House of Commons
Committee of Public Accounts

The fight against Malaria

Twenty-eighth Report of Session 2013–14

Report, together with formal minutes, oral and written evidence

Ordered by the House of Commons
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Committee of Public Accounts

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Summary

Malaria is a major cause of death and illness and a constraint on economic growth, particularly in Africa. The Department for International Development (the Department) has contributed to the effort to tackle this illness. However, we are concerned that the rapid increase in spending to combat malaria, rising to £500 million a year by 2014-15, risks outpacing the Department’s delivery infrastructure, reducing its ability to secure value for money. The Department has made progress in establishing information to measure the cost-effectiveness of its measures, but further work is needed to make well-informed choices about where and how to best spend money in future. We agree that sustaining progress requires a long-term commitment to combat malaria, but the Department needs to avoid intervening in a way that creates and increases long-term dependency on UK funding. It is also essential to support better diagnosis of malaria to avoid unnecessary spending on drugs.
Conclusions and recommendations

1. Malaria is a mosquito-borne infectious disease. It is transmitted by mosquitoes drawing infected blood from one person and transmitting it to others. In 2010 there were around 219 million malaria cases worldwide, leading to some 660,000 deaths. Malaria particularly affects low-income countries with weak public health systems; it is also a significant factor in constraining their economic growth. The Department's spending to combat malaria will increase from £138 million in 2008-09 to nearly £500 million by 2014-15. In the absence of a fully effective vaccine, the Department's strategy is to reduce new infections through distributing proven malaria controls, such as insecticide treated bed nets, and to reduce deaths and illness through supplying drugs to treat infected people. The Department plans to undertake a mid-term review of its malaria programme by the end of 2013.

2. The Department does not presently allocate its resources according to need. We recognise the scale of need on malaria, but at the same time it is an important value for money consideration that spending takes account of the relative scope for impact in different countries. About half of the total malaria cases worldwide are in Nigeria and the Democratic Republic of Congo, but the Department spreads its resources across 17 countries. The Department now agrees that it should be doing more in these two countries and less in other countries. The Department has been concerned about the ability of some of its country offices to expand, and the effectiveness of its operations in different country offices varies, but the Department represented these to us as "teething problems".

Recommendation: Following its mid-term review, the Department should improve its prioritisation of funding between countries, so it targets its resources on those countries where the need is greatest and expenditure is most effective.

3. The Department does not yet understand sufficiently the variations in cost-effectiveness between each of its country programmes. The Department has reduced the costs of the products it buys, such as bed nets. But it does not have a clear understanding of how cost-effective its programmes are in different countries. As malaria takes different forms in different regions, the Department tailors its approach to local contexts, and it is working to improve its data on spending and impacts in different locations. Drops in funding for anti-malaria programmes can also carry risks: the prevalence of malaria rose again quickly in Zanzibar in the past following the ending of anti-malaria programmes. The Department must use data intelligently to avoid experiences such as this.

Recommendation: Before the next Spending Review, the Department must be able to compare its cost-effectiveness at country level, to identify scope for further gains in value for money. In low prevalence countries, the Department should work with its partners, including the World Health Organisation, to focus on unit cost benchmarks for effective control systems, as well as for treatment.

4. The Department has not been sufficiently selective in allocating money to its country offices. The Department has not been able to rigorously select the best
interventions in distributing the increased resources. In 2010, the Department designed a competitive bidding process for its country based teams. However, it gave the teams little time to submit bids, and it then accepted all the bids received. Different solutions are needed in different contexts, for example, not just the use of bed nets for prevention. The Department considers that it knows generally what works in combating malaria but accepts the need to keep pushing to improve value for money.

Recommendation: The Department should make clear that it expects its country based teams to consider wider options across well-targeted malaria prevention, diagnosis and treatment activities, and it must allow sufficient time for these teams to develop their funding bids.

5. The Department’s on-going growth in expenditure to combat malaria risks creating protracted dependency on UK funding. UK funding to control malaria has been rising over a period in which global funding has been levelling off. Many African governments under-spend on health compared to the commitments they have made, for example in the 2001 Abuja Declaration. This reflects a dependency on international aid funding to support their health programmes. We heard of anecdotal examples of the Department’s staff securing non-UK resources, but this appeared to be the exception rather than the norm.

Recommendation: The Department should require country-based staff to design programmes that require the government of each country to contribute to the programmes funded, and to seek additional non-UK resources.

6. The mass distribution of free or subsidised bed nets suppresses local commercial markets. The Department feels that it is 15 to 20 years away from being able to transfer responsibility for bed net provision and replacement to the private sector. The Department wants to instil the routine use of bed nets by populations in malaria affected countries, while encouraging people to buy their own nets, to reduce the degree to which these are funded by donor organisations. In the meantime, commercial suppliers of bed nets in developing countries need public and private demand for their products to develop sustainable markets.

Recommendation: The Department should develop its programmes to avoid suppressing local commercial markets for “paid-for” bed nets, through targeting its free distributions on those who would not otherwise pay for bed nets.

7. The Committee also heard evidence that nets secured from western suppliers were often of an unsuitable size despite the availability of more appropriate products within the local market. The provision of free nets sourced from Western suppliers were therefore less than ideal whilst also having the unintended consequence of damaging the local business through the provision of free nets in competition with locally produced nets.

Recommendation: The Department should aim to procure bed nets on a local basis where a failure to do so might have a damaging long term impact upon the objectives of the project being supported.
8. The Department has not yet made the most of easy to use rapid diagnostic tests to increase the number of people who can be quickly and correctly diagnosed for malaria. The development of inexpensive rapid diagnostic tests—small, lightweight disposable blood tests which allow accurate diagnosis of cases without access to microscopes—is an important and effective advance. These devices have halved the unnecessary use of malaria drugs in trials. However, there has been a reluctance to extend the use of these tests in the private sector. The Department was concerned as to whether shopkeepers would use the tests as they had a financial interest in selling the drugs to treat malaria. The Department considers there is now evidence to merit at least piloting these devices in the private sector.

Recommendation: The Department should extend its support for rapid diagnostic tests to the private sector on a national or regional scale as well as using public sector outlets. It should do so in countries where competent private sector vendors exist, to seize the unquestionable benefits this would bring.
The fight against malaria

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department for International Development (the Department) on its work to control malaria.1

2. Malaria is a mosquito-borne infectious disease. It is transmitted by mosquitoes drawing infected blood from one person and transmitting it to others. In 2010 there were around 219 million malaria cases worldwide, leading to some 660,000 deaths. Pregnant women and young children are at greatest risk. Malaria particularly affects low-income countries with weak public health systems. Around 80% of deaths from malaria occur in just 14, mainly African, countries. It is a significant factor in constraining economic growth in these countries—by as much as 1.3% a year—and is a major burden on households.2 The disease is responsible for up to half of inpatient and outpatient cases in Africa.3 But important gains have been made, particularly in reducing childhood mortality.4

3. The Department aims to help halve malaria deaths in at least 10 countries by 2014-15.5 Its expenditure is increasing from £138 million in 2008-09 to nearly £500 million by 2014-15. Spending on this area is growing faster than for diseases like HIV/Aids.6 In the absence of a fully effective vaccine, the Department’s strategy is to reduce new infections through distributing proven anti-malarial products particularly insecticide treated bed nets, and to reduce deaths through supplying drugs to treat those infected. The Department plans to undertake a mid-term review of its malaria programme by the end of 2013.7

4. About half the total malaria cases worldwide occur in Nigeria and the Democratic Republic of Congo. However, the Department has spread its resources across 17 countries. The Department agreed that it should do more in these two countries and less in other countries.8 The Department provides lower funds per-capita for its operations in Nigeria and the Democratic Republic of Congo than it does for some countries with a lower malaria burden.9 The Department has asked the Global Fund, a multilateral organisation part-funded by the UK, to increase its malaria efforts in these two countries.10

5. The global pattern of need is an important basis for allocating resources between countries. A second factor is the impact which the Department can achieve in each country, taking into account their different local circumstances. The efficiency of the Department’s operations, and those of its partners, varies across countries. In Nigeria, the

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1 *Malaria*, National Audit Office, HC 534, 2013-14, 3 July 2013
2 C&AG’s Report, paras 1, 1.1, 1.4
3 Memorandum to the Committee by ‘Malaria No More’, September 2013.
4 Q 3
5 C&AG’s Report, para 3
6 Qq 4-5
7 Q 45, C&AG’s Report, paras 1.3, 1.10
8 Qq 30-32
9 C&AG’s Report Figure 8
10 Q 7
Department’s efforts to reduce the price of malaria drugs through a subsidy were ineffective because a shortage of drug stocks led to price increases. These constrained otherwise positive results. However, the Department represented such issues to us as “teething problems”. It had expanded its staff resources globally, from 37 health advisers in 2010 to 46 in 2013, to help manage the increased expenditure.

6. The Department has benefitted from reduced costs of malaria products. For example, it tracks the price of bed nets, and found this has fallen in recent years. The cost of malaria drug treatments has also fallen. Funding organisations have improved their efforts to create a more competitive market for malaria commodities and to increase competition between suppliers. But the Department does not have a clear understanding of its cost-effectiveness across the countries it supports. There remain wide variations, which appear attributable, in part, to different levels of disease and to local circumstances. The spending proposals which the Department received from in-country teams generally cited generic global evidence for their proposed malaria interventions, which the Department had itself supplied to them, rather than local evidence on the cost-effectiveness of local malaria interventions. The Department agreed that it needed to improve, and told us that it was working to improve its data on spending on interventions and on outputs and outcomes. While the Department considered its performance was cost-effective globally, it told us it would like to improve the value for money overall and within different countries.

7. There is extensive evidence that malaria returns to populations after control efforts have been reduced. On Zanzibar in Tanzania, the prevalence of malaria twice rose again quickly after anti-malaria programmes ended. There also is a tendency for donors, particularly those within a country, to reduce funding if there is a lower incidence of malaria and it is no longer seen as a priority. We asked the Department how it manages the risk of malaria resurgence in low prevalence countries, and how it factors this into its discussions internally and with partners. The Department agreed that it is vital to avoid the mistake of reducing efforts too quickly. It acknowledged that cost-per-case data should be interpreted alongside the need to maintain a low prevalence. The Department told us that it did not simply focus on where it could achieve the lowest costs-per-case.

8. In its 2010 bilateral aid review, the Department invited proposals from its in-country teams for alternative and innovative proposals for health funding, including for malaria. In practice, the process was constrained by a tight one month timetable for receipt of proposals, and in some countries by a lack of existing programme or specialist health staff. The Department took forward all the proposals received in some form. This represented

11 Q 13-14
12 Q 18-19
13 C&AG’s report 4.7
14 Q 43, C&AG’s Report Figure 1, para 4, 3.25-3.26
15 Q 37
16 Q 43
17 Q 22, Ev XX (Note from DFID)
18 C&AG’s Report, para 4.1
19 Q 46-48
92% by value of all proposals, as it scaled back some proposals at the margin. The Department acknowledged that, in considering proposals received, it needed a wider range of bids from which to choose, and that it should have given the in-country teams longer to put together their bids. The Department emphasised that its initial acceptance of a bid meant that this gave permission for teams to develop a full business case. It then required each business case to include a value for money economic appraisal, detailed evidence, and how the project would be implemented if approved. However, it should have been able to achieve its aim for alternative and innovative proposals more effectively if it had a broader choice of proposals. The Department accepted that future proposals from in-country teams should be more detailed, to enable better comparison and achieve greater competition.
2 Long-term commitment

9. In recent years, global funding has been levelling off at about half the US $5 billion annual amount which the World Health Organisation has estimated is needed for effective control of malaria.\textsuperscript{22} However, over this period, UK funding has been rising. The Department was concerned that the UK is bearing an increasing share of the financial burden in combating malaria globally. It considered this poses a risk to long-term sustainability.\textsuperscript{23} Many African governments under-spend on health compared to their stated commitments, such as those made in the 2001 Abuja Declaration, to devote 15\% of government spending to health.\textsuperscript{24}

10. The UK is recognised internationally as having a strong commitment to international development. The Department can use its position to draw attention to the shortfall in global funding to control malaria and to alert the governments of African countries about the relative under-spending on health. The Department has aimed to do so through the UN, other international organisations, and by working directly with the countries concerned. However, the Department did not see a realistic prospect to reduce UK contributions to fighting malaria.\textsuperscript{25} It was unclear to us how the Department’s advisory professional staff work to influence government spending on health in the affected countries. The Department did not consider that demonstrating any such influence was a top consideration.\textsuperscript{26}

11. One of the challenges in increasing the use of bed nets is the free distribution of bed nets to the targeted high-risk groups, such as the poor, children and pregnant women. Bed nets last for up to five years. This means there is an on-going need for new nets, either provided by donations or bought by individuals. However in Nigeria, the large-scale free distribution of bed nets had suppressed a commercial market for them.\textsuperscript{27} The Department considered that it was 15 to 20 years away from being able to transfer responsibility for the supply of bed nets to the private sector.\textsuperscript{28} The Department told us it wants to instil the routine use of bed nets by populations in malaria affected countries, while also encouraging people to buy their own nets.\textsuperscript{29}

12. The Department recognised that in Nigeria, there had been little appetite amongst donor organisations to fund the repeated distribution of free bed nets to the whole population, to replace worn out bed nets. It intended to ensure that, for the future, the distribution of free or subsidised bed nets was well-targeted on the poorest and most vulnerable people. It acknowledged, in the meantime, the need to develop a commercial market for the longer term. In Tanzania, the Department has funded a voucher scheme to

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\textsuperscript{22} C&AG’s report, para 5
\textsuperscript{23} Q 15
\textsuperscript{24} C&AG’s report, para 4.5
\textsuperscript{25} Qq 27, 49
\textsuperscript{26} Qq 35, 49
\textsuperscript{27} C&AG’s report, paras 4.10-4.12x
\textsuperscript{28} Qq 50-51
\textsuperscript{29} Q 20
\end{flushright}
enable consumers to pay commercial suppliers a supplement in return for a greater choice of bed nets.30

13. Rapid diagnostic tests represent an important and effective advance. The testing devices are inexpensive, small, lightweight, disposable blood tests. They are simple to use and allow accurate diagnosis of cases without access to microscopes. This makes them well suited to use by health care clinics.31 Malaria diagnosis through rapid testing has led to around a halving of the unnecessary use of drugs through the concentration of drug treatment only on those actually infected.32 Until recent years, the majority of anti-malarial drugs used in Africa were taken by people who had not been tested for the disease and who did not have malaria. Evidence of the effectiveness of rapid diagnostic testing has been available since 2007. However the Department described these tests to us as “quite new”. The use of rapid diagnostic tests has increased from 200,000 in 2005 to 74 million by 2011. Most rapid diagnostic testing is carried out in the public sector.33

14. Between 60-80% of people who think they have malaria go for treatment privately. The Department and the Global Fund subsidise the cost of private sector drug treatment for malaria. However, neither has subsidised the cost of private sector malaria rapid diagnostic testing.34 The Department told us it was concerned that blood tests carried out by private sector clinics might be unsafe. It also had concerns that the private sector might avoid carrying out the tests if this meant missing out on profits from sales of malaria drug treatment to people whose tests were negative. However, the Department told us it has been further reassured by the results of recent trials, and therefore considered there was merit in piloting these devices in the private sector.35

15. The global fight against malaria requires partnerships between research institutions in the UK and in developing countries. The Department spends around £20 million a year on malaria research. This involves many of the UK’s recognised global centres of excellence on malaria, including the London School of Hygiene and Tropical Medicine.36 The Department has recently announced a £42 million research programme over five years for product development partnerships. The programme will rely on contributions from academic groups, companies, donor groups, and policy groups, to produce drug treatments which will be made available at cost or near-cost.37

16. The Department has supported the work of the Ifakara Health Institute in Tanzania for a number of years. The National Audit Office found the Institute benefits researchers visiting from the UK and contributes to the Department achieving its goals for malaria control in Tanzania.38 We advised the Department of the case of a postdoctoral fellow from...
Ifakara who intended to work on research at the London School of Hygiene and Tropical Medicine, who had been refused a visa by the UK Border Agency. The Department told us it would look into this case.\textsuperscript{39}
Formal Minutes

Monday 21 October 2013

Members present:
Mrs Margaret Hodge, in the Chair
Jackie Doyle-Price
Chris Heaton-Harris
Mr Stewart Jackson
Fiona Mactaggart
Nick Smith
Justin Tomlinson

Draft Report (The fight against Malaria), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 16 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Twenty-eighth Report of the Committee to the House.

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

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Wednesday 23 October at 2.00 pm]
Witnesses

Wednesday 4 September 2013

Mark Lowcock, Permanent Secretary, Liz Ditchburn, Director, Value for Money and Professor Chris Whitty, Chief Scientific Advisor and Director, Research and Evidence, Department for International Development

List of printed written evidence

1 Department for International Development
# List of Reports from the Committee during the current Parliament

The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

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Committee of Public Accounts: Evidence Ev 1

Oral evidence

Taken before the Committee of Public Accounts
on Wednesday 4 September 2013

Members present:
Margaret Hodge (Chair)
Mr Richard Bacon
Guto Bebb
Jackie Doyle-Price
Chris Heaton-Harris
Amyas Morse, Comptroller and Auditor General, National Audit Office, Gabrielle Cohen, Assistant Auditor General, NAO, Phil Gibby, Director for International Development, NAO and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Department for International Development: Malaria (HC 534)

Examination of Witnesses

Witnesses: Mark Lowcock, Permanent Secretary, Department for International Development, Liz Ditchburn, Director, Value for Money, DFID, and Professor Chris Whitty, Chief Scientific Advisor and Director, Research and Evidence, DFID, gave evidence.

Q1 Chair: Welcome. Again, this is a very interesting Report, so we ask you to see anything that we query in the context of the huge success in rolling out a massive programme. This is a starter question: what strategic objective is the UK achieving by providing all this money to tackle malaria?
Mark Lowcock: The strategic objective is to reduce death and illness from malaria, which is one of the biggest child killers and a great cause of health burden, and therefore economic burden, in many of the poorest countries in the world. Malaria contributes directly to maternal mortality and child mortality, which are the focus of two of the millennium development goals. What we are trying to do is drive down the burden of the disease for the best value for money, particularly because there are now better prevention techniques available—the modern bed nets work better—there is better diagnosis, and there are more modern drugs. This is an opportunity to make big health gains with a number of new tools.

Q2 Chair: And why malaria? Why not HIV or other parasitic infections? I am trying to get a feel for why we ended up with a massive increase in spending in this area.
Mark Lowcock: Yes, that is a very good question. Perhaps I can ask Chris Whitty to say a bit. Essentially, we started with the millennium development goals and looked at the causes of child mortality and maternal mortality. I think malaria is No. 3 after respiratory infections, is it? I cannot remember.

Q3 Chair: HIV is the thing that struck me. Are we spending more here than we are on HIV? If so, why?
Mark Lowcock: The next thing we do, having looked at the problems we are trying to tackle, is look at who else is doing what. Malaria, for an important period—up to about seven or eight years ago—was, in our opinion, under-responded to, whereas there was a bigger international effort on HIV. Maybe Chris can say a bit more about the other things we are tackling.
Chris Whitty: Possibly the place to start is a headline from The Economist last year that said that the fall in childhood mortality in Africa, which is about 40% over the last decade, is the fastest that has ever been seen anywhere, and malaria has made up probably round about 25% of that fall. It is an astonishing achievement globally, in terms of public health. That is the grand strategic reason, in a sense. On malaria diagnosis, most people who attend health services in Africa with their children, who have fever, which is the commonest thing, start off because they think they have got malaria, so malaria is a gateway into a number of other diseases, which are important. If they have not got malaria and they have a fever, they may have pneumonia, meningitis, or a variety of other things that will kill them, so it gives you an entrée to other areas. Malaria is a major drag on the economies of the countries concerned, and particularly for women, who tend to have to be the people who take the children into the hospitals, and who are therefore not able to work. Malaria, of course, has its biggest effect during the rainy season, which is also the planting season in agricultural communities, so the number of knock-on effects for why malaria has an impact is very clear.
We do know what to do with malaria. There is a very good evidence base—much of it developed by scientists from the UK, over several decades—which means that we know that we can actually do this. I think the evidence for that over the last five years is there.
Q4 Chair: Has the increase in expenditure been greater than for HIV?
Mark Lowcock: As far as the UK is concerned, yes. We have significantly increased our funding—

Q5 Chair: From £138 million to half a billion over the period looked at by the Report.
Mark Lowcock: Exactly, quite so, and that is a substantially faster rate of increase than for HIV.

Q6 Chair: What is the HIV figure? Do you know the figures off the top of your head?
Mark Lowcock: I would need to double-check. About half of our funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria is directed to HIV, and about a third of it is directed to malaria, so some vehicles hit both things. I would need to check. It is possible that during the course of the hearing I will get the number for you.

Q7 Chair: When we spend this money, do we spend it where the problems are greatest, or where we think our interventions will have the greatest effect?
Mark Lowcock: Having identified the cost-effective, value-for-money interventions, the next thing we did was look at the places where the burden is highest and the response is weakest, and therefore the unmet need is highest, so the countries in which we are making the biggest effort at the moment—and in which we are asking the Global Fund, which accounts for half the total international aid on malaria, to make its biggest effort—are Nigeria and the Democratic Republic of the Congo, which between them account for maybe half the problem. The response has been weak until recent years, and insufficient numbers of other donors have been coming to solve the problem.

Q8 Chair: So it is more need than effectiveness.
Mark Lowcock: It is both, actually, because the effectiveness is high if the need is not being responded to.

Q9 Chair: The impact might be greater.
Mark Lowcock: Exactly.

Q10 Chair: Given the local variations—Nigeria, I recall from the Report, is an example: if you look at the cost of drugs, although we subsidised them, the cost still went up, because there were not enough drugs—there is an extent to which the intervention can be not very cost-effective, because we do not get everything in place at the same time.
Mark Lowcock: On the Nigeria case, the NAO looked at a couple of surveys of prevalence. I think the first survey was in 2008, at which point it found that 8% of the households of the country had a bed net—

Q11 Chair: 8%?
Mark Lowcock: Yes, 8%, and half the children in those households were sleeping under a bed net, so 4% of the children of that country were sleeping under a net. Two years later, which was the second survey, by which time there had been a big bed net roll-out, 24% of the children of the country were sleeping under a net—an increase of about 6 million. That is an illustration of how, where the needs are high and the measures to tackle them are insufficient, you can quickly have a big effect, but you also alluded to the fact that you also have to think about countries that maybe have made more progress but, if you are not careful, can face a resurgence. We have a significant programme in Burma, for example, not just because there is a malaria problem in Burma, but because there is a high level of resistance to the new drugs. If that is allowed to spread, it will undermine efforts globally, so we have to think about those dimensions too, from a value-for-money perspective.

Q12 Chair: The issue in Nigeria that I was raising was that you shovel in subsidy to the pharmaceutical companies to bring down the price of the drug, but in Nigeria there were not enough drugs around, so that pushed the price up again.
Chris Whitty: Can I correct that, because that is not exactly right? It certainly is the case that stock-outs of drugs in Nigeria have been a problem, and not just for malaria, but for a whole variety of other things that we are interested in. An independent analysis was done on the AMFm—the fund for malaria—that looked at the subsidise drugs in Nigeria—by the London School of Hygiene and Tropical Medicine for the Global Fund. It found that in rural areas the cost of drugs went down during that period of subsidy from $4.47 as a median cost to $1.48 as a median cost. In urban areas, it went from $2.98 to $1.57. It is not correct to say that the price went up.

Q13 Chair: Sorry, what I was saying was that, looking at figure 12, the subsidy should presumably have brought the price of the drug down to the recommended retail price.
Chris Whitty: I will correct that one. The figure is completely accurate, but it is potentially misleading when you read it. All the figure shows is the difference at a particular point in time in price between the subsidised drug with a logo on it and the same thing without a subsidy. It is essentially just a test of the degree to which the market has responded to there being an alternative.

Q14 Chair: Do you want to comment on that, Phil?
Phil Gibby: Yes, sure. The witnesses make a fair point, because Nigeria is a big country and these are prices at moments in time. You will get variations in the different states and between rural and urban. As figure 12 shows, prices in Nigeria have come down, but as we say in paragraph 3.15, price surges happen when you have stock-outs. There will be times when prices go up, but it will only be a moment in time.
Mark Lowcock: If I may come in there, your fundamental point that there are not enough drugs in the market is the key point, and that is what we need to keep working at.

Q15 Chair: I will ask one more general question, and then I am sure my colleagues will want to come in. DFID’s spend on this has gone up enormously, from £138 million to a £494 million projected spend in 2014–15, subject to some review that you are doing this year, as I understand it. In a way that is welcome, but in a way that is very worrying. I am always very sceptical of a massive hike in money invested at that speed, and of the ability to secure real value when you get that sort of growth rate. It is a huge amount of extra money over a very short space of time. I know that your resources are growing, but they are still limited. Is it the best way of doing it?

Mark Lowcock: I think the scope to use cheap, cost-effective interventions to reduce dramatically death and illness is not yet exhausted. My main concern, which is related to yours, is the share of the financial burden that the UK is having to bear. As the Report says, the market is driving this for us to persuade other donor countries—leaving aside the US, which has a creditable record here—and, crucially, increasingly developing countries themselves to take the value-for-money opportunities available by investing in proven measures to reduce the disease. I am worried about the long-term sustainability.

Q16 Chair: But you are not worried about that growth and, within that growth, the massive extra money that went to both the Global Fund and UNITAID. It is huge, huge growth. I have no doubt that they are all brilliant organisations, but you haven’t really tested whether that is the best way of using the money, and I have a niggling fear in the back of my mind that it is too much, too fast.

Mark Lowcock: What I would say in response to that is a decade ago, 5% of the children under five in Africa were sleeping under a properly functioning bed net. According to the UN, that has now got up to about 35%, but that still means that 65% of the children who should be under a bed net are not.

Q17 Chair: I have no doubt about the need: the question is, whether, when you grow spending at that level, you can provide the infrastructure to ensure that money is well spent. The Report says that we should be spending, globally, double what we are now, or something like that—quite a lot more, anyway: £5.5 billion. Globally, there is no doubt a case, but is the infrastructure in place to manage this sort of speed of growth effectively?

I will point you to one thing. You talk about nets a lot. At one point in the Report, in paragraph 3.5 on page 27, it says that in Tanzania there was “limited effect on overall bed net usage because logistical problems delayed the follow-up campaign reaching parts of the country soon after the net distribution”; your infrastructure was not in place to make sure that the nets you got out there were used. The next part of the paragraph states that, similarly, in Nigeria, “the managing agent had mainly focused on increasing bed

net coverage, limiting work on creating a demand for bed nets that increases usage.” For me, that is an example where you shovel the money in and get the nets out there but you have not had time to create the infrastructure to make sure that they are properly used.

Mark Lowcock: In the Tanzania case, as the figure opposite that paragraph says, there was an increase in the use of nets, and there has been a reduction in prevalence from about 18% to about 9% in Tanzania over the past several years. That reflects the fact that, partly through us, partly through what others are doing and partly through the effectiveness of campaigns—one thing that has happened in Tanzania is that they have had to switch from an old style of net, which had to be dipped in insecticide, to a new style that does not but that needs to be used properly, so a campaign was needed to help people with the transition from the old style to the new style—the effect of the campaign and the greater distribution has been to reduce the prevalence.

Q18 Chair: I am sorry to interrupt you and I am sure that, overall, there has been an improvement. But the Report actually says “the exercise had limited effect on overall bed net usage because logistical problems delayed the follow-up campaign reaching parts of the country”.

Mark Lowcock: I think that the communication exercise had some teething problems in its first phases. What I am saying, however, is that if you look forward to the outcome the communication exercise was supposed to achieve, which was higher proper usage of nets, the evidence so far is actually quite encouraging.

Q19 Chair: So you are disputing this finding?

Mark Lowcock: No, I don’t dispute the finding. I think it is a good Report, and I agree with all the recommendations. It is absolutely the case, as the Report says, that there are teething problems with lots of things we do. All I am saying is that it is not my view that the UK is doing so much in this area that we have lost the capacity to manage it well. We have beefed up our staff resources, we have better evidence, and we have better management of our portfolio. I would like other countries to be doing more of this, but I am confident personally that we are getting good value for the taxpayer from what we are doing.

Q20 Mr Bacon: I went round a bed net factory in Tanzania at the beginning of this year. It was making nets of the latter kind that you described, which do not need dipping, because essentially the insecticide is impregnated into the filaments as the net is made. The nets have an efficacy of about five years before the insecticide that is built into the net dies off. It was a very impressive operation, and outside the factory there were a whole load of logos—I did not see a big DFID logo, actually, although I think DFID was contributing—to a whole lot of different donors. The factory created a lot of local employment, as well, and the quality control was of quite a high standard—we watched it happening. But I also had the sense that although it was a hive of activity and it looked fairly robust in one way, in another way it was fragile,
because you sensed that the moment all the financial support from abroad was taken away, the whole thing would collapse. What is plainly needed is for an indigenous bed net market that works. These nets, by the way, were being subsidised and sold at a discount through pharmacies and so on rather than being given away, which is presumably a better way of doing it. I did have this sense of impending doom, a kind of fragility around the whole thing. It did not feel to us as if the indigenous market or the indigenous demand were there, or that the education was there, to make sure that this venture would carry on and indeed make and export nets all over Africa. It did not quite feel like that.

**Mark Lowcock:** Is this the factory in Arusha?

**Mr Bacon:** Yes.

**Mark Lowcock:** I have not been to it but I am familiar with it. I have a couple of points in response. First, it is very good that there is this African factory which is producing for the domestic market but also exporting to the region. For us the key thing is that they can do that at an internationally competitive rate, so that there is not a subsidy to the producer and so that there is competition in the bed net market. The second point is that producers need clarity about long-run demand. Clearly there is a long-run need because the net life is five years, so they have to be replaced. The question then is who is going to finance the purchase of the nets. Our view is that as time passes the international community should finance less. A number of African countries are deciding that the provision of a bed net, for example, to a pregnant woman should be part of their free health service for every pregnant woman. We think that is probably a sensible strategy. It is one of the things that will contribute to sustaining a permanent demand for these nets.

Our main worry for the moment is that there is a significant risk of demand falling off quickly. It is how to do the other thing you talked about, Mr Bacon, which is to inculcate into the local society and culture the value of a net to such an extent that people increasingly will be ready to use their own resources to buy them if they are not a pregnant women with a young child. This is the long-run basis for some sustainability. We hope that if African countries keep getting better off, and people see the value of these products in saving their children, that will be the direction of travel. However we need to keep following it, keep tracking the prevalence, make sure that where there is a public subsidy it is focused on the places where without subsidy, improvements would reverse. There are a lot of things to keep an eye on to achieve the goal you set out, which I support.

**Chris Whitty:** With the education being there, you should be able to make the indigenous market work. These nets, by the way, are being subsidised and sold at a discount through pharmacies and so on rather than being given away, which is presumably a better way of doing it. I did have this sense of impending doom, a kind of fragility around the whole thing. It did not feel to us as if the indigenous market or the indigenous demand were there, or that the education was there, to make sure that this venture would carry on and indeed make and export nets all over Africa. It did not quite feel like that.

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**Q21 Chair:** Why?

**Chris Whitty:** Because the subsidy and the free net distribution are being targeted at the people who could get malaria, who tend to be in the poorer, rural areas, and that has worked.

**Q22 Mr Bacon:** Could I ask about the way in which you evaluated the bids that came through? In paragraph 2.6 of the Report it says: “Country teams generally cited generic global evidence that the Department supplied to them on cost-effectiveness of malaria interventions, with little evidence on levels of cost-effectiveness achieved or achievable in their countries.” Without that sort of evidence being supplied by the different country bids, how did you evaluate the bids that came through?

**Mark Lowcock:** This is an area that we need to improve on. I agree with the recommendation. Perhaps Liz can tell you what we did and what we need to do better in future.

**Liz Ditchburn:** The process that we went through, which is part of the bilateral aid review that we have discussed with the Committee in the past, was to take all those offers, to screen them for quality to make sure that only offers that represented a reasonable level of quality in terms of the information presented and that could meet value-for-money benchmarks would be looked at in aggregate to see whether the congregation of the offers from different countries made sense in terms of the prevalence and the disease burden in different countries and in terms of the...
amount of funds that potentially the Department could allocate towards that.

For malaria, we were able to do some limited looking at the value of a multilateral root and the value of bilateral roots, although as the Report points out, and we agree, we would like to take those kinds of comparisons further in future. We looked at all those factors, and that resulted in accepting the majority of the bids that came forward, or the majority of the value of the bids that came forward on malaria.

There is something quite distinct about the malaria work. From my perspective as value-for-money director, this is one of the areas where I feel more confident because the evidence base is so strong. The evidence base around the potential—we know what works and we know what does not work, and we know that if those things work, we have real returns—gives us some real confidence. The Report rightly points out that even within that, it is a very cost-effective thing to do overall, but within that we would like to push it even further and get even more value for money.

The Report demonstrates that these interventions outperform global benchmarks on cost-effectiveness for health interventions, but of course we would like to take that even further and extract from it every single ounce of value that we can. But that confidence that we have in the evidence base and in the fact that we know what works gives us a very strong basis upon which to go forward.

Q23 Mr Bacon: The Report says in paragraph 2.7 that there was a constraint because there was only a one-month timetable for the teams to get their bids together. A figure of 83% is quoted. It sounds very much like, “We’ve got a big pile of money and we need to get it out of the door. Bid please, and by the way, you haven’t got very long in which to bid,” and more than four out of five were accepted.

Liz Ditchburn: But, as we have said to the Committee before, that initial acceptance of the bid only gave people permission to pursue the idea and develop the full business case. Those bids all had to go through the production of a full business case, which included the full value-for-money economic appraisal, pulling together the evidence in more detail and looking at implementation and how the project would be taken forward. Only once that business case was actually approved could the project go ahead.

Q24 Mr Bacon: But you still ideally want a wider range of bids from which to chose than you had and you probably want to give the country teams a little longer to put their bid together, don’t you?

Liz Ditchburn: Yes.

Q25 Chair: And how many did you knock out in that exercise?

Liz Ditchburn: All the offers went forward in some form.

Q26 Chair: Because it is 92% of the value.

Mark Lowcock: Yes, some were scaled back or pursued in other ways.

Q27 Chair: It does not look very rigorous—at this end, it does not feel it when you see that 92% of what was bid, in value terms, was accepted. I agree with Richard.

Liz Ditchburn: The diagram in figure 8 shows that, in the main, where malaria mortality is a major issue, we are investing in those countries. That distribution is the distribution which said, “yes, that set of country offers—which was bottom-up” which we believe is important because it is important that countries are determining priorities and that we are working in the context of those country priorities—that we are able to take into account which other donors are active and where the Government have a clear, strong strategy that we can get behind. All of those factors also come into play to select where we think we can have an impact. That distribution of bids was where we decided we could have an impact.

Mark Lowcock: In one way, it is a commentary on how very bad the previous response to malaria was that there were so many easy wins. In future, it will be essential to do exactly what Mr Bacon and the Report say, which is to be much more granular. We have had the low-hanging fruit. In future, we will have to be much more rigorous to ensure that there is more comparison and competition, because we will be trying to trade off between harder to achieve objectives. That is the value for money challenge.

Liz Ditchburn: And the data will be better. When we do this next time around, we will have, and are already building, a much stronger database in terms of information at the country level. The data that we will use to make choices will be even stronger.

Amynas Morse: Taking that future theme and looking realistically at where you come in the stack of international funding for malaria—I am quite sure that the USA is the biggest donor by a long way—I understand it to be the Global Fund and yourselves, both separately and jointly, so you are in a position where you are holding quite a significant proportion of the roof up. It would of course be great if you could persuade other people to come in, but you are in this for the long haul, are you not?

Mark Lowcock: We are going to try to accelerate the rate at which other people take up the burden. We are developing a lobbying campaign to spread what is essentially the good news portrayed in the Report and to encourage other people to get some of the reflected glory of doing as much good as you do through this. We have meetings planned at the World Bank and the UN over the next two or three months to market all this. Crucially, it is also about what developing countries themselves can do over time. The per capita health expenditure in Africa is very low, but it has been growing quite fast, so how they use that growing resource and how we portray to them the success that they are having will have an effect on how fast we can reduce the costs we need to bear.

Amynas Morse: I am not trying to make more of it than this. However, looking at the wall of water coming towards you in a few years’ time and looking at the fact that capacity is not being served now, realistically for the expectations of the British public, the chances of your being in a position any time soon of reducing the level of donations from the UK are—
to be frank, it does not sound terribly realistic to me even if you get these responses.

Mark Lowcock: I agree with that. It would be very bad value for money to allow there to be a reversal of the gains. There is a rather good picture on page 29 of the Report regarding Zanzibar, which is not a story about which anyone should be anything other than a bit ashamed. Prevalence came down. Then it went up again. Then it came down and went up again. Now it is coming down again. We should try to be the generation that keeps it down.

Q28 Chair: Can I ask about another distribution? I have a feeling that there is so much money that you can hardly get it out the door. There is a global goal to halve deaths from malaria by 2013 in 10 countries.

Mark Lowcock: 2015, yes.

Q29 Chair: You said at the beginning of this session that 50% of the deaths—I am not sure whether it was incidence or deaths—were in two countries.

Mark Lowcock: 50% of the total burden. I think that is incidence. Is it, Chris?

Chris Whitty: Yes.\(^1\)

Q30 Chair: Incidence. We have this global target and you have this knowledge that 50% of the incidents are in two countries and yet you fund in 17.

Mark Lowcock: Yes. I have a lot of sympathy with the direction of the question. One of the things that we have been doing is trying to get a greater effort in terms of resources from the countries themselves and the international communities in those two countries.

Q31 Mr Bacon: Can you just remind us which they were?\(^1\)

Mark Lowcock: DRC and Nigeria. It is the case that you also have to cover your back and avoid a decline in other places and learn the lessons from other places. The nature of the malaria challenge varies quite a bit from country to country. As with the Burma example that I gave earlier, we need to tackle drug resistance. We have said to the Global Fund, the biggest financier, that we want it to do a lot more in Nigeria and the Democratic Republic of Congo. We asked it to use its system, which requires the host country to pay a proportion of the costs. The Nigerian Government can get a lot of help if they have to use more of their own resources, of which they have some, if not sufficient, to tackle the problem. Those are the things that we have to weigh up in doing exactly what you have said.

Q32 Chair: Looking at figure 8 in respect of Congo and Nigeria, the number for Nigeria, in particular, is pretty low. You do it in particular localities. You talked about it being the low-hanging fruit. It does not look to me to be entirely consistent with your own stated and global objectives.

Mark Lowcock: I definitely think that we should be doing more in the likes of Nigeria and DRC, and reducing what we do in other places. To come back to your earlier point about the rate of scale-up that we can manage: in Nigeria, when we were starting this, there was a dreadful just 4% of children sleeping under a net. It is a big challenge to gear up a system to deal with that. I confess that I was worried about our ability as an organisation to manage the scale-up. I have been proved wrong. We have been able to do that better, and now we need to make sure that everyone invests still more—having proven the interventions and the success in those two countries.

Q33 Meg Hillier: I want to pick up on a couple of points that have arisen, and then I have other areas that I want to cover. I am looking at page 15, figure 4 and it is interesting to see that global funding overall is levelling off, which will leave the UK as the third biggest donor worldwide and the biggest bilateral donor. Does that give us some purchase power in terms of diplomatic negotiations with the countries that are supposed to be putting in?

Mark Lowcock: It does—I hope so.

Q34 Meg Hillier: Do you feel that it is increasing, because there has been a Government commitment across two Governments to increase our aid budget and keep it at a sustained level? Has that given us more clout?

Mark Lowcock: Maybe I can make a point about the picture. It is about the control effort: prevention as opposed to treatment, and so on. Of course, there is a big expenditure, met to a heavy degree by developing countries themselves, in dealing with cases of about $12 billion a year. That slightly underestimates the picture of what developing countries themselves are doing, especially in Africa. “Yes” is the answer to your question. To give you some examples: in Ethiopia, we basically lobbied the Government to increase the funding for malaria in the health budget on the back of that success. That is a strategy we are encouraging all of our country teams to replicate according to their own circumstances. We are doing the same thing with other international donors.

Q35 Meg Hillier: Have you any evidence or are you gathering any evidence to show how effective that has been?

Mark Lowcock: In the nature of this, let us say that the Ethiopian Government are increasing their spending on malaria and doing very well as a result of that. There are many people who want to claim the glory for it. It is not our goal to claim the glory. Our goal is to solve the problem. I can give you examples of when we believe that we have an influence, but claiming the influence is not the top thing.

Q36 Meg Hillier: No, I can see that. But we are all representing taxpayers who are contributing. I absolutely support this. I should say that I chair the all-party group on Nigeria and the all-party group on global health, with Lord Crisp, so I have quite an interest. A lot of my constituents are very supportive of this, as it happens, but it is taxpayers’ money. It is not a question of the money; we should be using our influence to make sure that other Governments around the world are putting their money in. You are being very diplomatic.
**Mark Lowcock:** I completely agree with you. We will do everything we can, exactly on the lines of that objective.

**Q37 Meg Hillier:** Some tough diplomacy does not hurt on this issue because children are dying, and that is obviously important.

I want to pick up some of the points that have been raised. Richard Bacon went into one of the areas that I am interested in, such as the commercial side of it.

Again, given the position as a donor, what purchase power is there in getting the price down? We are talking about support and manufacturing, and so on.

The Bill & Melinda Gates Foundation conducts tough commercial negotiations to make sure that the price of the drugs it is dealing with is really screwed right down. Does DFID have that capability, and have you got evidence you can point to? There is some evidence about the price of drugs going down, but can you point to a systematic approach?

**Mark Lowcock:** Yes. I will ask Chris to give you some of the detail, but the basic story is that drug and net prices have come down. More suppliers are emerging, because demand is higher, so there is scope to generate some revenue. The funders have got much better and tougher at creating a market, driving competition through it and therefore getting value for money. That is the basic story; the devil is in the detail. Perhaps Chris can give some examples.

**Chris Whitty:** I think the answer is yes, but it has to be done through multiple, different methods. The first and probably most powerful is investing in new drugs, because when you have proper competition between different companies with different drugs, the price tends to fall. When there was only one pre-qualified drug, the price was substantially higher than when the next one entered the market. This is as you would expect. DFID invests quite heavily in new drugs, largely because we are afraid of the resistance spreading, which is something we need to fend off.

The second is that, with several players in the market, there is a relatively small number of pre-qualified drug manufacturers, but there is only one major bidder, which is the Global Fund, which therefore has a lot of financial muscle. We fund the Global Fund and we also fund UNITAID, which does a lot in terms of market intelligence, forward planning and all the things that reduce risk pricing into drugs, so there are things to do with shaping the market.

**Q38 Chair:** Explain that to me. I had assumed that the Global Fund was an NGO.

**Chris Whitty:** The Global Fund is a multilateral organisation; it is not an NGO in the ordinary sense.

It is the route by which the great majority of these drugs are bought.

**Chair:** It is the buyer.

**Meg Hillier:** It is not competing.

**Chris Whitty:** It is the buyer of a competing group of drug manufacturers. Clearly, the more manufacturers there are, the better shape you are in, from that point of view. There are some areas in international development, such as neglected tropical diseases, where manufacturers have done fantastic things, giving free drugs. Malaria is far too big an issue for that. What most of them are aiming to do, in their public pronouncements, at least, is make neither profit nor loss in the area of malaria. That is the next piece of the puzzle.

There are two final pieces, one of which is that the more you drive down malaria, the fewer drugs you need. Until recently, the majority of anti-malarials, particularly in Africa, but probably in Asia as well, were given to people who did not have malaria, because of poor diagnosis. We are doing a lot to try to help strengthen the diagnostic side, so that we do not waste drugs on people who have got other problems, but who do not have malaria. If you add all those together, that has an enormous impact. Each one of those is not dramatic, but if you add them together, that is quite a substantial impact.

**Q39 Meg Hillier:** You mentioned diagnostic tests. I have seen the little diagnostic unit.

**Chair:** I think we have one here.

**Phil Gibby:** Shall I show it?

**Chair:** Yes.

**Q40 Meg Hillier:** They are so light and simple and easy to use. I have been out in Nigerian villages and have seen how little medical support there is. Also, through the all-party parliamentary group on global health, I did a report about what role lower-level health professionals can play. That brings me to several points: the diagnostic test and what you are doing to make sure that diagnoses are right; which level of health practitioner you are targeting it at; and how you are educating people about net distribution.

Beyond the supply of the nets, drugs or diagnostic kits, what are you doing about the implementation, because that seems to be the key thing? If we look at figure 10, the change is interesting; once the nets are there, if the education is there, people use them. It is nets used that matters. Are you measuring nets used, or nets distributed? It is easy to count nets distributed, but not so much the nets used.

**Chris Whitty:** That is several questions in one. I will try to answer them. I will divide them into two blocks.

The rapid diagnostic tests have been potentially transformational in the area of diagnosis, because they are simple to use. They were initially tried out in the formal health care setting by doctors and paramedics under supervision. They looked as if they worked moderately well there, but they did not change practice much, because the alternative was microscopy. Then they were taken to the next level down, which is peripheral health care clinics, where they led to about a halving of the unnecessary use of drugs. They did not get rid of it, but they led to a substantial improvement.

**Q41 Meg Hillier:** What level of professional would do that?

**Chris Whitty:** This would be a nurse out in a village health post. More recently, we have been trying them out in the private sector—not meaning a guy in a pin-stripe suit in Harley street, but a shop that sells lots of things, including drugs. The private sector is what provides malaria care for the majority of poorer people in most African countries.
The NAO Report makes the point, which is entirely fair, that currently we have not been subsidising or using rapid diagnostic tests, as opposed to the other ones, in the private sector. The reason for that is that there are substantial risks in doing it, which we wanted to be sure were not there. The first is a risk to both children and shopkeepers. These are countries where there is a high prevalence of hepatitis B and HIV. You do not want to give out blood tests to people until you have tested out whether this is a safe thing to do. The second thing is that the incentives for a shopkeeper are not, obviously, to use the test not to sell a drug that they are going to make a profit out of. We wanted to test out what the ways are in which you can get these to work in the private sector, where the system is completely different. Thirdly, we want to know what they would do with the people who do not have malaria. In my view, data are not yet in the public domain, but there are now trials coming out, including some that I have been involved in, that I think show that in the private sector it probably will be safe, so the next logical thing is to try and pilot settings and try them out in the private sector. Our view was that to do that too early was potentially dangerous and not something that should be undertaken. We agree with the NAO finding that we are not doing it, but there was logic behind that decision.

Q42 Meg Hillier: May I just chip in about the most rural areas, where you have to walk for days to get to a clinic? Is there any attempt to get this out through very local non-health workers, but trained people? Chris Whitty: Yes. That is increasingly the way people are moving. As you imply, that is where the biggest problem in people accessing health care is, and also where the biggest burden of malaria is. The logic is absolutely different. Further and further down the system, but at each stage, it is about checking that it is safe before you do. You do not want to end up with a disaster on your hands that could have been prevented. There are various pilots going on.

In terms of your bed net questions, which are a different set of questions, inevitably, slightly fewer people sleep under nets than have nets. By definition, you cannot have more people sleeping under nets than have nets; inevitably, it is less than that. In reality though, what we found is that the difference is relatively small. In most places, it is around 80% to 90% of people who have a net sleep under it. The rates are pretty good. What is encouraging is that on average, it is the poorer people in the rural areas who are more likely to sleep under nets. They are the ones who are more at risk of malaria. There are also some variations in terms of timing during the year, which sometimes I do not think is picked up in the broad sweep. For example, in northern Nigeria, which you know a lot about, almost all the malaria transmission occurs in about three months of the year—just in the rainy season. There is almost none in the rest of the year. The time, rightly, when you really want people to sleep under the bed nets is in that period. It is preferable if they do it in other periods as well, but the implications of sleeping under a bed net are much smaller. As the Report says, if you are sleeping under a bed net in a hot, humid climate—a hot, dry climate in northern Nigeria at that time—that can be quite problematic, so it is not an entirely straightforward situation.

Mothers in Africa know about malaria; their children get malaria four or five times a year. The idea that they need to be taught that bed nets are important can tend towards being a little bit patronising. They are very well versed in this, in most cases.

Q43 Meg Hillier: I would certainly say yes. I second that one. Going back to cost-effectiveness, figure 9 on page 23 shows—it is from a good base; the NAO looked at 43 studies to get these data—the maximum and minimum potential costs. There is a big spread. Are you monitoring, as a Department, the efficiency between countries? We heard what was said earlier—that different countries have different needs and issues—but are you looking at where you can learn lessons?

Mark Lowcock: One of the things that the Committee has asked us a lot about over the past two or three years is unit cost data down to project level, country level and so on. One of the data things we track now on malaria is bed net costs by project and by country, so we do have that. As you say, particularly for bed nets, the range in the left-hand side of figure 9 looks amazingly wide. The reason for that is not primarily to do with differences in the cost or distribution of the nets, but to do with whether, if you have a net, you are likely to be prevented from getting malaria. If you are sleeping outside in a place where there is a lot of malaria and you do not have a net, you are highly likely to get it. If, on the other hand, you are in a different place where there is a bit of malaria but not so much, you are less likely to get it. The reason why the range is so big is to do with the prevalence of malaria. Clearly, you could say, “Let’s use most of the nets in places where the problem is biggest,” but we also have to deal with the resurgence risk. The chart is helpful in making the point that almost all the activity is in the cheaper places. The top line is there for a reason, but it does not convey the sense that we are spending masses of money on loads and loads of nets in places where there is not a need to do that.

Q44 Chair: What is interesting about this graph is that it almost looks like you are spending on cure rather than prevention. It is a bit naughty to say that, but there is an element that, just on a cost basis, looks like cure is better than prevention.

Mark Lowcock: That is a very good point. Of course, when you apply the drug, you do it because you know the person has got the disease—you hope you do, anyway. When you give them a net, you are trying to stop them getting the disease.

Q45 Chair: So in a way it is a crazy comparison.

Mark Lowcock: It is a good comparison to have, as long as you interpret it sensibly. Can I answer the question you asked earlier, which I could not answer? On average, over the last two years, we have spent...
£200 million on HIV. That is actually a little bit lower than in some previous years, because other donors were funding more, so we felt that we should shift into the underfunded places.

**Q46 Meg Hillier:** Going back to the interesting figure 15 on page 39—the Zanzibar example—it strikes me that we should ask, as you said, “How can we have got to the point where we got things right down, and then they went back up again?” But of course the lower the prevalence, the higher the cost of the benefit per individual. How do you factor that into discussions, both in the Department and internationally? We are seeing a global funding decrease, though I know there are caveats to that. Is there a tendency for other funders, particularly in-country, to reduce the funding, so it is no longer the top priority?

**Mark Lowcock:** I think this is a really difficult challenge. Perhaps I can illustrate the challenge with reference to polio. Until recently, in all bar three countries—Afghanistan, Nigeria and Pakistan—polio had been eradicated. Now, unfortunately, there is a resurgence in Somalia and northern Kenya. The cost of eradicating it in the remaining countries is very high. By definition, the closer you get to the end, the higher the unit costs are. There is something a bit counter-intuitive about the fact that it gets more expensive the more of it you do. We have to keep in mind the fact that the danger of resurgence is what justifies the higher costs. Everyone who follows this issue should have the Zanzibar picture imprinted in their head, because that will help us to avoid repeating the same mistake.

**Q47 Meg Hillier:** Agreed. There should be a postcard for campaigns.

**Liz Ditchburn:** Your point is exactly why we are very cautious about using unit costs or some of the cost-effectiveness data as a mechanistic means to determine where we go and where we act. Rightly, we need to be tracking those data, we need to be very conscious of them, and we need to use them to look at what we can learn from what is working better or more cheaply somewhere else. What we absolutely need to do is bring all those other factors into play as well. That is what the business case process, which I was describing, is intended to do. That is where people need to put the unit cost information on the table, but put it into the context of what we are trying to achieve and the value of what we are trying to achieve. We need to be very cautious about going to a simplistic place, or saying “We will go where the best unit costs are.”

**Q48 Meg Hillier:** Absolutely. It is about interpretation. Can I pick up on what Mr Lowcock touched on? I asked whether other countries—particularly the Governments of developing countries—are reducing funding when it gets to a low level. There can be pressure from the MDGs. When I go to Nigeria now, they talk about the MDGs the whole time. Polio is one of the things that everyone is talking about at the moment. It seems that polio is up—it was down; now it is coming back up again. It is an embarrassment. I have not got a sense of this, but I know that they are reducing funding for malaria. There can be perverse incentives for Governments to change their funding approach, depending on those international, global headline pressures.

**Mark Lowcock:** This is a big problem in Nigeria. They are instrumental on polio, and we want to help them tackle that. They have a massive malaria problem, but they also have a massive under-immunisation of young children in the north of the country. There are three big things that they need to do together, and not stop-start the whole time. There are one or two countries, of which Nigeria is an example, where that is a real problem. Maybe Chris can correct this if it is wrong, but I have not seen countries that are further along the journey of bringing malaria under control phasing it out too quickly in the current phase. I think most countries have got that you need to keep going with this. To some degree, people have got the Zanzibar picture in their heads, but we will have to keep an eye on that and not pull back too quickly.

**Q49 Meg Hillier:** What can DFID do, realistically, to ensure that does not happen?

**Mark Lowcock:** There are obviously the things we can do through our own programmes. Because the UK is recognised internationally for having a strong commitment to development and a lot of expertise on various topics, we can use our position as a leading donor in lots of institutions to convey this message. That is what we are trying to do through the UN and other international organisations. There is also what we try to do at the country level. The Report makes the point that that is one of the important things our advisory professional staff should be doing at the country level.

**Q50 Meg Hillier:** I have two quick points. I will not go into arguments about the commercial supply of nets again, because Richard Bacon went into them a lot, but figure 17 on page 42 sums up the challenge of nets that become less effective three to five years on. You talked a bit about it earlier, but can you give us, now or later, an example of a country where it is working really well—where there has been a mass distribution programme, prevalence has dropped and you know with confidence that the market has been developed so that there will not be need for a mass distribution programme at the same level in a few years’ time?

**Mark Lowcock:** I will ask Chris to add to this, but my personal experience, having seen a bit of the malaria effort in east Africa 10 or 15 years ago, is that people reduced the subsidy too fast. There is a sort of implication that you can do one round of free nets and then commercial ones. That is not my personal view. My guess is that certainly somewhere like Nigeria, and for pregnant women and under-fives, you would need to do multiple rounds of free distribution, ideally through the public health system, before you can get to the point where you can rely on people to use whatever scarce resources they have to buy their own nets. That would be my guess.
Chris Whitty: I completely agree with that. I do not think any country with a high risk of malaria has yet got to the stage where it stably had a high enough coverage to start thinking that it could take the foot off the accelerator and try to transfer over. You absolutely want to avoid a stop-start thing, where you begin to develop a private sector and then it does not work and you have to go in with subsidised nets and knock the bottom out of that private sector. That would be the worst possible outcome. It is going to be a matter of taking our foot off the accelerator quite gradually.

Q51 Meg Hillier: We are talking 15 to 20 years easily.

Chris Whitty: Yes. That is the kind of time frame it is sensible to plan for. If we can do it faster, great, but it would be silly to say “The troops will be home by Christmas” kind of stuff.

Q52 Meg Hillier: There is 4.8% of the UK aid budget that goes on malaria prevention treatment. Professor Whitty, you talked earlier about the investment in drug development. Of that 4.8%, how much goes on that? If you cannot give me a figure or percentage now, perhaps you could drop us a line.

Chris Whitty: What percentage goes on research or what percentage goes on products specifically?

Q53 Meg Hillier: You were talking earlier about developing new drugs. I am not sure if you were talking about research or both. Perhaps you could break it down.

Chris Whitty: Overall, we spend around £20 million a year on research as a whole. I will need to double-check my figures. The Secretary of State has just announced funding for a round of research for malaria. She announced that over the next five years there will be £25 million for drugs, £12 million for new insecticides, because there is an increasing problem of insecticide resistance in Africa, and £4 million specifically for a particular kind of blood test that you need to use for vivax malaria, which is the main form in south Asia. That area also has a malaria problem, although we have talked almost exclusively about Africa. There are also some smaller amounts. In terms of product development partnerships, the Secretary of State announced a package, and that constitutes about 30% of the amount she suggested. Per year on average about £10 million goes on product development partnership things specifically for malaria.

Q54 Chair: I do not understand that, because she announced £138 million.

Chris Whitty: That is right.

Q55 Chair: Over what period is that?

Chris Whitty: That is over five years, so £138 million over five years, of which about £42 million is directly or indirectly around malaria, so that is around 30% of that total.

Q56 Chair: I see. In terms of research, where are the companies based?

Chris Whitty: This is obviously very different from what we do on trials, operational research and other practical things, but in terms of managing products, the mechanism that is being used is what is called product development partnerships. These are combinations of academic groups, companies that have agreed to produce drugs at cost or at near-cost, and donor groups and policy groups. Essentially, what they do is run as a virtual pharmaceutical: they take chemical entities from multiple different places—different companies and from the academic sector—and try them out in standard phase one—

Q57 Chair: Are they UK-based companies? Are they based in the developing world, or are they Swiss-based companies?

Chris Whitty: The product development partnerships tend to be based in northern countries. UK companies, and particularly UK academic groups, are some of the main people in this. But, as you know, UK aid is untied, so there is no bias towards the UK. The UK, though, has one of the largest groups of malaria researchers in the world. It has led malaria research in many areas for many decades and, as a result of that, some of the expertise in this is UK-based. GSK, for example, is one of the companies involved. Many of the major universities that do tropical research—Liverpool, London School, Oxford—also contribute in different ways to this.

Q58 Mr Bacon: To what extent do you co-operate with the Ifakara Health Institute?

Chris Whitty: Personally, I have been collaborating with it for many years. DFID has actually supported it over a number of years, and we are changing the modality of funding, but we are continuing to support it in Tanzania.

Q59 Mr Bacon: Would you agree with me that it would be ridiculous for British taxpayers’ money to be used to support the Ifakara Health Institute yet for a postdoctoral fellow to want to come to this country to work on research at the London School of Hygiene and Tropical Medicine and find the UK Border Agency refusing them a visa?

Chris Whitty: I think the question rests.

Q60 Mr Bacon: Well, for the record, would you tell me what you think? Would it be ridiculous? I think it would.

Chris Whitty: That is an opinion. I think I would be severely chastised by my colleague from the Home Office if I answered.

Q61 Mr Bacon: I can tell you, because I have talked to the Immigration Minister. I think it is ridiculous and it sounds ridiculous to everyone I have mentioned it to because it is ridiculous. I have visited the Ifakara Health Institute which, as you will know, is owned by the Government of Tanzania and the Government of Switzerland. It does have a lot of other international co-operation and if I were a young scientist from this country, probably before I had finished my doctorate I would want to go and do a bit of my research there, or to be working
there on a postdoc for two or three years. It is a lovely part of the world, on the east African coast, and I can think of few nicer places that I would want to go, so I would have thought that that was a pretty attractive gig for a lot of people. But plainly, in terms of academic transfer, the flow ought to be both ways, and I was told when I visited it that it was having problems with the UK Border Agency. I know, because I have raised this with the Immigration Minister, that he is keen that there should be bespoke, tailored visa programmes for specific, high-quality, recognised, verified, authenticated institutions so that when the application comes through, it has already got all the kitemarks that it needs and they go, “Uh-huh, it’s the Ifakara one,” and it automatically gets the visa. That is not in place at the moment, as far as I know, but I believe that if you were to talk to UKBA and the Home Office, you would be pushing at an open door, because the Immigration Minister told me that that is exactly the thing that he is looking to do more of in the right place.

Chris Whitty: Can I give one answer to that, which I think I can give without offending anyone? There are two things it is probably worth being aware of. First, our permanent secretary, Mark, is co-chairing something on higher education with the permanent secretary at BIS and I am sure that these kinds of issues will be raised. The other thing to say—I think this will be true for any organisation anywhere—is that sometimes what happens in practice and what is meant to happen does not always completely gel.

Fiona Mactaggart: And that is always the case in the Home Office.

Mr Bacon: Quite, which you say as a former Home Office Minister—we have two former Home Office Ministers on this Committee. But it struck me as ludicrous, as it did the people with whom I was on the visit with. Actually, the chair of the all-party parliamentary group on Tanzania is also the chair of the all-party parliamentary group on malaria: Jeremy Lefroy, the MP for Stafford. We went there with him; he used to live there. I fully appreciate your point—that there is many a slip twist cup and lip in the organisation and architecture of large organisations, and things can go wrong that should not. However, I think there is scope to create a bespoke programme in this area that would increase the quantity and quality of academic exchange, and you should look into that.

Q63 Chair: It is just that when I recently went to Nepal I felt that too much money was being spent on monitoring and evaluation as a proportion of the money out there, so I would be interested in seeing what it is in this programme. You don’t know, do you Liz?

Liz Ditchburn: No.

Q64 Chair: Just to get another thing clear and on record: although everybody is keen on this, according to paragraph 3.3 on page 25, you don’t report results against expenditure or progress against milestones. Are you going to do that?

Mark Lowcock: Yes, Chair. Part of the value of the Report is that it encourages us to do that not just in what the NAO was reporting on, but more widely across the board. We have added a substantial number of indicators that we are tracking and I am very happy to send you the full list of tracked indicators, if it will be helpful. We are absolutely going to do that.

Q65 Chair: Thank you. Paragraph 2.10 on page 24 says that although you are doing more analysis, that has not led to more robust judgments. That is a pretty negative view.

Mark Lowcock: Coming back to an earlier point we raised, having picked the low-hanging fruit, a lot more weight will rest on the quality of judgment and analysis in future. I suppose in one way we have been lucky to have the time to prepare for that. Certainly we updated the guidance on business cases at the end of last year in the light of the experience of the first 18 months, and stronger use as well as production of analysis is one of the key things we are trying to motivate.

Q66 Chair: We have talked a little bit about the tests—they have done the rounds around the Committee—being very important and effective. You had evidence from the Senegal programme in 2007, so it goes back a long way and we have known that they are a good thing for a long time. However, it appears to be really difficult to replicate. We are told in paragraph 3.9 on page 28 that Global Fund chooses not to fund tests consistently alongside treatments. There is also figure 11, on page 29. The Report goes on to say: “The Department recognises the need”, but what is it doing? You recognise the point, but this is about action, really.

So there are two questions there. One is specific to Global Fund: why aren’t you, as a major funder, bringing pressure on them to do it? The second one is more general: how do you get your game on something that we have known for six years is really important?

Mark Lowcock: The first thing I would like to say is that these rapid diagnostic tests are quite new. In 2005 there were only 200,000 of them. They have grown very dramatically: in 2011 there were 74 million of them, mostly in the public sector. The challenge we are trying to grapple with and that Global Fund have to up their game on, as you say, is how to handle testing in the private sector, given that, as the Report
says, between 60% and 80% of people who think they have malaria go to a private facility, and given that, as Chris described, there are all sorts of risks of hepatitis, meningitis and so on being spread if the tests are used badly. The challenge is doing the things the NAO says in the second half of paragraph 3.10: to get better use of those tests in the private sector. We are not there and we need to work harder at that.

Q67 Chair: Has Global Fund’s budget for next year been announced? I gather there was some uncertainty about its funding.

Mark Lowcock: Yes. The Global Fund is currently seeking funds from the international community for the three-year period beginning next year. It is seeking $15 billion. The US Government have committed $5 billion on the basis that they will not meet more than one third. The Secretary of State, following the spending review, has been weighing the options of how much we should do on the Global Fund versus how much we should do on other things. From the conversation I had with her the day before yesterday, I think that she wanted me to ensure that I convey at this hearing that she is positively disposed towards the Global Fund, but wants some issues sorted out. She is expecting to make a decision within the next few weeks, and we need to crack on.

Q68 Chair: A study in The Lancet about fake drugs was brought to my attention. A third of anti-malarial drugs in south-east Asia and sub-Saharan Africa are fake or contain insufficient active ingredients to kill the malaria parasites. What are we doing through our funding to tackle that?

Mark Lowcock: The NAO, as it should and as it always does, has looked at fraud and abuse, but it did not look at this counterfeiting problem because it had not become such a big issue. This is the biggest thing in terms of potential fraud and abuse that has come on to the agenda—this is specifically on malaria. We have been thinking about that and I will ask Chris to talk about the detail.

Chris Whitty: This is potentially a very serious problem. I think everybody who looks at this accepts that. The thing that really woke people up to this was a study in Laos done about seven or eight years ago that showed that, in some areas, 80% of the anti-malarials that were being sold were complete fakes—there was nothing in them which was useful at all. That problem has lessened in south-east Asia for a variety of reasons, but it is a real risk in Africa. In several countries in Africa, there have already been examples of fake drugs, including fake things with the logos that all of us subsidise the drugs for. There are two major pillars for trying to deal with this. To be honest, the most effective one is to make sure that the cost of real drugs is reduced because ultimately the fakes are fairly sophisticated. Most of them are not made in Africa. Without saying anything pejorative, I can say as a statement that the people who have so far been arrested for this by Interpol are in south China, but that is, I think, not the only place from which fakes come. The reality is that this is a big industry. People have to make a profit—that is what they are doing—and essentially the profit is the gap between the cost of the real drug and what they can pass it off for. Given that drug-testing authorities are relatively weak in many of the countries where malaria is a problem, the most effective thing we can do is to bring the cost of drugs down to the point where these people can no longer make a profit.

Alongside that there is a serious attempt by academic units, including here in the UK—in fact, I helped to set some of this up in the London School of Hygiene and Tropical Medicine—to try and track these around the world, and Interpol has a small group of people who have been involved in trying to deal with this problem. My own view—I am speaking personally, not for the Department—is that this is as bad as any other form of drug trafficking. These people are making money from killing children but, if they are prosecuted at all, they are likely to be prosecuted under Trade Descriptions Act kind of laws—as if selling fake Rolexes. This is a serious problem. The UK is contributing through a number of routes to combating it. The big thing that is going to solve it in practical terms, leaving aside the punitive measures, is to make sure the cost of real drugs is as low as possible so that the profits melt away.

Q69 Chair: And that means more subsidy to pharmaceutical companies selling the drugs if you want to bring the prices down, which to me is again a slightly iffy use of aid money.

Mark Lowcock: What it means is getting the purchase by consumers of good-quality drugs up high and consumers seeing that the drugs work. The actual cost per treatment is not that high—a dollar or two. That is within what a sick person can typically afford. If you flood the market with good-quality drugs that do not cost a vast amount to produce, the company can cover its costs and you can also get rid of the fakes. That basically is the strategy. The subsidy is there to flood the market and get people using the right drug, rather than to subsidise the company.

Chair: Good. One more question and I think we are there.

Q70 Meg Hillier: You spoke in a slightly exasperated aside about the USA, and you also then commented about the Secretary of State making a decision about whether to fund through the Global Fund or directly. What can be done to get the USA more on board on the Global Fund? Is there a big problem there?

Mark Lowcock: I did not mean to be exasperated about the USA on malaria. The USA is the biggest funder, including of the Global Fund. It deserves a lot of credit for what it does on malaria. There are others who need to play a bigger role, but I would not point the finger at them.

Meg Hillier: Okay. Thanks.

Chair: Good. That was an interesting subject. You are always good witnesses, so thank you very much.
At the PAC hearing on Wednesday 4 September on Malaria, Mark Lowcock said that we would write to the Committee on the three issues detailed below.

Firstly, the Committee asked how much of the £252 million the Department spent on malaria in 2011–12 was on monitoring and evaluation. Monitoring and evaluation activities are a key source of data needed to ensure decisions can be taken which maximise value for money. At present, there is not an OECD Development Assistance Committee (DAC) defined code for monitoring and evaluation. However, in 2012 the Department put in place systems to track allocations for evaluation. Based on analysis of these records, we estimate that the malaria programmes that were active in 2011–12 had allocated about £5 million to evaluation.

The DAC review of knowledge on good practice in evaluating development activities (Evaluating Development Activities: 12 lessons from the OECD DAC; 2013) highlights that in order to produce and use credible evaluation evidence aid agencies need to have adequate human and financial resources dedicated to it. Its review of the funds set aside to ensure adequate monitoring and evaluation at programme level notes that some organisations have a fixed 1% or 3% of programme budgets as a rough guide. DFID’s expenditure on evaluation of malaria programmes is in line with this.

Monitoring is an integral part of the Department’s programme management. Expenditure on monitoring arrangements is determined on a project by project basis, depending on the availability of existing data for monitoring purposes, and other factors such as project size and complexity. As such it is not possible to accurately estimate expenditure on monitoring activities, but our expectation is that it is likely to be less than 1%.

Secondly, the Committee asked what proportion of the Department's spend on malaria in Nepal was spent on monitoring and evaluating. Of the estimated 50% of programmes within DFID Nepal’s portfolio identified as suitable for evaluation, we expect that around 3% of the programme budget for each will be spent on evaluation. This means that DFID Nepal anticipates spending approximately £2 million on evaluation work over the current CSR period, equating to less than 1% of DFID’s total programme expenditure in Nepal over this period.

Thirdly, the Committee asked if the Department intends to report results against expenditure or progress against milestones. We can confirm that the Department does now record outcomes and outputs for each country—for outputs, both national outputs and outputs delivered by DFID are recorded.

Different indicators will be appropriate for different country contexts and progress will be recorded accordingly. The table at Annex A provides the details of the outcomes and outputs that are tracked in relation to malaria.

### Annex A

**THE MALARIA RESULTS TRACKER INDICATORS**

For each country, outcomes and outputs are recorded—for outputs, both national outputs and outputs delivered by DFID are recorded.

Different indicators will be appropriate for different country contexts. There is space in the sheets for additional indicators and narratives on progress. Indicators include:

#### Outcomes

- All cause under five mortality rate
- Number of malaria specific deaths, deaths per 1,000 persons
- % of households with at least one ITN
- % of households with at least one ITN for every two persons at risk
- % of children under five who slept under an ITN the previous night
- % of children under five years who received appropriate anti-malarial treatment (including ACTs) within 24 hours of onset of fever in the last two weeks
- % of children under five with fever in the last two weeks receiving finger/heel stick diagnostic test for malaria
- % of all suspected cases that received a parasitological test
- % of pregnant women who received at least two doses of IPTp during ANC visits during their last pregnancy
- % of people who know the cause of, symptoms/treatment for or preventative measures for malaria
- Number of doctors per 10,000 population
- Number of nurses per 10,000 population
- Number of midwives per 10,000 population
- Number of community health workers per 10,000 population
- % of health facilities without stockouts of a core set of essential drugs (including first-line anti-malarials) in the last six months
- ACT availability (most appropriate nationally defined measure)
### Outcomes

Weighted average unit price (Free Carrier) of all LLIN procured by (or on behalf of) the country  
Weighted average unit (per test) price (Free Carrier) of all RDTs procured by (or on behalf of) the country  
Weighted average unit (per treatment) price (Free Carrier) of all quality assured ACTs procured by (or on behalf of) the country

**Additional information on progress (country office decision to provide)**  
% of population potentially protected by ITNs delivered  
Any 1st-line treatment courses delivered (including ACT)  
ACT treatment courses delivered  
Population at risk (low and high)  
Population at risk (high)  
Suspected malaria cases  
Presumed and confirmed malaria cases  
Mic. slides/RDTs taken  
Mic. slides/RDTs positive  
Reported malaria cases P.falciparum  
Reported malaria cases P. vivax  
Inpatient malaria cases  
Malaria attributed deaths

### Output Indicators

**National output indicators**  
Number of bednets procured and distributed  
Number of people directly protected by IRS  
Number of pregnant women receiving a measure of prevention for malaria in accordance with WHO guidelines (ITN or IPTp)  
Number of ACTs procured  
Number of RDTs procured

**Outputs delivered by DFID**  
Number of bednets procured and distributed September 2012 DRF collection data has been added  
Number of additional bednets procured using DFID support but distributed using partner funds  
Number of additional bednets procured by a partner but then distributed using DFID support  
Number of people directly protected by IRS using DFID support  
Number of pregnant women receiving a measure of prevention for malaria in accordance with WHO guidelines (ITN or IPTp) using DFID support  
Number of ACTs procured using DFID support  
Number of RDTs procured using DFID support  
Number of DFID supported drug efficacy studies completed according to WHO protocols

11 September 2013