Allocation Methodology for Grant Cycle 8

52nd Board Meeting

GF/B52/08B
20 – 22 November 2024, Lilongwe, Malawi

For Board Decision

Purpose of the paper: Request the Board to approve the updated Allocation Methodology for Grant Cycle 8, taking into account the recommendation from the Strategy Committee.

GF/B52/DPXX: Allocation Methodology for the 2026-2028 allocation period (Grant Cycle 8)

Based on the recommendation of the Strategy Committee (the "SC"), as presented in GF/B52/08B, the Board:

a. ***Acknowledges the decision by the SC in October 2024 GF/SC26/DP05, under authority delegated by the Board, to establish technical parameters for Grant Cycle 8 (the "Technical Parameters"); and***
b. ***Acknowledges that the total amount of funds available for country allocation (including approved sources of funds for country allocation and any additional funds approved as available for country allocation) will be decided by the Board in November 2025, based on the recommendation of the Audit and Finance Committee following announced replenishment results from the 8th Replenishment.***

Accordingly, the Board:

1. ***Approves the allocation methodology, including its global disease split, presented in [Annex 1] to GF/B52/08B (the "Allocation Methodology");***
2. ***Requests the SC to review and approve, in 2025, the method by which the Secretariat will apply and report on the qualitative adjustment process; and***
3. ***Acknowledges that the Allocation Methodology and Technical Parameters shall apply for Grant Cycle 8 and supersede the 2023 – 2025 allocation methodology and technical parameters presented in GF/B47/03.***

Executive Summary

Context

Throughout 2024, the Global Fund Board and Strategy Committee (SC) have undertaken substantive discussions to consider how the Global Fund should adapt to the changing global environment to deliver sustainable impact, protect gains, continue progress towards ending AIDS, TB and malaria and deliver on the promise of Sustainable Development Goal 3. GF/B52/08A provides the overarching context for the proposed holistic changes recommended across the Allocation Methodology, Eligibility, Sustainability, Transition & Co-financing (STC) polices, as well as the Catalytic Investments (CI) priorities for Grant Cycle 8 (GC8). The recommended changes to the Allocation Methodology build directly from these holistic discussions and decisions.

Every three years, the Global Fund's Allocation Methodology is reviewed based on the latest evidence and lessons learned, in preparation for the upcoming allocation period. The review of the Allocation Methodology for GC8 also considers the findings and recommendations of the 2024 independent evaluation of the Global Fund Allocation Methodology.[1] At its 26th SC Meeting (GF/SC26/DP05), the SC approved the technical parameters of the allocation formula and recommended the Allocation Methodology presented in this paper to the Board for approval.

Conclusions

A. The Secretariat and SC recommend revising the Global Disease Split (GDS) to provide a greater share of funding for TB and malaria for available funds for country allocations above US$ 12 billion, while protecting essential services for HIV. As detailed in Annex 1, the recommendation is to reach a target split of 40% for HIV, 25% for TB and 35% for malaria at US$ 17 billion.
B. The SC approved the technical parameters of the allocation formula, including a refinement to the malaria disease burden indicator period to reflect the technical partners' recommendation, and to shift the Country Economic Capacity (CEC) curve to drive more funding towards lower income countries.
C. The Secretariat and SC recommend setting aside funding for Catalytic Investments (CIs) at sources of funds for allocation of US$ 12.26 billion and above, starting at US$ 260 million for CIs, with the full CI amount of US$ 800 million to be realized at sources of funds for allocation of US$ 15.2 billion and above.

[1] https://www.theglobalfund.org/en/iel/evaluations/2024-04-01-allocation-methodology-evaluation/

Input Sought

The Board is requested to approve the Allocation Methodology as described in Annex 1.

- Decision Point: GF/B52/DPXX: Allocation Methodology for the 2026-2028 allocation period (Grant Cycle 8)

Input Received

- The Board provided initial input on potential changes to several aspects of the Allocation Methodology as part of sustainability discussions during the July 2024 Board Retreat, including support for shifting the CEC curve to further prioritize funds towards lower income countries.
- At the Board's request, the Global Fund commissioned an independent evaluation of the Global Fund Allocation Methodology.[2] The evaluation's findings and recommendations have informed the proposed GC8 Allocation Methodology presented in this paper.
- Technical partners were consulted on the disease burden indicators and the global disease split, and provided inputs on the context for HIV, TB and malaria on disease burden, programmatic progress and challenges, funding needs and risks.

[2] https://www.theglobalfund.org/en/iel/evaluations/2024-04-01-allocation-methodology-evaluation/

1. Context and overview of recommended changes

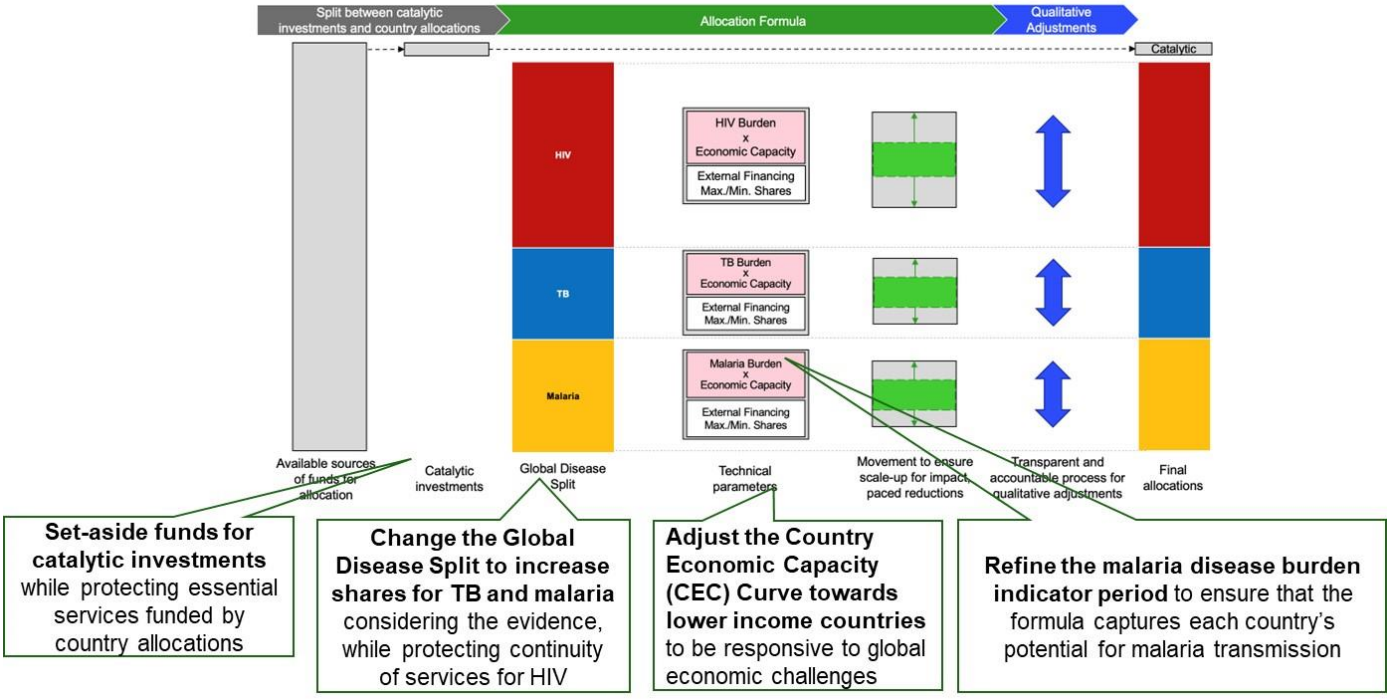
1. The Allocation Methodology[3] produces country allocations to maximize the impact of available resources by focusing funds on the countries with the highest disease burden and lowest economic capacity, while accounting for key and vulnerable populations disproportionately affected by the three diseases.[4] It also provides countries with predictable financing over three-year cycles through an approach that is transparent, rigorously driven by data and flexible to adapt to unique country contexts. This is achieved through the key steps of the Allocation Methodology, namely the global disease split, the allocation formula and the qualitative adjustments.
2. Every three years, the Global Fund's Allocation Methodology is reviewed based on the latest evidence and lessons learned, in preparation for the upcoming allocation period. As with Grant Cycle 7 (GC7), the Allocation Methodology for GC8 has been designed to support the delivery of the *Global Fund Strategy 2023-2028* (the "Strategy").[5] The recommended revisions to the Allocation Methodology have been considered as part of an interconnected, holistic set of policy levers aimed at reinforcing sustainability considerations across the portfolio, which are described in GF/B52/08A.
3. At the Board's request,[6] an independent evaluation was commissioned by the Global Fund in 2023 to provide an independent assessment of the Global Fund Allocation Methodology and process, with the aim to inform changes (if any) for GC8 to increase impact of Global Fund investments and more effectively deliver the Global Fund Strategy.[7] The evaluation, completed in 2024, concluded that many aspects of the Allocation Methodology are working well, and recognized the constant willingness to review, challenge, and improve the methodology. Many of the evaluation's recommendations are to continue current approaches. On the GDS, the evaluation recommends keeping an upfront split in the Allocation Methodology and revising the GDS in favor of TB to better align with the epidemiological context. The evaluation also assessed whether an allocation for Resilient and Sustainable Systems for Health (RSSH) would improve the current approach to Global Fund investments and concluded that creating a fourth share for RSSH in the upfront split of the Allocation Methodology is not recommended.
4. The SC and Secretariat reviewed all aspects of the allocation formula informed by the latest available evidence, input from the Board, consultations with technical partners, and the recommendations from the independent evaluation.

[3] See the Allocation Methodology glossary in Annex 4 for an overview of all the steps in the Allocation Methodology.
[4] GF/B47/03
[5] https://www.theglobalfund.org/en/strategy/
[6] GF/B46/DP04
[7] https://www.theglobalfund.org/en/iel/evaluations/2024-04-01-allocation-methodology-evaluation/

5. To adapt the Allocation Methodology to the current context, the SC:
    a. recommended changing the GDS to increase shares for TB and malaria from available funds for country allocations in scenarios of above US$ 12 billion, and to protect essential services for HIV;
    b. approved the technical parameters of the allocation formula, including (1) an adjustment to the CEC curve to drive more funding to lower income countries and (2) a refinement to the malaria burden indicator period in line with technical partner recommendations, namely to use data for the latest five years for the small number of countries with significantly higher transmission intensity due to sustained epidemics, while continuing the use of 2000-2004 data for all other countries; and
    c. recommended maintaining the other aspects of the allocation methodology, as they remain relevant in the current context.
6. For the CI funding scenarios, the Secretariat and SC recommend setting aside US$ 260 million of CIs at sources of funds for allocation of US$ 12.26 billion and above, with the full CI amount of US$ 800 million to be realized at US$ 15.2 billion and above.
7. Both the GDS and CI recommendations have been informed by the cost of essential programming (CoEP), which is an internal, minimum estimate used by the Secretariat in the qualitative adjustments process to ensure that decreasing country allocations do not disrupt the continuity of essential services funded by the Global Fund. For the GDS changes being considered, the CoEP estimate of the disease with a declining share (HIV) informs at what total allocation level a shift in the GDS can start without disrupting HIV programs. The CoEP estimate across all components also helps inform the threshold of sources of funds for allocation to begin setting aside funds for CIs so that essential services are protected in country allocations. Further information on the CoEP is provided in a supporting document.[8]
8. The effect of the changes to the Allocation Methodology are modelled under the four allocation scenarios presented at the July 2024 Board retreat.[9] Effects are presented separately as well as with all recommended changes combined to enable a holistic view. All scenario modelling for GC8 uses the latest eligibility list, GNI per capita data (from the World Bank, 2023), and latest disease burden data (from WHO and UNAIDS, 2022 and 2023).
9. This paper outlines the rationales for each of the recommended changes and their joint implications. The Allocation Methodology policy, reflecting the proposed changes, is outlined in Annex 1.

[8] Cost Of Essential Programming_FAQ_2024-09-24.pdf
[9] GF/BR2024-07/03

Figure 1: Summary of recommended changes to the Allocation Methodology for GC8



Note: Catalytic Investments are presented for Board approval in GF/B52/08C.

2. Global Disease Split

What is the need or opportunity?

10. The GDS defines the split of funding for HIV, TB and malaria in the Allocation Methodology. While it is an important factor affecting the final distribution of Global Fund resources across the three diseases, it is not the sole determinant: other levers also play a role, including country-driven program split flexibilities to change the distribution of allocations across diseases and for RSSH to address national priorities.

11. When the Global Fund established the allocation-based funding model for the 2014-2016 allocation period, the Board approved a global disease split of 50% for HIV, 18% for TB and 32% for malaria.[10] For GC7, acknowledging the increased share of deaths from TB among the three diseases, the Board approved a revised

[10] GF/B29/EDP11

GDS[11] to increase the funding share for TB for any additional available funds for country allocation above US$ 12 billion, while preserving funding and potential for scale-up for HIV and malaria. With the slightly higher resource envelope (US$ 13.1 billion[12] available funds for country allocation[13]) and the updated global disease split, this resulted in an effective split of 49.6% for HIV/AIDS, 18.6% for tuberculosis and 31.8% for malaria for GC7. As a result of the 3.3% increase in total allocations and the revised global disease split, the additional amounts of funding allocated for GC7 compared to GC6 were US$ 154.2 million (+6.7%) for TB, US$ 152.6 million (+2.4%) for HIV and US$ 111.2 million (+2.7%) for malaria.

12. The independent evaluation of the Allocation Methodology recommended keeping an upfront GDS in the Allocation Methodology, recognizing that there is no single measure that accurately reflects disease burden for all three diseases, and therefore, the upfront split allows for the distribution of funding to countries based on burden indicators tailored for each disease as recommended by technical partners. The evaluation recommended revising the GDS in favor of TB to better align with the epidemiological context. The evaluation did not include a recommendation on whether the increased share for TB should come from HIV, malaria, or both. The evaluation report, however, noted that the epidemiological and external financing context suggests a revised split in favor of malaria (as well as TB) and away from HIV. The evaluation also concluded that creating a fourth share for RSSH in the upfront split is not recommended. At the 51st Board Meeting and 24th SC Meeting, Board and SC members agreed with the evaluation's recommendation to maintain an upfront split, and expressed their alignment with the evaluation's recommendation against an allocation for RSSH as part of this upfront disease split, acknowledging the challenges and limitations noted by the evaluators.

Does the latest evidence indicate that the GDS should change?

13. To inform the direction of change to the GDS, the SC considered the latest evidence on relevant factors provided by the Secretariat and technical partners at its 25th and 26th SC Meetings.

14. A number of inter-related factors on HIV, TB and malaria need to be considered to inform the GDS. These include the epidemiological context for HIV, TB and malaria,

[11] GF/B46/DP04. Global Disease Split for the 2023-2025 Allocation Methodology: Any available funds for country allocation up to and including US$ 12 billion: 50% for HIV/AIDS, 18% for tuberculosis, and 32% for malaria. Any additional available funds for country allocation above US$ 12 billion: 45% for HIV/AIDS, 25% for tuberculosis, and 30% for malaria.
[12] Throughout this paper, including in the text and in graphs showing the funding scenarios, references to US$ 13.1 billion are rounded and refer to US$ 13.128 billion, in line with the previous funding level.
[13] GF/B48/DP04.

progress towards the SDGs, the distribution of disease burden by income group, the relative importance of Global Fund financing, the potential for mobilizing domestic resources in the countries most affected, and the consequences of any reduction resulting from a change.

15. All three diseases are off-track to meeting the SDGs, particularly TB and malaria.[14] Significant resources are needed to address coverage gaps and achieve the Global Plan targets for HIV, TB and malaria, with low-income (LI) countries remaining heavily reliant on Global Fund financing.

16. For TB, the globally reported number of people newly diagnosed with TB reached a new high of 8.2 million in 2023, out of an estimated 10.8 million incident cases.[15] Despite this progress, significant gaps and challenges remain to achieve the End TB goals. TB has the highest share of mortality across the three diseases, with 1.2 million deaths in Global Fund-supported countries in 2022 (see Annex 5). Drug-resistant TB continues to be a public health threat, and its per-case cost remains high.

17. Malaria cases and deaths have increased since 2019: in 2022, there were 249 million cases and 608,000 deaths globally, of which 76% were children under 5.[16] The disease is concentrated in LI and lower middle income (LMI) countries, including in fragile states, which are more reliant on external financing and disproportionately affected by debt and fiscal pressure. Malaria rebounds quickly when control activities are reduced. Climate change, biological threats, conflict and constrained financing are undermining gains and causing evolving challenges in ensuring the most effective malaria interventions are deployed.

18. The global response to HIV has made tremendous progress towards achieving the 95-95-95 targets.[17] However, progress remains uneven geographically and across population groups. In 2023, more than half of new infections were outside sub-Saharan Africa.[18] Key populations and their sex partners accounted for an estimated 80% of new infections outside sub-Saharan Africa in 2022.[19] HIV is a chronic lifelong disease, requiring early and sustained combination treatment, as such mortality data does not capture resource needs. In addition, treatment needs

[14] Global Fund Results Report 2024
[15] Global Tuberculosis Report 2024
[16] World Malaria Report 2023
[17] 2024 Global AIDS Update. Further analysis of UNAIDS epidemiological estimates, 2024.
[18] Outside of Sub-Saharan Africa includes countries which are not eligible for Global Fund financing. The urgency of now: AIDS at a crossroads. UNAIDS 2024.
[19] New HIV infections among key populations, proportions in 2010 and 2022. UNAIDS 2023. (www.unaids.org/sites/default/files/media_asset/new-hiv-infections-data-among-key-populations-proportions_en.pdf)

are increasing due to the expanding and ageing cohort of people on anti-retroviral therapy.

19. Recognizing the evidence and analysis provided by the Secretariat and technical partners, the SC affirmed their support to change the GDS for GC8 to drive higher shares of funding towards TB and malaria.

What are the principles to inform the GDS?

20. At its 25th and 26th SC Meetings, the SC broadly supported five principles to inform the GDS:

    a. Set the global disease split in line with most critical needs and impact, based on the evidence.

    b. Do no harm to existing programs: protect continuity of services for all three diseases.

    c. As overall funding increases, funding for all three diseases must increase.

    d. Do not reduce overall funding for LI countries, when considered holistically with other changes to the Allocation Methodology (e.g. the CEC Curve).

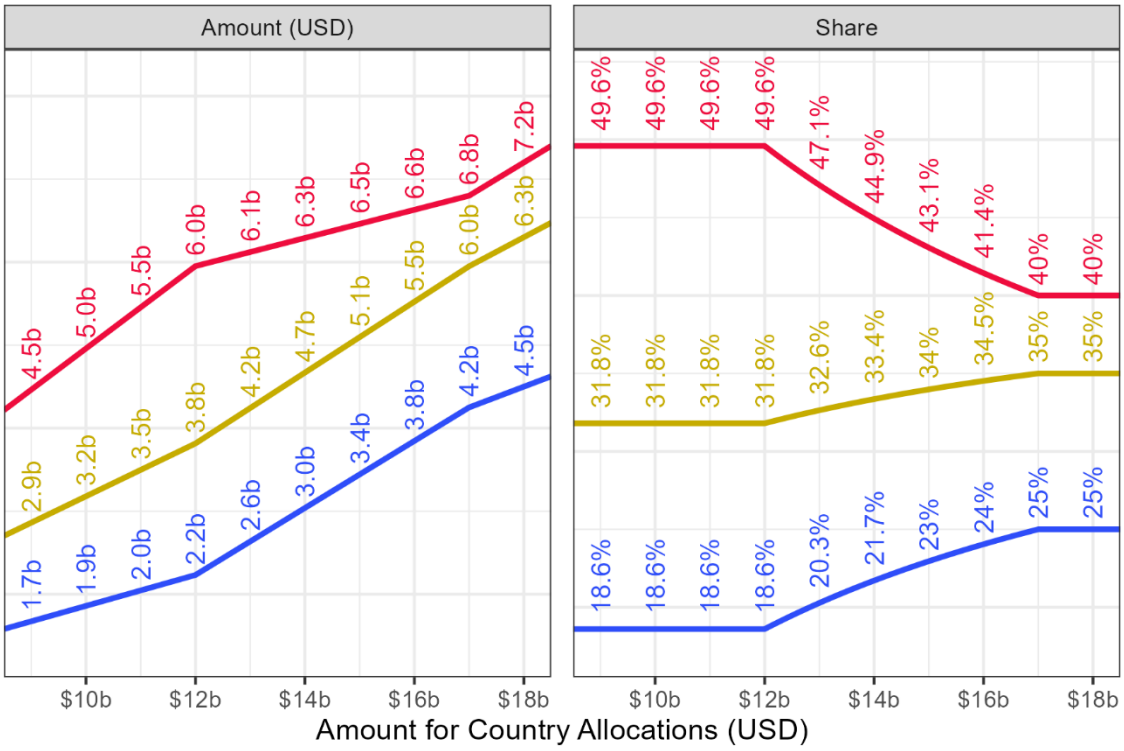
    e. Ensure changes support Replenishment efforts, as raising resources benefits all three diseases.

What is the recommended option on the GDS, and why?

21. Based on the latest evidence and in line with the above principles, and following discussions at the 26th SC meeting, the Secretariat and SC recommend changing the global disease split to the following: (1) apply a target split of 40% for HIV, 25% for TB and 35% for malaria when the available funds for country allocation are US$ 17 billion and above, (2) maintain the effective split from the GC7 allocation period at amounts less than or equal to US$ 12 billion, and (3) at amounts between US$ 12 billion and US$ 17 billion, define the split according to a linear extrapolation

between the US$ 12 billion share and the US$ 17 billion share for each disease.[20] Figure 2 depicts the recommended option.

Figure 2: Recommended option for the Global Disease Split



22. The recommended change to the global disease split would increase TB and malaria funding in all country allocation scenarios above US$ 12 billion compared to the effective GC7 split. The recommendation moves quickly towards the target split of 40% for HIV, 25% for TB and 35% for malaria without compromising the

[20] Mathematically, the recommended GDS is given by the following table:

Available funds for country allocations	***HIV/AIDS***	***Tuberculosis***	***Malaria***
Up to and including US$ 12 billion	49.6%	18.6%	31.8%
Between US$ 12 billion and US$ 17 billion	$(72.64 - 1.92a)\%$	$(3.24 + 1.28a)\%$	$(24.12 + 0.64a)\%$
At US$ 17 billion and above	40%	25%	35%

where a is the amount for country allocations in billions.

The split below US$ 12 billion is informed by the current effective global disease split for GC7. Under the approved GDS for GC7, at US$ 13.1 billion the effective split was 49.6% for HIV, 18.6% for TB, and 31.8% for malaria. To avoid reversing shifts made in the previous cycle, this split is used as the starting point for any future changes to the GDS.

principles that continuity of essential services is protected and that all diseases benefit from an increase in overall funding available. In the event of a robust Replenishment, the target split would be reached.

23. Compared to the GC7 split, the recommended GDS provides a more significant change to the split. This is because it uses an approach to reach a target split that is applied to the full amount available for country allocations, rather than changing the split for only the additional amounts above a threshold, which was the GC7 approach. With the SC-recommended split for GC8; for the first US$ 12 billion, for every additional US$ 100 million, HIV receives US$ 49.6 million, TB receives US$ 18.6 million and Malaria US$ 31.8 million; for every additional US$ 100 million between US$ 12 billion and US$ 17 billion, US$ 43 million would go to malaria, US$ 40 million would go to TB and US$ 17 million would go to HIV; for every US$ 100 million above US$ 17 billion, US$ 40 million would go to HIV, US$ 25 million to TB and US$ 35 million to malaria.

24. Acknowledging the need to protect life-saving services, a request was made to commit the Global Fund to achieving the target split over multiple replenishment cycles. The SC requested future SCs to consider this as part of its cyclical review of the Allocation Methodology.

What options did the SC consider for the GDS?

25. In line with the above principles, the SC considered the following parameters for a change in the GDS:

    a) What should be the new target split?

    b) At what funding level should the change towards the new target split begin?

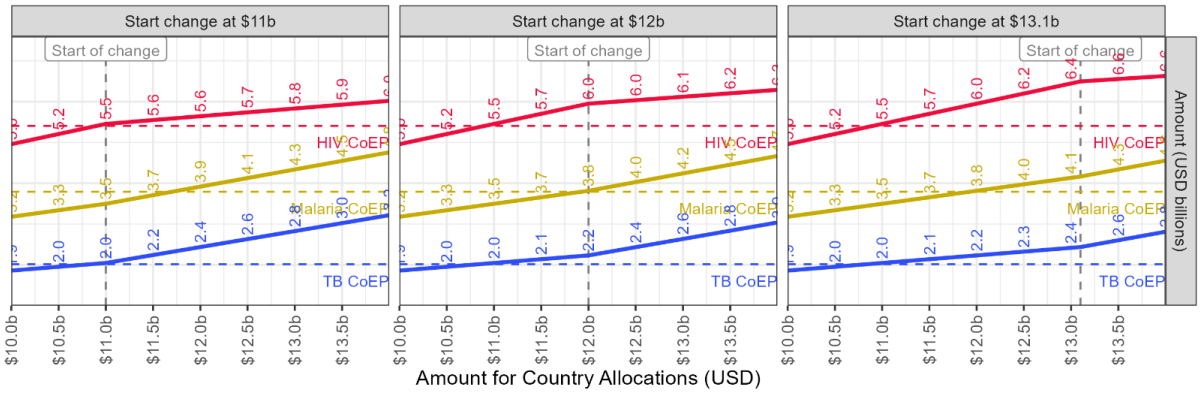
    c) How quickly should we move towards the target split?

26. On a), the recommended target split of 40% for HIV, 25% for TB and 35% for malaria significantly increases TB's share to align closer to what the latest epidemiological context indicates, and it provides an increase to malaria's share to help address urgent needs.

27. On b), the funding level at which the disease split should change towards the target split was informed by the estimate of the cost of essential services for HIV since it is the disease whose share is declining. In line with the principle to do no harm, the CoEP estimate represents the minimum amount needed to cover commodities and a portion of service delivery, RSSH and program management currently funded by the Global Fund. It contains no buffer, scale-up or forward-looking assumptions.

28. After considering multiple options for achieving the target split, including starting earlier and moving at a faster rate, the Secretariat and SC recommend that the change should start at US$ 12 billion as this would cover the CoEP estimate for HIV with a modest buffer. At US$ 12 billion, HIV's allocation would be US$ 5.95 billion, which is 10% above its CoEP estimate of US$ 5.4 billion. Since CoEP is an estimate based on current costs and does not account for any future trends, such as the introduction of new tools and technologies or a possible rise in ART costs,[21] it is prudent to start the disease split change at a slightly higher level than the bare minimum for essential services. Even at US$ 12 billion, the size of the HIV envelope would make it very challenging to meet CoEP for individual countries in the qualitative adjustments (QA) process.

Figure 3: Different starting points for the change in the GDS



29. Starting the disease split change at US$ 11 billion would provide no buffer to the estimated amount needed to continue essential HIV services, as shown in Figure 3, with only enough funding to cover the aggregate CoEP for HIV. While US$ 11 billion is sufficient to cover aggregate HIV CoEP costs across all countries, it is important to note that at this funding level, more than half of HIV allocations would be below CoEP based upon current estimates and would therefore require careful consideration in the QA process. In addition, HIV funding would be lower than its GC7 level at even much higher funding scenarios. For example, starting the shift at US$ 11 billion and reaching the target split of 40% HIV, 25% TB and 35% malaria by US$ 17 billion means that HIV allocations are significantly reduced from their GC7 levels (by US$ 156 million) even in a US$ 15 billion scenario (+14% compared

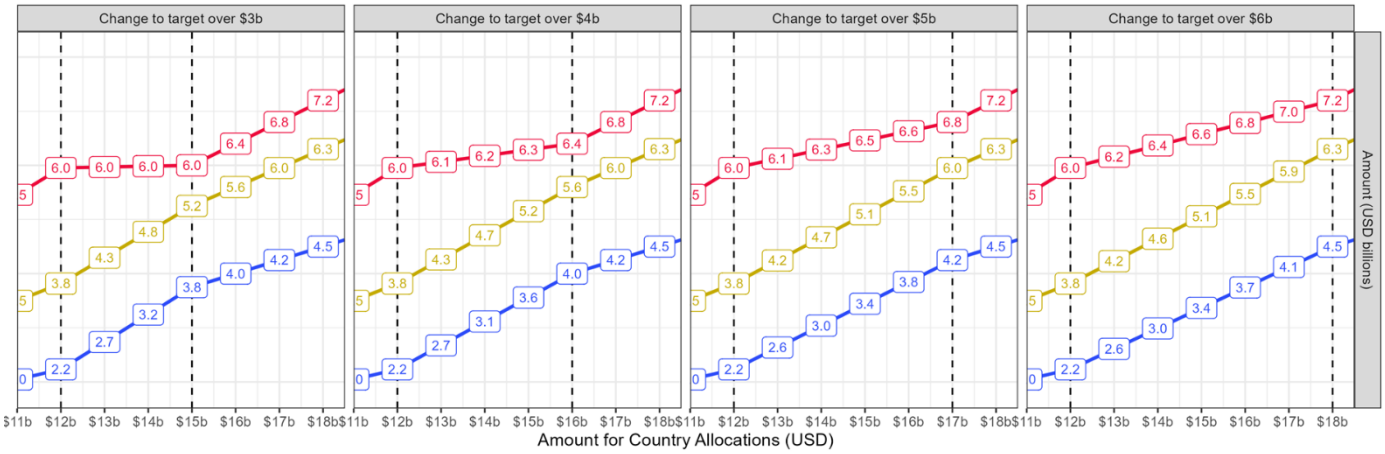
[21] Given emerging resistance to first-line anti-retroviral drugs, with second-line ART costs currently five times higher for adults. GF/SC25/06.

to GC7); and at a US$ 16 billion scenario, HIV allocations would only have just reached their GC7 levels. In addition, countries that only receive HIV allocations already get a decrease in flat funding scenarios with the recommended changes to the GDS and CEC curve. If the GDS change starts earlier, at US$ 11 billion, these countries will see steeper decreases. It is therefore not recommended to start the GDS change at funding levels below US$ 12 billion.

30. Starting the GDS change at US$ 13.1 billion is also not recommended because it provides no increase in funding to TB and malaria at the GC7 funding level and requires very high Replenishment scenarios to reach the target split.

31. On c), the recommended rate at which to move to the target split – over a US$ 5 billion range – was chosen to balance the ambition to increase TB and malaria funding with the need to avoid flatlining funding for HIV in higher replenishment scenarios, as Figure 4 shows. At US$ 13.1 billion for country allocations, the recommended option increases TB and malaria allocations compared to GC7 amounts while enabling HIV allocations to increase in higher funding scenarios. The SC considered moving faster towards the target split (over a US$ 4 billion range, between US$ 12 billion and US$ 16 billion), to more rapidly increase the shares for TB and malaria. However, it did not recommend this because over this range, it results in HIV receiving only approximately a US$ 450 million increase despite a US$ 4 billion increase in total funding. In addition, even at US$ 16 billion available funds for country allocations, HIV funding would still be below its GC7 level. Conversely, with a slower move towards the target split starting at US$12 billion, the target would only be reached at very high funding levels and is therefore not recommended.

Figure 4: Different ranges of funding to move to the target split



32. See Tables 1 and 2 for the disease allocation amounts, shares and changes compared to GC7 with each of the thresholds considered to start the change in the disease split.

Table 1: Absolute amount and share of disease under different GDS options

	$11b for country allocations			$12b for country allocations			$13.1b for country allocations			$14b for country allocations			$15b for country allocations			$16b for country allocations		
	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria
GC7	$6.51b 49.6%	$2.44b 18.6%	$4.18b 31.8%	$6.51b 49.6%	$2.44b 18.6%	$4.18b 31.8%	$6.51b 49.6%	$2.44b 18.6%	$4.18b 31.8%	$6.51b 49.6%	$2.44b 18.6%	$4.18b 31.8%	$6.51b 49.6%	$2.44b 18.6%	$4.18b 31.8%	$6.51b 49.6%	$2.44b 18.6%	$4.18b 31.8%
11b to 17b	$5.46b 49.6%	$2.05b 18.6%	$3.50b 31.8%	$5.68b 47.3%	$2.41b 20.1%	$3.91b 32.6%	$5.93b 45.2%	$2.83b 21.5%	$4.37b 33.3%	$6.13b 43.8%	$3.15b 22.5%	$4.72b 33.7%	$6.35b 42.3%	$3.52b 23.4%	$5.13b 34.2%	$6.58b 41.1%	$3.88b 24.3%	$5.54b 34.6%
12b to 17b	$5.46b 49.6%	$2.05b 18.6%	$3.50b 31.8%	$5.95b 49.6%	$2.23b 18.6%	$3.82b 31.8%	$6.14b 46.8%	$2.69b 20.5%	$4.30b 32.7%	$6.29b 44.9%	$3.04b 21.7%	$4.67b 33.4%	$6.46b 43.1%	$3.44b 23.0%	$5.10b 34.0%	$6.63b 41.4%	$3.85b 24.0%	$5.52b 34.5%
13.1b to 18b	$5.46b 49.6%	$2.05b 18.6%	$3.50b 31.8%	$5.95b 49.6%	$2.23b 18.6%	$3.82b 31.8%	$6.51b 49.6%	$2.44b 18.6%	$4.17b 31.8%	$6.63b 47.4%	$2.81b 20.1%	$4.56b 32.5%	$6.78b 45.2%	$3.23b 21.6%	$4.99b 33.3%	$6.92b 43.2%	$3.66b 22.8%	$5.43b 33.9%
12b to 16b	$5.46b 49.6%	$2.05b 18.6%	$3.50b 31.8%	$5.95b 49.6%	$2.23b 18.6%	$3.82b 31.8%	$6.08b 46.3%	$2.73b 20.8%	$4.32b 32.9%	$6.18b 44.1%	$3.12b 22.3%	$4.71b 33.6%	$6.29b 41.9%	$3.56b 23.7%	$5.15b 34.4%	$6.40b 40.0%	$4.00b 25.0%	$5.60b 35.0%

Note: SC-recommended option shown with black border.

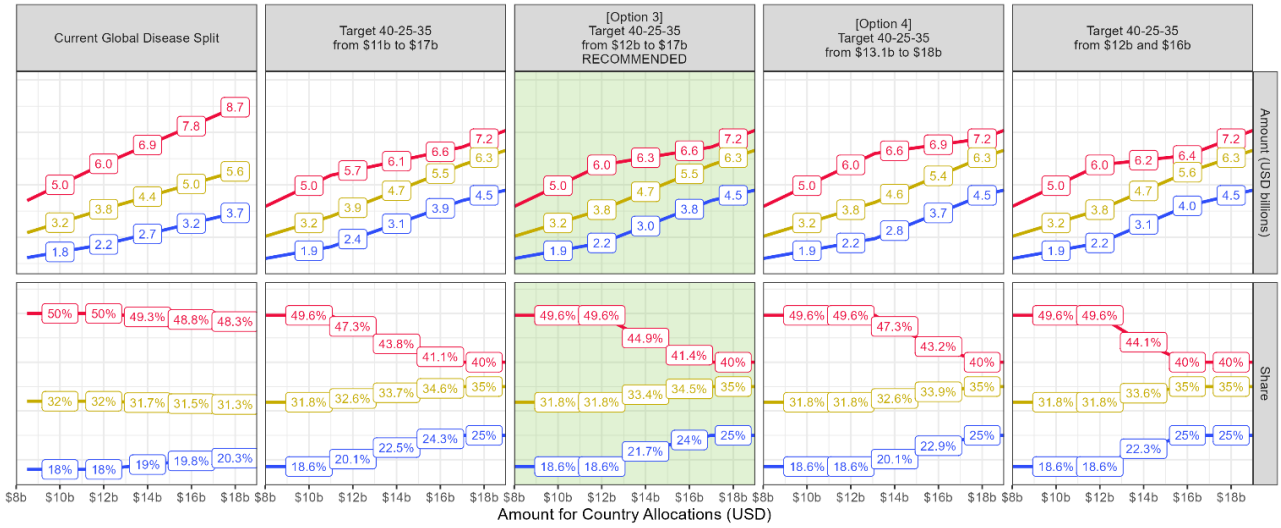
Table 2: Change in disease funding compared to GC7 allocations

	$11b for country allocations			$12b for country allocations			$13.1b for country allocations			$14b for country allocations			$15b for country allocations			$16b for country allocations		
	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria	HIV	TB	Malaria
GC7	$6.51b	$2.44b	$4.18b	$6.51b	$2.44b	$4.18b	$6.51b	$2.44b	$4.18b	$6.51b	$2.44b	$4.18b	$6.51b	$2.44b	$4.18b	$6.51b	$2.44b	$4.18b
11b to 17b	-16% -1,052m	-16% -396m	-16% -680m	-13% -828m	-1% -29m	-7% -272m	-9% -575m	+16% +386m	+5% +189m	-6% -380m	+29% +706m	+13% +546m	-2% -156m	+44% +1,073m	+23% +954m	+1% +68m	+59% +1,441m	+33% +1,363m
12b to 17b	-16% -1,052m	-16% -396m	-16% -680m	-9% -556m	-9% -210m	-9% -362m	-6% -364m	+10% +245m	+3% +119m	-3% -216m	+24% +597m	+12% +491m	-1% -47m	+41% +1,001m	+22% +918m	+2% +123m	+58% +1,404m	+32% +1,345m
13.1b to 18b	-16% -1,052m	-16% -396m	-16% -680m	-9% -556m	-9% -210m	-9% -362m	0% +4m	0% 0m	0% -4m	+2% +127m	+15% +368m	+9% +377m	+4% +268m	+32% +791m	+19% +813m	+6% +410m	+50% +1,213m	+30% +1,249m
12b to 16b	-16% -1,052m	-16% -396m	-16% -680m	-9% -556m	-9% -210m	-9% -362m	-7% -429m	+12% +289m	+3% +141m	-5% -332m	+28% +674m	+13% +530m	-3% -220m	+46% +1,116m	+23% +976m	-2% -108m	+64% +1,558m	+34% +1,422m

Note: SC-recommended option shown with black border.

33. In sum, the main options considered and the Secretariat's and SC's recommendation are outlined in Figure 5 and summarized below.

Figure 5: Options for the GDS



- ***Current GDS***: Not recommended because continuing to apply the GC7 global disease split in GC8 would only provide an incremental increase to TB and would further decrease malaria's share at higher funding levels.
- ***US$ 11b to US$ 17b***: Not recommended because the HIV amount, whose share is decreasing, has no buffer against the CoEP. In addition, HIV would see a significant reduction from its GC7 amount (US$ 6.5 billion) despite much higher funding scenarios.
- ***US$ 12b to US$ 17b [Option 3]***: **Recommended** because the GDS shifts appropriately in line with the stated principles. The shift starts at a level slightly above HIV CoEP, and the rate of increase balances the need for TB and malaria amounts to increase significantly while ensuring the HIV rate of increase is not too flat.
- ***US$ 13.1b to US$ 18b [Option 4]***: Not recommended because starting the split at US$ 13.1 billion would result in no change to TB and malaria in a status quo allocation scenario. In addition, the target split is reached only at US$ 18 billion.
- ***US$ 12b to US$ 16b***: Not recommended because HIV would still get a reduction from its GC7 amount (US$ 6.5 billion) in a US$ 16 billion allocation scenario.

3. Technical Parameters of the Allocation Formula

34. The technical parameters of the allocation formula are the disease burden indicators for HIV, TB and malaria, the CEC indicator, minimum and maximum shares, and the external financing adjustment.

35. The Secretariat and SC reviewed all technical parameters of the allocation formula to assess whether any revisions would be needed for the GC8 Allocation Methodology. Based on the review of the Secretariat and the recommendations of technical partners, the SC approved the technical parameters with two modifications from the GC7 allocation methodology:

    a. Refinement of the malaria disease burden indicator period

    b. Change in the Country Economic Capacity curve

36. All other technical parameters were approved unchanged.

Disease Burden Indicators

37. Based on the review of the Secretariat and the recommendations of technical partners, the SC approved a refinement of the malaria disease burden indicator period. The disease burden indicators for all three diseases are to be maintained as they remain relevant and appropriate. See Annex 2 for the SC-approved disease burden indicators. The full recommendations from technical partners are available in a supporting document.[22]

38. For malaria, technical partners affirmed that the historical period of 2000-2004 continues to be the most relevant period to use for the malaria burden indicator, as it captures the malaria transmission potential for most countries in the absence of control interventions. Based on the recommendations of technical partners, the SC approved that, for a small number of countries with significantly higher transmission intensity due to sustained epidemics, the average values for the last five years will be used.[23] For all other countries the 2000-2004 period will continue to be used. While this adjustment would have only very minor allocation implications, it is in line with the intent to best capture each country's potential for malaria transmission.[24]

Country Economic Capacity curve

39. The CEC curve aims to shift funding to lower income countries. Using GNI per capita as a proxy for economic capacity, country component allocations are

[22] Technical Partner recommendations disease burden indicators Eligibility Policy and Allocation Methodology.pdf
[23] Countries to be confirmed by WHO in 2025 based on latest data.
[24] In a scenario of US$ 13.1 billion, approximately US$ 10 million would be shifted across the portfolio due to this adjustment.

weighted according to a smooth curve where the value decreases as GNI per capita increases.[25]

40. All eligible components are run through the Allocation Formula. The CEC curve influences how the available funds are distributed across countries. It does not zero out eligible components. If the CEC curve results in a component allocation going below the minimum share of US$ 500,000, the component is brought to this minimum through the minimum shares step of the allocation formula.

41. An independent review commissioned by the Global Fund in 2021 found that GNI per capita continues to be a robust and suitable indicator to capture country economic capacity in the allocation formula.[26] The 2024 independent evaluation of the allocation methodology confirmed that GNI per capita remains the best primary indicator for economic capacity.[27] To complement the CEC adjustment, country financial capacity is also considered in the qualitative adjustments process, using a range of indicators including government revenue, public debt, overall economic growth prospect and domestic health expenditure.

42. At the Board Retreat in July 2024 and the 25th and 26th SC Meetings, both the Board and SC acknowledged the importance of the CEC curve as a sustainability lever and broadly supported revising the CEC curve to drive more funding to lower income countries, recognizing the disproportionate impact of global economic challenges on lower income countries and as part of broader considerations on sustainability as outlined in GF/B52/08A.

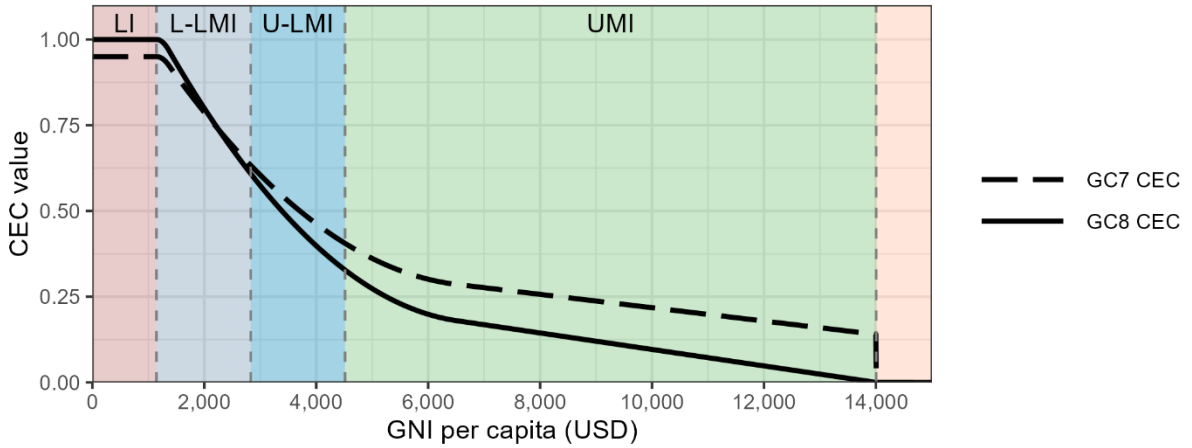
43. In line with the intent and sustainability considerations supported by the Board and SC, the SC approved a revision to the CEC curve to further shift funds to lower income countries. Specifically, the revised curve increases the aggregate allocation share of LIs and lower-LMIs by reducing the allocation share for higher income countries, namely upper-LMIs and upper-middle income countries (UMIs).

44. The same curve would be applied in all funding levels. This shift protects lower income countries and signals to higher income countries the expectation that domestic resources for health are mobilized in all funding scenarios. The revised CEC curve forms part of a set of holistic sustainability policy changes to the Eligibility Policy, Allocation Methodology, Sustainability, Transition and Co-Financing (STC) Policy and Catalytic Investments, which are all closely interlinked.

45. The revised CEC curve for GC8 is shown in Figure 6 along with the GC7 curve.[28] The new curve preserves the shape of the GC7 curve but re-sets the start and end points from 0 to 1.

[25] GF/SIIC17/06 – Revision 1
[26] SC17 Background Document "Assessing economic capacity in the Eligibility Policy and Allocation Methodology"
[27] https://www.theglobalfund.org/en/iel/evaluations/2024-04-01-allocation-methodology-evaluation/
[28] The mathematical formula for the GC8 CEC curve is defined in Annex 3 of GF/SC26/06C Revision 2.

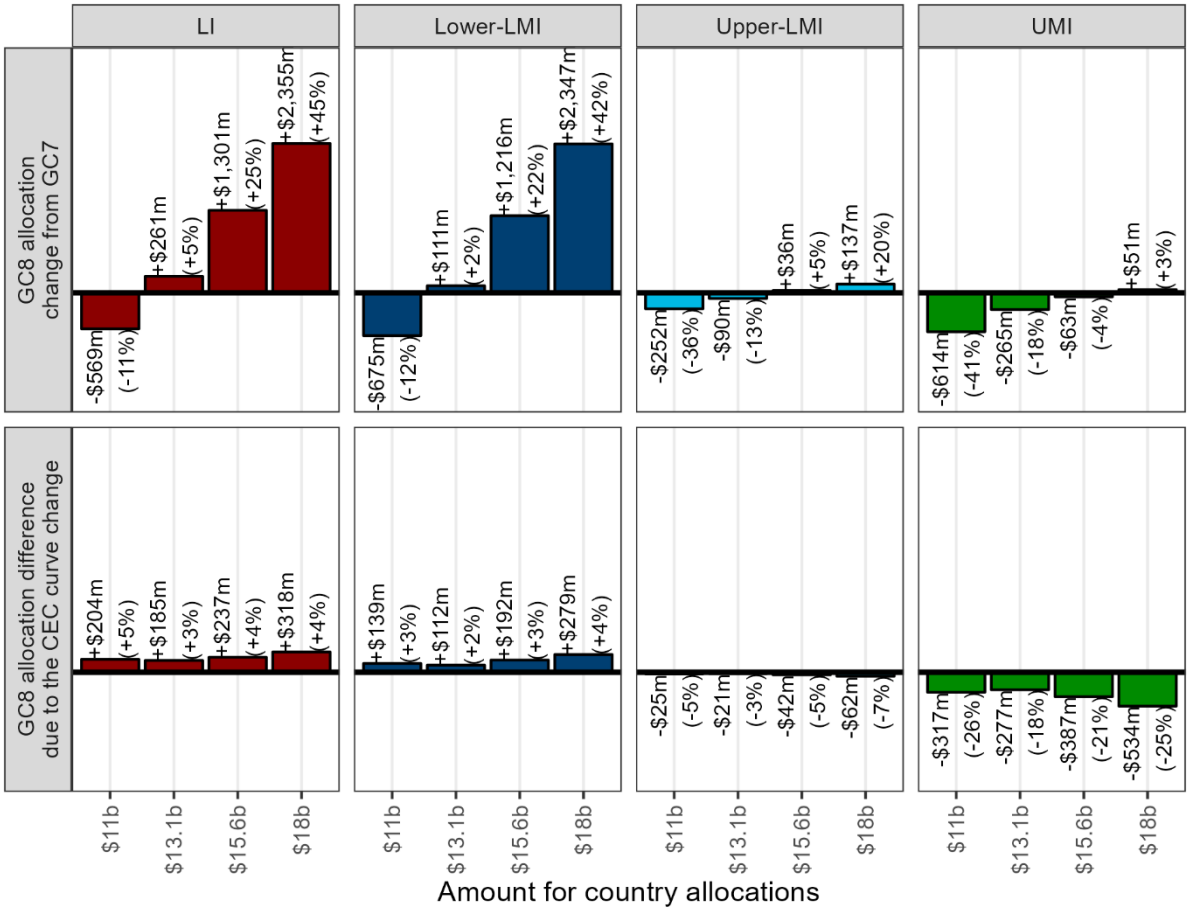
Figure 6: GC7 and GC8 CEC curve



Note: Lower middle income countries are divided into two groups (lower- and upper-LMI) to better distinguish between income levels of countries within that group.

46. The effect of the revised CEC curve is shown in Figure 7. Under all scenarios, the revised CEC curve would drive more funding to LI and lower-LMI countries compared to the current CEC curve. At US$ 13.1 billion, allocations to LIs would increase by US$ 185 million (+3%) due to this change in the CEC curve.

Figure 7: Effect by income group of the CEC curve change



Considerations of the Strategy Committee

47. While all SC members acknowledged the need to change the CEC curve in the context of the SC and Board sustainability discussions, some SC members asked whether the curve could be made more aggressive while other SC members asked about only applying the CEC curve change in scenarios of US$ 13.1 billion available funds for country allocations and below. A more aggressive change to the curve was not recommended due to the risk of causing unsustainable reductions in a small number of high burden UMI countries. Applying a shift to the CEC curve in only low funding scenarios was not recommended, as the intent of the curve shift was to respond to the disproportionate impact of global economic challenges on lower income countries, which remains relevant in any funding scenario. Therefore, enacting changes only in lower funding scenarios would undermine the Global Fund's efforts on sustainability. In addition, setting a different curve based on funding level would add complexity to the allocation model and would result in

unwanted effects as some countries would get less funding in a higher versus lower scenario due to the use of two different CEC curves.

48. The SC also considered whether to apply a 75% cap on UMI allocations, in addition to shifting the CEC curve, to predictably decrease funding for UMIs and signal to these countries to increase their domestic resources.[29] Applying a 75% cap *in addition to* other changes recommended in the Allocation methodology (including the CEC curve) would have almost no effect in low funding scenarios because most UMI allocations would already receive steep reductions well below 75%, since the allocation formula protects allocations for low income, high burden countries in low funding scenarios. In higher funding scenarios, the cap would have some effect: since most UMI allocations would already receive reductions, the cap would increase the scale of these reductions. The additional amounts freed up by a cap would come mostly from reductions in high burden UMI countries, with the remaining reductions coming from smaller UMI allocations that focus on key and vulnerable populations.

49. The SC recognized that UMI countries are a very diverse group, including countries with high disease burden, countries in active conflict, countries that are programmed regionally and are close to the minimum share (where formulaically reducing amounts could undermine ways to effectively implement and plan for transition), countries that were eligible but did not receive an allocation in GC7 for at least one disease, as well as countries in economic, humanitarian and regional crises. For these reasons, the Secretariat and SC did not introduce a country maximum cap and instead recommended applying a package of more effective levers to provide more predictability on reductions for UMI allocations. These levers include the ones related to the Allocation Methodology, such as the CEC curve change and qualitative adjustments, as well as other sustainability levers considered in the STC policy paper GF/B52/08E, including setting clear transition timelines.

Other aspects of the Allocation Methodology with no changes recommended

50. Besides the above changes to the GDS, the refinement of the malaria disease burden indicator period, and the CEC curve, no further changes to the Allocation Methodology were recommended or approved by the SC.[30] The following other

[29] In the allocation formula, a 75% cap on UMI allocations can be applied by adjusting the scale-up and paced reduction step for UMIs only. See Annex 5 for the additional effect of the cap on UMI allocations.
[30] SC review and approval of the qualitative adjustments factors and process is scheduled for 2025.

aspects of the allocation formula are recommended to be maintained as they remain fit for purpose. They are listed here and described in detail in Annex 3.

- Minimum share of US$ 500,000.
- Disease maximum share of 10% of total allocations per disease.
- Country maximum share of 7.5% of total country allocations.
- External financing adjustment to account for other donor funding.
- Scale-up and paced reduction to moderate steep increases and decreases from previous funding levels.[31]

4. Looking holistically at the recommended changes to the Allocation Methodology

51. In summary, the recommended changes to the Allocation Methodology are:
    - Change to the GDS, starting at US$ 12 billion with a target of 40% for HIV, 25% for TB and 35% for malaria at US$ 17 billion;
    - Change to the CEC curve to shift more funding to low and lower middle-income countries;
    - Refinement of the malaria disease burden indicator period based on WHO's recommendation to use the latest period disease burden data instead of 2000-2004 for countries with significantly increased transmission due to sustained epidemics.

52. The three graphs below show the combined effect of these recommended changes. As Figure 8 indicates, the combined changes would increase overall allocations for LI and lower-LMI countries in all four funding scenarios compared to no change. At the regional level, regions with high TB and malaria burden and LI countries gain relative to no change to the Allocation Methodology, as shown in Figure 9. Figure 10 shows that with the combined changes the Allocation Methodology continues to protect high burden countries, particularly in LIs.

[31] For the GC8 allocation period, the intent is to use communicated allocations from the previous allocation period to define "previous funding levels" in the allocation formula.

Figure 8: Effect by income group of recommended changes to the Allocation Methodology

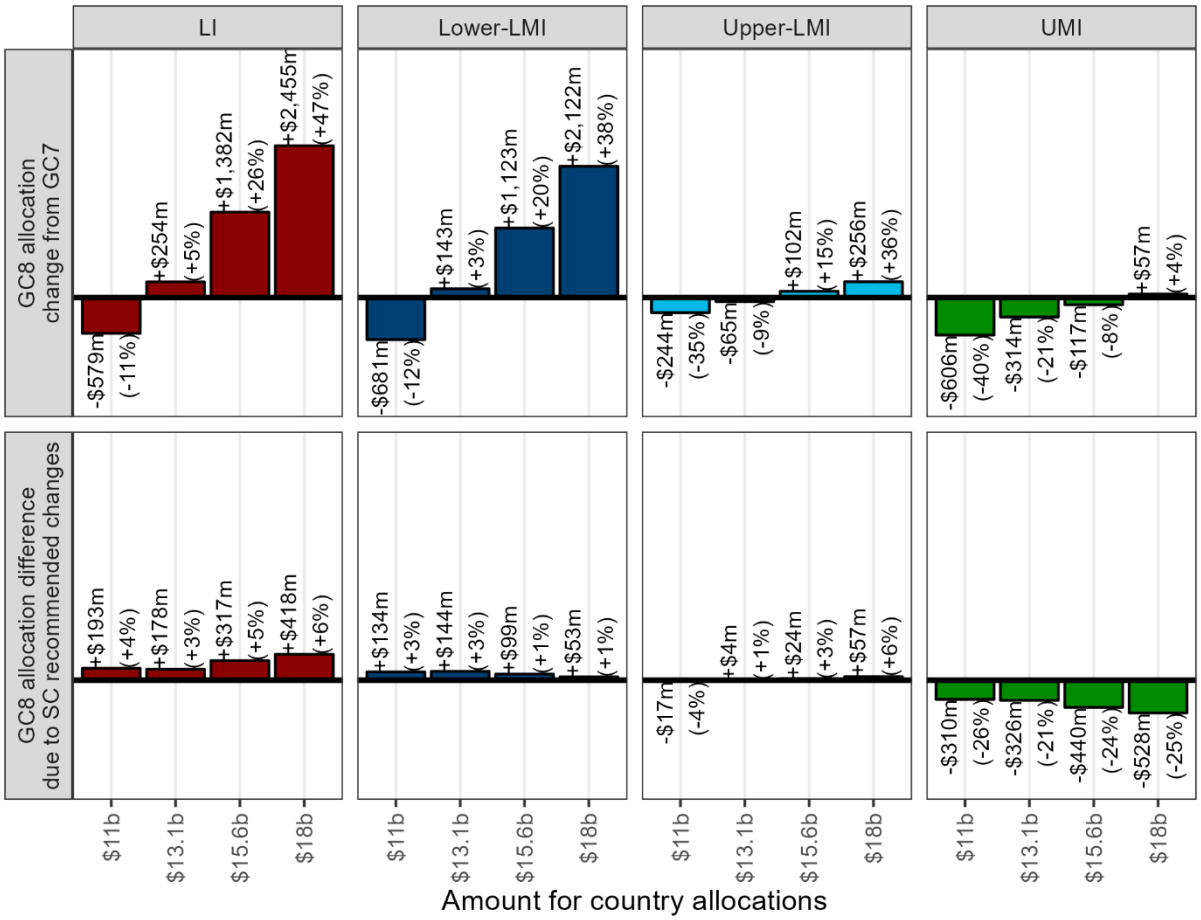


Figure 9: Effect by constituency region of recommended changes to the Allocation Methodology

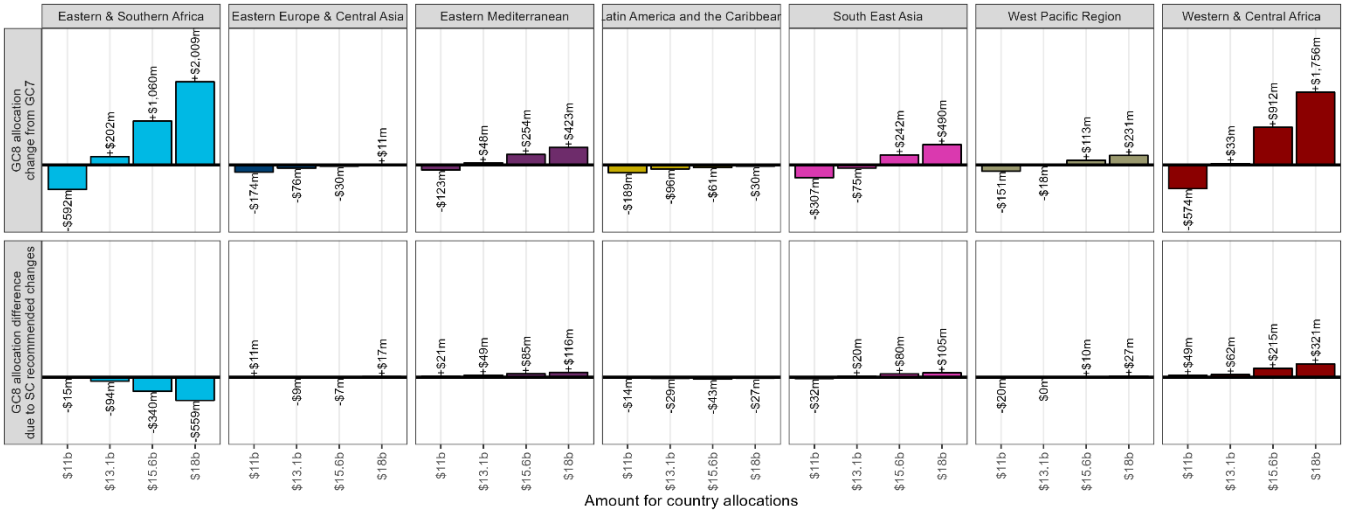
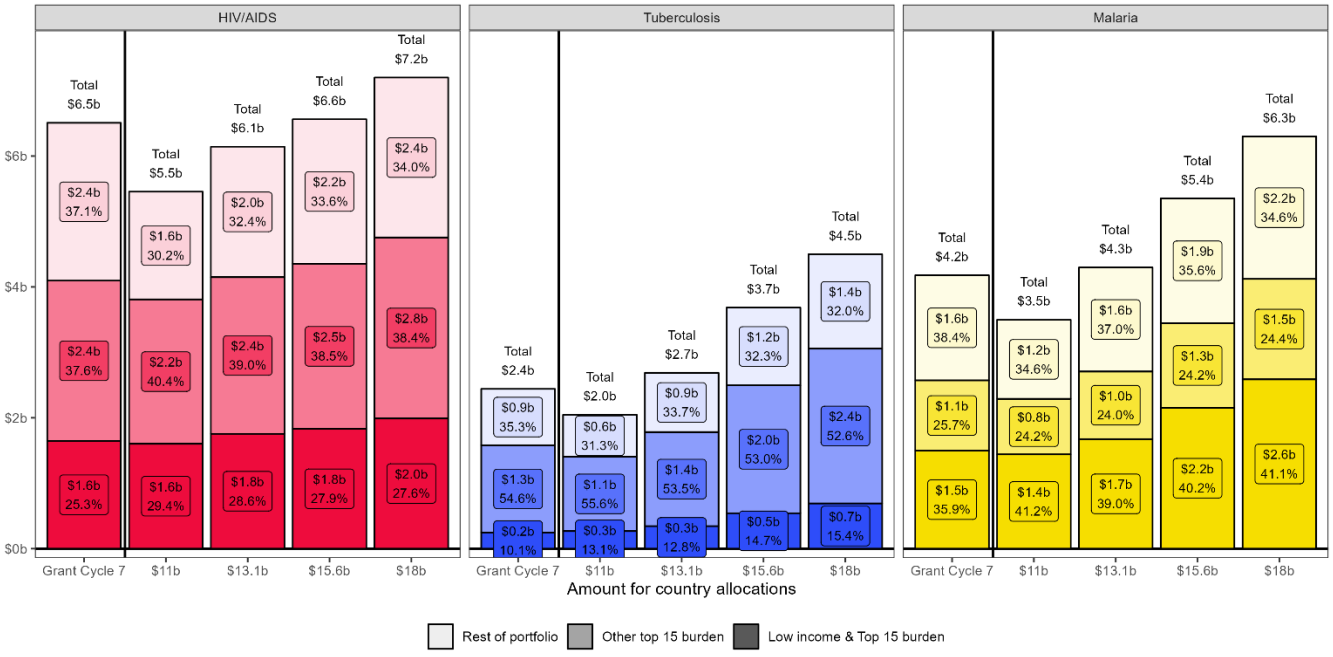


Figure 10: Effect of recommended changes for the top 15 burden countries for each disease, including those that are also LI



5. Qualitative Adjustments

53. Qualitative adjustments are the last step of the Allocation Methodology. After Replenishment, once the available sources of funds for allocation have been determined, the allocation formula will be run. The final 'Formula-Derived Amounts' will be reviewed through a qualitative adjustment process to account for key epidemiological, programmatic and other country contextual factors that are important to determine country allocations but either cannot be considered formulaically or are not fully represented in the allocation formula.

54. The Board noted at its July 2024 retreat that the Secretariat should have the space to flexibly determine the final country allocations based on context. At their 25th and 26th Meetings, SC members expressed their support for the qualitative adjustments step, noting their expectation that this step will continue to be used to refine country allocations.

55. The qualitative adjustment process is carried out by the Secretariat under the oversight of the SC. Prior to each allocation period, the SC approves the qualitative adjustment factors and process for applying the factors. To ensure that the qualitative adjustments process accounts for the current context and latest available data, the qualitative factors are approved by the SC as close as possible to the allocation formula run. For GC8, the review and approval by the SC is scheduled for 2025.

56. For GC7, the SC approved a transparent and flexible qualitative adjustments process, which was applied in two stages.[32] Stage 1 was to refine for epidemiological contexts insufficiently addressed through the allocation formula. For HIV only, an adjustment was applied in Stage 1 to account for key populations disproportionately affected by HIV in low prevalence settings. As part of initial consultations, technical partners indicated that the Stage 1 adjustment for HIV key populations should be reviewed for GC8 in line with sustainability considerations.

57. Stage 2 was a holistic adjustment to account for programmatic and other contextual factors. For GC7, the factors considered during the qualitative adjustments process included coverage gaps, cost of essential programming, performance, absorption, challenging operating environments, sustainability and transition considerations, as well as refined considerations on RSSH and economic capacity.

[32] GF/SC19/16

58. All adjustments were made to arrive at zero net changes per disease to maintain the GDS of resources in the final country allocations. The outcome of the process and all changes was reported to the SC,[33] with all changes greater than 15% and US$ 5 million reported to the Board.[34]

59. For GC8, the qualitative adjustments process will incorporate sustainability considerations and ensure its outcomes are aligned with the Global Fund's ongoing discussions on sustainability.

60. Building on the recommendations from the independent evaluation of the Allocation Methodology, as well as other lessons learned, the Secretariat will assess how RSSH and ongoing C19RM needs can be best considered as part of qualitative adjustments. As stated in the Secretariat Management Response to the Evaluation,[35] the Secretariat will consider all available levers, including catalytic investments, to help improve the impact of RSSH investments, in addition to strengthening RSSH considerations in the qualitative adjustments process.[36]

6. Catalytic Investments scenarios

61. As per the founding principles of the allocation-based funding model,[37] the Board can decide to set aside a portion of the available sources of funds for allocation for investments not adequately accommodated through country allocations. For GC8, CIs aim to focus on key investments that are needed to address mission critical needs in the delivery of the Strategy, which cannot be adequately addressed through country allocations alone, and also to mobilize aligned areas of investment, including from private and non-traditional donors, that advance the Strategy.

62. To prepare for different Replenishment outcomes, the Secretariat and SC recommend the total amounts for CIs to be grouped into scenarios based on the sources of funds for allocation. This section outlines the SC-recommended funding scenarios under which to set aside total CI envelopes, given their direct linkage to

[33] GF/SC20/ER03
[34] GF/B48/ER03
[35] https://www.theglobalfund.org/media/14708/iep_gf-elo-2024-02-secretariat-management_response_en.pdf
[36] As noted in the Secretariat Management Response, other levers include considering how allocation letters could be leveraged to help provide greater visibility on funding amounts and focus; working towards improved representation of RSSH stakeholders on Country Coordinating Mechanisms and optimized implementation arrangements for delivering RSSH interventions, which may help increase country accountability for RSSH investments; a holistic review of RSSH guidance for GC8; and more focused technical assistance (TA) as well as exploration of longer-term approaches to TA.
[37] GF/B27/DP07

the amount available for country allocations. The decision point on CI priorities recommended by the SC to the Board is presented in GF/B52/08C.

63. The following principles have guided the funding scenarios:

    a. Do no harm: protect continuity of essential services in the country allocations;

    b. Enable overall country allocations to reach previous funding levels at similar levels of sources of funds for allocation as in GC7;

    c. Enable scale-up in overall country allocations for the highest burden countries;

    d. Avoid reversing or significantly slowing down disease allocation increases resulting from the GDS change.

64. The Secretariat and SC recommend setting aside funding for CIs at sources of funds for allocation of US$ 12.26 billion and above, starting at US$ 260 million for CIs, with the full CI amount of US$ 800 million to be realized at sources of funds for allocation of US$15.2 billion and above. In the scenario where sources of funds for allocation are US$ 12.26 billion, setting aside US$ 260 million for CIs results in US$ 12 billion for country allocations. At this funding level, all three diseases are at or above their CoEP. As such, the recommended funding scenarios under which to set aside funding for CIs is consistent with the recommendation to begin the GDS change at US$ 12 billion for country allocations.

65. At this stage, the SC has not recommended CI amounts and priorities for scenarios below US$ 12.26 billion sources of funds for allocation, taking into consideration the US$ 12 billion for country allocations needed for HIV, TB and malaria to be at or above CoEP. As outlined in the CI Decision Point, CIs will remain necessary should sources of funds for allocation be less than US$ 12.26 billion. In such a scenario, the Secretariat, in coordination with SC leadership, will provide the Board with an updated recommendation on catalytic investment priorities and amounts that responds to the latest data and considerations on leveraging private sector funding.

66. In terms of moving to the next highest CI threshold, the recommended rate of increase is for this to occur at the next US$ 1 billion sources of funds for allocation. At this rate, TB and malaria allocations would increase with the recommended GDS change in higher funding levels, as shown in Table 3. With this approach, the full US$ 800 million catalytic scenario would be reached at US$ 15.2 billion sources of funds for allocation.

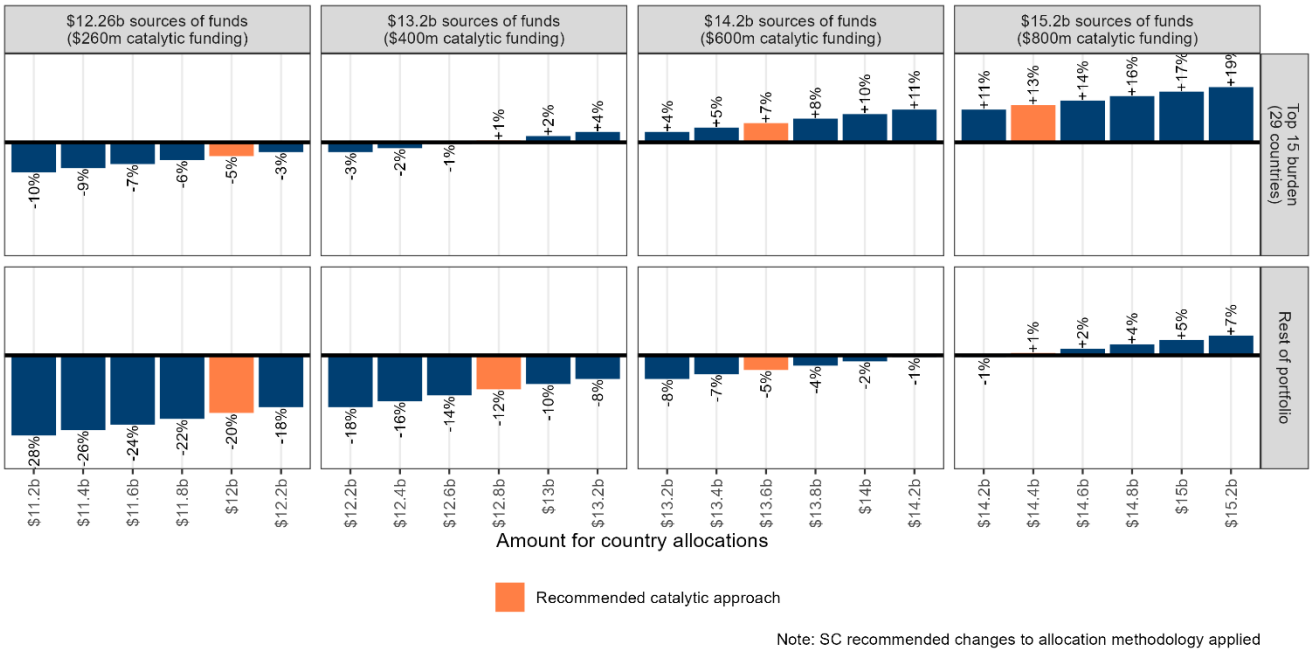
Table 3: Catalytic investments and country allocations by disease in the recommended scenario, change in funding compared to GC7

Funding in recommended scenarios			Change in funding compared to GC7			
Sources of Funds for Allocation (USD)	**Catalytic (USD)**	**Country Allocations (USD)**	**HIV/AIDS**	**TB**	**Malaria**	**Catalytic**
$12.26b	$260m	$12.0b	-9% -556m	-9% -210m	-9% -362m	-35% -140m
$12.7b	$260m	$12.4b	-7% -481m	-1% -32m	-4% -175m	-35% -140m
$13.2b	$400m	$12.8b	-6% -420m	+5% +113m	-1% -21m	0% 0m
$13.7b	$400m	$13.3b	-5% -335m	+13% +315m	+5% +192m	0% 0m
$14.2b	$600m	$13.6b	-4% -284m	+18% +436m	+8% +320m	+50% +200m
$14.7b	$600m	$14.1b	-3% -199m	+26% +638m	+13% +534m	+50% +200m
$15.2b	$800m	$14.4b	-2% -149m	+31% +759m	+16% +662m	+100% +400m
$15.7b	$800m	$14.9b	-1% -64m	+39% +960m	+21% +875m	+100% +400m
$16.2b	$800m	$15.4b	+0% +21m	+48% +1,162m	+26% +1,089m	+100% +400m
$16.7b	$800m	$15.9b	+2% +106m	+56% +1,364m	+31% +1,302m	+100% +400m
$17.2b	$800m	$16.4b	+3% +191m	+64% +1,566m	+36% +1,516m	+100% +400m

Note: amounts shown exclude any potential private sector funds.

67. Under the recommended approach, total allocations for high burden countries would increase in scenarios of US$ 400 million and above for CIs, as shown in Figure 11.

Figure 11: Scale-up of country allocations in highest burden countries under recommended catalytic investment amounts



Note: SC recommended changes to allocation methodology applied

68. Table 4 outlines the recommended funding scenarios for CIs.

Table 4: Recommended funding scenario for catalytic investments[38,39]

Sources of Funds for Allocation	Less than US$ 12.26b	US$ 12.26b to US$ 13.2b	US$ 13.2b to US$ 14.2b	US$ 14.2b to US$ 15.2b	US$ 15.2b and above
CIs	Amounts to be recommended[40]	US$ 260m	US$ 400m	US$ 600m	US$ 800m
Minimum amount for country allocations		US$ 12b	US$ 12.8b	US$ 13.6b	US$ 14.4b
Country allocation change from GC7		-8.6%	-2.5%	+3.6%	+9.7%

[38] GF/B52/08C
[39] Allocation amounts do not include overallocation. For GC7, $625 million was overallocated for country allocations.
[40] Catalytic investments will still be necessary should sources of funds for allocation for GC8 be less than US$ 12.26 billion. The Secretariat will make a recommendation on these amounts to the Board in such a scenario.

69. The SC-recommended CI priorities under each scenario are presented for Board approval in GF/B52/08C. Recognizing the importance of optimizing RSSH investments using available levers, the SC recommends funding a CI priority on RSSH in scenarios of US$ 12.26 billion sources of funds for allocation and above.

What is required to progress the proposal?

70. The Board is requested to approve the Allocation Methodology for GC8, including the SC-recommended revision to the GDS.

71. The Secretariat will develop and refine the qualitative adjustment process for GC8, under the oversight of the SC. In July 2025, under delegated authority from the Board, the SC will be requested to approve the qualitative adjustment process and factors.

72. In November 2025, once the replenishment outcome is known, the Board will approve the available sources of funds for allocation. The Secretariat will apply the Allocation Methodology to set aside funds for CIs and to produce the country allocations for the GC8 allocation period.

What would be the impact of delaying or rejecting the decision to progress?

73. A delay in the Board approval of the Allocation Methodology would prevent the sustainability policy decisions (GF/B52/08A) to be taken forward holistically to inform both the preparations for GC8 and the launch of the 8th Replenishment campaign.

7. Recommendation

The Board is requested to approve the Decision Point presented on page 1.

Annexes

The following items can be found in Annex:

Annex 1: Allocation Methodology
Annex 2: Technical Parameters approved by the SC
Annex 3: Other aspects of the allocation formula with no changes recommended
Annex 4: Allocation Methodology Glossary
Annex 5: Additional analysis to support the recommendations
Annex 6: Links to Relevant Past Documents & Reference Materials
Annex 7: Relevant Past Board Decisions

Annex 1 – Allocation Methodology

1. **Allocation Period**: The three-year period, aligned to each replenishment period, over which eligible applicants may apply for funding and the Board may approve such funding for grant programs.

2. **Implementation of Grants:** While the allocation period will be aligned with the replenishment period, the planning and implementation of grants will be aligned with country planning cycles. The standard period of Global Fund financing for an applicant will be three years, subject to flexibility where deemed appropriate by the Secretariat.[41]

3. **Apportioning Available Resources**: Prior to each allocation period, the Board will approve the total amount of available sources of funds for allocation based on the recommendation of the Committee responsible for financial oversight. From such amount, the Board may approve:

    a. Amounts for catalytic investments, as described further in paragraph 6 below; and

    b. Amounts to be included as part of the available funds for country allocation to ensure scale up, impact and paced reductions in funding as described in paragraph 4.c below.

    The Secretariat maintains flexibility to move funds for catalytic investments to available funds for country allocation for the purposes described in paragraph 3.b. above and will notify the Board accordingly.

4. **Country Allocations:** The Board will approve the amount of available funds for country allocation, which will then be allocated according to the approach outlined below:

- **Global Disease Split**: While applicants have flexibility in deciding how to allocate financing among their individual component programs, prior to the initial allocation of available funds for each allocation period, the Secretariat will apportion such resources among the three diseases based on the following distribution:

    i. Amounts up to and including US$ 12 billion:
        a. HIV/AIDS: 49.6~~50~~%;

[41] Justifications for variations from the three-year standard will be provided to the Board as part of the Secretariat's grant approval requests.

b. Tuberculosis: 18.618%; and
c. Malaria: 31.832%.

ii. Amounts above US$ 12 billion and up to including US$ 17 billion will be apportioned according to a linear extrapolation between the split detailed under 4(a)(i) above and the split detailed under 4(a)(iii) below.

iii. Amounts above US$ 17 billion:
a. HIV/AIDS: 4045%;
b. Tuberculosis: 25%; and
c. Malaria: 3530%.

- **Allocation Formula**: The formula for allocating available funds to eligible country components will be based on each country's economic capacity (measured by GNI per capita) and disease burden (following consultation with technical partners). These indicators for the allocation formula will be recommended by the Secretariat as part of the following allocation-formula parameters that the Committee responsible for oversight of strategic matters will assess and approve prior to each allocation period:

  i. Indicators for disease burden and country economic capacity;

  ii. Maximum and minimum shares for the allocation; and

  iii. External financing adjustment.

- **Formula-Derived Allocation:** After making the global disease split, the Secretariat will apply the allocation parameters to apportion a share of the available funds for country allocation to each eligible country component based on the shares produced by the allocation formula to obtain the initial calculated amount. The Secretariat will have flexibility to apportion the funding described in paragraph 3.b. above to ensure scale up, impact and paced reductions in funding across the portfolio, and be guided by the following initial approach to obtain the formula-derived allocation:

  i. Each eligible country component, which had a previous funding level below its initial calculated amount, will receive a funding level that is at least the midpoint between its initial calculated amount and its previous funding level;

ii. Each eligible country component, which had a previous funding level above its initial calculated amount, will receive a reduction of at least 10 percent from its previous funding level[42]; and

iii. Previous funding level represents allocations from the previous allocation period.

- **Qualitative Factors**: The Secretariat may further adjust formula-derived allocations, to account for specific circumstances in each eligible country component, under the oversight of the Committee responsible for strategy matters.

    i. Prior to each allocation period, the Committee responsible for strategy matters will approve the qualitative factors and the method for how they are applied, as well as oversee the adjustment process by the Secretariat; and

    ii. Any adjustment greater than 15 percent of an eligible country component's formula-derived allocation and greater than US$ 5 million shall be reported to the Board through the Committee responsible for strategy matters.

5. **Reallocation of Sources of Funds**: Upon confirmation by the Committee responsible for financial oversight, the Secretariat may conduct a strategic reallocation of available sources of funds according to the following parameters:

    a. Sources of funds that are additional to the amount initially allocated to eligible country components shall be reallocated to prioritized and costed areas of need identified and registered as unfunded quality demand, in accordance with a prioritization developed by the Secretariat and approved by the Committee responsible for strategy matters**;** and

    b. All reallocations of available sources of funds to grant programs shall be recommended by the Secretariat to the Board for approval.

6. **Catalytic Investments:** As described in paragraph 3.a, based on the recommendations of the Committee responsible for strategy matters, the Board may approve amounts to finance catalytic investments in priorities necessary to maximize impact and use of available funds, that are unable to be addressed through country allocations alone yet critical to deliver the Global Fund Strategy. The Committee responsible for strategy matters will review the type of priorities,

[42] Where the initial calculated amount is greater than 90% of previous funding, the formula-derived amount will be the initial calculated amount.

activities or initiatives to fund as catalytic investments, along with associated costs, prior to each allocation period, in consultation with the Committee responsible for financial oversight with respect to the available amount of sources of funds for allocation, and present recommendations to the Board for approval.

Annex 2 – Technical Parameters approved by the SC

Summary of technical parameters

Table 1: Technical Parameters	
Parameter	**Specification**
HIV burden indicator	Number of people living with HIV (PLHIV) Latest available data
TB burden indicator	[1*TB incidence] + [10*MDR-TB incidence] Latest available data
Malaria burden indicator	[1 * number of malaria cases] + [1 * number of malaria deaths] + [0.05 * malaria incidence rate] + [0.05 * malaria mortality rate] Latest available data for the average values between 2000-2004, except when a country's recent average incidence rate is significantly higher than the 2000-2004 average, indicating greater transmission intensity due to sustained epidemics. In such cases, as recommended by WHO, the average values for the last five years are used. Number of malaria cases and deaths adjusted by latest Population-At-Risk (PAR) ratio: PAR (latest year) / PAR (2000-2004 average) All indicators normalized
Country economic capacity indicator	Weighting determined by GNI per capita and smooth CEC curve Latest available data
Maximum shares	10% funding at a disease level 7.5% funding at a country level
Minimum shares	US$ 500,000 per component, subject to assessment of the impact that could be achieved, contribution towards achieving strategic objectives, and ability to efficiently manage such programs with differentiated and simplified grant management processes
External financing adjustment	Projections discounted by 50% for data quality, and can influence country allocations by up to 25%

Annex 3 – Other aspects of the allocation formula with no changes recommended

1. The *minimum share* ensures that no components receive less than US$ 500,000 in the allocation formula, with the aim of providing meaningful allocation amounts to operationalize and achieve impact. In the formula, component allocations below this amount are brought up to this minimum. Components at this minimum amount may be brought to zero in the qualitative adjustments process – this is subject to assessment of the impact that could be achieved, contribution towards achieving strategic objectives, and ability to efficiently manage such programs with differentiated and simplified grant management processes.

   For the GC7 allocations, the Formula Derived Amounts (FDAs) for 28 components were at this minimum level, of which six were brought to zero in the qualitative adjustments process due to consideration of the costs and benefits of the potential (re-)introduction of funding. For the components that were maintained at or around US$ 500,000, the majority were for small island economies, where country allocations were aggregated and programmed as part of a multi-country grant.

   The two *maximum shares* aim to ensure that overall funding does not become overly concentrated in a few countries. Components are limited to a maximum of 10% of total disease funding, and country allocations are limited to 7.5% of total funding.

   For the GC7 allocations, six countries were capped in the allocation formula by the maximum shares. The SC granted an exemption to exceed the maximum disease share for one country component due to its critical context.[43]

2. The *external financing adjustment* aims to align the distribution of total external financing to the distribution of disease burden and economic capacity. In the formula, country component allocations are adjusted based on projections of non-Global Fund external financing. To account for data quality and uncertainty regarding projected levels of external financing, the projections are discounted

[43] GF/SC20/ER02

by 50% and the effect of the adjustment on component allocations is limited to 25%.

Due to the larger volume of other donor financing for HIV, the adjustment had the greatest effect on HIV for the GC7 allocations with an 8% shift in funds between countries within the HIV envelope, as a significant number of HIV countries reached the maximum adjustment of +/-25%. In contrast, the adjustment had a lesser effect on TB and malaria, where the Global Fund accounts for a greater share of external funding.

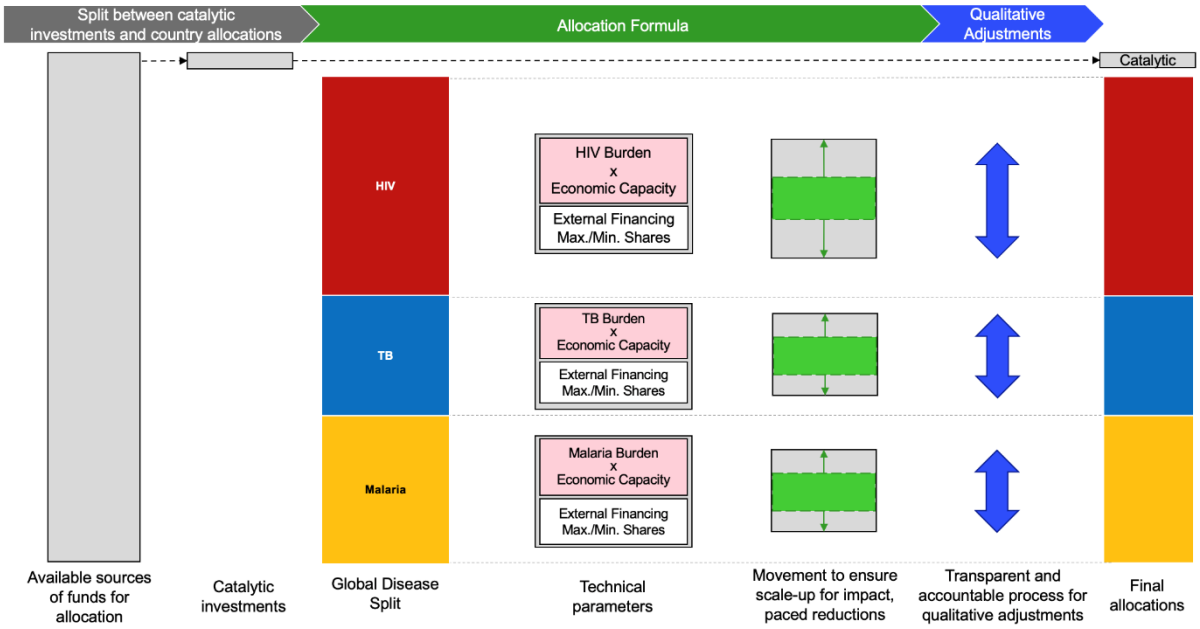
3. The *scale up and paced reduction* step aims to ensure predictable financing for all programs. While this step is no longer needed to transition from the rounds-based model, it is still needed to protect components from steep reductions when possible while also driving funding to the highest burden countries with the lowest economic capacity. In the formula, components that receive significant increases are moderated to the mid-point of the new amount and their previous funding level.[44] The funding freed up from these components is moved to components that receive large reductions so that they receive at most 90% of their previous funding. The amount of funding moved in this stage is capped at 7.5% of the total available funds for country allocations.

   For the GC7 allocations where total funding increased by 3.3% compared to the previous allocation period, the scale-up and paced reduction step resulted in limiting the largest reductions in allocations to 19% for HIV, 25% for malaria and 30% for TB. Without the step, these reductions would have been even more significant. In total, 7.5% of the total funding was moved in the scale-up and paced reduction step.

4. Based on the findings outlined above, the Secretariat recommends maintaining the minimum and maximum shares, the external financing adjustment, and the scale-up and paced reduction step for GC8.

[44] For the GC8 allocation period, the intent is to use communicated allocations from the previous allocation period to define "previous funding levels".

Annex 4 – Allocation Methodology Glossary



Allocation period: the three-year period, aligned to each replenishment period, over which eligible applicants that receive an allocation may apply for funding and the Board may approve such funding for grant programs.

Available sources of funds for allocation: the amount of funds for country allocations and catalytic investments approved by the Board prior to each allocation period.

Country allocation methodology: the methodology to determine the distribution of funds for country allocations, comprising of the allocation formula and qualitative adjustments.

Catalytic investments: funding set aside to invest in priorities that are unable to be addressed through country allocations alone and considered to be crucial to ensure delivery against strategic aims.

Global disease split: distribution of total country allocation resources across HIV, TB and malaria. This distribution is done upfront in the allocation formula and maintained throughout the allocation methodology.

Component: HIV, TB or malaria.

Technical Parameters:

- **Disease burden**: a country's disease burden, used in the formula relative to the overall disease burden of all Global Fund eligible countries, defined by the indicators recommended by technical partners and outlined in Annex 2.
- **Country economic capacity**: a country's GNI per capita, used in the formula by weighting according to a smooth curve where allocations decrease as GNI per capita increases.
- **Minimum share**: no component may receive less than US$ 500,000 in the allocation formula. Allocation amounts are brought to at least this amount in the formula. Components at this minimum amount may be brought to zero in the qualitative adjustments process – this is subject to assessment of the impact that could be achieved, contribution towards achieving strategic objectives, and ability to efficiently manage such programs with differentiated and simplified grant management processes.
- **Maximum shares**: components are limited to a maximum of 10% of total disease funding. Country allocations are limited to a maximum of 7.5% of the total funding.
- **External financing adjustment**: adjustment to component allocations based on projections of other external financing (non-Global Fund). To account for data quality and uncertainty, the projections are discounted by 50% and the adjustment can influence component allocations by up to 25%.

Initial Calculated Amount (ICA): initial allocation amount based on the technical parameters of disease burden, country economic capacity, minimum shares, maximum shares and external financing adjustments. Does not include formulaic adjustments for paced reduction/scale-up components (see below), nor does it include qualitative adjustments.

Previous funding level: allocation amount in previous allocation period.

Scale-up components: components where previous funding level is *lower* than the allocation formula's Initial Calculated Amount. For the formula-derived amounts, scale-up components receive *at minimum* the mid-point between their previous funding level and Initial Calculated Amount for the current allocation period.

Paced reduction components: components where previous funding level is *higher* than the allocation formula's Initial Calculated Amount. For the formula-derived amounts, paced reduction components may receive an increase up to *a maximum* share of their previous funding level.

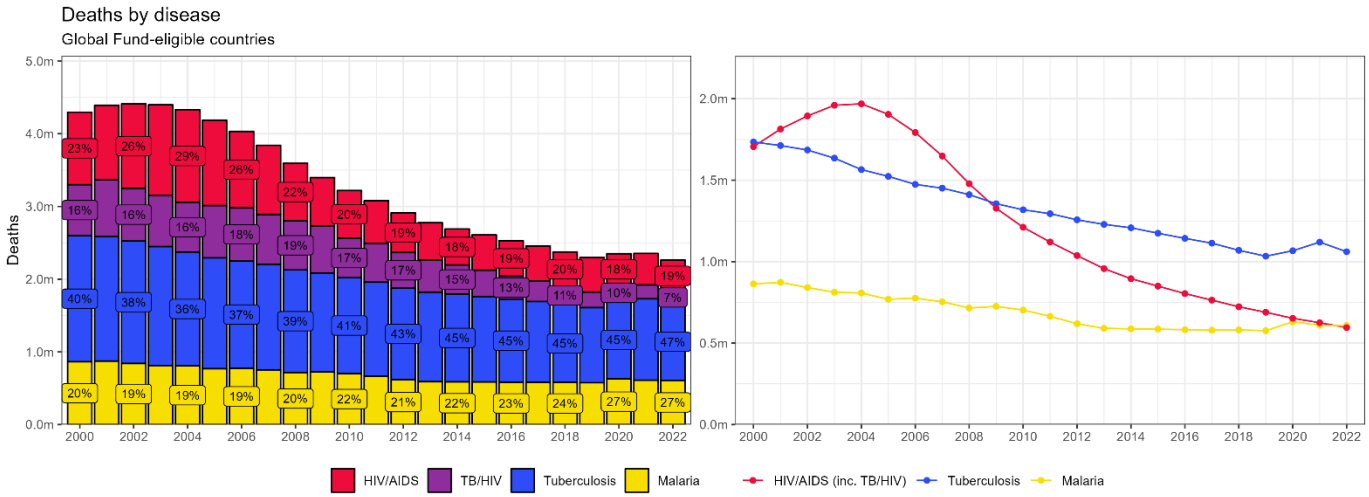
Formula-Derived Amount (FDA): allocation amount after scale-up and paced reduction adjustments based on funding levels in previous allocation period.

Qualitative adjustments: refinements to formula-derived allocations to account for epidemiological, programmatic and other country contextual factors that either cannot be considered formulaically or are not fully represented in the allocation formula, to maximize the impact of Global Fund resources in line with the Strategy. For GC7, Phase 1 consisted of adjustments for key populations for HIV to account for epidemiological contexts that are insufficiently captured in the formula. Phase 2 includes adjustments for key programmatic factors and other contextual considerations. All changes and rationale are reported to the SC, and all changes greater than US$ 5 million and 15% are reported to the Board.

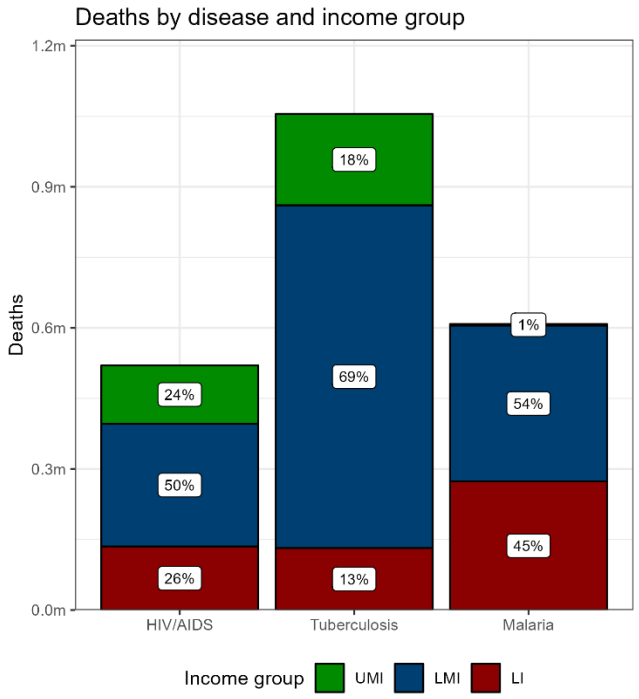
Program split: the distribution of country allocations across eligible disease components and standalone funding requests for RSSH. Based on the allocation methodology, the Global Fund provides countries with an indicative split of allocation funding between disease components. Countries have the flexibility to revise this distribution to address country contexts. The Country Coordinating Mechanism (CCM) uses a documented and inclusive process to determine the proposed split, which is agreed with the Global Fund Secretariat before submitting a funding request.

Annex 5 – Additional analysis to support the recommendations

Additional analysis to inform the Global Disease Split

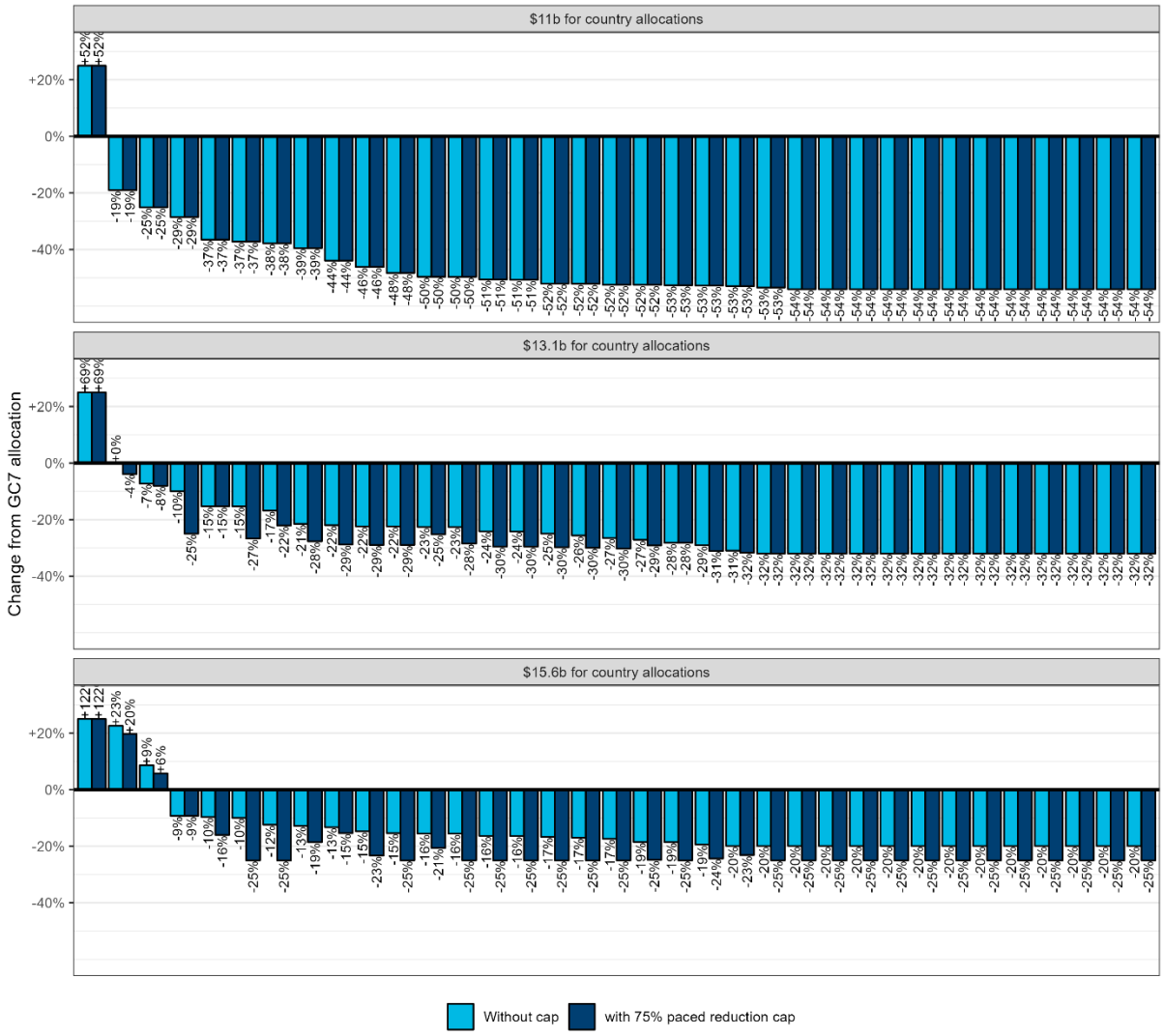


Source: WHO, UNAIDS



Source:
Deaths - UNAIDS (2024), WHO (2023)
Income classification - World Bank (2024)

Additional effect of the 75% paced reduction cap on UMI country allocations



Note: scenarios incorporate the recommended changes on GDS, CEC and malaria burden.

Annex 7 – Links to Relevant Past Documents & Reference Materials

- The 2023-2025 (GC7) Allocation Methodology (GF/B47/03)
- Cost of Essential Programming Frequently Asked Questions (FAQ)
- Technical partners' recommendations on disease burden indicators for the Eligibility Policy and Allocation Methodology
- Independent evaluation of the Global Fund Allocation Methodology
- External review of economic capacity indicators (2021): Assessing economic capacity in the Eligibility Policy and Allocation Methodology

Annex 8 – Relevant Past Board Decisions

Relevant past Decision Point	Summary and Impact
GF/B46/DP05: Allocation Methodology for the 2023-2025 Allocation Period (May 2022)	Based on the recommendation of the SC, the Board approved the allocation methodology for the 2023-2025 allocation period (GC7).
GF/B46/DP04: Global Disease Split for the 2023-2025 Allocation Methodology (November 2021)	The Board approved the apportionment of available country allocation funds across disease components ("Global Disease Split") for the 2023-2025 allocation period (GC7), which would be determined by the total amount of available funds for country allocation for the 2023-2025 allocation period (GC7).
GF/B41/DP02: Allocation Methodology for the 2020-2022 Allocation Period (May 2019)	Based on the recommendation of the SC, the Board approved an updated allocation methodology for the 2020-2022 allocation period. The global disease split remained unchanged from the 2017-2019 allocation period
GF/B35/DP05: Allocation Methodology 2017-2019 (April 2016)	Based on the recommendation of the SC, the Board approved an allocation methodology for the 2017-2019 allocation period. The global disease split remained unchanged from the 2014-2016 allocation period.
GF/B29/EDP11: Revising the distribution of funding by disease in the new funding model allocation methodology (October 2016)	The Board approved an initial apportionment of available resources across the three diseases as follows: 50% HIV/AIDS, 18% tuberculosis, and 32% malaria.