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GF/B23/14
Board Decision

JOINT PSC-PIC REPORT ON THE REVIEW OF THE GLOBAL FUND'S ELIGIBILITY, COST SHARING AND PRIORITIZATION POLICIES AND RECOMMENDATION FOR A NEW INTEGRATED POLICY

Purpose

This paper provides recommendations and rationale for an integrated policy on Eligibility, Counterpart Financing and Prioritization following a review by the Global Fund's Policy and Strategy Committee (PSC) and Portfolio Implementation Committee (PIC). A recommended decision point and Policy are presented to the Board for discussion and approval.

EXECUTIVE SUMMARY

1. At its sixteenth meeting in November 2007, the Global Fund Board agreed to review the *Eligibility and Cost Sharing Policy* by the end of 2010. The Joint PSC-PIC Working Group on Eligibility and Cost Sharing was constituted in May 2010, co-chaired by Suwit Wibulpolprasert (PSC Chair) and Michele Moloney-Kitts (PIC Chair) and four members from each Committee. The Working Group provided an update of its work at the twenty-second Board Meeting in December 2010. This paper presents outcomes from the extended review and presents recommendations for discussion and approval by the Board.

2. The recommendations in this paper seek to ensure that available resources flow preferentially to countries with the highest disease burden and the least ability to pay, while ensuring due priority to communities and subpopulations at high risk of disease.

3. To promote country ownership, accountability and sustainability, provisions for *counterpart financing* are better defined and nuanced, made more measurable, and can be monitored in order to ensure adherence and accountability.

4. *Eligibility* rules establish which countries may apply for funding from the Global Fund, and under what conditions. *Cost Sharing* (redefined by the Working Group as *Counterpart Financing)* addresses a country's investments of national resources in fighting the three diseases. *Prioritization* applies when Global Fund financial resources are constrained and available funds need to be prioritized.

5. An integrated and internally consistent model is presented that links Eligibility, Counterpart Financing and Prioritization. It has the following features:

i. Keeps Eligibility generally broad and builds on the positive response to the 'most at risk populations' (MARPs) reserve in Round 10;
ii. In addition to a General Funding Pool, it establishes a Targeted Funding Pool applying to all three diseases, which seeks to support programs focused on 'underserved and most-at-risk populations' and/or 'highest-impact interventions within a defined epidemiological context';
iii. Introduces a new approach to Counterpart Financing that is more grounded and operationally feasible and will help achieve the "additionality" principles of Global Fund financing; and
iv. Improves upon the existing Prioritization rules to better capture "need" as a mix of country disease burden and ability to pay and links with other policies.

6. Changes recommended to the current Eligibility criteria seek to ensure broad but focused access to Global Fund resources. The changes are primarily related to middle income countries, (lower middle tiers and upper middle tiers) which will henceforth be required to show greater emphasis on populations and/or interventions most in need of Global Fund support.

7. The diversity of country situations is explicitly acknowledged through the creation of two distinct funding pools.

i. The first, referred to as the *General Funding Pool* will principally be intended for the support of countries with a large disease burden relative to the domestic resources available for financing a response — i.e., those with the greatest need. The PSC and PIC recommend that 90 percent of available funds flow through the General Pool.

ii. The second, named the *Targeted Funding Pool*, builds on the successes of the MARPs Reserve in Round 10, but extends this to tuberculosis and malaria proposals. The smaller Targeted Pool (10 percent of available funds) will be reserved for proposals entirely focused on populations and/or interventions most in need of Global Fund support. It is aimed primarily at middle-income countries without large overall disease burdens but which face specific high-risk situations.

8. Prioritization will help guide countries towards the funding pool best suited to their specific country situation. A composite index consisting of the Technical Review Panel (TRP) rating of a proposal, the country's income level and a more nuanced disease burden scoring system will determine which applicants stand the highest probability of receiving grants from the General Pool. Within the Targeted Pool, the TRP will help prioritize proposals recommended for funding. Where resources are insufficient to meet recommended demand, the prioritization rules, in tandem with the general and targeted funding pool system, will allocate resources more equitably.

9. All countries will be required to make Counterpart Financing commitments as part of their shared responsibility in implementing disease programs. Across the income tiers, graduated thresholds for government contribution to national disease program spending are proposed, in a manner that reflects country ability to pay.

10. The new set of rules covering Eligibility, Counterpart Financing and Prioritization will require expanded dissemination, communication and monitoring efforts by the Global Fund Secretariat to allow countries and their partners to understand the implications of the new policy and adequately prepare for future Rounds.

PART 1: INTRODUCTION

1.1 At its sixteenth Board Meeting in 2007, the Board requested a review of the Eligibility and Cost Sharing Policy by the end of 2010. The *Eligibility and Cost Sharing Policy* defines the criteria for determining whether or not countries are eligible to apply for financial support from the Global Fund.[1]

1.2 A joint working group of the Policy and Strategy Committee (PSC) and the Portfolio Implementation Committee (PIC) (the Working Group) was constituted in May 2010 to review the current eligibility and prioritization policies and make recommendations to the Board at its twenty-second meeting. Since then, this ten-member working group, co-chaired by the PIC and PSC chairs, has had three in-person meetings and several teleconferences to discuss various options to revise these policies. The Working Group also led a survey of Board constituencies in June–July 2010 to ensure that the range of options for eligibility, cost sharing and prioritization were canvassed. The PSC and PIC held joint meetings in October 2010 and March 2011 to discuss the options recommended by the Working Group.

1.3 The existing eligibility determinations approved in 2007 are based on: (i) a country's income classification, using Gross National Income (GNI) per capita (World Bank, Atlas Method); and (ii) disease burden, using disease-specific criteria and epidemiologic data provided by the WHO and UNAIDS. Eligible applicants from lower-middle income countries (LMICs) and upper-middle income countries (UMICs) need to comply with minimum cost sharing requirements and have to focus on poor and/or vulnerable populations. These are based on the general principles guiding eligibility as outlined in Section VII of the Framework Document.[2]

1.4 The Eligibility and Cost Sharing Policy review is combined with a review of the criteria for prioritization of funding of TRP-recommended proposals when available Global Fund resources are constrained. These criteria are currently embedded within the Comprehensive Funding Policy[3], although superseded for Round 10 through the introduction of rules particular to that Round[4].

1.5 In line with the Framework Document, the PSC and PIC uphold and reaffirm the primacy of the following guiding principles:

i. Highest priority should be given to proposals from countries and regions with the greatest need, based on the highest burden of disease and the least ability to bring financial resources to address these health problems;
ii. Due priority should be given to communities, countries and regions with a high risk potential and rapid increase in disease;
iii. The Global Fund should seek to operate in a balanced manner in terms of regions, diseases and interventions; and
iv. There should be high-level, sustained political involvement and ownership, and national commitment in making allocations of domestic resources for the disease.

[1] Decision Point GF/B16/DP18 and Document GF/B16/7 Revision 1, Attachment 1
[2] The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Available at: http://www.theglobalfund.org/documents/TGF_Framework.pdf
[3] Decision Point GF/B6/DP4
[4] Decision Point GF/B21/DP17

1.6 This paper presents recommendations based on the joint discussions of the PSC and PIC in March 2011.[5] A recommended decision point and Policy on Eligibility, Counterpart Financing and Prioritization are presented in Part 2 for Board discussion and approval.

PART 2: ELIGIBILITY CRITERIA

The PSC and PIC examined in concert: (i) eligibility criteria, (ii) counterpart financing and (iii) prioritization criteria. For each area, recommendations are presented with the rationale and discussion.

ELIGIBILITY

Eligible Countries according to Income Level Criteria

2.1 The proposed eligibility policy maintains geographic diversity while focusing Global Fund resources on the neediest countries and subpopulations and the most cost-effective interventions for HIV, tuberculosis and malaria. It has several features:

i. A set of eligible countries
ii. A new dual funding pool system
iii. Eligibility filters based on history of recent funding by the Global Fund and the OECD Development Assistance Committee (DAC) list

2.2 Within the set of eligible countries, there are fully eligible and conditionally eligible countries. The dual funding pool system extends the most-at-risk-populations (MARPs) Reserve from Round 10 to tuberculosis and malaria by establishing a General and a Targeted Funding Pool.

2.3 **All low income countries (LICs) are fully eligible countries.** They may submit a grant proposal for the full range of HIV, tuberculosis, and malaria interventions deemed to be appropriate to the populations being served. The TRP review will assess suitability for funding based on soundness of approach, feasibility, value for money and potential for sustainability and impact.

2.4 **Conditionally eligible countries must focus all or part of their proposal on 'underserved and most-at-risk populations' and/or 'highest impact interventions within a defined epidemiological context' (hereinafter referred to as 'Special Groups and/or Interventions').** Countries in this category of conditional eligibility include:

i. All lower-middle income countries (LMICs), which are split into two income groups (Lower LMIC and Upper LMIC) using as the cut-off the midpoint of the range of GNI per capita for LMICs.[6] Although the condition for eligibility for LMICs is the same for Lower LMICs and Upper LMICs, the split into the two income substrata is being introduced into the revised policy for the purposes of counterpart financing requirements and prioritization criteria, which are integral components of the new policy.

[5] Co-chairs' summary of the Joint PSC-PIC meeting on the review of the Eligibility, Cost Sharing and Prioritization policies, Geneva, 16 March 2011.

[6] The 'midpoint' is defined as the average between the lower and upper bound GNI per capita of the LMI category. Based on the 2009 World Bank country classification by income, the GNI per capita range for Lower LMICs is US$ 996—2,470 and for Upper LMICs: US$ 2,471—3,945.

For applications from LMICs directed to the General Pool, at least 50 percent of the proposed budget should focus on the special groups and/or interventions. Applications to the Targeted Pool should be focused entirely on the special groups and/or interventions.

ii. UMICs that have *severe* or *extreme* disease burden for the corresponding disease component, as defined by Inter Agency Working Group (IAWG)[7].The entire disease proposal should focus on the special groups and/or interventions, regardless of the funding pool. These UMIC countries may also apply for cross-cutting Health Systems Strengthening (HSS) support through submission of an HSS proposal to the General Pool only. These proposals will need to comply with the focus of interventions as defined in Annex 6.

iii. UMICs that have *high* disease burden for the corresponding disease component are eligible only for the Targeted Pool and their applications must focus 100 percent on special groups and/or interventions.[8] These countries cannot apply for a cross-cutting HSS proposal.

2.5 Recommendations on parameters for defining special groups and interventions for the three diseases and cross-cutting HSS are found in Annex 6. At the time of launch of a call for proposals, illustrative guidance (including lists), based on input from technical partners, will be made available on the Global Fund website. Applicants can request funding for other interventions but must include evidence to justify such interventions within their proposal. A determination on whether countries meet the proposal focus requirements in either funding pool will not be made during the pre-TRP screening process which takes place within the Secretariat. Rather, the TRP will assess compliance with this focus as part of its regular TRP review process. Figure 1 illustrates the proposed eligibility criteria.

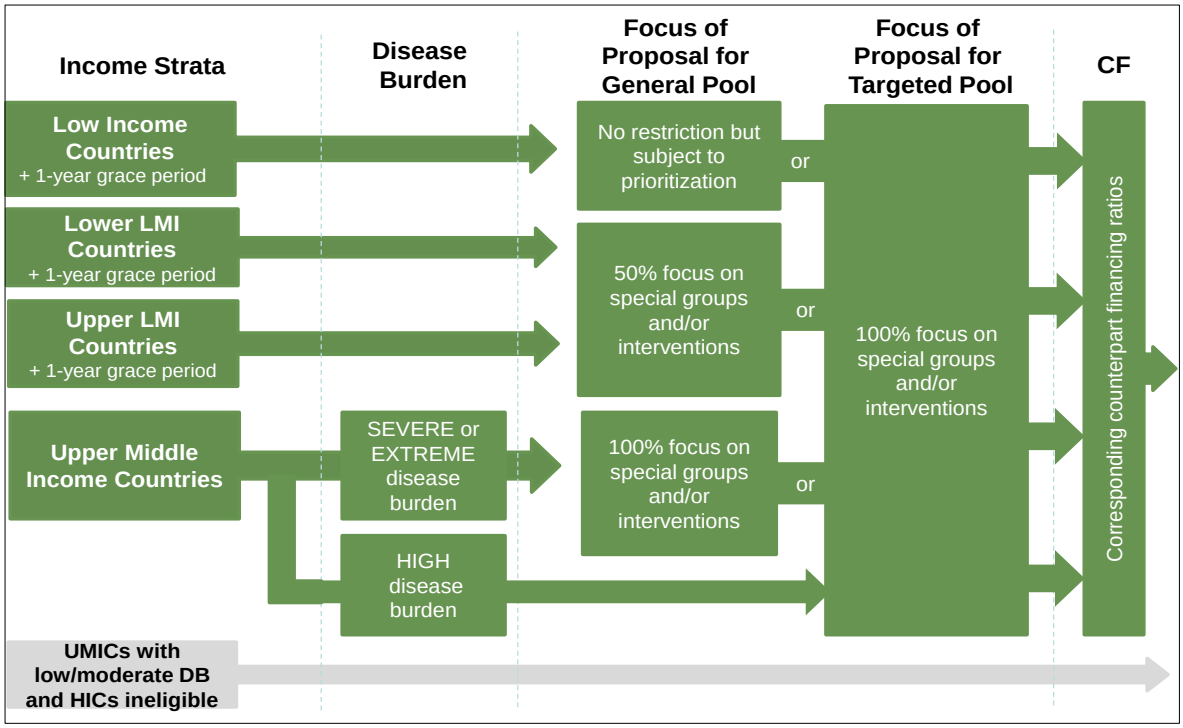
2.6 As in the past, **the PSC and PIC recommend that a one-year grace period be considered for countries that transition to a higher income level to allow enough time to adjust to the new eligibility conditions. The grace period does not apply to UMICs that transition to the category of high income countries.**

[7] See Annex 1 for the disease burden criteria recommended by the IAWG and Annexes 2-4 for the distributions of countries according to income level and disease burden criteria.

The IAWG was established at the request of the Global Fund to contribute to the review of the prioritization policy for Round 10, and subsequently to the work of the Joint PSC-PIC Working Group on Eligibility and Cost Sharing. The IAWG brings together the technical expertise from WHO, UNAIDS, the Stop TB Partnership and the Roll Back Malaria Partnership. It is coordinated by the Office of the Assistant Director General, HIV, TB, Malaria and Neglected Diseases Cluster, WHO. The IAWG is chaired by Dr Christopher Dye. The IAWG provided input to the Joint PSC-PIC Working Group on many technical areas related to eligibility and prioritization, including: the disease burden criteria, prioritization in the targeted pool, and definitions for special groups and/or interventions as a proposal focus requirement for some applicants.

[8] A minority of the PSC and PIC members disagreed with the recommendation to exclude UMICs with moderate disease burden. However, it was emphasized that the available resources of the Global Fund should be allocated to countries with the highest need and least capacity, particularly in the light of overall resource constraints facing the Global Fund. Some delegations favored additional changes in eligibility policies that would reduce, not expand, the total number of eligible countries and/or would restrict eligibility of some middle-income countries to the Targeted Pool. Annex 5 shows the distribution of UMICs according to disease burden.

Figure 1: Eligibility criteria*



* CF refers to Counterpart Financing

Eligibility under a Dual Funding Pool System

2.7 The second component of the recommended eligibility policy involves the creation of two distinct funding pools for applicants. Building on the successful MARPs reserve in Round 10[9], **the PSC and PIC recommend the establishment of a General and a Targeted Pool.** Doing so ensures that at-risk groups in relatively wealthier countries can still benefit from Global Fund financial support, while ensuring that the bulk of the available funds go to the poorest countries.

2.8 The General Pool, consisting of 90 percent of the total available funds in a Round, will principally support countries with large disease burden relative to domestic resources available for financing the national disease program — i.e., those with the greatest need. The General Pool will operate in a manner similar to the current system. Applicants will determine the size and scope of their proposals (within the guidelines for full or conditional eligibility, as applicable). In the event that demand exceeds available resources, TRP-recommended proposals in the General Pool will be prioritized as outlined in Sections 2.47—2.49.

2.9 The Targeted Pool will extend the Round 10 HIV MARPs reserve to the other two diseases (TB and malaria proposals), with a commitment of 10 percent of the available funds. It will consist of smaller proposals with a budget ceiling of US$ 5 million for the first two years or US$ 12.5 million lifetime budget (see Annex 7 for an analysis supporting these budget ceilings). In the event that either pool has a surplus after meeting demand within the pool, the remainder of the pre-allocated funds will be re-allocated to meet demand in the other pool (see Section 2.54).

[9] Decision Point GF/B21/DP18

2.10 Targeted Pool proposals must focus entirely on special groups and/or interventions as recommended by the IAWG (see Annex 6 for the definitions). The set of recommended special groups and/or interventions will be reviewed and revised periodically by an expert body as new and compelling evidence and best practices emerge.

2.11 Eligible countries may determine to which pool they will apply, but cannot apply for both pools for the same disease component. Exceptions to this general rule are: (i) UMICs with disease burden categorized as 'high' can only apply under the Targeted Pool; and (ii) applicants for cross-cutting HSS proposals can only apply under the General Pool. Countries eligible for at least one disease component under the General Pool may apply for cross-cutting HSS proposals from that pool.

2.12 A regional proposal may be submitted if majority of the participating countries in the coordinated proposal are eligible for the funding pool to which they are applying.[10] It is expected that regional proposals will address cross-border or regional issues, hence regional proposals should have 100 percent focus on special groups and/or interventions as defined in Annex 6. An exception to the 'focus' requirement would be when majority of countries in the regional proposal are low income countries.

Size of Available Resource Envelope

2.13 The PSC and PIC noted that the above provisions accompanying Eligibility and the dual funding pool system are most suited where Global Fund resources for a Round are expected to be US$ 1 billion and above. As the new Eligibility policy is intended to extend into the future, the PSC and PIC explored options in the event that funding falls below US$ 1 billion. One or more of the following actions may be considered:

i. If available funding is under US$ 500 million, the launch of a dual funding pool Round will be suspended. Available funds will be earmarked for continuation of existing programs;
ii. If available funding falls between US$ 500 million and US$ 1 billion, a hybrid model may be adopted for the Round. This hybrid model could include earmarked funds for continuation of services, a more targeted by-invitation round, and/or a dual pool system (90:10) that has an individual proposal budget ceiling for the General Pool and a lower individual proposal ceiling for the Targeted Pool.

Applying Eligibility Filters: (1) History of Recent Funding

2.14 In addition to the two key elements of the new eligibility criteria under the dual funding pool system, **the PSC and PIC recommend an eligibility filter based on history of recent funding**. In its recent report on Round 10, the TRP made the following observation: "*As with Rounds 8 and 9, the TRP did not usually recommend for funding a proposal to continue, scale-up or alter an existing program that had not yet reported progress beyond a few months or had not yet been signed.*"[11] Building on recommendations from earlier Rounds, the TRP strongly recommended that before the next round, the Board clearly define the rules for applying for new funds on a repeat basis.

[10] For regional proposals that include UMICs, a majority of the countries included must be eligible to submit a single-country application to the General Pool (i.e., UMICs must have an 'extreme' or 'severe' disease burden), in order to apply to the General Pool.
[11] In Round 10, 22 proposals (out of a total of 190 proposals received) were submitted by applicants that were approved for funding in Round 9, of which 4 were recommended for funding by the TRP.

2.15 The advantages of setting an eligibility filter using a history of recent funding are that it:

i. Encourages countries to focus their attention on the effective implementation of recently approved proposals and prevents countries from wasting time and resources on developing proposals that are less likely to be recommended by the TRP;
ii. Reduces the risk of poor performance associated with low 'absorptive capacity';
iii. Provides countries with more time to develop proposals based on a holistic approach with lessons learned from ongoing grants; and
iv. Can be flexible and allows the TRP to consider specific circumstances.

2.16 ***History of recent funding*** **refers to having a Board-approved proposal with less than 12 months of grant implementation for the same component (HIV, TB, malaria or HSS). The PSC and PIC recommend that under such circumstances, new applications will not be permitted, subject to the exceptions described in 2.17.** The time frame to determine the 12-month window of ineligibility is from the date of the program start date or implementation period starting date (as applicable and as set out in the grant agreement with the Principal Recipient) to the closing date for the new proposal submission. The Global Fund Secretariat will determine which countries are ineligible by disease/HSS component prior to the launch of a Round and will make that information available to countries.

2.17 **It is recommended[12] that there be exceptions to the above eligibility exclusion if**:

i. The proposal has a different geographic coverage that was not accounted for in the most recent proposal approved by the Board; or
ii. The proposal intends to roll out new technical guidance requiring significant investment.

2.18 Applicants with a history of recent funding who wish to submit an application must demonstrate that:

i. The proposal corresponds to one of the specific circumstances described above;
ii. The need addressed in the proposal cannot be addressed through reprogramming of existing grants; and
iii. There is adequate absorptive capacity and ability to roll out the proposed new interventions.

Such potential applicants must present their concept for a new application to the Global Fund Secretariat prior to proposal development. The TRP, with input from the Secretariat, will determine whether or not the concept meets the above exceptions criteria.[13] Based on a positive outcome from this review, the country/region will be able to submit a proposal, but the final eligibility determination for the application will still be made by the TRP as part of the normal review process. The Secretariat will establish communications and a process to facilitate this review.

[12] A minority of the PSC and PIC members suggested that programmatic scope be added to the list of exceptions to the recent funding history filter, but majority felt this was not necessary.
[13] Some constituencies preferred that pre-application consultations on potential exceptional circumstances be determined by the Secretariat rather than the TRP. The Secretariat will explore an appropriate process for this with input from the TRP.

Applying Eligibility Filters: (2) Use of the OECD-DAC List

2.19 Every three years, the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development publishes a list of countries eligible for Official Development Assistance (ODA) and tracks funding flows from donor countries to eligible developing nations. In 2005, the DAC created a new set of criteria[14] for countries eligible for ODA. These guidelines mandate that for a country to be eligible for ODA, it must not be: (i) above the high income threshold defined by the World Bank; (ii) a member of the G8; or (iii) a member of the European Union, or have a firm date set for EU admission. In accordance with these guidelines, the following five UMICs are not eligible for ODA: Bulgaria, Lithuania, Macedonia, Romania, and Russia.

2.20 In 2007, the Global Fund partially integrated ODA eligibility criteria into its policies, with the stipulation that UMICs must be ODA eligible to apply for an HIV grant[15]. Thus under the current policy, Bulgaria, Lithuania, and Russia are prevented from applying for HIV grants. The other two countries are classified as having moderate or low HIV disease burden (according to the existing disease burden categories), or have no data, and are thus not eligible for HIV support from the Global Fund, irrespective of the ODA provision.

2.21 As part of the review of the Eligibility Policy, the PSC and PIC considered a number of options presented by the Working Group, ranging from eliminating the OECD-DAC filter altogether to extending it to all three diseases (see Annex 8 for details on options considered by the Working Group and the PSC and PIC in 2010). A combined subgroup of the PSC and PIC worked beyond the joint PSC and PIC meeting in March 2011 to establish a process for the affected countries to submit proposals under exceptional circumstances.

2.22 It is recommended that: **UMICs not listed on the OECD-DAC list of ODA recipients are ineligible to apply for funding for HIV, except if the application is submitted by a non-governmental organization within the country in which activities would be implemented.** UMICs not classified as ODA recipients can continue to apply for Global Fund grants for the other two diseases, provided that the country meets the disease burden threshold for eligibility.

2.23 To be eligible, such funding requests shall demonstrate that they target key services, as supported by evidence and the country's epidemiology, and are not being provided due to other (political) barriers. These extraordinary funding requests will, in the same manner as other funding requests, be reviewed for technical soundness by the TRP and approved by the Board.

2.24 When funding opportunities are made available to countries, the Global Fund will list the relevant UMICs that are not included in the OECD-DAC list but may be eligible for HIV funding through this "NGO exception".

[14] The Organisation for Economic Co-operation and Development. History of DAC Lists of aid recipient countries. Paris, France: OECD, 2010. Available at: http://www.oecd.org/document/56/0,3343,en_2649_34447_35832055_1_1_1_1,00.html (last accessed 6 October 2010).

[15] Approved at the Fifteenth Board Meeting (GF/B15/7).

PART 3: COUNTERPART FINANCING

2.25 To promote shared responsibility and accountability between the Global Fund and principal recipients, **the PSC and PIC recommend applying counterpart financing requirements for all countries, with: (i) minimum graduated thresholds across income tiers for government contributions to national disease program spending, (ii) increasing government disease program and health spending over time, and (iii) co-financing by the Global Fund of international efforts with partners to generate improved national disease and health spending data.**

Current Cost-Sharing Approach

2.26 Under the existing cost-sharing requirement, Global Fund may fund up to 100 percent of the national disease program need in LICs, up to 65 percent in LMICs, and up to 35 percent in UMICs. The cost-sharing proportion is calculated at the time of proposal submission by the applicant by measuring the share of total Global Fund resources (including from existing grants) in "total program need" over the lifetime of the proposal.

2.27 The PSC and PIC identified a number of drawbacks with the cost-sharing approach approved by the Board in 2007. First, the concept of total program need is imprecise. Second, there is no focus on a minimum contribution from domestic public resources. As a result, numbers are difficult to verify and to monitor over time, and there is no clear accountability. The TRP report on the Round 10 proposals called attention to these issues and recommended that new cost-sharing requirements be developed so that compliance can be determined both at the time of proposal submission and throughout the life of the grant.[16]

Proposed Counterpart Financing Approach

2.28 The design of the counterpart financing requirement is guided by five principles: (i) all countries contribute; (ii) feasible to implement and built on existing systems and processes, wherever possible; (iii) easily communicated; (iv) fair and transparent; and (v) predictable financing for the country. More details are found in Annex 9.

2.29 Minimum counterpart financing threshold. The proposed counterpart financing requirement introduces the concept of a counterpart financing "minimum threshold". This is the minimum level that the government's contribution to the national disease program should reach, as a share of government plus Global Fund financing,[17] starting in Round 11. Applicants must either meet this minimum threshold at the time of proposal submission, or, if the country's share is below the minimum threshold, it must develop an action plan for moving towards it. Based on an analysis of Round 8, 9 and 10 proposals (see Annex 9), **it is recommended that the minimum threshold be set at 5 percent for LICs, 20 percent for Lower LMICs, 40 percent for Upper LMICs, and 60 percent for UMICs**. These levels recognize countries' differing abilities to contribute, yet at the same time challenge many countries to raise their contributions. UMICs will need to develop plans on how counterpart financing will increase significantly during the proposal period, and transition Global Fund-supported activities to the national program.

[16] Report of the Technical Review Panel and the Secretariat on Round 10 Proposals (GF/B22/13)

[17] Government contribution: the proposed measure is the annual average of government spending in the past two years (for example, in Round 11: 2009 and 2010) and current government budget (for example, in Round 11: 2011) for the relevant disease program. Government expenditure is ideally measured as all government spending on the disease program, excluding external assistance other than loans.
Global Fund contribution: the proposed measure is the annual average of financing requested and other existing Global Fund grants for that disease, for the Phase 1 period of new proposals.

2.30 Regional proposals and non-CCM proposals will not be required to meet the counterpart financing requirement. The counterpart financing requirement will apply to all other proposals, including those with civil society as Principal Recipients. Applicants applying for HSS support (cross-cutting HSS proposal or through the Health Systems Funding Platform[18]) are required to meet the counterpart financing requirement.[19] The new requirement will take effect by Round 11 for both the General and the Targeted Pools. It will not apply retroactively.

2.31 Increasing government contributions to the disease program and health in absolute terms. Data on government contribution to HIV, tuberculosis and malaria national programs highlight the problem that some countries have reduced their government contribution over time to the national disease program, in some cases significantly. To address this problem, **the PSC and PIC recommend that as part of t**he counterpart financing policy, **governments should increase their contribution to the national disease program and overall health spending each year** to avoid displacement of government spending by external assistance. There will be reasons why some countries may not be able to do so, such as an economic crisis. In monitoring compliance with the policy, these extenuating circumstances will be considered. Furthermore, as important contextual information, governments will also be asked to report on overall public spending on health over time, as reported to the WHO. Other donor funding will be included as contextual information.

2.32 Improving expenditure data. A primary source of information for the Global Fund with respect to government contributions will be the data collection and validation efforts that WHO, UNAIDS and other partners already support, together with health expenditure data submitted to the WHO. These partners request that countries annually provide financing information, broken down by source, for the national disease programs. The technical partners specify what should be included in the numbers in order to standardize its measurement and they carry out validation of the numbers provided. Coverage of reporting has improved steadily over the past few years but further improvements are needed in the quality of data to effectively operationalize this policy.

2.33 The counterpart financing policy will build on and help strengthen these existing reporting systems. **As a requirement for counterpart financing, it is recommended that countries be asked to report government expenditure to these organizations each year, which will result in increased coverage of these reporting systems.** The numbers, once validated, will be used by the Global Fund to assess progress.

2.34 Proposals may include targeted investments to improve expenditure tracking. This could range from minimal support to help countries report the data to large disease spending assessments, as may be warranted by the country situation. **The PSC and PIC recommend that proposals should make provision for up to US$ 50,000 (per disease) to support costing studies if needed and/or requested by the TRP.** The Secretariat will also make provisions to co-finance international efforts with partners to ensure the necessary data are improved. **The PSC and PIC also recommend that the Global Fund invest through partners up to US$ 630,000 to strengthen expenditure data coverage, timeliness and quality in existing partner systems. In 2011, this will be a material budget request for the Board to approve.**

[18] Decision Point GF/B21/DP25

[19] The minimum counterpart financing threshold for HSS proposals is set at the same levels as for disease proposals and is measured similarly. Counterpart financing in the context of HSS proposals is the total of the government's contribution to all national disease programs (HIV, TB and/or malaria as applicable to a country) which have either existing Global Fund support or a funding request under consideration. Global Fund financing is the total of existing and requested funding for the applicable diseases and HSS.

2.35 Assessing progress, action plans and consequences. The Counterpart Financing policy is ambitious in that it aims to shift grants and counterpart spending over time to reach the minimum thresholds recommended by this policy. To achieve this requires clearer expectations, accountability, assessment of progress, and consequences of non-compliance at each stage. The rules will be clear with consistent thresholds, though individual country explanations will be included to ensure balanced funding decisions at TRP and grant reviews. At the time of proposal submission, countries will be required to report on their counterpart financing percentages and trends. They will provide explanations and actions plans if counterpart financing is below the minimum threshold. The action plan needs to be tailored to the country situation. Some countries may need more time to scale up contributions, depending on the fiscal possibilities in the country. For some countries facing extenuating circumstances, it may be necessary to expect very modest improvements, if any.

2.36 **The PSC and PIC recommend that if counterpart financing amounts are below the threshold or trends are declining, are not satisfactorily explained, or the action plan is not responsive to the counterpart financing requirement, the TRP can decline to make a positive funding recommendation to the Board**. In many situations, where data are not clear, the TRP will include conditionality to ensure improved measurement and/or improvements to counterpart financing during program implementation. To assist the TRP in its review deliberations, the Secretariat will provide the necessary data on financing trends by country and disease program. The TRP and the Secretariat (the latter in the case of Phase 2/periodic reviews) are requested to consider counterpart financing as a material part of their recommendations to the Board.

2.37 Progress in meeting the counterpart financing requirement will be assessed at the time of grant review, and after several years of data collection by countries. If insufficient progress is demonstrated by the applicant, the Secretariat may recommend to the Board a proportional decrease in the next commitment. Compliance or credible progress on counterpart financing requirements will become part of the TRP's review of the next proposal. This will be done to allow continuous monitoring and review as well as create positive incentives to countries to comply with this requirement.

2.38 The implementation of counterpart financing will require investments with partners in improving measurement, and the Secretariat for analysis and compliance at grant signing and review. It will be progressively monitored in proposals, grant signing and grant reviews, and incorporated in the ongoing Secretariat operating budget and policies.

Country Transitions and Graduations

2.39 In the Global Fund context, country *transitions* are movements between the different income levels, other than the high income level. Transitions are typically upward as countries' economies expand, although drops in per capita income can result in downward movements. Country *graduation*, on the other hand, refers to the upward movement of a country from UMIC to the high income level. Clear graduation and transition procedures are critical to any eligibility policy as they help ensure that applicants are able to anticipate and plan for changes in levels of available support and/or eligibility status, and that critical disease program services are sustained. Examples of these country movements between income levels are shown in Annex 10.

2.40 To avoid abrupt transitions, **the PSC and PIC recommend the use of an "early warning system"** (see Annex 11) that will rely on an analysis of annual revised estimates for countries' GNI per capita and for their projected economic growth rates. This system will help to predict which countries may transition to a higher income tier three years in advance of the next funding opportunity.

2.41 The Global Fund Secretariat will identify and inform relevant national entities and CCMs promptly of these expected transitions, which will give countries four years (including the existing one-year grace period) to prepare for a transition that may either impact their eligibility for future applications, counterpart financing requirements or the focus of their applications. If a country transitions from one income group to another during the lifetime of a grant, such as from LIC to Lower LMIC, its minimum threshold will not be reassessed until it applies again for financing from the Global Fund**. However, the PSC and PIC recommend that countries receiving an 'early warning' for a pending transition be requested to produce a clear and feasible plan to move to, or close to, the minimum counterpart financing threshold of the next income tier by the last year preceding their likely transition**. The Secretariat will closely monitor this plan, stressing that failure to effectively implement it will make it difficult for the country to meet the counterpart financing requirements for subsequent proposals. UMICs will be encouraged to increase their counterpart financing contribution to above 90 percent during the life of the grant to encourage smooth graduation from Global Fund financing.

2.42 To encourage country ownership and sustainability, it is important to recognize as a "best practice", countries that voluntarily graduate from Global Fund support even though they may continue to be eligible. It is recommended that the PSC consider ways in which such recognition could be formalized, and also examine the relationship between donations to the Global Fund and counterpart financing, stressing that donations should not be a substitute for countries reaching and surpassing the counterpart financing minimum thresholds in the new policy being proposed.[20]

PART 4: PRIORITIZATION IN A DUAL FUNDING POOL SYSTEM

2.43 Prioritization rules are applied if TRP-recommended demand exceeds available funds. These rules have been applied several times. On all occasions until now, the rules have determined *when* rather than *whether* the TRP-recommended proposals would be approved by the Board for funding.

2.44 In reviewing the prioritization rules as part of this exercise there is recognition that they are an integral part of the overall set of policies that apply across Eligibility, Counterpart Financing and Prioritization. As such they cannot be considered in isolation.

2.45 For Round 10, the prioritization rules were substantially revised[21]: (i) the role of the TRP category in prioritization ranking was changed; (ii) disease burden scores within the Composite Index were refined to make them more gradual; and (iii) a prioritization model specific to the dedicated reserve for MARPs was designed.

2.46 As discussed in this paper (see Sections 2.7—2.12) the PSC and PIC recommend establishing two funding pools (General and Targeted) designed to respond to the diversity of country situations, with the countries having the option of choosing which pool to apply to. This choice will, among other factors, be informed by a country's expected prioritization rank within the General Pool. The proposed prioritization rules are designed in the context of this dual funding pool system and build on the enhancements made in Round 10.

[20] It was also requested that the approach to countries as 'donors' be referred to the appropriate Board Committee (FAC or PSC) for review.
[21] Decision Point GF\B21\DP17

Prioritization in the General Pool

2.47 Countries with greatest need (by reference to disease burden and income) will typically access the General Pool. The proposed prioritization model in the General Pool builds on a three-part Composite Index for Prioritization comprising: country income level, disease burden and TRP recommendation category adopted by the Board for Round 10. **The PSC and PIC recommend the following**:

i. Income Tiers/Scores: Adopting the four-tiered income stratification, described in Sections 2.3—2.4 and narrowing the score differential between LIC and UMIC categories;
ii. Disease Burden: Three enhancements to the approach used in Round 10 are recommended:
    - An increase in the weight (score) given to higher disease burden levels ("high" and "severe") resulting in scores of: 'Low' = 1, 'Moderate' = 2, 'High' = 4, 'Severe' = 6
    - In addition to the four levels above, introduction of an "Extreme" disease burden category for all three diseases to recognize exceptional situations (e.g., general HIV prevalence among adults of equal to or greater than 10 percent; see also Annex 2 for extreme disease burden for TB and malaria) and giving this a scoring weight of 8.
    - Recognizing that cross-cutting HSS applications will be presented as stand-alone proposals from Round 11 (including through the Health Systems Funding Platform), the introduction of a burden indicator for HSS proposals is necessary (equivalent to the disease burden indicator used for HIV, TB and malaria proposals). The recommendation is to use the average of the respective disease burden indicators based on the diseases benefiting from the HSS proposal.
iii. TRP Recommendation Category: To be scored and reflected in the Composite Index as in the Round 10 model.[22]

2.48 In cases where there is a need to sub-prioritize proposals within a particular score (due to insufficient resources to fully fund all proposals in that score), **the PSC and PIC recommend that GNI per capita be used as the "tie-breaker", with lower GNI per capita given priority.**

2.49 Table 1 illustrates how the scoring will operate (excluding the TRP score for this analysis). For example, a UMIC with "Extreme" disease burden will have the same ranking as a "Severe" burden Lower LMIC, but would rank above Moderate and Low burden LICs. This contrasts with the Round 10 prioritization scheme which has a "Low" burden LIC outranking an "Extreme" burden UMIC. What this proposed scoring and consequent ranking achieves is a more appropriate balance between disease burden and income level, recognizing that "need" is a function of both. The result of a reliability test of this refined scoring system, using HIV for illustrative purposes, is shown in Annex 12.

[22] Category 1—Recommended for funding with no or only minor clarifications; Category 2 and 2B—Recommended for funding provided that adjustments and clarifications are met within a limited timeframe. Score of 4 for Category 1 and 2. Score of 3 for Category 2B.

Table 1. Proposal scores based on Income Level and Disease Burden*

	Income level score			
Disease burden score	**Lower income = 4**	**Lower LMIC = 3**	**Upper LMIC = 2**	**UMIC = 1**
Extreme = 8	12	11	10	9
Severe = 6	10	9	8	7
High = 4	8	7	6	Not eligible**
Moderate = 2	6	5	4	Not eligible
Low = 1	5	4	3	Not eligible

* Shaded cells reflect the combined score for a proposal

** Not eligible for the General Pool; eligible for the Targeted Pool

Prioritization in the Targeted Pool

2.50 As described in Section 2.9, individual applications within this pool will be subject to limits on proposal amount. It is hoped that these parameters, which are central to the Targeted Pool, will enable all recommended applications within the pool to be fully funded, as was the case in the Round 10 HIV MARPs reserve. However the possibility exists that demand within the Targeted Pool will exceed available funds.

2.51 The PSC and PIC noted the observation from the IAWG that a prioritization method that used "disease burden" as a parameter may not always be feasible because of the challenges of identifying disease burden indicators for the different types of interventions that might be the focus of proposals to the Targeted Pool.

2.52 The TRP will therefore be requested to prioritize proposals being recommended for funding in the Targeted Pool. This process will involve two distinct steps. As per existing Board-approved policies, the TRP will first review the proposals to determine whether they are being recommended for funding. As with other proposals, they will be assigned categories (1, 2 or 2B). Next, all proposals recommended for funding will be assigned a score, based on an agreed methodology. The review process will incorporate steps to ensure consistency of approach. For example this may will include a plenary session at which all Targeted Pool recommended proposals are assessed.

2.53 As regards TRP review modalities, this is a new process. Consequently it is expected that experiences from Round 11 will provide lessons on how the prioritization process for the Targeted Pool can be improved for future application.

Additional Considerations

2.54 Overflow from the Targeted to General Pool (or vice versa). In the event that funds available in either pool exceeds TRP-recommended proposals in that pool, **the PSC and PIC recommend that any "surplus" funds be used to meet unmet demand, if any, in the other pool**. If funds become available subsequent to initial allocation across the pools, then any further funds will be allocated in the same ratio, again subject to reassignment if demand within a pool has been fully met.

2.55 Regional Proposals. The proposed prioritization model for regional proposals will reflect which pool the application was submitted to. In deriving the income and disease burden scores, **the PSC and PIC recommend that the resulting score will be the average of the individual scores of each country included in the regional proposal**.[23]

[23] One delegation suggested that further consideration be made on the merits of a weighted average (rather than a simple average) of the scores of countries involved in a Regional proposal.

2.56 Cross-cutting HSS Proposals. It is also recommended that prioritization will be done using a three-part composite index, with **the disease burden score calculated as an average of the disease burden scores of the corresponding diseases benefiting from the HSS proposal.**

2.57 UMIC allocation as percentage of overall portfolio. Under existing policy, funding for UMICs shall not exceed ten percent of the proposal value (lifetime) of the particular Round. **It is recommended that this ten percent limit continue to apply but be limited to the General Pool.**

PART 5: DRAFT DECISION POINT GF/B23/DP8:

Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals for Funding from the Global Fund

1. The Board refers to its decisions at the Twenty-Second Board Meeting entitled "Review of the Eligibility and Cost Sharing Policy" (GF/B22/DP8), "Measures associated with funding future proposals" (GF/B22/DP25), and "Launch of Round 11, the Second Wave of National Strategy Applications and a Health Systems Funding Platform Pilot" (GF/B22/DP26).

2. The Board approves the document entitled "Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization of Proposals for Funding from the Global Fund" as set out in Attachment 1 as the new policy governing these matters with the intention that this new policy shall apply to Round 11, the Second Wave of National Strategy Applications, the Health Systems Funding Platform Pilot and future funding opportunities.

3. To give effect to the new Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization of Proposals for Funding from the Global Fund from Round 11 onwards, the Board decides as follows:

a. To revoke the current policy on Income Level and Cost-Sharing Eligibility Criteria for Proposals for Funding from the Global Fund approved during the Sixteenth Board Meeting (GF/B16/DP18, Document GF/B16/7 Revision 1, Attachment 1) as amended at the Nineteenth Board Meeting (GF/B19/D13, GF/B19/DP14, GF/B19/DP15, Document GF/B19/05, Attachment 1); and

b. To amend the Comprehensive Funding Policy and Related Board Decisions as approved at the Sixth Board Meeting (as amended at the Thirteenth Board Meeting and by GF/B15/27, GF/B20/DP9 , EDP/B21/20 and GF/B22/DP22) by deleting paragraph 8 and replacing paragraph 7 b. of the Comprehensive Funding Policy with the following new sub-paragraph as follows:

"7 b. If sufficient resources are not immediately available to approve all TRP-recommended proposals, proposals shall be prioritized in accordance with the Prioritization requirements set out in the "Policy on Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals for Funding from the Global Fund" (GF/B23/DP8)."

The budgetary implications of this decision are estimated at approximately US$ 630,000 for professional fees for partner organizations to provide support, as needed, for the collecting and reporting on spending data for Counterpart Financing requirements. This amount is not included in the 2011 Operating Expenses Budget.

Annex 1

DISEASE BURDEN INDICATORS AND SCORES RECOMMENDED BY THE INTER AGENCY WORKING GROUP

	HIV*	TB*	MALARIA* ‡
Category and Score	*HIV prevalence in population and/or at-risk populations*	*Combination of TB notification rate per 100,000 population (all forms including relapses); and add WHO list of high burden countries (TB, TB/HIV or MDR-TB burden)*	*Combination of mortality per 1000 at risk of malaria; morbidity rate per 1000 at risk; and contribution to global deaths attributable to malaria.*
Extreme = 8	HIV national prevalence ≥ 10%	TB notification rate per 100,000 ≥ 300 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥2 **OR** Contribution to global deaths ≥2.5%
Severe = 6	HIV national prevalence ≥ 2% and < 10%	TB notification rate per 100,000 of ≥ 100[§] **OR** TB notification rate ≥ 50 and < 100 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥ 0.75[§] and morbidity rate ≥ 10 **OR** Contribution to global deaths ≥ 1%[§] **OR** country with documented artemisinin resistance
High = 4	HIV national prevalence ≥ 1% and < 2% **OR** MARP† prevalence ≥ 5%	TB notification rate per 100,000 of ≥ 50 and < 100 **OR** TB notification rate per 100,000 ≥ 20 and < 50 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥ 0.75 and morbidity rate < 10 **OR** mortality rate ≥ 0.1 and < 0.75 regardless of morbidity rate **OR** contribution to global deaths ≥ 0.25% and < 1%
Moderate = 2	HIV national prevalence ≥ 0.5% and < 1% **OR** MARP prevalence ≥ 2.5% and < 5%	TB notification rate per 100,000 of ≥ 20 and < 50 **OR** TB notification rate per 100,000 < 20 and high TB, TB/HIV or MDR-TB burden country	Mortality rate < 0.1 and morbidity rate ≥ 1 **OR** contribution to global deaths ≥ 0.01% and < 0.25%
Low = 1	HIV national prevalence < 0.5% and MARP prevalence < 2.5% **OR** no data	TB notification rate per 100,000 of < 20 **OR** no data	Mortality rate < 0.1 and morbidity rate < 1 **OR** contribution < 0.01% **OR** no data

* Data sources: HIV and AIDS: UNAIDS and WHO. If data are available for most-at-risk populations (MARPs), the highest prevalence will be taken into account. Tuberculosis: WHO. Malaria: WHO

† MARP: Most-at-risk population

‡ The Secretariat will use malaria data for earlier years (2000) as recommended by WHO. In the case that a proposal is submitted from a sub-national applicant it will be scored according to incidence and mortality rates for those specific areas (and the contribution of those areas to the global burden).

§ And not covered by the criteria for the Extreme category.

Annex 2

DISTRIBUTION OF COUNTRIES BY HIV AND AIDS BURDEN AND INCOME LEVEL†

HIV	LIC		Lower LMIC	Upper LMIC		UMIC	
Extreme	Zambia Zimbabwe	Lesotho Malawi Mozambique	Swaziland			Botswana Namibia South Africa	
Severe	Burundi Central African Republic Chad Gambia, The Guinea-Bissau	Kenya Rwanda Tanzania Togo Uganda Zanzibar	Cameroon Congo (Republic of) Côte d'Ivoire Djibouti Nigeria	Angola Belize		Gabon	
High	Benin Burkina Faso Cambodia Eritrea Guinea Haiti Kyrgyz Republic Liberia Mali	Mauritania Myanmar Nepal Niger Senegal Sierra Leone Somalia Tajikistan Uzbekistan Vietnam	Bolivia Egypt Ghana Guyana Honduras India Indonesia Pakistan Papua New Guinea Paraguay Sudan North Sudan South	Azerbaijan China El Salvador Guatemala Thailand Ukraine		Argentina Belarus Brazil Bulgaria Chile Costa Rica Dominican Rep. Jamaica Lithuania	Malaysia Mauritius Mexico Peru Russian Fed. Suriname Uruguay Serbia
Moderate			Nicaragua	Georgia Tunisia		Colombia Kazakhstan	Panama Romania
Low	Afghanistan* Bangladesh Comoros Congo (DR)* Ethiopia* Korea (DPR)*	Lao (PDR) Madagascar Solomon Islands* Yemen (Rep.)*	Bhutan Iraq* Kiribati* Moldova Mongolia Philippines São Tomé and Principe* Sri Lanka Syrian Arab Republic* Timor-Leste*	Albania* Cape Verde* Armenia Ecuador Fiji Iran Jordan Kosovo* Maldives Marshall Islands*	Micronesia (Federated States of)* Morocco Samoa* Tonga* Turkmenistan* Vanuatu West Bank and Gaza*	Algeria Antigua and Barbuda* Bosnia and Herzegovina Cuba Dominica Grenada Lebanon Libya*	Macedonia FYR* Montenegro Palau Seychelles* St. Kitts and Nevis* St Lucia* St Vincent & Grenadines Turkey Venezuela

† Based on UNAIDS country data for 2009
* No data

Annex 3

DISTRIBUTION OF COUNTRIES BY TB BURDEN AND INCOME LEVEL†

TB	LIC		Lower LMIC		Upper LMIC		UMIC	
Extreme	Zimbabwe Zambia Lesotho		Djibouti Swaziland				Botswana Namibia South Africa	
Severe	Afghanistan Bangladesh Burundi Cambodia Central African Rep. Chad Congo (Democratic Republic of) Ethiopia Gambia, The Guinea-Bissau Haiti Kenya Korea (DPR) Kyrgyz Republic Liberia	Madagascar Malawi Mali Mozambique Myanmar Nepal Rwanda Sierra Leone Somalia Tajikistan Tanzania (United Republic of) Uganda Uzbekistan Vietnam Zanzibar	Bhutan Cameroon Congo (Republic of) Côte d'Ivoire Ghana India Indonesia Kiribati	Mongolia Nigeria Pakistan Papua New Guinea Philippines Sudan North Sudan South Timor-Leste	Angola Armenia Azerbaijan China Georgia Marshall Islands Micronesia (Federated States of) Thailand Tuvalu Ukraine		Belarus Gabon Kazakhstan Lithuania Peru Russian Federation	
High	Burkina Faso Eritrea Guinea Lao (PDR) Mauritania	Niger Senegal Solomon Islands Togo	Bolivia Guyana		Cape Verde Morocco Turkmenistan Vanuatu		Algeria Brazil Bulgaria	Malaysia Palau Romania
Moderate	Benin Yemen (Republic of)		Honduras Iraq Nicaragua Paraguay	Sao Tome and Principe Sri Lanka	Belize Ecuador El Salvador	Guatemala Maldives Tunisia	Bosnia and Herzegovina Colombia Dominican Republic Libya	Macedonia, FYR Panama Suriname Turkey Uruguay Venezuela
Low	Comoros		Egypt (Arab Republic of) Syrian Arab Republic Moldova*		Albania El Salvador Iran (Islamic Republic of) Fiji	Jordan Samoa Tonga West Bank and Gaza Kosovo*	American Samoa Antigua & Barbuda Argentina Chile Costa Rica Cuba Dominica Jamaica Lebanon	Mauritius Mexico Montenegro Serbia Seychelles St. Kitts & Nevis St Lucia* St Vincent & Grenadines

† Based on WHO country data for 2009
* No data

Annex 4

DISTRIBUTION OF COUNTRIES BY MALARIA BURDEN AND INCOME LEVEL†

MALARIA	LIC		Lower LMIC		Upper LMIC		UMIC	
Extreme	Burkina Faso Central African Republic Chad Congo (Democratic Republic of) Ethiopia Guinea Guinea-Bissau	Kenya Liberia Mali Mozambique Niger Sierra Leone Uganda Tanzania Zanzibar	Ghana Nigeria São Tomé and Principe Sudan North Sudan South				Namibia	
Severe	Benin Burundi Gambia, The Malawi Myanmar Senegal	Solomon Islands Somalia Togo Zambia Zimbabwe	Cameroon Congo (Republic of) Côte d'Ivoire Djibouti India		Angola		Suriname	
High	Afghanistan Bangladesh Cambodia Comoros Eritrea Lao (People's Democratic Republic)	Madagascar Mauritania Rwanda Yemen (Republic of)	Bhutan Guyana Indonesia Papua New Guinea Sri Lanka Swaziland Timor-Leste		Vanuatu		Botswana Colombia Gabon South Africa	
Moderate	Haiti Korea (Democratic People's Republic)	Kyrgyz Republic Nepal Tajikistan Vietnam	Bolivia Honduras Iraq Nicaragua	Pakistan Paraguay Philippines	Armenia Azerbaijan Belize Cape Verde	Ecuador Georgia Guatemala Iran Thailand	Brazil Costa Rica Dominican Republic Malaysia	Mexico Panama Peru Turkey Venezuela
Low	Lesotho* Uzbekistan		Egypt (Arabic Republic of)* Kiribati* Moldova* Mongolia* Syrian Arab Republic*		Albania* China El Salvador Fiji* Jordan* Kosovo* Maldives* Marshall Islands*	Micronesia* Morocco* Samoa* Tonga* Tunisia* Turkmenistan* Tuvalu* Ukraine* West Bank and Gaza*	Algeria Argentina American Samoa* Antigua & Barbuda* Belarus* Bosnia & Herzegovina* Bulgaria* Chile* Cuba* Jamaica* Kazakhstan* Lebanon* Libya* Lithuania*	Macedonia, FYR* Mauritius* Montenegro* Palau* Romania* Russian Federation* Serbia* Seychelles* St.Kitts & Nevis* St Lucia St Vincent & Grenadines Uruguay*

† Based on WHO country data for 2000, as recommended by the IAWG
* No data

Annex 5

DISTRIBUTION OF UPPER-MIDDLE INCOME COUNTRIES BY DISEASE BURDEN: ROUND 10 VS NEW ELIGIBILITY CRITERIA*

		HIV		TB		Malaria		
Extreme*	Round 10							
	New eligibility criteria*	Botswana ‡ Namibia ‡ South Africa ‡		Botswana ‡ Namibia ‡ South Africa ‡		Namibia ‡		
Severe*	Round 10	Gabon		Gabon Kazakhstan	Russian Federation	Suriname		
	New eligibility criteria*			Belarus ‡	Lithuania ‡ Peru ‡			
High*	Round 10	Argentina Belarus Brazil Chile Costa Rica Dominican Republic Jamaica	Malaysia Mauritius Mexico Peru Russian Federation† Suriname	Brazil Palau Romania		Botswana Colombia Gabon South Africa		
	New eligibility criteria*	Bulgaria †,‡ Lithuania †,‡	Serbia ‡ Uruguay ‡	Algeria ‡ Bulgaria ‡	Malaysia ‡			
Moderate **	Round 10	Colombia	Panama	Bosnia & Herzegovina Dominican Republic	Panama	Brazil Costa Rica Malaysia	Mexico Panama Peru	Turkey Venezuela
	New eligibility criteria	Kazakhstan ‡ Romania‡		Colombia ‡ Libya ‡ Macedonia ‡ Suriname ‡	Turkey ‡ Uruguay ‡ Venezuela ‡			
Low**		Algeria Antigua & Barbuda Bosnia & Herzegovina Cuba Lebanon Libya	Macedonia Montenegro Palau Seychelles Turkey Venezuela	Antigua & Barbuda Argentina Chile Costa Rica Cuba Jamaica Lebanon	Mexico Montenegro Mauritius Serbia Seychelles	Algeria Antigua & B Argentina Belarus Bosnia & H Bulgaria Chile Cuba	Dominican R. Jamaica Kazakhstan Lebanon Libya Lithuania Macedonia Mauritius	Montenegro Palau Romania Russian Fed. Serbia Seychelles Uruguay

* Countries listed under Round 10 remain eligible under the new eligibility criteria.

** Countries in gray cells (moderate and low disease burden) remain ineligible

† OECD-DAC restriction applies (see Section 2.19-2.24)

‡ New eligibility criteria moved these countries one level up compared to Round 10 criteria

DEFINITIONS OF 'UNDERSERVED AND MOST-AT-RISK POPULATIONS' AND 'HIGHEST-IMPACT INTERVENTIONS WITHIN A DEFINED EPIDEMIOLOGICAL CONTEXT' (accepted by the IAWG and TRP)

Underserved and most-at-risk populations:

Subpopulations, within a defined and recognized epidemiological context:
1) That have significantly higher levels of risk, mortality and/or morbidity;
2) Whose access to or uptake of relevant services is significantly lower than the rest of the population.

Note: HIV, TB and malaria proposals may include embedded HSS elements. The above definition is intended to capture HSS interventions that benefit 'underserved and most-at-risk populations'.

Highest impact interventions within a defined epidemiological context:

Evidence-based interventions that:
1) Address emerging threats to the broader disease response; and/or
2) Lift barriers to the broader disease response and/or create conditions for improved service delivery; and/or
3) Enable roll-out of new technologies that represent global best practice; AND
4) Are not funded adequately

Note: HIV, TB and malaria proposals may include embedded HSS elements. The above definition is intended to capture 'highest impact HSS interventions' that may be part of a disease proposal.

Cross-cutting HSS interventions addressing needs of underserved populations:

Health systems and community systems strengthening interventions that, within the country context, improve program outcomes for underserved populations in two or more of the diseases by:
1) Improving equitable coverage and uptake addressing any, and preferably all, of:
    - Availability of services
    - Access to services
    - Utilization of services
    - Quality of services

AND
2) Are not funded adequately

Note: This definition only applies to the General Funding Pool and to LICs, LMICs and severe/extreme burden UMICs. Disease-specific HSS will usually be embedded in the disease proposal.

DETERMINING THE RELATIVE SIZE OF THE TARGETED AND GENERAL FUNDING POOLS[24]

Countries with high burden relative to income (HBI countries) are generally unable to finance a full programmatic response to HIV, tuberculosis and/or malaria with domestic resources. In keeping with the principles of the Global Fund as embodied in the Framework Document, the bulk of Global Fund resources should be allocated to HBI countries through the General Funding Pool. On the other hand, there are countries with lower burden relative to income (LBI countries) that may need external aid because of concentrated epidemics and/or special situations.

Table 1 shows the percentage distribution of HBI and LBI countries in Rounds 8—10, indicating that over 80% of available Round funds for HIV and 90 percent of available Round funds for TB and Malaria were allocated to HBI countries. The range of values shown in Table 1 reflect alternative 'cut-points' for HBI classification. The lower value for the HBI portion of grants includes LICs with at least moderate disease burden as defined by IAWG, Lower LMICs with at least high disease burden, Upper LMICs and UMICs with at least severe disease burden. The upper value for the HBI portion of grants adds Lower LMICs with 'moderate' burden and Upper LMICs with 'high' burden into the HBI category. Only the HIV allocation is sensitive to this variation[25]. The minimum size of the General Funding Pool should reflect the demand in previous rounds from HBI countries—i.e., 85 - 95 percent of available resources.

Table 1. Percentage distribution of approved funds to HBI and LBI countries in Rounds 8-10, by disease component

Group	HIV	TB	Malaria
HBI countries	82.2- 90.6%	93.9 - 96.8%	94.6 - 95.2%
LBI countries	9.4 - 17.8%	3.2 – 6.1%	4.8 – 5.4%

The Round 10 MARPs Reserve was pegged at a maximum value of US$ 75 million for two years and US$ 200 million for five years—equivalent to about 9% of R10 HIV grants. From the MARPs applications, the TRP recommended 12 grants for a two-year total budget of US$ 46.9 million for 12 grants (average of US$ 3.9 million per grant (2 years) and US$ 10.9 million (5 years).

Although there was no "reserve" for at-risk populations for tuberculosis and malaria in Round 10, a review of Round 10 grants showed 4 malaria grants and 3 tuberculosis grants to LBI countries. Assuming a doubling of demand for malaria and tuberculosis proposals under a new Targeted Funding Pool (as was observed between Round 9 and 10 with the introduction of the MARPs Reserve), the projected number of grants for the three diseases would be 26. At a two-year budget ceiling of US$ 5 million each for 26 grants, the total funds needed for the Targeted Funding Pool would be US$ 130 million, and US$ 325 million for five years.

Recommendation: Set aside 10 percent of total Round funds to the Targeted Funding Pool or, if more resources are mobilized, a maximum of US$ 150 million (for two years). The maximum value for the Targeted Funding Pool would be US$ 350 million.

[24] Extract from a report from the Center for Health Decision Science, Harvard School of Public Health and the Results for Development Institute, Washington D.C.

[25] For HIV, the Lower LMI-Moderate countries are Egypt, Honduras, India, Papua New Guinea, Paraguay and the Upper LMI-High countries are Azerbaijan, Guatemala, Thailand, and Ukraine.

Annex 8

CONSIDERATIONS FOR USING THE OECD-DAC LIST AS PART OF THE GLOBAL FUND'S ELIGIBILITY CRITERIA[26]

Background

The Global Fund has already partially integrated ODA eligibility[27] into its guidelines, with the stipulation that UMICs must be ODA-eligible to apply for HIV grants. Whether or not the Global Fund should maintain, abandon, or alter this ODA restriction in the new eligibility guidelines is a subject of much debate. Although the issue was discussed during the Joint PSC-PIC Meeting in October 2010, committee members could not reach a consensus and the discussion was postponed pending further investigation by the Working Group.

At the request of the Secretariat, Results for Development (R4D) has conducted interviews with representatives of the EC, the UK, Japan, the Point Seven, and the Developed Country NGO constituencies. It is clear from these discussions that representatives remain divided on the subject of ODA eligibility. Donor countries have expressed support for extending the DAC list to the three diseases, citing the growing strain on the Global Fund's financial resources. Furthermore, many donors striving to meet an annual target of 0.7% of GNI devoted to ODA have stressed the importance of the Global Fund donations remaining fully attributable as ODA. Restrictions can be applied if the Fund gives more than 10% of its resources to non-ODA eligible countries. Currently, the Global Fund is within an acceptable range; in 2009, the Fund only gave 3% to this group.

In contrast, several constituencies feel that the OECD-DAC provision negatively affects some EU member states or accession countries relative to other UMICs. There is strong concern about extending the restriction to all three disease areas given the rising rates of MDR-TB and XDR-TB in Eastern Europe[28]. Proponents of dropping the restriction argue that both the cost burden and potential public health impacts of these epidemics, and the fact that governments in the region are not yet fully committed politically to backing strong HIV and TB efforts for highly vulnerable population groups, presents a particularly compelling case for Global Fund support.

Given the strong donor preference for the ODA restriction, rescinding the ODA clause does not seem politically feasible. Based on the constituency interviews as well as the discussions from the Joint PSC-PIC Meeting in October 2010, the following three options were offered: (1) allow ODA-ineligible countries to apply solely through non-governmental organizations; (2) maintain the status quo; and (3) apply the restriction to all diseases. The summary table below highlights the key pros and cons of each option.

[26] Extract from a report submitted by The Results for Development Institute, Washington D.C.
[27] To be eligible for ODA, a country must not be: (i) high income; (ii) a member of the EU or the G8; or (iii) have a firm date set for EU admission. If a country falls into any of these three categories, it is considered ODA-ineligible.
[28] Bulgaria, Lithuania, and Russia are all on the WHO's list of high MDR-TB burden countries.

Description	Pros	Cons
1. The NGO Compromise		
Governments of ODA-ineligible UMICs are ineligible to apply for funding. Only NGOs will remain eligible to apply as principal recipients.	• Offers a tighter restriction on ODA-ineligible UMICs. • Proponents of both positions have signaled that this is a potentially acceptable compromise. • Donors may find it more acceptable to give funds to NGOs in ODA-ineligible countries	• May be restrictive for some countries; for example, the government has historically been the principal recipient in Macedonia • Whether or not a NGO is the principal recipient is inconsequential to the .7 ODA requirements. Aid to these countries 'counts' against the restriction regardless of recipient organization • Governments will lose the Global Fund's guidance and expertise on how to combat complex health challenges, like MDR- TB
2. The Status Quo		
UMICs must be ODA-eligible to apply for HIV support; there is no TB restriction.	• Countries would still be eligible to apply for TB support. This is particularly important given the rise in MDR-TB. • Conservative with Global Fund resources, by reducing demand for HIV support • Favored option of the European Commission • May be the easiest for the Global Fund to continue the status quo on this divisive issue	• There was no explicit support for this option at the PIC PSC meeting in October 2010. • Minimal risk of the Global Fund reaching the 10% threshold for non-ODA eligible countries; currently only at 3%
3. Complete ODA Restriction*		
UMICs must be ODA eligible to apply for Global Fund support	• Supported by most donors • The Global Fund avoids the small risk of exceeding 10% non-ODA requirements	• Countries would no longer be eligible for TB support, presenting potential significant public health concerns • Affects Russia, some EU member states and other accession countries

* Note: Complete ODA restriction was the third option discussed at the first Joint PSC-PIC Meeting in October 2010. However, at the third meeting of the Joint Working Group on 28 February – 1 March 2011, the Working Group members modified the third option to complete lifting of the ODA restriction.

It is clear from the constituency interviews that this remains a divisive issue. Each concern expressed — be it in regards to financial constraints, the 0.7% target, disease burden, or political equity — is valid and defensible. Often, although a representative expressed that the official viewpoint of his or her constituency was to apply the restriction fully, he/she acknowledged that the disease burden and principles of the Global Fund warrant support.

ADDITIONAL INFORMATION ON COUNTERPART FINANCING

1 Strengths and Weaknesses of the Counterpart Financing Approach

1.1 There are several advantages to the proposed approach:

i. The Counterpart Financing requirement is holistic, in that it addresses strengthening of expenditure data, minimum government contributions vis-à-vis Global Fund contributions, and, over time, increasing government contributions to disease programs and health in absolute terms.
ii. It is also flexible, in that action plans can be tailored to recognize different country starting points and what might be achievable in that context.
iii. It engages both the Ministries of Finance and Health on the disease program (and health overall) funding dialogue.
iv. Finally, it is tailored to ability to pay, as the minimum threshold varies by income group.

1.2 The proposed approach does have challenges, which include:

i. The minimum threshold calculation excludes other donor contributions, such as PEPFAR. In some countries, these contributions can be significantly large. Information on these contributions will be requested and considered as important contextual information in the countries where this is relevant.
ii. The data strengthening efforts will require investments by countries and international organizations, including the Global Fund. In some countries the standardization and timeliness of reporting government expenditure on disease programs need to improve. At the international level, efforts for validation will need to be increased.
iii. The serious effort needed to assess country situations, action plans, and progress will be a significant demand on the TRP and Global Fund Secretariat, requiring additional resources.

These challenges can best be addressed by budgeting sufficient resources to support implementation of the Counterpart Financing requirement, by closely monitoring the implementation of the requirement, and fine-tuning its implementation as needed.

2. Analysis of Potential Minimum Thresholds for Counterpart Financing

Using information from approved grants in Rounds 8-10, minimum thresholds for Counterpart Financing were set at levels that demonstrated reasonable government contributions while at the same time minimizing the number of countries that might not reach the threshold. At the proposed set thresholds of 5, 20, 40 and 60 percent for LICs, Lower LMICs, Upper LMICs and UMICs, respectively, about 34 percent of LICs; 27 percent of Lower LMICs; 34 percent of Upper LMICs; and 58 percent of UMICs would fall below the minimum threshold (See Table below).

The highest share of countries below the proposed threshold is the UMIC category. These countries have greater ability to pay, and high Counterpart Financing requirements can help smooth the way for graduation from Global Fund support and help place programs on a path towards long-term financial sustainability.

	Proportion of approved proposals below threshold cutoffs of government contribution, Round 8-10											
	<5%	**<10%**	**<20%**	**<30%**	**<35%**	**<40%**	**<50%**	**<60%**	**<70%**	**<80%**	**<90%**	**Total (No.)**
LI	34%	54%	71%	85%	90%	91%	95%	97%	99%	100%	100%	**100% (105)**
Lower LMI	2%	6%	27%	55%	61%	73%	76%	86%	92%	100%	100%	**100% (51)**
Upper LMI	0%	0%	9%	20%	29%	34%	49%	69%	77%	97%	100%	**100% (35)**
UMI	0%	4%	8%	12%	15%	27%	35%	58%	62%	69%	81%	**100% (26)**

EXAMPLES OF COUNTRY TRANSITIONS AND GRADUATION IN PAST GLOBAL FUND ROUNDS

Transitions across income levels: Since Round 4, 17 countries have made the transition from LMIC to UMIC. Of these, eight became ineligible as a result of the disease burden filter for UMICs. Of six countries identified to move into the UMIC group in Round 11, three lack transition plans for their Global Fund-supported programs scheduled to end in 2011. Over the next five years another 18 countries are forecast to transition from LMIC to UMIC status. The 18 countries expected to move to the UMIC category over the next five years will face a new set of rules to which they will have to adjust. The same challenges will face countries transitioning from the low-income level to lower LMIC, and from lower LMIC to upper LMIC.

Graduation: Country graduation can be either automatic or voluntary. *Automatic graduation* occurs when a country is classified as high income and thus no longer eligible to apply for Global Fund financing. To date only three countries that have received grants have automatically graduated: Estonia in Round 7 and Croatia and Equatorial Guinea in Round 9. Equatorial Guinea was an exceptional case, as it moved very quickly from LIC in 2002 to HIC by 2007. *Voluntary graduation* occurs when eligible countries have chosen to self-finance their disease programs, e.g., Russia, which agreed to reimburse Global Fund grants. The Counterpart Financing requirement for UMICs is described in Section 2.29; this requirement will be used to prepare countries for financial sustainability once Global Fund grants end.

DEVELOPING AN EARLY WARNING SYSTEM FOR POTENTIAL TRANSITIONS BETWEEN INCOME LEVELS[29]

This annex outlines how the Global Fund could develop an "early warning system" on when countries would be likely to transition across income categories so that the countries and the Global Fund Secretariat can anticipate and prepare adequately for such changes well before the transitions actually occur.

Release of annual GNI per capita estimates. The World Bank releases country level GNI per capita data in early July of each year. It issues both Atlas Method and Purchasing Power Parity (PPP) estimates; the Global Fund uses the Atlas method for eligibility. The July 2010 release covered 2009 GNI per capita estimates, while the July 2011 release will cover 2010 GNI per capita estimates, the July 2012 release will cover 2011 GNI per capita and so on. The World Bank does not release point estimates of GNI per capita for all countries, generally because of lack of solid data. When this occurs, the Bank puts them in a broad income category. For the July 2010 release, some 22 countries did not have point estimates but of these, only six were Global Fund-eligible countries, namely: Haiti, Korea D.R., Myanmar, Somalia, Zimbabwe and West Bank and Gaza. The first five were categorized as LICs. West Bank and Gaza was categorized as LMIC. When countries do not have point estimates but are in the LMIC category, the Global Fund can confer with the World Bank to determine if they are lower LMIC or upper LMIC.

Release of new thresholds for income categories. At the same time as GNI per capita are released, the World Bank issues its new thresholds for LI, LMI, UMI and HI countries. Thresholds are kept constant in real terms but adjusted each year according to an estimate of international inflation. In July, shortly after the GNI per capita estimates, and new thresholds for income categories, are released, the Global Fund could calculate its Lower LMI and Upper LMI threshold and post countries by category on its website.

Access to confidential, preliminary estimates. In the past, the World Bank has occasionally shared with international partners, on request, preliminary estimates of GNI per capita two to six weeks before the official release of the data. However, in our experience, some of the preliminary estimates can change before the official release, and mistakes are corrected. With the World Bank's new Open Data Initiative, it may no longer be willing to share preliminary data in advance. At any rate, the Global Fund does not gain much from getting these preliminary numbers only a few weeks early, as some may well change.

Changes in GNI p.c. during the year. Occasionally the World Bank updates a country's GNI per capita estimate during the year which is a significant enough change that the new estimate would push the country into a different income category. While the Bank occasionally changes a country's GNI per capita estimate, *it does not reclassify countries until the next round of official GNI per capita estimates in July.*

Early warning system. The Global Fund Secretariat will periodically examine which countries are getting near the income classification upper thresholds and consider these countries "at risk" of changing income classifications in the next release of data. The Global Fund will then take the World Bank's most recent GDP real growth rate projections, which are issued twice a year, in January and in June[30], and apply the country-specific

[29] Extract from a report submitted from The Results for Development Institute, Washington D.C.
[30] See the World Bank's Global Economic Prospects reports, issued in January and June each year. These reports contain real GDP growth projections for the next three years.

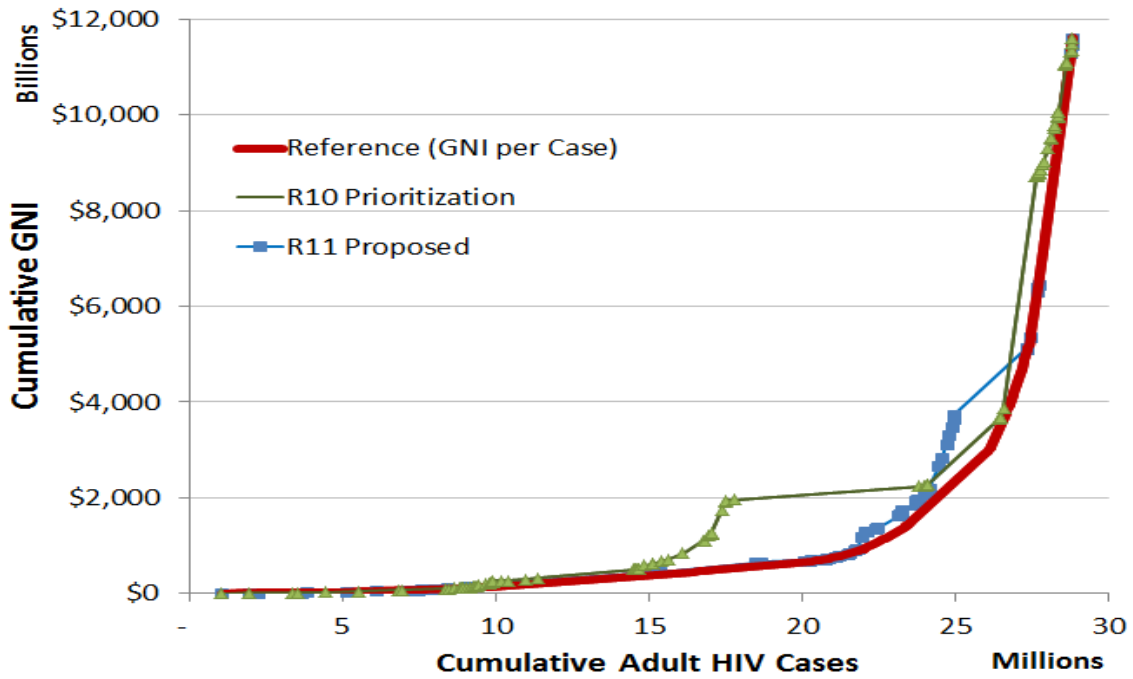
growth projections to those countries "at risk" of changing income categories, to get a sense of how quickly this might happen. Note that GDP growth projections will be applied to GNI estimates. GDP and GNI do differ. Essentially, GDP defines country income by location (what is produced in the country) while GNI defines country income according to ownership (income to nationals). For most countries (including most Global Fund-eligible countries) the numbers are usually very similar (inflows and outflows balance out). GDP growth projections will be used because GDP and GNI are usually very similar, and GDP projections are made available by the World Bank, while GNI projections are not readily available.

For example, China's 2009 GNI per capita estimate is US$ 3,620, placing it as LMIC. But with its fast income growth, it is getting close to the LMIC threshold of $3,946. The World Bank predicts that China's real GDP growth will be 10.01 percent in 2010, 8.71% in 2011, and 8.37 percent in 2012. One would apply these GDP growth rates to China's 2009 GNI (World Bank online database) to get projected GNI for 2010, 2011, and so on. And then one would divide these numbers by population projections for the relevant year (UN Population Prospects online database) to get projected GNI per capita. These calculations result in China passing the lower threshold for UMICs in 2012, with an estimated 2012 GNI per capita of US$ 4,231.

Summary of Practical Steps

1. July of each year, obtain new GNI per capita estimates from the World Bank. Calculate cutoffs for Lower LMI and Upper LMI. Post list of countries, by categories, on Global Fund website.
2. July of each year, take GDP growth projections from the World Bank's Global Economic Prospects report that is issued in June, to make GNI per capita projections for three years for countries getting close to the UMI threshold. Inform partners and countries about possible income category changes in the next 1-2 years, emphasizing that these are just "educated guesses" based on World Bank data.
3. January of each year, update GNI per capita projections using the Global Economic Prospects report issued in January. Inform countries/partners as appropriate.

TESTING THE EFFICIENCY OF THE PROPOSED PRIORITIZATION ALGORITHM[31] (EXAMPLE USING HIV BURDEN)



Arguably, the most efficient way to ensure that the neediest countries are funded would be to rank them by GNI per case. The red line shows the most efficient way to fund countries with the most need as measured by GNI per case. Moving right and up from the origin, as the resource envelope expands, more countries could be funded (i.e., more cases could be covered). The vertical axis shows the cumulative GNI of all countries funded. Scoring algorithms that produce curves farthest to the lower right (i.e. closest to the red line) give the most priority to the neediest countries—those with the least amount of GNI per case of disease.

Several scoring algorithms based on income categories and IAWG disease burden categories were considered. In all cases, it was assumed that tie scores would be broken by ranking within ties by GNI per case. The Round 10 scoring algorithm (green line) performs the worst of those considered because of the grouping of all countries with >2 percent HIV into the same category and the low weight it gives to UMICs with extremely high burden. By giving 2 additional points for HIV prevalence > 15 percent, and a 4-3-2-1 scoring for LIC—Lower LMIC—Upper LMIC—UMIC, the efficiency of prioritization improves considerably. The proposed model (represented by the blue line) correlates reasonably well with the theoretical "efficient" allocation represented by the red line. The 'reference' line (red) places no more value on an HIV case among MARPs than on a case occurring among a country's general population. Thus when judged against this 'reference', the new Prioritization Policy is somewhat less efficient at distributing resources to the countries with the most need. This efficiency loss (visible as the deviation of the blue line from the red line) is due to the implicit large relative weight given to disease prevalence among MARPs in the disease burden classifications considered in prioritization. Nevertheless, in contrast to the Round 10 scoring algorithm, the efficiency loss in the new Prioritization Policy is much smaller and appears much farther down the ranked list of countries.

[31] Extract from an analysis done by the Center for Health Decision Science, Harvard School of Public Health and the Results for Development Institute, Washington D.C.

Annex 13

GUIDANCE ON LOCATION OF OTHER ESSENTIAL INFORMATION

Attachment 1: Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization of Proposals for Funding from the Global Fund

Available at the Board Extranet