

International Development Committee

Oral evidence: Global Health Challenges and the UK , HC 1185

Tuesday 15 July 2025

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Members present: Sarah Champion (Chair); Tracy Gilbert; Monica Harding; Noah Law; Alice Macdonald; Brian Mathew; James Naish; David Taylor.

Health and Social Care Committee Member present: Dr Beccy Cooper.

Questions 1-71

Witnesses

I: Priya Basu, Executive Head, Pandemic Fund; Dr Ayoade Alakija, Ministerial Global Envoy on Antimicrobial Resistance, Government of Nigeria; and Dr Kalipso Chalkidou, Director of Health Financing and Economics, World Health Organisation (WHO).

II: Baroness Chapman of Darlington, Minister of State for International Development, Latin America and the Caribbean, Foreign, Commonwealth & Development Office; Ashley Dalton MP, Parliamentary Under-Secretary of State for Public Health and Prevention, Department of Health and Social Care; David Whineray, Director, Global Health, Foreign, Commonwealth & Development Office; and Anna Wechsberg, International Director, Department of Health and Social Care.

Examination of witnesses

Witnesses: Priya Basu, Dr Ayoade Alakija and Dr Kalipso Chalkidou.

Q1 Chair: We will start this one-off evidence session by the International Development Select Committee on global health challenges and the UK. We have two panels. Our first panel is before us both in person and virtually. Thank you all for making the time. I will start by asking you all to introduce yourself. Priya, can you introduce yourself and the organisation that you are representing today?

Priya Basu: I am very pleased to be here. I am Priya Basu. I am the Executive Head of the Pandemic Fund, which is a multilateral financing mechanism that is hosted by the World Bank. We are the first-of-its-kind dedicated financial mechanism that is focused solely on helping low and middle-income countries strengthen their capacities in the areas of pandemic prevention, preparedness and response.

Q2 Chair: Thank you. Dr Chalkidou, could I drop to you and ask you to introduce yourself and the organisation?

Dr Chalkidou: My name is Kalipso Chalkidou. I am the Director of Health Financing and Economics at the World Health Organisation based out of Geneva at the HQ. Thank you.

Dr Alakija: Thank you very much. My name is Dr Ayoade Alakija. I am the Chair of the Board of FIND, Foundation for Innovative New Diagnostics, based out of Geneva. I am also the Ministerial Global Envoy for Antimicrobial Resistance for the Government of Nigeria as well as WHO Special Envoy for the Access to COVID-19 Tools Accelerator.

Chair: Apologies for mispronouncing your surname. I will try to get better.

Dr Alakija: No, that is fine.

Q3 Chair: Thank you. I will ask the two doctors to reflect on the geopolitical and human consequences of the recent USAID, US aid funding, withdrawals and the broader ODA withdrawals that are happening, specifically reflecting on the global health impacts. I am thinking about HIV, TB, malaria, especially in the most affected regions. Can I ask both of you to give me your initial thoughts?

Dr Alakija: Geopolitical and human consequences. Let us start with the human because a human is very much at the forefront of the minds of those of us who work at the coalface in countries across the world. I come from Nigeria. My voice comes from Malvern in Worcestershire where I went to boarding school. I also have family and my daughter is Fijian and my husband is Afro-Brazilian, so I very much cover the globe in many ways. The human consequences I have seen recently when I was in Fiji, where we are seeing an incredible explosion of HIV/AIDS and young people catching AIDS, the despair, the lack of hope. These are in



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countries and places that we normally think are idyllic and wonderful. I had a phone call from *The Telegraph* just this morning asking if I would speak to the explosion in HIV/AIDS in the Fiji Islands, which I found quite interesting indeed.

Let me go to Africa, which is the home of my birth, my homeland, home to 1.55 billion people, the world's youngest population with over 60% under 25. We are seeing increases in people with HIV, mother-to-child transmission and people dying. We are beginning to hear of people dying of AIDS. What we had formerly thought was a disease that had become a chronic illness has now again become something that people are terrified of. Sex workers now have no access to the prophylactic drugs that they had before. Behaviours have changed. We used to teach behaviour change back in the day but now, with HIV drugs and with what was PEPFAR, people became complacent and got safe.

I am very focused on the effect on women and girls. As I tell everybody, I am a girl child, or was, and I am the mother of a girl child. The most vulnerable are the ones who are being left behind, and the most vulnerable are the ones who are going to die. We are seeing increases in child marriage, but it is not child marriage, is it? It is rape. We are seeing increases in girls being pulled out of school. Education is stopping across the world, all because suddenly we have decided to cut aid—not just the British Government, of course. It started with the US Government and what has recently gone on there.

Aid is not what I am here to argue for. I don't think that is a bad thing, but the geopolitical consequences of the sudden and abrupt shutdown in aid now follow on from these human consequences. I have given you the very real human consequences of children dying of entirely preventable diseases with no medical care in certain villages, people dying from trying to give birth, women dying in childbirth because the maternal healthcare service that they had just down the road in their village has suddenly disappeared.

Q4 **Chair:** You are painting a pretty grim picture, but are you able to attribute any of that to the USAID cuts?

Dr Alakija: Absolutely. Absolutely and directly. The cuts were so abrupt and because of the confusion and total chaos around—there is food, as we all know, in some warehouses still that people don't know whether they should distribute or not. I am in touch with USAID colleagues. I was formerly the Chief Humanitarian Co-ordinator for the Government of Nigeria for the Lake Chad crisis in north-east Nigeria and for that region. For that I worked very closely with USAID and I have been talking to people like Jeremy Konyndyk, who was a very close colleague at the time, and former USAID directors and ambassadors who were in total shock and did not know whether to go forward or backwards. People will not speak to you for fear, and so these are very directly attributable to the cuts in aid.



Q5 Chair: Dr Chalkidou, from a WHO perspective, are you able to have present data on the impact of the ODA cuts on health, not just in America but around the world?

Dr Chalkidou: Indeed. I think it is fair to say that we are living through a health financing emergency. The feedback to WHO over the past few months from over 100 countries shows severe disruptions to health services in about three quarters of countries and closures of health facilities in a quarter of countries. These are levels of disruption that we have not seen since the peak of covid. Indeed, as my colleague said, there is a direct effect on service provision and there is a danger to millions of lives, mostly vulnerable communities, people living in marginalised contexts, and this is exacerbating existing inequalities.

We are also seeing anecdotally—and unfortunately our data systems are a little bit outdated globally as a result of not enough investment in tracking resources—an increase in out-of-pocket spending. This is the most inefficient and inequitable way of financing health systems, as aid flows are reduced or cut abruptly. At the same time we have the debt crisis, we have lots of pressures—inflationary pressures.

Going back to debt, for instance, the African continent spends twice as much on servicing their debt than they do on health services. In addition to the tragic effect of the abrupt cuts to aid flows, this is all happening on top of a situation of chronic underinvestment in health by national Governments. To give you an example, low-income countries spend an average US\$8 per person per year on health, and in fact for low-income countries public domestic financing is the third most important source of funding below aid and out-of-pocket spending.

The gap that is being created is being filled by very poor people already being further pushed, hundreds of millions pushed into poverty because they have to pay out of pocket for the services they and their families and loved ones need. It is a really complex crisis and I think the debt situation, the high cost of debt, especially for the poorest countries, means that Governments have very limited space to reallocate resources. It is a little bit of a perfect storm, unfortunately.

Q6 Noah Law: Can I ask on that, Dr Chalkidou—potentially you also touched on this, Dr Alakija—where there is this suction effect almost of everything disappearing overnight, have you seen instances of where, notwithstanding the debt pressures that some of these countries have, the public sector or civil society by and large is stepping up and successfully filling the void? I am not asking that to be controversial; I am genuinely curious to hear whether you have seen instances where that has been successful.

Dr Alakija: For Nigeria specifically if I may, Kalipso, it has been a huge wake-up call not to be reliant on the Global North. In Nigeria we have closed gaps ourselves with emergency budget allocation. Within weeks of the Trump cuts, the Nigerian Government approved over US\$200 million



in its 2025 budget specifically to cushion the effects of USAID withdrawal and ensure continued access to critical diagnostics and treatments for HIV, TB and malaria. The Federal Executive Council also allocated about US\$3.2 million for procuring 150,000 HIV treatment packs and to the 2024-25 HIV programme alignment. An additional US\$1 billion has been approved for broader healthcare sector reforms. A multi-ministerial committee was established to develop a transition and sustainability plan for health programmes previously funded by USAID, aiming to secure new financial support and ensure continuity of care. That is a very direct example in which I am personally involved. Kalipso, over to you.

Dr Chalkidou: Yes, absolutely. I was going to mention this and it is wonderful to see the leadership from Minister Pate. In fact Nigeria sponsored a resolution at the World Health Assembly on health financing, including domestic health financing and the importance of self-reliance and independence—a resolution that was passed at the Assembly with co-sponsorship from the UK as well as another 25 countries. That is really important. We are seeing the South African Government stepping up and the Treasury allocating additional resources.

However, it is not just the financing gap. There is a triple gap that Governments and national planners are having to deal with. There are the steep cuts. We are not suggesting that there should be dollar-for-dollar substitution. We feel that domestic resources raised domestically, spent domestically through domestic channels, are more cost-effective, more efficient than aid, a lot of which ends up back at the originator countries, we know, with significant overheads and so on.

The second gap is one of visibility. Imagine being blind as a budget holder, as the treasury. You do not see these flows flowing into your system because the donors have set up parallel systems that bypass national Governments or off-budget flows, so you do not know who is funding what. There is an example of a country I would not like to mention that lost 28,000 community health workers overnight because of the effect of the USAID cuts and yet they were not aware that these people were working in their country; they did not know what they were doing. It is very difficult to replace these workers.

The third gap is one of capability. When we have procurement systems, ARP systems run out of Michigan, USA, these people then go home. It is very difficult for national planners to replace those functions, those capabilities, overnight. We have created the situation of aid dependency and it is like we are setting countries up to fail because now we are turning the tap off very abruptly.

Chair: Ladies, I am just going to say that we are 20 minutes in. I apologise for starting late but we are only on question 1 and we have loads of questions for you. I will ask you to be a little bit briefer and more direct in your answers, please. Over to Brian.

Q7 **Brian Mathew:** Dr Chalkidou, how will recent aid cuts impact global



efforts to strengthen early warning and disease surveillance systems?

Dr Chalkidou: We are faced with a very difficult situation and I want to appreciate the UK also for their support in this space, which is extremely valuable—even more so because of the cuts. We are seeing a number of crises, again a convergence of health threats, because we have the climate crisis, we have conflict-related crises, we have had 1,500 attacks against healthcare infrastructure workers in 2024 alone, and there are 40 active emergencies currently, many of them in protracted crisis contexts. Then of course we have displacement food insecurity. We have over 300 million people requiring health service provision on an emergency basis. We are now trying to address a number of outbreaks: cholera outbreaks in multiple countries, Mpox resurgence in both endemic and non-endemic areas, and then we have dengue as well as other bacterial-borne diseases, because of rainfall and temperatures being altered. This is extremely problematic for us.

At the same time as WHO were reducing the workforce, the people who were meant to be addressing this globally, by 25%, just as a direct result of the USA reductions we have seen an 18% decrease in available funding for emergencies because the US was a major contributor. This is affecting our technical operations, governance and data sharing capacity. It has a direct impact on early warning systems. It is jeopardising our ability to carry out real-time surveillance, so we have 24/7 event-based surveillance operations being shut down. We cannot operate the genomic sequencing and lab support in outbreak zones as we would have liked, and this is also crippling our ability to carry out cross-border co-ordination—information sharing. We have gaps in our contingency fund for emergencies and we have major gaps when it comes to other calls. We have the emergency appeal, for instance; we have a 40% reduction in financing for global humanitarian needs.

We have really major gaps we are grappling with right now and so do our partners, because these cuts have affected multiple institutions.

Q8 Brian Mathew: Could I extend this perhaps a little bit to the others? What are the biggest gaps in global health data, and how do they affect countries', including the UK's, ability to respond to current and future health crises?

Dr Alakija: First, you talked about surveillance and early warning systems. To be able to do surveillance, to be able to catch particularly pandemic threats and what-have-you, which I will hand over to Priya for, you need to be able to do diagnostics. As I said earlier, I chair FIND, which is the Foundation for Innovative New Diagnostics. I think the world is all so seduced by vaccines and by the language around vaccines, that we have forgotten that possibly the greatest bang for your buck that you can get is to invest in diagnostics and primary healthcare. We cannot do surveillance if we cannot develop new tools and the diagnostics. If we do not fund the diagnostics we are not going to catch pathogens where they occur.



If I go back to the coalface, organisations such as mine are critical to supporting countries to strengthen their early warning systems and develop the diagnostics for disease detection. Why? Let me go to antimicrobial resistance, which I know is another priority for the British Government. In a country such as Nigeria, when a woman takes a child who has a little fever to a clinic, it is cheaper for that mother to be given a bag of antibiotics—it is hit or miss—“Let me treat you for five different things. It could be one of these,” than it is to do a diagnostics test because there is no point-of-care testing.

These, for me, are some of the huge gaps. They are not really that big and it is not very complex, but we are so focused on the top of the chain, we are so focused on, “We have to raise money for vaccines,” that we are forgetting that spending a little bit in the right place can generate a significant return on investment. Egypt, for instance, recently did a huge hepatitis C surveillance programme, which they funded nationally. They will tell you that for every dollar they spent from their own national budget they saw a 354% return on that investment. That was by investing in diagnostics and in surveillance.

Q9 Chair: Why is that? Why do we focus on the outcome rather than the prevention?

Dr Alakija: We are in hock to big pharma potentially, because vaccines and things like that are sexy, because it is what has grabbed the headlines and the basics don’t grab the headlines. Those of you who are in the UK and have access to a GP can go to get a test when you need one, or you get a pack through the mail and you do your little screening test. You cannot imagine that people in other parts of the world are literally dying for want of a tiny pinprick or a swab. There is a blind spot there and I think it is a good one to look at.

Chair: We are fortunate because we have Dr Beccy Cooper guesting from the Health and Social Care Select Committee. Beccy, over to you.

Q10 Dr Beccy Cooper: To be fair, vaccines are also part of the preventative package, so my question is—I absolutely hear you about diagnostics: I chair the APPG on AMR—where in that strategic package of prevention, and perhaps this is a WHO question, are we considering diagnostics? Are we considering diagnostics as part of a preventative measure or is it a separate conversation that is happening at the strategic level? Where does it sit currently? Dr Chalkidou, is that one for you?

Dr Chalkidou: To go back to the earlier comment, I mentioned surveillance and I mentioned specifics, and specifics matter. At the same time, I don’t think we can build systems for health security, especially systems for health security built on external preferences and reliant on external funding. At the end of the day we need to strengthen health systems, the primary healthcare systems, the healthcare workers. As part of that, yes, the infrastructure for testing, for diagnosis, the healthcare workers who can take the samples and read them, the



infrastructure that allows for that to happen, the supply chains that allow for the vaccines and the reagents to be in place, to be refrigerated and so on. This is a peacetime operation and unfortunately we have had the peak during covid. That peak is no longer there, of course, because there was an emergency and on top of that we are seeing these steep cuts that result in, based on our calculations, about US\$10 billion in cuts of the aid budget just this year. It is a perfect storm.

Going back to the question of where diagnostics sit, they need to sit in the context of strategic planning and considering a health system. As my colleague said, the UK has the national health service, which is wonderful. You are investing big in the health service and it is great to see this. From where we are it is an example, it is a model, prioritising domestic spending towards healthcare systems—and ultimately health systems are not just about health. This is prevention, and they are also about financial protection. Universal healthcare coverage is a massive redistribution system, a mechanism that takes from the wealthy and gives to the poor and takes from the healthy and gives to the sick, and we should never forget that. Financial protection is critical, and right now we are seeing hundreds of millions of people falling into poverty and we expect to see way more in the future. You mentioned data, Chair, and if I may, I just want to make a plea—

Chair: No, thank you. We will come on to that in a bit. Priya.

Priya Basu: I want to add that diagnostics is very much at the front and centre of the work that the Pandemic Fund is doing. We are focusing on strengthening the capacity of countries to be able to quickly detect and contain an outbreak before it escalates into a pandemic. One point I wanted to make that also relates to some of the points that were made earlier is that these areas of early warning systems, surveillance, diagnostics have been neglected in the past as well. Outbreak after outbreak, pandemic after pandemic, have highlighted the fact that the world is not prepared to be able to quickly detect and contain an outbreak. We allowed a little virus to disrupt the entire world because we were not able to catch it fast enough. The investments that are needed to get all countries ready to that right level of preparedness to be able to quickly detect and contain an outbreak are a tiny fraction of the cost of not being prepared.

That is where the Pandemic Fund has come in and we are working with countries, using a country-led, country-driven approach, asking the countries, "Where are your gaps in these areas but if you have other gaps tell us those as well." We are hearing from countries that there are massive gaps in these areas of surveillance systems, basic surveillance at points of entry, waste water surveillance plans, diagnostic equipment at point of care that can be used for all kinds of diseases.

You don't know what the next disease will be, so there is no point in having a fancy diagnostic set-up for one particular disease because the



next one is always different. How do we build that capacity at the primary healthcare level to quickly repurpose rapid molecular tests for all kinds of diseases, disease X? It is X-ray machines, healthcare workers, community health workers that are trained not just to administer one type of vaccine but to administer multiple types of therapeutics. That is the work that we are doing, and from where I sit this is chronic underinvestment that has existed over the years and we are trying to address it now.

Chair: Okay. Let us stop and start addressing them.

- Q11 **Alice Macdonald:** Starting with Dr Chalkidou, we are in a 0.3 world if we are lucky in the UK at the moment. It is probably going to be less than that, given how much we are spending here in the UK. If you were sitting in the UK Government right now, where would you invest for maximum impact—where and in what? I will ask everyone to respond quickly with one or two points on that.

Dr Chalkidou: It is a disappointment to see the cuts. They do have an impact, and they have a negative signalling value because the UK has been a leader in this space. At the same time I think we are all being asked to do more with less. The work that the UK is doing as a player in the multilateral world is very important. I want to call out your efforts as part now of the intergovernmental negotiating body that is currently negotiating the treaty. In the last couple of days we had people from all over the world, representatives operationalising the pandemic treaty. In fact a colleague from the UK Government was elected as a co-chair, so being a citizen of the world and endorsing multilateralism and supporting WHO and its own processes and beyond through the UN is important because of the expertise that you bring and the signalling value of that. It is not just about money.

Another area of the importance of the UK is your role in reforming the global health architecture. I talked about off-budget financing and not funding through government systems and, therefore, not strengthening government systems. There is something called the Lusaka Agenda, which is a whole movement to challenge this approach to aid and the resulting aid dependency, and the UK is there. The voice of the UK is really strong in driving reforms, including through global health initiatives where the UK sits on the board of these initiatives.

The final point is that there are more than 50 institutions in the UK that are designated as WHO collaborating centres with fantastic expertise, deep expertise, badly needed expertise. We are very grateful for that; please continue that. Thank you.

- Q12 **Alice Macdonald:** Priya, can I ask you that, but also ask you while you answer about maximum impact? The UK has just made a big announcement to Gavi. Do you think the UK should prioritise multilateral or bilateral for health spending?



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Priya Basu: I want to emphasise also that the UK has been a real leader in global health and in innovation. As you prioritise, going forward, I would encourage you to look at mechanisms that maximise value for money and that create a catalytic impact. In today's world, if every pound that you give can be multiplied, that creates much greater impact and multilateral mechanisms allow you to do that. The Pandemic Fund, for example, brings you £7 for every £1 that you give us. We are able to multiply it seven times and we can do that even more by bringing in co-investments from countries themselves.

I cannot over-emphasise the importance of making sure that every pound you give incentivises the countries that you are trying to help to bring their own resources to the table and to ensure sustainability. That is one thing that we are doing that is baked into the DNA of the Pandemic Fund model. We don't grant a dollar without saying that countries must bring their own dollars to the table, and we are also trying to leverage the multilateral development banks and encouraging them to bring money. That is how with every dollar that we grant we bring seven. If you think about priorities, particularly in this aid-constrained environment, think about the multilateral mechanism that can maximise value for money and create a multiplier effect.

Q13 **Alice Macdonald:** Thank you. Can I ask Dr Alakija the first point about where you would be investing it now if you were the UK Government to get maximum impact for your aid?

Dr Alakija: Absolutely. I will quote the Minister of Health for Indonesia, Minister Budi—

Chair: Briefly, please.

Dr Alakija: —who often says that when you go to countries you have Ministers of health, not Ministers of sickness. I thought that was a very good point. He raised that at our diagnostics day event at the World Health Assembly this year. We work with them with their limited resources in Indonesia at FIND at community level to do what the UK does very well, which is the primary healthcare that I spoke about earlier—the screening, the diagnosis, making sure that people are kept well and they don't end up in tertiary centres or we don't have poverty as a result of sickness.

Let us use covid as an example; a lot of my work recently has been on covid. The lack of diagnostics in covid is what led us to Alpha, which led us to Omicron, which led us to Delta, which led us to wherever it led us to eventually. The lack of diagnostics is what led us to vaccine hesitancy in Africa and many parts of the world, because what you can't count you can't see. We had no point-of-care testing in much of Africa. I live in Abuja in Nigeria and there was zero rapid testing in Nigeria. To get a test it was US\$150 and you only got one if you were going to get on a plane to travel. Many people in the developed world don't understand what was lacking and what caused the knock-on effect. It caused countries to be



shut down, caused the spread of the virus and I would say definitely prolonged the pandemic.

Where would I focus investment? I would focus it at primary healthcare for health most certainly—who is doing that health system strengthening and capacity building. Both multilateral and bilateral funding streams have their value. Multilateral absolutely—and I hear Dr Cooper—vaccines absolutely completely. We must completely get rid of the rhetoric of vaccine hesitancy and that thing that is coming across from various parts of the world and is beginning to infect us in the Global South, because people are now beginning to be afraid of vaccines. Multilateral funding streams are more likely to be loaded with political agendas. A mix of both is likely to be more effective than focusing solely on one or the other, and Priya has just given us a great example. Without careful co-ordination, bilateral programmes will then lead to a duplication of effort, as Kalipso said earlier. I think a mix of both, because the world is changing, the global health architecture is changing, and that change has to be allowed to be led by us.

It cannot be led from the top down. I have recently seen something that has come out of Wellcome that says that Wellcome wants to lead a series of conversations around how the global health architecture changes. The Global South is just not going to accept that. It can no longer be a top-down thing. We must, with our own voices, with our own agency, come forward to say what will work for us.

Q14 Chair: We are just about to launch an inquiry specifically into Nigeria. Are there examples of that, that you could direct us to, not now, where you have seen that bottom-up pushing when it comes to preventative measures?

Dr Alakija: Yes.

Chair: Please write to us. We would be very grateful.

Q15 Alice Macdonald: Moving on to what a country-led financing mechanism looks like—and maybe this is to Dr Alakija—the Abuja Declaration, in theory African countries spending 15% of their own resources on healthcare. Dr Kalipso talked about debt at the beginning. How do we really get to country-led financing? Why have countries not met that, and is tackling debt one of the silver bullets that we could use to increase it? I am interested because it is a long—

Dr Alakija: You are totally reading my notes. I have just written down Abuja Declaration.

Alice Macdonald: Yes, but that should have been a target and only one or two countries have met it.

Dr Alakija: Two. This has been part of the work of my life, pushing countries to get to the Abuja Declaration and it is, I am sorry, part of this paternalistic attitude, part of what has happened in the past few years,



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which is why I think aid is a bad idea and partnerships are better. Countries have manipulated and used aid for various agendas, so bad governance has been rewarded for loyalty in certain ways—we will not get into the details of that now.

The Abuja Declaration absolutely must be implemented. That is why, when I was first interviewed by the *Financial Times* immediately after the Trump cuts, I said that we want to thank Mr Trump for cutting aid, because it will make some of our leaders sit up and recognise that they will have to put their money where their mouths are and that we cannot continue to— As we have just heard, much of it is inefficient anyway. Most of the USAID cuts affected mostly USAID employees. Yes, some does get to the coalface, but if we look at how much is being given versus how much has been spent in-country, we must find a more efficient way of doing this.

I was there in Abuja that day 20-odd years ago when that declaration was signed. I was not at the meeting, but I do remember it. We have to revisit that, and we have to work at country level with our Governments to ensure that that spend is increased, and that we are no longer there with our handout but we are together in partnership working with all of you—the UK and various other countries.

Ultimately, as we saw during covid—now with my AMR hat on, I am terrified; I am wearing masks on planes all the time now because we have unvaccinated people from all over the world who are mixing around airports. There are children dying of measles here in the UK, children dying of measles in America. It is the odd child. Any child is too many, but it is the odd child. Imagine if we had a measles outbreak in my village in Ekiti in south-west Nigeria where there is also no health system. There would be dozens—scores—of children dead. I am worried that the vaccine hesitancy that is coming, and the language that is coming out of many parts of the world, is going to come full circle and hit us, back in the low-income countries of the world. It will then explode out again around the world and we will be an even more divided world. These conversations are critical and the change that has been forced is important.

I am looking at the Chair and I am not going to take any more time. It is time for partnership, not aid. It is time for smart partnership, and it is time to look at the geopolitics of it as well as the human impact.

Q16 Chair: Thank you. Priya, I would like to come to you, and then Brian and Monica want to come in.

Priya Basu: I fully agree. I think this is a wake-up call, and aid dependency is not the way to go; it is not wise. Recent evidence from the Pandemic Fund's calls for proposals—because from time to time we call for proposals and we get huge demand from 147 developing countries around the world, low and middle-income countries, for our resources but they are not just asking for grants with nothing. They are putting their



own money on the table and they are saying that they want a small amount of grant money that can be blended with their money and the money of international organisations.

To give you some examples, countries are really stepping up, as was said. For every dollar of Pandemic Fund grants that are being awarded, Indonesia is bringing US\$9, so 227 million of Indonesia's own money. Rwanda is a 1:6 ratio—US\$25 million we have given, US\$154 million they have brought to the table. There is India. There is a lot of interest from developing countries to invest in this agenda to strengthen their ability to contain and prevent pandemics and they are willing to put their money on the table.

Q17 Brian Mathew: A few weeks ago Dr Cooper and myself were in South Africa and we visited the CERI Institute at the University of Stellenbosch. We heard about the amazing work that they have been doing there, which affects our health system here, but also doing diagnostics and offering a service across Africa where samples of unidentified diseases were coming back and being checked and identified. Are you familiar with their work in other places? I would be interested to hear from you on that.

Dr Alakija: Yes. The work that is being done in South Africa is incredible, and that was where in many ways most of the covid sequencing was done. We at FIND work very closely with them, but that is a great example—thank you for visiting and bringing that up. It is a great example of something that is going on in the Global South that often the rest of the world does not know. They saved the world in many ways during the Omicron wave. The sample first came from Botswana, I believe, and they confirmed it there. Yes, I am very aware of their work, as I know Kalipso and Priya are.

Priya Basu: So am I. We are working with them as well. We have a project in South Africa.

Q18 Monica Harding: I wanted to come back to your words about reimagining aid. You referenced the Wellcome Foundation's article yesterday. Can you talk to me about not the low and middle-income countries but the very poorest countries, and how these cuts in international aid budget translate there?

Dr Alakija: The very poorest countries—I think I have a list of them somewhere. Countries such as Nigeria have been able to step up and been able to meet the gap. The 13 countries that face the most severe impacts are Afghanistan, Burkina Faso, the Central African Republic, Chad, DRC, Ethiopia, Haiti, Mali, Mozambique, Somalia, South Sudan, Sudan and Yemen. Ten of these countries are of course in Africa, where the intersection of conflict, climate and economic struggles creates the most severe challenges, and that is where we are seeing the worst impacts, particularly—I go back to my favourite topic—on women and girls. Afghanistan tops that list, for that obvious reason. We are seeing



education almost immediately stop. In any situation like this, the first thing that goes is girls' education. The very first thing that happens is that the family will give their daughter away—they say give away in marriage—so that a man who is a little bit wealthy and potentially 60 years older can give the family a little bit of food and a little bit of money for an income and make sure that there is one less mouth to feed. These are the real impacts.

In many of these countries at least 25% of the population is experiencing crisis-level food insecurity. In four countries—Haiti, South Sudan, Sudan and Yemen—nearly half of those populations are suffering from hunger today. These are the real effects of these aid cuts. These are the real effects of what has been typically almost complete aid dependency in these countries. We must be honest about it. I say this all the time to my African leaders and presidents—it is not often very popular: "You will have to have reflexivity. What is your own part that you have to play in this?" We have not been necessarily responsible enough. Again you go to how politics and geopolitics interplays. Afghanistan is a perfect example where we suddenly have people who say that girls cannot go to school, be educated or even see a doctor, who we are suddenly calling our political partners. Where does that even work?

Sorry, I am not here to discuss politics, but these are the real issues and countries like these are in desperate trouble. They do not have the capacity—Kalipso spoke to capacity, spoke to community health workers disappearing. These are countries where the community health workers and the networks that have been set up by people like USAID and many of the beltway bandits, as they called them, from DC who would come in and set up these fancy offices and structures with their own staff, and they took them away overnight. I was there the weekend that the Abuja system, USAID system, collapsed, down to housekeepers, drivers, pet walkers, entire communities. That is at the top end of things; imagine the bottom end. Things are dire in those countries and we all must support and we must find a way to support.

Q19 **Chair:** The same question to Dr Chalkidou. A brief answer, please.

Dr Chalkidou: In some of these countries, the poorest countries, aid and USAID in particular and the financials that flow from USAID, make up a large chunk of the countries' GDP, let alone the proportion of the health budget. Yes, the cuts will affect these countries or are affecting them. If we are going to put things in perspective, to the previous question as well, if you look for instance at the total aid received in Africa, US\$74 billion in 2023, US\$90 billion illicit financial flows, flowing out of the continent, US\$55 billion forgone revenue because of corporate tax exemptions. I have mentioned earlier that twice as much on average is spent on debt servicing as on health from public budgets. There is a bigger issue when we talk about domestic financing. There are other systemic and structural inefficiencies and inequities that need to be



addressed for countries to be able to generate the revenue to invest in their own health systems and build them.

Q20 **Chair:** Thank you, proving Dr Alakija's point that you cannot separate politics from development.

Dr Alakija: Absolutely and many of those flows are coming to places like the UK. Sorry, Chair.

Chair: That was not a segue.

Q21 **Noah Law:** There are so many interesting examples on diversification. Are there any, Priya, that you feel could be applied to the UK's own context for healthcare, and what are the potential challenges to doing so? It is quite a strange question, I appreciate, but what do you feel we can learn from diversifying the approach to prevention, monitoring and so on in the context of our own healthcare challenges?

Priya Basu: I don't think I am in a position to give you advice on that. I will pivot that question back to when the UK thinks about how it wants to help the rest of the world—and obviously there are lessons from the UK experience—I again emphasise that in making your choices of where to put your order, please look at funds that are cost-efficient and maximise value for every pound that you provide. I advocate, obviously, for the Pandemic Fund. We are very grateful for the £25 million that the UK has already put in and know that the £25 million is multiplied seven times. We are very cost-efficient.

Q22 **Chair:** You have told us three times and I am delighted about that. When looking at all the places that you fund and the multiplier that your funding brings, who does it well and why? Who prevents pandemics?

Priya Basu: Who does it well is countries that invest in quick surveillance, and there are countries around the world that are getting better and better, but we are not there yet. What we are looking at right now are the countries that are at the highest risk and have the lowest capacity, and we are working on identifying those countries. There are 20 or so, most of them are in Africa, and the costs of getting them well prepared are tiny. Stay tuned, and by the end of the summer we will be able to share with you that group of countries with the highest risks and the highest needs that will help us create a world that is safer.

Q23 **David Taylor:** You have spoken to a lot of the question already, so if you could potentially put 75% of your answer, both of you, into what reforms would be needed to get pandemic preparedness to a place where it should be at a global level. By all means spend a little bit of time saying anything else you have not said about how we are not prepared, but if you could focus your answers more on what we would need to do to reach a place where we were properly prepared as a world for the next pandemic, starting with Priya.



Priya Basu: That is what the Pandemic Fund's work is about. We came out of lessons from covid-19 where we learned that the world was not prepared, did a lot of analysis, working with countries in the Global South, asking them where their gaps and their needs were. What you see in the model that we have, the areas that we focus on, are early warning systems, surveillance, laboratories and diagnostics, and a fit for purpose health workforce, including community health workers, and taking a multisectoral approach to what we do.

This is not just strengthening doctors and nurses. It is also veterinarians, animal health workers, livestock farmers, recognising that pandemics often are a product of animal-to-human transmission. When we talk of surveillance it is not just human beings. It is also wildlife and livestock, so taking what we call a one health approach with a strong focus on antimicrobial resistance as well and investing in the poorer countries of the world—getting them to that right level of preparedness.

What does this take? What covid has taught us, but also before that, SARS, MERS, Ebola, even influenza, Zika, is each time we realise that there was chronic underinvestment. What is needed is what we have right now—a dedicated financing mechanism that keeps the world focused on investing in pandemic prevention, preparedness and response even in so-called peacetime, so that when the next pandemic strikes—it is not a question of if; it is a question of when—we have the health workforce that can be surged, we have testing capacity that can be scaled up, we have labs that can do diagnostics more rapidly. It is building that capacity that serves countries every day but also has that surge capacity to be put into effect.

Q24 **Chair:** Is there or was there a specific fund anywhere, for the World Bank, for example, that was focused on pandemic preparedness?

Priya Basu: There was not. We are the first of its kind—a dedicated multilateral financing mechanism. There was not anything that was focused exclusively on pandemic prevention, preparedness and response.

Chair: We are very grateful for the work that you do. Thank you.

Priya Basu: Thank you to the G20 as well because they were instrumental in setting this up.

Dr Alakija: I think Priya and I came very aligned today. We even came wardrobe colour co-ordinated. Priya has spoken to the one health approach to the AMR and the AMR focus, which I think is critical. You are talking about what we can do to prevent, but we are already in another silent pandemic of AMR so I want to also put that on the table.

Q25 **Chair:** This is the first time in this session. Tell me more about that.

Dr Alakija: Thank you, Chair. Of course, as you may or may not know, Nigeria currently has a presidency for the High-Level Ministerial on AMR and will be hosting, so I announce it here. You heard it here first. I will be



hosting on 29 and 30 June next year the fifth High-Level Ministerial and we are beginning a troika mechanism, together with Saudi Arabia and Oman, on AMR which I will host, to participate or take the flag for the first troika.

Q26 **Chair:** What is AMR and why should we take it seriously?

Dr Alakija: Antimicrobial resistance, or antimicrobial—

Q27 **Chair:** Why is it the biggest threat?

Dr Alakija: It is basically, in layman's terms, to my mind about the fact that when you go to a hospital you will hear about people dying, people going into hospital for surgery on one thing and they come out or they do not and they are dead because they caught an infection that no antibiotic will treat, in layman's terms, or they cut themselves in the garden and they take antibiotics and they will not work. Why is this? Well, the world is very focused on developing new antibiotics, which will be very expensive. One was recently developed and I do not have the exact data on it but it has been a very long time.

The old ones really are not working because the bugs are getting more sophisticated. Bugs are getting more sophisticated because they are evading, and they are evading because there is overuse. There is evading because of the example I gave earlier, for instance that in Africa or Asia if you look at waste water and see the amount of antibiotics that are in waste water, if you look at the antibiotics, taking the one health approach, in animal use, in people who are rearing cattle, and even in fish—there is my work with the Government of Japan in fish—and in chicken. All these things are making our bodies sick, basically, in layman's language, and therefore our bodies are no longer responding to the wonderful work that was done by those who invented penicillin and what-have-you. The world is now asking how we fix this and you have your Chair of the APPG here, Dr Cooper, who I am sure will be able to tell you a whole lot more than me.

The focus for me in my ministerial role, and for Nigeria and for Africa—this will be the first in the African continent—is that the world has been very focused on the new drugs, which we will never be able to afford, but we want to focus ourselves on the access issues to even basic diagnostics. We are taking a diagnostics approach to AMR this time, to say that if we can we should prevent people being given 10 bags of different antibiotics for a cough when all they needed was a screening, and somebody says, "Oh, it is just the flu. Go and lie down and take a few Panadol." If we can strengthen health systems and have the tools, the multiplex tools, like Priya mentioned earlier, we can perhaps begin to address AMR as well as working hand in hand with those trying to develop the new technology.

Q28 **David Taylor:** Briefly to follow up on that overuse question, are you willing to share a view on what some of the biggest meat producers in



the world are doing and whether they recognise the problem—China and the US in particular? Are they recognising the problem and taking action to reduce the overuse of antibiotics in meat production?

Dr Alakija: You are trying to get me into political trouble again. I think that the US has shown us even recently with H5N1 that it is causing humongous problems at the moment and they are not sharing any data. We were working on that very closely. I was convening, which I still do, the Access to COVID-19 Tools Accelerator, which has the nine big boys of global health, but thankfully we now have a girl, Dr Sania Nistar of Gavi. They are the nine global health agencies that I chair. I chaired throughout covid weekly. I then started to chair it monthly when we were in peacetime and it is still the mechanism that is in place keeping the world safe, with Dr Tedros and Peter Sands and so on. We were doing fortnightly meetings on H5N1 and then the US stopped sharing the data, so never mind meat production, with something that is currently a proper threat we don't know what is going on.

On meat production, it will be interesting to see as we begin the negotiations for the outcomes document going forward. You also have Brazil of course and many others. People are very protective of their industries and the world has gone to a place where we have all become very protectionist and very nationalistic, and we are refusing to see the bigger picture. How will we help everybody to see sense? I would love to talk to Dr Cooper afterwards and see whether she has any views.

Q29 **Chair:** Can I instead talk to Dr Chalkidou now? On the bigger picture, what one message should we be taking into our session with the two Ministers on global health right now? Last word.

Dr Chalkidou: Get the treaty sorted, get the annexes shaped up and implemented, the pandemic treaty. That is very important. It is about sharing data and pathogen information, equitable access to countermeasures—we talked about it—and strengthening global co-ordination, so get the legal framework done. The UK has been fantastic at that. Keep it up.

Also, better data systems. I was going to talk about data. We are flying blind when it comes to financing data. Our time lag is two to three years. We don't really know how much is being spent on what and by whom, including on pandemic preparedness and response. Okay, it is hard methodologically but we should use technology and our brains and get it right so that we can track spending better, domestic spending better and household spending better and exactly who is being impoverished by the policies we put into place and roll out. It is those two things.

Chair: Ladies, thank you. Sorry for chivvying you along. Part of the reason, I am assuming, is that global health does not get mentioned or indeed recognised that often. It is something that this Committee, for the last six years that I have been chairing it, has tried to get more focus on but with limited impact. Of course it is something that literally impacts on



all of us if we don't get it right. A huge thank you for all that you are doing, and that your organisations are doing. We need you and we need many more of you, and hopefully we can bring you back for following sessions. I will pause this session while we change for the Ministers. You are of course most welcome to stay with us if you would like to.

Examination of witnesses

Witnesses: Baroness Chapman of Darlington, Ashley Dalton MP, David Whineray and Anna Wechsberg.

Chair: While you settle yourselves, Ministers, thank you so much for coming. I was just saying to the previous panel that this Committee is very committed to global health and has pushed the Government or Governments for many years on a global health strategy without success. We are very interested, as you are probably the first health-related session we have had post covid that is not specifically focused on covid. We will be very interested to see how your learning has developed over the horrific experience that the world went through.

Would you introduce yourselves and your teams? We all have different questions. You know the format. Some of them we have divided to one or other of you, but you might like to either speak to the other person's or delegate to your team members, whatever you think is most appropriate. We are keen for a conversation, if that is all right with you. Baroness Chapman, you are most familiar to this panel. Could you introduce yourself and the hat you are wearing when you sit before us today?

Baroness Chapman of Darlington: I am Jenny Chapman. I am the Minister for International Development based in the FCDO.

Ashley Dalton: I am Ashley Dalton. I am the Minister for Public Health and Prevention and global and international health comes under my brief.

Anna Wechsberg: I am the EU and International Director in the Department of Health and Social Care, Anna Wechsberg.

David Whineray: I am David Whineray. I am the Director for Global Health at FCDO.

Q30 **Chair:** Ministers, we asked the representative from the World Health Organisation what one question we should ask you, and she said it was, "When are you signing up to the pandemic treaty?", or "When are we having a pandemic treaty?" Do either of you have a view or an answer?

Ashley Dalton: The pandemic agreement was agreed at the World Health Assembly and I was there representing the UK on that. It was a very significant moment and we had spent a good three-plus years working on that. The agreement will not open for signature and ratification until follow-up negotiations on the annexe to the agreement, which is the pathogen access and benefit sharing system, which we call PABS. When that has concluded, it will open up for signature and



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ratification. There is an international working group that has been set up to manage those negotiations. It met for the first time on 9 and 10 July and I am delighted that the UK is co-leading on that group.

Q31 **Chair:** That is really important. Do we know timescale?

Ashley Dalton: I don't know if we have any specific timescales.

Anna Wechsberg: That working group is due to report back within a year. Whether it can conclude its work within a year we will have to see.

Q32 **Chair:** Thank you, but Minister, you are telling me you are on it?

Ashley Dalton: Absolutely.

Chair: That is very good to hear. Over to Tracy.

Q33 **Tracy Gilbert:** This is a question to everyone, and maybe we will start with Baroness Chapman. What do you perceive to be the main threats to UK health security?

Baroness Chapman of Darlington: If we are going to boil it down to the main threats, pandemic disease and antimicrobial resistance are the two that I would say. We have learned a hell of a lot through the experience of covid, and also sadly most recently the importance of vaccination. Those are my priorities.

Ashley Dalton: I agree with all of that. Pandemic preparedness, vaccinations, and we have done an awful lot of work on antimicrobial resistance and are an awful lot further along on that than we were a few years ago. Ensuring that the United Kingdom is prepared for a future pandemic is a real top priority for the Government and we are embedding a lot of the lessons that we learned from covid-19. We have a Joint Committee on Vaccinations that I sit on and I chair, and that meets regularly, bringing together representatives from the Department of Health and Social Care, NHS England, and the UK Health Security Agency. We meet regularly to discuss the approach to vaccinations and we will be rolling out strategies for encouraging vaccination take-up throughout the year.

Q34 **Tracy Gilbert:** What do you think the main opportunities and challenges are to our global health capacity and public health security?

Baroness Chapman of Darlington: From my development perspective, I think clearly a huge challenge is the withdrawal of the United States from international global health funding. This is proving a huge problem in many places. I am deeply concerned about what this means for HIV. We have seen some countries having to scramble to make up for that withdrawal to make sure that people are getting their medications and that some of the prevention of spread is kept a grip on. It is not possible for us to backfill that capacity, sadly, so we are working with Governments to try to help them to step in and strengthen their systems, which we are seeing, so that is a positive. This is a major cause of



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concern and it should be an international cause for concern, not just in the countries that are affected today because these things do not, as we know, respect borders.

Ashley Dalton: That is absolutely right. I think that is also where one of our opportunities is. A key expertise that we built here in the UK during covid was the creation of the UK Health Security Agency, which has fast become a renowned force globally for technical expertise. We have seen with the US pulling out of various fora across the globe, and with some of their funding cuts, other countries coming to the UK and saying, "We recognise that you have expertise in global health and that the UK Health Security Agency has something to offer." We have discovered that what people are looking for is expertise, information and support to develop their own expertise. There is an opportunity there for the UK to move into that space, and we are certainly exploring that more with the UK Health Security Agency.

Q35 **Alice Macdonald:** Going back to the first question, you said those two threats. It might sound like an obvious question, but how do you know, how are you tracking, where are you getting the data from? Is it via the WHO? Is the Cabinet Office involved? How do you identify threats? Climate change is obviously a massive threat for the spread of disease as well. Have you got forecasts and modelling of what different scenarios might mean, including withdrawals of funding? I am interested in how you identify the challenges, and through what mechanisms.

Baroness Chapman of Darlington: You are absolutely right that climate is a huge threat to global health. Some of the threats that it brings about are the spread of pandemic disease and AMR, and the ability to respond is hampered by increased heat as well and the impact that has on sanitation, water and hygiene. The reason we are so supportive of WHO is because it is so critical to this work and it provides the data and the early warning; it does the predictive work around climate among other things. We see WHO as being absolutely vital to, for want of a better expression, the global architecture on health.

Ashley Dalton: It is fair to say we do not have any actual modelling at the moment on how the USAID cuts will impact HIV or TB or malaria, and it is a bit difficult to do that at this stage. Having said that, we are continuing to monitor it. The UK Health Security Agency is providing expert scientific and public health advice, support and leadership to other countries so that they are in a position to help prevent, prepare and respond to various infectious diseases. We continue to monitor that.

On the specifics of HIV and AIDS, we have the UK's new HIV and AIDS Action Plan coming later this year. Global monitoring is part and parcel of that as well, so we will be able to feed back some more detail on how we aim to pick up the impact on the UK of some of those diseases.

Q36 **Chair:** Baroness Chapman, it is interesting to me that the example that you gave was HIV because we had a briefing last week that said that was



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one of the areas that USAID was, if not protecting, not hitting as hard, but they were very clear that maternal health, for example, was being completely stopped; and you know I chair the all-party group on sexual and reproductive health. You cited the US cuts, not the UK cuts, and I believe that we are cutting the WISH programme, which gives £2.6 million to women's contraception. Are you seeing a gendered impact on the cuts when it comes to global health across the board—not just the USA but many countries unfortunately are stepping back from ODA?

Baroness Chapman of Darlington: I am surprised that you received that on HIV.

Chair: We were surprised as well.

Baroness Chapman of Darlington: I don't know if David wants to come in on this but he probably ought to. I am surprised at that, because that is not the conversations that I have had.

Chair: We found it odd, and it was clarified a couple of times to us.

Baroness Chapman of Darlington: Let's see, I think. I am very concerned about it. I agree with you on the impact on women and girls, and also we are seeing an increasing prevalence of HIV among women and adolescent girls as well, so that is a huge issue. On sexual and reproductive health and rights, we will be protecting some of our funding to those specific programmes. On WISH, we are looking at it. I have had mixed views on the impact of that and how we might be able to do that better. It is very important that that work takes place in west Africa. It is very difficult contexts and often in places where it would be great to be able to work with the Governments and do systems-strengthening and get those Governments to deliver this stuff. That is not possible in some of these places, so we need to find other ways. I am open to looking at whether or not we keep that programme exactly as it is.

Part of the issue we have on women's health is with our advocacy and the work that we do with Governments of explaining and putting the arguments that we have on safe abortion, access to contraception, safe childbirth. The figures on this are not great. Things are better but there is an awfully long way to go. One of the reasons that I have been keen that we prioritise health is to make sure that work can continue in some way.

Chair: That is reassuring; thank you. Beccy, over to you. We are fortunate, Ministers, that we have Beccy Cooper guesting from Health.

Baroness Chapman of Darlington: Yes, I noticed.

Chair: You cannot escape her. She will find you.

Q37 **Dr Beccy Cooper:** Thank you, Chair. It is good to hear that AMR—antimicrobial resistance—is at the top of your agenda; or I suppose not good, but it is a necessity. Can we please hear about the closure of the Fleming Fund? I know that you know that it has been central for global



efforts to build lab capacity, enable data sharing and strengthen surveillance systems across low-income countries. The Global Health Partnership had a UK Africa health summit and looked at antimicrobial resistance and flagged the Fleming Fund as something that has been a huge success in getting to grips with surveillance systems and crucial data collection. Could you please let the Committee know about the decision to close that Fleming Fund and what was taken into consideration when the decision was made?

Ashley Dalton: We have done an awful lot of work with the Fleming Fund, as you will be aware. Dame Sally has led some amazing work on that. I co-chaired a breakfast on AMR specifically at the World Health Assembly earlier this year to share some of the expertise and work again with our global counterparts. What we have learned from the Fleming Fund is that it has done some amazing work to build the partnerships that we need, to get the evidence and the technical information that we need to establish what needs to go on moving forward and, more importantly, to build the relationships globally, because obviously this needs to be done on a global level. While the Fleming Fund itself is not continuing, the partnerships, the information and the expertise are. I know that Dame Sally is continuing to build on the relationships she has built on a global stage.

Q38 **Chair:** So you are saying there is nothing to see here and everything is fine?

Ashley Dalton: What I am saying is that we are all working in a difficult financial situation and some choices have had to be made. What I am saying is that from the work that we have done with the Fleming Fund, there is an awful lot that we can take forward from what we have learned without actually continuing with the actual fund itself.

Q39 **Dr Beccy Cooper:** Data has been amassed and surveillance systems have been strengthened through the Fleming Fund. Will the funding for that data amalgamation, collection, surveillance-strengthening and fortification continue elsewhere or will that funding not continue and we will simply take what we have learnt and change into a different model?

Ashley Dalton: The Department of Health and Social Care is looking at how we streamline AMR into tailored country pandemic responses so that it becomes something that countries across the globe are doing, not something that is sitting outside of that. We have a wide network of partners and we are maximising the opportunities for sustainability. We want to mainstream that into the work that other countries and ourselves are doing on things like pandemic preparedness. The FCDO is exploring how it can best integrate the expert technical support to transition from the Fleming Fund to country-based ownership. I do not know if you want to give a little bit more detail on that, Anna.

Anna Wechsberg: Yes. The Fleming Fund has done a huge amount over 10 years. It has been for a long time the only programme of its type



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investing in the production of surveillance data on antimicrobial resistance in a wide range of countries. We have had quite a lot of successes. In Malawi and Timor-Leste we have systems up and running now producing data, and those are reporting into the global databases held by WHO and others—

Q40 **Dr Beccy Cooper:** Will that continue to happen?

Anna Wechsberg: Right from the beginning we have tried to build in sustainability. All countries have national action plans and we are pushing for those to be funded. There is no hiding the fact that this is a reduction in the funding that we are putting in. We are working, as the Minister says, through our own programmes, including the international health regulations strengthening programme that we will continue to run from DHSC, to look at where we can pick up some of that AMR work but also, importantly, globally and through WHO and other funding partners so that that work does not just fall away.

Q41 **Dr Beccy Cooper:** Looking at global health and security as well as specifically at AMR through the global health and security APPG and the AMR APPG, we have been discussing with the Cabinet Office the National Security Strategy and where AMR fits into that particular approach. Baroness Chapman, from an FCDO point of view, how do you see AMR as a global threat but also a threat to UK health security and where are those conversations landing?

Baroness Chapman of Darlington: You are right; I agree with you. It is a huge problem, not just for us in the UK but for other Governments that are experiencing this too. We are trying to do expertise sharing, so looking at regulation, prescribing, working with other Governments on what steps they can take learning from our experience, and sharing that expertise with them.

The work that we are about to start over the summer is looking at what the expertise offer is in the UK. There will definitely be something on health, of course, but I am quite keen to spend a lot of time working out exactly what that looks like. What is it that the UK can offer that is specialist and would be most in demand around the world? What we have done on antimicrobial resistance and our work to understand it and to work out what practices need to change is something that we should be doing a lot more work on and trying to make sure that is shared. What exactly that looks like and who is involved will not, I hope, just be a couple of Government Departments employing some people. We need to look around the whole of the UK system, and partners elsewhere as well, and try to get the very best expertise we can available where it is urgently needed.

Q42 **Chair:** Thank you. Anna, for Fleming Fund, was it Government Departments or academic institutions that could bid in for the Fleming Fund?



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Anna Wechsberg: It was funded from DHSC and then run through a management agent and a series of grants to countries and country teams and teams based in countries, to invest in the production of data.

Q43 **Chair:** FCDO teams or the Government's own teams in-country?

Anna Wechsberg: The Government's own teams in country, and partners, specialist agencies that can work with the Government to help develop systems to monitor the spread and occurrence of resistance and then generate proper data that is fed into a global database on antimicrobial resistance.

Q44 **Chair:** Minister, from a purely selfish point of view, I don't think that covid started in the UK so I am assuming the next big pandemic will not necessarily start here. Without the pot of money and, therefore, the influence that comes with something that encourages Governments to look at AMR, how will we compel countries to do that sort of work when we are basically taking away the funds?

Ashley Dalton: The AMR work sits alongside a much wider approach to pandemic preparedness. We have absolutely no idea where the next pandemic will come from and it might very well start in the UK. We cannot say that is not the case. We don't know what it will look like. Chances are it won't look like covid did and we will have an awful lot of learning to do when it does arrive. On pandemic preparedness and the international element of that, we recognise that it is important that we have surveillance taking place.

We have some key things. Health ministries across the globe have benefited, and continue to benefit, from the UK skill development and expertise on emergency response. When we face the outbreak of a transmissible disease that could potentially become a pandemic, we continue to support the UK public health rapid support team, which deploys technical expertise in outbreak response to ODA-eligible countries to work with them to help stop those outbreaks becoming a public health threat in a much broader global way.

There have been 50 deployments since we started this in 2016 and they are wide-ranging. We supported the cholera response in South Sudan and have current support to Africa in its regional response to Mpox. We have two imminent remote deployments supporting the emergency response following the earthquake in Myanmar, and supporting the World Health Organisation in their global multi-country cholera response. That has been an important thing and continues to be funded.

We also have the Department's ODA-funded IHR-strengthening project. This provides peer-to-peer technical expertise for four priority countries and three regions. It is delivered through the UK Health Security Agency, which I talked about earlier, and offers support to ODA-eligible health partners to help increase compliance with the international health regulations, all of which are focused on monitoring and surveillance of



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developing infectious disease and preventing pandemics. We would much rather prevent one than have to learn how to deal with it.

- Q45 **Chair:** I could not agree more. I believe that the spending review outcomes are coming out next week. Have you had conversations with either the Treasury or with the Baroness to make sure that you will still have ODA funding for all of those things that we do? I do not think it is our duty, but I am very proud that our country does step up when we have these sorts of health crises happening.

Ashley Dalton: Absolutely. It is important to note that in the autumn Budget last year the Government announced funding for pandemic preparedness to the tune of £460 million.¹ That is an investment in strengthening the UK's pandemic preparedness.

- Q46 **Chair:** This financial year or the next financial year?

Ashley Dalton: That is I think over—I am looking at you for the detail.

Baroness Chapman of Darlington: I would have to clarify.

Ashley Dalton: Yes, I cannot clarify exactly but that is over the Parliament, is my understanding. The support for the public health rapid support team continues, and that has been prioritised. I think it is important to say that obviously decisions are having to be made about the spending review, but what we have done is prioritise health security, including pandemic preparedness and vaccines.

Chair: That is pleasing to hear. Monica, you want to come in

- Q47 **Monica Harding:** Back to the Fleming Fund.

Chair: We are slightly obsessed.

Monica Harding: Strengthen surveillance systems, which you say will be replicated by a new fund, but how would that intersect also with the surveillance that is diminished as a result of the WHO cuts to funding? While I understand that there are preventative measures here, what about the surveillance systems that the Fleming Fund was looking at and also would be diminished by WHO? How does that work?

Ashley Dalton: As Anna pointed out, part of the Fleming Fund was about creating databases so that we can monitor, and those databases are being created. What is really important is that we are moving towards mainstreaming this activity in other countries, pandemic preparedness. Rather than saying that the UK will pay for this across the globe ad infinitum, we have used the investment of the Fleming Fund to build capacity across the globe in various countries so that they can start to own and lead on that. We are working with them. A lot of the work of the

¹ Witness has sent a clarification/correction to this statement. See published written amendment here: <https://committees.parliament.uk/writtenevidence/144397/default/>



Fleming Fund was about awareness-raising and sharing the data so that other countries realise how important this is and can then start to allocate their own resources to not only keep up their surveillance but also to put in place some of the mitigating strategies that we have looked at, such as controlling prescribing of antibiotics.

Q48 Chair: If a country is unable to do that—maybe they have a regime that has no interest or just instability; we know how much global debt is impacting on some countries—would you be looking to step in and continue the assistance?

Ashley Dalton: I think it depends on what assistance we are looking at. Where we have the outbreaks, we will be responding to that. I do not know if you have any more detail on how we plan to take that forward.

Anna Wechsberg: I will add two points. One is on the UN General Assembly High-Level meeting last autumn, which delivered a political declaration that was important because it committed globally to, I think, a 10% reduction in AMR deaths over the period to 2030. It had a lot in there about countries investing in their own systems and their own national action plans, and it also committed to the establishment of an independent panel on AMR so that data keeps getting fed back into the system and people cannot look away from it. That was important.

On your question on alternate funding, that is also important. I think you heard from the Pandemic Fund earlier. It is able to fund interventions around AMR as well as broader pandemic preparedness. As the Minister was saying, those surveillance systems are interchangeable in some cases. We are also looking to the multinational development banks to make AMR more of a priority, and obviously we are working with WHO as well.

Maybe the last thing to say is that over the period that we have been running the Fleming Fund I think we have seen a step change in international understanding and acknowledgment of the problem and the challenge that AMR is posing to everybody. You see it come up regularly now in G7 and G20 health ministerials as a key threat, and crucially you also see it now in animal and environmental health. There has been a shift over the period that the Fleming Fund has been running. We are obviously nowhere near out of the woods but I think we have moved on a little bit since we started 10 years ago.

Q49 Chair: Let me quote the *Lancet*, which said, “Its closure risks undermining essential biosecurity infrastructure and jeopardising years of UK leadership and investment in AMR contamination”. Do you agree with the *Lancet*?

Ashley Dalton: On UK leadership, we remain co-ordinating on a global stage for AMR. Dame Sally remains as the AMR ambassador and has the networks and good will that she has built, and the understanding in other countries is phenomenal. I continue to work with my counterparts across



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the World Health Organisation membership in leading on the AMR conversations at that level.

Obviously there will be a shift in what the Fleming Fund did, because it will not be doing that any more, but there are other mechanisms. The Global AMR Innovation Fund has supported developments in new antibiotics, for instance, and those things are starting to be rolled out. We have had the first new treatment for gonorrhoea in 30 years, which is currently going through approvals at the moment. There have been significant developments and we will continue to make progress and mainstream those activities within individual countries, as well as at a global level with the World Health Organisation.

Chair: The Committee and the Baroness know I shudder each time things are being mainstreamed.

Q50 **James Naish:** Chair, I will come in on that. I thank Minister Dalton for her honesty there. You have mentioned the word “mainstreaming” three times so far.

Ashley Dalton: I love it.

Chair: You really want to bait him on this.

James Naish: I understand the sentiment and why it is happening, but our previous witness from the World Health Organisation said that we have “a global health financing emergency” that is on top of “chronic underinvestment in health already” and it is on top of the high cost of debt that a lot of the countries that we are talking about are having to finance. We heard great examples around Nigeria, South Africa and India, but there is a number of countries that are not yet in those positions. How confident are you that mainstreaming will work?

Baroness Chapman of Darlington: I hear the concern and I do not disagree with anything that your witness from WHO said. I think that is exactly the right thing to be concerned about. We are not sitting here telling you that everything is great, there is nothing to worry about and there is no risk. That is not our position. What we are saying, though, is that we think this particular fund has done an amazing job, and that we can build on that success by working with other health agencies and countries. There are 193 countries signed up to this now, which I don’t think would have happened even quite recently, so there is a huge amount of awareness and a desire to do what needs to be done on this. Is there the capacity everywhere to do that? Absolutely not, but we have other agencies and ways of getting to do that work where it needs to be done.

We are having to make some choices that you don’t want to be having to make, but we have to make them and, where we have to, talk to the UN, Gavi and Global Fund about being more streamlined, merging, sharing some functions, looking again at mandates. You cannot separate this



from the whole UN reform piece as well. There are a lot of these conversations taking place. Part of our job is to make sure vital work like this on AMR does not fall down anyone's priority list, because it is so important for global health security. I think that message has been very well received, not least thanks to the work that is being done through the Department of Health, but also our diplomatic work multilaterally.

- Q51 **James Naish:** Pandemic risk reduction: where are our remaining risks? Where are the weaknesses that we still have? You have mentioned a number of things that we are doing, Minister Dalton, but where do you still see problems and potential issues for the UK?

Ashley Dalton: The interesting thing is that we are at a pretty unique place with pandemic preparedness and agreement across the world. The pandemic agreement is three years of negotiations of member states of the World Health Organisation, and it has been adopted. I do not underestimate how astonishing it was to get to the stage where we were able to do that. That meaningfully improves UK and global pandemic prevention, preparedness and response capabilities. We were nowhere near doing that three years ago, and I think what we saw during covid-19—particularly with vaccines—was how excluded the Global South was from that. We are now in a place where we are leaning in to ensuring that that does not happen—at least not to the same degree as it did. That pandemic agreement also influences domestic policy because it is about saying, “We are signed up to this,” so we make that important.

On the risks, vaccines is probably one of the key things. Gavi is doing well and we are now the biggest contributor to Gavi. From a UK perspective we also need to do an awful lot of work on our vaccine take-up; it is not where we would want it to be. As I said earlier, I meet regularly with the Vaccines Board and that is something that we are working on. If we can maintain the level of vaccinations for vaccinatable, preventable diseases in the UK we maintain a resilience to any of those sorts of infections entering the UK. That is absolutely crucial, but the risk of course is always that new stuff arrives and we have never seen it before, we did not know what it looks like and we do not yet know how to respond to it. That is why surveillance has been the real priority, and we have ensured that we have prioritised that, and will continue to look to prioritise that in the outcome of the spending review.

- Q52 **Alice Macdonald:** It is great that the treaty has finally been agreed, but the US did not sign up to it. Part of the reason it probably was agreed was that they did not engage. That is what I think happened; I don't think the US signed it, did they?

Ashley Dalton: Well, nobody has signed it at all yet.

Alice Macdonald: But they did not even engage in the negotiations, did they?

Ashley Dalton: It was adopted by the World Health Assembly.



Q53 Alice Macdonald: My understanding was that the US did not engage in it, so are you concerned about that? Of course there are quite prominent voices from different countries that are not very pro-vaccines. Linked to that—and it might be both Departments—we heard on the communicable diseases we talked about before that because there had been so much investment on it there was less emphasis on behaviour change and public education about it, so we are now seeing a reduction in that. I suppose I am also asking about US engagement on this piece—is that a risk, maybe it is not—and then are we looking more at investing, maybe from the FCDO perspective, in some of the awareness and behaviour change things beyond just funding vaccines?

Baroness Chapman of Darlington: On the second part, yes, and we do need to do that. We should be doing that anyway and we have been doing that, but I think that needs to be stepped up. On the US positions on things, we are the largest donor to Gavi and it would be better if the US was the largest donor to Gavi. It is better when all countries come together and they try to deal with these things multilaterally. That is how these global issues should be attended to.

The fact that the US has taken the position it has does not mean that we don't continue to engage with them on vaccines, on AMR, on any of these issues and others outside of the health portfolio as well. We are finding an openness to that in the US. They have made their decisions and we do not criticise them for it—they are entitled to make the choices and the priorities that they make—but we have a job to continue to make the case that pooling our resources for vaccinating the world's poorest countries is a sensible thing to do. There is plenty of evidence for it and it has saved millions of lives. It will continue to do that, even without US participation, but we need to continue to have those conversations, as do others outside of government networks.

We are finding that there is an interest, there is a scepticism about whether or not the global system of doing things is the right one, how effective is it, how efficient is it. They are all fair challenges and we are happy to engage on that basis. We have not given up, I suppose is what I am trying to say, on achieving the maximum engagement from the maximum number of countries in a big economy like the US with so much to offer in its expertise as well. We think those are conversations that are worth our time.

Chair: Minister, if you do not mind I will move on to Brian.

Q54 Brian Mathew: This is to everyone. What are the implications of inequity between the Global North and the Global South on health security?

Baroness Chapman of Darlington: The implications are quite devastating, which is why we are prioritising health. From my perspective I am obviously very concerned about global health security, but I don't see how a country achieves anything that it wants to achieve while it is unable to support the health of its population. There are different ways of



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working in different places. We were talking about Gavi. Gavi can get in and provide a service and it can do that alongside nutrition support and work on maternal health. We can bring this all together and provide a service and deliver something in a country that is unable to do that for itself.

Better is when we can work with a Government on how that Government can decide for themselves, for their own population, how they want to do this. We are having some encouraging conversations with Health Ministers in other countries who say, "We want to get off this aid, we want to get into being able to deliver for ourselves." That is a tough thing to do. You have mentioned debt and that does not help. They have looked at what has happened, particularly with America's decisions, and they have realised how vulnerable that makes them. That is a huge motivation for them to strengthen their own provision.

Health Ministers also say to us that they are having arguments in their own Cabinet where their colleagues say, "We don't need to give you any money for health because the international community will pay for that," and the Health Minister is saying, "But we could do it much, much better if we delivered it ourselves because we know how to do this better," That is a conversation that we want to be on the side of the Health Minister in. Some of this will be working with the World Bank and working with the MDBs about how they can play their part, particularly in the more fragile places. They have not done enough of that in the past, so we want to do more there.

There will be some support for delivery—this is not a thing that you can switch on and off overnight—but a lot of this will be about expertise, how you fund a health service, how you improve your tax base. They were asking for HMRC to go and support them. They were talking to tech companies about how you build a state from scratch, in my cases. They don't have hundreds of thousands of people working in the civil service delivering things. Those things are not happening, so there is a new way of providing services in many places that has not been there before.

The way I see it is that health inequality globally is one of the key challenges we need to try to address, but you do that by looking in a more holistic way. That is different from mainstreaming. It is understanding how the different elements of development work alongside one another.

Q55 **Chair:** Minister, that is on the assumption that the Government want to do that.

Baroness Chapman of Darlington: Of course.

Q56 **Chair:** Before this job I ran a children's hospice. One of the children that we supported was from Afghanistan, and her father had enough money to basically bribe his way out of the country. That child, who would be about 11 when we gave her end-of-life care, had never had any support.



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That was 15 years ago. The Taliban now are even more brutal to women and girls, so I do not even want to think what their health is like. What role do you see that the UK would want to play in those sorts of situations when it comes to health?

Baroness Chapman of Darlington: You are absolutely right. You cannot do any work on strengthening systems with a Government who do not have it as a priority for themselves. You can try, but you will be wasting your money and your resource. The Government have to want to do it. More and more Governments do want to do this and they have the capability increasingly, with support, to be involved in that. There are obviously places where that would be a hopeless approach, and then you have to work through UN agencies, bilateral programming and local NGOs. You have to use what you can. I cannot think of many places more difficult to do that than Afghanistan. There is work happening, but it is incredibly difficult.

Q57 **Chair:** But under your watch you are still committed for that sort of work to happen?

Baroness Chapman of Darlington: We have to. You cannot do it any other way. We cannot do everything everywhere, but there are countries where you have no option but to work in that way. It is not a development goal, it is not long-term sustainable, but you are doing it while you wait for the Government to improve and the situation to change. Sometimes, sadly, you have to wait a very, very long time.

Brian Mathew: Shall I continue?

Chair: Please.

Q58 **Brian Mathew:** What are the benefits to the UK of adopting agreements such as the Pandemic Treaty that encourage equity?

Ashley Dalton: The Pandemic Agreement, which it is now called—I have called it all sorts of things, it was the Pandemic Accord at one point—is important. The benefit is that it should meaningfully improve the UK and global pandemic prevention, preparedness and response. What that means is protecting lives, protecting livelihoods, protecting the economy, protecting our NHS, and bringing genuine benefits to UK health security in being able to respond to a pandemic effectively. It not only secures health; it secures jobs, the economy and our NHS for the future.

At the same time the Pandemic Agreement protects the sovereignty of all the member states, including the UK, to make our own domestic public health decisions in the event of that. The benefits are that we can start to see a reduction in some of the inequities that we saw during the covid-19 pandemic across the globe. By doing that you are also improving the UK's health security, because as everyone has said many times, viruses don't pay any attention to borders.



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Q59 **Brian Mathew:** Back to you, Baroness Chapman. How is the UK fostering greater collaboration with partners in the Global South and between partners within the Global South?

Baroness Chapman of Darlington: That is such an important point. The conversations that I have with health Ministers—I was talking to the Nigerian Health Minister a couple of weeks ago, Pate—a friend of yours?

Ashley Dalton: Yes.

Baroness Chapman of Darlington: He is seen by the Global South as a leader in health. I also met the South African Health Minister recently. I see we have friends in common.

Ashley Dalton: As did I.

Baroness Chapman of Darlington: The message that we get is all about, "Help us to lead this ourselves." I don't know if any of you watched the Live Aid documentary at the weekend and the Nigerian President, "I am not a fan of aid, I am a fan of doing things for ourselves." We have to not leave people to their own devices, it is a lot harder to do this: talk to them about what kind of health service they think would work for their country, population, tax base, geography, climate and social structures. We have a responsibility and an ability to do that hard thinking alongside them.

We need to get to a place where they are supporting each other as well, so it is not a paternalistic relationship that they have with us. We are starting to see that happen. We have the G20; the Development Minister is in South Africa next week. One of the things we are hoping to talk to them about is where is everybody's thinking on support for health. South Africa is designing what could look like the NHS; it might look like something different. I hope it is something that is unique to South Africa, and that they create themselves, but they want to know the benefits of doing it the way we do it, and they also want an honest assessment of: if we were starting from scratch, would we do it like this?

Q60 **Brian Mathew:** Dr Cooper and I saw and witnessed, when we were in Cape Town a few weeks ago, what CERI is doing with its links right across Africa in disease identification. It is very important.

Baroness Chapman of Darlington: Yes, it is.

Q61 **Monica Harding:** I want to come back to the point you made, which is the partnership and reimagining aid in that event. The head of the Wellcome Charitable Foundation pointed out—I am sure you read the article in the *FT*—that aid cuts will have a bigger impact than the covid pandemic on health in the Global South. While I understand that middle-income and lower-middle-income countries may be able to step up, the 40 or so poorest countries will not be able to step up. How does



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development in aid and health security work in that context, and how does the UK help?

Baroness Chapman of Darlington: Not all aid cuts are the same and I think the way that we are doing ours is slowly and in a considered way. I contrast that with the way that others have done it, where medication has stopped being distributed overnight, where I know of warehouses with vaccine that there is no way of distributing. That is a real problem that will have a huge impact, and we would never do that. We want to be responsible and careful about the way that we do this.

This means that we are prioritising working multilaterally, because that is where you get the biggest impact when you are looking at how many people you can reach in those places in particular. Our bilateral programming health will be a priority for the UK. Where we have teams in countries that sense that there is a Government who want to do this work—that is absolutely essential, we cannot impose our view—we will do all of the system-strengthening, all of the broader work that we need to do to get them to a place where they can deliver for themselves.

I would not attempt to minimise the impact of the way that some of the decisions that have been made on health in recent months are being felt in some countries among some populations. I don't think we fully understand exactly what has happened yet.

Q62 **Monica Harding:** Will there be a situation where the UK would increase funding, obviously not to completely fill that gap but to go some way, with a coalition of other countries?

Baroness Chapman of Darlington: You have to be realistic, Monica. I think about 35% of global health funding is provided by the US, and with the best will in the world, the UK and Norway—we need to be strategic and collaborative about it. We are talking to our partners in the EU and in the Global South, to Canada—all the people that we traditionally work with—trying to make sure we know where the gaps are and we can make decisions on what to do about it. It is about making sure that we understand exactly what the picture is and we can make our decisions appropriately.

Q63 **James Naish:** I want to come back to the debt point from earlier, which is that if you could tackle that, that would suddenly enable countries. Is that same strategic partnership working being done on the debt front as much as it is on the healthcare system side, or could it be if we know that that might help?

Baroness Chapman of Darlington: There are different views, as you know, about what the right approach is. We are having lots of conversations about what we need to do. It is different from what it was 20 years ago, when you could do a big debt cancellation moment because the debt was owed to countries. Now a lot of the debt is owed to countries that would not want to play, or it is owed to the private sector.



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This presents a problem. You will know there is a view among many that this should be a UN process where there is a sort of debt agreement. That might be right—I am not completely against that—but my concern about that is it is unlikely to be quick.

At the moment we have the common framework, where there are also issues about the length of time it takes. I think it does not take sufficient account of parliamentary terms in countries, but there are huge politics around this and I don't think that is priced in sufficiently in the way that it works. We need to be clear that repayments stop when the negotiation starts and we need to find ways of making this less of a problem for countries to enter into. Where they have entered into it, it has been successful, but only five countries have done that in five years. That tells me that there is an issue here.

Q64 Dr Beccy Cooper: Going back to health system strengthening, it is the perennial conversation of everybody in international health. Health system strengthening basically is the pandemic preparedness baseline, it is non-communicable diseases baseline; it is everything. For us in the Global North, I wonder what the conversations are around human resources. I have seen figures that say that for human resources the Global North benefits from the Global South for health staff shortages here. I have seen numbers of up to £40 billion annually where we are benefiting from the Global South human resources. If we are serious about strengthening health systems globally, what conversations are going on in FCDO and the Department of Health to address those inequities?

Ashley Dalton: Those conversations are taking place and were the basis of many a conversation that I had at the World Health Assembly earlier this year. As you are probably aware, the World Health Organisation has a red list of countries where they have a shortage of certain health professionals, so we all agree not to recruit health service workers from those countries to reduce the exiting of those workers to other countries. We have developed quite a network and some really good partnerships around the global health workforce and it remains a topic of conversation. It is on the agenda and is something that we are committed to doing. You will have also seen that the Secretary of State has spoken about—

Q65 Dr Beccy Cooper: Sorry, Minister, when you said “committed to doing” you are committed to making sure that the Global South—

Ashley Dalton: Absolutely.

Dr Beccy Cooper: —have qualified—

Ashley Dalton: Absolutely, and so that we are not recruiting from countries that have a shortage of healthcare workers themselves, and I think that is really important. You will see that the Secretary of State has made some statements around that most recently.



- Q66 **Chair:** Could I move on a little bit from that? When we did our inquiry into the impacts of covid on the Global South it was very clear that it was disproportionately impacting on women, particularly women healthcare workers because they tended to be the frontline and, to be quite frank, a lot of them died. Is any work being done by FCDO to look at strengthening the recruitment and training, but also the resilience of the local community leg? I have also heard the same thing about vaccines, but the frustration is it is probably someone on a moped that is delivering those vaccines, or not.

Baroness Chapman of Darlington: Yes, I am sure we could do more. What we are hearing is most valued to try to make an impact on that is the professional-to-professional links. It is not necessarily the expertise that is employed by us in Government, but midwife-to-midwife connection. This relates to AMR as well, because some of the practices that we have had to develop here, because we have had hospital-acquired infections, are really important, and that sharing is best done, it seems, from a nurse to a nurse, or from midwife to midwife. We should work out how we do that at scale in the most cost-effective way that we can, because that seems to be one of the better ways of transferring knowledge.

Chair: We had some very compelling evidence about providing an iPad, and the links that consultants and midwives were having and how important that is.

- Q67 **Alice Macdonald:** Talking more broadly about priorities, and maybe you could address this in one—I know we have come to the end of the session—how would you say that the UK is intending to continue its historic leadership on health with a reduced budget? I know we have spoken about women and girls a lot, but you have said there is a direction towards mainstreaming. What does that look like within global health?

Baroness Chapman of Darlington: I think in global health it is probably one of the more obvious ways to mainstream support for women and girls because so many of the things that we do disproportionately benefit women, and we want to do more of that. On the budget cuts issue, the budget overall is being cut by 45% but our commitment to Gavi was only cut by 10%. I think that has been recognised internationally. On the point about global leadership, that did not go unnoticed.

We will always, I think, be seen as a country that takes its responsibilities on global health very seriously, but also we develop and manufacture vaccines. We have a huge health economy here in the UK. I am not saying this is a motivator, and this is not why we do this, but there is a benefit to us here in the UK too, with jobs in our pharmaceutical industries, and our universities are very active in this. We have some university partnerships with developing countries where they are looking



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at medical skills and training. We have an awful lot to offer. We have the London School of Tropical Medicine. I think all these things will make sure that our position as leaders on health continues—perhaps more than any other area in development.

Chair: I can't remember: is health one of the priorities? Climate, health and—

Baroness Chapman of Darlington: Humanitarian.

Chair: Thank you.

Q68 **James Naish:** What does a renewed relationship with the World Health Organisation look like in the context of the funding cuts, that partnership working moving forwards? You talk very highly about the World Health Organisation, but what does that look like practically?

Ashley Dalton: We continue to work closely with the World Health Organisation and it is going through a significant process of reform, which you will be aware about. I have met several times with Tedros to discuss the reforms that they are putting in place. I have also met with Hans Kluge, the director of the European element of the World Health Organisation. We are a key partner in that and we are building relationships and sharing expertise, and also supporting the WHO wherever we can, particularly in the transition that it is about to take further. It has done an awful lot of work on its global reforms. It is now looking at how that pans out in the regions and how it can build in efficiencies and be more impactful. We continue to be a key partner in how it does that.

Q69 **James Naish:** What alternative financing models are being explored? Are you aware of alternative models?

Ashley Dalton: I don't have any details at the moment. There is a whole host of stuff that is being looked at. I don't know if Anna can give a bit more detail. Obviously the WHO will be exploring a different range of things that will be different for different countries.

Anna Wechsberg: WHO has expanded quite significantly, particularly at headquarters, over the last few years. Some of this is, I guess, retracting back to what will be a steady-sized organisation. The key thing for us is that in that process WHO retains its excellent technical expertise and then, secondly, that it prioritises the sorts of things that we have been talking about today. In all organisations there is obviously a mix of activities. We consider things like disease surveillance and AMR, and some of these other global health security things, absolutely crucial for it to be prioritising.

One other quick point to make, which is not so well-recognised, is that the UK hosts over 50 collaborating centres for the World Health Organisation, ranging from health workforce to global influenza



surveillance to genomic surveillance for AMR. We are absolutely committed to carrying on doing that because it is a brilliant way of sharing our expertise globally and then us learning from that global development.

- Q70 **James Naish:** It was mentioned at the end of our last session, and I am sure the World Health Organisation will welcome our commitment to continuing those areas. Overall how would you describe our influence over the choices that the World Health Organisation is making? You mentioned, Anna, a number of the things that we would like to see them continuing to do. How strong is our voice, do you think, in making sure that those are the things that the World Health Organisation manages to continue to do?

Anna Wechsberg: Obviously we are one of a large number of countries around the table, but we do have influence. That is partly because we have historically been a big provider of resource to the World Health Organisation, but I think even more so because the quality of our expertise is really recognised. So I would say that we are absolutely listened to.

- Q71 **Chair:** We had a representative from the World Health Organisation in our first panel and she said that without realistic surveillance and data capture they are flying blind. With the increasing dual threats of decreasing surveillance and increasing infections and diseases emerging, how do you see the world and the UK's part in that global defence against not just future pandemics, but future illnesses that may devastate us all?

Baroness Chapman of Darlington: I think our role is one of leadership and I think we have historically provided leadership, but now is probably a moment where we need to be crisper and clearer about what we think needs to happen. We need to do that more often and more loudly. It is becoming quite urgent that the various agencies that are responsible for sometimes provision, sometimes investment and working with countries, consider very carefully how aligned they are, how much resource they can take out of their core—*[Interruption.]*—and get on to the frontline.

I am very encouraged by the close relationship between Gavi and the Global Fund, as an example, and the conversations they are having about how to look at their replenishment cycles, their back office functions. I think a merger might be a step too far for now; I do not know. I would not completely rule it out but it feels like a stretch. That kind of conversation that has been taking place for a while, now becomes immediately necessary to make decisions and choices on.

The same goes for UN agencies. I am amazed, really, that the UN bases itself in the two most expensive cities on the planet. Part of our responsibility is to be a voice of challenge and friendship, but certainly challenge in some of those places where challenge may have not been taking place. Some of the donor behaviour has not helped things, either.



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Chair: Ministers, you have given me, and I hope the Committee, reassurance and confidence that this is something that you care about, recognising the scale of the problems the world faces. I can see that it is obviously a focus for you. It is not something that we will step away from, so we will keep chivvying you along and obviously wanting you to do more. For today, thank you for the generosity of your time and for the good evidence you have given us.