HEALTH FINANCING ISSUES

Global Fund Grant Cycle 8

Dialogue & Advocacy Briefing for Civil Society Organisations

April 2026 | For use in GC8 Country Dialogue Processes

Prepared by GFAN & Health Financing Expert Network

A briefing on domestic resource mobilisation, the limits of transition, and how civil society can engage effectively.

OVERVIEW

The Situation at a Glance

US$12.64B

GC8 Replenishment total raised

Feb 2026 Board confirmation

~20%

Projected fall in development assistance for health by 2026

vs 2023 levels

9.4M+

Additional deaths projected by 2030 if cuts continue

The Lancet, 2026

Key message for CSOs

The Global Fund is looking to domestic resource mobilisation (DRM) to compensate for the aid reductions as a solution towards more sustainable health services.

This briefing explains what DRM is, why it is not a simple fix, and how civil society can engage effectively to protect health services and the most vulnerable.

The Most Severe Aid Disruption in a Generation

What has happened

- USAID dismantled in 2025 — previously funded over 40% of all international humanitarian assistance
- US cuts followed by significant reductions from UK, Germany, France, and other bilateral donors
- Sub-Saharan Africa faces projected declines of 16–28% in net ODA in 2025
- Health-specific aid projected to fall 19–33% vs 2023 levels (CIDRAP, 2026)
- ODA projected to fall overall by ~11% from 2025 to 2026

Disease-specific impacts already documented

HIV/AIDS

Clinic closures across sub-Saharan Africa. Models project 4.4–10.7M new HIV infections 2025–2030 without restored funding.

Tuberculosis

10,566 additional TB deaths and 13,426 new infections linked to funding freeze as of mid-2025 (Stop TB Partnership).

Maternal Health

45% increase in maternal mortality projected in 6 W/Central African countries — over 1,000 extra deaths in 2025 alone (H&P, 2026).

The Global Fund's GC8 Response

US$12.64 billion raised — but most countries face reduced allocations

GC8 Strategic Shifts CSOs Need to Know

- Accelerated transition timelines toward country self-reliance, differentiated by income level
- Most countries will receive reduced allocations — difficult prioritisation decisions required
- Differentiated co-financing: upper-income countries focus on key populations; lower-income countries on system-wide objectives
- Strong emphasis on value for money, integration, and equitable access
- US$20–45M set-aside for DRM transition support; US$50–75M for Resilient & Sustainable Systems for Health

Understanding Health Financing: Three Core Functions

Revenue Raising

How funds are mobilised — taxes, insurance contributions, donor grants.

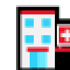
DRM = domestic public funds from taxation only. NOT out-of-pocket payments. NOT donor aid.

Pooling

How risks and resources are shared across the population.

Insurance schemes spread the financial risk of ill-health. Crucial for equity.

Purchasing



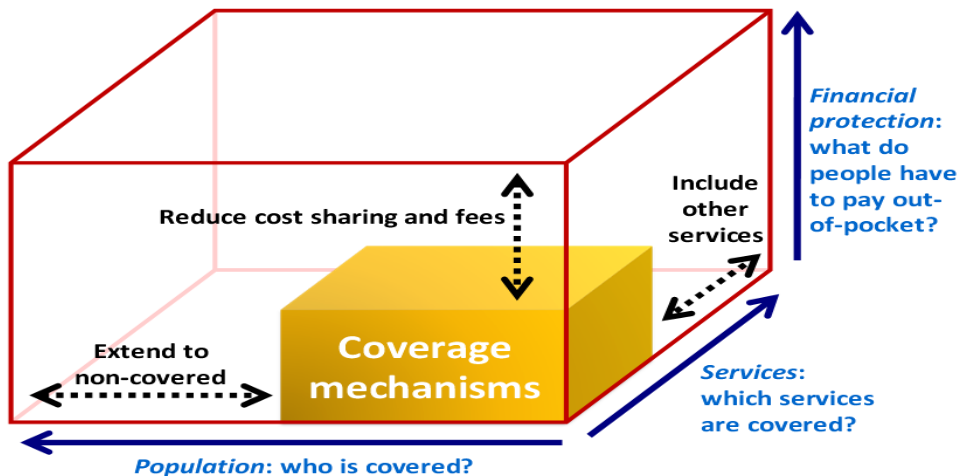
How and what services are bought from providers.

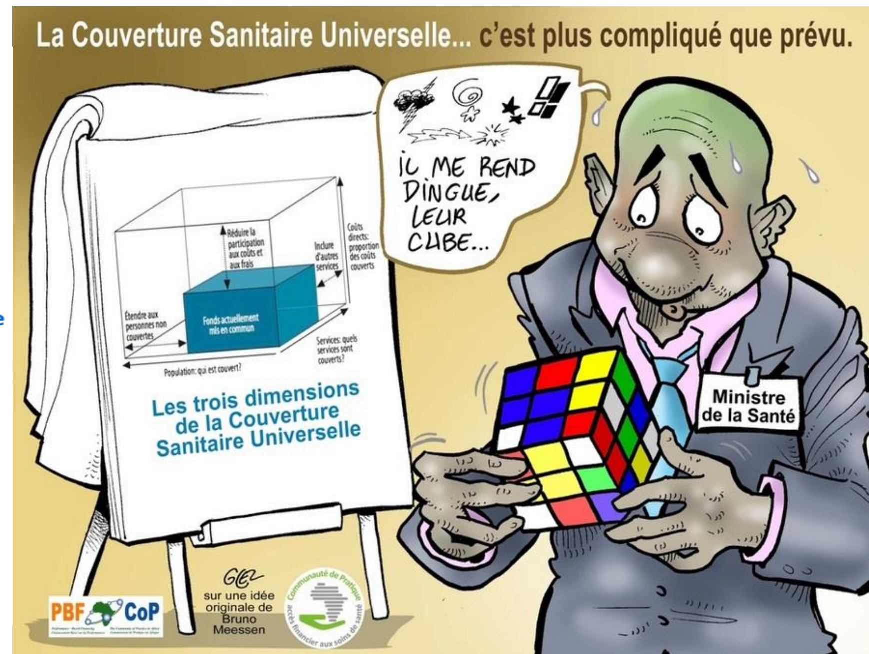
Benefit package design — what is covered, for whom, how — determines access in practice.

⚠ CRITICAL: Out-of-pocket payments are NOT DRM. Taxing the sick undermines UHC. CSOs must oppose proposals to expand patient fees.

Key concepts

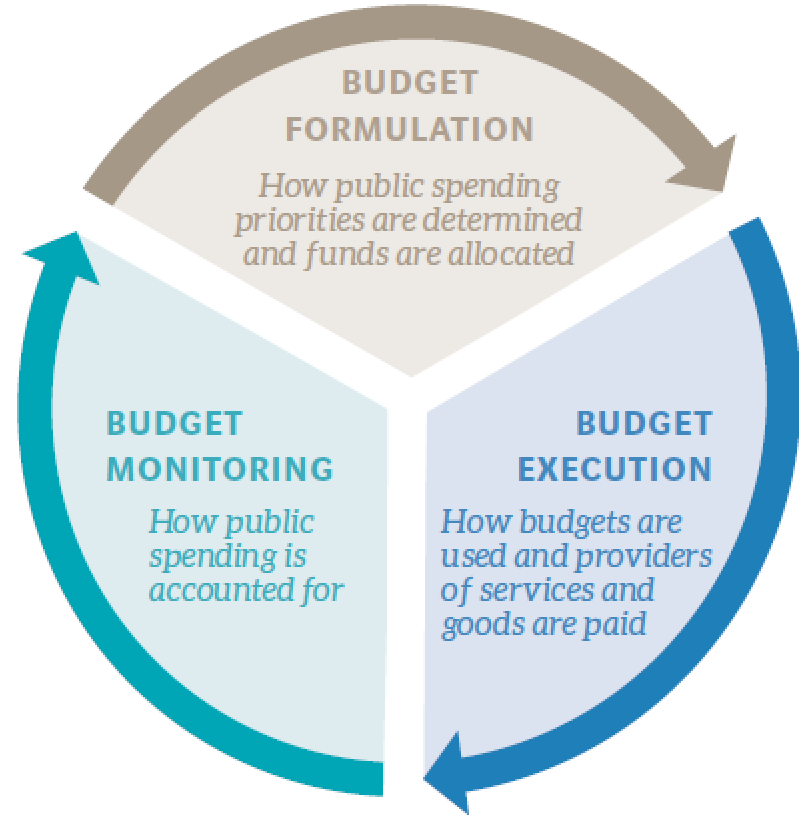
Towards universal coverage





SECTION 3 – FRAMEWORK

Other key concepts (Public Finance Management - PFM)



Sources: Allen, Hemming and Potter (2013); Cangiano, Curristine and Lazare (2013); ACCA (2011); PEFA Secretariat (2016); Simson, Sharma and Aziz (2011); World Bank (2004)

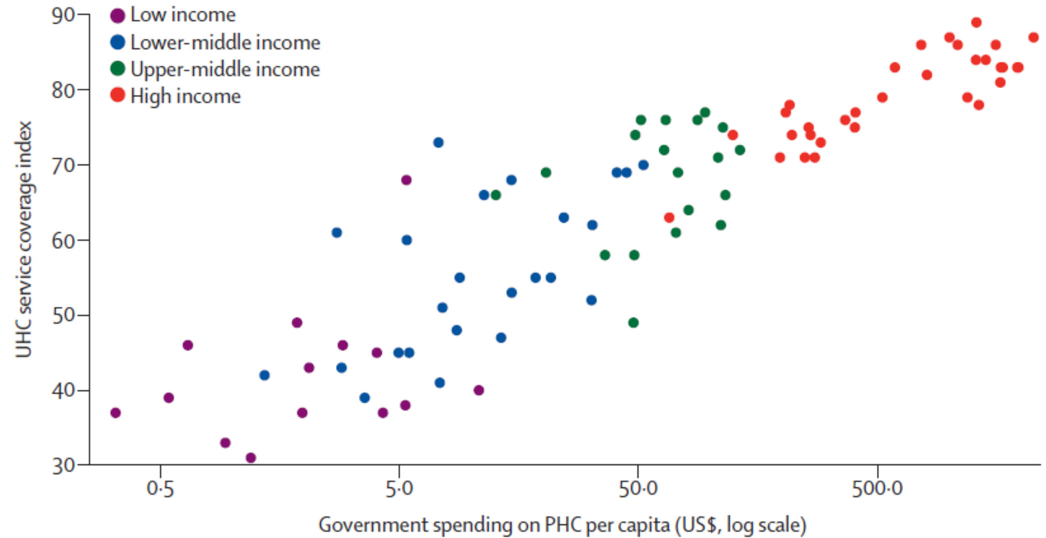
SECTION 3 – FRAMEWORK

International evidence

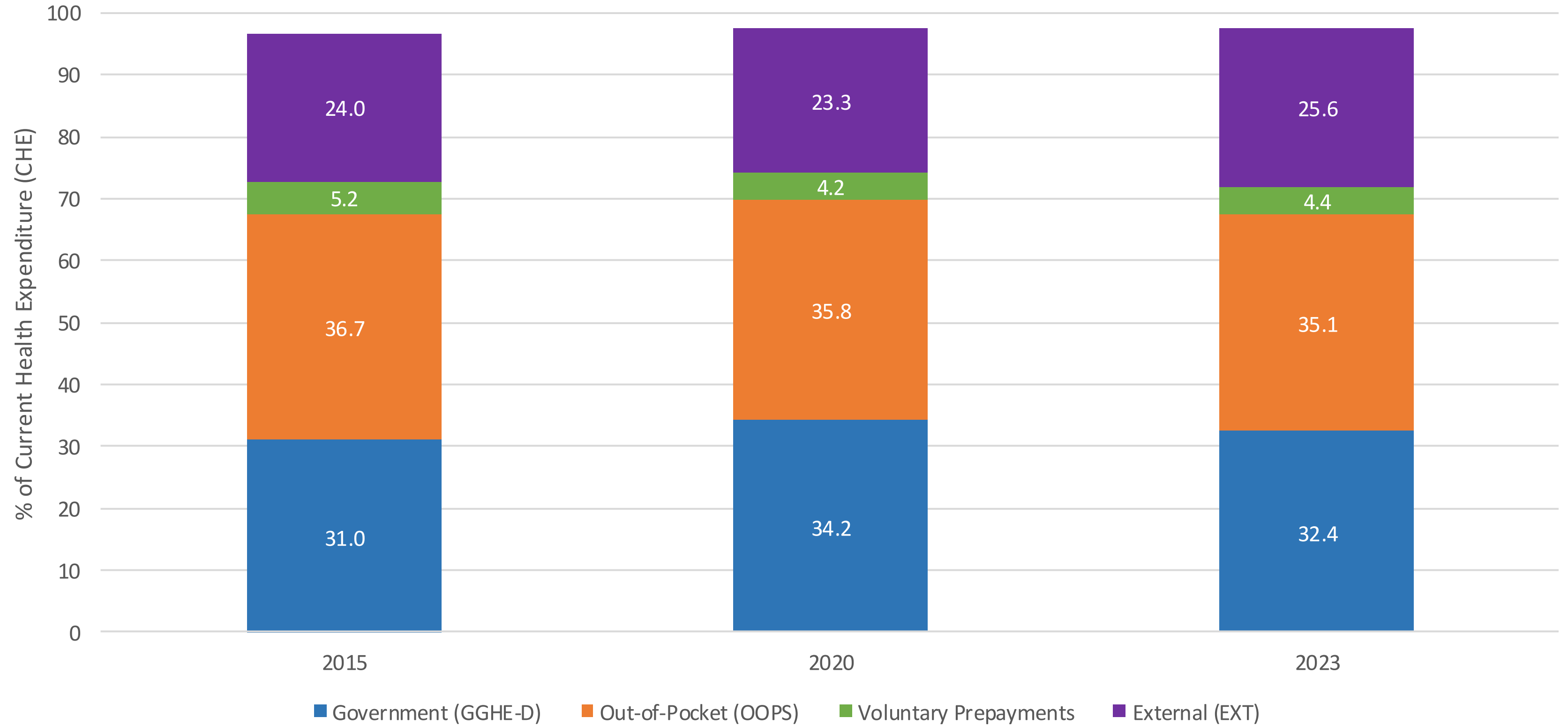
Revenue Raising

Public resources are essential.

OOP remain the primary source, despite their devastating impact



Source: Hanson et al (2024) Lancet Commission on PHC Financing



Health financing by source (Source: GHED)
100
90
80
70
60
50
40
30
20
10
0
% of Current Health Expenditure (CHE)
24.0
5.2
36.7
31.0
23.3
4.2
35.8
34.2
25.6
4.4
35.1
32.4
2015
2020
2023
Government (GGHE-D)
Out-of-Pocket (OOPS)
Voluntary Prepayments
External (EXT)

SECTION 4 – OOP ALERT

Out-of-Pocket Payments: A Non-Negotiable Advocacy Position

⚠ CRITICAL FOR ADVOCACY: Out-of-Pocket Payments Are NOT Domestic Resource Mobilisation

- ✓ DRM comes from the public/state budget — raised through taxation and public revenue.
- ✗ Patient co-payments, user fees, and household OOP expenditure are NOT DRM — they represent taxation of the sick.
- ✓ The objective is always to REDUCE OOP spending. Public resources should replace — not supplement — patient payments.
- ! Where governments or the Global Fund propose patient co-financing as a gap-filling measure, CSOs must push back firmly.
- ✗ In many countries OOP payments are being proposed precisely because DRM is insufficient. This is the wrong solution.

Understanding Health Financing: Three Core Functions

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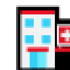

How and what services are bought from providers.

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Can Countries Realistically Replace Donor Financing?

The evidence says: not quickly, not easily, and not without risks

General Taxation

✓ Most sustainable long-term route

✗ Requires significant political change; takes years; even meeting Abuja may not reach per capita minimum

Sin Taxes

✓ Greater political acceptability; dual health benefit

✗ Limited revenue: only 0.1–0.5% of GDP; not a primary solution

Social Health Insurance

✓ Contributes to pooling and risk-sharing

✗ Coverage remains <12.5% in most LMICs; informal sector excluded; OOP rarely falls

Debt Relief / D2H Swaps

✓ Can unlock real fiscal space; proven in infectious disease

✗ Complex; dependent on creditor negotiations; not available to all countries

Efficiency

✓ Up to 40% of resources wasted

✗ Politically and technically complex

Tax to GDP ratio across 36 SSA countries (2023)

- World Bank sustainability benchmark at 15%

2.9%
Nigeria 9.4%
9.9%
Guinea 10.0%
10.1%
Sudan 10.5%
10.8%
Liberia 11.2%
11.4%
Mali 12.6%
12.7%
Cameroon 12.8%
13.0%
Mozambique 13.1%
13.4%
Gambia 13.8%
13.9%
Sierra Leone 14.0%
14.1%
Congo DR 14.2%
14.5%
Mauritania 15.2%
15.3%
Zambia 15.5%
16.1%
Gabon 16.9%
17.1%
Senegal 17.2%
17.4%
Namibia 17.6%
20.1%
Cabo Verde 22.0%
22.8%
Mauritius 23.0%
25.4%
Seychelles 31.5%

Only 15 Cs (42%) above 15% benchmark

Debt to GDP ratio across 39 SSA countries (2023)

- *IMF sustainability threshold at 60%*

Eswatini 19.0%
19.0%
Botswana 25.0%
28.0%
Ethiopia 32.0%
34.0%
Madagascar 39.0%
40.0%
Sierra Leone 43.0%
43.0%
Niger 47.0%
48.0%
Senegal 50.0%
52.0%
Nigeria 53.0%
53.0%
Liberia 55.0%
58.0%
Lesotho 60.0%
61.0%
CAR 61.0%
65.0%
Kenya 66.0%
67.0%
Togo 69.0%
70.0%
Ghana 71.0%
72.0%
Gabon 73.0%
77.0%
Mozambique 77.0%
80.0%
Mauritius 82.0%
87.0%
Malawi 88.0%
95.0%
Cabo Verde 109.0%
164.0%
Sudan 272.0%

Only 18 Cs (46%) below 60% WB benchmark

The Risk of Premature Transition

Setting overoptimistic DRM targets creates permanent damage

CSO Advocacy Responses

- Transition plans must be based on verified domestic financing trajectories — not aspirational targets
- Require the Global Fund and governments to demonstrate what financing will replace each programme component before transition is agreed
- Overoptimistic DRM projections should be challenged with World Bank GRPH data, WHO expenditure reports, and the Evans evidence base
- CSOs should resist pressure to accept transition timelines driven by donor budget constraints rather than evidence of country readiness
- GC8's 3-year cycle is an opportunity to insist on realistic DRM expectations and avoid permanent damage to programmes

SECTION 7 – BENCHMARKS

Key Benchmarks: What to Demand in Country Dialogue

WHO Minimum Spend

Target: US$60–80 per person/year

Now: LICs currently at <⅓ of minimum; LMICs ~50%

Abuja Declaration

Target: 15% of national budget to health

Now: Most LMICs remain well below this level

Alma-Ata / SDG

Target: 5% of GDP to health

Now: LMICs average 3%; LICs average 2%

Out-of-Pocket Limit

Target: < 20% of total health spending

Now: Current LMIC average: ~40%. 1.6 billion people at risk

Catastrophic Expenditure

Target: < 2% of households affected

Now: Current rate: 4.2%. WHO target not met in most LMICs

Progressive Universalism

Target: Worst-off first

Now: Priority must go to the most vulnerable before coverage expands

Key Takeaway for CSOs

The Global Fund's push for domestic resource mobilisation is legitimate — but it must be realistic, evidence-based, and equitable.

Premature transition without adequate domestic capacity will cost lives. Civil society's role is to hold all parties accountable — to the evidence, to the benchmarks, and to the people who depend on these services.

The Essential Role of Civil Society in GC8 Dialogue

What CSOs bring that others cannot

- Granular, real-world knowledge of how budget decisions translate into access at facility and community level
- Insight into how national statistics mask inequities among specific regions and vulnerable groups
- Independence from financial relationships that can distort government and implementing partner positions
- Connections to people most directly affected — who often have no other voice in these processes
- Ability to hold governments and the Global Fund accountable against internationally agreed benchmarks

Community contributions: invisible but critical

- Community health workers, voluntary organisations, faith-based providers form a critical layer of health infrastructure
- Community contributions are frequently invisible in national statistics and sustainability assessments
- Any assessment of health system capacity must account for community-level delivery
- Resist frameworks that treat communities primarily as substitutes for formal health workers
- Community health systems require adequate, predictable resourcing — including salaries, transport, and supplies
- Success of community-based service delivery and patient is that meets the targets in terms of coverage, access and quality

The Global Fund Community Engagement Strategic Initiative provides free technical assistance to CSOs— including for country dialogue engagement. Apply at any stage of the grant cycle.

CSO Advocacy Priorities for GC8 — Part 1 of 2

1. Scale & Pace of Transition

- Demand evidence-based transition timelines — not aspirational targets
- Require demonstration of replacement financing before transition is agreed
- **Challenge overoptimistic DRM** projections with World Bank & WHO data
- Ensure co-financing plans protect equitable access for key populations
- Ensure that the gaps created are visible – include them in the register of unfunded quality requests (UQD)

2. Out-of-Pocket Payments

- Oppose any proposal to introduce or expand patient fees as a gap-filling measure
- Monitor whether OOP costs are rising in your country — use as advocacy evidence
- Advocate for OOP reduction as an explicit GC8 outcome, not just higher budget lines
- **Target: OOP below 20% of total health spending**
- OOPS are NOT part of DRM – use public funding
- Use GF conditions re OOPs

3. Budget Transparency & Execution

- Monitor budget execution — not just allocation (10–20% routinely goes unspent)
- Advocate for health expenditure data disaggregated by level of care and population group
- Engage with national budget cycle, not just Global Fund country dialogue
- Demand accountability and transparency on budget allocations, executions and prioritization.
- CSOs are part of independent monitoring, showing the impact at patient/community/health facility level.

CSO Advocacy Priorities for GC8 — Part 2 of 2

4. Debt & Fiscal Space

- Advocate for debt restructuring and debt-to-health (D2H) swaps
- High debt servicing costs are the primary constraint on fiscal space for health in many LMICs
- Join international advocacy for debt relief initiatives
- Monitor IMF conditionality — fiscal austerity measures can directly constrain government health spending
- Engage with the IMF's updated civil society guidelines (reviewed October 2025)
- *Request and confirm MoH plans*
- *Request that money is allocated to specific interventions that improve access and quality of care and health outcomes*

5. Community Contributions

- Document and value community health contributions — including unpaid CHW and caregiver labour
- Push for recognition in national health accounts and sustainability assessments
- Resist frameworks that treat communities primarily as substitutes for formal health workers
- Advocate for adequate, predictable resourcing: salaries, transport, supplies
- *Include game-changing innovations in the provision of essential services; e.g., long-term ART (preventive & curative)*
- *Emphasize the value of CSOs and communities in care and monitoring*
- *Caution: integration into weak or inequitable services*

Remember: National statistics hide inequities. Budget figures are optimistic on execution. Always drill down — ask about disaggregated data, disbursement rates, and peripheral levels of care.

Fragile and Conflict Affected States

- (Repeated) Conflict, health emergencies (epid. & malnutrition outbreaks), acute severe economic crisis
- Extra vulnerability of people, vulnerable ppl extra vulnerable
- Health systems weakness & inequity of health services
- Ability & Willingness of government to people's (health) benefits
- Conflict - government not always benevolent to certain areas/pop groups

On average, one third of the Global Fund's investment is allocated to COEs

Disbursement to COE countries since 2002

In US$

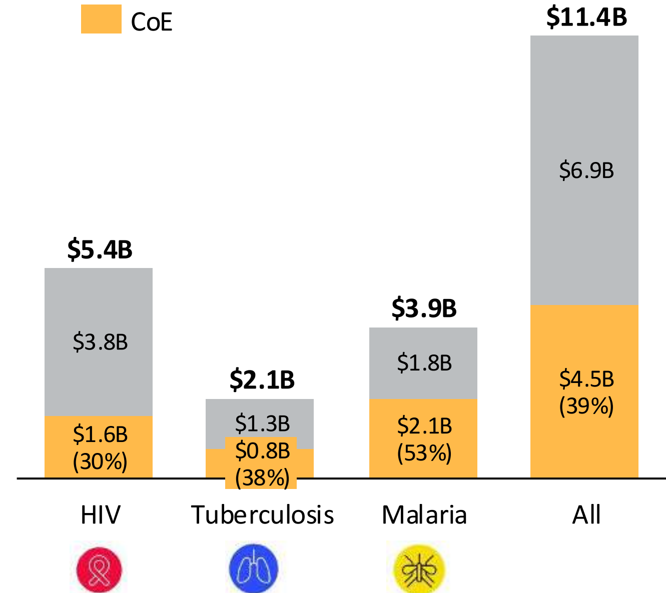
Country	Disbursement
Nigeria	$4.3B
Ethiopia	$3.4B
DRC Congo	$3.3B
Pakistan	$1.2B
Burkina Faso	$1.0B
Myanmar	$1.0B
Ukraine	$1.0B
Sudan	$986M
South Sudan	$741M
Mali	$734M
Haiti	$680M
Niger	$661M
Burundi	$603M
Chad	$587M
Guinea	$581M
Sierra Leone	$524M
Somalia	$524M
Central African Republic	$504M
Liberia	$431M
Papua New Guinea	$424M
Afghanistan	$369M
Eritrea	$354M
Guinea-Bissau	$255M
MC Middle East MER	$162M
Nicaragua	$152M
Korea	$119M
Yemen	$80M
Venezuela	$65M
Iraq	$46M
Palestine	$12M
Syrian Arab Republic	$11M

US$24.8 billion has been disbursed so far in COEs, representing 34% of the overall Global Fund's disbursements made

Grant Cycle 7 Allocation in COEs

By disease

In US$ billion



Data extracted on 26 Feb 2026

Fragile and Conflict Affected States

- Stress limited DRM potential
- Make funding & service gaps explicitely visible (UQD)
- Foresee buffer for response to crisis situations
- Include urgent measures to protect vulnerable ppl
- Independent monitoring (by CSO)
- Government channels less adapted: caution with alignment; change bad policies
- Caution with integration of services – risk exclusion and weakening care for all

Countries in transition for GC8

? continuity of the HIV and Tuberculosis response in low- and lower-middle-income countries

- 70.6% of the TB response depends on the Global Fund
- Even before budget cuts, many countries missed targets
- In particular, middle-income countries (MICs) are heavily dependent on the Global Fund for TB/HIV – steep cliffs
- In MICs 73% of risk reduction funds come from the Global Fund.

Several donors are making simultaneous funding cuts – a cumulative effect and a lack of compensation.

- The effects on service continuity and system fragility have been demonstrated.
- Deallocation by the Global Fund in 2025.
- Drastic reductions in US funding.

Questioning the reality of DRM targets within a 3-year framework

- Observation and analysis of the % of the public budget currently allocated to health
- Prospects for the public budget and its contribution to health in the current economic and political context
- How do these budget targets translate into targets for diseases and SDGs?
- What is a realistic expectation for the response after the 3-year period?
- What will happen with CSOs, their contribution to program effectiveness, and their financial support?
- Making funding and service gaps explicitly visible (UQD registry)
- Lack of access to Lenacapavir: an example of inequitable access - advocacy

Patents and Pricing Have Created a Two-Tier World

The Patent Wall

NO ACCESS for Excluded countries:

Argentina, Brazil, Colombia, Mexico, Peru, Venezuela.
Malaysia, and China.
Albania, Bosnia and Herzegovina, Kosovo, Montenegro, North Macedonia, Serbia, and Turkey.
Algeria, Iran, Iraq, Jordan, Lebanon, and Palestine.

The Price Abyss

This gap is not a market failure; it is a policy choice.

Key populations and vulnerable groups

- **Stigma & discrimination**
- Social & economic marginalisation – not a priority for government or (elite) society
- Exclusion and barriers to care from government and health systems

- **Progressive universalism: first include most vulnerable/those with less access to care**
- Advocacy for patient autonomy, differentiated delivery models, community approaches & specific facilitation measures for access
- Specific indicators & targets for certain pop groups & effective monitoring
- **Caution: Integration in services & systems without measures to improve access/quality & protection measures**
  - NB: For integration into health services that include patient payments: increasing OOP expenses, reducing access, adherence & quality; ensure effective exemptions
  - Caution: integration into insurance mechanisms; subsidized entry, remaining OOP, specific care excluded from package, lack of privacy & stigma

REFERENCE

Key Terms & Definitions

DRM

Domestic Resource Mobilisation. Public funds raised through taxation. Does NOT include OOP or donor funds.

Fiscal Space

A country's capacity to increase public health spending without compromising fiscal sustainability.

OOP

Out-of-Pocket Expenditure. Direct payments by households. WHO target: <20% of total health spending.

Catastrophic Expenditure

Health spending that forces a household into poverty. WHO target: <2%. Current rate: 4.2%.

Progressive Universalism

Coverage expansion that prioritises the worst-off first.

STC Policy

Sustainability, Transition & Co-Financing. GF policy governing transition to self-reliance. Updated for GC8.

CCM

Country Coordinating Mechanism. National multi-stakeholder platform for GF funding requests. CSOs must be represented.

Abuja Declaration

2001 AU commitment to allocate 15% of national budget to health. Most countries remain below.

GC8

Global Fund Grant Cycle 8, covering 2026–2028. Allocation letters issued from March 2026.

D2H Swaps

Debt-to-Health swaps — converting debt repayments into health programme funding.

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For further information and support, contact GFAN and the health financing experts in the CSO and academic network.

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