the key points that will influence how the whole system works and the individual countries.

**Richard Gledhill:** This is one example we came across. We had a meeting with an external organisation that was investing in new country-level surveillance systems. It was unaware until that time that the Fleming Fund was planning to do just that. It shows the challenge. Arguably it is as much their fault as ours, but it shows the challenge of communication and co-ordination.

There is also a good-governance point here. Taxpayers in the UK will be very familiar with the great work that was done by the UK to help resolve the Ebola crisis. It was regularly covered on the news. I suspect most taxpayers have no knowledge of what we are doing now on global health threats.



Q21 **Stephen Twigg:** Nick, in terms of your role, is there a network with similar people in other countries' Ministries of Health, or are we a bit ahead of the curve on this?

**Nick Adkin:** No, we do not have a network. Some of our programmes are in country; some of them are for the benefit of countries. The International Health Regulations work and the Fleming Fund are both in-country programmes that rely on the expertise of the DFID staff on the ground and the regional structures.

The work on the International Health Regulations is led by Public Health England, which has knowledge and expertise in the area as well. It will have contacts, people who have been through the Public Health England system; so personal contacts, as well as system contacts. But our primary go-to expertise when we go into a country is FCO and DFID.

Q22 **Stephen Twigg:** What about other donor countries? Would there be any sharing with the German Ministry of Health, the Swedish Ministry of Health or those sorts of things?

**Nick Adkin:** We seek to do that through the G20 forum in particular. We did good work with the German administration last year in G20. We are continuing that. In the same vein, we are working with Argentina this year to possibly launch a joint research call around AMR, which is about making sure we lever other countries as well as just putting our own money into research.

**Richard Gledhill:** I wonder whether I could just add a point.

**Stephen Twigg:** Please, yes.

**Richard Gledhill:** Your mention of G20 made me remember the response in relation to simulations on recommendation 2. The response talks about the simulation for flu pandemics. That is about rehearsing for things that could happen in the UK. It talked about the G20 simulation, which is about how participant Governments will work with WHO. Those are all important things to do.

The point we were making in relation to simulations was that it would be good to simulate an Ebola-type crisis in a developing country and to see how the different parts of Government in the UK work together in that response. In the response to Ebola, we saw how parts of Government, such as the MoD, which is not typically involved in global health threats, came together and played very important roles. There would be value in testing out how that might work again in the future.

**Jonathan France:** Two things are particularly interesting in terms of communication and external co-ordination. First of all, there are clearly a number of major global trusts and foundations that spend billions on health. Of course, there are also the private-sector pharmaceutical companies. They can provide a lot of the funding to help meet some of these objectives. We are a little surprised at the lack of a formal



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mechanism for engaging such bodies. We understand the issues around retaining the independence of Government, but there is potentially a need for greater co-ordination there, starting with communication and ending with co-ordination.

The second interesting thing is at a DFID country level. Positively, we found very strong relationships with existing donors, with friends of the UK: with Germany, the US and other more traditional donors. DFID country officers were increasingly realising that it is becoming a much more diverse space. China is getting increasingly involved in tackling global health threats, as is Japan. There are other new and emerging donors, such as Brazil. But they have not quite yet worked out how to engage with those countries.

**Q23 Chair:** If we turn to reform, I am wondering, Richard, why a specific reference to pursuing global health reform at WHO level was not included in the recommendations.

**Richard Gledhill:** The work we did in this review in relation to WHO looked at the influencing of WHO reform specifically in areas relating to global health threats, rather than looking at the full mandate of the WHO, which is much broader. That was outside the scope of our review.

In what we looked at in relation to global health threats, we saw and indeed heard from other external stakeholders that the UK had played an important role in influencing reform at WHO and encouraging it to take sensible steps on reform. It is still early days, but it appears to be having an impact on the accountability and responsiveness of WHO.

**Q24 Chair:** The review also identified that improvements were needed to pursue the other countries to join the UK in bolstering international global health efforts. Are there any particular areas in which improvement is needed in that regard?

**Richard Gledhill:** We flagged one disappointment, which one cannot necessarily put entirely at the UK's door, in relation to the funding for the WHO Health Emergencies Programme, where the UK was trying to encourage other donors to join in with that funding. That was not as successful as anyone would have liked. Jonathan, are there any other particular points?

**Jonathan France:** Yes. What happened in Sierra Leone with the Ebola crisis was relatively recent. The demonstration effects of working with WHO and proving that it can be accountable perhaps needed a little longer to play out before other donors would commit.

There are other areas where the UK has made a positive contribution. The UK and WHO developed what is called the Blueprint. The UK was fairly instrumental in helping to develop that. It essentially sets out a list of future priority epidemic diseases that we should be investing vaccine development in. With greater co-ordination, we could be encouraging other donors to link in and support that strategy.



**Q25 Chair:** Anna and Nick, how will DFID ensure that reform of international global health policy is interwoven into the refreshed strategy?

**Anna Wechsberg:** It absolutely needs to be. I am very pleased that ICAI felt positive about this. We have worked really hard, particularly with WHO, on the reform programme. As you know, our core voluntary funding contains a 50% performance-related tranche. We are seeing other people want to get behind that kind of approach to provide incentives for reform.

We work not just at headquarters level, very closely with Nick and his colleagues, but also at regional level. The report also talks about the work we have done with WHO-AFRO, its African regional team, which is really motoring ahead in terms of the quality of service it is providing in Africa now. We are delighted with that, and we have put a lot of support behind that. All these things will be completely fundamental to the strategy, and we cannot deliver without them.

You alluded to this earlier, but one of the points that we would perhaps bring out more strongly than the ICAI report does is the role of WHO, including in country. We need to make sure we have the capacity in country to join up and the health advisory capacity to support DHSC's work on the Fleming Fund etc.

But we also really, really need a strong WHO country presence. We are some way from that still. We are getting there, particularly in AFRO, but there is still some work to do. That is absolutely for the whole system to deliver better

**Richard Gledhill:** What is particularly interesting here is that for the most part the WHO has welcomed the influence and support from the UK, which you would not always find in the multilateral world. I would certainly agree with the progress that has been made in the Africa regional office. There is more to do in the other regional offices.

**Q26 Mr Lewis:** These questions are for Anna and Nick. What plans do the Government have to ensure there is sufficient capacity—we have touched on some of this—within DFID to play a co-ordinating role in in-country global health threat programme delivery? Are there specific plans to increase capacity relating to strengthening national health systems and influencing the reform of the global health preparedness of WHO? Again, we have touched on this.

**Anna Wechsberg:** We have a network of 60 health adviser posts. We have more health advisers than that, but some of them are doing other things temporarily, other jobs in DFID. We have a really strong country network of health advisers. We are focusing on making sure that the team of health advisers has the knowledge and the understanding to link up what we are now talking about on global health security with the work that is more familiar to them from what they have been doing over previous years on health systems and health services.



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I mentioned before the work at the recent professional development conference, where we had specific elements on that. We are looking at how we can integrate global health security more into the way we provide training and further development support to our health adviser cadre.

I would just re-emphasise the point about WHO. We will do as much of this as we can, but we need a World Health Organisation that is effective at country level. We must put as much focus on that as we do on developing our own capacity. Otherwise, we are setting up a system that just will not be able to cope in the future.

**Nick Adkin:** On the WHO point, it is worth reflecting that the change in director-general last year was accompanied by a change in almost all the senior-level posts in WHO. We, as the Government, have been heavily involved in a piece of work to ensure that our voice is quite clearly articulating these points.

We held a strategic dialogue with WHO over two days in December, which was led by the chief medical officer. We went through our agenda, including separate sessions on global health security and antimicrobial resistance. As Anna says, the challenge for us is to ensure this goes into the global programme of work and that, at the World Health Assembly later this year, it is properly reflected.

**Richard Gledhill:** The point we were making here was not so much about the expertise and capability of the health advisers. Generally, we found they were very dedicated, high-calibre, knowledgeable people held in very high regard in the communities in which they are working.

We were flagging their capacity to cope with the much greater workload. Ultimately, they are the face of UK aid in their countries. They are there when everybody else has gone home. They provide vital intelligence to programmes and partners. They co-ordinate programme activity, and they also have to maintain relationships with the host Government, with WHO and with other actors. Again, we were a bit disappointed with the response to recommendation 3. Yes, it was accepted, which is good, but the tone of the response to me sounded a bit "business as usual".

Q27 **Mr Lewis:** Yes, that was going to be my next question.

**Richard Gledhill:** I am sorry.

**Mr Lewis:** No, do not apologise. I will come to that in a second. The EpiThreat group is mentioned. Could you elaborate a little more on that? Could you also deal with the point that has just been made by Richard about freeing up the capacity of the health advisers? If you look at this objectively, it is clear that we are asking them to do a tremendous amount.

**Anna Wechsberg:** The EpiThreat group is chaired jointly in DFID by our chief scientific advisor and by our director of humanitarian. It meets monthly, but I might be wrong about that. The idea is to take stock on a



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regular basis of information that is coming out globally on emerging potential epidemics, and to do that in a systematic way and then feed that into the system. Typically, there will be a discussion around diphtheria in Cox's Bazar, the risks around cholera or something. There will then be contact with our country experts, who will give a view on the state of preparedness and readiness in country, and then a decision on whether we need to do anything.

That may be something we need to do ourselves in DFID; it may be something that involves Public Health England or some Department of Health and Social Care facilities; or it may be something we need to do in the international system. We might then go to UNICEF and say, "We think you need to be more active in a vaccination campaign with Rohingya refugees", with Gavi or whatever. The idea is exactly to be more systematic about making sure we know what is happening and that that is feeding into the system.

On the point about capacity, I recognise half of the picture Richard was painting, in that we have some very dedicated, very hardworking people who are trying to do a complex, difficult and extremely important job. But they are not doing that in isolation; they will have a team around them. They will have a deputy head and head of office who will obviously lean in on these issues, on the points about discussing with Government and all the rest of it. I would not like to give the impression that this network of people is acting unsupported. That is absolutely not the case.

It is fair enough to expect us to keep under review whether the demands, which are changing and increasing, on our advisory capacity match the number and type of the people we have. For the moment, we think we are stretched but we are okay. For the future, we will need to keep an eye on it, absolutely.

**Jonathan France:** We went to a country like Sierra Leone and we found the health team there was extremely well resourced. It could perform all of the functions we have talked about quite well, in particular working with the WHO country office. It was doing some great work. You could see the impact on that WHO country office. In some of the other countries we looked at, the teams were quite stretched. There was a much more hands-off relationship with the WHO country office and a correspondingly less strong WHO country office. It was interesting to look at the contrast between the countries.

In particular, there was a recognition that you need a core team of DFID advisers to oversee programmatic interventions in the programmes and show good value for money. But there is an increasing need for this advocacy/diplomacy role and influencing Governments, particularly when you start to talk about strengthening health systems.

**Anna Wechsberg:** Can I come back very quickly on that? There is truth in that. It is also the case that we need WHO to be playing that role. WHO will have people embedded in the Ministry of Health, who will



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be advising on how the health system should develop. We need to make sure that happens, support that and make sure it is of decent quality. But that is the role we see for WHO in the system as a whole.

Q28 **Mr Lewis:** What is your response to that?

**Jonathan France:** In some countries, it probably needs one or two extra health advisers.

Q29 **Mr Lewis:** Are you saying the UK's interaction with WHO, where it works, makes a big difference where WHO is weak?

**Jonathan France:** Based upon the experience of Sierra Leone, which of course is just one country, the answer would be yes.

**Richard Gledhill:** There is a danger of taking Sierra Leone as a benchmark, because there has been so much work done there since Ebola by a range of donors and actors. It is also a place that Ministers, royalty and other celebrities visit to see the action that has been taken. We were slightly concerned about the additional burden of a further visit to Sierra Leone, just because of that very fact, but we felt it was important to see the learning that had been achieved there and how it was being taken elsewhere.

**Jonathan France:** It was all sensible and replicable stuff. It was working with WHO to strengthen its country plans and strategies and up-skilling in a few small areas. It could be replicated across other countries beyond Sierra Leone in a relatively cost-efficient way.

Q30 **Mr Lewis:** Maybe I am wrong, but the implication seems to be that WHO is weak in some places. That would not be a major shock to me or a revelation. Is that what you are saying? Where that is the case, the UK could play a much more significant role.

**Anna Wechsberg:** If you look at the lessons from the Ebola crisis, it is fairly clear that there are weaknesses in WHO. We believe they are genuinely being addressed. There is commitment at the top of the WHO. The work that has happened on the emergencies programme, which we have really pushed for, has been very good. In particular, the Africa regional work has been very good. It is not job done yet, by any stretch of the imagination. I am sure WHO would say the same. These are complex, difficult issues.

**Jonathan France:** Again, to be fair, in terms of epidemic diseases, outbreaks and pandemics, sub-Saharan Africa is clearly a high-risk area. We have seen a concentration of activity working to improve WHO from DFID and DH in that region. The challenge is to ensure that WHO is effective everywhere, because no one can predict where the next epidemic or pandemic is going to emerge from.

Q31 **Mr Lewis:** Can I just ask one final question? When I was at DFID some time ago, the Government changed policy in relation to budget support.



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Has there been a shift, similar to budget support, in terms of the balance between overseeing programmes and strengthening health systems. Has the instruction gone out to DFID in country that the primary responsibility is the delivery and oversight of programmes rather than the strengthening of health systems? Has there been a shift in the UK's priorities?

**Anna Wechsberg:** No, there has not. I understand the question you are asking. It is not quite so either/or. When we are doing quite a lot of this programmatic work, it is in the context of working to strengthen a health system. But even where we are not providing budget support, there will be very regular contact between our health adviser, the WHO people in country, the Ministry of Health, etc. That will continue, and it is all about the outcome, which is a strong, resilient health system, even if our input in practice is through a particular programme.

**Richard Gledhill:** There is a real tension here. You have seen, particularly from philanthropic organisations, a focus on vertical programmes addressing individual diseases. With major programmes being implemented through UN bodies or other organisations, you have the risk of parallel systems being built up without providing additional support to strengthen the local health system. Those are not necessarily problems or consequences, but one needs to be very alert to them as issue and look to ways to strengthen national health systems at central and local levels. There is a range of ways you can do that besides budget support: through technical assistance and through involving them actively in programmes that are being run by others.

**Jonathan France:** We certainly saw an interest and an understanding among DFID country officers of the need for perhaps a more explicit recognition in future programming that health system strengthening is critical. That is partly why we are recommending that the paper on health system strengthening that has been drafted here is completed, published and circulated as quickly as possible.

Q32 **Chair:** Thank you very much. The final topic is about learning and evaluation, which is probably the bit that ICAI has the most concerns about. The report states that ICAI found evaluation systems and knowledge sharing to be inconsistent and undeveloped. Richard, I wonder whether you could tell us a little more about that.

**Richard Gledhill:** Yes, this is perhaps our strongest finding and our most important recommendation. It is interesting. The work that was done in real time to learn the lessons from Ebola was absolutely commendable, and it has been hugely valuable in forming the strategic framework. The commitment since then has been weaker, in part because programmes are getting up and running, being scaled up, and people are focused on the here and now. But we found inconsistencies and gaps in the evaluation of programmes and in the sharing of learning between programmes and across Departments. In part, that is because



there is no overarching evaluation and learning strategy in the strategic framework. We think that is an issue.

Jonathan, do you want to pick up on some specific examples?

**Jonathan France:** Part of it is this coming together of Government Departments, and new players such as Public Health England getting involved in overseas development. They are coming from different starting points in terms of a culture of evaluation. Bodies such as the Global Health Oversight Group can perhaps help to set common standards for programmes related to global health threats.

Again, I will go back to Sierra Leone. We also found a huge and immense amount of learning, because it has had such a concentration, that could be shared with other DFID country officers. But we were not quite sure that the mechanisms were fully formed to share learning and evidence between DFID country-office programmes.

Q33 **Chair:** Anna, why were evaluation and knowledge systems not given greater status in global health programming?

**Anna Wechsberg:** We accepted ICAI's finding and recommendation on this. We can do better in this area. We have scaled up our global health security portfolio quickly, rapidly and rightly in response to the Ebola crisis. We now need to make sure that the way we are approaching evaluation and learning is sensible across the portfolio and that we are taking the opportunities to learn from one piece to another.

You have made suggestions here and in the report in terms of the role of the Global Health Oversight Group, the use of the new framework as we develop it, articulating our approach to evaluation and learning more clearly within that and then putting that into practice. These are very helpful suggestions, which we will take forward.

We would not expect the approach to evaluation—I am sure this is not what you implied either—in every programme to look exactly the same, because it has to be context-specific. The key thing is that there is a process that is genuinely going to extract information, ideally as you go along, as well as at the end of a programme, which could be several years down the line. You do not want to be waiting to find out everything at the end. Then we can feed that back in.

We have talked about some of the other mechanisms we have for doing that, including the community of practice and the health advisers. But we agree that there is more we can do in this area.

Q34 **Chair:** Is the monitoring, evaluation and learning plan in place now to support the framework or is it something you are taking forward?

**Anna Wechsberg:** We will have a look at it as we revise the framework. We want to do the work on the framework and then have a proper discussion about how we need to approach learning and evaluation



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against the priorities that are in the framework so we are lining everything up, rather than doing it piece by piece. That is the plan.

Q35 **Chair:** How are you going to make sure that works right the way across Whitehall?

**Anna Wechsberg:** That is exactly the plan, yes.

**Richard Gledhill:** Given that I have said I was disappointed about some other management responses, it is fair to say that I am quite happy with the response here. But we will be looking very carefully at this issue in a year's time.

Q36 **Chair:** You will be coming back and revisiting it, yes. Are there any examples of good practice here?

**Jonathan France:** I was potentially going to answer that question.

**Chair:** Are there examples of good practice from other DFID programming related to monitoring, evaluation and learning that could be replicated?

**Jonathan France:** I was going to say that one of the positive examples was the Fleming Fund. DFID and DH demonstrated that they had worked together quite effectively to develop a potentially robust evaluation for the Fleming Fund. It is a large investment, so it is quite right that it should have a strong and robust evaluation critically embedded from the start, so that lessons can be learned from inception through to the end of the programme. That presents a good model or approach. It does not have to be on the same scale, but other programmes could learn from it.

Q37 **Chair:** That is very useful. Finally, are there any mechanisms in place to maximise opportunities for shared working and development of joint working related to global health threats such as the DFID, DHSC and PHE visit to Congo-Brazzaville that was referenced in your response?

**Anna Wechsberg:** Sorry, what was that? I heard most of it but not the bit at the beginning that was the question.

Q38 **Chair:** I am just wondering whether there are mechanisms in place to maximise opportunities for shared working and the development of joint learning.

**Anna Wechsberg:** There is more we can do. The visit we referred to was really fantastic, actually. The feedback from that was really good. We can do more of that. As I say quite genuinely, the DHSC-DFID relationship is stronger than it has ever been. We are working very well together. I am not sure whether we need anything formal or structural. We need to make the structures we have, like the Global Health Oversight Group and the in-country work, work well. That would be my view.

**Chair:** Thank you so much for your discussion. That was really useful.