Overseas Development Administration : health and population : twentieth report, together with the proceedings of the Committee relating to the report, minutes of evidence and an appendix / Committee of Public Accounts.

HOUSE OF COMMONS SESSION 1995–96

COMMITTEE OF
PUBLIC ACCOUNTS

Twentieth Report

OVERSEAS DEVELOPMENT ADMINISTRATION HEALTH AND POPULATION

Together with the Proceedings of the Committee relating to the Report, Minutes of Evidence, and an Appendix

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Ordered by The House of Commons *to be printed 15 May 1996*

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277

HOUSE OF COMMONS SESSION 1995–96

COMMITTEE OF PUBLIC ACCOUNTS

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The Committee of Public Accounts is appointed under Standing Order No. 122, viz:

Committee of Public Accounts

122.—(1) There shall be a select committee to be called the Committee of Public Accounts for the examination of the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit, to consist of not more than fifteen members, of whom four shall be a quorum. The committee shall have the power to send for persons, papers and records, to report from time to time, and to adjourn from place to place.

(2) Unless the House otherwise orders, each member nominated to the committee shall continue to be a member of it for the remainder of the Parliament.

(3) The committee shall have power to communicate to any committee appointed under Standing Order No. 130 (Select committees related to government departments) such evidence as it may have received from the National Audit Office (having been agreed between that Office and the government department or departments concerned) but which has not been reported to the House.

The following is a list of Members of the Committee since its nomination on 22 May 1992. The present Members are those marked with asterisks.

*Mr Robert Sheldon (elected Chairman 10 June 1992)
Mr Michael Ancram (discharged 26 July 1993)
Mr D N Campbell-Savours (discharged 9 June 1992)
*Sir Kenneth Carlisle (added 16 February 1995)
Mr James Couchman (discharged 21 November 1995)
*Mr Denzil Davies
Mr Terry Davis (discharged 23 May 1994)
Mr Stephen Dorell (discharged 18 October 1994)
*Ms Angela Eagle (added 28 November 1995)
*Mr Mike Hall (added 9 June 1992)
Mr John Horam (discharged 31 March 1995)
Dr Kim Howells (discharged 10 December 1993)
*Mr Michael Jack (added 17 October 1995)
Mr Robert Jackson (added 26 July 1993) (discharged 17 February 1994)
*Mr Robert Maclennan
Mr Alan Milburn (discharged 28 November 1995)
Sir David Mitchell (added 22 February 1994) (discharged 2 March 1995)
Mr George Mudie (added 10 December 1993) (discharged 20 January 1995)
Mr David Nicholson (discharged 22 February 1994)
Mr Richard Page (discharged 16 February 1995)
*Mr Andrew Rowe (added 21 November 1995)
*Sir Michael Shersby
*Mr Tim Smith (added 2 March 1995)
*Mr Michael Stern
*Mr Peter Thurnham (added 31 March 1995)
*Mr Richard Tracey (added 17 February 1994)
*Mr Mike Watson (added 20 January 1995)
*Mr Alan Williams
Sir George Young (added 18 October 1994) (discharged 17 October 1995)

The cost of preparing for publication the Minutes of Evidence published with this Report was £810.80.
The cost of printing and publishing this Report is estimated by HMSO at £2,280.

TABLE OF CONTENTS

TWENTIETH REPORT

The Committee of Public Accounts has agreed to the following Report:

OVERSEAS DEVELOPMENT ADMINISTRATION: HEALTH AND POPULATION

Introduction and Summary of Conclusions and Recommendations

C&AG's Report (HC 782 Session 1994–95), paras 1.1–1.3

1. The peoples of developing countries are at a high risk of disability and death as a result of disease. The world's population is 5.6 billion and is currently growing by nearly 2 per cent a year—at least a billion more people every 10 years. Developing countries' limited budgets, coupled with economic, political and technical constraints, hamper progress in meeting health care needs and in providing health care services. Many developing countries are struggling to finance accessible facilities from a budget of less than £7 a person a year.

C&AG's Report, paras 1.7 and 1.10

2. Between 1988 and 1994, the Overseas Development Administration spent £911 million on health and population projects, including £397 million on emergency relief, mainly in Asia and Africa. The objectives of this aid were to enable those most in need to gain access to essential health care, particularly reproductive health care, in ways which made efficient use of available resources.

3. Against this background we took evidence from the Overseas Development Administration on the basis of a report by the Comptroller and Auditor General. We have considered the evidence provided; and our main conclusions and recommendations are as follows:

On management and monitoring

(i) It is an inherent feature of their operations that the Administration fund projects in other countries and therefore cannot exert the same degree of direct control over those managing them as would be expected if they were running these projects themselves. They need therefore to be particularly effective in operating those controls which are available to them if they are to achieve the best returns for public expenditure (paragraph 22).

(ii) We are concerned about the lack of competitive tendering in nine of the projects examined by the National Audit Office. We note the Administration's evidence that project management is increasingly subjected to competition and that more use is being made of non-governmental organisations. We regard it as important that there should be competition for this business as a contribution to the delivery of good value for money (paragraph 23).

(iii) We note Ministers' policy of providing a guaranteed core of work for the Crown Agents, and we would wish to be assured that the relevant contracts are negotiated at arm's length and on sound commercial terms. We note that the Administration are now setting out clear responsibilities for remedial action, and for monitoring and reporting. We are pleased to see their positive response, through their new health and population guidance, to the criticisms and recommendations made by the National Audit Office (paragraph 24).

(iv) We are concerned that the Administration do not have a clear idea of the cost of administering their aid projects, especially as it is nearly four years since an Efficiency Scrutiny recommended the introduction of a time recording system which could provide the basis for such management information. We consider such a system to be important. We therefore look to the Administration to give early consideration to the costs and benefits of introducing it (paragraph 25).

(v) We are disturbed that a large quantity of condoms, part of a £1 million order destined for Zimbabwe, was found to be defective. Particularly in view of the importance of condoms in helping to contain the spread of

HIV-related diseases, we stress the importance of stringent quality assurance measures and endorse the efforts being made to apply them. We look to the Administration to ensure that all of their supplies of condoms to developing countries are safe (paragraph 26).

(vi) We note that an out-of-court settlement has been reached with the condom suppliers, Dongkuk Techo Rubber Industries, whereby the firm will refund US$ 479,000 to the Administration. So far, only US$ 120,000 had been received. We look to the Administration to secure the remainder as quickly as possible (paragraph 27).

(vii) We were pleased to hear the examples of research projects which had led to reductions in child mortality in Ghana, better treatment of sexually transmitted diseases, treatment of a particular problem in pregnancy which kills some 50,000 women a year, and anti-malaria measures (paragraph 28).

On impact and sustainability

(viii) Aid must lead to benefits which will continue when the project is completed, and we emphasise the importance of the sustainability of its impacts. We are concerned that in only three of the 13 projects examined by the National Audit Office were there good prospects that aid would have continuing and sustainable benefits (paragraph 46).

(ix) We recognise the difficulties of measuring the impact of aid, but we are concerned at the limited amount of information available to demonstrate the effects of the Administration's health and population measures. We stress the need for impact assessments to be made at an early stage and for the Administration to be able to demonstrate the impact of their work more clearly. We note that they are now measuring these impacts more carefully (paragraph 47).

(x) We note the improvements in health and population indicators at the aggregate level, such as in relation to fertility in Kenya. At the same time it is important for the Administration to assess what they have achieved from their own projects by comparing the objectives set for them with subsequent achievements. We note that the introduction of the Project Cycle Management approach will help the Administration to identify intended impacts; and that the Health and Population Aid Effectiveness initiative will offer more scope for measuring aid effectiveness and impact (paragraph 48).

(xi) We recognise that it is not easy to ensure that projects will be sustainable when recipient governments have limited resources, particularly foreign exchange, for health care activities. We therefore think it right that the Administration should make risk assessments at the project assessment stage. We agree with the Administration that sustainability is unlikely to be achieved without local involvement and ownership, as in Pakistan. We look forward to the Administration's policy statement about health and population sustainability (paragraph 49).

(xii) In the case of the Orissa project we note that, with the completion of all 1,484 clinics by June 1996, health facilities will have increased considerably in this poor area. We acknowledge the achievements of this project and hope the benefits will be sustained (paragraph 50).

Management and Monitoring

(i) Project management

C&AG's Report, paras 2.4 and 2.5

4. The management of health and population aid projects varies between regions. In south Asia, the Administration normally employ project managers, such as the British Council. In Africa they tend to manage projects themselves—except for procurement, which they contract out. Increasingly, however, the Administration are using contractors to manage individual projects on their behalf.

Q16 In addition, over the last four years they have appointed 14 specialist field managers; these health and population professionals provide advice on the design, management and implementation of their aid interventions. They keep an eye on projects, advise on the necessary remedial action and provide the front line dialogue with the recipients. Non-governmental organisations are also being used more to manage projects, particularly in emergency aid situations. The Administration said that they had put a lot of effort into their relationship with such organisations, setting out reporting and monitoring requirements so as to deliver the impact wanted.

Qs 101–103

C&AG's Report, para 2.18 5. In nine of the 13 projects examined by the National Audit Office where management, monitoring or procurement tasks had been contracted out, the Administration had not sought competitive tenders. Two of these were small but seven contracts ranged from £100,000 to £1.5 million. Competition was waived because the project was an extension of a previous phase, the manager had unique experience in the area, or because the Administration's contractual arrangements gave the Crown Agents exclusive rights in certain countries or because the Administration aimed to give the British Council the opportunity of first refusal. In the early and mid-1980s the British Council had been seen as an arm of the overseas enterprise. The Administration's policy now was to seek competitive tenders unless there was a good reason not to.

Q4

Q45 6. The Administration told us that there was still a policy endorsed by Ministers of ensuring that the Crown Agents had a guaranteed core of business in a certain number of countries. They assured us, however, that business with the Crown Agents was arranged on a commercial basis.

Q71 7. In the particular example of the Orissa project, the Administration did not have much experience when it began, of working with project management in India outside the British Council. The Council had now built up a very substantial level of competence on the project. The Administration accepted, however, that they should have reviewed the high fees charged by the Council for an Asian Development Bank project; they have looked at the value for money secured for what they had paid and had concluded that the level of inputs and charges were reasonable.

Qs 4 and 99 8. The Administration told us that they now had a more business-like relationship with the British Council and very often invited it to compete for management contracts. They had run a competition in India for the management of health projects, other than Orissa. The Council had bid; but the Administration awarded the contract to a consortium of technical co-operation officers.

C&AG's Report, para 2.6

Q13 9. Contracts with project managers did not specifically define the respective responsibilities for remedial action. The Administration told us that it had been implicit that, if something were wrong, they would expect people to respond. They have now tightened up their project management terms of reference to ensure that remedial action is explicitly included in contracts.

Q41

Evidence, Appendix 1 pp 18–20 10. More generally, the Administration have recently produced a new project design manual. This lists the main criticisms made by the National Audit Office—covering appraisal, monitoring, sustainability, project management, financial management and research—and their recommendations. It sets out in detail a range of techniques which members of the Health and Population Group, in particular field managers, can use for project management and monitoring. It aims to assist in the identification, management and implementation of sound development projects, drawing out elements of best practice, to set a framework which may be used as a basis for determining appropriate management arrangements.

(ii) Cost of aid administration

C&AG's Report, para 2.6

Q12 11. The Administration cannot identify the comparative costs of their alternative management arrangements as they do not have a system to allocate staff costs to individual projects. In evidence they accepted that they did not have a system

which generated the total management or staff costs of a project. They were not convinced that the benefits of establishing such a system would outweigh the cost of introducing it.

C&AG's Report, para 2.6
Qs 43–44

12. In response to an Efficiency Scrutiny recommendation in 1992 the Administration introduced a pilot time recording system in other aid sectors in 1993. We pressed the Administration as to why it had taken so long to review its implementation. They said that they faced some difficulties in this area because they were not producing a standard product: they were designing a whole series of interventions in order to respond to individual requirements in the field and people were heavily distributed across a large range of activities. The Administration were looking at the kind of software that might enable them to allocate activities more rigorously; but they considered that it was hard to introduce such measures without significant cost in terms of staff time. Nevertheless they would continue to reflect very carefully on the relative costs and benefits.

(iii) Women in development

Q15

13. Given that one of the most effective ways of delivering aid in developing countries was to target women, we asked the Administration what they had done to refocus aid in this way. They told us that improvements in the role and situation of women in developing countries had been one of their objectives for a number of years. They broadly approached this in two ways. First by considering women as a separate category and directing aid specifically at them; this was what broadly had happened in the family health and welfare area. Second, and more importantly, understanding the gender issues in development assistance and the role of women in development, permeated all their aid policies.

(iv) Procurement of condoms

C&AG's Report, paras 2.21 and 2.27(b), and Appendix 4B

14. The Crown Agents were appointed by the Administration, without competition, to manage the procurement of condoms for Zimbabwe. In July 1992 they ordered 66 million from Dongkuk Techo Rubber Industries costing over £1 million and to be supplied in six consignments between September 1992 and November 1993. Three consignments were shipped to Zimbabwe after they passed the pre-delivery inspection tests but they subsequently failed post-delivery tests carried out by the Zimbabwe Regional Drug Control Laboratory. Further testing confirmed that the condoms were of poor quality. The Administration approved a replacement project to provide emergency supplies of 24.54 million condoms which were delivered by August 1994.

Qs 18–23 and footnotes
Qs 31–33 and footnotes
Qs 29–30

15. The Crown Agents had invited Dongkuk to tender, along with four other companies, because of their previous experience in obtaining condoms from them. Dongkuk supplied the best value bid and were awarded a contract worth just over £1 million. When the initial shipments were found to be defective Dongkuk agreed to replace them; while these passed the tests when they were delivered, the packaging was defective. At that point the Administration cancelled the whole

Q35

contract, having paid only for the first two consignments. Dongkuk have agreed, in an out-of-court settlement, to refund to the Administration US$479,000; as of 19 February 1996 US$120,000 had been received.

Qs 32–34

16. At the time the order was placed, the Administration did not have any other agent on their books qualified to procure condoms. In the light of their experience they have now ensured that they have three registered procurement agents that they can use. The Crown Agents have also ensured that they have available to them expertise which is up to date on condom specification and testing. And they have been working with a number of manufacturers to ensure that they understand the importance of quality control, and to build the capacity in the world for providing high quality, safe condoms.

Qs 10, 28 and 31

17. The Administration assured us that none of the defective condoms had actually been supplied; they were incinerated and none had entered the market. Despite the setback, the Zimbabweans had never run out of condoms.

The Administration told us that, as a result of their and other efforts in Zimbabwe, the total fertility rate had been reduced over the last eight years or so; and that the contraceptive prevalence rate had increased from 36 per cent to 42 per cent. This would have a significant impact towards the reduced transmission of HIV.

(v) Health and population research

C&AG's Report, para 3.33

18. The Administration support a wide range of health and population research and development projects through partnerships with academic groups, non-governmental organisations, international bodies and the British Medical Research Council. Since 1989 they have spent £85 million on health and population research.

C&AG's Report, para 3.35

19. The one country-based research project examined by the National Audit Office, cervical cancer research in India, had been poorly designed, had been set unrealistic objectives and was inadequately implemented. The Administration nevertheless thought that, at a cost of £300,000, it had provided excellent value for money in improving screening procedures and in maintaining the viability of the local laboratory.

Q19

20. We asked the Administration what their research programme had achieved. They provided us with four examples of success:

- research in Ghana which had discovered that a dose of inexpensive Vitamin A produced a 19 per cent drop in mortality from all causes among children up to $7\frac{1}{2}$ years old;
- a treatment for sexually transmitted diseases that will reduce HIV infection by 40 per cent, costing roughly $1.80 a day;
- Epsom salts as a probable cure for eclampsia, a problem late in pregnancy which kills some 50,000 women a year; and
- cheap and easy to use insecticide-impregnated bed nets which will reduce malaria mortality by 30 per cent among small children.

Qs 78–80

21. We asked what effect these findings were having in practice. The Administration said that it was difficult to make a generalisation about the extent to which research penetrated. They told us that HIV prevalence amongst adult men had reached a position where it was plateauing; but it was still increasing among

Q83

women. Impregnated bed nets have been introduced in Cambodia but people rarely slept underneath them. In The Gambia, where malaria transmission patterns were different, these nets were starting to make a difference; they could also make a difference in coastal Kenya and Tanzania, though the intensity and transmission

Q85

rate of malaria made it more difficult. The Administration had provided a small grant to the London School of Hygiene and Tropical Medicine to test market a dip-it-yourself bed net kit to see whether there was a cheap way of impregnating bed nets.

(vi) Conclusions

22. It is an inherent feature of their operations that the Administration fund projects in other countries and therefore cannot exert the same degree of direct control over those managing them as would be expected if they were running these projects themselves. They need therefore to be particularly effective in operating those controls which are available to them if they are to achieve the best returns for public expenditure.

23. We are concerned about the lack of competitive tendering in nine of the projects examined by the National Audit Office. We note the Administration's evidence that project management is increasingly subjected to competition and that more use is being made of non-governmental organisations. We regard it as important that there should be competition for this business as a contribution to the delivery of good value for money.

24. We note Ministers' policy of providing a guaranteed core of work for the Crown Agents, and we would wish to be assured that the relevant contracts are negotiated at arm's length and on sound commercial terms. We note that the Administration are now setting out clear responsibilities for remedial action and for monitoring and reporting. We are pleased to see their positive response, through their new health and population guidance, to the criticisms and recommendations made by the National Audit Office.

25. We are concerned that the Administration do not have a clear idea of the cost of administering their aid projects, especially as it is now nearly four years since an Efficiency Scrutiny recommended the introduction of a time recording system which could provide the basis for such important management information. We consider such a system to be important. We therefore look to the Administration to give early consideration to the costs and benefits of introducing it.

26. We are disturbed that a large quantity of condoms, part of a £1 million order destined for Zimbabwe was found to be defective. Particularly in view of the importance of condoms in helping to contain the spread of HIV-related diseases, we stress the importance of stringent quality assurance measures and endorse the efforts being made to apply them. We look to the Administration to ensure that all of their supplies of condoms to developing countries are safe.

27. We note that an out-of-court settlement has been reached with the condom suppliers, Dongkuk Techo Rubber Industries, whereby the firm will refund, US$ 479,000 to the Administration. So far only US$ 120,000 had been received. We look to the Administration to secure the remainder as quickly as possible.

28. We were pleased to hear the examples of research projects which had led to reductions in child mortality in Ghana, better treatment of sexually transmitted diseases, treatment of a particular problem in pregnancy which kills some 50,000 women a year, and anti-malarial measures.

Impact and Sustainability

(i) Impact

C&AG's Report, paras 3.2–3.4

29. Project impact arises from the effects—direct and indirect, wanted and unwanted—of a project's activities. Comprehensive analysis of the impact of health and population projects is difficult. Impact becomes complex and costly to assess if attempts are made to disaggregate the Administration's contribution from those of others. In some cases it may be possible to assess impact at various stages of a project. In a number of the projects examined by the National Audit Office, the Administration had delayed their assessment of the impact or did not obtain sufficient information for this purpose.

Qs 2 and 5

30. The Administration shared our view of the importance of being able to display in advance what they are trying to do and to have systems in place which enable them to measure performance. They accepted that in the past they had been largely concerned with measuring activities or measuring inputs. But they had made a very substantial effort to measure more carefully the impact of what they were doing.

Q5

31. The Administration had previously been involved in the business of undertaking activities—supplying pharmaceutical supplies and building clinics, for example—which could be measured very readily. As aid systems have evolved, the Administration have more increasingly been involved in the business of building up institutional and management capacity and in changing the cultural environment. They told us that these activities are less easy to measure but that it has become much more important to measure the impact.

Q6
C&AG's Report, para 1.16
Q5

32. The Administration accepted that they had not institutionalised the measurement of impacts at the beginning of projects. In 1993 they introduced a "Project Cycle Management" approach—a computerised project design tool to improve implementation, planning, monitoring and evaluation. This approach

included a very explicit requirement to identify impact measures at the beginning of the project cycle and to report in a standard format against them to ensure that the Administration had a measure of the impact at the end of the project.

Q6

33. The Administration told us they did have information on the aggregate impact of their work along with that carried out by others. For example, in Kenya, the total fertility rate—the number of children in a family—was around 6.7 in 1989 but had now fallen to 5.5; and the contraceptive prevalence rate had gone up from 18 per cent to 27 per cent. In Pakistan, probably the hardest country in which to work in the population field, the Administration thought that their ability to influence population policy was probably greater than that of any others.

Q7

Qs 5 and 7

34. The Administration's "Health and Population Aid Effectiveness initiative" is focusing on improving the information flow and the way in which the Administration monitor it to enable them to provide a clearer assessment of the impact of health and population projects. As part of this initiative the Administration plan to undertake synthesis studies of the lessons learned from projects which will be fed into future project design.

Evidence, Appendix 1 pp 18–20

35. The Administration's new health and population project design manual (paragraph 10) provides for greater attention to be given to the assessment of effectiveness. It gives advice on how Administration staff should measure whether objectives are being achieved and emphasises the need to identify whether projects are making a difference in the health services provided to the poor.

(ii) Sustainability

C&AG's Report, paras 3.16–3.17, 3.21–3.22 and 3.28

36. Sustainability is the capacity to maintain the desired impacts beyond the end of the project. The Administration are reluctant to continue funding recurrent costs because of the long-term commitment which this would involve. But they accept that many developing countries are unable to meet the full cost of their contraceptives, medical supplies and drugs. Of the 13 projects examined by the National Audit Office which had started, only three had good sustainable prospects. Three main factors influenced sustainability: the degree of involvement and ownership by the recipients; the management capacity of recipients; and the availability of recurrent funds.

Q8

37. We asked the Administration what improvements they could make to ensure that projects were sustainable. They told us that the difficulty of sustainability was an inherent part of being a developing country. Poor countries, such as Kenya or Zimbabwe, could not generate enough foreign exchange to import all their contraceptive or health supplies needs. The Administration therefore looked at ways of building management capacity so that resources were maximised; and of ensuring that projects were cost-effective and did not add to the recurrent budget of the recipient countries.

Qs 75 and 77

38. The Administration told us that their project cycle management approach required them to consider sustainability issues at the beginning of a project. They also now undertake a risk analysis on the main risks to the success of a project, including sustainability issues such as institutional capacity and the availability of recurrent funds.

C&AG's Report, paras 5(m) and 3.16

39. The Administration consider that sustainability often needs to be addressed in a wider context than within individual projects. Hence, for most projects examined by the National Audit Office, sustainability considerations did not feature prominently and were not always documented in project files. The Administration are currently preparing a policy statement about health and population sustainability.

Qs 65, 66 and 75–77

40. The Administration told us that they considered involvement, ownership, management capacity and recurrent funds in assessing a project. They saw all these elements as absolutely central to the sustainable development of projects.

Involvement and ownership on the part of the local government, they had come to realise, was particularly important: if a recipient was committed to a project then
Q72 it would be sustainable; without such commitment it would not be. In this connection there had been good progress in Pakistan, as illustrated by President Benazir Bhutto's active participation following the Cairo population conference.

Qs 55 and 56 41. Projects were drawn up with recipients to identify what they want and how they can be helped. The Administration also have to be sure that projects are cost-effective and are not unrealistic in their demands on local, provincial or national budgets.

(iii) Orissa

C&AG's Report, Appendix 1 42. The wider project objective of the Orissa project in India was to improve the health and family welfare status of people in Orissa, giving particular priority to mothers and children, and tribal groups. It included the provision of 1,484 buildings, including health centres, staff quarters and district training units. By July 1994, 611 had been completed but only 279 were in use because the project authority had not released them to the health department.

Q2 43. The Administration told us that Orissa was very poor and virtually lacking in any form of rural health care system. Despite being one of the hardest sectors in one of the poorest States in India, the Administration consider that they have made a very substantial contribution to the health service infrastructure provided for large numbers of very poor people.

Qs 2 and 14 44. Orissa now has roughly half the number of rural health clinics that the Government of India regards as a desirable norm, about half of which have been provided by the Administration. 1,293 clinics were expected to be completed by 31 March 1996 and all 1,484 would be completed by the end of June 1996.

Q2
Q74 45. The Administration said that they did not originally have particularly high expectations for the project's sustainability. But they are now confident that the Government of Orissa is in a much better position to carry on and sustain the project.

(iv) Conclusions

46. Aid must lead to benefits which will continue when the project is completed, and we emphasise the importance of the sustainability of its impacts. We are concerned that in only three of the 13 projects examined by the National Audit Office were there good prospects that aid would have continuing and sustainable benefits.

47. We recognise the difficulties of measuring the impact of aid, but we are concerned at the limited amount of information available to demonstrate the effects of the Administration's health and population measures. We stress the need for impact assessments to be made at an early stage and for the Administration to be able to demonstrate the impact of their work more clearly. We note that they are now measuring these impacts more carefully.

48. We note the improvements in health and population indicators at the aggregate level, such as in relation to fertility in Kenya. At the same time it is important for the Administration to assess what they have achieved from their own projects by comparing the objectives set for them with subsequent achievements. We note that the introduction of the Project Cycle Management approach will help the Administration to identify intended impacts; and that the Health and Population Aid Effectiveness initiative will offer more scope for measuring aid effectiveness and impact.

49. We recognise that it is not easy to ensure that projects will be sustainable when recipient governments have limited resources, particularly foreign exchange, for health care activities. We therefore think it right that the

Administration should make risk assessments at the project assessment stage. We agree with the Administration that sustainability is unlikely to be achieved without local involvement and ownership, as in Pakistan. We look forward to the Administration's policy statement about health and population sustainability.

50. In the case of the Orissa project we note that, with the completion of all 1,484 clinics by June 1996, health facilities will have increased considerably in this poor area. We acknowledge the achievements of this project and hope the benefits will be sustained.

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

MONDAY 4 MARCH 1996

Members present:

Mr Robert Sheldon, in the Chair

Sir Kenneth Carlisle	Mr Michael Stern
Mr Denzil Davies	Mr Peter Thurnham
Ms Angela Eagle	Mr Richard Tracey
Mr Robert Maclennan	Mr Mike Watson
Sir Michael Shersby	Mr Alan Williams

Sir John Bourn, KCB, was further examined.

The Committee deliberated.

Mr F Martin, Second Treasury Officer of Accounts was further examined.

The Comptroller and Auditor General's report on Overseas Development Administration: Health and Population Overseas Aid (HC 782) was considered.

Mr J M M Vereker, CB, Permanent Secretary, Mr R Manning, Principal Finance Officer, and Dr D Nabarro, Chief Health and Population Adviser, the Overseas Development Administration, were examined.

The Committee further deliberated.

* * * * *

[Adjourned till Wednesday next at a quarter past Four o'clock.

* * * * *

WEDNESDAY 15 MAY 1996

Members present:

Mr Robert Sheldon, in the Chair

Sir Kenneth Carlisle	Mr Peter Thurnham
Mr Andrew Rowe	Mr Mike Watson
Mr Tim Smith	Mr Alan Williams
Mr Michael Stern	

Sir John Bourn, KCB, Comptroller and Auditor General was further examined.

The Committee deliberated.

* * * * *

Draft Report (Overseas Development Administration: Health and Population), proposed by the Chairman, brought up and read.

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

Paragraphs 1 and 2 read and agreed to.

Paragraph 3 postponed.

Paragraphs 4 to 50 read and agreed to.

Postponed paragraph 3 read and agreed to.

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

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 116 (Select Committees (Reports)) be applied to the Report.

[Adjourned till Monday next at half past Four o'clock.

MINUTES OF EVIDENCE

TAKEN BEFORE THE COMMITTEE OF PUBLIC ACCOUNTS

MONDAY 4 MARCH 1996

Members present:

Mr Robert Sheldon, in the Chair

Sir Kenneth Carlisle	Mr Michael Stern
Mr Denzil Davies	Mr Peter Thurnham
Ms Angela Eagle	Mr Richard Tracey
Mr Robert Maclennan	Mr Mike Watson
Sir Michael Shersby	Mr Alan Williams

SIR JOHN BOURN, KCB, Comptroller and Auditor General, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL. OVERSEAS DEVELOPMENT ADMINISTRATION: HEALTH AND POPULATION OVERSEAS AID: HC782.

Examination of Witnesses

MR J M M VEREKER, CB, Permanent Secretary, MR R G M MANNING, Principal Finance Officer, DR D NABARRO, Chief Health and Population Adviser, Overseas Development Administration, examined.

MR F MARTIN, Second Treasury Officer of Accounts, further examined.

Chairman

1. Welcome to the Committee. Today we are taking evidence on the report by the Comptroller and Auditor General on overseas aid in the health and population sector. I am looking at paragraph 3 at the beginning because this is the general claim made. It says, "The objective of the UK's health and population aid is to enable those most in need to gain access to essential health care". I know that is a very general observation but could you tell me how you go about picking those areas themselves? Although I know the areas you deal with there are several which would seem to fit into that category which you do not deal with. Could you briefly explain how you go about this?

(Mr Vereker) The need in developing countries for essential health care is very greatly in excess of what we can begin to address on our own with the British aid programme. We do have to be a little selective. Ministers have approved four priority areas for our health interventions. The first of these is reform of health management systems, to enable us to get inside the way in which systems of health management are organised in developing countries and through that means to have some leverage on the whole of the system that affects the health of large numbers of people. The second one is what we characterise as children-by-choice rather than by chance, that is our reproductive health effort, because that goes right to the heart of the question of whether growth per caput in developing countries can be accelerated; you not only have to work on growth but you also have to stop the numbers getting out of control[1]. The third one is directed at rather specific communicable diseases where we believe that the UK is particularly well placed to play a role, that is to say on malaria, tuberculosis and HIV infections, where we have some skills to deploy in this country. The fourth one is improving health care in emergency aid situations where again we have a lot of experience. Having identified these areas we then try to focus our efforts down on them because we think that is where we are particularly well equipped to respond. Of course I accept that there are many other essential health areas where we cannot begin to help.

2. Given that this is how you select then the next task that this Committee has to face is how effective you are at carrying out those tasks which you are able to identify. What this Committee is really concerned with is to have clear objectives and at the end of it to have a clear assessment of what you have achieved and be able to quantify your success in those areas by comparisons between objective and achievement and the essential monitoring which must take place between those two parts of the task in front of you so that we are able to see how it is going on. In connection with that I am looking at paragraph 2.10.

[1] *Note by witness:* Work to bring about population stabilisation is a means of preventing the numbers getting out of control. Providing men and women with the means to have children by choice is likely to contribute to the stabilisation of world population at about double its present size towards the middle of the next century (PAC74).

[**Chairman** *Contd*]
We see here "the wider goal to which the project contributes". We shall be examining a number of aspects of this. Can I first turn to Appendix 1 and the Orissa project? If we look at page 32 we see that as far as the impact is concerned "The sustainability of the project is in doubt because of: weak management in the Orissan health department". This was not a very good example of getting value for money. In that case you did not put the contract out to competitive tender. How were you able to satisfy yourself that you were going to get value for money in the light of these comments here in this Appendix?

(Mr Vereker) The first thing to say is that we entirely share the Committee's perception of the importance of our being able to display in advance that we know what we are trying to do and to have systems which enable us to say at the end how we are measuring our performance against that endeavour. In the case of the Orissa project the wider goal of the project, as the report identifies, was to improve family health and welfare in a very, very poor state in India, one of the poorest, which at the beginning of this project was virtually lacking in any form of rural health care system. We had quite deliberately decided to tackle what I think most people would agree is the hardest sector in one of the poorest states in India. Against that background we did not have particularly high expectations of sustainability at the end. What we were looking for in this case was to make a significant impact on the health of a very large number of very poor people. The principal indicator of success that I can offer to the Committee is that, at this stage of the project, Orissa now has roughly half the number of rural health clinics that the Government of India regard as being a desirable norm and roughly half of those have been provided by the ODA. I think we can say that we have made a very substantial contribution to the health service infrastructure provided for large numbers of people in Orissa[1].

3. Are you going to put these contracts out to competitive tender in the future? Was the failure to put contracts out to competitive tender in the Orissa project an error as you see it?

(Mr Vereker) The management of the Orissa project ——

4. Paragraph 2.18, which says, "In nine of the 13 projects examined ... the Administration had not sought competitive tenders".

(Mr Vereker) Our policy on the seeking of competitive tenders is that it is the norm unless there is a good reason not to. Good reasons not to would include circumstances such as this in Orissa where we really did not have at the time we began on this project much experience of working with project management in India outside the British Council. At the time, that is the direction in which we went. It is certainly the case now that we would expect increasingly to manage our projects on a competitive basis but we are looking at a period which extends quite a long way back and at a time when it was less likely that we were going to be going out of our way to seek competition. There is no doubt that the British Council in India has built up a very, very substantial level of competence in the management of this project in Orissa and we would expect that it would continue to do so until 1998. In the other health projects that we have in India, we have already run a competition for the management of health projects generally in India and it was interesting to see that we had five bidders, three of whom came from consultants, one was a consortium of technical cooperation officers, the fifth was the British Council, and the consortium of technical cooperation officers won it. We do have a competitive process in place in India but it is not at present the case that we are planning to put Orissa outside the Council.

5. Following on what I said about the need to compare achievement with objective, in paragraph 2.25 we see that it says in connection with the Pakistan Population I and II projects, "... project monitoring tended to focus too much on the provision and use of inputs and often did not relate progress to objectives and targets". This is a fundamental issue which we come across again and again. I must stress the importance of this. It is not sufficient to look at input, we want to see what you are getting for those inputs.

(Mr Vereker) We entirely agree with that and accept the comments that are made here. We have, along with other aid donors, been improving our systems over time. We have made a very substantial effort to measure the impact of what we are doing more carefully and this indeed reflects the changing nature of the business that we have been in. It is true that, if you go back to the period referred to in this report, the mid 1980s, when aid systems were largely concerned with measuring activity or measuring inputs, we were concerned with supplying pharmaceutical supplies, producing vehicles, building clinics. We were engaged in the business of providing activities which could be measured very readily. As aid systems have evolved we have been increasingly in the business of building up institutional and management capacity, changing the cultural environment. The activity becomes less easy to measure but it becomes much more important to measure the impact. We have over this period introduced new project cycle management techniques and they include a very explicit requirement to identify impact measures at the beginning of the project cycle, to report in a standard format against them so as to ensure that we have a measure of the impact of what we are doing at the end of the project. That applies all the way across our systems, not just to health and population. We also have a health and population initiative on aid effectiveness, the Health and Population Aid Effectiveness initiative, which is focusing very sharply on improving the information

[1] *Note by witness:* By way of background, Phases 1 and 2 of the Orissa Family Welfare Project put in place some of the essential infrastructure for health services: training, building and health education activities. We would expect subsequent government and donor investment in primary care in Orissa to build on this infrastructure and continue to improve service provision. This would, in turn, have an impact on health. But we have some way to go before we can confidently claim to have achieved this goal.

[Chairman *Contd*]
flow and improving the way in which we monitor it so as to get a handle on the impact of health and population projects.

6. What you said about the impact assessment is of enormous importance because we have to be able to assess the impact. I am looking at paragraph 3.4. Here an impact assessment had not been carried out properly. An example is given here of the Isiolo Hospital where there has been no impact assessment during the project's life. I know the difficulties under which you operate; it is perfectly well known to this Committee. Nevertheless you have to be able to make that kind of impact assessment by getting the information that is available to you; otherwise it is just words. You have not carried out the proper assessment during the project's life. What are you doing in this area and in comparable areas to make sure you have that kind of information?

(Mr Vereker) We do have information about the aggregate impact of our work along with others in Kenya, which indeed is having a tremendous effect. I think it is true to say that Kenya has turned the corner in terms of its use of contraception and in its total fertility rate. For instance, at the beginning of this project the total fertility rate, that is the average number of births per woman, was around 6.7 in 1989 and has now fallen to 5.5. The contraceptive prevalence rate has gone up from 18 per cent to 27 per cent and these are precisely the kind of output measures that we regard as being significant in terms of our family health, population and welfare projects in Kenya. It is true, as the report says, that we did not institutionalise the measure of these kinds of impacts at the beginning of the project but I do repeat that our project cycle management techniques now in use for our project design do require us to set output and impact targets at the beginning and will require us to measure them afterwards.

7. We see that you have had some successes and you mentioned the Kenyan family planning success. There have been similar failures of course; the Pakistan Population I and II. How are you able to make sure that the lessons you learn from your successes are passed on to the failures and the other way round as well? You are dependent on making sure that the systems that you have in place are used most effectively and this is one way of doing it.

(Mr Vereker) Yes, that is absolutely right. A part of the Health and Population Aid Effectiveness initiative is that we will undertake synthesis studies of the lessons we are learning from health and population projects and that we will then disseminate the results of those so as to feed back into project design in the health and population sector and indeed eventually into other sectors. If I may, I would dissent a little from the suggestion that the Pakistan I and II projects had had no impact. They were certainly troublesome and difficult and they certainly did not secure immediately what we were looking for. However, we were at the time able to get a foothold in what was at the time probably the hardest country in which to work in the population field, at a time when the overall cultural and political and social environment was somewhat unsupportive of what we were doing. It provided a foothold and a springboard on the basis of which we were able to do a great deal of useful work. I think it is true to say that we have been the only bilateral aid donor that has been in Pakistan continuously over the last ten years and our ability to influence their population policy as a result is probably greater than any others.

8. My last question concern sustainability: after you have finished that the good work is going to continue and be effective. We see in paragraph 3.21 that in the area we are looking at here, "... only three of the 13 projects examined, where activity has started, have good sustainable prospects in the sense that they will lead to continued services and benefits without external financing". That is really quite crucial. This is not a very happy story just here. Could you explain how it is you hope to improve on that?

(Mr Vereker) My own view on this is that difficulty of sustainability is an inherent part of being a developing country. It really is not terribly surprising to me that a country as poor as Kenya or Zimbabwe is unable to generate enough foreign exchange to import its whole contraceptive or indeed health supplies' needs. What we have to look for in terms of sustainability are two things: first of all, ways of building overall capacity, of managing the sector so that resources are not wasted and are maximised. Secondly, ensuring that particular projects we undertake are cost effective and do not add to the recurrent budget. It is crying for the moon to look for projects to be sustainable in the sense that we provide two years' worth of contraceptives and then hope that they will be able to carry on after that. They will not be able to; they do not generate enough foreign exchange for it.

Sir Michael Shersby

9. I see from the report, paragraphs 3.33 to 3.37, that you have now spent £85 million in six years on health and population research. What do you feel this has achieved?

(Mr Vereker) Our research has had some really quite extraordinary successes. I should like to give the Committee one or two rather vivid examples of that. We have discovered at rather small cost that there is an inexpensive vitamin supplement that will prevent nearly one child death in five. We did this through a research project in Ghana and we discovered that a dose of vitamin A produced a 19 per cent drop in mortality from all causes among children up to 7½ years old. We have discovered that there is a treatment for sexually transmittable diseases that costs roughly US$1[1] a day that will reduce HIV infection by 40 per cent. That has huge implications in terms of control of HIV spread. We have discovered that Epsom salts, of all things, will probably cure eclampsia which is a problem late in pregnancy which kills some 50,000 women a year. That is a very cheap and easy remedy. We have been looking at ways of protecting small vulnerable

[1] *Note by witness:* The cost is US$1.80 a day.

[Sir Michael Shersby *Contd*]

children from malaria and we have discovered that insecticide-impregnated bed nets, which are again very cheap and easy to use, will reduce malaria mortality by 30 per cent among small children. These are some examples of the kind of really practical effects that our research has had that has fed very quickly into the application phase.

10. That is encouraging news. I should like to ask you some questions about Zimbabwe which is a country I visited a couple of years ago as part of the UK delegation to the Commonwealth Parliamentary Conference. I see from Appendix 4, "Zimbabwe's population of 10.9 million is increasing by 2.8 per cent a year and, despite having the highest contraceptive prevalence rate in Africa, is expected to reach 13.2 million by the year 2000". I am concerned, as I am sure every other member of the Committee is, about the very serious AIDS epidemic in Zimbabwe. I see here that HIV prevalence is estimated at least at nine per cent and the number who may be infected with the disease by 2000 is estimated at two million. Despite this we still have a life expectancy of 58 years. Do you think that the programme that you have of supplying contraceptives to Zimbabwe has been successful in view of the report we have here about their poor quality and delays in delivery? Can you say a word or two about that, please?

(Mr Vereker) Certainly. The answer to your question is yes. First of all, in terms of the impact that we have all been having in Zimbabwe, of course you are absolutely right. Population growth is a serious threat to wealth and the ability of Zimbabwe to achieve self sustaining growth. AIDS is a very serious problem there. As a result of our and other efforts in Zimbabwe, the total fertility rate has dropped from 5.5 to 4.3 over the last eight years or so and the contraceptive prevalence rate has gone up from 36 per cent to 42 per cent which will make a significant impact on the reduced transmission of HIV. In terms of our own activities, the important features of the condom supply project to which you refer are first of all that the Zimbabweans never ran out of condoms—thanks to our prompt remedial action they never ran out. Second, none of the faulty condoms went anywhere near the black market, they were all destroyed. I can say with confidence that our activities kept them supplied with high quality condoms.

11. I seem to recall from my visit to Zimbabwe that one of the reasons why HIV is such a problem in that country is the propensity of men to have many partners and the different attitude towards stable families and marriage that exists in some other countries. Has that been changed at all by the results of this programme?

(Mr Vereker) It is true to say that we are not trying to change cultural practice in that sense. Our task is through education to explain to people how HIV is transmitted and to explain to people that there are ways of reducing family size if they wish to. Our experience is that when those two things are explained, the demand for condoms increases rather rapidly. You will see a number of references in the NAO report to a mismatch between our projections and the rate at which condom demand increased. It is very difficult to get these precisely right. Cultural practice may change as a result of that perception; it is not our job to do it directly.

12. Could I just take you back to paragraph 2.6 of the report? It says, "The Administration cannot identify the comparative costs of their alternative management arrangements as they do not have a system to allocate staff costs to individual projects". Can you say why that is?

(Mr Vereker) Yes, we do not. The question is whether it would be desirable if we did. I was reflecting on that when I read this paragraph. I guess the question we would have to ask is whether the benefits of establishing such a system would outweigh the cost of introducing it. Where we have got to at the moment is that we do have a system for more rationally allocating our running cost resources to match our programme activities. We brought the two cycles of resource allocation more closely together. We do not have a ready way, a system, which automatically generates or would in some way generate the total management or staff costs of a project. I am not entirely satisfied that it would be of sufficient use in comparison with the cost of it, although I have an open mind about it.

13. I should just like to refer you to paragraph 2.26. Here we are told, "When projects are not meeting their planned targets, remedial action needs to be considered". It goes on to say that the Administration "... did not specifically define respective responsibilities for remedial action in their contracts with project managers". Why was that?

(Mr Vereker) The best answer I can give you is that we have now tightened up our project management terms of reference to ensure that remedial action is explicitly included. I guess the best answer I can give is that it was implicit before that if something were going wrong we would expect people to respond. I hope this report satisfies the Committee that in practice we do respond and in most of the areas where action needed to be taken we certainly took it.

14. Could I refer you to paragraph 3.15 and Appendix 1A? Can you tell me how many of the planned 1,484 health clinics have now been built in Orissa and are they being used? Can you give us some idea of the project progress in terms of construction?

(Mr Vereker) I believe that all of them will be completed by the end of June 1996. I understand that 1,293 are expected to be complete by 31 March.

Ms Eagle

15. It is now recognised that one of the most effective ways of delivering aid in developing countries is to target it on women because they are the ones who look after families and effectively provide a lot of the social services that exist. What has the ODA done to refocus the aid that it gives in this way?

(Mr Vereker) We have for a number of years now identified the improvement in the role and situation of women in developing countries as being one of our targets, one of our objectives. There are broadly two

[**Ms Eagle** *Contd*]
ways of approaching this: one is to put aid to women in a separate category and say we will have a number of interventions that are directed specifically at women. I guess you could say that in the family health and welfare area that is broadly what happens. More importantly understanding gender issues in development assistance, understanding the role of women in development permeates all our aid policies so that we would not, for instance, look at a project in the education sector without considering very carefully what the impact is on women, how women would respond to it and how it can be adapted so as to ensure that the potential role of women is maximised. The fact that it permeates all our activities is the fundamental point.

16. What is the role of these health and population field managers? Fourteen of them have been appointed it says in the report.
(Mr Vereker) We deploy a rather large number of health and population professionals. We have roughly speaking 20 under Dr Nabarro's leadership in the ODA or its overseas offices whose principal job is to advise us on the design, management and implementation of our interventions. Because health and population projects in particular but our development assistance projects in general are increasingly operated through and with our partners in developing countries, we find it highly desirable to have field managers, people out there in the developing country, close to the beneficiaries, close to the institutions which we are working with, who will keep an eye on the project, who will advise us on the necessary remedial action, who will be the front line of the dialogue with the recipients. There are about 14 of them; they are absolutely key to the process of policy dialogue with the local governments and the local administrations.

17. How many of them are women?
(Mr Vereker) More than nine are women.

18. Could we look at paragraph 3.14 which lists some of the problems rather than the successes which are inevitably what we end up looking at in this Committee. The one I am interested in has already been referred to: it is the project in Zimbabwe and the fact that defective condoms were actually bought and shipped over there. Who decided to buy condoms from the company involved? Who made those decisions?
(Mr Vereker) We employed the Crown Agents as our procurement agent. They went through a competitive process as a result of which the contract was awarded to the Malaysian company Dongkuk.

19. Was there a competitive tender?
(Dr Nabarro) This company was selected by Crown Agents. Our understanding is that they were choosing them because of their previous experience in obtaining condoms from them and they then also obtained information from others to ensure that this was a satisfactory supplier.

20. Does that mean there was no competitive tender or there was a competitive tender?
(Dr Nabarro) We are just checking.
(Mr Vereker) I am advised that it was a restricted tender exercise in which Dongkuk submitted the best value bid. A restricted tender is where the Crown Agents draw up their own list of people they would like to tender. That is a competitive process.

21. How many other companies were on the list?
(Mr Vereker) I do not know; I would have to let you know[1].

22. Could you?
(Mr Vereker) Yes.

23. What was the contract worth?
(Mr Vereker) The contract with Dongkuk was just over £1 million.

24. How quickly did it become known that these condoms were defective?
(Mr Vereker) That was known when they were tested in Harare by the Zimbabwean Regional Drug Control Laboratory.

25. They were shipped out from the supplier to the regions where they were going to be distributed and tested and it was then discovered that they were of inferior quality?
(Mr Vereker) It is a little bit more complicated than that. The condoms were subject to quality control arrangements both at the point of manufacture and at the point of arrival. At the point of manufacture they were subject to what is known as consignment testing. That is to say that each shipment, broadly speaking, a very large number, was subject to a statistical sampling test. They passed that. They were also subject to the manufacturer's own quality assurance testing which was batch by batch. In the manufacture of condoms it is desirable, because of the variation in the quality of the latex, to test each run, that is a 24-hour run on the same machine. It is known as batch testing. That was undertaken by the manufacturer. In addition there was independent consignment by consignment testing. When they arrived in Harare, ZRDCL also undertook independent batch by batch testing and it was at that point that they failed one particular test, which was the air burst test.

26. They passed the manufacturing tests and they passed the tests before they were shipped but they failed.
(Mr Vereker) That is right.

27. Does that indicate that the tests at manufacturing stage were defective?
(Mr Vereker) It indicates that the ZRDCL tests were of a statistically larger sample. They were more rigorous tests.

28. You must be worried that having persuaded

[1] *Note by witness:* The Crown Agents approached five companies, including Dongkuk, for indicative quotations (PAC74).

[Ms Eagle *Contd*]

large numbers of people to use condoms ... Were any of these defective condoms actually supplied?

(Mr Vereker) No. What happened was that when the consignments arrived in Harare and were tested and failed, the first thing the Crown Agents did was to undertake some other tests to make sure that the tests they had had were not themselves faulty, that the machines were not faulty and so on, including independent testing in the United States. When everybody was satisfied that they were below the quality at the time recommended by WHO, they were incinerated.

29. It says in Appendix B on page 61 which deals with this issue that remedial action was taken to provide supplementary supplies, initially airlifted. What did all of the remedial action cost?

(Mr Vereker) A contract was let but it took a little time because it was necessary to be absolutely precise in this case about the specifications, about the demands, about the testing arrangements. The contract was let to replace the first two consignments and that was not in practice at the cost of the ODA because the cost was being recovered from Dongkuk. I should explain that the story has moved on a little bit since the Comptroller and Auditor General wrote his report. The report refers to the fact that Dongkuk also agreed to replace these themselves; that would have been an additional 25 million condoms which would have been appropriate for the following year's needs.

30. Why will they be any better than the other ones?

(Mr Vereker) They were; they passed all those tests but when they were delivered they actually had defective packaging and at that point we cancelled the whole contract with Dongkuk and Dongkuk have agreed to refund to us the whole value of that contract and are repaying us. That is why I am saying that the cost of the original replacements are being met from that.

31. I take it that Dongkuk are not going to be on or involved in any further restricted tender exercises that the Crown Agents might decide.

(Mr Vereker) I do not think you can assume that. It is now a matter for the manufacturers to put in place quality assurance arrangements that will pass the rigorous international requirements. I would not blacklist them for that[1].

(Dr Nabarro) We have a problem at the moment about condoms. They are not an easy item to manufacture, latex is not easy to deal with, there is not exactly a great abundance of condom manufacturers in the world. With the arrival of HIV disease the demand for condoms worldwide is just going through the roof. All this happened at a time when everybody who could make condoms was making them, they were working their plants to the full and it is very important that we do not try in any way to imply that a condom manufacturer, because they had an unfortunate experience, and this certainly was, should somehow cease to be eligible to supply a key purchaser like ourselves or the European Commission[1]. What we have done is to work with Dongkuk to get them to tighten up their manufacturing and testing procedures so that the rest of the world can avail themselves of these vital commodities and we do not continue with the kind of shortages and difficulty with procurement that we have had.

32. Do you recognise that mistakes have been made? One of the main lessons listed in the report from this whole issue, this whole thing, is that only agents with the relevant expertise should be appointed as procurement agents. That tends to imply that the original procurement agents was either inexperienced or did not know what they were doing.

(Mr Vereker) It is important to distinguish between the procurement agent, in this case the Crown Agents, and the supplier, in this case Dongkuk. It is true to say that we have all learned from this experience. At the time that the procurement agent, the Crown Agents, was chosen, we did not have any other agent on our books qualified to procure condoms for us. The Crown Agents had an office in Harare, they had an office out in the Far East where the condoms were being manufactured, they had experience in pharmaceutical procurement.

33. It is incredible that you did not have any procurement agents for that very important part of the work you are doing if you are doing population control. Surely that is one of the things you ought to have lots of?

(Mr Vereker) I agree with that. As my colleague Dr Nabarro says, what we were facing at the time was an explosive growth, rather sudden and unexpectedly explosive growth, in demand for condom procurement. In the light of this experience we have now ensured that we have available to us three registered qualified procurement agents that we can use. The Crown Agents themselves have ensured that they have available to them expertise which is right up to date on the condom specification and testing that is needed. They have been working indeed with a number of manufacturers, including Dongkuk, to ensure that the manufacturers understand the importance of quality control and to build up capacity in the world for providing high quality, safe, condoms.

34. Do you realise it could be a matter of life and death because of HIV infections and that wherever these condoms are supplied they have to be trusted by local populations or you defeat your own purpose?

(Mr Vereker) No one is more aware of it than we. We are aware of the very rigorous standards which require very low failure rates. When we sat down and did our post mortem of the Zimbabwe episode, which of course we did, we concluded that it was necessary to ensure that the Crown Agents had the adequate capacity, we concluded that it was necessary to ensure

[1] *Note by witness:* Crown Agents have established a prequalified list of condom suppliers. Dongkuk Techno are not on it (PAC74).

[1] *Note by witness:* They would have to prove, perhaps through prequalification, that they could perform to the standards required (PAC74).

[**Ms Eagle** *Contd*]
that every condom procurement action specified batch by batch testing, independently of the point of manufacture. We wrote to the Government of Zimbabwe and told them what we were doing, because as you will see from a subsequent project here, we agreed to supply 277 million condoms, four times as many as in the project we are talking about now. We had a letter back from the Ministry of Health in Zimbabwe thanking us for all our help in trying to straighten this out. They understood, as do we, that it was not easy. In the early 1990s it was not easy, as Dr Nabarro says, to procure condoms at the high level of specification required.

Mr Stern

35. One minor point. In your reply to Ms Eagle you said that Dongkuk are repaying us. Given that this particular contract ended in 1993 can you tell us how much is still outstanding and exactly what arrangements they are making to repay the amount that is still outstanding?

(Mr Vereker) We reached an out-of-court commercial settlement with Dongkuk, as a result of which payments are being made at a reasonably regular pace. I might be able to tell you exactly how much is outstanding. We have received, as of 19 February, US$120,000 and we have some US$359,000 outstanding; that relates simply to the first two consignments which were the only consignments for which we had actually paid. We did not pay them for the remaining three consignments.

36. Therefore this US$359,000 has now been outstanding in respect of payments made to them in 1993 and you say that meanwhile the Crown Agents are placing fresh orders with them.

(Mr Vereker) Not under aid finance.

37. But they are placing fresh orders with them.

(Mr Vereker) I believe that they have placed orders with them for an EU funded project in Bangladesh.

38. Has the attention of Crown Agents been drawn to this outstanding balance with a view to arranging a set-off?

(Mr Vereker) I should emphasise that we have endorsed this settlement. We thought it was right that the Crown Agents should agree an out-of-court settlement with Dongkuk and the rate at which they are repaying is satisfactory to us.

39. It sounds like they have got the best of both worlds in that they are taking fresh orders while at the same time they have a very extended programme of repayment of money they should never have had in the first place. Are you sure we are not being a bit gentle with them?

(Mr Vereker) Yes, I am quite sure. At the time this was a very significant issue for Dongkuk. They had lost roughly US$0.5 million of supplies which they expected in their cash flow and which they were being required to repay. Under those circumstances good procurement practice is to be aware of the circumstances of the supplier as well as the needs of the purchaser.

40. Can I return to what is for this Committee the major part of this report which is the question of the measurement of the impact of the programmes that have been carried out? I am sure you would agree with me that for a Committee that is concerned about the value achieved in public spending it must be a little worrying when we learn that in most cases routine monitoring does not include analysis of impacts, that the Administration have not carried out many impact assessments of the training components projects, that in seven cases the Administration did not ensure that sufficient information was provided to assess impact. Would you say that in this field the Administration was carrying out its duty to the British public?

(Mr Vereker) Yes, indeed. I should like to distinguish, if I may, between the actual impact which took place and the way in which we did or did not measure it at the time. In terms of the actual impact, to give the Committee some dimension of it, over the period of this report, which was six to eight years, looking at £900 million of taxpayer's money, we had an unquestionably significant impact on the health and welfare of 200 million very poor people. We gave them access to basic health facilities, we gave them the opportunity of children-by-choice, we reduced infant mortality, we reduced the spread of HIV. We did all that for a cost which would keep the National Health Service going for less than a fortnight. That is what we regard as impact. In each one of these projects I can put my finger on very concrete impact that it had. But you are right, we did not at the time that some of these projects, particularly the earlier ones, were designed, have in place the kind of structured rigorous requirement to identify impact measures at the beginning and to make those measurements at the end and feed it back into the process that we now do. There is an extremely helpful summary at the end of the summary of this report, paragraph 9 of the initial summary, written by the Comptroller and Auditor General which makes recommendations for improvements in systems which have helpfully reinforced the direction in which we in this sector and in other sectors have been moving in order to ensure that we do have systems which both set up targets in advance and measure impact afterwards.

41. I am grateful to you for that answer. I am not trying to undercut in any way the pride of the Administration in what it has achieved or indeed the difficulties in raising impact assessments. What I find worrying about this report—and I accept at this stage there is very little we can do about it—is that as we approach a period of what many people regard as unprecedented stringency in public spending in this country I as an advocate of the work that you are doing would have liked a better case on impact to be able to put before the public in the next few years than I have from this report. Nevertheless, I shall be working with what I have got.

(Mr Vereker) I am sympathetic to that and I very much hope that we will be able to produce that as the years roll on. I think you will see that the later projects examined by the Comptroller and Auditor General do

[**Mr Stern** *Contd*]

produce those kinds of impact measures. I have in front of me here the new project design manual which Dr Nabarro uses with his colleagues which is very explicitly designed with the recommendations of the National Audit Office in mind. It has a paragraph here, main NAO criticisms, failure to set measurable indicators of progress, failure to view appropriate indicators. We have gone through all these and we have ensured that we have addressed every one of the things that the Comptroller and Auditor General suggests. I hope that will give you what you are looking for.

42. It would be very helpful if that manual or suitable extracts from it could be sent to the Committee with a view to our being able to include those extracts in our final report.

(Mr Vereker) Certainly[1]; we have no secrets.

43. Can I deal with two slightly more routine matters? Paragraph 2.6 of the report dealing with the allocation of administration costs. Could you explain why, having received a recommendation in 1992 that a time recording system be introduced, we are still, nearly four years later, reviewing the implementation of a pilot scheme?

(Mr Manning) I should say that we do face some significant difficulties in this area because we are not an institution which by and large is producing a standard product. When you are producing a standard product it is rather easy to measure the amount of time put into the various stages of it. In the case of the aid programme, we are designing a whole series of interventions in order to respond to individual requirements in the field. That means that when you look at the time of individual people they are quite heavily distributed across a large range of activities. It is not very easy in our case—we have not found it easy —to allocate staff time in a simple and straightforward way to end products. We can do it for part of our business more easily than for other parts. As the introduction of resource accounting moves ahead in government, we will be looking seriously at ways of allocating our activities more rigorously than we have been able to do at the moment. We are looking at this very moment at the kind of software that might enable us to do that more effectively. The difficulty with our present situation is that it is hard to introduce such measures without significant cost in terms of staff time and the introduction of these things. They are not necessarily either easy to bring in or cost free and that is what has held us back.

44. I am not sure I can entirely let that answer go unchallenged. Firstly, what you were describing was the difficulty in time evaluation. What this paragraph of the report describes is a time recording system. Time recording is easy; it is a case of persuading the staff to fill out a time sheet. I am not sure that it requires four years to do that. Analysis of that time recorded is again easy. I can name you at less than ten minutes' notice at least half a dozen commercially available time recording and analysis systems which have been around for long enough that the cost of introducing them is relatively low. I accept the point you make about time evaluation. Once you have the measure of how much time has been spent by members of staff on a particular project it then becomes difficult to evaluate that time. Can I put it to you that the fact that we have had four years' delay in even recording the time in the first place does not make the evaluation of that time spent any easier?

(Mr Vereker) We note the point. We will have to continue to reflect very carefully on the relative costs and benefits, as I said in answer to an earlier question, but I certainly note the Committee's interest in that.

45. On the final point I wanted to raise, which has been touched on in questions already by one or two people, again, knowing the proclivities of this Committee, are you sure that it is sufficient in looking at contracts—and I accept they are contracts in the past—where the agency has been handed out to an organisation like for example the British Council purely because they already have exclusive rights or because you wanted to give them the opportunity of first refusal, can you assure us, such considerations do not rate highly in the placing of management contracts as of today?

(Mr Vereker) In the case of the British Council, we undoubtedly have a much more businesslike relationship with the British Council now than we did at the time that many of these projects were conceived. We have moved to a situation in which it is very often the case that we will be inviting the British Council to compete for contracts with us and that where they are awarded a contract that contract is written, it is an enforceable memorandum of understanding. We have moved a long way from the era of the early and mid-1980s when the British Council was very much seen as an arm of the overseas enterprise of the UK rather indistinguishable from the central government arms. There is a degree of development of an internal market there. In the case of the Crown Agents there is still a policy endorsed by Ministers of ensuring that the Crown Agents do have a guaranteed core of business in a certain number of countries, but where that applies, yes, we certainly ensure that the arrangements are on a commercial basis.

Mr Watson

46. Could I start by looking at total spending on health and population projects? I noticed in the figures provided on page 9 of the NAO report there has been a doubling, more than a doubling at constant prices, between 1988–89 and 1993–94. Given what has happened to the ODA budget over that period and what is now happening to it, are you able to say at the expense of what other projects spending on health and population issues has taken place? Just broad areas.

(Mr Vereker) In broad terms what has been happening to the aid programme is that we have been increasing our spend in certain sectors, capacity building, management development, transfer of know-how, and reducing our spend in the construc-

[1] *Note:* The manual, A Guide to Appraisal, Design, Monitoring, Management and Impact Assessment of Health and Population Projects, ODA, October 1995, has been submitted but has not been printed (PAC74).

[Mr Watson *Contd*]

tion of large infrastructure. Although I would not say there was a necessary close link between the growth of our work in health and population and the decline in the number of large pieces of infrastructure like power stations that we build, that is the broad trend. All of that within an overall picture in which the aid programme has been, broadly speaking, somewhat constant but the multilateral share has been increasing.

47. I got that figure of a doubling on which you did not comment but I do not think you would query it from the 1995 department report showing that total ODA expenditure has risen from £2.01 billion in 1989–90 to £2.276 billion in 1993–94. Within that health and population has gone roughly speaking from about 5 per cent to about 10 per cent.

(Mr Vereker) That is right.

48. I wondered whether we could extend that to the comments made both in the departmental report and in the NAO report in respect of the Cairo conference which took place in September 1994. That conference is reported in the NAO report—I do not have the paragraph number to hand. It says in there in some detail that a strategy was adopted at that conference calling for a four-fold increase in the investment in reproductive health and family planning to $21.7 billion a year by 2015. Could you state what plans have been set in place within the ODA to begin to move towards an increase of that sort?

(Mr Vereker) It is paragraph 1.5. We are undoubtedly honouring the Cairo commitment; we are continuing to move sharply in the direction of an increased investment in health and population, reproductive health and family planning spend. At this point it becomes slightly complicated. We have to distinguish between expenditure and commitment but we have in 1994–95 as part of our population initiative phase II, which is part of our follow-up to the Cairo conference, commitments ranging from around £10 million in Zambia to £19 million in Pakistan[1], as well as in Bangladesh, India, South Africa, Zimbabwe, Malawi, Tanzania, Uganda and Kenya and a number of smaller programmes[2]. We are starting to establish a rather substantial pipeline of new health and population projects post Cairo.

49. Relating to that could I quote to you from the departmental report of 1995? It says there in respect of the Cairo conference that ODA has already invested heavily in this area—that is in health and population—and expects to commit a further £100 million by the end of 1995. On the face of it that at least aligns with the comment in paragraph 1.10, "In 1994–95 the Administration planned to spend about £100 million". What I need to ask you to clarify if you will is that the departmental report talks of a further £100 million. Does that just mean the 1994–95 figure? I do not seriously expect you to tell me it is new money but does that just mean the 1994–95 figure is the same figure that appears in paragraph 1.10 of the report?

(Mr Vereker) It is different. My understanding is that it is still talking in terms of commitment. We did in fact hit something like commitments worth £180 million in 1994–95. We are planning another £70 million in 1995–96. We are well ahead of the target[1].

50. I am just worrying about moving ahead. If we look at the figure I quoted earlier on a year by year basis on page 9, we see that if we take away the emergency aid figure out of 1993–94 we reach a figure which my arithmetic tells me is £119 million, albeit a small fallback it does not even seem to be matched in the 1993–94 figure, if 1994–95 is £118 million. Can you tell us what the 1995–96 figure will be? I imagine your new departmental report must be just on the verge of publication so you must have that figure.

(Mr Vereker) This exchange is being complicated by the fact that Figure 1 related to health and population and the Cairo figures I have been giving you relate to population solely.

51. What was the figure of £118 million then?

(Mr Vereker) The figure was £180 million and it is the commitment figure not expenditure; it is the commitment figure on population for 1994–95, on top of which there is a £70 million commitment figure for population for 1996. Figure 1 relates to health and population but it is expenditure, not commitment. It is quite difficult to draw the comparison.

52. I accept that may be a false comparison. If the commitment is £180 million plus £70 million for 1994–95 that period is now over so what was the actual expenditure or does that mean expenditure commenced in that year but not yet completed?

(Mr Vereker) I am afraid it is too soon to tell you what the expenditure will be.

53. Will that figure be in the 1995 departmental report which is due out shortly?

(Mr Vereker) You will have to wait until British Aid Statistics this autumn.

54. It will not be in the 1995 departmental report.

(Mr Vereker) No, it will not; the departmental report is out before the end of the financial year and went to bed in the autumn.

55. Is that spending then on population issues as a separate entity and also health and population issues as a whole on an upward curve in line with the commitments given following Cairo.

[1] *Note by witness:* The commitments actually range from £7.24 million in Zambia (not £10 million) to £17.67 million in Pakistan (not £19 million).

[2] *Note by witness:* Commitments to programmes in countries other than Zambia and Pakistan were: Bangladesh, £7.49 million; India, £8.04 million; South Africa, £9.53 million; Zimbabwe, £10.4 million; Malawi, £11.57 million; Tanzania, £11.79 million; Uganda, £13.6 million; Kenya, £16.75 million; and £14.5 million to programmes in other countries, including Cambodia, Ghana, Kazakhstan, Mexico, Nepal and Peru (PAC74).

[1] *Note by witness:* In 1994 the ODA announced that it would commit £100 million to reproductive health by the end of 1995. It made commitments of about £180 million over the period in question (1994–1995) (PAC74).

[Mr Watson *Contd]*

(Mr Vereker) Yes. On population they are ahead of the Cairo commitment[1] and they are on an upward curve.

56. Can I turn to the question of sustainability which was touched on to some extent by the Chairman in his opening remarks? I notice in the mission statement contained in your report that the seven main areas which you highlight, one of which is to promote human development including better education on health and children by choice is prefaced by the comment that to achieve this ODA will take actions which promote sustainable economic and social development. I put it to you that the NAO report is actually quite critical in terms of sustainability. On page 4 of the report there are several comments on sustainability one of which says, "... for most projects examined, sustainability considerations did not feature prominently". It then goes on to talk about the issues and says, "Much of this is not documented in project files". Then at sub-paragraph q), "It seemed to the National Audit Office that most of the project proposals examined did not include sufficiently detailed assessments of the recurrent cost implications likely on project completion". This is in the context of a number of examples, not least the Orissa project, where sustainability is unlikely. I am a bit concerned about this, because it is part of your mission statement and anybody who has any knowledge of or involvement with aid knows that sustainability is essential, but it does not seem to be happening to any great extent in terms of those projects. I wonder what you specifically intend to do with regard to the Orissa project because that goes back to 1980 and it would be a tremendous shame if the money spent over a long period, probably two decades, was to prove not to be sustainable. More generally I wonder what the Administration intends to do to improve the sustainability of the projects it promotes.

(Mr Vereker) I think that the key to the argument about sustainability lies in the second sentence of paragraph m) on page 4. This is the reference to the fact that sustainability needs to be addressed in a wider context than that of individual projects. I do not of course deny that it is relevant to individual project design and management. We have to be sure that projects are cost effective, do not add to recurrent costs, are not unrealistic in their demands on local, provincial or national budgets. However, sustainability—I repeat the point I made earlier—is an aspect of poverty, it is an aspect of being a poor country and the key to sustainability lies in the ability of the recipient country to mobilise its own resources for development. That is why our mission to promote sustainable development underpins all of this. The fundamental mission we have, we believe, is to enable poor countries to manage their own growth, eventually to grow out of needing aid. The issue of sustainability, of ability to mobilise resources, ability to attract foreign investment, to mobilise savings, to generate growth, is addressed in the macro-economic context, in the work of the World Bank and the IMF, in our work on sector assistance, in our work on programme aid. In the cases of these very poor countries we are dealing with, Kenya for instance, we would expect that the sustainability of Isiolo Hospital, for instance, depends very much on the ability of Eastern Province to get enough resource from the central government which in turn depends on the central government being able to provide it with an adequate budget which turns on good economic management.

57. I understand the macro-economic aspect of it. At the same time a considerable amount of money could be put into projects which if not exactly going down the drain would have almost a finite end if you do not make greater attempts to ensure that the recipient countries are ensuring that there is going to be some sustainability. Of course it depends on their economic policy and the state of the country's finances but do you think there is any more the ODA can do to try to improve on the record in terms of examples we have been given here?

(Mr Vereker) There are always ways we can improve; I certainly accept that. What we have learned in the case of Orissa, which is probably about as difficult a place as we could choose to work, somewhere which virtually had nothing before so you were sustaining something which did not exist, is that we need to get inside the health management system within the state, we need to help them manage the health service and to make the best use of the resources they have and we are starting to do that. We need to put together increasingly interventions which address the whole sector, address supplies, training, management, construction of health centres, advice on how to use the whole system. We are starting to do that but I do not think that we are going to see complete sustainability in terms of their ability to run everything themselves, particularly in terms of condom purchases.

58. Do you have confidence that the measures you have outlined there will lead to an improvement in the projects which you manage in future?

(Mr Vereker) Yes.

59. I think the Committee will join me in expressing the wish that we hope so. There have been a couple of mentions of the British Council so far. I see that in Appendix 1 and Appendix 2 of all the Indian projects all three are managed by the British Council and one of the four in Pakistan. Can you say what proportion of health and population projects are currently managed by the British Council on your behalf?

(Mr Vereker) Do not hold us to it, but it is somewhere between one tenth and one fifth.

60. I was just wondering how that figure is going to change in the future. Mr Stern made comments about the question of the British Council being given preferential treatment. I know you are a member of the board of the British Council and the British

[1] *Note by witness:* i.e. The commitment which the ODA announced at the time of the Cairo conference (September 1994) (PAC74).

[**Mr Watson** *Contd*]
Council itself is facing considerable cuts as a result of FCO and ODA cuts, in fact disproportionate cuts. I have to ask you first of all whether you have any conflict of interests in your position as a member of the board when those sorts of cuts are being discussed at the British Council?

(Mr Vereker) No, I do not. I think it is helpful for the board to have on it not one but two representatives, myself and the Permanent Under-Secretary of State.

61. I am sure it is but do you feel a conflict of interests?

(Mr Vereker) No, I feel that it enables me to reflect the reality of funding life in the British Council board and to ensure that my colleagues in ODA are aware of the strains that the funding situation puts on the British Council.

62. It seems to me that it is going to become increasingly difficult for the British Council, whatever the system as far as tendering is concerned, actually to manage a certain number of projects, between one tenth and one fifth, in future if the sort of cuts being proposed in respect of their funding are carried through.

(Mr Vereker) There is no doubt the British Council does face difficulties. The extent to which they are able to win management contracts from us depends on their ability to display the necessary technical capability and value for money in managing the projects. That is very much in their hands.

63. Yes, indeed, but would you accept that they generally have a good record in management?

(Mr Vereker) I would accept that the British Council have played an extremely useful if not central role in the management of some of our projects in the past.

64. Are you not then concerned, whatever hat you are wearing, that the projected cuts might make it more difficult for the British Council to continue carrying out that role in the future?

(Mr Vereker) I repeat the point that it is very much in their hands whether they are able to maintain their capacity to provide professional service and to provide value for money under these circumstances. What we have discovered in the process of moving to a more competitive arrangement for the management of projects, is two things: first that the Council themselves sharply improved their performance in response to the competitive pressure and second that there was an array of alternatives out there. Faced with that competition I would expect the Council to respond.

Sir Kenneth Carlisle

65. May I just go back to sustainability? You have expressed quite clearly the parameters of it and how difficult it is and how it may not always be entirely possible and you have to go into some of these areas because of the condition of the country. It is important if one is to have true value for money and I should like to explore it a bit more. On page 25, paragraph 3.22, the three main factors on sustainability are mentioned: the degree of involvement and ownership, management capacity and the availability of recurrent funds. Which do you think is the most important of those three?

(Mr Vereker) I think the Comptroller and Auditor General has got it right here: I think they are all absolutely central. I suppose what we have learned, the surprising one if you like, over the last ten years is the importance of the first. They are apples and pears so you cannot really rate them but the one which aid donors were in danger of underestimating in the past was the degree to which the recipient government felt engaged with, shared, was a partner in the enterprise we were involved in. Ten years ago my predecessor, if you had asked him the same question, would have said the third one is the key one, recurrent funds. What we have learned is that if they are committed to it then it is going to be sustainable and if they are not then it will not be.

66. I would certainly agree with you because I do not see how you can begin to do anything if you are simply not wanted in a foreign country. In this respect, I was quite interested in the Asian Development Bank III case on page 42. Could we look at this? Part of this was to establish a specialist training course for nurses and also repair and maintenance workshops. It seemed that in both the people to whom you went were not interested in having you at all. For example, under impact it has been difficult to recruit nurses for courses because of the reluctance by the authorities to release nurses for training and those that have completed courses are not being posted to jobs where their new skills will be used. Surely this demonstrates a complete lack of sympathy to what you are seeking to do.

(Mr Vereker) It demonstrates the force of your point that local ownership is essential. I would say two things. First of all, this project was in the two remotest of the Pakistan provinces, Baluchistan and North West Frontier Province, which are very difficult to work in; Baluchistan in particular is extremely difficult to get to, difficult to operate around. The relationship between North West Frontier Province and the government comes and goes. We were tackling an area of great physical and practical difficulty where cultural change had perhaps not shifted very far anyway. The second thing is that this is not as discouraging as it seems. This report is based on work done by the National Audit Office in May 1994 when they looked at this project. Since then there has been rather good progress which illustrates an increasing degree of acceptance of what we are all trying to do in Pakistan, indeed as illustrated by Benazir Bhutto's active participation at the Cairo population conference. Things are moving in Pakistan. We do have post basic nursing training well established, led by ODA trained nurses. CIDA, our Canadian colleagues, are coming in with some resource which will support that. We do have well established maintenance workshops which are changing the management culture to preventive maintenance.

[Sir Kenneth Carlisle *Contd]*

67. Has that happened since this report was written?

(Mr Vereker) Yes, it is coming along nicely. The other feature is that the health planning companion to this has now been extended into all the Pakistan provinces away from these two so it is having some replicated effect.

68. Since you went in there has been a growing acceptance and understanding of what you are seeking to do.

(Mr Vereker) I believe so. It is getting a lot better and Pakistan is turning the corner.

69. Did you realise that this welcome did not exist when you first went into this project or were you just optimistic?

(Mr Vereker) We knew that it was difficult in 1991 but we thought it would be possible. If you go back to the earlier Pakistan projects we did not realise quite how difficult it was going to be then. Here we are reasonably confident that we can make some progress.

70. Now, if you had a project where you felt there was great need for something to be done, but yet you were doubtful about the acceptance and in fact they were hostile to you, would you still seek to get your foot in the door in the hope that you might persuade them even though you might well know that you were throwing money down the drain?

(Mr Vereker) We always try to disentangle a bit which the key actors are and who the interlocutors are that matter. It is not unusual for us to be aware of the fact that there may be some parts of the machine which are more welcoming than others. Deliberately what we have been doing in Pakistan is to try to reinforce those parts of the system which are committed to improving family health and population activities, improving reproductive health, working with them, strengthening their position, giving them confidence and hoping that they will act as change agents on the more conservative elements. We would always look very carefully to see the parts being played by the different actors.

71. Finally on this Asian Development Bank one I wanted to pick up the point about the British Council. It did seem intolerable that the management charges were so high and yet there is no attempt to get anyone else to help to do it. We just accepted the rather large charges by the British Council.

(Mr Vereker) This was a complex and difficult project and at the time we started it in the early 1990s it was normal to go with the British Council, it was a little before our policy of competition for health projects where possible. As the report indicates, we should have reviewed the fee; I agree with that. We did look in 1993 at the value for money we had secured for what we had paid the British Council and we did conclude that the level of inputs and charges were reasonable given the work they had had to do.

72. May I now go on to management capacity which is also quite important? You are trying to improve the management capacity of the people with whom you are working in these various countries. Do they not find it rather intolerable that you should assume that you have much greater management knowledge than they do? How do you get over those barriers? Can you?

(Mr Vereker) Our experience is that we are working with people who very readily understand that we have some expertise and knowledge to transfer and we would not be working with them if they did not feel that. It is important for me to convey to the Committee the way in which projects in this sector do not happen by way of our dreaming up some bright ideas and imposing that on them. It is very much working together with them and asking them what they will want and the ways in which they think we can help. I do think we have some experience in designing local management systems for health services from which they do benefit, yes.

73. Your people are presumably trained and skilled in going about this in a tactful constructive way. I expect you to say yes to that.

(Mr Vereker) Let me ask Dr Nabarro whether he is tactful and skilled.

(Dr Nabarro) It is important, seeing you have asked this question, that we do not simply sit here and say we always get it right. Finding people in Britain who are prepared to recognise that working on a health budget of 500 times less than our own is incredibly difficult yet at the same time poses challenges that are not dissimilar to those faced by people working in the British NHS, is quite difficult. When we find them, and there are perhaps now 150 such people on whom we can count, they get totally absorbed in this work. They will often stay attached to the needs of a particular country for five, six or seven years. They will build up personal relationships with people on the ground that flourish without our involvement and involve exchanges. Most interestingly, we find that quite often there are lessons to be learned from what happens in Quetta or some other part of Pakistan and what happens perhaps in the north of the UK or the south of the UK for that matter, where actually some feedback takes place. Catalysing these relationships is not easy and we have mistakes but those which succeed go way beyond any of our early expectations.

74. Those people provide very outstanding service, I readily give them credit for that. Can I turn to the final aspect of sustainability: current funds? It seemed to me from what you said that this was really not such an important thing now because you could not be sure about recurrent funds until your work had come to an end. I was interested, if I understood it, as far as Orissa goes although there was not really recurrent funding you still felt that one quarter of the health centres in there which are ongoing are a result of your own particular work.

(Mr Vereker) Yes, that is right. We are confident that the government of Orissa is in a much better position to carry on and sustain the project now than they were when we started. Of course I repeat the point that this is a very, very poor state of India.

[Sir Kenneth Carlisle *Contd*]

75. In assessing a project, do you analyse quite carefully what the possibilities of sustainability are in your project analysis?

(Mr Vereker) Yes, it is now a requirement of our project cycle management that we consider sustainability issues at the beginning.

76. Do you consider them under the three headings that we have explored this afternoon: involvement, ownership, management capacity and recurrent funds?

(Mr Vereker) Absolutely. We would certainly consider all of these.

77. Would there be an analysis of that and a proper write-up of the prospects?

(Mr Vereker) Yes, we would undertake an institutional appraisal of the state of the recipient, we would certainly look at the availability of recurrent funds.

(Mr Manning) I should add also that we now routinely undertake a risk analysis on these so we do look at what the main risks to the success of the project might be and clearly sustainability is a key part of that. We will categorise the risk for each project and see whether we are comfortable with those risks and see what actions we can agree with the recipient to minimise those risks.

Mr Williams

78. It is an encouraging report as I am sure you have gathered from the reaction of our colleagues. The trouble is that it is a portrait of a series of skirmishes, is it not? What about the war? Are we winning or losing? Let us see it in context. Let us take some simple examples. You referred to what I thought was very, very praiseworthy in the nicest sense—it is not meant in any derogatory sense—that research has shown that it is possible to reduce HIV in certain contexts by up to 40 per cent. Is that right?

(Mr Vereker) Yes.

79. Is it happening?

(Mr Vereker) It is very difficult to make a generalisation about the extent to which research penetrates. We have shown that if used in this way it will have. Your point about the battle, the war rather than the skirmish, is one that we are acutely conscious of. This report makes it clear that there are 5.6 billion people in the world at the moment. It projects a growth rate that, if unchecked, would result in the population of the world doubling in the course of the next century. The next century is about to begin. It is absolutely fundamental to the welfare of all of us but particularly the poor people in developing countries that we get a grip on population growth rates, that we ensure that contraceptive prevalence rises. Every year population increases in the world at approximately the same rate as the population of Germany: the population of Germany is added to the globe every year. I will ask Dr Nabarro to say something about AIDS transmission.

(Dr Nabarro) I was not quite sure of exactly your focus so if I get it wrong I hope you will correct me. The way in which we have tried to work over the last six years has been to ensure that within the bilateral aid programme we provide inputs of the highest possible calibre in partnership with groups on the ground, all the time monitoring the results of our endeavours and backing them up with the very best of research.

80. I am sorry to interrupt; what you are saying is very useful but the point I was making was a much more limited point. I was grateful also for the context in which you set the problem of population because that was extremely important. The question I specifically asked was purely about the 40 per cent reduction in HIV which sounds great and all I asked is whether it is happening.

(Dr Nabarro) The studies we have now from communities in western Uganda where we, together with the Medical Research Council have been working with them and studying HIV prevalence rates, show that among adult men now we have reached a position where prevalence is plateauing and not increasing. That situation has not been found for adult women, it is still increasing and in addition among women the age of first infection is getting younger. We do not have those data yet from any other part of Africa but we are seeing increased access to sexually transmitted services so we should move towards it if we can get the other interventions such as a viricide for women which we have embarked on developing.

81. The 40 per cent is interesting, it is notional, it is potential but it is not happening. Some years ago in Kampala in Uganda - you just quoted Uganda yourself coincidentally—the HIV sero prevalence amongst pregnant women was 24 per cent. HIV/AIDS was causing the infant mortality rate to rise by up to 30 per cent and it was projected might nearly double the under-five child mortality rate. That was going back at the beginning of this decade. Have we got on top of that problem? I do not mean we alone; obviously we cannot do it on our own.

(Dr Nabarro) The Government of Uganda, which is the lead group, together with non-governmental groups in Uganda, have certainly got on top of transmission among adult males. We do have plateau figures and these were reported at the international conference on AIDS in Africa which took place in Uganda last December. Yes, it is beginning. We may be starting to get there in east Africa, but we have a huge battle ahead of us in Asia and Latin America still.

82. At the end of 1990 the World Health Organisation forecast that by the end of the century 10 million children would be infected with HIV, most of whom would die and 10 million would be orphaned through AIDS' deaths. Is that still a realistic assessment? Has it been proved to be a grossly overrated assessment? What is your thinking on it, collectively internationally?

(Dr Nabarro) Collectively our thinking on those early estimates on both AIDS' orphans and infection rates amongst children are thought to be slight over-estimates. The transmission rate per pregnancy

[**Mr Williams** *Contd*]
from a mother who is HIV infected to the child was thought to be around 25–30 per cent likelihood and estimates more recently have come out at a slightly lower figure. What we are now finding is that if before delivery there is increased hygiene and washing of the birth canal then this actually further reduces the transmission rate. These are changes at the margins and obviously the real thing we have to do is to help reduce the infection rate through heterosexual sex among adults and adolescents. We are denting it but we have not got on top of it and obviously that is what my group are totally committed to doing.

83. Of course it is not just of local importance, it is of importance to the whole world that this is understood. Let us look at something else which was referred to, which again I am glad to hear, that drug impregnated bed nets are helping to reduce the malaria incidence amongst children, or at least you have shown that it is possible to do that. Are these being used? We are now at the stage where we are seeing these new strains, so we are told—I only know what I am told in the newspapers; you will understand it far better than I will—in Africa and Asia. Is this a battle we are beginning to lose again as far as infant deaths are concerned for example?

(Dr Nabarro) We certainly lost the battle against malaria in the 1980s as we realised that you just cannot deal with this problem by having armies of technicians going round the place spraying insecticides and doing the other things that they used to do. We have learned that if we want to do something about malaria we have to go at it multi-pronged because the parasite is highly capable of becoming resistant to our drugs. If we look at our experience of malaria, as you have asked a general question, in Cambodia where we have highly resistant malaria, by improving the quality of treatment of malaria cases at health posts and health centres we have dropped the mortality rates, as far as we can tell, by as much as 25 per cent simply by improved practice. We have also started to introduce these impregnated bed nets in Cambodia but that is more difficult because people very rarely sleep underneath them when they are in the forest and it is forest fringe malaria so it is not so useful. In parts of Africa where we have got a different pattern of transmission the bed nets come into their own, they have been introduced in the Gambia as part of national programming and we have helped with that and we are starting to make a difference. It looks as though we will get a difference as well in coastal Kenya and Tanzania though it is more difficult because the intensity and transmission is so high. What we are learning is you have to understand your malaria to get your strategies right rather than have a global strategy. This impregnated bed net is the most promising one we have had yet.

84. The 25 per cent reduction is dramatically effective. How does it compare with the rate of increase against which it is to be measured? How far had we lost the battle before you started to win some of the ground back again?

(Dr Nabarro) If we can find a way that will enable people to have access to the material with which to impregnate these bed nets at a price they can afford and if we can help them make sure they get this permethrin stuff onto the bed nets every six months—and with World Health Organisation and others we have developed ways of doing this—this will make a much bigger dent than the natural increase that you are describing here is going to do. We are not going to eradicate malaria.

85. No, of course not. Is it likely that the money will be available not just from us but from other sources as well? Having made these research breakthroughs is there a resource break-through to match?

(Mr Vereker) What we are doing now is to provide a small grant to the London School of Tropical Hygiene and Medicine to test market a dip-it-yourself bed net kit just to see whether there is a cheap way of doing this which can be replicated, which will not have to be expensively supported from the west for ever. We do not yet know the answer to that.

86. It is really a long way ahead before it is on a significant scale. I am not blaming you, I am just trying to get the picture.

(Mr Vereker) It might be a long way ahead.

(Dr Nabarro) One of the things we have been doing is that it is clear that governments and aid donors are not going to come up with the US$15 per head per year that is necessary for the range of essential interventions that we are focusing on here. We have governments spending US$3-$4 per head per year and even the most generous of aid donors cannot bridge that gap. What we are doing is looking for imaginative ways of sharing the cost through what we call social marketing[1] where we will try to subsidise a part of the cost or subsidise a part of the cost for groups of people so that we can make a dent. I must say, speaking for all of us, that we know that there are some real impossibles here because the gap is too big to be met by donors and governments, even with the cheapest of technologies. We are talking here about an annual spend per person on health care in developing countries that is the equivalent of what is spent per person in Britain in two days. The annual spend in developing countries is very, very small.

87. There we have had just two examples of the horrendous challenge that you and other aid authorities are having to face just from the natural disasters. Again around the beginning of this decade there was a great deal of criticism then of what might be seen as the sabotaging by the powdered milk companies of the work that was being done by the aid organisations in trying to combat infant mortality. Have they in any way relented on what they were doing? At that time diarrhoeal disease was the biggest killer worldwide: five million a year, one quarter of all children's deaths, and the risk was 14 times as high, according to the Lancet, for children who were bottle fed. Have the companies started to behave themselves?

[1] *Note by witness*: This is the subsidised distribution of products, including contraceptives, through the private sector, usually supported by a mass media campaign (PAC74).

[**Mr Williams** *Contd*]

(Mr Vereker) There is a much greater worldwide awareness of this issue.

88. They do not care about that; they did not at that time, did they?

(Mr Vereker) I will ask Dr Nabarro to comment on that too because he is very familiar with it but I do not think they are by any means indifferent to it, nor indeed to the publicity that it attracted.

(Dr Nabarro) The research over the last ten years, some of which you described, which has shown the increased risk to children associated with bottle feeding or at least with early cessation of breast feeding, has now been internalised by all the governments of this world with whom we regularly do business, which has meant that they have entered into various forms of regulatory arrangement with both local and international suppliers of breast milk substitutes to reduce the degree to which people are enticed into using this as an alternative. There is a difficulty that if you are a poor person with a child and you are trying to continue to get your living whilst at the same time to breast feed your child you often face real difficulties which push you towards perhaps ceasing breast feeding before it is to your child's benefit. We have to understand that. I must stress that it is our understanding that there has been a big change in the behaviour of the marketing companies as a result of tighter watching by national governments.

89. I am glad to hear that because UNICEF showed that bottle fed children were 25 times more likely to suffer from other major illnesses than those who are breast fed. Breast feeding is also advantageous to the mother as well, is it not, because it actually has a contraceptive effect for a limited time which can be beneficial?

(Mr Vereker) Yes, that is right.

90. That still leaves us without the final, the big one. Then we have malnutrition. The armies are marching on a major scale, are they not, and we are firing with pea shooters really in the western world. What is happening on this front on infant mortality?

(Mr Vereker) We are not marching with pea shooters and a lot of progress has been made. Infant mortality rates have sharply improved over the last five years.

91. Can you give us some figures?

(Dr Nabarro) I am just looking up my figures but wanting to stress to you that the real transformation that there has been in health figures over the last 30 years has been in infant mortality which is really dropping. It has dropped something like five- or six-fold. I do not seem to find them straightaway.

92. You can put in a note if you wish[1].

(Mr Vereker) Child death rates have fallen from 28 per cent of births to 10.6 per cent of births over the last 40 years. Life expectancy at birth has increased from 40 to 63. The key thing that I would say is that over the last 40 years the number of couples using contraceptives for family planning has increased from 10 per cent to 50 per cent. Huge progress has been made. However, you asked this question in the context of a discussion about health and population projects. I think I would answer it in the context of sustainable development as a whole. Child malnutrition is a terrible thing and it is a terrible thing from a health perspective, but it is very often a reflection of poverty rather than a reflection of poor health practice. There may be an education component there but we need to work on survival strategies of very poor people, we need to work on raising income levels of people in very poor countries, we need constantly to work away at sustainable development. Where there is sustainable development, poverty will be reduced and where poverty is reduced child malnutrition will be reduced. That is not a pea shooter, that is the big gun and that is the heart of our mission.

93. But the big gun is notional at the moment: it is not actually working. If you would like to put some further figures in, if there is anything you feel would help to illustrate the success you feel we are having in the big battle, by all means submit it as written evidence.

(Mr Vereker) Dr Nabarro is bursting with an example.

(Dr Nabarro) I fully understand your frustration about the big and the small. I suppose that is one of the difficulties that we are often working with relatively small instances and then laying them before our colleagues in national government. In our work with the Mbeya municipal and regional health authorities in south western Tanzania a relatively small additional input merely of sensitisation and training jointly between the Tanzanians and ourselves with the workers—health and community development workers—has been associated with a significant reduction in levels of child malnutrition and we believe, though we do not have the figures yet, improvements in survival. Our colleagues in other parts of Tanzania are finding the same. It is not all awful and we should like to submit some of that evidence to you[1].

Mr Thurnham

94. Could we just look at the figures in paragraph 1? Could you say a little bit more about whether you think there is any prospect of the growth of the world population coming to less than 1 billion in a decade?

(Mr Vereker) Yes, I do. Population growth rates are falling and will continue to fall with the increasing penetration of two factors: one is understanding, which reduces the number of children people want. The other is access to modern safe contraception which reduces the number of children that people do not want. That will have the effect and I myself would be confident—I do not know about my colleagues—that the global population will not actually double during the next century. But it could.

[1] *Note*: For population statistics for countries reviewed by the NAO see Evidence, Appendix 1, pages 18–19 (PAC74).

[1] *Note*: See Evidence, Appendix 1, pages 19–20 (PAC74).

[**Mr Thurnham** *Contd*]

(Dr Nabarro) I should just like to help you. I think it is going to double; we are going to end up with a population that will be around 11 billion. This demographic stuff is quite difficult because although we have slow growth rates at the present time the number of people already born are going to go ahead and have children so we have some inevitables. The critical thing is that with trends moving forward as they are at the moment and with these very significant increases in levels of contraceptive use, voluntary contraceptive use in developing countries, to the figure of greater than 50 per cent which we have now and the turns that we are seeing in Zimbabwe and Bangladesh and Pakistan, we reckon that with a fair wind and continuing investment we will end up at nearer 10 billion than 15 billion as the eventual stabilisation figure. That is what we need to be sure we aim at. We think we will get there.

95. How we manage this growth has to be the biggest problem facing the world. When we come to the work that is being done, this country has a record for perhaps having more expertise in this area than any other country. Is that true?

(Mr Vereker) I would not characterise it quite as sharply as that. We are confident that we have good expertise. I am not sure that we would say we are necessarily better than anyone else.

96. Where I am concerned about is that when it actually comes to implementation we seem to go wrong. Looking at paragraph 3.14 this refers to vehicles being purchased and left unused for years on end. How can this be when the problems are so severe and the resources so short?

(Mr Vereker) Let me give you the background to the reference in paragraph 3.14. As regards the minibus in Kenya we were determined to supply a UK model if we could, partly because although what they wanted was a local model, we were rather uncomfortably aware that the local models were being used as taxis or small buses and we were somewhat afraid of it being misused. We did check before we sent a UK model, both with the manufacturer and supplier and locally, that it could be both serviced and provided with spares. In the event that turned out not to be the case. In practice this was designed by KNUT, one of the less successful of the Kenyan NGOs and that project was not a good performer anyway. It was one small item in a £5 million project. I am rather robust about the Landrover for Zimbabwe. You always have a bit of a problem in trying to arrange to get out into the project area at the same time both the right technically qualified person and his vehicle. Both of them have certain lead times attached to them. A vehicle without the officer is a good deal less worrying than an officer without a vehicle; the officer is much more expensive. In this particular case we were right to wait until we got a good well qualified person and he is very good and he is using his vehicle. I think that it was not a major cost.

97. When you say "we" is that the ODA itself? Who is the "we"?

(Mr Vereker) Yes, ODA.

98. I am not sure quite why you have to be so much involved with the implementation of things. There is a difficult enough job to manage and monitor and control without actually getting involved with so much implementation on the ground. If we look at the projects in the appendices, I see most of them being carried out by the British Council although I think you said earlier that there were only between one tenth and one fifth of the projects overall carried out by British Council. Can we just look at the first one, Appendix 1, page 29, the Orissa project carried out by the British Council? How is that decision made? Who else could have carried out the project?

(Mr Vereker) Let me just explain that by "carried out" the project what we are talking about here is in essence the field management of the project, which would not relate to the question of recruitment of experts which would be done by ODA's recruitment office, now in East Kilbride, or indeed the procurement of vehicles. How was that decision made? At the time of the inception of the Orissa health and family welfare project there really was very little capacity in the field in India other than the British Council upon which we could rely. This was before the period when we had exposed the British Council to competition, at a time when the British Council was very much seen as part of the array of British foreign policy instruments, before we established an internal market to manage projects. We were very happy to go with them in those days. The alternative for us would have been continued management from the department in London, which was the way in which in the 1970s and early 1980s we were accustomed to running projects in countries such as India where we did not have a local development division.

99. Do you now have more alternatives available to you to manage the projects?

(Mr Vereker) Yes. As I mentioned in the case of health projects in India, we did run a competition for the management of all our health projects other than the Orissa one. The Orissa one is very substantial so we parked that with the British Council and we ran a competition for the rest. The British Council did bid for it but they did not succeed. There was a consortium of technical cooperation officers who succeeded.

100. It seems to me that the delivery of the services should be much sharper than it is, reading this report. I am not sure why ODA staff themselves have to be so involved. Why can you not use other agencies?

(Mr Vereker) In delivering services, there is a spectrum running from the role of ODA, in particular Dr Nabarro's division and the geographical departments, running through the field management arrangements whatever they may be, all the way through to the local recipients who themselves have a major role in the management and implementation of projects. We do not now, or at least very rarely, manage in detail a project from London. We will use an array of instruments. There might be a development division which has a regional remit, it might be an aid management office such as we have now in Delhi operating with a system of field managers or

[**Mr Thurnham** *Contd*]
operating with a project manager. It is not the case that we are micro-managing the detail much ourselves now.

101. What role can be played by NGOs, well known organisations like Oxfam? Can they not play a greater role in these projects?
(Mr Vereker) Yes, they do and in a number of health and population projects they do have a role; not in any of these covered in this report but particularly in those which are concerned with emergency aid situations.

102. That is what surprised me. Going through here, if we move on to the other projects, we just see the same thing largely. It is either project management by British Council or by the department itself. That seems to be the case looking at them one after the other.
(Mr Vereker) Time has moved on. We do use NGOs more now than we did in the period that was being examined in this report.

103. Do you not think that will enable you to focus on your job better so that you can monitor and control them more rather than being so involved?
(Mr Vereker) Yes, in system terms that is absolutely right. We have put a lot of effort, for instance, into the relationship we have with the NGOs, the requirements we put on them for reporting and monitoring, precisely so as to set up systems which will deliver the impact we want in the projects and leaving us to more of a core role. Managing a system like that does of course have its own challenges.

Sir Michael Shersby

104. One point of clarification. On the question of infant mortality caused by bottle feeding, was the problem which was identified not polluted water rather than the use of powdered milk?
(Dr Nabarro) Of course polluted water is a problem in making it likely that a powdered milk preparation will lead to diarrhoea. In practice the issue is not primarily polluted water in most of the diarrhoea that we see or that I used to see when I was doing this work in Bangladesh and Nepal in nutrition units where children come in dehydrated. What tended to happen was that the bottled milk would be made up, usually with dirty hands, then the bottle, the fluid and the teat would often be left by the mother with an elder sibling for four or five hours in the sun. During that time the multiplication of bacteria would take place and that would be the factor, the high bacterial load, that caused the diarrhoea. Indeed we used to say that when you are trying to rehydrate a child from diarrhoea, if you have a choice between polluted water or no water use the polluted water because it is the dehydration that is the killer. I would stress that it is not primarily the water itself but it is the subsequent process of leaving the stuff in the sun and the multiplication of the bacteria, then the failure to rehydrate the child, that actually causes the death.

Mr Watson

105. There is concern in some quarters about the increasing extent to which UK aid goes through the EC or might do in the future. I wondered, particularly in respect of health and population, whether there is any mechanism to ensure that there is investment in those areas which you have identified as priorities in any of the UK aid funding which might go to the EC? Specifically, what discussions does your department have with EC civil servants on that matter?
(Mr Vereker) We have extensive discussion with a number of areas of the European Commission about our respective programmes. We also work with them in a number of selected countries. I should stress that it is not simply a one-way process; it is not us going in arrogantly and telling them how to manage health and population projects. We have things to learn from them as well as they from us. We do have a constructive dialogue with them about aid systems, in particular about the quality of appraisal, the quality of management, the quality of evaluation and feedback of aid projects. We believe that this is effective, that it is having an increasing gearing effect and we have two[1] of my own staff currently working in the Commission as national experts working on health and population project design.
Chairman: Thank you for coming along and answering our questions today.

[1] *Note by witness:* In fact, one member of ODA staff (not two) is working on health and population project design. The other, funded by ODA, is working on health research.

APPENDIX 1

SUPPLEMENTARY MEMORANDA FROM THE OVERSEAS DEVELOPMENT ADMINISTRATION (PAC 95–96/74 (rev))

Question 92

Population statistics for countries reviewed by the NAO.

KENYA

	1977/78	1984	1989	1993
Total Fertility Rate (Average number of births per woman)	8.1	7.7	6.7	5.5
Contraceptive Prevalence (% couples using modern contraception)	n/a	10%	18%	27%

In 1993 (last year for accurate estimates) 79% of children aged 12–23 months were fully vaccinated; 71% of children received all the recommended vaccinations during their first year of life.

INDIA AND ORISSA

		1983	1993
Crude Birth Rate (Number of births per 1,000 population per year)	India	33.6	28.9
	Orissa	33.3	26.6
Total Fertility Rate (Average number of births per woman)	India	4.5	3.4
	Orissa	n/a	2.9
Contraceptive Prevalence (% couples using modern contraception)	India	25.9%	40.6%
	Orissa	27.5%	36.3%

		1977/78	1983/84	1992/93
Infant Mortality Rate (Infant deaths per 1,000 births)	India (rural)	139	114	85
	Orissa	136	130	112

PAKISTAN

	1985	Pakistan Demographic & Health Survey 1990/91	Pakistan Contraceptive Prevalence Survey 1994/95
Population	96.2m	112.4m (estimate)	128 m (estimate)
Population Growth Rate	3.1%	3.1%	2.8%
Female Literacy	n/a	n/a	21%
Contraceptive Prevalence Rate			
TOTAL	9.1%	11.8%	17.8%
URBAN	n/a	31.0%	36.0%
RURAL	n/a	6.0%	11.0%
Desired Fertility (Married women of reproductive age wanting no more children)	n/a	39%	52%
Married women of reproductive age who have heard of contraceptive methods			
ANY METHOD	62%	78%	91%
HORMONALS	50%	62%	76%
Total Fertility Rate	6.5	6.1	5.8
Infant Mortality Rate	112:1000	102.9:1000	95:1000

Various sources—extrapolated from the Staff Appraisal Report for the World Bank Programme Project Document 1995.

ZIMBABWE

	1986/88	1992/94
Total Fertility Rate (Average number of births per woman)	5.5	4.3
Contraceptive prevalence (% couples using modern contraception)	36%	42%

In 1994 (latest year for accurate estimates), 80% of children aged 12–23 months were fully vaccinated against major childhood diseases; 67% before their first birthday.

Question 93

Examples of the impact of ODA funded work.

1. Cambodia. A February 1996 ODA mission to review the ODA/WHO Malaria Control project found that the number of recorded deaths due to malaria appeared to have decreased sharply. There were 1,032 deaths in 1994 compared to 511 in the first ten months of 1995. The malaria case fatality rate (hospital deaths as a proportion of diagnosed cases) had fallen from 1.5% in 1994 to just under 1% in 1995. The number of provinces with a case fatality rate of more than 1% fell from 22 to 13. Malaria-related deaths as a proportion of all hospital deaths fell from 20% to 15%. Severe cases as a proportion of all malaria in patients fell from 32% to 18%.

2. Tanzania. The ODA-supported Health and Nutrition project (HANDS) offers a multisectoral approach to improving the health status of disadvantaged groups in urban areas in South West Tanzania. It has focused on improving maternal and child health and family planning services, improving health management in close coordination with other sectors, improving water and sanitation services and the promotion of legal rights for women and children. Resources have been reoriented towards poor and vulnerable groups by using the level of under-nutrition as a proxy for deprivation. Between 1992 and 1995 the prevalence of under-nutrition in project areas declined significantly from 29.5% to 26.9% (it increased from 19.5% to 27.2% in non-project

areas) whilst the presence of severe malnutrition declined from 3.3% to 0.4%. Anaemia in pregnant women declined from 36.7% to 32.8%; family planning uptake increased from 38.7% of women to 50.2%; vaccination coverage increased from 86.4% to 99.3% of children; and access to clean water increased from 59.6% of households to 96.3%. These improvements have been achieved at an annualised cost of just £2.25 per head per annum.

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