House of Lords Select Committee on Intergovernmental Organisations Report – Diseases Know no Frontiers: How Effective are Intergovernmental Organisations in Controlling their Spread?

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
October 2008

Cm 7475

£5.50

House of Lords Select Committee on Intergovernmental Organisations Report – Diseases Know no Frontiers: How Effective are Intergovernmental Organisations in Controlling their Spread?

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
October 2008

Cm 7475

£5.50

ISBN: 978-0-10-174752-3

The Government Response

We warmly welcome the Committee's report. Our cross-Government response to each of the recommendations is set out below. There are a number of areas where the UK Government can contribute even more effectively to global efforts to control infectious diseases.

The Committee's response comes at an important and exciting time for global health – both on the world stage and here at home. On 30 September we launched *Health is Global: A UK Government Strategy*. It sets out a coordinated cross-Government approach to global health. It highlights the links between domestic and foreign policy to improve global health and between domestic health and health outside our shores. This builds on other key initiatives in this area – notably the the National Security Strategy and the Department for International Development's (DFID's) strategy *Working Together for Better Health*.

At the World Health Organization (WHO), Dr Margaret Chan's strong leadership promises to deliver an ever more effective agency to lead the global health agenda. WHO's first ever Medium-Term Strategic Plan is key to this. The International Health Regulations show the impact WHO can have in leading global public health diplomacy. We are committed to supporting WHO. This autumn we plan to publish our first cross-Government (DFID–Department of Health–Foreign and Commonwealth Office) strategy for the way we work with WHO. This will improve coherence and consistency. We will use this as the basis for future engagement with WHO, in particular for the remainder of our time on the WHO Executive Board.

The UN High-Level event on the Millennium Development Goals (MDGs) held on 25 September in New York demonstrated the value and importance of global approaches to health and the UK's continued commitment.

The Committee's work has already helped shape the development of Government thinking – for example in finalising *Health is Global* and the UK Institutional Strategy with WHO and will continue to help us develop our thinking in this area.

Committee Recommendations

190. We recommend that at the High Level meeting called by the UN Secretary-General for September 2008 the Government not only re-affirm the MDGs but give a lead in ensuring that adequate resources are committed and targeted in particular on those areas where progress is lagging (including health). (Paragraph 28)

The High-Level meeting on 25 September offered an excellent opportunity for the Government to re-affirm and re-energise progress towards the MDGs.

The UK Government played a key role in the launch of the $3 billion multi-stakeholder Malaria Action Plan. The UK contribution is providing 20 million bed nets by 2010, increasing funding for research and development of up to £5 million by 2010 and encouraging the Global Fund to host the Affordable Medicines Facility, towards which the UK has committed £40 million to make sure the poorest has access to the latest and best malarial drugs.

The UK Government will continue to play its part in committing more resources to health. We will be spending £6 billion on international health over the next seven years, and in addition, we have committed £1 billion up to 2015 to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). We must look at other innovative financing tools for health. We are planning to spend more on health in all the International Health Partnership (IHP) countries where we have a programme.

Recognising the importance of health systems, the UK pledged £450 million to support national health plans in eight IHP countries as part of a wider set of commitments, including World Bank agreement to deploy expert teams of staff into some of the poorest countries to help strengthen their health systems for better maternal, newborn and child health.

The IHP, launched in September 2007, will lead to a clearer articulation of financing gaps in health. It offers a mechanism, through the development of agreements in-country (country compacts), for donors and national Governments to make transparent funding commitments for health. DFID will urge donors to strengthen their support to costed and prioritised national health plans. Nationally, Governments must also increase the resources they allocate to health.

In four countries (Ethiopia, Kenya, Mozambique and Zambia) where the IHP overlaps with the US President's Emergency Plan for AIDS Relief (PEPFAR), we are encouraging the US to extend their AIDS resources to back Government health workforce plans.

While traditional investments in the health of the poor remain vital to tackling disease, helping developing countries to recruit and retain health workers and build and develop their own health systems, it will not fill the whole financing gap. The meeting recognised the requirement for a new long-term approach to health financing by announcing the establishment of a high-level Taskforce on Innovative Financing for Health Systems, to make recommendations to the Italian G8 Summit in 2009 on how innovative aid mechanisms can complement other sources of finance to deliver the extra resources that are needed.

191. We recommend that the Government support and contribute to an increase in resources being allocated to family planning throughout the developing world and back other consensual programmes designed to slow world population growth. (Paragraph 29)

The UK Government recognises that more needs to be done towards improving the availability of sexual and reproductive health information, services and supplies. We have recently agreed an additional £100 million to the United Nations Population Fund (UNFPA) over five years to improve access to family planning services. We are also providing £42.5 million over five years to support the work of the International Planned Parenthood Federation (IPPF), as well as other organisations working to promote sexual and reproductive health and HIV prevention.

The UK Government policy on population growth aims to provide people with reproductive health choices. This policy is fully in line with the international consensus agreed at the International Conference on Population and Development at Cairo in 1994 and re-affirmed at the United Nations World Summit in 2005.

Improved reproductive health information enables women and men to make informed choices. Experience shows that improving health, education and livelihoods, and promoting gender equality and rights, together with ensuring access to sexual and reproductive health information, services and supplies, combine to give people the choice to have fewer children.

192. We recommend that the Government in its own aid programmes should aim to achieve an effective balance between 'vertical' and 'horizontal' health programmes and should encourage other donors and the World Health Organisation to do likewise. In this context the Government may wish to explore whether an appropriate percentage of health aid provided through IGOs should be earmarked for the strengthening of health systems. (Paragraph 43)

We welcome the comments of the Committee on the relationship between vertical and horizontal investments in health. We have a strong track record in both areas. On health systems, DFID emphasises investing in health systems through many of our bilateral programme instruments, such as programme support and sector or general budget support. We are also a major donor to international organisations that support health systems, such as the World Bank. We strongly supported their Health, Nutrition and Population Strategy at the Board level and continue to press them to improve their performance in line with their commitments. However, the World Bank has a country-led application process and it is our policy not to earmark our funds to the Bank for specific activities.

DFID also provides substantial resources to priority disease funding organisations, such as the Global Fund for AIDS, Tuberculosis and Malaria, the GAVI Alliance and several smaller neglected tropical disease initiatives. While the focus of these organisations is delivering disease-specific programmes, most are also now examining options for supporting health systems. We are already supporting this move, including participating in the health systems strengthening window working group at GAVI.

193. We recommend that the Government should press the issue of investment in health care infrastructures within the World Bank with a view to bringing about an increase in such investment within the framework of sensibly streamlined application procedures and appropriate safeguards in relation to in-country governance. (Paragraph 44)

The World Bank has a strong comparative advantage in investing in infrastructure in general and has an extremely rigorous approach to in-country governance. It has a particular track record with investing in health infrastructure, which it is currently keen to promote, especially in its work in Africa. This approach needs to translate into investing in decentralised primary health care infrastructure, including health centres, laboratories and surveillance system strengthening, rather than major hospitals in capital cities. Our position at the World Bank Board is thus that we support their role in infrastructure strengthening, but that they need to accompany this with evidence, rather than simply assume that such investment will deliver the desired health results.

194. We believe that it is an integral part of Britain's own defences against the spread of pandemic outbreaks of disease that warning and preventive systems in developing countries be strengthened and that, where necessary, the resources and skills to effect this are provided. We therefore recommend that the Government should consider urgently how greater priority can be accorded, both in its bilateral funding of developing countries and in the resources which are provided through organisations of which the UK is a member, to bringing infectious disease surveillance and response systems up to an effective level. (Paragraph 56)

The Government fully supports the need to improve surveillance and reporting systems in many developing countries. Many of these arrangements are poorly resourced and unreliable, and it is in all of our best interests to have accurate information on infectious disease outbreaks in order to try to contain any spread.

The UK Government is currently preparing its International Pandemic Influenza Preparedness Strategy,[1] which details the direction and objectives of the UK's international efforts on pandemic preparedness over the next three to five years.

A key objective of this Strategy will be to address, by July 2009, how we might best contribute to improving both animal and human surveillance systems in vulnerable countries for highly pathogenic avian influenza. We shall also endeavour to encourage the wider application of improvements made to those surveillance and response systems for H5N1. This is in line with the 'One World, One Health'[2] international joined-up approach to animal, human and ecosystem infectious diseases.

1 www.ukresilience.gov.uk/pandemicflu/whats_new.aspx
2 www.oneworldonehealth.org

195. We recommend that, in achieving an appropriate balance of investment, both of UK bilateral aid and of funding provided through IGOs, and in using its influence within the World Bank to encourage increased investment in health care infrastructure, the Government should regard the building up of in country surveillance and diagnostic capabilities for antimicrobial resistance as a high priority component. (Paragraph 65)

The Government agrees that the development of surveillance and diagnostic capabilities is an important part of comprehensive health systems. DFID is investing £6 billion in health from 2008 to 2015. This includes support to developing countries to develop and implement their own comprehensive strategies to strengthen health systems. The UK works with the World Bank and others to support the IHP. The IHP aims to improve donor coordination to support these country-owned strategies.

Country activities should be complemented by technical support and improved mechanisms for information sharing at an international level. WHO has an important role in monitoring and advising on antimicrobial resistance. This includes the publication of a *Global Strategy for the Containment of Antimicrobial Resistance*. The UK provided a total of $358 million over the 2006–07 biennium in assessed and voluntary contributions to support WHO's work.

196. We recommend that the Government should support, within WHO and other relevant IGOs, the development of health diplomacy training to enable developing countries to make the fullest use of the flexibilities in the WTO's Doha Declaration on TRIPS. (Paragraph 75)

Health diplomacy training is a new field. WHO and other institutions co-organised the first Summer Course on Global Health Diplomacy at the Graduate Institute of International Studies in Geneva only last year. However, the field of health diplomacy goes much wider than training in relation to the use of the flexibilities in the Doha Declaration. The Government supports WHO's involvement with other organisations, such as the World Trade Organisation (WTO) and the World Intellectual Property Organisation (WIPO), in training programmes to help countries utilise the flexibilities in the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) in accordance with the various resolutions of the World Health Assembly, including the recently approved *Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property*.

197. We recommend that the Government should consider whether the UK might provide a lead either by establishing relevant training courses in this country, perhaps under the auspices of DFID, for suitable officials from developing countries or by sponsoring officials from developing countries to attend existing courses, such as the Summer Programme on Global Health Diplomacy at the Graduate Institute of International Studies in Geneva, or by seconding suitably-trained UK officials to support selected developing countries in their negotiation of individual agreements. (Paragraph 76)

The Government will consider how it could most appropriately support relevant training for officials from developing countries.

198. We recommend that the Government should throw its weight against the inclusion, in bilateral or regional trading agreements, of proposals inhibiting the use by developing countries of the Doha flexibilities. (Paragraph 77)

The Government agrees that bilateral and other agreements should not oblige countries to adopt intellectual property standards or timetables that go beyond TRIPS. The Government will also seek to ensure that European Union (EU) agreements with developing countries avoid imposing obligations beyond TRIPS.

199. We recommend that the Government should support, both bilaterally and multilaterally, the development of sound long-term funding mechanisms, which are able to offer incentives to pharmaceutical companies to develop new medicines at prices which can be afforded by poorer countries. (Paragraph 81)

The Government agrees that a range of direct investment and incentive mechanisms are needed to ensure that appropriate and affordable health technologies are developed for diseases that are prevalent in developing countries.

In February 2007, the UK announced a contribution of $485 million towards a $1.5 billion pilot of an Advanced Market Commitment (AMC) for pneumococcal vaccines for use by developing countries. An AMC is a binding commitment by donors to subsidise the future purchase of a drug or vaccine that is not yet available. By creating a viable market, an AMC provides an incentive to private companies to develop and manufacture new products for developing country use. The subsidies are only paid if a product is successfully developed and is demanded by developing countries (who also make a co-payment). Participating companies agree to supply the product at a low long-term price once the AMC is exhausted. The pneumococcal vaccine AMC is the first of its kind to be launched.

In addition, the UK currently invests nearly £25 million per year in product development partnerships (PDPs) to develop new drugs and vaccines for diseases prevalent in developing countries. These non-profit organisations make specific commitments to develop appropriate and affordable products.

200. We have concluded that, so far as controlling the spread of infectious diseases is concerned, the deliberate release of toxic organisms should not be considered as in a separate category from the normal arrangements for controlling natural outbreaks. We recommend that the Government should support, both nationally and intergovernmentally, generic surveillance and response systems which are capable of addressing both deliberate and naturally-occurring outbreaks of infectious diseases. (Paragraph 87)

We are pleased that the Committee agrees that the strengthening of generic infrastructure for responding to infectious diseases is the right approach. In building a resilient capability and capacity for early detection of dangerous pathogens, we have built upon existing and successfully tested strategies for controlling major outbreaks of infection, while at the same time recognising that certain diseases demand very specific and unique medical countermeasures. Our preparedness planning has taken account of the potential need to scale up local and national responses and to sustain that response over long periods. Our preparedness planning for pandemic flu and possible bioterrorism threats has already yielded improvements in our capability locally, regionally and nationally to respond rapidly and effectively to any large-scale incident.

201. Reforming WHO's internal structure is an essential, though challenging, prerequisite of improving global health governance. While it is true that some progress has been made and that the Regional and Country Offices are now more willing to cooperate following the SARS experience, a more fundamental overhaul of the relationship between headquarters and regions and a review of the current procedures by which Regional Directors are appointed seems overdue. Given the threats to global health which we face from newly emerging infectious diseases, a dysfunctional organisational structure within the world's principal policy-making, standard-setting and surveillance body simply cannot be afforded. We therefore recommend that the Government should bring its influence to bear, along with that of other like-minded Member States, to ensure that a fundamental review is initiated of the inter-relationship between WHO Headquarters and its Regional and Country Offices and of the system of appointment of Regional Directors so that WHO as a whole is better structured to meet the contemporary challenges of global health management. (Paragraph 111)

We fully acknowledge and agree with the Committee's concern that an effective relationship between WHO headquarters, regions and country offices is a prerequisite to improving global health governance. That is why we are pleased there has been significant progress over the last 12 months, with a clear commitment to greater coherence by Dr Chan and her team of Regional Directors, and efforts to reform within some of the WHO regions. The new Medium Term Strategic Plan puts WHO on a sure footing for the future and the organisation should be congratulated on its global leadership. We are engaging with WHO on their reforms and will continue to do so.

As part of the new UK Institutional Strategy with WHO, we will continue to work closely with WHO on the performance of the country and regional level of the organisation, including through indicators to measure WHO's progress in these areas.

202. We recommend that, when budgetary negotiations for the next biennium get under way, the Government should support a re-balancing of WHO's budget in order to make more funds available for the core budget. (Paragraph 113)

We recognise the importance of increased levels of predictable, multi-year, unearmarked funding, if WHO is to take forward the actions set out in the Medium Term Strategic Plan. The UK aims in principle to increase the proportion of core voluntary funds we provide. In the long term, our aim is to move towards reintegrating some of our funding for global partnerships into core voluntary contributions. This will be taken forward with WHO, as it develops its core voluntary contribution approach to improving its resource management.

In the negotiations of WHO's new 2010–11 biennium Programme Budget at the Executive Board in January 2009, and at the World Health Assembly in May 2009, the UK will be supportive of WHO's proposals to direct more funding through the core voluntary contributions.

203. Infectious diseases pose a major threat both to this country and to the wider world and we believe that WHO will need additional funding if it is to be able to respond effectively to these threats on behalf of the international community. The UK is already a major funder of WHO and we are mindful of current budgetary constraints. We recommend however that the Government, in concert with other Member States, should work towards an increase in financial contributions to WHO. (Paragraph 114)

The UK in recent years has been the second largest funder to WHO, given the importance that the UK Government attaches to WHO's agenda on health. We will continue to provide substantial funding to WHO and to develop ways to provide funds as flexibly as possible, either fully unearmarked or earmarked at Strategic Objective level.

204. [As regards the European Centre for Disease Control (ECDC)] We believe that it will be important that duplication and overlap does not occur and that ECDC does not become a further complicating factor in an already complex system of global disease management. (Paragraph 119)

The Government will be working closely with the Commission, the Presidency and EU Member States to ensure that cooperative work between Member States is bolstered and that the EU institutions – the European Centre for Disease Control (ECDC) and the Health Security Committee (HSC) – and other groups involved in health security work are more joined up in their work and fit for purpose.

The ECDC is an EU agency that aims to strengthen Europe's defences against infectious diseases. ECDC's mission is to identify, assess and communicate current and emerging threats to human health posed by infectious diseases. To achieve its aims, ECDC works in partnership with national health protection bodies across Europe to strengthen and develop continent-wide disease surveillance and early warning systems. By working with experts throughout Europe, ECDC pools health knowledge and develops authoritative scientific opinions about the risks posed by current and emerging infectious diseases.

The organisational structure of ECDC is based on four technical units: the Scientific Advice Unit; the Surveillance Unit; the Preparedness and Response Unit; and the Health Communication Unit. ECDC's disease-specific activities are managed in horizontal disease programmes across the four technical units and these programmes are the cornerstones of the disease-specific scientific output of the Centre. The ECDC is thus uniquely placed to coordinate expert scientific input to disease control.

The HSC is a non-statutory committee of senior health security experts from EU Member States and is chaired by the European Commission. The HSC delivers opinions, identifies actions and decisions that might be taken at political level, endorses guidelines and/or recommendations, and considers scientific assessments in relation to EU health security issues. The work of the HSC is also supported by ad hoc working groups.

Responsibility to decide what actions are appropriate to manage health threats at a national level should rest wholly with the Member States. However, we agree that there is scope for greater clarity around the interface between ECDC and the HSC and a need for clear mechanisms to be agreed for effective communications between Member States in a rapidly developing international health emergency.

205. We recommend that the Government should pursue, as a matter of urgency, through its membership of the relevant IGOs the creation of an event-reporting system for animal diseases along the same lines as the new IHRs relating to human health and should encourage the building up of much stronger systems of cooperation between the bodies dealing with human and animal health in sharing information and handling reports of disease outbreaks. (Paragraph 128)

On balance, we consider that the existing Office International des Epizooties (OIE) Codes contain sufficient requirements for countries to report their animal health status. The vast majority of the OIE Member Countries comply with these requirements. It is also widely recognised that there is a certain percentage of developing countries that do not adequately comply with these requirements. The veterinary services in the latter countries are either under-resourced or not fully operational. Therefore, it is highly unlikely that the OIE Member Countries would agree to the OIE system being complemented with a new Animal IHR because of the potential for duplication and the significant resource issues that may be associated with taking forward any Animal IHR by OIE Member Countries.

The WHO and the OIE international surveillance systems for human and animal health provide a sound basis for surveillance. The collaborative links established through them in the field, together with the Food and Agriculture Organisation (FAO), provide vital early warning of disease, often even before it is officially confirmed. WHO, OIE and FAO work well together and complement each other. They all communicate with each other and each has developed its own early warning and response system. These are all brought together under the umbrella of the Global Early Warning and Response System (GLEWS), which adds value to the international community.

However, there is scope for these systems to be strengthened. The problem is that these surveillance systems are dependent upon the capacity and capability within countries to diagnose diseases accurately; to report through a reliable reporting infrastructure; to capture health data from the whole of its population; and to demonstrate political will to share early suspicion of diseases that they cannot diagnose themselves.

Not all countries have the veterinary and health infrastructures to deliver robust disease reporting data, and thus information remains incomplete for many countries. Therefore, we need to strengthen capability and capacity in developing countries and to develop internationally agreed protocols for the rapid sharing of information.

We also need agreed international mechanisms in place to provide rapid assistance where it is needed. WHO has the lead role in providing rapid assistance for human disease emergencies, and we will continue to support them in this task through our strategic engagement. The FAO leads on rapid assistance to tackle animal diseases. Our international aid initiatives sponsored by DFID will continue to support developing countries on health systems strengthening, which of course includes support to national surveillance systems for both human and animal diseases.

206. We recommend that the Government should continue to encourage the development of integrated strategies for combating TB and HIV and should satisfy itself, before committing funds to fight one or both of these two diseases in developing countries, that there is adequate local recognition of the problem of TB-HIV co-infection and that there are sound programmes in place to address it. (Paragraph 137)

The UK Government is committed to tackling HIV and TB co-infection. It recognises the need to scale up efforts to deliver universal access to TB and HIV prevention, treatment, care and support services by 2015; as well as to increase investment and facilitate research to promote the development of better tools for prevention, diagnosis and treatment of TB.

DFID's updated AIDS strategy 'Achieving Universal Access – the UK's strategy for halting and reversing the spread of HIV in the developing world', supports the integration of HIV and AIDS services with other health services, including those combating TB. There has been increased recognition of the problem of TB and HIV co-infection and significant progress in implementing of TB/HIV interventions, but still much remains to be done. DFID will continue to advocate for the integration of HIV and TB services.

As the Committee has noted, DFID has made a significant commitment to spend £6 billion over seven years to 2015 to strengthen health systems and services, including the integration of HIV and TB services. Additional, relevant DFID commitments include: to support countries with health worker shortages to provide at least 2.3 doctors, nurses and midwifes per 1,000 people; a long-term funding commitment of up to £1 billion (2007–15) for the Global Fund to fight AIDS, Tuberculosis and Malaria; and a 20-year commitment to the international drugs purchase facility UNITAID (2006–26), which is helping to increase access to, and affordability of, HIV and TB drugs.

DFID's Research Strategy for 2008–13 outlines how DFID will double its investment in research, including health, to £220 million a year by 2010. The new research strategy includes a focus on developing drugs and vaccines for HIV and AIDS, TB, malaria and other diseases that most affect poor people.

207. We recommend that the Government should, via its representatives in the relevant UK agencies, seek to ensure that instances of non-collaborative working are highlighted and remedied. We recommend also that the Government should urge the UN Secretary-General to give WHO a clearer lead role. (Paragraph 147)

The UK Government is committed to seeing improved UN system-wide coherence. This is being pursued through our meetings with UN agencies at all levels, through governance processes and through formal agreements such as Institutional Strategies, which include objectives and indicators that hold agencies to account.

On the specific point of the work of the UN Office on Drugs and Crime (UNODC) on drug control raised in evidence, the facilitation of coordination between UN agencies is the role of UNAIDS which needs to build an agreed UN position between relevant co-sponsors, on preventing and treating HIV infection among intravenous drug users.

UNAIDS has commissioned a second Independent External Evaluation that will report to the Programme Coordinating Board (PCB) in December 2009. Among other areas, it will review the corporate governance of UNAIDS, including the coordination and accountability of the co-sponsors. The evaluation recommendations should help UNAIDS and the co-sponsors to reassess priorities and strengthen the role of UNAIDS in coordinating the global HIV and AIDS response in a changing aid environment.

The UK works through its donor constituency at the UNAIDS PCB and challenges co-sponsors' own governance systems from UNAIDS PCB decisions. The UK is also working directly with UNODC to work towards greater political consistency on international policy for intravenous drug users across the relevant UN agencies.

We would support the WHO being formally given a heightened role in global outbreak detection and response. In particular, we support the WHO being given a clearer lead role on pandemic influenza.

A key objective of our draft UK cross-Government International Pandemic Influenza Preparedness Strategy refers to the need for clearer definition of responsibilities among the UN organisations, both at central and regional levels, on pandemic influenza planning, in particular in coordinating the efforts to achieve maximisation of synergy and minimisation of duplication and overlap.

We would support the UN Secretary-General in re-stating the WHO's leading role in the health response to a pandemic. As detailed in our National Strategy, we will support the UN Sectretary-General in clarifying the respective roles of the UN players and ensure that coordination between them is improved.

In the National Security Strategy, the Government also announces a bringing together of UN organisations to clarify their roles in pandemic planning.

208. Our assessment of the International Health Partnership concept is that it represents an interesting and innovative project which has the potential for bringing about considerable improvement in the coordination of global health efforts, particularly at the all-important country level. We shall, however, have to wait and see how the concept develops – whether other countries and implementing organisations join and whether the mutual obligations which participants undertake prove sustainable and really do result in the increased efficiency of health-related aid which is envisaged. We are pleased to hear the Minister's affirmation of the importance of the IHP. We therefore recommend that the Government should throw its weight behind development of the concept in order to turn it into a reality as soon as possible. We recommend also that the IHP should be developed in a way which simplifies and avoids complicating further the already complex global health governance picture. (Paragraph 158)

As noted by the Select Committee last year, the Government was instrumental in launching the IHP. The IHP is shortly to celebrate its first anniversary, during which time two new countries have signed up plus several new donors. At least one national compact will be signed (Ethiopia) shortly with more to follow. This compact is a document which donors and Government sign, which commits the Government to deliver a concrete set of health results in return for enhanced donor harmonisation. The Ethiopian Government would like donors to provide increased resources through common funds that would reduce transaction costs both for the Federal Government and for local administrations. We are very pleased to see this progress in a large country, with a difficult aid environment. We are pressing other countries to be similarly firm with their development partners to deliver IHP promises. In Mozambique, we worked successfully to support the Government in its efforts to press the Global Fund for AIDS, Tuberculosis and Malaria and GAVI to harmonise their disease-specific inputs with the existing health sector plans. And in four countries where the IHP overlaps with the US PEPFAR (President's Emergency Plan for AIDS Relief), we are encouraging the US to use more of their AIDS resources to support Government health workforce plans.

209. We recommend that the Government should take the initiative, within the global health community, to promote a strengthening of WHO's role in two principal respects. First, Member States should be asked to agree, at the 2009 World Health Assembly, on a new Mission Statement which would give WHO a role of preparing a strategy for global health governance and promoting, through negotiation, an increase of collaborative working among the various actors, State and non-State, in the field of infectious disease control. Second, Member States should be asked to agree, on the basis of evidence of need presented to them by WHO, a re-balancing of the WHO budget between Assessed and Voluntary Contributions. (Paragraph 173)

WHO is a key partner in championing the harmonisation and alignment of those working in health at global, regional and country level. The UK welcomes WHO participation in the Head of Agencies group (Health 8), which aims to improve global health governance. We would support WHO having a central role in developing a strategy for better global health governance, including better collaborative arrangements between the various actors involved in infectious disease control. However, we do not see the need for a new mission statement. WHO's leadership in this area is already clearly articulated in the Medium Term Strategic Plan.

The UK is fully supportive of WHO's establishment of a 'core voluntary contribution account' as a way to provide more flexible funding to WHO. This should ensure there is not such a great reliance on fully specified voluntary contributions.

210. We recommend that the Government, working with other donors and with recipients, should aim to lighten the administrative burden of health aid on developing countries and to strengthen the capacity of those countries to manage health programmes. The aim should be to secure the alignment of donor inputs to disease control programmes within the national health programmes of recipient countries and to simplify the procedures for their management and reporting. (Paragraph 176)

We welcome the Committee's comments. The Government has been consistent in advocating for approaches to health aid that reduce the administrative burden for developing countries. The IHP has a key role to play here.

Through the IHP, the eight main multilateral agencies and institutions in health are working together to agree common criteria for appraising national health plans as a basis for funding. Using this process, the GFATM, for example, has agreed that it will be able in future to accept national health plans as the basis for funding applications – a new procedure that will greatly reduce the burden of applying. GAVI is also actively looking at new, simpler ways of working in IHP countries, and may also adopt national strategy applications. In addition, IHP national compacts include commitments by donor signatories to accept common reporting and monitoring mechanisms – again simplifying life for the countries concerned.

Through our presence on the boards of key international health agencies, such as GFATM, we are active in pushing for changes in policies and systems that will make it more straightforward for developing countries to apply for and administer their funding.

211. We are pleased to hear that the Government is alert to the need to operate effective control mechanisms. In view of this and of the generally favourable comments which have been made to us in the course of our inquiry by IGOs and other organisations concerned with infectious disease control as to the competence and effectiveness of DFID support to developing countries in the health field, we do not believe in appropriate or necessary to make any further observations on the management of UK bilateral aid programmes in this field. (Paragraph 181)

We acknowledge the favourable comments the Committee has received regarding the management of UK bilateral programmes.

212. We recommend that the initiatives described to us – MOPAN and what might be termed a Service Level Agreement approach – should form the basis for new accountability arrangements between the UK – and, we suggest, other Member States – and IGOs operating in the field of infectious disease control. (Paragraph 184)

We agree that MOPAN and what might be termed a Service Level Agreement approach has much to offer to improve accountability arrangements between the UK and other Member States, and IGOs operating in the field of infectious diseases.

The new MOPAN approach will be tested later in 2008, with the expectation that it will be piloted on a number of multilateral organisations in 2009. In addition, the UK is presently negotiating a new Institutional Strategy with WHO, including a 'performance framework', which provides the strong accountability framework for UK funding to WHO mentioned in paragraph 183. DFID is also negotiating new Institutional Strategies with UNAIDS and UNFPA. For the latter this is being negotiated jointly with Denmark.

213. We do not suggest that the UK should simply replicate the Swiss arrangements for global health policy formulation. Nor do we have a readymade solution to the problem to offer. We do, however, recommend the Government should take another look at the machinery for coordinating UK policies with a view to ensuring that the interests of those Whitehall departments who are closely involved with the international dimension of global health are given their due weight and that this is reflected in the arrangements for leadership of the Global Health Strategy. (Paragraph 189)

The Global Health Strategy makes clear that global health is a matter of concern across Government. There are seven Government departments that lead on delivering specific aspects of *Health is Global,* with a large number more playing an important supporting role. DH chairs the Inter-Ministerial Group on Global Health and the senior-level officials group that supports it; this seems appropriate because of the huge range of global health issues, many of which affect the health of the UK population. DFID is clearly the lead Government department for UK development policy but, as the last Development White Paper makes clear, all of Government has a responsibility to support DFID in achieving its goals.

Printed in the UK for The Stationery Office Limited on behalf of the Controller of Her Majesty's Stationery Office
ID5957424 10/08

Printed on Paper containing 75% recycled fibre content minimum

TSO
information & publishing solutions

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/General enquiries 0870 600 5522
Order through the Parliamentary Hotline Lo-Call: 0845 7 023474
Fax orders: 0870 600 5533
E-mail: customer.services@tso.co.uk
Textphone: 0870 240 3701

TSO Shops
16 Arthur Street, Belfast BT1 4GD
Tel: 028 9023 8451 Fax: 028 9023 5401
71 Lothian Road, Edinburgh EH3 9AZ
Tel: 0870 606 5566 Fax: 0870 606 5588

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX

TSO@Blackwell and other Accredited Agents

ISBN 978-0-10-174752-3

9 780101 747523