

Response from London School of Hygiene & Tropical Medicine (LSHTM) to the UK Parliament call for evidence on Global Health

Call for evidence - Committees - UK Parliament

Summary

1. This submission represents an institutional response from the London School of Hygiene & Tropical Medicine (LSHTM), a world-renowned public health university with a global presence. Our cross-disciplinary research draws on world-leading expertise to address major public and global health challenges. We have a unique range and depth of work integrating laboratory, clinical, population and social sciences. Our School is highly rated for impact and our research contributes to health policy and practice in the UK and around the world. As such, LSHTM is strongly placed to comment on this parliamentary call for evidence for global health.
2. We provide evidence on the following areas:
 - 2.1. **Aid cuts:** The abrupt dismantling of USAID and wider development assistance cuts represents an unparalleled global health crisis and a catastrophic reversal in global health progress, with projections of over 762,000 excess deaths by early 2026, and potential for up to 14.1 million excess deaths by 2030. Aid cuts are crippling frontline health systems, causing the collapse of immunisation programmes, disruption of disease surveillance, and a resurgence of vaccine-preventable diseases and other infectious diseases such as HIV/TB and malaria.
 - 2.2. **Impact of aid cuts on the WHO:** The WHO and other critical global health institutions are severely weakened by funding shortfalls, with WHO facing a 21% budget cut and being further undermined by the withdrawal of the USA. This severely compromises the WHO's ability to deliver its mandate, including core functions of surveillance and outbreak response. The uncertainty caused by the US withdrawal has impacted other institutions' ability to plan and created a highly unstable environment.
 - 2.3. **Climate and Health:** The links between climate change and global health are complex and multifaceted. We have highlighted the impacts on three key areas: maternal and newborn health, mental health, and mosquito-borne diseases.
3. The current global health architecture is fragmented and fragile, but the crisis presents an opportunity to fundamentally reform it for greater equity and effectiveness. The UK must champion a shift toward systems strengthening, regional leadership, and predictable financing.

Question 1. What is the current state of global health and the global health architecture?

- a. What has been the impact of aid cuts, particularly the closure of USAID, on global health?
- b. What has been the impact of aid cuts on global health institutions, including the World Health Organization?

Impact of Aid Cuts, particularly the closure of USAID

4. The closure of USAID and subsequent cuts have precipitated an unparalleled global health crisis. The sudden withdrawal of the largest bilateral donor has created a funding gap of an estimated \$54 billion since USAID was placed on administrative leave on 23 February 2025 (1), devastating health systems that were already fragile.

5. Research reported in *The Lancet* (2) shows that the US has historically been the largest funder of global health and development assistance, despite contributing less than 0.3% of its national income. USAID funding accounted for more than 10% of total health expenditure in many LMICs: Somalia (27%), South Sudan (25%), Syria (18%), Mozambique (12%), and Malawi (12%). For many priority countries, USAID has historically provided as much as half of total external funding for reproductive, maternal, newborn, and child health.
6. USAID was also a major funder of the World Food Programme, the United Nations High Commissioner for Refugees, UNICEF, the Joint United Nations Programme on HIV/AIDS, and the United Nations Population Fund, as well as global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance. A sudden loss or major reduction of USAID support raises grave concerns about a scale-down of support to the delivery of life-saving care, particularly in low-income and humanitarian crisis settings.
 - 6.1. An ODA tracking exercise has shown that major increases in external funding for reproductive, maternal, newborn, child, adolescent, health and nutrition (RMCNAH) reduced child and maternal mortality since 2000. Country in-depth studies have shown the strong association between increased external funding, better intervention coverage, reduced inequalities, and increased maternal and child health (2: a., b., c.).
7. The impacts of global funding cuts include the below.
 - 7.1. **Catastrophic loss of life:** A modelling study published in *The Lancet* estimates that the end of USAID could result in 14.1 million excess deaths by 2030, including 4.5 million children under five (3). A separate analysis in early 2026 estimated over 762,000 deaths had already occurred, more than 500,000 of them children (4). These figures represent the collapse of treatment and prevention for diseases like HIV, TB, and malaria, alongside a breakdown of essential maternal and child health services.
 - 7.2. **Collapse of immunisation and disease control:** Funding cuts have directly led to the closure of over 450 clinics in Afghanistan, Sudan, and Syria alone, leaving 2.5 million people without access to medical treatment. In the Eastern Mediterranean Region, a rapid assessment conducted in March/April 2025 by WHO across 108 LMIC countries showed a 70% reduction in health emergency preparedness, a 66% reduction in surveillance, and a 58% reduction in service provision. This has already led to a resurgence of vaccine-preventable diseases like measles, cholera, and polio (5).
 - 7.3. **Frontline Health Worker crisis:** Mass layoffs of health workers, who were previously supported by development assistance, have been reported across multiple countries. This erodes decades of investment in human resources for health, a cornerstone of resilient health systems. In Nigeria, Madagascar, and the DRC, for example, funding cuts have disrupted vaccine supply chains, halted outreach programs, and demoralised the workforce (6).
 - 7.4. **Antimicrobial resistance:** As noted by the OECD, the countries most impacted by ODA cuts are those least likely to be able to absorb them. The areas most affected by cuts are reproductive health and infectious diseases, both of which impact antimicrobial resistance (AMR) (7).
 - 7.4.1. AMR is a priority policy area in the UK (8, 9, 10). It is also a health security issue, with risks transcending national borders. Successful UK AMR policy is heavily dependent upon global partners' access to good hygiene, public health, and health systems (11). Defunding structural sanitation initiatives in low and middle income (LMIC) countries will create the conditions for the emergence and transmission of resistant pathogens. In the absence of basic hygiene infrastructure and labour protections for workers, health systems and individuals will continue to be dependent on “quick fix” antibiotics to assure productivity (12). As is cogently summarised by the 2025 Chatham House report on UK aid: “a 15 per cent increase in [global] resistance rates would leave the global economy \$1.7 trillion smaller in 2050 than it would otherwise be, with the US, UK and EU economies among the hardest hit” (13).

7.4.2. AMR is a symptom of a lack of global public health investment. It is widely understood that effective global public health solutions for AMR prevention (such as improving water, sanitation, sewers, and nutrition) and treatment (strengthening health systems, investment in universal health coverage, implementing the International Health Regulations) improve health and wellbeing abroad, and pay dividends in donor countries (14).

7.5. **Changes in HIV funding and the implications for HIV control:** The President's Emergency Plan for AIDS Relief (PEPFAR) has gone from providing \$6.7 billion for AIDS programmes in 2024 to \$4.6 billion in 2025 and \$2.9 billion in 2026. Rapid reductions in international assistance for HIV programmes are unlikely to be replaced by domestic spending, especially in low resource settings like Malawi, Zimbabwe, and Zambia. Cuts in funding and restrictions imposed by the America First Global Health Strategy have already reduced support for HIV testing and prevention programmes and programmes supporting key populations (sex workers, men who have sex with men, people who inject drugs, trans genders, and prisoners).

7.5.1. Further rapid cuts in funding are planned by 2028 which are likely to undermine HIV treatment programmes. Over the short term these changes will likely increase AIDS deaths and over the medium term increase the spread of HIV. The goal of local ownership of domestically funded programs is admirable. However, the speed of change and the priorities of the US government will likely work against this goal. Whilst the UK has played a smaller role in the HIV response, the scale and timing of cuts in UK funding for HIV programmes will exacerbate the problems.

7.5.2. Two decades of global funding for HIV interventions has contributed greatly to reduced HIV incidence and AIDS deaths in the highest burden countries. This funding has greatly reduced new HIV infections and AIDS deaths, particularly in the countries of sub-Saharan Africa suffering from a high burden on HIV. Between 2010 and 2025 UNAIDS estimates that there has been a 62% decline in new HIV infections per year in Southern and Eastern Africa and a 46% decline in Western and Central Africa. Despite these successes, they estimate that 1.2 million people globally acquired HIV in 2025 with HIV causing 570,000 deaths (15). Most of the decline in burden is attributable to high antiretroviral coverage which has suppressed HIV viral loads preventing the transmission of infection. In addition to controlling HIV through vertical programmes, HIV funding has been used to strengthen health systems and improve other health outcomes with PEPFAR spending, leading to increased immunization rates and decreased infant and maternal mortality (16).

7.5.3. Rapid cuts in HIV funding will provoke a crisis, particularly in the countries of Southern and Eastern Africa with large numbers of people living with HIV. Other donors are unlikely to step in, and many poor and debt burdened countries will not have the fiscal space to replace PEPFAR and Global Fund spending. Integration of HIV prevention, treatment, and care into primary health services has been mooted to replace vertical HIV programmes but there is little evidence and experience of such integration, and it is likely to increase rather than decrease costs in the short term.

7.5.4. The impact of decreased funding has been modelled, showing an impact on AIDS deaths and HIV infections. Much of this modelling assumed a complete cessation of funding as occurred in February 2025 when the US government was reviewing its programs (17). However, reductions in services since this initial period have been more gradual. To date HIV treatment has been sustained for those within programmes, but there have been observed declines in HIV testing, treatment initiation, and HIV prevention. Honermann and colleagues analyzed PEPFAR indicators between 2024 and 2025 showing these declines (18). Such declines are likely to worsen over time, and as

funding is further reduced, many of the gains of the last two decades in tackling HIV are likely to be lost.

- 7.6. **Loss of global health infrastructure:** Aid budget cuts are undermining different aspects of essential global health infrastructure, such as the termination of the Demographic and Health Surveys which for the past 35 years had provided timely, comprehensive and vital statistics for policies, planning and monitoring.
- 7.7. **Reductions in global health research funding:** BMC journal *Implementation Science* has highlighted the negative impacts of recent grant termination from the US on implementation science, with hundreds of grants funded by the United States National Institutes of Health (NIH), the largest funder of biomedical research in the world, terminated between January and March 2025. The journal notes that the nature and magnitude of the terminations will diminish current implementation research (19). Universities in the UK have also been directly impacted with a number of research projects at Russell Group universities served stop notices by the US government (20).

Impact of Aid Cuts on Global Health Institutions, including WHO

8. The aid cuts have delivered a significant and destabilising blow to the institutions that form the bedrock of global health cooperation, including the WHO (which sets global standards and guidance for health care and provides technical assistance to ministries of health) and other multilateral bodies, threatening the effectiveness of these vital functions. Impacts include:
 - 8.1. **WHO severely weakened:** The US decision to withdraw from the WHO and the general reduction in ODA from other major donors have forced the WHO to make a \$1.1 billion (21%) budget cut for 2026-27 (21). The WHO's ability to fulfil its mandate is severely compromised: an analysis of its country offices found that 70% reported disruptions linked to aid cuts by mid-2025, particularly in the core functions of surveillance and outbreak response (22).
 - 8.2. The primary impact of these cuts has included health access (2,038 health facilities suspended operations in 2025, reducing healthcare access for 53.3 million people), women's health (60% of women's organisations around the globe have scaled back their operations) and tuberculosis (long-term cuts to international donor funding could result in up to two million additional deaths) (23).
 - 8.3. **Fragmentation and instability:** The uncertainty caused by the sudden US withdrawal and the dismantling of USAID have made it extremely difficult for other institutions to plan. The UK's decision to step back from mechanisms like the Global Polio Eradication Initiative (GPEI), despite its success in reducing cases by 99%, signals a retreat from proven, collaborative global public goods (24). This contributes to an unstable environment where institutions are forced to compete for dwindling resources, undermining the very cooperation needed to address global health threats. There is additionally a cascade effect, whereby other donor countries are also reducing their development assistance budgets to follow the US lead.
 - 8.4. **Undermining of core principles:** External aid is founded on principles of collective solidarity. Sudden cuts undermine these core principles, depriving countries of essential resources and adequate time to adjust budgets and explore alternative funding sources. Reallocations within domestic budgets and improved efficiency could help mitigate some of the effects and reduce dependence on development assistance. However, it is unlikely that such change can bridge the dramatic and sudden drop in external funding.
9. **Opportunity for reform:** The crisis, while dire, creates a critical juncture. As highlighted in recent analyses, the current architecture is expensive, duplicative, and politically fragile (25, 26). The vacuum left by the US withdrawal provides an opportunity to fundamentally reform the system for greater equity and efficiency.

10. **Conclusion:** The global health landscape is in a state of emergency. The combined effect of aid cuts is not merely a reduction in services but the collapse of systems that took decades to build. This will lead to millions of preventable deaths, a resurgence of infectious diseases, and a significant increase in global health insecurity. The UK, while facing its own fiscal challenges, must recognise that its reduction in ODA from 0.5% of GNI in 2021 to 0.3% in 2027 and its strategic decisions on funding allocation have real-world consequences. The Government's ongoing commitment must be matched by strategic, impactful, and transparent investments, and a leadership role in shaping a more resilient and equitable global health architecture for the future.

Question 2. How do reductions in Official Development Assistance from the UK and other countries impact healthcare provision across the world, particularly in relation to:

- a. Primary healthcare
- b. Marginalised communities, such as women and girls, people with disabilities, and elderly people
- c. Pandemic preparedness
- d. Conflict-affected states

11. LSHTM's Global Health Economics Centre led the Lancet Global Health Commission on Financing Primary Health Care (PHC) (27). Key points that have emerged from this analysis include the below:
- 11.1. ODA for global health tends to prioritise cost-effective interventions that are typically delivered through PHC infrastructure – so reductions in this area are likely to have significantly affected frontline PHC services.
 - 11.2. About one-third of PHC spending in low-income countries is from external donors and the majority of this funding is for prevention – which implies that prevention is particularly vulnerable to reductions in external funding.
12. Research published in the BMJ shows that reductions in UK aid have demonstrably harmed child health in LMIC countries. Increased child morbidity and mortality are linked to funding cuts impacting vaccination programmes, maternal and child health services and nutritional interventions, exacerbating the health crisis (28).
13. Cuts in HIV programmes have disproportionately targeted programs for key populations which is further marginalising those at most risk of acquiring HIV including sex workers, men who have sex with men, people who inject drugs, transgenders, and prisoners.
14. Investments in surveillance and pandemic preparedness have fallen. The effects are illustrated by the lack of control of the current Ebola epidemic where the majority of deaths are in the community rather than in appropriate clinics and the epidemic is still expanding.

Question 3. What are the links between climate change and global health?

15. The links between climate change and global health are complex and multifaceted. We present here evidence on three particularly important links.
16. **Maternal and newborn health:** Maternal and newborn health (MNH) is increasingly under threat from climate change. Due to a set of physiological, social, behavioural, and clinical factors,

pregnant and postpartum women and their newborns face increased risks (28) from extreme heat and weather events, food and water insecurity, and the expanding reach of infectious diseases.

- 16.1. Physiologically (30), pregnant women can be more at risk of heat-related illness than to non-pregnant women, while newborns whose mothers were exposed to extreme heat during pregnancy are at increased risk of stillbirth, preterm birth, and low birth weight. Women without access to cooling methods, for example those working outdoors or in lower resource settings, are particularly at risk, potentially widening existing inequities.
- 16.2. Extreme weather events (31), including wildfires, hurricanes, and flooding, can force women to give birth in unsafe conditions and increase stress while disrupting access to food, healthcare, and social support. When health services and support structures are disrupted, women are less likely to receive the life-saving care they and their children need.
- 16.3. Infectious diseases (see further information below) like malaria, dengue and Zika viruses are more harmful to pregnant women than non-pregnant women, and can cause life altering birth defects and increased risk of miscarriage and stillbirth.
- 16.4. Rising sea levels, extreme heat, and increased droughts, flooding, and other weather events can additionally reduce access to stable and safe food and water supply. Maternal malnutrition elevates the risk of anaemia, pre-eclampsia, postpartum haemorrhage, and maternal mortality in turn impacting foetal development, resulting in low birth weight, muscular atrophy, stillbirth, and an increased risk of chronic diseases later in life (32). After birth, nutritional deficiencies contribute to inadequate breast milk production, impacting growth, brain development, susceptibility to infections, and mortality. Water scarcity (33) can force pregnant women to walk long distances to collect water, while lack of access to clean water can increase pregnancy-related conditions and exposure to infectious diseases.
17. **Mental health impacts:** A growing evidence base (34) links climate-related hazards to adverse mental health outcomes. The strongest evidence, from a 2024 umbrella review of 32 meta-analyses covering 284 primary studies and 237 exposure-outcome associations (35), shows that short-term rises in temperature increase the risk of suicide, suicidal behaviour, and psychiatric hospital admissions, and that the time elapsed since exposure to tropical cyclones is associated with the severity of post-traumatic stress, with effects strongest in the immediate aftermath.
 - 17.1. The same body of evidence (35) links floods, storms, wildfires and air pollution to depression, anxiety and post-traumatic stress, and points to slower-onset hazards (e.g. drought, sea-level rise, environmental degradation) as sources of chronic psychological distress, particularly for rural, coastal and agricultural communities.
 - 17.2. These impacts are unevenly distributed: children, older people, Indigenous peoples, rural and displaced communities, and people already living with mental illness carry a disproportionate burden, compounded by intersecting gender, social and economic vulnerabilities. Indirect pathways (e.g. displacement, livelihood and food insecurity, and disruption to health systems and medicine supply chains, including heat-related degradation of some psychotropic medications) further extend climate change's reach into population mental health.
 - 17.3. Despite this, mental health remains marginal within global climate and health policy (36), financing and adaptation planning, and rigorously evaluated interventions and economic evidence remain especially scarce in low- and middle-income countries. We recommend that the UK's global health ODA and its approach to global health architecture explicitly recognise mental health as a core, quantifiable consequence of climate change; support its integration into national adaptation plans, Heat-Health Action Plans and disaster preparedness frameworks; and fund implementation research and community-based mental health system strengthening in climate-vulnerable, low-resource settings, where the burden is greatest and capacity most limited.
18. **Mosquito-borne diseases:** Climate change is already changing the global burden and geography of mosquito-borne diseases, a trend that is expected to accelerate, with severe consequences for

health systems and populations in low- and middle-income countries. This is exemplified by dengue, a rapidly expanding mosquito-transmitted disease that is beginning to spread northwards through Europe, the US and China. An estimated 18% of dengue cases are currently attributable to climate change, and an additional 2.25 billion people worldwide could be at risk by 2080 (37, 38).

18.1. Climate change can alter where and when mosquitoes can survive (39) and transmit viruses, as well as the intensity and seasonality of transmission. Research into these relationships helps us understand and project how changes in climate, urbanisation and socioeconomic development will shape future disease risks and, critically, plan interventions to mitigate their impacts. This research has enabled the development of dengue forecasting systems in Vietnam, Malaysia and Sri Lanka (40) that can predict outbreaks with >90% accuracy and inform when and where insecticide spraying is undertaken and hospital resources are deployed, helping to prevent infections and save lives.

18.2. As climate change accelerates the emergence of mosquito-borne diseases, investment in research that enables health systems to anticipate rather than react to outbreaks will become increasingly important. The experience with dengue demonstrates that sustained investment in research can generate practical tools with benefits extending well beyond the initial investment, helping countries make scarce public health resources more effective and reducing both the human and economic costs of disease.

Question 4. What should the future of the global health architecture look like?

- a. How should multilaterals be reformed in the future to more effectively achieve health for all?
- b. What place is there for private finance in a new global health architecture?

19. The current crisis is a catalyst for urgent, fundamental reform. The existing system is fragmented, donor-driven, and unsustainable. The future architecture must be rebuilt on principles of equity, country ownership, and resilience.

20. Multilateral reform must shift power from donors to countries. This means:

20.1. **Country-led partnerships:** Championing the Lusaka Agenda to align all funding behind single national health plans and supporting transitions to self-reliance.

20.2. **Consolidation:** Streamlining the fragmented landscape of initiatives (e.g., Gavi, Global Fund) to reduce duplication and administrative burden.

20.3. **Systems strengthening:** Moving from vertical disease programs to integrated primary healthcare that also addresses non-communicable diseases and pandemic preparedness.

20.4. **Addressing root causes:** Tackling structural inequities like unfair intellectual property rules and unsustainable sovereign debt that cripple health spending.

21. The role of private finance: private finance is risky and often extractive, prioritising investor returns over patient care.

21.1. **Fundamental conflict:** Profit motives are at odds with providing equitable health access. Examples show private finance has diverted billions in interest payments away from health and delayed emergency responses.

21.2. **A just alternative:** The UK should prioritise public financing models, including domestic resource mobilisation, global tax reform, and debt relief for health.

21.3. **Highly conditional role:** If private actors are involved, it must be under strict public governance and transparency to prevent exploitation. The UK should lead by investing more

in public goods like research and surveillance, not by opening the door to harmful privatisation.

Question 5. How effective has the UK's global health Official Development Assistance been in the past?

- a. How has this been measured previously?
- b. How could UK Official Development Assistance be made more effective in the future?

22. The UK has historically been regarded as a leader in global health – in terms of ODA effectiveness and on-the-ground expertise. However, UK ODA is increasingly being spent inside its own borders (26% in 2025) such that the share of ODA actually spent abroad has declined (41). This has concerning implications for the effectiveness of UK ODA to improve global health.
23. Beyond direct impacts on health service provision, reductions in the UK ODA budget have had a deep impact on global health research budgets outside the FCDO budget. ODA funded research has led to significant breakthroughs in global health, saving lives of women, girls and other vulnerable groups. The ODA budget held by the Department of Health and Social Care, which funds global health research through the National Institute for Health and Care Research (NIHR), will be cut by over 50% by 2028/29. As well as direct impacts on people living in LMICs, this decrease also stands to reduce global health research capacity in the UK, weakening national resilience to health security threats.

Question 6. How transparent is the UK's global health Official Development Assistance?

- a. Are there ways in which transparency could be improved?

Appendix: Sources

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