Detailed Explanation of the Allocation Methodology 2017-2019

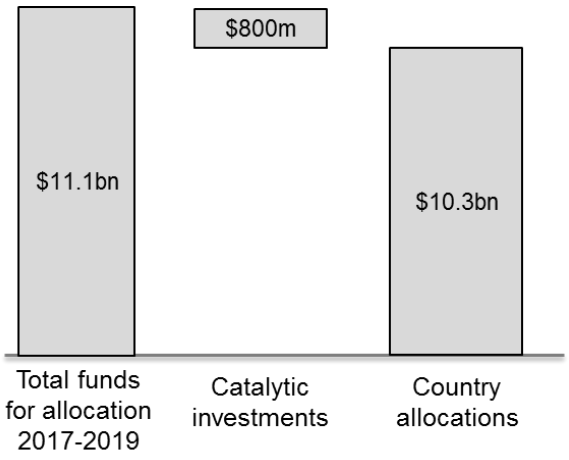
March 2017

For the 2017-2019 allocation period, the Global Fund adopted a refined allocation methodology to deliver the aims of its 2017-2022 strategy and to increase the impact of country programs that prevent, treat and care for people affected by HIV, TB and malaria and build resilient and sustainable systems for health.

The Global Fund's 2017-2019 allocation methodology does this by driving an increased proportion of funding to higher burden, lower income countries, specifically accounting for HIV epidemics among key populations, the threat of MDR-TB, and for malaria elimination efforts, while providing sustainable and paced reductions where funding is decreasing.

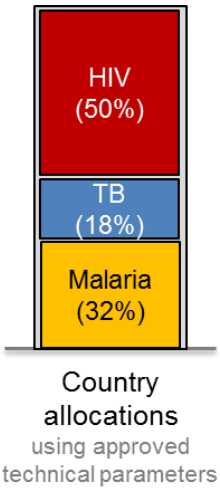
Overview

The allocation methodology is made up of two parts: country allocations and catalytic investments. Country allocations are the Global Fund's main source of funding to drive impact, comprising almost 93% of overall resources. Catalytic investments aim to catalyze the use of country allocations to achieve the aims of the Global Fund's 2017-2022 strategy and global partner plans[1]. For the 2017-2019 allocation period, the Global Fund's Board approved a total of US$ 10.3 billion for country allocations and US$800 million for catalytic investments.



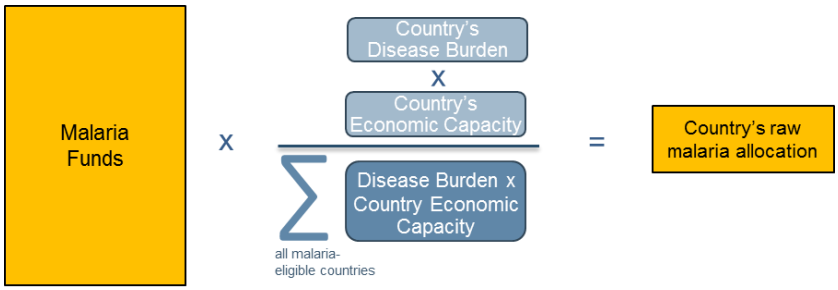
[1] UNAIDS: Fast Track: Ending the AIDS Epidemic by 2030; UNAIDS Strategy 2016-2021; WHO: The Global Technical Strategy for Malaria 2016-2030; and Stop TB Partnership: The Global Plan to End TB 2016-2020, WHO: End TB Strategy.

Country allocations



Country allocations are calculated by first dividing the total funds available (US$10.3bn) by the global disease split. This is 50% of resources for HIV, 18% for TB and 32% for malaria (although the split of resources at country level is different, as set out below).

The Global Fund's eligibility policy sets out the countries that are eligible to be calculated allocations for each disease. For all countries eligible to receive funding for each disease, their raw allocation for the disease is determined by multiplying their disease burden[2] by their country economic capacity[3]. On the recommendation of the Equitable Access Initiative, the curve that measures each country's economic capacity (based on their gross national income per capita) has been smoothened to avoid distinct thresholds as countries move between income classifications. Each country's disease burden multiplied by their country economic capacity is then divided by the sum of disease burden multiplied by economic capacity for all eligible countries, and then multiplied by the total available funding for the disease. Here is an example of how a country's raw allocation is calculated in the case of malaria:



The country's raw allocation for the disease is then adjusted to account for:

- Minimum shares (US$500,000 per disease component[4])
- Maximum shares (10% funding available for the disease; 7.5% total funding per country)
- Projections of other external financing, to help to align[5] the global distribution of resources for the disease in line with the distribution of the allocation formula

This gives an initial calculated amount for each eligible country disease program.

The initial calculated amounts are adjusted to provide scale-up for country programs that have received less funding from the Global Fund over the 2014-2016 allocation period than the formula has calculated them for 2017-2019; and to provide sustainable paced reductions for country programs that have received more funding from the Global Fund over 2014-2016 than the allocation formula has calculated them for 2017-2019. This adjustment guarantees increases

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[2] Disease burden for 2017-2019 allocation period is measured by: for HIV: the number of people living with HIV (latest available data); for TB: TB incidence + 10*MDR-TB incidence (latest available data); for malaria: [number of malaria cases]+[number of malaria deaths]+[0.05 * malaria incidence rate]+[0.05 * malaria mortality rate] (data from 2000, all indicators normalized).
[3] CEC values are between 0.95 and 0.14. In line with the recommendations of the Equitable Access Initiative, CEC values are measured by a smoothened curve, which decreases as gross national income
per capita (GNIpc) increases. For those countries with the lowest GNIpc, their CEC value is 0.95. The CEC value remains at 0.95 until just after the lower middle income threshold, where the CEC value starts to decrease gradually as GNIpc increases. This means that if there were two countries with the same disease burden, but one has a very much higher GNIpc than the other, the country with the higher GNIpc would get calculated a lower raw allocation than the one with the much lower GNIpc.
[4] Subject to assessment through the qualitative adjustment process 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.
[5] Projections are discounted by 50% for data quality, and can influence country allocations by up to 25%.

beyond 2014-2016 levels where scale-up is needed the most, and moves US$800 million towards the portfolio of country disease programs that should see more gradual decreases in their funding levels. The US$800 million is distributed between these countries in proportion to the difference between their 2014-2016 levels and their initial calculated amount, to help smoothen the reductions. After this step each eligible country disease program has been calculated their formula-derived amount.

Qualitative adjustment process

As the final step, the formula-derived amounts are refined through a transparent and accountable qualitative adjustment process approved by the Global Fund's Strategy Committee. The qualitative adjustment process aims to maximize the impact of Global Fund resources in line with the 2017-2022 strategy by accounting for 1) the needs in specific epidemiological contexts that are insufficiently reflected in the allocation formula's technical parameters; and 2) a single, holistic adjustment to account for all additional country-specific contextual considerations, including potential for impact and potential for absorption. The process is carried out under the oversight of the Global Fund's Strategy Committee and takes place in two stages:

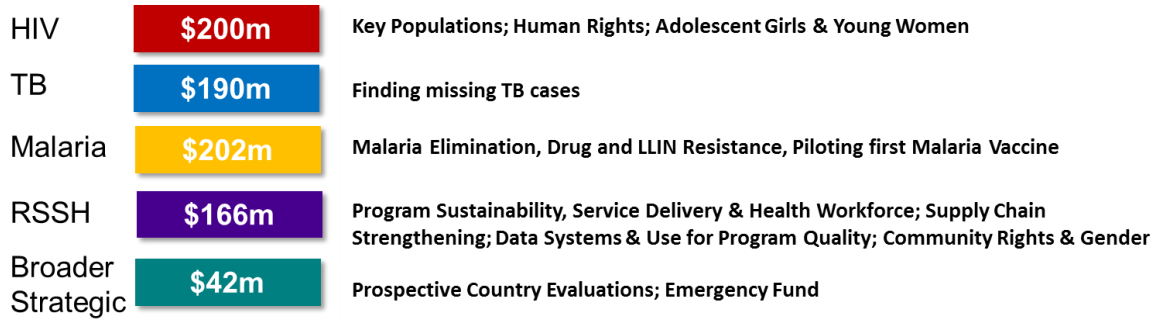
Stage 1: an analytical adjustment is made to increase HIV formula-derived amounts where there is evidence of high burden of HIV among key populations in countries with concentrated or mixed HIV epidemics, using data for UNAIDS. Using data from WHO, an adjustment is also made to improve the consistency of funding in settings with low endemicity malaria, to both continue funding elimination efforts and to ensure that no country gets a disproportionate allocation where there is very little malaria burden in absolute terms. For the 2017-2019 allocation period it was not possible to have an adjustment for populations disproportionately affected by TB, however this is will be pursued in advance of the next allocation period.

Stage 2: to account for other country-specific considerations and to further maximize the impact of Global Fund resources, a single, holistic adjustment is considered for each formula-derived amount. This holistic adjustment is carried out by a small, consistent panel under the oversight of a moderator, to ensure the process is carried out consistently across countries. The panel's decision considers predominantly each country disease program's potential for impact in line with global partner plans and each country disease program's potential to absorb the funds calculated, as well as a number of contextual considerations (including coverage gaps, past impact and risk environment) and supportive information (including trends in programs' domestic and external resources, program efficiencies, sustainability and transition, buying power and the cost of continuing essential programming).

This process results in final allocations calculated for each eligible country disease program. The total funding for a country is the sum of the final allocations calculated for each of its eligible disease programs. This final amount is communicated to the country in the allocation letter. During concept note development, countries are encouraged to adjust the disease split of their allocation to best address their needs and to fund investments to build resilient and sustainable systems for health.

Catalytic investments

Catalytic investments serve the critical role of catalyzing country allocations to ensure they achieve the aims of the Global Fund's 2017-2022 strategy and global partner plans. The catalytic investment priorities for 2017-2019 are:



The catalytic investments priorities will be operationalized by one of the following approaches, as appropriate to meet their aims:

- *Matching funds* to incentivize the programming of country allocations
- *Multi-country funding* to address critical, global multi-country challenges
- *Strategic initiatives* to provide funding for initiatives that are critical to support the success of country allocations but cannot be funded through country grants

Together with countries' domestic financing and other external resources, the allocation methodology for 2017-2019 and the funds raised through the Global Fund's 5th replenishment will enable increased impact, progress towards achieving the global goals for HIV, TB and malaria and the building of resilient and sustainable systems for health.