Global tuberculosis report 2026

World Health Organization

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ISBN 978-92-4-012648-0 (electronic version)
ISBN 978-92-4-012649-7 (print version)

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Cataloguing-in-Publication (CIP) data. CIP data are available at https://iris.who.int/.

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Designed by minimum graphics

Cover design by Irwin Law

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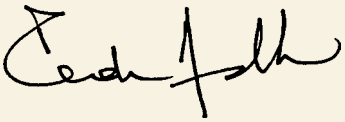
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Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

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The continued decline in TB cases and deaths is very encouraging, especially given the challenges many countries have faced from funding cuts. Many governments have dug deeper into their own budgets to protect the gains they have made. And yet, more than one million people still die each year from a disease that is preventable and treatable. We urge countries and partners to urgently expand access to TB services, protect essential funding and accelerate the development of new tools to end this epidemic.





Dr Tereza Kasaeva
Director
Department for
HIV, Tuberculosis,
Hepatitis and
Sexually Transmitted
Infections

WHO's *Global tuberculosis report 2026* shows that the world has reached an important milestone in the fight against TB. This achievement demonstrates what is possible when commitment is translated into action. But we cannot lose sight of the millions of people who are still not reached with the TB prevention, diagnosis, treatment and care they need. WHO is working with countries to build on this momentum, expanding access to rapid diagnosis and effective treatment and bringing new tools and innovations to the people who need them. Together, we can accelerate progress towards ending TB.



Acknowledgements

The World Health Organization (WHO) gratefully acknowledges the many individuals who contributed to the development of this report.

The report was prepared under the overall coordination and technical guidance of Katherine Floyd and Tereza Kasaeva (Department for HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections, WHO headquarters). The core report team comprised 13 departmental staff: Taghreed Adam, Nimalan Arinaminpathy, Annabel Baddeley, Mathieu Bastard, Josephine Dy, Dennis Falzon, Katherine Floyd, Nebiat Gebreselassie, Avinash Kanchar, Irwin Law, Cecily Miller, Yi Wang and Takuya Yamanaka (consultant). The team was led by Katherine Floyd.

The 2026 round of global tuberculosis (TB) data collection from 215 countries and areas was managed by Mathieu Bastard, Josephine Dy, Irwin Law and Takuya Yamanaka, with overall coordination by Nimalan Arinaminpathy. Data were reviewed by the following staff in the Department for HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections at WHO headquarters: Annabel Baddeley, Mathieu Bastard, Hannah Monica Dias, Dennis Falzon, Medea Gegia, Patricia Hall-Eidson, Tauhidul Islam, Monique Kamphuis, Avinash Kanchar, Mikashmi Kohli (consultant), Alexei Korobitsyn, Marek Lalli, Carl-Michael Nathanson, Linh Nguyen, Gita Parwati, Debora Pedrazzoli, Samuel Schumacher, Sabine Verkuijl, Kerri Viney, Yi Wang and Takuya Yamanaka.

The core report document was developed by Mathieu Bastard, Katherine Floyd, Irwin Law and Takuya Yamanaka, with overall coordination by Katherine Floyd and Irwin Law, and contributions from Taghreed Adam, Nimalan Arinaminpathy, Josephine Dy, Dennis Falzon and Tereza Kasaeva. The main text of the report was written by Katherine Floyd, with contributions from Taghreed Adam, Mathieu Bastard, Dennis Falzon, Tereza Kasaeva, Irwin Law and Takuya Yamanaka. Data analysis, and associated production of all figures and tables, was done by Nimalan Arinaminpathy, Mathieu Bastard, Irwin Law and Takuya Yamanaka. Annex 1 was prepared by Katherine Floyd; Annex 2 by Josephine Dy and Irwin Law; Annex 3 by Katherine Floyd and Irwin Law; Annex 4 by Nimalan Arinaminpathy, Mathieu Bastard and Katherine Floyd; and Annex 5 by Irwin Law.

The report webpages on TB incidence and mortality were prepared by Mathieu Bastard, with contributions from Katherine Floyd and based on estimates of TB disease burden that were produced by Nimalan Arinaminpathy and Mathieu Bastard. The webpage on drug-resistant TB was prepared by Mathieu Bastard. The webpage on national TB prevalence surveys was prepared by Irwin Law. The webpages on TB diagnosis and treatment were prepared by Katherine Floyd and Takuya Yamanaka, with contributions from Patricia Hall-Eidson, Alexei Korobitsyn, Fuad Mirzayev, Carl-Michael Nathanson and Linh Nguyen. The webpage on TB prevention and screening was prepared by Annabel Baddeley, Dennis Falzon, Avinash Kanchar, Irwin Law and Cecily Miller. The webpages on financing for TB prevention, diagnostic and treatment services were prepared by Taghreed Adam and Takuya Yamanaka, with contributions from Katherine Floyd. The webpages on universal health coverage (UHC) and TB determinants were prepared by Mathieu Bastard, with contributions from Katherine Floyd and Takuya Yamanaka. The webpage on national surveys of costs faced by TB-affected households, social protection and human rights was prepared by Takuya Yamanaka, with contributions from Taghreed Adam, Katherine Floyd, Debora Pedrazzoli and Monique Kamphuis. The webpage on multisectoral accountability was prepared by Hannah Monica Dias, Yi Wang and Takuya Yamanaka. The webpage on TB research and innovation was prepared by Nebiat Gebreselassie and Irwin Law, with contributions from Dennis Falzon, Katherine Floyd, Medea Gegia, Patricia Hall-Eidson, Avinash Kanchar, Alexei Korobitsyn, Cecily Miller and Fuad Mirzayev.

The featured topic on the report webpages, about a new method to estimate TB incidence using TB mortality data, was prepared by Nimalan Arinaminpathy and Mathieu Bastard.

The data and other content provided in the report mobile app were prepared by Katherine Floyd, Irwin Law and Takuya Yamanaka.

The web-based country, regional and global profiles were prepared by Mathieu Bastard.

The online technical appendix that explains the methods used to produce estimates of TB disease burden was prepared by Mathieu Bastard, with contributions from Nimalan Arinaminpathy. The online technical appendix that explains the methods used to produce estimates related to TB financing was prepared by Taghreed Adam and Takuya Yamanaka.

Outside the WHO Department for HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections, the report team is grateful to various individuals and external organizations for their contributions to report development.

The following staff in WHO regional offices made substantial contributions to data collection and validation, and the review and clearance of report material by countries prior to publication: Jean Louis Abena Foe and Akudo Ezinne Ikpeazu (WHO Regional Office for Africa); Pedro Avedillo and Ernesto Montoro (WHO Regional Office for the Americas); Giorgi Kuchukhidze and Askar Yedilbayev (WHO Regional Office for Europe); Vineet Bhatia (WHO Regional Office for South-East Asia); Martin van den Boom, Diana Hafez and Santosha Kelamane (WHO Regional Office for the Eastern Mediterranean); and Maria Regina Christian, Kiyohiko Izumi and Fukushi Morishita (WHO Regional Office for the Western Pacific).

At WHO headquarters, Bochen Cao, Jessica Ho and Wahyu Retno (Annet) Mahanani (Department for Data, Analysis, Digital Health and Artificial Intelligence) provided data from the WHO mortality database, country-specific estimates of the UHC service coverage index and very helpful reviews of content related to estimates of TB disease burden and UHC; Gabriela Flores Pentzke Saint-Germain and Hapsatou Toure (Department for Performance, Financing and Delivery) provided very helpful reviews of content related to TB financing and UHC.

Outside WHO, Peter Dodd (University of Sheffield, United Kingdom of Great Britain and Northern Ireland) made key contributions to the production of estimates of TB disease burden disaggregated by age and sex and estimates of the disease burden caused by drug-resistant TB; Andrew Siroka (Data Driven) made a substantial contribution to review of financing data; and Jennifer Woolley (International AIDS Vaccine Initiative, United States of America) provided inputs to report content related to TB research. Peter Dodd, Nicholas Menzies (Harvard University, United States of America) and Finn McQuaid (London School of Hygiene and Tropical Medicine, United Kingdom) provided very helpful inputs to the development of a new method for estimating TB incidence using TB mortality data, in their capacity as members of the WHO Global Task Force on TB Impact Measurement.

Hazim Timimi led the management of TB data at WHO headquarters between 2009 and 2025, including all global rounds of TB data collection that were implemented annually during this period. Prior to his retirement from WHO in February 2026, he also led and managed the work required for the 2026 round of global TB data collection. The report team extends special thanks to him, recognizing his enormous contribution to global TB data collection, management and reporting over many years.

The joint United Nations Programme on HIV/AIDS (UNAIDS) managed the process of data collection from national HIV programmes and provided access to their TB/HIV dataset and HIV-related epidemiological estimates. Review and validation of TB/HIV data were undertaken by WHO staff in collaboration with the Data and Evidence Department of UNAIDS.

The report team is also grateful to EyeSeeTea SL, the company that manages the WHO Integrated Data Platform that was used for the 2026 round of global TB data collection; and to Adappt for their excellent work on the development and maintenance of the report mobile app.

Funding for report production was provided by the government of China. WHO acknowledges this support with gratitude.

In addition to the core report team and those mentioned above, the report benefited from inputs from many staff working in WHO regional and country offices and hundreds of people working for national TB programmes or within national surveillance systems who contributed to the reporting of data and to the review of report material prior to publication. These people are listed below, organized by WHO region.

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Jean Louis Abena Foe, Nicole Anshambi, Lastone Chitembo, Jessica da Veiga Soares, Ndella Diakhate, Ismael Hassen Endris, Fatimetou Zahra Fall-Malick, Louisa Ganda, Akudo Ezinne Ikpeazu, Mugagga Kaggwa, Nzuzi Katondi, Aristide Désiré Komangoya-Nzonzo, Niaboula Kone, Johnson Lyimo, Shepherd Machekera, Casimir Manzengo Mingiedi, Mkhokheli Ngwenya, Amos Omoniyi, Mahamat Djarma Oumaima, Georges Perrin, Mpho Pitso, Kafui Senya, Danièle Simnoue, Eshetu Kebede Tabor.

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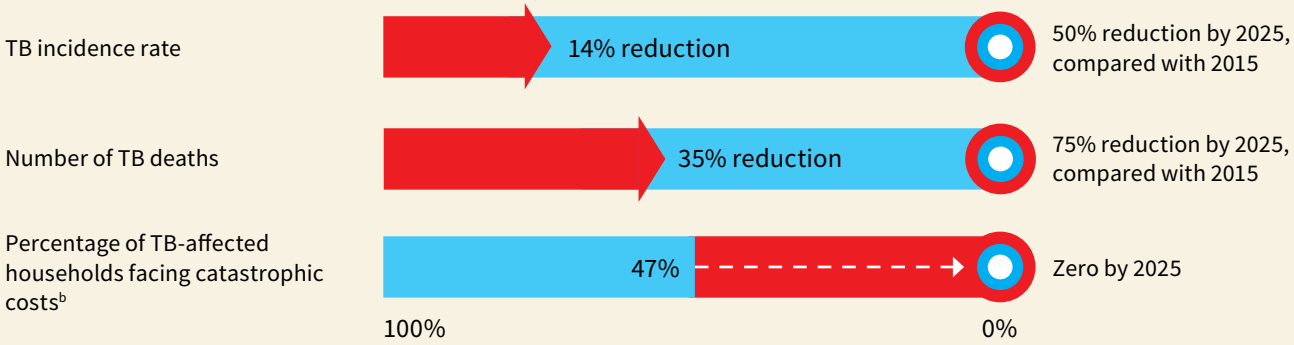
Siti Hafsah Abdul Halim, Shazelin Alipitchay, Renata Amos, Marvin Apas, Zirwatul Adilah Aziz, Nurul Badriyah, Ramon Basilio, Ladong Belari, Matthew Braganza, Luse Buinimasi, Risa Bukbuk, Kwok Chiu Chang, Wei Chen, Kuok Hei Chou, Alice Cuenca, Elwina Danstan, Jérôme Debacre, Ariunbolor Demchig, Dinh Van Luong, Triya Novita Dinihari, Gantsetseg Dorj, Meilina Farikha, Angela Fineanganofo, Gantungalag Ganbaatar, Tatiana Gonzales, Nurul Huda Hj Jeludin, Chan Yuda Huot, Donekham Inthavong, Audrey Jack, Moaraoi Kabiriera, Henry Kako, Seiya Kato, Jieun Kim, Phonesavanh Kommanivanh, Win Mar Kyaw, Thi Hai Minh Le, Shuk Nor Maria Lee, Seungeun Lee, Hyewon Lee, Leo Lim, Liza Lopez, Charisse Malbacias, Kevin Carter Marafi, Benhur Jr Matalavea, Chima Mbakwem, Krisia Misa, Serafi Moa Mulumulu, Suzana Mohd Hashim, Enkhnaran Myagmar, Deborah Ng, Binh Hoa Nguyen, Herolyn Nindil, Chanly Nou, Connie Bieb Olikong, Dk Aishah Pg Hj Muhd Sazali, Bereka Reiher, Eunjeong Shin, Ned Sikua, Phitsada Siphanhthong, Anousone Sisouvanh, Sulistyo Sulistyo, Sakhone Suthepmany, Lai Bun Tai, Joseph Takai, Dharshi Thangarajah, Sivanna Tieng, Marou Tikataake, Vivian Toaniso, Ka In U, Kazuhiro Uchimura, Wareti William, Subhash Yadav, Du Xin, Yan Lin Zhao.

Abbreviations

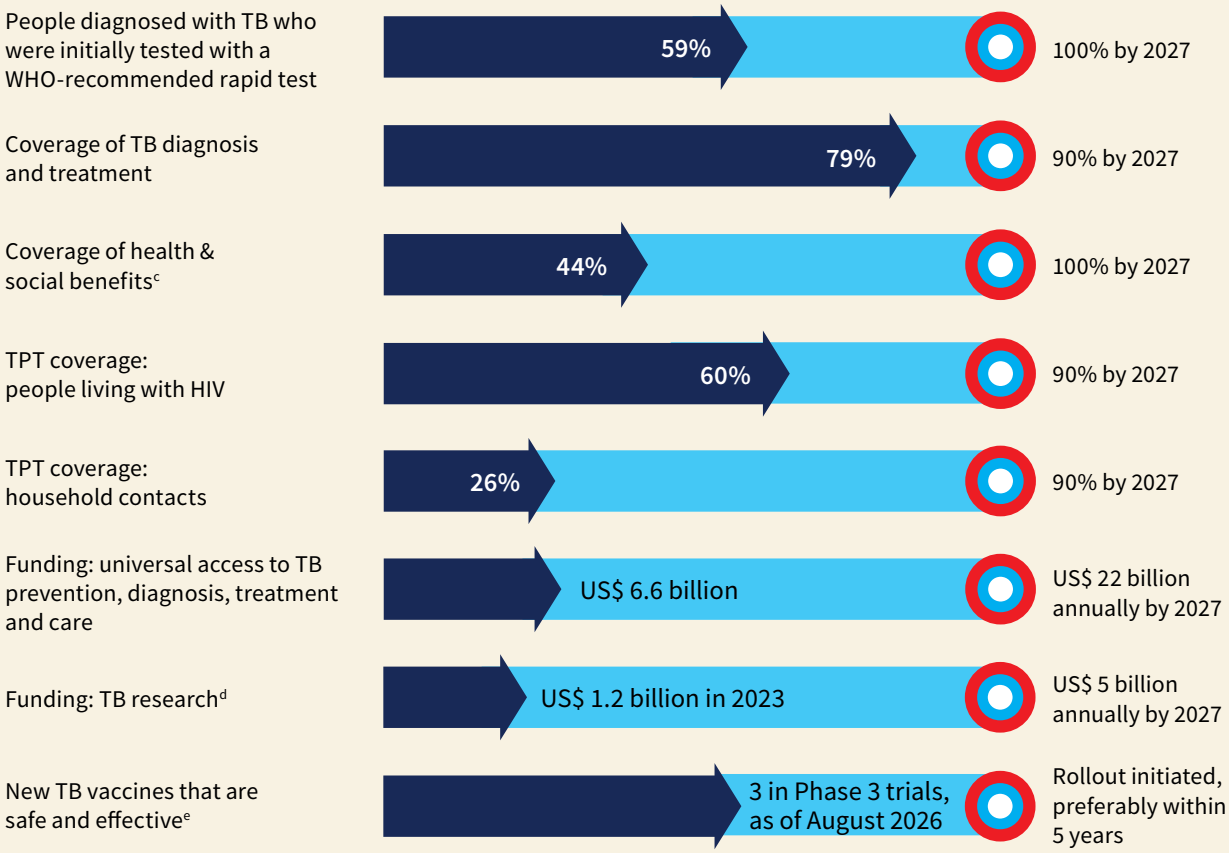
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
BCG	bacille Calmette-Guérin
BRICS	Brazil, the Russian Federation, India, China and South Africa
CSV	comma separated value
CI	confidence interval
COVID-19	coronavirus disease 2019
GDP	gross domestic product
GHO	Global Health Observatory
HBC	high burden country
HIV	human immunodeficiency virus
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organization
LF-LAM	lateral flow urine lipoarabinomannan assay
LMICs	low- and middle-income countries
MAF-TB	multisectoral accountability framework for TB
MDR-TB	multidrug-resistant TB
NTP	national TB programme
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket
PPP	purchasing power parity
PPPR	pandemic preparedness, prevention and response
RR-TB	rifampicin-resistant TB
SCI	service coverage index
SDG	Sustainable Development Goal
SHA	System of Health Accounts
TB	tuberculosis
TPT	tuberculosis preventive treatment
UHC	universal health coverage
UI	uncertainty interval
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNPD	UN Population Division
USG	government of the United States of America
VR	vital registration
WHO	World Health Organization
WRD	WHO-recommended rapid diagnostic test
XDR-TB	extensively drug-resistant TB

Global TB milestones and targets: latest status[a] of progress

End TB Strategy, 2025 milestones



2023 UN high-level meeting on TB, targets



TPT, TB preventive treatment.

[a] This is the end of 2025 for all indicators unless otherwise stated.

[b] This indicator is not the same as the SDG indicator for financial hardship related to out-of-pocket spending on health care.

[c] The value is a percentage of the general population covered by at least one social protection benefit, with the value for each country weighted according to its share of global TB case notifications. The unweighted value is 52%.

[d] Updated data are expected to become available in December 2026.

[e] The length of the arrow represents 3 years (out of five) since the 2023 UN high-level meeting on TB.

1. Introduction

Tuberculosis (TB) is a preventable and usually curable disease. Nonetheless, more than 10 million people continue to fall ill with TB every year and about 1 million die from the disease. It is the leading cause of death from a single infectious agent worldwide and ranks 13th overall *(1, 2)*.[1] Urgent action is required to end the global TB epidemic by 2030, a goal that has been adopted by all Member States of the United Nations (UN) and the World Health Organization (WHO) *(3, 4)*.

TB is caused by the bacillus *Mycobacterium tuberculosis*, which is spread when people who are sick with TB expel bacteria into the air (e.g. by coughing). About a quarter of the global population is estimated to have been infected with TB *(5)*. Following infection, the risk of developing TB disease is highest in the first 2 years (approximately 5%), after which it is much lower *(6)*.[2] Some people will clear the infection *(7, 8)*. Of the total number of people who develop TB disease each year, about 90% are adults, with more cases among men than women. The disease typically affects the lungs (pulmonary TB) but can affect other sites as well.

Basic facts about TB are provided in **Annex 1**.

Without treatment, the death rate from TB disease is high (close to 50%) *(9)*. With the treatments currently recommended by WHO (a course of anti-TB drugs for 4–6 months), about 90% of people with TB disease can be cured. Regimens of 1–6 months are available to treat TB infection. Universal health coverage (UHC), which means that everyone can obtain the health services they need without suffering financial hardship, is necessary to ensure that all people who need treatment for TB disease or infection can access it. The number of people acquiring infection and developing disease (and, in turn, the number of deaths caused by TB) can also be reduced by addressing broader determinants of TB. These include poverty, undernutrition, HIV infection, smoking and diabetes.

More than 40 countries have already reduced their burden of TB disease to fewer than 10 cases and less than one death per 100 000 population per year.[3] Research breakthroughs (e.g. a new vaccine) are needed to rapidly reduce the global number of cases and deaths each year to the levels already achieved in these low-burden countries.

In the past decade, political commitment to ending the TB epidemic has stepped up. The UN held its first-ever high-level meeting on TB in 2018 *(10)* and a second meeting was held 5 years later, in 2023. The political declaration at the 2023 meeting reaffirmed existing commitments and targets set in the UN Sustainable Development Goals (SDGs) and the WHO End TB Strategy *(11)*, and included new ones for the period 2023–2030 *(12)*. A third UN high-level meeting on TB is scheduled for 2028.

WHO has published a global TB report every year since 1997. Its main purpose is to provide a comprehensive and up-to-date assessment of the status of the TB epidemic and progress in the response at global, regional and national levels, in the context of global TB commitments, strategies and targets.

As with previous global TB reports, this 2026 edition is based primarily on data gathered by WHO from national ministries of health in annual rounds of data collection. In 2026, 187 countries and areas (out of 215) with more than 99% of the world's population and TB cases reported data (**Annex 2**), including all high TB burden countries (**Annex 3**). The report also uses data from the WHO mortality database and Global Health Observatory (GHO), as well as databases maintained by other UN agencies and the World Bank.

The report has three components: a short "core" report that focuses on the main findings and messages (this document); webpages that provide more detailed and digitized information, including a large number (>100) of interactive graphics;[4] and an app that contains country, regional and global profiles. This format ensures that all content is readily available in relatively small and digestible "bite-sized" chunks, facilitating access, navigation, reading and use. All data and estimates can be downloaded from WHO's online global TB database *(13)*.

A summary of the report's key findings, numbers, messages and conclusions is provided in **Box 1**.

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[1] The ranking is for 2023.

[2] For people with a long-established infection, empirical data suggest an annual risk of about 10–20 per 100 000 individuals.

[3] There are 29 in the WHO European Region, six in the Region of the Americas, five in the Eastern Mediterranean Region and four in the Western Pacific Region.

[4] There are 16 webpages organized according to six "standard" topics: TB disease burden; TB diagnosis and treatment; TB prevention and screening; TB financing; UHC, TB determinants and multisectoral accountability; and TB research.

BOX 1

A summary of the report's key findings, numbers, messages and conclusions

The global burden of TB disease is declining and a significant milestone for reducing the number of people dying from TB was reached in 2025, albeit 5 years behind schedule. In general, 2025 was a year characterized by stability or small improvements in TB services and epidemic trends, following COVID-related setbacks and subsequent recovery between 2020 and 2024. The main exception was a sizeable reduction in international donor funding.

Globally in 2025, an estimated 10.6 million people (95% uncertainty interval [UI]: 9.8–11.4 million) fell ill with TB (incident cases). This was almost unchanged (−0.7%, or a reduction of 75 000) compared with 2024.

Globally in 2025, the TB incidence rate was 129 new cases per 100 000 population (95% UI: 119–138). This was a 1.6% decline compared with 131 (95% UI: 121–140) in 2024. The reduction compared with 2015 was 14%, far from the End TB Strategy milestone of a 50% reduction by 2025 and the target of an 80% reduction by 2030.

Most of the people who develop TB disease each year are in 30 high TB burden countries: they accounted for 88% of the global total in 2025. The top eight (about two thirds of the worldwide total) were India (about a quarter), Indonesia (10%), the Philippines (6.8%), China (6.5%), Pakistan (6.4%), Nigeria (4.9%), the Democratic Republic of the Congo (3.9%) and Bangladesh (3.7%).

In 2025, 54% of people who developed TB were men, 35% were women and 11% were children.

TB is the leading cause of death from a single infectious agent worldwide and ranks 13th overall.

Globally in 2025, 1.13 million people died from TB (95% UI: 1.05–1.22 million).[a] This was a reduction of 4% from 1.18 million (95% UI: 1.10–1.28 million) in 2024. The reduction compared with 1.74 million deaths (95% UI: 1.58–1.90 million) in 2015 was 35%, making 2025 a landmark year in which the first milestone of the End TB Strategy, originally set for 2020, was finally reached. The target of a 90% reduction by 2030 remains distant.

Progress in reducing the annual number of people dying from TB has been particularly impressive in the WHO African and European regions. Numbers were halved between 2015 and 2025, with reductions of 50% and 51%, respectively. Outside these regions, two high TB burden countries reached the milestone of a 35% reduction in 2025: China and India.

Further reductions in the global burden of TB disease require improvements in the coverage of TB diagnostic, treatment and preventive interventions; multisectoral action on broader determinants that drive new infections or increase the risk of developing disease once infected; and technological breakthroughs, such as a new TB vaccine. All depend on adequate funding.

Funding for TB prevention, diagnosis and treatment in low- and middle-income countries was US$ 6.6 billion in 2025. This was up from US$ 6.0 billion in 2024, but still far below the target of US$ 22 billion per year by 2027. Domestic funding grew from US$ 4.9 billion to US$ 5.63 billion. International donor funding fell by 14%, from US$ 1.1 billion to US$ 0.94 billion.

Among 23 countries particularly exposed to changes in international donor funding since 2025, the total amount of funding for the TB response increased between 2024 and 2025 in 13 of them. In most of the countries that reported reductions, there was no clear-cut impact on TB diagnosis and treatment in 2025; however, some impacts may be delayed and this will need ongoing attention.

Globally, 8.4 million people were reported as newly diagnosed with TB in 2025 – a small increase from 8.3 million in 2024 and 79% (95% UI: 74–86%) of the estimated number of incident cases. Numbers have stabilized since 2023.

Of the 8.4 million people newly diagnosed with TB in 2025, 59% were initially tested with a rapid test, an increase from 54% in 2024 but still well below the target of reaching 100% by 2027.

Worldwide, 155 333 people were treated for rifampicin-resistant[b] TB (RR-TB) in 2025. This was 42% of the 370 000 people (95% UI: 330 000–400 000) who developed RR-TB in 2025, almost the same as in 2024. Treatment with the shortest (6-month) regimens expanded substantially in 2025; they were used for 42% of people treated for RR-TB in 2025, up from 18% in 2024.

Treatment success rates for drug-susceptible TB and RR-TB remain at about 90% and 70%, respectively. From 2000 to 2025, treatment of people with TB is estimated to have averted 86 million deaths.

Globally in 2025, 5.2 million people at high risk of developing TB disease were provided with TB preventive treatment (TPT): 3.7 million household contacts of people diagnosed with TB and 1.5 million people living with HIV. TPT coverage was 60% among people living with HIV (up from 58% in 2024) and 26% among household contacts (up from 25% in 2024).

Costs faced by people with TB and their households are a major barrier to accessing TB diagnosis and treatment; about 50% face costs exceeding 20% of annual household income. Reducing this economic burden requires faster progress towards UHC and better levels of social protection.

In most high TB burden countries, the UHC service coverage index (SCI) is in the range 40–70 (out of 100). About 44% of the global population (weighted for TB disease burden) has access to at least one social protection benefit.

Key drivers of the number of people developing TB disease each year at country level continue to include income per capita and the prevalence of undernutrition, diabetes, alcohol use disorders, smoking and HIV infection.

In August 2026, there were 12 TB vaccines in active clinical development; of these, three were in Phase 3 trials.

Important progress in reducing the global burden of TB disease is being made, although 2030 targets remain distant. The TB response at global, regional and country levels has demonstrated considerable resilience in the face of external shocks. Political commitment and domestic funding are critical to sustain and accelerate progress, especially in countries with the highest burden.

[a] This included 1.0 million among HIV-negative people and 137 000 among people with HIV (officially classified as deaths from HIV/AIDS).

[b] Rifampicin is the most powerful first-line anti-TB drug.

2. Global TB commitments, strategy and targets

In 2014 and 2015, all WHO and UN Member States committed to ending the global TB epidemic, through their adoption of WHO's End TB Strategy (**Box 2**) and the UN SDGs *(3, 4, 11)*. The strategy included milestones (for 2020 and 2025) and targets (for 2030 and 2035) for large reductions in the TB incidence rate (new cases per 100 000 population per year), the absolute number of deaths caused by TB, and costs faced by people with TB and their households.

Key requirements to reach the milestones and targets were defined within the three pillars of the End TB Strategy (**Box 2**). They included provision of TB prevention, diagnostic and treatment services within the context of progress towards UHC and social protection; multi-

BOX 2

The End TB Strategy at a glance

VISION	**A WORLD FREE OF TB — zero deaths, disease and suffering due to TB**			
GOAL	**END THE GLOBAL TB EPIDEMIC**			
INDICATORS	MILESTONES		TARGETS	
	2020	2025	2030	2035
Percentage reduction in the absolute number of TB deaths[a] (compared with 2015 baseline)	35%	75%	90%	95%
Percentage reduction in the TB incidence rate (compared with 2015 baseline)	20%	50%	80%	90%
Percentage of TB-affected households facing catastrophic total costs due to TB (level in 2015 unknown)	0%	0%	0%	0%

PRINCIPLES

1. Government stewardship and accountability, with monitoring and evaluation
2. Strong coalition with civil society organizations and communities
3. Protection and promotion of human rights, ethics and equity
4. Adaptation of the strategy and targets at country level, with global collaboration

PILLARS AND COMPONENTS

1. INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION

A. Early diagnosis of TB including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups
B. Treatment of all people with TB including drug-resistant TB, and patient support
C. Collaborative TB/HIV activities, and management of comorbidities
D. Preventive treatment of persons at high risk, and vaccination against TB

2. BOLD POLICIES AND SUPPORTIVE SYSTEMS

E. Political commitment with adequate resources for TB care and prevention
F. Engagement of communities, civil society organizations, and public and private care providers
G. Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control
H. Social protection, poverty alleviation and actions on other determinants of TB

3. INTENSIFIED RESEARCH AND INNOVATION

I. Discovery, development and rapid uptake of new tools, interventions and strategies
J. Research to optimize implementation and impact, and promote innovations

[a] This indicator is for the combined total of TB deaths in HIV-negative and HIV-positive people. Deaths from TB among people with HIV are officially classified as deaths caused by HIV/AIDS, with TB as a contributory cause.

sectoral action to address broader social and economic determinants of TB that drive new infections or increase the risk of developing disease once infected; and technological breakthroughs, such as a new TB vaccine.

The third target of the End TB Strategy is that no TB-affected households face costs that are catastrophic. This target was set in recognition of the fact that removal of financial and economic barriers to accessing TB diagnosis and treatment is a prerequisite for achieving the milestones and targets for reductions in TB incidence and TB mortality. "Catastrophic" is defined as total costs (direct medical expenditures, direct non-medical expenditures and indirect costs such as income losses) that exceed 20% of annual household income.

Further details about the rationale for the milestones and targets and how they were defined are available elsewhere *(14)*.

Within the SDG monitoring framework (2016–2030), the indicator being used to monitor progress towards ending the global TB epidemic is the TB incidence rate.

A global ministerial conference on TB was held in 2017, the outcome of which was the Moscow Declaration *(15)*. This was followed less than a year later by the first-ever UN high-level meeting on TB, at which commitments to the SDGs and End TB Strategy were reaffirmed and new ones added *(10)*. Global targets for mobilization of funding and provision of treatment were established for the first time, covering the period 2018–2022. Assessment of the extent to which these targets were achieved was part of WHO's *Global tuberculosis report 2023 (16)*.

A second UN high-level meeting was held in 2023. The political declaration *(12)* included new commitments and targets for the period 2023–2030 (**Table 1**, **Table 2**). The targets are for the coverage of rapid diagnostic testing, TB treatment, health and social benefits for people with TB, and TPT; funding for the delivery of TB-related health services and TB research; and the availability of new TB vaccines that are safe and effective. The funding targets were informed by the Stop TB Partnership's *Global Plan to End TB, 2023–2030 (17)*.

At the 79th World Health Assembly in May 2026, Member States requested that WHO initiate the process for developing a post-2030 global TB strategy, for consideration and possible adoption at the 81st World Health Assembly in 2028 *(18)*. This will be followed by a third UN high-level meeting on TB in September 2028.

TABLE 1

Global targets set in 2023 at the second UN high-level meeting on TB

INDICATOR	GLOBAL TARGET
Coverage of rapid diagnostic testing for TB (the annual number of people diagnosed with TB who were initially tested using a WHO-recommended rapid diagnostic test, as a percentage of the number of people diagnosed with TB in the same year)	100% by 2027
Coverage of TB diagnosis and treatment (the annual number of people provided with quality-assured TB diagnosis and treatment, as a percentage of the estimated number of people who developed TB disease in the same year)	90% by 2027 (equivalent to up to 45 million people globally in the 5-year period 2023–2027)
Coverage of health and social benefits package for people with TB	100% by 2027
Coverage of TPT (the annual number of people at high risk of developing TB disease provided with TPT, as a percentage of the estimated number of people eligible for treatment in the same year)	90% by 2027 (equivalent to up to 45 million people globally in the 5-year period 2023–2027: up to 30 million household contacts of people with TB and up to 15 million people living with HIV)
Annual funding for universal access to quality prevention, diagnosis, treatment and care for TB	US$ 22 billion by 2027, US$ 35 billion by 2030
Annual funding for TB research	US$ 5 billion by 2027
Availability of new TB vaccines that are safe and effective	Rollout initiated, preferably within 5 years

TABLE 2

Highlights of commitments and requests at the second UN high-level meeting on TB in 2023

a) Commitments

TOPIC OR THEME	COMMITMENT
Provide comprehensive care to all people with TB	Strengthen the provision of comprehensive care for all people with TB, with particular attention to people who are vulnerable or in vulnerable situations (e.g. people with HIV, people with TB-associated disabilities, older people, migrants, refugees, internally displaced people, and pregnant and lactating women), using specific models of care such as nutritional, mental health and psychosocial support, social protection, rehabilitation and palliative care
	Scale-up comprehensive efforts to close longstanding gaps in the prevention, diagnosis, treatment and care of children
Address the crisis of drug-resistant TB	Work towards the achievement of universal, equitable and affordable access to WHO-recommended diagnostics and drug susceptibility tests, and all-oral shorter-duration treatment regimens for people with drug-resistant TB, complemented by monitoring and management of side-effects, together with care and support to improve treatment outcomes
Build on interlinkages across the global health agendas of TB, UHC and PPPR, to strengthen the TB response	Establish TB services as essential elements of national and global strategies to advance UHC, address antimicrobial resistance and strengthen PPPR
	Integrate systematic screening, prevention, treatment and care of TB, and related health conditions, within primary health care, including community-based health services
	Invest in public health infrastructure and the health workforce
Address TB during health and humanitarian emergencies	Safeguard TB services as essential health services during humanitarian and health emergencies
Strengthen the engagement of civil society and communities affected by TB	Intensify national efforts to create enabling legal and social policy frameworks to combat inequalities, and to eliminate all forms of TB-related stigma, discrimination and other human rights barriers and violations
	Strengthen the meaningful engagement of parliaments, civil society, and TB-affected local communities, including young people and women, in all aspects of the TB response, to ensure equitable and people-centred access to TB services, with increased and sustained investments, especially in community initiatives
Enable and strengthen TB research	Create an enabling environment for TB research and innovation across Member States and partners
	Strengthen research capacity and collaboration through TB research platforms and networks across the public and private sectors, academia and civil society
	Accelerate the research, development and roll-out of safe, effective, affordable and accessible vaccines, preferably within the next 5 years, including through leveraging global collaboration mechanisms and WHO initiatives such as the accelerator council for new TB vaccines
Promote access to affordable medicines	Promote equitable access to affordable, safe, effective and quality medicines, such as generics, vaccines, diagnostics and health technologies, including through the Stop TB Partnership/Global Drug Facility, to ensure availability and access to quality-assured and affordable commodities recommended by WHO
Strengthen multisectoral accountability	Support the WHO multisectoral accountability framework for TB by strengthening high-level multisectoral accountability and review mechanisms, in line with national contexts, defining the roles and responsibilities of relevant sectors and stakeholders with the meaningful engagement of people and communities affected by TB
	Develop and implement ambitious, costed national TB strategic plans or health strategies with a multisectoral approach

b) Requests

TOPIC OR THEME	REQUEST
Role of WHO	WHO is requested to continue providing global leadership to support Member States to build a resilient response to TB as an integral part of the UHC agenda, and to also address the drivers and determinants of the epidemic, including in the context of health and humanitarian emergencies, with multisectoral engagement, the provision of normative guidance and technical support, and through monitoring, reporting and review of progress, and by advancing the TB research and innovation agenda
Report and review progress	The UN Secretary-General, with the support of WHO, is requested to report, as part of his annual SDG report, on the global effort to end TB
	The UN Secretary-General, with the support of WHO, is requested to present a report to the UN General Assembly in 2027, on the progress achieved towards realizing the commitments made in the 2023 political declaration on TB
	Heads of state and government are requested to undertake a comprehensive review of progress at a UN high-level meeting on TB in 2028

HIV: human immunodeficiency virus; PPPR: pandemic preparedness, prevention and response; SDG: Sustainable Development Goal; UHC: universal health coverage; UN: United Nations; WHO: World Health Organization.

3. Main findings and messages

The main findings and messages cover (in order) the following topics:

- estimates of TB disease burden,[1] including the annual number of people falling ill with TB (incident cases) and drug-resistant TB, the annual number of deaths caused by TB, progress towards End TB Strategy milestones and targets for reductions in TB incidence and mortality, and the data required to strengthen estimation of TB disease burden in the years up to 2030;
- TB diagnosis and treatment, including case notifications of people newly diagnosed with TB, diagnostic testing for TB, knowledge of HIV status among people newly diagnosed with TB, the coverage of TB diagnosis and treatment, provision of antiretroviral therapy (ART) to people diagnosed with TB who are living with HIV, and treatment outcomes;
- diagnosis and treatment of people with drug-resistant TB;
- TB prevention and screening, with particular attention to TPT;
- funding for TB services;
- UHC and results from national surveys of costs faced by TB-affected households;
- TB determinants, social protection and multisectoral accountability; and
- TB research, with particular attention to the latest status of the pipelines for new TB diagnostics, drugs and vaccines.

For most of these topics, estimates and data are for the period 2010–2025.

The main new content compared with previous editions of the report is an assessment of changes in the amount of funding for the TB response between 2024 and 2025 in 23 countries that were priorities for bilateral funding from the United States government (USG) in 2024 and that also receive grants from the Global Fund, both overall and by source of funding. This analysis is included given major concerns about how these countries might be affected by changes in the landscape of international donor funding since early 2025 *(19)*.

Since 2016, WHO has defined global lists of high burden countries for TB, HIV-associated TB and drug-resistant TB; each of these lists includes 30 countries. This report refers to and uses the global lists defined for the period 2026–2030 (**Annex 3**), replacing the previous lists for 2021–2025.[2]

Number of people developing TB

Falling slowly globally, regional and country success stories

Globally, an estimated 10.6 million people (95% UI: 9.8–11.4 million) fell ill with TB (incident cases) in 2025. This was a reduction of 0.7% (or 75 000) compared with 2024 (although the rounded total in 2024 was also 10.6 million).[3] This second consecutive year of a small reduction in the estimated number of incident cases confirmed the 2024 reversal of 3 consecutive years of increases (2021–2023) that resulted from COVID-related disruptions to TB diagnosis and treatment (**Fig. 1**).[4],[5] Nonetheless, the total in 2025 remained above the level of 10.3 million (95% UI: 9.6–11.1 million) in 2020.

There was a larger decline (of 1.6%) in the global TB incidence rate (new cases per 100 000 population per year)[6] between 2024 and 2025 (**Fig. 1**, right panel), from 131 per 100 000 population (95% UI: 121–140) to 129 per 100 000 population (95% UI: 119–138), below the level of 2020. The net reduction in the TB incidence rate from 2015 to 2025 was 14% – far from the End TB Strategy milestone of a 50% reduction by 2025 (**Fig. 1**, right panel) and an 80% reduction by 2030.

At regional level, recent trends in TB incidence rates vary (**Fig. 2**). In the WHO Western Pacific Region, the TB

[1] Updates to methods used to produce estimates of TB disease burden for this report are summarized in **Annex 4**.

[2] Global watchlists, consisting of countries that were in the lists for 2021–2025 but are not included in the lists for 2026–2030, have also been defined (**Annex 3**).

[3] The best estimates of the total were 10.56 million in 2025 and 10.63 million in 2024.

[4] Country-specific models have been used to produce estimates of TB incidence and mortality during the period 2020–2025 for a subset of countries that experienced considerable disruptions to TB diagnosis and treatment in 2020 or 2021 (defined as TB case notifications that fell by 10% or more in either 2020 or 2021). Reductions in notifications were assumed to reflect reductions in access to diagnosis and treatment (and some level of underreporting), causing an increase in the number of people with undiagnosed TB and, in turn, both an increase in the number of deaths from TB and increased transmission of infection. With a lag time, increases in transmission result in an increase in the number of people developing TB disease (i.e. TB incidence). Further details are provided elsewhere *(16, 20, 21)*.

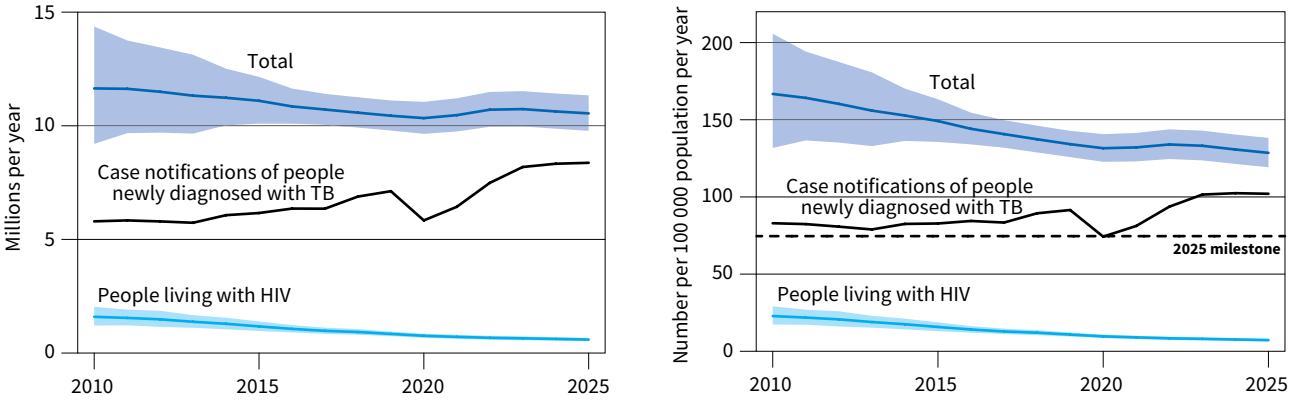
[5] The major contributors to the global increase between 2020 and 2023 were (in order of the absolute size of their contribution) Indonesia, the Philippines and Myanmar.

[6] The report uses the latest population estimates published by the UN Population Division (**Annex 2**).

FIG. 1

Global trends in the estimated number of incident TB cases (left) and the incidence rate (right), 2010–2025

The horizontal dashed line shows the 2025 milestone of the End TB Strategy, which was a 50% reduction in the TB incidence rate between 2015 and 2025. Shaded areas represent 95% uncertainty intervals.



incidence rate has been declining since 2024, following an upward trend in 2020–2023. In two other WHO regions, the Eastern Mediterranean Region and the South-East Asia Region, the TB incidence rate decreased for a third consecutive year in 2025, continuing to reinforce the 2023 reversal of the 2020–2022 COVID-related upward trend. In the WHO European Region, the TB incidence rate has been falling since 2021. In the WHO African Region, the decline in the TB incidence rate that has been sustained for many years continued in 2025.[1] The most concerning trend was in the WHO Region of the Americas, where the incidence rate increased for the fifth consecutive year in 2025, reflecting the continued impact of shortfalls in TB case detection in 2020, 2021 and 2022.

Regional progress in reducing the TB incidence rate since 2015 varies considerably (**Fig. 2**). Two WHO regions have made substantial progress: the European Region, with a net reduction of 42% by 2025; and the African Region, with a reduction of 30%. These are the only two WHO regions that have surpassed the first milestone of the End TB Strategy (a 20% reduction), and the European Region is approaching the second milestone (a 50% reduction). There were much smaller net declines in two other WHO regions: the South-East Asia Region (18%) and the Eastern Mediterranean Region (6.6%). In the two other WHO regions, there was no net change in the Western Pacific Region and an increase of 13% in the Region of the Americas.

Geographically, most people who developed TB in 2025 were in the WHO South-East Asia Region (35%), the Western Pacific Region (27%) and the African Region (25%), with smaller proportions in the Eastern Mediterranean Region (8.7%), the Region of the Americas (3.4%) and the European Region (1.7%).[2] The 30 high TB burden countries[3] accounted for 88% of all estimated incident cases worldwide, with eight of these countries (**Fig. 3**, **Fig. 4**) accounting for about two thirds of the global total: India (about a quarter),[4] Indonesia (10%), the Philippines (6.8%), China (6.5%), Pakistan (6.4%), Nigeria (4.9%), the Democratic Republic of the Congo (3.9%) and Bangladesh (3.7%). The top five countries accounted for more than 50% of the global total.

TB can affect anyone, regardless of age or sex (**Fig. 5**). The highest incidence is in adult men (aged ≥15 years[5]), with an estimated 5.7 million cases (95% UI: 4.1–7.3 million) in 2025, equivalent to 54% of the estimated total. There were an estimated 3.7 million cases (95% UI: 2.6–4.7 million) among adult women (aged ≥15 years), equivalent to 35% of the estimated total; and 1.2 million cases (95% UI: 0.86–1.5 million) among children and young adolescents (aged <15 years), equivalent to 11% of the estimated total. The higher share of TB cases among men is consistent with evidence from national TB prevalence surveys, which show that the burden of TB disease is higher among men than women *(22)*.

Among all incident cases of TB in 2025, 5.6% were people living with HIV, a decrease from 5.8% in 2024. This proportion has been steadily declining for many years, following a peak at 17% in 2000. The proportion of people with a new episode of TB (incident cases) who were living with HIV was highest in countries in the WHO African Region, exceeding 50% in parts of southern Africa.

[1] In terms of TB case notifications, disruptions to TB diagnosis and treatment during the COVID-19 pandemic were negligible in the WHO African Region.

[2] Regional percentages do not sum to 100 because of rounding.

[3] See **Annex 3**.

[4] Estimates of TB incidence in India are under review (**Annex 4**).

[5] The age groups for which WHO collects TB case notification data and produces estimates of disease burden are 0–4, 5–14, 15–24, 25–34, 35–44, 45–54, 55–64 and ≥65 years.

FIG. 2

Trends in estimated TB incidence rates by WHO region, 2010–2025

The overall TB incidence rate is shown in **blue** and the incidence rate among people living with HIV is shown in **light blue**. The black solid lines show case notifications of people newly diagnosed with TB, for comparison with estimates of the overall incidence rate. Shaded areas represent 95% uncertainty intervals. The horizontal dashed line shows the 2025 milestone of the End TB Strategy, which was a 50% reduction in the TB incidence rate between 2015 and 2025.

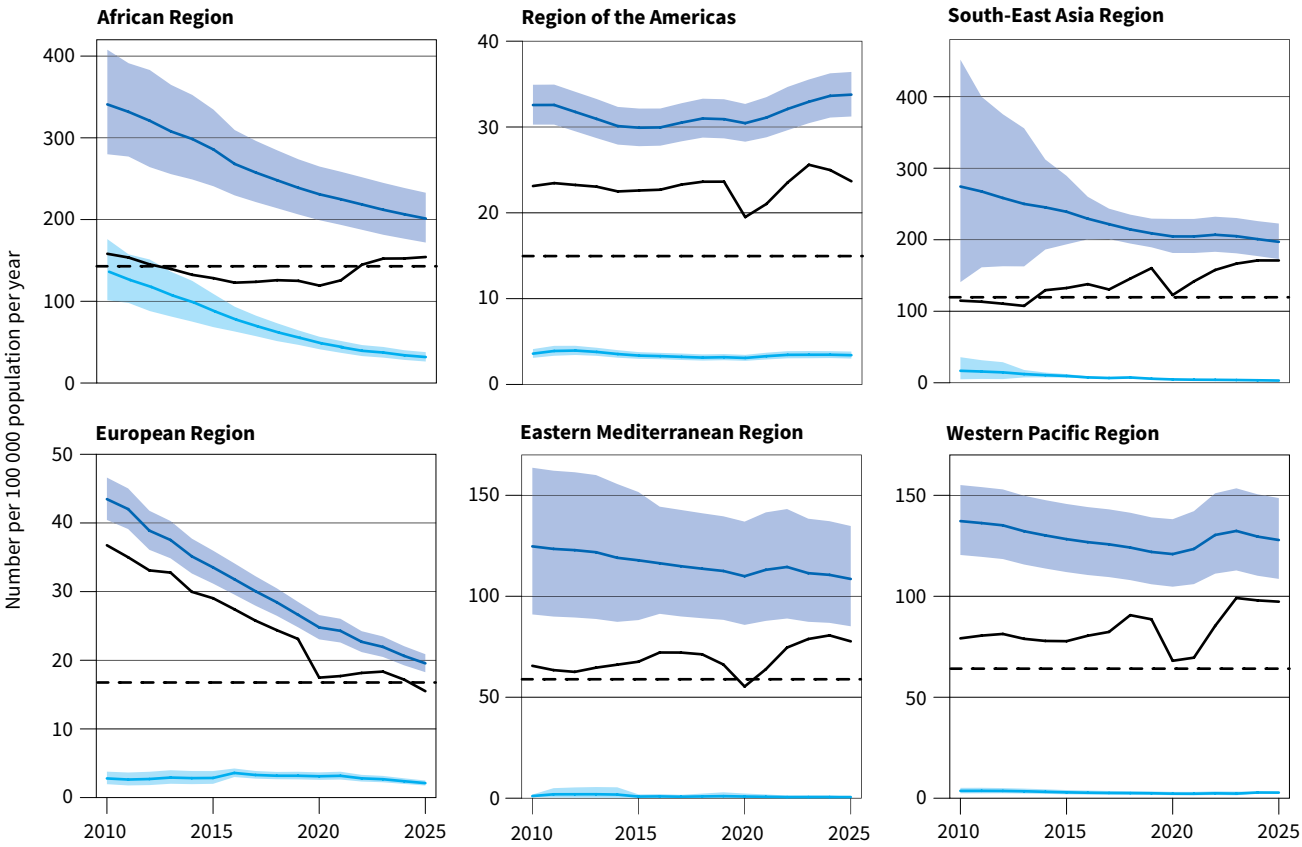


FIG. 3

Estimated number of incident TB cases for countries with at least 100 000 incident cases, 2025

The labels show the eight countries that accounted for about two thirds of the global number of people estimated to have developed TB in 2025.

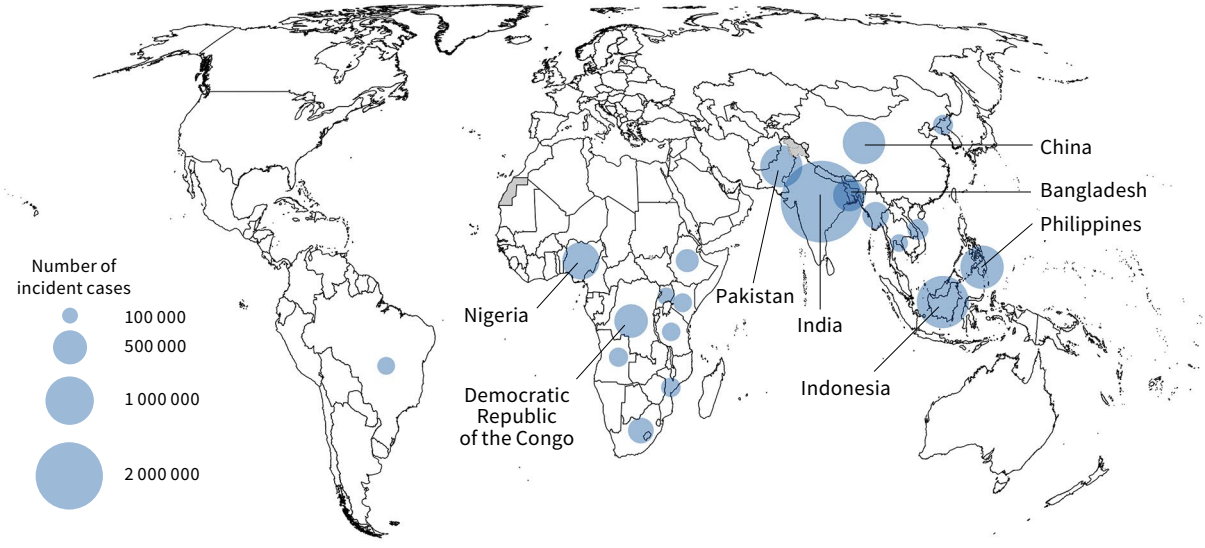


FIG. 4

Geographic distribution of the estimated global number of incident TB cases in 2025

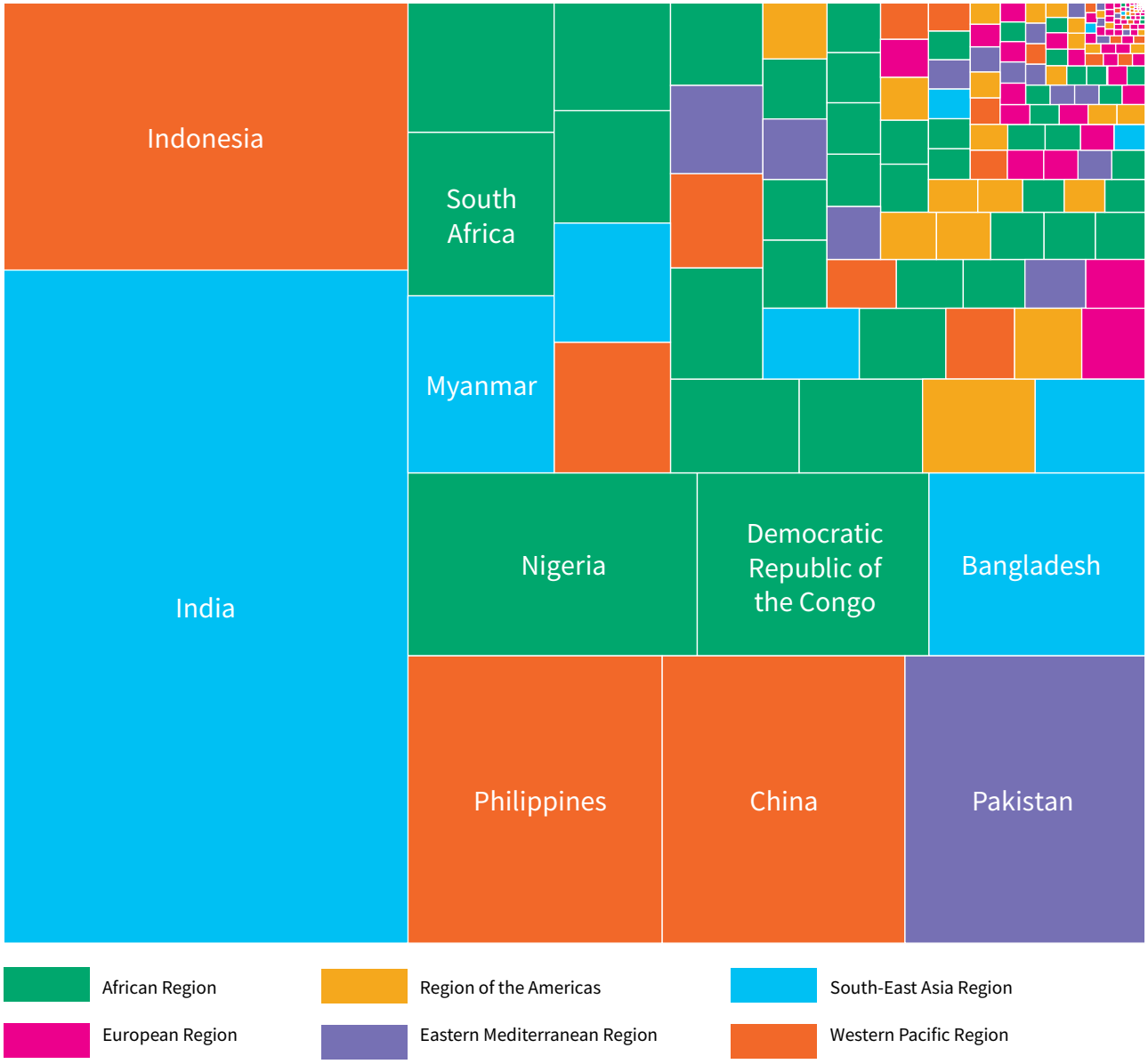


FIG. 5

Global estimates of TB incidence (absolute numbers) disaggregated by age group and sex (female in **purple**; male in **orange**), 2025

Dots and error bars show best estimates and 95% uncertainty intervals, respectively.

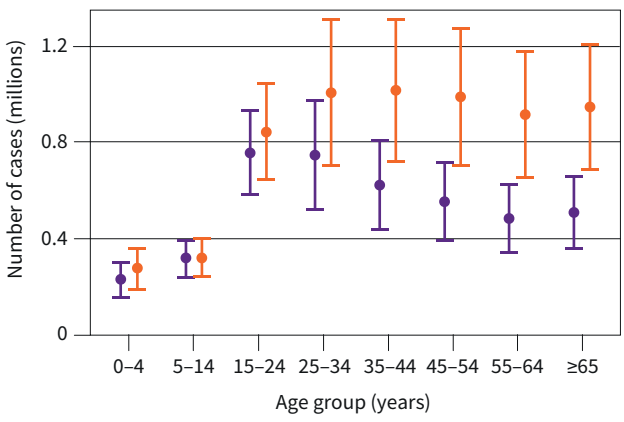


FIG. 6

Estimated TB incidence rates at country level, 2025

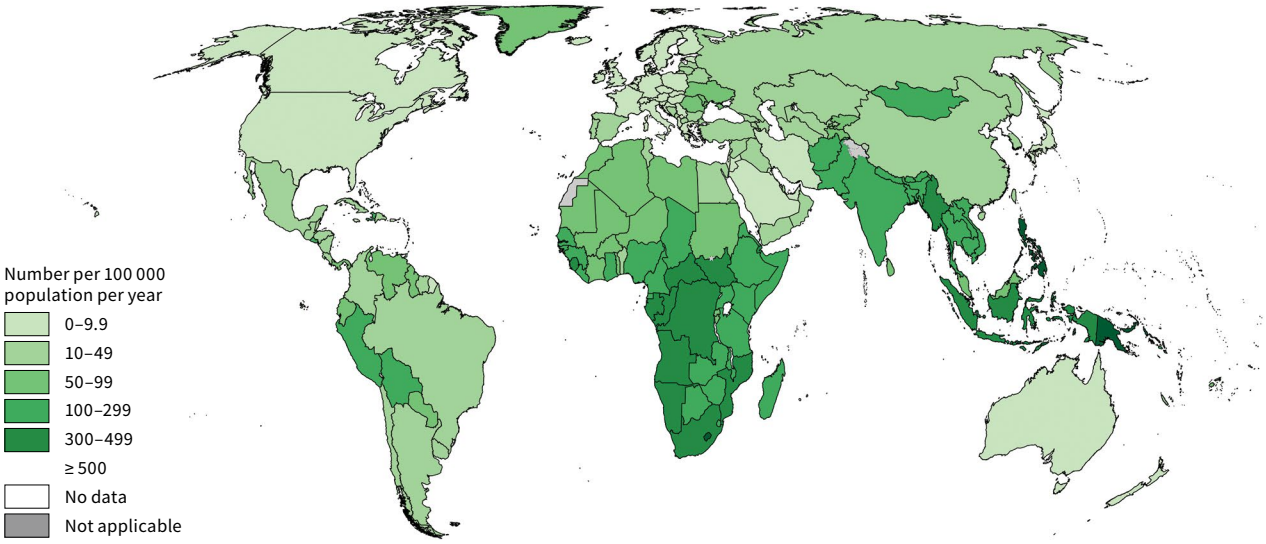
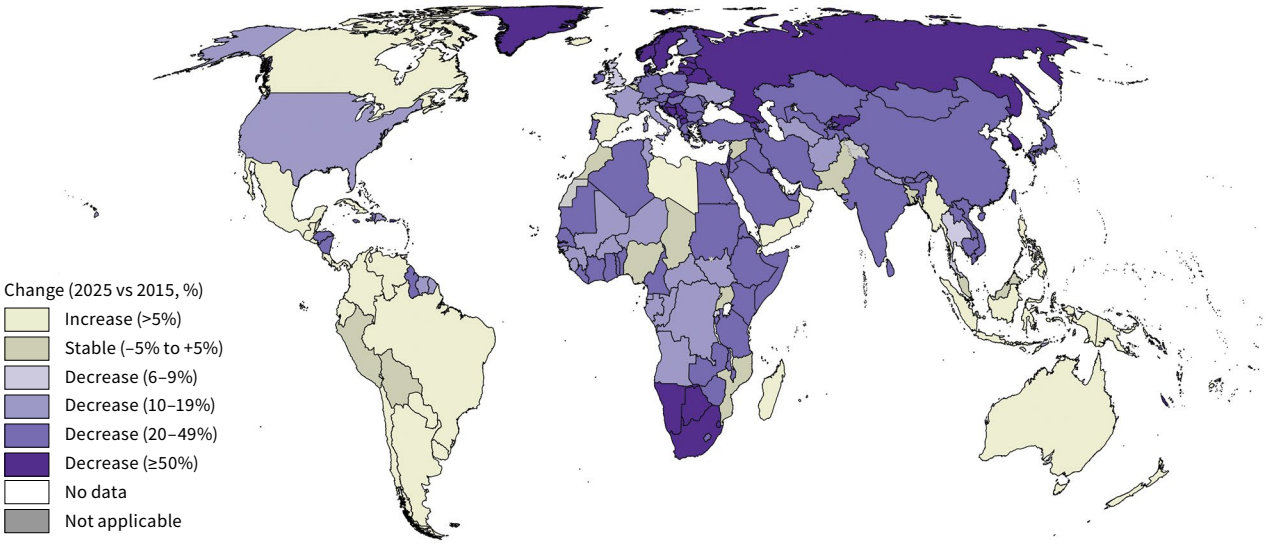


FIG. 7

Change (%) in the estimated TB incidence rate (new cases per 100 000 population per year) at country level, 2025 compared with 2015

The first milestone of the End TB Strategy was a 20% reduction by 2020, compared with 2015; the second milestone was a 50% reduction by 2025, compared with 2015. The last two categories (decrease 20–49%, and decrease ≥50%) distinguish the countries that have made the most progress towards the second milestone of the End TB Strategy.



The severity of national TB epidemics – in terms of the number of incident (new) TB cases per 100 000 population per year – varies widely among countries, from less than 10 to more than 500 (**Fig. 6**). In 2025, 50 countries had a low incidence of TB (<10 new cases per 100 000 population per year). Most of these countries were in the WHO Region of the Americas and the European Region, with the remainder in the Eastern Mediterranean and Western Pacific regions. The highest rates were mainly found in countries in the WHO African Region, where 11 countries had a rate of more than 300. Most of the 30 high TB burden countries had a rate of 150–400, but three had a rate of more than 500: Lesotho, Papua New Guinea and the Philippines.

Progress in reducing the TB incidence rate at country level is highly variable (**Fig. 7**). By 2025, a total of 99 countries, including 63 in the WHO African and European regions, had achieved estimated reductions of at least 20% since 2015 – reaching or surpassing the first (2020) milestone of the End TB Strategy, albeit with a delay of up to 5 years (**Table 3a**).[1] A total of 28 countries are estimated to have achieved reductions of at least 50% between 2015 and 2025, reaching or surpassing the 2025 milestone of the End TB Strategy (**Table 3b**). At the other extreme, there are 43 countries where the TB incidence rate in 2025 was estimated to be more than 5.0% higher than in 2015. Many of these countries are in the WHO Region of the Americas, but they also include three high TB burden countries in Asia: Indonesia, Myanmar and the Philippines.

In the 11-year period 2015–2025, 58 countries moved between the incidence rate categories shown in **Fig. 6**; of these, 48 progressed to a lower category and 10 moved to a higher category.[2]

Number of people developing drug-resistant TB

Slow year-on-year decline since 2015

Drug-resistant TB continues to be a public health threat. Resistance to rifampicin – the most effective first-line anti-TB drug – is of greatest concern.

Rifampicin-resistant TB (RR-TB) is included in WHO's Bacterial Priority Pathogens List, where it sits within the "critical group" category *(23)*.[3]

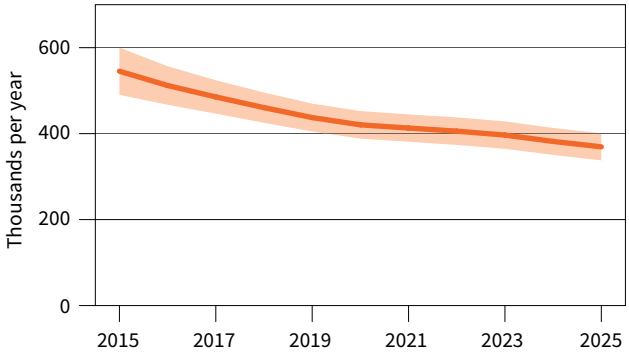
Globally, the estimated annual number of people who developed RR-TB has been declining slowly since 2015 (**Fig. 8**). The estimated number in 2025 was 370 000 (95% UI: 330 000–400 000).

In 2025, the estimated proportion of people with a first episode of TB (new cases) who had RR-TB was 3.1% (95% UI: 2.5–3.6%), a decrease from 3.2% (95% UI: 2.6–3.7%) in 2024 and 4.4% (95% UI: 3.5–5.3%) in 2015 (**Fig. 9**). The estimated proportion among people with a previous history of TB treatment was much higher, at 14.8% (95% UI: 11–19%) in 2025 (**Fig. 9**).[4] This was a reduction from 15.3% (95% UI: 11–20%) in 2024 and 20% (95% UI: 14–26%) in 2015.

FIG. 8

Global trend in the estimated number of people who developed RR-TB (incident cases), 2015–2025

The shaded area represents the 95% uncertainty interval.



Four countries accounted for more than half of the global number of people estimated to have developed RR-TB in 2025: China, India, the Philippines and the Russian Federation (**Fig. 10**). The highest proportions of people with TB who had RR-TB (>50% of previously treated cases in 2025) were found in Eastern Europe and Central Asia.[5]

Number of deaths caused by TB

Significant global milestone reached in 2025

Halved in the WHO African and European regions

Globally in 2025, TB caused an estimated 1.13 million deaths (95% UI: 1.05–1.22 million), including 1.0 million among HIV-negative people (95% UI: 0.92–1.08 million) and 137 000 among people with HIV (95% UI: 109 000–168 000).[6] This total was a reduction from 1.18 million (95% UI: 1.10–1.28 million) in 2024 and 1.74 million (95% UI: 1.58–1.90 million) in 2015 (**Fig. 11**).

Following increases in the global number of deaths caused by TB that occurred in 2020 and 2021 during the worst period of COVID-related disruptions to TB diagnosis and treatment, 2025 was the fourth consecutive year in which the global number of people dying from

[1] The analysis here is restricted to countries (excluding "areas").
[2] Further details are provided in **Annex 3** (see **Table A3.3**).
[3] The list includes 15 pathogens. Four are in the "critical group", seven in the "high group" and four in the "medium group".
[4] The best estimate here and in the next sentence is provided to one decimal place, to show the small reduction between 2024 and 2025. Elsewhere in the report, decimal places are not used for percentages of 10 or above.
[5] Further details are provided in the report webpages (section 1.3).
[6] Deaths from TB among people with HIV are officially classified as deaths from HIV/AIDS. Therefore, a clear distinction between deaths among HIV-negative people and those among people with HIV is made in **Fig. 11**, **Fig. 12** and **Fig. 13**.

TABLE 3A

Countries that have reached the first (2020) End TB Strategy milestones for reductions in TB incidence and mortality, by WHO region

The first milestones were a 20% reduction in the TB incidence rate and a 35% reduction in the number of TB deaths, compared with levels in 2015 (**Box 2**). The year in which the milestone was reached is shown.

COUNTRY	INCIDENCE	MORTALITY
AFRICAN REGION		
Total number of countries	**26**	**28**
Algeria	2020	
Benin	2020	2022
Botswana	2017	2017
Burkina Faso		2024
Burundi	2021	2023
Cabo Verde	2018	
Cameroon	2019	2022
Central African Republic[a]		2022
Comoros	2021	
Congo[a]		2025
Côte d'Ivoire	2019	2021
Democratic Republic of the Congo[a]		2022
Equatorial Guinea		2022
Eritrea	2019	
Eswatini	2017	2018
Ethiopia[a]	2020	2024
Gambia	2024	
Ghana	2024	
Kenya[a]	2018	2018
Lesotho[a]	2020	2024
Liberia[a]	2021	2021
Malawi	2018	2019
Mauritania	2019	2021
Mozambique[a]		2017
Namibia[a]	2019	2022
Nigeria[a]		2022
Rwanda		2023
Sao Tome and Principe	2017	2019
Senegal	2023	
Sierra Leone[a]		2023
South Africa[a]	2017	
South Sudan[a]		2019
Togo	2021	2022
United Republic of Tanzania[a]	2019	2019
Zambia[a]	2022	2021
Zimbabwe	2020	2025
REGION OF THE AMERICAS		
Total number of countries	**11**	**5**
Antigua and Barbuda[b]	2017	2021
Bahamas	2018	
Dominica[b]	2016	2017
Grenada[b]	2017	
Guyana	2019	
Haiti	2020	2025
Honduras	2019	
Jamaica	2019	2017
Nicaragua	2023	
Saint Kitts and Nevis[b]	2016	
Saint Lucia[b]	2016	2016
EASTERN MEDITERRANEAN REGION		
Total number of countries	**10**	**6**
Bahrain	2024	
Egypt	2023	2019
Iran (Islamic Republic of)	2019	2023
Iraq	2019	2025
Jordan	2022	2019
Kuwait	2022	
Saudi Arabia	2020	2021
Somalia	2025	
Sudan	2019	2025
United Arab Emirates	2024	

COUNTRY	INCIDENCE	MORTALITY
EUROPEAN REGION		
Total number of countries	**37**	**38**
Albania	2023	2023
Andorra[b]	2017	
Armenia	2017	2017
Austria	2020	2016
Azerbaijan	2020	2024
Belarus	2017	2018
Belgium		2016
Bosnia and Herzegovina	2017	2017
Bulgaria	2019	2020
Croatia	2017	2020
Czechia		2019
Denmark	2017	2018
Estonia	2018	2018
Finland	2020	2020
France		2022
Georgia	2018	2020
Germany	2020	
Greece	2025	2024
Hungary	2017	2016
Ireland	2019	2019
Israel	2017	2021
Kazakhstan	2020	2022
Kyrgyzstan	2020	2021
Latvia	2017	2018
Lithuania	2018	2018
Malta		2017
Montenegro	2022	2021
Netherlands (Kingdom of the)		2019
North Macedonia	2017	2017
Norway	2018	2022
Poland	2019	
Portugal	2020	2025
Republic of Moldova	2020	2024
Romania	2019	2025
Russian Federation	2019	2019
Serbia	2018	2019
Slovakia	2017	
Slovenia	2018	2016
Sweden	2017	2020
Tajikistan	2019	
Türkiye	2020	2020
United Kingdom of Great Britain and Northern Ireland		2021
Uzbekistan	2022	2018
SOUTH-EAST ASIA REGION		
Total number of countries	**4**	**4**
Bangladesh[a]		2021
Bhutan	2021	2025
India[a]	2024	2025
Maldives	2021	
Sri Lanka	2022	
Timor-Leste		2022
WESTERN PACIFIC REGION		
Total number of countries	**11**	**8**
Cambodia[a]	2025	
China[a]	2024	2025
Japan	2019	
Lao People's Democratic Republic	2022	2019
Mongolia[a]	2022	
New Zealand		2016
Republic of Korea	2019	2020
Samoa[b]	2016	
Singapore		2019
Solomon Islands	2019	
Tonga[b]	2016	2016
Vanuatu	2019	2022
Viet Nam[a]	2023	2023

[a] Countries in WHO's list of 30 high TB burden countries, and two global TB watchlist countries (**Annex 3**).

[b] The estimated annual number of incident cases is less than 20; small reductions in absolute numbers can lead to large relative reductions in a short time period.

TABLE 3B

Countries that have reached the second (2025) End TB Strategy milestones for reductions in TB incidence and mortality, by WHO region

The second milestones were a 50% reduction in the TB incidence rate and a 75% reduction in the number of TB deaths, compared with levels in 2015. The year in which the milestone was reached is shown.

COUNTRY	INCIDENCE	MORTALITY
AFRICAN REGION		
Total number of countries	**5**	**2**
Botswana	2021	2025
Cabo Verde	2022	
Eswatini	2022	2025
Namibia[a]	2025	
South Africa[a]	2022	
REGION OF THE AMERICAS		
Total number of countries	**2**	**3**
Antigua and Barbuda[b]	2017	2022
Jamaica		2024
Saint Lucia[b]	2016	2022
EASTERN MEDITERRANEAN REGION		
Total number of countries	**1**	**2**
Egypt		2025
Jordan		2023
Kuwait	2022	
EUROPEAN REGION		
Total number of countries	**18**	**4**
Andorra[b]	2017	
Armenia	2020	
Belarus	2022	2025
Bosnia and Herzegovina	2020	
Croatia	2020	
Denmark	2024	

COUNTRY	INCIDENCE	MORTALITY
EUROPEAN REGION		
Total number of countries	**18**	**4**
Estonia	2023	2025
Georgia	2022	
Israel	2025	
Kyrgyzstan	2024	
Latvia	2020	
Lithuania	2023	
North Macedonia	2025	
Norway	2020	
Russian Federation	2025	
Serbia	2024	
Slovakia	2024	
Slovenia		2023
Sweden	2020	
Uzbekistan		2025
WESTERN PACIFIC REGION		
Total number of countries	**2**	**0**
Republic of Korea	2023	
Tonga[b]	2022	

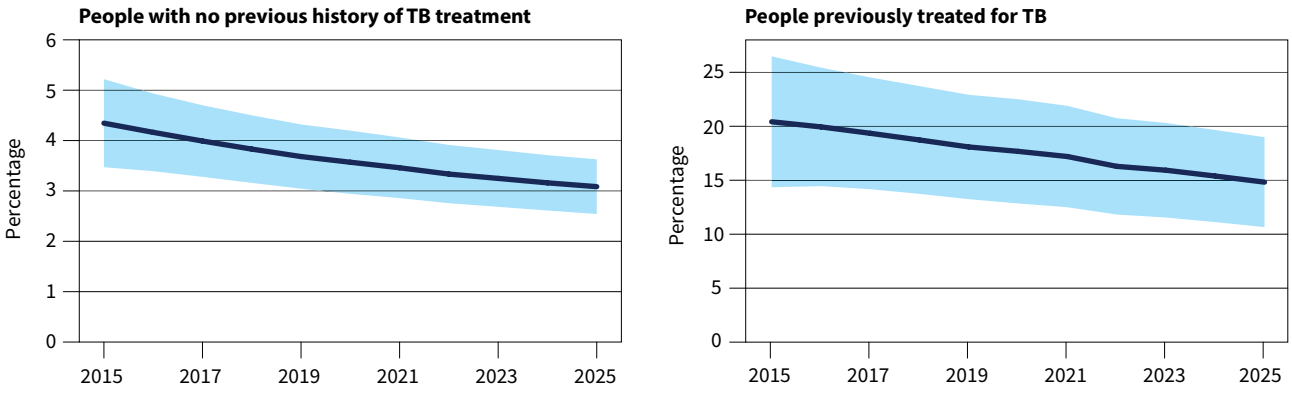
[a] Countries in WHO's list of 30 high TB burden countries, and two global TB watchlist countries (**Annex 3**).

[b] The estimated annual number of incident cases is less than 20; small reductions in absolute numbers can lead to large relative reductions in a short time period.

FIG. 9

Global trend in the estimated percentage of people with TB who had RR-TB, 2015–2025

The shaded area represents the 95% uncertainty interval.



TB declined, resuming the pre-COVID trend (**Fig. 11**).[1]

This further progress resulted in the achievement of a significant global milestone in 2025: a reduction of 35% in the annual number of people dying from TB between 2015 and 2025 – reaching the first (2020) milestone of the End TB Strategy (**Box 2**), albeit 5 years behind schedule.[2] The reduction of 35% is approaching halfway to the second milestone of a 75% reduction, originally set for 2025 (**Fig. 11**, left panel). The target of a 90% reduction by 2030 (**Box 2**) remains distant.

Globally, the case fatality rate in 2025 was 11%.[3]

[1] People with TB who remain undiagnosed and untreated have a higher risk of death than those started on treatment. The impact of disruptions to TB diagnosis and treatment is more immediate for TB mortality and more delayed for TB incidence. Similarly, the impact of recoveries in access to TB diagnosis and treatment is more immediate for TB mortality and more delayed for TB incidence.

[2] The reduction compared with 2010, when there were an estimated 2.09 million deaths (95% UI: 1.87–2.32 million), was 46%.

[3] This is approximated as the number of deaths in 2025 divided by the number of incident cases in 2025.

FIG. 10

Estimated number of people who developed RR-TB (incident cases) for countries with at least 1000 incident cases, 2025

The labels show the four countries that accounted for more than half of the global number of people estimated to have developed RR-TB in 2025.

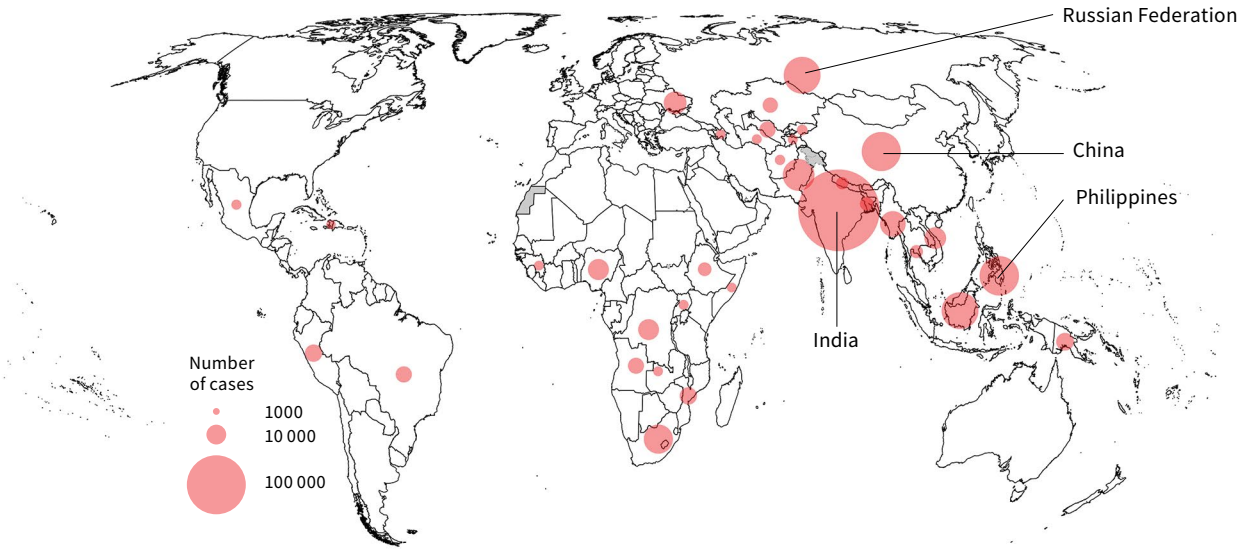
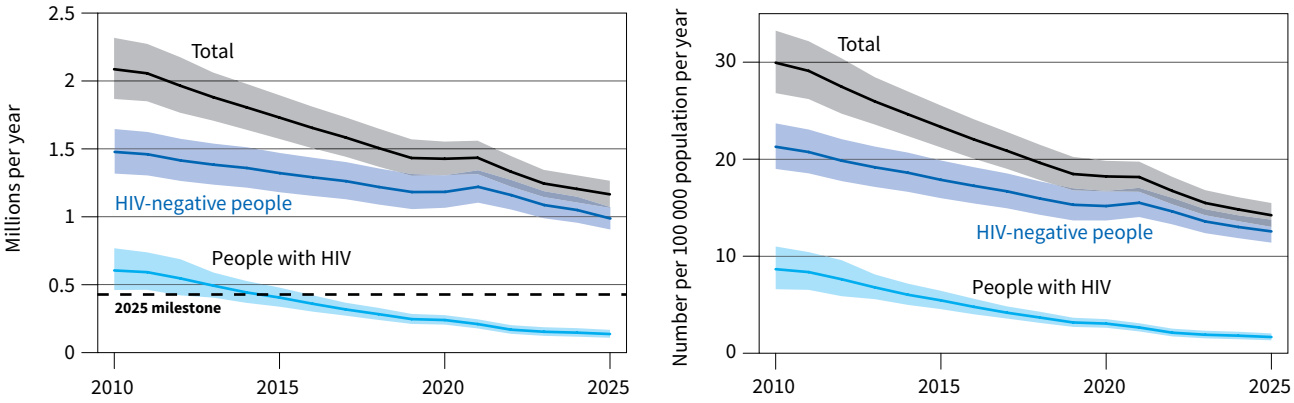


FIG. 11

Global trends in the estimated number of deaths caused by TB (left) and the TB mortality rate (right),[a] 2010–2025

The horizontal dashed line shows the 2025 milestone of the End TB Strategy, which was a 75% reduction in the total number of TB deaths between 2015 and 2025. Shaded areas represent 95% uncertainty intervals.



[a] Deaths from TB among people with HIV are officially classified as deaths caused by HIV/AIDS in the International Classification of Diseases, with TB as a contributory cause.

Global trends in the number of deaths caused by TB differ markedly by HIV status (**Fig. 11**, **Fig. 12**). Deaths from TB among HIV-negative people have driven the overall trend, with year-on-year reductions up to 2019 followed by increases in 2020 and 2021,[1] and then declines from 2022 to 2025. The net reduction between 2015 and 2025 was 25%. Deaths from TB among people with HIV have been declining for many years and by 2025 had fallen by 66% compared with 2015.[2]

The latest year for which WHO has published estimates of global deaths by cause is 2023 (**Fig. 13**). In that year, TB was the leading cause of death from a single infectious agent worldwide and ranked 13th overall. TB was among the top 10 causes of death in the WHO African and South-East Asia regions (ranking 8th and 7th, respectively).

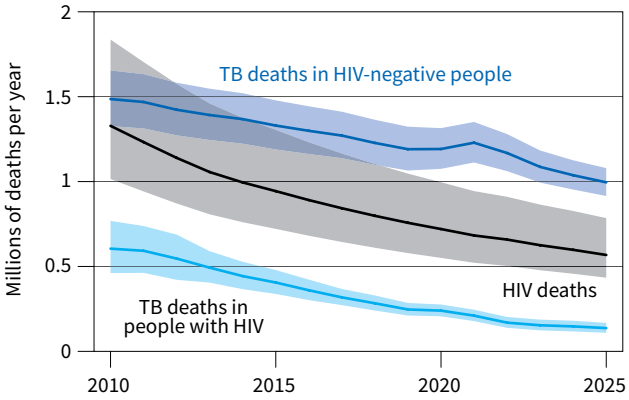
The global number of deaths officially classified as caused by TB in 2025 was considerably more than the 570 000 (95% UI: 430 000–780 000) caused by HIV/AIDS *(24)*.[3] Each year, TB also causes approximately twice as many deaths as malaria *(2, 25)*.

In 2025, 69% of the global number of deaths caused by TB among HIV-negative people occurred in the WHO African and South-East Asia regions; India alone

FIG. 12

Global trends in the estimated number of deaths caused by TB and HIV, 2010–2025[a,b]

Shaded areas represent 95% uncertainty intervals.



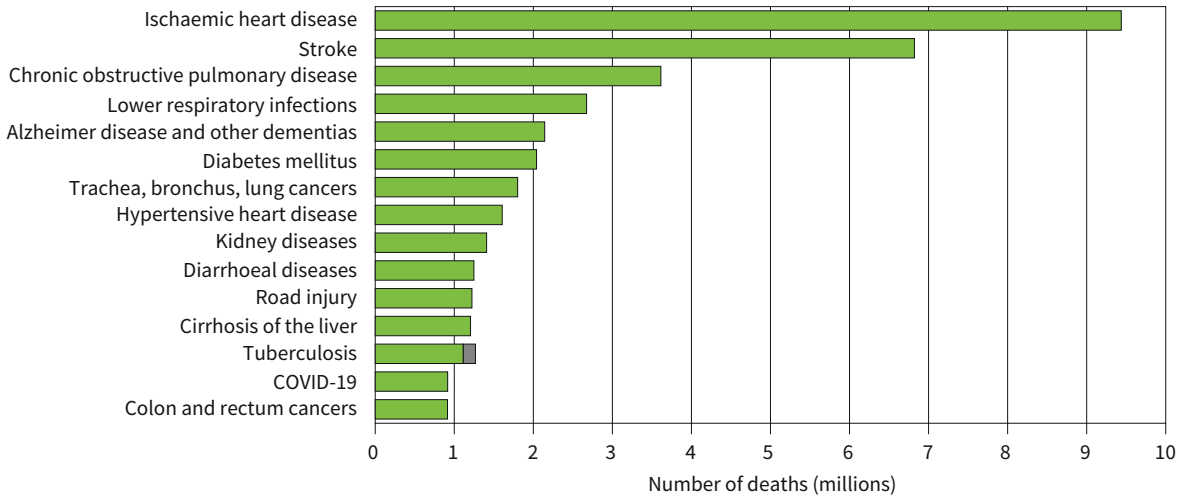
[a] For HIV/AIDS, the latest estimates of the number of deaths in 2025 that have been published by UNAIDS are available at http://www.unaids.org/en/ (accessed 27 July 2026). For TB, the estimates for 2025 are those published in this report.

[b] Deaths from TB among people with HIV are officially classified as deaths caused by HIV/AIDS in the International Classification of Diseases, with TB as a contributory cause.

FIG. 13

Top 15 causes of death worldwide in 2023[a,b]

Deaths from TB among people with HIV are shown in grey.



[a] This is the latest year for which estimates for all causes are currently available. See WHO estimates, available at https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death.

[b] Deaths from TB among people with HIV are officially classified as deaths caused by HIV/AIDS in the International Classification of Diseases, with TB as a contributory cause.

[1] The estimated number of deaths caused by TB among HIV-negative people was 1.19 million (95% UI: 1.07–1.31 million) in 2020 and 1.23 million (95% UI: 1.11–1.35 million) in 2021.

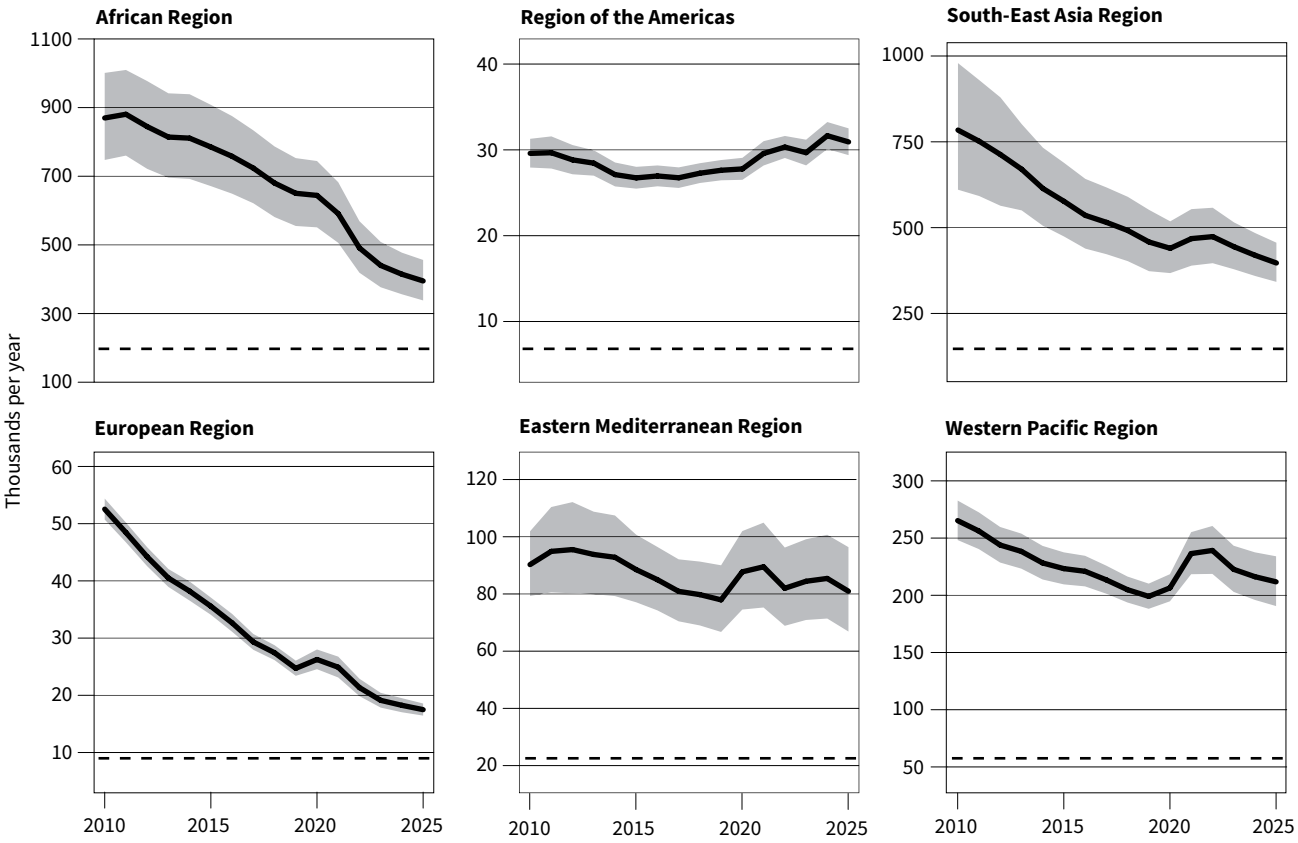
[2] The reductions by 2025 compared with 2010 were 77% for TB deaths among people with HIV, and 33% for TB deaths among HIV-negative people.

[3] For comparison, the total number of deaths caused by HIV declined by 39% between 2015 and 2025, and by 57% between 2010 and 2025.

FIG. 14

Trends in the estimated absolute number of deaths caused by TB (HIV-negative people and people with HIV[a]) by WHO region, 2010–2025

Shaded areas represent 95% uncertainty intervals. The horizontal dashed line shows the 2025 milestone of the End TB Strategy, which was a 75% reduction in the total number of deaths caused by TB between 2015 and 2025.



[a] Deaths from TB among people with HIV are officially classified as deaths caused by HIV/AIDS in the International Classification of Diseases, with TB as a contributory cause.

accounted for 26% of deaths globally. The WHO African and South-East Asia regions accounted for 70% of the combined total number of deaths caused by TB among people with and without HIV; India accounted for 23% of such deaths.

Of the 1.0 million (95% UI: 0.92–1.08 million) HIV-negative people who died from TB worldwide in 2025, an estimated 508 000 (95% UI: 354 000–661 000) were adult men (aged ≥15 years), equivalent to 51% of the total; 332 000 (95% UI: 230 000–433 000) were adult women (aged ≥15 years), equivalent to 33% of the total; and 157 000 (95% UI: 105 000–208 000) were children and young adolescents (aged <15 years), equivalent to 16% of the total.

Of the 137 000 (95% UI: 109 000–168 000) people with HIV who died from TB worldwide in 2025, an estimated 71 000 (95% UI: 34 000–108 000) were adult men (52% of the total), 64 000 (95% UI: 24 000–104 000) were adult women (47% of the total) and 1800 (95% UI: 1300–2400) were children and young adolescents (1.3% of the total).[1]

Regional trends in the annual number of TB deaths and progress in achieving reductions since 2015 vary considerably (**Fig. 14**).

Two WHO regions have made substantial progress. By 2025, the annual number of people dying from TB in the African and European regions had been halved compared with 2015, with reductions of 50% and 51% respectively.[2]

Following major reversals of progress during the COVID-19 pandemic, the net decline by 2025 compared with 2015 was 31% in the WHO South-East Asia Region, 8.6% in the Eastern Mediterranean Region and 5.2% in the Western Pacific Region. In the WHO Region of the Americas, the estimated number of deaths caused by TB in 2025 was much higher than in 2015 (+14%). Nonetheless, the absolute number of deaths in 2025 remained small (about 30 000) while the TB mortality rate was comparable to that in the WHO European Region

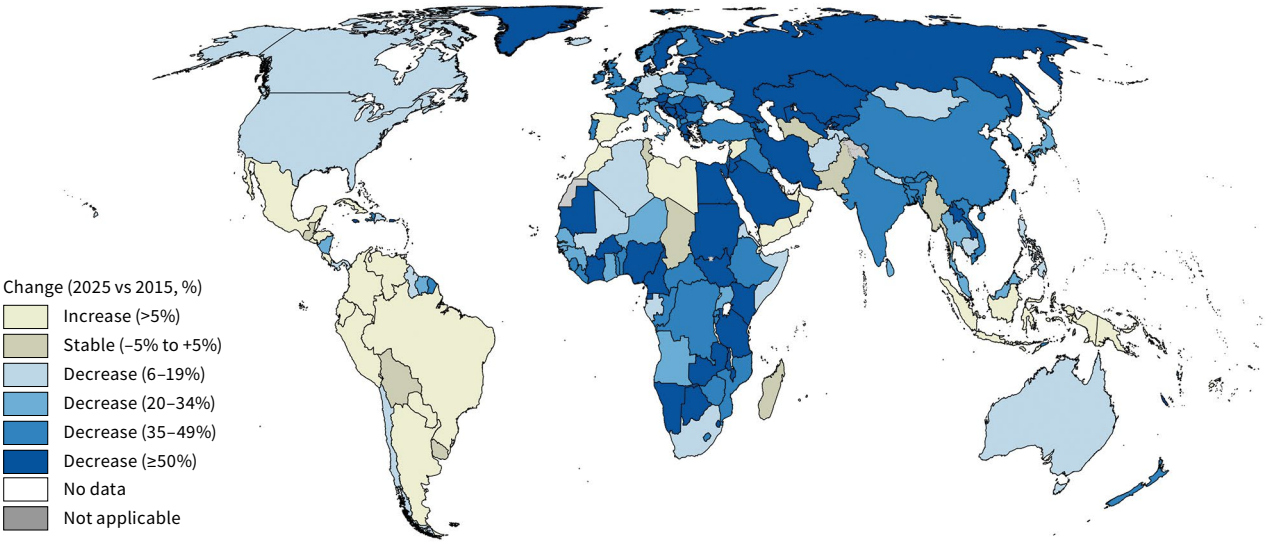
[1] Percentages do not sum to 100 due to rounding.

[2] These are the only regions to have surpassed the first milestone of the End TB Strategy.

FIG. 15

Change (%) in the estimated number of deaths caused by TB among HIV-negative people and people with HIV at country level, 2025 compared with 2015

The first milestone of the End TB Strategy was a 35% reduction by 2020, compared with 2015; the second milestone was a 75% reduction by 2025, compared with 2015. The last two categories (decrease 35–49%, and decrease ≥50%) distinguish the countries that have made the most progress towards the second milestone of the End TB Strategy.



and much lower than in the other four WHO regions.[1]

Progress in reducing the number of deaths caused by TB at country level is also highly variable (**Fig. 15**).

By 2025, a total of 89 countries had reduced the annual number of deaths caused by TB by at least 35% compared with 2015, thus reaching or surpassing the first (2020) milestone of the End TB Strategy, albeit with a delay of up to 5 years (**Table 3a**). These countries are mostly in the WHO African and European regions. Four of the 30 high TB burden countries outside these regions have reached the 35% milestone: Bangladesh, China, India and Viet Nam. Of these, China and India reached the milestone in 2025. Several high TB burden countries in the WHO African Region have achieved reductions of 50% or more (e.g. Kenya, Namibia, Nigeria, the United Republic of Tanzania and Zambia) (**Fig. 15**). In the WHO European Region, the Russian Federation has achieved a reduction of 65%.

At the other extreme, there are 40 countries where the number of deaths caused by TB in 2025 was more than 5.0% above the level of 2015, most noticeably countries in the WHO Region of the Americas.

A total of 69 countries have reached both of the first (2020) milestones of the End TB Strategy i.e. a 20% reduction in the TB incidence rate and a 35% reduction in the annual number of TB deaths (**Table 3a**).

[1] The TB mortality rate among HIV-negative people in the WHO Region of the Americas was 2.1 per 100 000 population in 2025, compared with 23 in the African Region, 21 in the South-East Asia Region, 9.5 in the Eastern Mediterranean Region, 8.9 in the Western Pacific Region and 1.5 in the European Region.

Estimation of TB disease burden

Repeat surveys and strengthened surveillance needed for 2030 targets assessment

Data sources used to produce estimates of TB incidence in the period 2010–2025 include results from population-based surveys of the prevalence of TB disease (used for 29 countries that account for about two thirds of global TB incidence), results from national TB inventory studies (used for 16 countries that collectively account for about 17% of global TB incidence),[2] mortality data (used for three countries that account for 2.0% of global TB incidence), case notification data (available for all countries) and values of the UHC service coverage index (SCI) (available for almost all countries).[3] For nine countries with the biggest absolute reductions in TB notifications during the COVID-19 pandemic that were a clear departure from historic trends, estimates of TB incidence in 2020–2025 were based on these data sources in combination with country-specific dynamic models.

The main data source used to produce estimates of TB mortality in the period 2010–2025 is cause-of-death data from national or sample vital registration (VR) systems. These data are available for 122 countries that

[2] These measure the level of underreporting of people diagnosed with TB in official TB case notification data; if certain conditions are met, capture–recapture methods can be used to estimate TB incidence.

[3] Further details about the data sources and analytical methods used to produce estimates of TB incidence are provided in the report webpages (section 1.1) and a technical appendix.

account for 56% of the global number of deaths caused by TB among HIV-negative people.[1]

In the years leading up to the 2030 target year of the End TB Strategy and SDG deadline, repeat national TB prevalence surveys, national TB inventory studies, up-to-date cause-of-death data from national or sample VR systems of high quality and coverage and improvements in the quality and coverage of TB notification data are needed to strengthen burden estimation, with the goal of ensuring that assessment of progress made between the baseline year of 2015 and the target year of 2030 is as robust as possible. WHO is coordinating global efforts to achieve this goal, under the umbrella of the WHO Global Task Force on TB Impact Measurement *(26, 27)*.

There are two excellent examples of recent studies to measure TB disease burden. The first is a repeat national TB inventory study that was completed in Indonesia in 2023. This showed a big reduction in the level of underreporting of people newly diagnosed with TB compared with the first study in 2017, and it produced estimates of TB incidence for 2023 that were consistent with model-based estimates *(28)*.

The second example is a national TB prevalence survey that was implemented in Cambodia in 2023. Cambodia was the first country to complete three national TB prevalence surveys in the 21st century (after previous surveys in 2002 and 2011) and the first to complete a survey after the COVID-19 pandemic. The three surveys showed reductions in TB prevalence of about 50% per decade between 2002 and 2023 *(19)*.

As of September 2026, national TB inventory studies were in the planning stage in the Lao People's Democratic Republic, the Philippines, South Africa and Viet Nam. Several countries were actively interested in implementing a repeat national TB prevalence survey: Bangladesh, Ethiopia, Ghana, Nigeria, Pakistan, Uganda, the United Republic of Tanzania and Zambia.[2] In Nigeria, an innovative approach to survey design and implementation has been developed; it involves leveraging existing staff, laboratory infrastructure and other resources that have already been established for large-scale community-based and health-facility-based active case-finding. The main constraint to progress in implementing repeat surveys is insufficient funding.

In 2026, WHO worked closely with national counterparts in Mongolia and Thailand to improve estimates of TB incidence using TB mortality data from each country's national VR system.[3] This approach will be expanded to other countries in future.

[1] Further details about the data sources and analytical methods used to produce estimates of TB mortality are provided in the report webpages (section 1.2) and a technical appendix.

[2] Further details are provided in the report webpages (section 1.4).

[3] Further details are provided in a "featured topic" on the report webpages.

TB case notifications

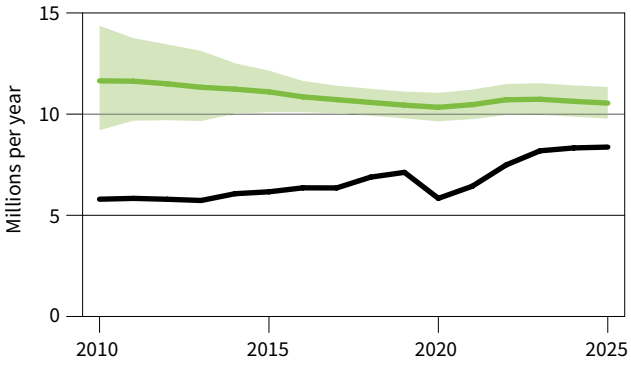
Stable globally, increasing in Africa

The global number of people newly diagnosed with TB and officially notified as a TB case has been relatively stable since 2023, following the large rebound that occurred between 2021 and 2023 as countries recovered from COVID-related disruptions to TB diagnosis and treatment (**Fig. 16**). Globally in 2025, 8.4 million people were newly diagnosed with TB and officially notified as a TB case, a slight increase from 8.3 million in 2024 and 8.2 million in 2023 (**Fig. 16**).

FIG. 16

Global trend in case notifications of people newly diagnosed with TB (**black**) and the estimated number of incident TB cases (**green**), 2010–2025

The shaded area represents the 95% uncertainty interval.



At the level of WHO regions, recent trends (since the pre-pandemic year of 2019) in TB case notifications vary (**Fig. 17**).

Patterns in the WHO Region of the Americas and the Eastern Mediterranean, South-East Asia and Western Pacific regions have been similar, with a marked drop in 2020 followed by a post-COVID recovery up to 2023 and then either a flat or declining trend; the South-East Asia Region was the strongest influence on the global trend. In the WHO African Region, notifications fell only slightly in 2020 and subsequently increased year on year; in 2025, the reported number of people newly diagnosed with TB in the African Region was 43% above the level of 2019. In the WHO European Region, notifications fell more sharply than the historic trend in 2020, increased in 2021 and 2022, and then resumed a decline consistent with the pre-COVID trend.

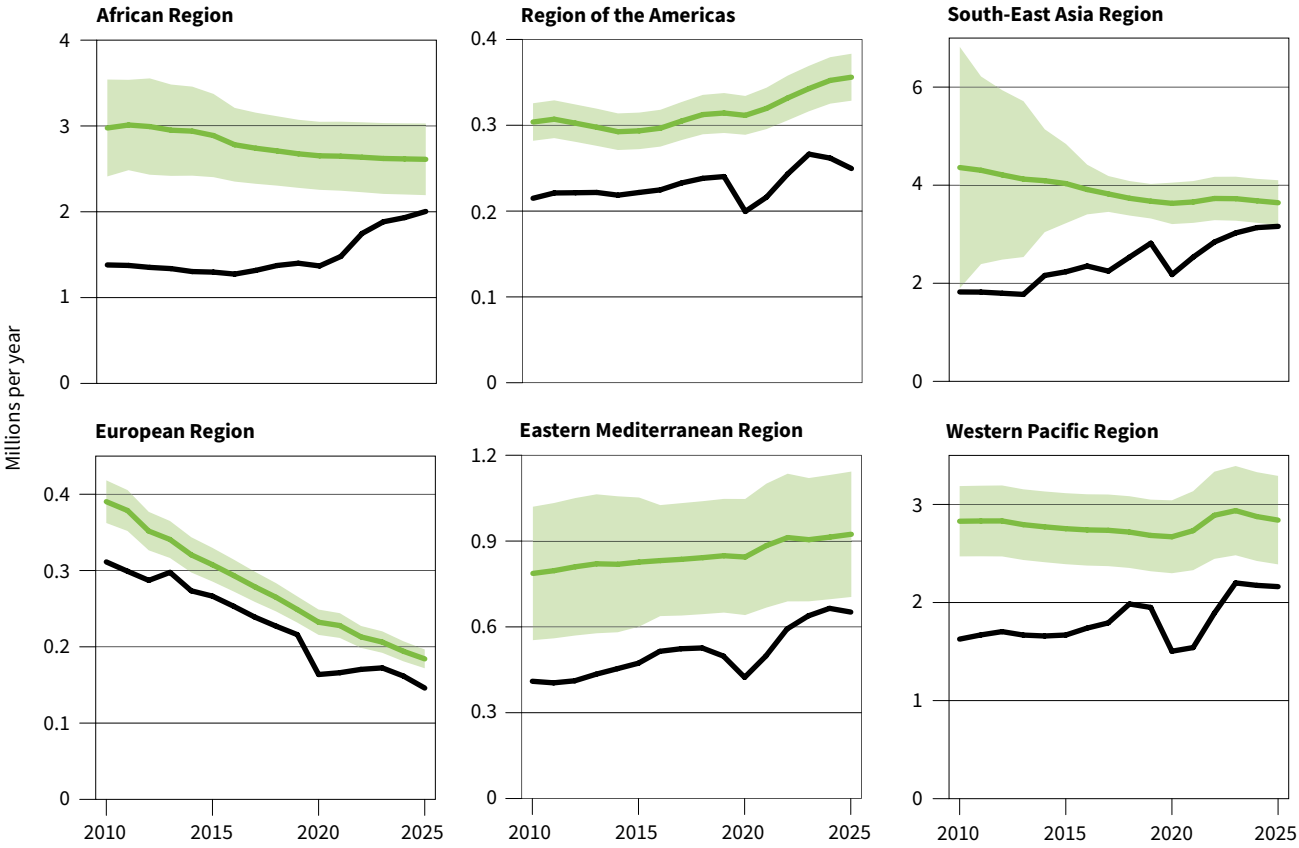
In most of the 30 high TB burden countries and two global TB watchlist countries, case notifications fell in 2020 and subsequently recovered to the pre-COVID level or beyond.[4] In some of these countries, notifications fell

[4] Further details are provided in the report webpages (section 2.1).

FIG. 17

Trends in case notifications of people newly diagnosed with TB (**black**) and the estimated number of incident TB cases (**green**) by WHO region, 2010–2025

Shaded areas represent 95% uncertainty intervals.



between 2024 and 2025; the most pronounced declines were in Cambodia, Kenya, Myanmar, the Philippines and Uganda.

Exceptions to this general pattern in the 30 high TB burden countries include the Central African Republic, the Democratic Republic of the Congo, Nigeria and the United Republic of Tanzania; in these countries, instead of an obvious COVID-related disruption to TB notifications, there was a continued upward trend throughout the period 2019–2025. Ethiopia is also an exception, where a relatively consistent decline until 2021 has been reversed, possibly as a result of active case finding efforts, with the number of notifications in 2025 comparable to those in 2010.

Diagnostic testing for TB

Coverage of rapid testing improving but not fast enough

An essential step in the pathway of TB care is rapid and accurate diagnostic testing. Since 2011, rapid molecular tests have transformed the TB diagnostic landscape, which previously relied on traditional microscopy and culture methods. In 2026, the range of rapid diagnostic tests recommended by WHO was expanded to include new near-point-of-care tests.[1]

People diagnosed with TB using WHO-recommended rapid diagnostic tests (WRDs) *(29)*, lateral flow urine lipoarabinomannan (LF-LAM) assays, sputum smear microscopy or culture are defined as "bacteriologically confirmed" cases of TB *(30)*. The microbiological detection of TB is critical because it allows people to be correctly diagnosed and ensures that the most effective treatment regimen (depending on the pattern of drug resistance) can be selected as early as possible.

The use of rapid tests is growing but remains much too limited and falls far short of the target of 100% coverage by 2027 (**Fig. 18**, **Table 1**).

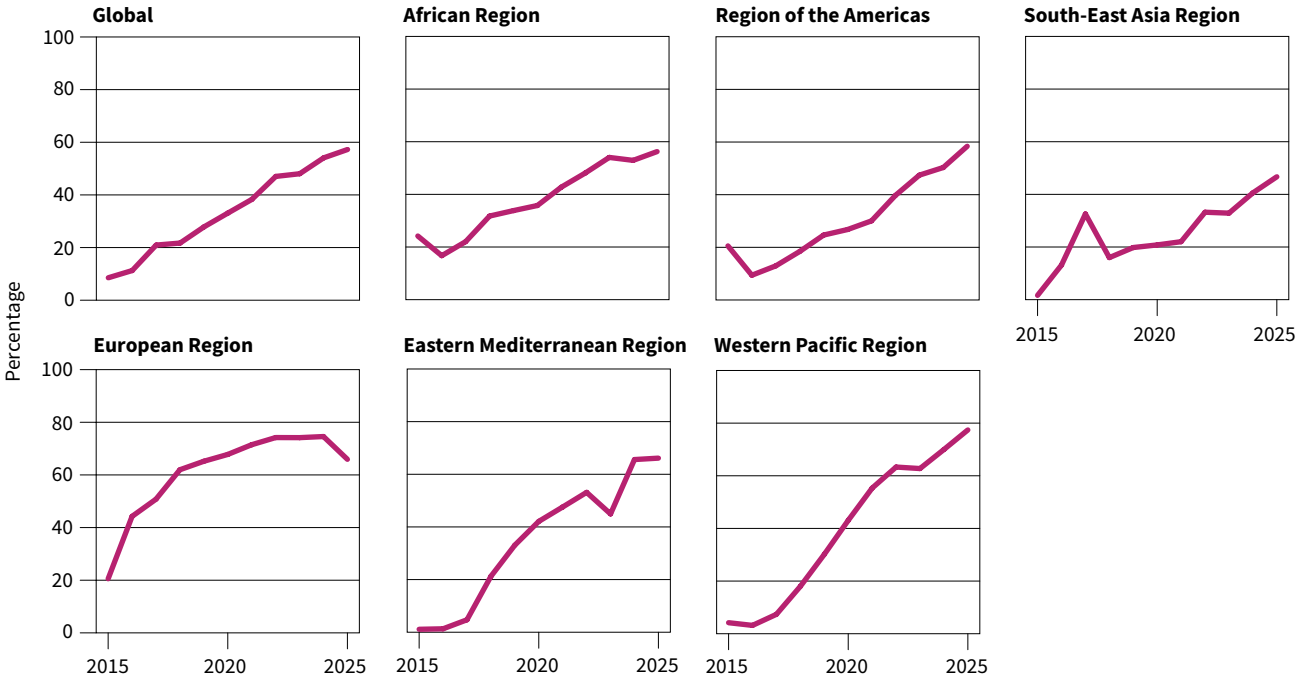
Globally in 2025, a WRD was used as the initial diagnostic test for 59% (4.9 million) of the 8.4 million people newly diagnosed with TB, an improvement from 54% (4.5/8.3 million) in 2024 and 48% (3.9/8.2 million) in 2023.

There was substantial variation in the coverage of rapid testing among regions and countries in 2025 (**Fig. 18**, **Fig. 19**).

[1] See **Box 4**.

FIG. 18

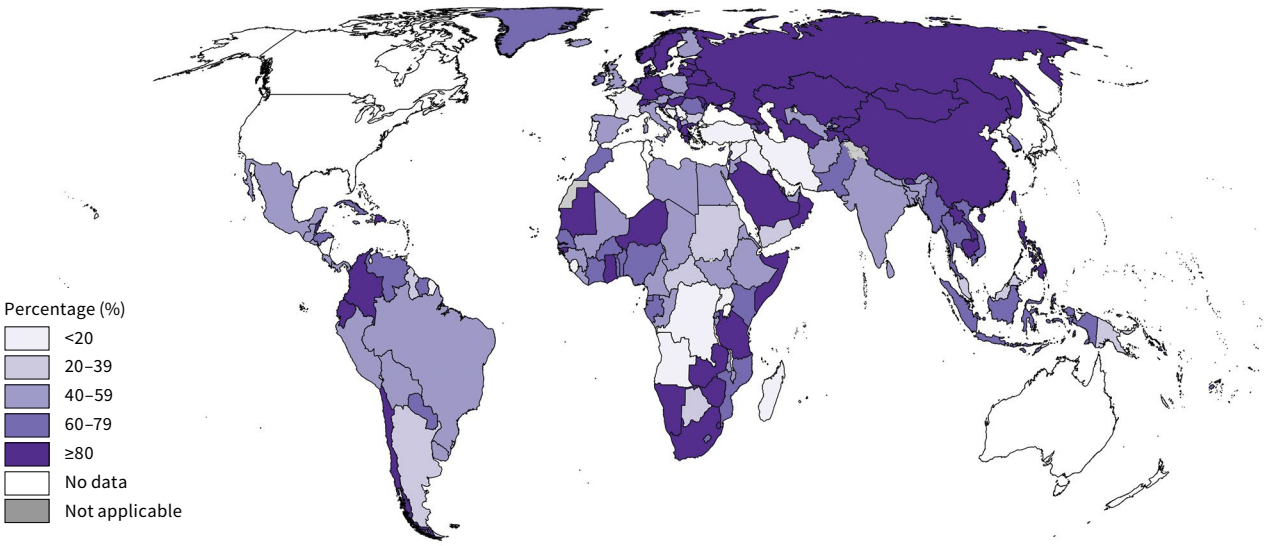
Percentage of people newly diagnosed with TB who were initially tested with a WHO-recommended rapid diagnostic test (WRD), globally and for WHO regions,[a] 2015–2025



[a] Data are for notified cases. Data on rapid testing for 2025 for the European Region are less complete than in previous years, due to a transition in the system used for reporting of data to the European Centre for Disease Prevention and Control.

FIG. 19

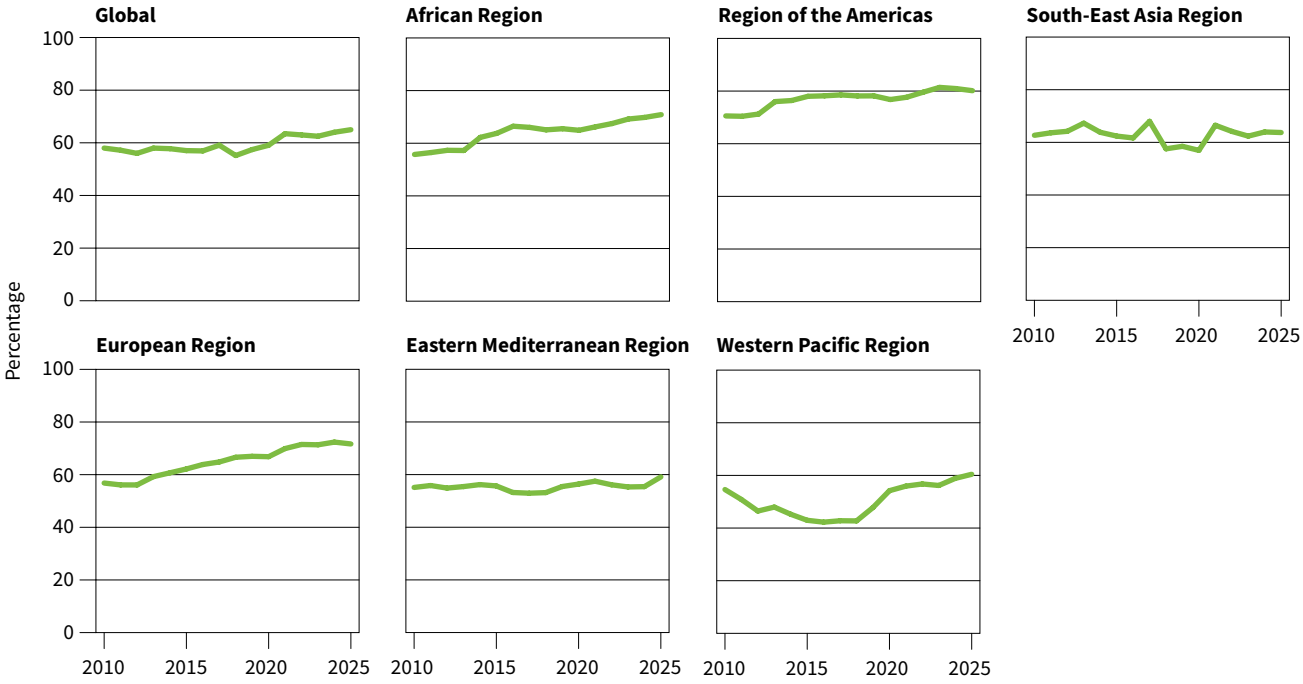
Percentage of people newly diagnosed with TB who were initially tested with a WHO-recommended rapid diagnostic test (WRD) at country level,[a] 2025



[a] Data are for notified cases.

FIG. 20

Percentage of people newly diagnosed with pulmonary TB who were bacteriologically confirmed, globally and for WHO regions,[a] 2010–2025



[a] Data are for notified cases. The calculation for years prior to 2013 is based on smear results, except for the European Region where data on confirmation by culture were also available for the period 2010–2012.

Among WHO regions, the best levels of coverage were achieved in the Western Pacific Region (76%) and the Eastern Mediterranean Region (66%); the lowest coverage was in the South-East Asia Region (47%).[1]

At country level, 73 countries achieved coverage levels of at least 80% in 2025. This included eight of the 30 high TB burden countries: Cambodia, China, Mongolia, Namibia, the Philippines, South Africa, the United Republic of Tanzania and Zambia. High TB burden countries in which there was a noticeable reduction between 2024 and 2025 included the Central African Republic, the Congo, the Democratic Republic of the Congo, Mozambique and Papua New Guinea.

Among the 50 countries in one of the three global lists of high burden countries (for TB, HIV-associated TB and drug-resistant TB),[2] 35 reported that a WRD had been used as the initial test for more than half of people newly diagnosed with TB in 2025. This was down from 38 in 2024, although still an improvement on 2023 (30 countries).

Worldwide, there were 20 countries in which the coverage of rapid testing was less than 20% in 2025.

A major influence on the coverage of rapid testing is the proportion of TB diagnostic sites with access to WRDs. In 2025, only nine of the 30 high TB burden countries reported that more than 50% of their TB diagnostic sites had access to WRDs: Bangladesh, China, Lesotho, Mongolia, Namibia, Nigeria, Papua New Guinea, South Africa and Zambia. Expanding access to TB diagnosis using rapid tests should be a top priority for all countries. Reductions in the price of rapid tests would facilitate such expansion, especially in countries without access to preferential prices.

In many countries, there is a need to increase the percentage of people diagnosed with pulmonary TB based on bacteriological confirmation, including by ensuring that all those diagnosed with TB are initially tested with a rapid test, in line with the global target set for 2027 (**Table 1**).

Of the 7.2 million people diagnosed with pulmonary TB worldwide in 2025, 65% were bacteriologically confirmed (**Fig. 20**), a slight improvement from 64% in 2024.

Among the six WHO regions, there were steady improvements between 2020 and 2025 in the African Region (from 65% to 71%) and the Western Pacific Region (from 54% to 60%); there was also an improvement in the Eastern Mediterranean Region between 2024 and 2025, from 55% to 59% (**Fig. 20**). In other regions, levels of bacteriological confirmation have remained stable (the European Region, at 72%, and the

[1] Coverage in the WHO European Region was 74% in 2022 and 2023, and 75% in 2024. The lower value of 66% in 2025, based on data reported by 25 August 2026, is explained by delayed reporting in 2026, during a transition to a new data collection system used by the European Centre for Disease Prevention and Control for reporting by countries in the European Union.

[2] See **Annex 3**.

South-East Asia Region, at 64%). Efforts to reach the level already achieved in the WHO Region of the Americas (81% in 2023 and 2024, 80% in 2025) are required in other regions.

At country level, the percentage of people with pulmonary TB who were bacteriologically confirmed was 80% or more in 118 countries. Among the 30 high TB burden countries, five achieved a level of 75% or above: Bangladesh, Mongolia, Namibia, Nigeria and Viet Nam. Seven others have made considerable progress in recent years: China, the Congo, Ethiopia, South Sudan, Thailand, Uganda and the United Republic of Tanzania.

The levels of bacteriological confirmation already achieved in the WHO Region of the Americas and in some countries in other parts of the world show what is feasible with currently available TB diagnostics. Efforts to reach comparable levels, particularly through expanded use of rapid tests, are required elsewhere.[1]

Testing for HIV among people diagnosed with TB

High coverage sustained

The global coverage of HIV testing among people diagnosed with TB remained high in 2025, at 83%. This was a slight increase from 82% in 2024 and 81% in 2023.

At regional level, the highest percentages were achieved in the European Region (93%), the South-East Asia Region (90%), the Region of the Americas (89%) and the WHO African Region (88%). In 102 countries or areas, at least 90% of people diagnosed with TB knew their HIV status; this included 34 of the 47 countries in the WHO African Region, where the burden of HIV-associated TB is highest.

Worldwide in 2025, a total of 405 436 cases of TB among people living with HIV were notified, equivalent to 5.9% of the 6.9 million people newly diagnosed with TB who had an HIV test result. Overall, the percentage of people newly diagnosed with TB who had an HIV-positive test result has been falling globally for many years, following a peak of 28% in 2006.

Coverage of TB diagnosis and treatment

Post-COVID recovery sustained, sizeable gaps remain

The 2025 milestone and 2030/2035 targets of the End TB Strategy can only be achieved if everyone who develops TB disease is promptly diagnosed using WHO-recommended diagnostic tests and then treated with drug regimens recommended by WHO *(29, 31, 32)*.[2] One of the targets set at the 2023 UN high-level meeting on TB is that 90% of people with TB have access to quality-assured diagnosis and treatment by 2027 (**Table 1**).

There are still sizeable global and regional gaps between the estimated number of people who develop TB each year (incident cases) and the number of people newly diagnosed with TB and officially reported as a TB case (**Fig. 16**, **Fig. 17**). In 2025, the best estimate of the global gap was 2.2 million,[3] a slight reduction from 2.3 million in 2024. Since 2010, the gap between estimated incidence and case notifications has generally narrowed year on year; the exception was 2020, when it widened substantially (to a best estimate of 4.5 million) amid disruptions caused by the COVID-19 pandemic.

Gaps have also been narrowing in five WHO regions, most notably in the African, Eastern Mediterranean and South-East Asia regions. The exception in recent years is the Region of the Americas, where the gap between estimated incidence and case notifications was wider in 2025 than it was in 2010. Gaps have also been narrowing in most of the 30 high TB burden countries.[4]

Reasons for gaps between the estimated number of people who develop TB each year (incident cases) and the number of people newly diagnosed with TB and officially reported as a TB case include underdiagnosis as well as underreporting of people diagnosed with TB to national authorities (with the latter not accounted for in official case notification data). It is also important to highlight that some of the people diagnosed with TB and officially reported as a TB case may not have had the disease. Overdiagnosis is most likely to occur among people who have TB signs and symptoms, but who have a bacteriologically negative test result, or no test result. Universal coverage of the most sensitive and specific WHO-recommended diagnostics for all people with presumptive TB is needed to minimize overdiagnosis.

In some countries, estimates of TB incidence would benefit from new studies (e.g. a national TB prevalence survey or national TB inventory study) to directly measure the underlying burden of TB disease in the population. For example, the main data sources used to inform the current estimates of TB incidence in Bangladesh, Nigeria, Uganda and Zambia are national TB prevalence surveys that were implemented in 2015, 2012, 2014–2015 and 2013–2014, respectively.[5]

The global number of people newly diagnosed with TB and officially reported as a TB case in 2025 (8.4 million) was equivalent to 79% (95% UI: 74–86%) of the estimated 10.6 million people (95% UI: 9.8–11.4 million) who developed TB in 2025. This was a slight increase from 78% (95% UI: 73–84%) in 2024 and was considerably higher than the levels of 50% (95% UI: 40–63%) in 2010 and 56% (95% UI: 53–61%) in 2020.

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[1] Further details (e.g. for individual countries) are provided in the report webpages (section 2.2) and the report app.

[2] A summary of the treatment regimens recommended by WHO is provided in **Annex 1**.

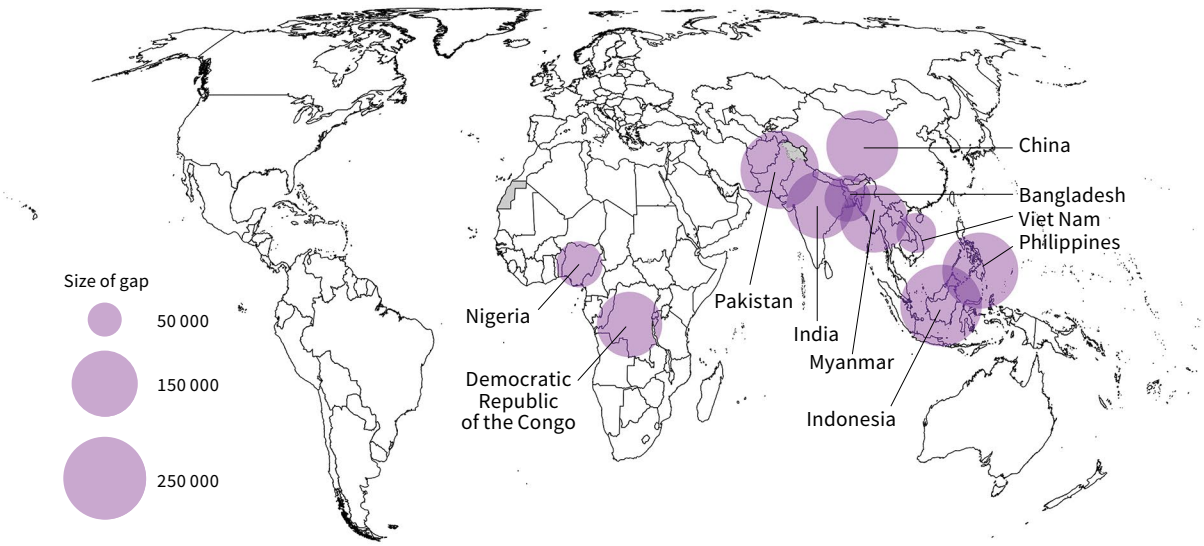
[3] That is, the difference between a best estimate of 10.56 million incident cases and 8.38 million people who were newly diagnosed with TB and officially notified as a TB case.

[4] Further details are provided in the report webpages (section 2.3).

[5] Further details are provided in the report webpages (section 1.4).

FIG. 21

The ten countries with the largest gaps between case notifications of people newly diagnosed with TB and the best estimates of TB incidence,[a] 2025



[a] The ten countries ranked in order of the size of the gap between notified cases and the best estimates of TB incidence in 2025 are Indonesia, Pakistan, the Philippines, China, Myanmar, India, the Democratic Republic of the Congo, Nigeria, Bangladesh and Viet Nam.

Among the 30 high TB burden countries in 2025, the number of people newly diagnosed with TB and officially reported as a TB case as a percentage of the estimated number of people who developed TB (incident cases) was highest (>80%) in Bangladesh, Brazil, Ethiopia, India, Indonesia, Mozambique, Namibia, Nigeria, South Africa, Uganda and Zambia.[1] In Mozambique especially, overdiagnosis may have artificially inflated notification data, given that the proportion of notified cases diagnosed based on bacteriological confirmation in 2025 was only 52%.

Two high TB burden countries had particularly low numbers of people newly diagnosed with TB relative to estimated levels of incidence in 2025: Mongolia and Myanmar (both <50%).

In 2025, about 60% of the global gap between estimated TB incidence and the reported number of people newly diagnosed with TB was accounted for by 10 countries (**Fig. 21**). From a global perspective, efforts to close remaining gaps between levels of case detection and treatment are of particular importance in these countries. Substantial progress has already been made in some of these countries in recent years, especially in Bangladesh, India, Indonesia, Nigeria and Pakistan.[2]

ART for people living with HIV and TB

High coverage, but worsened in 2025

Among people living with HIV who develop TB, both TB treatment and ART for HIV are required to prevent unnecessary deaths from TB and HIV. Since 2019, the global coverage of ART for people living with HIV who were newly diagnosed with TB and reported as a TB case has been maintained at a high level. However, coverage fell in 2025, to 87%; this was a reduction from 91% in 2024 and slightly lower than the level of 88% that was achieved in 2023.

It is possible that a sizeable reduction (18%) in international donor funding for the HIV response in low- and middle-income countries (LMICs) between 2024 and 2025 *(33)* affected the coverage of ART among people with TB in 2025.

When provision of ART to people diagnosed with TB is compared with the total number of people living with HIV estimated to have developed TB in 2025, coverage was only 59%, a reduction from 61% in 2024 and 60% in 2023. These levels are far below the overall level of ART coverage for people living with HIV, which was 78% (95% UI: 59–94%) at the end of 2025 *(34)*. The main reason for the relatively low coverage was the big gap between the estimated number of people living with HIV who developed TB in 2025 (a best estimate of 592 000) and the reported number of people living with HIV who were diagnosed with TB in 2025 (405 436).

[1] Further details are provided in the report webpages (section 2.3).
[2] Further details are provided in the report webpages (section 2.3).

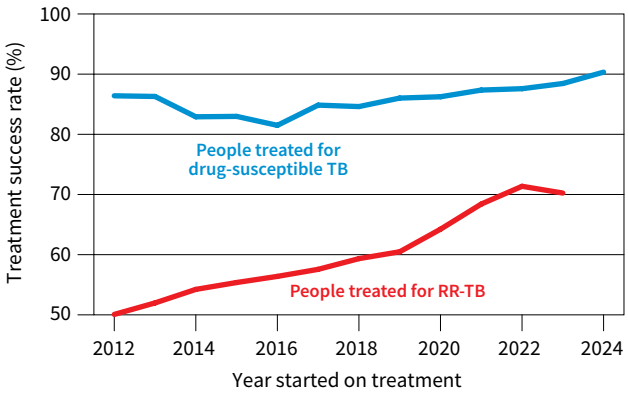
TB treatment outcomes, drug-susceptible TB

Sustained at high levels

The treatment success rate for people treated for drug-susceptible TB has been sustained at a high level in recent years. Globally, it was 90% in 2024 – an increase from 88% in both 2022 and 2023 (**Fig. 22**).

FIG. 22

Global treatment success rates for people with drug-susceptible TB and RR-TB, 2012–2024



Treatment success rates remain lower among people living with HIV (80% globally in 2024, up from 79% in 2023). The treatment success rate for children and young adolescents (aged <15 years) was 94% in 2024, an increase from 92% in 2023. Among 119 countries[1] that reported outcome data disaggregated by sex, the treatment success rate in 2024 was slightly higher among females (91%) than males (88%).

Provision of TB treatment to HIV-negative people is estimated to have averted 48 million deaths between 2010 and 2025; among people living with HIV who were diagnosed with TB, the combination of TB treatment and ART is estimated to have averted an additional 7.3 million deaths between 2010 and 2025 (**Table 4**). The combined total for the period 2000–2025 was 86 million.

Drug-resistant TB: diagnosis and treatment

Big growth in use of 6-month regimens, diagnostic gaps persist

WHO uses five categories to classify cases of drug-resistant TB:

- isoniazid-resistant TB;
- RR-TB (defined above);
- multidrug-resistant TB (MDR-TB), defined as resistance to both rifampicin and isoniazid;
- pre-extensively drug-resistant TB (pre-XDR-TB), defined as TB that is resistant to rifampicin and any fluoroquinolone (a class of second-line anti-TB drug); and
- extensively drug-resistant TB (XDR-TB), defined as TB that is resistant to rifampicin, plus any fluoroquinolone, plus at least one of either bedaquiline or linezolid.

Detection of drug resistance requires bacteriological confirmation of TB and testing for resistance using rapid molecular diagnostic tests, culture methods or sequencing technologies.

Since 2018, WHO has recommended all-oral regimens for the treatment of people with RR-TB *(35)*. The

TABLE 4

Cumulative number of deaths (in millions) averted by a) TB treatment as well as b) antiretroviral treatment for people diagnosed with TB who were also living with HIV, globally and by WHO region, 2010–2025

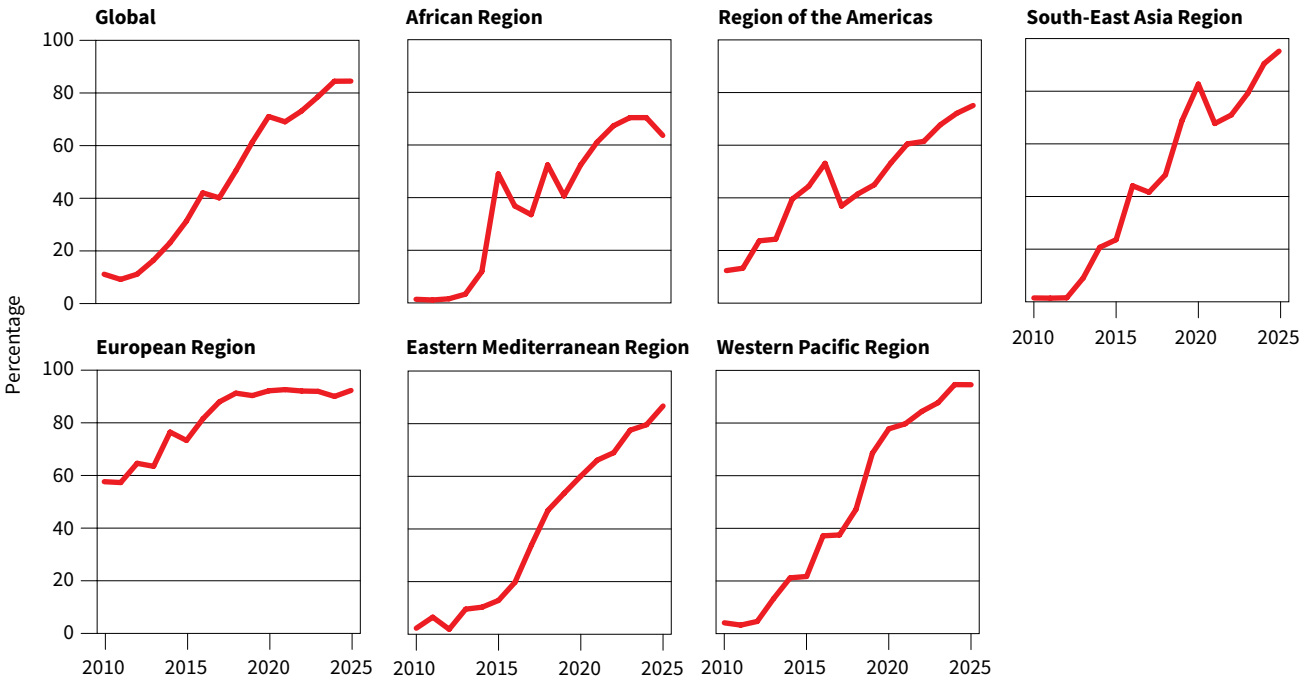
WHO REGION	HIV-NEGATIVE PEOPLE		PEOPLE LIVING WITH HIV[a]		TOTAL	
	BEST ESTIMATE	95% UNCERTAINTY INTERVAL	BEST ESTIMATE	95% UNCERTAINTY INTERVAL	BEST ESTIMATE	95% UNCERTAINTY INTERVAL
African Region	7.1	5.9–8.3	5.4	4.6–6.2	12	11–14
Region of the Americas	1.6	1.5–1.8	0.28	0.26–0.31	1.9	1.8–2.0
South-East Asia Region	18	15–21	0.89	0.56–1.2	19	16–22
European Region	1.3	1.2–1.4	0.26	0.23–0.28	1.6	1.4–1.7
Eastern Mediterranean Region	4.4	3.9–5.0	0.057	0.025–0.089	4.5	3.9–5.0
Western Pacific Region	15	14–17	0.48	0.40–0.56	16	14–17
Global	**48**	**43–53**	**7.3**	**6.4–8.3**	**55**	**50–61**

[a] Deaths from TB among people with HIV are officially classified as deaths caused by HIV/AIDS (with TB as a contributory cause). This is the reason why the estimates make a clear distinction between people with and without HIV.

[1] From 2021 to 2025, WHO requested data on treatment outcomes disaggregated by sex from the countries that were in one of the three WHO lists of high burden countries defined for this period. In 2026, data collection was expanded to all countries.

FIG. 23

Percentage of people diagnosed with bacteriologically confirmed TB who were tested for RR-TB,[a] globally and for WHO regions, 2010–2025



[a] Includes both new and previously treated cases; data for 2017 onwards are for pulmonary cases only.

latest recommendations for treatment of drug-resistant TB include three major categories of regimen *(31, 36)*:

- two 6-month all-oral regimens for people with RR-TB (with or without resistance to fluoroquinolones);[1]
- several all-oral short regimens of 9 months for people with RR-TB who do not have any resistance to fluoroquinolones; and
- longer regimens of 18–20 months that may include an injectable drug (amikacin).

The 6-month regimens are prioritized for use whereas the longest regimens are a last resort.

Globally in 2025, 85% of people with bacteriologically confirmed TB were tested for rifampicin resistance, unchanged from 2024 but representing major progress compared with 71% in 2020 and 31% in 2015 (**Fig. 23**). There has been substantial progress in recent years in all six WHO regions. In 2025, the highest coverage of testing was in the WHO South-East Asia Region (95%), the Western Pacific Region (95%) and the European Region (92%).

Of the 30 high RR-TB burden countries, 22 reached a coverage of testing for rifampicin resistance among people with bacteriologically confirmed TB of at least 80% in 2025: Afghanistan, Angola, Azerbaijan, China, Guinea, India, Indonesia, Kazakhstan, Kyrgyzstan, Mongolia, Myanmar, Pakistan, Papua New Guinea, Peru, the Russian Federation, Somalia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan, Viet Nam and Zambia. Three high RR-TB burden countries did not reach a coverage level of 50%: the Democratic People's Republic of Korea (1.9%), the Democratic Republic of the Congo (30%) and Mozambique (2.2%).

Among those tested for RR-TB worldwide, 155 333 people were diagnosed with RR-TB and started on treatment (**Fig. 24**). This was a reduction (of 5.8%) from 164 960 in 2024, following a previous reduction between 2023 and 2024 and between 2022 and 2023. The decline between 2024 and 2025 can be partly attributed to a declining global trend in the estimated incidence of RR-TB (**Fig. 8**). Almost all (98%) of those enrolled on treatment were people aged 15 years and older.

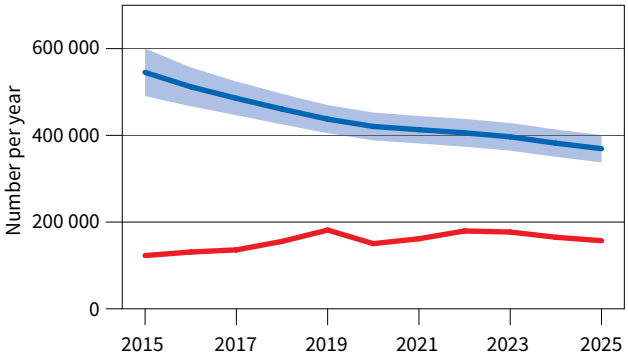
The number of people treated for RR-TB was equivalent to 42% of the estimated number of people who developed RR-TB in 2025 – virtually unchanged from 43% in 2024 (**Fig. 24**).

Five countries accounted for about 60% of the gap between the estimated global number of people who developed RR-TB in 2025 (incident cases of RR-TB) and the global number of people enrolled on treatment in 2025. These countries were China, India, Indonesia, Pakistan and the Philippines. Among WHO regions, the

[1] One regimen, referred to as BPaLM, comprises bedaquiline, pretomanid, linezolid and moxifloxacin. The other regimen, referred to as BDLLfxC, comprises bedaquiline, delamanid and linezolid, combined with levofloxacin or clofazimine, or both. In contrast to BPaLM, BDLLfxC can be used in children and during pregnancy.

FIG. 24

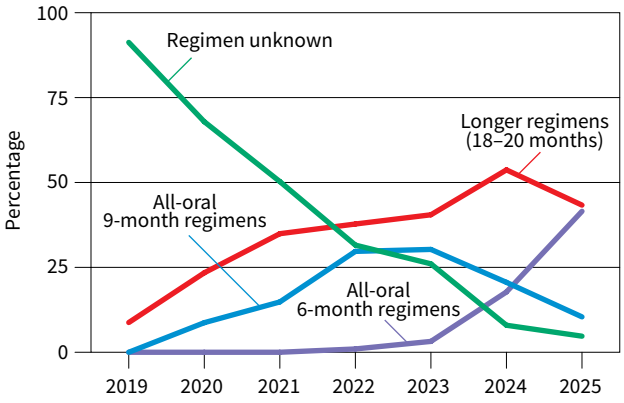
Global number of people enrolled on treatment for RR-TB (**red**), compared with estimates of the global number of incident cases of RR-TB (95% uncertainty interval shown in **blue**), 2015–2025[a]



[a] The time period corresponds to the period for which estimates of the incidence of RR-TB are available.

FIG. 25

Global percentage of people with RR-TB treated with 6-month, 9-month or longer (18–20 months) regimens, 2019–2025



smallest gap was in the European Region, and the largest was in the South-East Asia Region.

Closing the global and country-level gaps between the estimated number of people developing RR-TB each year and the number of people started on treatment for RR-TB each year requires further improvements in the coverage of testing for RR-TB among those with bacteriologically confirmed TB, improvements in the percentage of those diagnosed with TB who are bacteriologically confirmed (necessary to test for drug resistance) and improvements in the proportion of people with TB who are diagnosed.

In recent years, there has been considerable progress in the treatment success rate achieved among people diagnosed with RR-TB (**Fig. 22**). For people started on treatment in 2023 (the latest year for which outcome data are available),[1] the treatment success rate was 70% – a slight reduction from 71% in 2022 but still better than levels achieved in all previous years (e.g. 68% in 2021 and 64% in 2020), and much better than the level of 50% in 2012.[2] Among WHO regions, the treatment success rate in 2023 ranged from 56% in the Region of the Americas[3] to 77% in the African Region.

There was a big expansion in the use of 6-month treatment regimens in 2025 (**Fig. 25**). Globally in 2025, 6-month regimens were used for 42% of the people treated for RR-TB,[4] a substantial increase from 18% in 2024 and 3% in 2023. By the end of 2025, 6-month regimens were being used for the treatment of RR-TB in 106 countries, up from 98 at the end of 2024 and 60 at the end of 2023.

In five of the six WHO regions, 6-month regimens are now the most frequently used treatment for RR-TB – a landmark shift compared with previous years. The share of people diagnosed with RR-TB who were treated with 6-month regimens was highest in the WHO Eastern Mediterranean Region (72%) and the African Region (65%). The WHO European Region is now the only part of the world where longer regimens are still used for a large proportion (76%) of people with RR-TB.

TB prevention and screening

Global coverage of TPT improving, slowly

The main health care intervention available to reduce the risk of TB infection progressing to active TB disease is TPT. Other preventive interventions are TB infection prevention and control, and vaccination of children with the bacille Calmette-Guérin (BCG) vaccine. The BCG vaccine can confer protection, especially from severe forms of TB in children.

WHO recommends TPT for people living with HIV, household contacts of people diagnosed with bacteriologically confirmed pulmonary TB and people in clinical risk groups (e.g. those receiving dialysis) *(37)*. Options include a weekly dose of isoniazid and rifapentine for 3 months, a daily dose of isoniazid and rifampicin for 3 months, a daily dose of isoniazid and rifapentine for 1 month, a daily dose of rifampicin for 4 months and

[1] The time lag is because some treatment regimens last 18–20 months.

[2] 2012 was the first year for which WHO collected data on outcomes for people enrolled on treatment for RR-TB.

[3] The main explanation was high percentages of people who were either lost to follow-up (18%) or whose outcome was not evaluated (12%).

[4] 44% were treated with the longer (18–20 months) regimens and 11% were treated with a 9-month regimen; for the remaining people treated for RR-TB, the regimen type was not reported.

a daily dose of isoniazid for 6 or 9 months. For people exposed to MDR-TB, a daily dose of levofloxacin for 6 months is recommended.

The global number of people provided with TPT in 2025 was 5.2 million; this represents a reduction of 2.0% from 5.3 million in 2024 but is still fivefold higher than in 2015 (**Fig. 26**).[1] There were contrasting trends for the two main groups of people eligible for TPT – household contacts and people living with HIV.

Since 2021, there have been year-on-year increases in the number of household contacts enrolled on TPT. The total was 3.7 million in 2025, up from 3.5 million in 2024 and almost five times the level of 0.76 million in 2021. In contrast, the number of people living with HIV who were enrolled on TPT peaked at 3.0 million in 2019 and has subsequently fallen. The number in 2025 was 1.5 million, a reduction from 1.8 million in 2024. The main explanation is that most people in HIV care have already been offered TPT, and initiation of TPT is mostly among people newly enrolled on ART.

The estimated global coverage of TPT among household contacts was 26% in 2025. This was a slight improvement from 25% in 2024, although substantially better than levels achieved in 2015 (<1.0%) and 2019 (5.0%) (**Fig. 27**).[2] Coverage among people living with HIV who were newly enrolled on ART was 60%, a small increase from 58% in 2024. For both population groups, the global target of 90% coverage by 2027 (**Table 1**) remains some way off.

In 90 countries that reported outcomes, the completion rate for household contacts who started TPT in 2024 was 75%, a reduction from 82% in 2023 among 95 countries that reported data. The median in 2024 was 84% (interquartile range, 70–95%). For people living with HIV, the TPT completion rate was 87% in 2024, in 49 countries that reported data. This was a reduction from 90% in 2023, in 38 countries that reported data. The median in 2024 was 91% (interquartile range, 72–95%).

Substantial intensification and expansion of efforts and investment are needed to improve the provision of TPT. This includes providing more TB screening at household level, improving the follow-up to TB screening at household level and among people living with HIV, and increasing access to shorter (1–3 months) rifamycin-based regimens. The number of people treated using shorter regimens is growing; in 2025, it reached 3.1 million (59% of all those starting TPT) in 122 countries.[3] This was an increase from 2.1 million people (40% of those who started TPT) in 88 countries in 2024 and an enormous increase from 0.19 million people in 52 countries in 2021.

The ratio of the TB notification rate among health care workers to the TB notification rate in the general adult population reflects the effectiveness of TB infection control in health facilities; the ratio should be about 1. In 2025, the ratio was greater than 1 in 18 countries that reported five or more TB cases among health care workers; this was an increase from nine countries in 2024 and 12 countries in 2023.

The global coverage of BCG vaccination in children was 88% in 2025 – similar to the coverage levels of 87–88% that were achieved in the period 2022–2024 *(38)*.

FIG. 26

Global number of people provided with TB preventive treatment, 2015–2025

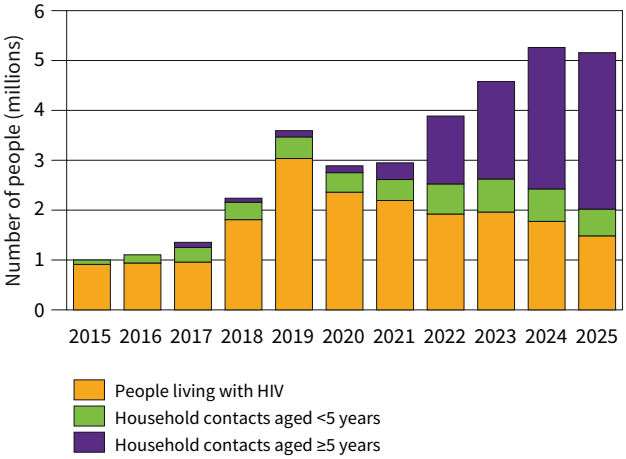
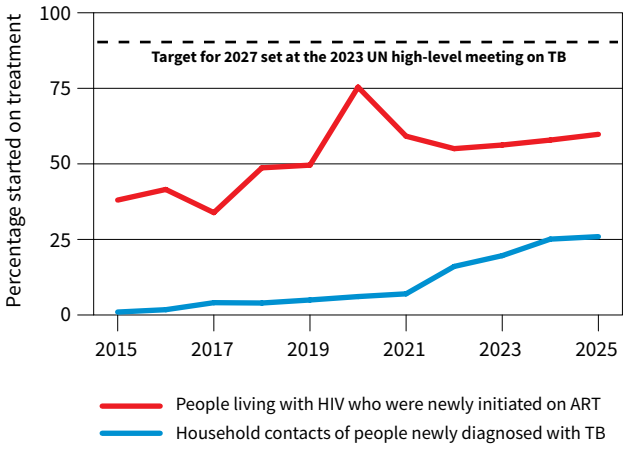


FIG. 27

Global coverage of TB preventive treatment, 2015–2025



[1] The number in 2015 was 1.0 million.

[2] Region- and country-specific data are provided in the report webpages (section 3) and the report app.

[3] Among these 122 countries, 95 reported using the 3-month weekly regimen of rifapentine and isoniazid, and 30 reported using the 1-month daily regimen of rifapentine and isoniazid. Overall, these two regimens were used for 78% of those treated using rifamycin-based regimens.

Funding for TB services

Overall growth in 2025 but far short of global target

Sizeable reduction in donor funding, mixed country impact

Progress in reducing the burden of TB disease requires adequate funding for TB prevention, diagnostic and treatment services, sustained over many years. However, in LMICs – which account for 99% of the reported number of people newly diagnosed with TB each year – funding has consistently fallen far short of what is needed to reach global targets for reductions in TB incidence and mortality (**Box 2**). In 2025, major changes in the landscape of funding for official development assistance, both overall and for the health sector specifically, generated new and significant concerns about how reductions in funding could affect the TB response in many LMICs *(19, 39–42)*. Data reported to WHO show a sizeable reduction in international donor funding for the TB response between 2024 and 2025, although impacts at country level were very mixed.

In 2025, the total funding available for the TB response in LMICs was US$ 6.6 billion (in constant 2025 US$).[1] This was an increase of 9.0% from US$ 6.0 billion in 2024 (**Fig. 28**),[2] mostly attributable to increased domestic funding in India, Indonesia and the Russian Federation.[3] Nonetheless, it was still only equivalent to 30% of the global target of reaching US$ 22 billion per year by 2027 (**Table 1**). The annual level of funding has been stuck at between US$ 6 billion and US$ 7 billion since 2015.

Throughout the period 2015–2025, the share of funding available from domestic and international sources in LMICs was relatively consistent. In 2025, 86% of the funding available for TB prevention, diagnostic and treatment services was from domestic sources. The total amount in 2025 was US$ 5.63 billion, an increase of 14% compared with US$ 4.9 billion in 2024.

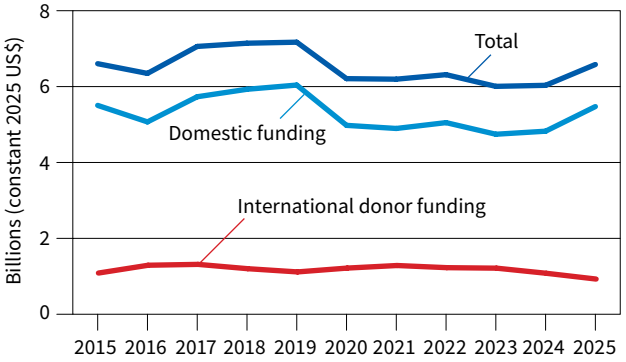
International donor funding for TB was relatively stable throughout the 10-year period from 2015 to 2024, at about US$ 1.1–1.3 billion per year. However, in 2025 it declined to US$ 0.94 billion, a 14% reduction from US$ 1.1 billion in 2024. For comparison, there was a larger absolute but comparable relative reduction in international donor funding for the HIV response, with funding falling from US$ 8.8 billion in 2024 to US$ 7.3 billion in 2025, a reduction of 18% *(33, 44)*. Both figures are lower than the global reduction in total official development assistance, which was 23% between 2024 and 2025 *(45)*.

In 2025, the overall figure for the share of funding provided from domestic sources in LMICs continued to be strongly influenced by Brazil, the Russian Federation, India, China and South Africa (BRICS)[4] (**Fig. 29**). Together, these countries accounted for US$ 3.7 billion (65%) of the total of US$ 5.63 billion in 2025 that was provided from domestic sources. Overall, 97% of available funding in BRICS and all funding in Brazil, China and the Russian Federation in 2025 was from domestic sources.

In other LMICs, international donor funding remained crucial (**Fig. 29**). In 2025, such funding accounted for 43% of the funding available in the 26 high TB burden countries and two global TB watchlist countries (Gabon and Liberia) outside BRICS, and 56% of the funding available in low-income countries. For comparison, the share of total funding for the HIV response in LMICs that was provided from international donor sources in 2025 was 41% *(33)*. The reduction in international donor funding for TB between 2024 and 2025 primarily impacted high TB burden countries outside BRICS; and within this category, reductions mostly affected lower-middle-income countries in Asia (the WHO South-East Asia and Western Pacific regions).

FIG. 28

Funding available for TB prevention, diagnostic and treatment services in 131 low- and middle-income countries by source,[a,b,c] 2015–2025



[a] Sources: data reported by NTPs and estimates produced by the WHO Department for HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections.

[b] The data sources, boundaries, accounting rules, and estimation methods used in this report are different from those of the System of Health Accounts 2011 (SHA2011). The TB funding data reported here are thus not comparable with the disease expenditure data, including for TB, that are reported in WHO's Global Health Expenditure Database.

[c] The 131 countries accounted for 99% of the global number of notified TB cases in 2025.

[1] All amounts quoted in this subsection are in constant 2025 US$. Numbers should not be directly compared with those in previous reports, because adjustments to the entire time series are made for each new report, to account for inflation.

[2] The exact figures for 2024 and 2025 are US$ 6.03 billion and US$ 6.57 billion, respectively.

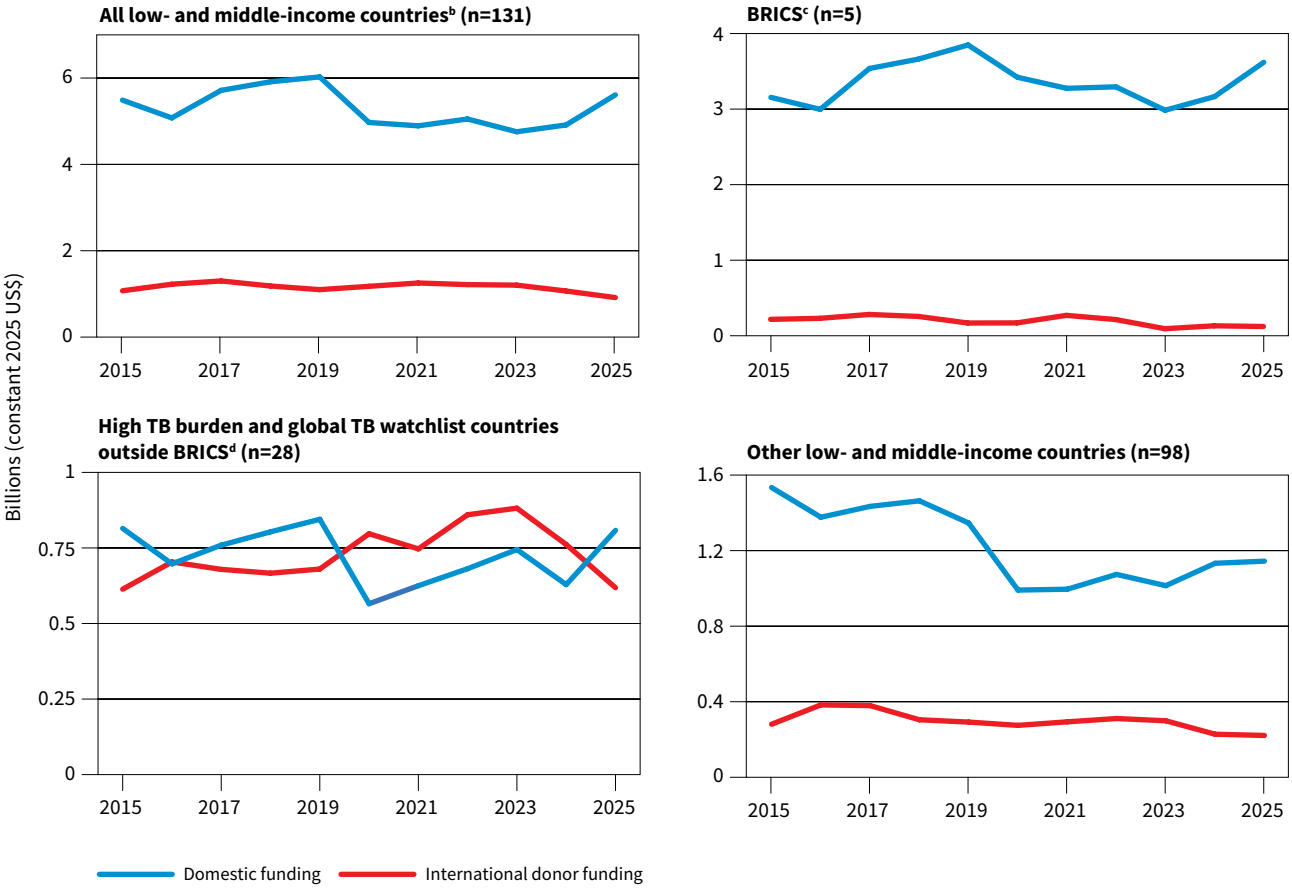
[3] In the most recent classification of countries by income group published by the World Bank *(43)*, the Russian Federation was categorized as a high-income country. It has been included in analyses for LMICs because it was an upper-middle-income country for most of the period 2015–2025 and it is in WHO's list of high-burden countries for drug-resistant TB (**Annex 3**).

[4] BRICS is used here to refer only to the five original members of the BRICS group of countries, acknowledging that this group expanded in 2024, and in 2025 comprised 11 countries.

FIG. 29

Funding available for TB prevention, diagnostic and treatment services in 131 low- and middle-income countries and three other country groups,[a] 2015–2025

BRICS: Brazil, the Russian Federation, India, China, South Africa.



[a] Sources: data reported by NTPs and estimates produced by the WHO Department for HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections.

[b] The data sources, boundaries, accounting rules, and estimation methods used in this report are different from those of the System of Health Accounts 2011 (SHA2011). The TB funding data reported here are thus not comparable with the disease expenditure data, including for TB, that are reported in WHO's Global Health Expenditure Database.

[c] The 131 countries accounted for 99% of the global number of notified TB cases in 2025.

[d] The two global TB watchlist countries included are Gabon and Liberia.

The Global Fund is the main source of international donor funding for TB.[1] In 2025, it accounted for 79% of the international donor funding reported by national TB programmes (NTPs) to WHO. Beyond 2025, funding for TB from the Global Fund is likely to decline. In the Global Fund's 2025 replenishment for the 2026–2028 grant cycle, US$ 12.6 billion was mobilized for HIV, malaria and TB, a 20% reduction compared with US$ 15.7 billion for the 2023–2025 cycle *(46, 47)*.

Throughout the period 2015–2025, the USG was the largest contributor of funding to the Global Fund (about one third); it was also the largest source of bilateral donor funding for TB. Through these two channels, the USG contributed about 50% of international donor funding for TB in the period 2015–2024.[2]

Given changes in the landscape of international donor funding since 2025, trends in funding for TB between 2024 and 2025 warrant specific attention, especially in countries that received both bilateral USG funding and grants from the Global Fund in 2024. Of the 24 countries that were priorities for USG bilateral funding in 2024, 23 have reported data on funding to WHO, both overall and by source, for all years between 2020 and 2025. These data reveal considerable variation in terms of how total funding changed between 2024 and 2025, and its distribution by source (**Fig. 30**).

[1] Further details are provided in the report webpages (section 4.1 and section 4.2).

[2] This figure is based on a comprehensive analysis of international donor funding for TB based on donor reports to the Organisation for Economic Co-operation and Development (OECD). A graphic that illustrates the shares contributed by OECD countries is provided in the report webpages (section 4.2).

FIG. 30

Funding available for TB prevention, diagnostic and treatment services in 23 countries[a] that were USG priorities for bilateral funding for TB and that received grants from the Global Fund in 2024, by source of funding,[b] 2020–2025

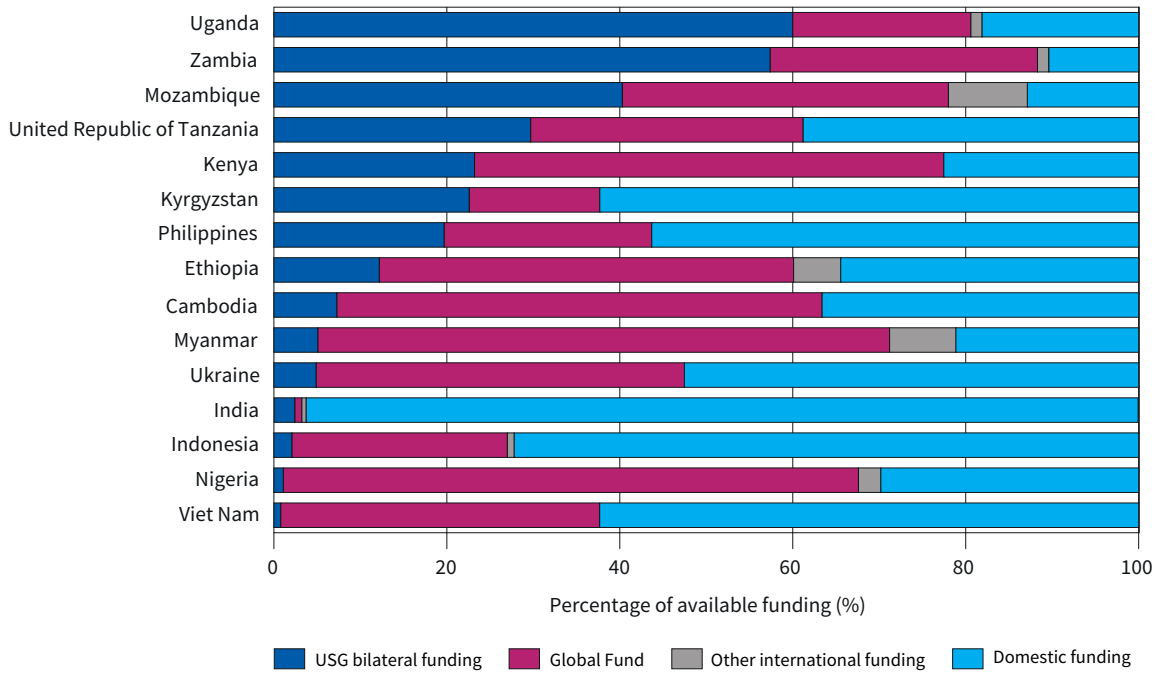


[a] The figure includes 23 of the 24 countries that were USG priorities for bilateral funding for TB in 2024. Data were not available for Uzbekistan.

[b] Domestic funding in this figure is based on data reported by NTPs, which typically do not include the financial costs associated with inpatient and outpatient care required during TB treatment.

FIG. 31

Sources of funding available[a] for TB prevention, diagnostic and treatment services in 2025, for 15 countries[b] that reported receiving USG bilateral funding and Global Fund grants in 2025



[a] Domestic funding in this graphic is based on data reported by NTPs, which typically do not include the financial costs associated with inpatient and outpatient care required during TB treatment.

[b] In addition, nine countries were USG priorities for bilateral funding for TB in 2024 but are not shown in the figure. Eight reported no USG bilateral funding in 2025: Afghanistan, Bangladesh, the Democratic Republic of the Congo, Malawi, Pakistan, Tajikistan, South Africa and Zimbabwe. Data were not reported by Uzbekistan.

Five patterns and associated country categories can be distinguished:

- An increase in both total funding and funding from USG bilateral sources between 2024 and 2025. This category comprises six countries: Kyrgyzstan, Mozambique, Uganda, the United Republic of Tanzania, Viet Nam and Zambia.
- An increase in total funding between 2024 and 2025, despite a reduction in USG bilateral funding, owing to an increase in domestic funding or support from the Global Fund. This category comprises six countries: Afghanistan, the Democratic Republic of the Congo, India, Indonesia, the Philippines and South Africa.
- An increase in total funding in 2025, with no USG funding reported in either 2024 or 2025. This category comprises one country, Pakistan, where funding from Global Fund grants increased between 2024 and 2025.
- A slight decline in total funding between 2024 and 2025, despite a small increase in USG bilateral funding. This category comprises one country, Kenya.
- A reduction in both total funding and USG bilateral funding between 2024 and 2025. This category comprises nine countries: Bangladesh, Cambodia, Ethiopia, Malawi, Myanmar, Nigeria, Tajikistan, Ukraine and Zimbabwe.

These varying patterns highlight the importance of assessing 2024–2025 financing trends at country level, from both domestic and international donor sources. They also appear to reflect new modalities for USG bilateral funding; for example, the replacement of funding previously provided by the United States Agency for International Development with new forms of bilateral support *(48, 49)*.

Among the 15 countries that reported receiving USG bilateral funding in 2025, this funding accounted for 20% or more of total available funding in seven countries; the share exceeded 30% in Mozambique, Uganda, the United Republic of Tanzania and Zambia (**Fig. 31**). Most of the 15 countries were also highly reliant on Global Fund grants in 2025. The country that reported the lowest share of total funding from Global Fund grants was India (0.79%).

Given the potential impact of changes in funding on the numbers of people falling ill with TB and the number of deaths caused by TB, it is critical to monitor how TB services are being affected as funding patterns change.

In most of the 10 countries that reported reductions in funding in 2025, there was no clear-cut impact in 2025.[1] For example, two of the countries that reported some of the largest absolute and relative reductions in funding – Bangladesh and Nigeria – also reported an increase in TB case notifications, improved coverage of rapid testing and improved TPT coverage. An important exception was Cambodia, where TB case notifications fell by 11%; the NTP has reported that this can be explained, at least in part, by a reduction in funding for active case-finding activities.[2]

Continued attention to changes in funding, and how these are related to key programmatic indicators, is necessary. Some impacts may be delayed or not yet visible; it is possible that some of the reported reductions in funding will be reversed as new funding modalities are established; and some reductions may be exacerbated as the reduced funds available to the Global Fund feed through in the current (2026–2028) grant cycle.

In 2025, several high TB burden countries increased their domestic funding for TB: examples include Bangladesh, the Democratic Republic of the Congo, India, Indonesia, Kenya, Myanmar, Nigeria, the Philippines, South Africa, Uganda, the United Republic of Tanzania and Viet Nam. Variation in the share of funding from domestic sources within a given income group suggests that there is scope to increase domestic funding in some other high TB burden countries.[3]

Strong national strategic plans for TB that are properly costed should provide the foundation for domestic resource mobilization; countries committed to such plans at the 2023 UN high-level meeting on TB (**Table 2**). WHO guidance on national strategic planning is available *(50)* and the TB module of the Integrated Health Tool for planning and costing (available online) can be used for budgeting as well as optimization of resource allocation and use.

UHC and costs faced by TB-affected households

Faster progress required, TB target off track

Global targets for reductions in TB disease burden can only be achieved if TB prevention, diagnostic and treatment services are provided within the context of progress towards UHC. For example, when the End TB Strategy was adopted in 2014, it was estimated that reaching the 2025 milestone of a 75% reduction in the number of deaths caused by TB (compared with 2015) would require reducing the TB case fatality rate to 6.5% by 2025.[4] Such a low case fatality rate is only feasible if everyone with TB can promptly access diagnostic and treatment services.

UHC means that everyone can obtain the health services they need without suffering financial hardship *(51)*. Through their adoption of the SDGs, all countries have committed to achieving UHC by 2030: Target 3.8 is "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" *(3)*. There are two indicators for Target 3.8: Indicator 3.8.1 and Indicator 3.8.2.

Indicator 3.8.1 is a UHC SCI. This can take values from 0 (worst) to 100 (best) and is calculated using 14 tracer indicators, one of which is the coverage of TB treatment.

Until March 2025, Indicator 3.8.2 was defined as the percentage of the population with catastrophic out-of-pocket (OOP) health expenditure. Two thresholds (10% and 25% of total household consumption or income) were used to define "catastrophic". An explanation of how this indicator differed from the TB-specific indicator related to catastrophic total costs (discussed below) was provided in previous editions of this report *(19)*.[5,6]

Indicator 3.8.2 was revised in 2025. The updated definition (used in this report) is the percentage of the population with positive OOP household spending on health that exceeds 40% of the household discretionary budget[7] (referred to as financial hardship due to large and impoverishing OOP health spending) *(52, 53)*.[8,9]

Estimates of the UHC SCI at global, regional and country levels are available for 2000–2023 *(52, 54)*.

Globally, there were steady improvements in the SCI between 2000 and 2023, from a score of 54 (out of 100) in 2000 to 71 in 2023 (**Fig. 32**). Most of this progress occurred between 2000 and 2015 and was primarily due to improvements in service coverage for infectious diseases, with more limited changes for other areas of service provision.

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1 In the 23 countries shown in **Fig. 30**, relative (%) changes in the total amount of reported funding between 2024 and 2025 were compared with relative changes in six programmatic indicators: the number of TB case notifications, TPT coverage, ART coverage, the coverage of rapid testing for TB diagnosis, the percentage of people diagnosed with TB whose diagnosis was bacteriologically confirmed, and the coverage of testing for rifampicin resistance among people diagnosed with TB.

2 Further details are available in the report webpages and in the country profiles of the report app.

3 Further details are provided in the report webpages (section 4.1).

4 This was in combination with a 50% reduction in the TB incidence rate. The estimated case fatality rate in 2025 was 11%.

5 See Box 3 of the *Global tuberculosis report 2025*.

6 Estimates based on this previous definition of Indicator 3.8.2 are available online. They should not be compared with estimates based on the revised definition or estimates for the TB-specific indicator.

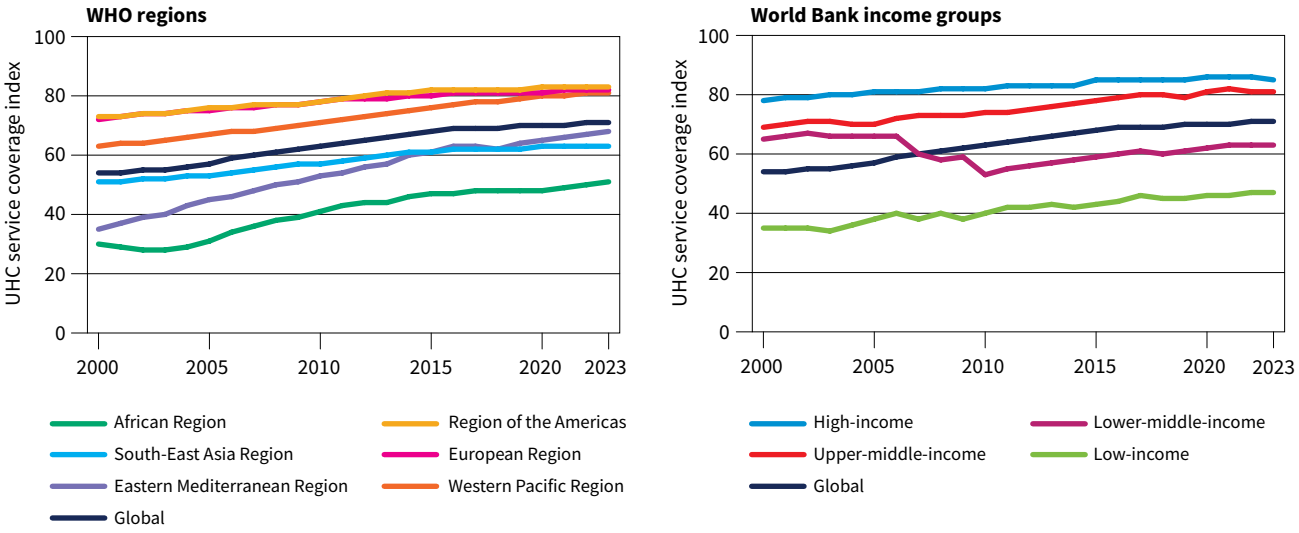
7 Discretionary budget is defined as the total household consumption expenditure or income (budget) minus the cost of basic needs, represented by the societal poverty line.

8 The rationale for the revised indicator is that it captures both impoverishing OOP household spending on health and large OOP household spending on health in the definition of financial hardship, through one single indicator.

9 The indicator has two subcomponents. The first is the percentage of the population facing impoverishing OOP health spending, defined as OOP that reduces a household's ability to meet basic needs. The second is the percentage of the population facing large but not impoverishing OOP health spending. Further explanation is provided elsewhere *(52, 53)*.

FIG. 32

Trends in the UHC service coverage index in WHO regions and World Bank income groups, 2000–2023



Source: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage

At regional level, the SCI increased in all six WHO regions between 2000 and 2023 (**Fig. 32**). The WHO regions with the highest values in 2023 were the Region of the Americas (83), the European Region (82) and the Western Pacific Region (81); the African Region had the lowest value (51). Between 2000 and 2023, the biggest absolute gains in the SCI were in the Eastern Mediterranean Region (+33), the African Region (+21) and the Western Pacific Region (+18).

There were increases in three of the four World Bank income groups,[1] and a decrease in lower-middle-income countries (**Fig. 32**).

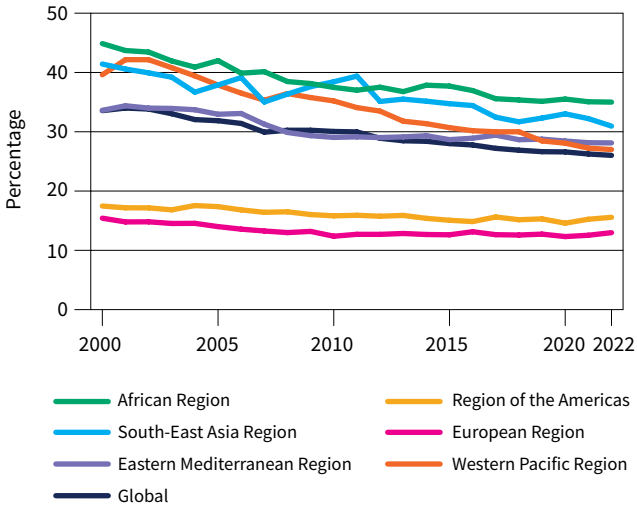
Among the 30 high TB burden countries, most made progress in service coverage between 2000 and 2023. The largest gains in absolute terms (+30 index points or more) were in India (+38), Cambodia (+36), Bangladesh (+30), Sierra Leone (+30), Uganda (+30) and Zambia (+30). In 2023, the high TB burden countries with the highest SCI values (80 or above) were Brazil, China and Thailand; most other countries had values between about 40 and 70.

Estimates of the percentage of the population facing financial hardship due to large and impoverishing OOP household spending on health at global and regional levels are available for the period 2000–2022 *(52)*.

Globally, financial hardship due to OOP spending on health decreased between 2000 and 2022. The percentage of the general population facing financial hardship due to OOP health spending declined from 34% in 2000 to 26% in 2022 (**Fig. 33**). There was also a decrease in

FIG. 33

Trends in the percentage of the general population facing financial hardship due to out-of-pocket health spending (SDG 3.8.2, 2025 definition),[a] globally and for WHO regions, 2000–2022

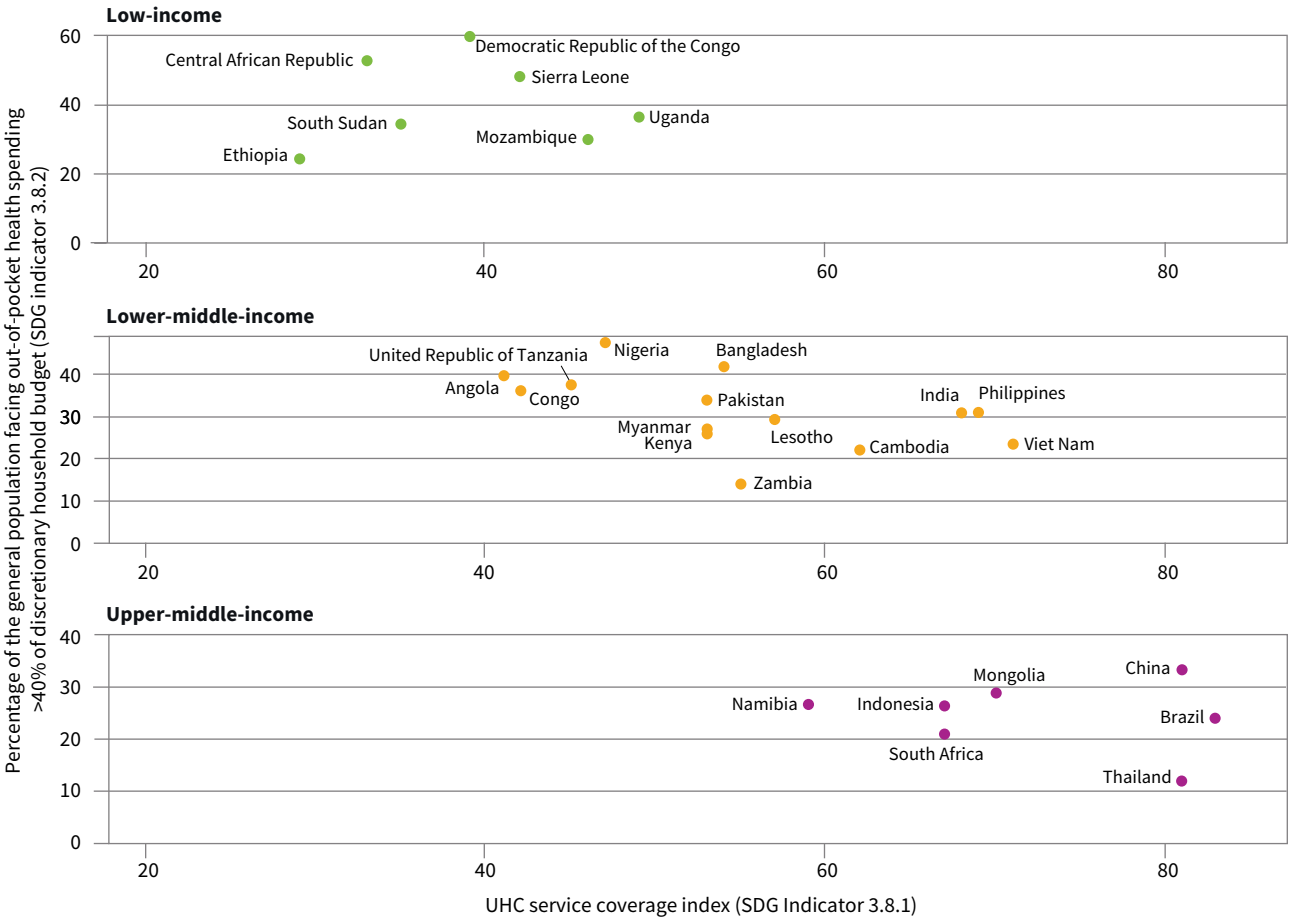


[a] Defined as out-of-pocket health spending exceeding 40% of a household's discretionary budget. (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/financial-hardship-and-components-percent-population)

[1] The income groups are those defined by the World Bank, as of July 2025.

FIG. 34

UHC service coverage index (SDG 3.8.1)[a] and percentage of the general population facing financial hardship (SDG 3.8.2, 2025 definition),[b] 30 high TB burden countries,[c] stratified by income group[d]



[a] The service coverage index (SCI) can take values from 0 (worst) to 100 (best) and is calculated using 14 tracer indicators, one of which is the coverage of TB treatment. Categories used by WHO for UHC SCI monitoring are "very high" (≥80), "high" (60–79) and "medium" (40–59).

[b] Defined as out-of-pocket health spending exceeding 40% of the household discretionary budget. The latest available year for which an estimate is available (based on data published in 2026) ranges from 2007 to 2023 for the 30 high TB burden countries.

[c] Data for SDG indicator 3.8.2 were not available for the Democratic People's Republic of Korea and Papua New Guinea.

[d] The classification is for the latest year for which data for SDG Indicator 3.8.2 are available.

Source: Global Health Observatory (https://www.who.int/data/gho)

all WHO regions between 2000 and 2022, despite an increase between 2020 and 2022 in the European Region and the Region of the Americas.

National values for the percentage of the population facing financial hardship due to OOP household spending on health are available for different years and there is more geographical variability than with the SCI, including within regions. Of the 30 high TB burden countries, estimates are particularly high (40% or above) for Angola, Bangladesh, the Central African Republic, the Democratic Republic of the Congo, Nigeria and Sierra Leone.

Values for both UHC indicators in the 30 high TB burden countries show that there is a long way to go before the SDG targets for UHC are achieved in most of these countries (**Fig. 34**). Thailand stands out as having a very high SCI (82 in 2023)[1] and the lowest level of financial hardship due to large and impoverishing OOP household spending on health (12% of households). In 2002, Thailand established a Universal Coverage Scheme to provide an explicit benefit to all citizens of the country who were not already covered by a health insurance scheme in the formal sector; the scheme is supported by domestic funding and a strong primary health care system *(55)*.

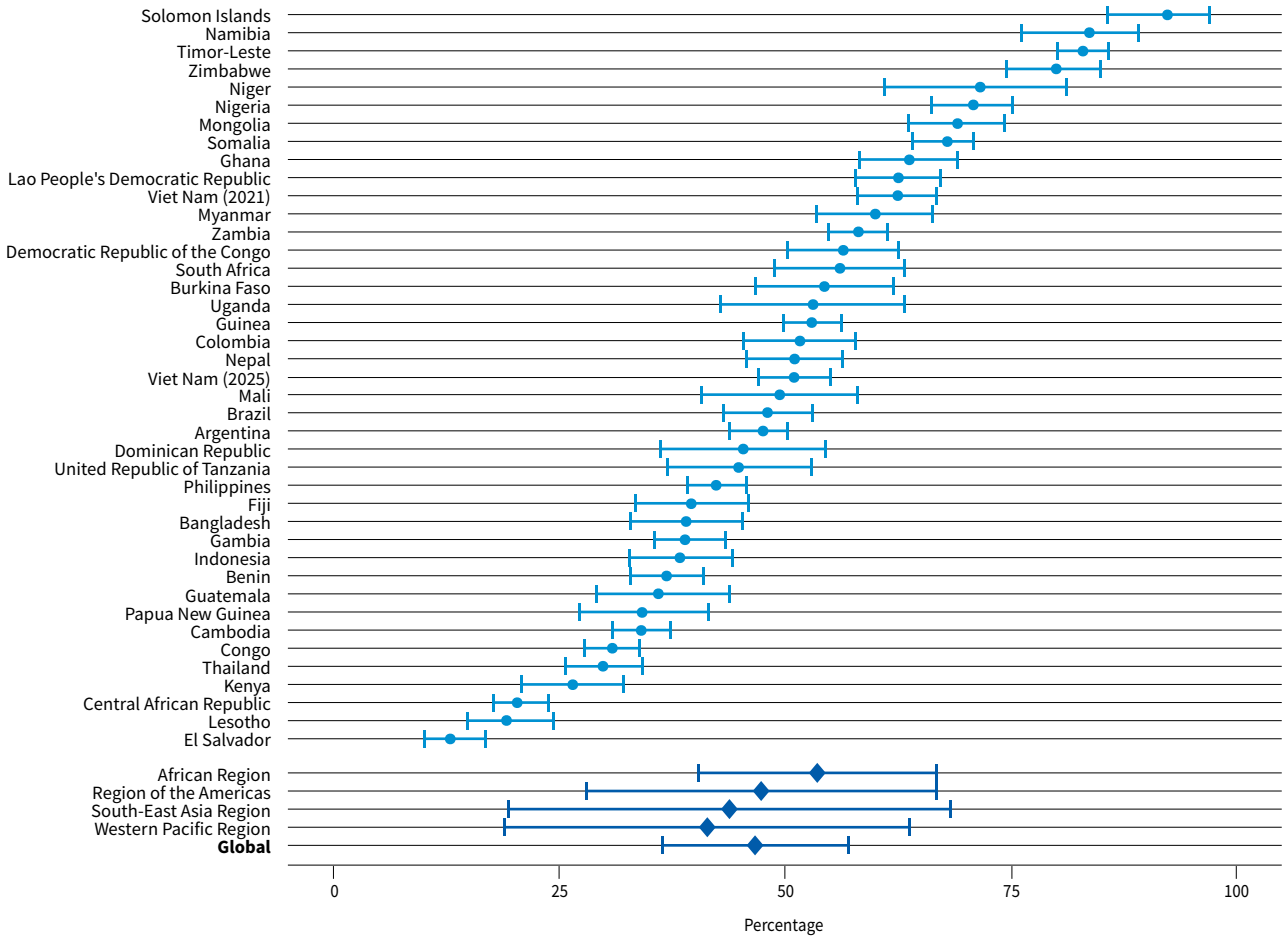
To achieve UHC, substantial increases in investment in health care are critical. Between 2000 and 2023,[2] there were striking increases in health expenditure (from all sources) per capita in a small number of high TB burden

[1] Categories used by WHO for UHC SCI monitoring are "very high" (≥80), "high" (60–79) and "medium" (40–59).

[2] 2023 is the latest year for which data are currently available.

FIG. 35

Estimates of the percentage of people treated for TB and their households facing catastrophic total costs (mean and 95% confidence intervals),[a] national surveys completed 2015–2025[b]



[a] Defined as direct medical expenditures, direct nonmedical expenditures and indirect costs (e.g. income losses) that sum to >20% of annual household income. This indicator is not the same as the SDG indicator for financial hardship due to out-of-pocket health spending and its components (SDG 3.8.2, 2025 definition).

[b] The percentages are shown for 41 national surveys that have been completed and for which data have been reported. Data were not available for China and Malaysia. Since the first survey in the Republic of Moldova sampled people treated for drug-resistant TB only, results of the first survey are not included. Regional and global estimates are calculated based on the latest survey results from each country.

countries, notably the upper-middle-income countries of Brazil, China, South Africa and Thailand. There have also been considerable increases in several lower-middle-income countries: Bangladesh, Cambodia, India, Indonesia, Kenya, Lesotho, Mongolia, Myanmar, the Philippines and Viet Nam. Health expenditure has been rising in most low-income and high TB burden countries – most noticeably in the Central African Republic, Ethiopia, Liberia and Mozambique – albeit from much lower levels.[1]

Given the importance of UHC to targets for reductions in TB incidence and mortality, the End TB Strategy included a target for the reduction of cost barriers to accessing TB diagnosis and treatment that are faced by people with TB and their households (**Box 2**). The target is that no TB-affected households face total costs (comprising direct medical expenditures, nonmedical expenditures and indirect costs such as income losses) that are catastrophic (defined as total costs exceeding 20% of annual household income). Between 2015 and August 2026, 45 national surveys of costs faced by people treated for TB and their households were completed in 43 countries, including 22 of the 30 high TB burden countries. Two countries – the Republic of Moldova and Viet Nam – completed a repeat survey. Results from 41 of these surveys have been shared with WHO.[2]

The mean total cost (in constant US$ prices for 2025)[3] incurred by people treated for TB and their households ranged from US$ 80 (95% confidence interval [CI]: US$ 64–100) in the Gambia to US$ 3922 (95% CI: US$ 3140–4703) in Mongolia.

[1] Further details are provided in the report webpages (section 5.1).

[2] Results from surveys in China and Malaysia have not been reported to WHO.

[3] All values were converted to a common year of prices (constant 2025 US$), to allow for fair comparisons among surveys.

The percentage of TB-affected households facing total costs that were catastrophic ranged from 13% (95% CI: 10–17%) in El Salvador to 92% (95% CI: 86–97%) in Solomon Islands; the pooled average, weighted for each country's number of notified cases, was 47% (95% CI: 36–57%) (**Fig. 35**).[1] Among 37 countries that reported disaggregated data, the percentage facing catastrophic total costs was much higher for drug-resistant TB, with a pooled average of 81% (95% CI: 70–92%).

Survey results have been used to inform approaches to health financing, service delivery and social protection that will reduce these costs *(56, 57)*. They have also been used to produce model-based estimates of total costs faced by TB-affected households in other countries *(58)*.

TB determinants, social protection and multisectoral accountability

Undernutrition and diabetes are leading TB determinants globally

Coverage of social protection inadequate

Global targets for reductions in TB disease burden cannot be achieved without addressing the broader social determinants that influence transmission of TB infection and susceptibility to development of disease once infected. Multisectoral action to mitigate or remove barriers beyond the health sector that affect access to essential TB services is also required. At the second UN high-level meeting on TB in 2023, Member States adopted a target that everyone with TB should have access to a health and social benefits package by 2027 (**Table 1**) and committed to strengthening multisectoral action and accountability (**Table 2**), including through use of the WHO multisectoral accountability framework for TB (MAF-TB) *(59)*.[2]

Many new cases of TB are estimated to be attributable to five health-related risk factors: undernutrition, diabetes, alcohol use disorders, smoking (especially among men) and HIV infection (**Fig. 36**) *(63–66)*.[3] Multisectoral action is needed to address these and other determinants that are strongly associated with TB incidence, such as gross domestic product (GDP) per capita (**Fig. 37**) and poverty.[4]

Social protection is a set of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion throughout the life cycle *(67)*. Such protection can help to address the social determinants of TB, improve treatment outcomes and mitigate the financial hardships faced by people with TB and their households.

Evidence about the coverage of social protection is available from the International Labour Organization (ILO). Although the data are for the general population rather than being specific to people with TB, they provide good evidence about overall levels of social protection, including in high TB burden countries. An estimated 52% of the world's population is covered by at least one social protection benefit (up from 43% in 2015),[5] with considerable variation among countries, WHO regions and income groups.

Coverage is above 80% in most parts of the WHO European Region and in a few countries in the Region of the Americas and Western Pacific Region; it is lowest in the African Region (<20% in most countries). Coverage is strongly related to income level, ranging from an average of 9.7% in low-income countries to 86% in high-income countries.

Among the 30 high TB burden countries, the percentage of the population covered by at least one social protection benefit varies from 0% in South Sudan to 94% in Mongolia; in 21 of these countries, the percentage is below 50% (**Fig. 38**).

When country values for the percentage of people covered by at least one social protection benefit are weighted according to each country's share of the global number of people newly diagnosed with TB and officially notified as a TB case in 2025, the global average is 44%. This weighted average provides a more "TB sensitive" global figure related to the coverage of social protection.

In 2025, the need for intensified efforts to improve levels of social protection was recognized by UN Member States in the "Sevilla Commitment" *(68)*, which was followed by adoption of a political declaration at a global summit on social development *(69)*. The commitment is to expand the fiscal space for social protection, with a view to increasing coverage by at least 2 percentage points per year in countries where social protection is not yet universal. Countries are being supported to achieve these objectives by ILO, together with the Global Partnership for Universal Social Protection (USP2030) and other international partners.

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[1] Further details are provided in the report webpages (section 5.2).

[2] To support use of the MAF-TB at national level, WHO has published a checklist for a situational assessment, an operational guide and examples of best practices *(60–62)*.

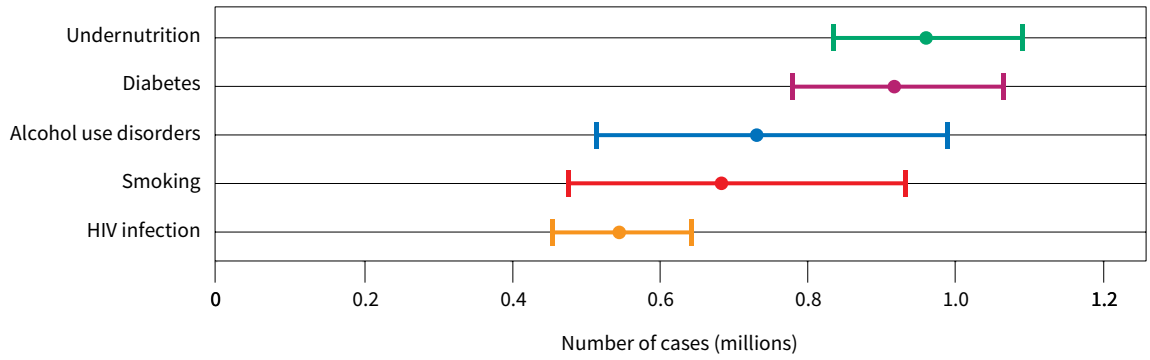
[3] Sources of data used to produce estimates include journal articles *(63–66)*, the World Bank SDG database, the WHO GHO and the WHO World Health Data Hub. Further details about methods are provided in the online technical appendix.

[4] SDG targets and indicators that are associated with TB incidence are described in **Annex 5**.

[5] This estimate is based on data for the latest available year in each country, which ranges from 2019 to 2025.

FIG. 36

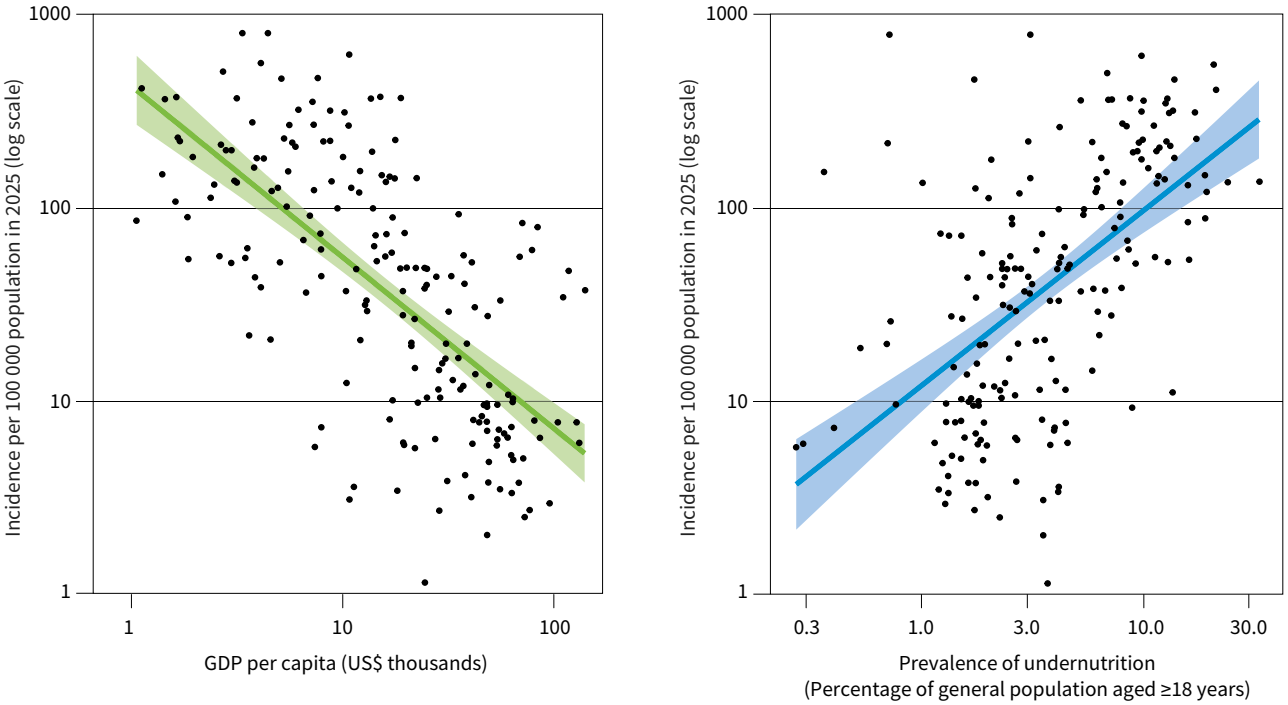
Global estimates of the number of incident cases of TB attributable to five health-related risk factors,[a] 2025



[a] Estimates for diabetes, smoking and alcohol use disorders are for the adult population only; this is consistent with available prevalence data. **Diabetes** in people aged ≥18 years is defined as fasting plasma glucose (FPG) ≥7 mmol/l (126 mg/dl), or glycated haemoglobin (HbA1c) ≥ 6.5% (48 mmol/mol), or on glucose-lowering medication for diabetes. For adults aged ≥18, **undernutrition** is defined as a body mass index (BMI) <18.5. For children and adolescents aged 5–17 years, it is defined as a BMI of less than minus 2 standard deviations below the median. For those aged <5 years, it is defined as wasting (weight for height of less than minus 2 standard deviations from the median).

FIG. 37

Relationship between two SDG-related indicators[a,b] and the TB incidence rate, 2025

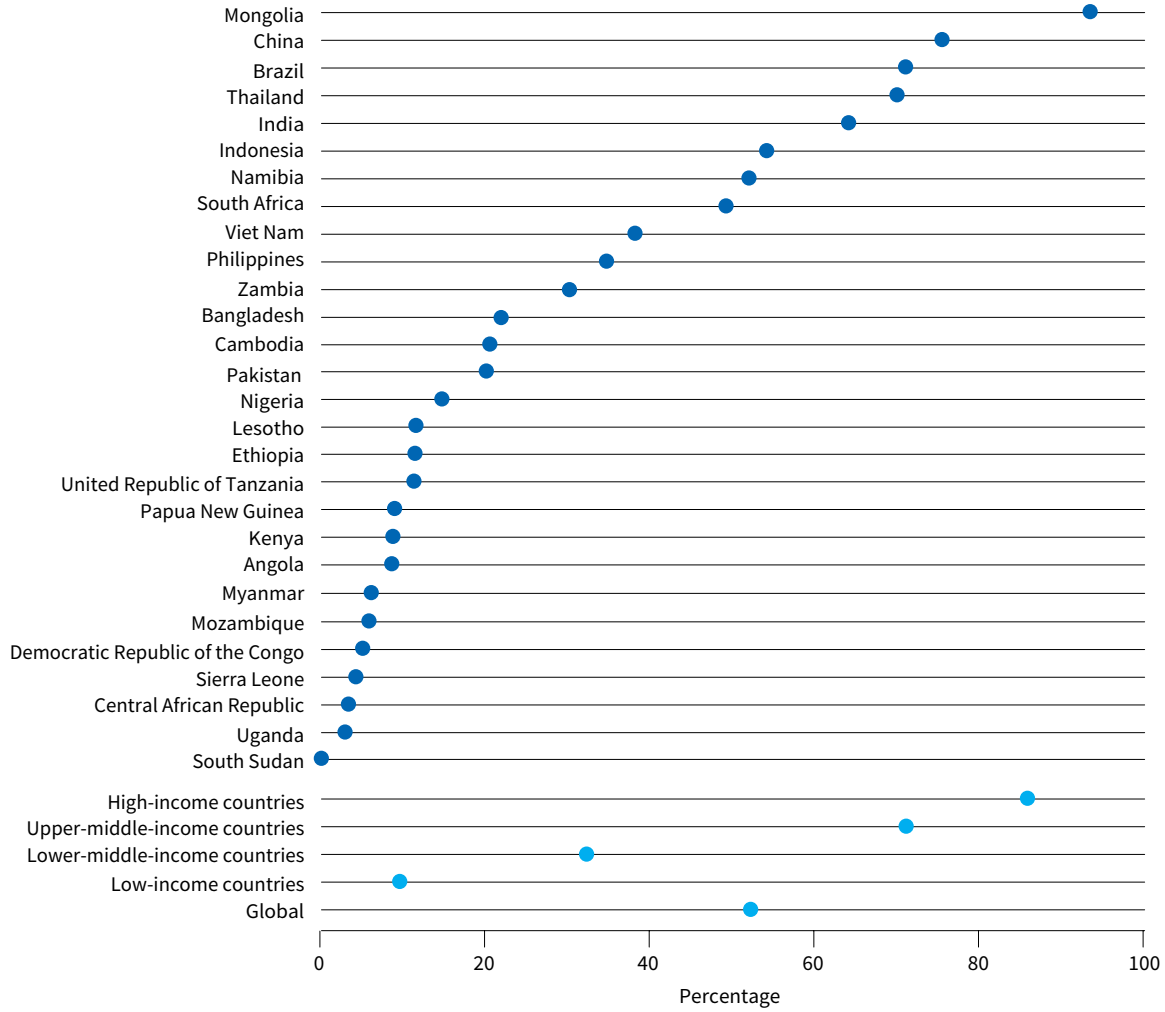


[a] The year of data used for GDP per capita and the population prevalence of undernutrition is the latest year for which data are available from the World Bank (https://data.worldbank.org/) and in the WHO Global Health Observatory (https://www.who.int/data/gho), respectively.

[b] For adults aged ≥18, undernutrition is defined as a body mass index (BMI) <18.5. For children and adolescents aged 5–17 years, it is defined as a BMI of less than minus 2 standard deviations below the median. For those aged <5 years, it is defined as wasting (weight for height of less than minus 2 standard deviations from the median).

FIG. 38

Percentage of the population covered by at least one social protection benefit, 30 high TB burden countries,[a] four income groups[b] and globally, latest available year[c]



[a] Data were not available for the Congo and the Democratic People's Republic of Korea.
[b] Data are shown for World Bank income groups since income level is a key influence on social protection coverage.
[c] The latest available year ranges from 2019 to 2025.
Source: International Labour Organization.

The status of progress in strengthening multisectoral accountability for the TB response at national level can be assessed using data that are available for three key elements of the MAF-TB:

- multisectoral reviews of progress in the TB response and associated recommendations for action, including representation from civil society and affected communities;
- production of an annual TB report, to inform high-level review; and
- engagement of different sectors of government in the TB response.

In 2026, 85 countries reported that they had a multisectoral review mechanism in place, including 20 of the 30 high TB burden countries. These review mechanisms had representation from civil society and affected communities in 69 countries, including 20 of the 30 high TB burden countries.

A total of 102 countries reported publishing an annual TB report on progress towards national TB-related targets and commitments, including 22 of the 30 high TB burden countries.

Beyond the health sector, the most widely engaged sectors of government were education (41% of countries), defence (34%), justice (28%) and social development (26%). There is considerable scope to increase engagement in these key sectors and beyond.

WHO also recommends that countries conduct MAF-TB baseline assessments, and then use the results to develop a MAF-TB implementation plan. In 2026, 49 countries reported that they had completed a MAF-TB baseline assessment and 68 reported that a MAF-TB implementation plan had been developed.

A total of 21 countries, including 10 high TB burden countries, had all five core elements of the MAF-TB in place. That is, they had a multisectoral review mechanism, engagement of civil society and affected communities in the review mechanism, an annual report, a baseline assessment and an implementation plan.[1]

In line with the global part of the MAF-TB and requests at the 2023 UN high-level meeting on TB (**Table 2**), WHO will continue to lead the coordination of global TB monitoring, reporting and review, and will provide technical support and guidance to countries and partners. This work will continue to be informed by the WHO Civil Society Task Force on TB.

TB research

Diagnostic and drugs pipelines expanding

Changes in funding landscape threaten progress

The End TB Strategy targets set for 2030 (**Box 2**) cannot be met without intensified research and innovation *(14)*. Major technological breakthroughs are urgently needed to accelerate the annual decline in the global TB incidence rate. Reductions in TB incidence achieved between 2015 and 2025 fall far short of the 2025 milestone of the strategy (14% compared with 50%).

Priorities include new vaccines to reduce the risk of infection; new vaccines or preventive drug treatments to reduce the risk of TB disease in people already infected; rapid diagnostic tests for accurate detection of TB disease at the point of care; and simpler, shorter treatments for TB disease. WHO has developed a global strategy for TB research and innovation, which was adopted by all Member States in 2020 *(70)*. The strategy aims to support accelerated TB research and innovation, and improve equitable access to the benefits of research.

Recent years have seen important progress in the development of new TB diagnostics, drugs and vaccines.[2]

The diagnostic pipeline has expanded considerably. In August 2026, there were 65 tests in development for diagnosis of TB disease. They included point-of-care tests (e.g. lateral flow tests), near-point-of-care nucleic acid amplification tests (NAATs), automated NAATs of both low and moderate complexity, line probe assays for detection of drug resistance and targeted next-generation sequencing. New tests for TB infection that were in development included interferon-gamma release assays and TB antigen-based skin tests. Novel technologies for TB screening (e.g. computer-aided detection using digital chest radiography) among people with a high likelihood of having TB disease were also in the pipeline.

As of August 2026, there were 31 drugs for the treatment of TB disease in Phase 1, Phase 2 or Phase 3 trials. This was an increase from 29 in 2025, and an impressive increase from only eight drugs in 2015.

The 31 drugs comprise:

- 20 new chemical entities: alphibectir (BVL-GSK098), BTZ-043, contezolid, delpazolid, GSK-286, ganfeborole (GSK-3036656), macozinone, MK-7762 (TBD09), quabodepistat (OPC-167832), TBAJ-587, TBAJ-876, TBD11, TBI-223, pyrifazimine (TBI-166), TBA-7371, telacebec (Q203), sanfetrinem, SQ109, sutezolid and sudapyridine (WX-081);
- three drugs that have already been approved by WHO for use in treatment: bedaquiline, delamanid and pretomanid; and
- eight repurposed drugs: clofazimine, levofloxacin, linezolid, moxifloxacin, rifampicin (high dose), rifapentine, sitafloxacin and tedizolid.

In addition, various combination regimens with new or repurposed drugs, as well as host-directed therapies, are in Phase 2 or Phase 3/4 trials, or are being evaluated as part of operational research projects.

In August 2026, at least 42 clinical trials and implementation research studies were underway to evaluate drug regimens and models of delivery for TPT. Nine studies are assessing new TPT regimens; these include a trial investigating 4 weeks of bedaquiline for both drug-susceptible and drug-resistant TB in contacts and people living with HIV, a trial evaluating delamanid for the prevention of MDR-TB, trials investigating short-course regimens (e.g. thrice-weekly isoniazid and rifapentine for 1 month), and trials of rifamycin monotherapies given over 6 or 8 weeks. At least 17 studies are focused on novel TPT delivery models in community-based and facility-based settings, targeting children, people living with HIV and other eligible populations. Other studies are assessing the safety and efficacy of TPT in people with diabetes, pharmacokinetics and dose optimization.

In August 2026, the clinical pipeline for new TB vaccines comprised 17 vaccine candidates. Of these, 12 were in active development: three in Phase 1 trials, six in Phase 2 trials and three in Phase 3 trials. The remaining five were classified as either inactive, or not under active development.[3] Candidates in active development include vaccines to prevent TB infection and TB disease, and to help improve the outcomes of treatment for TB disease. WHO is supporting global efforts to prepare

[1] Further details are provided in the report webpages (section 5.4).

[2] A high-level summary is provided in this subsection. Further details are provided in the report webpages (section 6).

[3] The category of "inactive or not under active development" is new. It has been introduced to distinguish candidates with no clinical development activity for 5 or more years, or whose sponsors have discontinued development, consistent with the approach adopted in 2026 by the Stop TB Partnership's Working Group on New TB Vaccines.

BOX 3

WHO efforts to support global efforts to prepare for new TB vaccines

In 2023, WHO's Director-General established a TB Vaccine Accelerator Council to guide and strengthen global efforts to develop and ensure access to novel, effective TB vaccines *(71)*. The Council includes ministers of health from high TB burden countries, representatives of people affected by TB, and senior leaders of international agencies, financing organizations and philanthropic foundations.

WHO serves as the secretariat of the Council and its three working groups. These comprise:

- a technical advisory group on evidence for clinical and policy considerations *(72)*;
- a working group on finance and access *(73)*; and
- a working group on country readiness, advocacy and community partnership *(74)*.

In 2026, key activities of the Council and its working groups included:

- a meeting of stakeholders from the three working groups in April, to discuss joint action;
- a meeting of the Council in May; and
- a meeting in June to discuss preparedness for vaccine introduction in Kenya, Malawi and Zambia.

BOX 4

Updated WHO guidance related to TB prevention, diagnosis, treatment and care

Between November 2025 and October 2026, WHO published updated guidance related to TB prevention, diagnosis and treatment. This included:

- new recommendations for TB diagnosis, including the use of new near-point-of-care tests, tongue swabs, and sputum pooling *(76)*;
- new recommendations about the management of palliative care for people with TB and the treatment of severe disease in people with pre-XDR-TB *(31)*;
- guidance on evidence generation related to new regimens for TPT *(77)*; and
- guidance on evidence generation related to TB diagnostics *(78)*.

In addition, a third edition of the catalogue of mutations in *Mycobacterium tuberculosis* complex and their association with drug resistance was published *(79)*.

Target regimen profiles for long-acting injectables for TB prevention and treatment were released in October 2026 *(80)*.

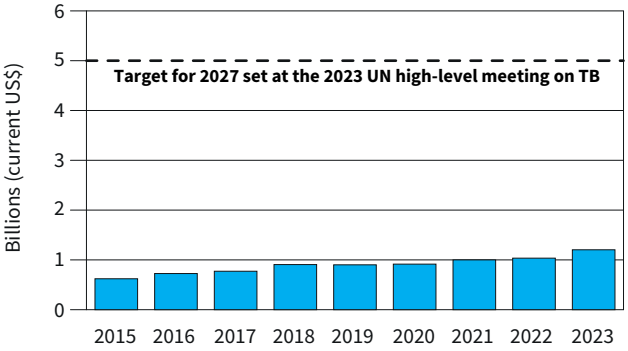
The latest WHO guidelines and operational handbooks, as well as other documents to support the production of evidence-based recommendations, can be found on a WHO Knowledge Sharing Platform *(81)*.

for new TB vaccines through a TB Vaccine Accelerator Council (**Box 3**).

Progress to date has been constrained by the overall level of investment in TB research. The most recently published data *(75)* show a total of US$ 1.2 billion in 2023 (**Fig. 39**); this represents a modest increase from US$ 1.0 billion in 2022 but is still only 24% of the global target of US$ 5 billion per year by 2027 (**Table 1**). Updated data are scheduled for publication in December 2026.

FIG. 39

Funding for TB research, 2015–2023



Source: Treatment Action Group, Stop TB Partnership. Tuberculosis research funding trends 2005–2023. New York: Treatment Action Group; 2024 (https://www.treatmentactiongroup.org/resources/tbrd-report/tbrd-report-2024/)

In 2023, drug development accounted for the largest proportion of TB research funding (35%), followed by vaccines (19%), diagnostics (14%), basic science (13%), operational research (11%) and infrastructure or unspecified research (8%). The public sector provided the largest share of the available funding, contributing 62% of the total, followed by philanthropic organizations (24%), the private sector (9%) and multilateral agencies (4%). The US National Institutes of Health was the largest individual funder, contributing 34% of all global TB research funding *(75)*.

Recent shifts in the global health landscape – including reductions in development assistance and growing pressure on public research budgets – have raised concerns about reductions in funding for TB research. Strengthening regional research capacity, expanding South–South collaborations, fostering public–private partnerships and aligning research priorities with national and regional needs may help to reduce dependence on a limited number of funders.

When new evidence related to new TB drugs, diagnostic tests, treatment regimens and vaccines becomes available, it is reviewed by WHO and used to update WHO recommendations related to TB prevention, diagnosis, treatment and care (**Box 4**).

4. Conclusions

All WHO and UN Member States have committed to ending the global TB epidemic, through their adoption of the End TB Strategy and SDGs. The 2030 targets of the End TB Strategy are a 90% reduction in the number of deaths caused by TB and an 80% reduction in the TB incidence rate, compared with levels in 2015.

These commitments were reaffirmed at two UN high-level meetings on TB, held in 2018 and 2023, and reinforced with additional targets related to funding, the provision of treatment to people with TB disease or TB infection, and the availability of new TB vaccines.

TB remains a major global public health problem, and progress in reducing the burden of disease falls far short of 2030 targets in most parts of the world. Nonetheless, important global progress has been made, especially in reducing the number of people dying from TB each year. In 2025, a significant global milestone was reached: a 35% reduction in the global number of deaths caused by TB compared with 2015, albeit 5 years behind the original schedule set out in the End TB Strategy. The number of people dying from TB each year has been halved in two WHO regions: the African Region and the European Region. A total of 99 countries have reduced the TB incidence rate by 20% or more since 2015, and 89 countries have reduced the number of people dying from TB by at least 35%.

In general, following a 5-year period of COVID-related setbacks and subsequent recovery in TB services and epidemic trends, 2025 was a year characterized by stability or small improvements. The main exception was a sizeable reduction in international donor funding. The TB response at global, regional and country levels has demonstrated considerable resilience in the face of external shocks.

Further and faster reductions in the burden of TB disease require improvements in the coverage of TB diagnostic, treatment and preventive interventions; action on broader determinants that drive new infections or increase the risk of developing disease once infected; and technological breakthroughs, such as a new TB vaccine. All depend on adequate funding.

Political commitment and domestic funding are critical to sustain and accelerate progress towards the goal of ending the global TB epidemic, especially in countries with the highest burden.

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Annex 1

Basic facts about TB

Tuberculosis (TB) is an old disease. Studies of human skeletons show that it has affected humans for thousands of years *(1)*. Its cause remained unknown until 24 March 1882, when Dr Robert Koch announced his discovery of the bacillus responsible, subsequently named *Mycobacterium tuberculosis (2)*. The disease is spread when people who are sick with TB expel bacteria into the air (e.g. by coughing). TB typically affects the lungs (pulmonary TB) but can also affect other sites (extrapulmonary TB). Most people who develop the disease (about 90%) are adults and there are more cases among men than women.

Diagnostic tests for TB disease have improved substantially in recent years. There are now several kinds of rapid molecular tests recommended by WHO as the initial diagnostic tests for TB, some of which can detect drug resistance simultaneously *(3)*. These tests can be used at the lower levels of the health system. A point-of-care lateral-flow test performed on urine is also recommended by WHO; its main use is to assist with diagnosis of TB in people living with HIV, in combination with rapid molecular tests that are also now available near point-of-care. There are additional rapid molecular tests specifically for the detection of resistance to a variety of first- and second-line anti-TB drugs, while sequencing technologies can be used to provide a comprehensive individual profile of drug resistance. The older method of sputum smear microscopy (developed >100 years ago) is still used for TB diagnosis in low and middle-income countries but is increasingly being replaced with rapid tests.

Culture testing remains the reference standard for TB diagnosis. In addition, culture is still recommended for the detection of resistance to newer anti-TB drugs and may also be used as a confirmatory test in settings and situations in which people have a low pre-test probability of having TB disease. Following diagnosis, culture or smear (as opposed to rapid molecular tests) are necessary to monitor an individual's response to treatment. WHO continues to promote development of new tests that could be used to monitor treatment optimization, efficacy and cure.

Screening can be used to detect people with TB earlier in the course of the disease, including people with TB whose diagnosis might otherwise be missed. TB screening algorithms recommended by WHO are based on chest X-ray, computer-aided detection software, molecular diagnostic tests, symptoms, physical signs and other tools *(4)*.

Without treatment, the death rate from TB is high. Studies of the natural history of TB disease in the absence of treatment with anti-TB drugs (conducted before drug treatments became available) found that about 70% of individuals with sputum smear-positive pulmonary TB died within 10 years of being diagnosed, as did about 20% of people with culture-positive (but smear-negative) pulmonary TB *(5)*.

Effective drug treatments were first developed in the 1940s.

For people with drug-susceptible TB (both pulmonary and extrapulmonary), the latest WHO treatment guidelines *(6)* include a strong recommendation for a 6-month regimen of isoniazid (H), rifampicin (R), ethambutol (E) and pyrazinamide (Z): all four drugs for the first two months, followed by H and R for the remaining 4 months. The guidelines also include recommendations that people aged 12 years and older with drug-susceptible pulmonary TB may be treated with a 4-month regimen of rifapentine (P), H, Z and moxifloxacin (M), and that children and adolescents between 3 months and 16 years of age with non-severe TB (and without suspicion or evidence of resistance to R and H) may be treated with a 4-month regimen (2 months of H, R, Z and sometimes also E, followed by 2 months of H and R). Globally, the treatment success rate for people with drug-susceptible TB has been sustained at a high level for many years. In the latest annual cohort of people enrolled on treatment for which data are available (2024), it was 90%.

Treatment for people diagnosed with R-resistant TB (RR-TB) requires other drug regimens. The latest WHO treatment guidelines *(6)* prioritize two 6-month regimens. One of these consists of bedaquiline (B), pretomanid (Pa), linezolid (L) and M (BPaLM); it was approved by WHO in 2022. The second consists of B, delamanid (D), L, levofloxacin (Lfx) and clofazimine (BDLLfxC); it was approved by WHO in 2024. Globally, the treatment success rate for RR-TB has been steadily improving. It was 70% in the most recent annual cohort of people enrolled on treatment for which data are available (2023), up from 50% in 2012. Further improvements are expected as the use of the 6-month treatment regimens expands.

Treatment for extensively drug-resistant TB (XDR-TB, defined as resistance to R, any fluoroquinolone and at least one of B or L) remains much more difficult and treatment success rates are typically low.

A global modelling study published in 2016 estimated that about a quarter of the world's population had been infected with *M. tuberculosis (7)*. More recent analyses and commentary suggest that the number of those currently infected is lower, given that some people will clear the infection *(8, 9)*. Following infection, the risk of developing TB disease is highest in the first 2 years (approximately 5%), after which it is much lower *(10)*. The probability of developing TB disease is much higher among people living with HIV, and among people affected by risk factors such as undernutrition, diabetes, smoking and alcohol consumption.

TB preventive treatment (TPT) is available to treat TB infection in people at risk of developing TB. Recommended options include: a weekly dose of H and P for 3 months (3HP), a daily dose of H and R for 3 months (3HR), a daily dose of H and P for 1 month (1HP), a daily dose of R for 4 months (4R) and a daily dose of H for 6 months (6H) or 9 months (9H) *(11)*. In people exposed to RR-TB, a daily dose of Lfx for 6 months (6Lfx) is recommended.

The only licensed vaccine for prevention of TB disease is the bacille Calmette-Guérin (BCG) vaccine. The BCG vaccine was introduced over 100 years ago, prevents severe forms of TB in children and is widely used. There is currently no licensed vaccine that is effective in preventing TB disease in adults, either before or after exposure to TB infection; however, results from a Phase 2 trial of the M72/AS01E candidate were promising *(12)*. This vaccine is currently in a Phase 3 trial. Two additional vaccine candidates are also in Phase 3 trials.

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Annex 2

Data sources and access

A2.1 Database contents

The Global tuberculosis report 2026 is based on data requested annually from 215 countries and areas, including all 194 World Health Organization (WHO) Member States. Data are stored in the global TB database, which is managed by the Monitoring, Evaluation and Strategic Information unit of WHO's Department for HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections.

WHO has implemented annual rounds of data collection since 1995. The main round of data collection for this report took place in April and May 2026. As in previous years, data were collected on the following: TB case notifications and treatment outcomes, including breakdowns by TB case type, age, sex, HIV status and drug resistance; laboratory diagnostic services; contact screening and TB preventive treatment; TB infection control; engagement of all public and private care providers in TB prevention and care; community engagement; specific elements of the WHO multisectoral accountability framework for TB; budgets of national TB programmes (NTPs); use of general health services (hospitalization and outpatient visits) during treatment; and NTP expenditures. A shortened version of the questionnaire was used for high-income countries as defined by the World Bank,[1] and any additional countries with an incidence rate of <20 cases per 100 000 population or <10 cases in total in 2024.

Countries and areas reported data via a dedicated website.[2] Australia and Chile also made updates to data reported for previous years. Additional data about the provision and completion of TB preventive treatment to people newly or currently enrolled in HIV care were collected by the Joint United Nations Programme on HIV/AIDS (UNAIDS). These data were jointly validated by WHO and UNAIDS, and then uploaded to the WHO global TB database.

Following review and follow-up with countries, the data used for the main part of this report were those that were available on **25 August 2026**. **Table A2.1** shows the number of countries and areas that had reported data by **25 August 2026**.

Indicators in the Sustainable Development Goals (SDGs) associated with TB incidence were imported into the global TB database on **25 August 2026**. **Table A2.2** shows the data sources used.

Population estimates from the United Nations Population Division's 2024 revision of World Population Prospects[3] were imported into the global TB database on 2 July 2024 and used in the analyses for this report.

TABLE A2.1

Reporting of data in the 2026 round of global TB data collection as of 25 August 2026

	COUNTRIES AND AREAS		WHO MEMBER STATES	
	NUMBER	NUMBER THAT REPORTED DATA	NUMBER	NUMBER THAT REPORTED DATA
African Region	47	47	47	47
Region of the Americas	45	34	35	29
South-East Asia Region	10	10	10	10
European Region	54	48	53	47
Eastern Mediterranean Region	22	21	21	20
Western Pacific Region	37	27	28	23
Global	**215**	**187**	**194**	**176**

A2.2 Accessing TB data using the WHO website

Most of the data held in the WHO global TB database can be accessed via the WHO TB data web page.[4] This page provides comma-separated value (CSV) data files, as well as country, regional and global profiles.

Data reported by countries, such as time series for case notifications and treatment outcomes, and WHO's estimates of TB disease burden, can be downloaded as CSV files covering all years for which data are available.

They can be imported into many applications such as spreadsheets, databases and statistical analysis software. These files are the primary resource for anyone interested in conducting their own analyses of the records in the global TB database. A data dictionary that defines each of the variables available in the CSV files is also available.

[1] https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups
[2] https://extranet.who.int/dhis2
[3] https://population.un.org/wpp/
[4] https://www.who.int/teams/global-tuberculosis-programme/data

TABLE A2.2

Data sources for indicators in the SDGs that are associated with TB incidence

SDG INDICATOR	DISPLAY NAME IN PROFILE	DATA SOURCE	NAME AT SOURCE	SOURCE URL
1.1.1	Population living below the international poverty line (% of population)	UN SDG database	Proportion of population below the international poverty line of US$1.90 per day	https://unstats.un.org/SDGAPI/v1/sdg/Series/Data?seriesCode=SI_POV_DAY1
1.3.1	Population covered by social protection floors/systems (% of population)	International Labour Organization	Coverage of social protection and labor programs (% of population)	https://rshiny.ilo.org/dataexplorer20/?lang=en&segment=indicator&id=SDG_0131_SEX_SOC_RT_A
2.1.1 *(alternative)*	Prevalence of under-nutrition (% of population aged ≥18 years)	WHO-GHO	Prevalence of underweight among adults, BMI <18.5 (crude estimate) (%)	https://ghoapi.azureedge.net/api/NCD_BMI_18C
3.3.1 *(alternative)*	HIV prevalence (% of population aged 15–49 years)	WHO-GHO	Prevalence of HIV among adults aged 15 to 49 (%)	https://ghoapi.azureedge.net/api/MDG_0000000029
3.4.1 *(alternative)*	Diabetes prevalence (% of population aged ≥18 years)	WHO-GHO	Prevalence of diabetes, age-standardized	https://ghoapi.azureedge.net/api/NCD_DIABETES_PREVALENCE_AGESTD
3.5.2 *(alternative)*	Alcohol use disorders, 12 month prevalence (% of population aged ≥15 years)	WHO-GHO	Alcohol use disorders (15+), 12 month prevalence (%) with 95% confidence interval	https://ghoapi.azureedge.net/api/SA_0000001462
3.a.1 *(alternative)*	Smoking prevalence (% of population aged ≥15 years)	WHO-GHO	Estimate of current tobacco smoking prevalence (%) (age-standardized rate)	https://ghoapi.azureedge.net/api/M_Est_smk_curr_std
3.8.1	UHC index of essential service coverage (based on 14 tracer indicators including TB treatment)	WHO-GHO	UHC index of essential service coverage	https://ghoapi.azureedge.net/api/UHC_INDEX_REPORTED
3.8.2	% of population with out-of-pocket health expenditure ≥40% of household discretionary budget (financial hardship)	WHO-GHO	Financial hardship due to out-of-pocket health spending and its components (SDG indicator 3.8.2, 2025 definition)	https://ghoapi.azureedge.net/api/FINANCIALHARDSHIP_PROPORTIONOFPOP
3.8.2 *(alternative)*	Health expenditure per capita, PPP (current international $)	World Bank	Current health expenditure per capita, PPP (current international $)	http://data.worldbank.org/indicator/SH.XPD.CHEX.PP.CD
7.1.2	Access to clean fuels and technologies for cooking (% of population)	World Bank	Access to clean fuels and technologies for cooking (% of population)	http://data.worldbank.org/indicator/EG.CFT.ACCS.ZS
8.1.1 *(alternative)*	GDP per capita, PPP (constant 2021 international $)	World Bank	GDP per capita, PPP (constant 2021 international $)	http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.KD
10.1.1 *(alternative)*	GINI index (0=perfect equality, 100=perfect inequality)	World Bank	GINI index (World Bank estimate)	http://data.worldbank.org/indicator/SI.POV.GINI
11.1.1	Population living in slums (% of urban population)	UN SDG database	Proportion of urban population living in slums (%)	https://unstats.un.org/SDGAPI/v1/sdg/Series/Data?seriesCode=EN_LND_SLUM

The CSV files are generated on demand directly from the WHO global TB database, and may therefore include updates received after publication of the *Global tuberculosis report 2026*.

A2.3 Accessing TB data using the WHO Global Health Observatory

The WHO Global Health Observatory (GHO)[1] is a portal that provides access to data and analyses for monitoring the global health situation; it includes a data repository.

Data from WHO's global TB database can be viewed, filtered, aggregated and downloaded from within the GHO data repository.[2]

There is also an application programme interface (API)[3] using the open data protocol. The API allows analysts and programmers to use GHO data directly in their software applications.

[1] https://www.who.int/data/gho

[2] https://www.who.int/data/gho/data/themes/tuberculosis

[3] https://www.who.int/data/gho/info/gho-odata-api

Annex 3

WHO global lists of high TB burden countries

A3.1 Background

During the period 1998 to 2015, the concept of a "high burden country" (HBC) became familiar and widely used in the context of tuberculosis (TB). The first global list developed by the World Health Organization (WHO) consisted of 22 HBCs with approximately 80% of the world's TB cases; this was established in 1998. Subsequently two other HBC lists, for HIV-associated TB and drug-resistant TB, were defined.

In 2015, three WHO global lists of HBCs – for TB, TB/HIV and drug-resistant TB – were in use. With a new era of the United Nations (UN) Sustainable Development Goals (SDGs) and the WHO End TB Strategy starting in 2016, a thorough review of the three lists was undertaken by the WHO Global Tuberculosis Programme in 2015 *(1)*. This included consideration of whether the lists should be modified (and if so how) or whether they should be discontinued. The outcome of the review was the definition of three new global HBC lists, of 30 countries each, for the period 2016–2020: one for TB, one for TB/HIV and one for drug-resistant TB. In 2021, the three lists were updated for the period 2021–2025 *(2)*, using the same criteria as those agreed in 2015 *(1,3)*.

In 2026, the three lists were updated for the period 2026–2030. To ensure consistency and continuity in the years up to the end of the SDG period (2016–2030), the three lists for 2026–2030 are defined using the criteria agreed in 2015 and already used for the period 2016–2025. Incidence estimates for 2024 were used *(4)*.

A3.2 Global HBC lists being used by WHO, 2026–2030

The three global HBC lists being used by WHO in the period 2026–2030 are defined as:

- the top 20 countries in terms of their estimated absolute number of new (incident) cases in 2024; plus
- the 10 countries with the most severe burden in terms of the incidence rate (new cases per 100 000 population in 2024) that are not already in the top 20, and that meet a minimum threshold in terms of their absolute number of cases.

FIG. A3.1

The three global lists of high burden countries for TB, HIV-associated TB and RR-TB being used by WHO in the period 2026–2030, and their areas of overlap

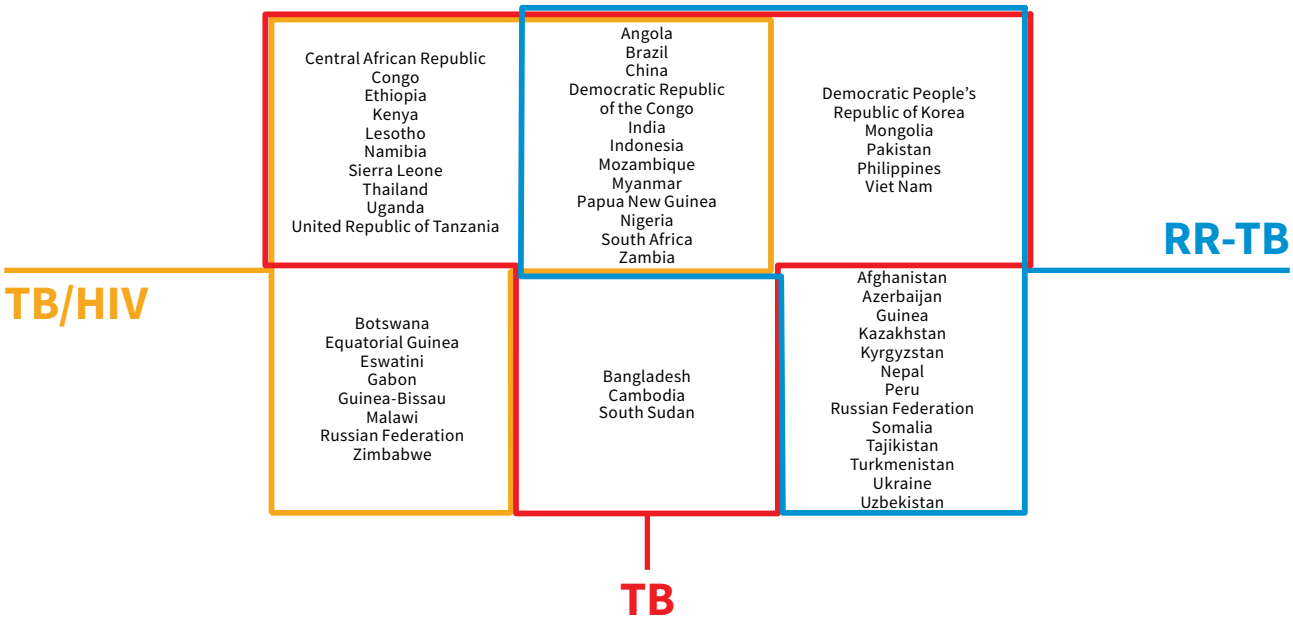


TABLE A3.1

Countries in the three global lists of high burden countries for TB, HIV-associated TB and RR-TB being used by WHO in the period 2026–2030

The red square indicates that a country is in a list.

COUNTRY	TB	TB/HIV	RR-TB
Afghanistan			■
Angola	■	■	■
Azerbaijan			■
Bangladesh	■		
Botswana		■	
Brazil	■	■	■
Cambodia	■		
Central African Republic	■	■	
China	■	■	■
Congo	■	■	
Democratic People's Republic of Korea	■		■
Democratic Republic of the Congo	■	■	■
Equatorial Guinea		■	
Eswatini		■	
Ethiopia	■	■	
Gabon		■	
Guinea			■
Guinea-Bissau		■	
India	■	■	■
Indonesia	■	■	■
Kazakhstan			■
Kenya	■	■	
Kyrgyzstan			■
Lesotho	■	■	
Malawi		■	
Mongolia	■		■
Mozambique	■	■	■
Myanmar	■	■	■
Namibia	■	■	
Nepal			■
Nigeria	■	■	■
Pakistan	■		■
Papua New Guinea	■	■	■
Peru			■
Philippines	■		■
Russian Federation		■	■
Sierra Leone	■	■	
Somalia			■
South Africa	■	■	■
South Sudan	■		
Tajikistan			■
Thailand	■	■	
Turkmenistan			■
Uganda	■	■	
Ukraine			■
United Republic of Tanzania	■	■	
Uzbekistan			■
Viet Nam	■		■
Zambia	■	■	■
Zimbabwe		■	

For the TB list, the threshold is 10 000 new cases per year. For the TB/HIV list, it is 1000 new TB cases per year among people living with HIV. For drug-resistant TB, it is 1000 new cases of rifampicin-resistant TB (RR-TB) per year.

The 30 countries that are in each of the three lists are shown in **Fig. A3.1** and **Table A3.1**. There is overlap among the three lists, but 50 countries are in at least one of them. The 30 countries in the TB, TB/HIV and RR-TB lists accounted for 87%, 85% and 90%, respectively, of the estimated global incidence of TB, HIV-associated TB and RR-TB in 2024.

The main changes compared with the previous lists for 2021–2025 are:

- The 30 high TB burden countries. Gabon and Liberia transitioned out of the list; Cambodia and South Sudan joined the list.
- The 30 high TB/HIV burden countries. Cameroon, Guinea, Liberia and the Philippines transitioned out of the list; Angola, Equatorial Guinea, Papua New Guinea and Sierra Leone joined the list.
- The 30 high RR-TB burden countries. Bangladesh, Belarus, the Republic of Moldova and Zimbabwe transitioned out of the list; Afghanistan, Brazil, Guinea and Turkmenistan joined the list.

The lists provide a focus for global action on TB, HIV-associated TB and drug-resistant TB in the countries where progress is most needed to achieve the targets set in WHO's End TB Strategy, the UN SDGs and political declarations at UN high-level meetings on TB (**Box 1**, **Table 1**). They also help to build and sustain national political commitment and funding in the countries with the highest burden in terms of absolute numbers or severity and promote global monitoring of progress in a well-defined set of countries.

The 30 high TB burden countries are given particular attention in the report. Where estimates of disease burden and assessment of progress in the response are for HIV-associated TB or drug-resistant TB specifically, the countries in the other two lists are given particular attention. Country profiles for all countries are available online, including in the report mobile app.

A3.3 Global watchlists

When the three global HBC lists were updated in 2021, WHO established a "global TB watchlist". This consisted of countries that exited the global list of 30 high TB burden countries defined for 2016–2020, but which nonetheless warranted continued attention in the period 2021–2025. The watchlist was updated in 2026, using the same principle. The global TB watchlist for 2026–2030 consists of the

two countries that were in the list of 30 high TB burden countries for the period 2021–2025, but which are not in the list for the period 2026–2030: Gabon and Liberia.

For the period 2026–2030, WHO has also defined global watchlists for RR-TB and TB/HIV.

The global RR-TB watchlist for 2026–2030 consists of the four countries that were in the list of 30 high RR-TB burden countries for the period 2021–2025, but which are not in the list for the period 2026–2030: Bangladesh, Belarus, the Republic of Moldova and Zimbabwe.

The global TB/HIV watchlist for 2026–2030 consists of the four countries that were in the list of 30 high TB/HIV burden countries for the period 2021–2025, but which are not in the list for the period 2026–2030: Cameroon, Guinea, Liberia and the Philippines.

A3.4 Regional priority lists

Global HBC lists can be complemented by regional priority lists that include additional countries *(3)*. A regional TB priority list has been established for the WHO Region of the Americas, the European Region and the Western Pacific Region.

The priority list for the WHO European Region is in the process of being reviewed and updated.

A3.5 Categorization of all countries and areas according to their level of TB disease burden

A categorization of all countries and areas according to their estimated TB incidence rate in 2025 is provided in **Table A3.2**. Countries that have moved categories between 2015 and 2025 are listed in **Table A3.3**.

References

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4. Global tuberculosis report 2025. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/383364).

TABLE A3.2

Categorization of all countries according to their level of TB disease burden in 2025

Countries are categorized using the estimated TB incidence rate (new cases per 100 000 population) in 2025. The categories were defined alongside the establishment of the WHO global HBC lists for 2021–2025 *(2)*.

Category 1, severely endemic; Category 2, highly endemic; Category 3, endemic; Category 4, upper moderate; Category 5, lower moderate; Category 6, low.

INCIDENCE CATEGORY	COUNTRIES BY WHO REGION[a]	NUMBER OF COUNTRIES AND CATEGORY SHARE (%) OF THE TOTAL ESTIMATED NUMBER OF INCIDENT TB CASES GLOBALLY IN 2025
Category 1 (≥500 incident cases per 100 000 population in 2025)	**African Region:** Lesotho **South-East Asia Region:** Timor-Leste **Western Pacific Region:** Kiribati, Papua New Guinea, the Philippines	5 countries 7.8% of global incident TB cases
Category 2 (300–499 incident cases per 100 000 population in 2025)	**African Region:** Angola, Central African Republic, Congo, Democratic Republic of the Congo, Gabon, Mozambique, Namibia, Sierra Leone, South Africa, South Sudan **Eastern Mediterranean Region:** Djibouti **South-East Asia Region:** Myanmar **Western Pacific Region:** Indonesia, Marshall Islands	14 countries 22% of global incident TB cases
Category 3 (100–299 incident cases per 100 000 population in 2025)	**African Region:** Botswana, Cameroon, Chad, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Nigeria, Sao Tome and Principe, Senegal, Uganda, United Republic of Tanzania, Zambia, Zimbabwe **Region of the Americas:** Bolivia (Plurinational State of), El Salvador, Haiti, Peru **Eastern Mediterranean Region:** Afghanistan, Pakistan, Somalia **South-East Asia Region:** Bangladesh, Bhutan, India, Nepal, Thailand **Western Pacific Region:** Cambodia, Lao People's Democratic Republic, Micronesia (Federated States of), Mongolia, Naoero, Solomon Islands, Tuvalu, Viet Nam	42 countries 55% of global incident TB cases
Category 4 (50–99 incident cases per 100 000 population in 2025)	**African Region:** Algeria, Burkina Faso, Burundi, Côte d'Ivoire, Mali, Mauritania, Niger, Rwanda, Togo **Region of the Americas:** Ecuador, Guyana, Panama, Paraguay, Venezuela (Bolivarian Republic of) **Eastern Mediterranean Region:** Libya, Morocco, Sudan **European Region:** Kyrgyzstan, Republic of Moldova, Romania, Tajikistan, Ukraine **South-East Asia Region:** Sri Lanka **Western Pacific Region:** Brunei Darussalam, Fiji, Malaysia, Palau	27 countries 3.3% of global incident TB cases
Category 5 (10–49 incident cases per 100 000 population in 2025)	**African Region:** Benin, Cabo Verde, Comoros, Mauritius, Seychelles **Region of the Americas:** Argentina, Bahamas, Belize, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Guatemala, Honduras, Mexico, Nicaragua, Suriname, Trinidad and Tobago, Uruguay **Eastern Mediterranean Region:** Bahrain, Egypt, Iraq, Lebanon, Oman, Qatar, Syrian Arab Republic, Tunisia, Yemen **European Region:** Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Latvia, Lithuania, Malta, Montenegro, North Macedonia, Portugal, Russian Federation, Spain, Türkiye, Turkmenistan, Uzbekistan **South-East Asia Region:** Maldives **Western Pacific Region:** China, Cook Islands, Niue, Republic of Korea, Singapore, Vanuatu	55 countries 10% of global incident TB cases
Category 6 (<10 incident cases per 100 000 population in 2025)	**Region of the Americas:** Antigua and Barbuda, Barbados, Canada, Dominica, Grenada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, United States of America **Eastern Mediterranean Region:** Iran (Islamic Republic of), Jordan, Kuwait, Saudi Arabia, United Arab Emirates **European Region:** Albania, Andorra, Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxembourg, Monaco, Netherlands (Kingdom of the), Norway, San Marino, Poland, Serbia, Slovakia, Slovenia, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland **Western Pacific Region:** Australia, Japan, New Zealand, Samoa, Tonga	50 countries 0.64% of global incident TB cases

[a] The Democratic People's Republic of Korea is not listed in the table because estimates of TB incidence are currently under review. Estimates for Timor-Leste are provisional pending finalization of results from the country's first national TB prevalence survey.

TABLE A3.3

Countries that changed incidence category (n=58) between 2015 and 2025, by WHO region

The colour coding indicates whether countries moved to a lower category (**green**) or a higher category (**orange**). Darker **green** indicates countries that moved down by more than one category.
An asterisk indicates countries that are in WHO's list of 30 high TB burden countries, 2026–2030.

a) African Region (n=16)

COUNTRIES	INCIDENCE CATEGORY IN 2015	INCIDENCE CATEGORY IN 2025
Central African Republic*	Severely endemic	Highly endemic
Eswatini	Severely endemic	Endemic
Namibia*	Severely endemic	Highly endemic
South Africa*	Severely endemic	Highly endemic
Botswana	Highly endemic	Endemic
Kenya*	Highly endemic	Endemic
Liberia	Highly endemic	Endemic
United Republic of Tanzania*	Highly endemic	Endemic
Zambia*	Highly endemic	Endemic
Burundi	Endemic	Upper moderate
Côte d'Ivoire	Endemic	Upper moderate
Mauritania	Endemic	Upper moderate
Niger	Endemic	Upper moderate
Benin	Upper moderate	Lower moderate
Cabo Verde	Upper moderate	Lower moderate
Seychelles	Low	Lower moderate

b) Region of the Americas (n=8)

COUNTRIES	INCIDENCE CATEGORY IN 2015	INCIDENCE CATEGORY IN 2025
Haiti	Highly endemic	Endemic
Guyana	Endemic	Upper moderate
Dominican Republic	Upper moderate	Lower moderate
El Salvador	Upper moderate	Endemic
Nicaragua	Upper moderate	Lower moderate
Ecuador	Lower moderate	Upper moderate
Venezuela (Bolivarian Republic of)	Lower moderate	Upper moderate
Cuba	Low	Lower moderate

c) Eastern Mediterranean Region (n=4)

COUNTRIES	INCIDENCE CATEGORY IN 2015	INCIDENCE CATEGORY IN 2025
Iran (Islamic Republic of)	Lower moderate	Low
Kuwait	Lower moderate	Low
Libya	Lower moderate	Upper moderate
Saudi Arabia	Lower moderate	Low

d) European Region (n=19)

COUNTRIES	INCIDENCE CATEGORY IN 2015	INCIDENCE CATEGORY IN 2025
Georgia	Endemic	Lower moderate
Kyrgyzstan	Endemic	Upper moderate
Republic of Moldova	Endemic	Upper moderate
Tajikistan	Endemic	Upper moderate
Armenia	Upper moderate	Lower moderate
Azerbaijan	Upper moderate	Lower moderate
Belarus	Upper moderate	Lower moderate
Kazakhstan	Upper moderate	Lower moderate
Lithuania	Upper moderate	Lower moderate
Russian Federation	Upper moderate	Lower moderate
Uzbekistan	Upper moderate	Lower moderate
Albania	Lower moderate	Low
Croatia	Lower moderate	Low
Estonia	Lower moderate	Low
Hungary	Lower moderate	Low
Poland	Lower moderate	Low
Serbia	Lower moderate	Low
United Kingdom of Great Britain and Northern Ireland	Lower moderate	Low
Malta	Low	Lower moderate

e) South-East Asia Region (n=1)

COUNTRIES	INCIDENCE CATEGORY IN 2015	INCIDENCE CATEGORY IN 2025
Maldives	Upper moderate	Lower moderate

f) Western Pacific Region (n=10)

COUNTRIES	INCIDENCE CATEGORY IN 2015	INCIDENCE CATEGORY IN 2025
Cambodia*	Highly endemic	Endemic
Mongolia	Highly endemic	Endemic
China*	Upper moderate	Lower moderate
Naoero	Upper moderate	Endemic
Republic of Korea	Upper moderate	Lower moderate
Vanuatu	Upper moderate	Lower moderate
Japan	Lower moderate	Low
Tonga	Lower moderate	Low
Cook Islands	Low	Lower moderate
Niue	Low	Lower moderate

Annex 4

Updates to estimates of TB disease burden

The report includes estimates of tuberculosis (TB) incidence and mortality for the period 2010–2025, estimates of TB incidence and mortality disaggregated by age and sex for 2025, and estimates of the incidence of rifampicin-resistant TB (RR-TB) for the period 2015–2025.

This annex summarizes updates to the methods and data used to produce these estimates.

A4.1 General updates to methods

All methods used to estimate TB incidence and mortality for the Global tuberculosis report 2025 *(1)* were retained.

A new method for estimating TB incidence, based on the use of death records from a national vital registration (VR) system, was developed. This method was used for two countries, Mongolia and Thailand (section A4.3), but could have wider applicability in future. The method was extensively reviewed and discussed with the World Health Organization (WHO) Global Task Force on TB Impact Measurement *(2)*.

A4.2 General updates to data

Several countries reported historical data that were previously missing, or corrected previously reported data; however, these changes had limited or negligible impact on updated estimates.

Since the publication of the *Global tuberculosis report 2025 (1)*, WHO has published updated estimates of the universal health coverage (UHC) service coverage index for the period 2000–2023 *(3)*. These updated estimates were used in combination with TB case notification data to estimate incidence in 123 countries.

Since the publication of the *Global tuberculosis report 2025 (1)*, WHO has also published updated estimates of all-cause and cause-specific mortality. These now extend to 2023 (instead of 2021). In this report, the updated estimates for 2000–2023 were used to estimate TB mortality in countries for which data from a national or sample VR system were available; they were also used to compare the number of deaths caused by TB with numbers for other causes.

In July 2026, the Joint United Nations Programme on HIV/AIDS (UNAIDS) published updated estimates of HIV prevalence and mortality *(4)*. These updated estimates were used in place of previous estimates.

A4.3 Country-specific updates

Croatia, Denmark, Finland, Poland, Portugal and Slovenia

Recently published results from national TB inventory studies in Croatia, Denmark, Finland, Poland, Portugal and Slovenia were used to directly estimate TB incidence, replacing the previous method based on the UHC service coverage index *(5, 6)*.

India

In recent years, the National TB Elimination Programme in India has made substantial efforts to improve TB prevention and care, with the goal of accelerating reductions in TB mortality and TB incidence. Robust estimation of TB disease burden that accounts for the impact of these efforts requires up-to-date and nationally representative data.

Estimates of TB mortality in India for 2023–2025 were updated using recently released cause-of-death data from the sample registration system for the period 2022–2024 *(7)*, complemented by programmatic data for 2025. The latter were used to estimate the number of deaths in 2025 among notified cases, differentiating between people who were treated and those who were lost to follow-up. It was assumed that the case fatality rate among non-notified cases in 2025 remained the same as in 2023.

Use of these new data resulted in a downward revision to estimates of the number of deaths caused by TB in 2023 and 2024 (by about 8000 and 20 000, respectively), compared with those published in the *Global tuberculosis report 2025 (1)*.

India has established a system for district-level sentinel surveillance (DLSS) of population-level trends in the prevalence of TB disease and TB infection. The system is based on a cluster sampling design and includes 300 clusters in 50 districts, with an eligible population (based on age and residency) of about 150 000 people. Methods for measurement of the prevalence of TB disease are based on the latest WHO guidance *(8)*. The first round of data collection was completed in 2025, with future rounds planned every 2–3 years. In addition to robust monitoring of trends in the prevalence of TB disease and infection, findings will be used to improve estimates of trends in TB incidence.

Joint work to review and analyse DLSS results is planned by the Central TB Division in the Ministry of

Health and Family Welfare, the Indian Council for Medical Research (responsible for DLSS implementation and data management) and WHO. **Following completion of this work, estimates of trends in TB incidence are expected to be updated in early 2027, after which WHO will publish an updated country profile for India**.

Therefore, the online country profile for India does not include estimates of TB incidence between 2010 and 2025, or associated derivative indicators. These estimates and indicators are also not included in the report webpages.

Mongolia and Thailand

Estimates of TB incidence in Mongolia and Thailand were updated, using a method developed in 2026 (**section A4.1**). The main data source was national death records from each country's national VR system. A mathematical model was used to reconstruct trends in TB incidence and TB mortality from 2000 to 2025; the model involved tracking how people move through the stages of TB from falling ill, to being diagnosed, receiving treatment and recovering. The approach accounts for shifts in diagnostic access, the protective effect of treatment and disruptions to TB services during the coronavirus disease (COVID-19) pandemic. The model was calibrated to three empirical data streams: death records from the VR system, reported TB notifications and results from a national TB prevalence survey. Additional details are available elsewhere in the report.[1]

A4.4 Overview of data sources for the 30 high TB burden and two global TB watchlist countries

The main data sources currently available to inform estimates of TB disease burden in the 30 high TB burden countries and two global TB watchlist countries (**Annex 3**) are summarized in **Table A4.1**. Technical details about the methods used for all countries are provided in the report webpages (section 1.1 and section 1.2) and the **technical appendix**.

References

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[1] See the featured topic "New method for estimating TB incidence", which is one of the report webpages.

TABLE A4.1

Sources of data available to inform estimates of TB disease burden in the 30 high TB burden countries and the two global TB watchlist countries, 2010–2025.[a]

Blue indicates that a source is available, **orange** indicates it will be available in the near future, and **red** indicates that a source is not available.

COUNTRY	NOTIFICATION DATA	STANDARDS AND BENCHMARK ASSESSMENT[b]	NATIONAL INVENTORY STUDY[c]	NATIONAL TB PREVALENCE SURVEY[d]	NATIONAL DRUG RESISTANCE SURVEY OR SURVEILLANCE[e]	NATIONAL VR DATA OR MORTALITY SURVEY[f]
Angola	2000–2025	2019, 2023	–	–	*2022–2025*	–
Bangladesh	2000–2025	2019, 2022, 2026	–	2015	2011, 2019, *2024, 2025*	–
Brazil	2000–2025	2018	–	NA	2008	2000–2025
Cambodia	2000–2025	2018, 2022	–	2002, 2011, 2023–2024	2007, 2018, *2024*	See footnote g
Central African Republic	2000–2025	2019, 2022, 2026	–	–	2009, *2024*	–
China	2000–2025	–	2018, 2022	2000, 2010	2007, 2013, *2020, 2022–2025*	2004–2021
Congo	2000–2025	2019, 2022	–	–	*2024, 2025*	–
Democratic People's Republic of Korea	2000–2025	2017	–	2016	2014	–
Democratic Republic of the Congo	2000–2025	2019, 2022, 2026	–	–	2017	–
Ethiopia	2000–2025	2016, 2023	–	2011	2005, 2018, *2018, 2020, 2023*	–
Gabon	2000–2025	2018, 2020	–	–	2023	–
India	2000–2025	2019	2016	2019–2021	2016, *2024, 2025*	2000–2019, 2020, 2022, 2023, 2024
Indonesia	2000–2025	2019, 2022, 2025	2017, 2023	2013–2014	2018, *2023, 2024*	2006–2007, 2009–2015
Kenya	2000–2025	2017, 2021, 2026	2013	2015	2014, 2024, *2020, 2024, 2025*	–
Lesotho	2000–2025	2017, 2022	–	2019	2014, 2024, *2019–2024*	–
Liberia	2000–2025	2015, 2019	–	–	–	–
Mongolia	2000–2025	2015, 2018	–	2014–2015	2007, 2016, *2018–2025*	2010–2024
Mozambique	2000–2025	2013	–	2017–2019	2007, 2021, *2021–2023*	–
Myanmar	2000–2025	2017, 2022, 2026	–	2009, 2018	2003, 2008, *2013, 2018, 2020, 2023–2025*	–
Namibia	2000–2025	2019, 2022	–	2017–2018	2008, 2015, *2018, 2020–2025*	–
Nigeria	2000–2025	2020, 2023, 2025	–	2012	2010, 2024, *2022–2024*	–
Pakistan	2000–2025	2019, 2022, 2025	2012, 2017	2011	2013, *2019–2020, 2025*	2006, 2007, 2010
Papua New Guinea	2000–2025	2017, 2023	–	–	2014, *2023–2025*	–
Philippines	2000–2025	2016, 2019	–	2007, 2016	2004, 2012, 2019, *2021–2025*	2000–2014, 2016–2019
Sierra Leone	2000–2025	2015, 2020, 2026	–	–	–	–
South Africa	2000–2025	2019, 2022, 2026	2022	2017–2019	2002, 2014, *2021–2024*	2000–2017
South Sudan	2000–2025	–	–	–	–	–
Thailand	2000–2025	2013, 2026	–	2012	2001, 2006, 2012, 2018, *2023–2025*	2000, 2002–2024
Uganda	2000–2025	2019, 2023	–	2014–2015	2011, *2018–2019, 2023, 2025*	–
United Republic of Tanzania	2000–2025	2018, 2023, 2025	–	2012	2007, 2018, *2021–2025*	–
Viet Nam	2000–2025	2019, 2023	2017	2007, 2017–2018	2006, 2012, *2018, 2020–2025*	–
Zambia	2000–2025	2016, 2020	–	2014	2000, 2008, 2020, *2018–2024*	–

NA, not applicable; VR, vital registration

[a] Data for the period 2000–2009 also inform estimates for the period 2010–2025 and are shown for this reason. The two global TB watchlist countries are Gabon and Liberia.

[b] The WHO TB surveillance checklist of standards and benchmarks is designed to assess the quality and coverage of notification data (based on 9 core standards), VR data (1 core standard) and drug-resistant TB, HIV co-infection and childhood TB (3 supplementary standards). The second edition of the WHO TB surveillance checklist also includes an assessment of monitoring and evaluation related to TB care (2 supplementary standards) and TB prevention (2 supplementary standards).

[c] Prioritization of TB inventory studies is recommended in countries where a large share of TB care is provided to TB patients outside the existing NTP network.

[d] Brazil does not meet the following criteria recommended by the WHO Global Task Force on TB Impact Measurement for implementing a national prevalence survey: TB incidence ≥150 per 100 000 population per year, no vital registration system and under-5 mortality rate (probability of dying by age of 5 per 1000 live births) is >10.

[e] Data points are shown for people without a history of previous TB treatment only. Data are available from continuous surveillance (indicated by italics in blue cells) based on routine diagnostic testing in all listed countries except Brazil, Democratic People's Republic of Korea, the Democratic Republic of Congo, Liberia, Sierra Leone and South Sudan.

[f] Years of data availability for Indonesia, Pakistan and South Africa were provided to WHO by IHME.

[g] Input data used to inform the covariates for estimating TB mortality in Cambodia are available here: Ma, J., Vongpradith, A., Ledesma, J.R. et al. Progress towards the 2020 milestones of the end TB strategy in Cambodia: estimates of age and sex specific TB incidence and mortality from the Global Burden of Disease Study 2019. BMC Infect Dis 22, 904 (2022). https://doi.org/10.1186/s12879-022-07891-5.

Annex 5

The WHO TB-SDG monitoring framework

In 2017, the World Health Organization (WHO) developed a framework for monitoring of indicators in the United Nations (UN) Sustainable Development Goals (SDGs) that are strongly associated with tuberculosis (TB) incidence. This was done as part of the preparations for the first global ministerial conference on TB *(1)*, building on previously published work that identified clear linkages between a range of social, economic and health-related indicators and TB incidence *(2–4)*.

In 2024, the framework was updated, with undernutrition replacing undernourishment as the selected indicator for SDG 2. This followed the publication of a systematic review related to the risk of TB in people with and without undernutrition *(5)*.

The TB-SDG monitoring framework comprises 14 indicators under seven SDGs (**Table A5.1**).

For SDG 3, the framework includes seven indicators:

- coverage of essential health services;
- percentage of the population with out-of-pocket health expenditure ≥40% of the household discretionary budget (financial hardship);
- current health expenditure per capita;
- HIV prevalence;
- prevalence of smoking;
- prevalence of diabetes; and
- prevalence of alcohol use disorders.

For SDGs 1, 2, 7, 8, 10 and 11, the seven indicators selected for monitoring are:

- proportion of the population living below the international poverty line;
- proportion of the population covered by social protection floors or systems;
- prevalence of undernutrition;
- proportion of the population with primary reliance on clean fuels and technology;
- gross domestic product (GDP) per capita;
- Gini index for income inequality; and
- proportion of the urban population living in slums.

Collection and reporting of data for the 14 indicators does not require any additional data collection and reporting efforts by national TB programmes (NTPs). Nor does it require data collection and reporting efforts that go beyond those to which countries have already committed in the context of the SDGs. At the global level, the UN has established a monitoring system for SDG indicators, and countries are expected to report data on an annual basis via the appropriate UN agencies (including WHO). Therefore, analysis of the status of, and trends in, the 14 indicators related to TB can be based primarily on data held in the UN's SDG database.

In some cases, the official SDG indicator was not considered the best metric, and a better (but closely related) alternative was identified and justified (one under SDG 2, five under SDG 3, one under SDG 8 and one under SDG 10). In such cases, the data sources are one of the following: WHO, the Organisation for Economic Co-operation and Development (OECD), the Joint United Nations Programme on HIV/AIDS (UNAIDS) or the World Bank.

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TABLE A5.1

TB-SDG monitoring framework: indicators to monitor within SDG 3

SDG 3: Ensure healthy lives and promote well-being for all at all ages					
SDG TARGETS FOR 2030	**SDG INDICATORS**	**ALTERNATIVE INDICATORS TO MONITOR**	**RATIONALE**	**DATA SOURCE**	**COLLECT DATA FOR TB PATIENTS SPECIFICALLY?**
3.3 End the epidemics of AIDS, TB, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	**3.3.1** Number of new HIV infections per 1000 uninfected population **3.3.2** TB incidence per 100 000 population	HIV prevalence	HIV is a strong risk factor for development of TB disease and is associated with poorer treatment outcomes. HIV prevalence is selected in preference to HIV incidence because it is directly measured.	UNAIDS WHO	Yes, already routinely collected. NA
3.4 Reduce premature mortality by one third from non-communicable diseases and promote mental health and well-being	**3.4.1** Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	Prevalence of diabetes	Diabetes is a strong risk factor for development of TB disease, although a link with TB incidence at the national (as opposed to individual) level has been difficult to establish due to confounding. Diabetes prevalence is more relevant than mortality for TB since it directly influences the risk of developing TB.	WHO	Could be considered at country level, to inform planning of care for comorbidities.
3.5 Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	**3.5.2** Alcohol consumption per capita per year (in litres of pure alcohol) among those aged ≥15 years (harmful level defined nationally)	Prevalence of alcohol use disorders	Alcohol use is a strong risk factor for TB disease and poorer treatment outcomes at the individual level, although a link with TB incidence at the national (as opposed to individual) level has been hard to establish due to confounding. The prevalence of alcohol use disorders is the most relevant indicator in the context of TB.	WHO	Could be considered at country level, to inform planning of care for comorbidities.
3.8 Achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	**3.8.1** Coverage of essential health services (defined as the average coverage of essential services based on 14 tracer interventions). **3.8.2** Percentage of population with out-of-pocket health spending ≥40% of household discretionary budget (financial hardship)	NA NA	Achieving UHC is required to achieve the three high-level targets of the End TB Strategy for reductions in the TB incidence rate, reductions in the number of TB deaths and elimination of catastrophic total costs for TB-affected households (defined as >20% of household income).	WHO	TB treatment coverage has been monitored for years and is one of the 14 tracer indicators that have been selected to measure SDG indicator 3.8.1. There is a TB-specific indicator that is complementary to 3.8.2 (see **Box 2** of the main report).
3.a Strengthen implementation of the WHO Framework Convention on Tobacco Control	**3.a.1** Age-standardized prevalence of current tobacco use among those aged ≥15 years	Prevalence of smoking among those aged ≥15 years (%)	Smoking is a strong risk factor for TB disease at the individual level, although a link with TB incidence at the national (as opposed to individual) level has been difficult to establish due to confounding.	WHO	Could be considered (e.g. to inform access to smoking cessation interventions).
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	**3.c.1** Health worker density and distribution	Current health expenditure per capita	Health expenditure per capita is negatively correlated with TB incidence.	WHO	No

AIDS, acquired immune deficiency syndrome; HIV, human immunodeficiency virus; NA, not applicable; SDG, Sustainable Development Goal; TB, tuberculosis; UHC, universal health coverage; UNAIDS, Joint United Nations Programme on HIV/AIDS; WHO, World Health Organization.

TB-SDG monitoring framework: indicators to monitor beyond SDG 3

SDG TARGETS FOR 2030	SDG INDICATORS	ALTERNATIVE INDICATORS TO MONITOR	RATIONALE	DATA SOURCE	COLLECT DATA FOR TB PATIENTS SPECIFICALLY?
SDG 1: End poverty in all its forms everywhere					
1.1 Eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day	**1.1.1** Proportion of population living below the international poverty line	NA	Poverty is a strong risk factor for TB, operating through several pathways. Reducing poverty should also facilitate prompt health-care seeking. Countries with higher levels of social protection have lower TB burden. Progress on both indicators will help to achieve the End TB Strategy target to eliminate catastrophic costs for TB patients and their households.	UN SDG database, World Bank	No
1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and achieve substantial coverage of the poor and vulnerable	**1.3.1** Proportion of population covered by social protection floors/ systems	NA		ILO	Could be considered (e.g. to facilitate access to social protection).
SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture					
2.1 End hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food year-round	**2.1.1** Prevalence of undernourishment	Prevalence of undernutrition among those aged ≥18 years (%)	Prevalence of undernutrition among those aged ≥18 years (%). A recent systematic review published in 2024 has provided estimates of the relative risk of TB among people with and without undernutrition (defined as a body mass index of <18.5 kg/m^2 among those aged ≥18 years).	WHO	Should be considered (e.g. weight collected from all TB patients to inform the need for nutritional support).
SDG 7: Ensure access to affordable, reliable, sustainable, and modern energy for all					
7.1 Ensure universal access to affordable, reliable and modern energy services	**7.1.2** Proportion of population with primary reliance on clean fuels and technology	NA	Indoor air pollution is a risk factor for TB disease at the individual level. There has been limited study of ambient air pollution but it is plausible that it is linked to TB incidence.	WHO	No
SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all					
8.1 Sustain per capita growth in accordance with national circumstances and, in particular, at least 7% GDP growth per year in the least developed countries	**8.1.1** Annual growth rate of real GDP per capita	GDP per capita	Historic trends in TB incidence are closely correlated with changes in the absolute level of GDP per capita (but not with the growth rate).	World Bank	No
SDG 10: Reduce inequality within and among countries					
10.1 Achieve and sustain income growth of the bottom 40% of the population at a rate higher than the national average	**10.1.1** Growth rates of household expenditure or income per capita, overall and for the bottom 40% of the population	Gini index for income inequality	TB is a disease of poverty. Decreasing income inequalities combined with economic growth should have an effect on the TB epidemic.	World Bank OECD	No
SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable					
11.1 Ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums	**11.1.1** Proportion of urban population living in slums, informal settlements or inadequate housing	NA	Living in a slum is a risk factor for TB transmission due to its link with overcrowding. It is also a risk factor for developing TB disease, due to links with air pollution and undernutrition.	UN SDG database	No

GDP, gross domestic product; ILO, International Labour Organization; NA, not applicable; OECD, Organisation for Economic Co-operation and Development; SDG, Sustainable Development Goal; TB, tuberculosis; UN, United Nations; WHO, World Health Organization.

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