

TB Alert

Submission to the UK parliament International Development Committee

Inquiry into Global Health

4th September 2026

TB Alert is registered in the UK as a charity (No. 1071886) and as a company limited by guarantee (No. 3606528), the format in company law for not-for-profit organisations. It was created in 1998 and is the one UK charity specifically concerned only with tuberculosis (TB). We are active in the UK and in India, through our sister organisation, TB Alert India (TBAI), that we helped to set up and which now has projects across 8 Indian States.

TB, supplanted for only a couple of years by Covid, continues to be **the infectious disease that worldwide causes the greatest number of deaths** (WHO Global TB Report 2025: 1.23 million deaths; 10.7 million new cases in 2024). We believe, therefore, that while our response in this submission largely reflects our experience in TB, that is relevant to the broader concerns of this IDC inquiry.

Work on TB is at an exciting stage:

- A new tool bringing diagnosis closer to the point of care is being actively promoted by the Global Fund (GF) and being included in country bids for the current round of GF support.
- A new treatment regimen, over the past couple of years, has already brought the length of multi-drug resistant (MDR) care down to 6 months, the same as for regular TB. There are also several late-stage trials in progress of alternative regimens for treatment of regular TB. As a result, it is highly likely treatment length will be brought down from 6 to 4 or even fewer months.
- Several candidate new vaccines against TB are in final trials, and there is real optimism that within the next 5 years, it will be possible to replace the famous BCG with a much more effective vaccine.

In other words, if these improvements in TB technology are to be brought into use as quickly as possible, the ODA environment will need to be both flexible and responsive; and the GF will need to be able to play a key role.

The section numbers used in this submission follow the numbering used by the IDC in its Call for Evidence.

1. Impact of USAID and other Official Development Assistance (ODA) cuts:

- a) - There will be many additional deaths from TB over the next few years due to the cuts of 2025. Several serious studies have quantified what is and will be happening. One, by Boston University Chan School of Public Health calculates that just due to the USAID cuts, 2.5 million additional children will have active TB disease and 340 000 will die over the course of the next 10 years. Another study by Portnoy and others, reported in PLOS this year that 3.9 million households will be pushed into catastrophic costs by TB over the next 25 years. These will largely be people already at the economic margins, that is the poorest of the poor.
- Neither TB Alert nor TBAI were in receipt of USAID grants, so were spared any immediate cuts, BUT both suffered indirectly.

TBAI was halfway through a project in Uttar Pradesh funded by a US Trust. As well as the cuts to USAID, the Trump administration also cut support to domestic US programmes. As a result, the Trust funding the TBAI project, decided to focus its funds on domestic US activities, and stopped the support to TBAI.

Similarly, TB Alert had been approached by another US Trust and discussions were well-advanced toward an interesting new project, but that Trust too suddenly decided to switch all its funds to domestic US needs.

- b) The US withdrawal from WHO also led to serious cuts. The WHO core budget that member states are obliged to contribute to, only covers a small part of its staffing and expenditure. Many posts are funded by voluntary additional programmes with separate budgets. The US had been the main supporter of additional programmes for TB. Thus, when WHO was forced into re-structuring over the past year, TB was especially hard-hit both in the global team and in the regional offices.

The TB team in WHO Europe, having been a team of half-a-dozen is now down to one person, and he has been moved from the Copenhagen office to Almaty in Kazakhstan. This is important for support to TB work in the UK; and also to action across the Eastern Europe and Central Asia (EECA) region which still has high rates of MDR-TB.

2. Impact of reductions in ODA from UK and other countries

- a) And b) Primary healthcare services are crucial in the prevention, detection and treatment of TB. While it can reach anybody, it is classically a disease of poverty.

Action with poor and marginalised communities often depends on work by charities and community groups.

Historically, TB Alert and TBAI received grants for important community engagement projects in India and Africa, complementing the national TB programmes and ensuring action in affected communities. TB is not just a medical problem; the need for social engagement is critical to the success of state programmes.

Such grants have disappeared. It is now several years since DfID/FCDO have invited applications for such work, whether from UK-based bodies like TB Alert or from local bodies such as TBAI. TB Alert used to have programmes in Malawi, Zambia and Zimbabwe but has had to withdraw from work in Africa. The current reduction in UK-ODA by 40% over 2 years, from 0.5% to 0.3% GDP means that it seems there is little likelihood of UK assistance for such work being re-established.

A particular issue for support of work against TB, is that the FCDO selection of priority countries does not follow the epidemiology of TB. India, with its large population, is the country with the highest number of new cases of active TB. EECA includes countries with some of the highest rates for MDR-TB. Neither India nor EECA are currently high priority for UK-ODA.

- c) **Pandemic Preparedness:** In March 2026 the annual review by FCDO of its support for the Pandemic Fund (PF) gave an A rating but on 19th May 2026 the then Secretary of State, presenting in Parliament the Department's allocations for the 2026/2027 to 2028/2029 period, stated that *We plan to end our funding of the Pandemic Fund.*

Then, only a few weeks after that statement, the World became aware of the latest Ebola outbreak in Central Africa, news of which was slow to surface because of surveillance limitations, leading to considerable transmission before health services could respond – A clear indication of the importance of building pandemic preparedness in regions that are poor and plagued by conflict.

The PF is an important instrument for channelling funds to Low and Middle Income Countries to help ensure they have pandemic surveillance and response infrastructure in place.

We would urge the FCDO to review its intention to stop funding the PF and to continue to support it.

- d) Conflict-affected States: Through our Executive Trustee who is also Chair of TB Europe Coalition, a network of civil society activists across the WHO Europe Region which is based in Kyiv, we are aware of the progress of TB services in Ukraine since the Russian invasion.

That is heartening. National TB services continue to work well, except in Russian controlled areas. A nice irony is that due to Ukrainian refugees with TB seeking Western doctors to continue their treatment, and ensuing contact facilitated by WHO between those doctors and the Ukrainian TB doctors who had originated treatment, the Ukrainians came to realise that their practice and access to the latest drugs, was more up-to-date than many Western services.

The lesson is that if support is maintained, medical services can continue to be effective even in conflict zones.

3. Climate Change and Global Health

TB Alert is aware that TB programmes will need to change as local weather changes, affecting communities that already have high rates of TB. If climate change has an impact on nutrition in an area, there could be a dramatically serious impact on the development of active TB, and a reduction in treatment success.

A particular issue in TB is that many people become infected - the WHO estimates as many as a third of the global population - but in most people that will never be a problem. They will not progress to active disease. Nutrition, however, is critical. With poor nutrition the body's immune system weakens and the likelihood of a TB infection progressing to active disease is much increased.

Furthermore, nutrition is important during and after treatment. Recovery is much assisted if the individual has good nutrition. That is why, across the World, many TB programmes include provision of nutritional packages to people under treatment.

Climate change is likely to exacerbate the need for this aspect of TB care.

4. The Future of global health architecture

a) Possible reform of multilateral agencies:

- i. The Global Fund has been absolutely key over recent years to the development of action against TB. It has made sure that national TB programmes in high burden countries have the funds and access to up-to-

date diagnostics and medications. It has also speedily promoted new tools as now with the arrival of near point of care (nPOC) diagnostics. It has also supported the engagement of civil society organisations both in the governance and implementation of national programmes.

Thus, we would stress that the Global Fund is a very positive example of a multilateral agency stimulating positive action for global health whose structure and governance could well be emulated elsewhere.

We have, however, one major criticism. The Global Fund is concerned with three diseases – AIDS, Malaria and TB. The share of funding between the three is not appropriate. TB is the poor cousin. HIV and Malaria each receive 31% of GF disbursements, TB only 15%, albeit improved by 19% going to joint HIV/TB programmes (Global Fund Financial Insights. July 2026 update).

TB/HIV co-infection is a major issue. TB is the greatest cause of death for people living with HIV. Only 5.8% of people with active TB, however, are co-infected (WHO Global TB Report). Thus the 15% of GF funds going to TB work should be significantly higher to be at parity with GF funding of HIV and Malaria.

Despite this we would strongly urge the government to maintain and increase its support for the Global Fund which is a highly effective multilateral agency that today is critical to the continuation of support for action against TB worldwide.

- ii. A further issue highlighted by our colleagues in India, is that while technical expertise is important, a significant portion of ODA funding currently flows through technical agencies, which can reduce the funding available for direct, on-the-ground field implementation. It would be valuable if more funds flowed directly to field execution.
- b) The role of Private Finance: TB Alert has received company funding in the past and TBAI does so at present. Private finance inputs are helpful but have always been a relatively small part of total income.

Donor circumstances and thus their priorities are always liable to change and private finance is no different. TB Alert had a very positive relationship with a middle rank company that lasted for around 10 years but then that company was taken over by another with no interest in TB. Support to TB Alert stopped completely.

In India, the experience of TBAI is that company interest in supporting them tends to focus on small projects in the area and community around a company's factory or HQ.

Overall, we see private finance as helpful for particular initiatives but not an answer to the need for major sustained funding.

5. Effectiveness of UK-ODA for global health in future

- a) Bluntly, the effectiveness of UK-ODA is not just a matter of 'architecture' and focus. It is crucially dependent on funding.

It was sad that after many years of both major parties promoting its value, the first area to be plundered to pay for an increase in military spending, was ODA.

Britain was a leader when it committed to spending 0.7% of GDP on ODA. That was dropped to 0.5% by the previous government; and now the present government is reducing it to 0.3%.

A commitment to at least starting to turn the tide and returning towards 0.7% would be extremely welcome. It would also be encouraging if the in-UK costs of asylum seekers were no longer a drain on ODA but embodied in another more appropriate budget.

- b) As explained above, support for the Global Fund is critical to continuation of positive action on TB worldwide, yet the UK pledge has been reduced in each of the last 2 replenishment rounds, even when in 2025, the UK was Co-Chair of the process. It was at £1.3 billion, then came down to £1 billion and is now at £850 000 and might have been worse.

It would be heartening if the IDC were to call on the government, at the next replenishment, not just to maintain the present level of support but to return towards the level existing before it started to drop.

- c) Tuberculosis is significant as being a disease that is important both abroad and in the UK itself. TB numbers within the UK were rising for several years. Then the 2024 figures suggested they may be stabilising again. Caution about the TB situation in Britain remains necessary.

Action against TB comes under ODA but also the NHS and the UK Health Security Agency (UKHSA). There needs to be good collaboration between FCDO, DHSC and UKHSA. Particular current issues for TB in Britain are:

- Ensuring full funding for the new TB Action Plan for England
- Facing supply problems for TB drugs. In July 2025, the NHS found it necessary to issue a National Patient Safety Alert that a range of TB medications were not available. The immediate problems behind that have been resolved but maintaining supply remains problematic.
- New TB drugs only being available in Britain and other European countries on a case by case basis because the manufacturers have not sought registration due to the time and cost involved for what they see as a small market.

To help respond to these issues, there is need for enhanced collaboration with other European countries.

6. Transparency

In general, our experience is that FCDO and DHSC staff are happy to engage with outside agencies such as TB Alert, and there are several examples of regular arrangements for conference calls where updates are given from the government side and there is openness in responding to questions from us NGOs.

Just occasionally there is a glitch. For example, for an informational call relating to the Patient Safety Alert mentioned above, access was limited to people with an NHS call address. We were assured that that was accidental and would not be repeated.

One area to improve, is the difficulty of seeing the totality of disease-specific spending commitments as they become split between different packets such as GF funding, bilateral country programmes, and research. The result is that it is impossible to know for sure the complete expenditure on TB and TB-related items.

Summary of Specific Recommendations (General comments are not included here)

- 2c. We would urge FCDO to review its intention to stop funding the Pandemic Fund and to continue to support it.
- 2d. If support is maintained, medical services can continue to be effective even in conflict zones.
- 4a. We would strongly urge the government to maintain and increase its support for the Global Fund which is a highly effective multilateral agency that today is critical to the continuation of support for action against TB worldwide.

- 5a.i. That government commit to at least starting to return towards 0.7% of GDP for ODA
- 5a.i And move the in-UK costs of asylum seekers from the ODA budget to some other more appropriate budget.
- 5b. It would be heartening if the IDC were to call on the government, at the next replenishment, not just to maintain the present level of support for the Global Fund but to return towards the level existing before it started to drop.
- 6. Improve disease-specific data across budgets so that it becomes possible to see the full amount of ODA going to TB or other particular diseases.

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