Note

December 2024

This document is the Executive Director's update for the Global Fund's 52nd Board Meeting. It was initially submitted to the Board on 8 November 2024 for a dedicated session on 20 November 2024.

This document does not attempt to be comprehensive. It builds on other materials, including documents provided to the Board or its Committees. Editorial adjustments have been made to this document, including the deletion of links to internal documents.

THE GLOBAL FUND

Report of the Executive Director

52nd Board Meeting

GF/B52/04

20 – 22 November 2024
Lilongwe, Malawi

Cover photo: Chifuniro Chimbalanga, whose family survived floods that swept across Malawi in early 2023, brings her 6-month-old child to test for malaria at a Global Fund-supported testing campaign. © *UNICEF/UN0805305/Chikond*

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1. Introduction

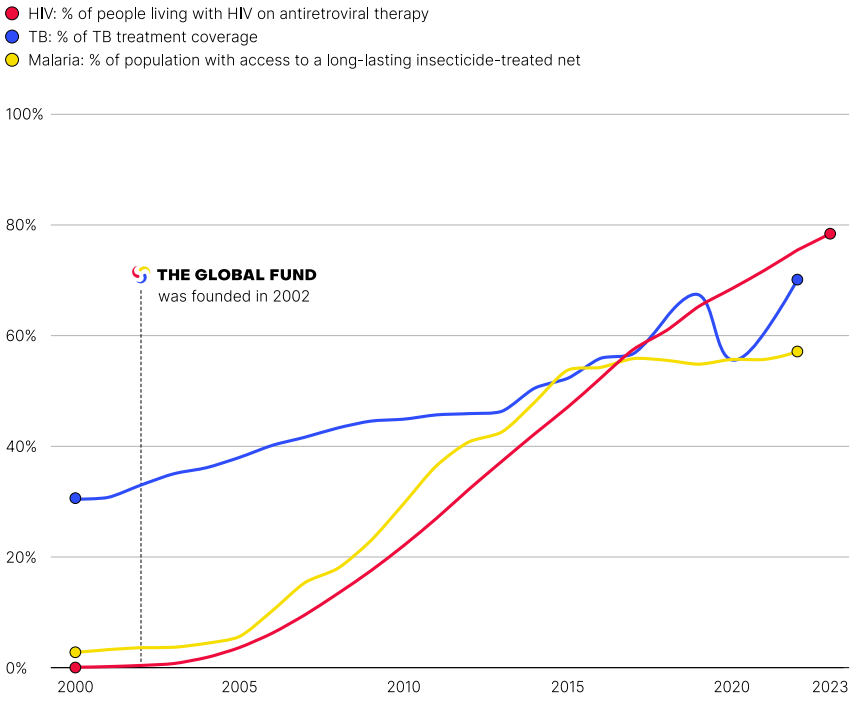
2024 has been another big year in the history of the Global Fund. We're on track to continue the record pace of disbursement, with 2024 likely to be the fourth year in a row around US$5 billion. We are investing more than ever in strengthening health and community systems. Building on the momentum described in the Results Report 2024 (based on our performance in 2023) the Global Fund partnership continues to save millions of lives and make significant progress against HIV, tuberculosis (TB) and malaria.

Yet the external challenges are growing. Climate change is having an escalating impact on the communities we serve. Conflict is derailing health programs and making people more vulnerable to disease in a growing number of countries. The erosion of human rights and pushback against gender equality exacerbates barriers to access for those most in need. Economic pressures on both donor and implementing countries put funding at risk. Geopolitical fissures and the rise of populist nationalism have undermined the sense of global solidarity that inspires and powers the Global Fund partnership.

Figure 1

Coverage of key treatment and prevention interventions

In countries where the Global Fund invests



Malaria coverage is calculated based on 38 African countries where the Global Fund invests, for which data is available from WHO/Malaria Atlas Project estimates. HIV and TB estimates are based on all countries where the Global Fund invests. Based on published data from WHO (2023 release for TB and malaria) and UNAIDS (2024 release).

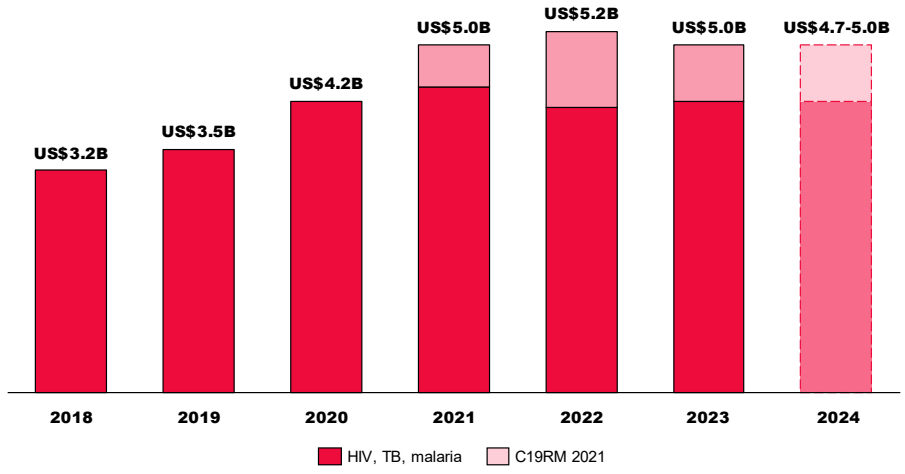
While there is much to be proud of in what the Global Fund partnership has achieved in 2024, there is also much to be concerned about when we look to the future. While the downward trajectories of deaths and infections in HIV and TB are encouraging, we are not on track to hit the Sustainable Development Goal 3 (SDG 3) targets for 2030. Malaria is even worse: In the highest burden countries a combination of climate change, conflict, resistance and inadequate funding means progress is stalling or even reversing. As the COVID-19 Response Mechanism (C19RM) comes to an end next year, our ability to sustain the scale of our investments in health systems strengthening is in doubt. The Eighth Replenishment will take place in one of the most challenging external contexts since the creation of the Global Fund.

So it is right that the Board has devoted so much time to such challenges this year: human rights and gender, climate change, and the overall challenge of sustainability. Through two productive Board retreats, and via intensive discussions at the Board and Committees, we have wrestled with the potential scenarios and difficult trade-offs ahead. While we must be realistic about the challenges, we must also remain ambitious. The progress we have made – saving 65 million lives and reducing mortality by 61% – is testimony to this partnership's capability to overcome even the most daunting obstacles.

In this Executive Director report, I will offer some observations on some of the key challenges ahead to help frame the Board's deliberations on the decisions to be taken. Yet before looking forward, let me first offer a brief assessment of our progress against the objectives set out this time last year.

Figure 2

Total disbursements by year: 2018-2024 and C19RM



Note: 2020 disbursements include amounts related to C19RM 2020. The 2024 figure reflects the latest full-year forecast for disbursement.

Case Study

Malawi: Investing in a Climate-Resilient Future

More frequent and severe cyclones, fueled by climate change, are placing a strain on Malawi's health system – especially at the community level.

Three major cyclones hit the country in 2022 and 2023, including Cyclone Freddy, which affected more than 2.2 million people. Dozens of health facilities were damaged or destroyed and critical equipment, drugs, health commodities and patient records were swept away by rains and floods. The storm also contributed to localized increases of malaria cases in affected regions, compounding the impacts of one of the worst cholera outbreaks in the country's history – also spurred by a tropical storm.

People navigating floodwaters that cut off access to roads in the Kaombe region of Malawi. © *UNICEF/UNI536230*

Working closely with the Ministry of Health, the Global Fund and partners rapidly deployed health commodities to communities affected by Cyclone Freddy, including supplies to test for, treat and prevent malaria. In early 2023, the Global Fund reallocated US$600,000 to support health facilities and community health workers fighting cholera; these health workers were also equipped to provide HIV, TB and malaria services.

Partners in Malawi are planning ahead investing in strong laboratory and wastewater surveillance systems so that health authorities can detect and respond to disease outbreaks, from malaria to other health threats that could emerge in the future. With Global Fund support, the Ministry of Health is pre-deploying supplies to regions most vulnerable to extreme weather and developing a more robust electronic medical records system to rapidly analyze and protect health data. With the support from the Global Fund in upskilling districts for detecting and reporting events, the country detected and reported cholera and measles outbreaks in one day, and responded to them in 2-4 days, meeting the 7-1-7 targets (i.e., detect outbreaks within 7 days, report them within 24 hours, and respond to them within 7 days).

2. Progress Against 2024 Objectives

2.1 Implement Grants for Maximum Impact

2024 is the first year of implementation for Grant Cycle 7 (GC7). Of the US$13.128 billion approved for country allocations for GC7, as of mid-October, 169 funding requests representing US$12.95 billion (99% of allocation funds) have been recommended for grant-making by the Technical Review Panel (TRP), with only five funding requests (or 3% of the total) sent back for iteration, compared to 6% in GC6. As of mid-October, 203 grants have been approved by the Board and have begun implementation. This means US$11.8 billion, or 90% of the US$13.128 billion country allocation, has been integrated into Board-approved grants. We anticipate a further 33 grants will be reviewed and approved by the end of 2024.

While it is too early in the cycle to have specific data on GC7 grant performance, the metrics for grant-related key performance indicators (KPIs) from 2023 paint an encouraging picture, with most rated green For example, the KPI for TB notifications (T1) is at 100%, the KPI for HIV status awareness (H1) is at 95%, and the KPI for adolescent girls and young women (AGYW) grant performance (H5) is at 103%. TRP survey results indicate that GC7 funding requests were generally of high quality, and the reduction in iteration rate indicates improvement versus GC6. Key areas of improvement indicated by the survey include the number of funding requests adequately addressing sustainability challenges (76% versus 67%), the proportion putting a strategic focus on resilient and sustainable systems for health (RSSH) (81% versus 71%) and the number incorporating value for money (82% versus 76%). However, the survey also indicated the challenges faced in the areas of human rights and gender, with a small overall decline in the quality of funding requests addressing human rights-related barriers to access (62% versus 66%) and negligible progress on gender (60% versus 58%).

From a financial perspective, GC7 has gotten off to a good start with US$2 billion (15%) of total allocation disbursed by the end of September 2024. Meanwhile, the GC6 grant closure process indicates that we will have exceeded the management target of 85% in-country absorption (ICA), well above the KPI. While GC6 closure is complicated by the inclusion of C19RM (which runs until end 2025), 70% of GC6 grants are in the closure process, with finalization targeted for the end of 2024. The progress of the partnership in achieving impactful financial performance is exemplified by

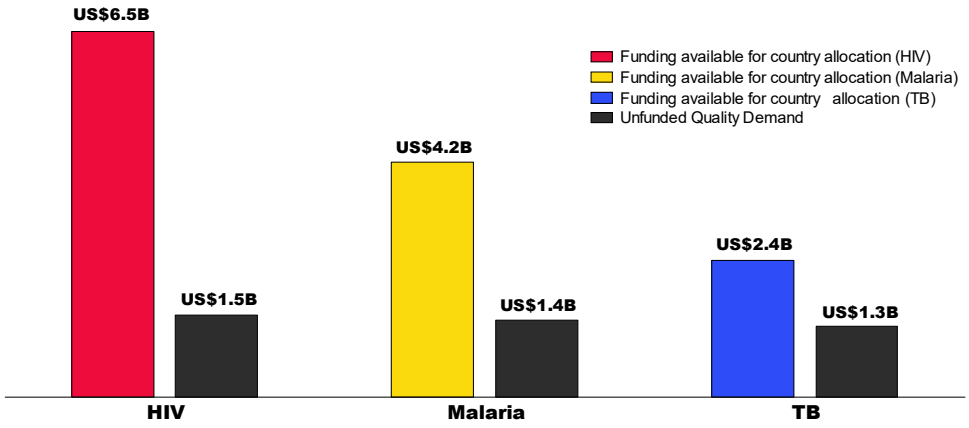
West and Central Africa, with GC6 ICA above 88% compared to 77%[1] in GC5.

In addition to country allocations, we began GC7 with US$521 million for catalytic investment priorities, of which US$400 million reflects the Board-approved amount from core funding – the balance is earmarked contributions from private sector donors. Of this total, US$275 million is in matching funds, of which 90% has now been integrated into grants. During 2024, additional pledges for more than US$75 million in private sector earmarked contributions have been secured in support of catalytic priorities. We anticipate launching the new Climate and Health Catalytic Fund very soon, following the Board's decision to make this escalating threat a catalytic priority in August 2024.

For GC7, the TRP approved US$6.4 billion in Unfunded Quality Demand (UQD). Of this amount, we have managed to find funding for US$1 billion, nearly all through savings and efficiencies identified in grant-making, underscoring the importance of this rigorous, iterative process involving Country Teams, Country Coordinating Mechanisms (CCMs) and Principal Recipients (PRs). However, it is also worth noting that the remaining US$5.3 billion is the highest ever figure for UQD at this stage in the grant cycle and reflects the scale of the gaps in core prevention, diagnostic and treatment coverage across all three diseases.

Figure 3

Country allocation funding and Unfunded Quality Demand for GC7



UQD for RSSH for GC7 is US$1.2 billion.

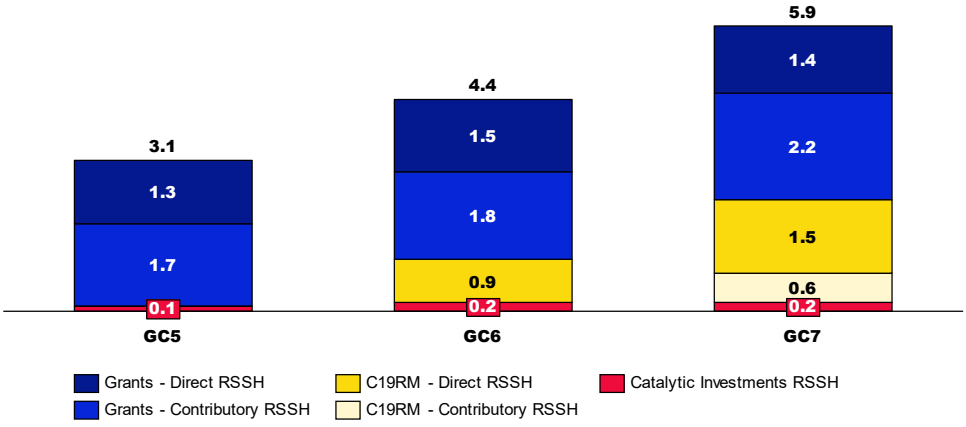
[1] Source: OIG report May 2019 (GF-OIG-19-013)

During GC7, US$2.7 billion in C19RM funding was initially estimated to be available for reinvestment alongside our core funding, with the vast majority directed towards strengthening components of health systems that are critical for pandemic preparedness and response (RSSH-PPR). This includes US$2.1 billion awarded for immediate COVID-19 response activities and reprogrammed in early 2024. C19RM investments in RSSH-PPR are focused on human resources for health and community systems strengthening (US$223 million), laboratory systems (US$347 million), health product and waste management systems control (US$301 million), surveillance systems (US$241 million), and medical oxygen and respiratory care (US$312 million).

Combining C19RM RSSH-PPR investments and RSSH investments from country allocations and catalytic priorities, the Global Fund is now investing more in health systems than ever before. GC7/C19RM RSSH-PPR investments during the GC7 period will be approximately US$5.9 billion (including direct and contributory RSSH, using the recently revised definitions endorsed by the Strategy Committee). This means about 40% of grant investments during the GC7 period will be directed towards RSSH-PPR. To support execution of this massive scale-up of health systems investments, we have established an RSSH-PPR Implementation Acceleration initiative, to provide extra support, monitoring and resolve any bottlenecks.

Figure 4

Total investments in RSSH-PPR: GC5-GC7 (US$ billion)



Figures are based on the recently endorsed Global Fund Strategy Committee methodology that integrates direct investments in RSSH and contributions to RSSH through investments in the fight against HIV, TB and malaria (contributory RSSH). The amount is derived from approved and signed grant budgets and RSSH-related catalytic investments and includes C19RM. This methodology excludes Global Fund Secretariat operating expenses. GC5 and GC6 Contributory RSSH are based on the previous methodology, while GC7 used the new approach endorsed at the July 2024 Strategy Committee meeting.

The increasing frequency of crises, whether caused by climate change, conflict or disease outbreaks like mpox, has tested our operational agility. So far this year we have released US$14.2 million from the Emergency Fund, representing 95% of initial Emergency Fund capacity for GC7. In October, we secured Audit and Finance Committee approval to replenish the Emergency Fund with a further US$30 million from Portfolio Optimization, alongside an additional US$45 million for critical emerging needs from UQD. We have also used reprogramming to help countries respond rapidly to crises. For example, in response to the mpox outbreak, we have so far provided the Democratic Republic of the Congo, Rwanda, Ghana, Côte d'Ivoire, Uganda, Liberia and Burundi with over US$19 million from C19RM through a combination of reprogramming and Portfolio Optimization. Within C19RM, we have made a notional cap of up to US$100 million for mpox (securing approval for US$50 million of C19RM Portfolio Optimization).

Alongside the deployment of grant funds, we have continued our efforts to counter the impact of the backlash against human rights and gender equality on our programs. We remain deeply concerned about the growing, well-financed and well-organized anti-rights and anti-gender movements. We hear the call for the Global Fund to use its diplomatic voice more assertively and to respond more robustly to human rights crises. We will continue to be guided by our community and civil society partners on the ground in calibrating our public and private interventions, in adapting service delivery modalities and in taking measures to protect the safety and security of the people we support. Effectively responding to this backlash will require the sustained engagement of the entire partnership, including multilateral partners, donor and implementer governments, civil society and communities, and the private sector. The achievements of the Breaking Down Barriers initiative demonstrate that carefully designed and well-executed multistakeholder efforts can deliver results in terms of removing barriers to access, even in difficult contexts.

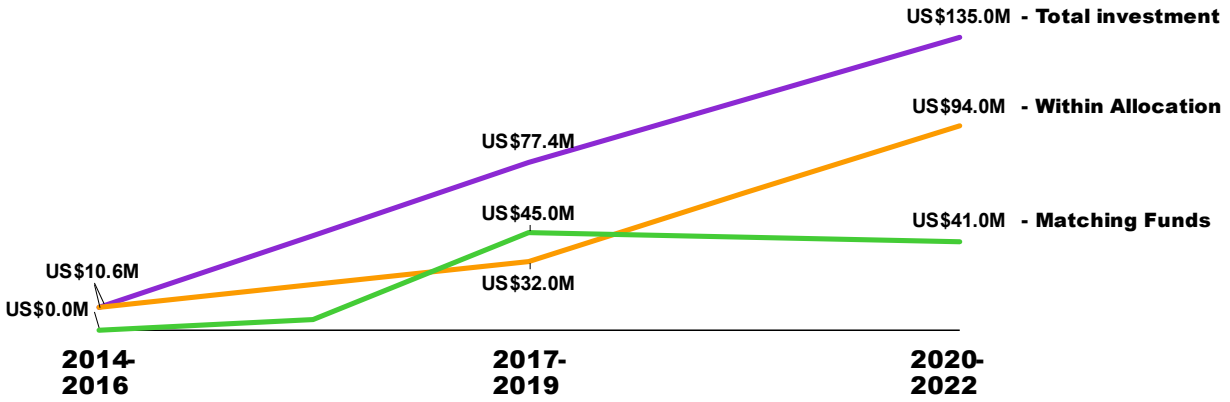
We also hear the demand for more progress on gender and are responding by embedding the Gender Equality Marker and launching the Gender Equality Fund, for example. Given the widespread resistance to efforts to tackle gender inequalities, both in individual countries and at a global level, we will have to show even greater determination and ambition in this area. This is a task for the entire Global Fund partnership. While action at a global and national level is essential, supporting context-specific community-led initiatives is crucial to delivering impact, such as in enabling community-led monitoring of AGYW programs in Lesotho and elsewhere, funding interventions to counter gender-based violence across

multiple countries, or empowering women to participate in decision-making through Her Voice Fund/Voix EssentiElles.

Figure 5

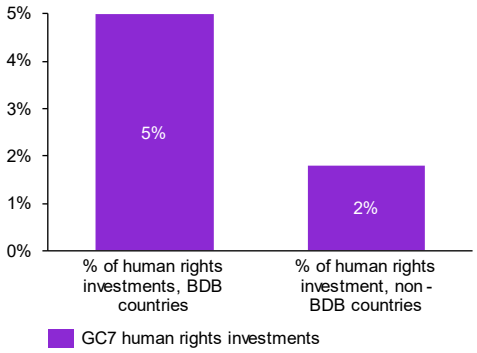
Programmatic impact of Breaking Down Barriers initiative

A. Increasing total investments

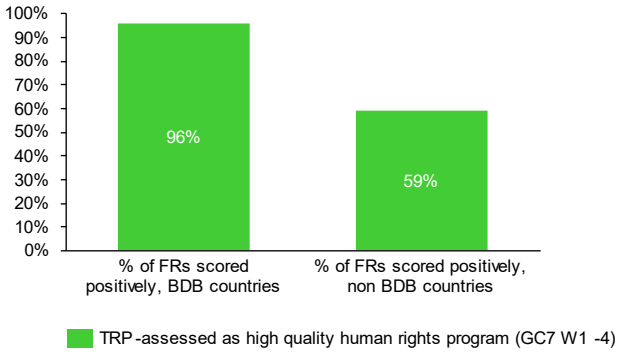


Note: Not all countries were included to measure investments.

B. Enhancing prioritization in grants



C. Impacting program quality



Note: Countries used to calculate percentages across charts may not be the same.

More generally, we remain concerned about the increasing pressures on the space for civil society and communities. While there is much to support in efforts to reinforce country ownership, the conflation of “country ownership” with “government ownership” that sometimes occurs can result in communities and civil society being squeezed out. The active engagement of communities and civil society in decision-making and governance at every level is a key reason why the Global Fund has been so successful, and one of the things that makes this partnership unique. As we work to support moves to strengthen country ownership and increase coordination with multilateral and bilateral partners – none of which give communities and civil society equivalent involvement in governance and decision-making – we must be careful to protect this vital aspect of our model.

Case Study

Lesotho: Community-Led Monitoring Empowers Adolescent Girls and Young Women to Overcome Health Barriers

Adolescent girls and young women continue to be disproportionately impacted by HIV and AIDS in Lesotho. HIV prevalence among women aged 20 to 24 years old is more than five times higher than among men of the same age group. AGYW face high rates of gender-based violence, unintended pregnancy and human rights violations. Too often, they struggle to have their health needs met by the institutions and health providers meant to serve them.

In response, the Global Fund is working closely with young people, community-based organizations, service providers and the Ministry of Health to implement an AGYW-driven community-led monitoring program.

Bacha Re Bacha Youth Forum's community monitors visit local schools to speak with adolescent girls and young women about access to health services. *Bacha Re Bacha Youth Forum*

Community-led monitoring is designed to empower communities facing inequities in treatment and prevention. It is a collaborative process where trained and paid community monitors assess the quality and accessibility of services, analyze and share their findings, and then advocate to service providers and decision makers to fix the problems identified.

Through the Lesotho-based Bacha Re Bacha Youth Forum, AGYW data collectors began work in June 2023. In less than a year, they surveyed more than 8,000 AGYW who received services at more than 50 health facilities.

Findings revealed some of the key barriers facing AGYW, including unfriendly attitudes among service providers, frequent stockouts of contraceptives and long wait times. Health providers are already responding to the findings by improving attitudes towards AGYW, adjusting facility operating hours and introducing multiple health screening points to reduce wait times.

These early and important successes demonstrate how community-led monitoring can be a powerful grassroots tool to help address health barriers and increase uptake of services among vulnerable groups.

2.2 Strengthen Organization Effectiveness and Adaptability

During 2024 we continued to invest in improving efficiency and effectiveness of our processes, and in adapting our organization structure and resourcing to evolving challenges and priorities. For example, we introduced a new automated travel management system that leverages modern technology, which has helped deliver a 7% reduction in airfare costs and an 11% reduction in carbon footprint, plus a reduction in administrative costs. Other critical system enhancements include OSKAR (the strategic performance portal), ADEx (DHIS2 data linkage), and enhancements to the co-financing database to support the reinforced approach to co-financing as part of the revised Sustainability, Transition and Co-financing (STC) policy.

Through our NextGen Market Shaping approach we continue to enhance our efforts to ensuring rapid and equitable access to innovations. In August 2023, we utilized our new Revolving Facility for the first time to make an advanced market commitment to secure affordable pricing for dual active ingredient (dual AI) insecticide-treated mosquito nets. Since then, we have seen unprecedented take up of these innovative nets, which are up to 45% more effective than standard mosquito nets. In fact, countries' enthusiasm to switch to the new nets has been so strong that we ran into manufacturing capacity constraints. In response, the Global Fund worked very closely with the U.S. President's Malaria Initiative (PMI), World Health Organization (WHO) and other partners to expand and diversify supply, including by accelerating pre-qualification for additional suppliers.

While the introduction of dual AI nets has been a huge success, ensuring better protection from malaria for hundreds of millions of people, it also illustrates the challenges of accelerating affordable and equitable access. Demand forecasting for new innovations is inherently uncertain, so it is easy to under- or overshoot. This underscores the importance of working together with partners to ensure an end-to-end approach linking demand and supply, and capable of dynamic adjustment.

Key organizational changes during 2024 include the next phase of the IT transformation, through which we aim to achieve further efficiencies, time to market and quality of output. We are well-advanced in establishing a

partner-operated IT Service Center in India, reconfiguring existing outsourced services, and are also working to establish a second center in Africa. This is the first step towards creating a capability that can be leveraged for other transactional services as appropriate. We expect the new service center to be fully operational by the beginning of 2025.

With the appointment of Michelle Beistle as our new Ethics Officer in March 2024, we have stepped up the pace of progress in embedding an ethical culture and increasing our organizational resilience to ethics-related risks. For example, 39 Principal Recipients (PRs) in the highest-risk countries are implementing protection from sexual exploitation, abuse and harassment (PSEAH) capacity building plans, and 27 PRs in the second tier of countries are undergoing PSEAH capacity assessments as the second phase of the PSEAH capacity assessment and building project that will encompass all Global Fund PRs. The Ethics Office has conducted training for 130 PSEAH Focal Points in Asia-Pacific, and three countries are currently piloting CCM-led communications campaigns to increase PSEAH awareness among beneficiaries. We have also opened 22 new SEAH cases this year to date. In addition, we are updating and clarifying our standards for ethical behavior in our Code for Employees, the Employee Handbook and associated policies, and are developing and implementing risk-based training programs.

Another example is the reconfiguration of the Chief of Staff's team to comprise three sub-teams: Global Partnerships, Organizational Planning and Leadership, and the Delivery Unit – previously the Performance Delivery Team. This will help enhance oversight of organizational priorities, strengthen delivery performance and reinforce strategic partnerships.

In September, we announced that Rahul Singhal, our Chief Risk Officer and Head of Programmatic Monitoring and Risk Division, will be leaving the Global Fund at the end of December 2024. I would like to take this opportunity to thank Rahul for his leadership and contributions over his nine years at the Global Fund, not least in transforming our approach to risk management and in leading C19RM. By the time the Board meets in Malawi, we anticipate we will have announced interim reporting arrangements for the three teams that currently report to Rahul: Risk, the Programmatic Monitoring department and the C19RM Secretariat.

By the time we meet, we also anticipate having announced our new Head of Health Finance. This is a critical role, not least given the proposed revisions to the STC policy, as well as the strategic priority attached to

catalyzing increased domestic resource mobilization and financial sustainability. As part of this effort, we remain very active in generating blended finance and debt swap transactions. For example, we recently approved a blended finance transaction focused on improving malaria coverage and strengthening health systems in alignment with partners in South Sudan and are scoping several other significant deals for the near future.

To complement our work on health finance, we made a significant step-up in our support to countries on Public Financial Management (PFM) in 2024, funded in part by additional earmarked private sector contributions. While past efforts on PFM have focused primarily on implementer governments' management of Global Fund grants, better PFM is also a critical foundation for effective fulfilment of co-financing requirements, and, more generally, for domestic resource mobilization for health. Building more effective approaches to mobilizing and deploying domestic funds alongside external funds takes time but is an essential foundation for robust sustainability planning and implementation. As part of this effort, we organized a high-level meeting with budget directors and other key stakeholders from 14 countries. Key outcomes included commitments to better align financial planning and investment, improve budget formulation and execution, and strengthen monitoring and evaluation mechanisms.

Health finance and PFM exemplify our close working partnership with relevant multilateral and bilateral agencies, including the World Bank Global Financing Facility (GFF), Gavi, the Vaccine Alliance, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Such partnerships are critical to achieving progress in almost every aspect of what we do, whether in market shaping (e.g., Unitaid, WHO), specific diseases (e.g., Stop TB Partnership, UNAIDS, RBM Partnership to End Malaria), responding to the challenge of climate change (e.g., the Green Climate Fund), or supporting regional initiatives (e.g., the African Union (AU), WHO Regional Office for Africa, Africa Centres for Disease Control and Prevention (Africa CDC)). During 2024 we invested in deepening our collaboration with a wide range of multilateral and bilateral partners, including by signing a number of memorandums of understanding to formalize coordination modalities, expand our ability to jointly invest in shared priorities and highlight priorities for coordination and collaboration.

During 2024 we have put particular effort into deepening our collaboration with Gavi and GFF, through four workstreams focused on:

1. Enhancing collaboration on malaria, particularly around the optimal deployment of the RTS'S/R21 vaccines (Gavi, Global Fund only).
2. Deepening collaboration on RSSH-PPR.
3. Enhancing coordinated engagement with countries.
4. Exploiting opportunities for realizing synergies in enabling functions (Gavi, Global Fund only).

Since the formal establishment of these four workstreams in October 2023, we have made some progress on each of them but rather less than we hoped for, perhaps reflecting different levels of prioritization and ambition across the different organizations. A Joint Committee Working Group (JCWG) – mandated to focus on the first three workstreams – was established, and met for the first time on 1 October, providing us with the opportunity to galvanize greater momentum. However, this will only happen if the JCWG stays focused on supporting tangible progress on these workstreams.

The Global Fund has increased the pace of Privileges and Immunities (P&I) conferrals during 2024. As of this writing, this year the Global Fund received P&Is in Benin and Suriname, two additional countries are completing ratification processes for agreements conferring P&Is, and a fifth country's Parliament has just approved legislation conferring the same. By the end of 2024, counting the above, the Global Fund should have P&Is in 32 countries including, for the first time, in the Latin American/Caribbean region. Further expansion of P&I coverage will continue to be a key priority for the Global Fund in the coming year.

Finally, we continue to work on clearing the backlog of overdue agreed management actions (AMAs) created during COVID-19 and ensuring more timely closure of AMAs. As of the end of August 2024, a combined 20 AMAS were either "overdue" or "long overdue", down from 30 at the end of August 2023. All this reduction relates to long overdue AMAs, which fell by 50% from 20 to 10.

2.3 Invest in Our People and Culture

The staff of the Global Fund Secretariat consistently demonstrate very high levels of commitment, effort and professionalism. The employee engagement survey conducted in February 2024 showed a very high level of overall employee engagement at 83%. However, previously reported concerns about workload, health and well-being at work, and psychological safety remain, and have been the focus of a range of specific initiatives as part of the People and Organization Ambition.

Responding to feedback about leadership engagement, communications and change management expressed in the survey and through other channels, the Management Executive Committee (MEC) has committed to stepping up its efforts and internal communications during this period of significant uncertainty and change. MEC is also doing a dedicated 360 feedback exercise to identify specific issues and opportunities for improvement in how we lead as individuals and as a leadership team.

Staff attrition rates remain extremely low, with attrition (excluding contracts ending) as of 31 December 2023 at 5.2% (down from 6.9% in 2021), and attrition of staff on permanent contracts at 3% (down from 4.5% in 2021). To increase organizational agility and better reflect business needs, there has been a deliberate shift away from permanent contracts to defined duration or temporary contracts: At the end of September 2024, our workforce on permanent contracts represented 61% of the total, compared to 80% at the end of 2019. At the end of September 2024, only 18% of new hires have been recruited on permanent contracts. While this shift increases organizational agility, it has also contributed to the rising concerns about job security, career development and future employment prospects seen in both the employee engagement survey and the Ombud's report.

Both the survey and the Ombud's report also highlight ongoing concerns about the clarity, integrity and fairness of our dispute resolution processes. Michelle Beistle, our new Ethics Officer, is leading a review of internal justice mechanisms, building on the OIG advisory review on this topic. We hope to start implementing recommendations from this review in the first half of 2025.

We continue to make progress on our Diversity, Equity and Inclusion (DEI) agenda with the celebration of thematic months/events (e.g., Black History Month, International Women's Day, Pride Month), encouragement of employee affinity groups (e.g., Women at the Global Fund), and the embedding of DEI metrics into leadership objectives. Ensuring we sustain a diverse, equitable and inclusive work environment will continue to be a priority.

Case Study

Democratic Republic of the Congo: Mpox Emergency Response Reinforced by Long-Term Investments Fighting Disease and Building Health Systems

The Global Fund responded rapidly when government partners in the Democratic Republic of the Congo (DRC) requested support to fight the ongoing mpox epidemic earlier this year.

This included US$9.5 million for the country's emergency mpox response to enhance disease surveillance and laboratory systems, support community-based awareness raising and education programs, reinforce infection prevention and control measures to protect frontline health workers, and strengthen health facilities.

All of these activities leverage two decades of work by the Global Fund partnership to fight infectious disease and strengthen health systems across the country.

A virologist at the National Biomedical Research Institute in Kinshasa, Democratic Republic of the Congo. Researchers at the institute use genome sequencing to better understand the epidemiology of the ongoing mpox outbreak. *The Global Fund/Vincent Becker*

For example, community health workers deployed to fight HIV, TB and malaria are now educating people on protecting themselves from mpox. Surveillance systems built to identify new health threats now track mpox cases and monitor the evolution of the epidemic, while lab technology used to diagnose TB and COVID-19 can now be used to diagnose mpox.

Global Fund support is also contributing to coordination efforts among the Ministry of Health and the National Public Health Institute, Africa CDC, WHO, humanitarian organizations and other key partners.

DRC continues to battle the largest mpox epidemic in the world. As of August 2024, more than 106,000 cases have been confirmed in 123 countries. Ongoing investments in early detection and rapid response to new and re-emerging health threats are vital for ensuring health security.

2.4 Sustain Resource Mobilization and Launch the Eighth Replenishment

In 2024, conversion of Seventh Replenishment pledges has been a priority, alongside preparation for the Eighth Replenishment. As of the end of September 2024, we have successfully converted 51% of Seventh Replenishment pledges into cash, compared to 41% at the same point in the previous cycle. As of the same date, cash conversion of adjusted Sixth Replenishment pledges stands at 99%. During 2024, we secured almost US$100 million in additional pledges for GC7, primarily from private sector donors.

As we prepare for the Eighth Replenishment, we have refreshed our public donor engagement strategies, drawing on the lessons from the Seventh Replenishment, and with extensive input from advocacy partners. We have deepened our engagement in the G7 and G20, securing important support to the Global Fund across both forums, and engaged in other advocacy efforts across national, regional and global platforms, including the UN General Assembly, World Health Summit and key regional gatherings such as the AU Africa Leadership Meeting.

3. Looking Forward to 2025

Looking forward to 2025, we face a complex and challenging situation. To start with, we anticipate a very full implementation agenda: As the second year of GC7 and the final year of C19RM, 2025 could well see another record year of disbursements. We will hold the Global Fund's Eighth Replenishment in an extremely demanding context, with donor official development assistance (ODA) budgets under acute pressure and development assistance for health (DAH) budgets under particular scrutiny given the competing demands from climate change as well as conflict-driven humanitarian crises and refugee flows. Geopolitical tensions, economic stresses and the ever more evident impact of climate change will no doubt intrude. The backlash on human rights and gender will continue to impede access to healthcare.

In this context, we must more than ever demonstrate our distinctive ability to translate donor dollars into impact, including by accelerating equitable access to innovations by driving efficiencies and by a relentless focus on value for money. We will also need to make a compelling case for a successful Eighth Replenishment, with a strong Investment Case and an effective advocacy campaign. A clear sustainability narrative will be an

essential component: we still need to finish the fight against HIV, TB and malaria; donors want to know what their path towards eventual exit looks like; implementer governments need to see a realistic trajectory of increasing obligations; and the communities directly affected by the diseases want to know they will not be left in the lurch. Four priorities will be critical in 2025.

3.1 Maximizing Impact From Grants

As the second year of GC7 implementation and the last year of C19RM, 2025 will be a crucial year from a grant implementation perspective. Effective execution will be critical to maximizing the impact from the approximately US$5 billion we will be investing next year. It will also be essential to ensuring we sustain stakeholder confidence in the Global Fund partnership's distinctive ability to translate donor dollars into impact.

Given the maturity and general quality of GC7 grant programs, we are highly confident that we can achieve high absorption and drive better health outcomes. As always, we will face many country-specific challenges (e.g., changes in government, bureaucratic obstacles, natural disasters, etc.). In addition, I anticipate five categories of challenge to effective implementation that will cut across multiple countries:

- First is the challenge of maximizing the opportunity from market shaping. As our experience with dual AI nets over the last 12 months demonstrates, accelerating access to new innovations requires intense coordination between multiple implementation, technical and development partners on an end-to-end basis, plus the agility to navigate the inherent uncertainties. Long-acting injectable pre-exposure prophylaxis (PrEP) presents a potentially game-changing opportunity to bring forward the end of AIDS as a public health threat, as long as the manufacturers deliver on their expressed intent to enable rapid, affordable and equitable access at scale. Adding highly effective injectable PrEP options to the existing HIV prevention toolkit will allow people to choose the protection option that best fits their needs. Making the most of this opportunity will require extraordinary collaboration between in-country partners (e.g., government, communities, civil society) and international partners (e.g., PEPFAR, WHO, Unitaid, UNAIDS, the Bill & Melinda Gates Foundation, Children's Investment Fund Foundation), plus significant resources (which will mean some difficult trade-offs). Equally important, but more defensively, we will need to execute market shaping approaches that accelerate access to alternative malaria treatments in order to counter the growing threat of resistance to the most commonly used first-line artemisinin

combination therapies (ACTs). In both cases, speed and scale, and an overriding focus on meeting the needs of the affected communities, will be critical to delivering impact.

- Second is the challenge of ensuring rapid and effective implementation of RSSH interventions, given the unprecedented scale and breadth of our current investments through GC7 and C19RM. For a variety of reasons, RSSH grants have typically achieved lower rates of absorption than disease-specific grants, and greater propensity to delay. However, in most countries and across most components of RSSH, we have seen marked improvements in RSSH grant implementation in recent years. Yet given the sheer scale and breadth of RSSH investments in this cycle, there is a risk that some countries will not be able complete full implementation of their C19RM-funded investments by the Board-approved deadline of December 2025. While we are reluctant to release the pressure on achieving rapid and effective implementation of C19RM interventions and are providing extra support through the RSSH-PPR Implementation Acceleration initiative, we will need to consider whether selective extension of the C19RM utilization deadline makes sense. This will be a Board decision.
- Third, ensuring the continued effectiveness of community-led and rights-based programming in a context where human rights and the space for community engagement are under threat in many countries. While many of the challenges in this area are specific to countries and communities, the broader geopolitical context is also crucial. The global pushback on human rights and gender is widespread, well-organized and well-funded. Some of the threats are explicit, some are more insidious. Fighting back is a prerequisite for delivering on our mission and will require determination and courage from across the partnership.
- Fourth, accelerating progress towards more integrated and people-centered service delivery models. While in many countries there has been more progress on this critical aspect of the strategy than is perhaps typically recognized (e.g., with polyvalent community health workers, integration of prevention of mother-to-child transmission services in broader maternal/neonatal packages, and integration of HIV prevention in broader sexual health services, alongside contraception and prevention of sexually transmitted infections), we recognize there is more to be done. Country-level institutional structures and incentives can be barriers to change, as can the absence of guidance (e.g., around schistosomiasis and HIV). Perhaps the most fundamental challenge is ensuring that taking a broader approach does not overly diffuse resources,

overstretch implementation capacities, or dilute the focus on outcomes that has powered our success so far.

- Fifth, responding to the increasing frequency of disruptions from conflict and climate change. It is hard to exaggerate the impact on human health from increased conflict across the globe, whether in Gaza, Myanmar, the Sahel, Sudan, Ukraine, or Yemen. Apart from the direct impact of violence on human lives, conflict increases delivery costs, reduces service access and disrupts programs. Scared, underfed people fleeing for their lives are much more vulnerable to infectious disease. The Global Fund partnership is uniquely adaptable to such contexts, given our ability to respond quickly and use a wide range of implementation modalities. Yet to deliver sustained progress against the three diseases and on the SDG 3 goal of health and well-being for all, peace is prerequisite.

On climate change, we are in uncharted territory. The increased frequency of extreme weather events and the extended periods of extreme heat experienced by some parts of the world are resulting in negative impacts on human health in excess of most predictions. Given that many of the countries we invest in are amongst the most vulnerable to climate change, and the already evident impact on the epidemiology of the three diseases – particularly malaria – we have no choice but to help countries respond to this immense challenge. Delivering on our mission of ending HIV, TB and malaria as public health threats demands a response to the effects of climate change. Helping countries build resilient and sustainable systems for health now requires us to factor in climate resilience. The Board's approval of the Climate and Health Catalytic Funding priority represents a first step in this response, but this is only the beginning of what is likely to be a challenging journey.

Case Study

The Philippines: Breaking Down Barriers for Key Populations

The Philippines has one of the fastest growing HIV epidemics in the world. But Global Fund partners are committed to fighting the disease, and the stigma and discrimination that can prevent people from accessing lifesaving care.

Through the Breaking Down Barriers initiative, the Philippines has been working since 2017 to increase investment and engage national leadership to implement programs that reduce human rights-related barriers to HIV prevention and treatment services for key populations. This includes transgender people and men who have sex with men, who are disproportionately impacted by new infections.

Since 2021, the Community Access to Redress and Empowerment (CARE) program has trained officers that provide support across all regions of the Philippines – people who work closely with clients, advocates and providers to reduce discrimination in health care settings and address other human rights-related challenges to accessing care.

Community outreach workers encourage people attending the Pasay City Pride Parade in Manila, Philippines, to test for HIV and other STIs. *The Global Fund/Vincent Becker*

CARE providers – called partners – act as a combination of paralegal and social worker, providing safe avenues for redress for people whose rights have been violated, such as filing letters of complaint with health facilities and mediating conversations among providers and community-members to foster trust and understanding.

In addition, Breaking Down Barriers-supported legal literacy programs help people better understand and act on their rights, and make them more comfortable with the health system – so they are more likely to seek care. This work also helps illuminate systemic discrimination and underlying social determinants of health that health systems must address to keep people safe and healthy.

3.2 Demonstrating Organizational Effectiveness and Agility

The end of C19RM and the uncertainties about the Eighth Replenishment will require us to be very focused on achieving greater efficiency and organizational flexibility.

At US$346 million, the 2025 Opex Budget is a 1.1% increase on 2024. Taking into account inflationary pressures on some non-discretionary elements of our cost base (e.g., medical insurance, sick leave) this implies a 2% reduction. Funding available for near term priorities, at US$8.1 million, is less than half the equivalent envelope in the 2024 budget (US$17.4 million). In addition to this core Opex budget, we are budgeting US$41.3 million for C19RM Opex in 2025, down 7.8% on 2024.

Looking ahead to potential scenarios for the Eighth Replenishment, we are also exploring more structural efficiency levers. These fall into four categories:

- Streamlining, automation and reconfiguration of key processes. The establishment of the IT Service Centre is a key step in taking forward this agenda.
- Selective reductions in reporting, controls and assurance. The Global Fund invests heavily in providing detailed reporting, implementing robust controls and imposing multiple forms of assurance. While there is a reason for everything we do, in aggregate this represents a very significant proportion of Opex, and also imposes substantial costs on implementation partners. In a highly constrained environment, the Board may need to take some tough decisions on simplifying reporting, accepting greater risks, and reducing layers of assurance.
- Deliberate decisions to end Secretariat participation in certain activities. Depending on the Eighth Replenishment outcome we may need to withdraw or scale down certain activities and rely wholly on partners, who may themselves face financial challenges. It will be difficult to do this without detriment to outcomes, but it may be better to keep this option on the table than to spread constrained resources ever more thinly.
- Increased sharing of functions and infrastructure with partners. This year we achieved some reduction in office infrastructure costs by releasing some space in the Global Health Campus (GHC) to Foundation for Innovative New Diagnostics (FIND). We also intensified efforts to share more functions with the other GHC organizations. While we have now created a shared translation service with Unitaid, the joint workstream with Gavi on this topic has

yet to yield concrete results. Transactional activities like travel management, payroll and IT application services are obvious candidates for a shared approach, and achieving greater progress in this area is a clear priority for 2025.

Since most of the Global Fund Secretariat's cost base is people, being able to adapt the organization and cost base to different financial scenarios and evolving priorities will inevitably involve making difficult decisions about the scale and composition of Secretariat staffing. To ensure we shift to a more agile organization and evolve to respond to business needs, we have been making a progressive shift from permanent employment contracts to defined duration contracts: In 2019, 0.5% of Global Fund Secretariat staff were on defined duration contracts; by the end of September 2024, this proportion was 25%. Of new recruitments in 2024, 66% were defined duration. The challenge is to balance the need for flexibility with the need to ensure our continued attractiveness as an employer, able to recruit and retain the best talent.

3.3 Investing in People and Culture

As we navigate a period of enormous political and financial volatility, there is an inevitable tension between, on the one hand, ensuring organizational flexibility so that we can adapt to different scenarios, and on the other, providing the clarity and certainty that staff understandably want. Colleagues naturally feel anxieties about the future of the organization and thus of their employment prospects. It is clear from the Employee Engagement Survey that we will need to do a better job on communication, being honest about the uncertainties and clear about the potentially difficult decisions, while ensuring continued focus on delivering the mission. The Global Fund's extraordinary record of delivering results depends to a very large degree on the professionalism, commitment and passion of the staff of the Secretariat. Successfully leading the Secretariat through this time of uncertainty and significant change will be a test of MEC and the executive leadership team.

3.4 Delivering a Successful Eighth Replenishment

The Global Fund's Eighth Replenishment, which will raise money for GC8 (2027-2029), will culminate in September/October 2025. This replenishment will therefore determine our trajectory in towards the SDG 3 goals for 2030.

While it is habitual to assert that every replenishment is the most difficult the Global Fund has ever done, it is hard to escape the conclusion that the

Eighth Replenishment faces a particularly acute set of challenges. Many of our biggest donors have cut (or are intending to cut) overall levels of ODA. Global health has lost ground against climate change and conflict-related humanitarian assistance (including refugee costs) in the ranking of donor priorities. Some donors have switched emphasis from multilateral to bilateral channels, often linked to the advancement of national agendas, such as trade or migration. Within global health, there is increased competition for resources across different themes (e.g., pandemic preparedness, antimicrobial resistance, regional manufacturing, universal health care (UHC)), and a queue of global health agencies seeking financial resources over the next few months (including Gavi, WHO, the Pandemic Fund and the International Development Association).

What is without doubt is that the Eighth Replenishment is incredibly important. We already face significant gaps in funding across all three diseases and in most countries, as evidenced by the scale of UQD. When the Investment Case is published in early 2025 it will undoubtedly show a massive difference between overall funding needs and prospective overall funding from all sources. Funding needs are expected to increase as a result of inflation, resistance, climate change, population growth and other external factors. External funding, bilateral and multilateral, is under pressure and likely to decrease. Domestic resourcing for health, by far the largest source of funding, is under acute pressure in many countries, often due to debt servicing or security-related demands on the budget. Only 2 of 55 African countries have met the Abuja Declaration target of devoting 15% of government budgets to health.

Whether the Global Fund's financial resources increase or decrease therefore matters enormously. How much this will affect progress against the three diseases varies by disease. At one end of the spectrum, for TB, the Global Fund provided 76% of total external funding, but given that most TB programs were domestically financed, only 15% of total funding across lower- and middle-income countries. At the other end, for malaria, the Global Fund provided 62% of total external funding, and given the paucity of domestic resourcing in the highest burden countries, about 39% of total funding in malaria endemic countries. For HIV, the Global Fund provided 28% of external funding (since PEPFAR was the leading source) and 11% of the total.[2] These differences mean the impact of an additional

[2] The percentages are based on data provided by the World Health Organization for TB (2023) and malaria (2022), and UNAIDS for HIV (2023). Percentages reflect all low- and middle-income countries (not only Global Fund supported countries). For malaria, only malaria-endemic countries are included.

dollar (or a dollar less) from the Global Fund varies significantly by disease. There are also sharp differences across countries. For some upper- and middle-income countries (UMICs), the Global Fund represents a very small percentage of total health spending. Our continued engagement in such countries is not driven by a lack of overall domestic resources, but by the need to support life-saving HIV and TB services for key populations that otherwise would not be funded. At the other extreme, in some of the very poorest and most conflict-ridden countries and regions in the world, such as in the Sahel, the Global Fund can represent the largest source of external funding for health and can be comparable to government spending.

At this point in the process, immediate priorities for the Eighth Replenishment, beyond close engagement with individual donors and our advocacy partners, include securing robust hosting arrangements, finalizing a compelling Investment Case, and devising a dynamic replenishment campaign. We are well advanced on all these priorities and aim to complete them before the end of the year.

Case Study

Iraq: Equipping Health Providers With the Latest Tools and Technologies to Tackle Tuberculosis

After decades of war in Iraq, vital infrastructure like hospitals, clinics and laboratories were damaged or destroyed, doctors and other health workers fled the country and disease spread rapidly. Iraq was left with one of highest TB burdens in the entire Middle East, including the persistent and deadly threat of drug-resistant TB.

Despite these monumental challenges and a particularly complex operating environment, the Global Fund – in partnership with Iraq's National TB Program and the International Organization for Migration – is making progress to overcome the disease.

A key component of this work includes equipping Iraqi health providers with the latest tools and technologies to better test for, treat and prevent TB.

Fadila Yunis Omar, 65, is screened for TB using a mobile X-ray machine in a home for elderly people in Mosul, Iraq. *The Global Fund/Ashley Gilbertson/VII Photo*

Global Fund investments supported the establishment of a network of innovative diagnostic facilities equipped with GeneXpert machines that can analyze sputum samples for TB, and a centralized digital health database that uses DHIS2 as part of integrated disease surveillance investments to improve reporting and notification.

Community and outreach teams have also been equipped with mobile X-ray systems to screen people for TB. The X-ray machines are easy to transport to refugee camps, prisons, nursing homes and other remote and at-risk communities, and use artificial intelligence to screen people for TB in seconds.

The latest treatments are also available across the country, including a drinkable, cherry-flavored treatment for children with TB and all-oral treatment regimens for people with drug-resistant TB.

These efforts are working. According to WHO, there has been a near 10% decrease in deaths due to TB between 2015 and 2022.

4. Concluding Observations

At this Board meeting, building on the robust and wide-ranging discussions at the two Board Retreats held earlier this year, the Board will make decisions on an array of interlinked policies (e.g., Eligibility, Global Disease Split (GDS), Allocation, STC). Together, this set of interlinked and interdependent crucial decisions will set the stage for the Eighth Replenishment and shape our approach for GC8.

Underlying these deliberations on specific policies is a set of fundamental questions about the future of the Global Fund and its mission. Since we are not on track to attain the SDG 3 ambition of ending HIV, TB and malaria as public health threats by 2030, should we redouble our efforts to reach the targets the world committed to? Or should we accept a slower trajectory towards defeating the three diseases, cognizant of what this means in terms of deaths and economic burden?

The way the debate has shifted from how to accelerate progress, to how to sustain progress, and even to how to protect the gains made indicates how ambitions have been scaled back. To some extent this a reflection of reality. While the recent Pact for the Future confirmed the commitment of the international community to the SDGs, getting back on track to meet the SDG 3 target of ending HIV, TB and malaria as public health threats by 2030 would require a step change that looks implausible. Yet we should also not delude ourselves about the consequences of falling short against these targets. A slower, longer path to defeating the three diseases will be massively more expensive, both in lives and money. Moreover, without a definitive deadline, we run the risk that we will lose momentum and never achieve the objective of ending HIV, TB and malaria.

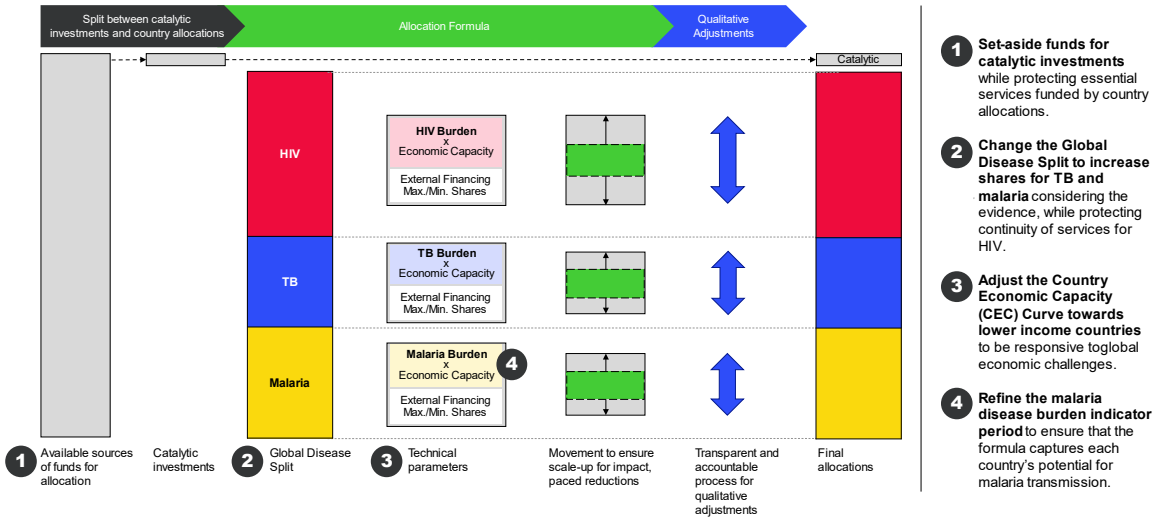
Much of this discussion is framed as a debate about sustainability. At one level the problem statement for sustainability is straightforward to articulate: How do we ensure sustained progress against the Global Fund's overarching mission of ending HIV, TB and malaria as public health threats? Yet below this, there are many differences of nuance and emphasis. For some stakeholders, the emphasis is on how to sustain progress given the prospect of potentially sharp reductions in donor funding. This angle puts the primary emphasis on domestic resource mobilization. For others, the priority is as much about how to sustain donor support for long enough to enable countries to fix the glaring inadequacy of other funding sources.

Addressing the sustainability question, showing how financial responsibility for the fight against the three diseases can be progressively shifted from external funders to domestic resourcing is essential. Donors are increasingly impatient and demanding of a pathway towards eventual exit, or at least, a light at the end of the tunnel. Implementer governments want greater control of health priorities and implementation modalities. Yet we must also confront the epidemiological, economic, programmatic and political realities. Sustainability planning built on wishful thinking will not result in the sustainability of progress against the three diseases; instead it will result in making the diseases themselves sustainable. There is a risk that we drift away from considering what must be done to ensure continued reductions in deaths and infections towards tacitly accepting solutions that keep deaths to a level that is in some way politically "tolerable" but do not deliver the necessary progress in reducing transmission. This again is a path towards the wrong kind of sustainability – of making the diseases themselves sustainable. The danger is that with pathogens as formidable as HIV, TB and malaria, there is no middle ground: If we are not winning, we are losing.

The discussions about sustainability are made more complicated because the challenge varies significantly depending on the disease and the country. For example, sustaining progress against TB in the Philippines is a dramatically different challenge from sustaining progress against malaria in Chad. Furthermore, while much of the discussion revolves around financial sustainability, in many UMICs the impediments to sustainability are more about structural inequalities (e.g., gender, extreme poverty), policy (e.g., criminalization of key populations) and political will.

Figure 6

Proposed revisions to the GC8 allocation methodology



To help frame the Board's deliberations on sustainability, I would offer five observations:

- First, and perhaps self-evidently, it is much easier to generate meaningful sustainability plans – including a progressive transfer of financial burden from donors to implementers – when the disease burden is relatively small and decreasing. This means the financial burden being transferred to the implementer government is relatively manageable. This holds true in a significant number of countries with limited disease burdens and demonstrably successful disease programs. In these situations, it clearly makes sense to put even greater effort into negotiating robust sustainability plans and using co-financing requirements to make these concrete (as is envisaged in the revised STC policy).
- Second, it is difficult to generate meaningful sustainability plans in situations when the disease burdens are very large relative to domestic resourcing capabilities and/or when the disease burden is growing. This applies, for example, in many high burden malaria contexts. This does not mean we should not be planning for sustainability in these countries, but that any such discussion must confront the epidemiological and economic realities. When an infectious disease is surging, the first step towards sustainability is to get the outbreak under control. For many of the countries most afflicted by malaria, focusing on how to shift financial responsibility for the fight, when we are already going backwards and where the near-term potential for increased domestic resourcing is negligible, arguably misses the point.
- Third, sustainability discussions must be grounded in the economic, institutional and security realities, particularly in the poorest, most fragile and war-torn countries. Until there is substantial progress towards peace in countries like Sudan, Yemen, Ukraine or Myanmar, there are limits to the utility of sustainability planning. In the very poorest countries, even those unaffected by conflict, the scope for additional resource mobilization is extremely limited. In many instances, much of what is currently reported as domestic resourcing for health is actually funded by multilateral development banks. The lack of transparency on this is unhelpful, since it means true domestic mobilization for health is overstated. Switching from external grants to concessional lending may be a step towards greater sustainability, but it is still donor dependent.
- Fourth, securing greater commitments for domestic resourcing for health must be accompanied by improvements in how the money is deployed. In a depressingly large number of countries, shortcomings in institutional capacities and governance mean that existing domestic funding is misspent or left unspent. This is where

our efforts to help countries in strengthening PFM are critical, and also where our expectations about the pace of progress must be realistic.

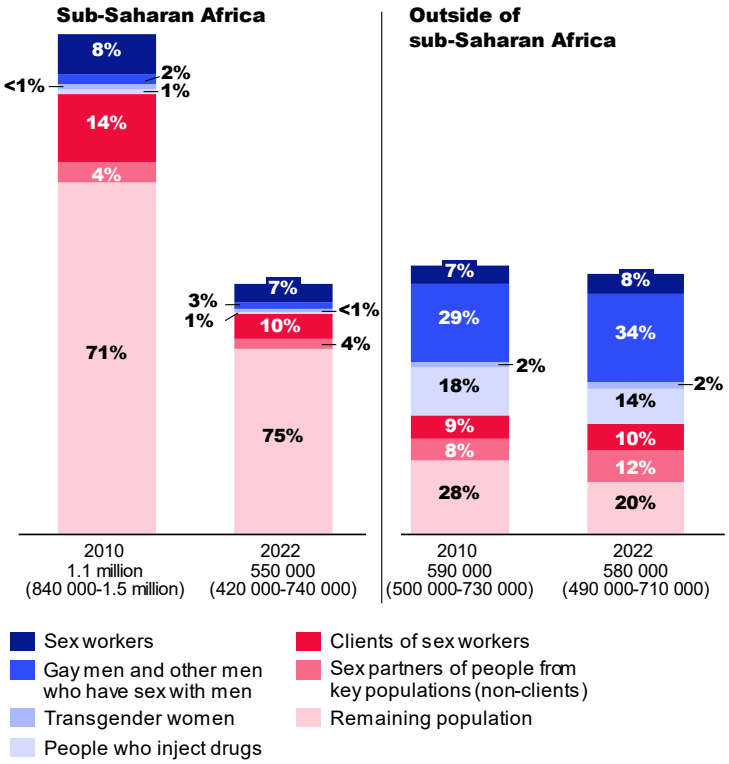
- Finally, we should acknowledge the limitations of Global Fund influence. While we can create incentives through robust co-financing requirements, provide support through our work on PFM or technical assistance on health financing, and use the breadth of the partnership to advocate for more domestic commitments to health, ultimately we have very limited influence over implementer governments' ability to mobilize fiscal resources through taxation or other means, and can only try to persuade political leaders to prioritize health versus other sectors.

Looking at sustainability from a disease perspective, I would add:

- For HIV, grasping the opportunity presented by long-acting injectable PrEP could be the most powerful sustainability lever we have against the virus. If we can secure pricing and volume arrangements that enable us to deploy these powerful new prevention tools at scale, we could cut new infection rates significantly. This would make the challenge of sustaining progress against HIV dramatically more manageable, since it would turn a still growing problem into a declining (albeit long-lasting) one. Of course, this only works if those most at risk and with the greatest prevention needs can get access to the tools they need to protect themselves. More than ever, tackling human rights and gender-related barriers is key to continued progress against HIV. Put another way, in some countries, it is the erosion of human rights for key populations, the stalling of progress on gender equality and the squeezing of space for civil society that represent the principal challenges to sustainability, rather than money.

Figure 7

Distribution of adult (aged 15-49 years) new HIV infections, by key population and region, 2010 and 2022

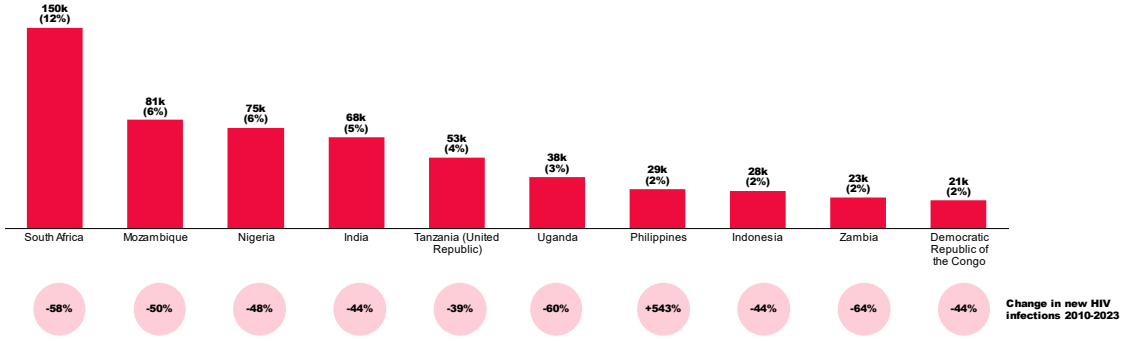


Source: Korenromp, Eline L et al. "New HIV Infections Among Key Populations and Their Partners in 2010 and 2022, by World Region: A Multisources Estimation." *Journal of acquired immune deficiency syndromes (1999)* vol. 95,1S (2024): e34-e45.| Note: the number below year is the number of new infections.

Figure 8

Top 10 Global Fund-eligible countries by number of new HIV infections

of new HIV infections 2023 (% share of global new infections 2023) and change in new HIV infections 2010-2023

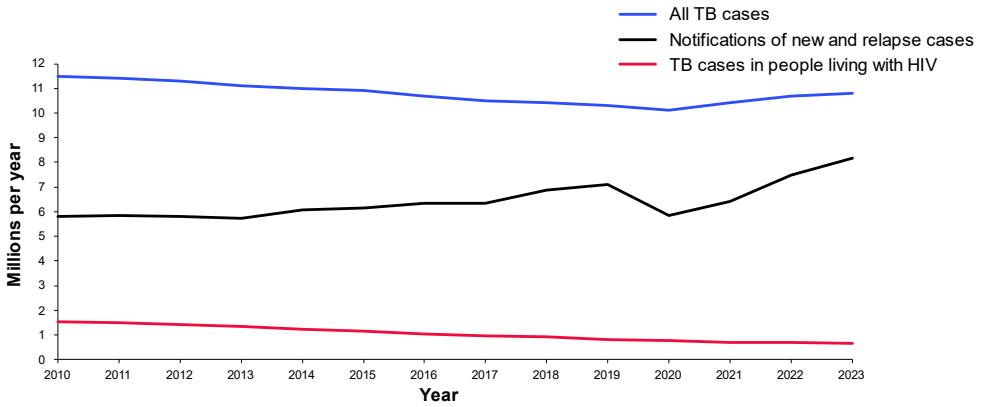


Brazil with 51k new HIV infections in 2023 is not shown as it is not a Global Fund-eligible country. Source: UNAIDS 2024 data release.

- For TB, the challenge will be to sustain and build on current momentum. The latest WHO Global Tuberculosis Report paints a picture of strong progress in 2023, with a record 8.2 million people diagnosed and treated, up 700,000 from the year before; treatment coverage at a record 75%; and a reduction in deaths to 1.25 million (below the pre-COVID-19 level of 1.34 million). Yet TB remains the biggest killer amongst infectious diseases. Sustaining progress will require continued efforts to reduce the number of missing people with TB (now 2.7 million), leveraging innovative diagnostic approaches (including AI-supported digital X-ray machines and even greater utilization of rapid molecular diagnostics) and tackling barriers to access, including criminalization and stigma. We also need to step up diagnosis and treatment of drug-resistant TB (since 66% of cases are missed), and put greater focus on pediatric TB and prevention (e.g., TB preventive therapy for household contacts). Funding for TB programs will continue to be a significant challenge. While the Global Fund represents a bigger share of external funding for TB than for the other two diseases, most TB funding is from domestic resources. This means domestic political leadership is essential for ensuring sustained progress against the disease. It is also why our efforts around blended finance and debt swaps put particular focus on TB.

Figure 9

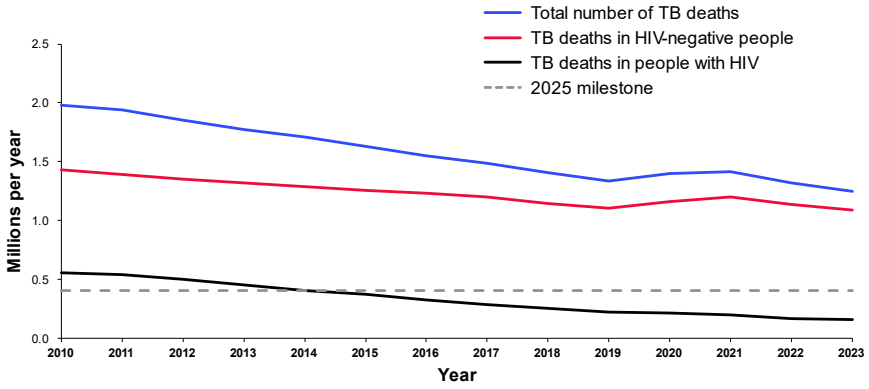
Global trends in the estimated number of incident TB cases



Source: WHO Global Tuberculosis Report 2024, Fig. 1

Figure 10

Global trends in the estimated number of deaths caused by TB



Source: WHO Global Tuberculosis Report 2024, Fig. 9

- For malaria, there are two distinct sustainability challenges. In low burden countries that are on track towards elimination, sustainability plans must balance continued progress towards eradication, with progressive transfer of funding responsibilities. By contrast, in the highest burden countries, the immediate priority must be to get the disease under better control and on a trajectory of reducing deaths and infections. The combined impact of climate change, conflict, parasitical and vector resistance, and population growth make this a daunting challenge. As RBM has pointed out, even with flat funding we face the prospect of over 280,000 more deaths over the GC8 period. Unless we can get malaria transmission under better control, the death toll (primarily children under 5 and pregnant women), massive morbidity burden and overwhelming pressure on fragile health systems will continue to hold back progress across the overall health and development agenda in many of the poorest countries and communities in the world. Across the three diseases, malaria worries me the most.

Figure 11

Trends in malaria cases and incidence rate

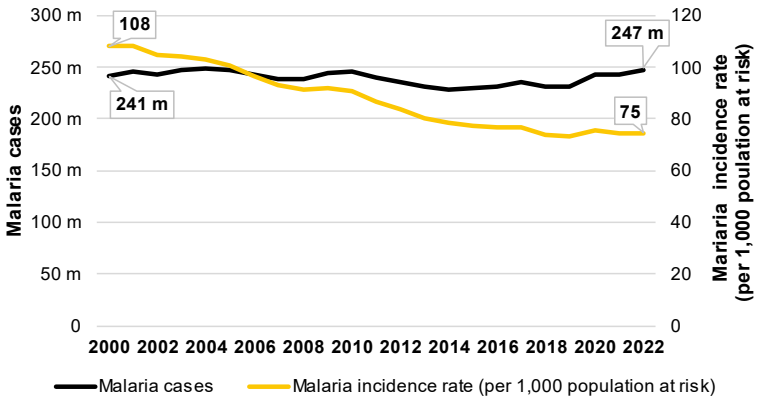


Figure 12

Trends in malaria deaths and mortality rate

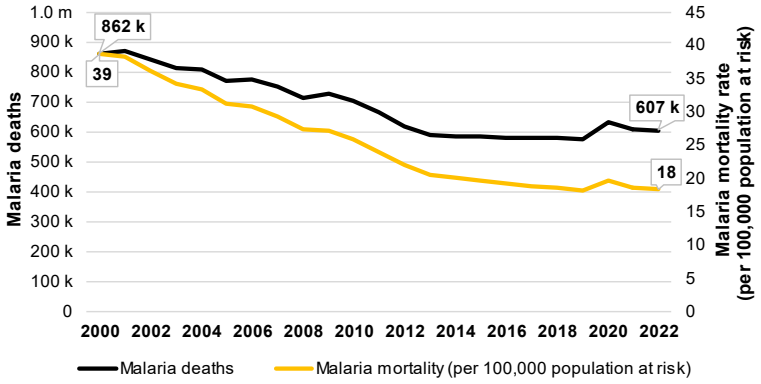


Figure 11 & 12: In countries supported by the Global Fund. Malaria burden estimates from WHO Global Malaria Programme, 2023 release. Countries that have recently received Global Fund malaria funding and have reported programmatic results over the past two grant cycles.

Looking beyond the three diseases, there is also the challenge of ensuring the sustainability of health systems strengthening. Investments in RSSH are often positioned as being key to sustainability, and it is true that strengthening platforms and capacities like laboratories, supply chains, health workforce and community health systems reinforces the effectiveness and resilience of disease-specific interventions. Yet such investments in health systems often also create future financial liabilities and thus pose their own sustainability challenge. This will be particularly true in GC8, given how much we have increased RSSH investments through GC7/C19RM. For example, securing sufficient funding for the ongoing operation and maintenance of the hundreds of oxygen plants we have funded for C19RM will be critical to ensuring we maximize the return on these investments. Laboratories present a similar challenge.

The closure of C19RM poses a particular challenge for RSSH, since about 36% of our current RSSH investments are funded by C19RM. Ongoing rates of RSSH investment are very dependent on the success of the Eighth Replenishment, since higher replenishment outcomes will likely see countries choosing to deploy a higher proportion of their allocation towards RSSH, and lower replenishment outcomes the opposite. Continued investment in RSSH is critical to delivering on our mission against the three diseases, and continued progress against the three diseases is critical to freeing up capacity in overstretched health systems. This is strikingly evident in high burden malaria contexts, where malaria case management often consumes over 50% of health facilities' capacity.

Underlying the discussions about sustainability is a deeper question about what external funders – and specifically the Global Fund – should

prioritize, and what we should leave to be financed by others or through domestic resource mobilization. As funding gets squeezed, answering this question becomes ever more important.

Whatever the source, it is obviously true that money should be directed towards the highest return investments. But beyond that, there are also considerations that point to certain types of investment as being more or less appropriate to be prioritized for external funding. For example, criteria for the prioritization of Global Fund investments might include:

- Investments which offer significant positive externalities, such as infectious disease programs or pandemic preparedness, since rational implementer governments will tend to underinvest relative to the wider benefit.
- Areas where the Global Fund has comparative advantage versus implementer governments and/or other external funders: for example, market-shaping and procurement of medical commodities, funding of community-led organizations, and interventions in challenging operating environments.
- Interventions for which alternative sources of funding, either from implementer governments or other external funders, are extremely limited, either because domestic resource capacity is negligible, or because of lack of political will. In many high burden malaria countries, the scope for significant domestic resourcing is extremely limited. In too many UMICs, it is politically difficult to secure sustainable domestic (or other external) funding such as services for criminalized or marginalized key populations, human rights, harm reduction and community systems.
- Investing in problems that can be reduced or eliminated, such as infectious diseases, since this makes transition more feasible, and provides donors with a clear pathway towards eventual exit.
- Investing in areas and in ways that preserve or reinforce incentives for domestic resource mobilization. In addition to mechanisms like co-financing requirements, this points to being thoughtful about the impact on incentives from fully aligning to national priorities as expressed by the government.

This is not a complete list, and by extension there should be an equivalent list of considerations pointing to what things should be deprioritized for external funding when trade-offs have to be made. The point is that as money gets tighter, it gets even more crucial to be clear why we should fund certain things and not others.

This also holds at the level of specific diseases. At a time when we are confronted by daunting challenges in containing malaria given the combined impact of climate, conflict, resistance and inadequate financial resources, it is problematic that we cannot be confident that countries are making optimal trade-offs in the deployment of malaria vaccines versus other tools. Indeed, the current funding arrangements for malaria vaccines do not permit such trade-offs. Countries can optimize the resources they receive for malaria across other tools, including long-lasting insecticidal nets, seasonal malaria chemoprevention, indoor residual spraying and case management (diagnostics and ACTs), as well as strengthening relevant components of their health systems (e.g., disease surveillance, community health workers). But the funding for vaccines is separately determined and non-fungible. It is far from obvious that what is happening represents the best use of resources.

As part of RBM's "Big Push" initiative, we need to fix this. There are various options, including pooling vaccine and non-vaccine funding in the allocations for GC8. However, this would require significant preparation and decisions by the Boards of both the Global Fund and Gavi.

Looking ahead, we will face similar issues with the TB vaccine, which will likely become available toward the end of GC8 implementation. We need to act now to avoid repeating the problems encountered with the malaria vaccines. Indeed, the need for a different approach for TB is arguably greater, given the geography of the disease and the fact that we could well see the emergence of long-acting TB prophylactics at the same time as the vaccine.

Deploying vaccines through dedicated channels with non-fungible funding makes sense when the vaccines represent "silver bullets", rendering other interventions unnecessary (e.g., measles, rotavirus). However, where vaccines are used as part of a broader armory, the principles of country ownership, value for money and integration argue strongly for a different approach. Moreover, the emergence of highly effective long-acting injectable prophylactics (i.e., cabotegravir and lenacapavir) with impact akin to that of vaccines, further points to the need for change. For lenacapavir, we are working with PEPFAR, WHO and others to assess the resource allocation trade-offs versus treatment and other prevention tools and devising and costing testing prevention and treatment campaigns to deliver much improved access and protection. This integrated approach is very different from the much more siloed approach we have seen with malaria vaccines.

More tightly constrained financial resources across the global health sector underscore the need for achieving greater efficiency and effectiveness in how scarce resources are deployed. This will require more rigorous analysis of the relative performance of different channels for external funding since these differ significantly, and more determined pursuit of opportunities for improvement. While greater collaboration between multilateral agencies can offer some benefits and should be pursued, more radical gains would require rationalization of the sector, through mergers or closure. Moreover, much of the burden on countries arises also from the long tail of bilateral donors, each with their own reporting, assurance and governance requirements. The next few years will be a test of stakeholders' appetite for real change.

The prospect of tightly constrained resources also intensifies the debate around the GDS. The option recommended to the Board by the Strategy Committee (option 3) envisages a shift in resource allocation from HIV towards TB and malaria above a $12 billion threshold. Having been involved in many debates on this topic, I know there is no easy answer to determining an optimal GDS since all three diseases need substantially more resources, the epidemiology and funding landscape of the three diseases is very different, and there is no single metric or analysis that provides a definitive answer to what the split should be. Given what is at stake, it should be no surprise that these discussions have been extensive, robust and sometimes quite challenging. These debates have been valuable and productive in informing the recommendations being put to the Board. However, it is vital that once the Board has made the GDS decision, the partnership puts this debate to one side and unites behind the overarching objective of delivering a successful Eighth Replenishment. This, far more than the GDS, will determine the amounts of money available to fight each of the diseases in GC8.

Indeed, the success of the Eighth Replenishment will be the critical determinant of our pace of progress towards the SDG 3 goal of ending HIV, TB and malaria as public health threats by 2030, and of our ability to enable countries to accelerate the path towards UHC. Therefore, our overriding imperative as a partnership must be to achieve the best possible replenishment outcome. We will only achieve a successful Eighth Replenishment if we are united in our determination to make it happen. In a world where nationalism and self-interest hold sway, the Global Fund partnership is a powerful demonstration of global solidarity, of humanity in the face of crisis. Our history also shows that it is when the challenges confronting us look most daunting that the true strengths of the partnership shine through. Our collective commitment, passion and determination to

overcome every obstacle has kept us going through so many crises. We need that same spirit and courage now. We owe it the people we serve.

Finally, I would like to thank the Board for your counsel and support throughout 2024, the Secretariat's staff for their energy, professionalism and teamwork, and our partners in countries and at regional and global levels for their collaboration and trust. Above all, I would like to thank those on the front line, from doctors and nurses to laboratory technicians and community leaders and health workers, for their tireless efforts and boundless compassion. Ultimately it is their efforts that save people's lives and ensure we continue to deliver on our mission of ending HIV, TB and malaria as public health threats, and make progress towards the overarching SDG 3 goal of health and well-being for all. ●