Overview of the Allocation Methodology (2014-2016)

The Global Fund's new funding model

Summary
The purpose of this document is to describe how the Global Fund allocates resources to countries for 2014-2016.

March 2014

Contents

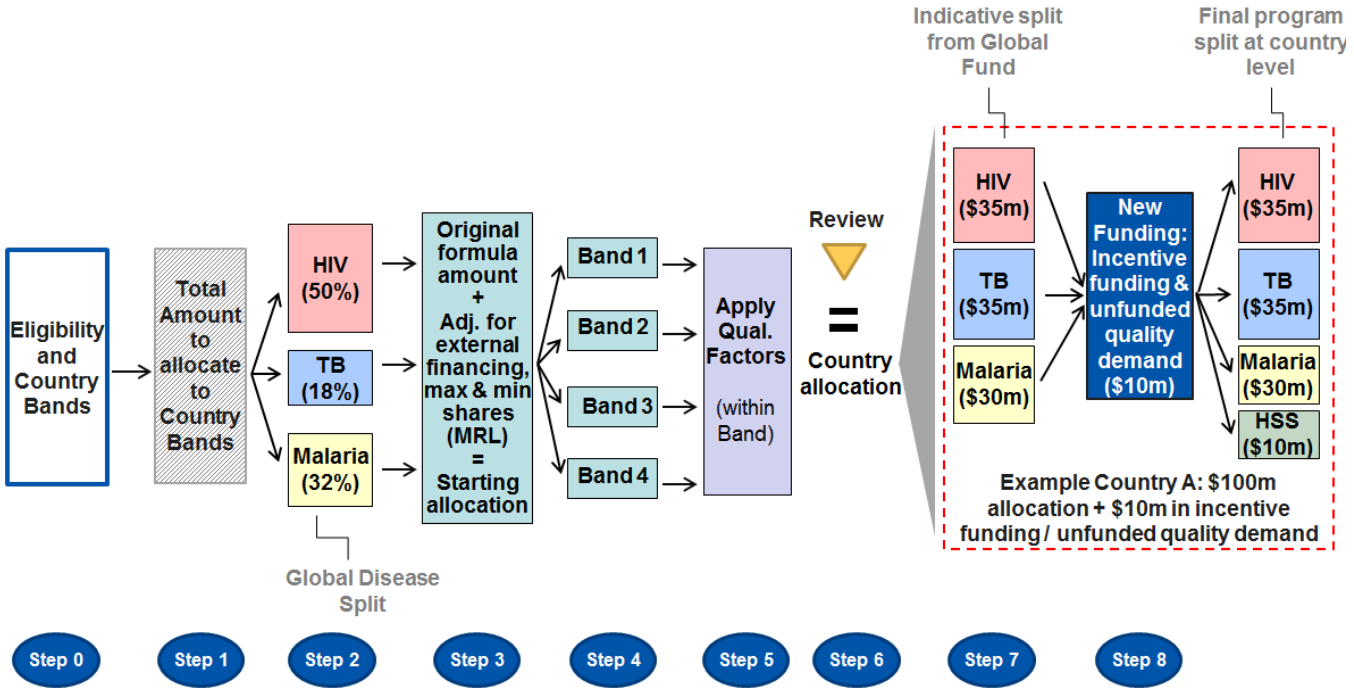
Executive Summary

The Global Fund is implementing a new funding model that is allocation based. At its Thirty-First Meeting, the Global Fund Board approved the new funding model, and the funds available for allocation. The Global Fund notified countries of their allocations on 12 March 2014.

A total of **US$14.82 billion** is available to allocate across eligible countries for the Fourth Replenishment, using the Board-approved allocation methodology. These funds are 20 percent higher than the amount of funding disbursed by the Global Fund over the previous period. Many countries will be eligible to compete for US$950 million of additional funding to encourage ambitious funding requests based on robust national strategies (called incentive funding). In addition, the Global Fund will provide US$200 million to countries through strategically focused regional grants. Added together, this represents **US$16 billion** in funding for countries.

The Global Fund is changing its funding model to focus on countries that are most affected by the three diseases. By investing as effectively as possible, the Global Fund and partners can reach more people affected by the diseases and have greater impact. (For more information on the principles underlying the new funding model, refer to Part I: Principles of the Global Fund's allocation methodology.)

Exhibit 1 – Overview of Allocation methodology



The key steps for determining country allocations are:

Step 0: Determine country eligibility and country band composition. The Global Fund determines which countries and disease components are eligible to receive a funding allocation from the Global Fund. The Global Fund Board then assigns countries to one of four groups based on income and disease burden (called "country bands").

Step 1: Approve the total amount to allocate to country bands. Based on the results from the Global Fund's Fourth Replenishment Conference and existing assets, the Board approves the total amount of funds that can be allocated to countries. For the 2014-2016 allocation period, US$14.82 billion has been approved by the Board to be allocated to country bands.

Step 2: Split resources across the three diseases. The Global Fund Board sets the share of resources available across the three diseases as an input into the allocation calculations. For the 2014-2016 allocation period, this distribution is 50 percent for HIV/AIDS, 18 percent for tuberculosis and 32 percent for malaria. The total amount to allocate to country bands is then multiplied by this distribution to determine the total funds that will be notionally allocated to each disease.

Step 3: Calculate the starting allocation for eligible disease components. Following the application of the allocation formula, original formula amounts for eligible disease components are calculated within the total funds available for each disease. The original formula amounts are adjusted by applying minimum and maximum shares, as well as initial qualitative factor adjustments for the level of past disbursements and existing grants (called Minimum Required Level) and external donor financing that a country receives.

Step 4: Finalize funding amounts for country bands. The starting allocations for disease components are added together to generate funding amounts for each country band. The Global Fund Board reviews and approves the funding amounts for country bands.

Step 5: Adjust starting allocations for qualitative factors. Within the total amounts for each country band, the starting allocations are further adjusted for other qualitative factors that the Board asked the Secretariat to apply. These qualitative factors account for specific circumstances in each country due to past program performance, impact, increasing rates of infection, risk, absorptive capacity and other considerations.

Step 6: Review and validate country allocations. The allocation amount for each country is the total of any disease allocation for HIV, TB and malaria for that country. After the qualitative factor adjustments, the Global Fund ensures that all the country allocations within the same country band add up to the total amount of funding approved by the Board for that country band. Part III describes the data inputs used in the allocation model. To the extent possible, data was validated by multiple persons. Additionally, the allocation model was reviewed by an external firm. The review confirmed that, based on the data supplied, the allocation model generated correct funding allocations for each eligible disease component and country band. (Refer to Annex 3 for an extract of the opinion report.)

Step 7: Communicate country allocations to each country. Following the review and validation of allocations, countries are informed of their country allocations via a letter tailored to their situation. Many country teams will travel to countries to explain the allocation and answer questions.

Step 8: Determine final funding amount for each country. After a country receives its country allocation amount, further adjustments may be made to the allocations for each disease component taking into account the government's willingness-to-pay commitments, incentive funding and funding provided through the register of unfunded quality demand. Countries may choose to redistribute their country allocation among eligible disease components and to cross-cutting health systems strengthening during their discussion around their program split. For these reasons, the allocations by country disease components could change, and will not be finalized for some time.

Each step is described in more detail in Part II: Steps to allocate funds to countries. If you wish to know more about the new funding model, a *Resource Book for Applicants* is available on the Global Fund website. The *Resource Book* provides an end-to-end overview of the new funding model and other key information that applicants may need.
The most current version of the Resource Book can be found at: http://www.theglobalfund.org/en/fundingmodel/support/

Part I: Principles of the Global Fund's allocation methodology

The Global Fund is evolving to have an even bigger impact against AIDS, TB and malaria worldwide, and to save more lives. The new allocation-based funding model is redesigned to bring the Global Fund strategy of "Investing for Impact" to life. It takes into account the challenges and lessons learned from more than a decade of managing Global Fund grants.
Despite the great achievements of countries and partners under the previous rounds-based funding model, there were several challenges:

- The Global Fund awarded funding based on the quality of individual proposals, with less consideration of the broader impact on its portfolio. As a consequence, funding was not always targeted towards countries with the highest disease burden and least ability to pay.
- Countries faced uncertainties because the predictability of funding depended on the timing of the rounds and the success of a grant proposal. This made it difficult for countries to plan beyond their current grants since they might not succeed in accessing additional funding from the Global Fund.
- Most funding requests had terms of five or six years, split into phases. In contrast, donors pledge in three-year replenishment cycles. Consequently, grant commitments could extend beyond the funds available.

The allocation-based funding model addresses these issues and offers:

- **Focus on countries with the highest burden and least ability to pay.** The new funding model is designed to focus funding on countries that are most affected by the three diseases and encourage all countries to invest scarce resources for greatest impact.
- **Predictable funding.** By introducing an "allocation amount", each eligible country will know up front how much money it may receive for an allocation period.
- **Improved success rate.** Global Fund teams and partners will actively support countries as they prepare their funding applications to help improve the quality of the applications and, ultimately, bring the success rate close to 100 percent.
- **Matching sources and uses of funds.** In adopting the new funding model, the Global Fund Board is aligning the three-year replenishment period (the period over which donors pledge contributions) with the allocation period (the period over which funding is allocated to countries).
- **Flexible timing.** Another big change is the move away from a set application date, allowing countries to apply during any of nine Technical Review Panel review windows.
- **Incentive to be ambitious.** It rewards ambitious vision by having a pool of competitive "incentive" funding available, to allocate additional funds to funding requests that make a powerful case for impact.

Key principles for the transition to the new funding model

As the Global Fund transitions from a rounds-based funding model to an allocation-based funding model, it faces a legacy of existing grants (US$9 billion) that are unevenly distributed across the portfolio. Country disease components with a similar disease burden and income level often have very different existing grants pipelines, depending on whether they successfully accessed funding from the Global Fund in recent years. If these existing grants pipelines are not taken into account, they could bias the allocations to countries considerably.

Over the 2014-2016 period there are country disease components that will receive more than the amount than they would receive under the allocation-based formula, due to large existing grants pipelines or high levels of recent funding awarded through the rounds-based model. Disease components that receive allocation amounts exceeding their original formula amount after the application of the graduated reduction, or due to their existing grants pipeline, are considered "over-allocated".

It is important to note that being "over-allocated" does not mean that a country has too much funding and could not put additional funding to good use. Rather the "over-allocation" designation is in reference to the appropriate share (in accordance with the methodology approved by the Board and the Strategy, Investment and Impact Committee), of the finite resources that the Global Fund has available to allocate.

As a result, the Global Fund has put in place measures to ensure that the transition to an allocation-based funding model is equitable and timely. With these measures the Global Fund hopes to ensure that future replenishment periods do not require the same degree of extraordinary transitional measures.

- **Comprehensive scope.** One overriding principle of the new funding model is that allocation amounts are based on all funds to be invested in a given period, not simply on new resources. This principle ensures that Global Fund resources are allocated holistically and fairly, in consideration of the amount of existing and new resources. Additionally, it honors the existing grants pipeline while at the same time allowing flexibility in transitioning to grants under the new funding model. This also allows the Global Fund to maximize country allocations and to emphasize the importance of using all funds – both existing and additional funds – for the greatest impact.
- **Gradual reduction.** Reshaping the portfolio to focus on the highest disease burden countries with the least ability to pay is difficult. The Global Fund has been instructed by the Board to decrease funding to over-allocated disease components over time. As a result, the Global Fund reduces funding by at least 10 percent per year as compared to past disbursement levels. This equals a 25 percent reduction in relation to the past four years of disbursements. To complete the transition will take time. By the next replenishment period, there will be fewer over-allocated countries as the portfolio is transitioned.
- **Existing grants pipeline minimum required level.** Countries also have existing grants pipelines that need to be covered from their allocations. For this period only, the Global Fund will treat the existing granst pipeline as the basis for

determining the allocation to make sure that the allocation model does not systematically reduce disease components below their existing grants (as would be the case if the level of existing grants are above either the allocation or 75 percent of past disbursements). In future allocations, all existing grants will be matched to resources from the last allocation period and therefore will not be taken into account.

- **Flexible grant implementation period.** The duration of grant implementation is flexible. The process of accessing funds should take less than one year on average, including country dialogue, concept note development, review by the Technical Review Panel and the Grant Approvals Committee, grant-making and, finally, Board approval. While a typical grant will run for three years, the Global Fund can work with countries to be flexible on timing, and to significantly shorten the timeline to maximize impact. The timeline will take into account factors including: ambition to achieve increased impact and sustain gains; whether a country has been relatively under-allocated or over-allocated; and alignment with national plans and schedules. Country dialogue will determine the length of a grant.

In the near term, in many countries, the country allocation amounts will still be insufficient to cover the funding gaps. Most countries are "under-funded" relative to their needs. This should not limit planning and ambition with respect to defeating the diseases, and countries should focus on investing the funds as strategically as possible through effective targeting of resources, leveraging existing delivery systems, reducing costs, improving procurement systems, etc.

Only by using all funds available in innovative ways to maximize impact will countries be able to change the course of the epidemics. Countries are asked to critically examine how available funds can best contribute to the impact they hope to achieve and with that objective in mind, to shift funds or significantly reprogram for greater impact.

With a more strategic approach based on national plans, the new funding model will help support countries in planning how to control these epidemics and how to provide care and treatment to people affected by them, including strengthening of health systems. The new funding model relies on strong country dialogue to bring partners together to best decide how to maximize impact, and to look at how all available resources can serve a country's objectives. In most countries, there will be a funding gap between ultimate goals and available resources. The Global Fund strongly encourages planning and ambitious national strategic plans and concept notes. To defeat these diseases, all partners need to think big.

The Global Fund is a partnership at its core, and the new funding model is an ambitious manifestation of that reality. By making partnership central to defeating HIV, TB and malaria, the new funding model calls on the skills, knowledge and determination of everyone responding to these diseases to find the best solutions. All partners look forward to serving countries and to advance together in the collective mission.

Part II: Steps to allocate funds to countries

Over the course of 2012 and 2013, the Global Fund Board made a number of decisions about how the Global Fund should allocate funds to countries under the new funding model. Described below are the main steps the Global Fund takes to arrive at the country allocations it communicates to countries.

Step 0: Determine country eligibility and country band composition

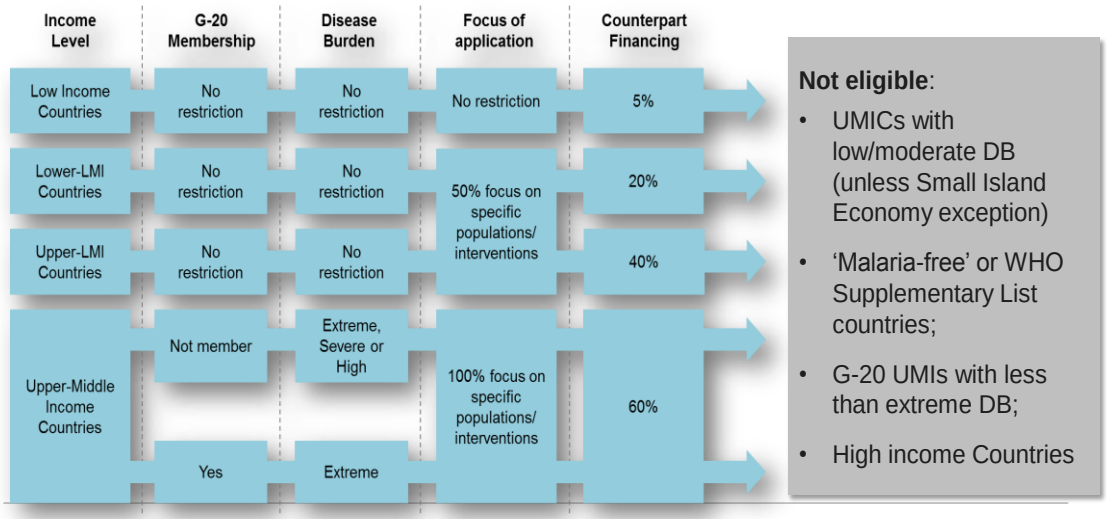
This section describes the way that the Global Fund determines which countries are eligible to receive a funding allocation for a disease component from the Global Fund and how the composition of country bands is determined.

Country Eligibility

To receive an allocation, a country must be eligible for funding from the Global Fund. Eligibility is determined based on the Global Fund's Eligibility and Counterpart Financing Policy. Based on this policy, the Global Fund publishes an Eligibility List identifying the countries and disease components eligible to receive an allocation. This does not mean each eligible disease component will receive an allocation. Exhibit 2 illustrates the criteria that a disease component must meet to be eligible.

The Global Fund Eligibility List is available at:
http://www.theglobalfund.org/en/fundingmodel/updates/2014-02-04_Eligibility_List_for_2014_now_available/

Exhibit 2: Overview of Eligibility Criteria



While the Global Fund will publish an eligibility list each year, country allocations will only be made once every three years. Countries or components that become eligible during an allocation period may receive an allocation, subject to the availability of funding, only after being newly eligible for two consecutive years.

Countries or components that become ineligible during an allocation period before accessing their allocation will not forfeit their allocation. However, the Global Fund may adjust the level of funding and require specific time-bound actions for transitioning to other sources of financing.

Newly ineligible components funded under an existing grant may be allocated funding to cover up to one allocation period to support an effective transition from Global Fund support.

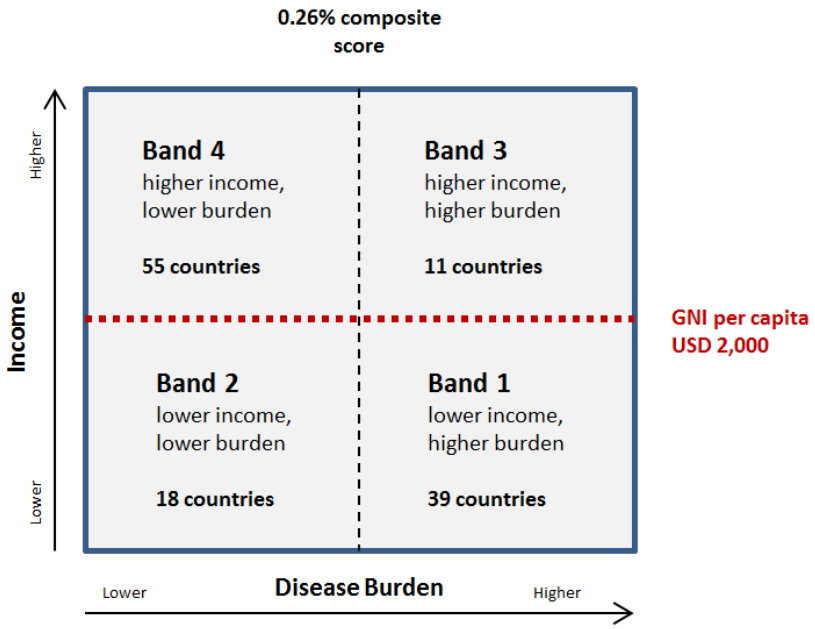
Country band composition

Country bands are groupings of countries based on disease burden and income level decided by the Global Fund Board. Eligible countries are placed in one of four country bands (Band 1: lower income, higher burden; Band 2: lower income, lower burden; Band 3: higher income, higher burden; Band 4: higher income, lower burden), as illustrated in Exhibit 3.

For the allocation period 2014-2016, the Global Fund Board has decided that countries are placed into country bands based on the following thresholds:

- US$2,000 gross national income per capita (GNI pc) to divide lower from higher income countries; and
- 0.26 percent of the total disease burden amongst Global Fund eligible countries to divide lower from higher disease burden countries.

Exhibit 3: Overview of income and disease-burden thresholds



Band 4 countries are unique because they do not have to compete for incentive funding. This means that no funding is subtracted from the Band 4 allocation amount for incentive funding. For Bands 1-3, 10 percent is subtracted from the initial allocation to Bands 1-3 to form a pool of incentive funding (US$950 million).

Prior to each allocation period, the Board may revisit the composition of the country bands. Annex 2 lists countries by band for the 2014–2016 allocation period.

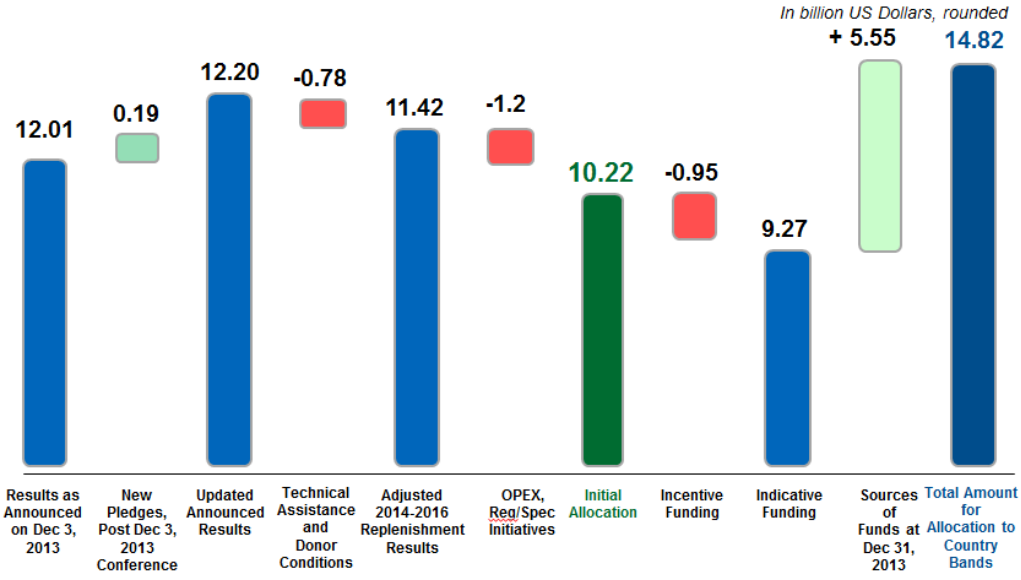
Step 1: Approve the total amount to allocate to country bands

The total amount of US$14.82 billion will be allocated to country bands for the 2014-2016 allocation period, using the allocation methodology consisting of the following amounts:

- an initial allocation of US$10.22 billion; plus
- existing sources of funds at 31 December 2013 of US$5.55 billion; less
- US$0.95 billion reserved for incentive funding.

Exhibit 4 illustrates the calculation of the total amount (US$14.82 billion) that is available for allocation to country bands, starting with the amount of funds pledged by donors.

Exhibit 4: From pledges to total amount to allocate to country bands (2014-2016)



The total amount available for allocation to country bands is determined in accordance with the principles contained in the Global Fund's Comprehensive Funding Policy. This amount is derived from pledges announced by donors during the Fourth Global Fund Replenishment Conference in December 2013 (including subsequent public donor announcements up to the date of the Thirty-First Board Meeting, and matching pledge amounts from relevant donors). Announced donor pledges are reduced by US$777 million to account for funds set aside by donors for technical assistance and other donor conditions. Deductions are also made for operating expenses (OPEX US$900 million), special initiatives (US$100 million) and new regional programs (US$200 million).

Ten percent of the initial allocation for Bands 1 to 3 (US$950 million) is set aside. This forms a separate reserve of funding designed to reward high-impact, well-performing programs and to encourage ambitious requests (called incentive funding). It is made available, on a competitive basis, to select applicants in country bands 1, 2 and 3. Regional applicants and significantly over-allocated disease components (components in country bands 1 to 3 that have a starting allocation after the minimum required level adjustment that is greater than 150 percent of the pre-minimum required level allocation) are not eligible for incentive funding. Band 4 countries cannot apply because, unlike countries in Bands 1 to 3, Band 4 countries receive their full allocation without the ten percent deduction for incentive funding.

Exceptionally for the transition from a rounds-based model to the allocation-based model, the Global Fund takes into account existing sources of funds. The amount of sources of funds as at 31 December 2013 (US$5.5 billion), consists of actual and anticipated cash and other financial assets that originate from the Third Replenishment period (2011-2013) or earlier replenishment periods.

The total amount available for allocation to country bands for the 2014-2016 allocation period (US$14.82 billion) is based on the recommendations and forecasts approved by the Finance and Operational Performance Committee of the announced Fourth Replenishment results and sources of funds as at 31 December 2013.

Step 2: Split resources across the three diseases

The funding available for country allocations is split between the three diseases by the Global Fund Board at the beginning of the allocation period. It distributes the available resources into three global envelopes, one per disease. This distribution is an upfront input into the allocation methodology. The split of resources between diseases (and health systems strengthening) **will change**. There are two main reasons. First, the split of resources shared by the Global Fund when country allocations amounts are announced are for information only and can be adjusted by the Country Coordinating Mechanism during the country dialogue. Second, the allocation of incentive funding and additional resources that become available during the allocation period across diseases will influence the disease split. Additionally, funding for regional proposals has not yet been allocated and will provide additional funding for each disease.

The distribution approved by the Board for the 2014-2016 allocation period is: 50 percent for HIV, 18 percent for TB and 32 percent for malaria. This ratio may be reviewed and updated before each subsequent three-year allocation period.

Three expert external institutions were engaged to propose approaches to determine the upfront global distribution of resources across the three diseases to be used in the allocation formula:

- The Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal;
- Imperial College London; and

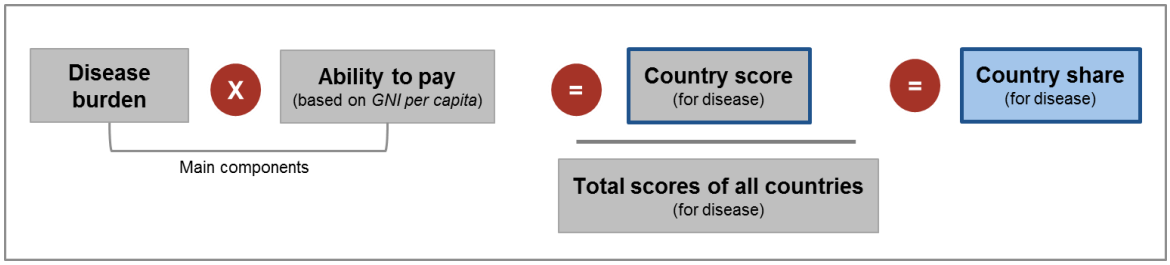
- The Institute for Health Metrics and Evaluation (IHME) at the University of Washington.

The findings of HEARD, Imperial College and IHME were shared with the Strategy, Investment and Impact Committee. Although the three expert institutions utilized different approaches (based on demand, weighted capitation payments and disability-adjusted life years, respectively), and worked independently, the resulting distributions were in the range of the historical distribution used for the transition to the new funding model.

Step 3: Calculate the starting allocation for eligible disease components

Prior to the qualitative factor adjustment process, the original formula amounts are initially determined based on disease burden and ability-to-pay.

Exhibit 5: Starting allocation calculation



For eligible components, the Global Fund calculates a score based on the disease burden indicators multiplied by the ability-to-pay factor. This score is then divided by the sum of all country scores to calculate a country share. The country share can then be converted into an original formula amount by multiplying it with the total funds available for each disease.

The indicators for disease burden for the 2014–2016 allocation period are presented in Exhibit 6. These indicators are based on recommendations from the technical partners (World Health Organization (WHO) and United Nations Programme on HIV/AIDS (UNAIDS)) and approved by the Strategy, Investment and Impact Committee.

Exhibit 6: Parameters for disease burden indicators

Indicators	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% 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

For the 2014-2016 allocation period, the ability-to-pay factor is 0.95 for countries in the World Bank's low income classification; a linear decline from 0.95 at the beginning of the lower-middle income classification to 0.4 at end of the lower-middle income classification; and a linear decline from 0.4 at the beginning of the upper-middle income countries to 0.2 at the end of the upper-middle income classification. These points are consistent with the Global Fund's Eligibility and Counterpart Financing Policy (see Exhibit 7 which shows the ability-to-pay curve and the Global Fund's counterpart financing thresholds).

Exhibit 7: Ability-to-pay factor

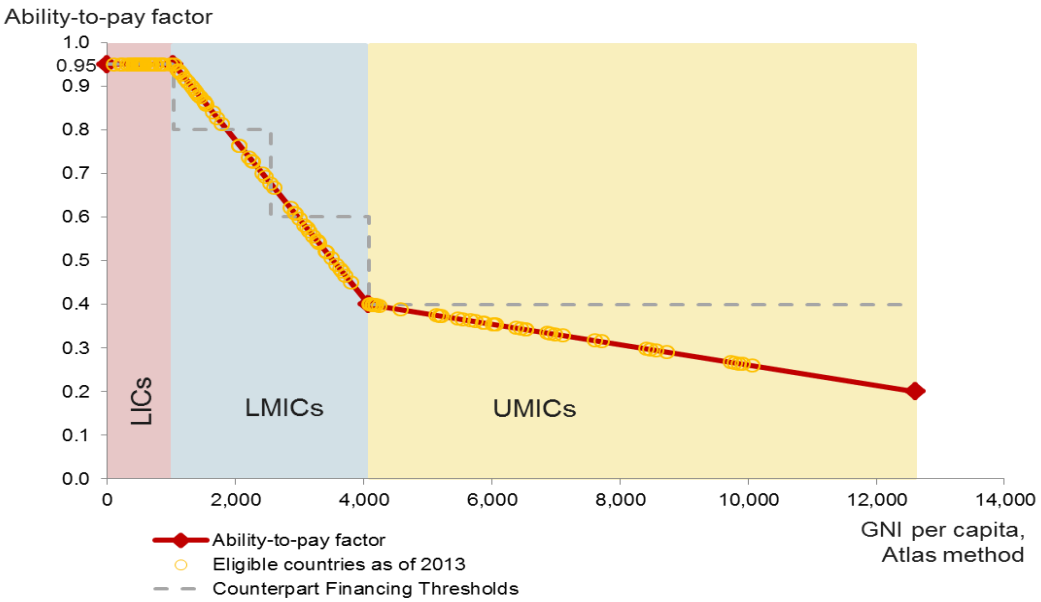
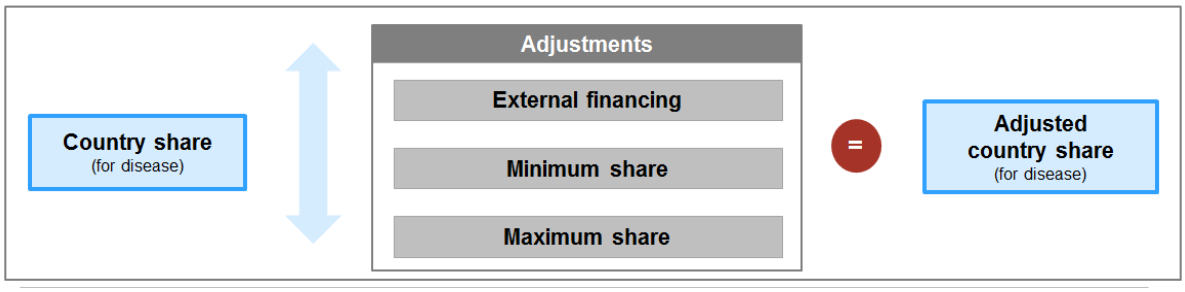


Exhibit 8: Adjusted country share calculation



External financing

The external financing adjustment shifts the country share so that the distribution of total external financing (Global Fund funding plus funding from other donors) is better aligned with the distribution of disease burden and ability-to-pay.

The adjustments for external financing are:

- data on other external financing is discounted by 50 percent (only half of the amount of other external financing that is reported is counted in the adjustment);
- no country can be adjusted by more than 50 percent of its original formula amount; and
- no country can receive more than the defined maximum shares or less than the defined minimum shares.

Minimum share constraint

The minimum share constraint ensures that allocations to disease components do not fall below a certain minimum share. The minimum share is the higher of:

- the minimum required level; and
- the amount the disease component would receive by applying the Band 4 methodology.

The minimum required level forms part of the qualitative criteria approved by the Board. Its purpose is to allow a graduated reduction to the funding levels of disease components that have received funding at levels above the original allocation amount adjusted for external financing under the allocation methodology, or which have an existing grants pipeline greater than its original allocation amount adjusted for external financing.

A target minimum graduated reduction will be applied to the funding levels of disease components that have received funding at levels above what their starting calculation amount under the allocation methodology would be, taking into account only disease burden, ability-to-pay and other external financing. For the 2014–2016 allocation period,

this graduated reduction will seek to reflect a target minimum reduction of 25 percent compared to disbursement levels over 2010-2013.

Additionally, if a disease component's existing grants pipeline as of 31 December 2013 exceeds the amount that would result from applying the graduated reduction, then this amount will serve as a basis to determine its country allocation starting from 1 January 2014.

Maximum share constraint

The maximum share constraint ensures that allocations to countries and disease components do not go above a specified ceiling. The maximum share that a country can receive is 7.5 percent of the total allocation to countries. Also, for a given disease component, a country cannot receive more than 10 percent of the total allocated to all countries for that disease.

The Global Fund Board decided there should be a special allocation approach for Band 4 countries (higher income and lower disease burden). This approach recognizes the special circumstances (concentrated epidemics, small island economies, etc.) in many Band 4 countries which may not be fully reflected in the disease burden definition and calculations underlying the allocation formula.

Consequently, eligible components in Band 4 are given an original formula amount that is the greater of the outcome from the disease burden and ability-to-pay-based formula and pre-defined amounts based on the total population size of a country. These amounts are indicative funding ceilings.

Exhibit 9: Indicative funding ceilings by population size

Population size	**Funding ceilings per disease component (HIV, TB, Malaria) (US$)**
Fewer than 500,000	1,282,149
Between 500,000 and 1 million	2,564,298
Between 1 million and 5 million	5,128,597
Between 5 million and 10 million	10,257,193
Over 10 million	12,821,492

The indicative funding ceilings are scaled such that in aggregate Band 4 accounts for 7 percent of resources that the Board has approved.

Disease components that are only eligible for a pre-defined maximum amount under the Eligibility and Counterpart Financing Policy, will be allocated the relevant funding ceilings set out in Exhibit 9, regardless of the outcome from the allocation formula. These are primarily upper-middle income countries with a high but not severe or extreme disease burden.

Exhibit 10: Initial country disease allocation calculation

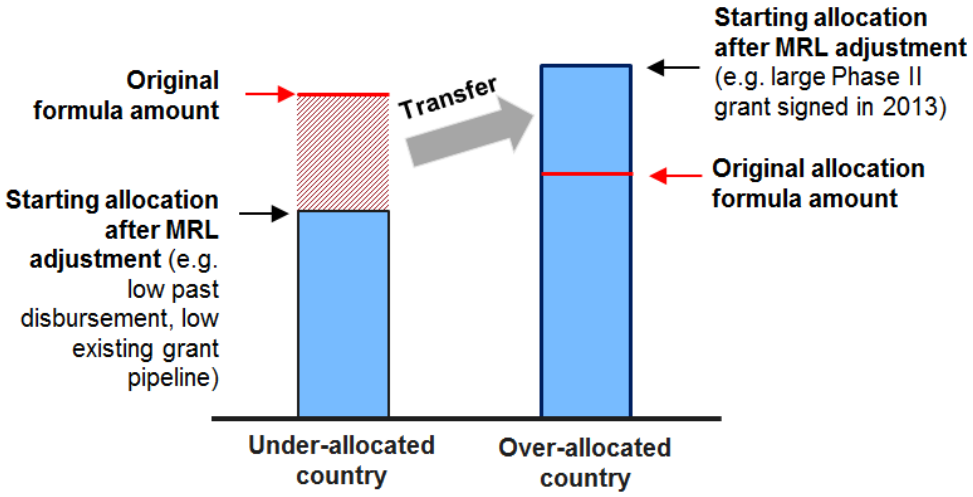
* Calculated using the global disease split.

After adjusting the original formula amount for minimum shares, maximum shares and external financing, the Global Fund arrives at the adjusted country share for each disease. The starting allocation is determined by multiplying the adjusted country share by the resources available for all country allocations for the disease.

After adjusting for minimum and maximum shares, the original formula amount can shift significantly making some components "over-allocated" and others "under-allocated".

The terms "over" and "under-allocation" refer to a disease component's starting allocation relative to its original formula amount based only on disease burden and ability-to-pay (with an adjustment for external financing). A disease component may receive more than its original formula amount if its level of recent funding (subject to a target minimum 25 percent reduction) or its existing funding pipeline is greater than its original formula amount. Over-allocated disease components are those that have their original formula amounts adjusted upwards. Since resources are limited, providing funding for some countries means that other countries receive less than would be allocated to them based on disease burden and income levels alone. This latter group is referred to as "under-allocated". Over time, the Global Fund will work with countries to transition to their original formula amount in a responsible and timely manner.

Exhibit 11: Under/Over-allocation



- Significantly over-allocated components (150% above original formula amount) are **not eligible** for incentive funding.
- **The Global Fund will work with over-allocated countries to take steps to move towards a more appropriate allocation in the future**

Step 4: Finalize funding amounts for country bands

Countries and their starting allocations are then placed in country bands. Starting allocations for countries within the same band are aggregated to generate funding amounts per band. Band composition for the 2014-2016 allocation period is set out in Annex 2.

The Board at its thirty-first meeting approved the following allocation of funding for the 2014-2016 allocation period:

- Country Band 1: US$11,250 million;
- Country Band 2: US$915 million;
- Country Band 3: US$1,530 million; and
- Country Band 4: US$1,105 million.

The Band 4 amount of US$1,105 million maintains resources allocated to Band 4 countries in line with recent funding levels.

Step 5: Adjust disease component allocations for qualitative factors

Within the total amounts for each country band, the starting allocation is further adjusted based on other qualitative factors to account for the circumstances in each country. These qualitative factors are: (i) past program performance; (ii) impact; (iii), increasing rates of infection; (iv) risk; (iv) absorptive capacity; and (v) other considerations. The application of the final qualitative factor, willingness to pay, happens during the country dialogue (see Step 8).

Each band has a fixed amount of funding: all adjustments must balance out to the total amount for each band. For example, if Band 1 is allocated US$4 billion, then the sum of the country allocations in Band 1 must add up to US$4 billion. So if the allocation to a country in Band 1 goes up due to strong performance, there must be a corresponding decrease across the other countries in Band 1 ensuring that overall the net change is zero across Band 1.
The qualitative adjustments are made first for each disease component and then added together in each country band. Applying the qualitative factors to Band 1 (higher-burden, lower income countries) was most difficult of all bands due to the level of funding needed to continue programs at their existing scale.

The Global Fund considers whether a component was over-allocated or under-allocated when applying qualitative factor adjustments. If a component was significantly over-allocated (i.e. 150 percent above the original formula amount) it did not receive any upward adjustments for performance, impact, increasing rates of infection or risk qualitative factors. This is because over-allocated components were already receiving more funding than they would have otherwise received through the allocation-based formula.

The adjustments for performance, impact, and increasing rates of infection work together to determine a percentage adjustment to the starting allocation. All starting allocations are first reduced to 70 percent. Then adjustments may be made upwards for performance (up to 25 percent), impact (up to 15 percent), and increasing rates of infection (5 percent). These adjustments are applied at the same time, so the maximum a component could receive would

be 115 percent of the starting allocation. For example, if a component were to receive a 25 percent adjustment for performance, a 10 percent adjustment for impact, and a 5 percent adjustment for increasing rates of infection, the calculation would be:

70% of starting allocation
+25% for *performance*
+10% for *impact*
+ 5% for *increasing rates of infection*
=110% of starting allocation

As mentioned above, all adjustments for qualitative factors must result in the same total amount of funding per band. So if the total amount of funds in each band differs because of these adjustments, then there will be a "rescaling", so that the total allocation in each band equals the total funds available. For instance, if the total for all component allocations in a band after these adjustments was 110 percent of the band's original band allocation, the components would be rescaled back down to 100 percent.

Performance. As performance-based funding is one of the guiding principles of the Global Fund, program performance is used to adjust starting allocations. A disease component's rating is calculated using the indicator-based performance of all grants for a particular disease component weighted by the grant budget over the previous 24-27 months (depending on grant timing) from June 2013. For more details on data used for performance, see Part III: Data Inputs for the 2014-2016 Allocation Period. The approach is similar to the performance-based funding approach applied to grant renewals under the rounds-based system.

Standard Global Fund grant ratings (A, B1, B2, and C) are used, and the adjustments for performance are as follows:

Exhibit 12: Performance rating adjustments

Performance Rating	Adjustment
A (≥ 90% performance)	**25% upward adjustment**
B1 (60-90% performance)	**15% upward adjustment**
B2 (30-60% performance)	**5% upward adjustment**
C (< 30% performance)	**0% upward adjustment** Additionally, a performance rating of C means that there can be no upward adjustment for *impact* for the component. This results in a net 70 percent allocation after *performance* and *impact* (excluding *Increasing Rates of Infection*) adjustments for the component.
No prior performance data	**15% upward adjustment** (assumed to be B1). When there is no previous performance data (there has been no grant in the disease component over the period of performance measured) or if there has been no data reported over the last 24 months (for newly signed grants), a disease component allocation is adjusted as if it had the average rating (mode) across the portfolio for all disease components (B1).

Impact: *Impact* is defined as progress made by a Global Fund-supported program in reducing mortality and morbidity to meet the 2015 MDGs 6/international targets. Similar to *Performance*, this qualitative factor is also based on the Performance Based Financing (PBF) principles of the Global Fund.

The *Impact* rating per disease component is calculated by the Global Fund using a methodology approved by technical partners. Each calculated rating is peer reviewed at least once, and if issues arose, twice, by a panel of experts including representatives from WHO and UNAIDS. For more details on how *Impact* ratings are determined, see Part III: Data Inputs for the 2014-2016 Allocation Period.

Four *Impact* ratings are used, each with a corresponding implication for the country allocation.

Exhibit 13: Impact rating adjustments

Impact Rating	Adjustment
Demonstrated Impact	**15% upward adjustment**
Progress Toward Impact	**10% upward adjustment**
No or Limited Progress Toward Impact	**0% upward adjustment**
Insufficient Data to assess impact	**0% upward adjustment** Countries with insufficient data are not adjusted upwards for two reasons: 1.Countries have been receiving funding to improve data for many years 2. The Global Fund does not want to incentivize/reward countries for not having data

Increasing Rates of Infection. The *Increasing Rates of Infection* qualitative factor addresses exceptional circumstances (not found in most countries) where the reported incidence of a disease has increased over the past five years primarily due to insufficient funding and is not attributable to: (i) an improvement in case finding/diagnostic efforts; (ii) a change in a reporting definition/coverage; or (iii) poor use of existing resources. This factor is also meant to take into account trends among key affected populations. Key affected populations are those populations within which an increase in infection rates is likely to have broad effects on the national burden (MSM, sex workers). The factor ensures there is additional money to combat the recent emergence or resurgence of a disease.

Increasing Rates of Infection ratings are based on whether there is robust evidence of an increase in the incidence rate of one of the three diseases over the past five years at either a national level, or at the level of a key sub-population that would have significant impact on the national burden. In all cases, ratings are reviewed by the same panel of technical partners that reviewed the *Impac*t ratings for each disease component. For more details on how *Increasing Rates of Infection* ratings are determined, see Part III: Data Inputs for the 2014-2016 Allocation Period.

Risk. Disease components that have programs operating in environments of extreme risk may receive up to US$1 million of additional funding to pay for risk mitigation measures. Countries in the top two categories of the 2013 Failed State Index (See:

http://ffp.statesindex.org/rankings-2013-sortable) were considered, plus countries identified by the Global Fund. Both country-specific and grant-specific factors are taken into account when determining the allocation of these additional funds. The cost of risk mitigation for each disease component is also taken into account when determining the amount of *Risk* funding. Over-allocated components were expected to fund the cost of risk mitigation through their allocation without additional funding for risk.

- Country context – Disease components are only considered eligible for additional *Risk* funding if:
  - Risk is considered to be extreme, not just endemic. As Global Fund grants are implemented in numerous contexts that could be considered as having a "risk" element, the additional *Risk* funding is meant only for exceptional circumstances;
  - Risk is beyond a country's control to mitigate internally;
  - Risk is not just political, but has operational (programming and financial) implications as well; and
  - There are clear areas where additional funding could help mitigate the risk (*Risk* funding is not provided if additional risk funding would not mitigate risk).
- Grant context – Disease components are only considered eligible for additional Risk funding if:
  - There is insufficient funding in the existing grant to pay for risk mitigation. In many countries that may otherwise qualify for additional Risk funding, the absorptive capacity is very low, meaning that risk mitigation activities can be financed out of the existing grant;
  - Risk mitigation is not already being managed by the Principal Recipient. In many circumstances the Global Fund has selected a Principal Recipient in part because of their ability to mitigate risk. Risk funding is not given because the risk mitigation should already be provided by the Principal Recipient;
  - There is a clear case that additional funds would mitigate risk in the context of the grant; and
  - The grant funds are sufficiently large to justify the expense for additional risk mitigation.

Absorptive Capacity. After taking into account all prior qualitative factors initial country disease allocations are re-calculated. This amount is reviewed to determine whether a disease program can absorb the funds based on past financial data and operational performance. The Global Fund checks for absorptive capacity because it wants to ensure that there are no unabsorbed funds that could have been used by another country to save lives.

One purpose of *Absorptive Capacity* is to identify outlying cases where the amount generated from the allocation model exceeds the expected absorptive capacity of the country (thus, tying up funds that could be effectively used elsewhere).

- For each component, a review was undertaken for *Absorptive Capacity*. Disease components were flagged for close review if past absorptive capacity indicates a potential inability to absorb the future allocation. This is based on two factors:

- The average spending rate (amount disbursed compared with the total grant budget, and cross-checked against the actual expenditure rate); and
- The ratio between average annual past disbursements and the annualized starting allocation adjusted for Performance, Impact, Increasing Rates of Infection and Risk.

For more details the specific data used to calculate *Absorptive Capacity*, see Part III: Data Inputs for the 2014-2016 Allocation Period.

Exhibit 14: Matrix for determining whether a review for Absorptive Capacity is necessary

	Spend Rate 24 Month Average				
Annualized preliminary allocation / past average annual spend	<50%	50-59%	60-69%	70-79%	>80%
<1	Review	Accept	Accept	Accept	Accept
1-1.5	Review	Review	Review	Review	Accept
1.5-2	Review (likely reduction)	Review (likely reduction)	Review	Review	Review
2-3	Review (likely reduction)	Review (likely reduction)	Review (likely reduction)	Review	Review
>3	Review (likely reduction)	Review (likely reduction)	Review (likely reduction)	Review (likely reduction)	Review

If a component falls into the "Review" or "Review (likely reduction) categories based on the criteria above, the Global Fund performs a detailed review to calculate adjustments based on country- specific factors.

Factors indicating a future increased ability to absorb funds include:

- The country is emerging from a period of civil strife or other exceptional events have occurred that would have depressed recent historical spending;
- The National Strategic Plan and country dialogue discussions demonstrate that the country has a coherent and credible plan to improve past performance or to expand programs;
- Evidence of other major donors planning to reduce funding, leaving gaps in existing programs;
- Clear and feasible plans to unlock grant management bottlenecks (such as a plan to strengthen procurement systems or improve financial systems);
- Evidence of greater political will to support programs;
- An upward trend of disbursements and expenditure rates over the most recent years; and
- Expected changes in grant implementers that would significantly increase disbursement and expenditure rates.

Factors indicating a future reduced ability to absorb funds include:

- The country is entering a period of civil strife or other exceptional events have occurred that are likely to depress future spending ability;
- Country dialogue discussions suggest new or heightened problems of governance and leadership of the program;
- No plans are in place to unlock serious grant management bottlenecks;
- Evidence of reduced political will to support programs;
- Key populations are not included in country dialogue discussions or program plans;
- A downward trend of disbursements and expenditure rates over the past few years; and
- Expected changes in grant implementers that would significantly decrease disbursement and expenditure rates.

Other Considerations. The Global Fund may also take into account other relevant considerations that could impact country allocations. While numerous *Other Considerations* can be considered, for the majority of cases, adjustments were made to allocations based on the following:

- Other Considerations resulting in increases:
  - The country is poised to make a disproportionate impact;
  - Additional funding is needed to support essential services through to the next replenishment (Nearly all increases for Other Considerations were due to this issue); and
  - Other sources of financing (not previously considered) within the country were decreasing beyond what the allocation model anticipated.
- Other Considerations resulting in decreases:
  - The country or component has never received funds from the Global Fund in the past and operational costs would be too high;
  - The programmatic needs in the country do not demand full resources, specifically:
    i. Where governments are taking on more of the costs;
    ii. For components that were allocated large population-based Band 4 amounts, but where the actual disease burden was either very low or there was very little data to support any disease burden at all; and
    iii. A component is receiving funding through a regional grant.

Step 6: Review and validate country allocations

The Global Fund undertook a number of internal and external checks to validate country allocations. Senior management from Grant Management, Finance and the Strategy, Investment and Impact Division were involved in internal review processes. Additionally, the allocation and review processes were documented including implementing appropriate controls and assessing and mitigating identified risks.

Following the application of qualitative factors each country allocation was reviewed through a series of review panels.

- Regional reviews: Global Fund senior management for each major geographic region[1] met to review allocations for every country and component. Regional Finance Managers and disease advisors also provided technical input into these reviews.
- Grant Management, Finance and Strategy, Investment and Impact Division reviews: Following regional reviews, a panel of senior Global Fund managers from the Grant Management, Finance and Strategy, Investment and Impact Divisions reviewed country allocations across the whole portfolio to ensure consistency across regions.
- Grant Approvals Committee review: The Grant Approvals Committee, including technical partners, met to discuss specific issues around the allocations and, in the executive session, reviewed and approved country allocations.

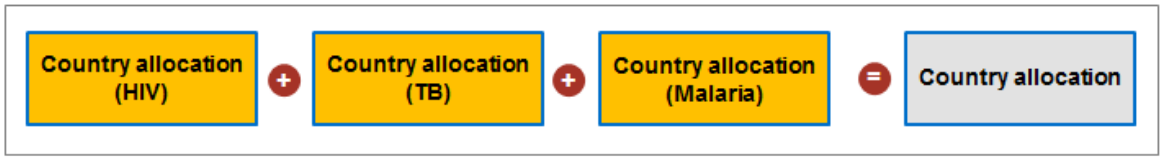
In addition to the review process, the allocation process was governed by a COSO-compliant framework which ensured that appropriate validation steps were applied to ensure accuracy of calculations and data entry at every stage. COSO is a risk framework developed by the Committee of Sponsoring Organizations of the Treadway Commission (COSO.) Specifically, both internal and external checks were applied:

- The COSO-compliant approach involves a risk assessment of each main process in the allocation methodology, addressing inherent risk (risk of error in the absence of any controls) and final or residual risk (the remaining risk after applying appropriate controls) to ensure that there is sufficient focus on high risk processes especially those where controls fail to reduce risk significantly;
- The approach breaks down each main process into sub processes and assigns ownership and accountability to specific staff positions. It also includes requirements to retain documentary evidence of the performance of each control;
- Importantly, it includes reference to validation steps involving outside partners – specifically technical partners for each disease who have been involved in validating disease burden and impact data;
- Internal processes were reviewed including the maintenance of proper records of all meetings at which decisions about allocations were taken to provide an audit trail;
- Stringent checks were made to all communications about country allocations before they were sent to countries; and
- A validation of the allocation model and input data was conducted by an external consulting firm, Results For Development (R4D). An extract of the opinion report is contained in Annex 3.

Exhibit 15: Calculation of country allocations

[1] There are 3 general geographic regions within the Global Fund Grant Management Division. These are: 1) High Impact: 20 countries in Africa and Asia that represent a large majority of the global disease burden in the three diseases; 2) Africa and the Middle East: Countries in Africa not categorized as "High Impact" as well as countries in the Middle East. 3) Rest of the world: Countries in Latin America and the Caribbean, Eastern Europe and Central Asia, and South and Eastern Asia.

After the review and validation process, the country allocations for HIV, TB and malaria are added up to arrive at the country allocation for each country.



Step 7: Communicate country allocations to each country

Following the review and validation of country allocations, countries were informed of their country allocations for the 2014-2016 allocation period by a letter from the Head of the Grant Management Division, sent by the Fund Portfolio Manager. Each letter was tailored to the particular circumstances of each country. Countries were provided with details about their existing grants pipeline and any new funding for each disease component, as well as key information on:

- Eligibility for HIV, TB, malaria and health systems strengthening funding;
- Counterpart financing threshold;
- Willingness to pay requirement;
- Country Band placement;
- Incentive funding for eligible components;
- Country program split process;
- Applicable investments in cross-cutting health systems strengthening;
- Recoverable amounts relating to audits or investigation processes;
- TB and HIV single concept note and joint programming for the two diseases; and
- Grant duration (While a typical grant is for three years, the Global Fund can work with countries to be flexible on timing based on multiple factors including: ambition to achieve increased impact and sustain gains; whether a country has been relatively under-allocated or over-allocated; and alignment with national plans and schedules.)

Step 8: Determine final funding amount for each country

The allocation amounts communicated to countries will not be the final amount countries receive from the Global Fund in many cases. After a country has been informed of its country allocation amount, further adjustments are possible:

- Willingness to Pay. 15% of a country's allocation can only be accessed by the government committing to make additional contributions. The minimum level and type of government commitments required to access 15% of the allocated funding through meeting willingness-to-pay commitments will be agreed during country dialogue.

- Program Split. Prior to concept note submission, countries have the flexibility to revise their country allocations among eligible disease components. They can also allocate funds to cross-cutting health systems strengthening.
- Incentive funding. This is a funding pool designed to reward high impact, well-performing programs and encourage ambitious requests. It is made available, on a competitive basis, to select applicants in Bands 1, 2 and 3, whose funding requests are based on robust national strategic plans or a full expression of prioritized demand. Applicants apply for incentive funding by submitting an 'above allocation' request in the concept note. The Grant Approvals Committee determines final funding amounts, and whether or not a country will be awarded incentive funding, based on the recommendation of the Technical Review Panel.
- Unfunded Quality Demand. This is funding requested through a concept note which is considered technically sound by the Technical Review Panel, but is above the funding amount available (country allocation and any incentive funding awarded). This funding may be placed on the register of unfunded quality demand for up to 3 years, and may be funded by the Global Fund or other donors when new resources become available.

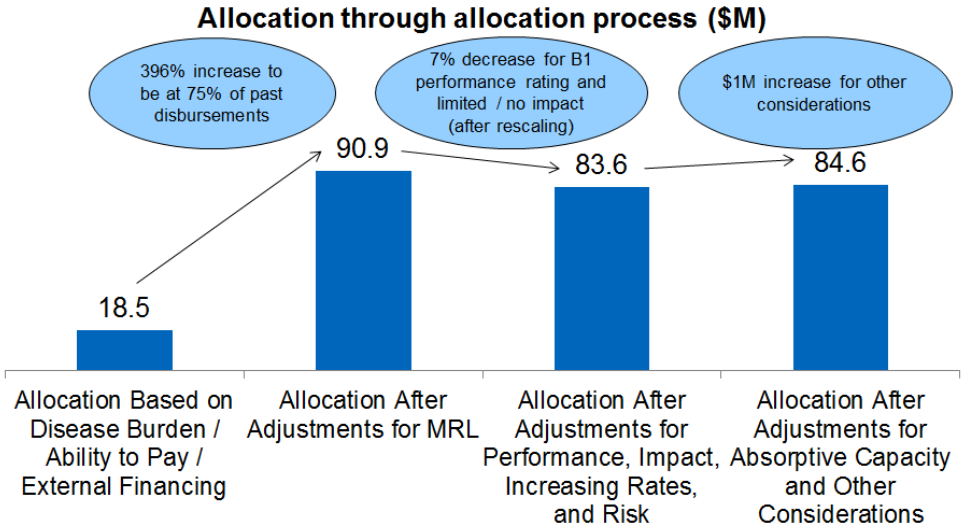
The Global Fund will monitor the total amount of funding provided to countries and report regularly to the Board and its Committee on key areas of interest (allocation by disease, region and use of funds).

For more information about these topics, refer to the Resource Book: http://www.theglobalfund.org/en/fundingmodel/support/

Examples illustrating how adjustments for qualitative factors work

The two examples below illustrate how adjustments are made to the starting allocation amounts to arrive at the country disease allocation amount.

Exhibit 16: Component A: High past disbursements/ existing grants pipeline



In Exhibit 16, the disease component begins with a starting allocation of US$18.5 million, based on its disease burden and income level. However, the disease component received US$120 million in disbursements over the past 4 years. To reach its minimum required level, the disease component is increased to US$90.9 million, a 396% increase that is 75% of the past disbursements. This results in the component being significantly over-allocated and therefore ineligible for incentive funding. Grants in the program have a weighted-average performance rating of B1 and limited impact, which means that the component is reduced by 7%. No adjustment is made for increasing rates of infection or risk. Finally, a US$1 million increase was provided for other considerations giving an allocation amount after qualitative factor adjustments of US$84.6 million.

Exhibit 17: Component B: Low past disbursements/existing grants pipeline

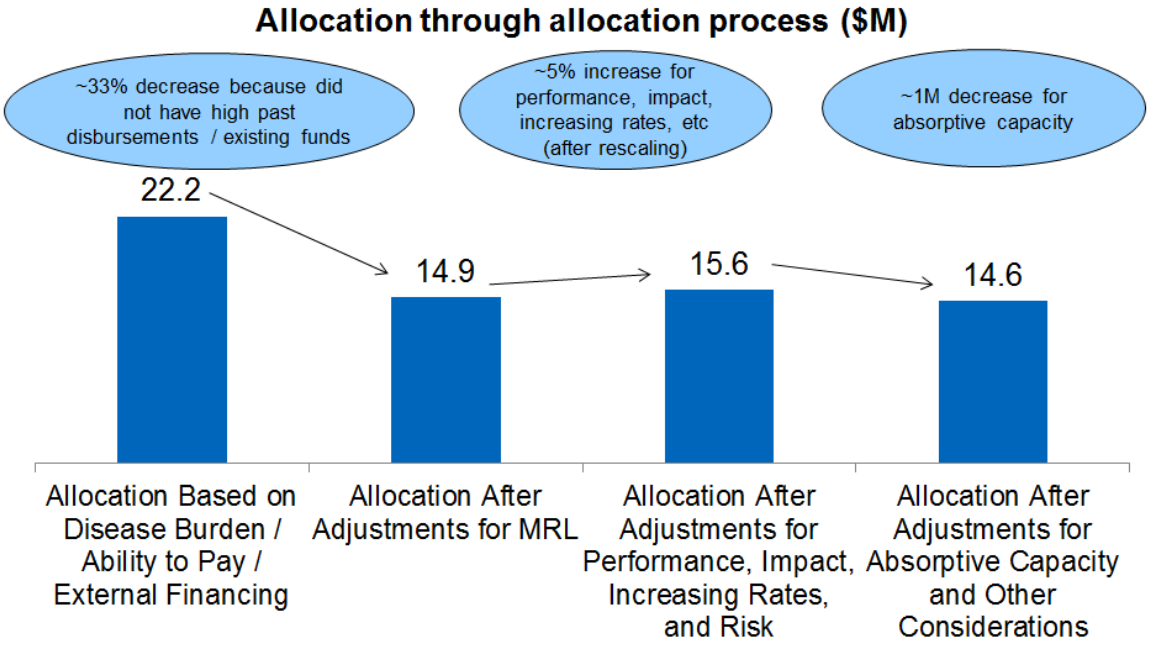


Exhibit 17 illustrates a case where the starting allocation had to be reduced to increase the allocation to other components that were below their minimum required levels (MRLs) (such as component A). The disease component begins with a starting allocation of US$35.1 million, based on its disease burden and income level. Unfortunately, the disease component has not been successful in recent years and has very low levels of disbursements and existing grants. As a result, in order to cover the minimum required level of over-allocated components like the example in Exhibit 16, the disease component is decreased by 52% to US$16.9 million. This results in the component being under-allocated.

Grants in the program have a weighted-average performance rating of B1 but have demonstrated impact, which results in the disease component receiving 95% of the amount. However, the band is relatively poorly performing compared to the disease component in our example, so after rescaling, the component is increased by 2%. No adjustment is made for increasing rates of infection or risk. Finally, a US$6 million increase was provided for other considerations because the level of the allocation was so low that it would have required the Global Fund to remove patients from treatment. This results in an allocation amount after qualitative factor adjustments of US$25.8 million, a net decrease of 27% relative to the starting allocation.

Part III: Data Inputs for the 2014-2016 Allocation Period

Part III explains the data sources that were used to determine eligibility, the starting allocation and the qualitative factor adjustments. It also provides an overview of the checks and validations undertaken to ensure the data was accurate.

Eligibility criteria

The four main criteria used to determine which disease components are eligible to receive an allocation from the Global Fund are:

- Income level, based on the World Bank (Atlas Method) Income Classification thresholds published in July of each year and GNI per capita data;
- Disease burden (for upper-middle income countries only), using official data provided by the headquarters of WHO and UNAIDS;
- G-20 membership (for upper-middle income countries only); and
- OECD-DAC list of Official Development Assistance (ODA) recipients (for upper-middle income countries).

Data inputs for the allocation formula

The Global Fund used the latest WHO and UNAIDS estimates of disease burden which were produced in consultation with countries. This information is important as it is used in determining a country's allocation and eligibility. The Global Fund communicated to countries in August 2013 that data being collected by UNAIDS and WHO during the partners' 2013 data collection cycle would be used in the allocation formula, so that countries could work with partners to provide the best available data.

Key data inputs for the allocation formula are:

- Disease burden for HIV, TB and malaria for each country
- Income levels for each country
- Population data for each country
- External financing estimates for each country
- Minimum required level (MRL)-related data for each disease component
  - Past disbursement data
  - Existing grants pipeline as of 31 December 2014

HIV burden data. This data was provided by UNAIDS in January 2014. In the small number of eligible countries where no official disease burden data was provided by UNAIDS for a country eligible for HIV funding, an estimate was made based on published reports. These estimates were shared with and validated by UNAIDS. There is no material impact on country allocations from these estimates due to the minimum provisions in the allocation methodology. No attempt was made at identifying estimates for eligible countries with total populations of less than 250,000, as it is considered unlikely for any plausible level of disease burden in these small countries to result in country allocations that exceed the

minimum share amounts[2]. Where no data or estimate was provided or subsequently identified for a country, the HIV disease burden was set to zero.

TB burden data. This data was provided by WHO/TB in January 2014. The same process for estimating HIV disease burden was used to estimate TB disease burden for the small number of countries with no official TB disease burden estimates[3]. These estimates were shared with and validated by WHO/TB. There was no material impact on country allocations from these additional estimates.

Malaria burden data. This data was provided by WHO/GMP in January 2014. The process for estimating HIV and TB disease burden was used to estimate malaria burden for the small number of countries with no official malaria disease burden estimates[4]. There was no material impact on country allocations from these additional estimates.

Income level data. World Bank GNI per capita (Atlas method) data available in January 2014 is the default source of income level data[5]. For the small number of countries where no World Bank estimate is available, the GNI per capita as reported by the UN Statistics Division on 20 January 2014 was used[6].

Total population data. Total population data from the World Bank was used[7]. Zanzibar is the only entity on the 2014 Eligibility List for which no World Bank estimate is available. For Zanzibar, an estimate was used based on the latest available census report and the same amount deducted from the World Bank estimate for Tanzania (mainland)[8].

External financing data. Projected or recent annual levels of funding from large donors (for the three diseases) was provided directly by donors. For the remaining donors, the OECD DAC database of annual level of funding for the three diseases was used. The most recent OECD DAC data available is 2011-2012 data and an average of the two years was used to calculate the amount used for the external financing adjustment.

Minimum Required Level (MRL). The MRL is defined as the greater of the following:

- The **last four-years' (2010-2013) grant disbursement data** available at the end of 2013, with a 25% reduction, as recommended by the Strategy, Investment and Impact Committee and approved by the Board. Disbursements for HSS grants are allocated to HIV, TB, and malaria components in proportion to the level of past disbursements across the three components in each country. Likewise, funding classified as HIV/TB is split 50:50 between HIV and TB components. To avoid incorrectly depressing disbursement levels Office of the Inspector General and similar recoveries (reflected as negative disbursements) are reversed from the historical disbursements data if the recoveries took place

[2] This is also consistent with the estimation approach of UNAIDS, which does not create estimates for countries with populations of less than 250,000. Twelve countries eligible for HIV funding fit this criterion.
[3] Only two countries eligible for TB funding were missing TB data.
[4] Only three eligible countries were missing malaria data.
[5] http://databank.worldbank.org/data/download/GNIPC.xls downloaded 3 January 2014. The indicators and use of these data is as per SIIC decision point: GF/SIIC09/08/DP1, part 2
[6] http://data.un.org downloaded 20 January 2014; currently there are only 7 eligible countries without GNI per capita (Atlas Method) data reported by the World Bank. The indicators and use of these data is as per SIIC decision point: GF/SIIC09/08/DP1, part 2
[7] http://data.worldbank.org/indicator/SP.POP.TOTL downloaded 3 January 2014
[8] http://www.nbs.go.tz/sensa/PDF/Census%20General%20Report%20-%2029%20March%202013_Combined_Final%20for%20Printing.pdf

during the 2010-2013 calendar period but relate to grant implementation that occurred prior to 2010; and

- Existing **grants pipeline** is defined as amounts from Board-endorsed proposals and other related Board decisions originating from the Third Replenishment Period or earlier, remaining undisbursed as of 31 December 2013. For example, Board approvals up to and including Round 10, Rolling Continuation Channel, National Strategy Applications, Transitional Funding Mechanism, as well as the Transition to the New Funding Model mechanism.

The existing grants pipeline consists of five main elements:

Exhibit 18: Elements of Existing grants pipeline

Element	Description	MRL treatment in allocation formula*
Committed / undisbursed grants	Grant amounts committed by the Global Fund for a grant which are undisbursed as at 31 Dec 2013	100% included in MRL
Signed / uncommitted grants	Grant amounts under signed Grant Agreements that are uncommitted (and therefore undisbursed) as at 31 Dec 2013	100% included in MRL
Board Approved / unsigned grants	Grant amounts approved by the Board and unsigned (and therefore undisbursed) as at 31 Dec 2013	100% included in MRL
Board endorsed / Yet-to-be-approved grants: Dec-2013 & Feb-2014 GAC waves	Grant amounts endorsed by the Board in principle, reviewed by GAC and not yet approved by the Board (and therefore undisbursed)	Taken at GAC recommended amounts
Board endorsed / Yet-to-be-approved grants: all others	Grant amounts endorsed by the Board in principle, not yet reviewed by GAC and not yet approved by the Board (and therefore undisbursed)	Taken at TRP recommended amounts, approved in principle by the Board, LESS 10% Board-mandated reduction and any applicable advance of funds from subsequent implementation periods, and average performance based funding reduction (see note) for rating

*For over-allocated countries, the Global Fund may negotiate reductions to elements of their existing grants pipeline to transition countries to the original formula amount derived from disease burden and ability-to-pay.

Data inputs for the qualitative factors

The starting allocations are adjusted for other qualitative factors that take into account specific circumstances in each country due to past program performance, impact, increasing rates of infection, risk, absorptive capacity and other considerations.

The key data inputs for the qualitative factor adjustments are:

- Performance ratings for each disease component;
- Impact ratings for each disease component;
- Increasing rates of infection ratings for each disease component;
- Risk-related data; and
- Past absorptive capacity data.

Performance ratings: The *Performance* qualitative factor is calculated for each disease component. It is based on average performance of grants weighted by grant size (amount budgeted for the period covered for performance assessment) and is calculated based on all indicators of grant performance and budget data. Generally, the performance period measured covers up to 24 months of past periods, with a cut-off date of June 2013. However, because it is based on the periods/months covered by Global Fund Progress Updates, which may not perfectly align with the June 2013 cut-off, the performance assessment may cover slightly more or less than 24 months depending on grant start date. In particular, Progress Updates with periods ending on or after 31 March 2011 were included for performance assessment; Progress Updates with periods ending before 31 March 2011 are not included so that the period covered for performance assessment does not significantly exceed 24 months from June 2013.

Illustration: periods to be covered for performance assessment. As illustrated below, assuming a disease program (HIV/AIDS) has two principal recipients managing different grants, the program performance rating will include all grants (in-progress, consolidated or closed) with targets and reported results in the last 24 months, (January 2011 – June 2013).

Exhibit 19: Performance assessment illustration

	PR1			PR2	
	XXX-H-PR1	XXX-708-G09-H (PR1)	XXX-506-G08-H (PR1)	XXX-H-PR2	XXX-506-G09-H (PR2)
Period/Grant status	In-progress	Consolidated	Closed	In-progress	Closed
Apr.-Jun. 2011		✓	✓		✓
Jul.- Sept.2011		✓	✓		✓
Oct.-Dec. 2011		✓		✓	✓
Jan-Mar. 2012	✓			✓	
Apr.-Jun. 2012	✓			✓	
Jul.-Sep. 2012	✓			✓	
Oct.-Dec. 2012	✓				
Jan.-Mar. 2013	✓				
Apr.-Jun. 2013	✓				
Grant budget for the periods covered	$1	$2	$3	$4	$5
Avg. grant performance (all indicators)	X1	X2	X3	X4	X5
Weighted Performance	$Y1=X1*\$1/\Sigma\$_i$	$Y2=X2*\$2/\Sigma\$_i$	$Y3=X3*\$3/\Sigma\$_i$	$Y4=X4*\$4/\Sigma\$_i$	$Y5 = X5*\$5/\Sigma\$_i$
Weighted program performance	Y1 + Y2 + Y3 + Y4 + Y5				

Periods covered for performance rating: Jul.2011 – June 2013 = 24 months

Impact Ratings: The *Impact* rating per disease component is calculated by the Global Fund using methodology approved by technical partners and data from partner databases (WHO TB database, AIDSinfonline database, and WHO malaria database). There are two main types of indicators considered:

- disease burden indicators; and
- coverage/outcome indicators.

These indicators are selected from the MDGs 6/international frameworks for the three diseases.

For disease burden indicators, progress is measured in relation to their respective MDGs 6/international targets, and falls into of the following categories:

- Already met the target
- On track to meet the target
- Will not meet the target, but progressing
- Will not meet the target and not progressing

The progress of coverage/outcome indicators is measured by comparing the latest measure (since 2010) with other Global Fund-supported countries. These have been ordered by rank, and given the following four categories depending on country rank:

- Very low – below the 25th percentile (25% of countries with lowest values)
- Low – between 25-50th percentile
- Moderate - between 50-75th percentile
- High – above 75th percentile (25% of countries with highest values)

An overall calculated *Impact* rating is then derived by combining the progress status of both impact and coverage/outcome indicators. Where data quality or availability are inadequate to make a sound judgment, the program is rated as "insufficient data." Each calculated *Impact* rating was carefully reviewed by technical partners. In some instances ratings were upgraded or downgraded taking into account the uncertainty around the estimates of disease burden and contextual factors.

Increasing rates of infection: For the preliminary assessment of *Increasing Rates of Infection*, data from partner databases is used (WHO TB database, AIDSinfonline database and, WHO malaria database). In certain circumstances, the Global Fund gathers additional information from Country Coordinating Mechanisms. To qualify for *Increasing Rates of Infection* adjustments, a country must have three elements:

- An increase in incidence rate of HIV, TB and/or malaria over the past five years at the national level or in key population/s (as defined in its National Strategic Plan);
- Supporting information to demonstrate that the recent increase in incidence rate is primarily due to insufficient funding and not attributable to an improvement in case finding/diagnostic efforts, a change in a reporting definition, or poor use of existing resources; and
- Where there is indication of an increasing trend in the incidence rate among the key affected population/s, a reliable estimate of the size of the key population.

Risk ratings: The starting data source for determining *Risk* adjustments was the 2013 Failed State Index, published by the Fund for Peace. For more information see: www. http://global.fundforpeace.org/. Countries ranked in the top two risk profiles were initially considered for the additional risk mitigation funding but were also evaluated based on a number of criteria, as described above. Additional countries were considered on an exceptional basis.

Absorptive capacity data: The information sources used as a benchmark for reviewing the initial allocated amounts for *Absorptive Capacity* are:

- The past spending rate compared with the corresponding budget;
- The past absolute amount absorbed for the equivalent period; and
- The past disbursement history as used in the Minimum Required Level (MRL) calculation in the allocation formula.

Data validation

Data used in the allocation process has undergone multiple rounds of data validation. A validation of the allocation model and input data was also conducted by an external consulting firm, Results For Development (R4D). An extract of the opinion report is contained in Annex 3.

Exhibit 20: Data Validation

Data input	Reviewed/Validated
HIV disease burden data	UNAIDS Global Fund Strategy Investments and Impact Leadership
TB disease burden data	WHO/TB Global Fund Strategy Investments and Impact Leadership
Malaria disease burden data	WHO/GMP Global Fund Strategy Investments and Impact Leadership
Income level data	Global Fund Strategy Investments and Impact Division leadership
Population data	Global Fund Strategy Investments and Impact Leadership
Past disbursement and existing pipeline of funds data (used for MRL)	Global Fund Grant Management, Finance, Treasury and Performance Division leadership
Performance rating data	Global Fund country teams Global Fund Grant Management Support Department Global Fund Strategic Information Leadership
Impact rating data	UNAIDS, WHO Global Fund country teams Global Fund Strategic Information Leadership
Increasing rates of infection data	UNAIDS, WHO Global Fund Strategic Information Leadership
Failed State Index data for Risk	Global Fund country teams Global Fund New Funding Model Leadership
Absorptive capacity data	Global Fund finance officers for each country Global Fund Finance, Treasury and Performance Division Leadership

Annex 1: List of Countries receiving allocations for 2014-16 allocation period

Country	Disease	Allocation (US$ million)		Country	Disease	Allocation (US$ million)
Afghanistan*	HIV	14.1		Madagascar	HIV	17.2
Afghanistan*	TB	22.4		Madagascar	TB	10.6
Afghanistan*	Malaria	31.3		Madagascar	Malaria	84.6
Albania	HIV	5.1		Malawi*	HIV	474.6
Albania	TB	0.9		Malawi*	TB	13.0
Algeria	HIV	6.5		Malawi*	Malaria	86.8
Angola	HIV	23.3		Malaysia	HIV	6.8
Angola	TB	8.8		Mali	HIV	110.6
Angola	Malaria	60.2		Mali	TB	13.9
Armenia*	HIV	9.8		Mali	Malaria	94.2
Armenia*	TB	12.6		Mauritania	HIV	11.5
Azerbaijan	HIV	19.8		Mauritania	TB	4.8
Azerbaijan	TB	18.0		Mauritania	Malaria	15.6
Bangladesh	HIV	34.5		Mauritius	HIV	5.1
Bangladesh	TB	90.4		Mongolia*	HIV	5.9
Bangladesh	Malaria	30.4		Mongolia*	TB	10.9
Belarus	HIV	20.6		Morocco	HIV	24.6
Belarus	TB	17.4		Morocco	TB	12.8
Belize	HIV	3.2		Mozambique*	HIV	252.6
Belize	TB	1.3		Mozambique*	TB	52.8
Benin*	HIV	86.7		Mozambique*	Malaria	144.8
Benin*	TB	14.4		Multi-country Caribbean[9]	TB-HIV	5.3
Benin*	Malaria	62.8		Multi-country Western Pacific[10]	TB-HIV	21.2
Bhutan	HIV	2.4		Multi-country Western Pacific[11]	Malaria	9.7
Bhutan	TB	2.6		Myanmar	HIV	117.7
Bhutan	Malaria	2.6		Myanmar	TB	81.8
Bolivia	HIV	15.6		Myanmar	Malaria	57.5
Bolivia	TB	12.8		Namibia	HIV	87.7
Bolivia	Malaria	12.8		Namibia	TB	18.1
Botswana	HIV	18.1		Namibia	Malaria	5.5
Botswana	TB	5.5		Nepal	HIV	38.2

[9] The multi-country Caribbean allocation for tuberculosis and HIV includes the following eligible countries: Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines.
[10] The multi-country Western Pacific allocation for tuberculosis and HIV includes the following eligible countries: Kiribati, Marshall Islands, Micronesia, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.
[11] The multi-country Western Pacific allocation for malaria includes the following eligible countries: Solomon Islands and Vanuatu.
* Country has existing funding in a health systems strengthening grant. This funding has been included proportionally in each eligible component for the purposes of this document. Allocation letters to countries show this funding separately.

Country	Disease	Allocation (US$ million)	Country	Disease	Allocation (US$ million)
Botswana	Malaria	5.1	Nepal	TB	23.7
Bulgaria	HIV	9.2	Nepal	Malaria	14.7
Bulgaria	TB	10.3	Nicaragua	HIV	17.4
Burkina Faso	HIV	77.1	Nicaragua	TB	11.7
Burkina Faso	TB	11.9	Nicaragua	Malaria	11.7
Burkina Faso	Malaria	115.6	Niger*	HIV	24.3
Burundi	HIV	82.3	Niger*	TB	51.6
Burundi	TB	9.5	Niger*	Malaria	88.1
Burundi	Malaria	36.3	Nigeria	HIV	477.4
Cambodia*	HIV	80.8	Nigeria	TB	160.5
Cambodia*	TB	15.9	Nigeria	Malaria	499.5
Cambodia*	Malaria	52.1	Pakistan	HIV	28.5
Cameroon	HIV	155.2	Pakistan	TB	174.5
Cameroon	TB	15.0	Pakistan	Malaria	52.0
Cameroon	Malaria	118.1	Panama	HIV	5.7
Cape Verde	HIV	5.0	Panama	TB	2.2
Cape Verde	Malaria	1.3	Papua New Guinea	HIV	25.2
Central African Republic	HIV	36.1	Papua New Guinea	TB	13.7
Central African Republic	TB	12.0	Papua New Guinea	Malaria	44.3
Central African Republic	Malaria	32.1	Paraguay*	HIV	12.5
Chad	HIV	64.1	Paraguay*	TB	8.4
Chad	TB	8.8	Paraguay*	Malaria	5.4
Chad	Malaria	97.9	Peru	HIV	12.8
Colombia	HIV	19.4	Peru	TB	15.0
Comoros	HIV	3.3	Philippines	HIV	14.4
Comoros	TB	2.5	Philippines	TB	71.7
Comoros	Malaria	13.3	Philippines	Malaria	22.2
Congo	HIV	27.5	Republic of Moldova	HIV	19.6
Congo	TB	3.9	Republic of Moldova	TB	19.9
Costa Rica	HIV	4.9	Romania	TB	12.8
Côte d'Ivoire	HIV	112.9	Russian Federation	HIV	15.7
Côte d'Ivoire	TB	28.5	Rwanda	HIV	294.6
Côte d'Ivoire	Malaria	118.7	Rwanda	TB	36.5
Cuba	HIV	21.8	Rwanda	Malaria	64.8
Democratic People's Republic of Korea	TB	43.0	Sao Tome & Principe	HIV	1.3

* Country has existing funding in a health systems strengthening grant. This funding has been included proportionally in each eligible component for the purposes of this document. Allocation letters to countries show this funding separately.

* Country has existing funding in a health systems strengthening grant. This funding has been included proportionally in each eligible component for the purposes of this document. Allocation letters to countries show this funding separately.

** Only eligible for transition funding

Country	Disease	Allocation (US$ million)	Country	Disease	Allocation (US$ million)
Democratic People's Republic of Korea	Malaria	15.9	Sao Tome & Principe	TB	1.4
Democratic Republic of the Congo*	HIV	177.9	Sao Tome & Principe	Malaria	10.9
Democratic Republic of the Congo*	TB	86.8	Senegal	HIV	47.8
Democratic Republic of the Congo*	Malaria	436.8	Senegal	TB	13.5
Djibouti	HIV	6.0	Senegal	Malaria	62.4
Djibouti	TB	6.4	Sierra Leone	HIV	48.2
Djibouti	Malaria	7.8	Sierra Leone	TB	10.8
Dominican Republic	HIV	37.0	Sierra Leone	Malaria	67.4
Dominican Republic	TB	12.8	Somalia	HIV	28.8
Ecuador	HIV	16.3	Somalia	TB	33.5
Egypt	HIV	7.0	Somalia	Malaria	49.9
Egypt	TB	11.1	South Africa	HIV	386.7
El Salvador	HIV	23.7	South Africa	TB	78.1
El Salvador	TB	10.3	Sri Lanka*	HIV	16.0
El Salvador	Malaria	3.9	Sri Lanka*	TB	12.2
Eritrea	HIV	39.2	Sri Lanka*	Malaria	17.3
Eritrea	TB	9.5	Sudan	HIV	38.0
Eritrea	Malaria	36.1	Sudan	TB	28.2
Ethiopia*	HIV	379.8	Sudan	Malaria	98.6
Ethiopia*	TB	60.4	Sudan South*	HIV	47.0
Ethiopia*	Malaria	150.9	Sudan South*	TB	15.6
Fiji**	TB	5.4	Sudan South*	Malaria	73.2
Gabon	HIV	0.2	Suriname	HIV	2.6
Gabon	TB	5.1	Suriname	TB	2.6
Gambia	HIV	20.1	Suriname	Malaria	2.6
Gambia	TB	6.8	Swaziland*	HIV	48.5
Gambia	Malaria	26.2	Swaziland*	TB	26.7
Georgia	HIV	33.9	Swaziland*	Malaria	5.2
Georgia	TB	22.6	Syrian Arab Republic	HIV	5.5
Ghana	HIV	121.2	Syrian Arab Republic	TB	7.2
Ghana	TB	27.7	Tajikistan	HIV	24.7
Ghana	Malaria	125.1	Tajikistan	TB	27.5
Guatemala	HIV	44.8	Tajikistan	Malaria	1.3
Guatemala	TB	9.9	Tanzania, United Republic (Mainland)*	HIV	402.5

Country	Disease	Allocation (US$ million)	Country	Disease	Allocation (US$ million)
Guatemala	Malaria	19.4	Tanzania, United Republic (Mainland)*	TB	27.7
Guinea*[19]	HIV	45.0	Tanzania, United Republic (Mainland)*	Malaria	202.4
Guinea*[19]	TB	12.0	Tanzania, United Republic (Zanzibar)	HIV	5.2
Guinea*[19]	Malaria	73.0	Tanzania, United Republic (Zanzibar)	TB	5.2
Guinea-Bissau	HIV	18.2	Tanzania, United Republic (Zanzibar)	Malaria	5.0
Guinea-Bissau	TB	7.0	Thailand	HIV	50.6
Guinea-Bissau	Malaria	27.4	Thailand	TB	22.7
Guyana	HIV	13.6	Thailand	Malaria	35.7
Guyana	TB	2.4	Timor-Leste	HIV	7.6
Guyana	Malaria	2.6	Timor-Leste	TB	5.1
Haiti	HIV	78.9	Timor-Leste	Malaria	16.0
Haiti	TB	15.6	Togo	HIV	52.3
Haiti	Malaria	25.6	Togo	TB	8.7
Honduras	HIV	20.4	Togo	Malaria	52.2
Honduras	TB	10.3	Tunisia	HIV	12.3
Honduras	Malaria	10.3	Turkmenistan	TB	9.8
India	HIV	562.3	Uganda*	HIV	251.7
India	TB	232.9	Uganda*	TB	23.9
India	Malaria	54.8	Uganda*	Malaria	145.4
Indonesia*	HIV	116.1	Ukraine	HIV	137.3
Indonesia*	TB	107.8	Ukraine	TB	47.3
Indonesia*	Malaria	78.4	Uzbekistan	HIV	27.7
Iran (Islamic Republic of)	HIV	20.2	Uzbekistan	TB	35.4
Iraq**	TB	10.7	Uzbekistan	Malaria	1.4
Jamaica	HIV	19.1	Viet Nam*	HIV	93.0
Kazakhstan	TB	43.5	Viet Nam*	TB	47.1
Kenya	HIV	337.3	Viet Nam*	Malaria	18.3
Kenya	TB	45.0	West Bank and Gaza (Palestine)	HIV	4.8
Kenya	Malaria	113.1	West Bank and Gaza (Palestine)	TB	1.8
Kosovo	HIV	4.9	Yemen	HIV	11.5
Kosovo	TB	5.1	Yemen	TB	11.5
Kyrgyzstan	HIV	29.1	Yemen	Malaria	16.8

* Country has existing funding in a health systems strengthening grant. This funding has been included proportionally in each eligible component for the purposes of this document. Allocation letters to countries show this funding separately.

** Only eligible for transition funding

[19]In this list, the health systems strengthening existing funding for Guinea has been allocated proportionally to each disease component to ensure consistency with other countries. However, in the Guinea allocation letter, health systems strengthening existing funding was included as part of the HIV component because the health systems strengthening grant has recently been consolidated with the HIV grant.

Country	Disease	Allocation (US$ million)		Country	Disease	Allocation (US$ million)
Kyrgyzstan	TB	14.7		Zambia	HIV	228.9
Kyrgyzstan	Malaria	0.5		Zambia	TB	14.5
Lao People's Democratic Republic	HIV	13.8		Zambia	Malaria	53.3
Lao People's Democratic Republic	TB	10.1		Zimbabwe*	HIV	398.9
Lao People's Democratic Republic	Malaria	14.5		Zimbabwe*	TB	38.6
Lesotho	HIV	86.2		Zimbabwe*	Malaria	40.2
Lesotho	TB	7.0				
Liberia	HIV	45.2				
Liberia	TB	9.6				
Liberia	Malaria	47.1				

* Country has existing funding in a health systems strengthening grant. This funding has been included proportionally in each eligible component for the purposes of this document. Allocation letters to countries show this funding separately.

Annex 2: List of Countries by Bands

	Band 1: Lower-income, higher-burden	Band 2: Lower-income, lower-burden	Band 3: Higher-income, higher- burden	Band 4: Higher-income, lower-burden	
	GNIpc < 2,000, DB > 0.26%	GNIpc < 2,000, DB <= 0.26%	GNIpc >= 2,000, DB > 0.26%	GNIpc >= 2,000, DB <= 0.26%	
1	Cambodia	Korea, DPR	Indonesia	Kiribati	Saint Vincent and the Grenadines
2	Myanmar	Lao PDR	Philippines	Malaysia	Suriname
3	Papua New Guinea	Solomon Islands	Thailand	Marshall Islands	Algeria
4	Viet Nam	Kyrgyzstan	Russian Federation	Micronesia	Egypt
5	Haiti	Tajikistan	Ukraine	Mongolia	Morocco
6	Chad	Uzbekistan	Angola	Samoa	Syrian Arab Republic
7	Mali	Nicaragua	Botswana	Timor-Leste	Tunisia
8	Niger	Djibouti	Congo	Tonga	West Bank and Gaza
9	South Sudan	Mauritania	Namibia	Tuvalu	Bhutan
10	Sudan	Somalia	South Africa	Vanuatu	Iran
11	Bangladesh	Yemen	Swaziland	Albania	Maldives
12	India	Afghanistan		Armenia	Sri Lanka
13	Pakistan	Nepal		Azerbaijan	Cape Verde
14	Benin	Comoros		Belarus	Gabon
15	Burkina Faso	Eritrea		Bulgaria	Mauritius
16	Burundi	Gambia		Georgia	Seychelles
17	Cameroon	Guinea-Bissau		Kazakhstan	
18	Central African Republic	Sao Tome and Principe		Kosovo	
19	Congo, DR			Moldova	
20	Côte d'Ivoire			Romania	
21	Ethiopia			Turkmenistan	
22	Ghana			Belize	
23	Guinea			Bolivia	
24	Kenya			Colombia	
25	Lesotho			Costa Rica	
26	Liberia			Cuba	
27	Madagascar			Dominica	
28	Malawi			Dominican Republic	
29	Mozambique			Ecuador	
30	Nigeria			El Salvador	
31	Rwanda			Grenada	
32	Senegal			Guatemala	
33	Sierra Leone			Guyana	
34	Tanzania (Mainland)			Honduras	
35	Tanzania (Zanzibar)			Jamaica	
36	Togo			Panama	
37	Uganda			Paraguay	
38	Zambia			Peru	
39	Zimbabwe			Saint Lucia	
	39 countries	18 countries	11 countries	55 countries	

Latin America & the Caribbean
East Asia & the Pacific
North Africa & the Middle East
Eastern Europe & Central Asia
South Asia
Sub-Saharan Africa

Annex 3: Verification of Global Fund Resource Allocation Model Calculations: Opinion Report (extract)

RESULTS FOR DEVELOPMENT INSTITUTE
1100 15th Street, N.W, Suite 400, Washington, DC 20005 R4D.org

Verification of Global Fund Resource Allocation Model Calculations: Opinion Report

March 6, 2014

Opinion Statement

Based on the verification process we have carried out, it is our opinion that the implementation of Global Fund (GF)'s new allocation model, consisting of the Initial Allocation Module (IAM) implemented in R and the Qualitative Factors Module (QFM) implemented in SalesForce, operate as described in the Detailed Methodology documents. When using the supplied data as inputs, our own independently developed implementation of the algorithm described in the Detailed Methodology produced the same final allocation amounts to those produced by GF's model (both IAM and QFM). The same values were also observed for all intermediate values logged during the calculation steps of the algorithm. Thus, it is our opinion that the IAM and QFM we tested with the data we were supplied generate correct funding allocations for each eligible disease component and each country band. We found the supplied input data used for the model calculations to be identical to the data referenced in the Detailed Methodology document and located in 'source files' provided by GF staff.

Results

When using the supplied data as inputs, our own independently developed implementation of the algorithm described in the Detailed Methodology produced identical final allocation amounts to those produced by GF's model (both IAM and QFM). Identical values were also observed for all intermediate values logged during the calculation steps of the algorithm. We did not find any discrepancies in the comparison of input data between 'source files' listed in Table 1 and input datafiles actually used in calculations.

Report use and limitations

The report was prepared for the Global Fund in order to provide assurance that the allocation model correctly derives country and disease component allocation amounts. Whilst the Global Fund may rely on this opinion, any third party using this report should be aware of the limitations over its usage as noted in various places in the report.

Signed for and on behalf of R4D

Signed by Robert Hecht, Managing Director R4D
RESULTS FOR DEVELOPMENT INSTITUTE