Tough Times, Tough Choices

Surviving the Aid Collapse

A Radically Simplified Global Fund to Meet the Moment

CENTER FOR GLOBAL DEVELOPMENT

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KEY MESSAGES

- The Global Fund faces an increasingly difficult set of imperatives: it must sustain core HIV, tuberculosis, and malaria programs and invest strategically in potentially transformative innovations, all while confronting funding cuts and responding to calls for reform.
- We propose "radical simplification" shifts across three dimensions to safeguard impact, stretch scarce resources, and enable reform:
    1. The Global Fund should concentrate resources in fewer countries where need is greatest. By phasing out grant support in wealthier middle-income countries, the Global Fund could absorb budget cuts without reducing support in the poorest countries and most fragile contexts.
    2. The Global Fund should align financing more closely with country priorities by easing disease-specific earmarks. Countries should receive a consolidated financing envelope and be allowed and encouraged to flexibly allocate resources across the three diseases and supportive health system functions, while maintaining accountability for disease-specific outcome targets.
    3. The Global Fund should, where feasible, prioritize on-budget country-led delivery and leverage complementary resources from multilateral development banks, particularly for "health systems" support.
- The Board should use the current moment as a leverage point to steer bold changes to the Global Fund's model. We urge the Fund's leadership—backed by Board approval—to operationalize the three shifts outlined above in differentiated ways across country contexts.

I. Introduction

The Global Fund stands at a crossroads. It faces a convergence of overlapping pressures: a deteriorating aid environment as major donors reduce commitments; uneven—and in some cases stalling—progress against HIV, tuberculosis (TB), and malaria;[1] and mounting demands for reform as the global health ecosystem evolves. Together, these forces are placing unprecedented strain on an initiative launched in the early 2000s—an era defined by expanding resources and broad political consensus on global health investment to combat key infectious diseases.

Yet these pressures coincide with major opportunities. First, a wave of transformative scientific and technological advances could significantly accelerate progress against the three diseases—if resources are mobilized and deployed effectively. Long-acting HIV prevention tools, such as lenacapavir, could dramatically reduce new infections if delivered at scale. The first generation of malaria vaccines offers new hope in the fight against one of the world's deadliest infectious diseases. And after decades of stagnation, new TB vaccine candidates are advancing through the development pipeline. Second, the Global Fund enters this new era with—perhaps surprisingly—enduring political support. While its most recent replenishment fell far short of topline goals (more below), it included sustained backing from the US administration—a notable outlier among multilateral initiatives facing retrenchment or skepticism.

These dynamics leave the Global Fund balancing an increasingly difficult set of imperatives: sustaining core services for millions of people who depend on Global Fund-supported HIV, TB, and malaria programs; investing strategically in innovations that could alter epidemic trajectories; responding to calls for reform, including greater country ownership, health systems investments, and less fragmented financing; and doing all of this amid shrinking global health resources.

Tough times demand tough choices—and fiscal pressures are already evident. In its current grant cycle, the Global Fund reduced previously approved country grant allocations by nearly $1.5 billion due to delayed disbursements from key donors; no clear rationale for the distribution of cuts was offered in the public domain.[2]

The next grant cycle is likely to be even more constrained. After its replenishment summit in November 2025, the Global Fund secured $11.34 billion in fresh pledges—falling 37 percent short of its $18 billion target for the 2026–2028 period.[3] To date, this total is approximately 28 percent shy of the $15.7 billion pledged for the previous 2023–2025 replenishment (see Figure 1).[4]

Still, the headline shortfall may paint an overly gloomy picture. Some key donors, such as France (€1.6 billion for 2023–2025)[5] and the European Commission (€715 million for 2023–2025),[6] have yet to announce pledges but are likely to do so at some (highly uncertain) level. And the US commitment of $4.6 billion was a welcome surprise given the Trump administration's otherwise skeptical posture toward multilateral global health institutions. Still, considerable uncertainty remains. Full disbursement of the US pledge will depend on passage of annual appropriations for FY2026–2028 in the relevant Congressional spending bills and other donors contributing sufficient funds to fulfill the Congressional 1:2 matching requirement. It is also still unclear whether the $4.6 billion US pledge includes funds previously committed—and still outstanding—from the 2023–2025 cycle.[7]

In this context, budget cuts appear unavoidable. The Global Fund's leadership and Board must now carefully consider how to realign its model and optimize spending to drive continued progress toward fighting HIV, TB, and malaria within a more constrained and rapidly evolving global health ecosystem.

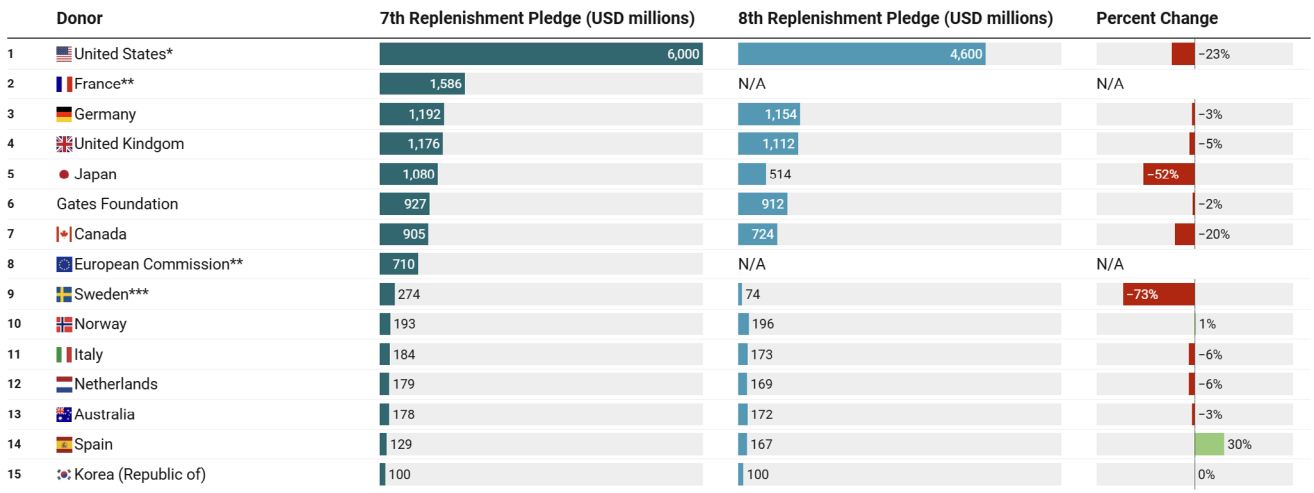
This brief—the latest in our *Tough Times, Tough Choices* series—examines the Global Fund's current approach to resource allocation and the implications of those choices in today's funding environment. It then outlines three "radical

simplification" shifts—implemented in differentiated ways across countries—to safeguard impact, stretch scarce resources, incentivize countries to mobilize greater domestic health spending, and support effective reform of the global health architecture.

Specifically, we propose three shifts:

1. **Where resources are spent:** Concentrating scarce Global Fund resources in fewer countries where need is greatest;
2. **What is financed at the country level:** Aligning more closely with country priorities by shifting toward a single, consolidated financing envelope that enables countries to flexibly allocate resources across all three diseases and supportive health systems functions; and
3. **How resources are channeled:** Prioritizing on-budget country-led delivery, where feasible, and leveraging complementary resources, particularly for "health systems" support from multilateral development banks (MDBs)—including as a new agreement to deepen the World Bank-Global Fund partnership is operationalized.

FIGURE 1 Global Fund pledges by top historical donors in 7th Replenishment (2023-2025) vs 8th Replenishment (2026-2028)



Notes: *For FY24, Congress reduced the US contribution the Global Fund due to a statuatory cap limiting the US share of paid contributions to not exceed 33% of total contributions. **Pledges from France and the European Commission have not yet been announced. ***"Sweden has reaffirmed its strong support to the Global Fund by confirming a contribution of SEC 683 million in 2026 as its first commitment toward the Eighth Replenishment period (2026–2028). This is a sustained level consistent with its 2025."
Source: http://www.theglobalfund.org/en/government/profiles/sweden. Created with Datawrapper.

II. Where, on what, and how the Global Fund currently spends

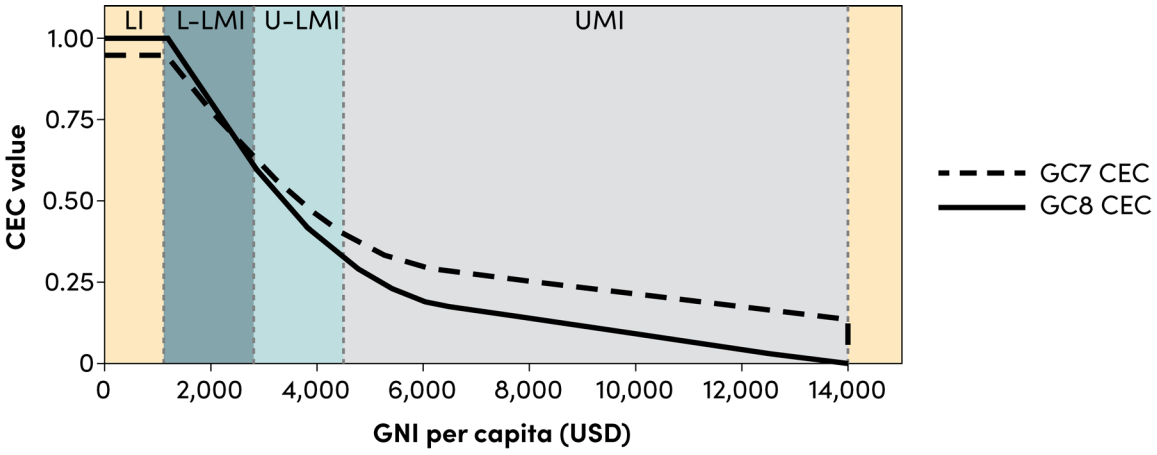
The Global Fund's previous budget allocations reflect strategic choices made during a period of expanding resources. However, given current resource constraints, its funding approach warrants renewed scrutiny. Three features of the current allocation model—the countries to which resources are directed, what they are spent on, and how they are channeled—are especially consequential in today's funding environment.

1. Eligibility rules channel grants to relatively wealthier middle-income countries

The Global Fund has a clear and explicit eligibility and allocation policy set by its Board. Country allocations are determined by a formula that combines gross national income (GNI) per capita with disease burden (HIV, TB, and malaria), alongside other indicators.[8] In November 2024, this formula was slightly adjusted to place greater weight on income (GNI per capita), with the stated aim of allocating modestly more resources to poorer countries (see Figure 2).[9]

Even under this revised approach, the Global Fund continues to provide significant grant financing to upper-middle-income countries (UMICs), and even some high-income countries (HICs). Historically, roughly 14 percent of Global Fund disbursements have gone to UMICs and HICs (see Figure 3). Under the Global Fund's most recently updated eligibility list for FY26, many UMICs, including large economies like Indonesia, Peru, South Africa, and Thailand, remain eligible for grants for two or more diseases: 38 UMICs are eligible for HIV funding, 31 for TB, and three for malaria. Twenty-five of these countries are classified as International Bank for Reconstruction and Development (IBRD) borrowers under World Bank lending terms—that is, countries that are too wealthy to qualify for concessional finance.[10]

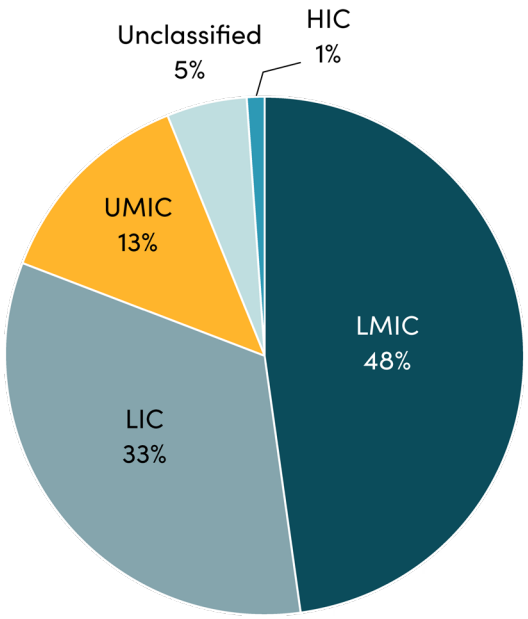
FIGURE 2 Proposed changes to Global Fund eligibility based on country economic capacity for 2023–2025 (grant cycle 7) vs 2026–2028 (grant cycle 8)



Notes: Lower-middle-income countries are divided into two groups (lower- and upper-LMI) to better distinguish between income levels of countries within that group. Country economic capacity (CEC) is considered "a robust and suitable indicator to capture country economic capacity in the allocation formula." The CEC curve influences how the Global Fund allocates resources across countries through the allocation formula.

Source: Reproduced from the Global Fund, available here: The Global Fund. 2024. "Allocation Methodology for Grant Cycle 8." November 20. https://archive.theglobalfund.org/media/15310/archive_bm52-08b-allocation-methodology-gc8_report_en.pdf.

FIGURE 3 Percentage of Global Fund disbursements to recipient countries by World Bank income group, 2002–2025



Notes: *Belonging to an unclassified income group: Venezuela, Ethiopia, Zanzibar. Multi-country disbursements (totaling $1,780,836,398) are excluded from this analysis.

Source: Authors' analysis using grant disbursement data from The Global Fund and World Bank lending group data for FY26. See here: The Global Fund. n.d. "Downloads." Accessed February 2, 2026. https://data-service.theglobalfund.org/downloads; The Global Fund. 2026. "World Bank Country and Lending Groups." https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

Continued eligibility of UMICs for grant financing inevitably crowds out resources for lower-income, higher-need contexts. Under conditions of fiscal constraint, the case for concentrating scarce grant resources in the poorest countries becomes increasingly compelling. Furthermore, the Global Fund's overall approach to transition is unlikely to resolve this challenge: CGD research from 2023 shows that countries projected to transition by 2040 accounted for just 1 percent of the Global Fund's annual disbursements.[11]

2. A disease-focused model with a rapid expansion into health systems support

The Global Fund's resource allocation remains overwhelmingly disease-focused, with the bulk of resources flowing through disease-specific country allocations for HIV, TB, and malaria. For the current grant cycle (2023–2025), the approved disease split was 49.6 percent ($6.52 billion) for HIV, 18.6 percent ($2.44 billion) for TB, and 31.8 percent ($4.17 billion) for malaria.[12] Each year, roughly $2.5 billion in country grant funding is used to procure medicines, diagnostics, and other essential commodities—accounting for roughly 40 percent of the Global Fund's total spending.[13]

These disease-specific investments have long been the backbone of the Global Fund's support for large-scale delivery of lifesaving products and services. At the same time, the Fund's reliance on disease-specific allocations imposes constraints on how countries set priorities, deploy resources, and deliver services. Under the current model, key parameters are largely predetermined: funding is pre-earmarked across HIV, TB, and malaria—and often the principal recipients for grants are also pre-specified.

While countries may, in principle, request adjustments within these parameters, in practice, the scope for reallocation is limited. Disease splits are relatively rigid, shaped by allocation formulas and driven by political economy dynamics surrounding disease-specific funding streams. As a result, countries have limited flexibility to reallocate resources across diseases or toward shared system functions—in line with their own priorities and other information such as evidence on cost-effectiveness.[14] This structure limits the extent to which Global Fund financing can genuinely support country-led prioritization.

Alongside core disease funding, a rapidly growing share of resources is now classified as health systems support under the category of "Resilient and Sustainable Systems for Health (RSSH)."[15] RSSH spending, as categorized by the Global Fund's own internal documentation, has increased

sharply—from roughly $3 billion in the 2017–2019 cycle to an estimated $5.7 billion in 2023–2025, approximately $1.9 billion on average per year.[16] As a result, the Global Fund now positions itself as the "largest multilateral funder of health systems."[17] This characterization, however, partly reflects *how* investments are categorized: a portion of RSSH spending likely consists of reclassified disease-related investments, rather than broader health system financing.

More fundamentally, it remains unclear whether the Global Fund's current approach represents the most effective way to finance health systems. Health systems investments delivered through relatively small, standalone, three-year grant-based channels that are coordinated by a country-coordinating mechanism (CCM) contribute to further fragmentation across donors. This is particularly so when they operate in parallel to, rather than through, national delivery systems and planning processes. Moreover, several features central to effective system-wide financing, including sustained engagement on public financial management, long-term sectoral planning, and larger-scale on-budget investment, fall more squarely within the comparative advantage of MDBs like the World Bank.

As fiscal pressures and calls for reform intensify, the growing share of Global Fund resources devoted to RSSH raises questions about how best to finance health systems. A more integrated financing approach—embedding health systems support within broader, country-led financing frameworks and MDB operations—may offer a more effective and sustainable path forward.

3. Grant delivery bypasses national systems

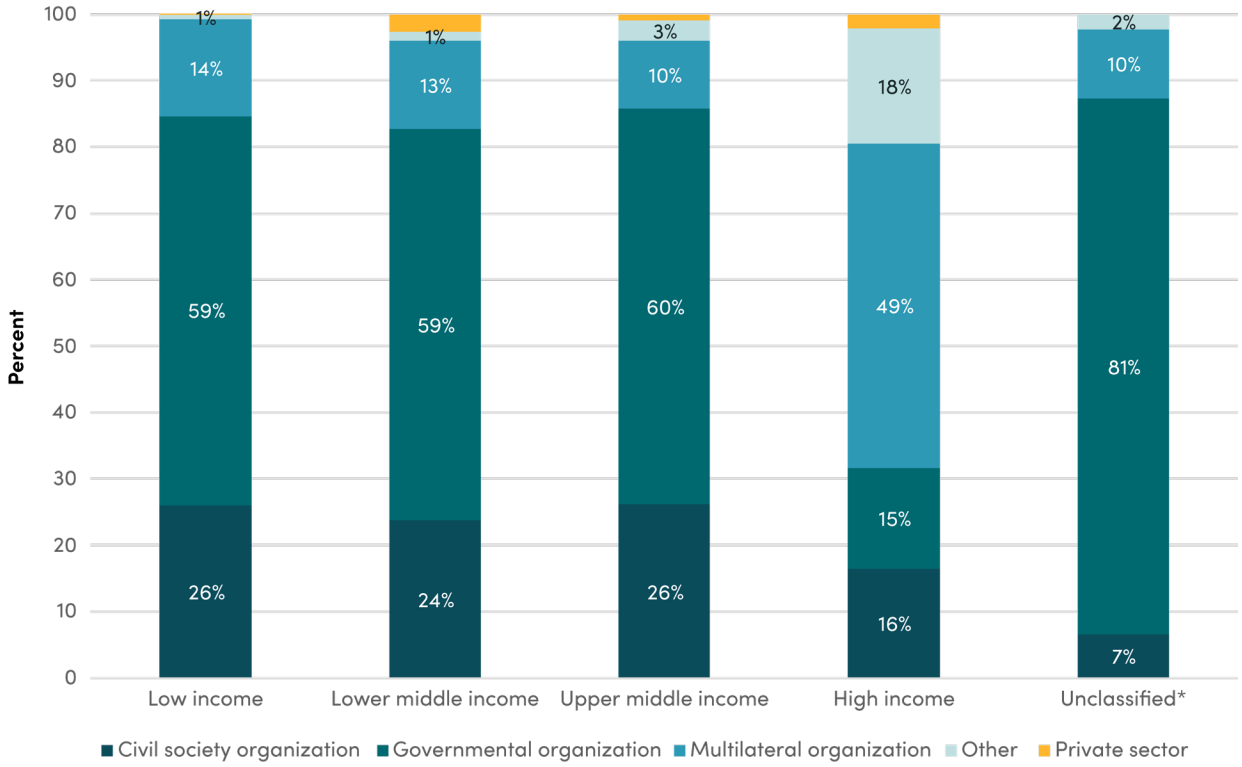
The Global Fund's own historical data (2000–2024) show that, on average, the majority (59 percent) of its disbursements are for grants for which governments are the principal recipient. The remaining resources (41 percent) are spent on grants where the principal recipient may be non-governmental organizations (NGOs), civil society organizations (CSOs), multilaterals, and other implementing partners (see Figure 4).

These figures, however, overstate the extent to which the Global Fund uses government systems. This is because labelling grants according to principal recipient status obscures the different ways Global Fund resources flow through non-governmental routes. This can be illustrated more precisely using publicly available data from grant cycle 6. Specifically, the Global Fund reports that 32 percent of all disbursements are transferred directly for centralized procurement, 14 percent are transferred to multilaterals and international NGOs, and 22 percent are paid to non-government implementers, with governments (e.g., Ministries of Finance, Ministries of Health, and other departments) directly receiving just 32 percent of disbursements.[18]

Therefore, even where Global Fund disbursements may be considered "on-budget" with the government designated as principal recipient, they are frequently managed at least in part through separate governance and implementation arrangements. Funding is earmarked and prioritized separately through a CCM, rather than national processes covering other health services; often overseen by separate disease-specific program units within government ministries/departments; and frequently supported by parallel procurement and supply chains.

There are a number of cases where use of non-government systems may be justified. Centralized procurement, managed by the Global Fund, can be a more cost-effective approach to purchasing commodities—with limited adverse effects on country ownership so long as commodities are managed and distributed through government-owned, integrated supply chains. In many cases, CSOs play a critical role in reaching populations and delivering services in community settings. And in fragile or conflict-affected settings, parallel service delivery through non-state actors may also be necessary to ensure continuity, quality, or anticorruption and fiduciary safeguards.

FIGURE 4 Distribution of Global Fund disbursements by recipient type and World Bank income group, 2000–2025



Note: *Belonging to an unclassified income group: Venezuela, Ethiopia, Zanzibar

Source: Authors' analysis using grant disbursement data from The Global Fund and World Bank lending group data for FY26. See here: The Global Fund. n.d. "Downloads." Accessed February 2, 2026. https://data-service.theglobalfund.org/downloads; The Global Fund. 2026. "World Bank Country and Lending Groups." https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

Outside of these contexts, however, channeling financing through earmarked, off-budget channels can entrench parallel financing, interest groups, and duplicative implementation structures operating outside national systems. This mode of delivery is increasingly misaligned with broader health system reform goals for building countries' public financial management systems and ensuring alignment with national priorities.

III. Toward "radical simplification": Rethinking the Global Fund's model

To deliver on its core mission in a more constrained and uncertain environment, the Global Fund must rethink *where* resources are allocated, *what* they are spent on, and *how* they are delivered. The current moment calls for a strategy of *radical simplification*—one that concentrates scarce resources where they are most needed, aligns financing more closely with country priorities, leverages complementary resources from MDBs, and reduces complexity in how funding is channeled.

We propose shifts across three dimensions that would radically simplify the Fund's overall operations:

1. The Global Fund should simplify *where* it spends resources by reducing the number of eligible countries and concentrating scarce grants in the poorest settings, where dependence on external financing is the greatest. Protecting health interventions that save the most lives in places with the greatest need and least ability to self-fund is the most *equitable* and *efficient* use of scarce global health resources (though we acknowledge MICs *and* low-income countries (LICs) alike are under fiscal stress due to other bilateral and multilateral aid cuts). We also note that this shift would require the Global Fund Board to revise its Allocation Methodology and Sustainability, Transition and Co-Financing Policy.

2. The Global Fund should simplify what it finances at the country level and align more closely with country priorities. Specifically, the Fund should provide countries with a single, consolidated financing envelope that eases pre-set, disease-specific earmarks. Under this approach, countries would remain accountable for advancing HIV, TB, and malaria outcomes, but would have greater flexibility to allocate resources across disease interventions and supportive health system functions based on country-led prioritization. This shift would require approval by the Global Fund's Board, but it is an essential step to advance the Fund's stated commitment to country ownership and country-led prioritization.

3. The Global Fund should simplify how it channels resources by primarily funding *on-budget* country-led delivery. Where feasible, support should be delivered through national public financial management systems and allocated via central government prioritization processes rather than through alternative mechanisms such as CCMs. In addition, the Global Fund should leverage complementary financing from MDBs, including by deploying joint financing arrangements more systematically. For example, as part of operationalizing the recently signed Memorandum of Understanding between the Global Fund and the World Bank, a pre-agreed ex-ante resource commitment—potentially in the form of a trust fund—should be set up to enable blending at scale, particularly for health systems-focused support.[19]

Together, these shifts aim to optimize Global Fund resources across two time horizons. In the *short term*, sharper prioritization can help protect lifesaving services—particularly in the poorest countries and most fragile settings. Over the *medium term*, this approach would support a more deliberate repositioning of the Global Fund within a changing global health ecosystem.

To operationalize the three "radical simplification" shifts, we propose a framework for differentiated support by country typology (see Table 1).

TABLE 1 Snapshot of proposed operationalization by country typology

COUNTRY GROUP	PRIMARY OBJECTIVE	TYPE AND MODALITY OF GLOBAL FUND FINANCING	MODE OF DELIVERY
1. Fragile and conflict-affected countries (LICs & LMICs)	Protect core allocation to ensure continuity of lifesaving services	Continuity of grant financing	Delivery through non-governmental partners and implementation flexibility as needed
2. Low-income countries	Protect core allocation to save lives and prevent backsliding	*Grant financing* but delivered via a consolidated envelope that eases disease-specific earmarks and leverages complementary MDB resources	Where feasible, greater use of *on-budget* support and health systems support in partnership with MDBs
3. Lower-middle-income countries	Support progressive transition toward integrated health system support and country-led prioritization, alongside a modest reduction in allocations	*Grant financing* but delivered via a consolidated envelope that eases disease-specific earmarks and aligns with "New Compact" principles where governments finance top priorities, alongside leveraging complementary MDB resources	*On-budget* delivery and health systems support in partnership with MDBs
4. Upper-middle-income countries	Accelerate country self-reliance	Phase out routine grant support by 2028, and support countries to access *lending and other financing arrangements via the MDBs.* Grants may be offered in exceptional cases, for example, to CSOs to support vulnerable populations and/or for innovation scale-up.	Transition to routine MDB lending

1. In fragile and conflict-affected settings, sustain lifesaving services

In LICs and LMICs classified as fragile and conflict-affected, where government capacity is limited or absent, the overriding objective should be to maintain the continuity of essential services. In these contexts, delivery through non-governmental partners and close partnerships with humanitarian partners (e.g., UN agencies) will remain necessary, and implementation flexibility should be preserved.

2. In the poorest low-income countries, protect core lifesaving services and promote integrated health system delivery

For the upcoming funding cycle, the Global Fund should protect grant allocations for LICs—those with the least ability to offset grant reductions through domestic resources. In these settings, Global Fund support should continue to prioritize core, high-impact HIV, TB, and malaria interventions, including longstanding tools such as antiretroviral therapy, TB diagnostics and treatment, insecticide-treated nets, and malaria treatment, as well as new innovations such as lenacapavir for HIV prevention and seasonal chemoprevention for malaria.[20]

At the same time, the Global Fund should provide countries with a single, consolidated financing envelope that eases disease-specific earmarks. This would allow countries greater flexibility to prioritize investments across the three diseases and supportive health system functions, aligned with country-led prioritization. As such, countries would be able to refocus health systems-focused support on specific (but disease-agnostic) functions that enable the delivery of lifesaving interventions (e.g., strengthening logistics to prevent service disruption and strengthening data systems). This approach would also enable countries to flexibly react to any future donor shocks that target one disease, for example, significantly reduced bilateral malaria support from major donors, such as the US. Where feasible, Global Fund catalytic investments should help bolster in-country prioritization capabilities to advance these goals.

Delivery modalities should also increasingly reinforce national systems rather than operate through parallel structures. In relatively stable, low-income settings, this includes greater use of on-budget delivery and closer alignment with central national planning processes (rather than separate CCMs).

There is also a strong case for expanding and more systematically deploying joint financing arrangements with MDBs—particularly the World Bank[21]—where systems-focused support can be delivered more coherently through larger, on-budget operations. Channeling more resources via joint financing or co-financing can help leverage complementary MDB resources, reduce fragmentation among funders, and place health systems support on-budget while ensuring alignment with national priorities.

3. In lower-middle-income countries, support progressive transition and more integrated delivery

In countries with greater fiscal capacity, prolonged reliance on disease-specific grants risks delaying transition toward more sustainable financing. While Global Fund support has helped sustain disease programs at scale, there is a need to adapt external support to promote greater integration beyond disease-specific siloes.

LMICs occupy a middle ground in the Global Fund's portfolio: many continue to face substantial HIV, TB, and malaria burdens, yet they also have greater fiscal capacity and access to development finance than their low-income peers. In these settings, sustaining large, standalone disease-specific grants is increasingly misaligned with longer-term sustainability.

For this group, the Global Fund should similarly ease disease-specific earmarks by providing a single, consolidated envelope, enabling countries to more flexibly allocate resources across the three diseases and supportive health system functions. In parallel, the Global Fund could modestly reduce per capita allocations to prioritize poorer low-income and fragile countries (see Table 2 below).

Importantly, the Global Fund's role should progressively shift to align with "New Compact" principles.[22] Governments should set their priorities—using local mechanisms, including health benefits package design and health technology assessment—and demonstrate how top health sector priorities will be financed domestically. Global Fund resources should support next-order priorities and expand the overall envelope.

Over time, responsibility for financing routine HIV, TB, and malaria services should increasingly shift to domestic budgets (to the extent this is fiscally realistic). The Global Fund should progressively shrink its overall envelope as countries grow, and support should increasingly focus on higher-cost technologies and/or functions that are harder to finance domestically. For LMICs classified by the World Bank as "Blend" or "IBRD," a portion of the funding envelope could also shift to being provided as loans, tiered to World Bank lending terms, as demonstrated by CGD research.[23]

In parallel, financing for broader system inputs (e.g., health worker salaries, support for health clinics, service delivery platforms, etc.) should increasingly flow through joint

financing arrangements with MDBs, rather than through standalone Global Fund grants. MDBs are arguably better positioned to finance system-wide investments at scale and over longer horizons. Closer partnerships with MDBs could enable the Global Fund to complement lending with targeted financing instruments, such as interest rate buy-downs or guarantees. For example, Global Fund grant resources could jointly finance a World Bank International Development Bank (IDA) operation that also includes other World Bank Trust Fund resources (e.g., the Global Financing Facility and Health System Transformation and Resilience Fund) to deliver a single five-year program of health systems support and expanded service provision, all aligned with a country's National Health Compact developed in partnership with the World Bank.[24] Nigeria could be an ideal pilot for this approach, given the government's strong partnership with the World Bank, growing fiscal space, and the existence of an effective sector-wide approach and National Health Compact.

4. In upper-middle-income countries, accelerate transition to self-reliance

While UMICs continue to face significant HIV and TB burdens, they are also better positioned to finance routine services through domestic resources and international borrowing. Continued grant financing in these countries, therefore, carries high opportunity costs and should be phased out in most cases.

For this group, the Global Fund's strategic objective should shift decisively toward self-reliance. This entails a phased exit from routine grant financing to be completed by 2028 (i.e., the end of grant cycle 8), requiring an urgent revision of the Allocation Formula and Sustainability, Transition and Co-Financing Policy to be approved by the Board.

Accelerated transition for these countries can be achieved by incrementally increasing domestic resources for health, or by shifting further support to MDB lending, such as via the World Bank for IBRD-classified countries.[25] Lending through MDBs can provide larger, more predictable, longer-term financing, reducing reliance on volatile donor flows and supporting system-level investments at-scale.[26] Global Fund grant resources should be reserved for limited, time-bound, catalytic, and exceptional purposes. For example, supporting CSOs to reach vulnerable populations, promoting legal reform, helping roll out high-value innovation, or other clearly defined public goods.

Establishing a clear transition pathway, anchored in differentiated financing instruments, offers a more realistic approach in an era of fiscal constraint. Under our proposed shifts, grants remain central where need is greatest and increasingly leverage complementary MDB resources, particularly IDA financing in LICs and LMICs, while non-grant instruments are tailored to countries with greater fiscal capacity—allowing scarce grant resources to be used more strategically and where marginal impact is highest.

Proposed strategic reallocation for the next grant cycle

Table 2 illustrates how the proposed shifts could translate into illustrative reallocations over the next three-year cycle. Our proposed approach intentionally protects current grant financing levels for fragile and conflict-affected countries and LICs.[27] In (non-fragile) LMICs, we propose a 15 percent overall reduction in financing over the three-year period. Reductions in grant financing are concentrated in UMICs and HICs, where fiscal capacity is higher and alternative financing options are more readily available. Under our assumptions, projected disbursements for the 2026–2028 period would be approximately $1.38 billion less than disbursements for 2023–2025.

Importantly, these adjustments do not result in abrupt or across-the-board cuts; they reflect differentiated and time-bound transitions aligned with country-specific circumstances. By phasing out grant support in wealthier countries and modestly reducing allocations in LMICs, the Global Fund could absorb budget cuts without reducing support in the poorest countries and most fragile contexts.

TABLE 2 Illustrative strategic reallocation of Global Fund grant disbursements for 2026–2028 grant cycle

COUNTRY TYPE	N	PROPOSED APPROACH	2023–2025 ACTUAL DISBURSEMENTS (USD)	2026–2028 PROJECTED DISBURSEMENTS (USD)	ESTIMATED REDUCTION (USD)
Fragile and Conflict-Affected LICs & LMICs	24	Grant continuity	4,663,344,515	4,663,344,515	-
LICs	10	Grant continuity	2,600,100,233	2,600,100,233	-
LMICs	36	15% cut over 3 years	4,300,926,410	3,655,787,448	645,138,962
UMICs	35	50% cut over 3 years, phase out by 2028*	1,450,392,229	725,196,115	725,196,114
HICs	5	50% cut over 3 years, phase out by 2028*	16,230,623	8,115,312	8,115,311
TOTAL	**110**		**$13,030,994,010**	**$11,652,543,622**	**$1,378,450,388**

Notes: *Starting in 2029, routine support for UMICs and HICs to be phased out and replaced with a new and smaller pot of resources for exceptional cases. One UMIC (Ukraine) is classified as a fragile and conflict-affected setting (FCAS).

Source: Authors' calculations based on Global Fund disbursement data for 2023–2025, downloaded January 2026. World Bank income classifications and FCAS classifications are for FY2026.

IV. Conclusion

To adapt to an era of shrinking resources and global health architecture reform, we propose "radical simplification" shifts across three dimensions: concentrating resources in fewer countries where need is greatest, moving away from rigid disease-specific earmarks to better align with country priorities, and providing on-budget funding while leveraging MDB resources.

The Fund's leadership—backed by Board approval—should operationalize these shifts in differentiated ways across country contexts to protect its core lifesaving mission, while creating budget space *and* repositioning the institution in a rapidly evolving global health ecosystem. We urge the Board to use the current moment as a leverage point to steer bold reforms, backed by accountability for real change.

Endnotes

1 The Global Fund. 2025. "Considerations for Grant Cycle 8 (GC8)." 53rd Board Meeting, Geneva, Switzerland, May 7. https://archive.theglobalfund.org/media/ekrjvofy/archive_bm53-18-considerations-grant-cycle-8_presentation_en.pdf.

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27 Note that this is an illustrative projection based on actual disbursements downloaded from the Global Fund website for the 2023-2025 period (the most recent three-year grant cycle): https://data.theglobalfund.org/ (accessed January 2026).

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