THE GLOBAL FUND

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Cover: Angela (25), Otilia (19) and Filomena (22) received lenacapavir, a groundbreaking HIV prevention medicine, through youth-friendly health services offered at Xipamanine Health Centre in Maputo, Mozambique, with support from the Global Fund.

The Global Fund/Vincent Becker

Introduction

2026 has been another exceptionally demanding and impactful year for the Global Fund partnership. It is only three months since my last report to the Board in July, but even in this short period we have made significant progress on a number of critical priorities, including the completion of Technical Review Panel (TRP) Windows 1 & 2 for Grant Cyle 8 (GC8), ongoing rollout of game-changing innovations, expansion on non-grant-financed procurement (NGFP), implementation of key components of the ongoing transformation of the Secretariat, and further conversion of donor pledges and mobilization of additional resources.

The next few months represent a critical juncture for the Global Fund partnership. Completion of Grant Cycle 7 (GC7) and the closure of the COVID-19 Response Mechanism (C19RM); the launch of GC8, including implementation of the strategic shifts; our engagement with the multitude of initiatives to reform the global health ecosystem; the next phase of organizational transformation; the emergence of new philanthropic opportunities; plus the complexities of the geo-political and economic context create a daunting array of competing and often divergent priorities. Leadership transitions at multiple levels – from Board Leadership to the Executive Director to the Management Executive Committee (MEC) – add to the challenge. How well we navigate these next several months will determine not just our immediate impact, but also what we deliver over GC8, and how well the Global Fund partnership is positioned for the longer term. This will be a test of our governance, our leadership and the partnership as a whole.

If we succeed, we could turbocharge progress against the three diseases, turning the dream of ending AIDS, TB and malaria into an attainable reality, and helping propel countries more swiftly along their path toward health sovereignty. If we fail, we could see progress against the diseases stagnate and the Global Fund partnership become increasingly peripheral to the achievement of global health goals. For the people and communities who depend on us, the stakes could not be higher.

In this report I take stock of progress against our key organizational objectives, briefly recapping what we have achieved over the year as a whole and highlighting progress since my last report to the Board in July. I also offer some perspectives on the challenges and opportunities ahead.

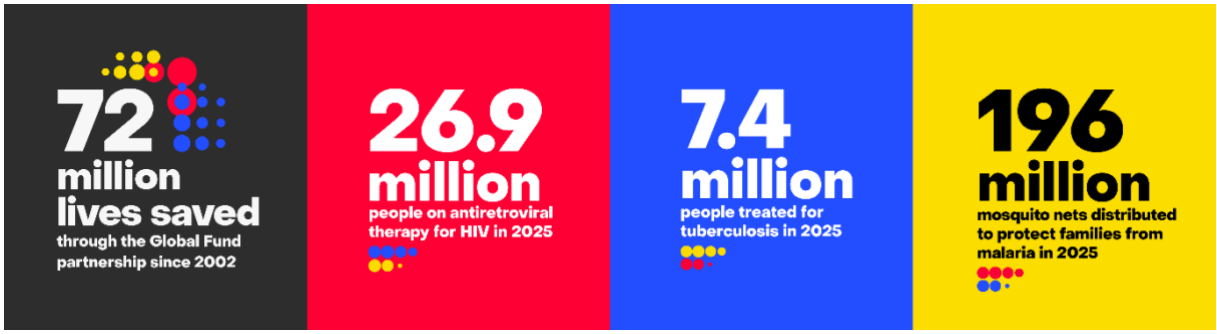
Progress on Key Priorities for 2026

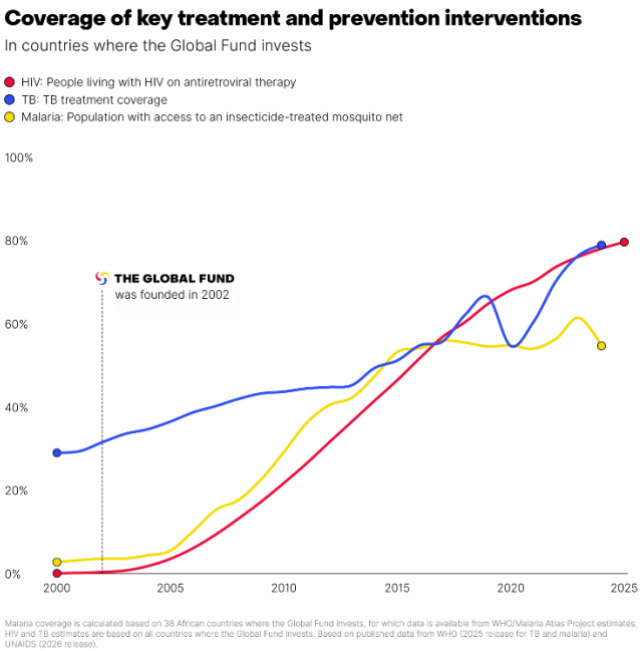
Maximizing the impact of GC7 and C19RM

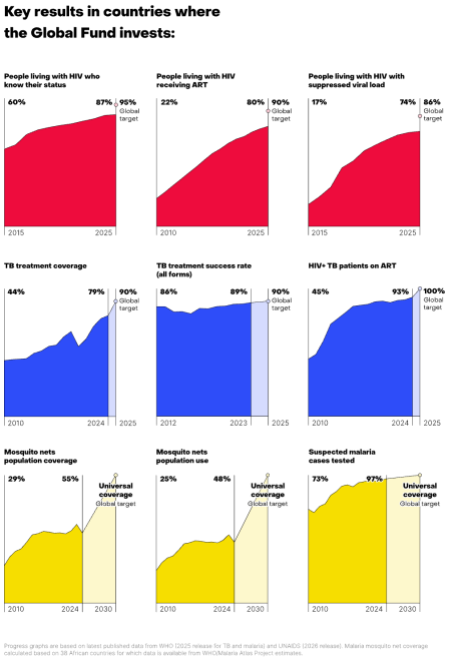
For most of the countries in which we invest, 2026 marks the final year of GC7. Following the reprioritization exercise in the second half of 2025, during which we took US$1.4 billion (or 11%) out of the total GC7 country allocation of US$13.3 billion,[1] there has been intense focus on delivering maximum impact from every dollar. In-country absorption for GC7 at 80% as at end June exceeds all previous cycles at this stage, and is on track to set a new record, well in excess of the Board target of 85%, and above the Grant Cycle 6 (GC6) figure of 92%.

On 16 September we released our Results Report for 2026. While the report focuses on programmatic metrics for 2025, and relies largely on health outcome data for 2024 – the most recent available from the World Health Organization (WHO) – it provides powerful insights into where we are in the fight against HIV, TB and malaria.

Progress on HIV, tuberculosis and malaria







[1] Total GC7 grant budgets of US$13.3 billion include the initial US$13.1 billion country allocation plus other funding sources, including catalytic investments, Debt2Health and emergency funding.

The abrupt and far-reaching reductions in external funding during 2025 undoubtedly had a significant, negative impact on health outcomes, although this varied enormously by country and disease. However, the Results Report also demonstrates the remarkable resilience and adaptability of the Global Fund partnership. Despite the disruption to services resulting from the funding cuts, programmatic metrics across the three diseases held up better than anticipated. Countries reprioritized interventions, found better, more efficient ways to deliver services and mobilized increased domestic resources. Communities and civil society programs – among the hardest hit by the cuts – demonstrated extraordinary determination and ingenuity in protecting services for the most vulnerable. The Global Fund worked intensely with countries and other partners to identify gaps and find solutions. We cannot gloss over the real and significant human costs of the funding reductions, but we should also recognize that it could have been much worse. We did face gaps and did not make the progress we aimed for in 2025, but neither did we see as dramatic a reversal of hard-won gains as many feared.

On **HIV,** the key priority in 2025 was to ensure continuity of lifesaving antiretroviral therapy (ART) for the almost 27 million people on treatment in the countries in which we invest. While there were ups and downs, in aggregate the numbers on treatment remained stable. Prevention interventions, such as programs for adolescent girls and young women, voluntary medical male circumcision, condom distribution and pre-exposure prophylaxis (PrEP) fared much worse. In 2026 we have sought to re-energize prevention programming, leveraging the introduction of lenacapavir, a long-acting injectable PrEP, to restore confidence and galvanize additional resources. Lenacapavir has now been launched in 10 countries, and over 120,000 people have received the injection. Yet funding constraints, an often increasingly hostile environment for community-based organizations, and in some places, disturbing trends on stigma and discrimination against key and vulnerable populations, continue to pose significant challenges in combating HIV. Furthermore, alarming increases in vertical transmission, and persistent weaknesses in pediatric HIV care in many countries, are urgent priorities to address in GC8.

TB was less affected than HIV and malaria by the funding cuts in 2025, since external funding represents a smaller proportion of total resourcing in the countries in which the Global Fund invests. Yet some TB programs also experienced stock-outs of treatments or diagnostics, and overall progress slowed. In 2026, we worked hard to regain momentum, leveraging the continuing rollout of AI-powered digital X-ray – now in over 20 countries – and the launch of innovative near-point-of-care (NPOC) devices offering accurate molecular diagnosis at a fraction of current costs. Following the first deliveries of the new NPOC devices to Benin in June, we have quickly expanded deployment to 13 countries. Using AI-powered digital X-ray to screen and identify presumptive TB cases, and NPOC molecular devices to confirm diagnosis, countries can dramatically accelerate case-finding and reduce the cost of finding new cases.

Case study

Bringing new TB diagnostic tools closer to communities in Peru

Peru has become a regional leader in TB prevention, diagnosis and treatment. The Global Fund has invested more than US$220 million in the country since 2002, accelerating the scale-up of molecular diagnostics, AI-assisted chest X-ray screening and shorter treatment regimens for multidrug-resistant TB, contributing to significant gains in TB control.

Yet challenges remain. Peru accounts for more than 13% of the region's TB burden and drug-resistant TB is a serious threat. Diagnosis and care services have expanded, but people living in rural, Amazonian and other hard-to-reach areas continue to face barriers.

To help close these gaps, the Global Fund is supporting Peru to roll out new NPOC TB testing, which has the potential to transform TB detection. NPOC devices deliver results in less than an hour, and they can operate during power outages, making them well suited for last-mile health facilities with unreliable electricity. Complementing technologies such as GeneXpert and TrueNat, they expand access to high-quality molecular diagnostics beyond laboratories and into primary health centers, mobile clinics and underserved communities.

A shipment of NPOC equipment, test kits and supporting commodities arrived in Peru in August. Health worker training, device installation and commodity distribution are now underway to facilitate a rapid rollout. One hundred devices will be distributed to 25 facilities across seven regions by the end of November 2026 – prioritizing communities in the Amazon and other hard-to-reach areas where people continue to be most at risk of TB.

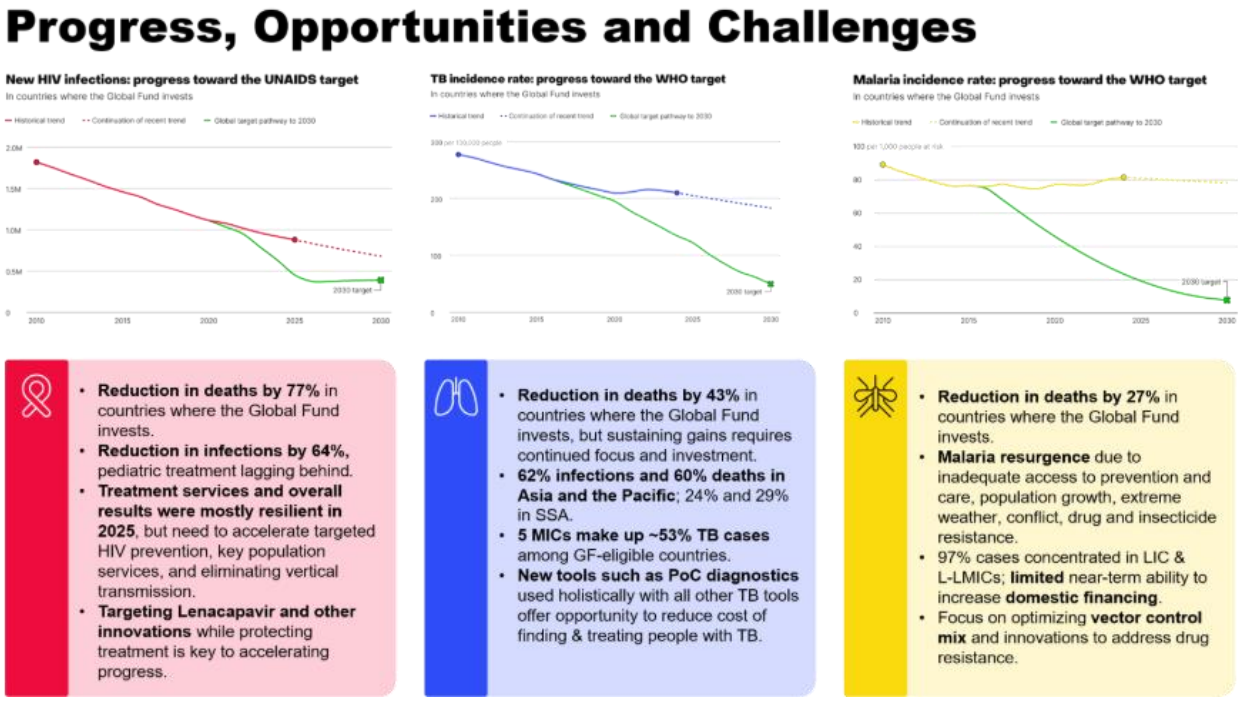
Peru's introduction of NPOC testing is part of a wider Global Fund effort to rapidly scale proven health innovations. NPOC testing is being rolled out in 13 countries this year, ahead of a further scale-up in 45 countries planned for GC8.

Scaling-up diagnosis and treatment for drug-resistant TB remains a significant challenge, with only 50% coverage in some high-burden settings. While new all-oral, short-course regimens are available, widescale rollout is critical. Without further investment drug-resistant TB could reverse global gains and increase mortality.

Even before the funding cuts in 2025, the fight against **malaria** was in a perilous position. A combination of vector and parasite resistance, conflict, climate change, demographics and inadequate funding meant progress had stalled. Many feared that the disruptions in 2025 meant we could lose up to a decade's worth of progress against the disease. While we must await the World Malaria Report in November to get a comprehensive view of the impact on malaria outcomes, our Results Report shows that programmatic metrics for 2025 have proved remarkably resilient. This was the result of determined efforts by countries, communities and partners to adapt quickly to the new context, filling gaps and protecting the most essential services. In

2026, we have continued in this vein, prioritizing the most cost-effective interventions and intensifying the emphasis on efficient implementation.

Challenges across HIV, tuberculosis and malaria



We have also faced new challenges. The Ebola outbreak in the Democratic Republic of the Congo (DRC) has not been contained, and in addition to its direct impact, will probably have had a significant impact on malaria in the region (based on the experience from earlier Ebola outbreaks). While the Global Fund is not in the lead on the Ebola response – that being the responsibility of DRC itself, the Africa Centres for Disease Control and Prevention (Africa CDC) and WHO – we have played our part. Prior investments in community health workers, laboratories and supply chain underpin the broader response. We moved swiftly to enable reprogramming for the Ebola response and to provide emergency funding to manage the knock-on impact on malaria.

Case study

Responding to Ebola while protecting essential HIV, TB and malaria services

Since the Ebola outbreak in DRC was declared in May 2026, Ebola cases have spread across seven provinces, with more than 7,200 confirmed cases and 3,475 deaths. Multiple cases and two deaths were confirmed in neighboring Uganda.

The Global Fund responded rapidly to the outbreak by mobilizing US$8.2 million in existing investments to support the Ebola response in DRC and Uganda. Working alongside national authorities, the Africa Centres for Disease Control and Prevention (Africa CDC), WHO and other partners, the Global Fund is supporting efforts to strengthen surveillance, diagnostics, case management, infection prevention and control, logistics and community engagement.

In July 2026, the Global Fund released an additional US$4.6 million in emergency funding to strengthen malaria prevention efforts in the areas hit hardest by Ebola in DRC.

To reduce malaria infections and slow transmission in communities most impacted by the Ebola outbreak in Ituri province, the emergency funds are supporting the widespread distribution of antimalarial medicines, insecticide-treated mosquito nets, and spatial repellents to nearly 400,000 people.

To ensure HIV and TB services are maintained, national programs are adapting service delivery by bringing treatment closer to communities and providing patients with several months of medicines at a time. Global Fund partners are helping reconnect people who have fallen out of care while ensuring health facilities maintain adequate supplies of HIV and TB medicines.



Together, these investments are supporting the country's response to the Ebola outbreak while protecting access to essential HIV, TB and malaria services for the communities most at risk.

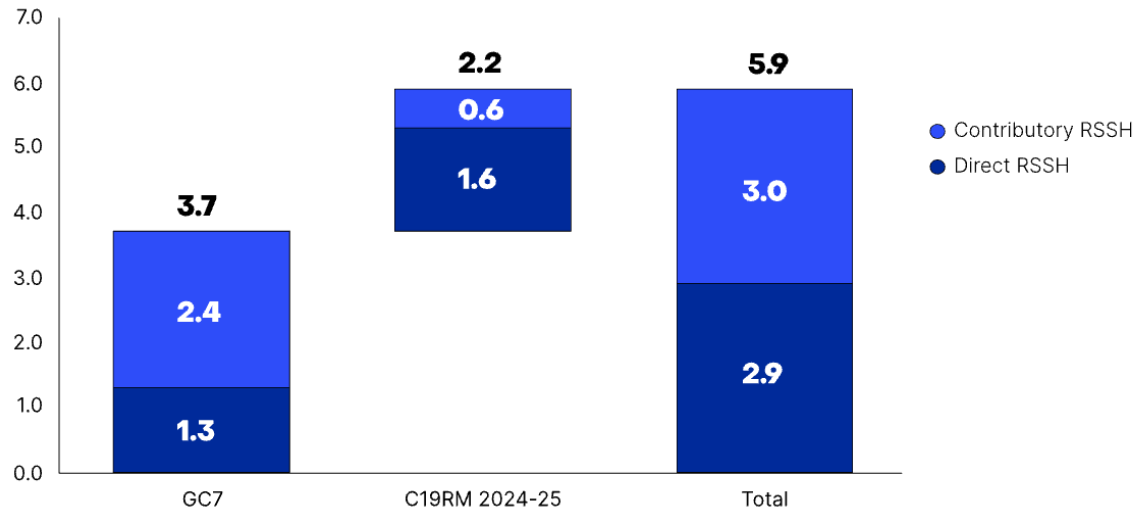
Asobe Wivine with her 1-month-old daughter Flavienne at the maternity ward of Mongbwalu General Hospital in Mongbwalu, Ituri Province, Democratic Republic of the Congo.

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2026 also represents the final year of C19RM, launched in April 2020, through which we ultimately channeled US$4.2 billion. In-country absorption as of 30 June 2026 stands at 82%. We are on track for allocation utilization of 100%.

C19RM went through two distinct phases: an initial phase when the priorities were supporting countries' immediate response to COVID-19, including diagnostics, personal protective equipment and treatments, plus mitigating the impact on HIV, TB and malaria services; and a second phase – following the end of the acute phase of the pandemic – when the focus switched to health system components critical to pandemic preparedness and response, including oxygen, laboratories, disease surveillance, community health workers and in-country supply chain. C19RM demonstrated the Global Fund's agility and responsiveness in the face of a new, deadly virus. It also contributed to the Global Fund becoming the biggest multilateral funder of health systems, providing US$5.9 billion in resilient and sustainable systems for health (RSSH) investment during GC7: US$2.2 billion from C19RM and US$3.7 billion from the core portfolio.

Total GC7 and C19RM 2024-2025 RSSH investments (US dollars, billions)



Source: GC7 and C19RM 2024–2025 signed budgets. The GC7 contributory figure reflects the amount reported in the 2026 Results Report, prior to a subsequent classification correction (US$21 million lower). The corrected total of US$5.8 billion is reported in the Strategic Performance Report H2 2026. Bars may not sum due to rounding. Excludes catalytic investments and Secretariat operating expenses.

The findings and recommendations of the independent End-Term Evaluation of C19RM will be published in early 2027, yet we can be confident that we played a crucial role in supporting countries' responses to COVID-19 and in countering the negative impact on HIV, TB and malaria services, and that our investments in health systems (via C19RM and our core portfolio) have had a transformational impact in many countries. For example:

- During 2024-2026 we have invested US$465 million in polyvalent human resources for health, including community health workers. That equates to 117,000 community health workers and 68,000 health professionals trained, equipped and supervised, with sustainability built into domestic budgets. Ten countries developed long-term financing plans for their health workforces.

- Over the same period, we invested US$480 million in strengthening in-country supply chains, including upgrading over 50 central and sub-national warehouses across 10 countries and introducing improved digital systems in 27 countries. We supported 43 countries in improving waste management, a critical component of infection prevention and control, including 140 incinerators and 110 autoclaves.
- Our investment of US$490 million in laboratories, included upgrading over 200 laboratories and proficiency testing to improve the quality of diagnostic services for over 30,000 sites.
- Our investments in early warning and event-based surveillance systems have had a significant impact. For example, supported by C19RM, Ethiopia's community health information system covers 27 million people and Rwanda's community electronic medical records are accessed by 58,000 community health workers. We have also helped 19 countries roll out event-based surveillance across 2,100 health administrative units and embed 7-1-7 (detect in 7 days, notify in 1, respond in 7) as an outbreak monitoring and response tool.
- Through C19RM we have invested nearly US$570 million in oxygen, including the procurement, delivery and/or installation of 414 pressure swing adsorption (PSA) plants across 57 countries, plus piping to wards, cylinders, medical devices and training. The rapid expansion in medical oxygen provision made possible through these investments represents an unprecedented step change in oxygen availability in low- and middle-income countries, particularly in Africa. Visiting a hospital supported by a PSA plant shows the breadth of lifesaving interventions made possible by the provision of medical oxygen, including for maternal and neonatal complications, acute trauma, severe malaria, other respiratory conditions and general surgery. However, it will be important that countries sustain investment in maintenance and training, and there are still significant gaps in oxygen availability, particularly at the primary healthcare level.

Over the GC7 period, the Global Fund has been the largest multilateral provider of external grant funding for strengthening RSSH, including community systems. With the closure of C19RM and the reductions in country allocations, the challenge for countries in GC8 will be to ensure these significant improvements in infrastructure and capacities are sustained and fully utilized.

Preparing for GC8

Following communication of GC8 allocations in March 2026, we have made enormous progress in preparing for the launch of GC8 in January 2027. With a significantly truncated timetable (nine months versus 12), the implementation of the strategic shifts, and the difficult trade-offs arising from reduced country allocations, this has been a challenging process for Country Coordinating Mechanisms (CCMs), Principal Recipients (PRs) and other implementers, Country Teams and technical partners. Yet with the completion of TRP Windows 1 & 2, 57 Funding Requests, representing US$7.9 billion, or 74% of total country allocations, have now proceeded to grant-making (plus US$218 million in matching and multi-country catalytic funds). Only one Funding Request has been iterated. By the end of 2026 we anticipate that US$9.3 billion, or 87% of country allocations, will have been reviewed by the TRP.

This is a remarkable achievement, and I appreciate the commitment and sheer hard work of all our partners. The changes we have implemented to streamline processes have also helped. We replaced previous technical guidance notes with more user-friendly and succinct Investment Guidance. By cutting almost 600 pages, we reduced guidance documents by roughly two-thirds versus GC7. The TRP has also further differentiated its reviews, aligning intensity and expertise with portfolio size, complexity and potential impact. The Grant Approval Committee (GAC) has been redesigned, drawing on the findings of an Office of the Inspector General (OIG) Advisory. For GC8, GAC will focus on strategic alignment with the GC8 shifts, and on critical risks and trade-offs. Finally, we have also reduced the number of grants – from 266 in GC7 to a projected 166 in GC8 – and PRs – from 162 to a projected 133 – to improve efficiency at country level.

TRP feedback on Windows 1 & 2 is overall positive, with Funding Requests generally of high quality and aligned with the strategic shifts. Reflecting the emphasis on country ownership, 98% of the Funding Requests were aligned with national disease and health sector plans. Countries also demonstrated their commitment to implementing the strategic shifts for GC8. For example, the TRP noted greater focus on evidence-based prioritization, stronger commitment toward the integration of disease-specific services, greater attention to community systems integration and financing, and increased domestic financing commitments. At the same time, the TRP underscored the need to translate strategic intent into implementation, noting the need for clearer links between prioritization, budgeting and trade-off decisions, and that long-term sustainability depends not only on financing, but also on reforms within governance, accountability and implementation structures. Detailed observations on Funding Requests reviewed in Windows 1 & 2 are provided in: GF/SC31/05: Country Funding Update and GC8 Monitoring.

The GC8 strategic shifts intensify the focus on transition planning. For the first time, we communicated explicit transition timetables to a significant number of countries. GC8 will be the final allocation for 63 disease components across 35 countries and three multicountry contexts. Grant Cycle 9 (GC9) will be the final cycle for a further 21 disease components across 12 countries. Communicating explicit transition timelines has had a profound impact on how countries approach GC8 planning. Instead of looking at GC8 primarily as a continuation of GC7, many countries have been working backwards from the planned transition date to identify what needs to be achieved to make transition feasible. While some countries will undoubtedly face challenges in achieving transition on the planned timetable, the discipline created by explicit transition timelines has undoubtedly been helpful.

Case study

Sustainable transition: Advancing a managed path to domestic financing in Indonesia



Through a clearly defined timeline, targeted technical assistance and strong collaboration between the Global Fund Secretariat, the CCM, the Ministry of Health and other in-country partners, Indonesia is advancing a well-planned transition to domestic financing, grounded in sustainability and focused on maintaining quality and continuity of care.

The Global Fund supported a comprehensive analysis of investments made in Indonesia to identify transition pathways and assess risks associated with a full shift to domestic financing. The analysis drew on extensive stakeholder consultations, assessments of available fiscal space and a review of the policy and regulatory environment governing domestic financing institutions.

Indonesia's malaria program is expected to transition from Global Fund support after the end of GC8, in 2029. The HIV and TB programs are scheduled to transition after the end of GC9, in 2032. The analysis identified critical areas currently supported by the Global Fund that must be transitioned before the end of the transition period, including the procurement of essential medicines and diagnostics, as well as community-based health services.

In March 2026, the Ministry of Health formally assumed leadership of the transition agenda, presenting a time-bound roadmap for a managed shift in financing, purchasing mechanisms and contracting models to ensure continuity of essential health services. Transition planning will build on existing national systems, distinguishing between activities that can be fully financed domestically in the near term and those that will require a phased or blended approach.

Indonesia has been a Global Fund donor since 2022, pledging to both the Seventh and Eighth Replenishments. This is a testament to the country's commitment to tackling HIV, TB and malaria globally and building strong and resilient health systems.

Staff in the TB Department at Ibnu Sina Hospital in Gresik, Indonesia.

The Global Fund/Vincent Becker

To strengthen sustainability and transition planning, we have reinforced our co-financing requirements, increased our work with governments on domestic resource mobilization (including social contracting), set predictable transition timelines and stepped up our support to countries on public financial management (PFM). On co-financing, we are further differentiating for country context and putting greater focus on reducing reliance on Global Fund financing for specific interventions, with improved monitoring and strengthened coordination with partner requirements. On domestic resource mobilization, we are working with individual countries on the expansion of health insurance schemes, including the inclusion of HIV, TB and malaria services, and with partners such as Africa CDC and the African Union on the broader advocacy agenda. We continue to pursue Debt2Health and blended finance opportunities, building on the 28 transactions we have already executed.

To reinforce financial sustainability, we are working with partners (e.g., Gavi, the Vaccine Alliance (Gavi); the World Bank Group (World Bank); WHO; Africa CDC) to strengthen country PFM systems and expand utilization for Global Fund grants. This is reinforcing domestic financial governance and accountability, while deepening country ownership and stewardship of health financing. We are increasingly bringing grants onto national budgets through treasury systems and under the oversight of Supreme Audit Institutions. Already, some 57% of our investment dollars flow through governments, and 53% are on budget.

GC8 plans also demonstrate countries' commitment toward integration of HIV, TB and malaria services into broader packages of people-centered care, and into their overall primary healthcare systems and strategy. These include the integration of prevention of mother-to-child transmission programs into broader ante/post-natal care services, as in Nigeria, or the inclusion of hypertension and diabetes screening in HIV care in Kenya, Tanzania and Zambia. Through the Optimizing RSSH Catalytic Fund, we are providing specific support to integrated service delivery in 16 countries. To scale up such efforts, we are also exploring opportunities to mobilize additional private philanthropic resources, with a particular focus on ante/post-natal care, and cardiometabolic comorbidities.

Case study

From strategy to service delivery: Integration in Côte d'Ivoire in GC8

Côte d'Ivoire is demonstrating how integration can move from strategy to implementation by placing people-centered service delivery and stronger health systems at the heart of its GC8 investments.

In preparing for GC8, a joint program review of HIV, TB, malaria and maternal, newborn and child health programs identified service gaps and opportunities for greater coordination across the continuum of care. The analysis informed a shift from parallel disease programming toward a national model that integrates services around the needs of people and communities.

As a result, Côte d'Ivoire's GC8 funding request was closely aligned with the Global Fund's strategic shift to integrate HIV, TB and malaria services within

stronger primary health care systems. The country aligned investments with its National Health Development Plan, using flexibility across disease allocations to address persistent health system challenges while sustaining progress against HIV, TB and malaria.



Côte d'Ivoire is now developing a national integrated service delivery strategy and operational plan, alongside efforts to scale up a comprehensive package of services that brings together HIV, TB, malaria, sexual and reproductive health, nutrition, immunization and hepatitis interventions through multiple entry points, including antenatal care, immunization services, community platforms and outreach activities.

GC8 plans also strengthen the systems that support service delivery. They advance decentralization and local accountability, expand the role of community health workers, integrate laboratory sample transport and health information systems, and strengthen community-led monitoring. Planned outreach combines interventions such as TB screening with insecticide-treated mosquito net campaigns. Services for key populations will also be increasingly integrated into broader public health facilities.

Côte d'Ivoire's experience shows how national leadership and vision can help embed integration in both service delivery and supporting systems, laying the foundation for more efficient, sustainable care while maintaining a clear focus on HIV, TB and malaria outcomes.

A community health worker tests Lohourignon Ornela for malaria in Menekré, Côte d'Ivoire.

The Global Fund/Olympia de Maismont

There is understandable concern that RSSH investment would get squeezed in a more resource-constrained environment. However, applications for Windows 1 & 2 show only a 3% reduction in direct RSSH investments, a slight proportionate increase given the 7% reduction in corresponding country allocations. Investments in community health workers and health finance, including PFM, have increased significantly, with the biggest drop in monitoring and evaluation and health information systems. Nonetheless, overall funding for RSSH in GC8 will inevitably fall significantly given the closure of C19RM.

Applications for Windows 1 & 2 reflect strong community input with Community, Rights and Gender technical assistance provided to enable meaningful community engagement in 46 out of 52 portfolios. Overall funding for community systems strengthening reduced by 7% in line with the overall reduction in country allocations. However, investments in community-led monitoring increased by half, and

investments to address human rights- and gender-related barriers to accessing health services grew by 4%. There are also positive efforts to integrate community systems into national systems, consistent with strategic shifts on integration and community financing.

Yet significant challenges remain in identifying sustainable financing pathways for programs and services for key and vulnerable populations. While social contracting can provide a technical solution, making this work well requires greater political commitment than is currently apparent in many countries. In fact, we see negative trends on human rights-related barriers to accessing health services for key and vulnerable populations in a number of countries, including discriminatory laws and policies, alongside shrinking space for community-led and civil society organizations. These trends underscore the vital importance of the partnership's efforts in this arena – tackling barriers to access and reaching the most marginalized. To reiterate what should be obvious, we will only beat HIV, TB and malaria if we are unwavering in our commitment to the epidemiological imperative of serving the communities most at risk.

TRP Windows 1 & 2 have also revealed the scale of unmet funding need. Alongside US$7.9 billion in interventions that can be funded, countries have generated approximately US$3.4 billion in Unfunded Quality Demand (UQD). Of this total, US$1.3 billion (38%) is related to malaria, US$987 million (28%) is related to HIV, US$402 million (12%) is related to TB and US$774 million (22%) is related to RSSH.

Market shaping, collaborative procurement and regional manufacturing

Throughout this year, our NextGen Market Shaping efforts, including collaborative procurement, have been critical to our overall strategy.

For **HIV**, the primary focus has been on long-acting PrEP and specifically lenacapavir. Over 450,000 doses have been delivered to 10 countries, with over 120,000 people having received the injection. Early indications suggest that lenacapavir is expanding PrEP reach, with 80% of recipients new to PrEP in Zambia and 88% in Kenya. Given the strength of demand, our primary challenge right now is ensuring sufficient supply to meet country growth aspirations as we transition from the branded product to generics. Following the Expert Review Panel process launched in April 2026, we anticipate the first generics becoming available before the end of the year, but we project a tight overall supply situation through the first half of 2027, which will need careful management with countries, suppliers and other partners and stakeholders.

Beyond this immediate challenge, which should ease as more generic supply becomes available in the second half of 2027, we are working with partners on the longer-term ambition, looking beyond six-month lenacapavir to encompass alimatravir (a monthly oral PrEP), 12-month lenacapavir, and other innovations in the pipeline. If we can mobilize sufficient resources to take advantage of this exciting array of new tools, we can achieve a dramatic cut in new infections, saving hundreds of thousands of lives, significantly reducing future treatment costs, and making the goal of ending HIV as a public health threat a realistic prospect over the next decade.

While countries are incorporating long-acting PrEP into GC8 plans, realizing the full potential of long-acting PrEP will require significantly more resources. At the United Nations General Assembly in September, in partnership with the Clinton Health Access Initiative, CIFF, the Gates Foundation and others, we launched the End HIV Council, with the ambition to mobilize at least US$1 billion in new philanthropic contributions for this purpose.

Long-acting PrEP is only part of the answer. It is vital to sustain provision of high-quality ART to achieve viral load suppression for the 26.9 million people on treatment in the countries in which the Global Fund invests, plus continued enrollment of HIV-positive people not yet on treatment. Indeed, one of the extra benefits of long-acting PrEP is how it changes the incentives to get tested, thus enabling treatment initiation for some who have previously remained undetected.

For **TB**, the principal focus of our market-shaping efforts in 2026 has been on screening and diagnostics, ensuring the continued deployment of AI-enabled digital X-ray screening, and launching the new generation of NPOC molecular diagnostics. Together these advances offer the potential to radically expand and lower the cost of finding people with TB. Often through mobile units, AI-powered X-ray screening enables high-volume, high-quality screening to identify presumptive cases. NPOC diagnostics significantly reduce the time to a positive diagnosis and offer dramatically reduced costs for instruments (approximately US$335 versus more than US$4,000) and cartridges (US$2.60 versus approximately US$8.00).

With support from CIFF and the Gates Foundation, we have so far delivered the new NPOC devices to all 13 early adopter countries, training has commenced in 11 and five (Bangladesh, Benin, Cameroon, Ethiopia and Uganda) have begun testing. Demand is strong: 45 countries have requested over 30,000 devices across Windows 1 & 2. Yet there is still considerable work to be done to ensure these ambitions are translated into robust operational plans.

Looking forward, alongside further diagnostic innovations, there is an exciting pipeline of new prevention and treatment tools, including the first TB vaccine (M72), new long-acting prophylactics, immunotherapy treatment and universal treatment for both drug-susceptible and drug-resistant TB.

For **malaria**, we continue to make good progress in driving the deployment of dual active-ingredient insecticide-treated mosquito nets, which now represent 78% of the nets procured through our Pooled Procurement Mechanism (PPM). We have also begun the rollout of spatial repellents, following the joint announcement by the United States and the Global Fund of the ambition to deploy 30 million of these devices to protect at least 60 million people. While there is a need to expand the evidence base for different use cases (which Unitaid and others are pursuing), the potential is illustrated by the fact that one of the first deployments (some 400,000 units) is to the Ebola-affected areas of DRC.

Another market-shaping priority for malaria is deploying cost-effective ways to counter the increasing prevalence of parasite resistance to the most commonly used first-line treatments. Through the Access Fund, we are promoting migration to multiple first-line treatment approaches, and working with partners, we have begun to explore access approaches for innovations such as ganaplacide-lumefantrine.

To accelerate our market shaping efforts, we have increased the size of our Revolving Facility by 50% with support from the Gates Foundation and MedAccess. The Revolving Facility allows us to make volume guarantees and address access barriers such as shortfalls in supply capacity and unaffordable pricing.

On collaborative procurement, we are working on multiple fronts to provide countries with greater options to access quality-assured medical commodities at the best available prices. Utilization of NGFP has increased rapidly in 2026, driven primarily (but not exclusively) by countries using the PPM/wambo.org for procurement financed by the United States. As of end September, we received 55 orders from 23 countries and anticipate continued growth in NGFP in 2027, driven by four factors:

- Annualized impact of United States-financed procurement.
- Implementation of new arrangements with the World Bank, making it much easier for countries using International Development Association (IDA) funding to finance medical procurement to utilize the PPM/wambo.org. Finalizing this new arrangement will be a significant milestone in our collaboration with the World Bank, and we are very appreciative of the efforts of our World Bank counterparts in bringing this to fruition.
- Introduction of new pre-financing facility (PFF) with the support of the Gates Foundation and CIFF. Pre-payment represents a significant obstacle for countries wanting to use their own domestic resources to procure through the PPM/wambo.org. Following Board approval of the revised NGFP policy in July, including the establishment of PFF, we are on track to introduce this service in early 2027.
- Inclusion of NGFP options in transition planning discussions as part of GC8 preparations.

Note that the objective of expanding NGFP is simply to provide countries with a cost-effective option. We are not compelling utilization of the PPM/wambo.org, and only seek to recover costs. Yet given that many countries pay significant premiums and incur much higher transaction costs when procuring medical commodities with their own or other funds, providing this option is a powerful way of ensuring scarce resources go further.

Alongside expansion of NGFP, we continue to build our collaborative procurement approach with regional and national partners:

- At a regional level, we are deepening our established partnership with the Pan American Health Organization (PAHO), supporting Africa CDC with the establishment of the African-Pooled Procurement Mechanism, and we have recently signed a memorandum of understanding (MOU) on procurement and regional manufacturing with the East African Community.
- At a national level, we continue to investment in building countries' own procurement capacities. For example, an increasing number of countries manage most of the procurement for Global Fund grants themselves – including Ethiopia (via EPSS, the Ethiopian Pharmaceuticals Supply Service), Kenya (through KEMSA, the Kenya Medical Supplies Authority) and Rwanda.

Consistent with our objectives of increasing supply resilience and national self-reliance, we are working with partners on diversifying product supply, including by increasing procurement from regional manufacturers. During GC6 we procured from

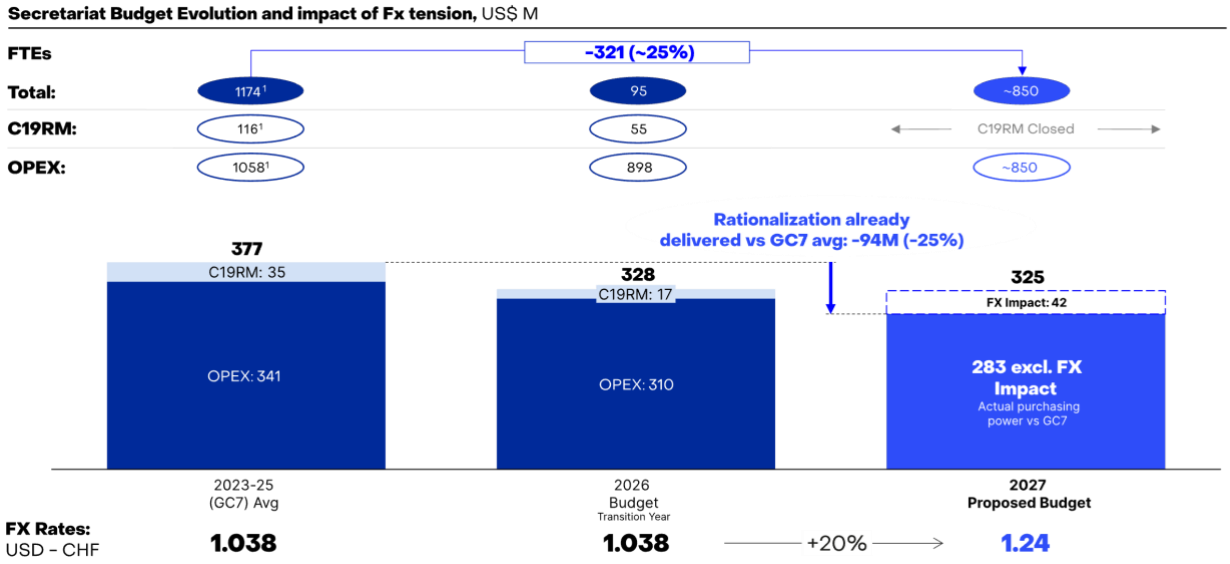
three manufacturers in Africa, while in GC7 we procured from 10. New African suppliers in 2026 include the first procurement of HIV professional rapid diagnostic tests manufactured in Nigeria and the procurement of spatial repellents manufactured in Kenya for use in DRC.

Continuing the transformation of the Secretariat

We continue to drive the transformation of the Secretariat. As indicated in GF/AFC31/07B: 2027 OPEX Workplan and Budget, we are on track to complete the year within the approved operating expenses (OPEX) budget for 2026 of US$310.3 million. Including both C19RM and OPEX, full-time equivalent (FTE) by 2027 will be down by approximately 25% on GC7.[2] On a constant currency basis, 2027 costs will be reduced by US$94 million compared to the GC7 average.

We are proposing a 2027 budget of US$325 million. While this is a nominal increase on 2026, it is a 14% reduction on a constant currency basis. The increase in the Swiss franc to US dollar exchange rate from a fixed hedge rate of 1.04[3] during GC7 (and 2026), to a hedged rate of 1.24 for GC8 means that despite some painful restructuring, our prospective cost base remains roughly the same in US dollar terms.

Secretariat OPEX evolution and the foreign exchange (FX) impact on 2027 proposed budget – annualized view



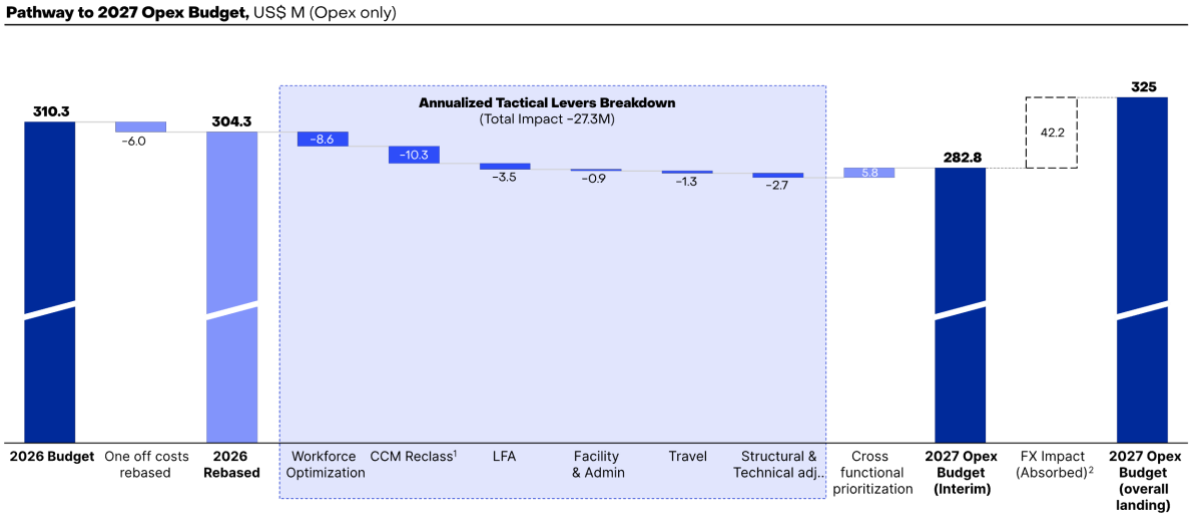
1. 2025 FTEs

Hitting the budget for 2027 will require continued progress on multiple cost reduction initiatives, including further staffing reductions resulting from organizational restructurings, automation and process streamlining, and continued expansion of our offshore service centers in Chennai and Nairobi. Since the last Board meeting in July, we have implemented the merger of the Strategy and Policy Hub (SPH) and the Strategic Investment and Impact Division (SIID) to create a new division called Strategy, Investment and Evidence Division (SIED), led by Julia Martin. We have

[2] 2025 resourcing levels (FTEs).
[3] Hedge rate is 1.038 (rounded to 1.04).

implemented the restructurings of the External Relations and Communications Division (ERCD), which was deferred until after the Replenishment, and the OIG. The Human Resources Department is currently undergoing a transformation, and we have completed another round of voluntary early separation/early retirement (VES/ER), taking the total number of staff benefiting from such schemes over the last two years to nearly 100.

Proposed 2027 budget of US$325 million integrates track 1 tactical levers and the foreign exchange (FX) impact



1. Subject to formal Board approval.
2. USD/CHF fixed hedged rate of GC8: 1.24.
Source: GF/AFC31/07B: 2027 OPEX Workplan and Budget.

Looking ahead, the key to further efficiency gains is greater differentiation, drawing on the rich discussions at the Board Retreat in July. We have begun a process to determine further differentiation of the country delivery model, but are pacing this work carefully so as not to cause too much disruption during the crucial period around the end of GC7 and the start of GC8. Further detail on this work is provided in GF/SC31/07: Evolving the Secretariat's Approach to Differentiation.

This scale of cost reduction entails much more than just trimming and streamlining. We have to stop doing some things, and we have to fundamentally reimagine and re-engineer the way we do other things. We have to accept more risk because we cannot monitor, troubleshoot or intervene in the way that we are used to doing (and as the Board expects). We must be very thoughtful about priorities and be careful not to cut too deep into the muscle.

We are also going through a period of significant leadership transition. Alongside the Board Leadership and Executive Director transitions, we have also seen this year the departure of three MEC members (Harley Feldbaum, Mike Johnson, Marijke Wijnroks), plus the announcement of one other retirement in the first half of 2027 (Mark Edington). Each of these exceptional leaders has made a massive contribution to the Global Fund and our mission, and I would like to acknowledge and thank them for their extraordinary contributions. They will be much missed.

From an organizational perspective, the number of simultaneous leadership transitions is exacerbating the strain on the Secretariat. Implementing the GC8 shifts,

finalizing GC7 and closing C19RM, responding to the turbulence in the external environment, while also undergoing restructuring and seeing colleagues leave is understandably stressful. I'm enormously appreciative of the professionalism and commitment of our staff in navigating this challenging period.

As we look forward to 2027 and beyond, we need to be careful not to allow our commitment to continuous improvements in efficiency result in organizational overstretch. There is a danger that too much focus on cost reduction will create undue operational risk or gaps in our ability to support programmatic impact. At a time when many of our partners are also cutting back their support to countries, we must be mindful of the overall impact on countries and on outcomes. While I am content that our budget proposal for 2027 of US$325 million reflects an appropriate balance of cost reduction and operational resilience, I believe that the overall aggregate forecast for OPEX for GC8 of US$930 million is no longer appropriate. I appreciate the constructive discussions we have been having with the Audit and Finance Committee on this topic.

In line with our commitment to transparency, we have published enhanced disclosures on operating expenditure metrics on our website. We believe these disclosures offer an unprecedented level of detail and accessibility, setting a new benchmark for transparency in the sector.

Sustaining resource mobilization

Over the last few months, we have continued to make good progress on pledge conversion, on securing additional resources and on engaging new sources of philanthropy.

At the last Board meeting the Replenishment total stood at US$12.68 billion, not what we aimed for, but better than many had anticipated 12 months ago. We appreciate the sustained commitment of our donors, despite the fiscal and political constraints they face. Since July we have received one further pledge: US$5 million from the Institute of Philanthropy.

On pledge conversion, we have now received US$2.72 billion in donor contributions for GC8, representing 22% of the adjusted pledge of US$12.11 billion. This compares to US$1.42 billion, or 10%, at this point in the last cycle. We have also received incremental sources of funds, primarily additional contributions from the United States and investment income, amounting to over US$700 million. We will therefore be able to make Portfolio Optimization awards for GC8 of up to US$400 million prior to the start of the new grant cycle. Given the scale of UQD, this is enormously welcome.

I would note that we face more conditions, reporting requirements and specific expectations from many of our donors, creating incremental cost and complexity for the Secretariat (and potentially putting pressure on our policy on restricted financial contributions). We are also encountering a mixed picture on set-asides, with some donors making great efforts to align and coordinate, which we really appreciate, while others are testing the boundaries of what should be counted as part of the pledge.

Much more positively, we are seeing incredibly exciting opportunities emerging in private philanthropy. The most immediate is the Malaria Impact Accelerator GF/SC31/06 - Malaria Impact Accelerator, which would enable the deployment of at

least US$2 billion to US$3 billion across GC8 and GC9 – and potentially much more – to fight malaria.

While the launch of an earmarked mechanism of such scale within the Global Fund framework raises a range of important policy issues and carries some risks, the prize is extraordinary. Moreover, these risks must be considered against the alternatives. Without significant incremental funding for malaria, there is a very high risk – almost a certainty – that we will fail to make rapid progress toward ending malaria as a public health threat. If the donor decides instead to channel these new resources through an entirely new entity created for the purpose, the incremental burden on countries, and the extra costs and coordination challenges, will be much greater.

How we respond to this specific opportunity will also impact the extent to which the Global Fund is perceived as a channel of choice for other potential opportunities emerging from the new wave of private philanthropy. Right now, we are actively engaged in exploring at least four such opportunities, some measured in hundreds of millions of dollars, others in billions. While it may well be that some of these discussions come to nothing, it is powerful testimony to the strengths of the Global Fund partnership that we are attracting such interest. Our record of delivering outcomes, our efficiency and effectiveness, and our established processes, relationships and infrastructure, plus our demonstrable adaptability, make us stand out in the eyes of such donors. Yet we should not assume they will choose us as a channel: These are smart and demanding donors, intensely focused on delivering demonstrable impact at pace and somewhat wary of the political complexities of multilateralism.

Throughout this period and despite the volatile mix of resource mobilization challenges and opportunities, the Global Fund has maintained a strong financial position, underpinned by robust financial governance, disciplined asset management, and a mature assurance framework. Consecutive unqualified external audit opinions reflect the strength and resilience of the Global Fund's compliance with International Financial Reporting Standards and financial stewardship. Given the strength of our balance sheet and the quality of our financial management, I am confident that the Global Fund remains well positioned to navigate the ongoing changes in the donor landscape, while sustaining our support to the countries and communities that depend on us.

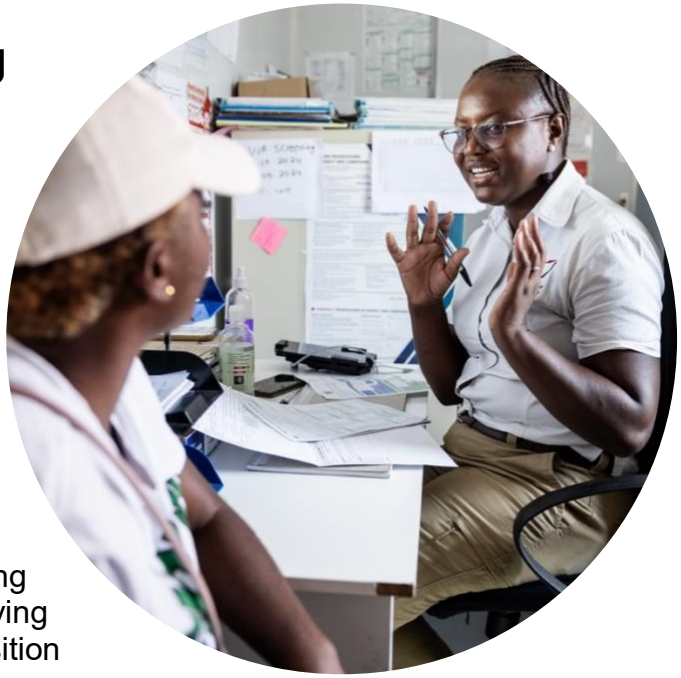
Engaging in the reform of the global health ecosystem

Throughout this year, we have committed significant time and effort to active engagement in the reform of the global health ecosystem. Our commitment to change is reflected in three interrelated strands of activity:

First, we are making significant changes in our own policies, processes and priorities as we transform to better deliver on our mission. The GC8 strategic shifts move more resources to the poorest countries with the greatest disease burden, intensify the focus on transition, put greater emphasis on integration, and reinforce our commitment to market shaping, including accelerated access to innovations, collaborative procurement and regional manufacturing.

Case study

Namibia: Managing an accelerated transition amid a changing funding landscape



The US$22.08 million allocation for HIV, TB and malaria in GC8 will be Namibia's final Global Fund country allocation. Namibia is among a relatively small group of African countries with at least one disease component transitioning during GC8, and it is notable in having all three disease components transition simultaneously.

The transition process overlapped with other changes in the external funding landscape. The prospect of major shifts in funding created uncertainty around future resources, reinforced the importance of domestic financing, and made long-term planning more complex. At the same time, the requirement to develop a transition plan as part of the GC8 Funding Request created an opportunity to align planning for the Global Fund and transition of bilateral funders, bringing these efforts together within a single strategic process.

Led by the Ministry of Health and Social Services, Namibia adopted an integrated approach that engaged the CCM and other national partners. By embedding transition planning within grant design from the outset and coordinating across partners and funding streams, the country is helping safeguard essential services, strengthen the sustainability of its health and community programs and sustain the delivery of proven innovations, such as long-acting injectable PrEP.

The clarity provided by Namibia's GC8 allocation and defined transition timeframe has given the country a stable foundation for both grant design and transition planning, while retaining the flexibility to adapt as partner financing evolves. Targeted catalytic funding is supporting the development of plans, systems and capacities needed to strengthen the long-term financial sustainability of priority health programs.

A predictable Global Fund transition timeframe, strong government leadership and integrated partner planning can help navigate a rapidly changing external financing landscape while identifying and managing risks, protecting essential services and advancing greater national ownership.

Nurse Lucia Ndemuweda administers PrEP to her client Erica at the Walvis Bay Corridor Group Station Clinic and Mobile Clinic at the Oshikango border post in Namibia.

The Global Fund/Karin Schermbrucker

Second, we are working with key multilateral and bilateral partners to strengthen collaboration, reduce the burden on countries, and realize synergies. Specific examples include:

- The Joint Taskforce with **Gavi**, which has involved more than 12 months of analysis, an independent assessment and considerable senior leadership time to build a detailed fact base and identify opportunities for collaboration. As communicated to Board members in a joint message from Sania Nishtar, CEO of Gavi, and me on 27 August, we are now shifting our focus toward delivering practical collaboration, with a primary emphasis on TB and malaria.
- Good progress has been made on implementing the new MOU with the **World Bank** across three workstreams: (1) health financing, including joint investment planning and PFM; (2) health systems and health security, including Climate x Health; and (3) procurement, supply chain and regional manufacturing capacity. There is a strong pipeline for joint/coordinated financing, including advanced discussions on Haiti. We are delighted at the progress made on facilitating use of IDA financing for procurement via the PPM/wambo.org.
- Deepening collaboration with the **WHO African Region** on multiple fronts, including WHO African Region-led mock TRPs, which have proved invaluable in strengthening alignment with technical guidance and the GC8 strategic shifts.
- On 6 October 2026, the **Islamic Development Bank** and the Global Fund signed a new agreement, establishing a framework for aligning investments and coordinating financing, mobilizing additional resources and supporting country-led efforts to build resilient and sustainable health systems.
- We signed an MOU with **Africa CDC** in May 2026, focusing on health systems strengthening and pandemic preparedness and response; advancing regional capabilities for procurement, manufacturing, supply chain and NGFP; and self-reliance and health sovereignty, including financial accountability, governance and sustainability.
- In September 2026 we signed an MOU with the **East African Community** Regional Center of Excellence for Vaccines, Immunization & Health Supply Chain Management on strengthening capabilities for regional procurement, manufacturing and supply chains, and accelerating scale-up of NGFP and health financing.

Across many countries, Country Teams are leveraging the preparations for GC8 as an opportunity to deepen collaboration with bilateral and multilateral partners, maximizing synergies and collective alignment behind country-led strategies.

Case study

Aligning partners, maximizing impact: Mali’s model for grant-making



Mali is demonstrating how strong country leadership and coordinated partnerships can maximize the impact of health investments, an approach that is especially valuable in a country facing insecurity, displacement and access constraints across several regions.

During GC8 grant-making, the Global Fund and Gavi joined Mali’s Ministry of Health, development partners, civil society and technical agencies to plan investments across the health sector.

Ministry of Health officials met with the Global Fund, Gavi, civil society representatives, UN agencies, the United States and the World Bank to align priorities and financing around the people and communities they collectively serve. Partners worked together under government leadership to clarify roles, coordinate investments and identify opportunities to deliver greater impact through collaboration.

The discussions focused on strengthening integration across community health, supply chains, digital systems, outreach activities and program management functions. Investments were adjusted where another partner was already providing support, ensuring resources could be directed to remaining gaps. Plans were developed to combine immunization outreach with malaria prevention, nutrition services and TB case finding where appropriate, while strengthening routine primary and community health services.

The grant-making process also laid the foundation for longer-term integration. Under GC8, Mali’s four Global Fund grants will be consolidated into two integrated grants beginning in 2027, strengthening joint planning and accountability across national, regional and district levels.

More broadly, Mali's experience demonstrates the power of partnership-led grant-making. By aligning investments early, clarifying responsibilities and planning around shared beneficiaries, the Global Fund, Gavi and partners are helping ensure resources go further, national priorities drive decision-making, and more people receive the services they need.

Women wait for health services at the Sebeninkoro CSCOM (*Centre de Santé Communautaire*) in Bamako, Mali.

The Global Fund/Vincent Becker

I would also highlight the continuing close partnership with Unitaid and express my personal appreciation to Philippe Duneton, Executive Director of Unitaid, for his extraordinary leadership and exceptional partnership with the Global Fund over many years. Together we have made a lot of difference. I look forward to working with his successor, Luis Pizarro.

Third, contributing to system-wide transformation through active engagement with global health reforms, with a primary focus on the WHO-hosted joint process, Accra Reset and the Multilateral Organisation Performance Assessment Network (MOPAN) exercise. We are a member of the WHO joint taskforce and are actively contributing to the work across the workstreams, helping inform recommendations on functions, coordination and decision-making, and health financing. We have been consistently engaged with the Accra Reset process, including the work of the High-Level Panel on Reform of the Global Health Architecture and Governance to advance country ownership, improve sustainability and enhance coordination across the global health ecosystem. We have contributed to MOPAN's mapping of organizational mandates and are also engaged with MOPAN's work on comparative advantages, including by bringing the Global Fund's experience on country-led delivery, use of national systems, integration of disease programs with broader health systems, and the reduction of fragmentation and transaction costs for countries. Together, our engagements seek to ensure that health architecture reform initiatives are grounded in evidence and country realities, informed by an accurate depiction of comparative advantages, and remain focused on delivering against country priorities, including stronger health systems and measurable impact for communities. Insofar as we can, we are also trying to ensure these processes are sufficiently inclusive, providing opportunities for communities and civil society, the private sector and other actors to have their voices heard.

Further information on our role in the global health ecosystem is included in GF_B56_09 The Global Fund in the Health Ecosystem.

Looking Forward Toward 2027

The next few months represent a critical juncture for the Global Fund partnership, given the state of the fight against the three diseases, the scale of the immediate operational imperatives, the challenges and opportunities of resource mobilization, the debates around the reform of the global health ecosystem, the ongoing transformation of the Secretariat, and the simultaneous leadership transitions.

Accelerating progress against HIV, TB and malaria

No one should have any illusions about the state of the fight against the three diseases. The sharp reductions in funding have had real consequences. While some countries have made commendable efforts to step up their own funding for health, and the shortage of resources has spurred everyone to find efficiencies, we cannot gloss over the fact that funding cuts have led to gaps in the delivery of critical services.

For **HIV,** the number of people on ART has remained remarkably resilient throughout all the turbulence, but treatment initiation fell, and prevention programs, including testing, condoms, voluntary medical male circumcision, prevention of mother-to-child transmission, harm reduction and community-based services for adolescent girls and young women and key and vulnerable populations have been significantly disrupted

in many countries. Cuts in funding, plus a deeply worrying upsurge in discriminatory laws and policies, have put more people at risk of HIV infection.

We are using lenacapavir to re-energize HIV prevention, to restore confidence and momentum. But while lenacapavir is a real game-changer, it is not a silver bullet. Neither is integration, although it can deliver savings. We need the full array of HIV prevention services. We need to dismantle the barriers to access that face so many of the people most at risk. We need resilient, outcome-oriented community-led services that reach those most in need.

I am optimistic that we can accelerate the end of AIDS as a public health threat, that with tools like lenacapavir, alimatravir and self-testing, we can go beyond restoring progress, to turbocharge it. But we will have to be ambitious, smart, disciplined and determined, find new efficiencies, push back on retrograde policies – and we will have to find more money. Building on our existing partnership with CIFF, we are looking to mobilize significant further philanthropic funding for HIV prevention.

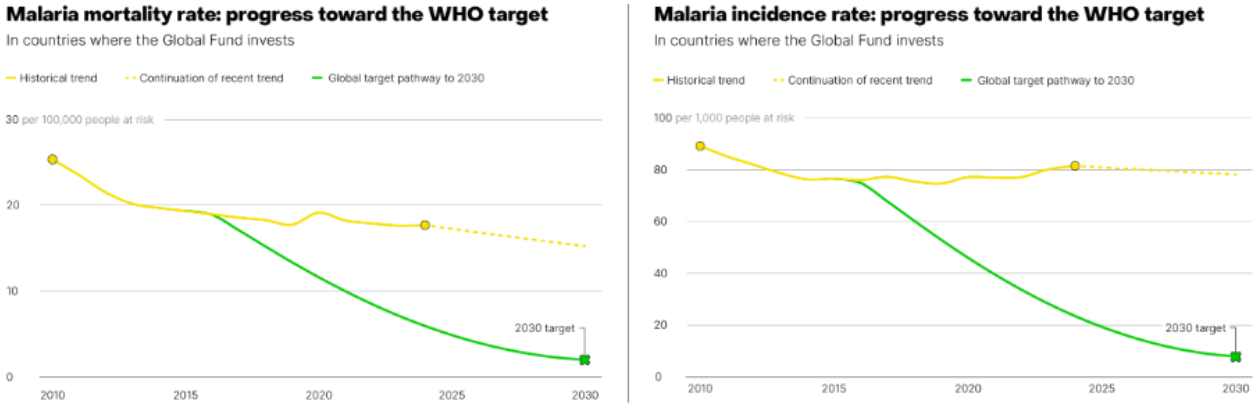
The picture for **TB** is similarly mixed. Reprioritization sought to protect core screening, diagnostic and treatment services. But the cuts in prevention activities, technical assistance, monitoring and evaluation, training, etc. will have a longer-term impact. As with HIV, innovation provides the upside: AI-enabled digital X-ray screening, plus new NPOC molecular diagnosis should radically reduce the cost of case-finding. But realizing the full potential of these tools requires deployment at scale – and that takes money. The support from CIFF and the Gates Foundation, plus the new pledge from the Institute of Philanthropy, are very welcome in this regard, yet we need much more.

Given the exciting pipeline of TB innovations, including the first TB vaccine (M72), long-acting prophylactics, better treatments and new screening and diagnostic tools, there is an imperative to rethink how we approach TB prevention, redefining how we optimize the mix of interventions. To prevent activation of latent TB, when should we use a vaccine versus a prophylactic? When should we put our focus on the triggers of activation, such as HIV, diabetes, malnutrition or air quality? When should we treat the latent disease? The answers will be very different depending on the epidemiological context. If we are serious about beating TB, we should be giving countries a single TB funding envelope, plus evidence-based guidance on how to make the most of new and existing tools given different epidemiological contexts. This is a priority for us to work on with partners such as WHO, Gavi and the Stop TB Partnership.

As I have repeatedly said, it is **malaria** that keeps me awake. We continue to make progress towards elimination in some low-burden areas, but in high-burden regions we face a perfect storm of parasite and vector resistance, inadequate funding, growing populations, conflict, and climate-driven extreme weather events. Persistent underinvestment in wastewater management and unmanaged changes in agricultural practices fuel transmission. Other disease outbreaks, such as Ebola in DRC, almost always kill more people from malaria than from Ebola itself.

Malaria progress has stalled, leaving mortality and incidence far off the 2030 target pathway

Gains have plateaued since 2015, leaving millions, especially children, at risk. **Regaining momentum needs sustained investment and strong systems to deliver new tools at scale.**



"Continuation of recent trend" projection is based on recent trends (10 years), excluding years affected by COVID-19. "Global target pathway to 2030" is based on targets from the WHO Global Technical Strategy for Malaria (2021 update). Countries that have recently received Global Fund malaria funding and have reported programmatic results over the past two cycles. World Malaria Report 2025 data. Source: 2026 Results Report

Malaria is a demonstrably solvable problem, and an extraordinary pipeline of innovations – new diagnostics, new first-line treatments (e.g., ganaplacide-lumefantrine), new vector control tools (e.g., spatial repellents, gene drive) – provide potential answers to all these challenges, but only if we put enough money behind them. Right now, that is not the case, and believing that somehow domestic resources will fill the gap is magical thinking.

That is why the Malaria Impact Accelerator is so exciting. Solving malaria means saving millions of lives in the very poorest communities in the world, and tackling the biggest driver of under 5 mortality and one of the biggest causes of maternal mortality. Solving malaria means strengthening primary healthcare across rural Africa, delivering health benefits that go far beyond the disease itself. When Ebola, Marburg virus disease or any such disease emerges, it is the community health workers funded by malaria programs that are the first line of defense.

Solving malaria also unlocks social and economic development potential. By only counting the deaths, we massively underestimate the full cost of the disease. The stillbirths, the damage to infant cognitive development, the protracted absences from school, the frequent time off work – malaria blights communities that already face so many other challenges.

Of course, beating malaria is not just about money and innovation – political will, community engagement and disciplined, consistent implementation also drive results. With the Malaria Impact Accelerator, we have the opportunity to achieve a decisive change in trajectory.

Delivering operational imperatives

Over the next few months, we must complete GC7, close C19RM, launch GC8 and, (if the Board approves it) establish the Malaria Impact Accelerator. This is a huge operational lift for CCMs, PRs, the TRP, the Secretariat and partners. Execution at pace, without compromising on quality, will drive programmatic performance.

GC8 will be different. We are leveraging the introduction of explicit transition timetables to drive a fundamental change in GC8 planning – from seeing GC8 as a continuation of GC7 to working back from the target transition date to determine what needs to be achieved to enable self-reliance. Setting explicit transition timetables has been very powerful in forcing a change in mindset, even in countries not yet facing such a deadline. It does not make the trade-offs easier, and by no means guarantees successful transition, but it is catalyzing the right conversations.

Implementation of the revised NGFP, including the launch of the PFF, will be an important milestone. It creates new opportunities to support countries beyond our grants through access to procurement solutions and market expertise, complementing national procurement capabilities and providing an additional option where countries determine it offers value. In 2026, the dollar volume of NGFP transactions exceeded the cumulative total of such transactions for all prior years. In 2027, we could double again. Equally important will be advancing collaborative procurement with countries and partners, helping to drive greater coordination and stronger market outcomes and improved access to quality-assured health products and innovations

The intensified focus on integration in GC8 is also challenging established models of service delivery, exploring where less-siloed, more people-centric approaches can deliver more, without diluting the focus on HIV, TB and malaria outcomes. I am excited at the prospect of working with countries to drive this shift, and to realizing the potential new opportunities for resource mobilization arising from taking a broader perspective on comorbidities, people-centered clinical pathways and primary healthcare.

Assuming Board approval, and donor confirmation of their willingness to proceed, we will move rapidly to create the Malaria Impact Accelerator as a dedicated mechanism, leveraging the Global Fund's systems and processes. Superb execution is crucial to realizing the health impact and retaining the confidence of the donor.

Sustaining resource mobilization

Pledge conversion will continue to be a top priority. The Global Fund's ability to commit three-year funding to countries enables them to plan properly and is key to maximizing programmatic impact. Yet any significant shortfall in pledge conversion will require us to pull back from these commitments, with a direct and disruptive impact on health outcomes. Unprecedented shortfalls in pledge conversion in GC7 resulted in us having to ask countries to reduce programming budgets by US$1.4 billion. We must avoid repeating this in GC8. Prompt pledge conversion enables us to mitigate this risk and optimize the United States match. We understand the constraints donors face and appreciate their efforts to support us in managing these risks to our mission.

Maximizing the opportunities from the new wave of philanthropy is an imperative. In a world where most of our public donors are likely to face continued fiscal and

political pressure to make further cuts, private philanthropy represents by far the biggest potential upside. Convincing the new sources of philanthropy that there is a compelling case for investing in health is not the primary challenge, despite many competing demands. But we must also demonstrate that investing through the Global Fund is how such philanthropists can maximize their returns. Our record of delivery is a powerful proof point. Yet we must also overcome their skepticism about the efficiency and effectiveness of multilaterals and concerns about politicization, over-bureaucratization and slowness. We can show that we are different, because we are, but we must deliver on the promise and must move fast. Our distinctive ability to turn donor dollars into health impact is our strongest selling point.

We must also continue to step up our engagement with countries and partners on catalyzing sustainable and significant increases in domestic resourcing for health. As the High-Level Panel on Reform of the Global Health Architecture and Governance of the Accra Reset makes clear, the path to health sovereignty requires tough decisions on taxes, domestic health budgets and a commitment to robust governance and accountability. While political commitment is vital, neither rhetoric nor glossy plans nor compacts will make a difference if disconnected from underlying fiscal and budget realities. Too often there is a significant gap. Tackling the health finance conundrum will require political courage, technical rigor and a willingness to have difficult conversations. We must play our part, aligning with partners behind country-led strategies, engaging with frankness and trust.

Driving the transformation of the Secretariat

We must continue our efforts to transform the Secretariat, not just to reduce costs, but also to improve effectiveness and sharpen priorities, exploiting the potential of offshore service centers and AI, ensuring we retain and motivate the talent we need to deliver our mission. There are definitely risks in the speed with which we are restructuring the Secretariat and changing the way we work. Yet there are also risks in moving too slowly. So, a key challenge for my successor and the new leadership team will be how to manage dynamically the pace of change.

Engaging with global health ecosystem reform

We must continue to be an active participant in the debates around the reform of the global health ecosystem, especially the WHO process, Accra Reset and MOPAN. I am fully committed to playing our part in these processes and believe we can bring a distinctive mix of radicalism and realism to these discussions.

To enhance the efficiency and effectiveness of the multilateral system, and to reduce the burden on countries, we must be prepared to make structural changes – so mergers and closures – since efforts to promote non-structural collaboration have had limited success. We must be bold and radical. If the global health ecosystem looks like it does today by the end of the decade, we will have failed.

We should also be realistic. While many countries could and should do more to exercise health sovereignty, the fact that many have not yet been able to do this is not primarily because of how external funding is delivered. It is because the political will to raise taxes and prioritize health budgets has been lacking. Or because debt servicing, security issues or fiscal leakage (or a lack of foreign exchange) mean that the money simply is not there. What I like about the Accra Reset is that it recognizes

this fact – it starts with what countries themselves need to do, and then goes on to articulate how partnerships like ours must adapt in support.

Realism also means acknowledging the tension between the wholly legitimate desire of implementing governments to exercise greater control over their national health agenda with the need to sustain mission-critical community systems and community-led interventions. Some implementer governments understand and embrace the role of civil society and community-led organizations in designing and delivering health services, particularly for the key and vulnerable populations that governments struggle to reach and serve. But others do not. In many of the countries for which GC8 will be the last grant cycle, the biggest challenge is often not the money, but the willingness of implementer governments to fund and work with the civil society and community partners that play an indispensable role in serving those most at risk.

We should also be realistic about the near-term prospects for health sovereignty, let alone transition, in the parts of the world where extreme poverty and protracted conflict blur the line between humanitarian assistance and development, or where acute governance and implementation weaknesses mean over-reliance on government-led approaches put health outcomes at risk.

In determining the optimal future configuration of global health actors, and a path forward for the ecosystem as a whole, we must ensure that facts and evidence, not just opinions, institutional politics or other agendas, drive the answers. Otherwise, global health reform could result in less impact, not more. We must never lose sight of the people and communities who depend on this ecosystem for their lives and wellbeing.

Managing leadership transitions

We have a lot to achieve over the next six months, and we are going to have to deliver on this agenda while navigating leadership transitions at multiple levels.

This is my last Board meeting. I am proud of what has been achieved over what will have been almost nine years as Executive Director. I congratulate my successor, wish them the very best, and will do all I can to ensure a smooth handover. Being the Executive Director of the Global Fund is demanding, exhausting and inspiring. It is a privilege to have had the opportunity to play a part in delivering such impact, in working with such extraordinary people, in saving so many millions of lives.

This is also Ros Morauta's last meeting as Chair of the Board, and Bience Gawanas' last meeting as Vice-Chair. Ros has played a pivotal role in guiding and leading this Board for over seven years, from 2019 to 2023 as Vice-Chair, and from 2023 to now as Chair. This partnership owes you an immense debt for your commitment, wisdom and skills. I owe you so much for your counsel and partnership.

Bience has been Vice-Chair since 2023, bringing her own distinctive energy, passion and insights, providing a perfect complement to Ros. Thank you, Bience, for your leadership.

I am also thrilled to be welcoming Erna Solberg and Javier Hourcade Bellocq as our new Board Leadership. Given the pace of change, and the tensions and tradeoffs confronting us, this is a testing time for the governance of the Global Fund. The partnership, and more importantly, the people who depend on us for their lives and health, need the Board and Committees to be at their best as we navigate the many

challenges and seize the opportunities. We need the Board focused on what is most important, prepared to confront controversial issues, and coming together to find workable solutions to difficult problems – working in partnership with the Secretariat. This does not happen automatically, or consistently. I know we can count on your leadership as Chair and Vice-Chair to make this happen.

As mentioned earlier, we also seeing considerable change at MEC. This will be the last Board meeting for both Marijke and Mark. Marijke has been with the Global Fund for 13 years, as Chief of Staff, Interim Executive Director and Head of the Strategic Investment and Impact Division. Marijke has been a tireless proponent of putting communities at the center of everything we do, of keeping the focus on delivering for the people we serve. Mark – who will be leaving at the end of April 2027 – has been with the Global Fund for 15 years, and it will be hard to imagine the Grant Management Division without him. Mark's relentless focus on getting things done, on making the money work and delivering better health outcomes has been key to the Global Fund's extraordinary record of delivering impact. We thank you both. You both leave big shoes to fill.

The first 10 months of 2026 have been extremely demanding, but also productive. We are adapting at pace to an extremely turbulent environment. More than ever, we are acting swiftly, in concert with partners, to deliver game-changing innovations to those who can benefit the most. We are laser-focused on delivering against our mission – saving lives, reducing the burden of HIV, TB and malaria, helping countries build more resilient and effective systems for health. We are finding new ways to raise the resources we need to win the fight.

The next few months will be pivotal – in the trajectory of the three diseases, in transforming the way the Global Fund works, in redefining our place in the global health ecosystem.

I want to thank you, the Board, for your counsel and support, as we navigate these stormy waters, the staff of the Secretariat for their extraordinary resilience and professionalism despite all the turmoil, to all our partners for making this special partnership work as well as it does, and above all, the people on the frontline – doctors, nurses, community health workers, lab technicians and others – who show such dedication in turning our dollars into care, saving lives, preventing illness, enabling individuals and communities to grow and prosper.