This document is the Executive Director's update for the Global Fund's 54th Board Meeting. It was initially submitted to the Board on 3 February 2026 for a dedicated session on 12 February 2026.

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.

Report of the Executive Director

54th Board Meeting
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Cover photo: Health extension workers in Debre Abay, Addis Ababa, are part of Ethiopia's nationwide Health Extension Program, which has trained and deployed more than 40,000 salaried workers since 2003. With core funding from domestic resources and decades of support from other partners, including the Global Fund, health extension workers have helped transform health systems in Ethiopia. A child born in the country today is nearly three times more likely to survive to their fifth birthday than a child born in 2000. A major contributor to this success has been a 71% drop in under-5 deaths from AIDS, TB and malaria. The Global Fund/Brian Otieno

Introduction

2025 was a tumultuous year, a true test of the Global Fund partnership's resilience and adaptability. Dramatic cuts in global health funding, sharp fissures in geopolitics and game-changing innovations simultaneously imperiled our progress and offered new opportunities for acceleration. No one should underestimate the scale of the reversals resulting from the abrupt reductions in global health funding, nor minimize the daunting challenges ahead. Yet the Global Fund partnership has shown remarkable resilience in weathering the storm. For the most part, our core lifesaving programs remain on track. We adjusted to funding shortfalls through swift reprioritization of grants and by restructuring the Secretariat. We launched lenacapavir, the game-changing HIV prevention tool. We achieved – given the context – a remarkable result in the Eighth Replenishment, with donors continuing to demonstrate strong support for this unique partnership despite extreme fiscal and political constraints.

2026 will be equally challenging. Sustaining momentum against the three diseases amidst severe funding cuts and disruption to partners will require intense focus on bold and disciplined execution as we complete the final year of Grant Cycle 7 (GC7). Being ready to launch Grant Cycle 8 (GC8) by the start of 2027 will entail the implementation of significant changes to processes and priorities (the "strategic shifts") despite the truncated timetable. Playing our part in the transformation of the global health ecosystem will demand action to make our own organization more efficient and effective, plus continued engagement in the complex reshaping of the broader architecture.

Our continued success will depend on our collective ability to surmount profound tensions. Sustaining programmatic impact with less money. Accelerating transition without derailing progress. Enabling countries to exert greater leadership without compromising impact or inclusivity. Adapting to the new politics while upholding our values and focus on communities. Leveraging innovations at unprecedented scale and pace without diluting deployment of highly cost-effective existing tools. Engaging proactively in reform of the broader ecosystem without becoming too distracted by the debates.

More than ever, the Global Fund partnership must be focused on the people and communities we serve, on delivering health outcomes at scale. Success will require a relentless focus on efficiency and effectiveness, on making tough trade-offs in the face of inescapable funding gaps, and on acting at pace to innovate and adapt. 2026 will test the resilience of the Secretariat, the capabilities of our leadership and governance, and the cohesion of the broader partnership. We should anticipate difficult discussions at the Board, within Country Coordinating Mechanisms (CCMs) and across the partnership: Given the stakes, and the scale of the gaps, there are no easy answers. Yet we must embrace these challenges, simultaneously recognizing the political and economic realities, while holding to our ambitions. Too many lives are at stake for us to flinch or fall short.

In the rest of this Report of the Executive Director, I will – as in previous years – briefly review some of the achievements and challenges faced in 2025, set against the objectives for the year I set out at the end of 2024. I will then share some reflections on the year ahead, primarily as a catalyst for discussion. As always, this is not a comprehensive review of what we have achieved or what lies ahead. For the sake of brevity, I have had to be selective.

1 Achievements and Challenges in 2025

Towards the end of 2024, I set out four priorities for the Secretariat for 2025. Specifically:

1. Implement grants for maximum impact.
2. Invest in our people and culture.
3. Deliver the Eighth Replenishment.
4. Prepare for the future.

In this section I briefly review how we did against these objectives.

1.1 Implement grants for maximum impact

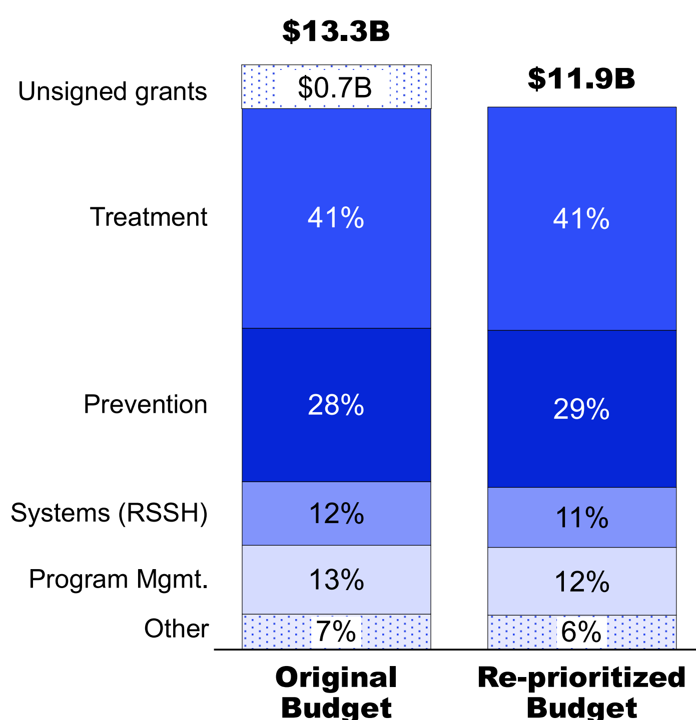
For most implementing countries, 2025 was the middle year of Grant Cycle 7 (GC7) covering 2024-2026. So, countries accounting for roughly 70% of our funding entered 2025 with grant programs already in full implementation mode. While grant performance varies by country and disease, the generally high effectiveness of these programmatic interventions has already been reported in the Results Report, published in September 2025, which provides data for 2024 and reported strong progress on HIV, steady progress on tuberculosis (TB) and a rather more mixed story on malaria.

However, in 2025 our grant programs encountered unprecedented disruption and change, which demanded extensive adaptation and reprioritization across the entire portfolio. Specifically:

- From February 2025, we had to adapt at pace to the significant reductions in United States bilateral funding. Given the sometimes extensive operational integration between Global Fund programs and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)/U.S. Agency for International Development (USAID) programs, sustaining lifesaving interventions entailed a range of workarounds and debottlenecking. The Global Fund worked intensely with implementing countries and other partners (many of which were also directly affected by funding cuts), as well as with our U.S. counterparts, to adapt to the rapid shift in operational realities, including by helping mobilize domestic and other resources. While we were largely successful in ensuring the continuity of our own programming, we were never in a position to be able to fill the gaps or offset the impact of discontinued bilateral programs.

- In response to the uncertainties about our own funding, we simultaneously implemented some controls to slow the flow of our grant disbursements, as a precursor to the Reprioritization exercise launched in May 2025. Reprioritization involved the reduction of US$1.43 billion from country budgets, or roughly 11% of the GC7 Country Allocation total. This was necessitated by the uncertainties about pledge conversion, and it was the first time we had ever attempted a portfolio-wide mid-cycle reduction of grant budgets, let alone at such scale. While there is no escaping the fact that reducing grant budgets by US$1.43 billion will have a negative impact on health outcomes, the process went remarkably smoothly, with most CCMs able to make the inevitably difficult trade-off decisions in an effective and inclusive manner, protecting the most critical lifesaving interventions.

Figure 1. Impact of Reprioritization on Grant Budget Composition (US dollars, billions)[1]

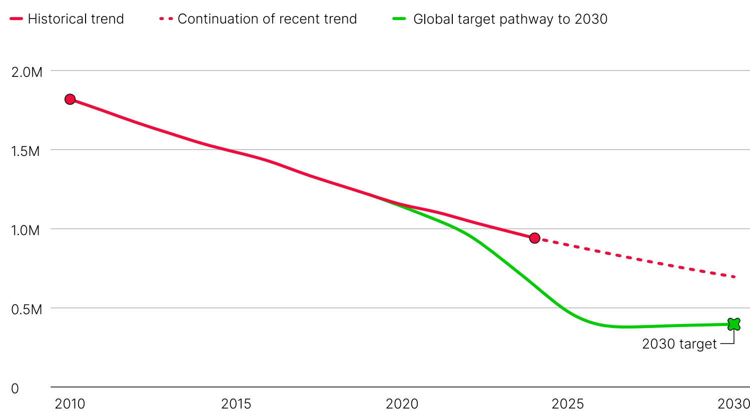


[1] Percentages do not add up to 100% due to rounding.

These two massive shifts – in the overall funding envelope, and in our own grant funding – will inevitably mean that when it is eventually reported, progress against the three diseases in 2025 will not be what we aspired to achieve. We will have to await the collation and analysis of outcome data by the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other partners to get the full picture, but multiple sources already point to reversals in critical areas like HIV prevention, seasonal malaria chemoprevention, and TB diagnosis. Moreover, while our Reprioritization exercise sought to protect immediate

lifesaving services, reductions in longer-term investments in training, infrastructure, surveys etc., will have a negative impact in due course. When we publish the Results Report 2026 in September, drawing on the work of our technical partners, we should be able to give a much more comprehensive assessment of health outcomes in 2025.

Figure 2. Context for GC8: Remarkable Progress, but Gains Are Fragile and Gaps Remain to 2030 Targets



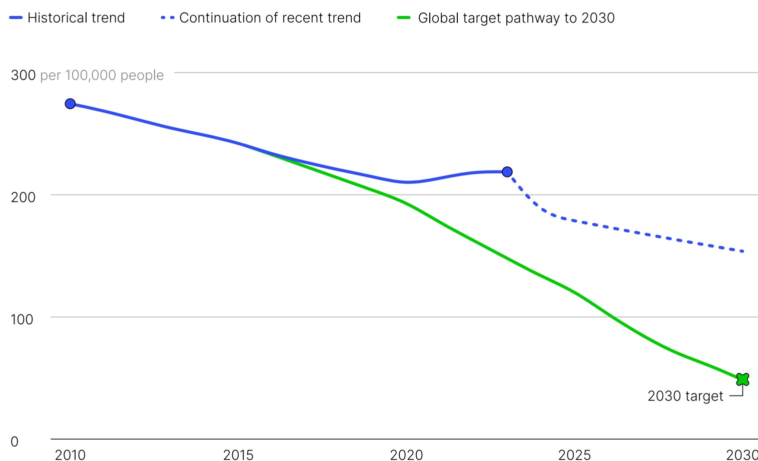
HIV: Progress, Opportunities, Challenges

- Since 2002, deaths have reduced by 74% in countries where the Global Fund invests.
- New infections have also reduced by 62%, but remain high especially in sub-Saharan Africa.[1]
- New infections increasingly concentrated in countries with <2% adult prevalence; key population epidemics essential to address.
- Lenacapavir and other innovations offer an opportunity to reinvigorate prevention, and opportunities to accelerate outcomes via integration and improved service access.

[1] Data sources: Global Fund Results Report 2025; UNAIDS 2024 for HIV data and WHO 2024 for TB and Malaria data. Proportions of cases or deaths are among Global Fund-eligible countries only.

TB incidence rate: progress toward the WHO target

In countries where the Global Fund invests

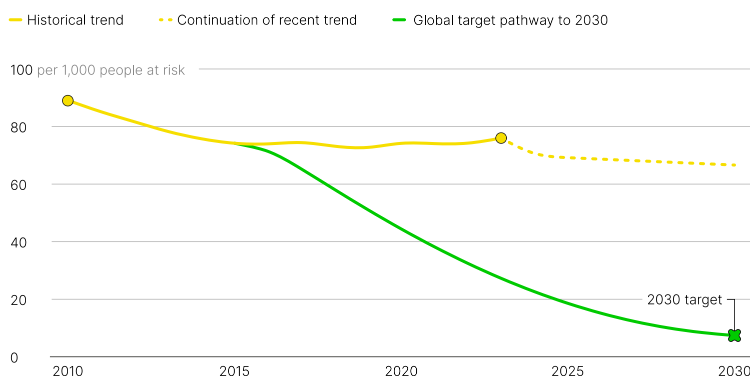


TB: Progress, Opportunities, Challenges

- Since 2002, deaths have reduced by 40% in countries where the Global Fund invests.
- 69% of infections and 66% of deaths remain in Asia and the Pacific, followed by 28% and 32% in sub-Saharan Africa respectively.
- 5 MICs (India, Indonesia, the Philippines, Pakistan and Nigeria) make up ~60% of TB cases among Global Fund-eligible countries.
- New tools such as point-of-care diagnostics offer opportunity to reduce cost of finding & treating people with TB.

Malaria incidence rate: progress toward the WHO target

In countries where the Global Fund invests



Malaria: Progress, Opportunities, Challenges

- Since 2002, deaths have reduced by 29% in countries where the Global Fund invests.
- Malaria resurgence rising due to inadequate access to prevention and care, population growth, extreme weather, conflict, drug and insecticide resistance.
- 99% of cases concentrated in LIC & L-LMICs (37% in Nigeria & DRC); limited near-term ability to increase domestic financing.
- Focus on optimizing vector control tool mix and innovations to address drug resistance.

Yet we must recognize that 2025 also saw some significant achievements in the fight against HIV, TB and malaria. Perhaps most notable was the launch of lenacapavir, the new game-changing, long-acting injectable pre-exposure prophylaxis (PrEP) for

HIV. Working in intense collaboration with partners, including WHO, Unitaid, UNAIDS and PEPFAR, as well as national AIDS programs, the Gates Foundation, the Children's Investment Fund Foundation (CIFF) and community and civil society partners, the Global Fund played a key role in ensuring accelerated access of lenacapavir to low- and middle-income countries: securing a global access arrangement with Gilead Sciences in July; establishing an access fund (with the generous and timely support of CIFF); developing an overall deployment plan with our U.S. counterparts; and working with the nine early-adopter countries to prepare and launch rollout. The first injections of lenacapavir on 1 December 2025 (World AIDS Day) represent a true milestone in the history of the fight against HIV – the first time a game-changing HIV intervention has been made available in low- and middle-income countries simultaneously with its launch in high-income countries.

2025 also saw the completion of many of the investments to enhance key components of health systems funded through the COVID-19 Response Mechanism (C19RM). Through this time-limited and focused funding arrangement, we have supported an unprecedented enhancement in the provision of medical oxygen in low- and middle-income countries, saving hundreds of thousands of lives from maternal, neonatal and other acute conditions. We have also enabled countries to strengthen their laboratory and disease surveillance capacities, significantly enhancing their capacity to detect and respond to disease outbreaks. Our C19RM investments in supply chains, waste management and community health worker networks have substantially strengthened these key pillars of national health and community systems, delivering substantial benefits beyond HIV, TB and malaria.

Reflecting the planned wind down of C19RM investments, plus the impact of Reprioritization, total resilient and sustainable systems for health (RSSH) investment in 2025 reduced from the US$2.7 billion figure in 2024 – an all-time record – to about US$1.8 billion (including both C19RM, direct and contributory investments through the core HIV, TB and malaria portfolio). With C19RM largely complete and closing in 2026, this figure will fall again. Since the Global Fund has been the largest multilateral provider of grants of health systems in low- and middle-income countries, and given the simultaneous sharp reductions in bilateral funding for health systems, we will almost certainly see a marked reduction in external support for such investments in 2026 and beyond.

In 2025 we also stepped up our efforts around co-financing, transition planning and public financial management (PFM), reflecting our strategic commitment to sustainability and transition. Intensified support to countries on PFM delivered in partnership with the World Bank and Gavi, the Vaccine Alliance (Gavi) is already yielding benefits, creating a platform on which we can build in 2026. Our partnerships with Supreme Audit Institutions, and the tripartite memorandum of understanding (MoU) recently signed between the Global Fund, Gavi and the Association of Certified Chartered Accountants (ACCA) reflect our commitment to ensuring sustainable capacity building in this critical arena. Stronger PFM capacities and infrastructure are a critical foundation for effective country ownership and stewardship.

Eswatini and Zambia

A Milestone in the HIV Response: The Rollout of Lenacapavir

Staff at Eswatini's Central Medical Stores receive the country's first shipment of lenacapavir on 11 November 2025. The Global Fund/Daniel Toro

Late last year, the Global Fund and partners achieved a historic milestone with the first deliveries of lenacapavir to sub-Saharan Africa – a twice-yearly injectable PrEP product shown to be up to 100% effective in preventing HIV.

The deliveries to Eswatini and Zambia in November marked the first time a major HIV prevention innovation was introduced in low- and middle-income countries at the same time as in high-income settings – a significant moment for equitable access to lifesaving health products. On World AIDS Day on 1 December, both Eswatini and Zambia started the first injections of this innovative product, ensuring rapid access to this new prevention option.

To further scale up lenacapavir, the Global Fund is working closely with seven additional early-adopter countries – Kenya, Lesotho, Mozambique, Nigeria, South Africa, Uganda and Zimbabwe – that have confirmed their commitment to introduce lenacapavir at scale in early 2026. An additional 10 countries, spanning Asia, Africa, Eastern Europe as well as Latin America and the Caribbean, are planning to introduce lenacapavir with Global Fund financing toward the end of this year.

To ensure lenacapavir reaches those who need it most, the Global Fund is supporting ministries of health that are working closely with local partners,

communities, and civil society to strengthen community structures, connect health and community services, and amplify trusted voices to drive awareness and demand.

The successful rollout of lenacapavir demands close collaboration across the entire partnership, especially with PEPFAR, UNAIDS, Unitaid and WHO, the Gates Foundation and CIFF, as well as Gilead Sciences, and at the country level, with ministries of health, national AIDS programs, communities and civil society. This rollout demonstrates the Global Fund at its very best: pairing innovation with scale and speed to drive lasting impact for those who need it most.

1.2 Invest in our people and culture

The intensity and scale of the external challenges underscored the importance of investing in our people and culture in 2025. As we began the year, we already knew we would have to adjust our workforce in response to the planned closure of C19RM and the likely donor funding challenges. Indeed, we started working on scenarios in April 2024, took anticipatory action by launching a voluntary early separation (VES)/early retirement (ER) window in November 2024, and also began some targeted restructuring of specific departments in the Secretariat. The events of 2025 reinforced the imperative to make significant reductions in our cost base and workforce numbers. We therefore launched a second VES/ER window in April 2025, plus a wide-ranging series of restructurings that encompass 73% of our staff and will ultimately impact every part of the Secretariat. As a result, we will deliver a roughly 20% reduction in staffing and costs.

The full-year figure for Secretariat operating expenditure for 2025, at US$346.0 million, aligned with the approved budget of US$346.0 million, and includes US$18 million of restructuring costs. The approved budget for 2026 is US$310.3 million. C19RM operating expenditure for 2025 was US$28.9 million, down from US$39.2 million in 2024, and C19RM costs in 2026 are budgeted at only US$17.5 million (covering closure of grants, final evaluation, etc.).

Implementing such wide-reaching changes in organization structure, with significant reductions in staffing numbers, has inevitably had an impact on staff morale across the Secretariat. Throughout the year we have sought to protect and nurture our mission-driven, outcome-focused culture by stepping up communication and support and providing a positive vision of our role and future as a partnership without glossing over the uncertainties and financial challenges we face. For example, in 2025 we conducted 10 town halls, more than we have ever done. While no one should underestimate the anxieties and professional stress faced by many of our staff, our people know that at a time when funding has been cut so significantly, and those most vulnerable to the diseases are at even greater risk, we must be prepared to make difficult changes ourselves. The culture of the Secretariat keeps us focused

on the mission. I am proud of and grateful to our staff, and appreciate their continued energy, passion and professionalism in such challenging circumstances.

As we continue to adjust the size and shape of the organization, we will need to continue to invest in our staff, since the distinctive effectiveness of the Global Fund partnership draws heavily on their commitment and excellence. Without them, we cannot deliver on our mission.

During 2025 we also made a number of significant changes at a senior leadership level. While we will be very sad to see Harley Feldbaum leave this February, we are delighted to welcome Julia Martin as the new head of the Strategy and Policy Hub. I would like to take this opportunity to thank Harley for his exceptional leadership during the over 11 years he held this role. Harley excels at making complex issues comprehensible, and in devising solutions to tough problems. During 2025 we have also been very appreciative of Annelise Hirschmann's leadership and adaptability as Acting Chief Human Resources Officer (CHRO), having taken on this role at an extremely demanding time for the Human Resources team. Annie will now return to a leadership role in the Grant Management Division at the beginning of February 2026, and we have just announced that Philippa Bonay will be joining us to become our new CHRO with effect from 1 April. Philippa brings a wealth of experience in leading organizational transformations. We also expanded the portfolios of two members of the Management Executive Committee (MEC). Michelle Beistle, our Chief Ethics Officer, now combines this role with leading Risk. Adda Faye, our Chief Financial Officer, has added Health Finance and C19RM Monitoring & Oversight to her responsibilities.

Reflecting the restructurings being undertaken across the organization, and the contemporaneous VES/ER programs, we are also seeing the departure of a significant number of leaders at the level of the Extended Leadership Team (ELT), the direct reports to MEC. Between the beginning of 2025 and the end of Q1 2026 we will have seen the departure of some 11 ELT members, roughly 15% of the total. Most of these leaders have been with the Global Fund for many years, and I want to thank them for their commitment and contributions to our progress.

1.3 Deliver the Eighth Replenishment

On 21 November 2025, we held the Global Fund's Eighth Replenishment Summit in Johannesburg, co-hosted by President Ramaphosa of South Africa and Prime Minister Starmer of the United Kingdom. We are extremely grateful to South Africa and the United Kingdom for their determined leadership and support in co-hosting our Replenishment.

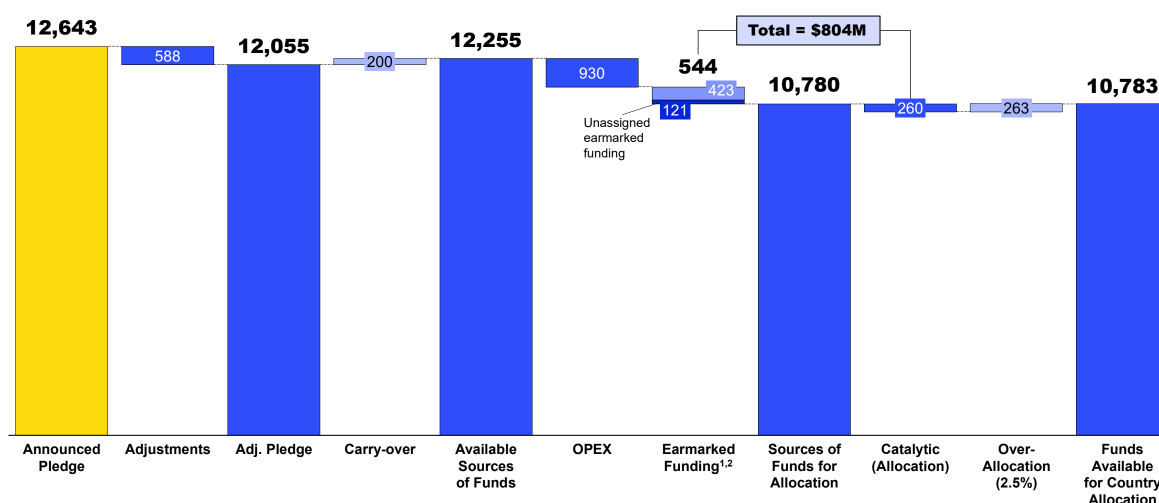
At the end of the Replenishment Summit, we were able to announce that US$11.34 billion had been pledged to fund GC8. Subsequent pledges mean this total now stands at US$12.643 billion,[1] and we still await a number of pledges from key

[1] At the time of writing this report.

donors. So far, we have received pledges from 33 public donors and 14 private donors.

This is a remarkable result in the context. While we have not achieved the US$18 billion needs-based target set out in the Investment Case, we always knew we were highly unlikely to attain such a total, and were more focused on getting as close as possible to the US$14.78 billion raised for GC7 (representing the matched component of the US$15.7 billion in pledges announced at the Seventh Replenishment in 2022). Taking account of anticipated pledges expected to be confirmed by the time of the Board meeting, plus changes in certain key donors' approaches to set-asides, we envisage Sources of Funds for GC8 of US$10.783 billion, compared to initial Sources of Funds for GC7 of US$13.128 billion, and post-Reprioritization GC7 funding of US$11.895 billion. This means a 17.9% reduction versus initial GC7 funding and an 9.3% reduction compared to GC7 post-Reprioritization. Further details of the financial results of the Eighth Replenishment are set out in GF_B54_04A Rev2 2026-2028 Allocation Sources and Uses of Funds.

Figure 3. Sources of Funds Cascade (US dollars, millions)*



*Sources of funds at the time of Board approval.

[1] Earmarked funding comprised of private sector investment to catalytic investment priority areas (US$306.3 million), Debt2Health (US$116.7 million) and an unassigned component of US$121.2 million.

[2] The unassigned earmarked funding of 121.2 million has been integrated and this amount may be used for Catalytic Investments or other Board-approved priorities pending donor confirmation.

While any reduction in funding is unwelcome given the scale of the needs, this is a much better outcome than we could have faced, given the pressures on donor budgets, the volatile political environment, and the many competing demands for resources.

We are extremely grateful to all our donors for making such determined efforts to sustain their support for the Global Fund's lifesaving mission, despite all the financial and political challenges. We are particularly appreciative of those public donors who

managed to increase their pledges, such as South Africa, Spain, Ireland and India. We also acknowledge and especially thank those donors who managed to keep their pledges flat, or to keep any reductions to a minimum. We further note with appreciation the decisions by certain donors to reduce or eliminate their set-asides to maximize the proportion of funding flowing through to Country Allocations but also note with concern the decisions by some other donors to increase such set-asides.

Amongst the highlights of the Eighth Replenishment result, based on announcements thus far, I would note:

- The pledge of US$4.6 billion from the U.S. as the largest pledge to the Global Fund. This pledge is subject to the well-established matching condition, which requires that every dollar the U.S. contributes to the Global Fund is matched by two dollars from other donors.
- The pledge of US$26.6 million from South Africa, which is an increase of over 100% on South Africa's pledge at the previous Replenishment and represents the largest percentage increase by any public donor.
- The pledge of US$200 million from CIFF, which is a more than five-fold increase from CIFF's US$33 million pledge at the Seventh Replenishment, and thus represents the largest increase in both percentage and absolute terms. In support of the accelerated deployment of lenacapavir, part of this pledge is being invested during GC7.
- The pledge of US$100 million from Korea, which matches the level pledged at the Seventh Replenishment and now means Korea is eligible for participation in the voting public donor constituency. This is the first time a public donor has qualified for inclusion in the voting public donor constituency since 2006.

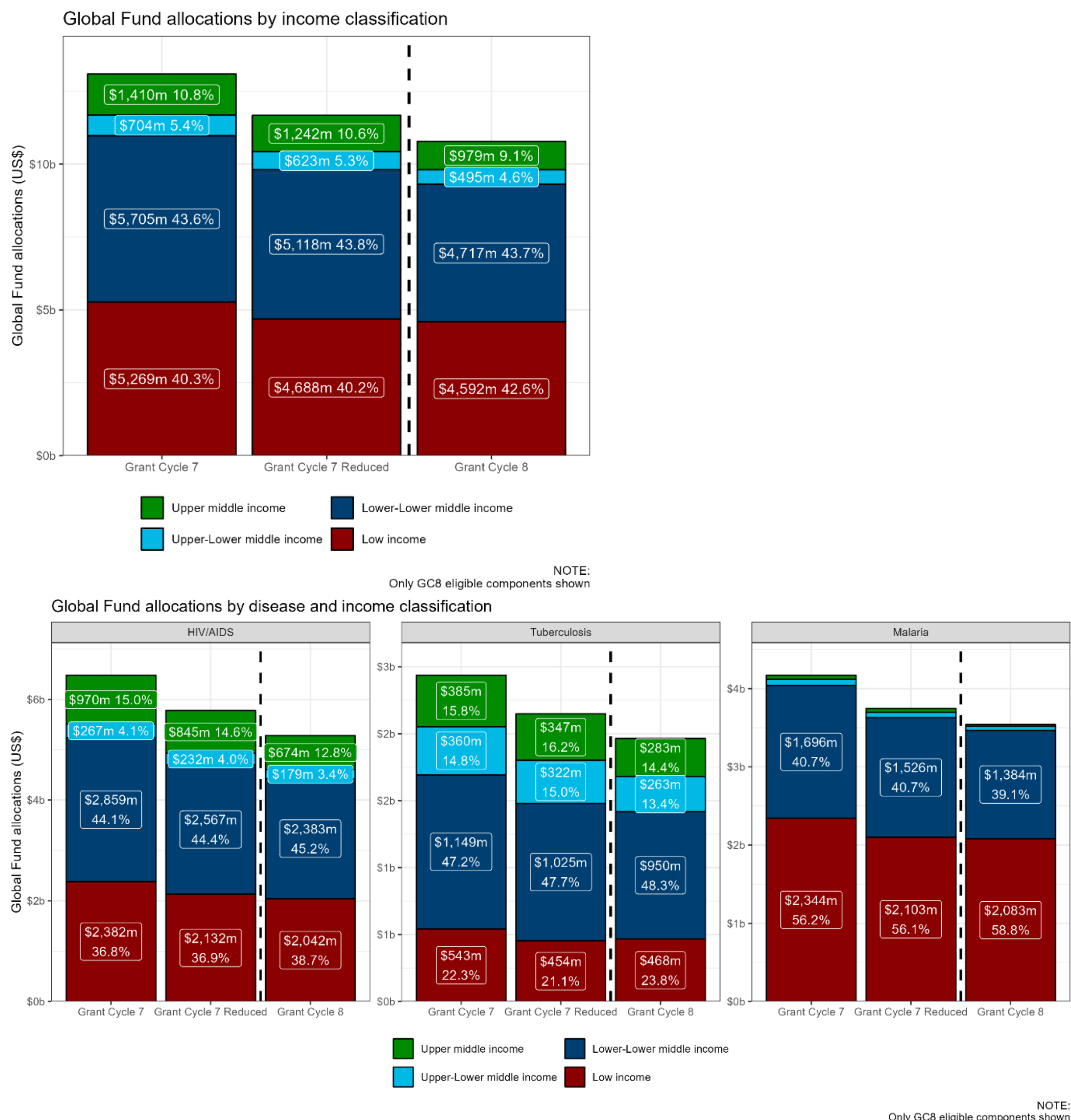
I would like to take this opportunity to express my personal thanks to the many individuals across the partnership who went the extra mile to surmount the challenges and make this Replenishment a success. Françoise Vanni, Dianne Stewart and the External Relations and Communications Division did a superb job, supported by their colleagues across the Secretariat. Donor Board Members and their colleagues in relevant ministries were tireless in their efforts to secure the best possible pledges from their governments. Private sector champions ensured that pledges from these sources hit a record total. Implementing partners and champions were determined and compelling advocates. Technical and other partners joined hands in making the case. Communities and civil society showed once again the power of passionate, creative and human-centered advocacy, rooting our case in their unique experience and expertise. The co-host teams from South Africa and the United Kingdom were united in their determination to get to a successful outcome. Thank you.

1.4 Prepare for the future

Throughout 2025 we have been transforming multiple aspects of the way the Global Fund partnership works to adapt to the changing environment. Key achievements in 2025 on this front include:

Reconfiguring processes for GC8 to reflect the key policy changes driving the strategic shifts. Following the decisions taken by the Board in November 2024 on Eligibility, Allocation Methodology, and the Sustainability, Co-Financing and Transition Policy, the Secretariat has been working to implement these strategic shifts in time for GC8 in consultation with the Strategy Committee. These changes result in a significant shift in resources towards the poorest, highest burden countries, and also enable a more systematic approach to sustainability and transition planning, including by setting target transition dates for a significant subset of countries. Further details on the changes being made for GC8 are set out in GF_B54_06_Strategic Shifts for GC8 _ Supporting progressive sustainability and effective transitions.

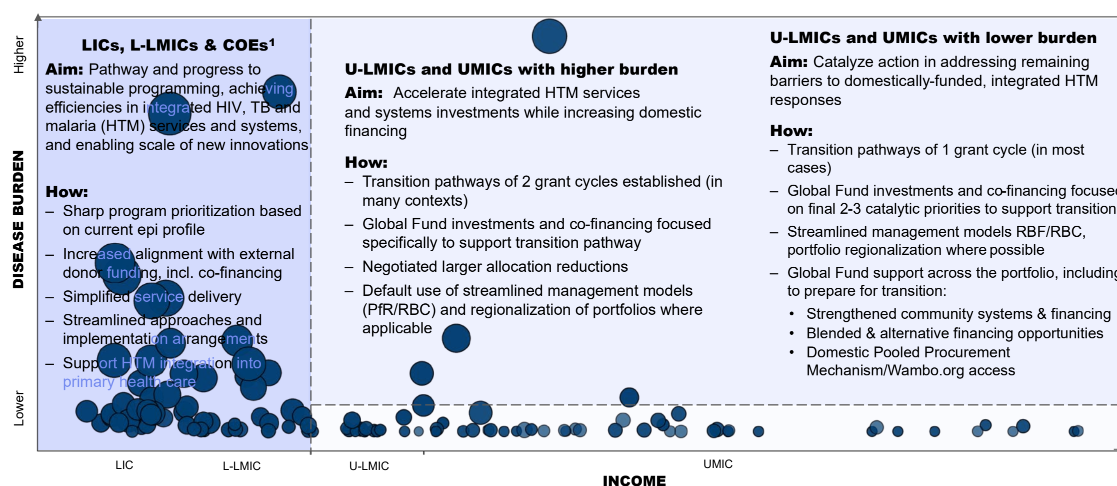
Figure 4. Final Allocations by Country Income Level



The approved changes to the Country Economic Capacity (CEC) curve[2] in the Allocation Formula shift funds from higher- to lower-income countries, in line with sustainability considerations. While absolute funding amounts decrease for all income groups, the funding share for lower-income countries slightly increases, and the funding share for UMIs and U-LMIs decreases.

[2] GF/SC26/06C; GF/SC26/DP05

Figure 5. Differentiating Countries by Economics and Epidemiology for GC8

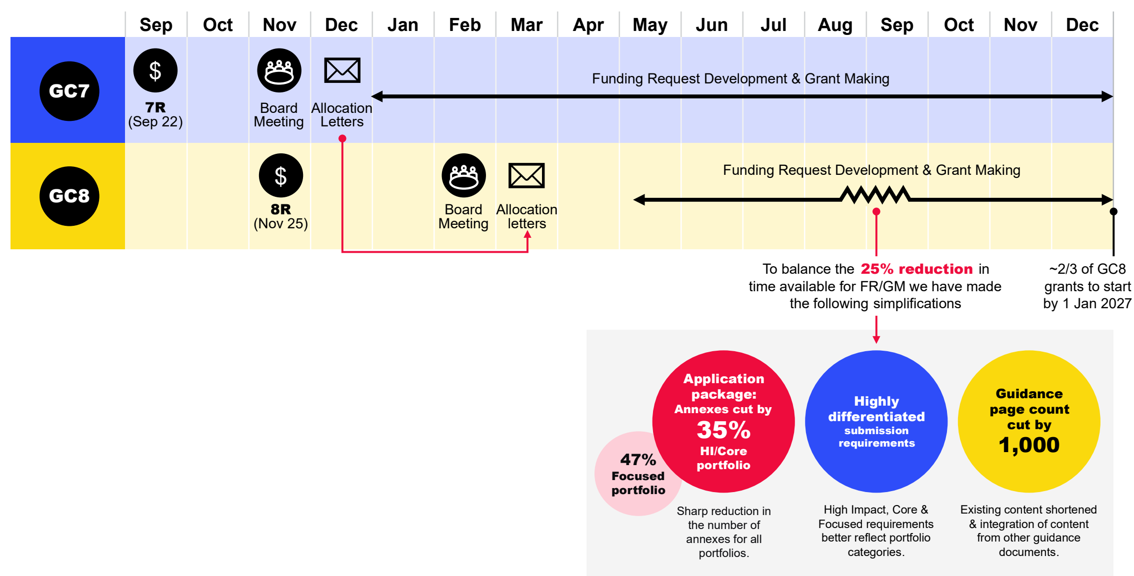


Notes: Allocation bubbles represent size of GC7 allocation (pre-2025 funding reprioritization). Income thresholds are using 2024 data and thresholds. Disease burden is a composite burden measure as used in GC7 allocation. PfR is payment for results, RBC is results-based contracting, and RBF is results-based financing.

[1] Placement on graphic does not necessarily represent the income level and disease burden of COE country.

Streamlining GC8 processes to take out cost and time. Alongside implementation of the new policies, we have simultaneously been working to reduce process steps and paperwork, so as to reduce the burden on CCMs, implementing partners as well as the Secretariat, without compromising the quality of programming. Given that countries will receive their Country Allocations for GC8 at least two-and-a-half months later than in previous grant cycles, simplifying and streamlining the Funding Request and grant-making process, including by refining the role of the Technical Review Panel (TRP), is an imperative. Otherwise, we risk delaying the start of GC8 grants.

Figure 6. Comparison of Replenishment and Grant-making Timelines between GC7 and GC8



Enhancing the flexibility of our grant revision processes. Through Portfolio Optimization and C19RM we have developed effective mechanisms for adding incremental funding to grant programs mid-cycle. With the Reprioritization exercise in 2025, we demonstrated we could also swiftly remove funding if needed. Given the potential opportunities for further off-cycle fundraising, plus the demonstrably increased risks relating to conversion of pledges, we recognize that further streamlining our approach to mid-cycle revisions, whether downward or upward, will enhance the resilience and adaptability of the partnership in an increasingly volatile world.

Creating space in our cost base in anticipation of required reductions. Through proactive management of discretionary cost levers, we realized about US$25 million in savings during 2025 to enable us to fund US$21.3 million in restructuring costs within the agreed budget. We will be taking a similar approach in 2026.

Improving the efficiency of Secretariat processes. We continue to invest in automation and process redesign to improve the efficiency and effectiveness of our operational processes. Our first offshore Service Center in Chennai, focused primarily on technology development and support, became operational in January 2025, and has already exceeded the cost savings forecast in the business case. Our second offshore Service Center in Nairobi is planned to be operationally ready in June 2026.

Working with partners to deepen collaboration. During 2025, the Global Fund invested significant time and resources into strengthening collaboration with key partners, including WHO, Gavi, Unitaid, UNAIDS, the African Union (AU) and the Africa Centres for Disease Control and Prevention (Africa CDC), the World Bank and other development banks. For example:

- With Gavi we have created a Joint Taskforce, supported by McKinsey, to build on the work overseen by the Joint Committee Working Group. This Joint Taskforce has been developing a common fact base, and exploring both structural and non-structural options for Gavi and the Global Fund to increase efficiency, country responsiveness and health outcomes. Further detail on our progress on the Joint Taskforce with Gavi is provided in GF_B54_10 Gavi-Global Fund Collaboration Update, and this topic is the subject of a dedicated session during the Board.
- We continue to work closely with the World Bank in a number of areas, including PFM and blended finance. However, we have not made as much progress as we would like in removing the barriers to countries using World Bank funding to procure through the Pooled Procurement Mechanism(PPM)/wambo.org. In December 2025 we signed an MoU with the World Bank laying out an even more ambitious approach to our partnership, including procurement, regional manufacturing and health finance.
- With the AU we signed an MoU in December 2025, with a particular focus on how we work together in supporting African countries on their path to self-reliance. Our partnerships with the AU and Africa CDC are increasingly important to delivering on our mission, and we are very supportive of the Accra Reset.

We will continue to work closely with all our partners, both global and regional, to ensure we work together to adapt to the new realities, maximizing the impact of every dollar, and to optimize our collective support to countries and communities.

2 Perspectives on Priorities for 2026 and Beyond

The last two decades have seen extraordinary progress in global health: tens of millions of lives saved, sharp reductions in mortality, and dramatic increases in life expectancy in even the poorest countries. The Global Fund partnership has played a key role in these successes, and we should be proud of what we have achieved.

Yet we must also recognize that our world has changed dramatically and irreversibly. Donors are cutting aid budgets. Implementing countries want to take the lead. Communities are demanding more agency. The model that has delivered such progress will not be the model to take us forward. To adapt, we must change the way we work as a partnership to become even more efficient, more responsive to countries, and more integrated and innovative. We must play our part in transforming the global health ecosystem, deepening our collaboration with partners to remove duplication and maximize synergies, rationalizing an overly fragmented architecture to improve efficiency and reduce the burden on countries, and ensuring every entity focuses on where it has comparative advantage.

Just over 20 years ago, the Global Fund partnership was created to fill a glaring gap in the existing system. Combining the strengths of governments with the passion of communities, the reach of civil society, and the pragmatism of the private sector, this

unique private-public partnership has proved extraordinarily successful, saving 70 million lives and cutting the combined mortality rate of AIDS, TB and malaria by 63%.

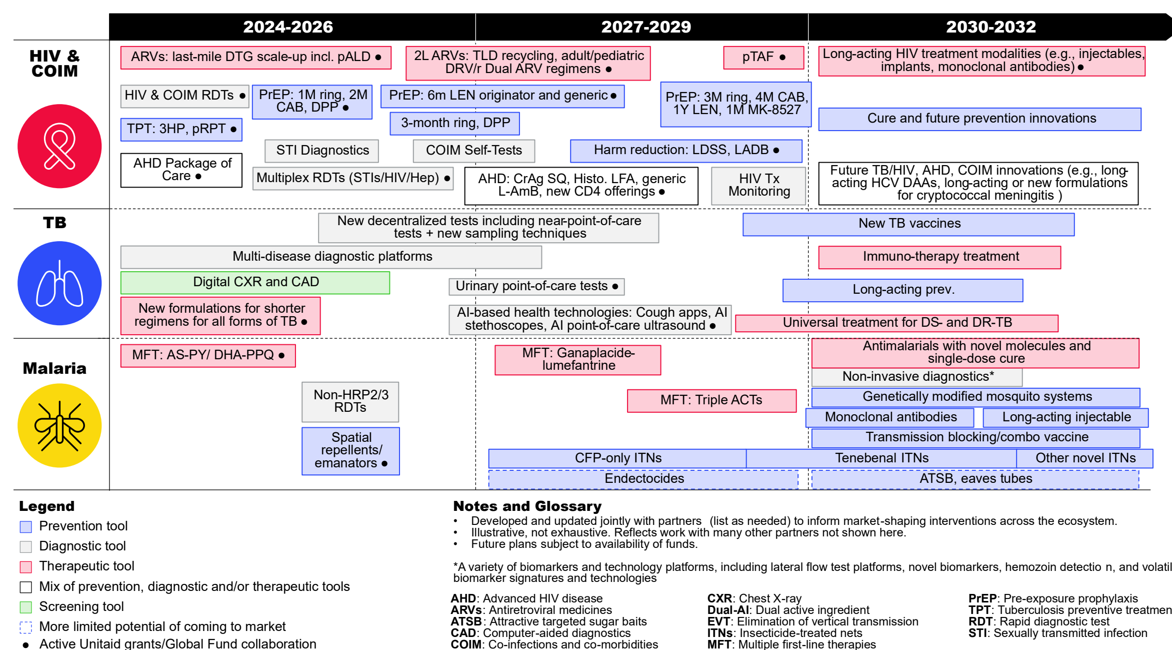
Now we must reinvent ourselves again: squeeze more from every dollar, support countries on their path to self-reliance, be unrelenting in our efforts to enhance our efficiency, effectiveness and agility, and contribute to the broader transformation of the global health ecosystem.

2.1 Maximizing the impact of every dollar to ensure sustained progress

Given the scale of the funding gaps across all three diseases, as well as across broader health system needs, we are going to have to be even more focused on maximizing the return on investment of every dollar we disburse. This means:

- **Accelerating affordable access to innovations at scale.** When money is short, innovation is the answer. Yet new tools will only make the difference if they can be deployed rapidly and at scale. This is exactly what we are doing with lenacapavir, and it is what we have also done with dual active ingredient (dual AI) insecticide-treated mosquito nets for malaria, and AI-enabled digital X-rays for TB screening. In 2026 the Global Fund partnership's market-shaping efforts will continue to play a vital role in determining whether we can sustain progress against the three diseases despite there being less money. Key priorities will include the continued expansion of lenacapavir (including the introduction of generics and the 12-month version in 2027), deployment of innovative near-point-of-care molecular (NPOC) diagnostics for TB, and accelerated access to alternative first-line treatments and innovative vector control tools for malaria (such as spatial emanators). Accelerating affordable access to innovations through market shaping requires close partnership with other agencies, such as Unitaid and WHO, yet is also a core strength and differentiator of the Global Fund. As elsewhere, we will face a challenge on funding. We will need to make tough choices about which innovations to focus our efforts on. We risk losing the full benefit of key innovations by underfunding deployment at scale (this is already the case with Dual AI mosquito nets).

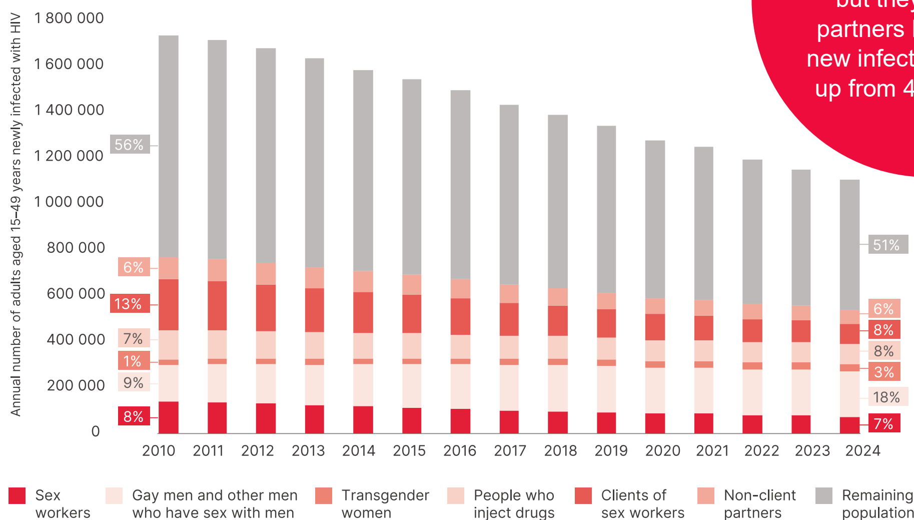
Figure 6. Indicative Pipeline of New HIV, TB and Malaria products



- **Tackling barriers to access faced by those most at risk**. As all involved in the Global Fund partnership know, innovations only improve health outcomes if they reach those who can benefit most. Unaffordability, weak health systems, stigma and discrimination remain formidable barriers, preventing vulnerable individuals and communities from accessing the services they need. Overcoming these barriers is an epidemiological and economic imperative. If innovations do not reach those at highest risk, we lose impact and waste resources. This imperative underscores the continued importance of investing in community-led outreach and service programming, of engaging communities in the design and implementation of interventions to deploy innovations, and of sustained multi-dimensional efforts to tackle the formidable barriers that continue to prevent access. Reconciling the imperative of ensuring those most at risk get access to lifesaving services with increasingly complicated donor conditions and – in many implementing countries – increasingly difficult legal and policy contexts will be a critical challenge to navigate.

Figure 7. Trends in Numbers of New Adult HIV Infections by Population, Global, 2010–2024

Key populations are less than 6% of the adult 15-49 population, but they and their partners bear 49% of new infections in 2024, up from 44% in 2010.



Source: UNAIDS World Aids Day Report, November 2025

- **Dismantling disease-specific or health product silos where a more integrated people-centered approach can deliver better outcomes and save money**. Greater integration of services can often deliver benefits, but can also be challenging from a practical execution perspective. In some circumstances, taking a focused approach to tackling a specific problem can have distinct advantages (e.g., simplicity, accountability). Yet many countries are at a stage in the fight against the three diseases, and in the development of their broader health systems, where taking a more integrated approach to at least some disease-specific interventions could yield significant benefits. Thoughtful design, careful implementation planning and excellent execution will be key.
- **Ensuring Global Fund dollars are invested in areas where our model has comparative advantages** versus either domestic funding or other agencies. This is too big a topic to be properly covered here, but it is an important issue. The Global Fund has clear comparative advantages in market shaping and procurement, versus both domestic and other international actors. Our scale and the efficiency of our model deliver not just lowest cost, quality-assured commodities, but best-in-class transaction costs. Likewise, we have distinct comparative advantages in funding civil society and community-based and -led interventions given our scale, experience and network of partners, plus the active engagement of communities and civil society in our governance at both the country and global level. Yet there are other, perhaps less obvious, areas in which we have built up distinctive expertise, and perhaps some areas we invest in where others might be better placed to take on the responsibility. For example, our role in human resources for health should probably be limited to catalytic interventions, rather than long-term funding, which is best done by governments. In a highly constrained resourcing environment, being clear on both what things should be funded, and who is best placed to fund them, will be essential.

Mali

Reaching Women and Girls with Lifesaving Care, Despite Colliding Crises

At 18 weeks pregnant, Astan Diabate receives antenatal care from midwife Keita Aissata at the Sebeninkoro community health center in Bamako, Mali. The Global Fund/Vincent Becker

In Mali, essential health services are delivered in a context marked by security challenges, population displacement and extreme weather events – from searing heat to devastating drought. Women and girls face heightened risks from malaria and HIV as well as health risks from pregnancy-related complications, while poverty and displacement continue to constrain access to care.

Despite these immense challenges, Global Fund-supported national and local partners are reaching women – even in the most difficult contexts – to deliver lifesaving services across the country. Global Fund investments support community health centers, known as *centres de santé communautaires* (CSCOMs) throughout Mali.

CSCOMs are core pillars of care for women and children, providing integrated antenatal services, malaria prevention and HIV and TB treatment. These facilities are reinforced by community health workers who extend care into communities and homes. This model is critical in a context where many pregnant women remain exposed to malaria, and too many lack consistent access to HIV treatment that can prevent mother-to-child transmission.

Between 2022 and 2024, these efforts delivered lifesaving protection to millions of families. More than 4.5 million mosquito nets reached pregnant women and young children, helping shield them from malaria during the most vulnerable stages of life. Over the same period, nearly 1.5 million expectant mothers received preventive malaria treatment during pregnancy – reducing the risk of severe illness, complications and death for both mothers and newborns.

For women and girls displaced by conflict, the Global Fund supports mobile clinics, maternal health services and health education programs delivered directly in displacement sites. These interventions reconnect families to essential care, reduce maternal and newborn risks, and restore access to disease prevention and treatment services in settings where health service delivery has faced significant disruptions.

Despite the immense challenges that persist, AIDS-related deaths in Mali have fallen by 60% between 2002 and 2024, and HIV treatment coverage has risen from 5% in the early 2000s to 68% in 2024.

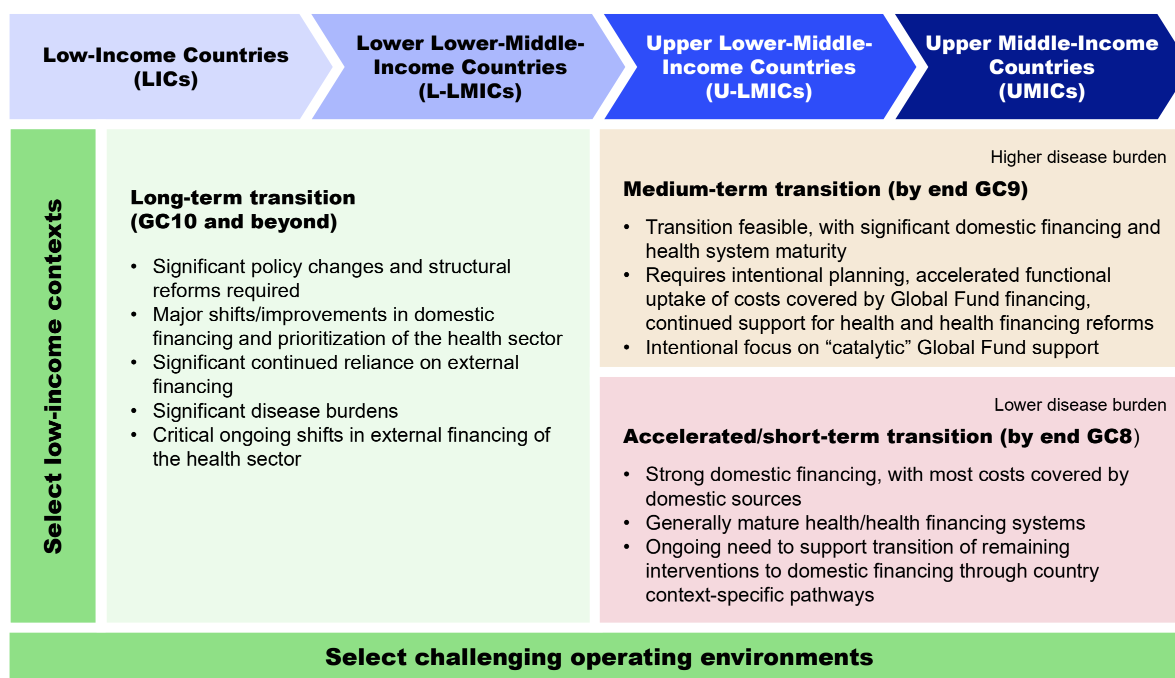
For more than two decades, the Global Fund has financed malaria programs, antiretroviral therapy and TB treatment in Mali – sustaining lifesaving care in one of the world's most challenging contexts.

2.2 Accelerating the path to self-reliance

Sharp cuts in external funding underscore the imperative for countries to accelerate their journey to self-reliance. Countries want to reduce their dependence on external funding. Donors want to see an exit path.

Yet as I have said on many occasions, this is a pathway, not a switch. Too abrupt a transition will derail progress, and cost millions of lives. Countries' readiness for transition differ enormously.

Figure 8. Differentiated Transition Approach



A differentiated approach to supporting progressive sustainability and transition will be core to GC8/GC9 & subsequent cycles.

Note: Illustrative conceptual framework. There may be some variation in transition timelines across cohorts.

The Global Fund will partner with countries to accelerate their journey to self-reliance by supporting, incentivizing, and, ultimately, getting out of the way. That's why we have revamped our transition planning and co-financing policies and processes. For some countries, GC8 should be their last grant cycle, so we must agree on a concrete plan for transition, and make sure it happens. For others, the target should be two grant cycles, so through GC8 and Grant Cycle 9 (GC9). For all but the poorest and most fragile states, notably those severely affected by conflict, we will work to agree transition timetables and corresponding plans.

The intensified focus on transition must also be reflected in GC8 grant design. For countries facing a specific timetable for transition, whether at the end of GC8 or GC9, the grants must be designed with this endpoint in mind, with increasing use of national systems, a phased shift in funding responsibilities, and full alignment with national sustainability and transition planning.

To support these transitions, we will further step up our support to countries to reinforce their public financial management systems, drawing on the expanded Catalytic Investment funding in GC8 for this purpose, working with partners such as the World Bank and Gavi, and building on the strategic partnerships and institutional foundations we have already established. We will also continue to work with countries and multilateral development bank partners to tap new sources of finance, building on the 14 Debt2Health swaps and the 14 blended finance transactions we

have executed already. Working with many of the same partners, we are directly supporting the development of national health insurance schemes in several countries.

We can also help countries sustain access to quality-assured affordable medicines by making it easier for them to use our PPM/wambo.org with their own money. Transitioning countries often pay far higher prices and incur significant transaction costs, but these can be avoided by leveraging our global scale and digital procurement platform. By offering pre-financing and working with regional procurement platforms, we give countries more options. Even when countries choose not to use the PPM/wambo.org, the fact that they could provides a benchmark for achievable commodity prices and transaction costs, enabling Supreme Audit Institutions and other stakeholders (e.g., community-led monitoring) to ensure accountability and value-for-money. Reinforcing our Non-Grant Finance Procurement offer by providing pre-financing, and technical assistance, will therefore be a key priority for 2026.

Supporting countries to transition away from Global Fund support is not new. Since 2002 we have transitioned 52 disease components across 38 countries, and 12 disease components will transition at the end of GC7. However, there is a significant shift in the scale and pace of transitions planned for GC8 and GC9. While we are still working on which countries should be in which cohort for transition planning, we could see around 60 disease components transition by the end of GC8 and another 20 by the end of GC9. We intend to communicate these transition timetables in Country Allocation letters.

Accelerating transitions to this extent is not without risk to health outcomes and to sustained progress against the three diseases. Given their economic constraints, and many other pressing demands on public budgets, countries may be unable or unwilling to step in to replace Global Fund funding, particularly when other sources of external resources are simultaneously being reduced. Countries may also choose not to prioritize specific interventions or services to key populations with their own resources. Critical community-based interventions may be starved if implementing governments fail to embrace social contracting. Such risks underscore the need for taking a very tailored approach to each country and for careful deliberation about what we as the Global Fund are or are not prepared to do when the risks materialize. This is a dilemma. Make it too obvious that the Global Fund will be the backstop when transitions go wrong, and we create perverse incentives. Ignore the reality that there will be failed transitions and we put vulnerable people at risk. Working with partners and the Strategy Committee, we will continue to develop our thinking on options for post-transition support mechanisms.

Of course, there are also countries where a combination of economic distress, conflict and governance weaknesses, plus the scale of the disease burden, make the transition to self-reliance a more distant prospect. Yet even in these contexts, we need to put greater emphasis on sustainability, helping build the systems and capacities that will be the foundation for the future. Here the tough trade-offs will revolve around balancing the focus on immediate lifesaving interventions and

investing in longer-term capacity building in a context where there are big gaps in the funding for either.

In working with countries to reinforce sustainability and accelerate transition, we must take account of epidemiology. Transitioning responsibility for a well-controlled disease, with infections and deaths already declining, is very different from handing over a situation where the disease burden is growing rapidly. One of the reasons lenacapavir is such a game-changer is that by enabling a sharp reduction in new infections, it offers the prospect of turning HIV into a long-lasting, but steadily declining problem from an overall health system perspective. By contrast, in places where malaria cases and deaths are increasing rapidly, it seems hard to see how responsible transition can take place before the disease is brought under control.

None of our work with countries on sustainability and transition will succeed if we do not take account of the funding and transition approaches of partners. Gavi has its own approach to co-financing and transition, but this is purely focused on vaccines. The bilateral MoUs agreed with countries under the new America First Health Strategy incorporate specific (typically 3-5 year) timetables for transitioning responsibility for funding overall health expenditure, including commodities and health workers. The World Bank and the International Development Association (IDA)/International Bank for Reconstruction and Development (IBRD) allocations and debt-servicing schedules, plus their work on health sector financing and policies, offer another set of sustainability and transition pathways. Beyond these three, which together with the Global Fund represent the largest external funders of health in low- and middle-income countries, there are a multitude of smaller multilateral, bilateral and philanthropic funders, each with their own approaches to sustainability and transition. The challenge for us – and even more for countries – is that none of these really take account of what others are doing. Given the scale of our investments and our longstanding and trusted partnerships with ministries of health and finance, the Global Fund has an important role to play in supporting them as they manage these complexities and chart overall transition pathways towards self-reliance.

Indonesia

A Country-led Fight Against Drug-resistant Tuberculosis

A patient has his blood pressure taken at a puskesmas (a government-mandated community health clinic) in East Java, Indonesia. The clinic provides TB services and treatment at no cost to patients. The Global Fund/Vincent Becker

Indonesia has the second-highest TB burden in the world – about 1 million people in the country fall ill with the disease every year. Drug-resistant TB is a persistent threat. But together with the Global Fund partnership, Indonesia is transforming the response to this disease.

Indonesia has been expanding timely and accurate diagnosis of drug-resistant TB; decentralizing drug-resistant TB care from hospitals to local primary health care clinics; establishing a specialized health workforce; and rolling out a revolutionary drug-resistant TB treatment regimen called BPaL/M. Because the treatment lasts just 6 months – rather than 18-24 months like other treatments – and has fewer debilitating side effects, and fewer pills to take, patients are more likely to successfully complete their treatment and become well again.

Indonesia moved rapidly to expand access to BPaL/M. In January 2024, only 17% of eligible patients were receiving the new treatment; by December,

coverage had surged to over 80% and continues to climb. While the Global Fund initially financed the rollout, Indonesia is now increasingly covering the costs itself.

This is just one example of how Indonesia is progressively increasing spending on health and moving away from donor financing. In Indonesia, transition planning is led by the Ministry of Health and aligned with national health insurance (JKN), and includes collaboration with international development banks and one of the largest Global Fund-facilitated Debt2Health agreements to date. Continued international and domestic investments in health are more critical than ever to end TB, AIDS and malaria. Indonesia is emerging as a global health leader – charting a path toward sustainable, domestically driven solutions in the fight against TB and beyond.

2.3 Continuously improving the Global Fund's efficiency, effectiveness and agility

The Global Fund is already one of the world's most efficient and effective global health and development organizations, with operating expenditures around 6.7%[2] of disbursed funds. However, it will be challenging to sustain such an efficiency ratio with a reduced funding envelope, since some of our costs are largely fixed. To continue to demonstrate best-in-class efficiency and effectiveness will demand a relentless focus on opportunities to do things differently, and an appetite – at the Board as well as within the Secretariat – to challenge conventional wisdom about certain aspects of our model.

No one should underestimate the scale of the organizational changes already in progress. The restructurings launched in 2025 cover 73% of our staff, and the departments containing the remainder will all be reviewed or restructured in 2026. The launch of the second Service Center later this year will see a much broader range of transactional activity taken offshore. The truncation of the GC8 funding request and grant-making timetable will force a streamlining of grant processes. We are ambitious in our plans to use AI and other forms of automation to take out costs and complexity.

Yet given the scale of the staff reductions we are making, we cannot just be improving the efficiency with which we do the same things. We cannot simply ask staff to work harder. We have to stop providing some services, relax some controls, or eliminate some reports. This will involve taking on more risk, and it will sometimes mean we have to say no when implementing countries, other partners or the Board want more support or information. We are already doing this, but will likely need to do more. What makes this particularly challenging is that we are doing this at a time when our ability to rely on partners – for example on technical assistance or data – is

[2] Average over 2023-2025, combining HIV, TB and malaria and C19RM and excluding in-country assurance and independent bodies.

diminished due to their own resource shortfalls. We will need the Board's support and counsel as we make these difficult trade-offs.

We will also continue to need to improve our organizational agility, by which I mean our ability to scale up or down, shift priorities, or take on new tasks, at speed and at scale. We have already demonstrated we can do this (C19RM, Reprioritization) and compared to many multilaterals we might already be considered agile, but the extreme volatility and uncertainties of the current external environment underscore the imperative to be able to anticipate risks and opportunities and to be able to move even more swiftly in response.

In response to the many demands for increased country ownership (e.g., the Lusaka Agenda, the Accra Reset), and for reducing the administrative and reporting burdens on implementing partners, we must be open to exploring further changes in how we engage with countries. The Global Fund model already gives countries more decision-making power over how our funds are used than is the case with most other external partners. CCMs decide how financial resources are allocated across diseases and health systems; the mix of interventions within each disease and health system component; the implementing partners;[3] and procurement channels and supply chain approaches. Co-financing and transition plans are negotiated rather than imposed through mechanistic formulae. With a few countries we have gone even further, given the maturity of their governance, PFM and accountability systems, adopting more of a payment-for-results approach. As countries reinforce the maturity of their systems, there will be opportunities to shift yet more responsibility to them, provided the Board has the corresponding risk appetite. This shift in approach is inextricably entwined with progress on sustainability and transition and will be very country specific: The more a government takes ownership of its health programs, in terms of both governance and financing, and does so effectively, the more the Global Fund will evolve in the way we engage. Ensuring continued support of essential civil society and community interventions will be an important test, and sometimes a problem to be surmounted, since many implementer governments appear reluctant to embrace social contracting.

2.4 Playing our part in the transformation of the global health ecosystem

Many of the things we must do to improve our efficiency and effectiveness lie within our control. But we also have to play our part in the reform of the broader global health ecosystem.

This is a big opportunity – to reduce fragmentation, clarify roles and make the system more efficient and country-responsive. From my perspective, we should be bold – merge and close some agencies, strip out duplication and focus on

[3] The Global Fund is more directly involved in the selection of implementers for countries managed under the Additional Safeguards Policy.

comparative advantage. As I said at the Replenishment Summit, if the global health architecture looks as it does today three years from now, we will have failed.

Yet I am also concerned that debates about reforming the global health ecosystem will become a distraction from actually delivering health outcomes, and might ultimately result in minimal change, or even change for the worse. The experience of the last few years is hardly encouraging in this respect, and there is now such a plethora of global health reform initiatives that engaging with them all could be a huge time-sink. The imperative for change is undeniable, and there are some good and radical ideas about what could be done to change the ecosystem, for example the Accra Reset or the recent paper by Kaberuka, Pate and Piot: Transforming the Global Health Ecosystem for a Healthier World in 2026. However, the political and institutional incentives appear to encourage performative actions rather than those that deliver tangible benefits, to create new entities rather than close existing ones, and to gloss over uncomfortable truths about relative performance of different components of the ecosystem.

From a Global Fund perspective, we will continue to be proactive in engaging with all the key global health initiatives, but we want to do so in a way that keeps a clear focus on making changes that will benefit those we serve, by improving our collective efficiency and effectiveness, and helping countries on their journey to self-reliance. As the largest multilateral funder in global health, both for the three diseases and health systems in general, the Global Fund has assets that could be leveraged more widely – for example, our market-shaping capabilities, our global procurement platform or our unique role in strengthening community systems for health. Yet how the Global Fund evolves in terms of mandate and priorities should not be determined in isolation, but as part of a broader vision for the future of the global health ecosystem, encompassing WHO, Gavi, disease-specific entities like UNAIDS, product development partnerships like Unitaid and the Coalition for Epidemic Preparedness Innovations (CEPI), and our engagement with the World Bank and other multilateral development banks.

Together, we must be prepared to make tough choices. Given the inevitable resource constraints, we must be rigorous in determining where external funding adds most value, and how best to divide roles between agencies, based on comparative advantage. How we go about this matters. Ultimately, reshaping the global health ecosystem will require political leadership at the highest level, potentially through the G7 or G20, and interacting with an inclusive process that ensures the meaningful involvement of a broad range of stakeholders, including donor and implementer governments, civil society and communities, and the private sector. A purely donor-driven process will lack credibility. A process driven entirely by governments, both donors and implementers, will lack legitimacy and miss the all-important voices of those directly affected by the diseases, plus the catalytic input of the private sector. A process driven by the agencies themselves will at best result in suboptimal compromises, and most likely at stasis, given institutional inertia and self-interest.

Given these considerations and the current geopolitical context, how to deliver a credible, objective and results-oriented approach to making change in the global health ecosystem appears extremely challenging.

3 From Disruption to Reinvention

The progress on global health over the last two decades has shown what the world can do when we come together. With skepticism, nationalism and more transactional approaches now, the more dominant themes, the facts – tens of millions of lives saved, sharp reductions in mortality, massive increases in life expectancy, huge economic benefits – are a compelling reminder that thinking big, and acting together, can deliver extraordinary results.

Yet the model that has worked so far must change. The progress of the past 20 years stands as one of humanity's greatest public health achievements. The next 20 will test whether we can be as bold in reinventing the system as we were in creating it.

The choice is stark: evolve or erode. We must adapt to new realities, and do so courageously, protecting what has made success possible, without being trapped in the past. Above all, we must remain committed to our goals – saving lives, ridding the world of the deadliest infectious diseases, and building health systems that deliver health for all and make us all safer. The Global Fund partnership is proof that when humanity stands together, no challenge is insurmountable.

I would like to take this opportunity to thank: the Board for its counsel, support and challenge; the staff of the Secretariat for their extraordinary commitment and professionalism throughout this turbulent period; and our partners for their consistent collaboration and engagement. Above all I want to express my thanks and admiration for the many thousands of front-line workers – doctors, nurses, midwives, community health workers, lab technicians and others – who turn the funds we deploy into lifesaving services. These are the people who turn up every day to help their fellow humans, and who through their work transform the vision that powers this partnership into saved lives, reduced infections and better health. They deliver the mission. ●