

International Development Committee

Oral evidence: Global Fund and GPEI, HC 2153

Wednesday 10 July 2019

Ordered by the House of Commons to be published on 10 July 2019.

[Watch the meeting](#)

Members present: Stephen Twigg (Chair); Richard Burden; Mrs Pauline Latham; Mr Ivan Lewis; Paul Scully; Mr Virendra Sharma; Henry Smith.

Questions 1 - 41

Witnesses

I: Laura Kerr, Senior Policy Advocacy Officer for Child Health, RESULTS UK; Mike Podmore, Director, STOPAIDS.

II: Dr Andrew Murrison MP, Minister of State for the Middle East, FCO, and Minister of State for International Development; Daniel Graymore, Head of DFID Uganda; Claire Moran, Country Manager, DFID Cambodia.

Examination of witnesses

Witnesses: Laura Kerr and Mike Podmore.

Q1 Chair: Welcome, everyone, to this session on global health, but with a focus on the Global Fund and the Global Polio Eradication Initiative. Welcome to our first panel, Laura and Mike. We will have about 40 minutes with you and then we have the Minister. We are seeking to cover nine areas in that time. We are going to start with some questions that will just be to one of you and then we will broaden out in the second half with questions to each of you. Let me start with Laura. Welcome. How close are we now to completely eradicating polio?

Laura Kerr: Thank you very much for inviting us to be part of the session today. When we think about where we have come on polio eradication and the fantastic work that the Global Polio Eradication Initiative has done, we have never really been in the place that we are. The stat that stands out for me is that we saw fewer than 40 cases in the last year, which is an amazing reduction of more than 99% in the last 30 years. 30 years ago, there were 40 cases every hour, so when I think about where we are now, through the power of the polio vaccine, more than 900,000 deaths have been prevented in that time. That is a lot of people in the world today who are walking, living healthy lives and contributing to their communities. I am really excited about where we are and for the next few years ahead and what more can be achieved.

Q2 Chair: Looking at GPEI, can you briefly say what its contribution has been to polio eradication, which I guess is a fairly obvious but important point, but then also to some wider health goals, because we are going to come back to that in a moment?

Laura Kerr: I do not think the world would be where it is today without the GPEI. When we think about the replenishments coming up and its strategies, it has got us to the point where we are, but it is also the only way in which we can reach the end goal. I do not need to reiterate the figures that I have just said, but looking at the investment in polio, it is funding health workers, fantastic surveillance systems and laboratories. It is making sure those health workers are in communities, making sure that children have polio drops but also making sure that the health of mothers is being checked and that they have been checked for other vaccines. The people and the money are really helping support the strength of immunisation and health systems.

Q3 Chair: GPEI's ambition is to achieve eradication by 2023, in four years' time. Is that attainable?

Laura Kerr: I like to stay optimistic. What we are really focusing on is a polio-free world and that is a long-term goal: the fact that nobody is going to suffer from polio. We are facing some of the hardest challenges in the world. We have two endemic countries. There are vast



humanitarian situations, the most complex positions in the world to make sure that people have access to polio drops and a number of other essential health services. Of course that is challenging, but the new GPEI strategy is going to drive urgency, effectiveness and efficiency in the programme to make sure that we are tackling those challenges as quickly as possible and in the quickest timeframe that we can.

Q4 Mr Lewis: Good afternoon. My question is to Mike. Obviously, the Global Fund is entering a new cycle, seeking \$14 billion in replenishment. There was a welcome announcement from the UK very recently of £1.4 billion. What do you think have been the key achievements of the fund thus far? As we think to the future, what lessons can be learned from the successes and the failures?

Mike Podmore: Thank you very much. The Global Fund has been an incredible institution since its founding, in 2002, and has made, as I think everybody agrees, really incredible achievements, not least—most importantly—saving the lives of 27 million people. It has made a contribution and been part of a partnership, working with other donors, civil society, the private sector, et cetera; it is a partnership that has made considerable progress against all three of the diseases: AIDS, TB and malaria. That fight is far from over in all three of those diseases and, to a greater or lesser extent, between them.

The key achievement of the Global Fund, as I mentioned, is very much this partnership working across all key stakeholders, with all implementing countries and donors, not just making progress against the three diseases but also addressing some of the underlying structural drivers for those three diseases, including human rights, gender inequality, stigma, discrimination, et cetera. We have made huge progress, but there is still a long way to go in each of the diseases, in particular in TB, where we are not making as much progress as the other two.

In terms of the learning that we could draw upon looking forward, there is so much that the Global Fund is doing right. It has a really coherent, strong strategy. As I said, it is making critical progress against all three diseases. With its partners, it is making progress in nearly all regions of the world, particularly in Africa, where there is the highest prevalence of the three diseases. There are some regions where we are not making the progress that we need, for example in eastern Europe and central Asia, in terms of HIV. There are some diseases where we need a lot more focus. The Global Fund is the biggest investor in TB globally, but it still needs a lot more funding and a lot more focus. There are some services that need a lot more focus, for example in prevention across the three diseases. There are some groups where, despite the Global Fund's right focus on those and being key parts of its strategy, there is a real need for a continued focus on key populations and on adolescent girls and young women.



The Global Fund is moving into its new focus in terms of how it allocates its money and which countries are eligible. There are some questions, taking a hard look at what we are doing well—and there is loads that we are doing well—but also asking where we are not making progress, and tweaking the model to address those areas. That might mean questioning how much funding we are putting into particular countries and groups, and looking at which countries receive funding. There has been a big question around the issue of transition and sustainability. It is about how we ensure that we sustain the progress that we have made, particularly as countries move into middle income and upper middle income country status. There are many things more I could cover, but I will stop there.

Q5 Mr Lewis: That was a good, comprehensive answer. We all acknowledge the progress that has been made—I think there would be consensus on the Committee about that—but the SDG target for each of the conditions is not being met. To meet those targets, is replenishment the issue? Is it just about the replenishment? Is the replenishment ambitious enough, in terms of the fact that we are not on track to meet those targets?

Mike Podmore: In terms of the replenishment, as you know, the Global Fund set the target of \$14 billion. It did so trying to set a target that was what was needed, and that target definitely gets the Global Fund back on track to meet the Global Fund targets by 2022. That is very important. Unfortunately, the \$14 billion target does not get us back on track to reach the SDG targets on AIDS, TB and malaria in order to end those three diseases by 2030. There is definitely a financing gap, and the Global Fund itself has been explicit in saying the \$14 billion is the minimum it needs in order to get back on track. As civil society, we have been very robustly calling for all of the donors to step up well beyond, if possible, the 15% increase that the Global Fund asked for. Of course, we were really pleased to see the UK hit that by committing to a 16% increase.

To answer your question, the money is absolutely fundamental, of course. We cannot get around that, but, as I referred to in my previous answer, it really matters where we focus and how we make difficult decisions about where the funding is targeted and the type of interventions we support. Also, crucially for the Global Fund, it is about how it works with the broader global health institutions to have the most impact that it can.

Q6 Mr Lewis: In terms of the three specific diseases, there are challenges for each of them and we have specifically said TB particularly. In a nutshell, what would you identify as the outstanding challenges in each of those diseases? Maybe focus your answer on TB, because that is where we have the greatest challenge.

Mike Podmore: I have mentioned quite a few on HIV. We have a massive challenge ahead of us with TB. It kills more people each year than HIV and malaria combined. With the majority of the burden concentrated among adults of working age, the implications are vast. A



third of all cases of TB remain undiagnosed and untreated each year. Diagnosis and treatment, finding the unreported and unfound cases, are really important, so there is a major focus on that. Progress is being made in a number of key countries, India being one. This is absolutely fundamental because the numbers are stratospheric there.

Drug-resistant TB is a massive area of need, particularly in eastern Europe and central Asia, but also more broadly, and MDR-TB. If we do not make progress against drug-resistant TB, we face a serious global health security crisis.

The last thing to mention on TB, which I alluded to earlier, is the Global Fund provides two-thirds of all international financing for TB. There is a challenge within the Global Fund in terms of the split between how much it spends on the three diseases. The Global Fund will be looking at that split in the next strategic period, to review whether that needs to be adjusted, but there needs to be significantly more investment by all major donors in TB. It is not enough, for example, to just say, "We will invest with the Global Fund and that is it", so we call on the UK Government to put much more focus on TB.

Q7 Chair: Mike, just to follow up Ivan's question on the \$14 billion, could you put a figure on what we really need? Is it possible to put a figure on it?

Mike Podmore: Yes. There is a network that we are a part of that unites all advocates working on and supporting the Global Fund globally; it is called the Global Fund Advocates Network. Based on the Global Fund's own figures, it produced a *Get Back on Track* report, and that estimated, based on all the figures from the technical partners, UNAIDS, Stop TB, et cetera, that we would need \$16.8 billion for the Global Fund. You can see that there is still a substantial gap, and that \$16.8 billion is what is needed to get us back on track for the SDG targets.

Q8 Paul Scully: Sticking with you, Mike, you have talked about the reaction to the UK pledge. Aside from the obvious financial benefits of the UK being a major donor within that replenishment, what additional added value does UK involvement bring?

Mike Podmore: The UK's involvement, apart from the money, of course, which is fundamental, is it plays an enormously valuable role on the Global Fund board. They are very active; I am also a board member of the Global Fund, so I have the opportunity to see that first hand. I work very closely with Sarah Boulton and Danny Graymore on a number of issues, and they are always asking probing questions and pushing the Global Fund, in a collaborative and supportive way, to have the most impact that it can. I cannot emphasise the importance of that role enough.

That has also been articulated in the performance agreement that the UK has attached to the funding that it gives. The UK also did a performance



HOUSE OF COMMONS

agreement last time, in 2016. The performance agreement is attached to £100 million of the commitment, and that links to particular aspects that the UK Government feel very strongly that the Global Fund needs to deliver on. It is important to be clear that they are not directing the Global Fund to do things that it has not committed already to do. That would not be right, because the direction of the Global Fund is determined by the board and all the partners within that. What the UK does, through that performance agreement, is highlight particular areas where it thinks it is critical that progress is made. It holds the Global Fund to account for the things it has already committed to. There are particular areas around its work on health system strengthening, UHC and a focus on the poorest and most marginalised. These are all, I agree, critical areas that it needs to focus on.

The other thing that the UK Government can do in the context of replenishment is use the fact that it has made a 16% increase to leverage other donors to step up. The UK is the second biggest donor to the Global Fund and the fact that it has made such a large increase gives it the clout to be able to turn around to all other G7 and G20 donors and say, "Okay, it is now your turn to step up".

As we go forward, and I alluded to this earlier, the UK's role through its bilateral programming is also fundamental. The UK cannot sit back and say it is only funding, through the Global Fund, for AIDS, for TB or for malaria. It really has stepped up and put a strong focus on malaria, which is great. Its bilateral funding for HIV has been going down considerably over the last few years, which is something we have highlighted to the IDC over the last couple of years, and it is the same with TB. It needs to be working in partnership, leveraging not just its financial interventions but its programmatic expertise and skill.

Q9 Paul Scully: You talked about the performance agreement. Obviously, there are some priorities identified in there: to improve leadership and collaboration, organisational effectiveness, impact on the three diseases and sustaining the fight against the three diseases. Do you think those are the right focuses for attention, or is there anything else that perhaps should have been included?

Mike Podmore: I agree with all the areas that are highlighted.

Paul Scully: I suspect, as a board member, I could probably have predicted your answer.

Mike Podmore: Yes. I agree with all the areas that have been highlighted. The integration of Global Fund programmes into national systems is one of the key challenges for all of the Global Fund countries, but especially as the Global Fund starts to reduce its funding and as donors are leaving upper middle income countries particularly, how we ensure sustainability of the programmes and the investments made is critical.



HOUSE OF COMMONS

There are different perspectives about the extent to which the Global Fund should still be funding some upper middle income countries across the board, but the recognition that we need to build that sustainability and build national ownership and increase domestic resource mobilisation is key.

Everybody agrees that prevention needs considerably more focus. I have spoken already about the focus on the poorest, most vulnerable and marginalised. The challenge is the extent to which we are focusing on the poorest countries or whether we are focusing on the poorest and most marginalised people, wherever they are. There is an active debate on the Global Fund board about how we manage that and make those difficult trade-off decisions.

Yes, there are more things that could be highlighted, but I definitely support all of the things there.

Q10 Paul Scully: What is the likelihood of the Global Fund meeting its ambition of \$14 billion? Are other donors stepping up sufficiently for it?

Mike Podmore: It is looking very positive. When I and my civil society colleagues started the whole replenishment process, we had \$16.8 billion that we knew we needed. We were not so happy with the \$14 billion, but we recognised it was realistic to get back on track. Things are looking very positive. For the donors who have already pledged—Portugal, Luxembourg, Ireland, Japan and now the UK—nearly all have increased substantially, in many cases well beyond the 15%, so that is looking very strong.

The key question now is those that remain and there are some big ones. First, there is the US. Despite some of the political realities in the US, there is strong bipartisan support from Congress. The House has provided and committed to \$1.56 billion in financial year 2020, which is nearly a 16% increase. The US provides one-third of all the funds to the Global Fund, so this is very important. The Senate will act in the coming weeks, but we think there is strong support there as well.

The Germans look likely to increase substantially, up to a billion. That just needs to go through Parliament, but it has been put on the table. The big question is the French Government. They have shown strong leadership by hosting the replenishment but have been quiet about whether they will increase. The UK pledge of a 16% increase really puts the pressure on them, particularly if maybe they want to become the second biggest donor and overtake the UK.

Q11 Mr Sharma: Laura, until recently, the intention was that the GPEI would begin to wind down in 2019, in the hope that polio eradication would have been achieved. Instead, as a result of recent increases in cases of polio, the GPEI has released a new strategy for 2019 to 2023 called the endgame strategy. Given that the previous strategy also had the words “endgame” and “eradication” in its title, what is new in the GPEI’s polio



endgame strategy that will help it achieve eradication? That is a long question.

Laura Kerr: We are happy to answer it. I was really excited reading the new strategy. The GPEI has an independent monitoring board that, every six months to a year, releases reports. Through these, the GPEI has done really detailed evaluations, especially in endemic countries, about what it needs to do to finish that endgame. I like to focus not too much on the fact that there are similar names but on where we are going. As I said before, it is about the polio-free world we want. Yes, there are some dates we wish we would have hit and we are still working towards that.

A big focus of the new strategy is on real integration and partnership. That is a recognition that we have seen from the GPEI, from all the global health multilaterals and, thankfully, from the work the UK does also to push that through the agenda. There are key challenges, especially in Afghanistan and Pakistan, in places where there are humanitarian situations and conflict, and people are not being reached with any essential services. If we are lucky enough to get a polio vaccinator there, there is resistance and there are other challenges in those situations. I really recognise that if we are working in partnership we can make sure that those children and families have access to other essential services, so working with partners who work on WASH, nutrition partners, making sure those children have other essential vaccines that they are more likely to uptake. There is a lot in there on the focus on that integration and partnership.

There is a lot of focus on the financial resources that are needed. Ultimately, we will not get to our endgame without them, but the challenges that we face are more than that: they are political; they are about the strength of the health system in these countries, but also other countries that we need to make sure have strong immunisation coverage, to make sure we see that global protection around the endemic countries as well. There is a real urgency and focus on the effectiveness and efficiencies that the GPEI can make to make sure that it is not just making sure children get polio drops but is being much more comprehensive, learning from its 30 years of experience, building on what it knows. As you know, there are fantastic successes that we have seen in India, which 12 years ago had 70% of all polio cases and has now been polio-free for five years. That is amazing and there are so many lessons there that are being brought through into equally challenging situations.

I certainly feel very hopeful with the new strategy. We are seeing the interlinkages more with Gavi, the Vaccine Alliance, as well, which is really promising. It makes sure that not only are we using the techniques that the GPEI has developed over the last 30 years in reaching every household, but that we are also looking at how we can be innovative and adapting, so that we can reach the very last child and that we are reaching them with a lot of other services as well.



Q12 Mr Sharma: Why do you think that the previous strategy failed or was not successful in achieving eradication? Is it that it started winding up earlier?

Laura Kerr: There are two parts to that question. It is quite harsh to say that the last strategy failed. There have been enormous efforts by the GPEI partners themselves—

Mr Sharma: Maybe unsuccessful.

Laura Kerr: Of course we wish that we did not have another strategy, but it is just the external circumstances. When we think of those pockets of children who are not being immunised in Afghanistan and Pakistan, the partners—WHO, UNICEF, CDC, Rotary—are doing everything they can and there are examples of health workers being banned from doing house-to-house vaccinations when there is so much they could do.

You asked if the wind-down affected where we are. One of the most important things is that we talk about eradication and we talk about that word “transition”, but it is not one or the other. We cannot think about this endpoint of whatever date we want to set it and then think about sustainability and what comes next after that. What we are doing now, and the new GPEI strategy sets it out in terms of integration and partnership, is thinking about the long-term sustainability of making sure that, even after we have seen the last case, children are still going to need to be vaccinated for 10 years. We are going to have to have robust, essential immunisation systems that deliver polio and all the other essential vaccines that every child deserves. We are seeing that, but we need to make sure that is happening now.

There has been a real focus, which has been fantastic to see, from the UK Government, on making sure that we are not pitching the idea of eradication, sustainability and transition against each other. Ultimately, the end goal that we want is a polio-free world. We are not going to be able to focus just on what we are doing in delivering the polio vaccine, but on the strength of the essential immunisation and health systems around that as well.

Q13 Mr Sharma: GPEI will be holding a pledging moment in Abu Dhabi in November and seeking \$4.2 billion. The UK previously committed £300 million to GPEI between 2013 and 2018 and announced a further £100 million in August 2017, in what DFID described as a final push to make polio history. Is there a case to be made for further funding commitments from the UK for a final final push? What is the current funding gap and what would you like to see from the UK in terms of a pledge?

Laura Kerr: Those are great questions. As I opened with, we are so close to eradication, far closer than we have ever been and we are going to need that continuous and ambitious investment in the GPEI as the best and the only way we can reach that end goal. The budget itself, the strategy and a summary of the investment case was launched in May,



which sets out, as you say, the \$4.2 billion. The GPEI is looking for \$3.2 billion of that to make sure that the strategy is implemented. We are really hoping that the UK will commit £400 million, which will enable the GPEI to implement the new strategy. By contributing that £400 million, it will ensure that no child is left behind and that we are reaching every child with the vaccines they deserve for these diseases that are preventable.

Could you repeat the second part of your question, just to make sure I cover it all?

Q14 Mr Sharma: Is there a case to be made for a further funding commitment from the UK for a final final push, and what is the current funding gap?

Laura Kerr: The case to be made is really strong. As I said, we are nearly there. There is a fantastic new strategy from the GPEI that brings that urgency into what we need to do to tackle the hardest challenges that the world faces in eradicating this disease. There have been amazing cost savings already made and amazing economic benefits from the importance placed on investing now to make sure that we see those economic savings in the future.

Ultimately, now is not a time that we can step back. We know where we are in terms of polio eradication. We are not at that stage, although we would love to be, with TB, HIV or malaria. We have seen the past investments, but now is the time when we can really excel that. The investments we see in the GPEI, that we have seen for the Global Fund and that we hope to see from the UK Government next year on Gavi are all essential parts of how we are going to accelerate progress to all our other health goals. The money that you are investing in one of the funds is having a downward and ripple effect on the overall health system that we are trying to create, so everyone has access to the polio drops and all the other essential health services.

Q15 Mr Sharma: What are some of the country-specific challenges that GPEI faces and how does the new strategy propose to deal with these?

Laura Kerr: I do not want to go into too much detail in terms of Afghanistan and Pakistan; they are conflict zones and we are dealing in an emergency setting with what is happening there. The GPEI strategy again is very strong on what we have seen in cases of vaccine-derived polio, which are there because there is low polio vaccine coverage in other countries. The strategy again is very strong on how we build global immunity towards polio, protecting all countries around us, because when we have polio in one country there is always that risk, and there are some scary figures out there about what could happen. I will leave it there.

Q16 Richard Burden: Could we move on to wind-down? I think I am right in thinking that there has never been a global development programme of



the scale of GPEI that has ever had to be wound down before. Could you tell us if you think there is a clear and concise strategy about how that will happen? Maybe in answering that you could say something about what you think the risks and opportunities are there and if you think there are any particular asks that need to be made of DFID in that process.

Laura Kerr: There has been a lot of work done over recent years, particularly led by the WHO. There is a WHO Strategic Action Plan on Polio Transition that is guiding the process going forward. They have a new team driving the development of transition plans going forward. There are certainly ways in which that process could be clearer as we see the extension of the GPEI over the next few years. In terms of wind-down, there is clarity that could be provided by the GPEI and the WHO going forward, to make sure countries are very aware of exactly when the next stage of that funding is going to change and by what amount. There have been fantastic efforts by the WHO to develop transition plans that are at different stages of implementation.

In terms of the risks and opportunities, RESULTS UK has done quite a lot of work on this. One of the opportunities is to look at, if polio funding is changing and is so essential to the immunisation system, what the needs are that are there and how we make sure they are all met. It gives the opportunity for reflection and to take that as an opportunity to strengthen the whole system, to make sure children have all their vaccines. Unfortunately, we think if that process is not managed and we do not see transparency, clear communication and clear and proper planning over the next few years, there are some risks there. The support that the GPEI is giving, largely through WHO and UNICEF, has been directly supporting disease surveillance, outbreak response, community mobilisation, health education and supply chains. We feel that if we are not adequately analysing what the change will be when polio funding is not there, there is a risk to the wider services.

In terms of UK asks specifically, as I said, the UK has been a fantastic champion of this, using the processes through the World Health Assembly and through sitting on the different strategic committees of the GPEI, and has been very strong and vocal. We just need the UK and other donors to make sure they are holding the GPEI to account on its responsibility to make sure that countries are adequately prepared and planned for, and that the process for transition, similar to what has been mentioned for the Global Fund, is done, by looking at who the people are who will be missed and how we make sure the process does not exacerbate any of the inequalities that exist. It also must ensure that we are not using it to just stick a plaster over what the gap is now, but using it as an opportunity to look at what we need to do to make sure that we are making progress towards the health SDGs specifically.

Q17 **Richard Burden:** You mentioned disease surveillance there. The GPEI accounts for about 70% of global disease surveillance funding. Do you



think there is a real risk that it will become underfunded in a post-GPEI world? At a more general level of the transition, which countries do you think are most at risk if we do not get the transition right?

I have a final question to add to your list: in your paper, *Polio Transition*, you said that there really needs to be some kind of global governance mechanism to oversee the transition from now until we reach the point of final eradication, but not to stop there—for it to go on for about 10 years afterwards. Could you perhaps say something about how you see that mechanism being established, how you see it operating in practice and again, as far as DFID is concerned, what role you think the UK could play in that?

Chair: If you can answer all of that in one minute, that would be even better.

Laura Kerr: I will do my very best, but I was told to talk slowly. The risk of surveillance is high, yes. At an African regional level, there is a lot of work being done by the WHO to come up with a plan that is costed and can help guide donors and country Governments with their domestic resources there. The risk is high and there is a lot more the WHO could also do, as the technical body linked to this. In simple terms, yes, we need to make sure that that is high on the agenda, but there are conversations happening about it.

The biggest risk if we do not get transition right is that children are not going to be immunised; we risk not having a polio-free world and we put at risk the immunisation systems, which we talk so much about as a global success story, which is fantastic. We have the highest number of immunised children that we have ever had, but there are still one in 10 kids who do not get any vaccines, so the risk is that in the whole infrastructure we could lose the gains from that as well.

In terms of governance mechanism, at the moment, the WHO is playing a leading role, but with what we are going to see with transition, it cannot just be a polio transition plan, an immunisation plan, a Global Fund transition plan. The governance mechanism really needs to bring lots of different partners from different sectors together to make sure that we are working collectively. Donors have an important role to play there, to make sure that multilateral investments, bilateral investments and other philanthropic investments are all supporting country ownership to take forward their national plans. The governance mechanism could be something like the independent body that has been set up for the GPEI. It has a transition independent monitoring board, and it would be great to see that continue and also expand the membership so that other health services are brought in.

Q18 **Henry Smith:** Mike, let me ask you a question. To what extent do you think that the Global Fund and the GPEI contribute to the UK's international development strategy, including progress towards the SDGs?



HOUSE OF COMMONS

Mike Podmore: I can particularly talk about the Global Fund; maybe you can pitch in on GPEI.

Chair: There is no time, so this one is just to you.

Mike Podmore: The Global Fund is a critical piece in the UK's international development work on global health. As we have been discussing, the Global Fund is a critical part of the jigsaw of the global health architecture that will really deliver a response to the different diseases, but of course also for broader health system strengthening and the realisation of universal health coverage, as well as the impact that it has on other SDGs, such as SDG 1 on poverty, on education, on gender equality, on inequality and on partnerships.

The role within the UK's international development strategy is two-fold. Obviously, it has an impact on three of the most deadly diseases the world has ever known and there is the impact on saving lives, and then there is the ripple effect that that has on the other SDGs that I mentioned, the economies of countries and achievement of the UK's international development objectives.

It is a critical component of global health, as I mentioned, not least because of the impact that it has in terms of lives saved, but also in terms of the health-system-strengthening work that it does, creating the models and mechanisms through which then a broader, successful health system can be constructed. Much of the success of the Global Fund is a beacon for other diseases that have not had as much funding and support, but also for how things can be done to reach the poorest and most marginalised. There is a real tension there for the Global Fund about how it continues to keep focused on its mandate to end the three diseases while, at the same time, investing and building health system strengthening and UHC, and that is something that the UK is very much focused on.

The other aspect to highlight is how the Global Fund operates as a model, as a public-private partnership in terms of, as I mentioned earlier, bringing all the key stakeholders together in the way that it operates and makes its decisions. I would also highlight how it ensures that it has impact and that it manages the large amount of funds that it has been invested in effectively. The fact that the Global Fund does this so well and that the UK Government invest in that is a really strong demonstration of how powerful investment in multilaterals can be. That also sends a strong message about the type of development that the UK wants to invest in and the types of mechanisms that it thinks are effective.

Q19 **Henry Smith:** Thank you. In that answer, you have anticipated my two next questions and answered them, in terms of Global Goal 3 and universal coverage. There is one very quick additional question, if I may, which is on HIV. As you will appreciate, women account for more than half the number of people with HIV and young women are around twice as likely to contract HIV as young men of the same age. To what extent



does the Global Fund treat HIV as a gender issue?

Mike Podmore: The Global Fund, in partnership with technical partners such as UNAIDS and others, is very clear that adolescent girls and young women, particularly in sub-Saharan Africa, are some of the most affected by HIV, and you cited some of the statistics there. It is still the leading cause of death of women of reproductive age in low and middle income countries; nearly 1,000 adolescent girls and young women are infected with HIV every day worldwide. Peter Sands, the executive director of the Global Fund, is absolutely clear and speaks very strongly about how important this is to the Global Fund. That is demonstrated in the fact that gender equality is a fundamental objective in the Global Fund's strategy. It is committed to promoting gender equality; it is a strategic pillar of its work and a core objective of its strategy and will continue to be so.

Some 60% of the current total spending of the Global Fund is directed towards achieving results for women and girls. That statistic speaks for itself. It has invested \$18 billion between 2002 and 2017 in work on women and girls and has set some really bold targets as well. It has set a target to reduce the number of new HIV infections among adolescent girls and young women by 58% in 13 African countries over the next five years. It is using some of this work to attract some investment from the private sector as well, which is really important.

Chair: Thank you both very much indeed for your evidence today. I invite the Minister and officials to join us now. Both of you are welcome to stay in the gallery if you wish to hear the second panel. Thank you.

Examination of witnesses

Witnesses: Dr Andrew Murrison MP, Daniel Graymore and Claire Moran.

Q20 **Chair:** Minister, welcome back. This is your second appearance before us and your second opportunity today to talk about global health, because we had the debate this morning in Westminster Hall. Let me start by saying, very much on behalf of all of us, how delighted we were by the pledge on the Global Fund. In a moment, Paul will ask some more detailed questions about the UK pledge of £1.4 billion, but I felt it right to start with that.

Let me begin, Minister, by asking you this: evidence from the WHO suggests that the targets in the Global Goals on HIV, TB and malaria are not on track to be met. What role do you think the Global Fund's replenishment can play in getting these targets back on track?

Dr Murrison: Thank you, Chair. It is a great privilege to be back here, to entertain you for a second time, particularly given this morning's outing.



What I would say is there was a degree of what is called optimism bias in what was likely to be achieved and you are right to point out that SDG 3 and particularly 3.3, which is the focus of the Global Fund, is not on track. I am sure we will come on to discuss polio as well and there is a very real risk there, too, that if we do not keep up the pressure we will slip back. Although what we are looking at are really huge sums of money and they require some justification, despite our misplaced optimism, if we do not continue the pressure then we will slip back on these “captains of the men of death”. We have to acknowledge the huge number of lives that have been saved because of these projects and these big multilateral funds. Cutting the numbers of deaths by a third since the inception of the Global Fund is extraordinary. We forget sometimes what has been achieved.

Chair: Absolutely. I agree with that.

Dr Murrison: I said this morning that I thought the glass was half full and half empty and that remains my view, coming to this relatively fresh, but I am quite clear that these big funds represent best buys and that we should all be proud of the achievements that they have made and our part in that.

Q21 **Chair:** You rightly say that these are huge sums and the \$14 billion figure is a very large figure, but is it ambitious enough? We have just heard from the first panel that there would have been a case for it to have been just that little bit more to really fulfil the objectives in the Global Goals.

Dr Murrison: There is some science behind this. This is something that the Global Fund itself has come up with and it believes that we can grip these epidemics using the sum of money that it has formulated. We have responded to that and have upped our donation by 16%, early, as I pointed out this morning, which I hope means others will follow. It is not just about money; it is socio-political and it is working with host countries as well. You were talking a bit about transition earlier on and we might touch on that. That means working with the Governments of the countries principally affected by this, so I do not think it is just money, though clearly money is central to it.

Chair: I absolutely agree.

Dr Murrison: It is our best guess, or the best guess of those who are in a position to know, based on some science, some epidemiology, and I hope it is enough. I hope this round will start to make progress on the three big diseases and, of course, contain polio.

Q22 **Chair:** Just on polio, before I pass over to Paul, the GPEI recently released a new endgame strategy in which they seek to eradicate polio by 2023, so in four years’ time. The previous strategy, of course, was to seek to eradicate it by this year. Do you think the GPEI has reflected sufficiently on lessons learned from previous performance, so that this time it might hit that target?



HOUSE OF COMMONS

Dr Murrison: I think it will. I hope it will. I think we will get some good news soon from Nigeria, for example—very soon—so the focus then will simply be Afghanistan and Pakistan. That is one epidemiological block, so there will be a real focus on that particular part of the world. The difficulty is that you deal with low-hanging fruit first, do you not? What we are left with is a rump of real difficulties, as you will appreciate. We are trying to get into these areas and communities that are deeply sceptical about any form of intervention. They are hostile in some cases; there have been some tragedies recently. April was not a good month to be a vaccinator in Pakistan. I really do take my hat off to those people; they are unsung heroes. It just shows you the difficulty of dealing with the residual problem that there is, as well as, of course, making sure that this does not spring up elsewhere, which is why it is important to continue with the vaccination programme into transition.

Chair: Let me absolutely echo what you said about the aid workers in Pakistan and what happened in April.

Q23 **Paul Scully:** I echo Stephen's appreciation of the early and increased pledge, and that is what I wanted to just open up with—how you arrived at the UK figure. You talked about the science behind the \$14 billion, but how did you arrive at the UK figure of £1.4 billion and the rationale for announcing it three months before the due date?

Dr Murrison: The rationale is clear: because we hoped in doing so at Osaka that other countries would note, respond and step up to the plate. It is the ideal forum to do it, so there seemed no reason to delay it to Lyon in October; it was far better to do it now. That question is relatively easy to deal with.

In terms of the sum, obviously it is a question of responding to the ask. As I said before, there is a bit of an evidence base for that in terms of the amount of money that is considered to be necessary to get on top of these conditions. We wanted to do better than we had done before, in order to display leadership. Given that we spend 0.7% of GDP on international development, this is all ODA-able, and this represents the best buy. Spending money through these multilaterals is the best way, generally speaking, of achieving a result. That is really how we came up with the 16%.

There are caveats to some of it, as you would expect. It is hedged around some performance vehicles within it, which we have retained, so we do expect the fund to continue to perform. We have no reason to suppose it will not, because it is among the very best performers of the multilaterals, but it is important that we continue to maintain the pressure.

Q24 **Paul Scully:** You have talked about "best buy" a couple of times now, and it is interesting that you talk about those performance vehicles. Can you talk a little bit more about those? I want to explore how you are going to maximise the best use of the money that the UK, in particular, is



HOUSE OF COMMONS

giving.

Dr Murrison: Obviously, the UK Government have certain imperatives of their own. It is important not to insist upon too many caveats, because clearly we want freedom for the professionals to get on and deal with these issues. One of the things that you were discussing in the earlier session was the position of the most marginalised. We are very keen that we should, within the money that we have given, see results in terms of those who might be left behind. That is one of the examples of the performance indicators we will expect to see in order for us to fully disburse the commitment that we have made.

I have to say the money potentially retained—do not expect it to be retained, I should add—is a relatively small part of this; it is £100 million of the £1.4 billion, but it is a significant sum and just puts a little bit of pressure on the Global Fund to make sure that it does what it says it is going to do in any event, but which the UK Government feel particularly strongly about.

Q25 **Paul Scully:** The same question was asked in the first session: there is the obvious financial benefit of the increased amount that the UK is giving, but what additional benefit does UK involvement in this fund bring, in terms of the overall impact of the project?

Dr Murrison: Do you mean apart from £1.4 billion?

Q26 **Paul Scully:** Yes, there is the obvious financial benefit, but is there additional value, as it were?

Dr Murrison: We bring, I suppose, a sense of direction. We have our own imperatives. We are particularly concerned about gender inequality and those sorts of issues. We feel quite strongly that there does need to be proper accountability and it needs to be results-based. In terms of universal health coverage, we want to make sure that this money is spent effectively. We bring a bit of steel to this, if I am honest with you, which I make no apologies for. My constituents and yours, if we are honest, tend to be a bit sceptical, very often, about international development. If we are to defend it, we have to be able to say that we go to quite a lot of effort to ensure that the money is being spent in a way that is going to demonstrate results. Those are the kinds of things that we bring to this, apart from the obvious £1.4 billion.

Q27 **Paul Scully:** According to the Global Fund website, in the 2014 to 2016 funding cycle, the UK pledged £1 billion and contributed £800 million. For the 2017 to 2019 funding cycle, it pledged £1.2 billion and, so far, has contributed £830 million. What accounts for the difference between the pledge and the contribution?

Dr Murrison: You are right to raise that. I have to say we do expect the whole £1.4 billion to be disbursed, but there are various things: matched funding was involved in some of that; there was burden-capping; in the earlier tranche, we did not disburse some because the others did not



HOUSE OF COMMONS

come up to the plate; there are also the aforementioned targets we expect to be met and, if they are not, in previous tranches the money has not been paid out. That probably accounts for the difference.

Q28 Mr Sharma: As part of the UK's pledge, a performance agreement was published between the UK and the Global Fund. Part of this agreement states that the UK is expecting a return of £19 for every £1 invested in the Global Fund. Is this a realistic figure and how will it be measured?

Dr Murrison: I believe it is. It sounds like quite a lot, but a lot of the interventions we do make have very large returns, so whilst this is a best buy, it is probably not the best buy. If I was to compose a list of supposed returns and, again, there is some science behind this, the Global Fund would not be number one, but it is a substantial amount. There is a methodology. From memory, it is called Copenhagen; I think it is named after the city of Copenhagen. It is an internationally recognised methodology that gives you a notional money return. It will involve productivity and things of that nature, and money that is not otherwise disbursed in treating the consequences of, for example, polio. That is how it is measured.

Q29 Mr Sharma: What will happen if this is not realised? What action, if any, would the Department take?

Dr Murrison: Having celebrated the amount of money we are spending on this, I have added the caveat that we are in real danger of slipping back. With multidrug-resistant TB, for example, the picture with TB is not great. We are in danger of slipping back in terms of malaria as new threats emerge: climate change, increased population, issues with insecticides and therapeutics and resistance to those. There are the difficulties we have, particularly with HIV/AIDS among women and girls, tragically. This is not an unadulterated positive picture. Clearly, if we do not continue to keep the pressure up in the way that we are, there is a real risk that things will not just keep getting better but will start slipping back. Nowhere is that more the case than with polio, and one of the real risks is that the global community will think, "Polio is pretty much settled, is it not? There were 33 cases last year. Why are we spending all this money on polio?" You have to measure the cost of taking the boot off the jugular. As far as polio is concerned, it would be enormous, in terms of human tragedy but also money cost.

Q30 Mr Sharma: The agreement also says that the UK expects high quality, collaborative leadership from the Global Fund. Could you expand on this?

Dr Murrison: We are fortunate in having Peter Sands as director. We are confident with him. I have met him and have given him the same sort of light toasting that you are giving me. I find him convincing and impressive and I am sure under his leadership the fund will do extremely well, but you are aware that all of these have a board; it is not run by an individual. We have various ways of making sure that performance is on track, the money is well spent, that there is oversight and the thing is



audited, and there are experts; Liam Donaldson, for example, is involved with polio. There is a whole raft of checks and balances that, collectively, should enable us to have real confidence in these big funds. Of course we do our own annual appraisal and we do mid-term reviews. We use everything we can to ensure that the money is being well spent and, ultimately, will generate results.

Daniel Graymore: Might I add something on the point about collaboration, if that is acceptable?

Chair: Please, yes.

Daniel Graymore: Thank you very much. Thank you, Minister. I just thought I would pick up on the point about collaboration, which is also a key element of the performance agreement going forward. We are talking about the Global Fund now and will be talking about GPEI, as well, on the polio side. Next year, we are hosting the replenishment for Gavi, the Vaccine Alliance, and there are other very important global health funds.

It is critical that we see, as we have seen over the last few years, ever greater collaboration between those funds, both in the way they operate globally but more so in the way they operate at the country level. They are all investing, in various ways, in health systems. They are all looking to address bottlenecks around the supply chains, around data, staffing and health resources at the country level. What we want to make sure is that they are collaborative and integrated in the way they work, and that they are well aligned behind Government priorities at the country level and are building long-term, effective, sustainable systems, so we can move towards achieving universal health coverage. For the Global Fund, for Gavi, for all the instruments, we are going to be really keen to see this strategic, collaborative approach, to make sure that we are seeing not only the results that they deliver but stronger systems, so we can achieve UHC and long-term sustainability.

Q31 **Mr Sharma:** Between 2013 and 2018, the UK committed £300 million to GPEI and a further £100 million in August 2017. GPEI will now be seeking further pledges for the period 2019 to 2023. Is the UK planning to make further pledges?

Dr Murrison: That decision has not been made yet. I expect there to be a determination fairly soon. Given the lead that we have already given in relation to the Global Fund, given the fact that we are hosting Gavi next year—and the reason for that, clearly, is that we are the number one contributor—given the need, as has been touched upon, for collaboration between all of these health-related multilaterals, it is pretty clear that we will be likely to fund this fairly well. I have also said what I think about polio in respect of not letting up on the pressure. It would send a very bad signal to the international community, at this point, for the UK to be trying to row back on polio, so I think you can be sure that we are likely to be supportive of this programme.



Of course, there does come a point when it has to transition, and it is interesting to explore where this ultimately lands up. That is why it is important for there to be discussion between not only the multilaterals but also host Governments, because this does need to be folded into health services domestically. You can only do that if you have robust health services to sustain this, and that is where a lot of the conversation is going to be in the very few years ahead.

Q32 Chair: Minister, you have tantalised us with that response. Can you give any sense of when we might have a UK pledge on the polio initiative?

Dr Morrison: I am not sure. I think it is right to say probably by the end of the year.

Daniel Graymore: I think that is a fair comment. There is a pledging event, as I am sure you are aware, in UAE, in November. You will also be aware that the strategy, as you have mentioned, has only recently come out, so we are looking very closely at that. You will also know that we are observers on the polio oversight board and represent donors on the strategy committee, so we have been quite closely involved. We have been very keen to make sure that the polio programme has learned from where there have been challenges, particularly, as the Minister said, in Pakistan and Afghanistan, as the key countries, and also is learning about the collaboration and integration agenda. We are looking at all of that in the round. Hopefully, either at UAE or shortly thereafter, we should be in a position to announce our commitment.

Chair: You have certainly set a great example on the Global Fund of pledging generously and early, which I would encourage you to follow in this example. I would also encourage the education parts of the Department to follow the health example in pledging early on Education Cannot Wait.

Q33 Mr Sharma: You have partly answered this question, but do you accept that by under-funding GPEI now there is a risk that even more will need to be spent tackling the spread of polio in the future?

Dr Morrison: Yes, and there are some good figures that have been crunched to suggest what it would cost. It may be that you have had some material about the epidemiology of polio, but it is important that we keep up OPV and the inactivated polio virus as it is introduced, and that there is an overlap between the two; otherwise, we are likely to start slipping back. It is quite a complex piece of epidemiology that has to do with the way the polio virus behaves in its uniquely human host. All of this means that it is important that we continue the pressure on this. As you will be aware, there will be calls to row back on this particular initiative because of the wild polio cases, which are very few indeed now, but it would be a mistake to do so at this juncture. However, we do have to start talking about transition, making sure that preventative measures continue, but probably using a different vehicle from GPEI as we come towards the end of this programme and celebrate it, of course.



Then there are other things we have to consider about what to do with this virus. This joins a very small group, with smallpox, which has now been completely eliminated and all of it has been destroyed. We are going to have to discuss which containment facilities keep this, for how long and how it is destroyed, and then we can celebrate.

Q34 Richard Burden: Staying with transition, given that GPEI will eventually be wound down, could you perhaps say a little more about the dangers, the risks and the opportunities that you see in that? In particular, could you say something about what role you think DFID will have going forward? One example would be your position on various technical working groups. Is there some way DFID's position on those could be used to make sure that wind-down does not negatively impact particularly on routine immunisation programmes, to make sure that the investments that have been made have a legacy that lasts?

Dr Murrison: It is fortuitous that we are hosting Gavi next year. I think the Chair would say it would be particularly fortuitous if it was hosted in Liverpool.

Chair: Absolutely. Thank you.

Dr Murrison: For which there is a very good case, and I am not short of people lobbying me on this matter.

What I would just observe is that the polio eradication programme has not simply been useful with respect to polio. Actually, the second Ebola outbreak was discovered because of the surveillance involved in that programme. That demonstrates that these programmes do not exist in isolation; they contribute to the whole. It also suggests that after the elimination of the condition concerned, there has to be a way of continuing the structure that has been set up in order to deal with, in this case, polio. It is important to try to roll over the public health gains that have been made in respect of polio so that other conditions are addressed after this. Clearly, there will be a whole raft that we are going to continue to have to deal with.

The Global Action Programme is part of that. The Global Fund is part of that, clearly, and it is very good that Gavi and the Global Fund are being co-located now. That will be helpful in terms of developing perhaps a more holistic approach to some of this, which will enable the gains that have been made that go beyond simply dealing with polio itself to be continued in the future.

Daniel Graymore: May I comment on your question? As the Minister said, we are very aware of the risks of transition and of wind-down. We are very keen to make sure that the sequencing of the programme going forward, through GPEI, the World Health Organization, Gavi and with other partners, is working effectively. One of the things we have been looking very carefully at is the role of the World Health Organization in supporting specifically the transition plans in 16 priority countries. We



HOUSE OF COMMONS

have been looking at people, the immunisation and surveillance systems and integrating those into those country systems. That is supporting, as you mentioned before, the longer-term health system-strengthening approach, and we have pushed that very hard through the World Health Assembly, the executive board and in various other fora, as the UK.

The other area that is critically important, which the Minister mentioned before, is inactivated polio vaccine. This will need to continue to be used for about 10 years after polio has been eradicated. As supporters of Gavi, we have worked very hard to see that the financing of inactivated polio vaccine is taken forward by Gavi in future and that it will be a key part of the programme for Gavi in providing that in countries around the world. That ensures both that it is being taken forward sustainably and that IPV and the continuation for the next few years of OPV in campaigns is integrated with routine immunisation at the country level, so we do not have these low coverage approaches. We have been able to push that also through the policy committee at Gavi and in various other ways.

We have been actively looking at how these pieces all join up, collaborate and have a sustainable, long-term impact to reduce the risks that were identified.

- Q35 **Richard Burden:** Thanks; that is very helpful. Laura Kerr, who gave evidence just before you, has written about some of these matters. She is basically saying that to get the transition right, you need to have some kind of global governance mechanism in place now to work through to eradication of polio, but probably which needs to stay in place for about a decade after that. Do you think that is the right kind of timescale to be looking for? How do you think that sort of mechanism could be established? Is it the right sort of mechanism? How do you think DFID could be involved?

Dr Murrison: It will be interesting to see what happens on 23 September in New York. This is our opportunity for a high-level meeting on universal health coverage, and it is this kind of item that could usefully be placed on the agenda. What we need to do is to incorporate vaccination programmes into domestic healthcare programmes. Clearly, the move from a pentavalent to a hexavalent vaccine programme requires that, but we cannot just rely on that, for reasons we have discussed. If we do, for countries that are fragile or do not have healthcare systems that can easily sustain it, we stand the very real risk of slipping back, so I do think there is going to be a need for continuing governance. Obviously, there are structures that are capable of sustaining such a system, but it is something that would have to be aired internationally, in the appropriate forum and it does seem to me that September will be an appropriate forum.

- Q36 **Richard Burden:** Given the kinds of constraints that you have mentioned, obviously there have been huge strides forward in reducing the overall number of cases, but still some particular forms of polio persist and offer new challenges. Do you think that it will be feasible to



begin wind-down in 2023?

Dr Murrison: I am not an epidemiologist and given that we have made predictions in the past and have not been correct, I would be very reluctant, and I know the programmes themselves are very reluctant. When we hear what the plan is towards the end of this year, as far as GPEI is concerned, I very much doubt that it will be attaching a time limit or a timeframe on it, because it has got it wrong in the past. First, I am not qualified to opine and, secondly, I suspect the experts would be very reluctant too as well. I know that sounds unsatisfactory, but that is where it is, really.

Q37 **Mr Sharma:** Minister, one of the core principles of the Global Fund is transparency. How transparent is the Global Fund? Is there room for improvement?

Dr Murrison: It is pretty transparent. Its aims and aspirations are very clear and it publishes its results. There are a number of ways it is audited and examined. It is not short of those, not just our own domestic, mid-term reviews, annual reviews, but its own mechanisms for investigating what it is doing and being clear and transparent about its targets and the extent to which they have been met. We are comfortable with its level of transparency, but given how much the public are spending on this, they have every right to expect that the Global Fund and others are clear about where the money has ended up.

Q38 **Mr Sharma:** Do you think there is further room to improve?

Dr Murrison: There is a danger in being too prescriptive, to be honest, because of course all these things have a cost. Particularly with these large organisations, with pretty rigorous structures for not only results but the way they conduct themselves, safeguarding and all the rest, they are allowed to do, as professionals, what they should do. There are epidemiologists and scientists who are engaged and whose business it is to try to make an accurate determination of effect. I would be cautious, given what I have seen, to insist upon more checks and balances and greater transparency. You will not be surprised to hear that we do not part with £1.4 billion easily, so we have to assure ourselves that this is money well spent. Notwithstanding the 0.7% target that has to be, by statute, fulfilled, we have other places where we could potentially spend this money in the event that we felt we could get a better effect elsewhere, but that is not the case here.

Q39 **Paul Scully:** I have quite a specific question. Laura Kerr from RESULTS UK, who we heard in the first session, identified in one of her papers that there are potential conflicts of interest in GPEI. This is because many of the oversight committees are dominated by polio experts and staff from GPEI partners themselves. Staff in those committees represent the views of organisations that, as GPEI winds down, stand to lose large amounts of financing. Do you think those committees are well placed to make potentially tough decisions? As GPEI winds down, how will DFID help



HOUSE OF COMMONS

manage those risks?

Dr Murrison: Yes, I understand that. Of course, the polio oversight board is not simply those who have a direct interest in this. It is not completely composed of people whose mortgages rely upon it. We are comfortable that there is a substantial challenge function within that oversight board. In addition, there is the polio independent monitoring board, headed up by Professor Sir Liam Donaldson, which is very incisive in determining whether the work is being done properly and the money is being spent to maximum effect in terms of healthcare outcomes. We are pretty confident that the sort of self-interest that you, quite rightly, suggest might be built into the system is being managed.

You are right to raise that and we have considered it. We are comfortable, given the structure of the board, the POB and the polio independent monitoring board, that there is not going to be a self-interested roll on of this thing beyond the point at which it is necessary on clinical and epidemiological grounds.

Q40 **Chair:** I have a closing question, and this is something that came up in the debate in Westminster Hall this morning. The predecessor but one International Development Committee, five years ago, recommended that the Department should have a global health strategy. My understanding is there is no such strategy on paper. Is that something that you would consider adopting?

Dr Murrison: You are right that there is not something on paper. I have thought about this, because, on the face of it, it sounds rather attractive, but the truth is we are not short of strategic guidance. As you well know, Chair, what we do in this space is determined by the SDGs, particularly, in relation to healthcare, SDG 3 and those directly related to it. That, in a sense, given that the creation of another plan might be finely balanced, would tip me over into perhaps saying we have enough direction. If we work to that, particularly given the UHC enjoiner, we are probably not going to go too far wrong.

I am trying to work out what would be on that one side of A4—because it certainly should not be any more than that—that I would put that we do not already have. I am reluctant to involve officials in creating some wonderful document that would not, at the end of the day, be particularly useful. I am going to resist the temptation to do such a thing, because, though it is finely balanced and I do see the merits of it, it probably will not add very much to the bottom line.

Q41 **Chair:** That is a very clear answer and I thank you for that clarity. In a sense, it is music to our ears that you are saying that basically the SDGs give you your global health strategy. There is a lot of sense in that. Just to probe slightly, the bulk of the expenditure in health with regard to official development assistance is through DFID, but some of it does come through other Departments, including the Department of Health. Might there be a case for something that is a coherent plan across all UK



HOUSE OF COMMONS

ODA relating to health that can then encompass the other Departments that maybe do not have the SDGs quite in their day-to-day thinking in the way that DFID does?

Dr Murrison: You will be very familiar with the recent National Audit Office report on this. We are all trying to digest that, at the moment, and what it means in terms of spending ODA in the best possible way to get effect. I would not want to pre-empt our determination on what that report means before we have formally responded, as Government. There are potentially quite far-reaching consequences for how we do aid that we want to consider and health might be part of that. I certainly note that DFID, which your Department is principally tasked with examining, came out very well from that report. Perhaps some other Government Departments that disburse ODA-able funds did less well. We are duty-bound to examine that, and it could be that we are tempted in the direction that you are, like a siren, trying to tempt me to as a consequence of our more global look, as it were, at the way we do international development across Departments.

Claire Moran: You will have seen the ICAI annual report on all of their studies. One of them was on global health security and, in that update, they recognise that the cross-Government co-ordination mechanism, called the GHOG—the Global Health Oversight Group—is now meeting more regularly, and that co-ordination through that mechanism feels really strong. For us, that is the way of coming together around very clear, shared cross-Government objectives. We feel it is working really well.

Daniel Graymore: I was going to make the same point.

Chair: Minister, thank you and your two officials very much indeed for coming to us today. When we set this up, we were hoping to be part of the pressure on the Government to make a pledge that you then made, which we are delighted about and, as I and others said before, we welcome. The opportunity to explore some of the detail on the Global Fund and to talk about the polio initiative and then put this in a broader context, leading into the September high-level meeting, has made today a very worthwhile session. Thank you for your time and your evidence.

Dr Murrison: Thank you. Can I thank you, too, for your letter of 26 June on this particular subject, which was signed by over 40 of our colleagues, which I know was influential?

Chair: Excellent. That is good to hear. Thank you very much indeed.