Strategy, Investment and Impact Committee

DRAFT Framework of Allocation 2017-2019

GF/SIIC16/09
Committee Information
Geneva, Switzerland
5 – 7 October 2015

Purpose of the paper: This paper presents the Strategy, Investment and Impact Committee (SIIC) with an overview of the allocation model, lessons learned over the 2014 – 2016 allocation period, and areas for consideration as the SIIC reviews current policies and prepares recommendations to the Board for the 2017 – 2019 allocation period.

I. Past Relevant Decisions

1. The following summary of relevant past Board and Committee decision points is submitted for background information and context.

Relevant past Decision Point	Summary and Impact
GF/B31/DP10: Composition of and Allocation to Country Bands (March 2014)[1]	Based on the recommendations of the SIIC, the Board approved: (i) the composition of four country bands for the 2014 – 2016 allocation period; (ii) the indicative amounts of funding allocated to each band; and (iii) the amount of incentive funding available for country bands 1, 2 and 3.
GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period (March 2014)[2]	Based on the recommendations of the FOPC and SIIC, the Board approved the total amount of funds to be allocated to country bands (the "Total Allocation"). It also approved, to account for the shift from the rounds-based system to the allocation-based funding model, establishing the minimum required level as the greater of: (i) a 25-percent target reduction of a country-component's most recent available four-year disbursements; or (ii) a country component's existing grants pipeline as at 31 December 2013.
GF/B31/DP07: Regional Programs (March 2014)[3]	Based on the recommendation of the SIIC, the Board approved US$200 million for new Regional Programs over the 2014 – 2016 allocation period, noting and distinguishing that multi-country applications would be funded through their constituent countries' allocations.
GF/B31/DP06: Special Initiatives (March 2014)[4]	Based on the recommendation of the SIIC, the Board decided that up to US$100 million would be available over 2014 – 2016 for a specified list of special initiatives, including potential reallocation of funding across the approved special initiatives upon the approval of the SIIC, in consultation with the FOPC.
GF/B30/DP05: Revision of the Policy on Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals for Funding from the Global Fund (March 2014)[5]	Based on the recommendation of the SIIC, the Board approved the amended Eligibility and Counterpart Financing Policy, which sets minimum thresholds for counterpart financing requirements for all applicants of funding.
GF/SIIC09/DP01: Indicators for the Allocation Formula and the Band 4 Methodology (October 2013)	Under authority delegated by the Board, the SIIC approved the following parameters for the 2014 – 2016 allocation: (i) indicators for disease burden and ability to pay; (ii) allocation methodology for Band 4 (i.e., countries with higher income and lower disease burden); and (iii)

[1] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP10/
[2] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP09/
[3] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP07/
[4] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP06/
[5] http://www.theglobalfund.org/Knowledge/Decisions/GF/B30/DP05/

Relevant past Decision Point	Summary and Impact
	maximum and minimum shares for apportioning indicative funding to countries.
GF/SIIC09/DP02: Management of Incentive Funding and Unfunded Quality Demand (October 2013)	Under authority delegated by the Board, the SIIC approved the process and methodology for awarding incentive funding as well as prioritizing and awarding potential funding for unfunded quality demand.
GF/B29/EDP11: Revising the distribution of funding by disease in the new funding model allocation methodology (October 2013)[6]	Based on the recommendation of the SIIC, the Board approved, for the 2014 – 2016 allocation period, the apportionment of resources available for allocation to country bands among the three diseases based on the following distribution: 50 percent for HIV/AIDS, 32 percent for malaria, and 18 percent for tuberculosis. The Board directed the Secretariat to ensure integrated TB/HIV services are addressed in the country dialogue and concept note development process for countries with high TB/HIV co-infection rates. Furthermore, the Board requested the SIIC to review this decision to develop and recommend appropriate modifications to the Board prior to the 2017 – 2019 allocation period.
GF/B29/EDP10: Division between Indicative and Incentive Funding (October 2013)[7]	Based on the recommendation of the SIIC, the Board approved the method for determining the amount of incentive funding available for the 2014 – 2016 allocation period as well as a minimum required level of funding in the form of a graduated reduction that would be applied to the country components receiving funding above their formula-derived amounts, and deemed those country components receiving more than 50 percent above their formula-derived amounts ineligible for incentive funding. Furthermore, the Board requested the SIIC to review this decision to develop and recommend appropriate modifications to the Board prior to the 2017 – 2019 allocation period.
GF/B28/DP04: Evolving the Funding Model (Part Two) (November 2012)[8]	Based on the recommendation of the SIIC, the Board approved: (i) the alignment of three-year allocation periods with three-year replenishment periods; (ii) the principles for determining and composing country bands; (iii) the principles for allocating to country bands based on ability to pay and disease burden; (iv) the purpose and principles of indicative and incentive funding, as well as unfunded quality demand; and (v) the existence and role of certain indicative qualitative factors that could adjust the results of the allocation formula, including "willingness-to-pay". Furthermore, the Board requested the regular review of the key elements decided prior to each allocation period.
GF/B27/DP07: Evolving the Funding Model (September 2012)[9]	Based on the recommendation of the SIIC, the Board adopted the principles for key elements of the allocation-based funding model, including a ceiling of 10 percent of the resources available for allocation that could be used

[6] http://www.theglobalfund.org/Knowledge/Decisions/GF/B29/EDP11/
[7] http://www.theglobalfund.org/Knowledge/Decisions/GF/B29/EDP10/
[8] http://www.theglobalfund.org/Knowledge/Decisions/GF/B28/DP04/
[9] http://www.theglobalfund.org/Knowledge/Decisions/GF/B27/DP07/

Relevant past Decision Point	Summary and Impact
	for programs or strategic investments outside of the allocation to country bands, and requested the SIIC to work further towards evolving the funding model.

II. Executive Summary

2. In 2014 the Global Fund moved from a rounds-based system of financing to an allocation- based model in order to reach more people affected by the diseases, increase overall impact and improve overall health outcomes.

3. The Global Fund is currently half way through the implementation of the 2014-2016 allocation with approximately half of the total allocation approved by the Board and signed into disbursement ready grants.

4. The current allocation model has enabled the Global Fund to more strategically invest resources through a formula-driven methodology in countries with the highest burden of disease and the least economic capacity.

5. Noting that no single formula will be able to address all the complexities of global health, the potential modifications presented in this paper attempt to address key areas of Board concern, including ensuring sustainable financing for countries with the highest burden of disease and least economic capacity, and ensuring concentrated epidemics, human rights, key and vulnerable populations, and disease elimination in low-burden settings are appropriately addressed.

6. When approving the different elements of the allocation model, the Board requested that prior to the 2017-2019 allocation period, the Strategy Investment and Impact Committee (SIIC) review the allocation model and propose appropriate modifications to the Board for approval.

7. The timing of the next allocation period (2017-2019) will coincide with the new strategy of the Global Fund (2017-2021) and the draft strategic framework provides direction for potential modifications to the existing allocation model.

8. The paper presents the SIIC with current policies and options for consideration with respect to 1) the methodology for country allocations; 2) methodology beyond country allocations; and 3) Board approval of allocations across country groupings.

9. The options and considerations presented include maintaining current policies to potential refinements and enhancements that avoid radical change but may further focus investments and achieve maximum impact to accelerate the end of the three epidemics.

III. Introduction

10. The evolution of the rounds-based system to an allocation-based funding model was a major innovation and achievement under the current Global Fund Strategy 2012 – 2016. The 2014 – 2016 allocation enabled the Global Fund to invest more strategically in the countries with the highest burden of disease and least economic capacity in a more predictable, transparent and impactful way. This paper responds to a request from the Board to review the allocation methodology before each allocation period. It presents the Strategy, Investment and Impact Committee (SIIC) with information that can be

used in its decision-making and recommendations to the Board on whether or not to a) evolve the allocation model to better deliver upon the Global Fund's strategic objectives based on challenges experienced and lessons learned from implementation and b) update technical aspects of the allocation methodology according to the latest data and information.

11. The allocation model is a critical mechanism to ensure the Global Fund Strategy translates strategic objectives into real investments to support people, communities and countries to fight the three diseases and improve health. Although it is not yet approved, following extensive consultation under the auspices of the SIIC, there seems to be some consensus around two key sub-objectives of the draft Strategic Framework 2017 – 2021 that provide direction for the allocation model:

12. **Strategic Objective 1: Maximize Impact through Tailored Investments**

a. Scale-up evidence-based interventions for the highest burden countries with the lowest economic capacity and for key and vulnerable populations disproportionately affected by the three diseases

b. Evolve the allocation model and processes for greater impact, including innovative approaches tailored to country needs

13. The core principles including predictability, transparency, and strategic focus that guided the current strategy and allocation remain relevant to achieve the greatest impact and reach the overarching goal of ending the three epidemics.

14. The allocation formula directs funds to countries with the highest disease burden and least economic capacity by using disease burden and an economic measure as the basis for allocation. No single formula can account for all of the complexities of global health. As such, the allocation model also provides for more strategic and focused investments outside of the formula to ensure comprehensive and effective ways to end the epidemics through a variety of programmatic, health systems and advocacy interventions, including to deliver on strategic directives related to gender, human rights and key populations. In this way, a refined allocation model may address not only the size of investments, but also what the Global Fund strategically invests to succeed.

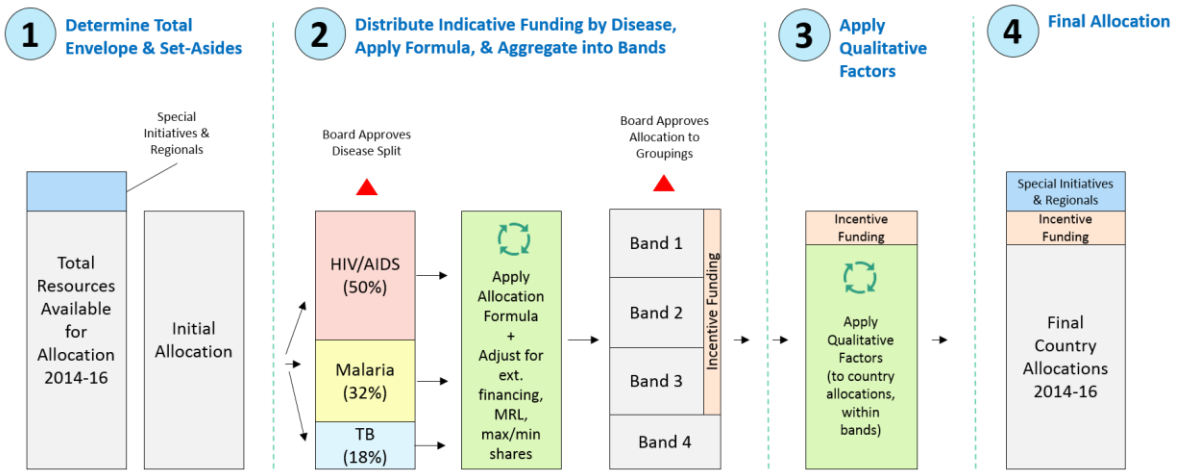
15. To fund ambitious global health impact in countries with the highest burden and lowest economic capacity, and make focused, high-impact investments in countries with concentrated epidemics, gender and human rights barriers, and disease elimination or drug-resistance campaigns, the SIIC could consider key options and choose those that will best deliver on the Global Fund's mission. This paper presents different elements of the allocation model with areas for consideration and options for either maintaining or modifying current policies, while seeking to avoid policies that could result in radical shifts in allocations. Based on the SIIC's direction, further analysis and refinement can be undertaken to enable the SIIC to recommend appropriate modifications or enhancements to the allocation model for Board approval at the first Board meeting of 2016.

IV. Strategic Decisions

16. The Global Fund is still in the first cycle of its allocation-based funding model, with about half of the total 2014-2016 allocation approved by the Board. However, in implementing the model, there have been several lessons learned, analyses conducted and perspectives voiced by stakeholders of the Global Fund through Partnership Fora and in other venues. While very few have suggested fundamental revisions to the allocation model, it is prudent to consider the evidence we do have to continue to improve the allocation model for the future.

17. The following chart illustrates the current allocation model:

Sequence of the 2014-2016 allocation model



18. The key elements of the allocation model can be organized into the following three groups of decisions and approaches that were used for the 2014 – 2016 allocation. They are presented in greater detail in their respective sections of this paper together with lessons learned, options and considerations.

Section 1: Methodology for country allocations

- Global Disease Split
- Allocation by disease burden and income
- Band 4 Methodology
- Minimum Required Level
- Co-Financing Policies

Section 2: Methodology beyond country allocations

- Incentive Funding
- Regional Programs and Special Initiatives

Section 3: Board approval

- Board approval and flexibilities using qualitative-factor adjustment

Section 1: Methodology for Country Allocations

01 Global Disease Split

"As previously agreed by the Board (GF/B27/DP7), to apportion resources to the Country Bands at the start of each allocation period, the Board will first split the total projected resources for a given allocation period between the three diseases."

- Global Fund Board Decision GF/B28/DP04, November 2012

19. In October 2013, based on the recommendation of the SIIC, the Board decided to divide resources first by disease – HIV/AIDS (50 percent), malaria (32 percent), and TB (18 percent). The SIIC agreed on these figures, which were in line with historical spending by the Global Fund, following consideration of independently developed analysis by three expert institutions. When finalizing its

recommendation in July 2013, the SIIC noted that "further technical analyses on the disease split would not bring significant additional clarity to the decision being taken[10]." It was also recognized that while the global disease split set targets, qualitative factors and country flexibility allows for movement of funds across component programs. Clearer communication from the Global Fund to encourage countries to determine the most impactful program split according to their needs could be strengthened going forward.

20. Below is a depiction of how the distribution of funding moved following qualitative factor adjustments and program-level flexibility exercised by countries (Note: joint TB/HIV funding is distributed here by disease; shortened grants are not included in this analysis):

Component	Global Disease Split (Board)	Final allocation[1] Communicated to Countries	Revised Program Split[2] (Country Flexibility)
HIV/AIDS	50.0 percent	52.0 percent	50.3 percent
Malaria	32.0 percent	29.0 percent	27.7 percent
TB	18.0 percent	17.0 percent	17.0 percent
Stand-alone HSS[3]	0.0 percent	1.9 percent	5.0 percent

21. The award of incentive funding provides additional funds that are distributed across the diseases. The distribution of US$803 million of incentive funding that has been awarded through the first six concept note review windows is 31 percent for HIV/AIDS, 33 percent for tuberculosis and 36 percent for malaria.

22. At its June 2015 meeting, the SIIC agreed and directed the Secretariat to provisionally maintain and use the global disease split applied for the 2014 – 2016 allocation for the purposes of modeling and additional analysis that would be used to develop and inform further recommendations related to the allocation model.

02 Allocation by Disease Burden and Income: Disease Burden Indicators

"The formula for apportioning funding to Country Bands will be based on each country's 'ability to pay' (measured by GNI per capita) and disease burden."

- Global Fund Board Decision GF/B28/DP04, November 2012

23. Based on the recommendations of technical partners, the Secretariat presented and the SIIC approved the following disease-burden indicators for the 2014 – 2016 allocation:

[10] CHAIR'S SUMMARY REPORT. GF/SIIC08/15. Geneva, 16-18 July 2013.
[1] Includes allocation for HSS to account for existing HSS grants in certain countries
[2] Includes 87 of 117 countries that have finalized program split; remaining countries are included with communicated split as placeholder.
[3] Please note that countries mainly included HSS (Health System Strengthening) components in disease specific grants. However, in some cases, countries opted to have also a standalone HSS grant.In the new draft strategic framework HSS is now referred to as: Resilient and Sustainable Systems for Health

Parameters for disease burden indicators[11]	Specifications
Estimated HIV burden	[People with HIV] data from 2012 (if not available, then latest year)
Estimated TB burden	[1 * HIV negative TB incident cases], [1.2 * HIV positive TB incident cases], [8 * MDR-TB incidence], and [0.1 * 50 percent of estimated number of people with known HIV positive status] data from 2012 (if not available, then latest year) Note: The TB indicator is based on the assumption that the entire budget for ART for HIV positive TB patients should be included in the HIV budget; all other TB/HIV interventions should be adequately budgeted and shared between both programs.
Estimated Malaria burden	[1 * cases], [1 * deaths], [0.05 * incidence rate], and [0.05 * mortality rate] data from 2000, indicators normalized

24. Review and assessment of these indicators with technical partners indicate the following:

- **HIV**: there is continued support for the current HIV metric. While HIV incidence would be a preferred metric, it is not directly measured and typically derived from modelled data based upon HIV prevalence and is therefore not recommended by technical partners.
- **TB**: the current coefficient for multidrug-resistant TB (MDR-TB) (meant to reflect the relatively higher cost of treating drug-resistant strains) may no longer represent the variance in treatment cost, and therefore should be increased.
- **Malaria**: the use of data from 2000 resulted in countries, which had recently seen significant decreases in burden, receiving sizeable allocations despite limited risk of malaria transmission while some high burden countries were left with critical gaps in LLIN coverage. The use of 2000 data was to account for inherent transmission potential and the risk of resurgence. It is noted however that risk of resurgence cannot be perfectly correlated with historic caseloads and an improved definition of malaria disease burden may be needed. Additionally, the current indicator does not account for support for malaria elimination programs.

25. As such, the following table presents a preliminary view of the updated disease-burden indicators for the 2017 – 2019 allocation:

[11] From "Overview of the Allocation Methodology – The Global Fund's New Funding Model". March 2014

Parameters for disease burden indicators[12]	Specifications
Estimated HIV burden	[People with HIV] data from 2014 (if not available, then latest year)
Estimated TB burden	[1 * TB incidence], [10 * MDR-TB incidence] data from 2014 (if not available, then latest year) Note: The TB indicator is based on the assumption that all interventions for TB and HIV co-infected patients should be included in HIV allocations.
Estimated Malaria burden	[pending]

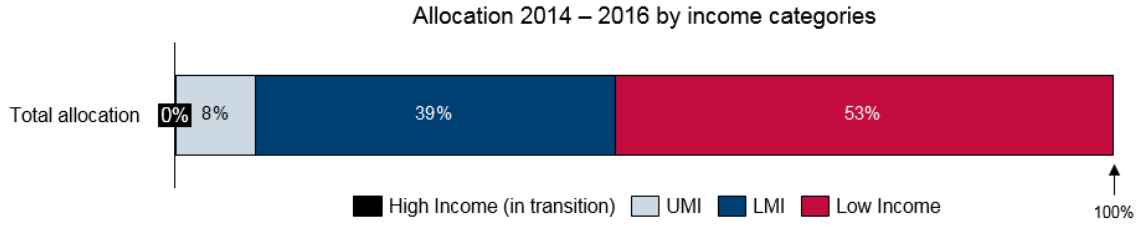
26. The current allocation formula's disease burden indicators do not specifically address the specific needs of countries where epidemics are concentrated amongst, and disproportionately impact on, key populations. The intent of applying a separate methodology for higher income and lower disease burden countries (Band 4) was to approximate this need by population-based floors. Together with evaluating methods for evolving a separate methodology to respond to such needs, review of disease-burden indicators could also consider whether more appropriate indicators for such contexts could be identified for integration into the allocation formula.

03 Allocation by Disease Burden and Income: Country Economic Capacity[13] Indicators (GNI per capita)

"The formula for apportioning funding to Country Bands will be based on each country's 'ability to pay' (measured by GNI per capita) and disease burden."

- Global Fund Board Decision GF/B28/DP04, November 2012

27. The allocation model focuses resources in countries with the lowest economic capacity. In the 2014 – 2016 allocation period, 53 percent of funding is in low-income countries and 39 percent of funding is in lower-middle-income countries, for a total of 92 percent of funding in the lowest-income countries.



	Allocation	Allocation-HIV/AIDS	Allocation-TB	Allocation-Malaria
Low Income	52.99 percent	53.66 percent	35.23 percent	62.30 percent
LMI	38.53 percent	35.64 percent	52.89 percent	35.19 percent
UMI	8.38 percent	10.49 percent	11.88 percent	2.51 percent
High Income (in transition)	0.11 percent	0.20 percent	0.00 percent	0.00 percent

[12] From "Overview of the Allocation Methodology – The Global Fund's New Funding Model". March 2014
[13] Formerly referred to as "Ability to Pay" in Board decisions GF/B27/DP07, GF/B28/DP04 and GF/SIIC09/DP01.

28. Based on the agreed principle of using widely available and accepted, as well as objective, data, GNI per capita was approved as the indicator of a country's economic capacity for the allocation formula[14].

29. Despite wide usage, GNI per capita has limitations, including not accounting for income inequality, a country's tax collection capacity and policies, or public and private spending on health. The Global Fund is increasingly engaging with countries across the development continuum on issues of both financial and programmatic sustainability, focusing investments on key sustainability gaps that would endanger successful transitions, partnering with countries to increase value for money and fiscal space for health, and advocating for increased domestic financing for health.

30. The Equitable Access Initiative (EAI) is a multi-stakeholder initiative, jointly convened by nine health and development organizations including the Global Fund. The EAI's objective is to develop a more nuanced health framework that can complement the widely used GNI per capita income classification by considering a broad set of economic, epidemiological, health system, performance and governance indicators. The work on the EAI is scheduled to be completed in February 2016, and the final EAI report and analytical products could inform any strategy deliberations in the governance bodies of the different convening organizations.

31. In the case that the EAI is able to identify complementary metrics and adjustments to the use of GNI per capita, such information may be presented to the SIIC for consideration in its review of the allocation model. In the absence of viable recommendations, GNI per capita would remain the indicator for economic capacity.

32. The draft Strategic Framework 2017 – 2021 also includes provisions for the Global Fund to "innovate and differentiate along the development continuum" as a key strategic enabler. Differentiation is already a priority at the Global Fund, as efforts are being made to tailor investments according to a country's location on the development continuum. For example, in Eastern Europe and Central Asia, Global Fund investment guidance is prioritizing harm reduction services, access to ARVs for key populations, and timely diagnosis and treatment of all forms of TB. In Latin America, similar guidance developed with partners focuses Global Fund investments on key populations and geographic hotspots, while supporting governments to take over increasing financing of the response, including for vulnerable and marginalized groups. In Africa, efforts are being made to overcome obstacles to rapid scale-up of critical public health interventions including key systems that are foundations both to end the three epidemics and for universal health coverage. The allocation model offers opportunities to strengthen these differentiated efforts to invest in the right things in the right places at the right time.

04 Band 4 Methodology

> *"Based on these composition criteria, eligible countries will be placed in one of four Country Bands. One of these Country Bands, corresponding to higher income (GNI per capita) and lower disease burden, will include countries that should finance strategies, projects or places targeted at most-at-risk populations (MARPs). For countries in [such Band, the] aggregation of shares will be based on a separate methodology that is currently under development by the Secretariat which recognizes the particular needs of countries in this band."*
>
> - Global Fund Board Decision GF/B28/DP04, November 2012

33. The Board has recognized the challenges for countries with higher income and lower disease burden, most specifically those where epidemics are concentrated amongst and disproportionately impact key populations, and for the 2014 – 2016 allocation approved a separate methodology and distinct allocation for these countries (currently grouped into "band 4"). This methodology was based on population size, not on income or disease burden, and was topped at 7 percent after considering the

[14] GF/B28/DP04

aggregate funding share for such countries would be[15]: (1) 2.2 percent of funds in the absence of the minimum required level or separate methodology for such countries, (2) 5.3 percent of funds where the minimum required level was applied but there was no separate methodology for such countries, and (3) 8.1 percent of funds if based on then-recent historical funding.

34. At the global level, Band 4 comprises 2.8 percent of global disease burden. However many of the countries in this category have concentrated epidemics amongst key populations with many times the prevalence and incidence of general populations, yet robust size estimation, incidence and program coverage data is not always available. Disaggregated data by gender also remains highly limited. While these challenges exist, development of a more sophisticated approach for measuring needs, and perhaps integrating such data into the allocation formula, remains an option for consideration, noting the need for significantly improved data quality.

35. Alternatively, focused investments can continue to be made through a separate, but evolved methodology. This approach would involve further examination of an alternative to the existing population-based method for distributing funding.

36. Further consideration could also entail reviewing how the needs of concentrated epidemics and key populations may be addressed through strategic investments or programs that are funded through a methodology beyond country allocations, such as through incentive funding and regional initiatives, also complemented with specific provisions for sustainability and transition planning. Strengthening sustainability and transition planning, along with increased domestic or regional commitments, will be important for success. The section below on the methodology beyond country allocations elaborates on these considerations.

05 Minimum Required Level (MRL)

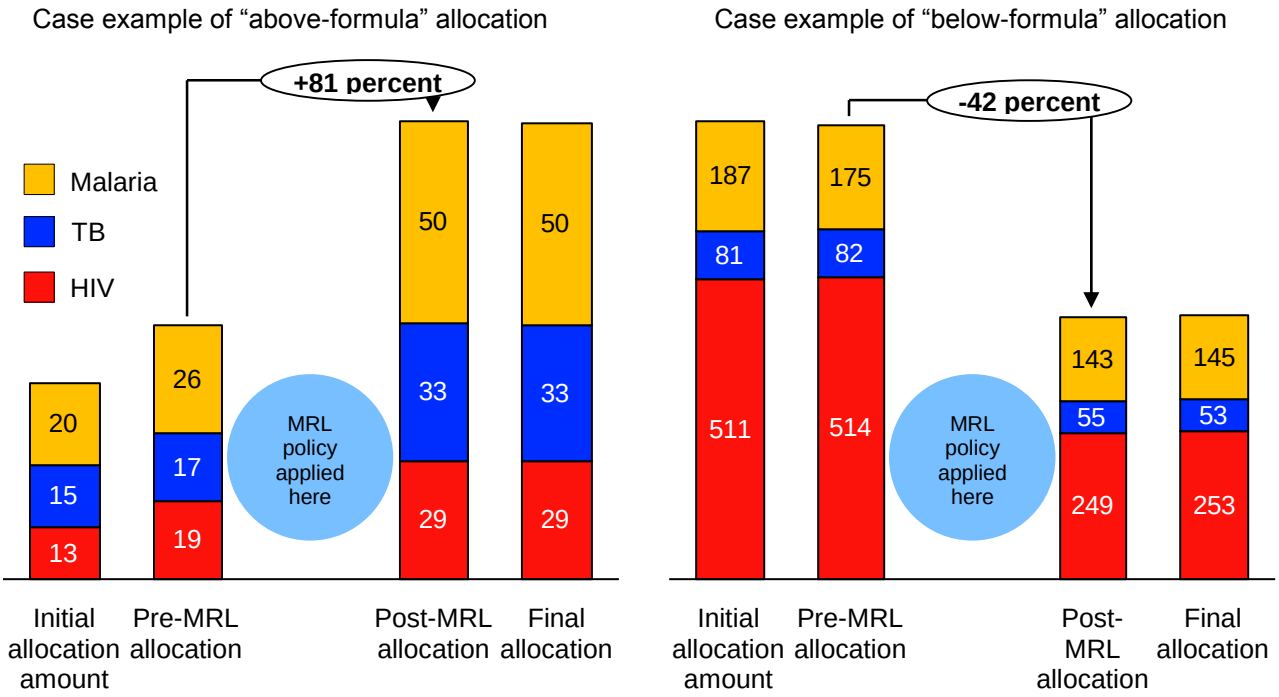
The Board decided to establish a transitional provision to ensure funding levels do not fall below a minimum required level (the "MRL") over the course of an allocation period. The Board agreed such MRL would be a gradual reduction based on achieving a target minimum 25-percent reduction across the portfolio of country components that receive funding levels above their formula-derived allocation over the four-year 2014 – 2017 period. Due to the total allocation of funds to cover the 2014 – 2017 period. The MRL is defined as the greater of the following:

1) *75 percent of a country component's disbursements over the four-year period of 2010-2013; or*
2) *100 percent of a country's existing grants pipeline as at 31 December 2013*

- Global Fund Board Decision GF/B31/DP09, March 2014

37. The Minimum Required Level (MRL) was a transitional provision to provide a graduated reduction of funding towards the formula-derived allocation. However, the MRL limited the allocation of funds to high burden countries that had been unsuccessful in the rounds system, or with previously slow use of funds due to investigations or absorption bottlenecks. The Global Fund has worked closely with countries and negotiated over 30 component reductions in MRL greater than 25 percent, therefore enabling more financing to be focused for maximum impact. While the MRL was a major factor in limiting higher allocations to certain high burden countries, there are clear limits on how quickly "above formula" countries can adjust to lower financing (TERG Effect of Allocation Methodology 2015). It should also be noted that some of the MRL limitations could have been overcome through qualitative factors had there been flexibility in moving resources between bands.

[15] Chair's Notes from 10th Strategy, Investment & Impact Committee. February 2014.



38. Noting both the impact and purpose of the MRL, consideration could be given to the extent to which the current pace of reduction is meeting the aim of this transitional measure. As the existing MRL was set as a minimum target at the relevant portfolio level, examples where greater reductions have been achieved can provide further insight as to how continued country negotiations can be utilized to optimize the balancing of the portfolio.

39. Options for consideration include maintaining the current pace of reduction over three years, accelerating the rate of reduction, as well as reviewing the appropriate basis for the calculation (e.g., disbursements, commitment, or allocations). Preliminary review suggests the 2014 – 2016 allocation amount could serve as an appropriate base for calculating the MRL for 2017 – 2019.

06 Co-Financing Policies

The minimum threshold for Counterpart Financing shall be 5 percent for LICs, 20 percent for Lower LMICs, 40 percent for Upper LMICs, and 60 percent for UMICs. UMICs will be encouraged to increase their Counterpart Financing contribution to above 90 percent during the duration of the grant implementation to facilitate graduation out of Global Fund financing.

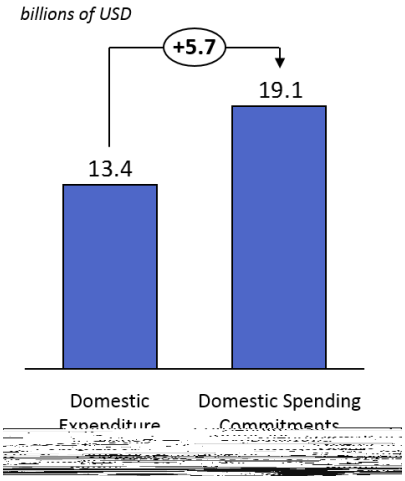
- Eligibility and Counterpart Financing Policy, as last amended and adopted under Global Fund Board Decision GF/B30/DP05, November 2013

The determination of indicative funding ranges will be supplemented by qualitative factors including, but not limited to, willingness-to-pay.

- Global Fund Board decision GF/B28/DP04, November 2012

37. The current policies on co-financing consist of: (a) the Eligibility and Counterpart Financing Policy (ECFP), which sets minimum thresholds of counterpart financing for countries to be eligible to apply for Global Fund financing; and (b) the "willingness-to-pay" qualitative factor that makes 15 percent of allocation amounts conditional to additional counterpart financing above minimum thresholds or existing levels.

Co-financing policies have significantly increased domestic financing commitments



40. The minimum thresholds of counterpart financing set forth in the ECFP were based on government spending during the global economic crisis of 2007 – 2009. As noted in the TERG's Strategic Review 2015, the minimum thresholds may be reviewed to sufficiently reflect the subsequent economic growth since they were initially established.

41. Implementation of the "willingness-to-pay" qualitative factor has led to additional government commitments for health of nearly US$6 billion over expenditures from the previous four-year period. Alongside work to differentiate investments along the development continuum, these additional requirements are a mechanism for increasing domestic financing that can be focused towards the most catalytic investments to fight the three diseases. However, concerns have been raised about the term "willingness-to-pay" by partners.

42. An option to consider is integrating the counterpart financing requirements and "willingness-to-pay" qualitative factor into a single co-financing policy. An integrated policy could be tailored to a country's location on the development continuum taking into account local capacity, domestic spending on health, and health impact, and potentially include categorizing what the Global Fund would finance at different stages of the development continuum.

Box 1: Selected evolutions in Global Fund financing for HIV/AIDS
Using the co-financing policy as a platform, the Global Fund has already started to change the way it finances the response to the three diseases in higher income countries. Below are several success stories in governments taking more responsibility for general services, and Global Fund being asked to target its financing support for key populations.

- Since **Honduras** signed its Phase 2 grant, the Global Fund has focused its investments on key populations, in line with a regional strategy endorsed by COMISCA – a regional committee of health ministers – which call for lower-middle-income countries to commit to absorbing 100 percent of treatment costs within three to five years and the majority of Global Fund investments to focus on key populations.
- Until 2013, **El Salvador** received Global Fund financing mostly for health products (mostly ARV, CD4, VL) and activities for the general population (e.g., national testing day). Recently, there has been a clear shift to financing key populations, with the target of at least 50 percent of total funds to go into outreach and testing for men who have sex with men, transgender people and female sex workers, with ambitious national coverage targets for these three populations (80 to 90 percent) by 2018.
- During country negotiations for allocation 2014-2106, **Azerbaijan** committed to increase its domestic investment in key populations (e.g., people who inject drugs, sex workers, and men who have sex with men) from 0 to 68 percent by 2018.
- In the **Philippine** HIV/AIDS program, the national budget will cover up to 90 percent of the estimated needs of ARV during the allocation period (2015 - 2017), while the majority of Global Fund investment funds prevention programs for key populations such as men who have sex with men, transgender persons and people who inject drugs.

Summary Table: Methodology for Country Allocations

Current Approach	Current Aim	Current Policy	Options and Considerations
Global Disease Split	Split the resources available for allocation between the three diseases to set global targets while allowing countries flexibility to allocate funding across their programs.	HIV-50 percent; TB-18 percent; malaria-32 percent; countries retain flexibility to move funds across component programs and to HSS/CSS.	• Maintain or modify the global disease split; • Consider emphasizing qualitative factors and country flexibility on country-level disease split
Allocation by Disease Burden and Income	Maximize funding to countries with the highest disease burden and lowest ability to pay, but within context of mission to support the end of epidemics and protection of human rights.	Disease burden and ability-to-pay indictors under GF/SIIC09/DP01.	• Update current formula indicators with technical partners and, if relevant, outcomes of EAI; • With respect to addressing concentrated epidemics, key populations, low endemicity malaria in higher income settings, consider: A. Focusing funds towards strategic priorities including human rights, harm reduction, and multi-country interventions for elimination, key populations, and key health and community systems investments (see incentive funding discussion); B. Integrating appropriate indicators for concentrated epidemics into the allocation formula where data is available; C. Consider implications of A and B for the current Band structure and methodologies.
Band 4 Methodology	Address the needs of concentrated epidemics, key populations, low endemicity malaria in settings not currently captured by the allocation formula's parameters.	Band 4 methodology: - 7 percent of available resources - Funds distributed according to population based floors, if formula-calculated amounts are lower.	

Summary Table: Methodology for Country Allocations

Current Approach	Current Aim	Current Policy	Options and Considerations
Minimum Required Level (MRL)	Transitional provision for a gradual reduction of funds for components above their formula-derived amounts towards the formula-derived distribution.	The greater of 75 percent of disbursements over 2010 – 2013 or existing grants pipeline as at 31 December 2013.	• Maintain or increase the current pace of reduction; • Revise the MRL policy to use the 2014 – 2016 allocation as the base for MRL; • In all instances, measures to encourage, incentivize and undertake proactive negotiations and planning with countries to bring them to their formula amounts
Co-Financing Policies	To ensure complementarity and sustainability of Global Fund financing and to leverage co-investment by the governments of countries with programs financed by the Global Fund.	Minimum counterpart financing eligibility thresholds of 5 percent for lower-income countries, 20 percent for lower-lower-middle income countries, 40 percent for upper-lower-middle-income countries, and 60 percent for upper-middle-income countries apply to countries applying for funding. Additional government investments beyond the counterpart financing requirements must be met to access 15 percent of an allocation amount and access incentive funding.	• Within the current policy: A. Maintain or modify current counterpart financing eligibility thresholds to access funds; or B. Maintain or increase current 15 percent requirement on additional government investments beyond the counterpart financing requirements. • Develop a unified co-financing policy tailored according to a country's location on the development continuum and differentiated by local capacity, domestic spending on health and other factors.

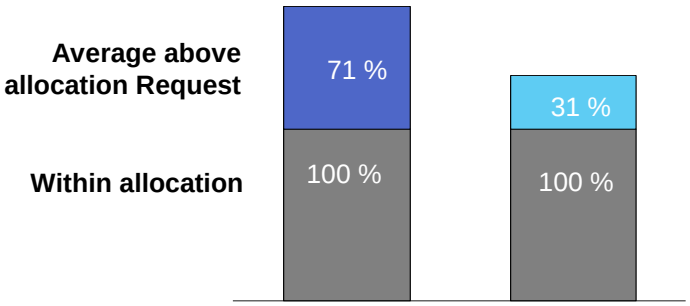
Section 2: Methodology beyond Country Allocations

01 Incentive Funding and register of Unfunded Quality Demand

Purpose of Incentive Funding: As the Board previously agreed (GF/B27/DP7), a portion of funds will be used to establish a funding stream to incentivize high impact, well-performing programs and the submission of robust, ambitious requests based on national strategic plans or investment cases. The apportionment of funding to this stream will be substantial so as to ensure sufficient funds are available to motivate full expressions of quality demand

- Global Fund Board Decision GF/B28/DP04, November 2012

43. The 2014 – 2016 allocation apportioned US$950 million for incentive funding, by taking 10 percent of the new funds that were available for allocation to Bands 1, 2 and 3. While the country components eligible to receive incentive funding, on average, requested larger percentages of funding above their allocation amounts compared to those not eligible to receive incentive funding, more efforts may be warranted to determine whether incentive funding has served to incentivize well-performing programs to submit ambitious expressions of full demand based on national strategic plans or investment cases. Among these considerations include the recognition that incentive funding has not been simple for countries to apply and access (TERG Strategic Review 2015, TRP Comments). Furthermore, incentive funding has been needed for continuity of critical interventions in high burden countries (TERG Strategic Review 2015, TRP Comments.)



	Eligible for Incentive Funding	Ineligible for Incentive Funding
Total CNs	87 (100%)	81 (100%)
- no above	14 (16%)	48 (59%)

Source: Data from TRP Windows 1-6. Only includes concept notes recommended for grant-making

44. In line with the Board's intent, the creation of a Register of Unfunded Quality Demand (UQD) aims to incentivize ambitious full expressions of quality demand and act as an additional resource mobilization tool for the Global Fund and for countries. The register is seen as critical for attracting additional resources from private foundations and high-net-worth individuals. There is a robust pipeline of resource mobilization opportunities, which may yield significant additional funding in the coming years. Increased engagement of private funders, enabled by the revised Policy on Restricted Financial Contributions and the UQD register, can also have other positive effects, including the establishment of new country-led financing vehicles for health and serve as a source for innovation in service delivery. While it is too early to evaluate the success of this method for incentivizing ambitious, full expressions of quality demand and mobilizing additional resources, it may be further refined with a view to structure the register in a manner to best deliver on its goal.

45. Any revisions to incentive funding could potentially include review of the amount of funding (i.e., maintain or modify the percentage) and the processes by which funding is requested, reviewed and awarded. Changes in the amount of incentive funding could be considered, balancing the desire to reward ambitious programs with higher and more predictable allocations. Further refinements to the process for incentive funding may also be considered which could alleviate certain challenges experienced by countries.

46. More comprehensive reimagining of incentive funding is also possible to meet strategic objectives. Although incentive funding, (also regional programs and special initiatives discussed below) had some success, there were also challenges and, perhaps, missed opportunities. These funding opportunities generated insufficient ambition, innovation and acceleration towards ending epidemics. As such, the SIIC and Board could consider bringing them together in a comprehensive way to focus, incentivize and sustain investment priorities and objectives of the Global Fund strategy beyond country allocations.

47. For instance, an area where incentive funding could have value is in catalyzing increased domestic financing. In one country with higher economic capacity recently, the Global Fund offered incentive funding to meet half a country's insecticide-treated net gap if the country provided the other half. In another, incentive funding will be provided only if the country fulfils its commitment on additional counterpart financing. An expanded use of incentive funding to catalyze increased domestic or regional financing, including, for example, loans from regional or global development banks, could also contribute to acceleration of the response to the diseases and contribute to successful and sustainable transitions.

48. In addition, in higher income, lower disease burden countries, where epidemics are concentrated amongst key populations, there is potential to further focus grants to support critical investments including:

- Building and strengthening capacity among civil society and communities;
- Advocacy, such as the promotion and protection of human rights and addressing gender inequality;
- Meaningful engagement with and participation by cross- and in-country key stakeholders in sustainability and transition planning and coordination.

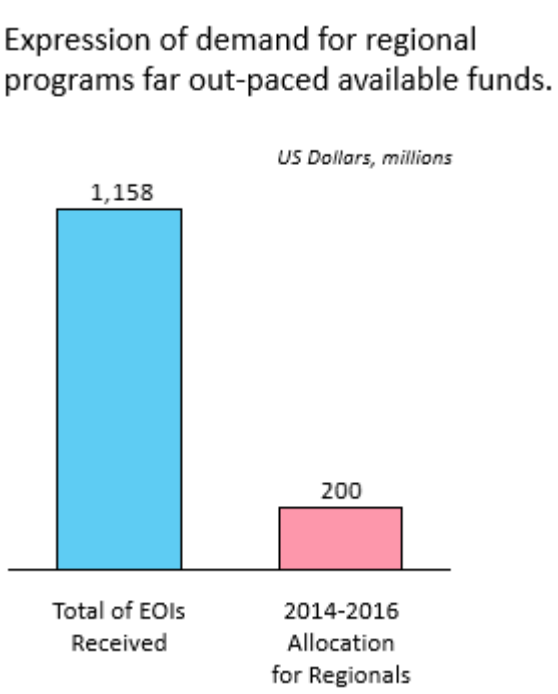
49. Such focused investments align with the principle of tailoring investments along the development continuum as well as the sustainability and transition objectives embedded in the draft Strategic Framework 2017 – 2021. Furthermore, incentive funding and regional approaches (discussed below) could be equally important for developing more effective programming to achieve and sustain desired health outcomes (e.g. programs to support adolescent girls and women, community based responses to reach key populations).

50. Finally, an analysis of underuse of funds has uncovered key systems issues, for example data management and supply chain, which are essential for achieving epidemic control but also for resilient and sustainable systems for health. A comprehensive incentive funding mechanism that includes the use of regional approaches could catalyze investments in prioritized areas to optimize the use of funds and ensure successful, sustainable transition for the three diseases as well as resilient and sustainable systems for health.

51. Altogether, there could be an opportunity to evolve from the current methodologies beyond country allocations (i.e., incentive funding, regional programs, special initiatives) into a single pool of incentive funding focused on key areas identified in the strategy. Should the SIIC direct the Secretariat to do so, the Secretariat could work with technical partners and implementers to provide detail and analysis around such an option.

02 Regional Programs & Special Initiatives

> *"In addition, based on recommendations from the SIIC, the Board may also choose to allocate up to ten percent of all available funding for programs, activities, and strategic investments not adequately accommodated through the distribution of funding to the Country Bands."*
> - Global Fund Board Decision GF/B27/DP07 – Annex 1, September 2012



52. The Global Fund reserved US$200 million from the 2014 – 2016 allocation to finance new regional programs outside of the allocation methodology. These programs were intended to be catalytic and targeted to cross-border or regional initiatives that worked in concert with country allocations, but did not duplicate investments or activities that could be provided through single-country grant programs. There was significant demand for regional grants around the world, and major grants were awarded for, among other things, TB in the mining community, malaria elimination, and a large number of grants focused on key populations, programs to promote and protect human rights, gender, and harm reduction.

53. Additionally, US$100 million was made available for special initiatives, enabling investments that supported a pre-defined set of prioritized areas for investment that could not be accommodated adequately through the allocation. This financing was used to capitalize an emergency fund (deployed in the Nepali earthquake, West African Ebola outbreak, and Syrian crisis), support Principal Recipient grant-making capacity building, provide technical assistance for strong concept note development, finance technical assistance for community, rights and gender, support value for money and financial sustainability studies, and to improve data quality.

54. In taking forward funding for regional programs and special initiatives, the Global Fund could take a more proactive approach, where specific priorities are identified and pursued to contribute to the objectives of the strategy. As currently formulated, regional programs provide limited, if any, programmatic support. This proved to be problematic, for example, for regional malaria elimination efforts and for addressing TB related to migratory mining in Southern Africa. Furthermore, significant amounts of country allocations in low-burden settings are being utilized for management costs. Regional approaches that include programmatic interventions could be a more efficient, smarter way to invest in certain areas for certain objectives (e.g., one grant for malaria elimination covering multiple countries in Southeast Asia with one management fee and opportunities to catalyze increased domestic or regional funding, including through the Asian Development Bank). Allocation to regional programs and global enabling investments such as data strengthening could be proposed and tailored to geographic and epidemic context.

55. As with incentive funding, both special initiatives and regional programs represent sources of funding for investments or priorities outside of the allocation methodology. There are also potential linkages to investments in higher income and lower disease burden countries, currently addressed under the Band 4 methodology. For example, the needs of epidemics that are concentrated amongst key populations might be addressed through strategic investments or programs that are funded outside of the allocation methodology. As such, there may be opportunities to bring these methods of financing together in a single pool of incentive funding to focus, catalyze, incentivize and sustain investments in key strategic areas.

Summary Table: Methodology beyond Country Allocations

Current Approach	Current Aim	Current Policy	Options and Considerations

Incentive Funding	Incentivize ambitious requests with full expressions of quality demand for well-performing programs based on national strategic plans or investment cases	Ten percent of available resources from each Replenishment, after subtracting of special initiatives, regional programs and funding to Band 4	• Consider workload for countries, rewarding ambition and innovation, strategic focus, and predictability of allocations
			
			• Maintain current approaches to incentive, regional and special initiatives:
			  • Maintain incentive funding and streamline procedures for countries
			  • Reduce incentive funding and streamline procedures for countries
			  • Consider proactive approach to regional programs to identify and focus on specific priorities that contribute to strategic objectives
			  • Consider new special initiatives to focus on specific priorities that contribute to strategic objectives
			
			• Evolve into a comprehensive and strategic incentive funding approach:
			  • Develop alternative approaches of operationalizing incentive funding, regional programs and special initiatives to incentivize ambition, leverage additional domestic co-financing and focus investments towards priorities that contribute to strategic objectives not adequately accounted for in the allocation formula, including human rights, adolescent girls, strengthening civil society and communities, key populations, harm reduction, sustainability and transition planning, and health systems components required to achieve epidemic control including data and innovation.

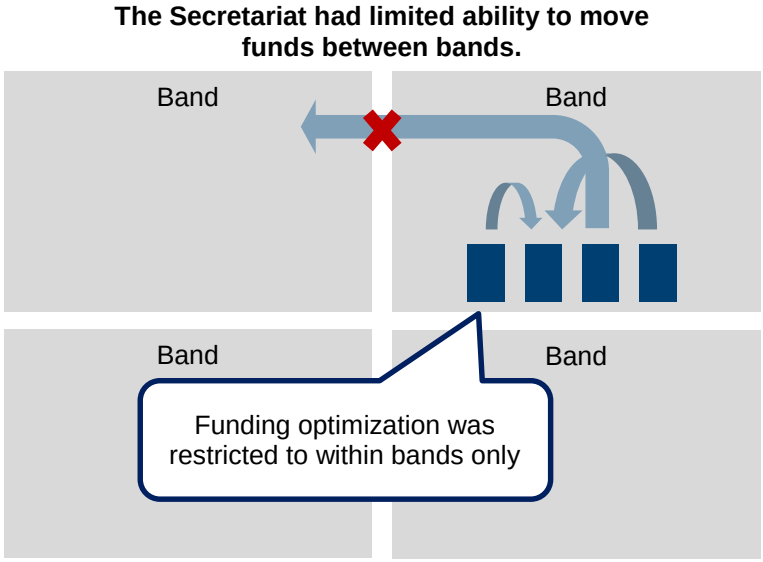
Regional Programs and Special Initiatives	Strategic investments that cannot be accommodated through an allocation approach	Regional programs – US$200 million Special initiatives – US$100 million	

Section 3: Board Approval

01 Board Approval and Flexibility using Qualitative-Factor Adjustments

The Board will undertake, on a regular basis, a strategic allocation of resources to Country Bands… The Board approves the following principle [that] each Country Band should have a large enough number of countries and sufficient resources to enable flexibility within it… The Board agrees on the following principles for allocating funding to Country Bands, [including] the output of the allocation formula is a guiding number, to be adjusted by pre-determined qualitative criteria.

- Global Fund Board Decision GF/B28/DP04, November 2012



56. Country bands, or groupings of comparable countries, enable the Board to approve the distribution of funding at aggregate levels. Under the current approach, qualitative factor adjustments can then be made within-band, but funds cannot be moved between bands when finalizing country allocations. For example, some Band 4 countries received sizeable malaria allocations despite having very minimal burden (see section on Allocation by Disease Burden and Income: Disease Burden Indicators). As a consequence, and without the flexibility to move funding across bands, approximately US$55 million could not be reinvested in countries where the duration of grants needed to be shortened to maintain programs at prior levels.

57. One option could be to grant the Secretariat the flexibility to shift funds across country groupings. So while the Board approves funding at aggregate levels by such groupings, the Secretariat could, potentially within certain thresholds, redistribute funds to optimize utilization of funds across the portfolio.

58. A final option would be to consider Board approval for a different grouping of countries than the existing bands. Depending on Board decisions on incentive funding, multi-country investments, and country groupings, approval of the allocation by alternative country groupings could be used for Board approval.

Summary Table: Board Approval

Current Approach	Current Aim	Current Policy	Options and Considerations
Board Approval and Flexibility using Qualitative-Factor Adjustments	Approval of funding at an aggregate level by country bands or groupings of comparable countries based on known and accepted data in a coherent way, enabling flexibility within bands or groupings	Board approval of aggregate funding ceilings at the country band or grouping level, with flexibility to move funds within such band or grouping, but not across such band or grouping, through the application of qualitative factor adjustments after Board approval	• Applying flexibility to make qualitative adjustments across country bands or groupings, possibly within certain thresholds • Board approval of the allocation by bands or alternative country groupings.

V. Timeline

2015 October	SIIC	**Framework of Allocation 2017-2019** **For Input** - Allocation Model Options - Updated Disease Burden Metrics **For Discussion/Information** - Technical Adjustments and Updates
2015 November	Board	**Framework of Allocation 2017-2019** **For Information** - Allocation Model Options - Updated Disease Burden Metrics -
2016 February	SIIC	**Allocation 2017-2019** **For Recommendation to the Board** - Decision on Final Allocation Model
2016 March	Board	**Allocation 2017-2019** **For Decision** - Decision on Final Allocation Model
2016 Summer		**The Fifth Global Fund Replenishment**
2016 October	SIIC	**Allocation 2017-2019** **For Recommendation to the Board** - Decision on Final Allocation
2016 November	Board	**Allocation 2017-2019** **For Decision** - Decision on Final Allocation
2016 November	Secretariat	**Final Allocations Communicated to Countries**