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Policy Brief

The Global Fund in Challenging Operating Environments

Allocation, grant design and readiness strategy for the Eastern Mediterranean Region in Grant Cycle 8 (GC8)

WISH–EMRC POLICY BRIEF SERIES

Roy Wakim

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TARGET AUDIENCE

Global Fund Board and Strategy Committee; Global Fund Secretariat; World Health Organization (WHO) Regional Office for the Eastern Mediterranean; Eastern Mediterranean Regional Committee (EMRC); Country Co-ordinating Mechanisms; principal recipients; and regional partners.

CORE ARGUMENT

HIV, tuberculosis, and malaria programs in the Eastern Mediterranean Region operate under overlapping pressures from conflict, displacement, economic instability and climate shocks. Their outcomes also depend on domestic policy choices, program quality, and financing. The Global Fund recognizes these constraints through its Operational Policy Note on Challenging Operating Environments and the updated Operational Policy Note, approved in August 2026. The policy question is whether that recognition is applied consistently and adequately across allocation, grant design, performance assessment, transition and sustainability. This brief proposes 10 targeted priority reforms within the existing Global Fund model, drawing on documented policy provisions and stakeholder experience. The immediate priority is to use existing permissions effectively; proposals for additional policy change are assigned to the relevant decision routes.

ABOUT THIS SERIES

This brief is one of two complementary policy briefs prepared under the WISH–EMRC partnership for Global Fund Grant Cycle 8. The companion brief on health innovation examines how countries in the region can prioritize and adopt health innovations. Read together, the two briefs connect operational resilience with equitable access to effective tools.

DISCLAIMER

This report is an independent policy analysis prepared within the Friends of the Global Fund partnership and in collaboration with the Eastern Mediterranean Regional Constituency. WISH facilitated and funded the technical work but did not direct or control the analytical content. The analysis and recommendations do not represent endorsement by the Global Fund Secretariat. The author declares no competing interests. Standard conflict-of-interest protocols apply to readers involved in governance, grant management, or procurement.

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FOREWORD

Health programmes in the Eastern Mediterranean Region are delivered under some of the most demanding conditions in the world. Conflict, displacement, economic instability and climate shocks shape access to health services, the costs and feasibility of delivering them, and the capacity of health systems to sustain essential care over time. For HIV, tuberculosis and malaria, these conditions can determine whether proven interventions reach the populations who need them and deliver lasting results.

The Global Fund has long recognised these challenges through its Challenging Operating Environments (COE) Policy, approved by its Board in April 2016. The Operational Policy Note, first issued in 2017 and most recently revised in August 2026, provides more detailed operational guidance on how this policy should be applied. The question this brief addresses is a practical one: whether the COE framework is being applied consistently and adequately across allocation, grant design, performance assessment and transition. It proposes 10 priority reforms within the existing Global Fund framework, distinguishing between improvements that can be pursued through the effective application of current policy provisions and those requiring further policy consideration or formal decisions.

This brief is one of two complementary publications prepared under the WISH–EMRC partnership for Grant Cycle 8. The companion brief examines how countries in the region can prioritise and adopt health innovations. Together, they connect operational resilience with equitable access to effective health interventions. Both draw on documentary evidence and the experience of 19 key informants, whose contributions are gratefully acknowledged.

WISH facilitated and funded this work but did not direct its analytical content. The analysis is independent and does not represent an endorsement by the Global Fund Secretariat. We hope it will inform constructive dialogue among the Global Fund, the Eastern Mediterranean Regional Constituency, Member States and partners, and contribute to ensuring that essential services remain accessible and sustainable for the populations who need them most.





Slim Slama
CEO, WISH

EXECUTIVE SUMMARY

This brief examines how Global Fund policies and grant arrangements respond to challenging operating conditions across the World Health Organization (WHO) Eastern Mediterranean Region (EMR).[1] It distinguishes formally designated Challenging Operating Environments (COE) settings from countries experiencing specific spillover pressures, including displacement, cross-border transmission, and local instability. These pressures affect program delivery alongside domestic policy choices, program quality, and health financing.

Epidemiology has direct implications for policy. HIV underdiagnosis and barriers affecting key populations call for performance and transition arrangements that protect access beyond routine facilities. Tuberculosis (TB) programs need continuity of treatment and follow-up across borders. Malaria programs need procurement, surveillance and delivery arrangements that can respond to changing transmission and operational access. Figure 1 links these disease-specific concerns to the policy questions (see Introduction).

The Global Fund already recognizes COEs. Its Operational Policy Note (OPN) on Challenging Operating Environments, approved on 26 August 2026, strengthens the basis for differentiated grant management, including approaches to unstable areas, context-sensitive performance assessment, and specified arrangements for displaced populations. These permissions have conditions and approval requirements; they do not amend the allocation methodology or the separate eligibility, transition and co-financing policies.[2]

This brief asks whether existing recognition of fragility is applied consistently and adequately across allocation, grant design, implementation, performance assessment and transition. Documentary evidence establishes the current rules. Interviews identify reported delivery constraints and concerns about predictability. The author's analysis connects those findings to five policy questions around: allocation of funds and operating costs; classification of countries and spillover effects; transition readiness; performance and accountability; and regional mechanisms for addressing disease risks. The interviews predate the August OPN and do not establish how effectively its new provisions have subsequently been implemented.

Ten headline priority reforms are proposed (PR1–PR10). They are distinct from the supporting implementation actions shown in the reform tables, which depend mainly on Member State leadership, and from the Middle East Response (MER) options listed under PR10, which illustrate how PR10 could be taken forward rather than adding to the headline agenda. For the Eastern Mediterranean Regional Committee (EMRC), three reforms are the most immediate priorities:

- PR1, building comparable evidence on COE operating costs for Grant Cycle 9 (GC9) allocation and qualitative adjustment (QA) review.
- PR3, securing recognition of sustained spillover pressures in host and transit settings.
- PR5, establishing a clearer route for reviewing transition risks after material shocks.

Grant Cycle 8 (GC8) offers opportunities to apply existing differentiated approaches, protect essential community services, improve continuity measurement, and strengthen regional co-ordination within current permissions. The longer-term agenda concerns the evidence used in allocation and qualitative adjustment, predictable consideration of spillover costs, and crisis-responsive transition review. Each proposal is assigned to the appropriate policy or operational decision route. Changes to transition or eligibility require their own governance process; the GC9 allocation review cannot authorize every reform.

The Middle East Response (MER) provides a practical basis for learning about multicountry services for mobile and cross-border populations. It is treated here as a valuable source of operational lessons, not as a model whose expansion is already justified; its effectiveness, costs and transferability still need to be assessed. Priorities include clearer governance, inclusive participation, transparent evidence on results and costs, and more predictable planning across grant cycles. Any extension of MER financing, or any proposal to transfer funds between disease allocations, would remain subject to the relevant policy, allocation and grant decisions.

Responsibilities are shared. The Global Fund can change its policies and grant arrangements; EMRC can assemble evidence and pursue governance proposals; Member States lead domestic financing, national systems, and cross-border agreements; WHO and other partners provide technical and delivery support. The objective is to make existing COE principles more predictable and responsive within the Global Fund model, while maintaining accountability and protecting continuity of care.

INTRODUCTION

THE EASTERN MEDITERRANEAN REGION AS A POLICY STRESS TEST

In this brief, the Eastern Mediterranean Region (EMR) means the 22 countries and territories in the WHO World Health Organization (WHO) Eastern Mediterranean Region: 21 Member States and the Occupied Palestinian Territory, including East Jerusalem. This geographic scope differs from the Global Fund's country and disease-component eligibility, its funded portfolio, and its formal Challenging Operating Environments (COE) designations. The analysis distinguishes formally designated COE settings from other settings experiencing specific operational pressures associated with displacement, cross-border transmission, or local instability. These pressures do not constitute a separate Global Fund classification, and should not be read as a request to classify every affected country as a COE.[1]

Within the WHO Eastern Mediterranean Region, 11 countries and territories are designated by the Global Fund as COEs for Grant Cycle 8 (GC8), as confirmed by the Secretariat's Implementation and Challenging Operating Environments Team on 2 November 2026, and listed in Table 1.

Throughout this brief, 'EMR' refers to the WHO region's 22 countries and territories, while 'COE settings' refers to settings formally designated by the Global Fund. Participation in the Middle East Response (MER) multicountry grant is a separate consideration: its six participating settings form part of the 11 designated COEs.

Table 1. Formally designated COEs in the EMR (GC8)

No.	Country or territory
1	Afghanistan
2	Pakistan
3	Iran
4	Yemen
5	Syria
6	Lebanon
7	Occupied Palestinian Territory
8	Iraq
9	Libya
10	Somalia
11	Sudan

Source: Global Fund Secretariat, Implementation and Challenging Operating Environments Team, written communication, 2 November 2026.

Interviewees described sustained pressures in Jordan, Egypt, Morocco and Tunisia associated with refugee hosting, transit migration and cross-border continuity of care. These examples illustrate spillover pressures affecting program delivery. The term 'spillover settings' is used descriptively and does not constitute a separate Global Fund classification.

Conflict, displacement, economic instability, and climate shocks place overlapping pressures on health services in the EMR. These conditions make the region a useful test of how Global Fund policies support program continuity when access, delivery costs and population needs change rapidly.[3]

Economic instability can constrain procurement, financial transactions, and workforce retention. Climate events and displacement can alter service needs and the capacity to meet them. The 2022 floods in Pakistan illustrate the interaction between environmental disruption and malaria risk.[4] Interviewees also described legal, financial and practical barriers to continuity of care for displaced populations. These pressures can affect areas or groups without establishing a country-wide COE designation.

These pressures interact and can change the resources and delivery arrangements needed to maintain services. Interviewees reported higher costs for access, logistics and staff protection in particular settings. The author proposes that those constraints be documented and reflected in grant design, rather than inferred solely from broad country classifications.

WHY THIS BRIEF AND WHY NOW

Grant Cycle 8 (GC8) is an immediate opportunity to apply differentiated grant-management provisions while examining longer-term policy questions. This brief distinguishes operational action during GC8 from proposals for GC9 and other governance processes. GC8 offers immediate scope to use existing grant design, performance, monitoring, and implementation permissions, subject to their applicable conditions. For GC9, allocation and qualitative adjustment (QA) proposals should enter the allocation-methodology and Strategy Committee processes. Proposed changes to eligibility, transition or co-financing require their own policy review and the relevant Board decisions. Changes to COE designation processes or operational guidance should follow Secretariat governance, with Board action where a Board-approved policy would need to change. The timing labels indicate an intended opportunity, not an approved timetable or commitment.

METHODOLOGY NOTE

This brief draws on a structured, purposive literature review, Global Fund policy and governance documents, epidemiological sources, and interviews with 19 key informants from Global Fund governance and Secretariat roles, Eastern Mediterranean Regional Committee (EMRC), WHO and other technical partners, and implementing organizations.

Documentary findings are cited. Interview findings are presented as reported experiences or perceptions, and the author's interpretations and proposals are identified as such. Interview accounts provide context and identify issues for further examination; they do not independently establish the size or cause

of a quantitative effect. The interviews preceded the August 2026 Operational Policy Note on Challenging Operating Environments The analysis considers the interview findings alongside the OPN's provisions and does not assess implementation of those provisions. Appendix 1 describes the methods and limitations. The analysis is independent and has not been endorsed by the Global Fund.

EPIDEMIOLOGICAL AND OPERATIONAL CONTEXT

DISEASE BURDEN AND POLICY IMPLICATIONS

The epidemiology is presented here to explain the grant design, performance and transition questions addressed by the brief. The geographic scope is the WHO EMR; evidence concerning the wider Middle East and North Africa is used only where its relevance to the policy analysis is explicit. HIV estimates refer to 2025; tuberculosis (TB) and malaria estimates refer to 2024.

HIV

WHO's July 2026 information sheet estimates 610,000 people living with HIV in the EMR in 2025. The cascade uses sequential denominators: 41 percent of all people living with HIV knew their status; 76 percent of those diagnosed were receiving antiretroviral therapy; and 79 percent of those on treatment had viral suppression. These gaps make access, diagnosis and treatment continuity central to program design and assessment in fragile settings.[5]

WHO estimated 66,000 new HIV infections and 22,000 HIV-related deaths in the EMR in 2025; estimated HIV-related deaths were 79 percent higher than in 2010.[5] Barriers to testing and sustained treatment, including stigma and difficulties reaching key populations, make facility-based coverage alone an incomplete account of program access. The policy implications are to protect confidential, community-based services and assess their continuity when grants are redesigned or transition is planned.[6]

Tuberculosis

WHO reported an estimated 920,000 incident TB cases and nearly 85,000 deaths in the EMR in 2024.[7] The burden is particularly concentrated in Pakistan.[8] These figures make the continuity of diagnosis and treatment a major regional policy concern.

Interviewees highlighted difficulties following patients who move across borders during treatment. These constraints support investment in referral arrangements, compatible reporting, and outcome confirmation, with clear responsibilities for sending and receiving services. Readiness for transition should include the capacity to sustain these functions for mobile and underserved populations.

Malaria

WHO estimated 11.1 million malaria cases and 22,100 malaria deaths in the EMR in 2024.[9] Conflict, displacement and climate shocks can disrupt prevention and treatment while altering transmission patterns, as illustrated by the 2022 floods in Pakistan.[4] These conditions require surveillance, procurement and delivery arrangements that can respond promptly to changing needs and access.

The WHO *World Malaria Report 2025* identifies changing vector and diagnostic challenges alongside continuing progress toward elimination.[10] The policy implication is to match procurement and surveillance choices to the local transmission setting and update them when evidence or operating conditions change.

Factors affecting regional progress

Progress across the three diseases is affected by interacting barriers to access, health system constraints and financial pressures. Their relative importance differs by country, disease and population. This brief examines how those differences should inform the application of COE policy.

Stigma, discrimination and difficulties securing access to treatment can affect refugees and other marginalized populations living with HIV.[6] Interviewees also described geographic and social barriers to reaching people with TB or at risk of malaria. Program assessment therefore needs to consider who is reached, as well as aggregate service volumes.

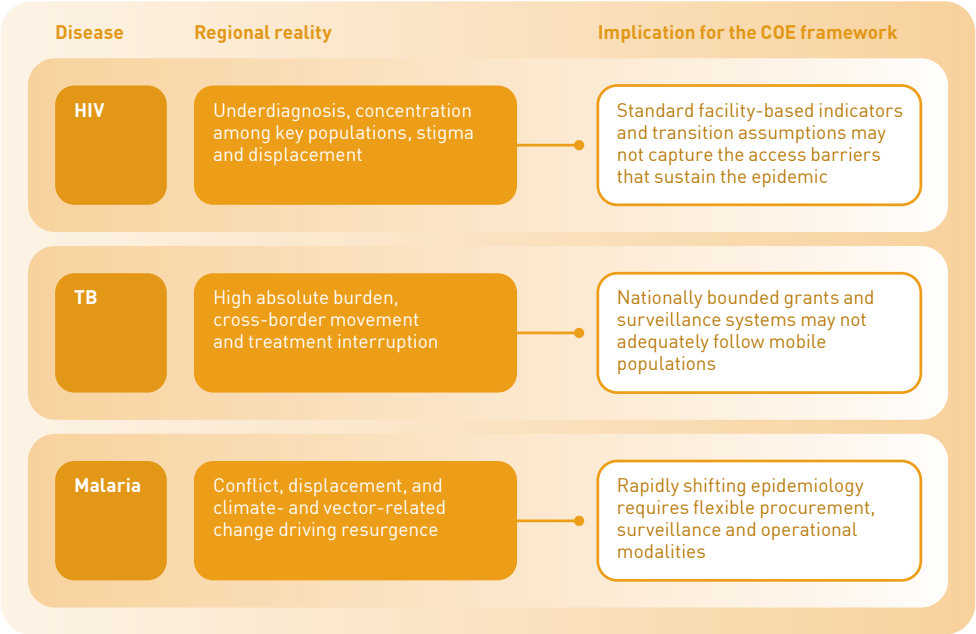
WHO's regional reporting describes the pressure that overlapping emergencies place on health systems and service delivery.[3] Interviewees reported workforce, infrastructure and surveillance constraints that can weaken implementation and the information available to assess it.

Financing vulnerability also varies across programs. Interviewees raised concerns about services whose domestic financing and contracting pathways remain uncertain as external support changes. The policy response should be based on verified expenditure, delivery arrangements and the needs of affected communities.

Conflict, climate events and displacement can disrupt services and aggravate existing system weaknesses.[3,4] In such settings, the capacity to maintain and restore essential services is relevant to grant design and performance assessment.

The regional evidence supports treating the operating environment as an important determinant of program feasibility, alongside domestic policy choices, program quality and financing. Disease control technologies need delivery systems, access pathways and enabling infrastructure that can sustain their use. Figure 1 sets out the implications for each disease.

Figure 1. What epidemiology means for COE policy



Source: The author's synthesis of the disease and policy analysis in this section.

THE EMR ACROSS GRANT CYCLES AND COE SETTINGS

The Board-approved allocation methodology provides for qualitative adjustment of formula-based allocations.[11] Interviewees described efforts to protect vulnerable settings within a constrained funding envelope. This policy brief treats those interviews as stakeholder evidence. The adequacy and distributional effect of the adjustments should be assessed using the published or otherwise citable allocation outcomes, with consistent country groupings, allocation baselines and grant-cycle definitions.

GC8 planning must balance continuity of existing services, the introduction of relevant health products, investment in delivery systems and the sustainability of services as external support changes. Interviewees described these competing demands as a significant financing challenge. Therefore, prioritization should explicitly state the resource requirements and service-continuity implications of each option.

The EMR includes formally designated COE settings (the 11 countries and territories identified in Table 1) and other settings experiencing substantial spillover pressures. The Global Fund reviews its COE list annually, and the OPN allows differentiated approaches to unstable areas within the applicable portfolios. Formal designation, country and disease-component eligibility, and participation in a regional grant remain distinct. The analysis below therefore focuses on operational constraints and the policy responses available to address them.[2]

Interviewees described sustained pressures in host and transit settings, including Jordan, Egypt, Morocco and Tunisia, and raised concerns about continuity of services as financing arrangements change. These examples illustrate operational pressures

rather than common formal classification. Transition and co-financing conditions must be specified by country, disease component and grant period; they should not be inferred from regional membership or from spillover pressures alone.

THE FIVE POLICY QUESTIONS

The Global Fund has a COE policy, further operationalized through the August 2026 OPN. The policy question is whether recognition of fragility is reflected consistently and adequately across allocation, transition, performance assessment and accountability. The analysis addresses five questions:

1. **Allocation:** Does the Global Fund's allocation architecture adequately account for the additional cost and operational complexity of delivering programs in COEs and in countries experiencing significant spillover effects?
2. **Classification:** Now that the COE framework recognizes unstable parts of countries and regions, is it sufficiently sensitive to cross-border displacement and prolonged spillover pressures in countries that are not designated as COEs?
3. **Transition:** Can transition and co-financing expectations be adapted when conflict, economic collapse, sanctions or large-scale displacement fundamentally alter a country's ability to sustain programs?
4. **Performance and accountability:** How should program performance be assessed when insecurity, displacement or loss of health system infrastructure directly affect the ability to achieve conventional coverage indicators?
5. **Regional mechanisms:** Can mechanisms such as the MER grant provide a more systematic model for addressing cross-border and displacement-related disease risks?

Question 1 is addressed through the analysis of operating costs and the qualitative adjustment process; Questions 2 to 4 through the sections on spillover, transition and performance measurement; and Question 5 through the MER analysis. The reforms responding to each question are consolidated in the Priority Reform Agenda (see Table 8).

COE POLICY AND THE COUNTRY EVIDENCE

Country and disease-component circumstances differ across the EMR. The analysis distinguishes the policy provisions that apply from the constraints described in interviews, and examines how allocation, eligibility, co-financing and grant management interact.

The 2016 COE Policy established a basis for differentiated support, and the August 2026 OPN provides more detailed operational guidance. The analysis below examines how those provisions respond to reported constraints and where further evidence or policy decisions may be needed.

Progress under the 2016 COE policy

The 2016 COE Policy formalized a differentiated approach to fragile settings. The Global Fund has also used policy-specific exemptions, waivers, and tailored implementation arrangements to sustain programs. The authority for each arrangement should be identified in the relevant decision or policy; it should not be attributed solely to the COE Policy.[12]

Interviewees described examples of contextual adaptation and concerns about the predictability of support across settings. These accounts support examination of how allocation, co-financing, transition and grant-management decisions interact. They do not establish that the same rule governs every waiver, or that allocation QA is the approval route for a co-financing exception. The author proposes clearer explanations of applicable criteria and decision routes while preserving judgment where contexts differ.

The August 2026 Operational Policy Note on Challenging Operating Environments

On 26 August 2026, the Global Fund's Executive Grant Management Committee approved the Operational Policy Note (OPN) on Challenging Operating Environments (COEs). It explains how the COE policy is applied across the grant life cycle, including to unstable parts of countries or regions. The COE list is established for a grant cycle and reviewed annually. The note sets out differentiated approaches to operational constraints, with implementation arrangements, monitoring and assurance adapted to context. Its principles and general requirements apply across portfolios. Specific COE deliverables do not generally apply to the Global Fund's Focused Public Health Portfolios unless expressly indicated; Appendix 1 distinguishes requirements and best practices for each portfolio category.[2]

COE designation does not confer automatic access to every flexibility. The differentiated approach is agreed through the relevant regional or departmental management route. The OPN provides Grant Approvals Committee and Portfolio Performance Committee routes at grant-making and implementation stages respectively; exceptions governed by other operational policies follow those specific approval routes. In multicountry grants, the differentiated approach applies to the countries or regions classified as COEs.[2]

In situations of significant cross-border displacement, host-country allocations may support displaced and host populations. Origin-country allocations may finance services in a host country. For an ineligible host, the Secretariat must assess case by case that its national health system lacks capacity to deliver the services; services for people remaining in the country of origin should continue wherever possible. The OPN also provides context-sensitive performance and assurance options and permits a single grant to contain several disease components where the principal recipient has capacity. Consolidation does not automatically authorize transfers between disease allocations. The Middle East regional grant is cited as an example of a regional management arrangement.[2]

The author considers these provisions directly relevant to concerns raised in the interviews. The remaining question is how consistently and adequately they are used. The OPN does not amend the allocation methodology or separate eligibility,

transition and co-financing policies. Proposals affecting those instruments therefore require their own decision routes. This brief distinguishes implementation of existing permissions from proposals for additional policy change.

Three issues for GC8 implementation

Three issues raised in the consultations are particularly relevant to GC8 implementation. Each issue needs to be considered against the permissions and limits of the current framework:

1. **Transition risks:** The 2026 Eligibility List states that country components that have received transition funding or have voluntarily transitioned are ineligible generally for an allocation. An exception applies to components that received transition funding in an earlier cycle, subsequently became re-eligible and are currently receiving an allocation.[13]
2. **Protection of community services during optimization:** Interviewees raised concerns about the protection of community-led and key-population services during optimization and transition. They described a risk that services with limited domestic financing pathways could lose support as budgets contract or shift toward facility-based delivery. The author proposes explicit service-continuity safeguards and a documented financing pathway for these functions. This is a response to reported risks, not evidence that every optimization decision excludes equity protections or necessarily reduces community services.
3. **Sustained spillover pressures:** Sustained spillover pressures raise questions about the predictability, adequacy and accessibility of support in host and transit settings.

Implications for the analysis

The following section examines the five policy questions alongside the OPN's existing subnational and cross-border provisions for the EMR.[2] It examines where reported constraints may persist despite existing policy permissions. Each subsection distinguishes the documented rule, stakeholder experience, and the author's interpretation. The Policy Reform Agenda proposals focus on more consistent use of current provisions and on specific changes that would require a separate policy decision.

Following the discussions of each of the five policy questions, Table 8 sets out 10 priority reform areas and the actors and partners responsible for taking action.

POLICY CONDITIONS FOR EFFECTIVE PROGRAMMING IN THE EASTERN MEDITERRANEAN REGION

This section connects the analysis to the five policy questions around: allocation of funds and operating costs; classification of countries and spillover effects; transition readiness; performance and accountability; and regional mechanisms for addressing disease risks.

1. **Allocation: Does the Global Fund's allocation architecture adequately account for the additional cost and operational complexity of delivering programs in Challenging Operating Environments (COEs) and in countries experiencing significant spillover effects?**

THE COST OF OPERATING IN COES

The 2017 Office of the Inspector General review of 10 high-risk countries during 2014–2015 reported that human resources, overheads, planning and administration represented at least half of grant expenditure, with a maximum of 66 percent. Because human resources included program staff, these categories cannot be treated as entirely indirect or non-service expenditure, and the figures do not estimate a current, causal 'fragility premium'.[14]

Interviewees reported additional costs associated with difficult access, workforce safety and logistics. They described limits to the predictability of adjustments for these pressures. The author proposes an updated, transparent assessment of delivery costs, distinguishing direct staffing from administration and documenting how insecurity and access affect comparable activities. Historical aggregate cost shares can motivate that assessment but cannot substitute for it.

BOX 1. REPORTED DELIVERY COSTS IN CHALLENGING OPERATING ENVIRONMENTS

Interviewees described additional last-mile delivery costs in conflict-affected areas of Sudan, including the need to adapt delivery frequency and routes when conventional storage and transport arrangements were disrupted. These accounts illustrate a mechanism through which costs may rise; they do not provide a comparable estimate of the size of that increase.

Implementers in Pakistan reported additional requirements for travel and work in high-risk provinces, including security clearances and staff protection measures. They also expressed uncertainty about how those costs would be treated in grant budgets. These accounts describe reported experience and expectations; they do not establish that the August 2026 Operational Policy Note on Challenging Operating Environments prevents context-specific budgeting.

Secretariat interviewees described management and intermediary costs as an important consideration in the choice of implementation arrangements. These accounts support comparing the full costs and functions of alternative arrangements before drawing conclusions about efficiency. Options for localization should be assessed against delivery capacity, comparable service requirements and fiduciary safeguards.

Some Secretariat interviewees suggested that implementers with an existing humanitarian presence may share operational infrastructure and reduce incremental costs. They cited the International Organization for Migration as an example. This is an interview-based explanation, not a comparative audit of overhead rates. Any assessment of cost advantage should compare equivalent services, cost definitions, operating risks and time periods.

Interviewees identified last-mile logistics, staff safety, storage, and supply-chain disruption as sources of additional operating pressure. Some also reported procurement delays. These qualitative accounts do not establish a typical delay or its cause. The appropriate response is to document the constraints by grant and assess the differentiated budgeting, implementation and supply arrangements available under the OPN.[2]

Table 2 sets out the corresponding priority reform agenda areas (PRAs): one for Grant Cycle 9 (GC9) allocation methodology; and one that can be pursued within GC8 grants under the 2026 OPN, with localization retained as a shared, system-level action.

Table 2. Priority reform areas (PRAs) on the cost of operating in Challenging Operating Environments (COEs)

Recommendation	Primary actor	Supporting actors
PRA1: Improve the evidence used to recognize COE operating costs in allocation and qualitative adjustment (QA). Develop comparable, current cost evidence and propose its systematic consideration through GC9 methodology and QA processes, while preserving justified contextual judgment.	Board: allocation methodology Strategy Committee: QA process	Secretariat: analysis and application Eastern Mediterranean Regional Committee (EMRC), countries, principal recipients (PRs) and partners: evidence and advocacy
PRA2: Apply the August 2026 Operational Policy Note during GC8 to differentiate budgets, delivery arrangements and contingency planning for relevant zones and constraints. Assess appropriate financing and verification options under the applicable policy conditions.[2]	Secretariat and Country Teams; approvals through applicable policy routes	Countries, Country Co-ordinating Mechanisms and PRs Technical and humanitarian partners

Recommendation	Primary actor	Supporting actors
Supporting action: Shared action supporting PRA2. Pursue feasible localization with appropriate delivery capacity, financial accountability and oversight. Countries and implementing organizations lead the arrangements; the Global Fund assesses support through grant design.	Member States (Ministry of Health, Ministry of Finance)	PRs Global Fund Secretariat (enabling)

2. **Classification: Now that the COE framework recognizes unstable parts of countries and regions, is it sufficiently sensitive to cross-border displacement and prolonged spillover pressures in countries that are not designated as COEs?**

SPILLOVER PRESSURES IN NON-CLASSIFIED SETTINGS

The spillover question concerns the predictability, adequacy and accessibility of support for sustained pressures in host and transit settings. The framework already permits subnational differentiation and specified financing arrangements for displaced populations. Consequently, the brief does not propose blanket COE designation for Jordan, Egypt, Morocco or Tunisia. It asks how relevant operating pressures can be recognized through the appropriate policy and financing channels.[2]

Interviewees described difficulties in planning for prolonged refugee hosting, transit migration and cross-border continuity of care. The author interprets these accounts as a case for clearer evidence requirements and more predictable consideration of spillover costs. Existing permissions may help finance services, but they do not by themselves create additional resources or establish that every affected setting receives adequate support. Their use should be assessed against the conditions described in the section 'The August 2026 Operational Policy Note on Challenging Operating Environments', including protection of services in the country of origin.

BOX 2. REPORTED EFFECTS OF SPILLOVER ON SERVICE DELIVERY

Interviewees reported difficulty confirming treatment outcomes when people receiving TB care in Pakistan returned to Afghanistan during treatment. Without reliable cross-border referral and outcome reporting, the initiating program may be unable to establish whether treatment continued. The proposed response is a practical agreement for patient referral, confidential information exchange and outcome confirmation, supported by financing arrangements that meet the applicable eligibility and OPN conditions.

Interviewees described a Syria–Lebanon TB continuity-of-care mechanism as a useful example for other corridors. They also reported discussion of wider coverage and possible inclusion of HIV services. These accounts support evaluating the approach before considering its use elsewhere; they do not establish an approved expansion program.

Interviewees described changing malaria service needs in Sudan as people were displaced and access to established facilities deteriorated. The author interprets these accounts as a case for linking surveillance and service planning to population movement, without assuming that reported increases can be attributed to a single cause.

Implementers in Morocco described reliance on Global Fund support for outreach, testing and related services for migrants and other key populations. They expressed concern about continuity as external financing changes, particularly where a domestic financing arrangement has not been established. This evidence supports checking service-specific transition plans and funding commitments; it does not establish that all migrant services will lose financing or that a country-wide transition date applies to every component.

The proposed reforms seek clearer consideration of sustained host and transit pressures while using existing permissions where they apply. Table 3 separates the policy and allocation questions from the government agreements and delivery arrangements needed for continuity of care.

Table 3. Priority reform areas (PRAs) on spillover pressures in non-classified countries

Recommendation	Primary actor	Supporting actors
PRA3: Recognize specific spillover pressures without presuming country-wide Challenging Operating Environments designation. Use current permissions during Grant Cycle 8 (GC8) and develop evidence on sustained hosting, mobility and cross-border transmission for GC9 allocation and qualitative adjustment review. Any classification or policy change follows its separate governance route.	Secretariat: existing permissions Board and Strategy Committee: relevant policy and allocation decisions	Eastern Mediterranean Region (EMRC): evidence and advocacy Countries, World Health Organization Eastern Mediterranean Regional Office (WHO EMRO) and International Organization for Migration (IOM): population, service and operational evidence
PRA4: Strengthen cross-border continuity of care. The Global Fund, EMRC and relevant Member States should assess financing and delivery options, using the Operational Policy Note's conditional cross-border provisions and lessons from reported experience. Countries lead agreements on referral, information protection and outcome reporting.	Shared: Member States, Global Fund Secretariat and EMRC, within their respective mandates	WHO EMRO, IOM, principal recipients (PRs), communities and humanitarian partners

3. **Transition:** **Can transition and co-financing expectations be adapted when conflict, economic collapse, sanctions or large-scale displacement fundamentally alter a country's ability to sustain programs?**

TRANSITION READINESS IN FRAGILE SETTINGS

Co-financing and transition arrangements differ across countries, disease components and grant periods. Interviewees described constraints related to fiscal pressure, procurement, financial transactions and the execution of domestic budgets. These accounts should be distinguished from the formal conditions set out in allocation letters and approved grant documents. They do not establish that policy assumes that every shortfall reflects weak political commitment.

A waiver or adjustment to a financing requirement can resolve a compliance issue without closing the underlying resource gap. The author proposes assessing both the applicable requirement and the resources needed to sustain services, alongside evidence of actual budget execution and delivery capacity. Where an external shock materially alters those conditions, the relevant authorities should review the risks and the options permitted by the applicable policies.

Interviewees expressed concern that financing responsibilities could shift before domestic arrangements for some services were secure. They highlighted community-led services, outreach to key populations and human rights programming as functions requiring explicit financing and delivery plans. The author proposes assessing those functions separately, with participation from affected communities, rather than assuming that national income or aggregate financing data establish their readiness for transition.

BOX 3. INTERVIEW ACCOUNTS OF TRANSITION READINESS

The following examples record concerns reported during interviews. They identify matters for verification and planning rather than independent determinations of country readiness. In Tunisia, stakeholders reported uncertainty about the timing of transition and whether the available readiness assessment reflected subsequent changes. Such accounts support clearer communication and updated assessments before financing responsibilities change.

Implementers in Morocco described reliance on grant-financed outreach workers. They raised concerns about the domestic financing of community services. Interviewees also described differences in social-contracting readiness across settings. These accounts support verifying the arrangements for specific services before external support changes.

In Pakistan, interviewees raised concerns about the capacity to absorb TB and HIV functions, and to execute planned domestic financing commitments. The assessment should compare the relevant grant conditions with verified budgets, expenditure and delivery capacity, rather than infer readiness from current commitments alone.

Implementing partners described political and institutional barriers to sustained services for key populations in some settings, including Egypt. They raised concerns that willingness to finance clinical services might not extend to the community organizations and outreach functions that support access. The author proposes documenting the financing, contracting and service arrangements for these functions and including community perspectives in readiness assessment.

These concerns support a clearer route for reviewing service-continuity risks when conditions deteriorate. Any adjustment to an existing grant should follow the permissions currently available; and any proposed change to eligibility, transition requirements or future allocation access requires its own policy decision. Challenging Operating Environments status or a readiness assessment does not automatically create a right to renewed financing.[2,13]

A 2024 Global Fund performance report presented preliminary evidence supporting achievement of 63 percent of GC6 co-financing commitments in the cohort reviewed. The analysis covered 68 countries and 206 components that had completed GC7 grant-making by September 2024. Where applicable, this included Resilient and Sustainable Systems for Health components. Verified data were missing for 10 percent of components. Therefore, this historical result needs to be interpreted within its reporting scope. Transition assessment should use verified country- and component-level commitments, expenditure, and service data.[15]

The author proposes a transition approach that combines the applicable eligibility rules with a documented assessment of service readiness and changes in context.

Table 4 identifies priorities for reviewing crisis-related risks, protecting essential community services, and improving the evidence available for decisions.

Table 4. Priority reform areas (PRAs) on transition planning and implementation

Recommendation	Primary actor	Supporting actors
PRA5: Establish a clearer process for reviewing transition risks after material shocks. Assess options under current policy during Grant Cycle 8 (GC8); consider separately any proposals to reassess, slow or pause requirements that would need changes to eligibility, transition or co-financing policy.	Secretariat: current policy options Board: required policy changes	Eastern Mediterranean Regional Committee (EMRC) Ministries of health and finance Communities and technical partners
PRA6: Protect community-led and key-population services during optimization and transition. Agree explicit continuity safeguards and a feasible financing and contracting pathway for essential services, informed by affected communities. Any transitional support must fit the applicable financing and policy rules.	Secretariat: grant design and revisions Board: any wider policy change	Countries EMRC Principal recipients (PRs) Civil society Technical partners
PRA7: Propose, for discussion and testing, a time-limited pilot of a proportionate assessment of transition readiness at entry, before the final shift in financing responsibilities, and after closure where an agreed follow-up arrangement exists. EMRC, the Secretariat, Member States and community representatives should develop the indicators and responsibilities together. The pilot would not establish a new Global Fund process and would only inform decisions; any change to eligibility, transition requirements or financing would require separate authorization under the applicable policy.	Secretariat: consideration of whether, and which elements of, a pilot are feasible under existing authority	EMRC Member States Technical partners Communities Board for any resulting policy change
Supporting action: Shared, system-level action (supports PRA6). Establish domestic financing and social-contracting pathways for community-led and key-population services ahead of transition. The Global Fund's role is to enable and incentivize this through co-financing and transition planning.	Member States (Ministry of Health, Ministry of Finance)	Global Fund Secretariat (enabling) Joint United Nations Programme on HIV/AIDS Civil society organizations

BOX 4. PROPOSED THREE-TOUCHPOINT SUSTAINABILITY ASSESSMENT: A PILOT FOR DISCUSSION

The author proposes a proportionate assessment of transition readiness at three points in the grant life cycle. This is a pilot option for discussion and testing with the Eastern Mediterranean Regional Committee, the Secretariat, Member States and affected communities. It is not an approved Global Fund instrument, an eligibility rule or a commitment to renewed funding. It does not establish a new Global Fund process, and it does not assume that the Global Fund or any other institution currently has the authority to implement every element described below; the feasible scope would be agreed with the relevant parties before any testing.

1. Assessment at transition entry should include: domestic financing commitments; actual expenditure; procurement and supply arrangements; the capacity to sustain essential services; and the inclusion of key populations and displaced people. The assessment should record material data gaps and assign responsibility for filling in missing data.
2. Before the final shift in financing responsibilities, check whether the planned transfer of functions is occurring in practice. Assess service continuity, budget execution, workforce and procurement readiness, and the financing of community-led services. Where significant gaps remain, identify corrective actions and refer any proposed change in requirements or timelines to the competent authority.
3. After grant closure, consider a follow-up assessment, for example at 18 months, where the data, financing and institutional arrangements for doing so have been agreed. Evidence of deterioration could prompt a documented review of available responses under the policies then in force. It should not automatically trigger re-entry into financing.

Any pilot should define the indicators, denominators, thresholds, data sources, review responsibilities and additional workload in advance. Existing data should be used where reliable, complemented by proportionate verification. Numerical thresholds should be tested and justified before being recommended as decision rules.

4. **Performance and accountability: How should program performance be assessed when insecurity, displacement or loss of health system infrastructure directly affect the ability to achieve conventional coverage indicators?**

PERFORMANCE MEASUREMENT IN COES

Interviewees described performance and reporting arrangements that could be difficult to apply during insecurity, displacement, or disruption of routine services. They emphasized the value of reaching populations who would otherwise receive no care and maintain services during crises. These interviews preceded the August 2026 OPN and should not be read as evidence that its subsequent implementation has failed.

The author proposes examining whether grant-level indicators and narrative assessment distinguish delivery weaknesses from documented operating constraints, while retaining accountability for what programs can achieve reasonably. Subnational and population-specific analysis can help identify service gaps that national totals may conceal.

BOX 5. PERFORMANCE AND SURVEILLANCE DURING SEVERE DISRUPTION

Interviewees in relation to Sudan and Yemen described tensions between reporting, assurance and delivery in insecure settings. They raised concerns about limited access for verification and the coverage implications of some delivery choices. These are accounts of operational constraints, not independently quantified findings about the proportion of assurance activities cancelled. The August 2026 OPN provides options for adapting assurance where conventional access is restricted. The practical task is to select, resource and document appropriate verification while protecting service access.[2]

Gaza illustrates the importance of interpreting low-reported HIV diagnoses alongside the availability of testing, treatment and follow-up. Majka and Abuzerr describe disruption of those functions and the resulting loss of visibility of HIV-related needs.[16] The author of this brief proposes prioritizing confidential testing, continuity of antiretroviral treatment, emergency commodity access, and restoration of minimum reporting, with action based on current needs assessments rather than reported diagnoses alone.

The OPN differentiates performance expectations by context: in protracted crises, targets should remain ambitious; however, acute or volatile conditions call for realistic expectations. In acute emergency settings, the Country Team may, in consultation with the relevant disease advisors, focus reporting on selected relevant indicators. The remaining indicators are deactivated for the relevant period and do not affect the grant rating. These provisions accompany context-sensitive monitoring and analysis of service continuity.[2] The author proposes complementing them with a small set of clearly defined continuity and recovery measures wherever useful. Measures should reflect the context and replace unnecessary reporting rather than add burden. Any common indicator should be tested for feasibility and comparability before routine use, preserving accountability for program decisions.

Table 5 sets out the corresponding priority reform, which can be pursued within GC8 using the 2026 OPN.

Table 5. Priority reform areas (PRAs) on performance measurement in COE settings

Recommendation	Primary actor	Supporting actors
PRA8: Apply the Operational Policy Note's context-sensitive performance provisions during Grant Cycle 8 (GC8) and test a small number of useful continuity and recovery measures. Define indicators and denominators clearly, disaggregate where feasible and replace unnecessary reporting rather than add burden.[2]	Secretariat and Country Teams, within approved grant frameworks	Principal recipients (PRs) Eastern Mediterranean Regional Committee (EMRC) World Health Organization Eastern Mediterranean Regional Office (WHO EMRO) (technical standards)
Supporting action: Shared action supporting PRA8. Strengthen national and subnational data systems for service continuity and population-specific reporting. Member States lead; World Health Organization (WHO) provides technical support and the Global Fund assesses eligible Resilient and Sustainable Systems for Health financing.	Member States (Ministry of Health)	WHO EMRO Global Fund Secretariat (enabling)

Regional mechanisms: Can mechanisms such as the MER grant provide a more systematic model for addressing cross-border and displacement-related disease risks?

QUALITATIVE ADJUSTMENT AND TRANSPARENCY

The Board approves the allocation methodology. For GC8, the Strategy Committee was tasked with approving the qualitative-adjustment process, while the Secretariat applies it and reports through the established governance arrangements.[11] The author proposes clearer public explanation of how contextual factors inform QA outcomes, without disclosure of confidential country deliberations or a requirement for fixed numerical weights.

Governance and advocacy routes

EMRC should direct evidence on operating costs and displacement to the allocation and QA review processes. Requests concerning eligibility, transition, co-financing, classification, or grant management should also be pursued through the policy bodies and approval routes responsible for those subjects. Allocation QA should not be presented as the source of authority for all such decisions.

Fragility considerations under GC8

The August OPN bases COE classification primarily on a very high External Risk Index. Excluding such a portfolio requires strong Country Team justification; acute or post-crisis settings may also be added. The Executive Grant Management Committee approves the list for each grant cycle and reviews it annually.[2] That process should be distinguished from the qualitative judgment used to adjust allocations. Both can draw on contextual evidence, but they have different purposes and decision routes.

Secretariat interviewees reported greater attention to conflict, implementation costs and displacement in the GC8 QA process. They described a contextual judgment rather than a fixed fragility multiplier. These accounts identify relevant questions for the review of QA evidence and reporting, but do not independently establish the magnitude or cause of an allocation change.

How contextual evidence informs QA

Formal COE designation, subnational differentiated management, and allocation QA are related but distinct. Evidence that a grant can use a differentiated approach does not immediately show how much its allocation was adjusted. The author proposes reporting that makes the role of contextual evidence easier to understand while preserving the flexibility needed for different operating conditions.

Reported protection of vulnerable settings

Secretariat interviewees described an intention to limit severe allocation reductions in vulnerable settings during GC8. This account helps explain their approach to contextual judgment but does not establish the distributional effect of QA or the adequacy of any grant envelope.

EMRC can contribute to future decisions by assembling comparable cost and service evidence and presenting it through the appropriate governance channels. Interviewees associated constituency engagement with greater attention to displacement and operating constraints, but the evidence reviewed does not isolate the causal effect of that advocacy on allocation outcomes. The brief therefore recommends continued evidence-based engagement without claiming that a particular future allocation result is secured.

Table 6 shows priority areas for reforming QA transparency.

Table 6. Priority reform areas (PRAs) on Qualitative Adjustment (QA) transparency, with shared regional evidence action

Recommendation	Primary actor	Supporting actors
PRA9: Seek clearer explanation of how contextual factors inform QA outcomes, while protecting confidential deliberations. Use existing reporting during GC8 and propose improvements through the GC9 allocation and Strategy Committee QA processes.	Secretariat and Strategy Committee: reporting and QA Board: any methodology change	Eastern Mediterranean Regional Committee (EMRC) and other constituencies: advocacy and evidence
Supporting action: Shared, system-level action (supports PRA1 and PRA9). EMRC, World Health Organization Eastern Mediterranean Regional Office (WHO EMRO) and Member States should explore establishing a regional technical co-ordination mechanism able to generate cost, implementation and operational evidence for qualitative adjustments and fragility-sensitive allocations, with the Global Fund assessing whether existing Resilient and Sustainable Systems for Health or regional grant mechanisms could support it.	EMRC WHO EMRO Member States	GF Secretariat (assessing support options)

Subject to agreement by the participating institutions, this evidence function could be organized as a workstream within the light regional learning arrangement proposed in the companion brief on health innovation.

THE MIDDLE EAST RESPONSE (MER) GRANT AS A REGIONAL APPROACH

The MER grant provides a practical example of regional programming for settings affected by conflict and displacement. Interviewees described its contribution to continuity of care, co-ordination, and the movement of commodities across borders. These accounts support examining what can be learned from existing practice, including the conditions under which it works and the evidence available on results.

The COE OPN cites the Middle East regional grant as an example of a regional management arrangement.[2] The author proposes using that experience to inform grant design, with attention to service needs, governance, delivery capacity and cost. Features appropriate to one corridor or implementation period should be properly assessed before being extended elsewhere.

The Global Fund's published account describes the launch of MER in 2017 and the consolidation of regional programs under a platform implemented by the International Organization for Migration. Its early grants supported services in

conflict-affected settings and for displaced populations in neighboring countries. This documented experience provides a basis for assessing the mechanism's future role; its geographic and disease coverage varies by grant period.[17]

Stakeholders described practical strengths and continuing concerns about governance, financing and sustainability. Table 7 summarizes those accounts and the author's proposed responses, including options under PRA10. PRA10 has two core elements: documenting MER governance, resource allocation, delivery results, costs and continuity of care; and using that evidence to inform future decisions. The options in Table 7 are illustrative ways of taking PR10 forward, to be prioritized in light of that evidence. They are not additional headline recommendations or an independent evaluation of MER impact.

Table 7. MER experience and options under priority reform area PRA10

Area	Evidence and interpretation	Options under PRA10
Strategic role	The Global Fund's published account documents Middle East Response (MER) as a regional program implemented through International Organization for Migration. Interviewees described the value of co-ordinated delivery in fragile settings.[17]	Assess a more predictable regional mechanism using evidence on needs, results, costs and feasible delivery arrangements.
Cross-border continuity	Interviewees cited movement of commodities and continuity arrangements across participating settings as operational advantages. These accounts do not establish comparative effectiveness across all corridors.	Assess stock-sharing, referral and buffer-stock options, with government agreements, safeguards and the required financing permissions.
Governance and representation	Interviewees raised concerns about community and country participation in oversight. The Operational Policy Note expects inclusive and participatory engagement in exceptional non-Country Co-ordinating Mechanism arrangements, to the extent possible.[2]	Clarify the role and accountability of the Technical Support Group and strengthen appropriate country, community and key-population participation.
Allocation predictability	Interviewees sought clearer explanations of how resources are distributed within the regional mechanism and how this affects service planning.	Explain allocation parameters and distribution criteria at an appropriate level, while preserving operational flexibility and confidentiality.

Area	Evidence and interpretation	Options under PRA10
Operational innovation	Interviewees described opportunities for co-ordinated introduction of TB diagnostics and treatment innovations. Individual deployment and performance claims require program-specific evidence.	Assess appropriate technologies against country needs, delivery capacity and implementation evidence, with monitoring of uptake and results.
Cross-disease flexibility	Combining disease components in one grant does not automatically authorize transfers between their allocations.[2] The January 2026 malaria decision concerns limited allocation-stage flexibility during QA.[18]	Examine any proposed implementation-level transfer authority separately, specifying the competent decision-maker, limits, safeguards, and reporting route.
Emergency response and longer-term systems	Published MER experience combines service delivery in crises with support to continuing disease programs.[17]	Assess how regional arrangements can support preparedness and continuity across cycles, subject to financing and policy decisions.
Financing adequacy	Interviewees considered the available envelope insufficient for some reported needs. No independent costing of the full regional mandate is presented here.	Review needs, delivery costs, coverage, and available resources before proposing changes to the envelope.
Management and localization	Interviewees raised questions about management and co-ordination costs. Cost-sharing alone does not establish inefficiency or the feasibility of national takeover.	Develop a phased localization plan where capacity and accountability arrangements support it, comparing full costs and service requirements.
Replication	MER offers an experience that other regional arrangements may learn from; transferability depends on context.	Assess whether comparable approaches are appropriate elsewhere, drawing on documented results, operating conditions and governance requirements.

The Secretariat, working with participating countries, International Organization for Migration and other implementing partners, should document the MER's governance arrangements, including:

- The participation of national programs and affected communities.
- How resources are allocated across participating settings.
- Delivery results and costs.
- Continuity of care for people moving between countries.

This documentation should be used to assess the mechanism's effectiveness, costs and transferability before any expansion or replication is proposed. Participating partners should agree on their respective responsibilities and set them out clearly. EMRC should use this evidence to inform constituency positions on more predictable planning across grant cycles. Any extension of MER financing, or any new authority to transfer funds between disease allocations, would remain subject to the relevant policy, allocation and grant decisions.

PRIORITY REFORM AGENDA

The priority reform agenda responds to the five policy questions with a list of 10 priority reform areas (PRAs) – see Table 8. The responsible actors and partners are listed here to outline their individual remits.

RESPONSIBLE ACTORS AND PARTNERS

Global Fund Board, Strategy Committee and Secretariat: The Board determines Board-approved policy and allocation methodology; the Strategy Committee has the delegated QA role described in the Grant Cycle 8 (GC8) decision; the Secretariat manages operational guidance and grants within those authorities. Specific changes must follow the decision route governing the relevant instrument.[2,11,13]

EMRC and other Global Fund constituencies: Assemble evidence, develop proposals and pursue advocacy through the appropriate Board, committee, and Secretariat processes, including the GC9 allocation and QA reviews. Support cross-country learning and explain regional implementation experience.

Member States: Lead domestic financing, regulatory reform, national surveillance, inclusion of displaced populations, national procurement and the financing and contracting arrangements needed to sustain community services. Government agreements are essential for cross-border co-operation.

WHO EMRO and regional technical partners. Support technical standards, surveillance, evidence generation, regulatory co-operation and implementation capacity within their mandates.

Humanitarian and development partners: Support implementation in settings with restricted access, service continuity across borders, logistics and the transition toward feasible national and local delivery arrangements.

Actions requiring Member State leadership are retained as supporting, system-level actions. The Global Fund can enable, incentivize, finance, or facilitate those actions within its mandate, while countries remain responsible for domestic financing, national systems and government agreements.

Table 8 lists only the 10 headline reforms; the supporting actions in Tables 2, 3, 4, 5 and 6, and the MER options in Table 7 are means of implementing them, not additional recommendations.

Table 8 distinguishes implementation under existing rules from proposals that require separate policy decisions.

Table 8. Priority reform areas (PRAs) and institutional responsibilities

Reform	Global Fund	Eastern Mediterranean Regional Committee (EMRC) and constituencies	Member States and partners	Window
PRA1: Improve evidence on Challenging Operating Environments (COE) operating costs in allocation and qualitative adjustment (QA)	Secretariat develops comparable evidence; Strategy Committee (SC) considers QA; Board considers methodology changes	Assemble regional evidence and advocate through Grant Cycle 9 (GC9) review	Countries, principal recipients (PRs) and technical partners contribute comparable cost and service data	GC9
PRA2: Apply differentiated budgeting and delivery	Country Teams and managers define the approach; flexibilities follow applicable approval routes	Share experience and monitor uptake	Countries and PRs implement feasible delivery and localization arrangements with safeguards	GC8
PRA3: Address specific spillover pressures	Assess current permissions and gaps. Further QA, methodology or classification changes follow their responsible decision routes.	Develop the evidence case for host and transit settings	Countries lead inclusion in national plans; International Organization for Migration (IOM) and partners support population and service evidence	GC8 options; GC9 proposals
PRA4: Strengthen cross-border continuity of care	Assess financing within the Operational Policy Note conditions and other applicable rules	Convene relevant countries and support learning	Countries lead agreements and data safeguards; partners deliver referrals and follow-up.	GC8 and GC9
PRA5: Review transition risks after material shocks	Assess current options. Board considers proposals requiring eligibility, transition or co-financing policy changes.	Document cases and advance policy proposals	Health and finance ministries provide readiness evidence and revised financing plans; communities contribute service priorities.	GC8 options; GC9 policy review

Reform	Global Fund	Eastern Mediterranean Regional Committee (EMRC) and constituencies	Member States and partners	Window
PRA6: Protect community and key-population services	Review grant-level continuity safeguards; Board considers any wider policy change.	Monitor service risks and support advocacy	Countries lead domestic financing and social contracting; communities define access needs.	GC8 and GC9
PRA7: Pilot proportionate readiness assessment	Consider whether a time-limited pilot is feasible. Financing and policy changes require separate authorization.	Develop the proposal and review learning	Countries, partners and communities agree measures, verification and follow-up responsibilities	GC8 pilot if agreed; GC9 learning
PRA8: Improve continuity and recovery measurement	Apply OPN provisions and test measures within approved grant frameworks	Share portfolio learning	Countries strengthen data; World Health Organization supports technical definitions and feasibility	GC8
PRA9: Explain the role of contextual factors in QA	Secretariat reports: Strategy Committee considers QA reporting improvements; Board considers methodology changes	Advocate for clearer explanation while protecting confidentiality	Countries and partners support the quality of evidence	GC8 reporting; GC9 review
PRA10: Strengthen Middle East Response governance and predictability	Review governance, results, costs and grant arrangements. Future financing and transfer authority follow relevant decisions.	Support inclusive governance and evidence-based proposals	Countries, IOM, communities, and partners strengthen delivery, accountability and feasible localization	GC8 and GC9

CONCLUSION

Health programs in the Eastern Mediterranean Region operate under differing combinations of conflict, displacement, economic instability and climate shocks. These conditions affect access, delivery costs and continuity of care alongside domestic policy choices, program quality and health financing. The region therefore provides a useful setting in which to examine how the Global Fund's existing Challenging Operating Environments (COE) principles work across the grant life cycle.

The August 2026 OPN responds to several concerns raised during the interviews, and creates an immediate basis for more consistent use of differentiated approaches. The next task is to apply and assess those provisions under their stated conditions. The evidence reviewed does not establish their subsequent implementation or effect. The remaining policy agenda concerns the adequacy and predictability of resources, recognition of sustained spillover pressures, and transition decisions informed by service readiness and material changes in context.

The 10 priority policy reform areas distinguish Grant Cycle 8 (GC8) operational opportunities from proposals for GC9 and other policy reviews. Allocation and QA proposals should follow the relevant Board and Strategy Committee processes. Transition, eligibility and co-financing changes need their own decision routes. Member States retain responsibility for domestic financing, national systems, and cross-border agreements, supported by the Global Fund, World Health Organization and other partners within their respective roles.

The Middle East Response experience offers practical lessons for continuity of care, inclusive governance and regional co-ordination. Those lessons should be documented and used to improve grant design and planning, while the mechanism's effectiveness, costs and transferability are assessed. More predictable support, or new authority to transfer resources between disease allocations, should be considered explicitly through the appropriate mechanisms.

The purpose of the proposed reforms is to make existing COE principles more dependable in practice while maintaining accountability and protecting essential services. Together with the companion brief on health innovation, this priority reform agenda links operational resilience to the capacity to sustain and improve equitable access to HIV, TB, and malaria programs.

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APPENDICES

APPENDIX 1. METHODOLOGY

The two policy briefs were developed through a structured, purposive literature review and qualitative interviews. This appendix describes the methods and the limitations relevant to interpretation of the findings.

Literature review

The review informed two complementary policy briefs: *The Global Fund in Challenging Operating Environments*; and *Health innovations for HIV, TB, and Malaria*. It covered disease epidemiology, Global Fund policies and financing, operating constraints, and adoption of innovation.

Two literature searches used concept blocks covering diseases, geography, operating context, policy and innovation. Sources included PubMed, Cochrane Library, Google Scholar, and Google, complemented by targeted searches of World Health Organization (WHO) and Global Fund resources. References were made using the Zotero app. The review record reports that all PubMed and Cochrane results and the first 100 results from each Google and Google Scholar search were transferred for screening. English, Arabic and French documents were considered, with a focus on the preceding 10 years.

Appendix 2 summarizes the search concepts. The two briefs use the same epidemiological sources: WHO's July 2026 HIV information sheet, *Global Tuberculosis Report 2025* and *World Malaria Report 2025*, with the cited 2026 WHO regional updates.[5,7–10] Non-public allocation and grant documents informed the analysis but are not reproduced.

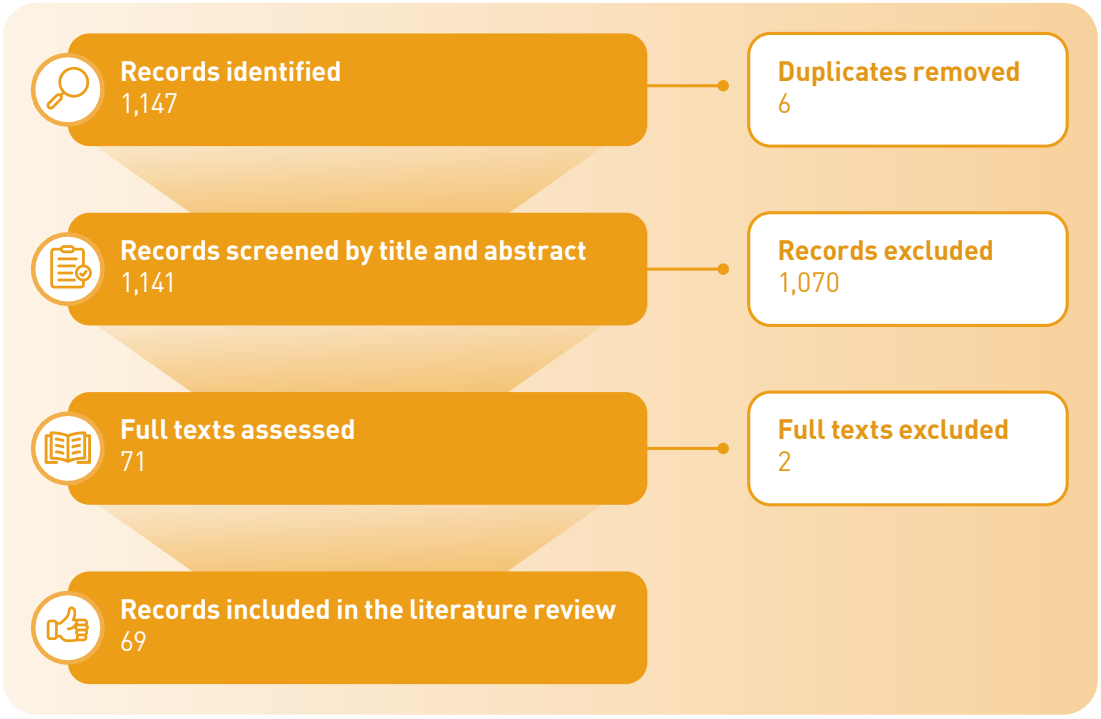
Titles and abstracts were screened for relevance, followed by review of selected full texts. Institutional and peer-reviewed material was selected for its contribution to the policy questions. The approach prioritized relevance and applicability rather than exhaustive identification of every study.

Figure A1 presents the author-reported aggregate selection counts for joint literature review. Supplementary institutional and policy sources informed the analysis and are outside these selection counts.

Selected material was synthesized thematically across epidemiology, Global Fund policy, Challenging Operating Environments (COE) operations, innovation adoption, and cross-cutting health system issues.

The purposive approach may omit lower-visibility publications and program reports. Documentary findings were considered alongside interviews, with disagreements and differences in evidence type retained in interpretation.

Figure A1. Selection flow for the literature review



Source: Author-reported aggregate counts for the joint review of the paired briefs. Additional stakeholder documents informed the qualitative analysis.

Key informant interviews

Participants

A total of 23 key informants were invited to participate in the study, of whom 19 completed interviews. Four individuals could not be reached despite repeated follow-up. Participants were purposively selected to ensure representation across the key institutional actors relevant to Global Fund programming in the Eastern Mediterranean Region. The sample spanned the five categories shown in Table A1.

Table A1. Interview sample by institutional category

Institutional category	Completed interviews	Position
Eastern Mediterranean Regional Committee and Global Fund governance representatives	2	• Eastern Mediterranean Regional Committee (EMRC) Board Member, SC Member & Vice-Chair of Implementers Group
Country technical partners	2	• Sudan – WHO Technical Officer, Malaria • Morocco – UNAIDS Country Director
Global Fund Secretariat	10	• GMD MENA/SEA Regional Manager • FPM (Middle East Response) • Head of Health Finance Department • Head of Africa & Middle East • Health Product Manager, Africa & Middle East • Senior FPM, West & Central Africa / Middle East • Middle East Lead, Donor Relations • Manager, Implementation & COE Team • Senior Specialist, New Health Products In-country Introduction • Advisor, Strategy and Policy Hub
World Health Organization Eastern Mediterranean Regional Office	2	• Regional Malaria Adviser • Regional Adviser, Integrated Disease Surveillance
Implementing partners	3	• Senior Regional Project Coordinator, Middle East Response – IOM • Senior Technical Officer, MC-MENA – EMPHNET • Pakistan – TB Private Sector PR (Mercy Corps)
Total	19	

Interview tool and topic guides

Structured topic guides were developed specifically for this study based on the evidence gaps systematically identified during the literature review phase. The gaps spanned three thematic clusters – COE policy and governance, innovation adoption and health system readiness, and data and digital health – and were translated into focused interview probes designed to elicit experiential, institutional, and contextual knowledge not accessible through the published and grey literature. The topic guides were tailored by respondent category to reflect the specific mandate and vantage point of each stakeholder group, ensuring relevance and depth across the diverse sample. Semi-structured interviews were conducted in English, Arabic and French, according to each participant's preference, to facilitate open and authentic engagement. All interviews were conducted remotely and, following the obtaining of informed consent from each participant, were recorded to enable full and accurate transcription. One key informant declined to have their interview recorded; in this case, detailed notes were taken by the interviewer during the session to ensure the integrity of the data. All recorded interviews were subsequently transcribed in full, and transcripts in Arabic and French were translated into English prior to analysis, ensuring a unified and comparable dataset across the entire corpus.

Analysis: Thematic coding and policy synthesis

Thematic analysis was conducted using a deductive coding framework anchored in the structured evidence gaps identified in the literature review. Each transcript and interview note was systematically coded against these pre-defined thematic categories. This coding process allowed the analytical team to map interview findings directly onto the structural gaps informing the policy reform agenda. The outputs of the thematic coding informed both the findings sections and the policy recommendations of each brief, ensuring that the recommendations are grounded in stakeholder-validated evidence rather than literature alone.

Triangulation

Findings from the key informant interviews were systematically triangulated with the evidence synthesized through the structured literature review. Where interview data confirmed, extended, or nuanced the documentary evidence, this convergence was treated as a basis for stronger policy recommendations. This triangulation approach strengthened the analytical rigor of both policy briefs and ensured that recommendations reflect the interplay between global evidence and regional operational realities.

Factual check

Upon completion of the analysis, first drafts of both policy briefs were prepared and circulated to WISH, EMRC leadership, Audit and Finance committee representative, WHO EMRO and Global Fund Secretariat for technical review. Reviewers were asked to assess the briefs across four dimensions: factual accuracy, including the correctness of country-level data, allocation figures, policy mechanisms, and institutional descriptions; evidentiary sufficiency, including whether claims are adequately supported by cited evidence and whether additional published or operational evidence would strengthen or challenge the analysis; operational fidelity, meaning whether the briefs accurately reflect realities at program and

governance level; and omissions or sensitivities, including whether significant issues have been missed or whether any material requires careful handling ahead of dissemination.

This consultation process was completed in June 2026, and the feedback received was incorporated into the final versions.

Technical review

Technical input was obtained from WISH, EMRC leadership, an Audit and Finance Committee representative, WHO EMRO and Global Fund stakeholders. This information addressed accuracy, evidence, operational relevance and omissions. The analysis incorporates the Operational Policy Note on Challenging Operating Environments, approved on 26 August 2026. Consultation does not imply endorsement of the analysis or recommendations.

Ethics, confidentiality and limitations

Non-public documents and interview data

Several non-publicly available documents were received from stakeholders for analytical purposes, including GC8 allocation letters and internal Global Fund documents covering countries and grants across the EMR. These materials were used exclusively to inform the analysis and are not reproduced in full in either policy brief. With respect to primary data, all key informant interview data were used in aggregate and in anonymized form throughout the analysis and reporting. No attribution of views or statements to individual participants was made without their explicit prior consent, in accordance with the confidentiality commitments extended to all interviewees at the time of recruitment and consent.

Data currency

Both briefs use a common WHO epidemiological baseline: 2025 HIV estimates published in July 2026, and 2024 TB and malaria estimates from the 2025 global reports and cited 2026 regional publications.[5,7–10] The evidence base includes stakeholder material received between March and May 2026 and policy and epidemiological sources available by October 2026, including the COE OPN approved on 26 August 2026. Publication dates and data years are distinct. Estimates may be revised retrospectively, so trend comparisons should use one consistent release. Interview findings describe conditions and views at the time of consultation.

Limitations

The review was purposive and may not capture all national, program or non-indexed evidence. Non-public documents and interviews reflect the periods in which they were obtained. This brief does not present an independent audit of country cost estimates or allocation outcomes, nor an evaluation of implementation after the August 2026 OPN. Quantitative claims are therefore tied to their stated source, period, and population, while interview accounts remain explicitly attributed.

The purposive interview sample leaves gaps in perspectives. National governmental stakeholders were not systematically included, and key populations and community-based actors directly affected by programming were not represented in the interviews. These omissions limit claims about country-wide readiness or stakeholder consensus and support broader participation in any follow-up policy or pilot design.

Affiliation with the Global Fund or its implementing partners may have affected how participants described institutional practice. Anonymization and semi-structured interviews reduced but could not eliminate social desirability bias or self-censorship.

Interviews capture views at a particular point in time. Because they preceded the August 2026 OPN, they identify concerns relevant to its implementation but cannot establish its subsequent effects.

APPENDIX 2. SEARCH STRATEGY TABLES

Tables A2 and A3 summarize the concept blocks and illustrative combinations in the search protocol for the paired briefs. They are not completely executable database strategies. Middle East and North Africa (MENA) and other broad regional terms were used to locate relevant literature; this brief distinguishes their geographic coverage from the World Health Organization Eastern Mediterranean Regional Office (WHO EMR).

Table A2. Challenging Operating Environments (COE) search strategy

Concept block	Index terms in the review protocol	Keywords and free text	Search string block
Diseases	"HIV"[Mesh]; "Acquired Immunodeficiency Syndrome"[Mesh]; "Tuberculosis"[Mesh]; "Malaria"[Mesh]	HIV, AIDS, tuberculosis, TB, malaria	("HIV" OR AIDS OR tuberculosis OR TB OR malaria)
Geography Eastern Mediterranean Region (EMR)	—	EMR, MENA, Middle East, North Africa + countries	("Eastern Mediterranean" OR "Middle East" OR "North Africa" OR MENA OR EMR OR Lebanon OR Syria OR Yemen OR Sudan OR Pakistan OR Afghanistan)
Epidemiology / burden	"Epidemiology"[Mesh]; "Disease Outbreaks"[Mesh]	epidemiology, incidence, prevalence, trends	(epidemiology OR incidence OR prevalence OR trends)
Conflict / fragility	"Armed Conflicts"[Mesh]; "War"[Mesh]; "Fragile States"[Mesh]	conflict, war, fragility, crisis, instability	(conflict OR war OR fragility OR crisis)
Displacement	"Refugees"[Mesh]; "Displaced Persons"[Mesh]	refugees, displacement, migration	(refugees OR displacement OR migration)
Climate shocks	"Climate Change"[Mesh]	climate change, drought, floods, shocks	("climate change" OR drought OR floods OR shocks)
Health system impact	"Health Services Accessibility"[Mesh]; "Delivery of Health Care"[Mesh]; "Health Policy"[Mesh]; "Financing, Government"[Mesh]	access, coverage, service delivery, health system, financing, cost, resilience	(access OR coverage OR "service delivery" OR "health system" OR financing OR cost OR resilience)
Global Fund / Challenging Operating Environments (COE) policy	—	Global Fund, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), COE, challenging operating environments, health systems strengthening	("Global Fund" OR GFATM OR COE OR "challenging operating environments" OR "health systems strengthening")

Table A3. Innovation search strategy

Concept block	Index terms in the review protocol	Keywords and free text	Search string block
Diseases	"HIV"[Mesh]; "Acquired Immunodeficiency Syndrome"[Mesh]; "Tuberculosis"[Mesh]; "Malaria"[Mesh]	HIV, AIDS, tuberculosis, TB, malaria	("HIV" OR AIDS OR tuberculosis OR TB OR malaria)
HIV: Long-acting PrEP	"Pre-Exposure Prophylaxis"[Mesh]; "Anti-HIV Agents"[Mesh]	long-acting PrEP, cabotegravir, CAB-LA, lenacapavir, injectable PrEP	("long-acting PrEP" OR cabotegravir OR "CAB-LA" OR lenacapavir OR "injectable PrEP")
HIV: Self-testing	"Self Testing"[Mesh]; "HIV Infections/diagnosis"[Mesh]	HIV self-testing, self-test kits, community testing	("HIV self-testing" OR "self-test" OR "self testing kits")
TB: Artificial intelligence (AI) detection	"Artificial Intelligence"[Mesh]; "Tuberculosis/diagnosis"[Mesh]; "Radiography"[Mesh]	AI-CAD, computer-aided detection, AI TB screening, digital radiology	("AI-CAD" OR "computer aided detection" OR "AI TB screening")
TB: DR-TB treatment (BPaLM)	"Tuberculosis, Multidrug-Resistant"[Mesh]; "Drug Therapy"[Mesh]	BPaLM, BPaL, DR-TB short regimen, treatment simplification	(BPaLM OR BPaL OR "short DR-TB regimen")
Malaria: Vaccines	"Malaria Vaccines"[Mesh]	RTS,S, R21, malaria vaccine	("malaria vaccine" OR RTS,S OR R21)
Malaria: Urban transmission	"Malaria/transmission"[Mesh]; "Mosquito Vectors"[Mesh]	urban malaria, Anopheles stephensi, urban transmission	("urban malaria" OR "Anopheles stephensi")
Malaria: Vector control (optional)	"Insecticide-Treated Bednets"[Mesh]	next-generation ITNs, dual insecticide nets	("next generation ITN" OR "dual insecticide nets")
Innovation (general)	"Medical Innovation"[Mesh]; "Biomedical Technology"[Mesh]	innovation, health innovation, new technologies	(innovation OR "health innovation")
Digital / AI (cross-cutting)	"Telemedicine"[Mesh]; "Artificial Intelligence"[Mesh]	digital health, AI, telemedicine	("digital health" OR telemedicine OR "artificial intelligence")

Concept block	Index terms in the review protocol	Keywords and free text	Search string block
Adoption / implementation	"Delivery of Health Care"[Mesh]; "Health Policy"[Mesh]	implementation, adoption, scale-up, integration	(implementation OR adoption OR "scale-up" OR integration)
Regulation	—	regulation, regulatory, approval, WHO prequalification	(regulation OR regulatory OR approval)
Financing / market shaping	"Health Care Costs"[Mesh]; "Financing, Government"[Mesh]	financing, affordability, procurement, pricing, pooled procurement	(financing OR affordability OR procurement OR pricing OR "pooled procurement")
Local production / positioning	—	local manufacturing, generics, technology transfer, South-South collaboration	("local manufacturing" OR generics OR "technology transfer" OR "South-South collaboration")
Geography Eastern Mediterranean Region (EMR)	—	EMR, MENA, Middle East, North Africa + countries	("Eastern Mediterranean" OR MENA OR EMR OR Lebanon OR Pakistan OR Sudan)
Challenging Operating Environments (COE) / Fragility context	"Fragile States"[Mesh]; "Refugees"[Mesh]; "Climate Change"[Mesh]	conflict, fragility, war, displacement, migration, climate shocks, drought, floods	(conflict OR fragility OR displacement OR "climate change" OR drought OR floods)

ABBREVIATIONS

AI	artificial intelligence
BPaLM	Bedaquiline-Pretomanid-Linezolid-Moxifloxacin
CAD	computer-aided detection
COE	Challenging Operating Environment
DR-TB	drug-resistant tuberculosis
EMR	Eastern Mediterranean Region
EMRC	Eastern Mediterranean Regional Constituency
FPM	Fund Portfolio Manager
GC8	Grant Cycle 8
GC9	Grant Cycle 9
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
IOM	International Organization for Migration
ITN	insecticide-treated net
MENA	Middle East and North Africa
MER	Middle East Response
OPN	Operational Policy Note
PR	principal recipient
PRA	priority reform area
PrEP	pre-exposure prophylaxis
QA	qualitative adjustment
TB	tuberculosis
WHO	World Health Organization
WHO EMRO	World Health Organization Eastern Mediterranean Regional Office
WISH	World Innovation Summit for Health

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